Medicines Policy 2011

Policy and Procedures for the Prescribing, Supply, Administration and Control of Medicines.

Amendments or variations to this Medicines Policy are not valid unless authorised by the Drugs and Therapeutics Committee.
**META DATA**

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<td>Effective from 2(^{nd}) January 2011</td>
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<td>31st October 2012</td>
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<td>Approved by:</td>
<td>Drugs and Therapeutics Committee on 14(^{th}) November 2007, 8(^{th}) December 2010</td>
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**Linked Trust Policies:**
- Non – Medical Prescribing Policy
- Policy for the Safe Prescribing, Handling and Administration of Cytotoxic and other Chemotherapeutic Agents for Oncology and Haemato/Oncology
- Intrathecal Chemotherapy Policy
- Intravenous Potassium Policy
- Incident Reporting and Management Policy and Procedure
- Patient Group Directions – Policy for the Development, Approval, Ratification and Use of Patient Group Directions
- Oxygen Prescription Guidelines
- Guidelines for the Management of a Patient with an Epidural Infusion
- Guidelines for the Management of Patient controlled Analgesia
- Policy on the use of Unlicensed and Off-label Medicinal Products for Adults and Children
- Self-administration Policy
- Managing patients who may require a blister pack on discharge

**Relevant legislation and guidance:**
See Section 1.9 of the Policy

**Revision History**

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<td>HEFT 2005 March 2006</td>
<td>M. Phillips, T. Carruthers</td>
<td>Update</td>
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<td>3</td>
<td>2(^{nd}) January 2008</td>
<td>R. J. Walton</td>
<td>Update and merger of HEFT and GHH Policies</td>
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<td>3.01</td>
<td>1(^{st}) May 2008</td>
<td>R. J. Walton</td>
<td>Appendix 1 revised and various minor technical/typographical changes</td>
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<td>23(^{rd}) June 2008</td>
<td>R. J. Walton</td>
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<td>3.03</td>
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SECTION 1

INTRODUCTION

1.1 Policy Statement

Heart of England NHS Foundation Trust is committed to the safe and secure handling of medicines to protect its patients, staff and visitors.

1.2 Policy Aim

The purpose of this document is to provide a Trust Policy for all members of staff groups involved in the use of medicines within the Trust. It indicates how medicines will be prescribed, supplied and administered to patients. It also defines the processes that will be used to assure safe procurement, supply, custody and disposal of medicines. The ultimate aim of the document is to ensure effective systems are in place to safeguard the welfare of patients, visitors and staff in regard to the use of medicines.

It is essential that all staff involved in the prescribing, supply and administration of medicines are made aware of this policy on joining the Trust and practice at all times in accordance with it.

Overall Responsibility

The Chief Executive of the Trust has overall responsibility for medicines management within the Trust. The Clinical Director of Pharmacy has delegated responsibility as the Trust’s Head of Medicines Management which includes the safe and secure handling of medicines throughout the Trust. The Clinical Director of Pharmacy reports directly to the Chief Executive for this purpose across the whole of the organisation. The Clinical Director of Pharmacy is also the Trust’s Accountable Officer for the safe and secure handling of Controlled Drugs within the Trust.

1.3 Medicines Policy Accountability

The Trust’s Drugs and Therapeutics Committee is responsible, with the Clinical Director of Pharmacy, for producing and distributing this Medicines Policy.

The Medicines Policy is a Trust Policy approved by the Drugs and Therapeutics Committee.

The Trust’s Drugs and Therapeutics Committee reports to the Trust’s Safety Committee. The Medicines Policy describes the Trust’s control measures for reducing medicine-related risks.

For Terms of Reference of the Drugs and Therapeutics Committee see Appendix 4

The Medicines Policy supports clinical governance within the Trust.
1.4 Medicines Policy Application and Personal Responsibility

The Medicines Policy covers the policy and procedures associated with prescribing, administration, requisitioning and storage of medicinal products. **It is mandatory for all staff employed by and/or working for Heart of England NHS Foundation Trust.** This includes all midwifery and nursing personnel working in the home or visiting general practitioners’ premises but excludes those staff seconded to other organisations.

Healthcare staff involved with medicines should undertake continuing professional development, keeping up to date with changes in medicines and medicines management, and regularly updating themselves on the changes in content of this policy.

1.5 Consultants’ and Department Managers’ Responsibilities

Consultants are responsible for ensuring that all medical officers in their team are trained to be competent in all aspects of prescribing medicines, as specified in the Medicines Policy.

Senior Sisters and Managers of all departments using medicines must ensure that:

- A copy of the Medicines Policy is available to their staff
- Staff are fully aware of the Policy and associated procedures applicable to their ward or department
- Staff are competent to carry out any of their duties encompassed by this Policy and associated procedures.

1.6 Definition of ‘Medicines’

The term ‘medicines’ embraces all products that are administered by mouth, are applied to the body or introduced into the body for the purpose of treating or preventing disease, diagnosing or ascertaining the existence, degree or extent of a physiological condition, contraception, inducing anaesthesia, or otherwise preventing or interfering with the normal operation of a physiological function.

**CE Marking** is a mandatory conformity mark on a product placed on the single market in the European Economic Area (EEA). The CE Marking certifies that a product has met EU health, safety and environmental requirements, which ensure consumer safety. For the purposes of this policy, products with a CE Mark being used for a medicinal use will be considered equivalent to licensed medicines.
1.7 Implementation of the Medicines Policy

The Medicines Policy will be placed on the Trust’s intranet site under ‘Policies and Procedures’ and on the Trust’s Medicines Management intranet website http://medman/policies.

An e-mail with a link to the Medicines Management location of the policy will be circulated to:
- All senior sisters (for cascade to ward/department nurses/ midwives)
- All matrons
- Chief and Deputy Chief Nurse
- Nursing Heads of Clinical Groups
- All Clinical Directors (for cascade to consultants and junior medical staff)
- Medical postgraduate tutors
- Heads of Departments (Radiology, Therapies, Dietetics)
- All pharmacists and pharmacy technicians.

An ‘all users’ e-mail communication will be sent

To be included in a Trust’s monthly Staff Brief.

Reference to relevant parts of the Medicines Policy is included in: induction training of nurses, midwives, doctors and pharmacy staff; band 5 nurse training programmes; and in FY1 doctors’ seminar on medication prescribing risks.

1.8 Assessment of Compliance

Part of the daily activity of pharmacy staff is to ensure that medicines management throughout the Trust is undertaken in accordance with the Medicines Policy. Variation from policy will initially be taken up with the clinical practitioner concerned unless of a serious nature or repeated transgressions, when the matter will be appropriately escalated to consultants and/or managers.

Monitoring

Monitoring of this policy will be undertaken by the Drugs and Therapeutics Committee with regular reports from the responsible leads. The reports for safe and secure handling of medicines (including CDs) and the medication incidents are also reported to Safety Committee and Safe Medication Prescribing Group.

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<td>Controlled drugs – safe and secure handling</td>
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<tr>
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Each year, aspects of the Medicines Policy are included in the nursing metrics.

1.9 Training Requirements & Monitoring

Awareness training is delivered at Corporate Induction day 2 for clinical staff and is included on the FY1 and FY2 web-based induction. This training is provided to staff prior to commencing work.

A training needs analysis has been developed to outline the Trust’s expectations in relation to staff training.

Monitoring Mechanisms

Corporate day 2 training is logged on OLM and tracked by Corporate Induction Team. The Professional Education Team monitors completion of the pre-start website information prior to the doctors starting in the Trust. Professional Education follow up staff who have started in the Trust but who have not (for varying reasons) have not completed the training.

Amendments or variations to this Medicines Policy are not valid unless authorised by the Trust’s Drugs and Therapeutics Committee.
1.10 References

Due regard has been taken of all appropriate statutory medicines legislation and professional guidance including:-

Medicines Act (1968) & associated regulations

Misuse of Drugs Act (1971) & associated regulations.

S I 2005 No 2864 Dangerous Drugs – The Misuse of Drugs and the Misuse of Drugs (Supply to Addicts) (Amendment) Regulations 2005


Midwives’ Rules and Standards, Nursing and Midwifery Council, August 2004

The NMC Code of professional conduct: standards for conduct, performance and ethics. Nursing and Midwifery Council (November 2004)

Standards for Medicines Management, Nursing and Midwifery Council, (October 2007)

National Patient Safety Agency – patient safety alerts

Medicines, Ethics and Practice: A Guide for Pharmacists and Pharmacy Technicians No.34, July 2010
SECTION 2

GROUPS OF STAFF

Throughout this Medicines Policy the term “his” or “her” refers to all staff for whom the Policy is intended.

2.1 In the application of this Medicines Policy the following groups of staff are referred to: -

Nurse: This encompasses all practising nurses and midwives, registered with the Nursing and Midwifery Council, working for and on behalf of the Trust.

Nurse-in-Charge: The most senior nurse or midwife on duty for the ward or department who has been identified as the nurse/midwife in charge for that shift.

Designated Nurse: Any nurse or midwife who has been identified by the Ward/Department Manager as competent and appropriate to perform a specific task or function. This competence should be communicated to and recognised by any other relevant professionals.

Senior sister: The senior nursing appointment for the ward or department (e.g. senior sister, charge nurse, clinical nurse manager, team leader, senior midwife).

Duty Senior Nurse: The most senior nurse or midwife on hospital site cover.

Non-medical prescriber: A nurse, midwife, physiotherapist, radiographer, podiatrist, chiropodist or pharmacist who has successfully completed a validated supplementary / independent prescribing course and who has been designated to carry out a role as a supplementary prescriber or as an independent prescriber.
Pre-registration Nursing Students: Pre-registration students can administer drugs only under the direct supervision of a nurse. In this case the nurse is responsible for both the conduct of the learner and the safety of the procedure. Pre-registration students taking part in these procedures must ensure they are familiar with the particular policies and procedures of the hospital.

Students who are already registered on another part of the register and are undertaking further training (e.g. conversion course students) are not considered to be registered in their training allocations for the purposes of this Policy.

The exceptions to this note are student midwives undergoing post registration midwifery training courses and post registration Adult Critical Care pathway students from Birmingham City University, who have gained competence in medicine administration in their base intensive care units, all of whom must adhere to the guidelines specific to them.

Operating Department Assistants/ Operating Department Practitioners: Operating Department Assistants/Practitioners (ODAs/ODPs) having completed a recognised training course, assist in theatre procedures. ODAs/ODPs who have attended an approved training course and who have been deemed competent by the Theatre Manager may be involved in the administration of a limited range of medicines. ODAs/ODPs are not legally authorised to requisition Controlled Drugs.

The nature of the involvement of an ODA/ODP is set out in local policies agreed by the Clinical Director (Anaesthetics) and the Theatre Manager. These policies are reviewed annually.

Health Care Assistants: Nursing Auxiliaries and Nursery Nurses are excluded from participating in the administration of medicines except in the circumstances described in section 6.7

Health Care Assistants may only assist in the administration of medicines where they have undertaken an appropriate NVQ module relating to this practice and where they have successfully completed all of the assessment criteria.
Medical and Dental Staff

Doctors & Dentists: All medical and dental staff are registered with the relevant professional body. Medical staff may have full, limited or provisional registration. For the purposes of this document the three types of registration will be treated as synonymous.

The term "registered dental practitioner" refers to a dentist or orthodontist or any dental practitioner qualified and registered to prescribe or administer medication.

Throughout the document, in respect to prescribing rights, the term “doctor” applies to other professional staff authorised to prescribe such as dentists and non-medical prescribers working within their remit of authorisation.

Prescribers: The term is used to include doctors, dentists and non-medical prescribers working within their remit of authorisation.

Pharmaceutical Staff

Pharmacists: Pharmacists are registered with the General Pharmaceutical Council. The terms "clinical pharmacist” and “ward pharmacist” are used synonymously. See also role of the pharmacist, section 3.9.

Pharmacist-in-Charge: The term "pharmacist-in-charge” refers to the most senior pharmacist on duty at that site, at the time (usually the Clinical Director of Pharmacy or Deputy Director). Outside normal working hours, this will be the on-call pharmacist. The Responsible Pharmacist is the pharmacist in charge at that time for the registerable activities of the pharmacy.

On-call Pharmacist: A pharmacist providing an emergency out-of-hours pharmacy service when the Pharmacy Department is closed.

Pharmacy Technicians: Pharmacy technicians have completed a recognised Pharmaceutical Sciences course and gained an appropriate qualification.
### Medicines Management

**Technician:** A pharmacy technician undertaking a specific role relating to the management of patients’ medicines, usually on the wards.

### Dieticians

**Dieticians:** Dieticians are registered with the Health Professions Council.
SECTION 3

PRESCRIBING

3.1 General Guidance

Prescribing should conform with the advice which appears in the current British National Formulary (BNF) under "Guidance on Prescribing" and applies to the use of all prescribing documents used within the Trust.

The following points should be particularly noted:-

(a) When prescribing for inpatients, outpatients, day case patients, Accident Unit patients or on discharge prescriptions forms¹ (TTO), the Trust approved form must be used.

(b) The patient's full name, date of birth, registration number, gender, name of current consultant and ward must be entered on the drug prescribing and recording sheet.

(c) The names of all medicines must be PRINTED in BLOCK CAPITALS.

(d) The approved name of a medicine should be used at all times. (Except where the current BNF cautions against this e.g. slow release theophylline preparations, for multiple component medicines and other drugs where specific risks have been identified.)

(e) It is essential that the metric system is used for all prescribing. The writing of the dosage should be in accordance with the recommendations in the BNF. In particular, if the drug is one for which strength is expressed in units, then the word “UNITS” must be written in full. Similarly doses expressed as micrograms or nanograms must always have “micrograms” or “nanograms” written out in full.

(f) Although directions should be in English, without abbreviation, it is recognised that some Latin abbreviations are appropriate. (For details of acceptable abbreviations see the inside back cover of the current BNF and Appendix 2 of this Policy). No other abbreviations are acceptable.

(g) The route of administration must be clearly stated.

(h) Prescriptions must be signed in full, in indelible, black ink and dated by the prescriber.
(i) Medical gases, including oxygen, must be prescribed. Oxygen therapy should be prescribed in accordance with the “Oxygen Prescription” guidelines available at [http://intranet_1/guidelines/](http://intranet_1/guidelines/) (then search for “oxygen”).

(j) For children:
- Prescribe paediatric preparations whenever possible to avoid the risk of giving adult dosages.
- Always include the patient’s age and weight on the prescription sheet.
- Prescriptions should also detail calculations, i.e. mg/kg/dose or mg/kg/day but the prescription must state the actual calculated dose for the patient.

(k) Prescribers are strongly encouraged to ask a colleague to check any calculations that may be required when prescribing or administering medicines.

