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| **POLICY TITLE:** | **Medicines Management in Hospitals** |
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| **Policy Owner:** | Adrian Cree, Executive Medical Director |
| **Ratified by:** | Adrian Cree, Executive Medical Director |
| **Responsible Signatory:** | David Watts, Director of Risk Management |
| **Outcome:** | This policy:<br>• Aims to ensure that measures are in place to ensure the safe management and secure handling of medicines. |

**Cross Reference:**

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| H02 | Admission, Transfer and Discharge |
| H06.1 | Guidelines for Medically Assisted Withdrawal from Substances |
| H22.1 | Management of Medications in Sites Homes with No Nursing Services |
| H22.2 | Controlled Drugs |
| H24 | Off-Licensed Prescribing and Unlicensed Medication |
| H37 | Prevention and Management of Disturbed/Violent Behaviour |
| H62 | Healthcare Records |
| H&S06 | Medical Gases & Compressed Gas Cylinders |
| H&S15 | First Aid |
| MHA18 | Consent to Treatment Section or Treatment Requiring a 2nd Opinion under Sect 58 or 58A MHA 1983 |
| MHA19 | Section 58 Administration of Medication by Nurses |
| OP03.1 | Duty of Candour |
| OP04 | Incident Management, Reporting and Investigation |
| OP05 | Mental Capacity |
| OP13 | Cardio-Pulmonary Resuscitation (CPR) |
| OP16 | Advance Decisions |
| OP54 | Community Treatment Orders (CTO) |

**EQUALITY AND DIVERSITY STATEMENT**

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

*If you are using the electronic eWorks system at your site, then the information should be recorded in eWorks rather than the current paper process

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

# MEDICINES MANAGEMENT IN HOSPITALS



## 1 INTRODUCTION

1.1 This policy applies to Healthcare sites that are registered with the relevant Regulatory body as a Hospital. The policy works within the four core governance principles that underpin a framework for the safe and secure handling of medicines. These are:

1. Establish Assurance Arrangements
2. Ensure Capacity and Capability
3. Seek Assurance
4. Continually Improve

1.2 Medicine Management considers best practice in the use of medicines by:

(a) Obtaining and receipt of medicines
(b) Providing medicines to patients
(c) Preparation of medicines
(d) Removal and disposal of supply and waste medicines
(e) Transport and transfer
(f) Storage and product integrity
(g) Health and safety of staff
(h) The safe and secure handling of Medicines is essential to ensure patient safety.

1.3 Hospitals have comprehensive pharmaceutical services, including out of hours arrangements. This needs to be overseen by a pharmacist who is a registered member of the General Pharmaceutical Council (GPhC) or of the Pharmaceutical Society of Northern Ireland.

## 2 ORDERING, RECEIPT AND DISPOSAL OF MEDICINES

2.1 A record of ordering, receipt, supply, administration and disposal of medicines is kept to maintain an audit trail and to ensure there is no mishandling.

2.2 There should be a local procedure for recording the medicines brought in by patients on admission. Ashtons patients own drugs form (PODS) can be used to document any medication that a patient brings into hospital. Checks should always be made to ensure that the medication prescribed on admission is current and correct. This process of medicines reconciliation should be carried out in a timely fashion and should be completed by the MDT and documented in the care records, where the Ashtons Medicines on admission reconciliation form should be used. In respect of accurate medicines, reconciliation information must be sought from the patient, their family, the referrer and general practitioner as required. Additional caution must be exercised in respect of the prescription of controlled / particularly dangerous or rarely used drugs. On discharge, the patient's medication should be reviewed, confirmed and recorded in

the discharge documentation a copy of the Ashtons patients own drugs form (PODS) should be given to the patient.

2.3 Monitoring and audit of medicines management including stocks and administration is done by an external company, Ashtons, for all hospitals and any gaps identified are actioned. All Doctors and Ward Managers have access to Live View where the Pharmacist for the hospital can raise concerns requiring actions.

2.3.1 These audits are also reported divisionally as a medicines scorecard so performance can be monitored. These are in the form of Group Benchmarking Prescription Chart Error Audit, Significant Interventions, Prescription Chart Audit Summary, Persistent and Important Issues and Significant Thematic Review.

2.4 The hospital shall have a procedure for procurement of medicines, which includes:
(a) Details of the supplying pharmacy and pharmacist in charge.
(b) Details of arrangements for regular supplies of routine prescriptions including ordering, receiving and disposal.
(c) Details of how to obtain medicines out of hours.
(d) Arrangements for the supply of medical gases.
(e) Details of arrangements for the safe receipt of medicines.
(f) Arrangements for obtaining emergency supplies of medicines.
(g) A medical practitioner must countersign orders signed by the registered nurse for a controlled drug. In the case of controlled drugs (except those in Schedule 4) an appropriate record is kept of the invoices, receipt, administration and disposal of the drugs in accordance with the Misuse of Drugs Regulations 2001.
(h) Details of how drugs liable for misuse are monitored in order to be able to identify all medications are accounted for and early detection is made of missing items.
(i) Details of how stock takes will take place on all medicines.

2.5 If stock medicines have exceeded their expiry date, or when medicines issued for an individual patient are no longer required by the patient, they are placed into a pharmaceutical waste container and sent to an authorised licensed waste contractor for disposal. Appropriate records must be kept. Controlled drugs must be denatured before disposal and an authorised witness nominated by the hospital's Accountable officer must be present.

