Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 4421

Please reply to:
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Trust Management
Maidstone Hospital
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Maidstone
Kent
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Email: mtw-tr.foiadmin@nhs.net

18 March 2019

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Pharmaceutical samples.

You asked:
1) Please confirm if the Institution accepts pharmaceutical samples of licensed medicines (i.e. sample packs provided free of charge)?
2) If it does, please confirm whether the Institution also accepts "cold chain" samples? If it does, is there any restriction on pack size?
3) Does the Institution have a formal policy relating to the receipt of samples in either of the above cases? If yes, please can you provide an electronic copy of this policy?
4) Excluding samples, are there any other circumstances or criteria under which the Institution would accept free of charge licensed medicines?

Trust response:

1) As part of DTMMC governance, the Trust will accept free samples of licenced medicines if an application has been submitted to use that product by a consultant and DTMMC has agreed that trialling that product would be appropriate. In practice this hardly ever happens – we generally get no free of charge samples
2) If the request met DTMMC guidance we would include cold chain samples
3) Please see page 14 of the following policy.

Medicines Policy and Procedure

Requested/ Required by:	Medicines Management Committee
Main author:	Chief Pharmacist **Contact details:** mildred.johnson@nhs.net
Document lead:	Medical Director
Directorate:	Diagnostics & Pharmacy
Specialty:	Pharmacy
Supersedes:	Medicines Policy and Procedure (Version 6.0: February 2013) Medicines Policy and Procedure (Version 6.1: July 2013)
Approved by:	Trust Standards Committee, April 2015 (Version 7.0)
Ratified by:	Policy Ratification Committee, 7th May 2015 (Version 7.0)
Review date:	May 2018

Document history

Requirement for document:	To comply with legal requirements and good practice in medicines management
Cross references:	The Medicines Act 1968, The Misuse of Drugs Act 1971, the Misuse of Medicines Regulations 1973 and subsequent amendments to these. It also reflects the recommendations made in the Safe and Secure Handling of

	Medicines: A Team Approach, Duthie Report, 2005. Other related guidance that has been used in developing this document are: • Audit Commission, 2001 *A Spoonful of Sugar - Medicines Management in NHS Hospitals*. London: Audit Commission. • Department of Health. (2000). *Pharmacy in the Future - Implementing the NHS Plan*. London: Department of Health. • Department of Health. (2003). *Medicines Management in NHS Trusts: Hospital Medicines Management Framework*. London: DoH. • Department of Health. (2004). *Building a Safer NHS for Patients: Improving Medication Safety. A Report by the Chief Pharmaceutical Officer*. London: Department of Health. • Department of Health and NHS Practitioner Programme, 2006. *Medicines Matters - A Guide to Current Mechanisms for the Supply, Prescribing and Administration of Medicines*. London: Department of Health. • Department of Health. (2006). *Final Guidance Safer Management of Controlled Drugs (CDs) Changes to Record Keeping Requirements*. London: Department of Health. • Department of Health. (2007). *Safer Management of Controlled Drugs (1) Guidance on Strengthened Governance Arrangements*. London: Department of Health. • *Health and Social Care Act 2001*. London: The Stationery Office • Healthcare Commission. (2007). *The Best Medicine: The Management of Medicines in Acute and Specialist Trusts*. London: Commission for Healthcare Audit and Inspection. • *The Controlled Drugs (Supervision of Management and Use) Regulations 2006. SI 2006/3148*. London: The Stationery Office. • National Patient Safety Agency, Rapid Response Report (2010) Safer administration of insulin NPSA/2010/RRR013 • National Patient Safety Agency, Patient Safety Alert (2011) The adult patient's passport to safer use of insulin, NPSA/2011/PSA003 • NHS Improvement, Patient Safety Alert (2016), Risk of severe harm and death due to withdrawing insulin from pen devices NHS/PSA/W/2016/011
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Serious Incidents (SI) Policy and Procedure* [RWF-OPPPCS-NC-CG23] • Maidstone and Tunbridge Wells NHS Trust. *Medicines Reconciliation Guidelines* [RWF-OPG-CSS1] • Maidstone and Tunbridge Wells NHS Trust. *Intrathecal chemotherapy policy and procedure, Safe administration of* [RWF-OPPPCSS-C-PHAR3] • Maidstone and Tunbridge Wells NHS Trust. *Operational Discharge Policy and Procedure* [RWF-OPPPES-C-AEM6] • Maidstone and Tunbridge Wells NHS Trust. *COSHH, Control of Substances Hazardous to Health Policy and Procedure* [RWF-OPPPCS-NC-CG16] • Maidstone and Tunbridge Wells NHS Trust. *Non-Medical Prescribing Policy and Procedures* [RWF-OPPPCSS-C-PHAR8] • Maidstone and Tunbridge Wells NHS Trust. *Non Medical Prescribing Database* [RWF-OPF-CSS-C-PHAR1] • Maidstone and Tunbridge Wells NHS Trust. *Unlicensed medicines and licensed medicines for unlicensed use, Use of* [RWF-OPG-CSS3] • Maidstone and Tunbridge Wells NHS Trust. *Patient Group Directions (PGDs),*

	Policy and Procedure for Development and Implementation [RWF-OPG-CSS6] • Maidstone and Tunbridge Wells NHS Trust. *Oral/enteral syringes for the administration of liquid medicines and enteral feeds, Policy and Procedure, The use of PURPLE plunger* [RWF-OPPPCSS-C-PHAR5] • Maidstone and Tunbridge Wells NHS Trust. *Medication not available flowchart* [RWF-OPPM-CSS1] • Maidstone and Tunbridge Wells NHS Trust. *Self-Administration of Medicines by Patients, Guidelines for the* [RWF-OPG-CSS2] • Maidstone and Tunbridge Wells NHS Trust. *Controlled Drugs in Wards and Departments, Management of* [RWF-OPG-CSS5] • Maidstone and Tunbridge Wells NHS Trust. *Controlled Drugs in Operating Theatres, Management of* [RWF-OPG-CSS4] • Maidstone and Tunbridge Wells NHS Trust. *Incident Management Policy and Procedure* [RWF-OPPPCS-NC-CG22] • Maidstone and Tunbridge Wells NHS Trust. *Potassium chloride and other strong potassium containing solutions, Management of Strong (Policy and Procedure)* [RWF-OPPPCSS-C-PHAR6] • Maidstone and Tunbridge Wells NHS Trust. *Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas* [RWF-OPPM-CSS2] • Maidstone and Tunbridge Wells NHS Trust. *Aseptic Non Touch Technique (ANTT) Policy and Procedure* [RWF-OPPPCSS-C-PATH5] • Maidstone and Tunbridge Wells NHS Trust. *Analgesia, Adult Patient Controlled (PCA): Clinical Practice Guidelines* [RWF-OPPPPS-C-TIO4] • Maidstone and Tunbridge Wells NHS Trust. *Risk Management Policy and Strategy* [RWF-OPPPCS-NC-CG13] • Medusa Injectable Medicines Guide – via Trust intranet • Maidstone and Tunbridge Wells NHS Trust *Critical Medicines List (Loading doses) [RWF-OWP-APP300]* • Maidstone and Tunbridge Wells NHS Trust *Critical Medicines Mist (Missed doses) [RWF-OWP-APP299]* • Maidstone and Tunbridge Wells NHS Trust *Antibiotic Lock Therapy [RWF-OPG-CSS19]* • Maidstone and Tunbridge Wells NHS Trust *Guidelines for management of acute pan in patients with history of substance abuse [RWF-OPPPPS-C-TIO11]* • Maidstone and Tunbridge Wells NHS Trust *Adult Conscious Sedation Guidelines* [RWF-OPG-PS2] • Maidstone and Tunbridge Wells NHS Trust *Thalidomide Policy [RWF-OPPPCSS-C-PHAR7]* • Maidstone and Tunbridge Wells NHS Trust *Oral Anti-cancer Medicines [RWF-OPPPCSS-C-PHAR4]* • Maidstone and Tunbridge Wells NHS Trust. *Pathway for use of insulin needles or syringes [RWF-OPPM-ES18]*

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Initial document	November 2003
2.0	Update	November 2005
3.0	Update	November 2007
4.0	Update	January 2009

Version control:		
Issue:	**Description of changes:**	**Date:**
5.0	Update	February 2011
5.1	Added Appendices 6 and 7	January 2012
6.0	Review and update	February 2013
6.1	Added 3 appendices (RWF-OPPM-CSS2, RWF-OPG-CSS4, RWF-OPG-CSS5)	July 2013
7.0	The areas that have been updated : • Use of digital locks for storage of drug keys and on cupboards. • Expanded information on fridge security and temperature monitoring. • Reference to Pharmacy Returns Bins for secure return of medicines to pharmacy. • Reference to escalating concerns over unusual, excessive or inappropriate prescribing.	May 2015
7.1	• Added a further appendix - Record sheet for wards to use to monitor their fridge temperatures	June 2015
7.2	Updated section 7.3 on Verbal Orders	January 2016
7.3	Updated section 7.3 on Verbal Orders	July 2016
7.4	Amended contact details on front page	October 2017
7.5	Updated associated documents Updated section 6.2 – Record date when a digital lock code is changed Updated section 10.8 – Advice on safe administration of insulin following the Patient Safety Alert NHS/PSA/W/2016/011	November 2017

Policy statement for

Medicines Policy

This policy is designed to inform and direct the practice of all staff involved with the storage, supply, security, prescription and administration of medicines and related substances.

This policy has been compiled by the Chief Pharmacist in conjunction with the Medicines Management Committee and after consultation across Maidstone and Tunbridge Wells NHS Trust (called 'the Trust' from now onwards).

The policy and procedures cover the prescribing, ordering, storage, security, and administration of medicines and therefore forms an important part of the Trust risk and medicines management strategy.

The policy takes into account the requirements laid down by the Medicines Act 1968, The Misuse of Drugs Act 1971, the Misuse of Medicines Regulations 1973 and subsequent amendments to these. It also reflects the recommendations made in the Safe and Secure Handling of Medicines: A Team Approach, Duthie Report, 2005. It should be read in conjunction with any medicines related guidelines from individual professional organisations and it supersedes all predecessor organisation medicine policies. It will be subject to review every three years.

Medicines Procedure

Contents **Page**

1.0 Introduction and scope

Purpose of the document

This policy and procedures have been compiled by the Chief Pharmacist in conjunction with the Medicines Management Committee and after consultation across Maidstone and Tunbridge Wells NHS Trust (called 'the Trust' from now onwards).

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The policy and procedures takes into account the requirements laid down by the Medicines Act 1968, The Misuse of Drugs Act 1971, the Misuse of Medicines Regulations 1973 and subsequent amendments to these. It also reflects the recommendations made in the Safe and Secure Handling of Medicines: A Team Approach, Duthie Report, 2005. It should be read in conjunction with any medicines related guidelines from individual professional organisations and it supersedes all predecessor organisation medicine policies. It will be subject to review every three years.

This policy and procedures applies to all individuals who deal with medication throughout the Trust. Temporary staff are subject to this policy in the same capacity as permanent staff. Responsibility for medicine management is an integral part of the day to day responsibilities of every member of Trust staff who contributes in any way to the care of patients being treated with medicines. Failure to adhere to this policy may result in disciplinary action.

This policy/procedures and its appendices plus all supplementary policies, procedures and guidelines mentioned are available on the Trust approved document management database (Q-Pulse).

2.0 Definitions

'Medicines management' - a system of processes and behaviours that determines how medicines are used by the NHS and patients.

3.0 Duties

The responsibilities of the various practitioners associated with the prescribing, ordering, dispensing, storing and administration of medicines are as follows:

- The Trust Chief Pharmacist has an overall responsibility for establishing and maintaining a system for medicines management across the Trust. This is in consultation with appropriate senior medical, nursing and other healthcare practitioners.
- In most situations medical practitioners are responsible for prescribing medicines for patients. They, and any other authorised prescriber, must comply with legislation and this policy when performing these duties.

- The Appointed Practitioner in Charge of a ward or department is ultimately accountable for the stock of all medicines held and is responsible for ensuring that medicines policies and procedures are followed correctly and that the security of medicines is maintained. They are also responsible for ensuring that all members of staff, including new starters, bank and agency staff are aware of and follow this policy accordingly.
- The Registered Nurse in Charge of a ward or department is responsible for the stock of medicines held in the ward or department and for ensuring that stocks of controlled drugs, if held, correspond with the details shown in the register. The administration of medicines is also the responsibility of the Registered Nurse in Charge of the ward or department who may delegate these duties to a Registered Nurse, but who must exercise supervision as is necessary. The Appointed Practitioner in Charge (if not the same person) is responsible for ensuring that the above are carried out.
- Authorised Pharmacy Staff are responsible for the stock of medicines held in the pharmacy, their procurement, manipulation and preparation into user ready presentations and for their supply to wards and departments. They are also responsible for advising on the safe, effective and economic use of medicines. These responsibilities include advising practitioners on the storage of medicines in clinical areas. Authorised Pharmacy Staff may inspect the stocks of medicines held on the ward or department at any time to ensure the medicines are in date and stored under proper security, legal and environmental conditions.
- Practitioners in training must be given every opportunity to become proficient in medicines related activities under appropriate supervision. The Supervising Practitioner has responsibility for medicine procedures at such times.
- The responsibilities for medicines procedures that may be held by various grades of practitioner are indicated in this document. Practitioners must be aware of the tasks they may or may not be permitted to perform.

