SAFE STORAGE, CONTROL AND ADMINISTRATION OF MEDICINES POLICY

1. INTRODUCTION

This policy:

- Outlines roles and responsibilities of professionals involved in the safe storage, prescription, and administration of medicines.
- Clarifies legal parameters within which medicines will be prescribed, ordered, stored and administered
- Provides a standard for the handling of all medicines that creates a robust audit trail which can be regularly monitored

The Nurse in Charge of the ward is ultimately responsible for medicines; however, each nurse is accountable for his/her practice. In this document 'Qualified Nurse' means a nurse qualified to have custody of and administer medicines.

This policy should be read in conjunction with:

- PiC Operational Policy – *Consent*
- PiC Operational Policy – *Managing Incidents & Untoward Occurrences*
- PiC Operational Policy – *Guidelines for the Use of Rapid Tranquilisation*
- PiC Operational Policy – *Physical Healthcare*
- PiC Operational Policy – *Clinical Supervision for Nurses*

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

This policy reflects the following national guidelines:

- Nursing & Midwifery Council (NMC) 2010 – *Standards for Medicines Management*
- Department of Health 2007 *Safer Management of Controlled Drugs*
- The British National Formulary
- The National Prescribing Centre – *A Guide to Good Practice in the Management of Controlled Drugs in Primary Care*
- National Patient Safety Agency – *Guidelines for the prescribing of Controlled Drugs for inpatients*
- General Medical Council Good Practice Guidelines
- Mental Health Act – Code of Practice 2015
- Mental Capacity Act (2005)

- Medicines Act 1968
- Nice Guideline 25: Violence the short-term management of disturbed / violent behaviour in psychiatric in-patient settings and emergency departments (2005)
- NPC A guide to good practice in the management of controlled drugs in primary care (England) (2007)
- The Misuse of Drugs Regulations 2001

Expectation

Staff members involved in prescribing and/or administering medication, are aware of their individual responsibilities and accountabilities.

2. ORDERING AND RECEIPT OF MEDICINES

Medicines are classified in a number of ways:

- Controlled Drugs (CD/POM), as defined by the Misuse of Drugs Act 1971
- Prescription Only Medicines (POM), Pharmacy Only Medicines (P) and General Sales list Medicines (GSL), as defined by the Medicines Act 1968

Since all medicines administered to patients in hospitals must be prescribed / authorised by a doctor or nurse prescriber, medicines used in this setting can be divided into two categories, Controlled Drugs (CD/POM) and Prescription Only Medicines (POM).

Stock Items

The Pharmacist / pharmacy technician will review stock and order any drugs needed. This will be done to a schedule that is agreed locally with Lloyds pharmacy.

Non-stock items and General Practitioner / Dental Prescriptions

Patient named medicines should be ordered from the pharmacy on a named drug order form or FP10 prescription issued by the GP / Dentist / A&E department. Upon receipt, patient named items must be entered into the individual patient's drug receipt records. The nurse must then bring forward in the ward diary the next date that these medicines need re-ordering.

Controlled Drugs

Controlled drugs will only be supplied by the pharmacist against a valid medical prescription for the controlled drug. On return to the ward, receipt of the drug will be recorded in the Controlled Drug Register by two registered nurses. Any tamper evident packs shall be opened to confirm quantity received. Any discrepancies must be reported to the pharmacist immediately. The supply must then be locked in the approved controlled drugs cupboard. All administrations of a controlled drug must be entered in the register. Private prescriptions for controlled drugs can only be written on private prescription forms issued by the relevant department of Health. The prescribing doctor must be registered with the appropriate regulation body for that country.

Receipt of Medicines

There will be agreement with the local pharmacy on when routine medicine supplies can be delivered to the unit and GP prescriptions delivered / collected.

Collections and deliveries should be accompanied by a delivery note; this may be a handwritten list or a copy of the stock order form. This must be checked immediately when the stock is received onto the ward and the amount received entered into the receipt records. Any discrepancies must be reported immediately to the Nurse in Charge and the issuing pharmacy.

All receipts must be signed for by a qualified nurse, witnessed by a second person, and entered into the drug ordering and receipts file as either ward stock or individual patient's receipts. This includes hospital and dental prescriptions. The receiver is responsible for ensuring that the supply matches the order.

Controlled Drugs will be recorded in the Controlled Drug Register by two Registered Nurses or, in circumstances where a service does not have a second registered nurse or authorised member of staff available, by one registered nurse and a Health Care Worker (HCW) who has completed a competency training pack and been assessed as competent to witness the administration of Controlled Drugs (see Section 15).

Expectation

There will be a clear audit trail for all medications from the point of order to administration.

3. STORAGE OF MEDICINES

All medicines must be stored in a locked cupboard, refrigerator, or medicine trolley, in the original containers they were dispensed in. They must not be transferred from one container to another or left loose. Internal and external products must not be stored together. The Nurse in Charge of the unit is responsible for seeing that medicines are stored correctly.

Controlled Drugs must be stored in a designated Controlled Drugs Cupboard, which complies with British Standard No. 2881.

Only authorised nursing staff have access to medicine cupboards. No member of nursing staff may have unattended access to the controlled drugs cupboard.

Clinic room temperature should be maintained between 15°C and 25°C.

The temperature of the clinic room refrigerator will be recorded using a maximum / minimum thermometer and a daily record kept in the clinic room book which should be kept in the clinic room at all times. The maximum / minimum thermometer must be reset after each recording and the refrigerator must be defrosted regularly (every eight weeks) to prevent ice build-up. Both these actions must also be documented in the clinic room book.

In the event of temperature failure (i.e. outside the 2 – 8° Celsius range) or power failure, the contents of the refrigerator will be removed and stored in a medicines refrigerator on another ward. If this is not possible they must be placed immediately on the top shelf of another designated refrigerator (as agreed locally) labelled MEDICINES FOR REFRIGERATION – DO NOT USE – DO NOT PLACE FOOD ITEMS ON THE SAME SHELF. The Pharmacist should be contacted immediately for advice. This should be clearly documented in IRIS the incident management reporting system.

4. DISPOSAL OF CONTROLLED DRUGS

For information regarding the disposal of controlled drugs, follow this link.

5. SAFE CUSTODY AND CONTROL OF MEDICINES

The Nurse in Charge of the ward is responsible for the custody of all medicines held on the ward. The keys to all medicine cupboards, trolleys and refrigerators will be attached to a key ring, which will be kept on the person of the nurse with delegated responsibility for the control of medicines for that shift.