2.6 Following the death of a patient, all medicines held in the patient's name shall be retained for a minimum of seven days in case there is a coroner's inquest. If the medicines are not required, the medicines are to be disposed of appropriately.

2.7 Procedures are in place for recording the delivery, handling and storage of full and empty medical gas cylinders, with an indication of who is responsible for this procedure. Separate designated storage areas are provided for medical gases.

## 3 STORAGE OF MEDICATION

3.1 Medicines in the custody of the hospital/unit are handled according to the requirements of the Medicines Act 1968, guidelines from the Royal Pharmaceutical Society and the requirements of the Misuse of Drugs Act 1971. Nursing staff abide by the professional guidance by the Royal Pharmaceutical Society (RPS) and Royal College of Nursing (RCN) and Health Education England (HEE) Administration of Medicines by Nursing Associates for the administration of medicines.

3.2 A clinical area must be available for the storage and assembly of medicines and completion of records. The temperature of this area shall not exceed 25°C. The temperature of the room should be checked daily and any persistent temperatures over 25°C must be reported to the nurse in charge and the ward manager and an appropriate solution sought such as a permanent/portable air conditioning unit in summer months. The staff should have access to

hand washing facilities and sufficient work surfaces together with appropriate security measures.

3.3 Separate lockable storage is provided for:

(a) Controlled Drugs (CD) - stored in a metal cupboard that complies with the Misuse of Drugs (Safe Custody) Regs 1973. It is important that a storage system for CDs is established to protect staff from allegations of mishandling and misuse. For further information on storing CDs see H22.2 Controlled Drugs.
(b) Medicines for external use - stored in a separate locked cupboard or physically separated from internal medicines on separate shelves in the main medicine cupboard.
(c) Medicines for internal use - stock should be stored securely in a locked trolley or cupboard.
(d) Stock medication should be kept separate from patient's personal medication.
(e) Cool storage - stored in a separate, lockable medication refrigerator, used exclusively for medicines. The maximum and minimum temperatures of the refrigerator are to be checked daily and appropriate action taken which includes reporting to the Ward Manager if the temperature is outside the normal range of 2°C to 8°C. A signed record of temperature records shall be kept.
(f) IV fluids where IV fluids are used and staff trained and deemed competent to use them.
(g) Flammable substances.
(h) Diagnostic reagents.
(i) Self-medicated drugs such as asthma inhalers may be kept by patients, if this has been risk assessed and agreed by the MDT and local procedures are in place and detailed in the patients Care Plan. Lockable storage should be available.

3.4 Medicines in current use are kept in a locked cupboard or trolley and the trolley is fastened to a wall when not in use. Medicines must be kept in original containers and there should be no loose strips of tablets/capsules. A drug trolley, lockable container or other secure method is used to transport medicines to wards. Please refer to local procedure.

3.5 Keys are held securely and there are local procedures in place for their handover at changes of duty. Keys should not be lent or given to patients or any non-nursing staff under any circumstances. Medicine cupboard or trolley keys and CDs keys are the responsibility of the nurse in charge, but can be handed to another Registered nurse or the pharmacist when necessary. The keys should always be returned to the nurse in charge after use.

3.6 A full set of spare keys should be available for each clinic room and medicine cabinets. It should be clearly documented where these spare keys can be accessed and what to do if the ward set go missing, such as report as an incident, instigate a search, etc. The spare keys should be locked away, and limited to nominated individuals at site, and logged in and out.

3.7 Eye drops, inhalers and creams are issued for individual patients only and should not be shared between patients. They are marked with the name of the patient and date of opening on the container not the box.

3.8 Stocks of liquid medication must be marked with a date of opening and kept for a maximum period of three months after opening. Follow manufacturer's guidance for each medicine as some products should be discarded sooner. Other non-liquid medicinal products such as creams have a reduced shelf life after opening and must be labelled with the date opened.

## 4 DRUGS LIABLE FOR MISUSE

4.1 A number of medicines (in addition to Schedule 2 controlled drugs, such as morphine) have the potential to be misused or abused. All staff should therefore be alert to the possibility of drug-seeking behaviour by patients, or theft by staff or patients/visitors.

4.2 Signs that might indicate abuse or diversion of medicines include changes in an individual's behaviour (such as lack of concentration, regular unexplained absences from the work area) or other changes such as loss of stock; inappropriate or excessive ordering.

4.3 If a staff member is concerned a patient may have drug seeking behaviour, then this should be discussed with the Responsible Clinician and Director of Clinical Services/Medical Director. If there are concerns about a member of staff in relation to this, then this should be reported to the Hospital Director.

4.4 Misappropriation or theft of medicines is a serious criminal offence and will be reported to the police.

4.5 Some common drugs liable for misuse include:

(a) All benzodiazepines, including:
  (i) Diazepam.
  (ii) Lorazepam.
  (iii) Lormetazepam.
  (iv) Midazolam.
  (v) Nitrazepam.
  (vi) Oxazepam.
  (vii) Temazepam.

(b) Analgesics:
  (i) Codeine.
  (ii) Dihydrocodeine.
  (iii) Gabapentin.
  (iv) Pregabalin.
  (v) Tramadol.
  (vi) Ketamine.