4.0 Training / competency requirements

A Training Needs Analysis for the Medicines Policy and Procedure is attached as **Appendix 4**.

5.0 Purchasing, ordering and supply of medicines

[For ordering, supply and delivery of controlled drugs – see Section 9.0]

5.1 Purchasing and procurement of medicines

The purchasing and procurement of all medicinal products must be under the control of the Chief Pharmacist and carried out under the supervision of a registered pharmacist from one of the Trust Pharmacy Departments.

Medical, nursing or other non-pharmacy staff are not permitted to undertake contracting or tendering for, or purchasing of, medicines intended for administration to service users of the Trust.

It is standard practice within NHS Hospitals to substitute branded products with generic equivalents when appropriate. The quality of these medicines is of prime importance and is controlled through the pharmaceutical contracting and purchasing procedures. If there is a problem with the quality of a medicine it must be reported promptly to the local pharmacy department and they will decide if any further action needs to be taken. A national network for reporting and disseminating drug defects exists to ensure patient safety.

All orders for the purchasing of medicines will be authorised by an approved signatory in line with Trust Standing Financial Instructions (SFI).

For orders in excess of £25k the Chief Pharmacist and two named deputies will have the authority to certify individual orders of medicines in agreed categories up to a value of £100k. These orders must be restricted to medicinal products subject to a completive tender completed by the Trust, the Regional Procurement Hub, the NHS Commercial Medicines Unit or a comparable organisation. Alternatively the product must be subject to an agreed national NHS price or pricing framework. Individual orders for medicines in excess of £100k must be countersigned in accordance with limits in section 3.3.4 (f) of the Trust SFIs.

5.2 Order and supply of stock medicines

Ward stocks are defined by the stock list of each individual clinical area. The stock list consists of those items in regular use within the clinical area together with items held for use in emergency situations. The stock list is reviewed regularly and agreed between the ward manager and the technician or pharmacist. Stock is issued from pharmacy following topping-up to the agreed stock levels.

If additional stock is required between top-ups this can be arranged via the ward pharmacist or by completing the ‘Ward Stock Requisition Book’ and taking the order directly to Pharmacy.

For planned replenishment of ward stock by pharmacy staff i.e. ‘top-up’, the following system will operate: -

a) the ward/department will be visited by a pharmacy assistant or technician on a regular basis to check the stock and replenish the required items up to the agreed stock limits;
b) the stock will be delivered to the ward or department along with a record of each item delivered;
c) a registered member of the ward nursing staff will oversee the checking of items received against the delivery note, sign it and return it to the pharmacy. If two people are involved both should sign the delivery note. Any discrepancy should be reported to the pharmacy as soon as possible.
d) Stock should be put away in the appropriate locked areas as soon as possible.

5.3 Order and supply of non-stock medicines

The procedure for obtaining non-stock medicines will differ depending on whether the ward in question is visited by the Clinical Pharmacy Teams.

5.3.1 For wards which are visited by Clinical Pharmacy Teams
From Monday to Friday, 9am till 5pm, these wards are covered by local 'clinical teams'. Should a patient be newly written up for a non-stock medicine, the ward should bleep the appropriate clinical team who will attend the ward and arrange supply.

5.3.2 For wards which are not visited by Clinical Pharmacy Teams
In most cases these wards have a traditional ward pharmacist visit at regular, known times throughout the week. During this visit, the ward pharmacist will check the prescription charts and organise which non-stock medicines will need to be supplied. If a dose of the drug is required before the ward pharmacist is due to visit, the chart can be taken directly to pharmacy for that medicine to be supplied where it considered safe and practical to do so.

5.3.3 For supply of non-stock medicines to either type of ward out of normal pharmacy working hours see Section 5.6.

5.4 Medicines for discharge (eDN)

Discharge prescriptions are 'written' using the electronic discharge notification (eDN) system. The procedure for having discharge prescriptions (eDNs) dispensed will depend on whether the ward is visited by the Clinical Pharmacy Teams. It is the responsibility of the nurse overseeing the discharge of the patient to ensure that the patient has been given **all** of their medicines from e.g. locker, fridge etc. to take home and to check these are correctly labelled for that patient according to the discharge prescription.

5.4.1 For wards which are visited by Clinical Pharmacy Teams

From Monday to Friday, 9am till 5pm, these wards are covered by local 'clinical teams'. If an eDN is 'written' and ready for dispensing, the ward should bleep the appropriate clinical team as soon as possible, and they will attend the ward and arrange for the discharge supply.

5.4.2 For wards which are not visited by Clinical Pharmacy Teams
As soon as possible after the eDN is completed by the doctor, the patient's prescription chart plus all the patient's medicines from the POD locker, fridge etc must be taken to Pharmacy so that the eDN can be checked and dispensed.

An indication to the pharmacy of when the patient is due to leave is essential to prioritise eDNs.

5.5 Compliance devices

Compliance devices ('Nomads') are aids used for unit dose dispensing in order to assist patients to comply with medication intake.

Compliance devices brought in with the patients will not be used during admission, as it is not possible to easily verify the identity of each item included in the packaging. An exception to this is packaging where each blister contains a single medicine dose only and is clearly labelled with the medicine name, dosage etc., e.g. Boots MDS system.

A one week supply of medicines in a compliance aid may be supplied by pharmacy to patients on discharge from hospital in the following circumstances, only:

- the patient has been using a compliance device prior to admission, will be self-medicating in their own homes post discharge, (i.e. not a nursing home), and will obtain continuing supplies from their community chemist.
- the patient has not been using a compliance device prior to admission but has been assessed during current admission as requiring a compliance device, either by care agency or is self-medicating in their own homes post discharge, and who will obtain continuing supplies from their community chemist

The assembling of discharge prescriptions in a compliance device is a very time consuming task with significant risks inherent in the process. In order to minimise these risks, the Pharmacy Departments must have 24 hours notice if a discharge prescription is to be dispensed in a compliance device. In addition, discharge prescriptions cannot be dispensed in a compliance device on Saturday mornings or by an on-call pharmacist out of hours.

5.6 Out of hours supply / emergency cupboards

When the pharmacy is closed, a selection of medicines may be obtained from the local pharmacy 'emergency cupboard' in accordance with the individual procedures defined at each site. In each case the senior nurse or site bleep holder is the first point of contact.

When a medicine is required out of hours and is unavailable in the emergency cupboard, the doctor or the site bleep holder may contact

the ‘on-call’ pharmacist through the switchboard in order to obtain supplies.

5.7 Supply of medicines to Outpatients and A&E Departments attenders

Medicines for patients attending outpatient clinics or A&E departments must be written on a hospital outpatient prescription form or the appropriate A&E form and always dispensed by Pharmacy during normal working hours. In some departments FP(10)HP (green) prescriptions may be given to patients which can be dispensed at a local chemists shop. When the pharmacy is closed, other arrangements apply. Relevant departments will be issued with specially pre-packed, labelled containers to meet these needs.

In all cases the medicines must be prescribed on: a hospital outpatient prescription form, the appropriate A&E form or eDN. Medicines supplied under a Patient Group Direction (PGD) must be recorded on a PGD supply form. When no pharmacy service is available, the doctor, or qualified healthcare professional working under an authorised PGD (see Section 7.15) must take responsibility for the supply of the medicines.

5.8 Collection of NHS prescription charges

The Trust must comply with Regulation 5(1) of the NHS (Charges for Drugs and Appliances) Regulations 2000 which states that medication taken away from hospital premises should have an NHS prescription charge levied. The exceptions to this are for discharge medication and those items used to treat cancer, tuberculosis and genito-urinary medicine patients. Medicines administered on hospital premises are not charged for.

Certain categories of patients receive medication to self administer at home prior to a diagnostic test, treatment or procedure. Examples include bowel preparations used the evening before a colonoscopy, pre-op drinks and antibiotics prior to a urological scan. The NHS prescription charge will not be levied in these circumstances, because the medication facilitates the patient's visit as an Outpatient/Day Case.

All other patients, including Accident & Emergency and Day Surgery must pay unless they hold a valid exemption.

5.9 Inter-ward borrowing

Medicines should only be obtained from other wards in an emergency.

In the case of a non-Controlled Drug, the ward/department manager must be alerted to the nature and quantity of the medicine that is being given out so that they are aware of the legitimate removal of that medicine from the ward.

This information may have to be passed from shift to shift. The details should also be noted on the Ward Pharmacy Requisition Sheet for pharmacy information and costing purposes.

Medicines must not be transferred from one container to another container or receptacle. When residual stock is insufficient for the day's requirement, a replacement stock should be obtained. Whole packs to be transferred only i.e. not just individual (unlabeled) strips of tablets.

For inter-ward borrowing of Controlled Drugs, see Section 9.16.

5.10 Transfers of medicines with transferred patients

When a patient is transferred from one ward to another within the Trust, it is the responsibility of the nurse in charge of the sending ward to ensure that any medicines in the patient's medicines locker and any medicines not available on the receiving ward are transferred securely with the patient. This includes medicines brought into hospital by the patient, non-stock and non-formulary items dispensed for that patient. Out of hours it should also include items that are stock on the sending ward but non-stock on the receiving ward.

(Order the stock medicines from the sending ward on a pharmacy requisition form. Return the requisition form to pharmacy on the next working day to allow stock replacement and reconciliation of charging information.)

The medicines should be transferred separately, **not** mixed with the patient's property. The transferring nurse should hand the medicines to the receiving nurse **in person**.

5.11 Patients' own drugs

The Trust encourages the system of using Patients' Own Drugs (PODs) during an inpatient stay and on discharge. However, the use of PODs must be strictly controlled and only used under specific circumstances. Section 8.6 details the procedures to follow in using PODs and checking the suitability of the PODs for use. It is normally the responsibility of the pharmacy technician or ward pharmacist to check the validity of the PODs. PODs are patient's personal property and must not be used for another patient.

5.12 Cardiac arrest boxes

For clinical emergencies, all wards and relevant departments will be supplied with a 'cardiac arrest box' from Pharmacy. These boxes are tamper-evident and have clearly defined expiry dates. They should not be held in a locked cupboard but at agreed strategic and readily accessible sites in case of emergency.

Once a box has been opened or reached its labelled expiry date, a replacement should be sought from Pharmacy as soon as possible.

5.13 Medicine labels

All containers must only be labelled by pharmacy. The label on the container should be clear and distinct. Labels must not be altered. If the label is illegible, defaced or becomes detached the container must be returned to the pharmacy or be given to the ward pharmacist and a replacement obtained. Medicines labelled for a specific patient must not be used for other patients – a separate supply must be arranged. Pre-pack medicines for use in e.g. A&E departments may have the name of the patient added in the designated space on the label.

5.14 Clinical trials medicines

Where the Local Research Ethics Committee has approved a clinical trial, supplies of the trial material will be issued from the pharmacy by the same procedure as for other dispensed medicines.

Where a patient is transferred or admitted already on a trial medicine initiated outside the Trust, pharmacy staff will ensure the trial details are investigated.

5.15 Pharmaceutical samples

Under no circumstances should members of staff accept pharmaceutical samples from a medical representative.

If medical representatives offer to leave pharmaceutical samples they should be referred to the local Pharmacy Department. Any member of staff receiving pharmaceuticals directly from representatives without the agreement of the Chief Pharmacist may be subject to disciplinary action.

6.0 Security, storage and transport of medicines

6.1 Security of medicines

There must be strict control on the use of all medicinal products to ensure that products are managed carefully and that there is no misuse or theft.

All medicines for use in wards / departments should be stored in separate lockable cupboards, trolleys, bedside medicine lockers or refrigerators. These storage places must be kept secured and any keys kept by the nurse, midwife, radiographer or ODP in charge of the area. This person is responsible for the medicines' cupboards and their contents and has the right to challenge access by other personnel.

In the event of an apparent loss of a drug, the Practitioner in Charge must immediately inform the Nurse Manager on duty or Site Co-ordinator and immediately take action to investigate the loss. If, after the initial investigation theft or fraud is suspected, then the Nurse Manager or senior nurse on duty must take action within the procedure laid down by the Trust on the reporting of a loss or theft.

An adverse incident form (e-reporting) must be completed and further action determined jointly with senior colleagues. The local Pharmacy Manager must be informed and a decision taken whether to inform the Chief Pharmacist and/or the Chief Nurse.