Any discrepancies between the amounts supplied to the ward and the amounts prescribed must be reported to the Lead Nurse / Nurse in Charge of Unit. Labels must not be altered, nor containers relabelled by nursing staff.

Defects suspected in medical products must be reported immediately to the Responsible Clinician or Duty Doctor, Lead Nurse / Nurse in Charge of the unit and pharmacist. The product must not be administered to a patient until it has been cleared for use.

6. STOCK BALANCES, LOSSES AND DISCREPANCIES

The Nurse in Charge of the ward will monitor stock balances. They should be assessed at least weekly by a Registered Nurse, to ensure that the stock is consistent with the pattern of usage.

The stock balance of all controlled drugs must be entered in the controlled drug register and drugs liable to misuse (DLM) must be entered in the DLM register. These must be checked at least once in a 24-hour period. The check must be undertaken at the end of a shift and recorded in the appropriate register, confirming the stock is correct. The entry must be signed and dated by two qualified nurses, one from the current shift and one from the oncoming shift. Stock balances must be checked after every administration and recorded in the register. When full, these registers must be kept on the unit for two years from the date of the last entry.

Drugs contained in any special purpose packs e.g. Emergency drugs box, should be checked monthly by a designated senior nurse at each hospital.

Where there is any suspicion of loss or discrepancy, the Shift Coordinator and Senior Nurse on call must be informed. A stock balance must be recorded and regular checks introduced. If this shows discrepancies, the medicine must be made subject to the procedure for controlled drugs. A register must be kept and entries made when the medicine is administered. Any discrepancy in the stock balance of controlled drugs or DLMs, which is not satisfactorily resolved by the Shift Coordinator, Ward Charge Nurse / Ward Manager or pharmacist, must be reported immediately to the Registered Manager and Controlled Drugs Accountable Officer. This should also be recorded in the IRIS.

7. RETURN OF MEDICINES NO LONGER REQUIRED

Medicines that are no longer required or are out of date (other than controlled drugs) can be disposed of on site. Please refer to Section 13.

Drugs disposed of must be recorded in the destruction records and these must be retained for two years.

All outer packaging must be removed before disposal, other than for liquids. When the bin is full, close the lid, and arrange for collection and exchange of this.

Stock medication that is no longer required or is required for use on another ward can be transferred using an Inter Ward Transfer sheet. An Inter Ward Transfer is also required to transfer drugs back to the central stock / emergency cupboard if there is one.

Individually named medicines must not be used for other patients. If these are no longer required for the specified patient, they should be disposed of in line with policy.

8. PATIENTS' OWN MEDICINES

Any medicines, other than controlled drugs, brought to the ward by a patient on admission must be listed and stored in the emergency cupboard (if there is one) and brought to the attention of the pharmacist.

9. PRESCRIBING OF MEDICINES AND USE OF THE MEDICINE CARD

Medicines may only be administered on the authorisation of a medical practitioner or non-medical prescriber. This is a written prescription by the Practitioner on the 'Drugs Prescription and Administration Record' (the Prescription Card / Chart).

Under exceptional circumstances, a qualified nurse or pharmacist may accept a faxed prescription from a practitioner or accept a clinical note made in CAREnotes (see Section 13).

Prescriptions must be PRINTED CLEARLY, preferably in black ink and a photograph of the patient should be attached to the medicine card. The Prescriber must always fill in:

- The name of the medicine. Generic names must be used except when prescribing a compound preparation, or a preparation with specified pharmacokinetic properties, e.g. Modified Release preparations. In these circumstances, the brand name may be used if this achieves greater clarity.
- The form of the medicine. For liquids, the strength must be specified.
- The route of the medicine. A single route must be specified. It is not permissible to prescribe a medicine by more than one route e.g. O/IM
- The times of administration.
- The starting date for administration.

A specimen signature of every medical practitioner / non-medical prescriber must be supplied to the Pharmacy and the local Governance Committee, before he/she is authorised to use the prescription card. Agreement should be sought on where this should be held locally.

The prescriber will not normally write on the administration record section of the prescription card except to indicate that an individual dose must be missed by blocking the appropriate square with a bold X, or to terminate treatment.

“Once only” prescriptions must specify the time of administration.

As required prescriptions (PRN) must specify a single dose of medicine to be administered by a single route. The practitioner must give a full description of the indication for which the medicine is to be administered and the minimum interval in hours between doses and a maximum dose to be given within a 24hr period.

If a prescription is in any way unclear, ambiguous, or illegible, it should be presented to the prescribing practitioner for re-writing or clarification. Nurses must not amend or change prescriptions under any circumstances. The pharmacist may make minor amendments but must consult the prescriber if the intention is at all unclear.

Certain specified products may be given at the discretion of a Registered Nurse without counter-signature of a doctor. Drugs should be removed from this section of the medicine card when the medication is prescribed routinely or for PRN.

To cancel a prescription a bold line must be drawn across the prescription. A vertical line must be drawn at the end of the last day that the medicine is required to be administered and a bold line drawn across the reminder of the administration section. The stop date of the prescription must be completed by the doctor making the cancellation.

If alterations in dose, route, etc. are required then the original prescription must be cancelled and a new one written.

When no further space is available for the required prescription, or the administration record is full, or the clarity of the prescription is impaired by soiling, then a new card must be written and all treatment that is to continue must be transferred to it. Continuation sheets must not be used.

Prescribers must not alter the established sequence of dates on the administration record to prolong the life of a prescription card.

When a new prescription card is started, the previous card must be kept on the ward for reference.

Expectation

Doctors and nurse prescribers are aware of their responsibilities for prescribing medicines in a manner that meets national and good practice standards.

10. CONSENT TO TREATMENT

The law relating to consent to treatment for detained patients is laid out in the governing countries mental health legislation.

It is the responsibility of the Responsible Clinician / RMO to ensure that the provisions of the Act are complied with and informed consent is properly obtained. Where the patient is unwilling or unable to give consent, that a statutory appointed Doctor should be called in to consult the appropriate professionals concerned with the patients treatment / care and then to decide whether the medicines should be prescribed / administered. The Responsible Clinician / RMO will ensure that an appropriate Form is completed for each patient and regularly updated. The original will be filed in Medical Records, and a copy kept with the current medicine card (prescription chart). The doctor should check this form when any drug for mental disorder (including treatment for side effects) is changed or added to a prescription. The nurse must also check it when administering a drug. Once a form becomes non-current it should be scanned into CAREnotes. The Pharmacy will audit the use of these forms.

