# MEDICINES MANAGEMENT POLICY

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<tr>
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<td>Chief Pharmacist</td>
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1 INTRODUCTION

1.1 RATIONALE

Yeovil District Hospital NHS Foundation Trust has a duty of care to both staff and patients to ensure that policy and procedures for the safe and secure handling and administration of medicines reflect the latest guidance and professional practice possible.

Medicines Management is a complex process but in summary, the concept includes how healthcare staffs carry out the selection, procurement, delivery, prescription, administration and review of medicines to produce informed and desired outcomes of patient care.

Whilst this policy sets out how healthcare staff should manage all issues relating to medicines use at YDH, it is important that all staff who work with medicines should take the time to read the NHS Constitution which describes the holistic principles healthcare workers should aspire to, when considering how medicines are selected and administered to patients.


This policy covers Medicines Management issues across Yeovil District Hospital NHS Foundation Trust and has been compiled by a multi-disciplinary team. It is intended to be used by all individuals who deal with medicines within the Trust including all locum, bank and agency staff.

1.2 AIM OF THE MEDICINES MANAGEMENT POLICY

This Policy provides guidelines aimed at safeguarding patients and staff from error when involved with medicines. It aims to ensure and enable safe practice in the prescribing, ordering, storage, administration, recording and disposal of medicines throughout Yeovil District Hospital NHS Foundation Trust and covers the following classes of medication:

- **Controlled Drugs (CDs):** medicines included in, and controlled under, the provisions of the Misuse of Drug Acts 1971.
- **All other medicines and medical preparations:** any substances prepared and intended for administration to patients.
- **Other pharmaceutical preparations:** These include disinfectants, reagents and other products not used directly to treat patients and some medical devices.


1.3 Definitions

Doctor
Medical practitioner registered with the General Medical Council (GMC).

Non-Medical Prescriber (NMP)
Nurses, pharmacists, physiotherapists, podiatrists and radiographers who have undertaken a recognised prescribing course and possess a recordable qualification. Non-medical prescribers work within their clinical competence as either independent or supplementary prescribers.

Independent Prescriber
A prescriber who is legally permitted and qualified to prescribe and takes responsibility for prescribing and the appropriateness of prescribing.

Supplementary prescriber
A voluntary partnership between an independent prescriber and a supplementary prescriber to implement an agreed patient or client specific clinical management plan, with the patients or clients agreement.

Accountable Officer
A designated individual responsible for the safe, appropriate and effective management and use of controlled drugs (CDs) within the Trust and for the supply of CDs by the pharmacy department to external organisations. For Yeovil District Hospital NHS Foundation Trust, the Accountable Officer is the Chief Pharmacist.

Pharmacist
A pharmacist registered to practice with the General Pharmaceutical Council (GPhC).

Pharmacy Technician
A pharmacy technician registered to practice with the General Pharmaceutical Council. Through further accreditation, a pharmacy technician may practice as an accredited final checker of prescriptions (ACT) and practice on the wards as a medicines management technician (MMT).

Registered Nurse/Midwife/ODP/Radiographer/Physiotherapist
A practitioner currently registered with the Nursing and Midwifery Council (NMC) or Health and Care Professions Council (HCPC).

Authorised Employee – (e.g. student nurse, student ODP, student midwife, assistant practitioner, pharmacy assistant and Health Care Assistant (HCA))
A member of staff who, following training, has been authorised by an appointed practitioner in charge to undertake specific named duties in relation to medication.
1.4 RESPONSIBILITIES

The Chief Pharmacist is responsible for establishing and maintaining appropriate systems for the safe and secure handling of medicines across the Trust.

All procedures involving the prescribing, ordering, storage, administration, recording and disposal of medicines are described in, or signposted within, this Policy. In all cases, staff involved in these activities (including medical, nursing, midwifery, Allied Health Professional (AHP) and pharmaceutical disciplines) are required to undertake these duties with due diligence and in accordance with this policy.

Registered staff of all disciplines are personally accountable for their actions and omissions. In prescribing, dispensing or administering medicines each profession must abide by the standards/code of conduct laid down for these activities by their professional body. Each individual is required to exercise their professional judgement and apply up to date knowledge and skills in all situations involving medicines.

In accordance with the principles of Clinical Governance staff must:

- Always act in such a manner so as to promote and safeguard the interest and well being of patients.
- Ensure that no action or omission on their part or within their sphere of responsibility is detrimental to the interest, condition or safety of patients.
- Maintain and improve their professional knowledge and competence.
- Acknowledge any limitation in their knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner.

In addition, the Trust has a legal responsibility for ensuring that it meets essential standard of quality and care in order that patients will:

- be involved and told what’s happening at every stage of their care
- have care, treatment and support that meets their needs
- be safe
- be cared for by qualified staff
- know the Trust constantly checks the quality of its services.

All staff must be aware of these essential standards and implement them in the course of their work.

Newly appointed medical, nursing, midwifery, AHP and pharmaceutical staff must read the Policy, acquaint themselves with the procedures described within it and act upon them.

The ward/department lead is responsible for ensuring that ward/departmental staff, including bank and agency staff, carry out the safeguards referred to in this document and abide by Trust Policy at all times.

Consultant medical staff are responsible for ensuring that their teams, including locum staff, are aware of the safeguards referred to in this document and of their individual responsibility to abide by their professional standards and Trust Policy at all times.

The Director of Nursing is responsible for ensuring that all nurses and midwives within the Trust are aware of the safeguards referred to in this document and of
their individual responsibility to abide by their professional standards and Trust policy at all times.

The Chief Pharmacist and the professional leads of AHP staff are responsible for ensuring that all pharmacists and AHPs within the Trust respectively are aware of the safeguards referred to in this document and of their individual responsibility to abide by their professional standards and Trust policy at all times.

Throughout this document the generic term ‘nurse’ is used for nurses, midwives and health visitors and is defined as those registered with the Nursing and Midwifery Council. Aspects of this policy relating solely to midwives are clearly indicated.

A copy of the Medicines Policy must be available on all Wards and in all Departments where medicines are used. Consultants are required to ensure that all clinical teams have access to a copy of the Medicines Policy.

Comments/suggestions regarding this Policy should be made in writing to the Chief Pharmacist.

All staff involved in the prescribing, dispensing, preparation and/or administration of medicines must undertake regular training and be able to demonstrate competence in respect of their roles in relation to medicines. Records of training and competency assessments must be retained. All professional training and development for staff dealing with medicines is as per professional requirements and may be identified via staff appraisals.
2 PRESCRIBING OF MEDICINES

2.1 RESPONSIBILITIES

It is the responsibility of all prescribers to prescribe in accordance with statutory and local rules and with guidance issued by their professional bodies. Primary legalisation concerning the prescribing of medicines is contained in The Medicines Act 1968 and The Misuse of Drugs Act 1971.

Where prescribing is undertaken by fully or provisionally registered doctors, this policy must be read in conjunction with:

- Good Practice in Prescribing Medicines, GMC, 2008

For non-medical prescribers, this policy must be read in conjunction with:

- Standards of Proficiency for Nurse and Midwife Prescribers 2006
- General Pharmaceutical Council Standards of Conduct, Ethics and Performance 2010

All prescribers are reminded of their responsibility to elicit accurate medication histories from patients, to document these appropriately and for inpatients, to complete the patient’s prescription chart fully and accurately in the light of the medication history and the patient’s presenting condition, resolving any anomalies as soon as is practicable. See Section 3 – Medicines Reconciliation.

Prescribers also have a responsibility to take into consideration patients’ cultural and religious beliefs. Advice should be sought from pharmacy regarding alternative treatments where appropriate.

Consent for treatment must always be sought from the patient. Refer to the Trust’s Consent for Examination and Treatment Policy on YCloud for further information.

2.2 AUTHORITY TO PRESCRIBE

A medicine can only be supplied in accordance with a prescription written by an authorized prescriber. Prescriptions, including those for controlled drugs, can be signed by fully registered doctors within the meaning of the Medicines Act 1968, or by provisionally registered doctors such as Foundation Year 1 Doctors. Provisionally registered doctors are not allowed to prescribe for their own use, for people who are not patients of the Trust or for his/her own private patients. ‘Prescriptions’ written by medical students are not valid without the signature of a registered medical practitioner or Foundation Year 1 Doctor.

Prescriptions may also be signed by supplementary and/or independent non-medical prescribers who have the appropriate designation against their name on the relevant professional register and who are named on the local register maintained by the Chief Pharmacist.

Prescriptions may be amended by registered pharmacists in respect of drug, dose, route or frequency of administration. These amendments should normally be discussed with and reported to the prescriber and where appropriate recorded in the patient’s medical notes. Such amendments, signed by a pharmacist, are accepted as the ‘definitive’ prescription. Other unsigned alterations invalidate a prescription.
2.3 MEDICINES PRESCRIBING FORMULARY

Yeovil District Hospital NHS Foundation Trust operates a local mandatory Medicines Prescribing Formulary which must be adhered to by all prescribers working in the Trust irrespective of grade. The formulary provides a list of licensed medicines which, following review by the Drugs and Therapeutics Committee, are considered suitable for use on the grounds of safety, efficacy and economy. All prescribing must be in accordance with this formulary unless:

- there is a demonstrable and compelling clinical need to use a non-formulary medicine or
- the patient is admitted on a non-formulary item for which there is no clinical justification to substitute a formulary medicine.

Any requests for additions to the formulary or for exceptions to formulary prescribing should be made to the Chief Pharmacist or to the Secretary of the Drug and Therapeutics Committee. New Drug Request Forms can be found on YCloud and staff should follow the Trust’s Protocol for Requesting a New Drug be added to the Hospital Formulary. All requests are considered and ratified by the Drug and Therapeutics Committee.

2.4 FUNCTION OF THE PRESCRIPTION CHART

i) To provide a permanent record of the patients’ medication.

ii) To facilitate the provision of the correct medicine from pharmacy.

iii) To direct the administration of the medicine to the patient.

Not more than one prescription chart must be in use at any one time for any one patient, unless the number of items prescribed exceeds the available spaces. If a patient requires two or more prescription charts the number of charts in use should be clearly identified on each chart e.g. chart 1 of 2. Multiple charts should be attached together with a treasury tag. Cross reference must be made to medicines prescribed on specialist prescription charts e.g. warfarin, heparin, gentamicin, intravenous fluids, MRSA topical treatment and diabetic therapy.

2.5 ALLERGIES AND DRUG INTOLERANCES

The prescriber is responsible for entering any known allergies and drug intolerances in the appropriate section on the front of the prescription chart and at the top of every page of the prescription chart.

Prescribers should ascertain whether patients are reporting a true allergy, in which case it should be documented, or simply a side effect. Where an allergy is judged to be ‘real’ details should be provided e.g. ‘rash’. If there are no allergies or drug intolerances the ‘NKDA’ box on the front of the prescription chart must be ticked. All entries made in the allergy box must be signed and dated. This section should always be checked before any drugs are prescribed and nursing staff must not administer medication unless this information is complete.

2.6 VTE RISK ASSESSMENT AND PROPHYLAXIS

A Venous Thromboembolism (VTE) risk assessment must be completed, signed and dated by the admitting/consenting clinician and all relevant action taken (e.g. prescription of LMWH) for all adult patients on admission to hospital. See the Trust’s Venous Thromboembolism (VTE) Prevention Policy on YCloud.
2.7 INITIATION OF TREATMENT

Prescribers are reminded of the need to explain to and discuss with patients what medication is being proposed and why, and to ensure that the patient is aware of all significant risks associated with the medication.

Prescribers are also reminded of the need to ensure that prescription charts accurately reflect current treatment decisions (initiation of new medicines/dose modifications/discontinuation of therapy) at all times. In addition, the treatment plan, including how the response to the drug therapy is to be monitored, should be clearly documented in the patient’s medical record.

Prescribers must ensure they are aware of the allergy status of the patient before prescribing any medicines and ensure that any potential interactions between medicines for a given patient are considered and avoided. The patient’s medical record should always be checked before a new prescription is written.

2.8 PRESCRIBING ON THE INPATIENT PRESCRIPTION CHART

The inpatient prescription chart must be an accurate and unambiguous description of medicine treatment. If the prescription is ambiguous, illegible or an error in prescribing is suspected, then the drug MUST NOT be dispensed or administered. The prescriber must be contacted immediately and the prescription must be re-written.

In writing prescriptions, the advice given in the British National Formulary (under “Guidance on Prescribing”) should be observed. All prescriptions must be completed in indelible blue or black ink and comply with the following:

i. The patient’s full name, date of birth, weight on admission (for paediatric patients and those requiring weight adjusted dosing), ward, NHS number/hospital number and responsible lead consultant must be documented (affix addressograph if available). Information relating to drug allergies MUST be recorded, in the provided section, by the prescriber when initially completing a prescription chart. If none are known then this should also be indicated (see Section 2.5 – Allergies and Drug Intolerances).

ii. Every prescription must be signed and dated by the prescriber who must be a registered prescriber employed by the Trust i.e. cannot be a medical student or clinical attachment. Recognisable valid signatures are required for all items prescribed. A full signature is mandatory for controlled drugs. Unsigned prescriptions are invalid. All prescribers must provide the Trust with a specimen of their signature. The prescriber must also print their name or use a name stamp. Prescribers are encouraged to provide their bleep/contact number on the prescription.

iii. All medicines must be prescribed by the approved generic name, written in block capitals (except where prescribing by trade name identifies a particular product where the brands bioavailability may vary e.g. specific sustained release brands. Such products are indicated in the BNF).

iv. The dose must be stated in terms of the quantity of active ingredient not, for example, the number of tablets or volume of liquid except in the case of compound preparations. Doses of medicines must be prescribed using the metric system. Quantities such as units, micrograms or nanograms MUST be
written in full and not abbreviated as u, iu, mcg, μg and ng. Solid quantities of
less than 1 gram should be written in mg, for example 500mg, not 0.5g.
Quantities less than 1mg should be written as microgram, for example
100microgram, not 0.1mg. Decimal points should be avoided wherever
possible by using whole units, for example 125micrograms rather than
0.125milligram. If a decimal cannot be avoided a zero must be written before
the decimal point.

Care is needed where prescribing requires calculation of the dose, for
example where the dose is based on weight. In such situations it is
considered good practice for prescribers to specify the dose per kg AND the
total dose required.

Rate of administration of medication should be clearly stated to avoid
misunderstandings over drops/min, micrograms/min, micrograms/kg/min,
milligrams/litre or the equivalent doses per hour or day.

v. The route of administration must be documented and an indication of where
the treatment (e.g. topically to leg) must be given. Wherever possible,
combinations of routes should not be prescribed e.g. PO/IV. Specific routes
e.g. ‘Intrathecal’ or ‘epidural’ must be written out in full.

The following abbreviations are recognised within the Trust as a standard
means of indicating the route:

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<th>Route</th>
<th>Full Form</th>
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<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
</tr>
<tr>
<td>PR</td>
<td>per rectum</td>
</tr>
<tr>
<td>SC</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>SL</td>
<td>sublingual</td>
</tr>
<tr>
<td>Buc</td>
<td>buccal</td>
</tr>
<tr>
<td>NG</td>
<td>nasogastric</td>
</tr>
<tr>
<td>Neb</td>
<td>per nebulizer</td>
</tr>
<tr>
<td>PV</td>
<td>per vagina</td>
</tr>
<tr>
<td>PO/Oral</td>
<td>by mouth</td>
</tr>
<tr>
<td>Inh</td>
<td>by inhalation</td>
</tr>
<tr>
<td>Top</td>
<td>topical</td>
</tr>
<tr>
<td>TD</td>
<td>transdermal</td>
</tr>
<tr>
<td>PEG</td>
<td>via gastrostomy tube</td>
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All other routes of administration must be written out in full.

vi. The prescriber must clearly indicate the time that each drug must be
administered, by ticking the appropriate pre-printed time on the prescription
chart or by utilising the 24-hour clock. Where a medicine is prescribed at
unusual intervals such as alternate days or 3 days weekly, the doctor must
state this on the prescription. The administration record boxes for days when
medication is not required must be crossed through as soon as the
prescription is written.

vii. The duration of treatment must be clearly indicated by the prescriber where
this is less than the number of day/time spaces available on the prescription
sheet i.e. five days for oral antibiotics or 48 hours for IV antibiotics.

viii. Variable dose prescribing must clearly state the dosage range and the
criteria, which determines the dosage given.

ix. Any alteration must result in the re-writing of that prescription. Prescriptions
must not be amended; the required item must be prescribed as a new entry
and the previous treatment cancelled. It is essential that cancellation of
treatment is shown clearly and unambiguously. The discontinued drug must be crossed out and a line drawn through the unused recording panels on the drug chart and administration record. The cancellation should be dated and initialled, and where appropriate the reason for cessation stated.

x. In addition to the approved abbreviations for the route of administration listed above, the following abbreviations are permitted on prescriptions:

- **OM** morning
- **BD** twice daily
- **TDS** three times daily
- **QDS** four times daily
- **ON** at night
- **PRN** as required

xi. An indication and frequency of administration of ‘as required’ drugs must be given by clearly defined stated intervals with maximum dose over 24 hours to be included (PRN alone is unacceptable). Where defined by clinical policy a maximum duration must also be stated.

xii. Prescriptions must be completely rewritten if any of the administration rows or columns are full. This is the responsibility of the prescriber and provides an opportunity for a thorough review. The use of continuation sheets and the margins for prescriptions is forbidden. When the prescription chart is full, all current prescriptions must be cancelled and the cancellations must be signed and dated by the prescriber. The current therapy must then be entered on the new prescription chart. Cancelled charts must be retained in the patient’s medical notes.

2.9 SPECIAL PRESCRIPTIONS

2.9.1 Oral Anticoagulants

All anticoagulants must be prescribed in the regular medication section of the prescription chart AND on the pink anticoagulant chart. The dose section of the anticoagulant prescription on the prescription chart should be annotated ‘as per chart’.

The indication for anticoagulation and target INR range must also be completed on the pink anticoagulant chart.

2.9.2 Oral Cytotoxic Therapy

For inpatients, oral cytotoxic therapy for haematology/oncology can only be initiated by a Consultant haematologist/oncologist and only Consultants and Specialist Registrars who are competent in this speciality can prescribe an oral cytotoxic agent. A register of approved prescribers is required to be maintained for the Trust.

New inpatients currently taking a cytotoxic medicine must have their therapy reviewed by the relevant haematologist/oncologist before continuing
treatment. Out of hour admissions must be referred to the on-call haematologist/oncologist and any advice given must be acted upon and clearly documented in the medical notes and on the prescription chart.

All prescriptions for oral cytotoxic medicines must be checked by a pharmacist who has undergone specialist training, demonstrated their competence and is locally authorised/accredited for the task. Pharmacists will sign the prescription to indicate that it has been verified and validated for the intended patient and that all the safety checks have been undertaken.

Refer to the Trust’s Cytotoxic Policy available on YCloud for further information relating to the prescribing of cytotoxic drugs.

2.9.3 Diabetic Medication

Oral hypoglycaemics, subcutaneous insulin, intravenous infusions of insulin and injectable GLP-1 medication must be prescribed using the Trust’s ‘Two Week Adult Diabetes Treatment and Blood Glucose Monitoring Chart’ designed for this purpose. Reference MUST be made on the standard prescription to indicate existence of the diabetic chart.

NB: ‘UNITS’ of insulin MUST ALWAYS BE WRITTEN IN FULL AND NEVER ABBREVIATED.