Any staff involved who are anticipating absence in the next 24 – 48 hours must prepare and submit a statement to the investigating manager before leaving work.

If the loss is considered serious the 'Serious incident (SI) policy and procedure' will be followed and, in most cases, the police involved.

In addition to loss, any concerns about unusual, excessive or inappropriate prescribing of medicines should be escalated as above.

6.2 Keys

Keys to the medicines cupboards, trolleys and refrigerator on a ward or department must be held by the registered practitioner in charge of the ward for that shift unless they have been handed to another qualified nurse to undertake medicines administration or an authorised member of pharmacy staff to order supplies of medicines. The keys must be handed over to the registered practitioner in charge at the end of each shift.

As the level of delegation relating to access to the general medicines cupboard and the controlled drug cupboard are different, the controlled drug cupboard keys must be kept on a separate ring of keys from the general medicines cupboard keys.

The use of digital key locks is permissible on wards and departments to store non-controlled drug cupboard or fridge keys or as locks on cupboards. Suitable safeguards should be in place to ensure the key code is; available only to those delegated members of staff with permissible access, the code is changed regularly (at least every six months), and a record is kept of the date of the last code change.

The pharmacy department keeps spare keys for all medicine cupboards and trolleys. 24-hour access to these keys is available through the appropriate site manager. It is the responsibility of the clinical area's manager, however, to ensure that the keys are kept up to date and that pharmacy receives a copy of any new drug cupboard keys fitted.

If any of the ward medicines keys are missing:

- Make a thorough search of the clinical area.
- Check whether someone from the previous shift has taken the keys home.
- Contact the bleep holder (out of hours – the site practitioner) to report the loss and for access to the spare set of keys.
- Complete an e-incident report.
- If the keys cannot be located, contact security (or porters) and consider contacting the police. If the keys remain missing for longer than 24 hours, contact Estates department to arrange to have all the medicine locks changed. A spare set of the new keys must be sent to the pharmacy department.

6.3 Medicines cupboards

Medicines must be stored securely in the appropriate location on each ward or department. All cupboards must comply with current national standards (this is currently BS2881 (1989) – NHS Estates Building Note No 29) or be authorised as being suitable. Controlled drugs must be stored in a suitable cupboard that meets the requirements of the 'Misuse of Drugs (Safe Custody) Regulations 1973'.

These cupboards should be used only for the storage of medicines and no other purpose. Internal and external medicines should be stored separately.

6.4 Medicines trolleys

When the medicines trolley is not being used for a medicine round it must be locked and secured to a fixed point or parked in a locked cupboard or room. An unlocked or open trolley must never be left unattended.

Medicines must not be kept on the bottom shelf of the trolley when it is not in use.

6.5 Medicines refrigerators

6.5.1 Medicines refrigerators must be kept locked either with a key or digital lock.

6.5.2 Refrigerators for storing medicines and vaccines must be maintained at a temperature of 2°C - 8°C.

6.5.3 All refrigerators used for storing vaccines and/or other medication must have an integral or separate thermometer to continuously record its temperature and must ideally have an audible alarm to alert staff if the temperature goes out of range.

6.5.4 Thermometers/fridges should be serviced and re-calibrated annually.

6.5.5 The ward/department manager must ensure the refrigerator is cleaned internally regularly. An approved cool box or alternative refrigerator should be used to store medicines/vaccines during cleaning of the refrigerator

6.5.6 No food or drink other than a small stock of nutritional supplements or pro-biotic drinks should be stored in a medicines refrigerator.

6.5.7 Refrigerators must have a switchless socket or a cautionary notice attached to the plug/socket to prevent accidental interruption of the electricity supply.

6.5.8 Refrigerator temperatures must be checked and recorded on a daily basis. The actual temperature at the time of monitoring and the minimum and maximum temperatures since the last record should be recorded. A pre-printed record form is available for use. See **Appendix 10.**

6.5.9 The thermometer MUST be reset after the temperatures have been recorded.

6.5.10 Any deviations from the range should be reported to the pharmacy department or EME and appropriate action taken and documented on the temperature recording form.

If the temperature excursions are regular, inform the nurse in charge/head of department, EME and the Pharmacy.

If the temperature excursion is sudden, notify the EME immediately for advice on action to be taken.

Spare fridges will normally be available at all times via EME (in and outside normal hours)

6.5.11 Further information regarding the stability of the medication can be obtained from Pharmacy Medicines Information department.

6.6 Patients' own drugs

Patients' own drugs (POD) must be stored in the bedside medicine lockers where these are available. These bedside lockers must be kept locked and the keys held by a qualified nurse. If the patient is participating in a self-administration scheme the patient may hold the locker key.

Where bedside lockers are not available, patients own medicines should be stored in a secure cupboard set aside for this purpose.

If patients bring in Controlled Drugs, these must be stored in the Controlled Drugs cupboard and a record kept of their receipt on to the ward.

6.7 Storage of medicines and other pharmaceutical supplies

6.7.1 Medicines must be stored in locked cupboards, grouped separately in the following categories: -

a) Solid oral preparations e.g. tablets and capsules
b) Liquid internal preparations
c) Small volume injections e.g. ampoules and vials
d) External medicines e.g. lotions and creams
e) Controlled drugs.

Where space does not allow for a separate 'external medicines' cupboard, these preparations must be kept separately from internal preparations e.g. on lower shelves.

Separate locked storage must also be provided for diagnostic reagents and disinfectants.

Intravenous fluids, dialysis fluids and sterile topical fluids and dressings should be stored in an area away from public access; this does not have to be lockable. However ready mixed infusion bags (containing drugs e.g. metronidazole, bupivacaine etc.) should be stored in locked cupboards.

Medicines must not be stored under sinks.

6.7.2 Medicines required in an emergency for cardio–pulmonary resuscitation (CPR) are exempt from the requirements for drugs to be stored in a locked cupboard. They must however be stored in a manner designed to ensure their safekeeping using tamper evident seals – see Section 5.12

6.7.3 Oral medicines that are in current use (with the exception of controlled drugs) may be stored in the medicine trolley. Stock medicines that are not in use should be removed from the trolley and stored in the appropriate cupboard.

6.7.4 Cupboards, lockers, trolleys and refrigerators designated for the storage of medicines and other pharmaceutical supplies must on no account be used for the storage of food, drink, valuables or other items.

6.7.5 Medicines brought into hospital by the patient (PODs) and medicines dispensed by the hospital for that sole patient's use can be stored in the bedside medicine lockers.

6.7.6 Stocks of flammable liquids should be kept to a minimum. Bottles should be stored securely closed. Lids should be replaced immediately after use. Flammable liquids should be stored on the bottom shelf of a medicines cupboard, away from naked flames and electrical appliances.

6.7.7 For storage of Strong Potassium Chloride Injection please refer to the specific policy available on Q-Pulse.

6.7.8 Injectable cancer chemotherapy medicines will be prepared on an individual basis prior to their immediate use, therefore no injectable cancer chemotherapy medicines should be prepared outside pharmacy.

6.7.9 When transferring patients within and between hospitals, the registered health care professional is accountable at all times for the security, safe administration and recording of all medicines on the prescription chart during the transfer.

6.7.10 All medicines and pharmaceuticals stored on the wards must have expiry dates checked regularly. In areas that are topped-up by a pharmacy assistant or technician, the expiry date will be checked by the pharmacy assistant or technician. In areas that are not topped-up e.g. certain departments, Controlled Drug cupboards, then the responsibility for the expiry dates lies with the ward/department manager.

6.8 Transport of medicines

Transport and distribution systems must provide adequate security for medicines, consistent with efficient use of resources. All medicines must be transported from the pharmacy in sealed tamper evident containers, locked boxes or via the Trust secure pneumatic tube system. Bags and boxes must not be left unattended during transit.

Medicines delivered to wards and departments in sealed bags will be signed for at the time of sealing within the pharmacy and signed for on collection by ward staff to ensure that the contents of the sealed bag have not been tampered with during transit.

Medicines returned to pharmacy must be locked into the pharmacy box or locked in a medicines cupboard and returned via ward top up technician/assistant or pharmacist.

Authorised clinical staff are permitted to collect medicines from the Pharmacy Departments where appropriate. Any non clinical staff or contractors who transport medicines must be authorised by the Trust. Medicines transported by non clinical staff must be in tamper evident or locked containers. The pharmacy department has the right to ask for identification if they do not recognise somebody who wants to pick up medication.

Any refrigerated items must be transported in such a way that the cold chain is not interrupted.

6.9 Disposal / return of unwanted or expired substances / medicines

6.9.1 All unwanted or expired medicines should be returned to the pharmacy for disposal or re-issue as appropriate. These should be placed in the designated 'Pharmacy Returns Units' for safe storage on the ward prior to return to Pharmacy; except for controlled drugs and re-usable fridge items. These must be stored in an appropriate cupboard or fridge until they can be handed directly to a member of the Pharmacy staff for return to Pharmacy. The 'Pharmacy Returns Units' must only be used for medicines and must never be used for clinical and general waste, blood products, patients' property (apart from PODs) etc.

6.9.2 Pharmacy staff are responsible for emptying the returns units on a regular basis and taking the returned medicines back to Pharmacy. Procedures will be in place for the sorting of returned medicines in Pharmacy departments which allow for the reuse of medicines where it is safe to do so and for the safe and legal disposal of the remainder.

6.9.3 The destruction of these medicines must be arranged with contractors approved by the Trust and licensed under the Hazardous Waste Regulations. Such medicines must be disposed of in accordance with the Regulations and Trust policy "COSHH, Control of Substances Hazardous to Health Policy and Procedure".

6.10 Storage of vaccines

6.10.1 Vaccines must be refrigerated immediately on receipt in the ward / department medicines refrigerator. This refrigerator must be secured and maintained as detailed in section 6.5.

6.10.2 Vaccines should be stored in the original packaging and protected from light.

6.10.3 A designated person or deputy within each department must be responsible for receipt and storage of vaccines.

7.0 Prescribing

Please note that this section EXCLUDES the prescription of INTRATHECAL chemotherapy which is subject to a separate policy.

7.1 Introduction to prescribing

7.1.1 All medication must be prescribed. This includes all oral and injectable medicines, topical or external preparations, medical gases and medicated dressings. Any over the counter or herbal medicines that it is agreed should be continued whilst somebody is on an inpatient ward must also be prescribed.

7.1.2 Some products e.g. nutritional supplements, wound care products, MRSA eradication therapy do not require to be prescribed however they should be written on the in-patient chart as a means of recording their administration. In this case they can be written on the chart either by a prescriber or an appropriate registered health care practitioner working within the area of their expertise e.g. dietician, speech and language therapist, infection control nurse or tissue viability nurse.

7.1.3 All prescriptions must be written by a registered medical practitioner or a non-medical prescriber who is registered on the Trust NMP Database on designated Trust or NHS stationery. Pharmacists may also be allowed to transcribe medicines under certain protocols and can amend prescriptions after speaking to the prescriber.

7.1.4 Patient Group Directions can be used as a means of supply and administration without a written prescription. This is not a form of prescribing but allows medicines to be given in one off situations. All PGDs used within the Trust must be written in accordance with national guidelines and approved by the Medicines Management Committee. (See Section 7.15)

7.1.5 All in-patient prescription charts will be monitored regularly by Clinical Pharmacy Teams comprising of suitably trained and experienced pharmacists and technicians. This will be carried out at ward level to avoid prescription charts leaving the ward. Prescription charts will be monitored as soon as possible after admission to ensure accuracy and reconciliation with the patient's current medication (see 'Trust Medicines Reconciliation Guidelines'), following any newly added prescription item and to reconcile with the discharge prescription at discharge.

7.2 In-patient prescribing and good prescribing practice

7.2.1 All prescriptions must be written clearly and unambiguously in black ink. Changes or alterations to the original prescription must be made by rewriting the prescription.

7.2.2 The prescription chart must clearly state (using a patient identification label where possible):

a) The patient's name and date of birth/age
b) The patient's weight and height (where appropriate)
c) The patient's NHS number and hospital registration number
d) The ward and consultant
e) Any known medicine allergies / hypersensitivities / adverse reactions

If commenced in writing all the details on the prescription chart should be completed in writing and no identification labels placed over the details.

7.2.3 The prescription must clearly have:

a) The approved name of the medicine (whenever possible)
b) The dose in metric or SI units
c) The times and routes for administration
d) The valid period
e) The signature of the prescriber and the date of the prescription

7.2.4 Medicines should not be administered or dispensed against unclear or ambiguous prescriptions. The prescriber should be asked to rewrite the prescription to make clear his or her intentions. Out of hours this is the responsibility of his or her on-call team. Pharmacists may accept a verbal order to clarify a prescription.

Where the intention of the prescriber is clear to the pharmacist, but where misinterpretation is possible, the pharmacist can endorse the prescription in such a way as to make the intention clear.

