Agenda Item
Executive Team Meeting
Date

SEPT

PROCEDURAL GUIDELINES ON SAFE AND SECURE HANDLING OF MEDICINES (CLPG13)

PURPOSE OF REPORT

To update the members of the Executive Team on the changes that have been made to the procedural guidelines for the safe and secure handling of medicines in the Essex part of the Trust.

EXECUTIVE SUMMARY

The current version of this procedural guideline was approved in February 2009, and work is underway to integrate CLPG13 which applies in Essex with the equivalent policy and procedure in the Bedfordshire and Luton part of the Trust.

However there are a number of changes which were made to the procedural guidelines in March 2010 which need to be ratified, prior to completion of this process. The attached version contains these changes including the following:

- The changes in titles of pharmacy staff to reflect the introduction of the in-house pharmacy service.
- A section covering the use of emergency drug cupboards to increase access to medicines out of hours.
- The separation of the handling of medicines in inpatient areas and community team bases.
- A section covering the recommended limitations to the use of PRN antipsychotics.
- A section covering the covert administration of medicines.
- A section covering the handling of prescriptions by community drug and alcohol services

ASSURANCE

CQC Registration Standards, Commissioning Contracts; Trust Annual Plan and objectives

An up-to-date policy and procedure for the safe and secure handling of medicines forms part of the Trust's key evidence for compliance with core standard C4d of Standards for Better Health.

NHS Constitution
The policy and procedure do not directly relate to the NHS Constitution.

Data Quality
The changes to the procedural guideline have no implications for data quality.

Involvement of Service Users /Links
There has been no involvement of service users in the updating of this procedural guideline.

Communication and consultation with stakeholders
The changes to CLPG13 were agreed by the Trust's Drugs and Therapeutics Committee (Essex) in March 2010.

Service Impact/Health Improvement Gains
The use of medicines represents the most frequent therapeutic intervention in healthcare services. The safe and secure handling of medicines is fundamental to provision of safe, effective and high quality services.

Financial Implications
There are no financial implications associated with updating the procedural guideline.

Governance Implications
The safe and secure handling of medicines procedures have been updated to ensure compliance with the updated Controlled Drugs regulations, National Patient Safety Agency alerts, Nursing and Midwifery Council guidance, NICE requirements and the 2008 Amendments to the Mental Heath Act 1983.

Patient Safety/Quality
The safe and secure handling of medicines is fundamental to provision of safe, effective and high quality services

RECOMMENDATION

It is recommended that the Executive Team approves the changes to the procedural guidelines in Essex prior to preparation of integrated procedural guidelines across the area of the new Trust.

ACTION REQUIRED:

The Executive Team is asked to:
Approve the changes made to procedural guideline CLPG 13.

Cathy Willan
Pharmacy Services Manager

on behalf of
Andy Brogan
Executive Director of Integrated Governance and Quality.

Date 21st May 2010

SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURAL GUIDELINES ON SAFE AND SECURE HANDLING OF MEDICINES

Assurance Statement

This document aims to ensure that all risks associated with the management and use of medicines are minimised by defining the systems that are in place within the Trust for the control, storage, prescribing and administration of medicines

1.0 Introduction

1.1. This document defines systems for the control, storage, prescribing and administration of medicines. The document is laid out in the chronological order that medicines are managed.

1.2. Although primarily directed at nursing and medical staff who are responsible for the prescribing and administration of the majority of medicines, references are also made to the many other professions who may be involved in these activities.

1.3. This document is based upon statutory requirements and guidance issued by various official bodies including the Department of Health (DH) and Nursing and Midwifery Council (NMC).

1.4. For convenience and by custom the feminine pronoun is used throughout to refer to nurses and the male pronoun to doctors and patients. All statements can refer equally to men and women.

2.0 Responsibility

2.1 Responsibility for reviewing the document in relation to medicines management rests with the Chief Pharmacist working through the Drugs and Therapeutics Committee.

2.2 Responsibility for establishing and maintaining a system for the security and safe handling of medicines rests with the Chief Pharmacist in consultation with appropriate medical, nursing and administrative staff.

2.3 The appointed nurse in charge of a clinical area is responsible for ensuring that the system is followed and that the security of medicines is maintained.

2.4 All stocks of medicines in clinical areas will be checked by a member of pharmacy staff at regular, frequent intervals not exceeding six months.

3.0 Definitions

3.1 For the purpose of this document: -

3.1.1 The definition of medicine is that used in the Medicines Act 1968. That is, any substance used for treating, preventing or diagnosing disease, for contraception, for inducing anaesthesia or modifying a normal physiological function.

3.1.2 A Controlled Drug is any substance controlled by the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001, Schedules 2 and 3. Certain drugs may be designated locally to be treated in the same way as controlled drugs, by agreement between senior medical, nursing and pharmacy managers.

3.1.3 The term "Nurse in Charge" is a registered nurse who is shown to be competent in the administration of medicines as determined by the competencies laid down by the Trust.

3.1.4 The term “Nurse” is used in its generic sense to include a nurse, on all parts of the register. The term “Associate Practitioner” is a qualified practitioner approved by South Essex Partnership University NHS Foundation Trust and Anglia Ruskin University, having achieved the competencies outlined in the curriculum.

3.1.5 The Term “First Level Nurse” is a nurse whose name appears in Part One of the register.

3.1.6 The term “Clinical Area” means a ward or department in which patients are treated or a group of such wards or departments which form a single management unit. It also includes residential units operated by the Trust.

3.1.7 The term “Prescriber” means a registered medical doctor, or a nurse, pharmacist or other allied health professional, who has undergone a specified training course in supplementary and independent prescribing and have been registered by their professional body (see also CLP53 Policy on Non Medical Prescribing).

4.0 Safety

4.1 The Trust is committed to the safe management of medicines and takes a lead from The National Patient Safety Agency (NPSA). The NPSA leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. It issues Patient Safety Alerts and Rapid Response Reports as safety issues with medicines arise. These are reproduced on the Medicines Management section in the Library on the intranet. All staff involved in the management of medicines should be familiar with these publications, and ensure that they implement the actions recommended in them.

5.0 Procurement of Medicines

5.1 Medicines may only be purchased on behalf of the Trust by a pharmacist acting in accordance with local procedures.

5.2 Samples or clinical trial material may be accepted only by the pharmacy department, for issue as appropriate. If left in a clinical area by a company representative such medicines shall be sent immediately to the pharmacy department (see Pharmaceutical Representatives Policy CLP51).

6.0 Receipt of Medicines from Suppliers

6.1 Trust staff should not accept medicines direct from manufacturers. Medicines must only be accepted from Trust recognised pharmacy services.

7.0 Supply of Medicines

7.1 Medicines reconciliation

When a patient is first admitted to a ward a medicines history must be completed as per the Medicines Reconciliation Policy CLPG63. This is to ensure that medicines prescribed correspond to those that the patient was taking before admission and reduce medication errors commonly associated with the transfer of patients from one area to another.

7.2 Stock medicines

7.2.1 A list of medicines to be held as stock in each clinical area shall be agreed between the appropriate nurse in charge/team manager and pharmacist. This list shall be subject to regular review, at least annually. These medicines may only be administered to a patient by a nurse or designated carer and never issued to them to be self-administered.

7.2.2 Where a pharmacy 'topping-up' service is in operation, technicians/ pharmacy assistants will restock clinical areas on a regular basis. The nurse in charge/team manager remains responsible for identifying fluctuations in medicines requirements, ordering appropriately and notifying the pharmacist when it becomes necessary to review the current stock list.

7.2.3 Where a 'topping-up' service is not in operation, computer-generated stock sheets or requisitions will be completed and signed by the nurse in charge/team manager and sent to the pharmacy. This system may be used for all wards in the event of an emergency such as a flu pandemic.

7.2.4 A delivery note will be issued by the pharmacy when stock medicines are supplied. The nurse in charge/team manager or their deputy must check and sign this and notify the pharmacy of any discrepancies immediately.