2.9.4 Medical Gases

Medical gases are regarded as Prescription Only Medicines (POMs). Oxygen must be prescribed on the prescription chart using the oxygen prescription section at the front of the chart. The prescription must include the target oxygen saturation and where possible the device, flow rate etc. The nurse must record administration on each drug round.

2.9.5 Benzodiazepines

The prescribing of benzodiazepines is discouraged. Benzodiazepines act as hypnotics (induce sleep when given at night) and anxiolytics (sedate when given during the day). When benzodiazepines are prescribed, physical and psychological dependence and tolerance occurs. This will lead to difficulty in withdrawing the drug after the patient has been taking it regularly for more than a few weeks. See Appendix 1 – Guidelines for Prescribing Benzodiazepines and Z-Hypnotic Medicines.

2.9.6 Complimentary Medicines

Patients admitted to hospital on complementary medicines (e.g. herbal preparations) may continue to take them provided:

a) a medical assessment is made of their safety and appropriateness for the patient concerned.

b) the preparation(s) are written on the PRN or regular section of the drug chart and administration record as appropriate

c) the patient has their own supply.
The Pharmacy Department does NOT stock complementary medicines. Prescribers should note that patients using such products in hospital will be expected to make their own arrangements for ongoing supplies.

2.9.7 Antimicrobial Medicines

Antimicrobial prescribing must follow the Trust’s **Antimicrobial Prescribing Guidelines** which are available on YCloud. The aim of these guidelines is to provide appropriate advice for prescribing antimicrobial agents and to preserve their therapeutic value. Inappropriate prescribing may be harmful to patients, lead to the emergence of resistant strains and is costly.

Gentamicin, an intravenous antibiotic, is associated with significant patient harm when prescribed incorrectly. Gentamicin must be prescribed on the regular prescription chart AND on the dedicated **Once Daily Gentamicin Prescribing, Administration and Monitoring Record** which offers advice on how to prescribe and administer this high risk antibiotic.

2.9.8 Licensed Medicines Used Outside Their Licensed Indications (Off-Label Use)

The Trust generally supports the use of a licensed medicine for an unlicensed indication (so called “off-label” use) provided that the unlicensed use would command peer group support and the Trust’s Guidelines for Prescribing Unlicensed and Off-License Medicines has been followed (See Appendix 2). Prescribers are encouraged to discuss the prescribing of off-label medicines with the Chief Pharmacist. It should be noted that a licensed medicine should be used within its licensed indications in preference to using a medicine “off-label”, for the same indication.

2.9.9 Unlicensed Medicines

Medicines that have no Product License for use in the UK are also sometimes used within the Trust. The Trust supports their use if used in accordance with the Trust’s Guidelines for Prescribing Unlicensed and Off-license Medicines (See Appendix 2). Prescribers should seek advice from the Chief Pharmacist when prescribing an unlicensed medicine.

2.9.10 Controlled Drugs (CDs)

Preparations detailed in the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001 are controlled by procedures additional to those used for other medicine. For details relating to the prescribing of these controlled drugs, the prescriber is referred for full guidance to the current edition of the British National Formulary under the section CONTROLLED DRUGS and DRUG DEPENDENCE. In all cases the prescriber must be familiar with the characteristics of the controlled drug to be used.

Controlled drugs prescribed for inpatients should follow the prescribing guidance in section 2.8 of this policy. Controlled drugs for outpatients or for patients being discharged from the Trust must be prescribed using the Trust’s dedicated ‘Prescription for Controlled Drugs’.
Prescriptions for controlled drugs should state clearly the dose, maximum frequency and route of administration and need to satisfy legal requirements for style and content.

- The prescription must be SIGNED and DATED by the prescriber.
- The prescriber must state in the PRESCRIBERS OWN HANDWRITING in ink or so as to be otherwise indelible:
  - The name and address of the patient.
  - The preparation e.g. morphine sulphate.
  - In the case of a preparation, the form and where appropriate, the strength of the preparation.
  (NB. The dosage form (e.g. tablets) must be included on the CD prescription irrespective of whether it is implicit in the proprietary name (e.g. MST Continus) or of whether there is only one form available).
  - The total quantity of the preparation (or the number of dose units) in BOTH WORDS and FIGURES (e.g. 14 tablets (fourteen)). This requirement is not necessary on inpatient prescriptions.
  - The dose and frequency.

Self-prescribing of controlled drugs is not permitted.

2.9.11 Clinical Trials Medication

Medicines that are prescribed for inpatients as part of a clinical trial must be prescribed on the standard prescription chart, in the same way as other medicines. The prescription must clearly indicate that the patient is part of a clinical trial and the Research and Development Department must be informed of all trial patients. Administration of such medicines must be recorded in the usual manner on the prescription chart.

When a patient currently taking medication as part of a clinical trial is admitted, medical staff must assess the risk/benefit of continuing/stopping trial medication. This may involve contacting the principal investigator for the trial, and, if deemed appropriate, these patients should be allowed to take their own trial medication whilst a patient at Yeovil District Hospital.

See Appendix 3 - Guidance for Clinical Trials.

2.10 PRESCRIBING FOR OUTPATIENTS

Prescribing for outpatients should be limited to the requirement for immediate initiation of treatment. For these patients, the hospital doctor should prescribe, and the pharmacy dispense, 28 days’ supply of treatment unless the required course is shorter. Trust outpatient prescription forms should be used for this purpose.

Where immediate commencement of treatment is not required, the hospital doctor should write to the GP and request that the GP consider initiating or continuing treatment, giving sufficient information to allow safe and effective prescribing. The hospital doctor must ensure that any recommended treatment is for medication included in the Somerset Clinical Commissioning Group Prescribing Formulary. The patient should be advised to make a non-urgent GP appointment which allows time for receipt of written information by the GP.
The Trust should retain prescribing responsibility where:

1. There is a need to retain responsibility for monitoring the effect of treatment or adjusting the dosage in which case a supply to see the patient through to the next outpatient appointment should be prescribed and dispensed.

2. The prescribed preparation is designated as a “hospital only” medication by the Medicines and Healthcare Products Regulatory Agency (MHRA) or by the Drugs and Therapeutics Committee.

3. The prescription forms parts of a clinical trial for which the Consultant is responsible.

2.11 PRESCRIBING ON DISCHARGE

All medication required by a patient on discharge from Yeovil District Hospital must be prescribed on the Trust’s Discharge Summary. Whenever possible this should be sent to pharmacy 24 hours in advance. The prescription section of the Discharge Summary must comply with section 2.8 of this policy. Any changes made in drug therapy during a patient’s stay in hospital must be communicated to their GP via the relevant section of the Discharge Summary. This ensures primary care prescribing systems are updated with medication changes.

See Appendix 4 – Guidance for Managing Medicines on Discharge.

2.12 PRESCRIBING FOR PRIVATE PATIENTS

The Trust’s blue ‘Private Outpatient Prescription’ chart must be used for all prescriptions written for private outpatients. Such patients will be charged for the medication supplied together with a dispensing fee.

2.13 FP10 HNC PRESCRIPTIONS

FP10 HNC (previously known as FP10 (HP) prescriptions can be dispensed at any community pharmacy and are available for use in emergency situations or when the on-site pharmacy service is unavailable. Prescriptions written on FP10 HNC forms must comply with the Trust’s Medicines Formulary.

2.14 SELF PRESCRIBING AND PRESCRIBING FOR FAMILY AND FRIENDS

It is recognised that there may be instances when it is in the best interest of the Trust and of its staff to allow for immediate access to medicines. In such circumstances the Trust will allow the managed supply of small quantities of medicines in emergency or urgent situations, in order that key staff may remain on duty.

All hospital staff and their families/friends should be registered with a G.P. through whom they will obtain all routine NHS care. In line with GMC advice, Trust medical staff may not, at NHS expense, prescribe for themselves and for their families. Prescribers wishing to prescribe outside this guidance must do so on a private basis and following discussion with the Chief Pharmacist.

Medical staff are not permitted to use FP10 HNC forms to prescribe for individuals other than NHS outpatients of the Trust and use of these forms for a private prescription constitutes fraud and will be managed in accordance with the Counter Fraud and Corruption Policy.
2.15 VERBAL PRESCRIPTIONS

Instruction by telephone to administer an unprescribed substance is no longer permitted. The principles of good prescribing e.g. anticipating patients' needs in advance and the use of appropriate Patient Group Directions (PGDs) should negate the need for practitioners to administer medicines from verbal prescriptions. The prescriptions should always be written by the prescriber.

2.16 PROCESS FOR ENSURING THE ACCURACY OF PRESCRIPTION CHARTS

Ensuring the accuracy of the prescription chart must be a multidisciplinary approach. Nursing and midwifery staff involved in the administration of medicines have a responsibility to ensure, prior to administration, the prescription chart conforms to all the requirements detailed above. Pharmacy staff must clinically screen each prescription at the earliest opportunity to ensure appropriateness of prescribing. A therapeutic assessment of the prescribed medication will be conducted by a pharmacist and recorded on the prescription. This process includes:

- Medicines reconciliation for all new admissions.
- Advising medical staff of changes and recommendations.
- Recording interventions by completing an intervention form. One copy is attached to the prescription chart for medical staff and one copy is returned to pharmacy for audit purposes and reporting.
- Checking for clinically significant interactions and contraindications.
- Ensuring doses of each medicine are appropriate with respect to renal and hepatic function, patient age and weight.
- In the event of an error the relevant staff are informed and the incident reported.

2.17 MEDICATION INCIDENTS INVOLVING PRESCRIBING

Incidents involving the prescribing of a medicine to a patient include:

- Inappropriate drug/confusion over drug name
- Inappropriate dose, frequency, route
- Prescription of a drug despite known intolerance/allergy
- Significant interaction
- Inadvertent omission of critical drug.

Whenever such incidents in the prescribing of medicines are found or observed then:

- The incident should be brought to the attention of the prescriber
- An incident form must be completed on Safeguard.
3 MEDICINES RECONCILIATION

3.1 RATIONALE

In December 2007, the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) issued joint guidance on medicines reconciliation on admission of adults to hospital. The guidance stated that “the aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission”. The guidance highlighted the possible threat of harm to hospital inpatients as a result of medication errors, leading to increased morbidity, mortality and economic burden to health services. It also recognised that medication errors occur most commonly on transfer between care settings and particularly at the time of admission.

The following actions were recommended in the guidance:

- All healthcare organisations that admit adult inpatients should put policies in place for medicines reconciliation on admission. This includes mental health units, and applies to elective and emergency admissions.

- In addition to specifying standardised systems for collecting and documenting information about current medications, policies for medicines reconciliation on admission should ensure that:
  
  o Pharmacists are involved in medicines reconciliation as soon as possible after admission
  o The responsibilities of pharmacists and other staff in the medicines reconciliation process are clearly defined; these responsibilities may differ between clinical areas
  o Strategies are incorporated to obtain information about medications for people with communication difficulties.

3.2 AIM

The aim of the medicines reconciliation process is to reduce the number of medication errors occurring on the transfer of patients between care settings and therefore minimise the threat of harm to a patient as a result of such errors.

This policy is aimed at all staff involved in the admission of patients to hospital. Staff have a responsibility to:

- Collect relevant information to enable an accurate medication history to be established

- Ensure the medicines prescribed on admission correspond to those that the patient was taking prior to admission (where appropriate), and
• Communicate effectively with other healthcare professionals any intentional changes made to the medication during a patient’s stay.

3.3 DEFINITION

The National Prescribing Centre (NPC) defines medicines reconciliation as:

• Collecting information on medication history (prior to admission) using the most recent and accurate sources of information to create a full, accurate and current list of medicines
• Checking or verifying this list against the current prescription chart in the hospital, ensuring any discrepancies are accounted for and actioned appropriately, and
• Communicating through appropriate documentation any changes, omissions and discrepancies.

3.4 AUTHORISED PERSONNEL

The following groups of staff are permitted to take medication histories and reconcile medication:

• Registered doctors
• Registered non-medical prescribers
• Registered pharmacists
• Pharmacy technicians with accreditation in medicines management (drug history taking module)

3.5 ROLES AND RESPONSIBILITIES

It is the responsibility of all staff involved in the admission of patients to request and record all relevant information regarding a patient’s medication.

Primary care teams

For planned admissions, it is essential that there is clear, unambiguous and legible information about a patient’s medication and medical history at the time of admission. Full patient details must be stated i.e. name, address, date of birth, registered GP, surgery address and telephone number and date of admission to hospital. There must be a complete list of all medicines currently prescribed for the patient (repeat and acute prescriptions) and for each medicine the dose, frequency, formulation and route must be stated. The date of last issue for each medicine must also be included and details of the indication for any medicines that are short-term use only are needed. It is essential that any known allergies, sensitivities or significant adverse drug reactions are stated. There must also be detailed information of the presenting condition and any co-morbidities. For unplanned admission, this information must be made available to the hospital at the earliest possible opportunity.

Admitting Consultants
The admitting consultant is responsible for ensuring compliance with this policy.

**Prescribers**

It is the admitting prescriber’s responsibility to take and document a patient’s medication history (see Appendix 5 for Procedure for Medication History Taking). For medical and surgical patients this information should be documented in the medical clerking record (or Stroke Pathway Pro Forma if appropriate) and for patients admitted via a pre-assessment clinic the information should be recorded on the dedicated medicines reconciliation form used in these clinics and filed in the patient’s medical notes ready for their admission. Any decisions to change a patient’s medication must be clearly stated and an inpatient prescription must be written. On discharge it is the prescriber’s responsibility to write the discharge prescription and to clearly state all changes to the patient’s medication list, together with the clinical reasons for those changes. The discharge prescription should also indicate the length of treatment and any relevant instructions for the ongoing monitoring of the prescribed medication.

**Pharmacy staff**

Pharmacists and accredited pharmacy technicians must verify the patient’s medication history as soon as possible after admission. This should be carried out within 24 hours however if admission takes place at the weekend medicines reconciliation must be completed as soon as possible at the start of the following working week. On discharge it the pharmacy staff’s responsibility to ensure the medication prescribed at discharge corresponds to the medication the patient was receiving during their hospital stay.

**Nurses**

Nursing staff should discuss any concerns about a patient’s medication with the relevant medical team or pharmacist at the earliest opportunity.

3.6 THE RECONCILIATION OF MEDICINES ON ADMISSION

**Medication History Taking**

All patients must have a medication history taken on admission to hospital (see Appendix 5 for Procedure for Medication History Taking). When the medication history cannot be completed due to lack of access to the patient’s GP or other records then the medication history must be confirmed as soon as this is possible.

**Medicines Reconciliation**

All patients must have their medicines reconciled on admission to hospital by a pharmacist or accredited pharmacy technician (see Appendix 6 for Pharmacy Procedure for Medicines Reconciliation). Medicines reconciliation must be completed by the pharmacy team within 24 hours of admission. For patients admitted during the weekend, the reconciliation process must be completed as soon as possible at the start of the next working week.
3.7 PATIENTS WITH COMMUNICATION DIFFICULTIES

For patients with communication difficulties, every effort must be made to translate or interpret any questions/information being conveyed into a format that is understood by the patient.

- For patients with hearing impairment a hearing loop may be used if available on the ward. Notes can be written for the patient or a qualified British Sign Language interpreter may be used. The use of pictorial images may be helpful for specific patient groups e.g. those with learning difficulties.

- For the visually impaired, the patient should be asked how they manage their medicines at home.

- For patients whose first language is not English, an official translation service is provided by the Trust. Translators may be able to provide formal written translation.

- For patients with learning disabilities, input from carers and health facilitators is essential or other guidance such as hand held patient records might be useful.
4 ORDERING AND SUPPLY OF MEDICINES

Pharmacy staff may only dispense prescriptions that comply with all legal requirements and are completed in accordance with the procedures outlined in this policy. In all cases drug allergies and intolerances must be checked before any item is dispensed. The dispensing procedure must ensure that the prescriber’s intentions are accurately interpreted, that the medicine is correctly dispensed and that an appropriate container and correct label are used.

Within the Pharmacy Department a full range of Standard Operating Procedures are in place which are in compliance with the General Pharmaceutical Council standards.

The issue to a patient of pre-packed containers of medicine supplied by Yeovil District Hospital NHS Foundation Trust (e.g. in the Emergency Department (ED) or held as TTO packs on other designated wards) is the responsibility of the relevant medical & nursing staff in accordance with local procedures, which identifies the responsibilities of these staff.

4.1 PROCUREMENT OF MEDICINES

All medicines procured by Yeovil District Hospital NHS Foundation Trust must be purchased through the pharmacy department. The procurement process is to be executed under the supervision of a pharmacist, in accordance with the Trust Standing Financial Instructions and the recommendations of the Duthie Report. Under no circumstances should individuals order medicines independently.

Medicine samples offered by pharmaceutical company representatives must not be accepted on wards and departments. All drug representatives should be referred to the pharmacy department.

See Appendix 7 – Guidance for Working with the Pharmaceutical Industry and the Commercial Representatives and their dealings with Yeovil District Hospital NHS Foundation Trust Policy.

4.2 PHARMACIST WARD VISIT

Each ward (except maternity) within Yeovil District Hospital NHS Foundation Trust has a designated pharmacist who will visit the ward regularly, at times agreed between the pharmacy and the senior nursing staff.

Pharmacists will monitor the prescription charts, both in the dispensary and on the ward, assessing prescribing for accuracy, legibility, interactions and appropriateness of therapy in line with department standards and evidence based clinical practice. Any clarification of a prescription made by a pharmacist will be carried out in green ink and dated and initialled, following, where appropriate, consultation with the prescriber.
Pharmacists will record interventions made and any major (life threatening) interventions will be recorded using the Trust's incident reporting system (Safeguard).

Medicines Management Technicians (or Pharmacists) will assess the need for non-stock and One Stop Dispensing/Dispensing for Discharge medicines and arrange their requisition on an 'individual named' basis from Pharmacy. All medication will be labelled with the approved 'generic' name of the preparation except where a proprietary name defines a specific formulation or combination.

4.3 PHARMACY STOCK TOP-UP

Each ward and clinical area will be visited at a designated time each week by a Pharmacy Assistant. This person will ensure stocks of pharmaceutical products for that area are replenished to agreed stock levels. The stock levels will be agreed after discussion between the relevant ward pharmacist, senior technician and appropriate medical and nursing staff. These levels will be reviewed at regular intervals by the staff concerned. Pharmacy staff must be notified by nursing staff if unusual amounts of any item are being utilised to allow stock levels to be re-calculated.

4.4 DELIVERY OF DRUGS TO WARDS/DEPARTMENTS

All medicines will be delivered to the ward/department in a dedicated tamper evident container. ALL drug deliveries will be notified to ward staff by the person delivering the container(s) to ensure the drugs can be secured. The nursing/requesting department staff are responsible for the security of this container on the ward/department and for transferring the contents of the container into the appropriate locked cupboards immediately upon receipt. Items requiring special storage conditions (e.g. refrigeration) will be clearly labelled and must be stored appropriately immediately upon receipt on the ward/department. (For delivery of controlled drugs see Section 11 of this policy).

4.5 ONE STOP DISPENSING/Dispensing for Discharge (DFD)

Yeovil District Hospital NHS Foundation Trust has a system in place to support the One Stop Dispensing/Dispensing for Discharge process for inpatients.