(l) For “Sources of Information about Medicines for Professional Staff”, see Section 9.19 of this Medicines Policy.

3.2 Prescribing for Inpatients

In addition to the general prescribing guidance (3.1) above, the following should be noted:

(a) The Drug Prescribing and Recording Sheet

(i) The drug prescribing and recording sheet should be available to the doctor whenever the patient’s treatment is being reviewed, to the nurse/midwife whenever medicines have to be given and to the clinical pharmacist when reviewing the inpatient treatment and discharge prescriptions.

(ii) Not more than one drug prescribing and recording sheet should be in use at any one time for any one patient. When 2 sheets are in use but the current treatment could be easily accommodated on 1 sheet, the doctor should be asked to re-write the drug prescribing and recording sheet to reduce the risk of medication errors and missed doses.

(iii) Where it is unavoidable for a patient to have more than one current drug prescribing and recording sheet at any one time, each sheet must be clearly marked as sheet 1 of 2, or sheet 2 of 2.

(iv) A new sheet should not be started merely because the first is not immediately available, e.g. if it is misplaced or in use elsewhere.
(i) For drugs which are to be given by intravenous infusion refer to Section 7.

(ii) The times of administration must be clearly indicated and should reflect appropriate practice on that ward. Prescribing drugs for 0600 hours should be avoided if possible.

(iii) The frequency of administration of "as required" medicines should be indicated by clear and definitely stated intervals, where possible. The maximum number of doses in any 24 hour period must be clearly stated where appropriate. The circumstances for administration must be defined.

(iv) Any instructions as to the application of treatment e.g. left eye, or the duration or timing of treatment must be written in the "special instructions" box.

(v) Allergy Status

Any known drug, food or substance hypersensitivity (including nut, arachis oil and latex allergies) that the patient suffers, the nature of the reaction and the source of the information MUST be recorded, signed and dated in the appropriate spaces provided on the drug prescribing and recording sheet. This information must be recorded by the person undertaking the clerking of the patient. This will usually be a prescriber, but other staff, specifically authorised* to undertake clerking-in of patients or drug history recording, can record allergy status information in the patient’s notes and on their drug prescribing and recording sheet (including outpatient prescription).

*Restricted to specifically named nurses and midwives authorised by the Director of Nursing and pharmacists authorised by the Clinical Director of Pharmacy.

It is not uncommon for other healthcare professionals to become aware of a previously unrecorded hypersensitivity. Such new information must be recorded and signed in the appropriate places in the patient’s notes and on the treatment chart, and a member of the patient’s medical team informed when considered appropriate.

Inpatients and day care patients who are allergic/ hypersensitive to any drugs, food or substances that they may come into contact with whilst being cared for by the Trust must wear a red ‘allergy’ wrist band.

If it is established that the patient has not suffered from any previous drug allergies /hypersensitivities, the prescriber², or other
specifically authorised * nurse/midwife or pharmacist, **MUST** state on the drug prescribing and recording sheet “No known drug allergies” (or NKDA), “None Known” or “None Declared”.

Where it has not been possible to determine the allergy status of a patient, the term “Undetermined” can be used on a temporary basis to allow essential/ life saving drug treatment to progress until the true allergy status of the patient can be established at the earliest opportunity.

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**N.B. Whatever the patient’s allergy status, a prescriber **must always** ensure that there is an entry in the allergy section of prescribing documents, and check against it, before writing a prescription. Nursing staff have been instructed not to administer, and Pharmacy not to dispense, any drug treatment for the patient.**

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(vi) The prescriber’s **full** signature, written in **black, indelible ink**, is necessary with each prescription and the date on which administration of the medication is to be commenced must be clearly stated.

(vii) **The date of prescription** – for new medication.

Drugs that have been started pre-admission to hospital and which need to be continued should have the word “Pre-admission” (“P/A”) written in the ‘start date’ box.

When rewriting the prescription sheet any start date / “pre-admission” appearing on the old sheet should be transferred to the new sheet. A date reflecting the day/time at which the prescription is rewritten should not be used.

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(c) Cancelling, Rewriting and Amending Prescriptions

(i) Cancellations of any prescriptions no longer current must be **signed and dated**. A heavy line must be drawn through both the prescribing and recording sections of the drug prescribing and recording sheet.

(ii) When a new drug prescribing and recording sheet is required, medicines still in use must be transferred from the old to the new sheet by the prescriber, the old drug prescribing and recording sheet
being cancelled by a heavy line, signed, dated (showing day, month and year), and retained in the patient’s records.

(iii) In most circumstances the drug prescribing and recording sheet should not be altered. If a change is required, the old prescription should be cancelled and a new one written. It is only permissible to amend the dose or frequency of a prescription if this can be done clearly, with detail of the change documented within the “special instructions” box. The amending prescriber’s signature and date must be written underneath the change details, and if appropriate, the time of the change. It is not permissible to alter a previously altered prescription; in such circumstances the prescription must be re-written.

See also “Amendment to a drug prescribing and recording sheet by pharmacist” in Section 3.11.

3.3 Legibility and Detail of Prescriptions

If the nurse is in any doubt whatsoever concerning a prescription, the drug must not be given until the prescription is verified and the doubt resolved. In the case of any difficulties, the Nurse-in-Charge must be informed so that appropriate action can be taken.

3.4 Prescribing by Medical Students

Medical students are NOT allowed to prescribe drugs under any circumstances. They may prepare a prescription but it must be signed only by a registered doctor / non-medical prescriber in order to authorise the prescription.

3.5 Electronic prescribing

Electronic Prescribing (EP) is in use in several ward areas and expanding. In areas where EP is in use all patients under admitting consultants recognised by the system must have their main drug prescription and administration record on the EP system. For prescriptions which the EP system does not yet handle (e.g. continuous drug infusions, intravenous fluids, patient controlled analgesia devices, epidurals and warfarin), the Trust’s appropriate specialist prescribing sheet must be used (e.g. a warfarin prescription sheet) – in each case a corresponding electronic prescription should be written to refer staff to the paper prescription (e.g. Warfarin – variable dose, see Anticoagulation sheet). Under no other circumstances should patients have both electronic and paper prescriptions.
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Each ward area using the system has a folder signposting users to EP Standard Operating Procedures, EP back up procedures and Training.

The username and password provided by the EP team to each member of staff forms the basis of their electronic signature and their accountability for actions recorded on the electronic prescribing system. Staff will protect their password in accordance with Trust policy and should not share it or allow it to become known by anyone else. If this should occur staff must change it immediately. If they are unable to do this they must contact the EP Team directly.

If a patient transfers from an EP ward to a non-EP ward, a printed copy of the EP prescription chart must be transferred with the patient and utilised in place of the conventional drug prescribing and recording sheet on the new ward.

### 3.6 Patient Group Directions

Arrangements exist within the Trust for administration of medicines by specified healthcare professionals without the necessity of a prescription written by a prescriber for an individual patient.

Similar arrangements exist for supply of medicines to patients by specified healthcare professionals without individual patient prescriptions written by a prescriber.

These arrangements are known as patient group directions (PGDs) and are approved by the Trust’s Drugs and Therapeutics Committee on behalf of the Trust Board.

Such arrangements are strictly limited to the detail in the patient group direction and to specified healthcare professionals, as detailed on the patient group direction. No variation from the detail in a patient group direction is allowed. Users of PGDs are authorised to write on the prescription sheet where this is specified and required in the PGD.

Further information is contained in “Patient Group Directions – Policy for the Development, Approval, Ratification and Use of Patient Group Directions” which is available on the Medicines Management intranet website [http://medman/pgd](http://medman/pgd).

### 3.7 Anaphylactic Shock

See Trust guidance.

### 3.8 Verbal Orders

...
**Verbal orders are not permitted.** Prescriptions must always be in writing and signed by the prescriber, prior to administration – but see section 3.11 for prescription amendments by a pharmacist.

### 3.9 The Pharmacist's Role

(a) It is the hospital pharmacist’s responsibility to promote safe, effective and economic drug therapy. They provide information and advice on drugs to those involved in the prescribing and administration of drugs. This also covers aspects of security and storage requirements. It is also the duty of the pharmacist to encourage the reporting of adverse reactions to drugs.

(b) The clinical pharmacist examines prescriptions to check that they comply with the recommendations in sections 3.1 and 3.2, and additionally will ensure that:

(i) They are complete and valid.

(ii) The dosage is within acceptable limits for that particular patient.

(iii) There are no significant therapeutic or pharmaceutical incompatibilities or interactions.

(iv) The treatment seems to be appropriate and is not duplicated.

(v) No drug is prescribed to which the patient is stated on the drug prescribing and recording sheet to be hypersensitive/allergic. **N.B. Medication for inpatients/day cases will not be dispensed if the patient’s allergy status has not been stated.**

(vi) It is in accordance with any relevant hospital formulary, protocol or policy.

(vii) Where improvement to drug therapy is considered possible the pharmacist will convey such information to the prescriber so that he may consider amendment of the treatment.

(c) The pharmacist will also annotate the prescription, in green or black ink, with any clarifications needed and/or advice on the preparation, administration method, dose calculations or monitoring of the drug treatment.

(d) Pharmacists may transcribe inpatient drug treatment from an existing inpatient prescribing and recording chart onto a new one in preparation for a prescriber to sign to authorise continuation of the treatment.
(e) Pharmacists may also transcribe inpatient treatment onto a discharge prescription form which can then be dispensed prior to the prescriber signing the form/discharge letter.

3.10 The Role of the Medicines Management Technician

The medicines management technician, where such posts are available, will assist the pharmacist in ensuring that patients have their current drug therapy appropriately prescribed and that treatment is available for administration in a timely manner. The principal roles of a medicines management technician are to:

i) Review the patient’s own drugs which they bring into hospital and ascertain their fitness for use.

ii) Where necessary, assist the pharmacist to clarify the drug history with the patient, carer or GP practice.

iii) Annotate prescription sheets with additional information where appropriate.

iv) Provide information on their drug treatment to the patient.

v) Assist the ward-based staff with provision of medicines information where appropriate or refer to the pharmacist.

vi) Expedite the provision of new drug treatment.

3.11 Amendment to a Drug Prescribing, Recording Sheet and EP Discharge Letter by a Pharmacist

In accordance with Directorate or Trust-wide signed orders
Directorates may agree to specified pharmacists being mandated to make defined amendments to prescriptions for patients of the Directorate e.g. to ensure compliance with directorate–specific guidelines. Similarly the Drugs and Therapeutics Committee may agree Trust-wide signed orders e.g. to substitute one drug for another, or to limit duration of therapy. Such agreements, including directorate–specific ones, must be clearly stipulated in writing and be formally approved by the Drugs and Therapeutics Committee.

Inpatient or TTO amendments to CDs
When the drug concerned is a CD, Schedule 2 or 3 (except Temazepam) the prescription must be referred back to the prescriber for amendments. Pharmacists may amend CD prescriptions for Temazepam, Schedule 4 and 5 as long as the intention of the prescriber is clear. These should be processed as below.

Minor Amendments
Pharmacists, at their own professional discretion and in the interests of providing best patient care, may modify the prescribed treatment of a patient in a number of ways without the need to necessarily refer to the prescriber. The circumstances when this can be undertaken are:

• When there is no doubt as to the prescriber’s intentions
• When some missing detail of an already prescribed maintenance
treatment, which the patient was taking immediately prior to
admission, comes to light through the taking of a drug history or
confirmation of one.
• When the prescribed times for administration differ from that
recommended in the BNF or Summary of Product Characteristics
(SPC) e.g. statins, diuretics, diabetic medications, relationship to
food intake etc. to ensure best therapeutic response
• When relevant standard prescribing information has been omitted by
the prescriber e.g. strength, form, injection diluent/ diluting infusion
fluid, rates of administration, frequency and treatment duration
• Duplications of treatments
• Discontinued medications e.g. PCAs

Moderate Amendments
Pharmacists may in the interests of providing best patient care, using their
professional discretion, add or amend items.
Examples of when this might be appropriate include:
• Medication missed unintentionally or unintentional dose changes from
drug history that is essential e.g. Anti-epileptics
• Medication omitted form TTO letter e.g. Preadmission medication
• Stop date for antibiotics

It is at the pharmacist discretion, taking into consideration area of work and
personal experience, to determine the need for additional documentation of
their actions. Pharmacists are reminded that the Electronic Prescribing
system maintains accurate records of these moderate amendments.
If an intervention note is required the relevant documentation for that area
should be utilised e.g. EP intervention note, paper intervention note, Doctor
Handover Book or Patients Medical Notes. These notes must include the
following information:
• Actions taken, why and specific details of any Prescriber contacted
• Name and bleep number of Pharmacist

Significant Amendments
Suspend or Cancel
After discussion with the prescriber the Pharmacist if necessary, in the
interests of providing best patient care, can cancel or suspend a
prescription if the prescription is deemed to be potentially dangerous and
the prescriber is unable to review the prescription immediately.
These may include:
• Potentially toxic dose of medication
• Incorrect medication, dose or frequency of medication
• Contra-indication to prescribed medication

The Pharmacist must use their professional judgement and make an
intervention note to the patient’s record, make an entry in the patient’s
medical notes or complete a Trust incident form as appropriate.
The prescriber must review the prescription as soon as possible and the Pharmacist must ensure the prescription has been followed up

**Prescribe and Suspend**

The pharmacist can prescribe an omitted or requested drug and immediately suspend it. The prescriber must review the patient in a timely manner to resume the prescription, ensuring that no doses are missed due to the drug being suspended. This may be of benefit in specialist areas e.g. Admissions units.

The EP system maintains accurate and auditable records of this activity that could be called upon at a later date if required. In non-EP area accurate records of this intervention must be made using paper intervention notes or patients records.

The pharmacist must use their professional judgement and make an intervention note if there will be any delay in the prescriber resuming the order.

### 3.12 Amendment to an Outpatient Prescription or a Paper Discharge Prescription by a Pharmacist.

**After discussion with the prescriber**

A pharmacist, or a pharmacy technician / pre-registration pharmacist on behalf of a pharmacist, may contact the prescriber concerning a prescribed item on an outpatient prescription or a discharge prescription. If this should result in a change to the prescribed treatment, the prescription may be amended and the prescription annotated with the term “prescriber contacted” or “PC” and be signed, dated and timed by the pharmacy staff member. However, the prescriber or the pharmacist may insist on the prescription being returned to the prescriber for a signed, dated and timed amendment before the prescription is dispensed.

When the drug concerned is a CD, Schedule 2 or 3 (except Temazepam) the prescription **must** be referred back to the prescriber for amendments.