7.3 Items for individual patients

7.3.1 Ward pharmacists or technicians will visit clinical inpatient areas in line with a timetable agreed with the nurse in charge/team manager and in line with the contract for pharmacy service and arrange the supply of medicines for individual patients.

7.3.2 When items are required urgently or are prescribed following the pharmacist's visit, the treatment card, together with a requisition signed and dated by the nurse in charge, shall be sent to the pharmacy.

7.3.3 Prescriptions may be faxed from clinical areas on a site remote from a pharmacy. A copy of the treatment card together with a requisition signed by the nurse in charge may be faxed. Original prescriptions should be seen by a pharmacist within 7 days of supply, where possible.

7.4 Medicines supplied to a patient on discharge/leave

7.4.1 All medicines given to a patient on discharge shall be individually dispensed by the pharmacy department for that patient. It is not necessary to provide a new supply of any medicines, if the pharmacist considers that the patient has a sufficient quantity which is still appropriate to his needs.

7.4.2 If a patient is going on leave an individual supply of medicines shall be dispensed by the pharmacy for the duration of the leave. Where individual patients have a supply labelled with full directions, this may be issued to the patient for leave with the agreement of the multidisciplinary team. Under no circumstances should stock medicines ever be issued to a patient for leave. If patients' relatives or carers collect the medicines from the pharmacy or a ward in the absence of the patient, ID must be confirmed.

7.4.3 With the agreement of the Chief Pharmacist, Consultant(s) and the nurse in charge, certain clinical areas may be issued with a limited range of preparations ready packed for patients to take home/use at home.

These packs must:

- Be provided by the pharmacy department
- Be issued only in accordance with a prescription written by a registered prescriber
- Have the label endorsed with the patient's name and the date of supply.
- Be labelled with clear directions for use.
- No alteration may be made to the label.

A register must be kept of all pre-packs issued. This register will be issued by the pharmacy and must be held in the clinical area at all

times. Details to be recorded are patient's name, time, date, name of medicine, quantity issued and signature of two members of staff, one of whom shall be a first level nurse or registered prescriber.

7.5 Medicines required when pharmacy department is closed

7.5.1 Basildon mental health unit, Brockfield House and Rochford Hospital all have an emergency drug cupboard that can be used to access medicines out of hours. The site officer should be contacted to obtain the key to the cupboard. A record must be kept of all medicines taken including the name and quantity of the medicine(s), name of patient and ward.

7.5.2 A medicine, other than a Controlled Drug (CD) may be borrowed from another clinical area provided that it is transferred in the original, fully labelled pack (see also section 11). Individual strips of medicines must not be removed from the original package and transferred. CDs may be borrowed as individual dose units with full CD records kept (see section 12.3.13).

7.5.3 Each clinical area must keep a record of medicines transferred to another clinical area, in the ward/departmental diary. The nurse in charge must inform the pharmacy department as soon as it reopens, so that supplies can be replenished to the issuing ward.

7.5.4 If a medicine is required urgently and is not available from the emergency drug cupboard or another clinical area, the doctor or nurse in charge should telephone the on-call pharmacist, who will either advise of a suitable alternative or make arrangements to dispense the medicine.

7.6 Transfer of medicines when a patient moves from one ward to another

7.6.1 If a patient moves from one ward to another medicines that have been individually dispensed for the patient should be sent to the new ward along with his other property.

8.0 Patient's Own Medicines

8.1 Medicines administered to patients shall be supplied against a prescription dispensed by the hospital or community pharmacy.

8.2 Community teams may store medicines for patients who are at risk of self harm. When a patient uses his own medicines during an in-patient stay or under the care of a community team, pharmacy or nursing staff must ensure that a reasonable quantity is supplied on discharge. This will normally be four weeks supply but must be at least two weeks, unless the patient has a history of self-harm and the prescriber indicates that a smaller supply is required.

8.3 Patients' own medicines may only be used when they can be positively identified and have been approved for use by a pharmacist or a doctor. This should include checking that medicines are in appropriate containers and clearly labeled. The suitability of these medicines should be recorded in the patient's healthcare records.

8.4 If patients' own controlled drugs are to be used a record of each administration must be kept in the ward controlled drug register. A separate page must be used for each drug held for individual patients. As soon as these controlled drugs are removed from the ward a line should be drawn through the remainder of the page to prevent it being used again.

8.5 If a patient is self-administering his medicines, he may continue to use his own medicines during an in-patient stay if the consultant/RMO agrees to this.

8.6 Medicines brought into hospital or other clinical areas remain the patient's property. If the medicines are no longer prescribed they may be sent to the pharmacy department for disposal with the patient's consent. This must be recorded in the patient's healthcare record. Alternatively, the medicines should be stored in a locked medicines cupboard on the ward to return to the patient on discharge or returned to a relative or carer for safe keeping. The medicines must never be used to treat another patient.

8.7 Details of medicines brought into hospital or a community team base by a patient shall be recorded in the patient's healthcare record by a member of the nursing, or pharmacy staff. When the medicines are removed from the clinical area details of disposal or onward transfer should also be recorded in the healthcare record.

8.8 Homeopathic, herbal or other alternative medicines may be retained in the clinical area for administration to a patient at the discretion of the appropriate Consultant provided that they are prescribed on the treatment card.

8.9 Patients admitted through the Accident and Emergency Department must have their medicines sent to the clinical area, together with documentation of any doses administered in that department.

9.0 Transport between Hospitals, other NHS Premises and a Patient's Home

9.1 Medicines shall be transported in sealed tamper-evident containers.

9.2 Where padlocks are used, the keys to the transit containers shall be held by the pharmacy staff and by other members of health service staff authorised by the Pharmacy Service Manager.

9.3 A consignment note stating the number of sealed containers to be transported shall be completed by pharmacy staff and accompany each load.

9.4 A signature shall be obtained each time the consignment changes hands.

9.5 The vehicle used to transport medicines shall be kept locked at all times.

9.6 Medicines which require refrigeration must be accompanied by a consignment note on which is recorded the time of leaving the pharmacy and the time of placing in the refrigerator.

9.7 Nursing staff should carry medicines in a locked bag when transporting them in the community. This should be transported in the locked boot of a vehicle and any remaining medicines should be returned to Trust premises at the end of a shift.

10.0 Transport of Medicines Within a Hospital

10.1 Medicines, other than Controlled Drugs, may be delivered to the appropriate clinical area by a messenger, provided that they are packed in sealed tamper-evident packages and are handed to the nurse in charge or her deputy on arrival.

10.2 If medicines are transported between a clinical area and the pharmacy by a qualified nurse, doctor, pharmacist or pharmacy technician there is no need to use a sealed tamper-evident package. However, the person concerned must ensure that the medicines are placed in the appropriate medicine cupboard immediately upon delivery to the clinical area.

10.3 Controlled drugs may be delivered to the appropriate clinical area by a messenger, in a tamper-evident package, provided that a signature is obtained on the appropriate document each time the package changes hands. The completed documentation will be archived in pharmacy. Upon delivery to the clinical area the package shall be handed to the nurse in charge who shall sign to acknowledge acceptance. The messenger must be a person employed on Trust business.

11.0 Storage of Medicines in a Clinical Area

11.1 All clinical areas in both inpatient and community settings shall have a designated nurse with responsibility for the management of medicines.

11.2 Inpatient Areas

11.2.1 All medicines shall be stored in one of the following locked cupboards, as appropriate: -

- Controlled Drugs cupboard
- Internal medicines cupboard
- External medicines cupboard
- Disinfectant and antiseptics cupboard
- Medicines refrigerator kept solely for medicines
- Urine testing reagent cupboard

11.2.2 Where separate cupboards are not available, internal and external medicines should be stored on separate shelves in a locked cupboard. Any new medicines cupboards must comply with BS2881 or the Misuse of Drugs Safe Custody Amendment Regulations 2007, as relevant.