Medical records will ensure that the Responsible Clinician / RMO is duly informed when the 'Three-month Rule' is due to expire, in order to ensure appropriate Informed Consent or Second Opinion is obtained.

If a particular treatment does not appear to be covered by a valid Consent or Second Opinion, then the Responsible Clinician / RMO or duty doctor should be informed immediately.

All clinical staff have the obligation to recognise that the patient is entitled to change their mind regarding consent to treatment once the relevant form has been completed and are required to take seriously any subsequent indications of withdrawal of consent.

Nurses must not give medicines to non-consenting patients, except in an emergency and then only with a written prescription. These drugs can be given under and the relevant Acts in England, Wales and Scotland. The appropriate form should be completed by the doctor and filed with medical records. They can only be given under the following circumstances:

- To save the patient's life;
- To prevent serious deterioration in their condition;
- To alleviate serious suffering;

- If it represents the minimum interference necessary to prevent the patient from behaving violently or being in danger to him/herself or others.

Informal patients

The law relating to consent to treatment for informal patients is the Mental Capacity Act 2005. The Act sets out the test for capacity assessment and how to approach best interest decisions when the person lacks capacity. For more information please see Consent policy.

Expectation

Valid consent is obtained from patients when prescribing and administering medicines. When this is not possible the necessary safeguards are introduced to ensure prescribing and administering medicines remains within the legal framework of the MHA and MCA.

11. MEDICATION GIVEN IN EXCESS OF BNF LIMITS

The Royal College of Psychiatrists 1994 Consensus Statement on the Use of High-Dose Antipsychotic Medication states that doses in excess of BNF limits should only be used 'with caution and under specialist supervision'. It goes on to state that 'the evidence and scientific rationale for the effectiveness of high doses is limited'.

The main dangers of using high dose antipsychotics are sudden cardiac-related death and CNS toxicity.

Factors that need to be considered before prescribing high-dose antipsychotics are:

- That the diagnosis is fully correct
- That plasma levels are therapeutic and drug compliance is assured.
- That treatment duration has been fully adequate.
- That reduced doses for a trial period have been tried.
- That adverse social and psychological factors have been minimised.
- That alternative therapies such as atypicals, lithium, antidepressants, Carbamazepine, have been tried.

If doses are used above BNF limits, then the following should be routine:

- Multidisciplinary team and patient (or advocate) discussion, obtaining valid consent if possible, making a thorough record of the decision and reasons, including target signs and symptoms and outcome evaluation.
- Consideration of any contraindications.
- ECG pre-treatment to exclude QT prolongation repeated after every dose change and then when steady state achieved every 6 months thereafter.
- Doses increased very slowly.
- Regular checks carried out on pulse, B/P, temperature and hydration.
- Prescription reviewed regularly and reduced after 3 months if no improvement.

If a drug is prescribed at a dose exceeding the BNF recommended maximum daily dose,

this should be clearly documented in CAREnotes and the MDT care plan and a review date clearly stated.

If a patient is receiving a drug above BNF limits then a second opinion must be sought. The Second Opinion form must clearly state that the drug is to be used in excess of BNF limits.

Expectation

Patients will not be prescribed medicines that are in excess of BNF limits unless there is a clear reason for this and a second opinion has been sought.

12. PRESCRIBING AND ADMINISTERING DRUGS LIABLE TO MISUSE

For reconciliation purposes, the administration and receipt of all 'Drugs Liable to Misuse' will be recorded in a ledger similar to the controlled drugs register.

Drugs Liable to Misuse include all benzodiazepines (Diazepam, Lorazepam, Lormetazepam, Midazolam, Nitrazepam, Oxazepam, Temazepam); Analgesics (Codeine, Dihydrocodeine, Gabapentin, Pregabalin, Tramadol, Ketamine) and Hypnotics (Zopiclone, Zolpidem)

It should be noted that the type of drugs potentially misused by patients / staff is continuously changing. Examples can include corticisteroids, sildenafil and laxatives.

Benzodiazepines are only licensed for short-term relief of anxiety. The Committee on Safety of Medicines advice for avoiding benzodiazepine dependence is as follows:

- Benzodiazepines are indicated for short-term relief (2 to 4 weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness.
- The use of Benzodiazepines to treat short-term 'mild' anxiety is inappropriate and unsuitable.
- Benzodiazepines should be used to treat insomnia only when it is severe, disabling or subjecting the individual to extreme distress.

If a prescription for a benzodiazepine is extended for more than 6 weeks, an entry must be made in CAREnotes and the MDT care plan, indicating the reason for extending the prescription beyond that permitted by licensing restrictions and a review date clearly stated.

If the benzodiazepine is being used to treat epilepsy, then the above restrictions do not apply.

Expectation

Practitioners are aware of their responsibilities for Drugs Liable to Misuse and Doctors and non-medical prescribers are prescribing Benzodiazepines within national guidelines.

13. ADMINISTRATION OF MEDICINES BY NURSING STAFF

All medicines to be administered must be properly prescribed by a doctor or nurse prescriber.

Patients must not be allowed access to open medicine cupboards or drug trolleys.

The nurse administering medication is responsible for ensuring that medicines are administered as prescribed. A nurse must never administer medicines without an authorised prescription.

In exceptional circumstances, prescriptions to administer drugs (except controlled drugs) may be given by fax, or a clinical note made in CAREnotes.

Medicines dispensed for an individual patient and bearing that patient's name must be administered only to that patient. Only medicines ordered and issued as stock drugs may be administered to more than one patient.

Before administering a medicine, the nurse must:

Read the prescription carefully. The medicine must not be given unless the prescription, dose, and route of administration are clearly understood. 'As required' medicines must only be administered for the stated indication. If there is doubt or the prescription is ambiguous, the doctor must be contacted for clarification.

Check that the prescribed dose has not already been given.

Ensure that the drug, where appropriate, is covered by a valid Consent / Second Opinion Form.

Select the medicine required and check the label with the prescription details, paying particular attention to the strength.

Check that the expiry date of the medicine has not passed.