**Without reference to a prescriber**

Pharmacists, at their own professional discretion and in the interests of providing best patient care, may modify the prescribed treatment of a patient in a number of ways without the need to necessarily refer to the prescriber. The circumstances when this can be undertaken are:

- When there is no doubt as to the prescriber’s intentions
- When the prescribed times for administration differ from that recommended in the BNF or Summary of Product Characteristics (SPC) e.g. statins, diuretics, relationship to food intake etc. to ensure best therapeutic response
• When relevant standard prescribing information has been omitted by the prescriber e.g. strength, form, frequency and treatment duration.

Pharmacists may amend CD prescriptions for Temazepam, Schedule 4 and 5 as long as the intention of the prescriber is clear.

3.13 Generic Substitution

The Trust accepts the principle of ‘generic substitution’ whereby the Trust’s pharmacies stock only one manufacturer’s product of any one drug form and will routinely substitute that product if an alternative manufacturer’s brand of that same drug form is prescribed. This is a routine practice in all NHS hospitals.

3.14 Discharge Medicines (TTOs)

Discharge medication can be prescribed using one of the three currently approved systems, these are –

- e-TTO – a web based system
- EP -TTO – the Trust’s electronic prescribing (EP) system
- paper based system (traditional discharge letter)

The EP system should be used when the patient is located within a clinical area utilising EP. Elsewhere the e-TTO system is the preferred method for both prescribing discharge medication and producing a GP letter. Details on using both these electronic systems can be found on the Trust’s website.

The discharge letter is a communication to the general practitioner (GP) and so must show a full record of the patient’s discharge treatment including any items which may not need dispensing because the patient has sufficient supplies of their own. Such items should be endorsed “patient’s own medication” whichever prescribing system is utilised. The prescriber should make it clear on the discharge drugs form which medicines it is anticipated will need to be continued by the patient’s GP.

**Exception.**

For patients who are an in hospital for less than 24 hours (e.g. short stay surgery, assessment units), it may be more appropriate to prescribe only the additional medication needed if the patient’s pre-admission medication is to remain totally unchanged on discharge. If only additional treatment has been recorded on the discharge drugs form, this must be made absolutely clear on the form and the prescriber must ensure that the new medication is compatible with the patient’s pre-existing medication.
If there are any changes whatsoever to the pre-existing medication, the discharge drugs form must show the full record of discharge medication.

Special care is needed in the prescribing of Controlled Drugs for discharge. Reference should be made to section 4.5, or the BNF or the Medicines Management intranet website http://medman/advice where there are ‘exemplar prescriptions’ to demonstrate the legal requirements.

**N.B. If Controlled Drugs are not prescribed in the legal manner the prescription cannot legally be dispensed.**

A maximum of 28 days supply of discharge drugs will normally be dispensed unless other arrangements are made with the Pharmacy. If ‘original pack dispensing’ is operating on the ward, patients may be supplied with up to 41 days of treatment (with a minimum of 14 days) for on-going maintenance therapy.

3.14.1 e-TTOs – a web based system

See Trust website for details

3.14.2 EP - TTOs – the Trust’s electronic prescribing system

See Trust website for details

3.14.3 Paper based system TTOs (traditional paper discharge letter)

These are prescribed on the appropriate official document at least 24 hours in advance of discharge. Unless the pharmacist had been able to clinically check a TTO whilst on the ward, the patient’s prescription chart must be sent to the Pharmacy with the TTO form to enable the prescribed discharge treatment to be checked against the impatient treatment.

When patient addressograph labels are used, a label must to be affixed to every copy of the discharge drugs form.

It is essential that the information on the discharge drugs form is absolutely clear and complete and drug names must be written, generically where appropriate, in BLOCK CAPITALS in black ink.

In the event that Pharmacy is closed, see section 5.22.

3.15 Outpatient Prescribing
Doctors, dentists and other specifically authorised healthcare professionals may write prescriptions for outpatients only on the appropriate official document. (See Appendix 3 for further information).

Drug treatment referral letters are available in outpatient clinics and may be used to advise a recommended treatment to a patient’s GP but not if the treatment is:

- needed urgently
- a specialised course of treatment
- a product only available in hospitals

In the above circumstances a hospital prescription, or FP10(HNC) prescription where these are used, must be provided.

Any treatment recommendations made must be in line with the Interface Formulary for Adults (see section 3.17) as GPs may decline to prescribe non-formulary and unlicensed medicines.

### 3.16 Antimicrobial Prescribing

**Antibiotics should only be prescribed if there is a culture proven or clinically suspected, treatable infection.**

Good collaboration between the clinicians, the microbiology laboratory, the Antimicrobial Steering Group, the Infection Control Committee and pharmacy is necessary in order to ensure rational prescribing of antimicrobials. Antimicrobial prescribing must be in keeping with the current adult and paediatric guidelines.

The guidelines must be regularly updated based on local epidemiology surveillance and resistance patterns. The choice of antibiotics has important public health implications. It is sometimes necessary to restrict the use of certain antimicrobials for reasons related to selection or transmission of resistance. The indication, choice, duration and route of administration must be regularly audited. Before starting antibiotic therapy, appropriate specimens should be taken wherever possible. Microbiology laboratory results must be used to guide and modify therapy. Prophylaxis when indicated must be restricted to a single dose for surgical patients. Consultation with the Consultant Microbiologists or the Antibiotic Pharmacist is encouraged for advice and guidance.

### 3.17 Trust Formulary

Prescribers should comply with the joint health economy “Interface Formulary for Adults” for their routine prescribing needs. The Formulary has been jointly agreed with our local Primary Care Trusts and is therefore used by local GPs. The Formulary can be accessed on the Medicines Management website [http://medman/formulary](http://medman/formulary) where further explanatory information can be found.
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In exceptional cases, consultants may prescribe non-formulary medicines and special procedures are in place to enable this.

Information on how a consultant can propose a new addition to the Formulary is available from Pharmacy.

3.18 Licensed/ Unlicensed Use of Drugs

Medicines are granted a Marketing Authorisation (MA) (previously known as a Product Licence) if they meet standards of safety, quality and efficacy. The MA defines the indication, dosage ranges and routes and methods of administration.

A doctor prescribing an unlicensed medicine or a licensed medicine in an unlicensed way does so entirely on their own responsibility, carrying the total burden for the patient’s welfare and may be called upon to justify their actions in the event of an adverse reaction. Prescribing medicines in an unlicensed way may therefore have medico-legal implications. The prescriber is responsible for ensuring that informed consent is obtained as necessary. The Trust’s ‘Policy on the Use of Unlicensed and ‘Off-label’ Medicinal Products for Adults and Children’ requires a doctor to sign a “Declaration of Medico-legal Responsibility for Prescribing Unlicensed or Off-label Medicines’ form on the first occasion of use.

A pharmacist who manufactures, prepares or purchases an unlicensed medicine in response to a prescription is professionally accountable for any harm caused by a defect in the medicine, which is attributable to the pharmacist’s own actions or omissions.

The Pharmacy Department is required to record the names of patients who are prescribed unlicensed medicines and this is achieved in part by requiring the ward nursing staff to record the names of the patients to whom the unlicensed medicine is administered on the pro-forma provided.

The practitioner administering an unlicensed medicine, or administering a medicine in an unlicensed way, in accordance with a prescription written by a registered medical practitioner, should be satisfied that they have sufficient information to administer the drug safely, as detailed in Section 6 of this Policy. Liability for use of the medicine lies with the prescriber and liability for any defect in the product supplied lies with the supplying pharmacy.

3.19 Clinical Trial Drugs/ Investigational Medicinal Products (IMPs)

The responsibility for regulation of clinical trials within the UK is undertaken by the MHRA.

A clinical trial can only take place in the Trust if it has full Research Ethics approval, authorisation by the MHRA and approval by the Trust’s Research and Development Department.
Most IMPs are either unlicensed drugs or established products being investigated for a new indication. The labelling on IMPs will include the trial code and the wording “For Clinical Trial Use Only”, but other aspects may be deliberately unclear, i.e. it may be blinded, so that neither hospital staff nor patients will know which active ingredient is in the medication, or if it is a placebo.

a) Outpatient Prescribing

Each trial has its own prescription form which should include the specific protocol number and patient number.

b) Inpatient Prescribing

Properly labelled clinical trial medicines brought in by a patient on admission as part of current medication can be checked by an authorised prescriber in the ward setting, noted, prescribed and administered as directed.

When prescribing for inpatients the standard approved inpatient prescribing form should be used. The prescription should include the trial drug approved name or code number, the protocol number, patient number and clearly indicate “CLINICAL TRIAL”.

Study Organisation

The Clinical Director of Pharmacy or Clinical Trials Pharmacist must be provided with a copy of all clinical trial protocols, including codes, for all studies involving medicines. All IMPs for use in clinical trials must be delivered to the Pharmacy. IMPs should be stored and dispensed by the hospital pharmacy and managed to the same standards as licensed medicines. The Clinical Trials Specialist Pharmacist will determine the appropriateness any storage requirements that are needed on wards, units or clinics.

Some IMPs may be in the early stages of development when the side effect profile is still being determined.

It is the investigator’s (consultant in charge of trial) duty to ensure the practitioner is fully trained/has access to the appropriate protocol/investigator brochure. Records must be maintained of IMP receipt, storage temperatures, dispensing, use by patients and returns reconciliation, with disposal to be agreed with the trial sponsor.

Emergency Breaking of Randomisation Codes

In an emergency it may be important to find out what medication a patient has received during a trial, e.g. whether it is active or placebo, and the dose. These details can be obtained from the randomisation code. Randomisation codes should be easily accessible from the investigator, pharmacy department or via a trial-specific telephone access number set up by the sponsoring company.
3.20 NON-MEDICAL PRESCRIBING

Nurses, pharmacists, physiotherapists, radiographers, chiropodists and podiatrists who have successfully completed a validated supplementary/independent prescribing course, are registered with their respective registration body and have been issued with a practice certificate are able to prescribe for patients of the Trust subject to limitations detailed in the Trust’s “Non-Medical Prescribing Policy”. See http://sharepoint/policies/ in clinical section under medicines management.

With regards to the legislation for independent and supplementary prescribers to prescribe controlled drugs, refer to the Trust’s Non-Medical Prescribing Policy.

3.21 Use of the Prescription Sheet by Other Specific Clinical Practitioners

Dieticians may write enteral feeds and dietary supplements on the prescription.

Tissue viability nurses or other nominated nurses specialising in wound care may write dressings on the drug chart (except those containing Prescription Only Medicines).

SECTION 4

CONTROLLED DRUGS

Throughout this document the term Controlled Drugs refers to those medicines which have been designated either in law or in Trust policy as requiring strict control. Very specific prescribing and storage requirements apply to Controlled
Drugs. Such drugs are distinguished throughout the BNF by the symbol CD (Controlled Drug). A summary of Controlled Drug requirements can be found in Appendix 1.

The Trust is required to have a nominated **Controlled Drugs Accountable Officer** who is responsible for all matters in relation to the systems for prescribing, dispensing, administration, care and custody of Controlled Drugs within the Trust. The Accountable Officer is also required to monitor the use of Controlled Drugs and to liaise with other bodies outside the Trust sharing intelligence or concerns about possible inappropriate use of Controlled Drugs. The Accountable Officer for the Trust is the Clinical Director of Pharmacy. Any member of staff having concerns about systems of control or possible misuse of Controlled Drugs in the Trust must report the matter directly to the Accountable Officer.

From time to time the Accountable Officer may deem that other drugs be treated as Controlled Drugs. For clarification as to which drugs restrictions apply, contact the pharmacy. It may occasionally be necessary to record the use of other medicines for a temporary period. This can be arranged locally by agreement with the senior sister and a senior pharmacist.

### 4.1 Storage

Controlled Drugs must be stored in a designated Controlled Drugs cupboard. This is usually a cupboard contained within the main medicine cupboard. See also section 5.2 (a).

Storage facilities should be approved by the Clinical Director of Pharmacy.

(a) **Controlled Drugs register**

The senior sister shall be responsible for maintaining a register of the receipt and use of Controlled Drugs, See section 5.16. A running balance of each controlled drug preparation must be maintained in the register. Any new supply of a drug preparation must be entered onto the page of the existing balance of that preparation (even if the balance is zero).

(N.B. the out-dated practice of using the number of the CD requisition to correlate to the page number in the CD register is NOT to be used.)

(b) **Keys**

See section 5.3 (a).

(c) **Stock Checks**

See section 5.4.

### 4.2 Ordering, collection, receipt and recording of Controlled Drugs

Ordering, collection (where necessary), receipt and recording of Controlled Drugs for the ward/unit stock must be undertaken in accordance with the relevant Standard Operating Procedure (SOP) / 'fact sheet' which is available on the...
4.3 Patient's Own Controlled Drugs

Patient’s own Controlled Drugs must be dealt with strictly in accordance with the Standard Operating Procedure (SOP) / ‘fact sheet’ entitled “Dealing with Patient’s Own Controlled Drugs on the Ward”.

Controlled Drugs brought into hospital by patients should not usually be kept on the ward. They should be given, with the patient’s other medication to a responsible adult relative or carer to be taken to the patient’s home, or, with the patient’s permission, destroyed (see section 5.9 ).

If a ward needs to store a patient’s own Controlled Drugs while waiting for collection or destruction then an entry must be made on a page in the ‘Record of Controlled Drugs Brought Into Hospital by Individual Patients’ (CDBIP) reserved for this purpose and the Controlled Drugs stored in the Controlled Drugs cupboard. When the Controlled Drugs are returned to the patient or their representative, transferred to another ward or returned to pharmacy for destruction, an entry must be made in the relevant section of the CDBIP recording the destination.

In particular circumstances it may be necessary to use the patient’s own Controlled Drugs for administration to the patient on the ward. (see section 5.9b). The medicine must have been positively identified and approved for use by a pharmacist or doctor. Receipt and administration must be recorded in the CDBIP. A separate page must be used for each “patient’s own Controlled Drug”.

Under no circumstances should a patient’s own Controlled Drugs be added to the ward stock or administered to another patient.

Special arrangements exist for the management of Controlled Drugs when they are part of the treatment of a patient who is taking part in a “patient self-administration scheme”. Full details are provided by Pharmacy when such a scheme is implemented.

For illicit drugs/ illegal possession of Controlled Drugs which are brought into hospital by patients, carers or visitors see Section 4.10

4.4 Prescribing Controlled Drugs for Inpatients

In response to the NPSA Rapid Response Report number five, the following recommendations must be complied with when opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor, should:

- 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 effects.

This guidance applies to the following opioid medicines: Buprenorphine, diamorphine, dipipanone, fentanyl, hydromorphone, meptazinol, methadone,
morphine, oxycodone, papaveretum, and pethidine.

NOTE - While dose increments should be in line with this guidance, it is recognised that in palliative
care higher than normal doses may be required. These recommendations are not designed to
restrict clinical use of opioid medicines, but to ensure they are used in a way that is as safe as
possible for patients.