11.2.3 A designated, domestically clean area, for the storage of large volumes of sterile fluids, including IV infusion solutions and irrigation solutions. If it is not possible for this area to be locked, then it shall be suitably segregated according to the needs of the individual ward. Small quantities (5 or 6 bags) may be stored in the treatment room.

11.2.4 Medicines in current use may be stored in a portable, lockable medicine trolley which is fixed securely to the wall when not in use.

11.2.5 A limited range of medicines for life-threatening emergencies may be kept on a resuscitation trolley or in an emergency drugs box.

11.2.6 Medicines which have been individually dispensed for self-administration by a named patient or for those wards where “one-stop dispensing” takes place may be kept in a locked container adjacent to the patient’s bed (see also section 24).

11.2.7 All medicine cupboards and refrigerators shall be kept locked. The keys shall be held on the person of the nurse in charge of the clinical area or her designated deputy. No other person may have access to these medicines without her permission.

11.2.8 The keys to the controlled drugs cupboard shall be kept on a separate bunch to the keys for other medicines storage facilities.

11.2.9 The keys to other cupboards and storage areas shall be stored in a safe place chosen by the nurse in charge of the clinical area.

11.2.10 Medicines must never be transferred from one container to another for the purposes of storage.

11.2.11 Once a dose of any medicine has been removed from its container it shall never be returned. If not required it must be discarded, by placing in a sharp’s container (see special requirements for controlled drugs).

11.2.12 The temperature of all areas where medicines are stored, including medicines refrigerators, shall be monitored on a daily basis and temperatures recorded. Temperatures above 25°C for rooms and outside the range 2-8°C for refrigerators shall be reported to the Consultant Practitioner for action.

11.3 Community Team Bases

11.3.1 All medicines shall be stored in one of the following locked cupboards, as appropriate: -

- Controlled drugs cupboard
- Internal medicines cupboard
- External medicines cupboard
- Disinfectant and antiseptics cupboard
- Medicines refrigerator kept solely for medicines
- Urine testing reagent cupboard

11.3.2 Where separate cupboards are not available, internal and external medicines should be stored on separate shelves in a locked cupboard. Any new medicines cupboards must comply with BS2881 or the Misuse of Drugs Safe Custody Amendment Regulations 2007, as relevant.

11.3.3 All medicine cupboards and refrigerators shall be kept locked. The keys shall be stored in locked combination lock key safe. Only qualified nurses will have access to the key safe and combination number

11.3.4 Medicines belonging to individual patients and stored in the community team base for safety reasons, must be stored in a locked medicines cupboard.

11.3.5 There must be a record of all medicines held in community team bases. This must include name, strength and quantity of each medicine and date received / destroyed / returned to patient. If the medicine is the property of an individual patient then the patient's name must also be included in the record.

11.3.6 Medicines must never be transferred from one container to another for the purposes of storage.

11.3.7 Once a dose of any medicine has been removed from its container it shall never be returned. If not required it must be discarded, by placing in a Sharp's Container (see special requirements for controlled drugs).

11.3.8 The temperature of all areas where medicines are stored, including medicines refrigerators, shall be monitored on a daily basis and temperatures recorded. Temperatures above 25°C for rooms and outside the range 2-8°C for refrigerators shall be reported to the Team Manager for action.

11.3.9 Nurses should advise patients on the safe storage of medicines in their homes.

12.0 Security and Administration of Controlled Drugs in Clinical Areas

12.1 Controlled Drugs shall be ordered by the nurse in charge or her deputy in the appropriate requisition book. Two separate books shall be used for Schedule 2 and Schedule 3 controlled drugs. A separate page must be completed for each preparation and the name of the drug shall be written in full. Nursing staff must ensure that the carbon paper is placed between the first and second sheet of the paired pages of the book and that a clear copy of the order is visible on the second page.

12.2 Any nurse who is authorised to requisition controlled drugs shall provide a specimen of her signature to the pharmacy department of any hospital in which she may work.

12.3 On receipt the nurse in charge shall check the drugs, sign the copy of the requisition and immediately record the receipt of Schedule 2 controlled drugs in the controlled drugs record book. The receipt shall be witnessed by a second nurse, who shall also sign the controlled drugs record book. There is no need to record the receipt of Schedule 3 controlled drugs in the record book unless requested in a special case to do so by a Consultant Practitioner.

All Controlled drugs (Schedule 2 and 3) must be stored in a locked controlled drug cupboard. Any new cupboards must comply with the misuse of drugs safe custody amended regulations 2007. It is recommended good practice that all controlled drugs cupboards conform to these standards.

12.3.1 All stocks of Schedule 2 controlled drugs should be checked by nursing staff at least once a week.

12.3.2 A registered nurse and one other person should remove each preparation one at a time from the controlled drugs cupboard and count the stock.

12.3.3 The correct page for the preparation in the controlled drugs record book should be opened.

12.3.4 The balance in the record book should be checked against the count of the stock.

12.3.5 If the balance in the record book and the stock count agree an entry should be made in the record book, writing the date, time and “stock checked and correct”. Both persons involved should sign the entry.

12.3.6 If the balance in the record book and stock count do not agree, other entries for that preparation should be checked for accuracy. If the problem is not found entries for other preparations in the book should be checked.

12.3.7 Any errors found should be marked in the record book by bracketing the entry and writing “error”. The nurse should initial outside the

bracket. On no account should any entry in the record book ever be crossed out.

12.3.8 The process should be repeated for each preparation held in stock.

12.3.9 Any preparations not currently in use on the ward should be returned to the pharmacy via the ward pharmacist when they next visit. An entry in the record book should be made. “Returned to pharmacy, stock balance NIL”. A registered nurse and the pharmacist should sign the record book.

12.3.10 Any schedule 2 controlled drugs not currently needed in departments outside the hospital should be returned to the hospital pharmacy by a registered nurse. An entry in the record book should be made. “Returned to pharmacy, stock balance NIL”. A registered nurse and the pharmacist should sign the record book.

12.3.11 When checking controlled drugs a package closed by the manufacturer’s un-broken seal may be assumed to contain drugs of the quantity and description on the label. If the seal is broken the contents must be examined individually.

12.3.12 If there is a discrepancy between the stock levels held and the amount entered in the register that cannot be explained the pharmacy department, ward manager and Consultant Practitioner should be notified. If the stock does not agree after an investigation an incident form should be completed.

12.3.13 If controlled drugs are required after pharmacy opening hours the nurse in charge may either contact the pharmacist on-call or obtain the drug from another clinical area. (See section 7.5.1). If the latter, the following procedure must be followed: -

12.3.14 A treatment card for the patient requiring the drug is taken to the ward from which the drug is being borrowed.

12.3.15 It is checked by a qualified nurse, from the ward, on which the stock is held, together with a nurse or doctor from the clinical area on which the drug is to be administered.

12.3.16 The procedure for giving controlled drugs shall be followed throughout by the two members of staff involved.

12.3.17 When entering the administration details in the controlled drug register of the issuing ward, the name of the patient’s ward must be entered alongside the patient’s name.

12.4 The controlled drug register and requisition books must be retained in the clinical area for two years after the date of the last entry. It may be destroyed after this period.

12.5 Controlled Drug Administration

12.5.1 The whole procedure shall involve two persons at least one of whom shall be: a registered nurse, doctor or designated trained carer (see section 3.1.6).

12.5.2 The procedure for administration of a Schedule 2 controlled drug is the same as for other medicines with the following additions: -

- The Quantity of stock remaining should be checked and recorded in the controlled drugs record book.
- Details of the administration must also be recorded in the Controlled Drugs Record Book, together with a full signature of both the witness and the person who administered the drug.
- If the controlled drug is wasted or only partially used, it shall be destroyed by placing it in a sharps container in the presence of a witness and a record made in the Controlled Drugs Record Book.