All regular and stabilised medications a patient needs as an inpatient are supplied to ward areas labelled with the prescribed directions for the patient and with all relevant patient information leaflets. If the patient is then discharged without any changes to their medication requirements these labelled drugs can then be issued directly to the patient upon discharge without further dispensing. Controlled drugs cannot be included in the One Stop Dispensing scheme due to legal constraints.

The Pharmacy Department provides a One Stop Dispensing service on all wards. The medicines management technician, ward pharmacist and ward nursing staff will
initially assess the patient’s pharmaceutical needs. This will include the potential of utilising the Patient’s Own Drugs and the possibility of self-administration.

The pharmacist will review the prescription for clinical appropriateness and will sign the prescription to authorise supply. Supply will be made by either:

- The ward Medicines Management Technician (MMT) who will manage the supply of drugs to patients, once they are clinically checked.

OR IN EXCEPTIONAL CIRCUMSTANCES (e.g. to avoid a missed dose)

- The ward staff who will request a supply from the pharmacy. N.B. For One Stop Dispensing if the chart has not been screened by a pharmacist the drug chart must be sent to pharmacy for the supply of medication to be made.

One Stop Dispensing supplies will be stored in the approved patient’s drug locker. The ward technician will visit the ward daily at a pre-assigned time to manage the patient’s stocks of medicines.

**Discharge from Hospital:**

Once the decision to discharge a patient has been made a Discharge Prescription (TTO) must be written. This can be completed by a member of the medical staff or an appropriately trained clinical pharmacist. Any discharge prescription written by a pharmacist must be checked, signed and dated by a registered Doctor.

Ward One Stop Dispensing supplies should be checked by the ward pharmacist, an appropriately accredited pharmacy technician or experienced registered nurse to ensure:

- That all prescribed medication is available.
- That more than 7 days supply is available.
- That the label directions are legible and match those of the current prescription.
- That the available medication is not damaged.
- That the patient is clear on how to take their medication and how to obtain additional advice.

If One Stop Dispensing items are acceptable for the patient to take home, the TTO should be marked to indicate that One Stop Dispensing supplies are being used. If all items are not available then ward staff should either contact the discharge pharmacist who will undertake the necessary checks and supply processes OR if outside normal Medicines Management times the TTO form must be sent to the pharmacy for supplies to be made. The pharmacy department will re-label Patients’ Own Drugs that require the directions changing without obscuring the original label.

Under NO circumstances may ward stock/non-stock that has not been dispensed for an individual patient with specific directions be given to patients to take home. See Appendix 4 – Guidance for Managing Medicines on Discharge.

**Nursing Staff Responsibilities:**

A registered nurse may only assess the quality of One Stop Dispensing supplies when that nurse has been deemed competent by the appropriate ward manager under a relevant competency framework:
1. Registered nurses must be aware of the correct procedure for reviewing One Stop Dispensing stocks.
2. A registered nurse must be confident of his/her ability to initially assess the quality & content of One Stop Dispensing.

Registered nurses must be aware of the correct procedure for obtaining drugs from pharmacy when One Stop Dispensing stocks do not match the criteria above. All required documentation must be completed.

**Pharmacist’s responsibilities:**

The pharmacist must ensure that:

- The patient receives safe, effective & clinically appropriate treatment.
- That relevant other standards are applied including:
  - Yeovil District Hospital NHS Foundation Trust Patients’ Own Drugs scheme procedure.
  - Yeovil District Hospital NHS Foundation Trust Self Administration procedure.
- Existing clinical pharmacy standards are adhered to.
- Supplementary instructions are provided where necessary.
- That any changes in medication are reflected in the One Stop Dispensing supplies (i.e. changes in directions, drug additions or deletions).

Ward Medicines Management Technicians (MMTs) will review the contents of patients’ lockers to ensure that adequate stocks are available.

### 4.6 PATIENTS’ OWN DRUGS (PODS)

Patients being admitted to hospital (elective and non-elective) should be encouraged to bring their medicines, in their original containers, into hospital with them whenever possible. This includes medicines which have been prescribed for them by a GP AND those they have bought over the counter at a pharmacy AND any herbal medicines. Where safe and appropriate to do so, these patient’s own drugs should be used by the patient during their stay in hospital and taken home on discharge.

**On admission**

Patients should be encouraged to bring their own drugs in their original containers when admitted to hospital. Information to this effect will be supplied to all patients for planned admissions. Any drugs remaining at home should, if possible, be brought in by relatives/carer at the next visit. The drugs should be locked in the patient’s POD locker, except for patient’s own controlled drugs, which should be stored in the ward CD cupboard.

**Consent**

Drugs brought from home remain the patient’s property. Consent for their use or destruction whilst the patient is in the care of the Trust, however, is considered to be implicit unless specifically directed otherwise by the patient.
Patients should be informed that the medicines they have brought in to hospital with them may be used as part of their treatment and will not be used by anyone else. If the patient needs any more the Trust will supply them and make sure the patient has suitable supply on discharge. If any of the medicines are out of date, or otherwise unsuitable for use, the Trust will replace them. If the hospital doctor decides that any of the medicines are no longer appropriate, the Trust will assume that the patient is happy for them to be destroyed unless specified otherwise. This is done to help to avoid confusion when the patient goes home.

The medicines remain the patient’s legal property and if they have any questions concerning the above, they should be encouraged to discuss them with the named nurse, midwife, doctor or pharmacist.

Patients have the right not to agree to the use or destruction of their medicines. When this occurs the medicines should not be used or discarded. They should be returned to the patient on discharge or sent home prior to this with a relative/carer. Where a patient’s medication has been changed or discontinued or is considered unsuitable for use (e.g. out of date), staff should advise the patient accordingly that continued possession is medically inadvisable.

Patients’ own medicines no longer needed by a patient where consent to their destruction has been secured should be sent to pharmacy for disposal. Medicines of deceased patients may be sent to pharmacy for disposal after the relatives or carers collecting the effects have been informed.

**Assessment of PODs**

Patients’ own drugs MUST be assessed prior to use following the suitability criteria below. This can be done by a nurse, midwife, pharmacist or accredited pharmacy technician or doctor. If the medicines are suitable for use the pharmacy column on the prescription chart will be endorsed “PODs” with the quantity and will be signed and dated by the pharmacist or accredited pharmacy technician.

Unsuitable drugs should be returned to the pharmacy for destruction unless the patient has specifically stated that they do not agree to this.

**Suitability criteria**

All of the following criteria must be met in order for PODs to be considered safe for use during the patient’s stay and on discharge:

- The medicines (including controlled drugs) must be identifiable. Only medicines that can be identified will be accepted for ongoing use.
- Medicines must be in a suitable condition for use.
- Medicines must have been dispensed within the last 6 months, unless an expiry is stated on the container. Ophthalmic preparations must have been in use for less than one month.
- Medication must be correctly labelled with the patient’s name, product name and strength, supplier’s address and date of dispensing.
- Each container must hold only one preparation. Containers holding several different drugs or dosage strengths should be discarded or the products/strengths separated.
- Directions printed on the container must agree with the inpatient prescription chart or TTO prescription. If patient’s own drugs are re-labelled by pharmacy with
revised instructions, the POD must be positively identified and meet all suitability criteria. The new label must not obscure the original dispenser’s name and address.

- In exceptional circumstances, to prevent a missed dose, tamper-proof patient compliance aids can be used as PODs if the individual products are labelled and the identities can be confirmed. Patient compliance aids which are NOT tamper-proof MUST NOT be used as PODs.

NB. The responsible pharmacist/technician or nurse, midwife or doctor must be satisfied with the general condition of the product and its packaging and labelling. Professional discretion should remain the overriding factor in assessing suitability.

**Patients’ own controlled drugs**

Where patients’ own controlled drugs are identified on admission they must be counted and entered into the dedicated ward CD register set aside for patient’s own CDs.

A separate page must be used for each patient. The patient’s name together with the name, form and strength of the CD(s) must be stated together with the quantity received. The receipt and recording of patient’s own CDs must be witnesses by a second qualified member of staff.

Where patients’ own CDs are used during their admission, administration and recording procedures must be as for other CDs (see Section 11).

If any remaining patients’ own CDs are issued to the patient on discharge this must be witnessed by authorised staff and the register updated to reflect this.

**Administration**

A nurse or midwife may administer patients’ own drugs prior to them being assessed formally by pharmacy if he/she is satisfied that the drugs are suitable for use, in accordance with the above criteria.

Patients may begin self-administration with their own medicines before formal assessment by pharmacy if the assessing nurse/midwife is satisfied that the drugs are suitable for use. However, the ward pharmacist or the pharmacy technician should check the medicines at their next visit.

Ward stock should be used until a labelled supply for the patient is available. However, ward stock should never be left in the PODs locker and patients must never self-administer from ward stock.

**Discharge**

Patients’ own drugs can be issued to the patient on discharge provided it is safe and appropriate to do so. They must be checked against the prescription in the same
manner as the TTO-labelled supplies from the hospital pharmacy. If there are insufficient supplies of any item, a fresh supply should be made of at least 7 days.

4.7 STANDARD DISCHARGE MEDICATION ON NAMED WARDS/DEPARTMENTS

In some cases wards/departments have standard requirements for discharge medication where the involvement of pharmacy in the medication supply adds little value to the process for the patient. Where this is the case and is approved by the Trust, appropriately trained and assessed nursing and midwifery staff on the named wards/departments may supply standard discharge prescriptions (TTOs) at ward level during pharmacy opening hours and out of hours.

Standard TTO items are specific to the ward/department concerned. Each participating clinical area will have an agreed list of medications what are considered standard TTO items for their area. The medications must be available as pre-labelled packs for discharge and be specifically agreed and documented for each area.

4.8 SUPPLY OF MEDICINES OUT OF HOURS

The pharmacy department at Yeovil District Hospital NHS Foundation Trust is open every day as follows:

- Monday to Friday: 9.00 am to 5.30 pm
- Saturday and Bank Holidays: 9.00 am to 12.30 pm
- Sunday: 10.00 am to 12 noon

If medicines are required out of hours the doctor/registered nurse/midwife must first attempt to obtain a supply by contacting the Clinical Site Manager (CSM) who has access to the pharmacy dispensing robot and to the Emergency Drug Cupboard. The CSM must clearly record any medication removed from either location using the paperwork provided to ensure that items can be routinely replaced and to avoid out of stock situations occurring. Only complete packs can be removed by the CSM – individual tablets or strips of tablets must not be supplied to wards/patients.

Borrowing of medicines from other wards should only be necessary in exceptional circumstances and only when pharmacy is closed and when medicine or a suitable alternative is not available from the robot or Emergency Drug Cupboard. When borrowing is unavoidable, wards/departments may borrow a minimum quantity of medicine provided the medicine is clearly identifiable on arrival on the ward where it is intended to be used.

In the event that it is not possible to secure a supply of medication via the routes described above, the CSM should contact the on-call pharmacist for assistance. The pharmacist is available for information/advice and where necessary supply of medicinal products in emergency situations only. All patient discharges should be planned and dispensed during the working day. The on-call pharmacist may ONLY be contacted to dispense a TTO in the following circumstances:
• A pharmacy dispensing error that is found at the point of discharge.
• A palliative care patient who, due to unforeseen circumstances, requires rapid discharge.
• A bed crisis in the Trust.

Controlled Drugs must NOT be supplied by one ward to another out of hours. Under the provisions of the Misuse of Drugs Act 1971, nurses/midwives/ODPs are authorised to possess controlled drugs for the purposes of administration within their ward/department: they are not authorised to supply controlled drugs to other wards/departments.

In cases of emergency however, a registered nurse/midwife may attend another ward with the urgent prescription and, with a registered nurse/midwife from the second ward, may sign out one dose of the necessary medication from the CD register for that patient making sure that all details are recorded clearly and take it back to the original ward for immediate administration to the patient concerned.

The registered nurse/midwife obtaining a dose in this manner MUST be accompanied throughout by a second member of staff who will witness the transaction on the second ward and the administration of the dose to the patient. Both members of staff must sign the administration record box on the patient’s drug chart.

4.9 COMPLIANCE AIDS

The pharmacy department has arrangements in place for an alternative supplier to provide appropriate patients with compliance aids on discharge from Yeovil District Hospital NHS Foundation Trust. A compliance aid should not be requested until the patient is medically fit for discharge as medication can often change and this has financial implications for the Trust in terms of drug wastage and staff time. Nursing staff must notify pharmacy by 12 noon to ensure same day delivery of a compliance aid. The dispensing of compliance aids is not available at weekends or bank holidays.
5 ADMINISTRATION OF MEDICINES

5.1 RESPONSIBILITIES

It is the responsibility of nurses/midwives and other relevant practitioners including doctors administering medicines to do so in accordance with statutory and local rules and guidance issued by their professional bodies. Primary legislation concerning the administration of medicines is contained in the Medicines Act 1968 and the Misuse of Drugs Act 1971.

Where administration is undertaken by registered nurses and midwives this Medicines Management Policy must be read in conjunction with the following NMC papers:

- Standards for Medicines Management 2008
- The Code: standards of conduct, performance and ethics for nurses and midwives 2008

The administration of medicines is an important aspect of professional practice irrespective of the discipline involved. It is not solely a mechanistic task to be performed in strict compliance with the written prescription or protocol. In exercising professional accountability in the best interests of patients, nurses and midwives must ensure the “principles for the administration of medicines” as described by the NMC (Standards for Medicines Management 2008) are followed at all times.

5.2 AUTHORITY TO ADMINISTER

Medication must only be administered to patients when it has been prescribed by an approved prescriber, using an official prescription chart provided by Yeovil District Hospital NHS Foundation Trust. Where a prescription does not comply with the prescribing guidelines outlined in Section 2 of this policy, the drug must not be administered and the chart must be returned to the prescriber for re-writing.

The following are authorised to administer medicines within the Trust:

- The authorised prescriber may administer medicines he or she has prescribed.
- All registered nurses and midwives provided they have been deemed competent by the person in charge of the clinical area to administer medicines. Newly qualified nurses may be permitted to administer medicines at the discretion of the registered nurse with 24 hour responsibility for the clinical area/lead midwife for the shift. Bank and agency nurses are individually responsible and accountable for their practice and should only administer medication if they are competent to do so. The nurse in charge of the shift is responsible for determining competence with the nurse as soon as he/she reports for duty. Student nurses/midwives may administer medication under the direct supervision of a registered nurse. The supervising qualified nurse remains accountable for the administration.
- Patients may administer their medication within formal self-administration schemes (see Section 6 of this policy).

General medication administration by Healthcare Assistants and Assistant Practitioners is not permitted with the exception of specifically listed medication for use in specific department(s) authorised by the Safer Medicines Group. Staff
undertaking administration of medicines need to complete Trust approved training and competency assessment. A current register of those competent to administer the identified medications must be maintained by the Department Manager.

For all staff, some drug administration can require complex calculations to ensure the correct volume or quantity of medication is administered. In these situations, it is recommended that a second practitioner checks the calculation in order to minimise the risk of error.

5.3 GENERAL GUIDELINES FOR DRUG ADMINISTRATION

All staff on or visiting the ward must be made aware that a nurse/midwife should not be interrupted whilst administering drugs. Where an interruption is essential, the nurse/midwife carrying out the drug round must ensure that he/she completes the administration for the patient being dealt with at that time.

The nurse/midwife responsible/accountable for a group of patients should administer the drugs to those patients and wherever possible should discuss the medicines including the purpose of the medication and any likely side effects with patients or their representatives at the time of drug administration.

The entire drug chart and administration record must be reviewed at each medicine round.

5.4 PROCESS FOR THE SAFE ADMINISTRATION OF MEDICINES

When administering medicines, nurses and midwives and other relevant practitioners, including doctors, MUST adhere to the following procedures:

- Carefully read and understand the prescription. Check its validity (prescriber’s signature, the prescription date and time of administration) and that it is completed in accordance with section 2 of this Policy.

- It is very important to check the administration time carefully. Do not be distracted by previous signatures in the administration columns: if an error was made previously it may be continued.

- Ensure the prescription including the dose, form and route of administration can be clearly read and fully understood.

- If the prescription is not clear in any detail, it must be checked with the prescriber. Staff administering the drug should not proceed until they are completely satisfied (if doubts persist contact the pharmacist or nurse manager).

- In addition, the nurse/midwife should have knowledge of the medicine and be able to calculate the dose. Doses requiring calculation should be checked independently by a second practitioner.

- Ensure that they are aware of the patient's current assessment and planned programme of care.

- Ensure appropriate consent has been obtained from the patient. Refer to the Trust's Consent for Examination and Treatment Policy on YCloud for further information.

- Note any contra-indication or change in the patient's clinical condition which might require a medicine to be withheld. Seek medical advice should the unplanned withholding of a medicine be indicated.

- Check allergies and drug intolerances associated with the medicine to be given. If there is no entry in the allergy section of the prescription, an allergy history must
be established using the patient’s medical notes, contacting their GP or talking with the patient prior to administration.

- Consider carefully whether any of the prescribed medicines will or might interact dangerously with each other.
- Check to see if the prescription has been annotated (either by the pharmacist or doctor) giving further guidance concerning its administration.
- Check that the patient has not already received the dose which is about to be administered.
- There may be changes in the presentation or appearance of a medicine as the pharmacy department routinely uses more than one source of supply. If the appearance of the medicine gives cause for concern or is queried by the patient, a pharmacist must be contacted before it is given.
- Select the medicine and check the following aspects to ensure that the selected medicine is correct and is administered according to the prescription:
  - Medicine name
  - Dose form
  - Strength of preparation
  - Quantity to be administered
  - Expiry date (if available)
  - Additional instructions on container label and prescription
  - Appropriate setting of infusion device (where used)
  - Correct drug through correct line (where appropriate)
  - Special storage requirements have been adhered to
- If there is any substantial interruption during the process it may be necessary to discard the medicine and start again.
- Confirm the patient’s identity by checking the patient’s identification name band. Ensure the identity of the patient matches that on the inpatient prescription chart.
- Administer the medicine and immediately record the administration on the appropriate documentation. Where the medication given is oral the nurse should ensure the dose(s) have actually been taken before signing the administration record. Where the prescription allows for a range of doses to be given e.g. codeine phosphate 30mg to 60mg QDS, the dose given should be stated in the administration record.
- Wherever possible draw the attention of patients to information concerning their prescribed medicines including the purpose of the medication and any likely side effects as patient education is an important aspect of care and helps improve compliance and reduce drug related adverse events.

When administering any medication, the prescription chart must be taken to the patient to ensure that the medicine is administered appropriately and the process completed i.e. the patient has swallowed the medicine or received an injection or suppository etc. There are a few exceptions e.g. nebulised drugs and syringe drivers, where it is not possible to observe administration through to completion.

Any medication or remainder of medication not administered must be destroyed immediately.

Where a maximum number of doses to be given is stated or a specified maximum length of treatment, that number or length must not be exceeded and, after completion of prescribed doses, remaining administration boxes must be cancelled.
5.5 SINGLE NURSE ADMINISTRATION

Single nurse/midwife administration of medicines is the normal practice within the Trust except in situations listed in Section 5.6.

All nurses must be aware of their level of competence and of their individual accountability when administering medicines. The nurse/midwife in charge of the ward/department is responsible for ensuring appropriately trained and competent staff are involved in the administration of medication.

In exceptional circumstances, where in the opinion of the nurse/midwife in charge, a nurse requires extra support then a second nurse must be used as a checker. This second practitioner must be a registered nurse or midwife. Where a nurse and/or their line manager has repeated doubts relating to their level of competence, it is their responsibility to identify any development needs and to undertake appropriate training and assessment.