There are no special requirements for the prescribing of Controlled Drugs for
inpatients. For general prescribing guidance see section 3.2

4.5 Prescribing Controlled Drugs for Outpatients, as Discharge Medications
(TTOs), and on FP10(HNC) or Accident Unit Prescription Forms

The prescriber must write the prescription in indelible black ink on one of the
specific outpatient or discharge medicine prescription forms, Accident Unit
prescription forms or FP10 (HNC). The prescription form MUST comply with
ALL of the following legal requirements before it can be dispensed:

(i) The name and address of the patient (handwritten, computer printed or with
the prescriber’s signature across part of the label if an addressograph label is used)

(ii) The name of the drug.

(iii) The form and strength of the preparation, e.g. 10mg tablets (even if
there is only one form of preparation or only one strength).

(iv) The dose to be given and frequency of administration (e.g. ONE bd or
ONE, twice daily).

(v) The total quantity of the preparation or the number of dose units to be
dispensed in words and figures [e.g. "100 (one hundred) mL or 10
(ten) tablets"]

(vi) Dated, signed (full signature) and the prescriber’s printed name.
In response to the NPSA Rapid Response Report number five, the recommendations above must be complied with when opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor (refer to advice in section 4.4)

It is an offence for a prescriber to issue, or for a pharmacist to dispense, a prescription which does not comply with these legal requirements.

3 The total quantity of the active drug SHOULD NOT be used as an alternative (Home Office Advice)

4.6 Prescribing Methadone for Addicts

Methadone may be prescribed and administered to established opioid drug misusers (as methadone oral solution 1mg/ml) as a continuation of their usual drug use whilst in the Accident and Emergency Department or on a ward as an inpatient. Methadone should not be prescribed for the addict on discharge from the hospital as they should revert immediately to their normal supply arrangements after discharge. Only in exceptional circumstances should a TTO supply be considered and then only when unavailability of the normal supply mechanism has been confirmed. In such circumstances just one day’s supply would normally suffice but with an absolute maximum of three day’s supply.

4.7 Administration

The procedure for the administration of Controlled Drugs must be carried out by a nurse/midwife and either another nurse/midwife, a doctor or a student nurse in their final year of training. See also section 6.

In response to the NPSA Rapid Response Report number five, the recommendations above must be complied with when opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor (refer to advice in section 4.4)

4.8 Checks of Controlled Drugs

Stocks of Controlled Drugs must be checked at least daily and the check recorded. (For Midwives, see Nursing and Midwifery Council (Midwives) Rules 2004). The full signatures should be legible. Full boxes need not be opened.
It is not appropriate that liquid medicines are measured out into a measuring cylinder at each stock check. Any discrepancies in the actual and calculated volumes must be accounted for when the bottle is nominally empty.

When the stock level in the cupboard and CD Register do not reconcile, the discrepancy must be reported and escalated as stated in section 5.7.

4.9 Ward Closures

When a ward/department is to be closed, special arrangements must be made with the Pharmacy department to safeguard the security of drugs. The duty senior nurse should be involved with this process to ensure appropriate communication and to ensure safe keeping of drugs.

4.10 Illegal Possession of Controlled Drugs

A Trust standard operating procedure covering the action to be taken following the discovery of illicit drugs in the possession of patients, visitor or staff, or found on Trust premises is currently under review and will supersede the guidance below in due course.

The general duty of confidentiality applies to patients found in possession of illegal drugs. However the obligation of confidentiality will need to be weighed against the duty to disclose this information “in the public interest”. The police must be informed where the quantity of drugs found is sufficient to cause suspicion that the supply of, or dealing in, drugs is involved i.e. beyond personal use, and in circumstances where staff suspect a crime is about to be committed.

In the event of a patient being found in possession of a drug in contravention of the Misuse of Drugs Regulations 1985, the nurse-in-charge must:

(i) Inform the duty senior nurse, who will decide the relevant action to be taken in conjunction with the relevant medical officer and directorate manager (in hours) or on-call manager (out of hours).

(ii) The relevant medical officer will notify the consultant responsible for the patient.

(iii) The suspected illicit substance should be placed in a sealed envelope, signed and dated across the seal by two nurses or a nurse and a doctor and then placed in the Controlled Drug Cupboard for safe keeping.

(iv) The Police should be contacted to request the removal of the substance from the hospital.

(v) In the event that the police are unable to attend immediately the substance should be retained in the ward’s Controlled Drugs
cupboard (if police arrival is anticipated within a few hours, or Pharmacy is closed). If police arrival time is to be longer than a few hours, the substance (in the sealed envelope) should be taken to the Pharmacy for safekeeping, by a nurse/midwife and accompanied by a second qualified nurse/midwife.

(vi) Details of the police officer taking away the substance should be recorded by the nurse-in-charge within the patient’s notes. Details include name, rank and police number.

(vii) The Trust’s solicitors have advised that the patient’s details should not be given to the police, unless there is a “duty to disclose this information in the public interest” (see above).

(viii) An Incident Report Form (IR1) must be completed.

4.11 “Borrowing” of Controlled Drugs

(a) When a Controlled Drug is required and is not available on the ward and the Pharmacy is closed the following must be adhered to:-

(i) Ascertain a ward that has the required drug. The Duty Senior Nurse may be able to assist in this.

(ii) Make arrangements with the ward to borrow a dose of the Controlled Drug.

(iii) The prescription chart must be taken to the loaning ward by a nurse.

(iv) The ward supplying the drug must check the prescription chart and must enter the dose supplied in their register, along with the ward to which it is supplied and the patient’s name.

(v) The witness signature must be that of the nurse accepting receipt of the drug on behalf of the receiving ward.

(vi) The ward accepting receipt of the drug must enter details in the ward register including the ward from which the dose was obtained.

(vii) Details of administration to the patient must be recorded in the normal way.

(b) (i) This procedure should be followed for all drugs that are recorded in the ward’s controlled drug register either as a legal requirement or in accordance with a locally agreed policy.
e.g. Morphine sulphate oral solution 10mg/5ml and temazepam are not legally required to be recorded in the ward controlled drug register and could be borrowed under the guidance in section 5.12 of this policy.

However, if a local policy is in place on the ward requiring them to be recorded in the controlled drug register then the guidance in section 4.11 (this section) should be followed.

(ii) It is the responsibility of staff on the borrowing and supplying ward to be aware of such local policies if they are in place on their ward.
SECTION 5

WARD/DEPARTMENT CONTROL OF MEDICINES

5.1 Custody

The Senior Sister is legally responsible for the possession and safe custody of all medicines in the ward/department which includes custody of all drug keys, controlled stationery (see section 5.4), balancing of ward Controlled Drugs stocks, and reporting of discrepancies.

This responsibility for the possession and safe custody of medicines must be held by a registered nurse/midwife. In areas where a nurse/midwife is not employed, an appropriate healthcare professional carries the responsibility.

The Senior Sister may decide to delegate some of the duties in accordance with locally agreed procedures; however the responsibility always remains with the Senior Sister.

5.2 Storage

Every ward and department should have separate storage facilities as listed below and they must be kept locked.

(a) Controlled Drugs cupboard\(^4\) - for the storage of drugs controlled by the Misuse of Drugs Act (1971) and subsequent legislation.

NB. Containers of Controlled Drugs must be returned to the cupboard immediately after use.

(b) Internal medicines cupboards - for the storage of medicines for internal use which are not Controlled Drugs.

(c) External preparations cupboard - to store preparations for external use.

(d) Disinfectants cupboard.

(e) Drug refrigerator\(^4\) - for drugs requiring storage at a temperature between 2-8°C.

\(4\) Only if drugs requiring such storage are kept on the ward/unit

Each refrigerator must contain a maximum/minimum thermometer which must be checked, recorded and reset daily by the nurse-in-charge. If the temperature is recorded as outside of the range 2-8°C, the Estates
Department must be asked to check the refrigerator urgently and Pharmacy must be contacted to assess whether the drugs in the refrigerator can be used and to suggest alternative cold storage arrangements for the drugs until the problem is resolved. It is the responsibility of the nursing staff to ensure the fridge is defrosted regularly.

No other products, foods etc., must be stored in the medicines fridge.

(f) Reagents cupboard - to contain reagents for urine and other tests.

(g) Medicine trolley - for the convenient storage of oral medicines for current administration, except Controlled Drugs. When the trolley is not in use, it must be locked and secured to a wall or other immovable object. Drugs must not be stored on the shelf under the trolley other than during the medicine round when the trolley must be constantly under supervision.

(h) Patient bedside drug lockers – where these exist and have been introduced into use, they are used for the storage of medicines specifically labelled for that individual patient.

(i) Medicines intended for patients to take home on discharge which have been obtained directly from pharmacy on the authorisation of an authorised prescriber must be securely stored on the ward in a way that allows them to be easily identified and separated from ward stocks. They may be stored in the patient’s bedside drug locker if required during the inpatient stay.

(j) Certain medicinal products do not need to be stored in locked cupboards but they must be kept in separate storage areas that are constantly under supervision by nursing staff/ professional staff in non-nursing departments. The list of such items which do not need to be stored in a locked cupboard is restricted to:

- Intravenous fluids (except those containing drugs)
- Topical/ irrigation fluids
- Dialysis fluids
- Resuscitation/ emergency drug boxes
- Water for Injection ampoules (but must be kept within the manufacturer’s box and not emptied out into a container)
- 0.9% Sodium Chloride Injection ampoules (must be kept within the manufacturer’s box and not emptied out into a container)
- Contrast media in Radiology departments
- Medical gases
- Inflammable liquids storage

5.3 Keys
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(a) Medicine cupboard, patient bedside drug lockers and trolley keys (including controlled drug keys) must be kept on the person of a nurse. Access to the medicine cupboards may be delegated to another nurse, pharmacist or designated member of pharmacy department providing ward based supply service. In operating theatres, delegation may be to a medical officer or an operating department practitioner. Medicines stored in any other area of the hospital will be similarly safeguarded by the trained nurse or other professionally qualified person in charge.

All drug keys are kept together (separate from other ward keys) and these keys are held by a designated trained nurse on each shift.

(b) Loss of Keys

Loss of keys must be reported immediately to the duty senior nurse.

(i) A thorough check with all persons known to have held the keys must be undertaken. This may mean contacting nurses who have finished their shift.

(ii) If a nurse has taken the keys home with him/her, he/she should be asked to return them personally. If this is not possible for any reason the duty senior nurse must be asked for advice.

(iii) The duty senior nurse may authorise release of any duplicate keys, as necessary.

(c) Any duplicate keys must be kept in an agreed secure place within the hospital. The Senior sister should check that spare keys are available every 6 months.

5.4 Controlled Stationery

The following items are designated as controlled stationery:

- Outpatient and A&E prescription forms
- FP10(HNC) forms
- Stock requisition books
- Controlled Drug order books

Controlled stationery must be kept in a locked cupboard and the key kept on the person in charge of the ward/department. Blank prescription forms/pads must never be left unattended.

Blank Inpatient drug prescribing and recording forms and discharge medication forms must similarly not be left in places from where they might easily be misappropriated.
5.5 Signature Logs

There must be a signature log kept on each ward and department in a secure place that contains all nurse/midwife signatories of those working within the area (including bank staff).

Specimen signatures of all medical staff should be sent to pharmacy when starting in the Trust (including locums).

All other departments with authorised persons who may administer medicines must similarly keep records of signatures and initials.

The records of signatures and initials must be kept for as long as the documents on which they appear.

5.6 Inspection and Checking of Ward/Department Stocks

Daily: Controlled Drugs must be checked at least daily by two nurses. A record of the checks must be made on the designated record form.

Weekly: The Senior Sister is responsible for ensuring that all drug storage cupboards, patient bedside drug lockers and trolleys are inspected.

This inspection should include checking:

(i) the tidiness/cleanliness of cupboards/lockers/trolleys
(ii) that drugs are in properly secured cupboards
(iii) for excess stocks
(iv) for any drugs that should have been returned to pharmacy
(v) that Controlled Drugs checks have been properly recorded
(vi) that drug refrigerator temperatures have been checked and recorded each day and action taken if temperatures were outside of range
(vii) that stock expiry dates have been checked recently.

Three monthly: All drugs stored in the ward/department will be checked by an appropriate member of the pharmacy staff. Checks will include balances of Controlled Drugs and expiry dates, stock holding and fitness for use of all drug stocks in the cupboards.
5.7 Discrepancies of Any Medicines

It is essential that any discrepancy be reported immediately to the nurse-in-charge who will:-

(i) Check the drug stock, relevant treatment charts, appropriate drug stock records, drug delivery box and bags on the ward.

(ii) If the drugs cannot be located the discrepancy must be reported immediately to the duty senior nurse.

(iii) If the discrepancy still cannot be resolved the duty senior nurse must inform the directorate or on-call manager and the pharmacist in charge as soon as possible.

(iv) The incident must be reported on an Incident Form (IR1). Staff statements must be obtained as appropriate.

(v) The duty senior nurse and the pharmacist-in-charge or deputy will determine if any other action is required.

(vi) Where this medicine discrepancy involves a Controlled Drug, a pro-forma for the ‘Investigation and Escalation of Controlled Drug Loss/Theft’ must be completed within 24 hours and sent to the Trust’s Accountable Officer, (the Clinical Director of Pharmacy). This can be found on http://medman/

(vii) The Clinical Director of Pharmacy/Director of Medical Safety/Director of Healthcare Governance must be informed if the discrepancy is considered to be of such a serious nature as to warrant police investigation.

5.8 Disposal of Medicines at Ward Level

Controlled Drugs

Out of date Controlled Drugs must be returned to the Pharmacy for destruction. The drugs should be stored in a sealed envelope (signed over the seal by a registered nurse/technician) until such time as they can be returned with the ward pharmacist or pharmacy technician. An appropriate entry must be made in the Controlled Drugs register and signed by the nurse and pharmacist/technician along with the completion of a duplicate form which both the ward and Pharmacy department must retain a copy of.

Small quantities of Controlled Drugs can be destroyed on the ward by a nurse/midwife and must be witnessed by a second nurse/midwife or ODP. A ‘small quantity’ refers to the surplus when a dose smaller than the total quantity in an ampoule or vial is drawn up or when a dose is drawn up but not used. Destruction can be
done by either emptying the contents of the vial/ampoule/syringe into a sharps bin, or for areas that regularly need to dispose of Controlled Drugs, e.g. partly used PCAs or epidural infusions, a denaturing kit should be used. All destruction must be documented in the appropriate section of the CD record book and signed by both the individual carrying out the destruction and the witness.

In date stock Controlled Drugs can be returned to the pharmacy by agreement with the ward pharmacist. The same process for returning out of date Controlled Drugs applies to returning surplus/unused stocks.

Ward stock items
Ward stock items are not normally returned to pharmacy, but may be, with the agreement of the ward pharmacist or pharmacy technician.