13.0 Authority to Prescribe

13.1 Medicines will be prescribed by medical staff or non medical prescribers according to their professional registration restrictions and the Policy for Non Medical Prescribing (CLP53).

13.2 Provisionally registered medical staff may prescribe for in-patients including prescriptions for leave or discharge. They may not prescribe for out-patients. Unregistered medical locums (e.g. medical students) do not have the authority to prescribe.

13.3 In some clinical areas, nurses and members of other professions may have the authority to administer and supply certain medicines at their own discretion. The precise circumstances in which this is permitted will be defined in a Patient Group Direction or local procedure for unqualified care staff (see section 17).

13.4 Should a prescriber consider it unwise for a patient to receive medicines in accordance with a Patient Group Direction or local procedure, that fact shall be recorded in the patient's medical notes and on the treatment card.

13.5 All staff who are authorised to prescribe shall provide a specimen of their signature to the pharmacy department of each hospital and clinical area in which they may work.

13.6 In certain circumstances a nurse, pharmacist or other authorised member of staff may alter the formulation or dose of a medicine prescribed by a medical practitioner. Circumstances in which this is permitted will be defined in a protocol agreed by the Drugs and Therapeutics Committee (see Formulary and Prescribing Guidelines).

13.7 A pharmacist may alter a prescription written by a prescriber in accordance with a protocol for therapeutic substitution which has been agreed by the Drugs and Therapeutics Committee (see Formulary and Prescribing Guidelines).

14.0 Verbal Orders

14.1 Verbal orders for the administration of a previously un-prescribed substance are not acceptable. In exceptional circumstances, where the medication is currently prescribed but where changes to the dose are considered necessary, the use of information technology, such as fax or email is acceptable.

14.2 In an emergency, when no other form of communication is possible, a verbal order for dose changes may be accepted but must be witnessed by a second nurse. This shall be entered in the "once only" section of the patient's treatment card, and then read back to the medical practitioner checking the patient's full name and age, the name of the medicine, dose and route.

14.3 The nurse shall endorse the prescription "dose change instruction by telephone" and enter the date, time, name of the prescriber, her own signature and the signature of the witness. It is the responsibility of the Medical Practitioner to countersign the prescription as soon as possible, and in any case within twenty-four hours after the verbal order.

14.4 Such a change is valid for one dose or 24 hours, whichever is the shorter.

14.5 Verbal orders are not permitted when the patient is a child.

14.6 A prescription may be amended by a pharmacist following verbal consultation with the prescriber. Such alterations shall be initialled by the pharmacist and endorsed "PC" (prescriber contacted).

14.7 At the discretion of the pharmacist, a prescription may be dispensed following a verbal order from the Medical Practitioner. Full details must be given including the age and weight of the patient, drug allergies and concurrent medication. A signed prescription must be provided within twenty four hours.

14.8 Text messages may not be used to confirm verbal orders.

15.0 Prescribing For In-Patients

15.1 Prescriptions for in-patients shall be written on the treatment card (see Appendix 7). Supplementary cards may be used in certain specialist situations e.g. for IV therapy and anticoagulant treatment.

15.2 It is essential that prescribers provide clear and complete written instructions to staff responsible for administering the medicines.

15.3 The instructions shall be written in the appropriate section of the treatment card.

15.4 The prescription should be written in block capitals, black ink, must be legible, and contain the following: -

- Patient details
- Name
- Hospital number
- Date of birth
- Weight
- Known allergies
- The approved name of the medicine.
- The form the medicine should take (e.g. tablet, suppository).
- The strength, written in full or using only the abbreviations listed below:

    - microgram microgram
    - milligram mg
    - gram g
    - millilitre ml
    - millimole mmol

- The route of administration, written in full or using only the abbreviations listed below:

    - Intravenous IV
    - IntramuscularIM
    - Subcutaneous SC
    - Oral O
    - Rectal PR
    - Topical TOP
    - Inhalation INH
    - Sublingual SL
    - Nebuliser NEB

- The timing and frequency
- The site of application for special treatment (e.g. to eczema, to left eye etc)

15.5 All prescriptions shall be dated and signed by the prescriber and endorsed with the prescriber's name in block capitals.

15.6 When treatment is to be discontinued the prescriber must cancel the prescription by drawing a line through it and dating and initialling the cancellation. A line should also be drawn after the last signature of administration to ensure no further doses can be given

15.7 If it is necessary to change the route or dose of the medicine the prescription must be cancelled and rewritten.

Note: It is not acceptable to prescribe alternative routes of administration (e.g. IM/Oral).

15.8 For inpatients, Controlled Drugs can be prescribed in the same way as all other medicines.

15.9 Prescribing Regular Medicines

15.9.1 Medicines written in the Regular Medicine section of the treatment card will be given every day at the times specified, until the prescription is cancelled or instructions are given to the contrary.

15.9.2 Treatment shall be kept under regular review and cancelled when no longer required.

15.9.3 Prescriptions for systemic antimicrobial therapy should always state the period for which treatment is to be given. Pharmacists will automatically stop a prescription for antimicrobials after 7 days unless specifically prescribed for longer. If treatment needs to be continued after this time, the prescription should be rewritten.

15.9.4 Treatment cards shall be rewritten by an approved prescriber once the administration record columns have been filled. A pharmacy medicines management technician may rewrite a treatment card, but no doses may be administered until it has been signed by the prescriber.

15.9.5 If more than one treatment card is necessary the cards shall be endorsed “Chart 1 of 2, 2 of 2”, etc.

15.10 Prescribing "when required" medicines

15.10.1 In addition to standard requirements (see section 15.4), prescriptions for medicines to be given when required shall include: -

- the maximum frequency and/or
- the maximum number of doses in 24 hours
- the reason for administration

The maximum number of doses to be administered and/or maximum duration of treatment should be stated where relevant.

15.10.2 If antipsychotics are prescribed on an “as required” basis the prescription will only be valid for 6 doses or a period of 7 days whichever is the shorter. After this time the prescription should be reviewed by a senior doctor and an entry made in the health care record.

15.11 Prescribing Variable Dose Medicines

15.11.1 Variable dose prescriptions allow for continuing changes of dose.

15.11.2 This section of the treatment card shall not be used for regularly administered medicines where the dose is only occasionally varied but for medicines where the dose may vary daily or more frequently e.g. Clozapine starting regime or Chlordiazepoxide reducing regime.

15.12 Prescribing Intravenous Fluids

15.12.1 In addition to standard requirements (see section 15.4), prescriptions for intravenous fluids shall include: -

- The duration of administration
- The total volume to be administered
- The concentration of the solution

15.13 Prescribing Medicines to Take Home

15.13.1 Medicines for patients to take home on leave must be prescribed in the relevant section of the treatment card. Medicines prescribed for patients at the time of discharge must be written on separate triplicate discharge prescription forms. All three copies of this form must be sent to the pharmacy when dispensing is requested. The white copy should be filed in the patient's notes, the pink copy sent to the patient's GP and the green copy should be retained by the pharmacy.

15.13.2 Administration instructions shall be given to the patient or their carer by the doctor, pharmacist or nurse. Information leaflets should also be offered to the patient. A manufacturer's Patient Information Leaflet all medicines to be taken home will be issued by the pharmacy.

15.13.3 In some cases a period of training for the patient may be necessary prior to discharge.

15.13.4 Normal duration of supply of medicines to take home should be 28 days. Duration for less time should be clearly specified by the prescriber. Patients with a history of self harm in the last three months should receive no more than 14 days supply.

15.13.5 Monitored Dose Systems (MDS). Medicines may only be supplied in an MDS if their use has been agreed as part of the discharge planning process and the pharmacist is satisfied that adequate arrangements are in place for refilling (see also section 19).

15.13.6 **Prescribing Controlled drugs to take home**

Very specific requirements for writing prescriptions for controlled drugs are contained in the Misuse of Drugs Regulations 2001.