Prepare the medicine and check with the prescription:

- The name of the patient
- The name and form of medicine
- The route of administration
- The calculation (if any)
- The measured dose
- The date and time of dosage
- The time of last dose
- Check the identity of the patient

If for any reason the administering nurse has concerns over the quality, or identification of a drug, then it should not be administered until a pharmacist has confirmed patency

Drugs should NEVER be put out in advance.

As far as practicable, drugs should not be allowed to be exposed to hands or fingers. A no-touch administration technique should be used.

Drug administration must always be carried out in the presence of a witness. In general, the witness should preferably be a Qualified Nurse. However, it is recognised that there are occasions when this may not be possible. In such cases the pharmacist, doctor, or a Health Care Worker (HCW) may act as a witness.

HCW's should have no part in administering or witnessing injections unless they have undergone additional training and then been assessed as being competent to do this. Under normal circumstances HCWs should also have no part in witnessing the administration of controlled drugs apart from the circumstances described in Section 15 of this policy.

NB: Health Care Workers (HCWs) are to have no part in the administering of Cytotoxic preparations.

Following administration of a medicine:

Should any practitioner become aware of either a prescribing, dispensing or administration error, the Nurse in Charge of the ward must be informed immediately, who will in turn inform the Responsible Clinician, pharmacist and senior nurse. This will be reported through IRIS.

The nurse administering a medicine must initial the prescription card at the time of administration.

If a medicine is refused, a 1 must be entered on the prescription administration chart. If omitted for any other reason, the corresponding code must be used.

An entry must be made in the clinical notes as to the reason for omitting the prescribed dose.

Medicines prepared for administration, which are not required, should be placed in the sharps bin, with the exception of Cyctotoxic drugs or vaccines, which must be disposed of by a pharmacist.

In order to maintain standards of practice, internal and external audit will be completed at regular intervals.

Depot Medication

Depot antipsychotics are administered by deep intramuscular injection. In general, not more than 3ml of oily injection should be administered at any one site. Correct injection technique (including the use of the z-tracking technique) and rotation of injection sites is essential.

The administration of depot medication must always be carried out in the presence of a witness. In general, the witness should preferably be a qualified nurse. HCWs should

have no part in administering or witnessing injections unless they have undergone additional training.

Nursing and Midwifery Council (NMC) guidance supports using HCW's to witness Deep Intramuscular Medication providing they have received appropriate training.

Training should cover the following:

- Witnessing the removal of the vial from the container and checking it against the name, dose, and strength of the medication.
- Checking the batch number and expiry date, which are stamped on the vial.
- Numeracy skills – To a level of competency which allows the HCW to safely cross check measured units, e.g. How to draw a prescription of 400mg of Clopixol from a vial containing 500mg.
- Recognition of the importance in using the colour coded needles.
- Training will only be provided by recognised trainers, and a record will be kept on the individual staff members file.

Expectation

Nurses operate in a manner that protects patient safety when administering medicines. This includes ensuring that HCW's that are involved in the administration of medicines have had appropriate training

14. USE OF FACSIMILE TRANSMISSION FOR URGENT TREATMENT OUT OF HOURS

Instruction by telephone to a practitioner to administer any drug / substance is NOT acceptable.

Outside of normal working hours, the Nurse in Charge of the ward will be required to liaise with the Doctor on call to discuss any relevant concerns regarding patients' medications, i.e:

- Does the patient require medication that is currently not prescribed, and if so, how urgently is it needed?
- In emergencies, if possible, the Doctor / GP will be asked to attend to assess the situation and if necessary, prescribe treatment.
- Where a delay would be unacceptable to the health and welfare of the patient, receipt of a prescription via fax transmission will be accepted. It is preferable if at all possible that the prescriber makes a clinical note in CAREnotes.

Fax prescriptions will be accepted using a local format.

Any prescriptions received by fax will be signed and dated as for regular prescriptions (including STAT does) and an entry will be made in CAREnotes.

Nursing staff will be required to ensure the use of fax prescriptions is discussed with the patients RC or nominated deputy the following morning, to ensure further planned

treatments are prescribed using the patient's own medicine card.

Once completed, the facsimile prescription must be photocopied, with the original attached to the patient's medicine card and a photocopy uploaded into CAREnotes.

Expectation

Doctors and non-medical prescribers are aware that telephone prescriptions are not acceptable and prescriptions by fax are only used in exceptional circumstances

15. CONTROLLED DRUGS

Most PiC services should have at least two registered nurses available for the administration of Controlled Drugs. Under such circumstances, a qualified nurse, medical practitioner, or pharmacist must witness the administration of all Controlled Drugs apart from the exemptions outlined in the most current BNF Guidelines on Controlled Drugs and Drug Dependence Section.

In line with NMC guidance on the administration of Controlled Drugs (NMC Standards for Medicine Management, 2010), in services where there is no second registered nurse or authorised member of staff. Health Care Workers (HCWs), who have completed a competency training pack and been assessed as competent, may sign to say that they have witnessed the administration.

An example of a form to attest to the competence of Healthcare Workers to witness the administration of Controlled Drugs is included in Appendix A of this policy.

The Controlled Drugs Register must be completed after each administration and the remaining stock balance accounted for and confirmed.

The contents of any partly administered broken ampoule or omitted dose must be disposed of using a denaturing kit in the presence of a second qualified nurse, medical practitioner or pharmacist. A note must be made in the Controlled Drugs Register of the disposal, signed and witnessed.

The persons authorised for the destruction of Controlled Drugs will be appointed by the Controlled Drugs Accountable Officer, one of the people not being a nurse who is involved in the day to day administration of medicines. Details of the Controlled Drugs Accountable Officer and the Authorised Witnesses should be highlighted within each ward clinic.

Controlled drugs in liquid form, once measured, must never be returned to their original container.

Expectation

Controlled drugs will be administered in accordance with national guidelines.

16. OBSERVATION OF RESPONSE TO MEDICINES

All patients should be continually monitored and evaluated to see how they respond to medicines.

When a patient starts treatment or has had their medicine changed, it is essential that specific observations are made.

Information about medicines and their side effects should be available to patients, and nursing staff should be aware of what they are. Specific observations pertaining to these side effects should be maintained. To aid these observations the LUNSERS tool must be used. Particular note should be made to:

- Lethargy, drowsiness
- Tremor, agitation
- Behaviour / mood changes
- Changes in sleep pattern
- Physical co-ordination and mobility
- Rashes
- Pallor
- Fluctuation in temperature

Nursing observations are an essential part of evaluating patients' response to medicines. If a patient complains of any symptoms that are causing concern, medicines should be withheld and the Responsible Clinician or duty doctor informed immediately. The patient's vital signs should be monitored and any abnormalities reported to the duty Responsible Clinician or duty doctor.