(c) Hypnotics:
  (i) Zopiclone.
  (ii) Zolpidem.

4.6 The type of drugs potentially misused by patients/staff is continuously changing so staff managing medicines need to be alert for all stock as, they can also include corticisteroids, sildenafil and laxatives. This is not an exhaustive list. Therefore, accurately following the ordering, storage and stock taking processes for site is key. Local procedures must include how Drugs Liable for Misuse (DLM) are monitored at site. The pharmacy provider has a DLM book that can be purchased for this purpose.

4.7 Tamazepam and Tramadol should be recorded with the controlled drugs - see paragraph 5.11.

## 5 PRESCRIBING MEDICINES

5.1 The hospital/unit shall have copies of, or access to electronic versions of up to date relevant reference sources, e.g. BNF and a summary of product characteristics (SPCs) for every product used, and shall have access to evaluated information about medicines. The SPCs can be downloaded from the Medicines Compendium website or obtained from the manufacturer. Staff should know who the supplying pharmacist is and how to contact them for information and advice.

5.2 Information is given to patients about the use, benefits and potential harms of medication prescribed. It is a requirement for patients to have access to the manufacturer's Patient Information Leaflet (PIL) for dispensed medicines. A Patient Information Leaflet folder must be kept on each ward. Leaflets are supplied with the original pack of medication or can be downloaded from the Medicines Compendium website. Other sources of information, including Patient Information Leaflets are available from the pharmacy provider's website.

5.3 The Regulatory Registered Manager (usually the Hospital Director) of the hospital/unit has overall responsibility for medicines and for ensuring appropriate maintenance of records. A designated officer, who must be appropriately trained, may be appointed to look after

medicines. The supplying pharmacist shall know the person responsible for medicines. Interventions initiated by the pharmacist are to be recorded and reviewed.

5.4 A prescription chart which incorporates a medicines administration record (MAR) is kept for each patient (including those that are self-medicating see Section 8) and shall include the following legible information:

(a) Name of the patient.
(b) Date of birth.
(c) Where possible a Photograph, especially for those who may lack capacity.
(d) Details of allergies or previous adverse drug reactions.
(e) Other information such as the Consultant's name, the patient's ward.
(f) Full details of all prescribed medicine, dose, routes, strengths and times and frequency of administration and start and finish dates where appropriate signed by a Doctor or Non-Medical Prescriber.
(g) Record of administered medication and also when refused by recipient.
(h) Date medicines were stopped and by whom, including a line at the end of the row after the last dose and the doctor's initials to avoid medicines being given in error.
(i) The indication, maximum frequency, and total daily dose of "as required" medicines.
(j) The issues around consent have been considered.

5.5 The Prescription Chart/MAR is a working document that is signed to record administration of medicines. It shall include details of prescribed medicine. All records shall be available and consulted when administering medication.

5.6 Medicines are used as specified in the Summary of Product Characteristics, unless there is a body of evidence to support any use outside this licence, in which case patients are informed that the medicine is used out of Summary of Product Characteristics and subsequently documented in patient's Healthcare records. Please refer also to H24 Off Licensed Prescribing and Unlicensed Medication.

5.7 The contracted pharmacist shall notify the person responsible for medicines of any drug alert or recall as appropriate and a record kept of any action taken. There is a local procedure to ensure that safety notices from the MHRA, NHS England, Department of Health, manufacturers and other organisations are received, distributed to appropriate staff, and acted upon in a timely and appropriate manner.

5.8 The doctor or pharmacist must report suspected adverse incidents involving medicinal products and devices to the relevant agencies (MHRA - Medicines & Healthcare Products Regulatory Agency) and manage appropriately any subsequently required action (also see 9.6(d)).

5.9 All hospitals have an Accountable Officer who is responsible for the governance of CDs, liaising with the Local Intelligence Network (LIN) and appointing suitable persons to act as witnesses for disposal of CD waste. For information on prescribing and CDs see H22.2 Controlled Drugs

5.10 The Hospital Director shall ensure there is a local procedure for the management of medicine administration that takes into account any requirement of the local regulating authority and the system of medicine administration used in the hospital. The procedure shall also include a list of recognised and approved household remedies (usually bought over the counter medicines) and a record of registered staff with their signatures and initials. The procedure shall also reflect evidence of audit procedures in place for the administration of medicines.

5.11 In life threatening situations, drugs contained in the resuscitation bag may be used without prior prescribing by those trained in intermediate or advance life support.

5.12 Any changes to the prescription must be made on the prescription card. Crossings out and overwriting are <u>not</u> allowed and records must be rewritten by a doctor or an independent prescriber.

5.13 On no occasion is it acceptable that prescribed medication is changed without authorisation from the responsible doctor. Instruction by telephone to a registrant to administer a previously unprescribed substance is also not acceptable. In exceptional circumstances, where the medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of fax or e-mail is the preferred method. This should be followed up by a new prescription confirming the changes within a maximum of 24 hours.

## 6 ADMINISTRATION OF MEDICINES

6.1 The Hospital Director ensures that there is a procedure, which staff adhere to for administration of medicines. This must take into account the system of medicine administration in the hospital, any requirements of the regulatory body that they are registered with (e.g. CQC, CCSIW, HIS, HIW) and Royal Pharmaceutical Society (2018) Professional Guidance on the Safe and Secure Handling of Medicines Appendix B Controlled Drugs supplementary guidance.