7.2.5 The names of drugs must **not** be abbreviated – common examples of abbreviations which must not be used are GTN, ISMO or $FeSO_4$.

7.2.6 The dose to be administered should be specified whenever possible, rather than the number of tablets or volume of liquid.

7.2.7 The unnecessary use of decimal points should be avoided. Where decimals are unavoidable a zero should be written in front of the decimal point, where there is no other figure.

- Quantities less than 1g must be written in milligrams
- Quantities less than 1mg must be written in micrograms
- Quantities less than 1 microgram to be written in nanograms

'Micrograms', 'nanograms', and 'units' must not be abbreviated. In particular the use of mcg, μg, ng, u, are <u>not</u> acceptable.

7.2.8 The frequency of administration must be stated. The prescriber should specify the time of administration where this is critical. In other cases the time of administration will be determined by registered nurses. A pharmacist may change times of administration, for time critical medicines, where optimal timings have not been chosen. The pharmacist will sign and date any alteration.

7.2.9 The use of a superscript zero to denote 'hourly' (i.e. 4°) is not acceptable.

7.2.10 For medicines prescribed on an as required basis the minimum interval between doses must be specified. The maximum amount that may be given in 24 hours must be specified where appropriate.

7.2.11 The route of administration must be stated. If the route is changed the prescription should be re-written. Abbreviations such as 'o' for oral are not acceptable – please write route in full.

7.2.12 Prescriptions must be signed and dated. Medical students are not allowed to sign prescriptions.

7.2.13 For treatment prescribed in courses, e.g. antibiotics, steroids, etc. the length of course must be specified.

7.2.14 Where a choice of 'as required' medicines has been given for the same indication (e.g. two analgesics), the prescriber should indicate how the choice between the two should be made.

7.2.15 Pharmacists may annotate inpatient prescriptions to clarify the prescribers intention. Minor amendments such as the timing of doses may also be made without reference to the prescriber. Any substantive changes including additions, deletions, and changes to the drug ordered, strength, dosage regime etc. must be done in consultation with the responsible medical practitioner except where specific policies are in place. Any changes or additions must be signed and dated.

7.2.16 Existing prescriptions must not be altered but should be cancelled by crossing through, dating and initialling and then rewriting the item on the chart. Sticky labels/correction fluid must not be used for altering prescriptions.

7.2.17 The prescription is valid up to three months from the date it is written, but is invalidated on discharge.

7.2.18 When there are similarly named patients on a ward, 'same name' caution labels should be affixed to the medicine chart. The label should be clearly cancelled, signed and dated when the situation changes.

7.2.19 Normally not more than **ONE** prescription chart for the same patient should be in use at the same time. When a new prescription chart is needed, all currently prescribed medicines must be transcribed by the doctor onto a new prescription chart and the entries on the old chart cancelled.

The **only** exceptions to this are:

- when a patient is on a number of drugs greater than can be prescribed on a single chart. These charts must be attached to each other to make one 'large' chart.
- intrathecal therapy,
- chemotherapy
- TPN
- saline flush chart

7.2.20 When no longer required, all prescription charts for recording medicine administration should be filed in the patient's case notes.

7.2.21 Prescribing of weekly ***oral methotrexate***, either for in-patients or out-patients, constitutes a specific hazard that has been highlighted by the NPSA. In order to reduce these hazards the following actions have been taken and specific guidance issued :

- Only 2.5mg methotrexate tablets will be stocked and dispensed from the Trust in order to avoid confusion with the 10mg tablets.
- All prescriptions must be absolutely clear that the intention is for once weekly dosage only.
- The use of 'as directed' as an instruction on prescriptions must be avoided – a specific dose must be applied to each prescription.

- Communication with GPs must be clear with respect to dosage instructions and any dose changes must be promptly reported.
- Information on the risks and benefits of the treatment must be given to the patient. Trust patient information leaflets and patient monitoring booklets should be used for this purpose and are available from the Pharmacy Departments.

7.2.22 When prescriptions for insulin are prescribed, dispensed or administered, healthcare professionals must cross reference available information to confirm the correct identity of insulin products.

7.3 Verbal orders

7.3.1 In the case of Registered Midwives, the Trust takes the view that verbal orders are **not** acceptable. Prescribers are available across the Trust for new medications that may be required. In addition, midwifery exemptions and Patient Group Directions are available to Midwives. If the required medication is not available via these methods, a prescriber should be contacted to review and prescribe for the woman or baby.

7.3.2 Verbal orders from a medical prescriber for administration of medicines may only be given to a registered practitioner in *exceptional circumstances*, and for a SINGLE DOSE only. Both the medical prescriber and the registered practitioner must agree that it is medically appropriate, safe, and in a situation where a delay in prescribing would be detrimental to the patient.

7.3.3 Verbal orders cannot be accepted for controlled drugs.

7.3.4 Any person taking a verbal order must assure themselves that they are completely sure what is required, and that the person giving the order is authorised to do so. A request to accept a verbal order may be refused if the registered practitioner feels that it compromises patient care or if they are unclear as to the directions of the medical prescriber.

7.3.5 When taking a verbal order, the registered practitioner must record all details of the order including the name of the drug, strength, form and route of administration. The medical prescriber's details must also be recorded, as well as the date and time the verbal order was taken. The registered practitioner should repeat the information back to the medical prescriber to ensure the instruction has been heard correctly.

7.3.6 In all cases, the medical prescriber must repeat the verbal order to a second member of the clinical team who must verify the verbal order by repeating all details back to the medical prescriber.

7.3.7 Where possible, the verbal order should be accompanied by either a fax or e-mail from the medical prescriber confirming the details of the verbal order which should be attached to the in-patient prescription chart.

7.3.8 Verbal orders must be documented on the in-patient prescription chart, indicating that it is a verbal order, giving the name of the authorising medical prescriber, and signed by both people taking the verbal order.

7.3.9 Medical prescribers issuing a verbal order must, for legal reasons, countersign the order, as documented on the prescription chart by as soon as possible - within four hours for a medical emergency, within a maximum of 24 hours in other cases.

If a discrepancy is discovered between the prescription and the verbal order details appropriate arrangements must be taken for the patient to be seen for assessment and an incident form completed.

7.4 Prescribing for patients being discharged from hospital

7.4.1 All discharge prescriptions (eDNs) must be 'written' using the electronic discharge notification (eDN) system. All standards of good practice for prescribing as indicated in Section 7.2 above apply to the writing of discharge prescriptions.

7.4.2 Discharge prescriptions (eDNs) must be completed by the doctor in good time, with sufficient time allowed for the eDN to be; checked by pharmacy, the patient counselled on their medicines, dispensed, returned to the ward and checked by the discharging nurse before handing to the patient. The Trust Operational Discharge Policy and Procedure states all discharge medication should be prescribed 24 hours before the planned date of discharge. In exceptional circumstances prescriptions can be written a minimum of four working hours before the planned discharge. It is the responsibility of the medical team caring for the patient to ensure that discharge is planned in a way that makes this happen.

7.4.3 The eDN must include full details of all medicines that the patient is expected to take after discharge from the hospital, including any items needed to reconstitute or dispose of medicines. The eDN must also include information for the GP on any medicines started or discontinued during the patient's admission.

7.4.4 The eDN system includes a 'supply' box which must be completed for each medicine. Prescribers are encouraged to enter 'pharmacy' for supply of all medication. The Clinical Pharmacy team will always check all medicines as part of the discharge procedure. The pharmacy team will then adjust the eDN supply for each medication to advise the discharging nurse whether the item is either; in the POD locker, the fridge, with the patient, already at home or dispensed from pharmacy on discharge. It is vital that this information is correct and checked at discharge by the discharging nurse to ensure that the patient leaves the hospital with all medication they have been prescribed on the eDN. The information is also vital to the GP for further treatment.

7.4.5 The purpose, frequency and side effects of each individual drug should be explained to the patient by the nurse or midwife discharging the patient. A pharmacist or pharmacy technician may also be involved in counselling patients on their medicines.

7.5 Out-patient prescribing

7.5.1 Patients being treated in outpatient clinics may be prescribed up to 28 days supply of medicines to take away. All standards of good practice for prescribing as indicated in Section 7.2 above apply to the writing of out-patient prescriptions.

7.5.2 Prescriptions on hospital outpatient prescription forms may only be dispensed at the hospital pharmacy, however some departments may write prescriptions on green FP(10)NC forms. These may be dispensed at any community pharmacy but can also be dispensed at the hospital pharmacy if the patient chooses.

7.5.3 Out-patient prescriptions are subject to a prescription charge for each item on the prescription unless the patient can prove his/her exemption to payment according to current Department of Health guidelines. See Section 5.8 for full details on prescription charges – other exemptions may apply.

7.6 Accident & Emergency prescribing

7.6.1 Patients being treated in Accident & Emergency can be prescribed / supplied by PGD a short term supply (up to 7 days) of medicines to take home.

7.6.2 Over-labelled packs of medicines are available in A&E for direct issue to patients by healthcare professionals operating under PGDs or for issue by prescribers out of hours. During Pharmacy opening hours, prescriptions should be dispensed at the hospital pharmacy rather than issued by the prescriber from A&E. All standards of good practice for prescribing as indicated in Section 7.2 above apply to the writing of A&E prescriptions.

7.6.3 A&E prescriptions and PGD supplies are subject to a prescription charge for each item on the prescription unless the patient can prove his/her exemption to payment according to current Department of Health guidelines. See Section 5.8 for full details on prescription charges.

7.7 Day case prescribing

7.7.1 Patients being treated in Day Case facilities can be prescribed a short term supply (up to 7 days) of medicines to take home.

7.7.2 The eDN system must be used for all discharge prescriptions following day case treatment. All standards of good practice for prescribing as indicated in Section 7.2 above apply to the writing of day case prescriptions.

7.7.3 Day Case prescriptions are subject to a prescription charge unless the patient can prove his/her exemption to payment according to current Department of Health guidelines. See Section 5.8 for full details on prescription charges.

7.8 Non-medical prescribing

Non-medical prescribing is the prescribing of medicines by nurses, midwives, pharmacists, physiotherapists, radiotherapists, podiatrists and optometrists who have successfully qualified as prescribers. The Trust encourages the development of non-medical prescribing where appropriate. Please see the Trust *Non-Medical Prescribing Policy and Procedures* for more detail. There are two main types of non-medical prescribing:

Supplementary prescribing

Nurses, pharmacists and AHPs (physiotherapists, radiotherapists, podiatrists and optometrists) can qualify as supplementary prescribers and may then prescribe all medicines in the BNF for a specific disease area *in partnership* with the patient and an independent prescriber (doctor or dentist) in accordance with a clinical management plan.

Independent prescribing

Nurses and pharmacists can qualify as independent prescribers and may then prescribe any drug for any condition *within their level of competence* from the full British National Formulary (BNF) excluding controlled and unlicensed drugs. Health visitors, district nurses and specialist community public health nurses can prescribe independently but from a *limited Formulary* (Community Practitioner Formulary).

This information is correct at the time of writing, however, this is an expanding area and changes to the range of practitioners and to the range of medicines e.g. controlled drugs will occur over time.

All issues related to Non-Medical Prescribing within the Trust is administered by the Non-Medical Prescribing and Patient Group Directions Group (NMP&PGD group), which is a sub-committee of the Medicines Management Committee. The Trust Non-Medical Prescribing Lead is responsible for updating the Trust's database of registered non-medical prescribers.

7.9 Trust Formulary

The Trust Drugs Formulary exists to promote effective, safe and cost efficient prescribing. The Formulary is maintained and updated by the Drugs and Therapeutics Committee and co-ordinated by a Formulary Pharmacist. Prescribers are asked to prescribe all medicines within the confines of the Formulary as much as possible. The prescribing of non-formulary medicines will lead to pharmacy having to contact the prescriber and result in possible delays in treatment for patients. An exception might be where a patient is admitted on a non-formulary drug but has their own supply which can be used on the ward.

Should a prescriber wish the Drug and Therapeutics Committee to consider a new drug for inclusion in the Formulary, a consultant request form can be obtained from the Formulary Pharmacist (via the local pharmacy department). Once completed, the application will be considered by the Committee and the requestor informed as soon as possible.

The Trust Drugs Formulary is now in electronic form and is available to all healthcare providers on the Trust intranet site, directly accessible from the Trust Home Page.

7.10 Generic substitution

Products should be prescribed by the approved name wherever possible. Pharmacy is authorised to operate a system of automatic generic substitution for prescribed items written for patients.

7.11 Unlicensed medicines / indications

The use of unlicensed medicines or licensed medicines for unlicensed indications has to be monitored carefully within the Trust according to strict guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA). This activity is monitored through the Drugs and Therapeutics Committee and the Pharmacy.

A separate Trust policy exists to guide prescribers in the use of unlicensed medicines/indications and this is available on Q-Pulse (see Associated Documents section).