Non stock items
Drugs which have been dispensed for individual patients should be returned to the pharmacy.

Patient’s own medicines
See section 5.9

6 In accordance with the Misuse of Drugs Regulations (1985), supervisors of midwives are “authorised persons” for the purpose of witnessing the destruction of Controlled Drugs issued to midwives practising in the community.

5.9 Medicines Brought into the Hospital by Patients/Relatives

(a) Patients should be encouraged to bring their medicines into hospital with them so that the prescriber can ascertain previous/current treatment.

Increasingly, the patient’s own medicines will be used in hospital during their stay [see 5.9 (b)], but if the medicines are not to be used, one of the following actions should occur, either:

(i) The drugs (including Controlled Drugs) should be sent home in the care of a responsible adult and the details of action recorded on the nursing record.

It must be explained to the patient (or the responsible adult) that normally the patient will be given a supply of all necessary medicines upon discharge as the discharge treatment regimen may differ from that previously prescribed. The hospital cannot accept responsibility for future use of returned medicines.

OR
(ii) The patient agrees to destruction of their medicines. In this case, they may be sent to pharmacy for destruction.
OR

In certain situations neither (i) nor (ii) will be appropriate or possible and the medicines will need to be stored on the ward for later return to the patient when they leave. Medicines which are to be stored on the ward must either:

a) be placed in an envelope, sealed and signed across the seal by a nurse, and the patient’s full name and hospital registration number written on the outside of the envelope. The sealed envelope must be stored in a locked cupboard on the ward.
b) be placed in the patient’s bedside drug locker when these are in use.

If the patient is transferred from one ward to another during their stay the medicines must also be transferred at the same time (as they are part of the patient’s property).

When the drugs are eventually returned to the patient on discharge it must be explained that their drug treatment may have changed or that some or all of the returned medicines might duplicate their discharge medicines. It should additionally be stated that the hospital cannot accept responsibility for the future use of returned medicines.

7 Day patients and short stay patients might only be prescribed any additionally required drugs on discharge.

(b) Use of Patient’s Own Medicines

It is permissible in certain circumstances to use a patient’s own drugs on the ward if they can be positively identified and meet the other criteria noted below. The circumstances for such use are:

(i) It is known that the patient will only be in hospital for less than 48 hours.

OR

(ii) The item is currently not available from pharmacy.

OR

(iii) The pharmacy is closed.

OR

(iv) A “Use Of Patient’s Own Drugs” scheme is authorised to operate on the ward.

To “positively identify” a drug preparation means being able to recognise the medicine by means other than, but in addition to, the dispensing label on the container e.g. by detail printed on the foil or markings on the tablet, capsule etc. Additionally the drug preparation must have been dispensed for the patient in question in the last 6 months and be within its expiry date.
The drugs must be used **solely** for that patient and be prescribed and administered following the approved procedures.

### 5.10 Container Labels

If the container label is damaged or obliterated, the container must be returned to the pharmacy for relabelling. Container labels must not be altered/ amended.

### 5.11 Transfer of Medicines

Medicines **must not** be transferred from one container to another.

Similarly, medicines **must not** be emptied from the pack in which they are supplied from Pharmacy into any other container for ease of access etc.

### 5.12 Borrowing of Medicines

Attention to ward drug usage and stock levels, and prompt requests for dispensing of newly prescribed, non-stock items should help to minimise ‘stock out’ situations on the wards. However, it is accepted that there are occasions, **but only when the pharmacy is closed** and where the drug is not available from the out-of-hours emergency bay / drugs cupboard, that a ward may need to borrow a dose of a drug from another ward.

In such circumstances, a nurse from the ‘borrowing ward’ must take the patient’s treatment chart to the ‘lending ward’ to ensure that the correct drug is chosen. If possible an original pack should be obtained from the lending ward rather than an individual dose. On returning to the original ward, the nurse must confirm, as far as is possible, with a second nurse that the correct drug has been obtained.

If it is necessary to borrow Controlled Drugs, the duty senior nurse must be contacted and the Trust procedure followed (section 4.11). This includes any drug recorded in the ward’s controlled drug register either as a legal requirement or in accordance with a locally agreed policy.

**Borrowing of drugs between wards must not occur** when the pharmacy is open, except in extreme situations, when a patient’s health would be put at significant risk by any delay in treatment.

Medicines must not be taken by, given to or loaned to staff for their own personal use. See Section 5.23

Any request from other hospitals, healthcare establishments or healthcare professionals to borrow drugs from this Trust must be discussed with pharmacy staff beforehand - outside of opening hours this will be the on-call pharmacist.

### 5.13 Medicine Samples from Pharmaceutical Representatives
Any samples received **must** be sent to the pharmacy. Medicine samples are not used within the Trust.

### 5.14 Defects of Medicinal Products

(a) If any defect or error regarding a medicine, label or container is suspected or identified, e.g. a labelling error, the wrong ampoules found inside a differently labelled box, or particles in an intravenous infusion container, the nurse must immediately inform the nurse-in-charge and the Pharmacist-in-Charge and retain the item together with its outer container and any associated giving sets etc. and complete an Incident Form (IR1). If necessary, further action will be taken by the nurse-in-charge and the Pharmacist-in-Charge.

(b) Drug Alert notifications (drug withdrawals) from the pharmacy department must be dealt with **immediately** by the nurse-in-charge.

### 5.15 Ordering and Receiving of Ward Stocks

(a) The responsibility for ordering of ward stocks lies with the senior sister. Sample signatures of any staff likely to requisition medicinal products must be provided for pharmacy. These will be updated annually.

(b) Ordering of Controlled Drugs is addressed in section 4.2.

(c) Other medicines must be ordered using the appropriate order form or requisition book, which must be signed. This is a legal requirement.

(i) The senior sister and ward pharmacist must review stock lists on at least an annual basis. Amendments to the standard stock levels will only be made following discussions between a sister and a member of the pharmacy staff.

(ii) Ward stock drug requisitions may be completed by a pharmacy staff member (where a "topping up" service is in place), or by the designated nurse.

(iii) Requests for **non-stock** items which are sent to the pharmacy must be accompanied by the relevant prescription/treatment charts.

(iv) Ward drug stocks received on the ward must be checked and signed for as received. Depending on the drug stock supply system used, either the copy of the requisition or delivery note accompanying the supplied drugs must be retained for a period of at least six months.

(v) Supplies initiated by pharmacists/ pharmacy technicians in response to an individual patient’s prescription do not need a requisition signed by a nurse.
(d) Any discrepancies in the drugs received or the accompanying documentation must be reported immediately to the nurse-in-charge and a pharmacist/pharmacy technician.

5.16 Records

**Controlled Drugs**  
Receipts and administrations must be entered in the Controlled Drugs register. These books must be kept on the ward/department for two years after the date of the last entry, after which time they must be incinerated/shredded.

**Vaccines and Immunological Products**  
The batch numbers of all vaccines and immunological products must be recorded on the patient's notes and/or drug prescribing and recording sheet.

5.17 Resuscitation Boxes

All wards and departments have access to resuscitation drug boxes for emergency use.

It is the responsibility of the nurse in charge of the ward/department where the boxes are located, to ensure, **on a daily basis**, that the boxes held are sealed and in date and that arrangements are made for the replacement of boxes prior to the expiry, after use or in the event of breakage of the seal. Normal practice is for the new box to be obtained **before** the used/almost expired box is returned to pharmacy. Outside normal pharmacy hours the replacement boxes can be obtained from:

- Heartlands Hospital - Emergency Drug Cupboard
- Solihull Hospital - Emergency Drug Cupboard
- Good Hope Hospital – Emergency Bay

5.18 Outside Normal Pharmacy Hours:

(i) Each hospital operates a system giving access to an emergency drugs cupboard which contains important drugs (but not Controlled Drugs) that may be needed when the pharmacy is closed. Access to the cupboards is usually through the appropriate senior nurse on duty for the site. It is essential that any drugs taken from the cupboards are fully recorded so that they can be replaced at the earliest opportunity by pharmacy staff.

(ii) Pharmacy On–Call Service

An on-call pharmacist is available 24/7 and may be contacted by the appropriate senior nurse or by individual medical staff via the hospital
switchboard. The on-call pharmacist can provide advice on where essential
drugs can be obtained from or if necessary will dispense any newly
prescribed and urgent medication.

The on-call service is not available to supply routine ward stock medicines,
to provide repeat dispensing or for the dispensing of discharge drugs except
in exceptional circumstances, when the prescriber should contact the on-call
pharmacist personally.

The pharmacist may be called for urgent advice on drug treatment,
by nursing and medical staff.

5.19 Supply of Medicines on Discharge

a) Discharge drugs prescriptions, written using the traditional paper based
system or e-TTO, should be sent promptly, with the patient's current
inpatient treatment chart(s), to the pharmacy for dispensing.

Those utilising the e-TTO system should print, sign and send the e-TTO to
pharmacy with the inpatient chart.

The dispensed drugs will be returned to the ward for supply to the patient (or
carer if more appropriate). Inpatients being discharged must not collect
their medicines from pharmacy except in exceptional circumstances by
prior agreement.

Oral medicines (but not foil packs) for discharge patients will normally be
supplied in child-resistant containers unless requested otherwise for an
appropriate reason by the ward staff.

b) The Trust does not supply discharge medication in medication compliance
aids (or blister packs) either for new patients or patients who were admitted
with such a device. Arrangements are made, at least two days prior to
discharge, for the patient’s regular community pharmacist to be requested to
prepare the patient’s discharge medicines in an appropriate compliance aid.
The ward pharmacist must be notified early in the patient’s stay of any
potential need for a compliance device so this can assessed at the time and
ensure there is no delay to discharge. The policy for ‘Managing Patients who
May Require a Monitored Dosage System/Blister Pack on Discharge’ is on
the Trust's sharepoint.

c) Before giving the patient their TTO medication:

- The TTO medication must be checked against the current inpatient
  sheet at the point of discharge
- Any discrepancy must be escalated to medical staff
- If an error has occurred an IR1 must be completed
• All medicines required at discharge must be reconciled against the discharge letter e.g. ensuring inhalers, creams, original packs of medication (over-labelled) are added to the bag where the letter is annotated ‘from ward’.

It is essential that information relating to the patient’s discharge medicines is given to the patient (or carer) prior to discharge. Counselling patients on their drug treatment will usually be undertaken on the ward by qualified nursing/midwifery staff but may also be undertaken by qualified pharmacy staff working on the ward or in the discharge lounge where such arrangements exist.

d) When counselling patients on their drug treatment, it is important to have available both the discharge drugs form and the medicines. Taking each medicine in turn, the patient (or carer if more appropriate) should receive information about:-

(i) the drug name and form  
(ii) the dose and frequency  
(iii) the times of the day for administration  
(iv) any additional information on the label and any supporting information (e.g. patient information leaflets, steroid card etc)  
(v) when to commence treatment at home  
(vi) how to obtain further supplies if necessary

Consideration should be given to also informing patients about any significant common side effects and what to do if they occur.

The patient must be given their copy of the discharge letter.

e) After the patient has been informed about their discharge drugs they can be given charge of their discharge drugs if:-

(i) they are being discharged within the next few hours  
(ii) they are safe to be left in charge of them  
(iii) they can be kept in a secure place where other patients/visitors cannot gain access to them.

In the event that a patient needs to leave their medication, it must be returned to a locked cupboard until the patient returns.

f) Any medication that the patient brought into hospital with them which is still on the ward and is not part of their discharge medication, must be returned to the patient as it is their property. However it must be explained to the patient that their drug treatment may have changed whilst they have been in hospital and that some or all of the returned medicines might duplicate their discharge medicines. It should be additionally stated that the
hospital cannot accept responsibility for the future use of the returned medicines.

Unless the patient’s own medicines are to be utilised as part of the drug treatment regimen on discharge, the patient should be advised not to use them until they have discussed them with their GP.

g) Except in very unusual circumstances, patients should not be discharged from the ward or discharge lounge without their discharge medication. If such a circumstance does occur, arrangements must be made with the patient/carer for a relative/friend to collect the medication at some time later on the patient’s behalf. Use of taxis etc to deliver discharge drugs to patients should only happen in extreme circumstances and can only be sanctioned by the duty senior nurse/midwife/pharmacist.

5.20 Supply of Medicines from the A & E Department

(a) During the hours 9.00 a.m. - 5.00 p.m. Monday to Friday, patients requiring medication to take home from the A & E Department will be given a prescription for dispensing at the Trust’s designated pharmacy, except where patient group directions (PGDs) are in operation.

(b) Outside of the above hours, a range of pre-packed medicines are available in the A & E Department for supply to patients being sent home. A nurse must write the patient’s name and the date of supply on the pre-printed label. Should any other detail on the label require amending for the particular patient, this should normally be carried out in a legible way by the prescriber. If this is undertaken by a nurse, the drug amendments must be checked by the prescriber who should also give the patient any relevant information on the medicine (refer to standard operating procedure for issuing pre-packs (on medman)).

The casualty card must be completed to record the supply of the medicine and signed by the member of staff supplying the medication.

5.21 Supply of Medicines to Day Case Patients/Ward Attenders

A limited range of standard dose packs are available in the Day Surgery Units and specific wards treating day case patients/ward attenders. The appropriate pack should be prescribed on the pre-printed prescription form and a nurse should supply the prescribed pack, appending the patient’s name and date of supply in accordance with standard operating procedure for issuing pre-packs.

If a prescriber requires any variation of the standard packs, a discharge drugs prescription form must be completed instead and sent to pharmacy for dispensing in the normal way (refer to standard operating procedure for issuing pre-packs (see medman)).
5.22 Provision of Discharge Drugs - Outside Normal Pharmacy Hours

From time to time patients may be discharged when Pharmacy is closed. Anticipation of discharge can avoid most of the problems and the Pharmacy out-of-hours arrangements at Heartlands, Good Hope and Solihull Hospitals are not intended for supply of discharge drugs.

A limited range of pre-packed and labelled medication is available on site. The prescriber should be contacted to see if this provides a suitable alternative. Senior nursing staff have access to these medicines.

Medication required close to the time of discharge can be administered prior to discharge, and a supply for subsequent doses obtained the following day when Pharmacy is open.

However, in circumstances where the supply of discharge drugs outside normal pharmacy hours is essential, and there are no discharge pre-pack arrangements in place that are appropriate for the patient’s needs, the prescriber must personally contact the on-call pharmacist to request dispensing of the discharge medication.

5.23 Medicines for Staff

Medicines must not be taken from ward or department stock for personal use by staff. Normally a member of staff will see his/her GP for their medication needs or purchase medications ‘over the counter’. In an emergency, staff should attend A & E. The Trust Occupational Health doctor may prescribe a short course of treatment for staff (i.e. a maximum of 2 weeks) on a hospital prescription form - FP10(HNC) forms must NOT be used – and, unless an exemption applies, a prescription charge will be levied.