6.2 All medicines are administered through a written prescription, or internal to the hospital/unit, a Prescription Chart/MAR authorised by a doctor, or non-medical prescriber, in line with written policies and procedures of the organisation. In medical emergencies, such as anaphylaxis or opioid overdose, adrenaline injection or naloxone injections can be used without prescription.

6.3 Where medicines are received against a prescription for a patient, they are administered to that particular person and under no circumstances are they used for other patients. Where patient's own drugs are used, there should be a local policy/procedure in place for management and appropriately care planned.

6.4 The professional who administers medication must be a registered nurse or doctor and as such accountable for his/her actions with due clinical judgement applied.

6.5 All registered nurses, nursing associates and locum agency nurses, who have had a full priory induction, should complete H Form 138 - Group Medicine Management Competency Framework and Administration before they administer medication. This should be completed as part of their initial induction, and for newly qualified Nurses, as part of their Preceptorship and sign off.

6.5.1 For sites with no nurses, medication can be administered by suitably qualified support workers, please see policy H22.1 Managements of medications in sites/homes with no nursing services, for more information.

6.6 The registered nurse must know the therapeutic uses of the medicine, normal dosage and side effects, and any precautions or contra-indications. The medicines shall be administered according to local procedure, with the professional ascertaining that the prescription is unambiguous, the medicines have not already been administered, the identity of the patient is correct, and that the expiry date of the medicines has not been reached. The record of administration must be completed and a reason given if the medicine is not administered. This includes the administration of household remedies.

6.7 For administration of Controlled Drugs (CDS) please see policy H22.2 Controlled Drugs

6.8 The person administering the medication must ensure that the patient has capacity and is therefore able to properly provide informed consent to the medication. In the case of a person who does not have capacity to consent, he or she is, so far as is practicable, consulted before any medicine is administered.

6.8.1 **Patients detained under the Mental Health Act 1983** - see relevant MHA Policies such as MHA 18 Consent to Treatment Section or Treatment Requiring a Second Opinion Under Section 58 or 58A MHA 1983 and MHA 19 Section 58 Administration of Medication by Nurses,

MHA 21 Urgent Treatment Section 62 (1) & (2) etc. These can be found on the intranet under Policies and Forms>Healthcare Policies>MHA Policies.

6.8.2 For patients currently subject to a Community Treatment Order, see policy MHA 60 Community Treatment Orders.

6.9 **Covert Administration of Medicines -** There may be certain circumstances in which covert administration of medication may be considered to prevent a patient from missing out on essential treatment. This is only likely to be necessary in the case of patients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal. In such circumstances and in the absence of informed consent the following considerations may apply:

(a) The best interests of the patient must be considered at all times and recorded appropriately (See OP05 Mental Capacity Act).
(b) The medication must be considered essential for the patient's well-being, or for the safety of others.
(c) The decision to administer medication covertly shall not be considered routine and shall be a contingency measure. Any decision shall be reached after assessing the needs of the patient and in open discussion with the multi-disciplinary team (MDT) and the supporters of the patient, such as carers or advocate.
(d) The method of administration shall be agreed with the pharmacist. This is because some medicines cannot be crushed, such as slow release tablets. Also, the medication may affect the flavour of the food, which could be a problem.
(e) The decision and the action taken, including all the names of the parties concerned shall be documented in the records and appropriately care planned.
(f) Regular attempts shall be made to encourage the patient to take their medication.
(g) The prescribing doctor or multidisciplinary team need to record in the healthcare records the following:
    (i) Why there is no alternative to giving medication covertly.
    (ii) Why the physical and/or mental health is at risk by not having the medication.
    (iii) Why it is necessary now: Describe how the patient will be without the medication being given (the description of the consequences of not having the medication needs to demonstrate why it is necessary to have it now, and that it cannot wait in the event of refusals).
    (iv) Why it is necessary (not merely desirable) to administer the medication covertly (e.g. giving it otherwise will cause distress to the patient).
(h) The prescriber must give written directions for the nurse to follow in the care notes in order to authorise covert administration to the patient. Advice should be sought from the pharmacist as to the suitable covert method used and the instruction for this clearly labelled on the Prescription Chart/MAR.
(i) There should be regular review of covert administration by the MDT at each MDT meeting when the medication and treatment plan are reviewed.

6.10 All medicine doses will be prepared immediately prior to administration from the container in which they are dispensed. The medicines for individual patient usage must be clearly labelled with the patient's name and details right up to the time of administration.

6.11 Staff shall monitor the patient following administration of medicine and call the doctor if any unexpected change in their condition occurs which may be a result of the medicines. The use of rating scales should be considered for monitoring where appropriate.

6.12 Regular reviews of prescribed medicine shall be carried out when clinically indicated and at least every three months.

6.13 Medicine Administration Records (MAR) should be retained in line with the policy H62 Healthcare Records - Appendix 3.