5.6 SECOND CHECKING OF MEDICINES

Second checking of medicines is required in the following situations:

- Where the medicine is a controlled drug.
- Where the medicine is to be administered to a child up to 14 years of age.
- Where the dose to be given requires a complex calculation.
- Where the medicine is to be administered by a student nurse/midwife, return to practice nurse or adaptation nurse.
- Wherever possible two registrants should check medication to be administered intravenously, one of whom should also be the registrant who then administers the intravenous (IV) medication. In the exceptional circumstance where this is not possible, intravenous medication should be checked by one registrant with another competent person. At a minimum, any dose calculation must be independently checked.

When a checking nurse is used, the legal liability for the administration of the medicine lays with the nurse who physically administers the medicine to the patient. The checker remains professionally accountable to the NMC and should undertake the procedure as if he/she were administering the medicine.

When two nurses are involved in the administration of medicines, both practitioners should sign the prescription chart.

The second signatory should normally be another registered healthcare professional but in the interest of patient care, where this is not possible, a second suitable person who has been assessed as competent may sign. The registrant responsible for the administration of the medicine to the patient must be confident that the second signatory is competent.

Perceptorship nurses awaiting their PIN numbers are authorised to second check a registered nurse/midwife when administering intravenous medication, controlled drugs and discharge medication providing they have received appropriate Trust approved training and have been assessed as competent. The legal liability for the administration of the medicine lays with the registered nurse/midwife who physically administers the medicine therefore use of a perceptorship nurse as a second checker is at the discretion of the administering registrant.
5.7 RECORD OF ADMINISTRATION

The person administering a medicine is responsible for completing the administration record immediately afterwards. The relevant initials box adjacent to the prescription must be signed. For ‘as required’ medication, the date, time and dose given boxes must be completed and signed. Where a check of the administration is required by a second person their initials must also be recorded.

Administration of medicines prescribed on an Emergency Department record sheet or anaesthetic record sheet must be recorded adjacent to the signed prescription including the date/time and the signature of the person who has administered the medicine.

5.8 PREPARATION OF MEDICINES IN ADVANCE

Medicines for injection must not be routinely prepared at ward level in advance of their immediate use. Individuals must not administer medicines prepared by another practitioner when not in their presence unless the product is an already established infusion which has been instigated by another practitioner in accordance with their professional code of practice or products that have been prepared and supplied by the pharmacy department.

When taking over a patient with an established infusion/PCA etc. from another ward/department the receiving nurse must ensure appropriate checks are made.

5.9 NIL BY MOUTH (NBM)

Patients who take essential medication should not have their medication withheld when NBM. All essential medication should be administered, with a small amount of water (60ml) if necessary unless specifically instructed by a member of the medical team not to give the medication or if it is deemed unsafe to administer the medication to the patient e.g. in patients with poor swallowing. In such cases this must be clearly documented and written on the drug chart. If the oral route is contra indicated an alternative must be used.

5.10 SWALLOWING DIFFICULTIES OR ADMINISTRATION VIA ENTERAL FEEDING TUBES

For patients with swallowing difficulties or those being fed via nasogastric, JEG or PEG tube, liquid medication may be available for use instead of a solid dosage form. However, formulations may not be directly equivalent and the nurse must check with pharmacy before substituting one for the other. Solid dosage forms are not always suitable for crushing to aid administration e.g. those in slow release formulation. In all cases of uncertainty, advice should be sought from a pharmacist.

5.11 MEASUREMENT OF LIQUID MEDICATION

Where administration of oral liquid preparations involves the use of volumes other than multiples of 5mls then only ORAL syringes must be used. For the administration of medication via a nasogastric tube, JEG or PEG, the required dose must be measured and administered via a clean oral/enteral syringe.

5.12 SECURITY OF MEDICINES

Medicines must not be left unattended in any area of the ward/clinical area including the treatment room and in the patients’ bed area. The nurse/midwife must stay with the patient until the medication has been taken by the patient.
Self-administration by the patient is encouraged on some wards and medicines for these patients should be kept locked in the patients' own bedside locker and Trust procedures must be followed (see Section 6 of this policy).

5.13 OMITTED DOSES

Missed or late doses may pose a significant risk to the patient's continued wellbeing and should be avoided at all times. Where a drug is not immediately available it is the responsibility of the nurse or midwife concerned to secure a supply of the medication, either as soon as possible (for critical medicines e.g. antibiotics) or by the next due dose (for routine medication).

When a prescribed medication is not administered to a patient, this omission must be recorded on the prescription sheet in the relevant box using the appropriate code as detailed in the inpatient prescription chart. It is the responsibility of the nurse or midwife concerned to inform the prescriber when a clinically significant medication has not been given and to seek medical review. The nurse/midwife should document the action taken in the patient's notes.

For a dose given significantly later than intended (i.e. later than 2 hours) the actual time should be written into the initials box of the administration record by the prescribed time. The entry should be signed.

A Safeguard report must be completed when doses are missed resulting in care being compromised.

5.14 ADDITIONAL MEDICATION ADMINISTERED

Where authorised by a Trust approved written Patient Group Direction (PGD), a nurse, or other relevant practitioner, may administer relevant medicines in accordance with the terms of the written authorisation.

In such instances, a record must be made of this administration on the relevant prescription chart and/or the patient's medical notes. All records of medicines given in this way must include details of the product, dose, date and time given and the signature of the person administering the medicine and state the authority under which it was given e.g. PGD. See Section 7 of this policy for information relating to PGDs.

5.15 ADMINISTRATION OF INTRAVENOUS DRUGS

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

It is best practice to ensure that the administration of medication by all other routes has been completed before preparation for administration of injectable medication is commenced (e.g. do not prepare oral medication via an oral syringe and injectable medications at the same time).

Intravenous medicines can be administered by qualified medical staff, suitably trained medical staff in training and by registered nurses/midwives with evidence of competence to administer intravenous products. Wherever possible, a second registered practitioner should check the medication to be administered intravenously, one of which must be the practitioner who administers the medication. In the
exceptional circumstance where this is not possible, intravenous medicines should be checked by one registrant with another competent person. As a minimum any dose calculation must be independently checked.

If there is any doubt about the drug, its dose, its route etc., the nurse/midwife concerned must contact the prescriber. It will then be the responsibility of the prescribing doctor to administer the drug if he/she insists that it must be given.

All nurses/midwives must be fully aware of the possibility of reactions which may result following the administration of intravenous drugs. It is incumbent on all nurses/midwives to ensure that they continually keep themselves updated about all such reactions.

When using mechanical equipment to administer intravenous medicines, care should be taken to achieve correct flow rate, in accordance with the manufacturer’s instructions. Nurses must have undergone training and ensure that they are competent to use the infusion pump in question. Any calculations involved in setting up an infusion device should be checked by a second qualified person.

Where intravenous medicines are appropriate for bolus administration, this is the method of choice. However, if medicines are to be added to intravenous fluids, the following precautions should be taken:

- Check for incompatibilities. The addition of more than one medicine to a fluid should generally be avoided although some combinations are compatible. Intravenous compatibility data is available in the BNF, Summary of Product Characteristics (SPC) for the medicine, the Trust’s Intravenous Monographs and from pharmacy.
- Strict aseptic procedures should be followed to avoid the possibility of contamination.
- A ‘red’ intravenous label must be completed and attached to the intravenous fluid bag.
- Ready made products should be used wherever possible.

Additions must NEVER be made to TPN bags at ward level.

Once intravenous access has been established it should be flushed before and after intravenous medicine with 5ml Sodium Chloride 0.9% unless contraindicated. Smaller volumes should be used for neonates and infants. Saline flushes should be prescribed using the pre-printed box at the top of page one of the ‘as required medicines’ section of the inpatient prescription chart. Only when this instruction has been completed and signed does this become a valid authorisation to administer a flush.

Most vials/ampoules of injectable products are for single use only. They must not be used as multidose containers or used for subsequent doses unless specifically stated as multidose on the label or package information.

5.16 ADMINISTRATION OF CYTOTOXIC DRUGS

The administration of cytotoxic drugs by any route other than the oral route of administration, must only be take place in designated ward/department areas by suitably trained and competent staff. Refer to the Trust’s Cytotoxic Policy available on YCloud for further information relating to the administration of cytotoxic drugs.
For the oral administration of cytotoxic drugs, a minimal touch technique must be used and hands washed immediately before and after administration. Tablets must not be crushed.

Intrathecal chemotherapy is no longer prescribed or administered at Yeovil District Hospital NHS Foundation Trust.

5.17 ADMINISTRATION OF SPECIFIC MEDICINES

5.17.1 Strong Potassium Chloride Injection

National guidance stipulates the controls required for the safe administration of potassium chloride concentrate and other strong potassium solutions. Serious or fatal incidents have been reported as a result of inadvertent rapid infusion or injection of strong potassium chloride. Mistakes have occurred when:

- Potassium chloride 15% ‘strong’ injection (2mmol/ml) has been added to infusions and not adequately mixed, resulting in pooling at the base of the container.
- Infusions of undiluted solution have been given.
- Ampoules of potassium chloride 15% ‘strong’ injection (2mmol/ml) have been accidentally administered as a flush or bolus instead of water or sodium chloride 0.9%.

Potassium chloride 15% ‘strong’ injection (2mmol/ml) and high strength potassium chloride infusion (40mmol in 100ml) are widely recognised as high risk medicines. Within Yeovil District Hospital NHS Foundation Trust, potassium chloride 15% ‘strong’ injection is only kept as stock in pharmacy, on ICU and on CCU. Other wards and departments must NOT keep, and will NOT be supplied with, this strength of potassium chloride in any circumstances. High strength potassium chloride infusion (40mmol in 100ml) is a stock item in the following areas only: pharmacy, ICU, CCU, Ward 10 and Main Theatre Recovery.

Both presentations of high strength potassium chloride must be handled as a full controlled drug. Supplies are requisitioned using the ward controlled drug order book. Stocks are supplied and received as full controlled drugs and administration is recorded in the ward controlled drug register (see Section 11 of this policy). Wards authorised to hold stock of potassium chloride 15% ‘strong’ injection and potassium chloride infusion 40mmol in 100ml are NOT permitted to issue these products to other clinical areas within the Trust. For the infusion, it is essential that it is kept segregated from all other infusion solutions kept in the controlled drug cupboard.

When potassium chloride infusion is required, pre-diluted solutions of potassium (excluding potassium chloride 40mmol in 100ml) should be used whenever possible. There are no restrictions on the availability of these pre-mixed infusions and there are no requirements for special storage arrangements. All prescriptions for potassium chloride infusions must state clearly the dose in mmol per litre, the infusion fluid required and the rate of administration.
Preparation of an infusion using potassium chloride 15% ‘strong’ injection (2mmol/ml) must only be undertaken on the designated wards by fully trained and competent medical/nursing staff when a pre-mixed form is not suitable. A second practitioner should always check the correct product, dosage dilution, mixing and labelling during the preparation of infusions and again prior to the administration of infusions prepared from potassium chloride 15% ‘strong’ injection. In addition, the nurse/doctor should invert the container at least 10 times to ensure thorough mixing. The infusion must have a label attached containing details of the medicine, strength etc. before the infusion leaves the preparation area. Under no circumstances should potassium chloride 15% ‘strong’ injection be added to a hanging infusion container as it is difficult to ensure thorough mixing. A potentially fatal bolus dose of potassium chloride may result.

5.17.2 Methotrexate (Oral)

Methotrexate is an antineoplastic and an immunosuppressant which is used in low doses on a ONCE WEEKLY basis in rheumatology for the treatment of inflammatory arthritis and other connective tissue diseases. It may also be used for psoriasis, and in gastroenterology for the treatment of inflammatory bowel disease in a similar dosage regime.

Methotrexate is only available as 2.5mg tablets in Yeovil District Hospital NHS Foundation Trust (the only exception is for the management of paediatric oncology patients).

Prescribers who initiate oral methotrexate therapy must be consultant or registrar status and must be familiar with the usual dose and monitoring requirements for methotrexate. It is the prescriber’s responsibility to record the correct dosage and frequency on the prescription chart, and to strike out the six days of the week when a dose must not be administered.

For continuation of treatment, when patients are admitted in an emergency or for elective surgery, the prescriber must check the dosage of methotrexate with the patient, their methotrexate booklet and their notes. Junior doctors may prescribe continuation methotrexate therapy for patients.

Be aware of patients who attend with symptoms such as breathlessness, dry persistent cough, vomiting or diarrhoea, as these can be signs of oral methotrexate toxicity or intolerance.

The dose, route and day of administration must be stated on the prescription chart. The day of administration should be clearly indicated on the administration section of the chart and the following six days of the week crossed out to avoid inadvertent administration of methotrexate on a daily basis.

All staff involved in the prescribing, dispensing, administration and monitoring of methotrexate must follow the Trust’s Oral Methotrexate Policy on YCloud.
5.17.3 Low Molecular Weight Heparins (LMWHs)

The Medicines Formulary at Yeovil District Hospital NHS Foundation Trust includes enoxaparin, a low molecular weight heparin (LMWH), for the prophylaxis and treatment of thromboembolic events. For treatment doses of enoxaparin, all staff involved in the prescribing, dispensing and administration of this LWMH must follow the recommendations of **NPSA/2010/RRR014 Reducing treatment dose errors with low molecular weight heparins**. The Rapid Response Report states that:

- The patient's weight must be used as the basis for calculating the required treatment dose of LMWH. The weight must be accurately recorded in kilograms (kg) on the inpatient prescription chart (when in use), and clinical record. Patients should be weighed at the start of therapy and, where applicable, during treatment.
- Renal function must be considered when prescribing treatment doses of LMWHs. The renal function test should not delay initiation of the first dose but every effort must be made to base subsequent dosing on these results.
- Dose calculation tools are available for a range of body weights, specific clinical indications and LMWH products.
- Essential information such as dose, weight, renal function, indication and duration of treatment is communicated at transfers of care (e.g. by discharge letters) and used to ensure that future doses are safe.
- Dosing checks based on patient information are made by healthcare professionals who review, dispense or administer LMWH when this information is readily available to them.
- Any medication incident involving a LMWH must be reported on Safeguard.

5.17.4 Insulin

To ensure the safe administration of insulin, all staff involved in the prescribing, dispensing and administration of insulin must follow the recommendations of **NPSA/2010/RRR13 Safer administration of insulin**. At Yeovil District Hospital NHS Foundation Trust staff must ensure the following:

- The Trust's Two Week Adult Diabetes Treatment and Blood Glucose Monitoring Chart must be used to prescribe insulin. Reference must be made on the standard inpatient prescription chart to indicate existence of the diabetic chart.
- 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.
- The term 'units' is used in all contexts (this is pre-printed on the Trust's diabetic chart). Abbreviations, such as 'U' or 'IU', must never be used.
- All clinical areas treating patients with insulin have adequate supplies of insulin syringes and subcutaneous needles, which staff can obtain at all times.
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.

All staff must ensure their knowledge regarding the prescription, preparation and administration of insulin is up to date. An e-learning programme is available from www.healthcareaa.co.uk/nhsdiabetes via YCloud.

Staff should refer to policies and procedures where they exist or contact the diabetes team if expert opinion is required.

5.17.5 Lithium

To minimise the risk to patients, all staff involved in the prescribing, dispensing, administration and monitoring of lithium therapy must follow the recommendations of NPSA/2009/PSA005 Safer lithium therapy. It states the following:

- All patients prescribed lithium must be monitored in accordance with NICE guidance.
- There must be reliable communication between laboratories and prescribers relating to blood test results.
- At the start of lithium therapy and throughout their treatment, patients must receive appropriate ongoing verbal and written information and a record book to track lithium blood levels and relevant clinical tests.
- Prescribers and pharmacists must check that blood tests are monitored regularly and that it is safe to issue a prescription and/or dispense the prescribed lithium.
- Staff must be able to identify and deal with medicines that might adversely interact with lithium therapy.

5.17.6 Oral Anticoagulants

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital. All staff involved in the prescribing, dispensing and administration of oral anticoagulants must follow the recommendations of NPSA/2007/PSA018 Actions that can make anticoagulant therapy safer. The Trust must ensure:

- All relevant staff are trained and competent when handling these high risk medicines.
- All oral anticoagulants are prescribed on the standard inpatient prescription chart and on the Trust’s pink anticoagulant chart.
- The indication for anticoagulation and the target INR must be completed on the anticoagulant chart.
- Potential interactions with the prescribed anticoagulant must be identified and closely monitored with additional INR blood tests.
- Patients prescribed an anticoagulant must receive appropriate verbal and written information. This provision of information is the responsibility of medical, nursing and pharmacy staff.
- Patients must always have a sufficient supply of oral anticoagulants both in hospital and on discharge to avoid missed or delayed doses.
- For patients new to anticoagulation, the nurse/midwife must give the patient an oral anticoagulation therapy pack. For patients previously prescribed an
anticoagulant, the nurse/midwife must ensure the patient has their pack on discharge. In both situations it is the responsibility of the nurse discharging the patient to ensure that he/she has been issued with the relevant information and that the patient knows the dose to take and when their next blood test is due.

- Any medication incidents involving an oral anticoagulant must be reported on Safeguard.

5.17.7 Unfractionated Heparin

In the same NPSA Patient Safety Alert on anticoagulant therapy, guidance is given on the use of intravenous sodium heparin infusions. The Trust has a dedicated Heparin Infusion Administration Record and this must be used for all patients prescribed a heparin infusion. Reference must be made on the standard inpatient prescription chart to indicate existence of the heparin chart. The Trust follows the NPSA recommendation that changes in the daily dose of heparin infusion should be made by adjusting the rate of administration rather than the strength of the infusion and detailed information on how to adjust the rate is included on the heparin chart. When heparin is prescribed, the word 'units' should always written in full to express the dose and abbreviations such as ‘U’ must not be used as these can be misread and cause dosage errors.

5.17.8 Bowel Cleansing Solutions (Oral)

Death and harm from electrolyte abnormalities, dehydration and serious gastrointestinal problems have been reported following the inappropriate use of oral bowel cleansing solutions (Picolax®, Citrafleet®, Fleet Phospho-Soda®, Klean Prep® and Moviprep®) prior to surgery and/or investigative procedures. Frail and debilitated elderly patients, children and those with contraindications are particularly at risk.

A clinical assessment must be undertaken by the clinician authorising the surgery or investigative procedure to ensure that there is no contraindication (e.g. clinical condition such as diverticulitis) or risks (e.g. concurrent medication such as diuretics) from the use of a bowel cleansing solution.

Use of a bowel cleansing solution must be authorised by the clinician at the same time as the surgery or investigative procedure. The clinician requesting the surgery or procedure and authorising the use of a bowel cleansing solution is responsible for ensuring that an explanation on the safe use of the product is provided to the patient or carer.

All staff involved in the prescribing, dispensing and administration of bowel cleansing solutions must follow the recommendations of NPSA/2009/RRR012 Reducing risk of harm from oral bowel cleansing solutions.

5.17.9 Paraffin Based Skin Products

All healthcare staff involved in the prescribing, dispensing or administration of paraffin based skin products need to be aware of a potential fire hazard.
Bandages, dressings and clothing in contact with paraffin based products, for example White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment are easily ignited with a naked flame or cigarette.