A Trust wide patient group direction for paracetamol is available for use by nursing staff authorised to use the PGD. This allows administration of a dose of paracetamol to a member of staff on request.
SECTION 6

ADMINISTRATION OF MEDICINES

This section relates to administration of all forms of medicines.

More detailed information about intravenous administration of fluids and medicines is available in section 7, but must be read in conjunction with section 6 and the relevant clinical procedures in the Nursing Policies & Procedures file.

6.1 Introduction and General Principles of Drug Administration

(a) Whilst most drug administration is undertaken by nursing/midwifery staff, section 6 equally applies to doctors when administering drugs.

(b) The prescriber has responsibility for telling the assigned nurse-in-charge about any new prescriptions that have been written and that he/she has not administered themselves.

(c) It is that nurse’s responsibility to ensure that, if necessary, a medicine is ordered from pharmacy and that a nurse has been allocated to carry out administration at the prescribed times.

(d) The appointed nurse in charge has responsibility for putting systems in place on the ward for ensuring the availability of medicines and for the allocation of trained nurses to the administration of medicines at the prescribed times. Missed doses should be avoided.

(e) All newly qualified and newly appointed nurses to the Trust on either permanent or temporary contracts (but excluding bank and agency nurses) must undertake assessment of competence for medicines administration before administering medicines alone.

(f) The appointed nurse must ensure that nurses have been assessed as competent in all aspects of the administration of medicines, including performing calculations.

(g) No nurse should be expected to accept the responsibility for administering any medicines against his/her will and those who do accept the responsibility must remember the requirements of the Code of Professional Conduct; standards for performance, conduct and ethics. Nursing and Midwifery Council (November 2004) and Standards for Medicines Management Nursing and Midwifery Council (October 2007).
(h) It is the responsibility of the nurse administering the medicine to ensure that he/she is aware of the following:

(i) Drug being given and its purpose  
(ii) Major contra-indications  
(iii) Main side effects  
(iv) Normal dose  
(v) Correct method of administration  
(vi) Appropriate nursing interventions which need to be undertaken e.g.: pre and/or post administration observations

For “Sources of Information about Medicines for Professional Staff”, see Section 9.19 of this Medicines Policy.

(i) It is the responsibility of the nurse/midwife to ensure that medicines are administered at, or around, the prescribed time. When a drug is not administered as prescribed, the nurse/midwife must have a good, justifiable reason for not so doing, and the appropriate code must be recorded on the drug prescribing and recording sheet. It may be appropriate for the nurse/midwife to contact the prescriber to inform him/her and ask for advice.

(j) Medicines must not be prepared in advance of administration except when reconstituted by pharmacy staff or when authorised by the Trust’s Drugs and Therapeutics Committee.

(k) Crushing tablets or opening capsules are unlicensed uses of a medicine and should only be carried out after consultation with the pharmacy.

(l) If there are any risks associated with handling or administration of a medicine, a pharmacist must advise the staff in order that risks may be minimised or suitable equipment provided.

6.2 Controlled Drugs

The procedure for the administration of Controlled Drugs must be carried out by a nurse/midwife and either another nurse/midwife, a doctor or a student nurse in their final year of training. Where a student nurse is the second nurse, this must be recognised as an opportunity to learn and accountability lies with the nurse.

If a dose of Controlled Drug is accidentally broken or wasted this must be recorded in the Ward CD Record Book. Where fractions of doses are given e.g. 2.5mg diamorphine from a 5mg ampoule, the remainder must be discarded, recorded as “wasted” and signed by the administering nursing staff in the Ward CD Record Book.
6.3 Other Medicines (but see section 7.3 for intravenous drug administration)

Nurses with the necessary knowledge and competence may administer medicines alone, the EXCEPTIONS BEING:--

(a) When medicines are being administered to children under the age of 16 years. It is essential that the administration be undertaken by two nurses one of whom should preferably be a Registered Nurse (Children’s Branch) or by a nurse and a doctor.

(b) When instruction is being given to a nurse in training.

(c) Where ward or unit policy is for two nurses to be involved in the preparation, checking and administration of drugs.

(d) When the patient’s condition is such that two nurses are required.

(e) When complicated dose calculations are required e.g. weight related doses. (nurses and doctors are strongly encouraged to routinely ask a colleague to check any calculations that may be required when administering medicines).

(f) In any other circumstances where the nurse deems it is necessary to have a second nurse present.

In all the above exceptions, where a check by a second person is essential, the identity of the checker must also be recorded.

6.4 Procedure for Administration

It is essential that all drugs be administered in accordance with the patient’s current drug prescribing and recording sheet (see sections 3.1 and 3.2).

The steps in the procedure are:

(a) Read the drug prescribing and recording sheet carefully, taking note of any special instructions or patient drug sensitivities/ allergies recorded. N.B. If the “allergy” box has not been completed (with either details of allergies or a statement that the patient has no known allergies), then drug administration for that patient must be put on hold pending urgent resolution of the situation by a prescriber.

(b) Read each prescription, taking note of any special instructions and ensuring that the prescribed dose has not already been administered and the prescription is still valid.
(c) If the prescription is unclear in any respect whatsoever, the drug must not be given until the prescription is verified and the doubt resolved. In the case of any difficulties, the nurse in charge must be informed so that appropriate action can be taken.

(d) Select the medicine required, check the dispensing label or the manufacturer’s pack labelling with the prescription and check that the medicine is within its expiry date. Do not use any medicine if the dispensing label is unclear in any way. Where possible, confirm correct selection of solid dose medicines by checking the information printed on the foil pack.

(e) Prepare the medicine and check with the drug prescribing and recording sheet:

(i) The medicine including form and strength.
(ii) The calculation, if any.
(iii) The measured dose.
(iv) The route of administration.

(f) Take the measured dose and the drug prescribing and recording sheet to the patient.

(i) Address the patient by name.
(ii) Where it is the hospital policy to use an identity band, read aloud the patient’s full name and registration number and check against the drug prescribing and recording sheet.
(iii) Where the nurse is unable to identify the patient in the normal way, alternative means of identification must be used. i.e. checking the patient’s address and date of birth.
(iv) Where there are two patients with the same or similar name on the ward, extra care must be taken in the identification of the patient.

(g) It is the nurse’s responsibility to ensure that the medicines are taken/given. After the medicine has been administered, the nurse responsible for administration must initial the drug prescribing and recording sheet in the appropriate place.
Medication must not be left on the patient’s bedside locker/table if unable to be taken at that time.
If a dose of a drug is removed from its container/packaging and then not used it must be destroyed.

(h) Where a prescription is for a variable dose, e.g. 1 or 2 tablets, the dose given must be recorded along with the initials.

(i) Where a specific dose is prescribed, the nurse administering the drug does not have the authority to titrate or vary the prescribed dose. If the nurse has any concerns about the appropriateness of the prescribed dose it must not be given until the matter has been verified with a prescriber.
(j) **If the drug is wasted** or cannot be given to the patient and is destroyed a note to this effect must be made on the drug sheet and recorded in the nursing/midwifery documentation.

(k) **If a medicine is omitted**, the reason must be stated on the prescription sheet and identified by the appropriate code. (See the Trust’s “Guidelines for the Omission of Patient’s Medication Due to Unavailability” on the Medicines Management intranet website [http://medman/advice](http://medman/advice)).

(l) **In the case of Controlled Drugs**, the details must be entered in the ward Controlled Drugs register. The record must be signed in full by both the nurse giving the drug and the witness, one of whom must be a registered nurse on that ward/department.

(m) **For pre-operative patients**, all prescribed medications should be administered on the day of surgery with the exception of any oral/subcutaneous hypoglycaemic drugs which should be omitted. Oral anticoagulants should normally be omitted in the days prior to surgery. It is the responsibility of the medical team to determine when oral anticoagulants should be stopped and to prescribe heparin cover if required.

(n) **Administration of oral liquid medicines.**

Oral liquid medicine doses of 5mL, or multiples of 5mL, for inpatients should normally be measured in a calibrated plastic medicine measure which must be discarded after administration of the dose. (the medicine measures are for single use only).

**Oral dose syringes** (labelled “oral” and/or “enteral” and coloured purple) should be used for measuring oral liquid medicine doses in the following circumstances:

- For oral doses of less than 5mL
- For oral doses of more than 5mL that are NOT multiples of 5mL e.g.7.5mL, 12.5mL etc.
- For all oral doses of Controlled Drug liquids
- For all liquid medicine doses being administered into enteral feeding lines.

**Under NO CIRCUMSTANCES should intravenous syringes be used to measure oral liquid medicine doses or doses to be given into enteral feeding lines.**

Ref. NPSA Patient Safety Alert number 19
6.5 Administration of Medicines via Enteral Feeding Tubes

Liquids or soluble tablets are the preferred formulations to be administered via a feeding tube. Crushing tablets or opening capsules should be considered as a last resort as this generally falls outside a drug’s product licence and in these circumstances the prescriber and practitioner accept liability for any adverse effects resulting from this administration.

**Medicines that must not be crushed:**
Enteric coated (EC)
Modified Release/Slow Release (MR, SR, LA, XL)
Cytotoxics and hormonal preparations

It is important that exposure to drug powder is kept to a minimum

Administration of doses into an enteral line should be undertaken by the use of enteral/oral dose syringes.

The enteral feeding tube must be flushed with water before and after drug administration to reduce the risk of tube blockage.

**Tube blockage.**

Inadequate flushing is the most common cause of tube blockage. Using the wrong formulation of medication can also cause tube blockage. If flushing with warm water does not unblock the tube, seek specialist advice, do not apply excessive force.

There may be interactions between the feed and the medicine – check with Pharmacy for advice. Where possible give the dose during a break in the feeding regimen to minimise this.

6.6 Multiple Doses from One Vial.

Only one single dose, for one single patient, on one occasion, should be taken from a drug vial unless the vial label/package information indicates that it is for multiple dose use, or shows the presence of a preservative on the vial label, or is prepared in the Pharmacy Aseptic Dispensing Unit. Most vials and all intravenous fluid bags are for single use only. A notable exception is insulin in vials where multiple doses can be taken from one vial.

All ampoules are single use only.

Ref. NPSA Patient Safety Alert No. 20
6.7 **Health Care Assistants and Non-Clinically Qualified Staff**

Healthcare assistants may only **assist** in the administration of medicines where they have undertaken an appropriate training programme and where there is a locally agreed policy.

In certain specified circumstances, nursing healthcare assistants and nursery nurses, with further training and able to demonstrate competence, may **undertake** the administration of medicines against agreed written protocols, subject to the approval of the Chief Nurse.

In certain specified circumstances, healthcare assistants or other non-registered staff working in professional specialties, if appropriately trained and able to demonstrate competence, may **undertake** the administration of medicines against agreed written protocols signed by the Clinical Director of the specialty and approved by the Trust’s Clinical Standards Committee or Safety Committee.

Radiology administrative staff and certain consultant secretaries may **supply** to patients, in advance of their appointment, appropriate pre-investigation medicines. However this must only be on receipt of an individual patient investigation request signed by a medical practitioner and where there is a written protocol in place specifying the medicine, dose, patient instructions and quantity to be supplied. The written protocol must be signed by the Clinical Director.

The Clinical Director of Pharmacy must be notified in writing, and approve of all arrangements where health care assistants and non-clinically qualified staff are **supplying or undertaking** the administration of medicines to patients.

6.8 **Assistance with Medicine Administration by Parents and Carers.**

It is accepted that, in certain circumstances, the assistance of parents/ carers in helping patients to take medicines, after the nurse has selected and prepared the medicine for administration, can be beneficial in ensuring treatment is taken. The nurse who selects and prepares the medicine must be assured that the parent/ carer is fully capable of safely administering the medicine by explaining why the drug is being given, how it should be given, observing administration and documenting actions taken. **The nurse retains full responsibility for the administration and recording of the medicine.**
SECTION 7

INTRAVENOUS INFUSION AND INTRAVENOUS DRUG ADMINISTRATION

Important Notes

1. This section of the Medicines Management Policy does not refer to intravenous cytotoxic drug administration (see below).

Separate Trust Policy documents exist for:

(a) Intravenous cytotoxic drug use
   “Policy for the Safe Prescribing, Handling and Administration of Cytotoxic and other Chemotherapeutic Agents for Oncology and Haemato/Oncology”

(b) Intrathecal cytotoxic drug use
   “Intrathecal Chemotherapy Policy”

2. A separate Trust policy document also exists for:

Intravenous potassium infusion/ strong injection use.

“Intravenous Potassium Policy” See http://medman/policies or sharepoint

7.1 Prescribing and Documentation

(a) It is the responsibility of the prescriber to prescribe all intravenous fluids, whether or not they contain drug additives. These must be prescribed in the appropriate section of the drug prescribing and recording sheet, intravenous fluid chart or other specialised approved treatment recording sheets.

(b) When prescribing a drug for intravenous use that is to be administered in an infusion fluid, it is the prescriber’s responsibility to also specify the name and volume of the infusion fluid into which the drug is to be added, the final concentration of the drug in the infusion fluid, the rate of administration, the duration and method of administration. However, it is not necessary to specify the injection solution to be used when re-constituting a dry powder vial as this is normally specified by the injection manufacturer.

For “Sources of Information about Medicines for Professional Staff”, see Section 9.19 of this Medicines Policy.
(c) In some specialised areas of practice (e.g. midwifery, High Dependency Unit) patient group directions may exist which allow the administration of specified drugs and intravenous fluids without the prior need for an individual prescription. In such circumstances, the signed patient group direction is the prescription. If the patient group direction requires that such treatment be documented, this must be done on an approved drug prescribing and recording sheet, intravenous fluid chart or treatment recording sheet.

(d) Unless an approved specialised treatment recording sheet is used, infusions of volumes greater than 250ml (in adults) should normally be prescribed on the intravenous fluids section of the drug prescribing and recording sheet. If infusions contain drug additives, such drugs should also be prescribed on the drug prescribing and recording sheet and annotated "see IV Fluids section".

An exception to this requirement is when a drug is being administered in an infusion fluid greater than 250ml (in adults) and the drug is required to be given on a regular daily, or several times a day, basis. In this situation the infusion-drug additive mixture should be prescribed only in the regular medications section of the drug prescribing and recording sheet. The prescriber must however be alert to the possibility of fluid overload if intravenous fluids are also prescribed on the intravenous fluids section of the drug prescribing and recording sheet.

(e) When small volume infusions (250ml and less) are prescribed for adults for the purpose of administering an intravenous drug that has been added to the infusion, such infusion-drug additive mixtures should be prescribed only in the regular medications section of the drug prescribing and recording sheet.