6.14 If a patient goes out regularly for the day then if possible the medicine regime should be changed to avoid having to take medication whilst they are out. If this is not possible, such as for unplanned leave then a separate container, called a Dispensing Resource Pack, is to be requested from the pharmacy provider. Medicines must not be placed in envelopes or temporary containers. Nurses should not provide medication for leave from the medication held either in stock or the patient's own supplies; it must be prepared by the Pharmacy Service, unless there is a set procedure to cover this whereby the medication is dispensed into a Dispensing Resource Pack by a registered nurse and checked by another registered nurse. The pack will be clearly labelled with the following:
(a) Name, strength and form of medication.
(b) Quantity.
(c) Dosage Direction.
(d) Name of patient.
(e) Date.
(f) Name and address of hospital.

6.15 If a patient is going on leave, separate medicines should be requested for the period away from the hospital.

6.16 If oxygen is prescribed, the signs noting its use are in place, and it is delivered at the rate and concentration that has been prescribed.

## 7 PRESCRIBING AND ADMINISTRATION OF "AS REQUIRED" (PRN) MEDICATION

7.1 The prescribing of 'as required' (PRN) medication should be part of a care plan documented in the patients' health record and should include the circumstances for administration, and any special monitoring requirements following administration.

7.2 Whenever possible, medication should be prescribed after discussion with the patient and other relevant care professionals in the multidisciplinary team. Where this has not been possible, then the reasons for this must be documented in the healthcare record with further attempts made when able.

7.3 Treatment objectives should be outlined at the outset. The care plan should include the methods for measuring the outcomes over an established period of time. The care plan must also include directions for monitoring and recording potential adverse effects and should include what action should be taken if side-effects are observed.

7.4 Repeated doses of "when required" medication may be necessary, and guidance on how many doses and for how long this can be done must be stated in the care plan.

7.5 **Medication for Physical Health Conditions** - Informed consent must be sought and documented in the patient's health record.

7.5.1 In cases where a patient with a physical health condition has capacity but is refusing treatment, treatment cannot be forced upon them for this condition, in keeping with the principles of the Mental Capacity Act 2005.

7.5.2 In cases where a patient with a physical health condition lacks capacity to make a decision about accepting or refusing treatment, the principles of the Mental Capacity Act 2007 (Adults with Incapacity Act [Scotland] 2000) should be followed. In such cases, it is usually best practice to discuss any proposed treatment with their family and carers, and follow any "advanced treatment directives" which are in place. If no advanced treatment directive is in place, the clinical team can give treatment in the patient's best interests. (See OP05 Mental Capacity Act, and OP16 Advanced Decisions).

7.6 **Medication for Mental Health Conditions** - Informed consent for any proposed treatment should be sought. This discussion should be documented in the patient's health record.

7.6.1 For informal patients, treatment can usually only be given to patients with their informed consent.

7.6.2 For patients detained under the Mental Health Act, as required medication should be prescribed in accordance with the checks and safeguards contained within the Act.

7.7 **Guidance for the Prescriber** - For medication for rapid tranquilisation and for the management of aggression and violence, the prescriber is referred to guidance contained in H37 Prevention and Management of Disturbed/Violent Behaviour.

7.7.1 The prescriber must clearly note the indication for administration of any 'as required' medication on the patient's prescription chart, and nurses should only administer for the stated indication.

7.7.2 The prescriber must indicate a dose, route, frequency, and maximum dose (including any regular doses) over 24 hours.

7.7.3 The 'as required' medication that may be administered by more than one route (e.g. orally or IM) should be prescribed separately with clear direction as to why one should be preferred.

7.7.4 The 'as required' prescription must be reviewed at regular intervals, and the review period should be set at the time of prescribing.

7.7.5 The prescriber should not prescribe more than two PRN medications for any one indication unless there are exceptional reasons, and these should be documented.

7.7.6 If the prescriber wishes to offer more than one medication as 'as required' treatment then they should stipulate the order in which they should usually be administered.

7.7.7 The prescriber should be careful to monitor medication from the same therapeutic category that is used simultaneously as regular and 'as required' prescription in order to avoid inadvertently overdosing.

7.7.8 The prescriber should check that the total daily dose of the regular and the 'as required' prescription does not exceed the maximum BNF recommended dose. If a dose higher than BNF recommendations is required then the rationale for high-dose prescribing must be documented in the patient health record.

7.7.9 The prescriber should consider discontinuing any 'as required' medication that has not been administered since the previous prescription review. Some medications which are used to treat acute exacerbations of illnesses such as asthma, diabetes, epilepsy, and similar chronic conditions will need to be prescribed long-term as PRN.

7.7.10 The prescriber should review and re-write medication as regular prescriptions if it is considered that the medication is now needed regularly but was originally prescribed as 'as required' medication.

7.8 **Guidance for Nursing Staff** - The appropriate use of PRN medication requires clinical judgement and this requires nurses to be familiar with the patient's care plan and also be aware of the patient's prescribed medication.

7.8.1 Instigation of PRN administration may be as a result of a request by the patient, or PRN medication may be offered to the patient by a nurse. PRN treatment can result in over-medication or under-medication, so nurses must use clinical judgement when administering PRN medication, and document their rationale when making the decision (to administer or not to administer).

7.8.2 The nurse administering PRN medication must record in the patient healthcare record, the clinical reasons for doing so and any other clinically relevant information such as the effect of the treatment and any additional monitoring or observations that were undertaken.