Any prescriber wanting to treat a patient with an unlicensed medicine or use a licensed drug for an unlicensed indication should read the policy prior to doing so.

7.12 Shared care

7.12.1 In most cases, once a patient has been seen by a consultant as an in- or out-patient, transfer of care will revert back to the GP. In some circumstances, however, the consultant may seek the agreement of the GP to share care.

7.12.2 This may involve a consultant advising the GP which medicine to prescribe. When a new or rarely prescribed medicine is being recommended, its dosage and administration must be specified by the consultant so that the GP is properly informed and can monitor treatment and adjust the dose if necessary.

7.12.3 Occasions may arise when responsibility for prescribing for a patient, who is otherwise under the care of his/her GP, will more appropriately rest with a consultant e.g. clinical trial drug, the need for specialist monitoring or investigations, hospital only drugs or treatment regimes where the GP is unable or unwilling to accept clinical responsibility.

7.13 Self and family prescribing

All staff and their families should be registered with a GP. However the Trust accepts that as it may be difficult in some circumstances for some medical staff to visit their GP they may prescribe medicines for themselves or their families under the following conditions:

- The full cost of the medicines will be charged plus a dispensing charge to cover container costs etc.
- Treatment can only be for the prescriber or immediate family.
- Only medication normally held in the Pharmacy will be supplied.
- The prescriber may be asked to present current ID
- Medication should be prescribed on a hospital out-patient prescription form fulfilling all the normal legal requirements.
- A maximum of one month's supply will be dispensed.
- This is for single episode prescribing only and is not designed for regular/continued prescriptions for chronic therapy
- The following medication groups are excluded: all schedules of controlled drugs; CNS drugs e.g. hypnotics, antidepressants, anxiolytics; potent analgesics and other drugs liable to misuse.

7.14 'Sick at work' prescriptions

There is **no** facility within the Health Service to provide free prescriptions to Health Service staff, even when they are on duty. All staff and their families should be registered with a General Practitioner from whom they should receive their medical care.

It is recognised, however, that occasions may arise when provision of a short supply of medication to staff members would enable them to remain on duty, thus benefiting the Trust.

Under these circumstances only, a small supply of appropriate medication may be dispensed free of charge. This is defined as a 'sick at work' prescription and the following conditions apply:

- The member of staff must present a valid prescription signed by a doctor.
- The member of staff must present current I.D. at the Pharmacy.
- A short supply (max 5 days) may be supplied of acute medication which will allow the member of staff to remain on duty.
- If the medicine required is available for sale 'over the counter', the staff member will be expected to purchase this item (where available) rather than obtain a 'free supply' on prescription
- If a member of staff has forgotten to bring their regular medication to work and requires to take some whilst on duty, a short supply (one dose may be sufficient) can be provided. Examples may include inhalers and diabetic medication.
- The following exclusions for all 'sick at work' prescriptions are absolute: All schedules of controlled drugs; all CNS drugs e.g. hypnotics, antidepressants; potent analgesics and other drugs liable to misuse.
- Regular submission of 'sick at work' prescriptions by the same member of staff will be reported to the local Pharmacy Manager for investigation.

7.15 Patient Group Directions

Patient Group Directions (PGDs) are written instructions for the supply and/or administration of medicines in identified clinical situations. These may be appropriate for groups of patients who may not be individually identified before presentation for treatment.

The supply and administration of medicines under Patient Group Directions should be reserved for situations where this offers an advantage for patient care, without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability.

Patient Group Directions should be written in the standard format agreed by the Trust and following the Trust 'Patient Group Directions (PGDs), Policy and Procedure for Development and Implementation of' available on Q-Pulse. Each Patient Group Direction should be drawn up by a multi-disciplinary team, with input from the relevant consultant(s), pharmacist(s) and nurse/midwifery manager or other appropriate professional. All those health care professionals involved in its development must sign the completed Patient Group Direction. The appropriate Clinical Director must also sign the Patient Group Direction, on behalf of the Care Group.

All issues related to PGDs are managed by the Non-Medical Prescribing & Patient Group Direction Group. All Patient Group Directions must be approved by the Medicines Management Committee and will be authorised by the Medical Director on behalf of the Trust.

Each Patient Group Direction must be reviewed and updated at least every 2 years by a named individual.

7.16 Inappropriate prescribing

Any concerns or suspicions about unusual, excessive or inappropriate prescribing of medicines must be reported and escalated as soon as possible to the appropriate managers.

8.0 Administration of medicines

[For the Administration of Controlled Drugs – see Section 9, for the Administration of Injectable Drugs – see Section 10, for Administration of Intrathecal Chemotherapy see "Intrathecal chemotherapy policy and procedure, Safe administration of "available on Q-Pulse.]

8.1 Introduction to administration

8.1.1 All medicines should be administered in accordance with the relevant health professionals' statutory bodies.

8.1.2 The responsibility for the correct administration of medicines rests with the administering registered health care practitioner.

8.2 Authorised personnel

8.2.1 Any health practitioner whose professional body allows them to administer medicines has authorisation to undertake administration.

8.2.2 Newly qualified health care practitioners must be directly supervised by another experienced registered health care practitioner when administering medicines until they have successfully completed the Trust's document: "The Management and Administration of Medicines – Record of Learning and Supervision" and undertaken a theory and practical assessment.

8.2.3 Each clinical area will keep an up-to-date record of sample signatures and initials of staff who administer medicines.

8.2.4 Registered practitioners remain accountable for the appropriate delegation of any aspect of the administration of medicines and for ensuring that the patient, parent/carer or support worker is competent to carry out the task.

8.2.5 The competence of the support worker to whom the task has been delegated should be assessed and reviewed each year at the individual's performance review meeting. Records of the training support workers receive (regarding assisting registered practitioners in helping patients ingest medicines or help in the application of a medicinal product) and outcomes of all competency assessments should be clearly documented.

8.2.6 Student nurses are not allowed to single check medicines. Student nurses must gain experience in administering medicines (as this is an essential part of their training), but registered nurses must always directly supervise them. Both student and registered nurse must initial the patient's prescription chart.

8.3 The procedure for checking and administering medicines

Intrathecal chemotherapy must ONLY be double-checked and administered by suitably trained practitioners whose names are recorded on the Intrathecal Trust Register - see 'Safe Administration of Intrathecal Chemotherapy Policy and Procedure' on Q-Pulse.

Single checking is acceptable for most medicines, except in the case of controlled drugs, which must be double checked – see Section 9, and unless local circumstances require double-checking.

In accordance with NMC Guidelines, wherever possible, two registrants should check medication to be administered intravenously, one of whom should be the registrant who then administers the IV solution. However any health care practitioner can request to double-check any medication if he/she desires.

Prior to administering or applying a medication, if the registered practitioner obtains the assistance of a support worker (to help a patient ingest medicines or help in the application of a medicinal product), the patient's identity must be checked by both parties using the patient's identification bracelet. After positively identifying the patient, if the support worker has been assessed as competent, the support worker may administer or apply the medication without direct supervision from the registered practitioner. Once the medication has been administered or applied, the support worker must immediately report to the registered practitioner who delegated the task and the prescription chart should be initialled by both parties.

Support workers must remain under the direct supervision of registered practitioners when assisting with the administration of controlled drugs.

For all medicines:

a) Read the prescription chart carefully. If there is any doubt about the legibility of the prescription or other particulars such as dosage, route, time or frequency of the administration of the medicine, the nurse or midwife should check with the doctor concerned or the pharmacist.
b) Check that the prescribed dose has not already been administered.
c) Select the medicine required and check the following:
   - the medicine (name, strength and formulation) with the prescription
   - the calculation, if any
   - the measured dose
   - the correct time
   - the correct route
   - appropriate storage;
   - the expiry date;
   - the validity of the prescription
   - any known allergies.
d) In the case of controlled drugs, and wherever possible IV solutions, the medicines must be double checked.
e) Take the measured dose and prescription chart to the patient.

f) Positively identify in-patients by using the patient name-band. Any out-patients not wearing an identification bracelet should be positively identified by asking them to state their name and date of birth.

g) Administer the medication to the patient.

h) In the case of oral medication, ensure the medicine has been swallowed.

i) Substances prepared for administration and subsequently not used must be disposed of in an appropriately safe manner. They must not be returned to the containers from which they were removed.

j) Sign for the administration or enter the details of non-administration and sign in the appropriate place on the prescription chart. In the case of a Controlled Drug the details must also be entered in the Ward Controlled Drugs Register.

k) In cases when medicines are administered in an emergency e.g. cardiac arrest, a record of their administration is entered on the medical records as soon as possible. The cardiac arrest audit sheet must also be completed.

l) Tablets may only be crushed, or capsules opened, after prior agreement with the pharmacist. Confirmation of this should be written in the additional instruction box on the prescription chart.

8.4 Administration of liquid medicines

IV SYRINGES MUST NEVER BE USED TO MEASURE OR ADMINISTER LIQUID ORAL MEDICINES EITHER ORALLY OR THROUGH AN ENTERAL FEEDING TUBE.

A medicine cup or 5ml spoon should be used to measure and administer liquid oral medicines except in the following situations where an oral syringe is appropriate:

- The dose cannot be accurately measured using a medicine cup or a 5ml spoon i.e. the dose is not 5ml or a multiple of 5ml.
- Administration is via an enteral feeding tube
- Administration from a medicine cup or a 5ml spoon is unsuitable e.g. babies and young children.

For more information, please refer to the Trust “Oral/enteral syringes for the administration of liquid medicines and enteral feeds, Policy and Procedure, The use of PURPLE plunger” available on Q-Pulse.

8.5 Omitted or delayed doses of medicines

It is important to recognise that harm can arise from the omission or delay of the administration of a medicine and, if that medicine is critical (e.g. insulin, antibiotics, anticoagulants) the consequences can be serious or even fatal.

The Trust expects that all healthcare staff should endeavour to prescribe and administer all medicines in a timely manner. A medicine should be administered within one hour of the prescribed time (before or after).

If more than one hour has elapsed, the nurse should discuss with a prescriber at the earliest opportunity whether a STAT dose should be written and administered, or the dose can be safely missed. This discussion and the outcome should be documented in the patient's medical records.

The NPSA Alert 2010/RRR009 highlighted the risks to patient safety of omitted or delayed doses. As part of the recommendations from this document a list of 'critical' medicines where timeliness of administration is crucial has been compiled. This list is available as **Appendix 5** to this document.

It is the responsibility of the administrating healthcare professional to:

1. Document the details of any non-administration on the prescription chart using the appropriate non-administration codes, and sign.
2. Ensure that adequate supplies are obtained for subsequent doses in the event that medicines are not available on the ward for the current dose. See 'Medication Not Available' flowchart for guidance on Q-Pulse.
3. Inform the prescriber if a patient refuses a dose of medication on the 'critical list' or misses a dose (or doses) as action may need to be taken to ensure optimal treatment is maintained.
4. Escalate and document actions when a prescribed medicine has not been administered or significantly delayed.
5. Complete an incident report where considered appropriate and for all 'critical list' medicines.

8.6 The use of patients' own drugs (PODs) on wards

The Trust encourages the use of patients' own drugs during an inpatient stay and on discharge. The use of PODs, however, must be strictly controlled and only used under the circumstances outlined in the following procedures. Patients' own drugs must only be used for the patient who has brought them in – not for any other patient.

8.6.1 Use of patients' own drugs

1. At the earliest opportunity the nurse admitting the patient will ask patients upon admission if they have brought their own drugs in with them. If they have not brought them in, or they have not brought them all in, arrangements need to be made for them to be brought in.
2. The PODs will be checked for suitability to use according to the 'Validating PODs' Section 8.6.2. This can be carried out by a nurse, pharmacist or pharmacy technician using the combined suitability checklist. If a nurse carries out the initial check, a member of the pharmacy staff will carry out a second check at a later time.
3. The patient must give verbal consent for their medication to be used. A patient has the right to refuse to use their medication.
4. Any unsuitable PODs will be returned to Pharmacy for destruction after the patient or a patient's representative has given verbal consent.

5. Patients' own controlled drugs and cytotoxics will not be routinely used while in hospital. If a patient brings any of these items in, they will be returned to the patient's home or sent to the Pharmacy for destruction as appropriate.
6. Patient's own Dosette boxes or Nomad trays filled outside of the hospital will not be used. They should be returned to the patient's home or returned to the pharmacy of origin.
7. Where a suitable POD is unavailable from the patient or a new drug is prescribed, the nurse will request a new supply via the clinical pharmacy team.
8. All PODs must be stored in the patient's medicine locker except for fridge items. The ward staff and clinical pharmacy team will hold the master locker key.
9. All drug charts must be endorsed that PODs are in use for that particular drug.
10. If a patient transfers to another ward, all PODs must be transferred with the patient.
11. The PODs will be used during the patient's stay and on discharge.
12. Should a dosage change occur during the patient's stay the POD will be re-labelled by the pharmacy team as appropriate.