Information must be given about the potential fire risks of smoking (or being near to people who are smoking), or exposure to any open flame or other potential cause of ignition during treatment and about regularly changing clothing or bedding impregnated with paraffin based products.

Fire safety information should be displayed prominently in every clinical area where patients may be treated with large quantities of paraffin based products. If, against advice, a hospitalised patient intends to leave the ward to smoke, they should be informed of the risk and advised to wear a thick outer covering that has not been contaminated with paraffin based products.

All staff involved in the prescribing, dispensing and administration of paraffin based skin products must follow the recommendations of NPSA/2007/RRR04 Fire hazard with paraffin based skin products on dressings and clothing.

5.18 ADMINISTRATION OF MEDICINES TO CHILDREN

In the context of this policy, children will be defined as any patient up to 14 years of age. The policy will apply to any clinical area where children are cared for.

Where children’s drug doses are calculated according to the weight of the child, it is essential that their weight is recorded in kilograms on the prescription chart. The child’s weight must be checked at regular agreed intervals, according to their plan of care. It is a statutory requirement that the date of birth is recorded on the prescription.

Paediatric formulations must be used wherever possible. Extreme vigilance must be exercised when these are not available and adult strength preparations are used.

Oral syringes of appropriate size must be used to administer all liquid medicines when the volume does not correspond to a 5ml spoonful or multiples thereof. In addition, where oral doses of less than 1ml in volume are required, these must be drawn up in a 1ml oral syringe graduated to 0.05ml.

If administration of a dose can only be achieved by crushing a tablet or opening a capsule the advice of a pharmacist should be sought.

All dose, volume and rate calculations must be carefully checked by 2 registered nurses/midwives and documented before administration of medicines. It is good practice for medical staff who do not commonly undertake drug calculations for children to have any calculations checked prior to administration.

In ALL situations, medicines administered to children MUST be undertaken by 2 registered nurses or midwives. Both nurses/midwives must check that it is the correct drug, the correct child, the correct date and time, the correct route and the correct dose or rate. Both registered nurses/midwives MUST sign the administration box of the inpatient prescription chart.
Where children or young people with long term conditions or their parents or carers are competent in managing their medicines, they should be allowed to do so during hospital stays.

5.19 ADMINISTRATION BY REGISTERED MIDWIVES

Registered midwives are able to supply and administer, as appropriate, on their own initiative and as part of their professional practice certain medicinal products covered by legal ‘exemptions’. In addition, student midwives may administer medicines on the exemption list (except controlled drugs) under the direct supervision of a registered midwife. The midwife must record such administration on the prescription chart or midwifery documentation.

Refer to maternity guidelines Drugs supplied and Administered by Midwives in the course of their professional practice available on YCloud.

5.20 COVERT ADMINISTRATION OF MEDICINES

The covert administration of medicines is not to be confused with the administration of medicines against a person’s will which may be considered unlawful. Nurses must refer to the NMC position statement (September 2001 and the Code of Practice for the Mental Capacity Act 2005) on this issue and the Trust’s Implementing the Mental Capacity Act 2005 Legislation and Deprivation of Liberties (DOLs) Authorisation Policy and Guidelines on the Use of Restraint, both available on YCloud.

As a general principle, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication, when in fact they are. This covert administration of medicines is only likely to be necessary or appropriate in the case of patients who actively refuse medication but are judged not to have the capacity to understand the consequences of their refusal.

Where adult patients are capable of giving or withholding consent to treatment, no medication should be given without their agreement. A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life. The exception to this principle concerns treatment authorised under the relevant mental health legislation, when specialist advice is necessary.

Every adult must be presumed to have the mental capacity to consent or refuse treatment, including medication. The Mental Capacity Act 2005 sets out the requirements that must be met when making a decision that an individual patient lacks the capacity to consent. This requires the two-stage test of capacity;

1. Is there an impairment of, or disturbance in, the functioning of the person’s mind or brain?
2. If so, is the impairment or disturbance sufficient that the person lacks capacity to make the specific decision to comply with medication administration?

Any assessment of capacity must consider;

- whether they are able to understand the information
- whether they are able to retain the information relating to the decision to be made
- whether they are able to use or weigh that information as part of the process for the decision
The assessment of capacity is primarily a matter for the treating medical staff, but nurses and midwives retain a responsibility to participate in discussions about this assessment. Assessment of capacity must be documented in the patient record. Refer to the Trust’s Mental Capacity Assessment Form.

Where a patient is assessed as lacking capacity then the treating clinical team should check whether any other individual holds a Lasting Power of Attorney that enables them to consent on behalf of the patient in relation to treatment decisions.

The Trust recognises that there may be exceptional circumstances, in the absence of informed consent, in which covert administration may be considered necessary to prevent a patient from missing out on essential treatment. However:

- The best interests of the patient must be considered at all times. Staff must complete the Trust’s Best Interests Checklist and file in the patient’s medical notes.
- The treatment must be necessary in order to save life or to prevent deterioration or ensure an improvement in the patient’s physical or mental health, or for the safety of others.
- The decision to administer a medication covertly should not be considered routine and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient individually.
- There should be a broad and open discussion among the multi-professional clinical team and the supporters of the patient and agreement that this approach is required in the circumstances. It is inadvisable for the nurse or midwife to make a decision to administer medication in this way in isolation. Those involved should include carers, relatives, advocates, and the multidisciplinary team (especially the pharmacist). Family involvement in the care process should be positively encouraged. In circumstances where a patient has no relatives or friends it may be advisable to contact the Independent Mental Capacity Advocacy service. Life-sustaining treatment should not be delayed for the purposes of contacting an IMCA.
- The method of administration of the medicines should be agreed with the pharmacist.
- The decision, the reasons for it and the action taken, including the names of all parties concerned, should be documented in the care plan and reviewed at appropriate intervals.
- Capacity can fluctuate and regular attempts should be made to encourage the patient to take their medication. This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual.

The administration of medicines to patients who lack the capacity to consent and who are unable to appreciate that they are taking medication (unconscious patients, for example) should not need to be carried out covertly. If such patients recover awareness, their consent should be sought at the earliest opportunity.

All staff must be aware that the covert administration of medicines is a restrictive practice within Yeovil District Hospital NHS Foundation Trust and staff should notify the Safeguarding Adults team of any patient where this method of administration is considered necessary. It is essential that both the Mental Capacity Assessment Form and the Best Interests Checklist list are completed and filed in the medical notes.
6  SELF- ADMINISTRATION

Patient self-administration allows patients, who have been carefully screened by a multi-disciplinary team, to administer their own medication whilst in hospital. Self-administration provides opportunities for medication review and an assessment of how patients manage their own medicines enabling the introduction of any training strategies. This in turn should reduce adverse effects and unnecessary admissions due to poor understanding and compliance with medicines. The rationale for self-administration is to be proactive in improving compliance and concordance leading to increased patient satisfaction, better preparation for discharge and effective use of medication following discharge.

The following patients may be considered unsuitable for the self-administration of medication:

- Patients who are confused or disorientated.
- Patients with a history of drug or alcohol abuse.
- Patients thought to be at risk of deliberate overdose.
- Patients being discharged to a nursing home.
- Patients with unstable Mental Health Conditions.
- Patients must not self-administer controlled drugs.
- Patients on compliance devices.
- Patients identified as having difficulty in opening bottles or reading labels. These patients should be referred to a pharmacist.

6.1  RESPONSIBILITIES

Medical staff must:

- Agree to a patient self-administering.
- Inform the nursing staff of any changes to a patient’s medication.

Nursing staff are responsible for:

- Patient assessment.
- Patient education.
- Patient supervision.
- Completing the assessment form and medication card in conjunction with pharmacy. These forms must be signed and dated by the registered nurse.
- Documenting that a patient is self-administering in the patient’s notes.

Pharmacy staff must:

- Assess a patient’s suitability in conjunction with nursing staff.
- Supply each patient with their own medication dispensed ready for discharge. Pharmacy staff must respond quickly to the request of medication supply to ensure patients do not miss doses.
- Check, and complete if necessary, the patient’s assessment form and medication card. These must be signed and dated by the pharmacist.
- Provide regular medication locker checks to ensure the content matches the prescription chart.
Medical, pharmacy and nursing staff are all responsible for informing patients of any changes to their medication.

6.2 ACCOUNTABILITY FOR SELF-ADMINISTRATION

It is the responsibility of the registered nurse to ensure that, if delegating administration of medicines to the patient, the patient is competent to undertake this. The registered nurse is accountable for the appropriateness of this delegation. The registered nurse must also ensure the safe and secure storage of medicines with access only for the individual patient.

6.3 ASSESSMENT FOR SELF-ADMINISTRATION OF MEDICATION

All patients MUST be fully assessed prior to commencing self-administration and must consent to all aspects of self-administration. The assessment must be carried out by a registered nurse who has received training and been assessed as competent. The Yeovil District Hospital NHS Foundation Trust Self Administration Assessment Form must be completed and filed in the patient’s notes. Patients are assessed as:

Level 1 – The nurse administers the medication to the patient giving a full explanation to the patient. Medicines are locked in the patient’s bedside locker and the key is kept by nursing staff.

Level 2 – The patient administers the medication with direct registered nurse supervision. The patient is encouraged to ask the nursing staff to open the bedside locker but where a patient does not initiate this process, it should be initiated by the nursing staff. This should be recorded on the patient’s assessment form. Prescription charts must be signed by the registered nurse directly supervising the administration of the medicines. The nurse should monitor the patient with a view to moving to level 3 if appropriate, or to level 1 if the patient’s condition is such that they are unable to self-administer. Having satisfied the nurse responsible of their proficiency in self-administering their medication, after a review of the nursing assessment and in consultation with the doctor, the patient may be moved to level 3.

Level 3 – The patient administers their medicines without direct supervision. Medicines are locked in the patient’s bedside locker and the key to the locker is kept by the patient. These patients must be asked by the registered nurse to state which medicines have been taken. The prescription chart must be annotated with an encircled S denoting a self-administered medicine. The patient’s ability to self-administer must be assessed frequently by a registered nurse i.e. at least once every 24 hours.

Patients prescribed insulin whilst in hospital are permitted to self-manage their insulin following an assessment carried out by a registered nurse. The Trust’s Diabetes Treatment and Blood Glucose Monitoring Chart includes a self-management decision tree which must be used to establish whether a patient is suitable for the self-management of their insulin. Each time an assessment is completed by a registered nurse, a record must be made in the Diabetes Chart clearly indicating if the patient is able to self-manage their insulin. For patients assessed as not competent a reason must be recorded in the assessment record. Both the registered nurse and the
patient must sign the assessment record prior to commencing the inpatient self-management of insulin.

Wherever possible patients, who are assessed as competent to self-manage their insulin, should be provided with a secure cabinet for storage and are responsible for ensuring the key is kept secure at all times. If the ward is unable to provide a locked cabinet, this should not be a barrier to self-administration of insulin provided that:

- The patient is made aware of the potential risks of leaving insulin, needles, syringes, pen devices, or blood glucose monitoring equipment within reach or sight of others.
- There is a regular risk assessment and the patient does not remain in the same area as patients who are:
  - At risk of deliberate self-harm
  - Acutely confused
  - Have a current history of drug or alcohol abuse
  - Have a history of medication overdose.

### 6.4 SECURITY FOR SELF-ADMINISTRATION OF MEDICATION

Medicines for self-administration must be stored in the patient’s bedside locker which must be kept locked at all times when not in use. Individual locker keys should be issued to patients assessed as level 3. The patient must be asked to sign for the key and to return it on discharge or on transfer. A system for tracking the custody of keys must be in place on each ward where self-administration is in operation. Patients MUST be made aware of their responsibilities to keep the bedside lockers locked at all times to ensure the safe custody of their own medicines.

Not more than two master keys for the bedside lockers should be in use on the ward at any one time and allocation of the master keys is the responsibility of the nurse in charge of the shift. Only registered nurses and pharmacy staff may have custody of a master key - under no circumstances must a patient be in possession of such a key.

A lost key must be reported via Safeguard and a risk assessment must be undertaken to determine the appropriate course of action. The relevant Matron must be informed as soon as possible. If the lost key cannot be traced, a duplicate key should be issued and the lock changed if necessary. Lost master keys are associated with a much greater risk and all locks will require changing. An incident report must be completed and submitted to the Clinical Governance department.
7  PATIENT GROUP DIRECTIONS (PGDs)

A Patient Group Direction (PGD) is a specific written instruction for the supply and/or administration of a named licensed medicine in an identified clinical situation. PGDs are drawn up locally by doctors, pharmacists and other appropriate health professionals, and must be approved by the Trust before implementation.

In 2013, the MHRA re-issued guidance on when a PGD should be used. It stated that the majority of clinical care should be provided on an individual, patient-specific basis. The supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability i.e. the nurse or allied health professional must act within their own area of expertise and competence.

PGDs can only be used by the following registered healthcare professionals, acting as named individuals: nurses, midwives, health visitors, paramedics, optometrists, chiropodists and podiatrists, radiographers, orthoptists, physiotherapists, pharmacists, dieticians, occupational therapists, prosthetists and orthotists, speech and language therapists and dental hygienists and dental therapists.

Each individual practitioner must:

- Be trained to operate within a PGD
- Be competent
- Be familiar with the medication to be administered
- Be able to evaluate symptoms
- Be able to select the most appropriate course of action
- Monitor the patient following administration

A list of the individuals named as competent to use PGDs must be held locally within each ward or department. A senior person in each profession locally will be designated with the responsibility to ensure that only fully competent, qualified and trained professionals operate within PGDs. It should be noted that not every practitioner is expected to use PGDs. Patient and service need should be considered when deciding who needs to use them.

A PGD can include a flexible dose range so the healthcare professional can select the most appropriate dose for the patient. A PGD does not give a legal framework for healthcare professionals to adjust a dose of a medicine already in a patient’s possession. In addition, a PGD does not allow a named healthcare professional to direct another practitioner not named within the PGD to supply/administer on their behalf.

Medicines can be used outside the terms of their Summary of Product Characteristics (SPC) (so called ‘off-license’ use), provided such use is supported by best clinical practice. The PGD must state when the product is being used outside the terms of the SPC and why this is necessary.

7.1  RECORDING ADMINISTRATION UNDER PGD

The administration of medication under PGD must be recorded by the practitioner. For inpatients, details of the medication administered must be recorded in the ‘once only, pre-operative and PGD medicine’ section on the front of the inpatient prescription chart or on the Emergency Department record sheet. The entry must be
signed by the practitioner and must clearly state that the medication has been administered under PGD. It is not necessary for a Doctor to initial this record. An entry must also be made in the patient’s medical notes to ensure communication with the medical team responsible for the patient.

7.2 PATIENT GROUP DIRECTION DEVELOPMENT/AMENDMENT

Development of a Patient Group Direction must involve a doctor, nurse/midwife or AHP and a pharmacist.

All Patient Group Directions must:

i) Recognise that discretionary administration and supply must only be delegated to approved practitioners where there are clear benefits of improved patient care or organisational advantages without any reduction in patient care.

ii) Specify the additional training process and competency for approval a practitioner must undergo before authority is granted to that individual to supply and/or administer under a Patient Group Direction, as an approved practitioner.

iii) Specify the mechanism and time scale for regular updating of knowledge and review of relevant skill and knowledge of approved practitioners.

iv) Identify the person/job role responsible for training staff in the use of the PGD, maintaining an up to date list of staff assessed as competent and authorised to operate under the PGD and reviewing the PGD

v) Specify the review date.

Once approved, PGDs must be signed by the Chief Pharmacist, Director of Nursing, Clinical Governance lead for the Trust and the Medical Director before being put into clinical use. A copy of the Patient Group Direction will be:

i) Held in Pharmacy

ii) Held by the individual responsible for managing the PGD

iii) Available within the area of practice

iv) Available to each approved practitioner

If a PGD is an amended version of one already in operation it will immediately supersede the previous one. The relevant Lead should ensure that the amended PGD is substituted as soon as possible for the previous version and that all relevant staff are made aware of the change and sign the departmental copy of the new version. All copies of the previous PGD for that area of practice should be destroyed. (Original copies will be retained by Pharmacy).

The Trust accepts responsibility for the actions of the approved practitioner, properly acting in the course of his/her duties and in accordance with the current Patient Group Direction in force in his/her area of practice. However the Trust accepts no responsibility for an approved practitioner who attempts to act/acts outside the scope of the approved Patient Group Direction.

PGDs have superseded the need to supply medicines as Discretionary Drugs or under Standing Orders. These provisions have now been withdrawn within the Trust.
8 STORAGE OF MEDICINES

The registered nurse with 24 hour responsibility for the clinical area is responsible at all times for the safe keeping of all medicines stored in his/her ward/department.

All internal and external medicines, disinfectants and reagents must be stored in locked cupboards, trolleys or other secure receptacles at all times. The only exception to this requirement are the storage of intravenous fluids and sterile topical fluids which are stored in a secure clean area (as agreed between the registered nurse and pharmacy). Internal medicines must be stored separately from all external medicines.

Medicines must always be stored in their original container. Under no circumstances should medicines be transferred from one container to another, nor should they be taken out of their container and left loose.

All wards and departments will have their facilities for the safe and secure storage and handling of medicines assessed by senior pharmacy staff on an annual basis.

All lockable drug storage facilities must be kept locked at all times.

8.1 WARD/DEPARTMENT MEDICINE STORAGE FACILITIES

Medicines should be kept in locked cabinets or rooms which are constructed and maintained so as to prevent unauthorised access to the medicines.

Cupboards and trolleys should be sited where it is most convenient for nursing staff, allowing adequate space and permitting surveillance, to afford maximum security against unauthorised entry. Medicine cupboards should generally be sited in a clean treatment room to which the general public does not have access. Cupboards should not be sited above or near radiators or major sources of heat, nor above sinks where they may be subject to higher than average humidity. Reagent cabinets should be sited in areas where testing is carried out.

Advice on placement of drug cupboards and drug security in general is available from the Pharmacy Department.

8.2 INTERNAL MEDICINES

The internal medicines cupboards should contain stocks of internal medicines such as tablets, capsules, mixtures and injections, with the exception of those needing special storage or refrigeration.

On no account should external medicines be stored in this cupboard.

8.3 CONTROLLED DRUGS

The controlled drugs cupboard should contain only those medicines controlled by the Misuse of Drugs Act 1971 and marked Controlled Drug, plus others as deemed necessary by Pharmacy from time to time. Such storage must comply with the Misuse of Drugs (Safe Custody) Regulations 1973.

8.4 EXTERNAL MEDICINES

The external medicines cupboard should contain all applications for external use such as ointments and creams.

On no account should internal medicines be stored in this cupboard.
8.5 THE REAGENT CUPBOARD

This should be situated in the area where urine testing is carried out (usually the sluice). It contains all reagents, strips and tablets used in testing.

8.6 STERILE FLUIDS

It may not be practical to store large volumes of sterile fluids in cupboards. In this case there should be designated clean storage areas in wards, theatres and departments.

8.7 REFRIGERATOR (2-8°C)

The medicines refrigerator should be reserved solely for the storage of medicines marked 'store in a refrigerator'. The refrigerator is part of medicines storage facilities and should be situated in an area not generally accessible to the public. Medicines must not be stored with food or pathological specimens. The fridge must be lockable with an indicator of internal temperature. The registered nurse with 24 hour responsibility for the clinical area is responsible for ensuring that fridge temperatures are monitored and recorded on a daily basis. Where evidence is found of temperatures falling outside the normal range, this must be reported to the registered nurse in charge of the shift and appropriate remedial action taken immediately.