7.8.3 The decision to administer PRN treatment must correlate to the prescriber's indication for administration. The administration must also be recorded on the patient's prescription chart in the appropriate section at the time of administration by the nurse.

7.8.4 The decision and reasons to administer PRN medication must also be included in the verbal reporting at the handover of shifts.

7.8.5 **Appendix 2** should be copied and placed in a prominent position in the clinic room or wherever appropriate for nurses prescribing and administering PRN medication.

## 8 SELF ADMINISTRATION OF MEDICATION

8.1 Patients who wish to self-medicate shall be assessed as to their capability and understanding of the requirements and risks, considering the following factors:
(a) State of mental health, the degree of disorientation, risk of self-harm or other problems.
(b) State of physical health, the degree of frailty which may affect the ability to handle the medicines.
(c) Security and storage.
(d) The wishes of the patient.
(e) The disposal system, for insulin needles and other medicine containers.

8.2 A risk assessment shall be completed and documented in the patient's healthcare records. Competency should be reviewed periodically.

8.3 Once self-medication has been agreed a lockable space must be made available in which to store medication, if patients are in possession of their drugs. Designated staff should have access, in order to monitor compliance with treatment. A sharps container must be provided if necessary.

8.4 If the hospital/unit orders and receives medicines for patients who are self-medicating, a record of medicines received and disposed of shall be kept to maintain an audit trail, including if possible, the signature of the patient on receipt.

8.5 All patients shall have their medication prescribed as "self-administered" on their individual Prescription Chart/MAR. Regular checks shall be made on the quantity of medicine taken by the patient to ensure that a higher or lower dose of medicine is not being taken.

8.6 A local procedure based on the Royal Pharmaceutical Society and Royal College of Nursing (2018) Professional Guidance on the Administration of Medicines in Healthcare Settings point 3 is required if patients self-administer medication. As a registrant, you are responsible for the initial and continued assessment of patients who are self-administering and have continuing responsibility for recognising and acting upon changes in a patient's condition with regards to safety of the patient and others.

## 9 ADMINISTRATION OF MEDICINE VIA MEDICAL DEVICES

9.1 Nurses are not to use or oversee the use of medical devices unless they know how the device should perform.

9.2 The Hospital Director is responsible for obtaining from the manufacturer detailed information regarding the safe use and maintenance of medical devices. This is of particular importance for devices such as syringe drivers that vary in design from manufacturer to manufacturer and where use in the hospital/unit is often infrequent.

9.3 The Hospital Director is responsible for ensuring that staff who will use and oversee the use of such devices receive appropriate training. However, all health care professionals and support workers have personal responsibility and accountability to ensure that they are trained in the safe use of the devices they need to use.

9.4 The Hospital Director is responsible for keeping records of medical devices in use, which should include unique identification of each device, routine maintenance, and history of the device and evidence that the legal requirements regarding the device have been met. Details of staff training and evidence that the staff know how to use, carry out day-to-day checks and routine maintenance on the devices used in the hospital/unit shall also be kept.

9.5 Before using a device to administer medication the professional must check that the device:
(a) Will do what is intended.
(b) Has been regularly maintained and checked since maintenance.
(c) Has no evidence of faults.
(d) Has the correct additional equipment for use when needed e.g. correct needles for insulin injectors or syringes for syringe drivers.

9.6 The professional must ensure that:
(a) They are familiar with the unit and the user instructions and can set up and use the device.
(b) They understand the monitoring necessary to check the performance of the device.
(c) They have recorded the details and serial number of the device used.
(d) If there are any problems during administration the device is to be stopped and steps taken to rectify the situation. Any adverse incident must be reported to the MHRA via the reporting links on their website (www.mhra.gov.uk). General reporting enquiries should be directed to the Adverse Incident Centre - Tel: 0207 084 3080. (Also see 5.8).
(e) Before administering medicines via PEG or nasogastric tubes the professional is to ensure that the pharmacist is aware of the change from solid to liquid form of medication and the correct dose has been calculated. Most drugs are not licensed for enteral feeding and therefore if the patient has an adverse reaction, the doctor, nurse and pharmacist would be liable, not the pharmaceutical company. The drug regime should be simplified if possible.
(f) Some tablets, such as those that are sugar coated, film coated or in capsule form can be crushable or dissolved in water. Those which are enteric coated or for sustained release must not be crushed as gastric irritation or increased toxicity may occur. Buccal or sublingual tablets are ineffective when crushed but may, depending on the patient's condition, still be given orally. Advice should be sought from a pharmacist.
(g) Enteral feeding can reduce the absorption of some medicines in which case there must be a four-hour gap after feeding and before restarting the feed to allow for this. Medicines that are known to interact with food such as penicillin and phenytoin are to be considered to interact with enteral feeds. Advice must be taken from the pharmacist and the manufacturer.
(h) The procedures for the administration of medicines shall be checked with the manufacturer and the pharmacist.
(i) A local procedure is required if medication is administered via enteral feed tubes.