8.6.2 Validating PODs

PODs must only be used if they meet the following requirements:

1. For each POD the bottle/box must contain the correct drug as stated on the label. There must be only one type of medication in each bottle/box.
2. The label must be correct and contain the following information :
   - Patient's name
   - Name and strength of the medication
   - Form of the medication
   - The date dispensed (which should be within the last 12 months for blister packs and 6 months for loose tablets and liquids)
   - Directions and any additional warning labels/instructions
   - Name and address of the supplier
3. Confirmation should be obtained that suitable storage conditions have been maintained.
4. The container must be checked and assessed as suitable only if it meets the following requirements :
   - The container must be clean and intact
   - The label must be clean and legible
   - The contents must be clean and without signs of deterioration
5. The PODs must be within the expiry period. This is within the manufacturers given expiry and the PODs should have been dispensed within the last 12 months for blister packs and 6 months for loose tablets and liquids.

6. PODs must not be used in any of the following instances:
    - No label
    - Unidentifiable drugs
    - Mixed drugs in one container
    - Poor condition of preparations
    - Unsuitable containers (e.g. envelopes)
    - Unsure as to correct storage
    - Change in medication on admission
    - In compliance devices filled outside the hospital
    - More in the container than originally dispensed
    - Controlled drug or cytotoxic drug
7. If unsuitable or unsure do not use and obtain a new supply from Pharmacy.

8.7 Patient self administration of medicines

8.7.1 All professionals working in the Health Service should encourage patients to take responsibility for their own health when at home. One aspect of this is to facilitate patients to take their medicines correctly and to improve their knowledge about their medicines. Supervised self administration may be of benefit to patients and ensures that administration has taken place and the appropriate documentation has been completed by the supervising practitioner.

8.7.2 A separate Trust guideline “Self-Administration of Medicines by Patients, Guidelines for the” directs staff on best practice in relation to patient self administration.

8.8 Staff self administration of medicines

8.8.1 On no account may any member of staff take for themselves or give to any other person ward/department/pharmacy based medicines. Should the situation arise that a member of staff is unwell and requires treatment they should inform their immediate manager who will take appropriate action which may involve the A&E department or Occupational Health.

8.8.2 The Pharmacy departments on both Trust sites hold a small supply of medicines that can be purchased over the counter.

8.9 Medicines rounds

8.9.1 When medicine rounds are in progress, the nursing staff involved should not be interrupted. If a situation arises where the nurse is required, an interruption should only be made after a patient’s medicines have been administered, not during administration.

8.9.2 Should an emergency occur, e.g. cardiac arrest or fire, and disrupt the administration of a patient’s medicines, on resumption of the round any medicines already dispensed from the container should be discarded and the administration recommenced.

8.10 Children under 12 years of age

8.10.1 Medicines (except intravenous injections) may be single-checked and administered by a Registered Paediatric Nurse (RPN).

8.10.2 All other registered practitioners will double-check medicines for children with a second person who may be:

- another registered practitioner
- OR a student nurse or midwife
- OR a doctor
- OR a parent / guardian who is actively involved in the full care of the child including administration of medicines.

8.10.3 Intravenous injections for children (including within Neonatal Unit) should be checked and administered by two people, one of whom should be an RPN or a doctor/RN with appropriate experience and training in giving intravenous medicines to children. The second person may be:

- another registered practitioner
- OR a student nurse or midwife
- OR a doctor
- OR a parent / guardian who is actively involved in the full care of the child including administration of medicines.

8.10.4 Two people should check controlled drugs for paediatric patients, one of whom should be an RPN or an RN with competencies assessed by an RPN and recorded in their professional portfolio in the administration of medicines to children. The second person may be:

- another registered practitioner
- OR a student nurse or midwife
- OR a doctor

9.0 Controlled drugs

9.1 Introduction

The purpose of this chapter is to ensure the legal, safe and effective use of controlled drugs (CDs) across the Trust. This chapter has been written in line with the Government's response to the Shipman Inquiry's Fourth Report which was set out in the document '*Safer Management of Controlled Drugs'*.

9.2 Accountable Officer

The above legislation requires that the Trust appoint an Accountable Officer (AO) for CDs. The Accountable Officer is responsible for all aspects of the safe and secure management of CDs in his or her organisation. This includes ensuring that safe systems are in place for the management and use of CDs, monitoring and auditing the management systems and investigation of concerns and incidents related to CDs. The current Trust Accountable Officer is the Chief Pharmacist

9.3 Accountability and responsibility

The registered nurse or midwife in charge of a ward or department is responsible for the safe and appropriate management of CDs in that area.

Even if a theatre suite is managed by an Operating Department Practitioner (ODP), the **most senior registered nurse or midwife present** is responsible for controlled drugs under the present Regulations.

The registered nurse or midwife in charge can delegate control of access (i.e. key-holding) to the CD cupboard cabinet to another, such as a registered nurse or Operating Department Practitioner. However, legal responsibility remains with the registered nurse or midwife in charge. Whilst the task can be delegated, the responsibility cannot.

Similar considerations apply to requisitioning and checking of CDs.

9.4 Standard operating procedures

Separate Trust Standard Operating Procedures (SOPs) are in place for a) wards and departments, b) operating theatres and c) Pharmacy departments. These SOPs cover a range of activities including prescribing, requisitioning, receipt, administration and returning of CDs to Pharmacy.

The ward and theatre SOPs are available on Q-Pulse ("Controlled Drugs in Wards and Departments, Management of" and "Controlled Drugs in Operating Theatres, Management of") and should be read in conjunction with the policy statements laid out in this chapter. **See Appendix 8 and 9.**

9.5 Prescribing

Prescribing of controlled drugs will be in accordance with the Misuse of Drugs Act (1971) and its associated Regulations, and the Medicines Act (1968) Additional statutory measures for the management of CDs are laid down in the Health Act (2006) and its associated Regulations.

Procedures and legal requirements for the prescribing of CDs are laid out in the relevant SOPs available on Q-Pulse.

9.6 Requisitioning of controlled drugs

The registered nurse or midwife in charge of a ward, department, operating theatre or theatre suite is responsible for the requisitioning of controlled drugs for use in that area.

Procedures for the requisitioning of CDs are laid out in the relevant SOPs available on Q-Pulse **(see Appendix 8 and 9)**.

9.7 Delivery and transport of controlled drugs

9.7.1 Controlled drugs will be delivered to wards/departments by a member of staff authorised by the Pharmacy Department and in line with Pharmacy delivery standard operating procedures.

9.7.2 Wherever possible CDs will be delivered / transferred in a secure, locked or sealed, tamper evident container.

9.7.3 At each point where a CD moves from the authorised possession of one person to another, a signature will be obtained by the person handing over the drug and the person receiving it as a means of keeping a full audit trail. This is outlined in detail in SOPs in Pharmacy and related to requisition and receipt of CDs.

9.7.4 If Controlled Drugs are needed urgently between delivery rounds a responsible representative from the ward, nominated by the ward manager, may collect them directly from the pharmacy. In this situation a valid ID badge will be required to be displayed at the Pharmacy.

9.7.5 Delivery or transport of controlled drugs to areas outside of the Trust is detailed in the relevant Pharmacy standard operating procedures.

9.8 Receipt of controlled drugs

Procedures for the receipt of CDs on wards and departments are laid out in the relevant SOPs available on Q-Pulse **(Appendix 8 and 9)**.

9.9 Storage

9.9.1 Ward and departmental CD cupboards should conform to the British Standard reference BS2881 or be otherwise approved by the Pharmacy Department.

9.9.2 All controlled drugs must be stored in a locked cupboard which can only be opened by a person who can lawfully be in possession, such as a pharmacist or the registered nurse or midwife in charge, or a person working under their authority e.g. a pharmacy technician or ODP.

9.9.3 In certain circumstances, for example when CD discharge medicines (CDs on eDNs) are sent to the ward several hours before the patient leaves, the medicines may be stored in the CD cupboard. These medicines should be segregated from the ward CD stock.

9.9.4 General measures for the storage of CDs include the following:

- Cupboards must be kept locked when not in use
- The lock must not be common to any other lock in the hospital
- Keys must only be available to authorised members of staff and at any time the key-holder should be readily identifiable
- The cupboard should be dedicated to the storage of CDs.
- No other medicines or items should normally be stored in the CD cupboard.
- CDs must be locked away when not in use
- There must be arrangements for keeping the keys secure.

9.10 Key holding and access to CDs

9.10.1 The registered nurse or midwife in charge is responsible for the CD key.

9.10.2 Key-holding may be delegated to other suitably-trained, registered healthcare professionals but the legal responsibility rests with the registered nurse or midwife in charge.

9.10.3 As the level of delegation relating to the general medicines cupboard keys and the controlled drug cupboard keys are different, the controlled drug cupboard keys must be kept on a separate ring of keys from the general medicines cupboard keys.

9.10.4 The controlled drug key should be returned to the nurse or midwife in charge immediately after use by another registered member of staff.

9.10.5 On occasions, for the purpose of stock checking, the CD key may be handed to an authorised member of the pharmacy staff.

9.10.6 If the CD keys cannot be found then urgent efforts should be made to retrieve the keys as speedily as possible e.g. by contacting nursing, midwifery or ODP staff who have just gone off duty.

9.10.7 The senior registered nurse, midwife or matron or the duty nurse or midwife manager must be informed of any loss of keys informed as soon as possible and the duty pharmacist as soon as appropriate.

9.10.8 If the keys cannot be found then the Accountable Officer should be informed. An incident form must be completed and, depending on the circumstances, it may also be appropriate to contact the police.

9.11 Record keeping

9.11.1 Each ward or department that hold stocks of CDs should keep a record of CDs received and administered in a CD record book (CDRB). The Registered nurse or midwife in charge is responsible for keeping the CD Record book up to date and in good order.

9.11.2 The CDRB will be bound (not loose-leaf) with sequentially numbered pages and it will have separate pages for each drug and each strength, so that a running balance can be kept easily. Entries must be made in chronological order, in ink or be otherwise indelible.

9.11.3 All entries should be signed by a registered nurse, midwife or ODP. It is good practice that entries into the register are witnessed, preferably by second registered nurse, midwife or ODP. If a second registered nurse, midwife or ODP is not available, then the entry can be witnessed by another registered practitioner (e.g. doctor, pharmacist, pharmacy technician) or by an appropriately trained healthcare assistant.

9.11.4 On reaching the end of a page in the CDRB, the balance should be transferred to another page. The new page number should be added to the bottom of the finished page and the index updated. As a matter of good practice this transfer may be witnessed.

9.11.5 If a mistake is made it should be bracketed or neatly scored through in such a way that the original entry is still clearly legible. This should be signed, dated and witnessed by a second registered nurse, midwife or other registered professional or by an appropriately trained healthcare assistant. The witness should also sign the correction.

9.12 CD stationery

9.12.1 CD stationery includes:

- Controlled drug requisition books
- Controlled drug record books

9.12.2 Stocks of the above CD stationery are kept in Pharmacy Departments and can only be issued from the Pharmacy against a written requisition signed by a member of staff authorised to requisition CDs.

9.12.3 The written requisition must be written on a page of the Controlled Drug Requisition Book.

9.12.4 The registered nurse or midwife in charge is responsible for the CD stationery and all CD stationery must be kept securely on the ward, ideally under lock and key when not in use.

9.12.4 Loss or theft of any controlled stationery which may be used to order CDs must be reported immediately to the Chief Pharmacist and Accountable Officer.

9.12.5 Only one requisition book per ward or departmental area should be in use at any one time.

9.12.6 When a new CD Record Book is started, the balance of CDs in stock must be written into the new book promptly by ward staff. This transfer must be witnessed by a registered nurse or midwife or authorised member of staff e.g. pharmacy technician.

9.12.7 Completed ward CD requisition books and record books must be retained for a minimum of two years on the ward from the date of the last entry.

9.13 Controlled drug stock checks

The ward/department manager is responsible for ensuring that the stock of Controlled Drugs is checked at least every 24 hours by two registered practitioners against the record in the Controlled Drug Register and that an entry confirming that check is made in the register. Where a ward or department is only open part time e.g. weekdays only, the stock need only be checked on the days the department is open.

The entry must include the date, the signatures of both checkers and a statement e.g. '*Stocks checked and correct'*. Some areas may have a local policy for more frequent stock checks e.g. ICU, Theatres.

The stock and general security of Controlled Drugs will be checked by pharmacy staff with audit and reconciliation at least every 6 months.

If a discrepancy is discovered in the stock levels of Controlled Drugs within a ward or department, the following must be implemented:

- Inform the line manager
- If the loss is considered serious in terms of quantity, or concerns possible misuse of drugs, the Senior Nurse, or out-of-hours, the Site Practitioner responsible for the clinical area should be notified immediately.
- Investigate discrepancy e.g. re-check cupboard, check patients prescription charts, etc.
- If investigation confirms medicines are missing, inform the local Pharmacy Manager.
- Complete an e-reporting incident form and record discrepancy on record sheet.
- Any staff involved anticipating absence in the next 24-48 hours should prepare and submit a statement to the investigating manager.