Prescriptions must be indelible and signed by the prescriber. They must include:

- The name and address (or hospital unit number in the case of a hospital prescription) of the patient.
- The name, form and strength of the preparation.
- The dose.
- The total quantity or the number of dose units to be dispensed. This shall be stated in both words and figures.
- The prescription shall be signed and dated by the doctor.

It is an offence in law for a prescription for a controlled drug to be dispensed unless it is complete in every detail. Prescriptions not correctly written cannot therefore be dispensed.

15.14 Prescribing Antipsychotic medication above BNF Limits

15.14.1 The decision to commence a patient on a higher dose than British National Formulary (BNF) upper recommended limit of antipsychotic medication is the responsibility of the patient's consultant. Supplementary Prescribers should not make the decision to proceed to the use of high dose antipsychotics.

15.14.2 An elective trial of high dose antipsychotic medication must be a decision made by the Responsible Medical Officer (RMO) or the ST4/5. The reason for the treatment, should be documented using a high dose therapy (HDT) form (see Appendix 8), and the patient be given an explanation why they are receiving a trial of high dose medication. Forms are available on wards and in the pharmacy departments. If an individual patient is not informed then an explanation why that was not done should also be documented in the patient's healthcare records.

15.14.3 Pharmacists will place a “high dose sticker” on treatment cards where they notice HDT is being prescribed. This will act as a reminder to RMOs to review therapy.

15.14.4 In those circumstances where higher than BNF limits might be prescribed for quite some time, the RMO will ask for a second opinion from a senior colleague not involved in the day to day care of the patient.

15.14.5 The clinical indications should be recorded, documented in the patient's healthcare records, and the outcome reviewed every three months.

15.14.6 Consideration before initiating therapy should be given to baseline tests for renal and/or hepatic insufficiency i.e. urine electrolytes and liver function tests and also an ECG to exclude significant cardiac

disease. If these investigations are not carried out an explanation for not doing so should be documented in the healthcare records. Repeat investigations of renal and hepatic function should be considered at each regular review of the patient and any change in the patient's physical health documented (see also The Physical Health Care Policy CLP55).

15.14.7 A trainee reviewing follow-up patients must confirm with the consultant any repeat prescription for prescriptions above BNF limits.

15.14.8 If the dose of antipsychotic medication is changed, the reason should be documented i.e. whether due to lack of response, intolerance of side-effects or the patient's improving mental state.

15.14.9 If there is no clear response to high dose medication, a reduction in the dose that meets the maximum permissible BNF limit should be made after defining an adequate trial period.

15.14.10 General Practitioners will be kept informed and asked to prescribe regular prescriptions.

15.14.11 It would be expected that the consultant would reduce the dosage to within BNF limits as soon as clinical indications make this possible.

16.0 Prescribing For Out-Patients

16.1 Prescriptions for out-patients shall be written in block capitals and contain all relevant information as detailed in section 15.4.

16.2 Prescriptions for out-patients shall be written on either a triplicate out-patient prescription or an A+E prescription form.

16.3 The normal duration of supply of medicines should be 28 days. Shorter duration should be **specified by the prescriber**. Patients with a history of self harm in the last three months should receive no more than 14 days supply.

16.4 FP10(HP) forms for dispensing by community pharmacists are also used for out-patients. It is essential that these prescriptions are completed correctly and in full to avoid inconveniencing patients. If in doubt, prescribers should check the section on prescribing in the British National Formulary. FP10(HP) prescriptions for controlled drugs must contain all details as set out in section 5.13.6. A photocopy of the prescription should be kept in the patient's healthcare record. Substance misuse services will use forms FP10MDA. These forms will be completed on the computer and a copy of the prescription kept in the patient's healthcare record.

16.5 FP10(HP) forms may not be used for private patients or for staff prescriptions.

16.6 When FP10(HP) forms are kept in a department, the nurse in charge shall keep a register in which are recorded details of the serial numbers of all forms received

from pharmacy and supplied. Security of pads or FP10(HP) forms issued to an individual prescriber will be the responsibility of that individual. When a trainee doctor leaves the Trust or move to another part of the rota it is the responsibility of the consultant to make sure that any remaining FP10(HP) forms are returned to the pharmacy.

16.7 **Medicines for Personal Use**

16.7.1 Doctors should, wherever possible, avoid treating themselves or anyone with whom they have a close personal relationship and should be registered with a GP outside their family.

16.7.2 Only in exceptional circumstances, may medical staff obtain medicines, excluding controlled drugs, for themselves or for their immediate families providing that: -

- a prescription is written on their individual prescription form held in pharmacy
- the quantity prescribed is the smallest practical and does not exceed one month's supply

16.7.3 A member of staff who is not registered as a hospital patient may, in exceptional circumstances, have his GP prescription dispensed in the hospital pharmacy when this facilitates him remaining at work.

16.7.4 In exceptional circumstances, if their own GP is unable to see them, a hospital doctor may prescribe small amounts of medication for staff through the usual A+E or Occupational Health procedures. Normal prescription charges apply.

17.0 Prescription Charges

17.1 Prescription charges are payable in respect of drugs supplied to out-patients, day case patients, A+E patients and ward attenders.

17.2 Prescription charges are not payable in respect of drugs supplied on discharge to in-patients or in respect of any drugs administered whilst the patient is on health service premises. Patients treated under the terms of Supervised Community Treatment are also exempt, provided they receive their medicines from a hospital pharmacy.

17.3 Prescription charges normally shall be collected by the pharmacy department, but staff who issue pre-packed medicines from other departments are responsible for ensuring that the appropriate charge is collected.

17.4 If a patient requires medicines for immediate treatment and has no cash, staff may issue an invoice in respect of the prescription charge.

17.5 The prescription charge is not refundable unless it has been levied incorrectly or if no proof of exemption can be supplied. If this is the case a form for reclaiming the prescription charge can be obtained from the pharmacy. Credit is not possible in respect of medicines returned by the patient at a later date.

18.0 Supply or Administration of Medicines under a Patient Group Direction

18.1 In certain clinical areas nurses or members of other professions may be allowed to administer or supply medicines at their discretion in accordance with a Patient Group Direction.

18.2 Each Patient Group Direction shall be drawn up by an appropriate group of doctors, pharmacists and other relevant professionals using the enclosed template (Appendix 6) and shall be valid only if approved by all of the following:

- The Medical Director/Clinical Director or designated deputy
- The Director of Integrated Governance or nominated deputy
- The Chief Pharmacist or nominated deputy
- The Drugs and Therapeutics Committee
- The Trust's Advisory Nursing Group

18.3 Each Patient Group Direction shall include details of the clinical situation in which it applies, including: -

- criteria for confirming the clinical condition
- clinical criteria under which patients are excluded

18.4 Each Patient Group Direction shall include details of staff who are authorised to act in accordance with it, including: -

- the professional qualification required (PIN Number)
- any specialist qualification, training or experience required
- requirements for continuing training or education

18.5 Each Patient Group Direction shall include details of the medicines which it covers including: -

- the name, form and strength of the medicine which may be administered or supplied
- the dose(s) which may be administered and the criteria for choice of dose.
- the route(s) of administration which is permitted the frequency of administration which is permitted and the total number of doses which may be given within a stated time period
- details of any follow-up treatment which is required
- details of information or advice to be given to the patient
- instruction for identifying and managing any adverse outcomes
- arrangements for referral to medical advice contra-indications to administration or supply of the medicines, including concurrent medication

18.6 Each Patient Group Direction shall include the following:

- the names of the persons involved in drawing it up
- the signatures of the managers approving it in accordance with paragraph 18.2
- the date on which it was approved and a review date, after which is no longer valid

18.7 Any patient excluded from treatment under a Patient Group Direction shall be referred to a doctor so that appropriate medicines may be prescribed.

18.8 All medicines administered or supplied under a Patient Group Direction shall be recorded in the healthcare record and signed and dated by the practitioner.