Expectation

When a patient starts a new medicine or has a dose increased nurses continually monitor and evaluate how they are responding to the medicine paying special attention to potential side effects.

17. PRN MEDICATION

PRN medicines should only be given occasionally and in the particular circumstances described on the prescription card. If for any reason it comes to be given frequently or regularly, the Responsible Clinician or duty doctor should be consulted in order to review medication.

Administration of PRN medication must be documented on the prescription card and ward handover sheet and the circumstances described in CAREnotes.

N.B. When a patient is refusing medicines and is disturbed and aggressive, very careful assessment must be made before considering any enforced medicines. If an intramuscular injection is to be given to a violently disturbed patient, the Responsible Clinician or duty doctor will be informed (Clinical observation is particularly important if MVA is used prior to/at drug administration).

When a patient has received PRN medicines, nursing staff must monitor the efficacy and possible side effects and this should be documented in CAREnotes.

Frequency of PRN use must be monitored at least monthly.

Expectation

PRN medication will only be administered in the *particular circumstances described on the prescription card. Patients who have had an intramuscular injection whilst being restrained will be monitored closely*.

18. SUPPLY OF MEDICINES FOR VISITS (LEAVE DRUGS)

In some circumstances patients will require drugs for periods spent outside the ward. The authorisation required and the quantities of drugs supplied will vary according to need.

Prescriptions for leave drugs should be sent through to the pharmacy as soon as the leave is approved, unless the pharmacist or a medical practitioner is available to dispense the prescription (if dosette boxes are used, these must be sealed once the appropriate medicine has been dispensed and checked).

When there is not enough time for the prescription to be delivered and collected or when the pharmacy is closed, the out of hour's protocol should be followed.

Leave drugs can only be dispensed from unit stocks in exceptional circumstances. This may be due to an emergency transfer or 'out of hours' prescriptions. In these circumstances labels for medication should be completed for each item stating; drug name; drug strength; drug form; dose; patient's name; date of dispensing; quantity; dispensed instructions.

A pharmacist, medical practitioner, or Nurse in Charge of the ward can carry out dispensing but it is preferable that the final check **is made** by a doctor (if available) before the medication is given to the patient. If this is not possible the check should be done by two Registered Nurses or one Registered Nurse and a HCW who has had appropriate training. The person/s checking must sign and date what was dispensed in the once only section of the prescription chart.

A TTO prescription form is available that is separate from the patients' medicine card. This will enable the TTO prescription to be forwarded to Lloyds for dispensing, without having to send the patients medicine card.

19. ARRANGEMENTS FOR MEDICATION POST DISCHARGE

All patients who require treatment with medication to continue post discharge should be given a supply before they leave hospital. This supply may take the form of discharge medication supplied by the unit against a TTO prescription or the return of supplies of patient's own medicines brought into hospital on admission or a combination of the two.

Patients who discharge themselves against medical advice but who require medicines post discharge should be provided with a supply of discharge medication obtained in the usual manner through the pharmacy against a TTO prescription. If the patient wishes to leave the unit immediately it will not be possible to provide the supply prior to their departure and arrangements must be made with the patient or their carers to collect the medication from the unit at an agreed time following delivery from pharmacy.

If discharge occurs out of hours (i.e. when pharmacy is closed) arrangements should be made to provide a supply at the earliest opportunity. The ward team should follow the local practice relevant to their supplying pharmacy. TTOs may not be available until the next working day. Arrangements should be made for the patient or carer to return to collect the medication at an agreed time.

When a patient is discharged, information about their discharge medication must be forwarded to the GP as part of the discharge summary.

20. MANAGEMENT OF MEDICINES ON HANDOVER BETWEEN CARE SETTINGS

When patients are transferred between the care of any PiC units and another hospital or care setting, details of their current medication must be transferred with them. This may be in the form of a copy of their current prescription chart or detailed within any letters of referral to the receiving organisation. A record of what information has been transferred with the patient should be made within the patient's notes. Medication issued to an individual patient should not routinely be transferred with the patient unless it is labelled with instructions for use i.e. dispensed as discharge medication.

21. SERUM DRUG LEVELS

Nursing staff must ensure that when blood is taken from a patient for serum drug level monitoring, that it is taken before the patient is given the morning dose of that medication (as appropriate).

22. SELF-ADMINISTRATION OF MEDICINES (SELF MEDICATION SCHEME)

In some circumstances patients will self-medicate and when this is the case procedures to protect the safety of patient and others must be in place and approved by the RC.

23. LEAVE

Where a planned outing will exceed the time of the next regular medication dose, and where the escorting staff is unqualified, the projected dose may be dispensed prior to leave by the Nurse in Charge of the ward, in accordance with leave drugs for 'out of hours' prescriptions. The drugs may be carried during the leave period by an HCW on behalf of the patient. The administration and witnessing of the dose will be governed by procedure.

24. EMERGENCY DRUGS, EQUIPMENT AND LOCATIONS

A store of emergency and supplementary medicines must be maintained.

The emergency drugs are available for psychiatric and medical emergencies and are usually kept in the Ward clinic.

If items are removed from this stock, they must be replenished by a qualified nurse.

25. PATIENT ADMISSION TO A GENERAL HOSPITAL

In the event of a patient being admitted to a general hospital for the assessment and treatment of physical illness their regular medication is to be available to them, as it is acknowledged that there is often a delay in the sourcing / administration and availability of psychotropic medication in the general setting.

The patient's medication should be transported in its entirety and in its original packaging.

The patients' medication should be secured by the Nurse in Charge with a witness. A copy of the patients prescription chart should accompany their medication.

The medication should then be taken to the general hospital and handed over to the Nurse in Charge.

The medication must be transported to the general hospital by a regular member of staff (Qualified Nurse or HCW).

26. DRUG ERRORS

This section of the policy is designed to protect the interest of our patients and staff. It should be regarded as a professional and supportive approach to dealing with an area of critical importance, one that is wholly dependent on professional practice and vulnerable to human error. The first and foremost consideration in circumstances of this kind is the welfare of the patient. The second consideration should be the welfare and support of the nurse who is likely to be traumatised as a result of making such an error. Managers and supervisors must bear in mind these two key issues when involved in the management of such circumstances.