In line with the Trust Incident Management Policy and Procedure and where a criminal offence is suspected, the police will be asked to investigate any loss of controlled drugs after the relevant managers have discussed this option with the Accountable Officer.

9.14 Administration of controlled drugs

Administration of controlled drugs must be double checked. Procedures for the administration of CDs are laid out in the relevant SOPs available on Q-Pulse **(see Appendix 8 and 9)**.

9.15 Management of controlled drugs brought in by patients

Controlled drugs brought in by patients should be stored in the ward Controlled drugs cupboard (and a record made of their receipt) until they can be returned home with a responsible adult or taken to the pharmacy by a pharmacist for destruction, following completion of the patient authorisation form. Removal from the ward should also be recorded.

9.16 Inter-ward borrowing

As with all other medicines, controlled drugs may not be obtained from other wards except in an emergency.

If controlled drugs are taken from one ward to be administered to a patient in another ward, an entry must be made in the Controlled Drugs Register of the ward from which the medicine was obtained, including details of the patient's name and location. A stock check on the ward from which the stock was borrowed must be completed at the end of the transaction.

9.17 Disposal of controlled drugs on wards and departments

Individual doses of controlled drugs, which are prepared, but not administered, must be destroyed on the ward in the presence of a second person who may be a pharmacist, nurse or doctor. They must not be returned to the containers from which they were removed and the details must be entered in the appropriate section of the controlled drugs record book.

Part used preparations e.g. incremental dose, part used PCA pump must be disposed of and documented in the same way as above. If a PCA dose has been prepared within e.g. Theatres and the patient transferred to a ward during the administration period, any part used preparation for disposal should be documented in a 'Destruction' section of the wards controlled drug record book.

Small amounts of CDs can be destroyed and rendered irretrievable by emptying into a sharps bin. The emptied vial or ampoule should then also be placed in the sharps bin. When the bin is sent for destruction it should be labelled "*contains mixed pharmaceutical waste and sharps – for incineration*".

All other unwanted or expired controlled drugs should be delivered securely to the Pharmacy for destruction and the action noted in the Controlled Drugs Register.

9.18 Returning controlled drugs to pharmacy

Procedures for the return of CDs to Pharmacy Departments are laid out in the relevant SOPs available on Q-Pulse **(see Appendix 8 and 9)**.

9.19 Destruction of Trust controlled drugs in the pharmacy

Any pharmacy or ward held stock of expired, obsolete, damaged or unwanted CDs can only be destroyed in the presence of an authorised person who has authority from the Trust Accountable Officer.

At Maidstone and Tunbridge Wells NHS Trust, the Trust Risk and Compliance Manager is the named authorised person delegated by the Accountable Officer to carry out this task.

All Schedule 2 and those CDs in Schedule 3 that are subject to safe custody requirements must be rendered irretrievable in the presence of the authorised person according to Pharmacy procedure CD10.

10.0 Use of injectable medicines

Please note that this section EXCLUDES the prescription, supply and administration of INTRATHECAL chemotherapy which is subject to a separate policy

10.1 Introduction

The use of injectable medication has many healthcare benefits for patients. The complexities associated with prescribing, preparing and administering injectable medicines, however, means that there are greater potential risks for patients than for other routes of administration. Weak operating systems increase the potential risk of harm and safe systems of work are needed to minimise these risks.

Further detailed clinical information on injectable medicines is available on the 'Medusa Injectable Medicines Guide' site available via the Trust intranet.

This section describes the multi-professional safer practice standards for prescribing, preparing and administering injectable medicines and has been written incorporating guidance from the NPSA 'Promoting Safer Use of Injectable Medicines' documents. *For injectable use of potassium containing solutions please also refer to the 'Potassium chloride and other strong potassium containing solutions, Management of Strong (Policy and Procedure)'.*

Section 10 is designed to refer to all injectable routes e.g. i.v., i.m., s.c. etc. (with the exception of intrathecal) however more specialist injectable routes e.g. sub-conjunctival, intra-articular etc. may be subject to more detailed policy.

A Trust Standard Operating Procedure for prescribing, preparing and administering injectable medicines in clinical areas is in place and should be used in conjunction with this policy section (see **Appendix 7** [RWF-OPPM-CSS2]). The Standard Operating Procedure "Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas" is on Q-Pulse.

10.2 Prescribing injectable medicines

10.2.1 Medicines should be given by injection only when the practicality and appropriateness of other routes of administration have been excluded. The use of this route should be regularly reviewed in favour of switching to oral administration as soon as clinically appropriate.

If there is any doubt, it is the prescriber's responsibility to consult with a pharmacist or a senior medical colleague.

Consultants must ensure that junior medical staff are fully aware of the hazards associated with injectable therapy, and must act in an advisory capacity to junior doctors and nurses in the event of problems arising.

The prescriber must write the prescribed medicine on the prescription sheet (or a readily available local protocol) in clear legible writing providing all the relevant details in accordance with the Trust Injectable Medicines Standard Operating Procedure "Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas" available on Q-Pulse (see **Appendix 7** [RWF-OPPM-CSS2]).

10.2.3 Verbal prescriptions to registered health professionals must be restricted to exceptional circumstances only and must be made and confirmed according to Section 7 of this policy.

10.2.4 When two or more prescription sheets are in use, it is essential that they are cross-referenced so that practitioners aware of *all* prescribed medicines

10.2.5 Particular care must be taken when prescribing loading doses of potent injectable medicines. The NPSA Rapid Response Alert RRR018 highlighted the risks to patient safety of prescribing complex loading doses.

As part of the recommendations from this document a list of 'critical' medicines where loading doses are recommended has been compiled to provide further guidance and information. This list is available in **Appendix 6** of this document.

10.3 Supply and storage of injectable medicines and the role of the Pharmacist

10.3.1 Ready-to-administer products will be supplied and used in preference to those needing preparation before use. The pharmacist must encourage the use of manufactured drug infusion mixtures where these are available.

10.3.2 Injectable cytotoxics and parenteral nutrition will be supplied to clinical areas only as ready-to-administer products.

10.3.3 Most injectable medicines are licensed for 'once only' use. Unless the manufacturers label specifically indicates that the injection contains a preservative, the container should only be used to prepare a single dose for a single patient on one occasion.

10.3.4 A risk assessment of all injectable medicines must be undertaken by a pharmacist and senior practitioner to determine the safest presentation and location for storage.

10.3.5 The pharmacist is responsible for providing advice and information to healthcare professionals on all pharmaceutical aspects of injectable medicines.

10.3.6 The responsibility of the pharmacist includes the monitoring of prescriptions with regard to:

- safety
- stability
- compatibility
- clinical appropriateness
- accuracy

10.4 Preparation

10.4.1 Injections should only be prepared by healthcare staff who: understand the risks involved; have been trained to use safe procedures and have demonstrated their competence for the task. Preparation should only take place if: there is a prescription; a Patient Group Direction or other written instruction; and essential information is available about the product(s) and processes needed for safe preparation and administration.

10.4.2 Healthcare staff must not prepare substances for injection in clinical areas in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence.

10.4.3 Preparation should be carried out in accordance with the Trust Injectable Medicines Standard Operating Procedure "Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas" available on Q-Pulse (see **Appendix 7** [RWF-OPPM-CSS2]).

10.4.4 Aseptic (non-touch) technique should be used during preparation and administration. Please see the Trust "Aseptic Non Touch Technique (ANTT) Policy and Procedure". Injectable medicines prepared in clinical areas should always be administered immediately after preparation. They should not be stored for a period of time before use.

10.4.5 Administration of infusions prepared in clinical areas should be completed within 24 hours of preparation. In exceptional circumstances where infusion from a single container is intended to continue for more than 24 hours, a risk assessment should be undertaken to determine the safest course of action. Every effort should be made to use a ready-to-administer product.

10.4.6 All syringes, including flushes and infusions, must be labelled immediately after preparation (or made readily identifiable) by the person who prepared them. 'Flag labelling' should be used to ensure that volume graduations on small syringes are not obscured. The only exception to this is in situations where preparation and bolus (push) administration is one uninterrupted process and the unlabelled product does not leave the hands of the person who prepared it. Only one unlabelled or readily identifiable medicine must be handled at one time.

10.4.7 Medical devices with luer connectors must be used only for preparation and administration of injections.

10.5 Administration

10.5.1 The administrator is any Trust registered health professional who has undertaken the required training in the use of safe procedures, been assessed and declared competent in the administration of injectable medicines.

10.5.2 Registered health professionals working on the Trust Bureau, via agencies, or new Trust staff declared competent to administer injectable medicines in another NHS organisation can be assessed and declared competent by the relevant ward manager or nurse in charge of the shift.

10.5.3 Unregistered professionals in training (e.g. student nurses), in order to develop their skills, may administer or assist in the administration of injectable medicines only under the direct supervision and at the discretion of an eligible registered healthcare professional who remains accountable for their delegation decision.

10.5.4 The administrator can refuse to administer a drug that he/she does not have the knowledge and competency to administer. In this instance the administrator should either discuss the situation with a more senior colleague or contact the prescriber.

10.5.5 The methods of administering *intravenous* injectable medicines may be divided into 3 main categories:

- Continuous intravenous infusion
- Intermittent intravenous infusion
- Bolus intravenous injection

Unregistered healthcare professionals in training e.g. student nurses may assist with the administration of intravenous preparations **only** under the supervision and discretion of an eligible registered practitioner (see 10.5.3 above)

To administer *continuous intravenous infusions*, the registered health professional will become competent to do so by translating the acquisition of knowledge and skills acquired in pre-registration training.

To administer *intermittent intravenous infusions* and *bolus injections* requires the registered health professional to undertake specific training to acquire the knowledge, skill and competence required.

The term 'intravenous infusion' covers the administration of fluids or blood products or drugs in large volume infusions via burettes or by the use of syringe pumps and PCA pumps.

These methods have the common feature that they do not, of themselves, require the registered health professional to be in constant attendance during administration. However, patients receiving drugs by this method do require continuing observation.

The administration of an IV bolus injection can cause a more intense adverse reaction; therefore, the registered healthcare professional must remain in constant attendance.

The *intermittent and bolus* methods require the registered health professional to adjust his/her scope of practice by developing his/her knowledge and skill to undertake the activity safely and effectively.

(a) The registered healthcare professional must be registered with the appropriate body and practising in a clinical area appertaining to their statutory qualification.

(b) All staff must have received appropriate theoretical training and have subsequently worked with a competent supervisor linking theory to good practice until such times as the health professional has been assessed and is competent to undertake the activity without supervision.

(c) The theory and practical process is recorded in the health professional's personal professional portfolio.

(d) Practice is reviewed annually during the IPR interview.

10.5.6 Administration must be carried out in accordance with the Trust Injectable Medicines Standard Operating Procedure "Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas" available on Q-Pulse (see **Appendix 7** [RWF-OPPM-CSS2]).

10.5.7 Before administration, the following must be available: a current prescription, a Patient Group Direction or other written instructions, essential technical information and a prepared and labelled injectable medicine. The patient's identity and details must be confirmed according to local policy.

10.5.8 The person administering the medicine must personally make a record of administration as soon as possible after the event. This is extremely important in circumstances such as in theatres, where the person administering the medicines may also be the prescriber and there may be no written prescription.

10.5.9 Risk assessment will have identified those products representing the highest risk to patients at the time of administration. Consideration should be given to the use of safer products and systems of administration, for example, double-checking, the use of 'smart' infusion pumps or similar rate control technologies.

10.5.10 Infusions must be monitored according to local policy to ensure safe administration of prescribed treatment.

10.5.11 A registered health professional administering medicines via the injectable route is personally and professionally accountable for maintaining safe practice. In the event of a claim of negligence made against a health professional, providing he/she has acted in accordance with this policy and the appropriate Trust Standard Operating Procedures, or can justify reasons for his/her actions for having acted outside of them, Maidstone and Tunbridge Wells NHS Trust will accept vicarious (delegated) legal liability for the registered healthcare professional's action.

10.6 Patient controlled analgesia (PCA) pumps

PCA pumps enable the patient to self-administer a measured dose of analgesia. This method of pain management is prescribed for selected patients who have received education on the use of PCAs. The prescribed analgesia is loaded into the pump in the Recovery Room or ward clinical area; the pump is then controlled by the patient.

Registered health professionals preparing PCA pumps in Recovery and other clinical areas must have previously undertaken the training to include administration of drugs via the intravenous route (bolus). For more detailed information please refer to the Trust PCA Guidelines "Analgesia, Adult Patient Controlled (PCA): Clinical Practice Guidelines".