18.9 Any health professional authorised to act in accordance with a Patient Group Direction shall: -

- have the written authority of the head of their profession or nominated
- deputy
- satisfy the head of his/her profession that he is competent and has received
- appropriate training
- sign a copy of the relevant Patient Group Direction to confirm that s/he has
- understood its content
- be aware of the need for vigilance in reporting any adverse outcomes
- experienced by patients being treated in accordance with the Patient
- Group Direction.

18.10 Copies of Patient Group Directions will be held by the Chief Pharmacist.

18.11 The master copy of each Patient Group Direction will be held by the Director of Integrated Governance.

18.12 Records of staff authorised to act in accordance with Patient Group Directions shall be held by the Director of Integrated Governance. A list should be provided to the Chief Pharmacist.

19.0 Filling And Use Of Monitored Dose Systems (MDS)

19.1 A nurse or pharmacist should assess patients to establish the type of support needed to assist patients with their medication. This may not necessarily involve the use of a MDS. MDS should not be used where nursing staff are visiting to administer medicines.

19.2 Patients should be assessed for their ability to:

- Remember the time when medicines are due
- Open the device
- Select the right compartment

- Remove medicines from the device

19.3 Patients should normally supply their own Monitored Dose System.

19.4 A nurse or pharmacist should explain to the patient the role of each person providing medication support to him or her.

19.5 Patients should be monitored and re-assessed at least once every 3 months or when prescribed medicines are changed.

19.6 The decision to use a MDS and the outcome of the assessment and evaluation must be documented in the patient's care plan.

19.7 A registered nurse may enable patients to fill and label their own MDS. In exceptional circumstances, where it is not possible to find a pharmacist to fill the MDS, the patient or carer is not able to fill it and the assessment of the patient has shown that a MDS is essential, a registered nurse may fill the device. A device containing a maximum of one week's supply can be filled by a nurse. Ideally daily devices only should be filled by nurses. When filling the device care should be taken that it is filled in accordance with the directions on the boxes and bottles supplied by a pharmacist.

19.8 Only use medicines, which are sufficiently stable, as exposure to other medicines, moisture and light may affect efficacy. If necessary, contact a pharmacist for advice.

19.9 Do not keep medicines in a device for longer than two weeks.

19.10 MDS must be labelled with:

- Patients full name
- Quantity, name and strength of medicine and prescribed dose.
- The date filled
- The name of the person filling it

The same details of filling must also be recorded in the patient's healthcare records.

19.11 MDS should be re-labelled each time there is a change in prescribed medication.

19.12 Patients should be encouraged to self-administer medication from their MDS.

19.13 Medicines should only be removed from MDS at the time of administration.

19.14 If one medicine is no longer prescribed the whole contents of the MDS should be returned to the Pharmacy and the MDS refilled with the correct medicine.

19.15 A nurse should never attempt to identify and remove individual discontinued medicines.

20.0 Dispensing of Medicines

20.1 The pharmacist will check that: -

- the prescription is clearly and correctly written to avoid misunderstanding and error
- the medicines prescribed are appropriate for the patient
- the dose prescribed is appropriate for the patient. N.B. Amendments to the prescription which are made and signed by the pharmacist after consultation with the prescribing doctor or in accordance with policies previously agreed with the medical staff are acceptable.

20.2 The pharmacist is also responsible for:

- ensuring the quality, efficacy and safety of all medicines used in trust premises
- advising on security and storage of medicines
- compounding medicines in a form suitable for administration to the patient
- annotating prescriptions to render them accurate and providing any relevant additional information on container labels.

20.3 Approved names shall be used for prescribing, dispensing and labelling of medicines. Pharmacists will normally supply the most appropriate branded or generic product bearing in mind the clinical needs of the patient, the quality, efficacy and safety of the medicine and any financial implications.

21.0 Preparation of Medicines for Administration

21.1 Wherever possible, medicines will be supplied by a pharmacy in a form suitable for direct administration to the patient.

21.2 When medicines have to be measured, mixed or reconstituted in a clinical area, prior to administration, this shall be undertaken in a designated clean area which is approved for the purpose by the appropriate Consultant Practitioner and pharmacist.

22.0 Administration of Medicines

22.1 Medicines shall only be administered in accordance with a prescription or Patient Group Direction. Medicines must be administered directly from the labeled container into which they were dispensed by pharmacy staff and never transferred into another container prior to administration.

22.2 The administration will be recorded on the patient's treatment card.

22.3 Staff who are authorised to prescribe are also authorised to administer medicines.

22.4 Medicines prescribed by a registered prescriber may be administered by the following staff:-

- A registered nurse
- A student nurse who is accompanied and supervised by a registered nurse
- A qualified Associate Practitioner
- A student Associate Practitioner who is accompanied and supervised by a registered nurse.

Where two persons are involved the responsibility for the accuracy of the administration is attached to the senior qualified person, however, both shall sign the administration record.

22.5 Injections are to be administered in accordance with the procedure for administration of injections (see Appendix 8).

22.6 If anticoagulants e.g. heparin and warfarin are to be administered the nurse must check that the patient's blood clotting (INR) is being monitored regularly and refer to the patient's anticoagulant clinic card as appropriate (see also National Patient Safety Agency (NPSA) Alert 18 – Anticoagulants: '*Actions that can make anticoagulant therapy safer*').

22.7 Covert administration of medicines should not take place unless it is felt that to disguise medication in food and drink can be justified in the best interest of the patient. Every effort should be made to encourage a service user to take their medicines in the normal way prior to administering it covertly. Every adult must be presumed to have mental capacity to consent to or refuse treatment unless stated otherwise in the healthcare record. It is usually not assumed that children under the age of 16 are competent to give consent. However they can consent to or refuse treatment if they have sufficient understanding and intelligence to do so (refer to Fraser guidelines/Gillick Competence).Otherwise the decision should be made by an adult who has parental responsibility for the child.

A multidisciplinary discussion including the pharmacist and, if possible the service user's carers or relatives, should be held to discuss covert administration of medicines. This should be documented in the healthcare record. If possible written consent of the carers / relatives should be recorded in the healthcare record.

22.8 The pharmacist should advise on the suitability of mixing the medicines with food and drink.

23.0 Procedure for Administration of Medicines (See Appendix 3)

23.1 Medicines should be administered in a quiet area to allow patients to discuss their medicines if necessary. The nurse administering medicines should ensure that she is not disturbed throughout the process.

23.2 The person administering the medicine shall read the prescription and ascertain that the dose has not already been given. Prescriptions must be legible. If any doubt arises, the prescriber must be consulted.

23.3 If contra-indications to a medicine are observed, the dose shall be withheld and the appropriate prescriber informed without delay. A record should be made in the patient's healthcare record.

23.4 The person administering the medicine shall select the medicine required, check the label with the prescription and note the expiry date.

23.5 The person administering the medicine shall check the prescription and/or treatment card with: -

- the name of the patient
- the patient identity number where appropriate
- the medicine
- the calculation, if any (with a second person)
- the measured dose
- the time of administration
- the dosage instructions and compare with the label on the container

23.6 The person administering the medicine shall take the measured dose and treatment card to the patient, checking his identity, and remain with him until the medicine has been taken.

23.7 The person administering the medicine shall complete the record of administration of the medicines on the treatment card at the time of administering.

23.8 When medicines are administered "as required" (PRN) there should be a note in the healthcare record stating the reason the medicine was administered and the outcome.

23.9 If treatment is refused, professional judgement will be used to determine the level of persuasion necessary to induce the patient to accept. An entry shall be made on the treatment card to indicate when doses are either refused or omitted using the codes on the front of the card. The prescriber shall be informed and a record made in the patient's healthcare record.

23.10 Medication shall normally be administered in the form in which it is supplied. If this is not possible for physical reasons then the advice of a pharmacist should be sought on appropriate alternatives.

23.11 If a syringe is required to administer an oral liquid medicine it must be a specific oral syringe. Under no circumstance must an intravenous syringe be used for this purpose.