8.8 RESUSCITATION TROLLEY

This should be readily accessible in an emergency and kept in a prominent position to prevent unauthorised access. Emergency resuscitation drug boxes with tamper evident seals are available in designated wards and departments. They should be stored in their sealed container and when the seal is broken or the drugs are near their expiry date, the box should be returned to pharmacy for replacement. Nursing staff should check daily that these boxes are intact and in date.

8.9 PATIENTS' OWN DRUG LOCKERS

Each bed space has a lockable bedside locker for the purpose of storing medicines dispensed to individually named patients, stock items as per the patient prescription chart and PODs. These lockers must be secure and kept locked at all times. Where patients are competent to administer their own medication, access is provided by way of a key. Where patients are not competent, access is confined to nursing staff only. See Section 6 – Self-Administration.
9 SECURITY OF MEDICINES

9.1 PHARMACY PREMISES
Access to the pharmacy department is restricted to personnel authorised by the Chief Pharmacist. The means of access to the department is fully alarmed. All entrances have solid doors and are fitted with security locks. A member of the pharmacy department should be present whenever the department is open.

9.2 WARDS AND DEPARTMENTS
The registered nurse or midwife in charge of the clinical area is responsible for the security of the medicines on the ward or department. These medicines should only be used by staff that understand their responsibilities and are competent and authorised to administer medicines. All staff handling medicines must be security conscious.

Anyone discovering apparent or suspected unauthorised access to medicine storage areas must report the matter immediately to a senior colleague and the Chief Pharmacist.

Cupboards and refrigerators containing medicines must be kept locked at all times when not in immediate use. The keys for these storage facilities must be held on the person of the registered nurse with 24 hour responsibility for the clinical area or on the person of a designated registered nurse or midwife competent in the administration of medicines. Where duplicate keys exist these should be kept on the person of another registered nurse or midwife.

Where patients are assessed as competent to self-administer their own medicines (see Section 6) the patient takes possession of the individual bedside locker key. The patient is then responsible for storing the key securely.

Any loss of medicine cupboard keys must be reported to the appropriate Matron, or if out of normal hours the Clinical Site Manager must be informed. If available, the duplicate keys should be obtained. If duplicate keys are not available, the nurse in charge should arrange for the cupboard to be broken open. In either situation, a new lock must be fitted. The nurse with 24 hour responsibility for the ward must instigate an investigation into the loss of the key(s) to ascertain the potential level of the security breach. The pharmacy department must be informed and an incident report completed.

Each ward/department must maintain a register of ward staff signatures and initials used on prescription charts. This allows traceability of staff administering medicines. Maintenance of this register is the responsibility of the nurse/midwife in charge of the clinical area.

9.3 CONTROLLED STATIONARY
Controlled stationary is any stationary which could be used in the wrong hands to obtain medicines fraudulently. It includes FP10 HNC forms, outpatient, discharge and inpatient prescription charts, controlled drug order books, record books and prescriptions and other stationary used for requisitioning medicines. Access to controlled stationary is restricted and any loss or theft must be reported immediately to the Chief Pharmacist. All controlled stationary must be stored as securely as possible without compromising timely access and the security of such stationary is the responsibility of the nurse/midwife in charge of the clinical area. Only limited quantities of controlled stationary should be held at any time.
9.4 LOSSES

Great care must be taken at all times to safeguard the security of medicines and controlled stationery within the Trust. This is a responsibility of all involved in handling these items.

Any member of staff discovering or suspecting a loss or abuse of medicines of any kind must notify the appropriate Matron and a senior pharmacist.

In some situations it may be appropriate to record a stock balance and implement regular stock checks. If this shows discrepancies, the matter should be discussed urgently with the Chief Pharmacist and a incident form must be completed.

Alternatively, the situation may be so serious as to warrant involvement of the police. Such a decision will be taken by the Chief Pharmacist in conjunction with the relevant Directors in the Trust.

9.5 TRANSPORTATION OF MEDICATION

All medicines must be packaged securely and transported in a safe and secure manner. All staff required to carry medication must have a valid identification card issued by the Trust. This must be shown if requested by a client or any other person having reason to check the identity of the employee.

Within the hospital

The movement of medicines around the main hospital and the women’s hospital is a task primarily carried out by the portering department. The pneumatic tube system is used for the movement of prescriptions and may also be used to transport medicines. Liquids, live vaccines, glass containers, cytotoxic agents and controlled drugs must not be transported via the pneumatic tube.

Between healthcare settings

The transportation of medicines between healthcare settings is carried out by couriers contracted by the Trust for the movement of pharmaceuticals and other sundries. Medicines may accompany a patient from one unit to another in an ambulance or by authorised hospital transport or by taxi.

Controlled drugs

All controlled drugs must be transported in a secure container. The person transporting the controlled drugs is responsible for their security until they have been delivered to an authorised person and the delivery acknowledged.

By freewheelers/taxi

The freewheelers should not be used routinely for the delivery of medication especially to patients’ homes following discharge. Freewheelers should only be used for the transport of medication in emergency situations. Only hospital contracted taxis with drivers able to produce identification bearing a photograph can be used for the transportation of medicines.
10 DISPOSAL OF MEDICINES

Pharmaceutical waste is classified as Hazardous, Non-hazardous or not pharmaceutically active. Hazardous waste is waste that contains cytotoxic and/or cytostatic products i.e. those which have one or more of the following properties: toxic, carcinogenic, toxic for reproduction or mutagenic.

10.1 MEDICINES READY FOR ADMINISTRATION

Medicines prepared for administration but not administered together with empty containers and sharps used to prepare or administer medicines are classified as pharmaceutical waste and must be disposed of in accordance with the Trust’s Waste Policy. Items that are contaminated with cytotoxic and cytostatic products must be segregated from other medicinally contaminated items by placing them in the appropriate cytotoxic/cytostatic sharps bins with a purple lid. See the Trust’s Cytotoxic Policy for further information on the disposal of cytotoxic and cytostatic products.

All other sharps and items containing drug residues (e.g. medicines vials etc.) from products other than those identified as cytotoxic or cytostatic are classified as non-hazardous medicinal waste and must be disposed of in sharps bins with yellow lids and sent for incineration.

Disposal of individual doses of controlled drugs prepared but not administered or wastage from part doses drawn up for an individual patient should be destroyed on the ward and witnessed by a second member of staff (e.g. nurse, doctor, ODP) and the appropriate entry made in the controlled drugs record book.

10.2 MEDICINES NO LONGER REQUIRED OR OUT OF DATE

All medicines no longer required or out of date (except controlled drugs) should be returned to pharmacy or handed directly to a member of pharmacy staff for processing in accordance with the Trust’s Waste Policy or for return into pharmacy stock if appropriate. Medicines no longer needed after the death of a patient should be returned to pharmacy in a secure manner for destruction.

Controlled drugs which are no longer needed should be removed from the ward by a pharmacist, witnessed by a registered nurse/midwife. An appropriate entry must be made in the controlled drugs record book which must be signed and dated by both the pharmacist and the nurse/midwife. Nursing staff must not remove controlled drugs from the ward for transport to pharmacy and controlled drugs must not be returned to pharmacy in the ward box.

In some cases (e.g. for small volumes of patient’s own liquid controlled drugs) it may be appropriate for controlled drugs to be destroyed on the ward or department by a pharmacist, in the presence of a registered nurse/midwife. Details must be recorded in the controlled drug record book and signed and dated by the nurse and pharmacist.
11 CONTROLLED DRUGS

Preparations detailed in the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001 are controlled by procedures additional to those used for other medicines.

11.1 PRESCRIBING
See Section 2.9.10 of this policy for details relating to the prescribing of controlled drugs.

11.2 ORDERING WARD STOCK
Orders for controlled drugs must be made in the controlled drug order book. A separate requisition is needed for each medicine which must comply with the legislation as set out in the Misuse of Drugs (Safe Custody) Regulations 1985 and contain:

i) Ward or department name and address.
ii) Description of controlled drug required including the form.
iii) Total quantity to be supplied ("one box" is not sufficient).
iv) Signature of authorised signatory.
v) Signature of supplier.
vi) Signature to receive goods for transit.
vii) Signature for receipt at ward or department.
viii) Date.

Pharmacy maintain a register of all nurses/midwives with authorisation to order controlled drugs. All authorised nurses/midwives must provide pharmacy with a sample signature and the authorisation form must be signed by the nurse/midwife in charge of the ward/department. Any order for a controlled drug by an unauthorised nurse/midwife will not be issued by pharmacy.

The CD requisition book is an item of controlled stationery and must be stored securely in a locked cupboard when not in use (e.g. in the CD cupboard).

Some medicines e.g. temazepam and midazolam belong to a separate CD classification. Trust policy requires that these should be ordered via the CD order book and be stored in the CD cupboard. There is, however, no requirement to maintain a record of administration in the CD record book.

11.3 DELIVERY AND RECEIPT OF CONTROLLED DRUGS
All stock controlled drugs in transit to wards or departments are transported within a secure pharmacy bag. Controlled drugs are generally delivered by a pharmacy assistant and this person is required to:

i) ensure that the pharmacy bag is secure and intact
ii) sign (and date) for delivery of the CD in the CD order book and remove the top copy of the relevant page(s) from the book
iii) transport the CD in the pharmacy bag in a secure manner
iv) deliver the CD to the ward or department to which it is addressed and
v) obtain the signature (and date) of a registered nurse/midwife/ODP for receipt of the CD in the CD order book at the point of delivery.

On receipt of the controlled drugs, the receiving nurse/midwife/ODP and an approved witness must make the relevant entry in the CD record book (including the CD requisition number) and lock the CDs away in the CD cupboard.

If, at any time, a registered nurse/midwife/ODP is not available to accept delivery of the controlled drugs from the pharmacy assistant, the drugs will be returned to pharmacy and the ward/department will the responsible for making arrangements for collection.

On occasions it may not be possible for a pharmacy assistant to deliver the stock controlled drugs i.e. for urgent requests or at weekends. The ward/department will be responsible for making arrangements for collection by a member of their ward/department team.

Controlled drugs for patients to take home (TTOs) must be collected from pharmacy and signed for by ward staff.

11.4 COLLECTION OF CONTROLLED DRUGS FROM PHARMACY

If the person collecting a controlled drug is the patient or the patient’s representative the pharmacy staff will request evidence of that person’s identity and may refuse to supply the CD if they are not satisfied as to the identity of the person. Pharmacy staff have the discretion to decide whether to ask for proof of identity and also the discretion to supply the CD, even if there is no ID available, or refuse to supply if they are not satisfied that the person collecting is who they say they are. Circumstances where ID may not be required includes when the person collecting the CD is known to the pharmacist (the patient, close relative or friend) or when the pharmacist feels that asking for ID may compromise patient confidentiality.

If the person collecting a controlled drug is a healthcare professional acting in their professional capacity on behalf of the patient, the pharmacist must obtain the name and address of the healthcare professional and, unless they are already acquainted with that person, they must request evidence of that person’s identity. However, even if ID is not provided the pharmacist may still supply the CD.

11.5 STORAGE AND SECURITY

11.5.1 Storage of Controlled Drugs

Controlled drugs must be stored in a secure area usually within an inner locked compartment, within an internal medicines cupboard, assigned to the storage of controlled drugs. All storage facilities for controlled drugs should be permanently fixed to an appropriate surface. If controlled drugs are stored in other secure areas these must be approved by the Chief Pharmacist.

Only controlled drugs and the CD order book may be kept in the controlled drugs cupboard except for other specified medicines deemed necessary by the Trust from time to time.

11.5.2 Controlled Drug Cupboard Keys

The controlled drugs cupboard must be kept locked at all times.
The ultimate responsibility for the CD keys rests with the nurse with 24 hour responsibility for the area/lead midwife. This individual may delegate responsibility for holding the keys to others (e.g. to the nurse in charge of the shift). The person with delegated responsibility is responsible for ensuring the security of the keys and knowing their location at all times. They are permitted to hand the keys to other trained staff on the shift in order to allow access to CDs to meet patient needs but the keys MUST be returned to the safekeeping of the person with delegated responsibility once this has occurred. The keys must not be handed over to medical staff.

11.5.3 Records

Details of receipt, administration and disposal of controlled drugs must be entered in the ward/department controlled drugs record book. There must be separate record books for recording hospital CDs and those brought in by patients. The record books must be kept in a secure place.

11.6 ADMINISTRATION

For controlled drugs, two members of staff must be involved throughout the process of dose preparation and administration. These staff may be either a registered nurse/midwife/ODP or a designated learner (i.e. a student nurse on placement).

BOTH members of staff must sign the CD record book and the registered nurse/midwife must initial the patient’s drug chart to indicate that the whole process from drug selection to administration has been witnessed in accordance with Trust policy. The checker must recognise their accountability for ensuring that all the requirements for safe administration and security are met.

Should a doctor administer or check a controlled drug, he/she must do so in the presence of a witness and both must complete the relevant sections of the ward controlled drugs record book.

Although normally the second signatory should be another registered healthcare professional (i.e. registered nurse, midwife, doctor, ODP), in order to achieve the standards required for professional registration, student nurses, student midwives and student ODPs must be given the opportunity, where possible, to participate in the administration of controlled drugs, therefore if appropriate they can perform the second check. This is suitable for 2nd and 3rd year students only. The registered practitioner’s signature in the CD record book is acceptable as the countersignature to the student’s signature.

Both practitioners should be present during the whole administration procedure. They should witness:

- The preparation of the CD to be administered.
- The CD being administered to the patient.
- The destruction of any surplus drug (e.g. part of an ampoule not required).

Any drug spilled or tablet dropped must be destroyed, adhering to the Waste Policy, and a record to this effect entered in the controlled drug record book. This must be signed by a witness and reported to the nurse/midwife in charge.

Where multidose bottles of oral liquid CDs are in use, one bottle only should be used at any one time. Any volume discrepancies that may occur must be recorded and witnessed in the CD record book and reported to the nurse in charge and a senior pharmacist.
11.7 STOCK CHECKS AND MAINTENANCE OF RECORDS

The CD record book must be checked and reconciled at least every 24 hours by two appropriately qualified authorised members of staff. The check must include all CDs held within the clinical area including Patients’ Own CDs.

It is essential that the stock check is undertaken diligently as follows:

1. The stock level of every item in the CD cupboard (including patient’s own and TTOs awaiting issue) must be reconciled with the relevant page in the CD record book.

2. The stock level indicated on every page of the CD record book (including patient’s own and TTOs awaiting issue) must be reconciled with appropriate items in the cupboard.

3. The check must include a review of patients’ names, dates and doses and staff signatures in addition to the stock balance check.

A record indicating that the check has been carried out must be made in a format agreed by the ward/department manager. All discrepancies in stock balances or other anomalies MUST be reported to the registered nurse in charge of the shift and a senior pharmacist. A Trust incident report must be completed. If an error cannot be reconciled and corrected, the Chief Pharmacist as the Accountable Officer for controlled drugs must be informed. Any member of staff who has concerns about the use or misuse of controlled drugs must contact the Accountable Officer.

Ward and departmental stocks of controlled drugs are checked every three months by the pharmacy department.

11.8 RETURN OF CONTROLLED DRUGS TO PHARMACY

See Section 10 of this policy.

11.9 PRESCRIBING OF OPIOID MEDICINES

When opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor, must:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records.

- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).

- Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effect.

- Be aware of the risks when prescribing for opioid naïve patients.
Nursing staff in each clinical area should ensure that naloxone is available where opioid medication is administered. It is the responsibility of the nurse in charge to ensure that all staff know where to find naloxone in an emergency situation.

11.10 ILLEGAL SUBSTANCES BROUGHT INTO HOSPITAL BY PATIENTS

It is illegal for an individual to be in possession of a controlled drug unless it has been prescribed by a doctor. If a patient is admitted with a drug or a substance which is known or suspected to be illegal, then it must be handed to the nurse in charge who, with an approved witness, will describe the drug as an "unknown substance" in the nursing record and store the substance immediately in a signed, sealed container, e.g. envelope, and place in the controlled drug cupboard, with a record made in the relevant CD register. If a patient refuses to hand over an illicit substance the police should be contacted. Patient confidentiality should be paramount at all times. All staff should refer to the Trust’s Policy on Illicit Drugs Found on Hospital Premises.

11.11 MANAGEMENT AND OVERSIGHT OF CONTROLLED DRUGS AND OTHER MEDICINES OF POTENTIAL ABUSE

Yeovil District Hospital NHS Foundation Trust is registered as a hospital with the Care Quality Commission (CQC). One of the responsibilities associated with this registration is the requirement to ensure that there is appropriate management oversight of controlled drugs and other medicines of potential abuse. This oversight requirement is delivered through the post of Accountable Officer (AO) for controlled drugs. At Yeovil District Hospital, this position is held by the Trust’s Chief Pharmacist.

The oversight requirement is delivered in a number of ways. Yeovil District Hospital has access to some important computer software which examines trends in the use of medicines of abuse, to assess signs of possible diversion by healthcare staff.

Regarding the routine interventions and bureaucracy associated with controlled drugs, all anomalies, prescribing, dispensing or administration errors must be recorded on Safeguard. These are automatically directed to the AO who will ensure that each incident recorded is investigated and an acceptable outcome delivered.

All controlled drugs issues must be noted by the AO and must be recorded in a quarterly Occurrence Report to the Local Intelligence Network (LIN), now managed by NHS England. The AO at Yeovil District Hospital is a member of this LIN. All occurrence reports are reviewed by the LIN committee meeting. The aim of the LIN is to ensure that, post the Shipman enquiries, there is a sharing of any relevant intelligence regarding controlled drugs anomalies and that any healthcare staff who pose a risk to patients may be identified and appropriate action taken.

All issues or queries associated with controlled drugs must be raised with the Chief Pharmacist at Yeovil District Hospital.
12 RISK MANAGEMENT

12.1 CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)

A patient’s exposure is excluded from consideration under COSHH (so long as it results from direct clinical care) but incidental or accidental exposure of staff administering medication does fall within the COSHH regulations and should not be neglected. Medicines are exempt from the labelling requirements of the Chemical (Hazard Information and Packaging for Supply) Regulations 1994 (CHIP2) so where practitioners are at risk from medicines there is no clear indication of the need for safety measures. It is vital that practitioners are familiar with the contents of their local COSHH assessment that is available for all staff to inspect.

12.2 MEDICATION ADVERSE INCIDENTS

A medication adverse incident or near miss is an incident associated with the use of a medicine which has or may have put a patient at risk. Such incidents may be related to any step of the medicine use process i.e. the prescribing, dispensing or administration of medicine. Incidents involving administration of medicine to a patient include:

- A medicine is given which has not been prescribed.
- An incorrect dose of medicine is given.
- The correct medicine is given but at an incorrect interval.
- All unplanned omissions or delays in administering a drug.

Whenever incidents involving medicines are found or observed then:

- The appropriate doctor in charge of the patient should be contacted and, when necessary, remedial action taken to ensure the safety of the patient.
- Any incident involving nursing/midwifery staff should immediately be reported to and investigated by the appropriate line manager/ward manager or a person delegated to act on their behalf.
- A Trust incident report form must be completed on Safeguard.
- The relevant incident form should be informed if appropriate.