Examples of medication errors:

- The medicine is prescribed incorrectly
- The medicine is given at the wrong time and/or date
- The wrong dose is administered or dispensed to a patient
- The wrong concentration is administered
- Medication is administered to the wrong patient
- The medicine dispensed to a patient is labelled with the wrong medicine name, strength, or dosage instructions
- The prescribed medicine is 'omitted' in error

- Not obtaining or maintaining stock to avoid omission
- No signature after medicine is given by a nurse
- Medicine is not covered on the Consent / Second Opinion forms
- Prescription is not signed by the doctor

In the event of a Drug Error Occurring:

a) The nurse responsible must immediately inform the Nurse in Charge and contact the RC or on-call doctor and inform them of the administration error and any additional information requested;

b) The nurse responsible will act immediately upon any remedial action advised by the RC or on-call doctor;

c) The patient will be informed of the error and the doctor's advice and offered support. The complaints procedure will be facilitated if requested;

d) The error will be recorded on the patient's prescription chart, documented in CAREnotes and on the handover sheet, and reported through IRIS;

e) A statement will be written by the responsible nurse for the attention of the Charge Nurse, who should, under normal circumstances, receive this within twenty-four hours of the error occurring.

Managerial Action in Response to Drug Error

Stage 1

The Charge Nurse will arrange to see the responsible nurse within forty-eight hours of receiving their statement and will discuss with them the circumstances and consequences of the error.

This discussion will form the basis of a supervision session and this will be documented, along with the professional support and advice offered. In cases where the error is the first one made by the nurse concerned, this action will be considered sufficient, unless there are issues that cause the Charge Nurse particular concern. In these circumstances, the Charge Nurse will discuss the matter with the Registered Manager and invoke Stage 2. Any documentation will be placed on personnel files for three months. After this it will be discarded from the file.

Stage 2

Where the same nurse has made a drug error for a second time, the initial procedure will be as Stage 1.
The Lead Nurse through the identified process will return the nurse concerned to preceptorship and they will no longer hold the ward drug keys until they complete three supervised medicine rounds under the direct supervision of the Charge Nurse.

On completion of three satisfactory supervised medicine rounds, the nurse concerned will have a joint interview with the Lead Nurse and a Charge Nurse or Deputy Charge Nurse. If all three parties are satisfied with the resultant level of competence, the nurse

will be taken off preceptorship and will resume normal duties. If there is doubt with regards to competence, the Charge Nurse will liaise with the Registered Manager who will invoke Stage 3.

Note: Should a nurse be returned to preceptorship as outlined in Stage 2, a period of at least one month will elapse before they should be reinstated to normal duties.

Stage 3

Where a nurse makes an error for the third time or in circumstances where competence is not demonstrated at Stage 2, the nurse will be immediately placed back onto preceptorship and will have no access to medicine keys.

They will be referred directly to the Lead Nurse / Director of Nursing who, on receipt of all supervision records pertaining to the nurse concerned, will interview them in the presence of the Charge Nurse, before reaching a final decision on the appropriate course of action.

It is likely that the progression of such an interview will be through formal disciplinary proceedings, the precise nature and outcome being decided by the Lead Nurse / Director of Nursing, having taken into account any mitigating circumstances.

Any drug errors made and not reported which indicate that they may have been deliberately kept hidden will immediately invoke Stage 3, regardless of previous performance and will automatically result in disciplinary action. Such an action would **inevitably invite consideration by the Lead Nurse / Director of Nursing to report the matter to the NMC.**

27. MONITORING

- Medicine cards are audited weekly using the Clinic Room Checklist. These cover both prescribing and administering, including Section 62 MHA. Audit results should be discussed at Clinical Governance meetings and at Ward meetings with a view to focus on steps which can be taken to reduce the number of medicine error incidents.
- A local record will be kept of actions taken in response to medication errors including which stage of managerial action is implemented.
- The Lead Nurse / Director of Nursing will monitor the standards of practice through a regular medicine audit.
- In order to keep patients safe it is important that an open culture exists in order to encourage the immediate reporting of errors or incidents in the prescribing and administration of medicines.
- The Pharmacy and local Governance Committee will audit quarterly data on medication errors.

Empirical data on any drug error incident should be passed to the Hospital Director / Registered Manager by the manager involved. This information should include:

a) Date and time of error

b) PiC patient number
c) Type of error with brief description of events

28. SPECIFIC MEDICINES

Clozapine Care Pathway Protocol

The purpose of this protocol is to provide a framework for the initiation, administration and subsequent monitoring of Clozapine. This is informed by the BNF (2012) and The Maudsley Prescribing Guidelines (2007).

Rationale

Clozapine is an atypical antipsychotic licensed for the treatment of resistant schizophrenia and psychosis in Parkinson's disease. The use of Clozapine, in the event of drug resistant schizophrenia, has been supported by the National Institute of Clinical Excellence (NICE). Patients with other diagnoses can be considered for Clozapine by the consultant responsible for their treatment.

Clozapine has a wide range of adverse effects, many of which are serious or potentially life threatening. Careful monitoring is therefore mandatory.

The following table highlights the management of the most common adverse effects (adapted from Maudsley prescribing guidelines, 9th Edition).

Adverse Effect	Time Course	Suggested Action
Sedation	Most prominent in the first 4 weeks	Give smaller doses in the mornings and reduce dose if necessary
Hypersalivation	Most prominent in the first 4 weeks	Hyoscine 300mcg at night
Constipation	Usually persists	Recommend a high fibre diet. Bulk forming laxatives may be used.
Hypotension	Most prominent in the first 4 weeks of titration	Advise patient to take care standing up, and getting out of bed etc, to reduce risk of falls. If BP drops more than 30mm Hg the Nurse in Charge must seek advice of a doctor.
Hypertension	First 4 weeks, sometimes longer	Monitor closely and increase dose as slowly as necessary. Anti-hypertensive therapy is rarely necessary.
Tachycardia (pulse>100bpm)	First 4 weeks, but sometimes persists	Usually benign and often occurs if dose escalation is too rapid. If tachycardia is persistent at rest and associated with fever, hypotension or chest pain seek urgent medical advice as this may