(f) All prescriptions must be written clearly in black ink in **BLOCK CAPITALS** and must state:

(i) the infusion fluid including strength and pre-mixed additives, where appropriate.
(ii) the dose/volume.
(iii) the precise method of administration.
(iv) the rate and duration of administration.
(v) the dose of any drug to be added and the final concentration of drug in the infusion fluid.
(vi) signature of the prescriber.
(vii) date of prescribing.
(viii) date of administration, if different from date of prescribing.

Where an infusion fluid is supplied from Pharmacy with a pre-mixed drug additive (e.g. sodium chloride 0.9% with 20mmol potassium), the combination of infusion fluid with the added drug should be prescribed as the ‘infusion fluid’ and the ‘additive’ box should be left empty.
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**ONLY** where a drug is to be added to an infusion fluid on the ward/unit should the drug be written in the 'additive' box for the intravenous infusion fluid prescription.

(g) Patient group direction administrations must be written up as above and signed by the designated nurse instituting treatment where this is specified in the patient group direction document.

(h) When drugs are to be added to intravenous infusion fluids, the prescriber must ensure that the drug is appropriate for this method of administration and that it is compatible with the infusion fluid and any other drugs that may already be in the infusion fluid. Advice on these aspects can be obtained from the current BNF or from the pharmacy department/on-call pharmacist.

(i) Drugs must **not** be added to:

- Blood.
- Plasma or other blood products.
- Intravenous feeding solutions.
- Amino acid solutions.
- Fat emulsion preparations.
- Mannitol infusions.
- Sodium bicarbonate infusions.

(j) Wherever possible, commercially available drug-infusion mixtures should be prescribed in preference to those requiring preparation.

NB. There is little published information on the compatibility of multiple drug additions to intravenous fluids. Such mixtures should be avoided unless positive information on compatibility is available.

7.2 **Storage and Prevention of Contamination**

(a) Before an infusion fluid container is connected to a giving set, the designated nurse/prescriber must check:

(i) the name and strength of the intravenous fluid.
(ii) the expiry date.
(iii) for evidence of damage to the container.
(iv) for leakage.
(v) for particle formation.
(vi) for cloudiness/opalescence.
(vii) for change in colour.

(b) If there are any concerns about the quality of the infusion fluid (e.g. it contains particles, is cloudy, opalescent or there are changes of colour) then the infusion fluid must not be used but retained, together with its outer wrapper and any drug additive vial/ampoule and packaging.
(i) The designated nurse/doctor must immediately inform the duty senior nurse who must urgently inform the pharmacist-in-charge or on-call pharmacist.

(ii) Arrangements must be made to inspect the remainder of the containers in that batch.

(iii) Should any such abnormalities only be noticed after administration has started, the infusion must be stopped immediately.

(iv) Additionally, in these circumstances, the doctor must be urgently notified and the giving set, infusion fluid, any drug additive vial/ampoule and associated packaging must be retained for inspection.

(c) Good aseptic technique is essential when making drug additions to intravenous infusion fluids and when inserting giving sets into intravenous infusion containers.

(d) If an injection is drawn up into a syringe and is to leave the hands of the operator before being administered, the syringe must be labelled with the drug name, dose or strength of injection, route of administration, diluent and final volume, patient’s name, expiry date/time and the name of the person who prepared it.

(e) Under no circumstances must an operator be in possession of more than one unlabelled syringe at any one time, nor must an unlabelled syringe be fitted to a syringe driver or similar device.

(f) Under no circumstances must an intravenous infusion container be used on more than one occasion. Any unused solution MUST be discarded on disconnection from a giving set.

7.3 Personnel Who Can Administer Intravenous Fluids and Medication

An appropriately IV trained, competent nurse is able to administer all prescribed intravenous fluids and drugs alone, including first doses, subject to the following exceptions.

a) When intravenous fluids or medication are being administered to children under the age of 16 years. In these circumstances it is essential that checking and administration be undertaken by two nurses one of whom should preferably be a Registered Nurse (Children’s Branch), or by a designated nurse and a doctor.

b) Controlled Drugs – The procedure for the preparation, checking and administration of Controlled Drugs must be carried out by two people as described in Section 6.2
c) Cytotoxic and other chemotherapeutic drug administration must be carried out by two people in accordance with the “Policy for the Safe Prescribing, Handling and Administration of Cytotoxic and other Chemotherapeutic Agents for Oncology and Haematology/Onology”.

d) When administering an unfamiliar drug

e) When instruction is being given to a nurse in training.

f) When the patient’s condition is such that two nurses are required.

g) Where complicated calculations are involved e.g. weight related doses, variable administration rates, changes between units of measurements etc. (nurses and doctors are encouraged to routinely ask a colleague to check any calculations that may be required when administering medicines).

h) Where ward or unit policy is for two nurses to be involved in the preparation, checking and administration of intravenous fluids or drugs.

i) In any other circumstance where the nurse deems it necessary to have a second nurse present.

7.4 Intravenous Fluid Administration

Intravenous fluids may be administered by a designated nurse or a doctor who has the necessary knowledge and competence and should be able to successfully handle any anaphylactic reactions.

. The prescription details on the relevant charts must be followed.

7.5 Administration of Intravenous Fluids Containing Drugs

(a) Certain drugs may be available already mixed in intravenous infusion fluids e.g. potassium chloride, lidocaine, metronidazole and others which are prepared in pharmacy.

(b) Administration of such pre-mixed drug and intravenous fluid combinations, whether commercially manufactured or prepared in the pharmacy may be undertaken by a designated nurse or doctor with the necessary knowledge and competence. The prescription details on the relevant charts must be followed.
7.6 Addition of Drugs to Intravenous Fluids

(a) This procedure may be carried out by a designated nurse or doctor with the necessary knowledge and competence.

(b) Drugs should not be added to fluids where pre-mixed solutions are available in the hospital.

(c) An approved additive label must be fully completed and attached to the intravenous infusion container. It should be placed so that it is easily read and must not obscure the details of the infusion fluid.

(d) When a drug is added to intravenous fluids, thorough mixing must be ensured before the infusion is set up.

For “Sources of Information about Medicines for Professional Staff”, see Section 9.19 of this Medicines Policy.

7.7 Infusion Pumps

(a) Only designated nurses or doctors who are IV competent and have been trained in accordance with the manufacturer’s guidelines are allowed to set up infusions using a pump.

(b) All lines must be labelled and dated.

(c) Designated nurses and doctors must not prepare substances for injection in advance of their immediate use, nor administer a medicine that has not been drawn into a syringe by her/him or in her/his presence, or prepared in the pharmacy department, except where there is already an established intravenous infusion in progress via a mechanical pump, which has a valid prescription and a responsible practitioner has signed to identify that the infusion is correct.

(d) All infusions must be checked on a regular basis to ensure administration is timely and that there are no mechanical failures. This should be recorded on a ‘Pump Check Chart’ at the specified interval.

7.8 Bolus Intravenous Injection

(a) Bolus injections may be given by a doctor. Additionally they may be given by a designated nurse, providing there is a cannula in situ.

(b) The injection of a drug into a cannula or the additive port of a giving set should always be done slowly and in accordance with instructions in the package insert or BNF.
(c) In situ intravenous cannulae that are not being used should be flushed through with 5ml of 0.9% sodium chloride injection every six hours to maintain their patency, except for paediatric patients where there is a separate policy.

(d) When a bolus injection is to be given through an intravenous cannula, the cannula should be flushed through both before and after the injection with 5ml of 0.9% sodium chloride injection (unless the drug is incompatible with 0.9% sodium chloride injection).

If two or more bolus injections are to be given consecutively, the intravenous cannula must be flushed with 5ml of 0.9% sodium chloride injection between the bolus injections (unless either drug is incompatible with 0.9% sodium chloride injection) to avoid the possibility of interaction between the two drugs.

(e) Sodium chloride flushing solutions used in situations as described in (c) and (d) above are covered by a Trust-wide patient group direction (PGD) which can be utilised by nurses authorised to use the PGD.

(f) Flushing solutions other than 0.9% sodium chloride injection must be prescribed on the drug prescribing and recording sheet by a prescriber in the normal way unless the flushing solution is the subject of a local patient group direction.

(g) Undiluted potassium chloride injection must never be given directly into a cannula or the additive port of a giving set. (See the Trust’s “Intravenous Potassium Policy”).

7.9 Setting Up and Commencement of Intravenous Therapy

A designated IV trained nurse who has the appropriate competencies may insert a cannula and commence intravenous therapy in accordance with local patient group directions if authorised to use the appropriate PGD.

7.10 Intravenous Feeding

(a) Intravenous feeding of patients is a complex process. The multi-disciplinary nutrition team should be involved directly in the care of every patient requiring intravenous feeding.

(b) Administration of parenteral nutrition must be in accordance with the Trust Policies and Procedures.
(c) Designated nurses and doctors administering parenteral nutrition must be trained and competent in the use of the apparatus involved.

7.11 Monitoring of prescribing and drug compatibilities

(a) The clinical pharmacist should routinely monitor drug prescribing and recording sheets and the intravenous fluid section of the chart and, where appropriate, advise medical and nursing staff on any specific problems regarding appropriateness, safety, stability and compatibility.

(b) The clinical pharmacist or medicines information pharmacist can be consulted for any advice that is required concerning intravenous therapy, including compatibility of drug additions to intravenous fluids.
SECTION 8
NURSES AND MIDWIVES PRACTISING IN THE COMMUNITY

Where Trust staff are required to supply and/or administer drugs to patients in the community the following guidance should be followed.

8.1 Supply of Drugs

Patients’ drugs will normally be supplied by the hospital pharmacy as TTOs and thereafter through a GP prescription. However, there may be occasions when it is more appropriate for the nurses/midwives to carry their own stock. Permitted drugs will be identified in local specific guidelines. These drugs will be supplied by the hospital pharmacy.

The nurse or midwife may requisition those approved drugs and preparations as she requires using the pharmacy requisition form. Any midwife requiring a supply of pethidine can obtain a supply form from a supervisor of midwives.

8.2 Restriction on the Use of Drugs for Midwives (Rule 7)

A practising midwife shall only supply and administer those medicines, including analgesics, in respect of which she has received the appropriate training as to use, dosage and methods of administration.

8.3 Storage of Drugs

When undertaking home visits, the nurse’s/midwife’s bag must be transported in a locked car boot. At the end of visits, if the bag is not to be returned to base, the nurse/midwife must remove the bag from the car and keep it in a safe place at home, inaccessible to the public. Drug cupboards or locked receptacles can be supplied, if necessary. Controlled Drugs must be kept in a locked receptacle reserved solely for this purpose which itself must be stored in a locked receptacle. The Controlled Drugs record book should be kept with the supply of Controlled Drugs.

All medicines must be stored in the container supplied by Pharmacy and must not be removed from the container, except on administration.

Medicines to be left with patients should be supplied in the form of individually labelled dispensed packs, as provided.

Normally Controlled Drugs are stored in a locked receptacle in the nurse’s/midwife’s home. They should be stored in a place inaccessible to the public. In transit, Controlled Drugs must be kept in a locked bag or container in a locked boot of the car.
8.4 Recording Administration of Drugs

(a) For all drugs administered:

(i) The nurse or midwife must write on the patient's record the drug name, dose and route of administration of the drugs given, signing and printing her name and recording the date and time of administration.

(ii) These records must be kept up to date and produced if requested by the manager or supervisor of midwives.

(b) For midwives, the name and address of the patient, date, time, dosage and method of administration must also be recorded in the midwives Drug Record Book and in the midwives Register of Cases. These records must be kept up to date and produced if requested by the supervisor of midwives.

N.B. When working in hospital, all nurses and midwives must comply with all other sections of this Medicines Policy.

8.5 Surrendering/Destruction of Drugs

(a) Items issued by Pharmacy are expiry dated. It is up to the individual nurse or midwife to ensure that all drugs in their care are within the expiry date.

(b) Expiring stocks, except Controlled Drugs should be returned direct to pharmacy. Expired stock of Controlled Drugs held by midwives must be brought to the attention of the supervisor of midwives (see footnote 6).

(c) Replacement stocks (see section 8.1) may be obtained from pharmacy, using a supply order form.

(d) In the case of Controlled Drugs supplied direct to the patient on a prescription from a general practitioner the responsibility for destruction of any which are unused is that of the patient to whom in law they belong.

In such a situation a nurse/midwife should advise the patient to return the drugs to a community pharmacist for subsequent collection and safe destruction. This advice should be recorded in the patient’s records.

6. In accordance with the Misuse of Drugs Regulations (1985), supervisors of midwives are “authorised persons” for the purpose of witnessing the destruction of Controlled Drugs issued to midwives practising in the community.
8.6 Drugs Which May be Carried and Used by the Practising Nurse or Midwife

Those drugs to be carried by nurses and midwives practising in the community are subject to Trust approval. The drugs or preparations must be agreed with each Directorate and the Pharmacy Department. A list will be available within the Pharmacy area.

8.7 Anaphylaxis

When administering drugs which may cause an anaphylactic reaction, the nurse/midwife must carry an anaphylaxis kit and be competent in the management of any reaction which may occur.

8.8 Adjustments to Patient’s Drug Dosage

In certain community based specialities there is a requirement for specialist nurses to adjust patients’ drug regimens according to written clinical guidelines. Any such adjustments to treatment regimens must be fully documented within the clinical records.
SECTION 9

OTHER MISCELLANEOUS INFORMATION

9.1 Cytotoxic Drugs

Cytotoxic drugs may only be given in accordance with the approved Trust policy, “Policy for the Safe Prescribing, Handling and Administration of Cytotoxic and other Chemotherapeutic Agents for Oncology and Haematology/Oncology.” These drugs must be administered by appropriately trained staff and the chemotherapy nurses must be contacted for all patients receiving intravenous cytotoxic therapy outside the Oncology and Haematology units.

Handling of cytotoxic drugs and some other non-cytotoxic drugs is hazardous. These drugs are transported to wards and departments in special boxes highlighting the nature of the contents. Staff handling these drugs must be aware of the procedure to follow in the light of any spillage on route or in ward areas. Any member of staff involved in preparation or administration of these drugs by routes other than oral should have undergone specific education and training recognised by the Trust.

9.2 Intrathecal Cancer Chemotherapy

No one can be involved in the prescribing, preparation, supply, transport, storage or administration of intrathecal cancer chemotherapy in the Trust unless they have satisfactorily undergone the required Trust training AND have been entered onto the Trust’s Register of approved staff.

Training for intrathecal chemotherapy is provided to medical, nursing and pharmacy staff who will be involved in any aspect of intrathecal chemotherapy service provision. This is provided on induction to all new appropriate staff by the nominated training leads with an update provided annually. Each member of staff receives a certificate on completion of the training and the training is logged on a local haematology database. This also provides an audit trail for each member of staff and their involvement in any aspect of the provision of intrathecal chemotherapy.