10.7 Intravenous pumps for other drugs

Registered health professionals preparing and/or adjusting intravenous pumps containing drugs other than analgesics must satisfy themselves that they are competent to use the particular pump in use and be familiar with the drug regime prescribed. Please refer to the Trust Medical Devices Policy and Procedure regarding the use of medical equipment.

10.8 Administration of insulin

In accordance with the following national guidance: Safer administration of insulin (NPSA/2010/RRR013); The adult patient's passport to safer use of insulin (NPSA/2011/PSA003); and the Patient Safety Alert, risk of severe harm and death due to withdrawing insulin from pen devices (NHS/PSA/W/2016/011):

- All regular and single (bolus) doses of insulin must be measured and administered using a BD safety glide insulin syringe or commercial insulin pen device. **Intravenous syringes must never be used for insulin administration**
- The term 'units' must be used for all prescriptions of insulin. Abbreviations, such as 'U' or 'IU', must never be used. Any prescriptions with abbreviated formats of "units" must be challenged immediately and re-prescribed, clearly endorsing "units", before the administration takes place
- A BD safety glide syringe U100 must always be used to measure and prepare insulin for intravenous infusions.
- When prescriptions for insulin are prescribed, dispensed or administered, healthcare professionals must cross reference available information to confirm the correct identity of insulin products and ensure the correct patient is receiving the right insulin, the right dose, the right way and at the right time
- High strength insulins are increasingly available in pre-filled pens that are double (200units/ml), triple (300units/ml) or five times (500units/ml) the strength of standard insulin (100units/ml)
    - Never withdraw insulin from a pre-filled pen using an insulin syringe U100 – this is dangerous and could result in an overdose
    - Always use a BD Autoshield® DUO safety needle to administer insulin from a pre-filled pen
    - A non-safety pen needle should only be used under supervision for self-administration as per the pathway for use of insulin needles or syringes (RWF-OPPM-ES18)
    - Always use a BD safety glide insulin syringe U100 when administering insulin at the standard strength (100units/ml) from a vial

10.9 Checking of injectable medicines

10.9.1 In accordance with NMC Guidelines, wherever possible, two registrants should check medication to be administered intravenously, one of whom should be the registrant who then administers the IV solution.

Registered health professionals, who have not developed their role to include the administration of medicines via injectable route may act as a second checker, but may not undertake the administration themselves.

10.9.2 The registered health professional administering the medication should check the prescription and the medication in accordance with the Trust Injectable Medicines Standard Operating Procedure “Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas” available on Q-Pulse (see **Appendix 7** [RWF-OPPM-CSS2]).

10.10 Flushing intravenous sites

All intravenous sites should be flushed both before *and* after the administration of each medicine. This is normally with 5-10ml of sodium chloride 0.9% (may vary in paediatrics depending on age of child) although glucose 5% may be necessary for certain drugs (e.g. amiodarone).

Sodium chloride 0.9% injection used for flushing must be prescribed and the administration recorded as with all medicines.

There is little evidence to suggest that heparin solutions have any advantage over normal saline for maintaining peripheral intravenous catheters. This is also noted in the British National Formulary (section 2.8.1) (35).

In line with the NPSA Alert Rapid Response Report: *Risks with Intravenous Heparin Flush Solutions* (Reference: NPSA/2008/RRR02) issued on 24 April 2008, heparin flushes should NOT be used to flush peripheral intravenous catheters.

Whenever heparin flush solutions are used they must be prescribed and the administration recorded, as with all medicines, in the patients prescription chart.

The need for the cannula should be re-assessed on a regular basis and removed if no longer required. If, in exceptional circumstances, a cannula is left in situ for access only, this should be flushed a minimum of every 12 hours. This needs to be documented on e.g. the prescription chart or the record of insertion chart.

10.11 Care of site and cannula

Microbial contamination from air-borne organisms necessitates the change of the intravenous cannula every 72 hours (may be longer in paediatrics according to local protocol). Changing the cannula, however, may be necessary before that time due to other factors e.g. phlebitis, infection etc.

Cannulae inserted in an emergency situation cause a higher risk of infection and therefore should be changed within 24 hours. Intravenous administration sets for clear fluids will be changed at 72 hours. Administration sets will be changed immediately following a blood transfusion, drug treatment or intravenous feed or at 24 hours, whichever is sooner. All intravenous lines must be labelled with the date and time the giving sets were primed and commenced use, and documented on the prescription chart.

The number of intravenous lines, lumens and breaks in the system must be kept to an absolute minimum consistent with clinical need.

All intravenous sites should be checked every time medicines are administered and status recorded on the ‘Record of Insertion Devices’ on a shift basis. This chart must also be used to record the insertion and removal of all intravenous devices.

When equipment is used to administer intravenous medication the administrator should regularly check the equipment is working correctly and be competent in using the equipment (refer to Medical Devices Policy and Procedure).

11.0 Adverse events associated with medicines

11.1 Medication errors / incidents

11.1.1 Root causes

An incident can be as a result of one or a combination of the following categories. These can arise from prescribing, dispensing and/or administration errors, including:

a) an incorrect medicine given to a patient;
b) a medicine given to the wrong patient;
c) a patient failing to receive a medicine;
d) an incorrect dose given to a patient;
e) incorrect route/site of administration of a medicine;
f) a medicine administered more than one hour before or past the prescribed time;
g) an extra un-ordered dose given;
h) a medicine given past its expiry date;

11.1.2 Management of incidents

This section should be read in conjunction with the Trust Risk Management Policy and Strategy which provides further information and guidance on dealing with clinical incidents.

11.1.3 Principles

Follow-up of a medication error/incident should include, in order of priority:

- Minimisation of risk to the patient
- Reassurance for the patient and their relatives and carers
- Analysis of the incident to understand its causes
- Prevention of further similar incidents
- Accurate and timely transmission of information about the incident to all parties concerned including rapid response to any formal complaints received
- Counselling for the members of staff involved
- Recording of the incident
- Avoidance of formal complaints or litigation

11.1.4 Clinical management

In cases in which a patient receives incorrect medication, or medication is omitted, the responsible medical officer and nurse in charge of the ward/department must be informed. Responsibility for patient management lies with the responsible medical officer, who may wish to take advice from the pharmacy or a Poisons Information Centre.

Any action taken must be documented in the medical notes and nursing records.

11.1.5 Informing the patient/carer

The patient should be informed that an error has been made. The member of staff informing the patient should be a member of the immediate care team who will be able to counsel the patient as appropriate e.g. ward pharmacist, senior house officer, nurse in charge of the ward/department.

In the event that the patient is not satisfied with the actions taken, the Senior Manager must be called to see the patient immediately and the complaints procedure followed (Concerns and Complaints, Policy and Procedure for Management of).

11.1.6 Recording / reporting of incidents

All incidents or near misses should be reported using the Trust e-reporting incident form.

Any incident that gives cause for concern should be reported.

Any member of staff can report an incident or near miss.

The senior practitioner for the area must be made aware as soon as possible of **all** medication incidents.

The purpose of the drug incident report is to ensure that lessons are learnt to prevent/minimise the chances of reoccurrence and to enable procedures and practices to be reviewed through an educational/ developmental approach.

11.1.7 Medicines Incident Group

The Medicines Incident Group is a sub-committee of the Trust Medicines Management Committee.
All medicines related incidents reported are reviewed on a monthly basis by the Medicines Incident Group. Actions arising from trends and individual incidents will be carried out in conjunction with the Trust Medicines Management Committee.

11.2 Adverse drug reactions / interactions

Any drug may produce unwanted or unexpected adverse reactions. Detection and recording of these is of vital importance. Where there is a serious or unusual reaction i.e. an adverse reaction to the administration of a medication, this must be reported to the doctor and no further doses of that medicine should be given. The reaction should be documented in the patient's notes and on the allergies section of the prescription chart, and on the allergies section of the eDN. Consideration must be given to reporting the incident to the Medicines Healthcare products Regulatory Authority (MHRA) using the Yellow Card System. Blank yellow card are attached to each copy of the BNF. Doctors, nurses or hospital pharmacists can complete these cards. All suspected reactions to new medicines (indicated by a black triangle in the BNF) and any serious suspected reactions to established medicines, even if well recognised or causal link uncertain should be reported.

11.3 Equipment failure / defect

In the event of any medical device or medical equipment failing to work as intended, this should be reported to the EME Manager and an e-reporting incident form completed. An adverse incident report will then be raised and forwarded to the Medical Devices Agency. Any equipment involved in an incident should be quarantined immediately and put back into use only on the authorisation of the EME Manager.

11.4 Medicinal product defects

During the manufacture or distribution of a medicine, an error or accident may occur whereby the finished product does not conform to its specification. When a quality problem with a pharmaceutical product is identified, the use of that product should be discontinued. Notify Pharmacy Department routinely or the on-call pharmacist if a serious problem which presents a hazard to patients, staff or the public is suspected. Retain the product and its container (including any delivery systems in the case of injectables) and pass it to the pharmacy for inspection at the earliest opportunity. Keep a record of any batch numbers. The Trust's incident reporting procedure (Incident Management Policy and Procedure) should also be followed in all cases.

12.0 Monitoring and audit plan

The Chief Pharmacist as Chairman of the Medicines Management Committee and main author will be responsible for monitoring the effectiveness of this policy on behalf of the Trust. All aspects of the monitoring will be reviewed by the Medicines Management Committee who will maintain a rolling audit plan for the policy which will include the monitoring of:

- Process for prescribing medicines in all care environments
- Process for ensuring the accuracy of all prescription charts
- Process for the administration of medication in all care environments
- Process for learning from medication errors
- Process for managing patients medicines on handover between care settings
- Process for patient self administration
- Procedure for the safe disposal of controlled drugs
- Trust's expectations in relation to staff training, as identified in the training needs analysis

Specific annual audits will be:

- Medicine Security in Wards and Departments
- Controlled drugs,
- Intrathecal chemotherapy

In addition, one-off audits on differing aspects of the policy e.g. oral syringes, strong potassium solutions, missed doses etc. will be undertaken as part of the rolling programme.

The audit plan will be carried out in conjunction with the Trust Clinical Audit Committee, reported and monitored at the bi-monthly Medicines Management Committee meetings and evidenced by the minutes. A standing agenda item on audit will allow for regular review and updates at each meeting.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- Once approved the document lead/author will submit this policy/procedural document to the Corporate Governance Assistant who will activate it on the Trust approved document management database.
- A monthly publications table is produced by the Corporate Governance Assistant which is published on the Trust intranet under “Policies”; notification of the posting is included on the intranet “News Feed” and in the Chief Executive’s newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

An awareness memo will be released via Trust communications.

Apr 15 (Chief Pharmacist)

An awareness report will be presented to relevant senior staff.

Apr 15 (Chief Pharmacist)

Rolling programme of Mandatory Training monitored by Education and Training Committee.

2.0 Review

It is essential that Trust policy / procedural documents remain accurate and up-to-date; this policy / procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy / procedure. It is the responsibility of the document lead for this policy / procedure to ensure this review is undertaken in a timely manner.

3.0 Archiving

The Trust approved document management database retains all superseded files in an archive directory [obsolete register] in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Medicines Policy and Procedure
Please return comments to: Chief Pharmacist, Pharmacy Dept., Maidstone Hospital
By date: 31st March 2015

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Medical Director	13.3.15			
Director of Infection Prevention Control	13.3.15			
Chief Nurse	13.3.15			
Heads of Nursing and Midwifery	13.3.15			
Clinical Governance Lead	13.3.15			
Quality and Patient Safety Manager	13.3.15			
Clinical Directors	13.3.15			
Risk and Compliance Manager	13.3.15	7.4.15	Y	Y
Members of Medicines Management Committee	13.3.15	13.3 15	Y	Y
Heads of Pharmacy Departments	13.3.15			
Local Counter Fraud Specialist	13.3.15			
Clinical Governance Assistant	13.3.15			

APPENDIX THREE

Equality Impact Assessment

In line with race, disability, and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups. They are also required to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's website.

Title of Policy or Practice	Medicines Policy and Procedure
What are the aims of the policy or practice?	This Policy is designed to inform and direct the practice of all staff involved with the storage, supply, security, prescription and administration of medicines and related substances.
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	When the Medicines Policy and Procedure is reviewed
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three to this policy and procedure on the Trust approved document management database

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database:

No.	Title	Unique ID
4	Training needs analysis	RWF-OWP-APP674
5	Critical Medicines where Timeliness of Administration is Crucial	RWF-OWP-APP299
6	Critical Medicines Loading Doses	RWF-OWP-APP300
7	Standard Operating Procedure for Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas	RWF-OPPM-CSS2
8	Standard Operating Procedures for the Management of Controlled Drugs in Operating Theatres	RWF-OPG-CSS4
9	Standard Operating Procedures for the Management of Controlled Drugs in Wards and Departments	RWF-OPG-CSS5
10	Record sheet for wards to use to monitor their fridge temperatures	RWF-OWP-APP828

4) No