The objective of reporting all medication adverse incidents is not to apportion blame but to identify changes needed to prevent further errors/incidents. Electronic details of all such incidents are forwarded to the Chief Pharmacist and other senior pharmacy staff. Medication adverse incidents are reviewed by the Clinical Governance Delivery Committee via quarterly and annual Medicine Management Reports from pharmacy. All staff must be familiar with the Trust’s Incident Reporting and Investigation Policy.

In the case of repeated adverse incidents or incidents involving gross negligence, the use of the Trust’s Capability Policy and Management of Discipline Policy should be considered. Where adverse incidents are deliberately concealed or where there is collusion to conceal an adverse incident, staff must be dealt with according to the
Trust’s Discipline Policy. This may include referral of the staff involved to their appropriate professional body. Incidents involving malicious intent or deliberate illegal activity will be dealt with according to the Trust’s Discipline Policy and the police may be informed.

It is the responsibility of the professional in charge of the patient’s care to ensure that the patient is informed of any medication incident within 24 hours of the incident. The only exception to this is, where in the opinion of the Consultant in charge of the patient’s care, to do so would seriously compromise the patient’s medical condition.

### 12.3 ADVERSE DRUG REACTIONS

Any medication may produce unwanted or unexpected adverse reactions. If a patient suffers a suspected adverse reaction to a prescribed, over-the-counter or complementary medicine, the adverse reaction should be reported directly to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme using the electronic form at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk). Alternatively prepaid yellow cards are available at the back of the current BNF. Any healthcare professional may complete a yellow card. In addition, patients and carers may self-report suspected adverse drug reactions to the MHRA using the web address above or by telephone.

Doctors and pharmacists should report all suspected reactions to newer drugs. These are identified in the BNF by the black triangle symbol and are monitored intensively by the MHRA.

For established drugs, doctors and pharmacists should report all serious suspected reactions, including those that are fatal, life-threatening, disabling, incapacitating, or which result in, or prolong hospitalisation. Well known, relatively minor side-effects should not be reported for established drugs. However, all suspected adverse reactions occurring in children should be reported.

Nurses and pharmacy staff must inform the prescribing doctor without delay if they observe or suspect adverse effects of a medicine and an incident report form should be completed on Safeguard.

### 12.4 DEFECTIVE MEDICINES

All incidents involving defective or suspected defective medicines within the Trust MUST be reported to pharmacy as soon as they are suspected. If a drug defect is suspected outside normal pharmacy opening hours, the on-call pharmacist should be contacted via switch board.

On suspecting a defect in a medicinal product the nature of the defect and the time and date of discovery should be recorded with the manufacturer’s name, name of product, batch number and expiry date. The suspect product should be retained. If the product has been administered to the patient, the doctor responsible for the patient must be informed. Pharmacy must be provided with all the information specified above and the incident should be reported to the nurse/midwife in charge and an incident form completed.
12.5 PRODUCT RECALLS, SAFETY ALERTS AND LEGISLATIVE CHANGES

All medicines related drug recalls, safety alerts and legislative changes will be introduced across the Trust through the pharmacy department and Clinical Governance including those from: MHRA, NICE, Department of Health Central Alerting System and Care Quality Commission.
13 LIMITATIONS

This policy applies to all staff who deal with medicines within Yeovil District Hospital NHS Foundation Trust including all locum, bank and agency staff. It is aimed at medical, nursing, pharmacy, technical and administrative staff who are responsible for the selection, procurement, delivery, prescription, administration and review of medicines in the Trust.

14 IMPLEMENTATION, MONITORING AND EVALUATION OF THE POLICY

All staff involved in the prescribing, supply, administration and handling of medicines will receive appropriate training for Medicines Management in accordance with the Trust’s Training Needs Analysis (held by the Academy), Corporate Induction and Local Induction Policy.

Staff must not prescribe, supply or administer medicines unless they are assessed as competent to do so by their line manager or professional supervisor.

All staff involved in the prescribing, supply and handling of medications will be appropriately trained with regard to safety of medicines and to safeguarding themselves and those under their supervision from the risks posed by the products.

Any difficulties encountered by staff in the implementation of this policy should be discussed with their line manager, Director of Nursing or the Chief Pharmacist.

Healthcare professionals should read this policy in conjunction with their own Code of Conduct/Code of Ethics and any relevant Trust documents that relate to the use of drugs.

The Medicines Management Policy is monitored via the following processes:

Incident Reporting
All staff involved in the process of prescribing, dispensing or administration of medicines must report any untoward incidents/errors via Safeguard.

Trend Analysis
The Medicines Information pharmacist conducts trend analysis on all reported medication related incidents reported on Safeguard. This information is reported to the Clinical Governance Delivery Committee each month.

Medicines Management Reports
Quarterly and Annual Medicines Management Reports are prepared by a senior pharmacist and presented to the Clinical Governance Delivery Committee. These reports include detailed information relating to antibiotic prescribing, medicines
reconciliation, missed doses, high INRs, activity within the Aseptic Services Unit, medication related incidents, pharmacy interventions and any other issues relevant to the management of medicines in the Trust.

**Pharmacy Intervention Monitoring/Reporting**

All medication related incidents/errors identified by pharmacy staff must be recorded on intervention forms. A senior pharmacist is responsible for grading the interventions in terms of their severity. Information relating to pharmacy interventions is included in the Medicines Management Reports presented to the Clinical Governance Delivery Committee.

**Baseline Medicines Audit**

Pharmacy staff are responsible for conducting a baseline medicines audit each month across the Trust. Five prescriptions per ward per month are reviewed by pharmacy to audit the quality of the prescribing of medicines. Detailed information relating to missed doses is also included in the monthly audit. The results of the audit are analysed and reported by the Clinical Governance department and distributed to all ward managers.

15 **EQUALITY IMPACT ASSESSMENT**

An Equality Impact Assessment has been completed to ensure the Medicines Management Policy is fair and does not discriminate any staff groups (see Appendix 8).
APPENDIX 1 - GUIDELINES FOR PRESCRIBING BENZODIAZEPINES AND Z-HYPNOTIC MEDICINES

1. INTRODUCTION

The prescribing of hypnotics is widespread throughout the NHS. Dependence (both physical and psychological) and tolerance can occur with this group of medicines resulting in difficulties withdrawing the drug after only a few weeks of treatment. The term “hypnotic” applies to all benzodiazepines and z-drugs (including zopiclone, zolpidem and zaleplon) prescribed for insomnia. The unnecessary prescribing of hypnotics for inpatients at Yeovil District Hospital must be discouraged to limit the adverse effects of use in community.

The Committee on Safety of Medicines issued advice on the prescribing of benzodiazepines which states the following:

- Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient 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.
- Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress.

In 2004, the National Institute for Clinical Excellence (NICE) issued a quick reference guide on zaleplon, zolpidem and zopiclone for the short-term management of insomnia. The key points are:

- After consideration of non-pharmacological measures, hypnotic drug therapy may be considered appropriate for the management of severe insomnia interfering with normal daily life. It should be prescribed for short periods of time only, in strict accordance with their licensed indications.
- Due to a lack of compelling evidence to distinguish between the z-hypnotics or the short-acting benzodiazepine hypnotics, the drug with the lowest acquisition cost (bearing in mind daily required dose and product price per dose) should be prescribed.
- Switching between these hypnotics should only occur if the patient experiences adverse effects considered to be directly related to a specific agent. These are the only circumstances that hypnotics with higher acquisition costs are recommended.
- Patients who have not responded to one of these hypnotic drugs (benzodiazepines or z-hypnotics) should not be prescribed any of the others.

2. AIM

The aim of this guidance is to discourage unnecessary prescribing of hypnotics for insomnia to inpatients, whilst in hospital and at the point of discharge, and hence to limit the effects of unnecessary use (for example falls and dependency) in the community.
3. DEFINITIONS

Hypnotic – a drug used to induce sleep. Hypnotic applies to all benzodiazepines and z-drugs prescribed for insomnia.

4. THE PRESCRIBING OF HYPNOTICS TO INPATIENTS

- Non-pharmacological measures should be used whenever possible for the management of insomnia.

- Prior to the initiation of pharmacological treatment, consideration should be given to:
  - Underlying causes e.g. depression, mania, pain.
  - Substance misuse.
  - Sleep hygiene measures e.g. address excessive caffeine intake.
  - Other medication that may cause insomnia e.g. SSRIs and procyclidine administered at night.

- Patients admitted to hospital without a hypnotic as part of their regular medication should not generally be offered a hypnotic for insomnia whilst in hospital and should not be discharged with a supply of hypnotics.

- If hypnotic therapy is considered appropriate for the treatment of severe insomnia interfering with daily life, it is recommended that hypnotics should be prescribed for short periods of time only in strict accordance with their licensed indications.

- Due to the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorter-acting benzodiazepine hypnotics, the drug with the lowest purchase cost should be prescribed (refer to the Trust’s Drug Formulary for the latest recommended medicine).

- Prescriptions should be limited initially to no more than 7 days and then reviewed. The duration of therapy should be stated on the inpatient prescription chart.

- Only 7 days supply of hypnotics will be dispensed for inpatient prescriptions. The pharmacist will request a review of the prescription before further issues are made.

- A clear indication for the hypnotic should be stated in the patient’s medical notes with an appropriate review date.

- Intermittent use (every 2nd/3rd night) should be considered to help prevent tolerance developing.
• Hypnotics should not routinely be prescribed on an “as required” basis for insomnia.

• Switching from one hypnotic agent to another should only occur if a patient experiences adverse effects considered to be directly related to a specific agent.

• Patients who have not responded to one hypnotic agent should not be prescribed any other treatment which acts at the benzodiazepine receptor.

• The lowest dose that can control the symptoms should be used.

• With regard to “as required” prescriptions, prescribers should review medication after three doses.

• There may be exceptional cases where patients with severely disabling symptoms may benefit from longer courses of hypnotics. This should only be done after careful assessment of the patient and the reasons clearly documented in the patient’s medical notes and communicated to the GP.

• The suitability of benzodiazepines, especially long-acting agents, should be taken into consideration in certain patient groups e.g. elderly patients, hepatic impairment etc.

5. THE PRESCRIBING OF HYPNOTICS ON DISCHARGE

• All prescriptions for hypnotics must be reviewed regularly and where possible discontinued before discharge from hospital.

• Unless patients have been receiving hypnotics long-term, patients should not be discharged home with a supply.

• If hypnotic use is to continue on discharge from hospital, the consultant must clearly state this in the patient’s medical notes and the reason for the decision.

• Only 7 days supply will be dispensed on a 4 week prescription for hypnotics unless the prescriber states reasons for extended use.

• All discharge correspondence to the GP with regards to hypnotics, must clearly indicate whether the drug is to be continued and, where appropriate, the mechanism for discontinuing the prescription.
REFERENCES


APPENDIX 2 - GUIDELINES FOR PRESCRIBING UNLICENSED AND OFF-LICENSE MEDICINES

Licensed medicines

A licensed medicine is a medicine that has a UK product license which defines its terms of use. This product license will outline, among other things, the indication(s), recommended dose(s), contraindications, and special warnings and precautions for use on which the license is based, and it is in line with such use that the benefits of the medicine have been judged to outweigh the potential risks.

Furthermore, a licensed medicine: has been assessed for efficacy, safety and quality; has been manufactured to appropriate quality standards; and when placed on the market is accompanied by appropriate product information and labelling.

Unlicensed medicines

The term ‘unlicensed medicine’ is used to describe medicines that are used outside the terms of their UK licence (often referred to as “off-license”) or which have no licence for use in the UK. Unlicensed medicines are commonly used in some areas of medicine such as in paediatrics, psychiatry and palliative care. They are also used, less frequently, in other areas of medicine.

Yeovil District Hospital NHS Foundation Trust Policy

At Yeovil District Hospital NHS Foundation Trust, where a suitable licensed medicine exists, it must always be used in preference to an unlicensed medicine. Such licensed medicines must be prescribed in accordance with their product license as outlined in the Summary of Product Characteristics (www.medicines.org.uk).

However, an unlicensed medicine may be prescribed where, on the basis of an assessment of the individual patient, the prescriber concludes, for medical reasons, that it is necessary to do so to meet the specific needs of the patient.

Prescribing unlicensed medicines may be necessary where:

- There is no suitably licensed medicine available in the UK to meet the special need of the patient.
- A licensed medicine is available but not in a suitable formulation/presentation for the patient in question.
- A suitably licensed medicine is likely to be unavailable for a significant period.
Advice for prescribing an unlicensed medicine

- You must be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy.

- Make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine.

- Patients (or their parents or carers) must be given sufficient information about the medicines you propose to prescribe to allow them to make an informed decision. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence.

- You must take responsibility for prescribing the medicine and for overseeing the patient’s care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so. This may be a GP where a suitable shared care protocol exists.


However, it should not be assumed that GPs will take on responsibility for prescribing unlicensed medicines. Unless the GP agrees to assume prescribing responsibility, this should continue to rest with the consultant initiating treatment.

Request for a new unlicensed medicine

- A “New Drug Request Form” will need to be completed by the consultant, and returned to the Formulary Pharmacist.

- Together with any supporting evidence, this request is then submitted by the Formulary Pharmacist to the Chairman of the Drug & Therapeutics Committee for his/her approval.

- If the unlicensed medicine is to be prescribed on a regular basis for several patients, or if it is part of a Trust prescribing guideline, assessment and approval for use must be carried out by the Drug & Therapeutics Committee.

Responsibility

Although the use of unlicensed medicines is widespread in hospitals, individual prescribers and pharmacists are jointly responsible for their use. Therefore, it is important that all prescribers and pharmacists are aware of the associated medico-legal implications of such practice.

A prescriber has the right to use any material for any purpose in the treatment of his own patient, although he does so under his own responsibility. However, if a patient is harmed by an unlicensed medicine, or a licensed medicine as a result of it being used for an unlicensed indication, and not because of any defect in the product itself, then the prescriber is professionally accountable and liable for the harm.
References


APPENDIX 3 - GUIDANCE FOR CLINICAL TRIALS

Research and Development

All research hosted by the Trust must have the relevant regulatory and ethics approvals in addition to Trust Research and Development approval before any work proceeds. The Research and Development Department at Yeovil District Hospital must be informed of any intended research activity at the earliest available opportunity.

Clinical Trials

Clinical research trials usually involve the use of a medicine outside its licensed use and these trials are strictly regulated and run to the International Conference on Harmonisation of Good Clinical Practice (ICH GCP) standards and the EU Directive 2001/20/EC relating to the conduct of clinical trials.


http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Clinicaltrials/Legislation/ImplementationofClinicalTrialsDirectiveintheUK/index.htm

The Research and Development Department and Pharmacy staff work closely to enable the safe conduct of all clinical research in the Trust by ensuring trial protocol adherence, correct storage and administration of trial therapy and reporting and monitoring of adverse events. Nominated pharmacy staff attend study initiation meetings and assist with monitoring as required.

If a patient consents to participate in a clinical trial at Yeovil District Hospital there will be a copy of the consent and patient information sheet in the case notes together with an annotation explaining what the trial involves. The notes will be clearly labelled with a trial specific sticker.

Study specific prescriptions need to be used unless the protocol allows standard Trust prescriptions i.e. inpatient medications. Pharmacy keep detailed records of the trial medication via accountability logs as well as procedures for unblinding a drug. All instances of adverse drug reactions whilst a patient is on a clinical trial must be reported immediately to both the Research and Development Department and Pharmacy to ensure the safety of the patient and the timely reporting of events through the correct systems.
APPENDIX 4 - GUIDANCE FOR MANAGING MEDICINES ON DISCHARGE

Prescriber’s responsibilities

On discharge it is the prescriber’s responsibility to write the discharge prescription, or sign the discharge pharmacists TTO medication section, and to clearly state a summary of the diagnosis and details of any medication prescribed at the time of the patient’s discharge. All changes to the patient’s medication must be listed, together with the clinical reasons for those changes, on the discharge summary. The prescription should also indicate the length of treatment and any relevant instructions for the on-going monitoring of the prescribed medication. Any allergies or hypersensitivities must also be documented on the discharge summary.

Pharmacy staff’s responsibilities

On discharge it is the pharmacy staff’s responsibility to ensure the medication prescribed at discharge corresponds to the medication the patient was receiving during their hospital stay or that changes to existing or new medication are appropriate (pharmacist clinical screen). Pharmacy must also ensure patients have at least a seven day supply of regular medication on discharge from hospital or that the patient has more at home (MAH).

Nurse’s responsibilities

Nursing staff must counsel all patients on their discharge medication. The verbal information given to the patient must include the name, dose, route, frequency and clinical reason for each of the medicines prescribed. Nursing staff must also inform the patient of any changes to their medication during their hospital stay. A copy of the discharge prescription must be given to the patient prior to discharge.

Nursing Staff must ensure that medication issued to patients on discharge is appropriately labelled – never ward stock – unless it is clearly the patient’s own drug e.g. an unlabelled inhaler or loose strip, and the patient is cognisant of its dose and frequency.
APPENDIX 5 – PROCEDURE FOR MEDICATION HISTORY TAKING

Introduction

Establishing an accurate medication history for patients admitted to hospital is important since this will form the basis on which future inpatient decisions are made. The medication history process is used to identify any patient-related medicines management issues that may have affected the patient’s admission to hospital or that may affect discharge.

It is important to establish at the earliest possible opportunity an accurate medication history which can be obtained from many different sources. These sources should be accessed until it is believed that an accurate account has been achieved. It will usually be necessary to refer to more than one source, and the decision on which sources to use should be adapted to the situation using professional judgement. It is important to interview the patient whenever possible (unless they are confused or too unwell) as they may be the only person aware of certain medications. The patient’s own drugs (PODs) must also be examined and discussed with the patient whenever possible to ensure an accurate account of the patient’s usage is determined.

Objective/Purpose

To establish an accurate and complete medication history for all adult patients on admission to hospital.

Authorised Personnel

The following groups of staff are permitted to take medication histories:

- Registered doctors
- Registered non-medical prescribers
- Registered pharmacists
- Pharmacy technicians with accreditation in medicines management (drug history taking module).

Accredited pharmacy technicians are not expected to:

- Identify drug interactions or adverse drug interactions
- Issue any advice/interpret treatment choices
- Make any clinical decisions
- Make any treatment changes
- Have involvement in clinical monitoring

If a medication history is taken by a pharmacy technician and discrepancies are identified, these should be passed onto the relevant pharmacist to discuss with medical staff. The
outcome of any such queries should be fed back to the pharmacy technician where appropriate.

**Taking a Medication History**

- All patients must have a medication history taken on admission to hospital.

- When the medication history cannot be completed due to lack of access to the patient’s GP or other records then the medication history must be confirmed as soon as this is possible.

- The date of the medication history and the date of any amendments to the medication must be documented.

- If a patient’s medication history was taken during a pre-admission clinic, it is important to consider whether any changes have occurred prior to admission.

- The medication history must be documented either in the medical clerking record for medical patients or the medical notes for all other patients.

- Details of all medication altered, stopped or started on admission must be documented in the medical clerking record or in the medical notes. The clinical indication for these changes must also be recorded.