## 10 EMERGENCY DRUGS

10.1 See OP13 Cardio-Pulmonary Resuscitation Policy and Other Medical Emergencies - Appendix 2.

## 11 MANAGEMENT OF MEDICINE ADMINISTRATION ERRORS

11.1 Errors can occur when prescribing, dispensing or administering medication. All errors should be reported on the Incident Reporting system and investigated. It should be reviewed whether a referral to safeguarding is necessary, which is generally based on the occurrence of patient harm, wrong prescribing, wrong administration or neglect in administering medications incorrectly or for an extended period of time when a prescription has ceased. These examples

are not exhaustive. Discuss with the Designated Safeguarding Officer if in doubt. If a safeguarding referral is made, then notification to the regulator will also be necessary. Any lessons learnt should be disseminated.

11.2 Errors must be reported immediately to the nurse in charge and medical staff if a prescribing error. The consultant, pharmacist, patient and their family are to be informed.

11.3 Expert emergency advice should be sought from the supplying pharmacist, doctor and/or helpline numbers that can be found inside the front cover of the BNF, and any necessary immediate action taken. Any remedial drugs given or action taken must be fully recorded in the healthcare records and on the Prescription Chart/MAR.

11.4 An assessment of the error shall be made, distinguishing between reckless and incompetent practice or concealment of the error, and those errors made because of pressure of work and where immediate honest disclosure was made. Subsequent action will depend on the assessment and the critical incident analysis. Each error shall be judged in its own right, and corrective actions taken. Where a nurse makes repeated drug errors, then these incidents may need to be reviewed together.

## 12 LEAVE AND DISCHARGE MEDICATION (TTOs)

12.1 The purpose of this procedure is to improve patient care whilst minimising the risks associated with dispensing medication from a hospital ward or unit. It applies to all units where patients go on leave or are discharged requiring medication. Only qualified nursing staff and doctors can dispense medication and work under this procedure.

12.2 Leave or discharge medication should be ordered from the pharmacy. Planned leave or discharge should take into account access to pharmacy services and arrangements to order medication in advance whenever possible. Leave medication must only be dispensed from ward stocks when delayed access to the leave medication via pharmacy would significantly compromise the start of the leave.

12.3 **Urgent dispensing from ward stocks for unplanned leave -** See **Appendix 1** for the Standard Operating Procedure for Dispensing for Unplanned Patient Leave.

12.4 Dispense each individual drug into an appropriate container and then apply its completed label, before dispensing the next item. When all items have been dispensed double check the details before filling in the dispensing record for urgent leave.

12.5 A second competent person, who could include medical, nursing and pharmacy staff if available, must check all items dispensed against the drug card and complete the dispensing record.

12.6 **PRN Medication** - If PRN medication has been required as part of the leave medication, this must be authorised by a doctor and documented in care notes that it is authorised and the rationale behind it.

12.6.1 The dispenser is then responsible for ensuring the patient (or carer) is counselled on the medication including:

(a) Explicit instructions on when 'as required' medicines should be taken.
(b) Directions for use.
(c) Very common or common side effects to watch out for.
(d) The importance of bringing any unused medication back with them when they return to the ward.

12.7 **Discharge medication -** Discharge medication should be ordered from the pharmacy.

12.7.1 Seven days' supply of discharge medication should be prescribed.

12.7.2 On no account may more than seven days' supply of medication be issued, either for discharge or for leave without authorisation from a member of the senior management team.

12.7.3 The nurse should offer/provide written information to the patient and carer in relation to the discharge medication or obtain a MAPPS (Medicines: A patient profile summary) from the Ashtons website.

## 13 REFERENCES

13.1 British National Formulary (BNF)
BNF for Children
Summary of Product Characteristics (SPCs) are available online www.emc.medicines.org.uk
www.choiceandmedication.org.uk
Mental Welfare Commission for Scotland (2006) Covert Medication: Legal and Practical Guidance
GMC (2013) Good Practice in Prescribing and Managing Medicines and Devices
NPSA (2008) Independent Investigation of Serious Patient Incidents in Mental Health Services
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MHRA (2015) Managing Medical Devices: Guidance for healthcare and social services organisations
Single use Medical Devices: Implications and consequences of Reuse MHRA DB2006(04) v.2.0
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DH (2013) Controlled Drugs (Supervision of Management and Use) Regulations 2013: Information about the Regulations
NPSA (2008) Seven Steps to Patient Safety in Mental Health
Dougherty, L and Lister, S (eds) (2015) Royal Marsden Hospital Manual of Clinical Nursing Procedures 9th edition, Wiley-Blackwell
Royal Pharmaceutical Society (2018) Professional Guidance on the Safe and Secure Handling of Medicines
Royal Pharmaceutical Society and Royal College of Nursing (2018) Professional Guidance on the administration of medicines in healthcare settings
Health Education England (2018) Advisory guidance on the administration of medicines by nursing associates
Maudsley Prescribing Guidelines in Psychiatry 12th edition (2015)
The Health Act 2006
NICE guideline (NG46) Controlled Drugs: Safe use and management

**Appendix 1** - Standard Operating Procedure for Dispensing for Unplanned Patient Leave
**Appendix 2 -** Guidelines for Prescribing and Administering 'PRN' Medication (This appendix should be clearly displayed in Clinic Rooms)

**Associated Forms:**

**MAR** - Medication Administration sheet (pre-printed)
**H Form: 62** Fax to GP Informing of Patient Discharge
**H Form: 114** Dispensing Record for Emergency or Urgent Leave/Discharge Medicines
**H Form: 114A** Transdermal Patch Application Record
**H Form: 138** Group Medicines Management Competency Framework and Administration

**APPENDIX 1**

# STANDARD OPERATING PROCEDURE FOR DISPENSING FOR UNPLANNED PATIENT LEAVE

It is essential that all patients can have their medication whilst on unplanned leave. To dispense medication safely within the following operating procedure must be used.