Adverse Effect	Time Course	Suggested Action
		be indicative of mycocarditis. Referral to a cardiologist is advised. Clozapine should be stopped in the context of chest pain or heart failure.
Weight gain	Usually during first year of treatment	Weight gain is common. Dietary counselling is essential and will be more effective if given before weight gain occurs.
Fever (temperature > 38˚C)	First 3 weeks	Give antipyretic and check FBC urgently. Fever is usually benign hyperthermia. If persists over 38.5C withhold Clozapine and contact DMS. If associated with signs such as those indicative of myocarditis seek urgent medical advice.
Seizures	Dose dependent but may occur at any time. Incidence rises at doses > 600mg a day	Contact doctor immediately and get urgent advice.
Nausea	Usually first 6 weeks	May give anti-emetic. (Avoid prochlorperazine and metoclopramide if previous EPSE).
Nocturnal enuresis	May occur at anytime	Try manipulating dose schedule. Avoid fluids before bedtime.
Neutropenia / agranulocytosis	Most commonly occurs in the first 18 weeks but can occur at any time	STOP clozapine. Take URGENT advice from doctor and DMS. May need admission to a medical hospital.
Impairment of glucose tolerance	Any time – usually known risk factors	Regular blood glucose measurement and appropriate management is required.

Clozapine can cause agranulocytosis, which is a potentially fatal adverse effect. Therefore, as part of the monitoring process, all service-users prescribed clozapine MUST have regular FBCs that will be reviewed by DMS (Denzapine Monitoring Service). DMS use a traffic light system to report the results (see table 2).

Table 2: DMS blood results monitoring system

COLOUR	BLOOD RESULTS	INTERPRETATION
GREEN	WBC > 3.5 Neutrophils > 2.0	Clozapine may be given.
AMBER	WBC 3.0 – 3.5 Neutrophils 1.5 – 2.0	Caution – further sampling required – bloods taken twice weekly.

RED	WBC < 3.0 Neutrophils < 1.5	DO NOT GIVE CLOZAPINE. Seek advice and inform Consultant.

Mycocarditis

Clozapine is associated with an increased risk of myocarditis, which has in rare cases been fatal. The increased risk of mycocarditis is greater in the first two months of treatment. Rarely fatal cases of cardiomyopathy have also been reported.

Myocarditis and cardiomyopathy should be suspected in patients who experience persistent tachycardia at rest and/or palpitations, arrhythmias, chest pain or other signs and symptoms of heart failure e.g. unexplained fatigue, dyspnoea, and tachypnoea, or symptoms that mimic mycocardial infarction. If suspected Clozapine treatment should be stopped and the patient referred to a cardiologist. Patients who develop Clozapine induced myocarditis or cardiomyopathy should not be re-exposed to Clozapine.

Screening for myocarditis includes a base-line ECG and regular monitoring of troponin and CRP levels. Recent research suggests that combining the monitoring of symptoms of illness with checking troponin and CRP gives a sensitivity of a 100% for symptomatic myocarditis (Ronaldson et al. 2011).

Observations and Monitoring

It is very important to monitor the patient's physical observations during their initial treatment period. This will enable the clinical team to identify adverse reactions / side-effects and respond appropriately (see Table 3).

Table 3

Observations	Rational
Blood pressure	Hypotension may lead to fainting or light-headedness when standing up. Rarely this may be profound and accompanied by cardiac and or respiratory arrest. Incidence 1 in 3000.
Pulse rate	Clozapine is associated with an increased risk of myocarditis and cardiomyopathy. Tachycardia in early stages of titration is common and usually benign. However if persistent, at rest or associated with fever, hypotension or chest pain it may indicate serious heart conditions.
Temperature	Temperature above 38˚C should be urgently reported to a doctor. It is usually benign but may need to be investigated to rule out possible underlying infection due to neutropenia, or neuroleptic malignant syndrome.
Weight	Clozapine can cause significant weight gain.
Bowel habit	Clozapine has anti-cholinergic activity. Severe constipation, intestinal obstruction, faecal impaction and paralytic ileus can in rare cases be fatal. Particular care is therefore needed to enquire about Bowel habits.
Sedation	Clozapine causes sedation. This can increase the risks associated with immobilisation and falls.

Guidelines for Testing Serum Clozapine

A base-line level should be requested following initiation once:

- An individual is clinically stable
- Is not clinically stable but experiencing significant side-effects
- An individual has been on the same 'target' dose of clozapine for a maximum of 2 weeks.

Routine monitoring of levels following base-line should be as follows:

- Annually for doses up to 325mg
- Six monthly for doses of 350-525mg
- Three monthly for doses over 525mg.

Additional levels should be taken when:

- Concerns about possible toxicity
- Significant deterioration of mental state
- Possible non-compliance
- An individual suddenly stops smoking

Clozapine Treatment Monitoring

If a patient is being considered for clozapine:

1. Obtain base-line observations
2. Perform ECG, test blood for FBC. As part of myocarditis screen also obtain CRP and Troponin level
3. Results reviewed by medic
4. If any abnormal results, or history of pre-existing cardiac condition, query need for cardiology referral.
5. Register patient with DMS

Following commencement of clozapine patients will require close monitoring:

- After first dose – Monitor Pulse, BP, Temperature & Respiratory rate hourly for the first 6 hours
- Then 3 times a day for the first 2 weeks
- Twice weekly monitoring should be undertaken until stable dose is achieved
- Blood monitoring weekly for first 18 weeks
- Once a fortnight from 18 weeks to one year
- Then 4 weekly

The above observations should be recorded in a Clozapine Treatment Monitoring Record and in CAREnotes.

References

Joint Formulary Committee, (2012). *The British National Formulary*. 64th Edition.

London: British Medical Association and Royal Pharmaceutical Society of Great Britain.

Ronaldson, K.J., Taylor, A.J., Topliss, D.J., Fitzgerald, P.B., & McNeil. J.J. (2011) A New Monitoring protocol induced myocarditis based on an analysis of 75 cases and 94 controls *Australian and New Zealand journal of Psychiatry 2011,* Early online; 1-8. Taylor D, Paton C and Kerwin R. (2007) *The Maudsley Prescribing Guidelines.* 9th Edition. Informa Healthcare.

Guidelines for the Prescribing and Monitoring of Inpatient Lithium Therapy

1. At the earliest opportunity contact the patient's previous MDT for the latest medication history, if the patient is admitted without up-to-date documentation.

2. Ensure that the patient fully understands their lithium treatment and monitoring requirements and if not, provide a clear explanation.