23.12 If it is felt that to disguise the medication in food or drink can be justified in the best interests of the patient the nurse must ensure before doing so, that she has made every effort to obtain the consent of the patient to receive the medicines in the normal way, has discussed the issue with other members of the health care team, including the pharmacist and, if possible, with the patients carers and relatives, documents these discussions in the patient's records and provides a detailed account of the disguised administration. If it is possible to obtain the

written consent of carers and relatives this should be done and the consent retained with the records.

24.0 Self-Medication

24.1 Patients wishing to take responsibility for their own medicines shall be entered on the Trust's self-medication programme.

24.2 Before any patient is started on the self administration of medicines programme there must be agreement from the multidisciplinary team (MDT) that the patient is suitable for the programme and an entry stating this made in the patient's healthcare records.

24.3 The risk assessment form (See Appendix 2a) must be completed and the stage of the programme that the patient should start on agreed. A record should be made in the healthcare records.

24.4 The patient must complete and sign the consent form (see Appendix 2b). The patient may withdraw consent at any time and the programme stopped. A copy of this form should be stored with the prescription and administration card and a copy in the medical notes.

24.5 The programme may be started at any stage depending on the patient's ability.

24.6 Before a patient moves from one stage to the next there should be an assessment of their progress by the MDT and the risk assessment form amended (see Appendix 2a). If a patient is removed from the self administration programme and subsequently recommenced, a new risk assessment must be completed.

24.7 Injections, medicines required for one dose, medicines prescribed in variable doses, controlled drugs and some medicines prescribed "as required" (PRN) will continue to be administered by nursing staff.

24.8 Medicines must be prescribed by a medical officer on a current treatment card.

24.9 All medicines will be dispensed for the individual patient and labelled with full instructions. Additional instructions should be made available to the patient if necessary in the form best suited to their needs, e.g. printed leaflets, large print, pictures describing administration times etc.

24.10 Stock medicines should never be used for patients who are self administering medicines, except if the prescribed medicines have been changed and a supply awaited from pharmacy. In this case the nurse must administer the medicines.

24.11 If a patient on Stage 3 goes on leave they may take their supply of medicines with them preventing the need to write up leave prescriptions. If the supply is considered too much then a leave prescription must be obtained in the normal way.

24.12 Nurses involved in the supervision of the programme must be registered nurses

or designated trained carers.

24.13 A lockable medicines locker, or other suitable storage approved by the pharmacist, must be made available to each patient for storing their own medicines. The nurse in charge should hold a duplicate key, but this should not be used routinely. The patient's key may be removed if the nurse in charge considers it necessary in the interests of safety.

24.14 Self Administration" should be written in the appropriate section of the prescription and administration card.

24.15 When patients are on stage 1 & 2 of the programme each dose administered must be signed for on the treatment card by the nurse administering/supervising. Monitoring form 1 should be completed (see Appendix 2c).

24.16 The pharmacist and/or nursing staff will check at an interval agreed by the MDT that a patient on stage 3 has administered their medicines correctly and complete monitoring form 2 (see Appendix 2d).

Patients on stage 3 may wish to keep a record of their own medicine administration (See Appendix 2e for an example).

24.17 **Stages of the Programme**

24.17.1 Stage 1

Twenty eight days supply of medication for each patient included in the programme will be dispensed by the pharmacy and kept together in a plastic bag. This should be stored in the medicines trolley. The nurse should sign the prescription and administration record card.

At the appropriate times the nurse will give the plastic bag containing the entire patient's medication to that patient and supervise the selection and administration of the correct dose(s). Monitoring form 1 should be completed.

24.17.2 Stage 2

As for stage 1 except that the patient will be expected to request their medicines at the correct time. If after 30 minutes (or other time agreed with the MDT) the patient has failed to request their medicines, the nurse should remind them. Monitoring form 1 should continue to be used. The nurse should sign the prescription and administration record card.

Patients receiving depot medication will be given an appointment card for their next injection. They will be expected to request their injection from nursing staff at the appropriate time.

24.17.3 Stage 3

The patient will store their own medicines in their locked medicines locker and will be expected to take their medicines correctly with minimum intervention from nursing staff.

The pharmacy will dispense an appropriate quantity of medicines for the individual as determined by the nursing, medical and pharmacy staff. This will usually be seven days, but more able patients may join the scheme storing a larger supply. These medicines may be issued to the patient when they go on leave.

Nursing staff should monitor the patient as agreed with the MDT.

At agreed time intervals dose counts should be undertaken to ensure that there is a high level of compliance. Monitoring form 2 should be completed.

The nurse need not sign the prescription and administration record card unless administration is actually witnessed.

Patients receiving depot medication will be given an appointment card for their next injection.

25.0 Errors of Administration

25.1 Errors in the administration of medicines may include: -

- a medicine given to the wrong patient
- the wrong medicine given to a patient
- an incorrect dose of a medicine given to a patient
- the wrong route of administration used for a medicine
- a patient failing to receive a medicine without due record
- failure to make appropriate records of drug administration.

(NB. This list is not exhaustive)

25.2 In the event of an error in administration, the person in charge shall inform the appropriate doctor, manager and pharmacist. The Consultant or GP in charge must be informed of the error at the earliest opportunity. In the case of a serious error the Consultant or GP on-call must be informed.

25.3 A record of the error shall be made in the healthcare records.

25.4 In all cases an incident/accident form shall be completed and forwarded to the line manager, within 24 hours of the incident.

25.5 In cases where the error involves a member of the nursing staff, the Director of Integrated Governance shall be informed.

25.6 In cases where the error involves a member of the medical staff, the Medical Director shall be informed.

25.7 In cases where the error involves a member of the pharmacy staff, the Chief Pharmacist shall be informed.

26.0 Losses of Medicines

26.1 If there is any loss of medicines from a clinical area the nurse in charge shall notify the appropriate manager and pharmacy manager.

26.2 Loss of medicine cupboard keys will be reported to the appropriate Manager and pharmacist immediately.

26.3 The manager and pharmacist will decide the appropriate action required.

27.0 Disposal of Medicines

27.1 A dose of a medicine prepared for administration and subsequently not used must be disposed of safely by placing in a sharps container. It shall not be returned to its original container.

27.2 All medicines no longer required must be returned to the supplying pharmacy as soon as possible.

27.3 Medicines returned to pharmacy for disposal will be handled in accordance with the detailed local procedure.

28.0 Suspected Illicit Substances discovered on Trust Premises

28.1 Where a suspected illicit substance is brought into Trust premises by a patient, the police will not normally be involved unless they are suspected of supplying other patients or posing a threat to staff or patients.

28.2 As soon as a suspected illicit substance is discovered it should be removed from the area where it was found and stored in the controlled drugs cupboard in the ward or department. An entry should be made in the ward CD Record book stating, eg “Small quantity of brown substance”. The entry should be signed by two members of staff (preferably qualified nurses). There should be a separate page at the back of the CD record book reserved for entering details of suspected illicit substances.

28.3 If the substance is discovered by non-ward/Community team based staff, it should be taken immediately to the Pharmacy and an entry made in the Pharmacy CD Register.

28.4 The substance should be placed in a suitable container e.g. a sealed plastic bag or envelope and labelled with:-

- A brief description of the item

- The quantity
- Where it was found
- The date

28.5 AS SOON AS POSSIBLE (preferably within one working day), the item should be transferred to the pharmacy either by giving to the ward pharmacist or taking the substance to the pharmacy along with the ward CD record book.

28.6 An entry should be made in the ward CD record book stating that the substance has been transferred to pharmacy, and signed by the nurse and the pharmacist.

28.7 An entry should be made in the pharmacy CD register and disposed of in accordance with local pharmacy procedures.

29.0 Recall of Defective Medicines

29.1 Anyone becoming aware of a defective medicinal product shall contact a pharmacist without delay. Outside pharmacy department opening hours the site officer must be informed and will notify the on-call pharmacist and senior clinical on-call person.