## PURPOSE

The ordering of TTOs and discharge medication should be carried out from the pharmacy as early as possible.

For unplanned leave, or when late changes are made to the medication regime, authorised hospital staff can dispense.

In the first instance staff must converse with the medic at site or on call medic to check that medication cannot be administered at an alternative time and the prescription card written up to reflect single dose change.

Any decision made must be robustly recorded in CareNotes by both nursing staff and medics.

If medication is anticipated to be required whilst the patient is on unplanned leave then staff should dispense it by following the procedure below using the Ashtons Dispensing Resource Pack.

The Dispensing Resource Pack must be stored in the Treatment room at all times.

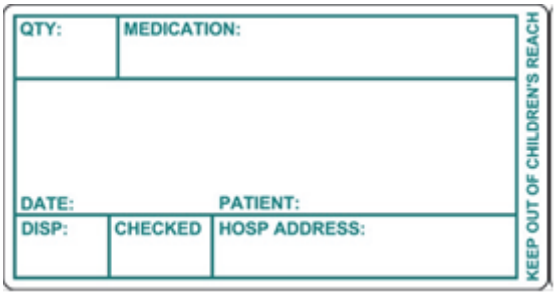
## PROCEDURE

(a) Obtain the patient's current prescription card(s).
(b) Check which drugs will be required during the leave and include PRN drugs if they may be needed.
(c) Prepare each drug separately. Dispense one drug completely before going on to the next drug.
(d) Select the first item to be dispensed.
(e) For each drug, decide the number of doses required by the patient. For instance if a lunch time dose is required then give one dose. If evening medication is required as well then two doses will be needed.
(f) Write the details of the medication on the dispensing label contained in Ashton's Resource Pack.

To include:
(1) Name, strength and form of medication.
(2) Quantity.
(3) Dosage Direction.
(4) Name of patient.
(5) Date.
(6) Name and address of hospital.

| Prescription Example - "Fluoxetine 20mg at 8am" | |
|---|---|
| Drug Name | Fluoxetine |
| Strength | 20mg |
| Form | Capsule |
| Dosage | ONE in the morning |
| Quantity | 1 (For 1 days leave) |

Patient Name, Date of dispensing, hospital name and address must be filled out at the bottom of label.




(7) Put the calculated quantity of medication into a suitable container (carton or bottle) and affix the label immediately.
(8) The label should be initialled by the person dispensing in the "DISP" box.
(9) This process must be carried out by a registered nurse then be checked by another Registered Nurse who must also initial the label, in the "CHECKED" box. (Two registered nurses must be involved in this procedure at all times). A doctor or pharmacist can also act as the "checker".
(10) The dispensed medication is then put in the bag provided for transporting medication.
(11) For liquid medication, supply a measuring cup or 5ml spoon.
(12) Whenever possible for discharge medication, the manufacturers patient information leaflets should be supplied (this is not a requirement for inpatient TTOs).
(13) Repeat steps 4 to 12 for each medication.

**ESCORTING STAFF MEMBER**

Escorting staff member must be trained to administer medication during leave by attending the Medicines Management course and be signed off as being competent.

A list of staff trained to administer medication during leave will be stored in the resource pack.

**Note:** A Section 17 leave of absence document must be completed if the patient is detained. Escorting staff should be given details of the medication to be administered during leave, this must include administration instructions and any risks associated including side effects.

Should the patient refuse medication whilst on leave the escort must contact the hospital immediately to inform the Responsible Clinician/Nurse in charge who will assess the risk of leave continuing and advise best course of action.

On return from leave, the escort must document robustly all medication administered, dosage and time given, compliance and any side effects if any experienced by the patient.

The patient's prescription chart should have the code "T" written in the appropriate boxes of the administration record on the prescription chart, as this is the code to use when patients are on leave,

In order to provide least restrictive practice the Ashton's Resource pack can also be used for planned leave following this procedure.

**APPENDIX 2**

## GUIDELINES FOR PRESCRIBING AND ADMINISTERING 'PRN' MEDICATION

The administration of *PRN* (when required) medication requires clinical judgement.

*PRN* Medication may be requested by a patient, or it can be offered to the patient by a nurse.

Nurses have discretion whether to administer the *PRN* medication or not. This can result in over-medication or under-medication.

To promote safe and effective treatment the nurse must:
(a) Be familiar with the patient's care plan.
(b) Have relevant knowledge of the patient's prescribed medication, regular and PRN, and take this into account.
(c) Ensure that the reason for administering PRN corresponds with the prescriber's indication on the prescription chart.
(d) Document the rationale for making the decision to administer PRN medication.
(e) Record the administration on the prescription chart without delay.
(f) Record in the Daily Report the clinical reasons for administering PRN medication.
(g) Monitor the patient for signs of adverse side effects and check that the treatment was effective.
(h) Follow the care plan where appropriate.
(i) Report PRN treatment in the handover meeting between shifts.
(j) Seek assistance from appropriate members of the clinical team if in doubt about a patient's treatment.