3. Ensure the following checks (or requests) are made before commencement of treatment:

    - ECG if history of cardiac disease, risk factors known to prolong the QT interval (e.g. uncorrected hypokalaemia, bradycardia) and/or on other psychotropics known to prolong the QT interval.
    - Weight and height
    - Urea and Electrolytes
    - Serum creatinine or eGFR
    - Serum calcium (corrected)
    - Thyroid Function Tests (TFT)
    - Full blood count if clinically indicated

4. Ensure the correct brand and salt of lithium is prescribed as different preparations may vary in bioavailability.

5. Key points when prescribing lithium:

    - The starting dose is normally 400mg / 450mg (200mg / 250mg in the elderly).
    - Lithium plasma concentration should be checked 5 - 7 days (depending on renal function) after starting or changing dose and then weekly until two similar results are obtained at the same dose.
    - The blood taken for lithium levels should be taken 10 - 14 (ideally 12 hours) after the last dose administered. To assist sampling, lithium is usually given as a bedtime dose so that blood can be taken the following morning.
    - Care should be taken, including additional monitoring, when changing brands or formulations. Tablets contain lithium carbonate and the liquid contains lithium citrate.
    - Doses should be adjusted to achieve serum lithium concentration between 0.4 and 1.0mmol per litre. In people prescribed it for the first time a range of between 0.4 and 0.8mmol should be used. The lower end of the range is usually the target for maintenance therapy and treatment of elderly patients.

6. Nurses need to be aware of common side effects of lithium listed below and report to the ward doctor if they have concerns.

    - Dry mouth or metallic taste in the mouth
    - Thirst
    - Passing more urine
    - Dizziness
    - Mild diarrhoea or nausea (particularly on initiation and increases dose)
    - Mild shaking or fine tremor of the hand(s)
    - Weight gain
    - Oedema

7. Nurses need to monitor the patient and immediately report to the doctor if any symptoms of lithium toxicity appear such as:

    - Severe or coarse hand shaking or tremor
    - Blurred vision
    - Stomach ache along with vomiting or severe diarrhoea
    - Unsteadiness of their feet
    - Difficulty in speaking or slurring words
    - Muscle twitches
    - Clumsiness
    - Confusion
    - Muscle weakness

Safer Administration of Insulin

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

2. The term ‘units’ is used in all contexts. Abbreviations, such as ‘U’ or ‘IU’, are never used.

3. All clinical areas treating patients with insulin have adequate supplies of insulin syringes and subcutaneous needles, which staff can obtain at all times.

4. Although this situation is likely to be rare within PiC an insulin syringe must always be used to measure and prepare insulin for an intravenous infusion. Insulin infusions are administered in 50ml intravenous syringes or larger infusion bags. Consideration should be given to the supply and use of ready to administer infusion products e.g. prefilled syringes of fast acting insulin 50 units in 50ml sodium chloride 0.9%.

APPENDIX A

SECOND SIGNATURE FOR DLMS AND CONTROLLED MEDICATION

Name of Learner: _____

Outcome: ***For the Health Care Worker(HCW) to be competent in observation, medication and recording of Drugs Liable for Misuse and/or Controlled medication in order to sign as a second signatory.***

Prior to the competency below being followed, the learner will observe two qualified nurses demonstrating the administration, second signatory and recording of the DLM and/or Controlled drug regime.

- The learner will observe this process prior to completing this competency
- Orientation of the clinic
- Role of the qualified nurse in administering medication
- Role of the Health Care Worker being the second signatory of DLM and controlled medication
- The learner will familiarise themselves with the medication chart and DLM book
- Reporting process of errors

The rationale for this competency is that at Partnerships in Care we may only have one qualified nurse available. Therefore, when administering DLMs and/or controlled medication a second signatory is required.

The following training is to ensure that the Health Care Worker is competent and comfortable in this task and that the qualified nurse feels confident in the Health Care Worker's ability to undertake such task.

The task for the Health Care Worker is only to perform as a second signatory and **not** to administer any medication. The Health Care Worker should not under any circumstances carry the clinic keys; this should always be a qualified nurse.

To ensure that our Health Care Workers are competent in this area, senior management will ensure that this competency is assessed annually and that a copy of the assessment will held in their employee file. The Health Care Worker will be offered a copy for their CPD.

Learning Outcome - The learner will:	Assessment Criteria - The learner can:	Assessment:	Signature by assessing qualified nurse and Learner
What is a Drug Liable for Misuse (DLM)? What is a controlled medication?	• Refer to PiC Medication policy to see the definition of a DLM and controlled medication.	• Policy • DLM book • Own research ie. BNF, ask qualified staff.	
The learner will identify where the DLM and controlled mediation is stored?	• The learner will show the qualified nurse where the DLM medication is stored.	• Visual Check by qualified nurse. • The learner will explain where the DLM cupboard is within the clinic.	
Why are the DLMs and controlled medications stored in a double locked cupboard?	• Explain the rationale for this.	• Ensure the Health Care Worker understands this competency.	
How do you know that the qualified nurse is giving the correct medicine to the correct person and that it has been ingested?	• You and the qualified nurse should check the correct medicine chart against the patient. • Observe the patient taking the medication when at the clinic.	• ID photograph in the back of the medicine chart. • Date of birth • Observe the patient has swallowed the medication.	
Describe the different routes by which DLMs and Controlled medicines can be administered?	Administration routes: To include: • **mouth** as tablets, capsules, liquids; • **Skin,** injection or patches • **rectal**	• Question the learner.	

Learning Outcome - The learner will:	Assessment Criteria - The learner can:	Assessment:	Signature by assessing qualified nurse and Learner
Why do you and the qualified nurse count the DLMs and controlled medications?	• Open to misuse/abuse. • Legal requirement	• Recording. • Ensure the count is correct.	
What would you do if there was a discrepancy with the DLMs and/or controlled medication count?	• Try and check where the error has occurred. • Check all DLMs and controlled medications to investigate the error. • Ensure that it is reported to the Ward Manager and Hospital Director. • IRIS report • Refer to medication policy	• Check the policy for procedure of errors.	
Learners Comments: **Assessors Comments:**			

Assessor's signature: _____ **Print Name:** _____ **Date:** _____

Hospital Director's signature: _____ **Print Name:** _____ **Date:** _____

Ward Manager signature: _____ **Print Name:** _____ **Date:** _____