An accurate medication history should establish the following:

- Medication allergy/sensitivity status
- Regular medication used (including dose, route, frequency, formulation and brand if specific brand is clinically important)
- Occasional medication used (e.g. analgesia, inhalers, GTN spray)
- Use of topical preparations including any eye drops
- Herbal, homeopathic or other complimentary medications purchased or prescribed
- Any recent changes in prescription and why

In addition to the essential information listed above, medication history taking may also establish the following:

- Any adverse effects of current or past medication
- Any treatment failures in the past
- Whether the patient’s own drugs (PODs) are available /suitable for use on the ward
- Whether the patient has any further supplies of medications at home
- How the patient usually manages their medication (i.e. the need for medication compliance devices)
- Any concordance issues
Any concerns regarding the quantity of medication to be supplied (e.g. patients with previous history of drug misuse or overdose)

Recreational use of substances

It is important to indicate the source(s) of the medication history and where appropriate to record the date of any document(s) used. The following sources of patient medication histories are discussed in detail in the guidance notes:

- Medication Administration Record Sheet (MAR)
- Previous hospital chart/discharge letter
- GP printouts/repeat prescriptions
- Patient's own drugs (PODs)
- Patient
- Medicines compliance aid / monitored dosage system
- GP referral letter
- Telephone conversation with GP surgery
- Pharmacist / community pharmacy
- Relative or carer
- Summary Care Records (SCR)

Guidance Notes On Sources Of Medication History

It should never be assumed that a medication history written in a patient’s Emergency Department (ED) notes is accurate. Whilst in ED the patient may be confused, too unwell or just unable to remember all their medication/doses accurately, possibly without the medication itself. It may not be possible for the medical staff in ED to contact the patient’s relative/GP out of hours to confirm medication histories.

**Important.** Always check documents for the patient's name, date of birth, address and the date, as discrepancies frequently occur.

MARS sheet (medication administration record sheet)

These are the equivalent to drug charts used in nursing homes and are an accurate account of which medicines the patient has been receiving. Ensure that there is a complete set of records. Pay attention to the administration section to establish if the medicines are still current, and to confirm that the patient has been taking them.

Previous hospital prescription (inpatient or discharge)

If the patient was discharged from hospital within the last month, use the last discharge letter or inpatient prescription as a record of all current medicines for the patient. It is important to confirm with the patient/GP that no changes in medication have occurred since discharge. Always ensure that a full and accurate medication history was obtained at that admission.
**GP printouts/repeat prescriptions**

This is a very good source of information. Take care to note when a medicine was last issued and how many were issued; this will indicate if something is current.

When assessing information from repeat prescriptions be aware that this does not always list the current acute medicines. The GP may have told the patient to alter the dose, but the computer has not been updated. Sometimes part of the information may have been cut off by the printer. Try to check with patient or GP surgery if there are any other medicines that are not listed.

If date last issued is not recorded on the scripts ask the patient or GP surgery to confirm if each item is current. If a medicine was last issued some time ago this may indicate that either it has actually been stopped or the patient has not been ordering any. This in turn may indicate a concordance issue; discuss these with the patient if possible.

Note that information on drug sensitivities and allergies can be found on GP patient summaries.

**Patient and patient's own drugs (PODs)**

Establish if the patient is alert, if so they can be a good source of information but if they are confused or too ill they should not be approached for information.

It is best to refer to the PODs (patient’s own drugs) and/or the GP summary/repeat prescription whilst discussing medicines with a patient. Ask the patient whilst showing them each medicine, how they usually take them because this will not always match the label. If the patient is unable to help, check PODs against another source of information. When using PODs for information always note the date of issue and check that they are for the correct patient.

Patients can tell you about recent changes that may not register on the GP’s computer yet. They can also tell you if they have been recently admitted to hospital. Be aware of this as GP records may not have been updated if the patient has had medicines recently changed in hospital but the GP has not yet seen a discharge letter or acted upon one.

Compliance aids are another source of information. Check the patient name and date on them to indicate they are current and make sure all items are present (some cannot be stored in compliance aids and are provided separately to the patient). If there is any doubt, contact the pharmacy whose details will appear on the label. Identify all medication in the box.

If the patient did not bring in their own medicines ask them if they can remember what they take. Do not suggest drug names to patients’ as drug names can often sound alike. Make sure you have a BNF to hand and be aware that patients may refer to items by the trade name. Always use terms and language that the patient will easily understand.

Ask the patient if they have any allergies to any medicines that they know about or are unduly sensitive to the effects of any medicines. Remember that patients often describe side effects as ‘allergies’.
GP referral letter

Always check the date on which the letter was written to establish if it is current. The medication history in these letters can be inaccurate and often refers to presenting complaints alone and may not list medication for other complaints. Try to confirm any information from this source.

GP telephone conversation

When ringing a GP surgery for a medication history ask for it to be faxed to the ward. If the surgery refuses to fax, information may be taken over the phone. Be sure to confirm the patient’s name, address and date of birth before receiving information. Ask for all repeat medicines and any acute medicines prescribed recently. Pay particular attention to dates on which items were last issued and always double check that they have given you all relevant information. Take the opportunity when they are on the telephone to ask if the patient has any allergies. Consider that the GP receptionists are not trained about medication so the information will have to be teased out. Ask them to spell out the medication name if necessary, don’t be tempted to finish their sentences for them.

Always ask the name of the person you are speaking to and record this in the patient’s notes with the medication history.

Community Pharmacy

If the patient attends the same community pharmacy for all their medicines, a faxed or verbal list can be obtained from them in the same way as for GP telephone conversation.

Patient’s relatives / carer

If a close relative or other carer is involved in the patient’s care, they may be a good source of information. Discuss the medicines in the same way as with the patient themselves.

Do not discuss patient’s medication with a relative or carer unless the patient has given their permission (be aware of patient confidentiality).

Summary Care Records (SCRs)

These records are populated by GP surgeries and can provide information relating to allergies/drug intolerances, acute prescriptions, repeat prescriptions and discontinued prescriptions. SCRs must not be accessed without obtaining the patient’s permission except in emergency situations where timely access to an accurate drug history is essential. The practitioner must claim a legitimate relationship with the patient before accessing their SCR.

It is important to check when the SCR was last updated by the GP surgery to ensure any recent admissions to hospital have been included. Some versions of the SCR give
information relating to the date the prescription was last authorised rather than the date the prescription was last issued therefore care is needed when trying to establish whether repeat prescriptions are still current.

**Hints for talking to patients**

Introduce yourself to the patient and tell them that you would like to talk to them about their medicines. Ensure that the patient is comfortable; position yourself so that you do not intimidate them.

To check their alertness you could ask them for their date of birth and address.

Use open and not leading questions.

**Allergy/sensitivity status**

Ask the patient if they have any allergies/sensitivities to any medicines that they know of. If they respond with “none”, it may be useful to prompt those who may not have understood the question with “so you’re ok with penicillin?” Information from old prescriptions or notes may help clarify ambiguities.

If allergy or drug sensitivity is identified, the nature of the reaction should be documented clearly in the patient’s medical notes and the allergy/sensitivity status should be amended on the patient’s inpatient prescription.

**Medicines taken by mouth**

Ask the patient about any medicines taken by mouth that they obtain from their GP. Say “tablets, capsules and liquid medicines” if necessary.

**Other medicines from the GP**

Ask if the patient uses any inhalers, eye-drops, creams, ointments, nasal sprays, patches, etc. prescribed by their GP. Remember some patients do not regard topical treatments as ‘medicines’.

**Medicines from the chemist**

Use this phrase rather than “community pharmacy” as older people may not know what this is. If clarification is required, prompt with “any painkillers or cough medicines”.

**Herbal remedies, complementary or ‘alternative’ remedies**
Usually people who don't know what you mean by this do not take them. Similarly those who do, reel off the list with confidence.

Vitamins and supplements

Suggest multivitamins or cod liver oil if clarification is required.

Patients with Communication Difficulties

- For patients with communication difficulties, every effort must be made to translate or interpret any questions/information being conveyed into a format that is understood by the patient.
- For patients with hearing impairment a hearing loop may be used if available on the ward. Notes can be written for the patient or a qualified British Sign Language interpreter may be used. The use of pictorial images may be helpful for specific patient groups e.g. those with learning difficulties.
- For the visually impaired, the patient should be asked how they manage their medicines at home.
- For patients whose first language is not English, an official translation service is provided by the Trust. Translators may be able to provide formal written translation.
- For patients with learning disabilities, input from carers and health facilitators is essential or other guidance such as hand held patient records might be useful.
APPENDIX 6 – PHARMACY PROCEDURE FOR MEDICINES RECONCILIATION

Introduction

In December 2007, the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) issued joint guidance on medicines reconciliation on admission of adults to hospital [1]. The guidance stated that “the aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission”. The guidance highlighted the possible threat of harm to hospital inpatients as a result of medication errors, leading to increased morbidity, mortality and economic burden to health services. It also recognised that medication errors occur most commonly on transfer between care settings and particularly at the time of admission.

The following actions were recommended in the guidance:

- All healthcare organisations that admit adult inpatients should put policies in place for medicines reconciliation on admission. This includes mental health units, and applies to elective and emergency admissions.

- In addition to specifying standardised systems for collecting and documenting information about current medications, policies for medicines reconciliation on admission should ensure that:
  
  - Pharmacists are involved in medicines reconciliation as soon as possible after admission
  - The responsibilities of pharmacists and other staff in the medicines reconciliation process are clearly defined; these responsibilities may differ between clinical areas
  - Strategies are incorporated to obtain information about medications for people with communication difficulties.

The National Prescribing Centre (NPC) issued support material and guidance to implement medicines reconciliation in Trusts and across care interfaces [2]. The NPC defines medicines reconciliation in more detail as:

- Collecting information on medication history (prior to admission) using the most recent and accurate sources of information to create a full, accurate and current list of medicines
- Checking or verifying this list against the current prescription chart in the hospital, ensuring any discrepancies are accounted for and actioned appropriately, and
- Communicating through appropriate documentation any changes, omissions and discrepancies.
Aim

To reduce the number of medication errors occurring on the transfer of patients between care settings and therefore minimise the threat of harm to a patient as a result of such errors.

Objective/Purpose

- To collect relevant information to enable an accurate medication history to be established

- To ensure the medicines prescribed on admission correspond to those that the patient was taking prior to admission (where appropriate), and

- To communicate effectively with other healthcare professionals any intentional changes made to the medication during a patient’s stay.

Authorised Personnel

The following groups of pharmacy staff are permitted to take medication histories and reconcile medication:

- Registered pharmacists
- Pharmacy technicians with accreditation in medicines management (drug history taking module)

Medicines Reconciliation

- Medicines reconciliation must be completed within 24 hours of admission. For patients admitted during the weekend, the reconciliation process must be completed as soon as possible at the start of the next working week.

- Wherever possible, medicines reconciliation must be carried out using two sources of information and the date of any documents used to verify the medication history must be recorded. Sources of information include the patient, relative/carer, patients’ own drugs, GP printout/fax, repeat prescription slip, GP referral letter, medication administration record (MAR), Summary Care Record (SCR), previous hospital prescription (inpatient or discharge), medicines compliance aid/monitored dosage system, telephone conversation with GP surgery and community pharmacists. This list is not exhaustive and other appropriate sources for a medication history may be apparent.

- If any errors are identified with the medication history documented in the medical notes i.e. the medication history differs to that verified by pharmacy, then the
medication history in the medical notes must be amended by pharmacy so that it is accurate. These corrections must be written in green and all amendments must be signed and dated. The same procedure should be followed by both pharmacists and accredited pharmacy technicians but any discrepancies identified by a pharmacy technician should also be brought to the attention of the relevant ward pharmacist.

- The inpatient prescription chart must be checked to ensure that the medicines prescribed correspond to those that the patient was taking prior to admission. It is the responsibility of pharmacy to act on any errors or discrepancies identified. The relevant medical team must be contacted and an entry made in the patient’s medical notes if appropriate. When it is not possible to contact the medical team and resolve a discrepancy, a pharmacy intervention note must be completed and attached to the front of the inpatient prescription requesting clarification. Any identified discrepancies must also be endorsed under the medicines reconciliation section of the inpatient prescription. This endorsement must be signed and dated by the relevant pharmacist/pharmacy technician. Pharmacy technicians must also inform the ward pharmacist of any such errors or discrepancies.

- When the medicines reconciliation process is complete, the medicines reconciliation section of the inpatient prescription chart must be completed. This entry in the prescription must indicate which sources of information were used to confirm the medication history. The medicines reconciliation section of the inpatient prescription chart must be signed and dated by the pharmacist/pharmacy technician involved in reconciling the medicine.

- Medicines reconciliation is essential on hospital discharge. The GP or destination hospital must be informed of all changes made to a patient’s medication, together with the clinical reasons for those changes. The information on discharge must also include relevant instructions for the ongoing monitoring of those medications and details as to length of treatment.

- On discharge the following information must be provided as a minimum standard:
  
  o Complete and accurate patient details (full name, address, date of birth, NHS/unit number, consultant, ward discharged from, date of admission and date of discharge)
  o The diagnosis of the presenting condition and co-morbidities
  o Procedures carried out during the admission
  o A list of all the medicines prescribed for the patient on discharge (and not just those dispensed at the time of discharge which are in addition to the regular medication)
  o Dose, frequency, formulation and route of all the medicines listed
  o Medicines stopped, started or changed during the admission with reasons
  o Length of courses where appropriate (e.g. antibiotics, clopidogrel)
  o Details of variable dosage regimens (e.g. oral corticosteroids, warfarin etc.)
  o Known allergies, hypersensitivities and previous significant drug reactions
  o Any additional patient information provided

This information must be clear, unambiguous and legible and should be available to the GP (or other primary care prescriber) as soon as possible after discharge.
Patients with Communication Difficulties

- For patients with communication difficulties, every effort must be made to translate or interpret any questions/information being conveyed into a format that is understood by the patient.

- For patients with hearing impairment a hearing loop may be used if available on the ward. Notes can be written for the patient or a qualified British Sign Language interpreter may be used. The use of pictorial images may be helpful for specific patient groups e.g. those with learning difficulties.

- For the visually impaired, the patient should be asked how they manage their medicines at home.

- For patients whose first language is not English, an official translation service is provided by the Trust. Translators may be able to provide formal written translation.

- For patients with learning disabilities, input from carers and health facilitators is essential or other guidance such as hand held patient records might be useful.

References

APPENDIX 7 - GUIDANCE FOR WORKING WITH THE PHARMACEUTICAL INDUSTRY

Purpose

The purpose of these guidelines is to specify the approach and procedures of the Trust and its interactions with the Pharmaceutical Industry. It is designed to allow the Trust to enter into useful relationships with the Pharmaceutical Industry which:

- Benefit the local population by improving and maintaining the quality of healthcare
- Develop education, training and service opportunities for the Trust clinicians and healthcare staff
- Are transparent and open to public scrutiny
- Fulfil the highest standards of professional, financial and ethical probity

For the purpose of this annex, pharmaceutical sponsorship includes funding from a pharmaceutical company for all or part of the costs of:

- a member of staff
- NHS research
- training
- pharmaceuticals
- equipment
- meeting rooms
- costs associated with meetings
- meals
- gifts
- hospitality
- hotel and transport costs
- provision of free services (e.g. speakers) buildings or premises
- course fees

Principles for working with the pharmaceutical industry

The Trust wishes to work with the Pharmaceutical Industry on issues where there is a common aim and where there are benefits for patients in working together. It is intended that the relationship will be supportive of strategic education, training, professional and service developments.

Any joint working between the Trust and the Pharmaceutical Industry must:

- Be for the benefit of patients
- Promote and enhance equitable access to evidence based high quality health care
- Adequately respect and preserve patient confidentiality
- Be made in accordance with the YDH NHS Foundation Trust Standing Orders and Standing Financial Instructions, Codes of Accountability and Conduct
- Adhere to the Association of British Pharmaceutical Industry (ABPI) Code of Practice
- Be handled in an open and transparent manner
Any joint working between the Trust and the Pharmaceutical Industry must not:

- Be seen as an endorsement or promotion of a specific medicine or technology
- Undermine or conflict with the ethical requirements of any healthcare professional, including the duty of clinicians to provide whatever treatment they consider clinically appropriate

The Trust will offer equitable access and opportunity for involvement to all pharmaceutical companies involved in a specific therapeutic area, regardless of size, taking into account the companies’ proven history of ethical and productive joint working.

Any agreements made to pursue collaborative working must contain a clause providing for termination in the event that the expected outcomes are not being reached.

Contact procedure

Within the Trust a Pharmacist is the first point of contact for all communication with the Pharmaceutical Industry.

Every company should nominate one contact person for dealings with the Trust. To ensure that a full range of product information is available, a visit by a senior representative may be encouraged.

All staff will comply with the guidance on the acceptance of gifts and hospitality when dealing with the Pharmaceutical Industry.

Hospitality gifts and inducements

Staff must not ask for or accept fees for agreeing to meet representatives of the Pharmaceutical Industry.

It is inappropriate to ask for, or accept, any material gifts except those of insignificant value and relevant to the organisation. Examples of items that may be considered appropriate include pens, memo pads, diaries, calendars etc.

Representatives organising educational meetings may offer to provide hospitality. This is generally considered acceptable if it is secondary to the purpose of the meeting, and the level of hospitality is appropriate and not out of proportion to the occasion. The costs should not exceed the level that the recipients would normally accept if they were paying for themselves.

Obligations relating to the provision of inducements and hospitality are also placed on the Pharmaceutical Industry and Health Professionals by the Human Medicines Regulations 2013.

Trust-led initiatives
Where the Trust has identified projects or training programmes which could be taken forward in collaboration with the Pharmaceutical Industry, the appropriate Director should be informed.

The Director, in conjunction with a Chief Pharmacist, will agree the scope and detail of the project.

**Provision of information on products and therapeutic issues**

Representatives will only be seen by appointment.

**Education and training**

The Pharmaceutical Industry can provide resources which can be beneficial when organising meetings and educational events. Note that this only applies to those products which form part of the Trust formulary.

**Hospitality and Meetings**

Trust staff may accept from Pharmaceutical Representatives appropriate hospitality and/or the payment of actual costs, which may have been incurred for organising meetings or training events. However, hospitality must be secondary to the purpose of the meeting.

The level of any hospitality offered must be appropriate and not out of proportion to the occasion; the costs must not exceed that level which the recipients would normally accept when paying for themselves or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it inappropriate for them to attend the meeting or training event.

Training sponsored or provided by the Pharmaceutical Industry should be unbiased, have mutual benefit for both the NHS and the sponsoring company and be evidence-based. However, participants should assess whether they may be influenced unduly and also have consideration of what benefits the company might derive.

**Research and development**

Any collaboration between the Trust for the purposes of research and development will be governed by the ABPI and the National Institute of Health Research (NIHR).

If the project involves research, consultation with the relevant Local Research Ethics Committee should be sought.
Governance arrangements

A Register of Declarations will be maintained by the Director of Finance and Performance. All staff must declare hospitality/gifts in excess of £25.

In the event that a member of staff receives an offer which could breach the terms of this policy and/or the Codes of Conduct, this should be reported to the Chief Pharmacist.

Staff representing the Trust on any contract adjudication must comply with CMU requirements to complete a declaration of interest form.

References:


APPENDIX 8 – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Nationality</td>
<td>No</td>
<td></td>
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<tr>
<td>• Gender</td>
<td>No</td>
<td></td>
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<tr>
<td>• Culture</td>
<td>No</td>
<td></td>
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<tr>
<td>• Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
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<tr>
<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
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<tr>
<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td></td>
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</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust’s lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust’s lead for Equality & Diversity.

Signed: Sharon Hodges (Clinical Pharmacy Manager)      Date: 21st May 2014