29.2 A local recall or required action following a Drug Alert will be instituted by the pharmacist, as necessary, and the Department of Health notified, if appropriate.

30.0 Monitoring and Reporting Adverse Drug Reactions

30.1 All suspected adverse reactions to a medicine must be reported to the patient's RMO. This can be reported by the patient, nurse, pharmacist, doctor, carer or other health care professional. The detection of previously un-recognised adverse drug reactions depends largely on the receipt by the Committee on Safety of Medicines of Yellow Card reports. All suspected adverse reactions to recently introduced medicines should be reported. These products are marked with a black triangle in the British National Formulary and MIMS.

30.2 For all other medicines serious or unusual reactions which may be due to the treatment shall be reported.

30.3 Yellow Cards are available in the British National Formulary, from pharmacies and on-line at www.medicines.mhra.gov.uk .

30.4 All suspected adverse drug reactions should be reported to the doctor and the pharmacist. A record needs to be made in the patient's health care records giving details of the suspected adverse reaction and any action taken.

31.0 Controlled Stationery

31.1 Pharmacy requisition books, Outpatient prescriptions, FP10(HP)s, FP10s intended for non-medical prescribers and medicines delivery documents, controlled drug record books and controlled drug order books shall be regarded as controlled stationery.

31.2 All these shall be serially numbered.

31.3 Controlled stationary shall be kept in the pharmacy department or other designated area.

31.4 A record shall be kept of the date, ward or department and signature of the recipient whenever controlled stationary is issued.

31.5 No FP10(HP) forms shall be destroyed. If spoiled the form shall be crossed through and retained with the pad. These forms should be returned to the pharmacy of origin.

31.6 Pads of FP10(HP) forms shall be kept in a secure location in the ward or department and shall be the responsibility of the nurse in charge. FP10 pads are the responsibility of the prescriber who signed for their collection.

31.7 Treatment cards are not treated as controlled stationery. However, the following precautions shall be observed: -

- Unused forms shall be kept securely in wards and departments and issued only to staff who have authority to prescribe medicines.
- Used forms shall be retained as part of the patient's medical records.
- A file of specimen signatures of all staff authorised to prescribe shall be kept in each pharmacy department.

31.8 Other forms used for ordering medicines are not treated as controlled stationery but the following precautions shall be observed:-

- Unused forms shall be kept securely and issued only to staff who have authority to order medicines.
- Used forms shall be retained in the pharmacy after dispensing.
- A file of specimen signatures of all staff authorised to order medicines shall be kept in each pharmacy department.

31.9 Stationery used for ordering or prescribing medicines shall not be taken away from NHS premises except in the custody of an authorised member of staff who shall be responsible for its safe keeping.

31.10 FP10(HP) forms may be issued to an individual Consultant for personal use. The Consultant must sign to accept responsibility for the forms. When a trainee doctor leaves the Trust or move to another part of the rota it is the responsibility of the consultant to make sure that any remaining FP10(HP) forma are returned to the pharmacy.

31.11 FP10 forms for supplementary and independent prescribers may be issued to an individual nurse/pharmacist/allied health professional for her use who must sign to accept responsibility for the forms.

31.12 Loss of FP10 forms should be reported immediately to the hospital pharmacy or origin and the Primary Care Trust (PCT).

32.0 Management of Medicines by Local Authority Staff seconded to the Trust in Community Teams

32.1 This guidance must be used in conjunction with the individual policies and procedures of each local authority.

32.2 All staff managing medicines on behalf of South Essex Partnership University NHS Trust will have completed the Trust training and will be certified as competent.

32.3 Any medicines related tasks expected to be carried out by staff will be documented as part of the risk assessment and managed through the CPA care plan and be under the continuing supervision of a registered nurse.

32.4 Managing medicines will be limited to prompting service users to take their medicines correctly. This must be carried out with the permission of the service user, which must be recorded in the healthcare record. In cases of severe dementia staff may administer medicines in line with individual local authority guidelines.

32.5 Staff must not purchase or offer advice on non-prescribed medicines for the service user.

32.6 Any concerns relating to medicines, either raised by the service user, carer or staff member, should be reported to the CPA care coordinator.

32.7 Any interventions relating to medicines must be recorded in the service user's healthcare record.

33.0 Day Care Facilities

33.1 Service users attending day care facilities will normally bring their own medicines with them if they require to take any during their time at the facility. Nursing staff should check with the GP or Consultant Psychiatrist the current medicines prescribed.

33.2 If the service user is able, they may keep their own medicines with them and self-administer at the appropriate times. Staff must ensure that the service user will store their medicines safely and not allow other less able service users access to the medicines.

33.3 If it is felt that service users are not able to take their own medicines, then staff may administer them. The service user must bring their medicines with them fully

labelled with name and directions for use. The medicines will be stored in a locked medicines cupboard for the duration of the service user's visit.

33.4 If staff are not confident that the medicines are in a suitable condition for administration to the service user, or they are unsure of the identity of the medicines, then an alternative supply must be obtained from the hospital pharmacy. This supply must be made against a hospital prescription.

33.5 If staff are administering medicines to a service user then all medicines need to be prescribed on a treatment card and all doses administered signed for. Omitted doses should also be recorded in the same way as for an inpatient.

33.6 There should be a locked cupboard for the storage of medicines.

34.0 Community Drug and Alcohol Services (CDAS)

34.1 All Controlled Drugs prescribed by the CDAS services (e.g. methadone, buprenorphine , Subutex etc) will be prescribed on Forms FP10MDU which will be generated using the Care Plus software.

34.2 Occasionally other medicines will be required to be prescribed by CDAS services and in these instances form FP10(HP) will be used. This should be used only in exceptional circumstances as normally these items will be prescribed by a GP.

34.3 Administration support workers, and all care coordinators can generate repeat prescriptions on the computer system once the prescriber has written an initial prescription. All these prescriptions must be checked and signed by the prescriber before they are handed to the client by a care coordinator.

35.0 Rapid Tranquilisation

35.1 Rapid Tranquilisation (RT) should be managed in conjunction with CLP25 Policy for Prevention and Management of Violence and Aggression, CLPG52 for Rapid Tranquilisation and the Trust formulary and prescribing guidelines. All staff carrying out RT must have attended a two or five day Ethical Care course and be up to date with Medicines Management training.

36.0 Treatment of Anaphylactic Shock

36.1 All clinical areas will hold a stock of adrenaline for the treatment of anaphylactic shock. Refer to the Trust formulary and prescribing guidelines for more information. All staff must have completed the Enhanced Emergency skills course.

37.0 Training

37.1 Through the Trust analysis of training needs it has been agreed that medicines management is core practice training for appropriate staff. All mandatory/core practice training is provided by Workforce and Development. Please see analysis below for staff groups:

Core Practice Training	Update Interval	Staff Category	Delivery Method
Medicines Management	Three yearly	All qualified staff	Direct learning with competency assessment by observation and e-test.

37.2 Staff who are booked onto mandatory/core practice training who do not attend will receive a letter from the information department informing them of their non-attendance, which will be copied to the appropriate Line Manager. Non-attendees will be automatically rebooked onto another course by the information department.

37.3 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training to the Trust Executive Team, Workforce and Business Support Service Board and Risk Management Committee. Compliance for all Mandatory/Core Practice training fields is set at a minimum of 75%. The trust has an agreed target figure that is adjusted to account for sickness/absence, maternity leave etc.

37.4 Monthly mapping reports will also be sent to operational managers and directors identifying which of their staff are up-to-date with their training and when they are approaching update deadlines. Non-attendance of courses will also be recorded. It is the line manager's responsibility to ensure all their staff have attended appropriate training as identified in the trust training needs analysis.

38.0 Policy Reference Information

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The Director responsible for monitoring and reviewing this procedure is
The Executive Director of Clinical Governance and Quality and the Executive Medical Director