9.3 Patient Controlled Analgesia (PCA)

Patient controlled analgesia (PCA) should be given in accordance with the Trust’s “Guidelines for the Management of Patient Controlled Analgesia” - see nursing policies and procedures file. PCA should only be administered in areas where staff have the necessary competence and experience. The specified PCA treatment chart must be used for the prescribing, recording and monitoring of the treatment. Additionally however, it is essential that a reference to the PCA treatment is made on the main drug prescribing and recording sheet so that all relevant staff are aware of all the treatment that the patient is having.
9.4 Epidural Therapy

For all epidural therapy the Trust’s “Guidelines for the Management of a Patient with an Epidural Infusion” should be followed. Epidural therapy should only be administered in areas where staff have the necessary competence and experience. The specified Epidural treatment chart must be used for the prescribing, recording and monitoring of the treatment. Additionally however, it is essential that a reference to the epidural treatment is made on the main drug prescribing and recording sheet so that all relevant staff are aware of all the treatment that the patient is having.

9.5 Oxygen Therapy

Oxygen therapy should be prescribed and administered in accordance with the “Oxygen Prescription” guidelines available at http://intranet_1/guidelines/ (then search for “oxygen”). In some areas patient group directions are available, see section 3.6.

9.6 Administering Infusion Fluids Subcutaneously (Hypodermoclysis)

Administering infusions by the subcutaneous route, albeit unlicensed, can be a useful alternative to intravenous infusions. Guidance on this route of administration is available from the Pharmacy Medicines Information Centre.

9.7 Self-Administration

A self administration scheme for patients on a ward can only be established and undertaken as part of an organised arrangement agreed with a senior pharmacist and fully supported by relevant procedures. Refer to Trust policy.

9.8 Administration of Homoeopathic or Herbal Substances

Where a patient wishes to use a herbal or homoeopathic preparation, its use should be discussed with the patient’s consultant prior to the patient using it.

9.9 Complementary and Alternative Therapies

Some nurses, midwives and health visitors, having first successfully undertaken training in complementary or alternative therapy may provide the service. It is essential that practice in these respects, as in all others, is based upon sound principles, available knowledge and skill. The importance of consent to the use of such treatment must be recognised. So, too, must the practitioner’s personal accountability for their professional practice.

Complementary and alternative therapies involving the use of substances such as essential oils may only be carried out where there are approved policies and procedures in place.
9.10 Nutritional Therapy

Many hospital patients require nutritional support. This is usually given orally as high protein, high calorie drinks and snacks with or without nutritional supplements or enteral tube feeding.

Nutritional Supplements (Sip Feeds)

In some circumstances where patients are not receiving sufficient nutrition from diet alone, nutritional supplements may be appropriate. If a nurse believes that a patient’s intake is not adequate she/he should refer the patient to the dietician for assessment, quoting the patient’s Nutrition Risk Score (NRS).

Following referral, dieticians will assess the patient’s nutritional status and requirement, and establish whether their nutritional requirements are being met. In the event that nutritional supplements are indicated, these will be prescribed by the dietician on the patient’s drug prescribing and recording sheet or on electronic prescribing.

The nursing staff must document the patient's intake of nutritional supplements either on the patient’s drug prescribing and recording sheet, fluid balance chart if in use, otherwise in the medical notes.

At weekends, if a nurse believes that a patient needs supplements, he/she should:

a) Ensure the supplement offered is compatible with any special diet the patient requires and check the patient’s risk of Refeeding Syndrome (see Enteral Feeding Guidelines);

b) Inform the dietician as soon as possible that supplements have been administered;

c) Record the administration in the nursing documentation.

Enteral Tube Feeding

If a patient requires an enteral tube feed, an appropriate feed will be prescribed on an Enteral Feeding Regimen form (refer to Enteral Feeding Guidelines) or a milk kitchen card for some paediatric patients (does not apply at GHH). At weekends, the Emergency Feeding Regimen should be used to commence an enteral feed (available on the HEFT intranet). Nursing care plans for all types of enteral feeding are available as an appendix to the Enteral Feeding Guidelines.

Parenteral Feeding

If oral/enteral feeding is not possible parenteral feeding may be required. Patients must be referred to the Nutrition Team by contacting the TPN Pharmacist, or Clinical Nurse Specialist Nutrition (only at BHH/SH) or the
dietician. TPN is never an emergency and will not be commenced over weekends or Bank Holidays.

The relevant Policies and Procedures relating to this method of administration can be found in the Nursing Policies and Procedures manual.

9.11 Purchasing of Medicines

The Clinical Director of Pharmacy (with delegation as appropriate) is responsible for obtaining all medicinal products that are required in hospitals of the Trust, ensuring that they are of a suitable quality, and for their issue against an appropriate order. Other employees of the Trust are not empowered to purchase drugs for use within the Trust other than by delegated authority of the Clinical Director of Pharmacy.

In purchasing medicines for the Trust, the Pharmacy Department makes full use of national and consortium purchasing contracts to minimise the acquisition costs of drugs but also for the assurance that contract lines have undergone additional NHS Quality Control assessment prior to the awarding of contracts. In certain circumstances, consideration is also given to the impact of differential pricing between primary and secondary care.

In an effort to minimise the risks associated with medicines, the Trust is increasingly adopting a “Purchasing for Safety” approach in the choice of drugs in line with the national strategy.

9.12 Medicines Security in Transit

All medicinal products that are issued from a pharmacy or returned to it must be in a locked or sealed tamper-evident container unless:

- Given direct to the patient.
- The messenger is a member of the pharmacy staff, or nurse/midwife from the ward/department concerned, a community midwife, medical officer or a healthcare assistant acting under direct instructions from a trained nurse.
- The medicine does not require locked storage on the ward e.g. intravenous fluids, irrigation solutions

Similar considerations apply to requisitions for medicines.

Packages other than ward boxes must not be left unattended.

Locked/ sealed ward boxes should only be left unattended whilst the porter is collecting or delivering a box from/to a ward/department. Deliveries of ward drug boxes must not be “parked up” anywhere once a delivery run has been commenced.
All deliveries to wards in security bags via the porters require a signature on the log sheet and a signature on delivery at the ward by a member of the nursing team. Log sheets are returned to pharmacy to complete the audit trail.

9.13 Authorised Prescription Documents

The format of all prescription documents used within the Trust must be authorised by the Drugs and Therapeutics Committee before the documents are used for prescribing. The only exceptions are formal clinical study prescription documents whose format is determined as part of the study. Any proposals for new prescription documents or amendments of existing documents should be forward in the first instance to the Pharmacy Governance Lead or Clinical Director of Pharmacy.

9.14 Pre-printed Prescription Labels

Pre-printed prescription labels for specific, but often complex dose regimens can be used to improve the safety of prescribing in certain situations. Such pre-printed labels must be authorised by the Drugs and Therapeutics Committee and in the first instance, should be forwarded to the Pharmacy Governance Lead or Clinical Director of Pharmacy.

9.15 Faxing of Prescription Charts

It is not normal practice to fax prescriptions or drug prescribing and recording sheets. In the event that this practice is required, an approved local procedure must be available. This procedure must have been ratified by the Trust Drugs and Therapeutics Committee.

9.16 Defective Medicines

Any suspicion that a medicine may be defective must be discussed with the most senior pharmacist on duty (or the on-call pharmacist out-of-hours) who will advise on the appropriate action to take. Details of the products including batch numbers will be taken. Where necessary, the pharmacist will liaise with external agencies such as the Pharmaceutical Company, Medicines and Healthcare products Regulatory Agency (MHRA) or National Patient Safety Agency (NPSA). Refer to the Trust Policy: Incident Reporting and Investigations (including serious clinical incidents).

9.17 Reporting of Suspected Adverse Drug Reactions

If a doctor, nurse or pharmacist is suspicious that an adverse reaction may be related to a drug or combination of drugs, a Yellow Card (which can be found in the back of the BNF) should be completed. Reports can be made online at www.yellowcard.gov.uk. Or sent FREEPOST YELLOW CARD (no address details
required). All adverse reactions must be reported for black triangle drugs and only serious adverse reactions for established drugs. An admission to hospital that may be directly due to a drug is also considered serious and must be reported. Do not be put off reporting because some details are not known. Prescribers are encouraged to liaise with the Pharmacy Department before submitting as further information may be helpful.

9.18 Medication Errors

No matter how careful clinical practitioners are in their provision of healthcare, medication errors will occasionally happen. It is important that errors are fully investigated to determine whether changes in practice, procedures or policies might minimise the chance of similar errors occurring in the future.

Whenever it is discovered that a patient has been given administered incorrect drug treatment through a prescribing, dispensing or drug administration error, the person noting the error must:

- Immediately inform the nurse in charge of the ward/unit
- Urgently contact the appropriate medical officer in charge of the patient so that, if necessary, remedial action can be taken (e.g. discussions with the Poisons Unit) to ensure the safety of the patient. The notified medical officer has a duty to inform the appropriate consultant during normal working hours unless he/she has been called to take remedial action.
- Urgently report the incident to the matron for the area.
- Ensure that the incident is documented in the patient’s notes along with details of any remedial action taken and the individuals informed.
- Complete an incident report form (IR1 form) online.

It is the responsibility of the nurse-in-charge to ensure that the patient (and/or relatives, depending on circumstances) is/are advised at an early stage. How this occurs, and by whom, will need to take account of the nature of the error and any adverse consequences suffered by the patient. Any discussions should be documented in the patient’s notes.

It is imperative that an incident report form is completed for any prescribing, dispensing or administration error where a patient receives incorrect treatment and also for a ‘near miss’. The Trust’s Incident Reporting Policy must be followed and details of the error/near miss must be reported to the pharmacist-in-charge and the nurse-in-charge (if not already aware).
9.19 Sources of Information about Medicines for Professional Staff

Information on medicines that can be accessed easily whilst working on the ward/unit includes the following:

- The latest **British National Formulary (BNF)** available in hard copy or via the intranet [http://www.bnf.org](http://www.bnf.org) or [http://medman/medinfosources.aspx](http://medman/medinfosources.aspx)

- **Package inserts** in medicines

- The **Electronic Medicines Compendium (EMC)** containing the ‘Summary of Product Characteristics’ (data sheets) and patient information leaflets of branded proprietary medicines, via the intranet [http://www.medicines.org.uk](http://www.medicines.org.uk) or [http://medman/medinfosources.aspx](http://medman/medinfosources.aspx)

- ‘**Medusa**’ – the intravenous drug database for information on the preparation and administration of intravenous medicines

- **Your ward pharmacist**

- **The Trust’s Medicines Information Centre** (Mon. – Fri. 9.00am – 5.00pm) on Ext. 45508 for Heartlands and Solihull, and Ext. 2296 for Good Hope.

For **urgent and essential** medicines information outside the local Pharmacy’s opening hours contact the **out-of-hours on-call pharmacist** via switchboard.

For information on **medicines management policies, procedures and guidance** that has been issued by Pharmacy visit the Medicines Management intranet website on [http://medman](http://medman)
Summary of Requirements for Requisitioning, Storage, Recording and Prescribing of Controlled Drugs.

The table summarises the legal and/or the Trust’s Controlled Drug requirements relating to Controlled Drugs in schedules 2 and 3 and those relating to oral morphine sulphate mixture 10mg in 5mL.

Common schedule 2 drugs are: diamorphine, morphine tablets, capsules and injections, oral morphine sulphate solution 100mg in 5mL concentrate, methadone, pethidine, remifentanil, cocaine, amphetamines and quinalbarbitone.

Common schedule 3 drugs are: buprenorphine, midazolam, phenobarbitone.

<table>
<thead>
<tr>
<th>Schedule 2 Controlled Drugs</th>
<th>Schedule 3 Controlled Drugs (except temazepam in column to right)</th>
<th>Temazepam &amp; morphine sulphate 10mg in 5mL solution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stocks must be ordered in Controlled Drug Requisition Book</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Must be stored in Controlled Drug cupboard (except during medicine rounds)</td>
<td>✓</td>
<td>✓**</td>
</tr>
<tr>
<td>Controlled Drug Register must be kept</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Daily stock checks required</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>TTOs, A/E and OPD prescriptions need full Controlled Drug particulars (see BNF)</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* NB: Oral morphine sulphate solution 100mg in 5mL concentrate is a schedule 2 Controlled Drug.

** Midazolam in second line resuscitation boxes is exempted from this requirement.

Whilst some of the above details are not strictly legally required, they have been determined to be necessary requirements in this Trust by the Trust’s Controlled Drugs Accountable Officer.
Accepted Abbreviations

The use of abbreviations on prescriptions **MUST** be confined to those noted below. **No other abbreviations are acceptable.** Directions for which there are no accepted abbreviations **MUST** be written in full.

**Strengths and quantities**

- G or g - gram
- mg - milligram (1000 mg = 1G)
- microgram - microgram (1000 micrograms = 1mg)
- nanogram - nanogram (1000 nanograms = 1 microgram)
- ml or mL - millilitre
- unit - unit, to be written in full

**Routes of Administration**

- O - oral
- P.R. - rectal
- P.V. - vaginal
- I.V. - intravenous injection
- I.M. - intramuscular injection
- S.C. - subcutaneous injection
- I.P. - intraperitoneal
- INH - inhalation by inhaler through mouth
- Neb - inhalation by nebuliser (via mask)
- Top - topical
- NG - via a nasogastric tube
- PEG - via a PEG tube

N.B. There are no approved abbreviations for (i) unit of blood (ii) epidural. **These must be written in full**

**Dose Frequency** (to be used on outpatient prescriptions only)

- OD - once a day
- BD - twice a day
- TDS - three times a day
- QDS - four times a day
- MANE - in the morning
- NOCTE - at night
- PRN - when necessary
- STAT - immediately

**Other Abbreviations**

- a.c. - before food
- p.c. - after food
**Hospital Outpatient Prescription Forms**

Treatment which is required to start **immediately** or when the drug required is only available from hospital sources may be prescribed on these forms.

They should **not** be used to supplement a patient’s routine supply from the G.P.

Up to 28 days treatment will be issued unless it is a hospital only product or other arrangements have been made with the Pharmacy.

**Non - formulary** items are not stocked by the Pharmacy and therefore will be unavailable for dispensing (see Formulary for further guidance).

Hospital prescriptions are only valid for dispensing at pharmacies within the sites of the Trust and at the Trust’s on-site dispensing pharmacy partner. The prescriptions cannot be taken for dispensing at a normal community/high street pharmacy (not even to another branch of the Trust’s partner).

**FP10(HNC) Forms**

The use of these prescription forms is limited. However, if it is necessary to issue one, the following procedure should be observed.

Drugs prescribed on FP10(HNC) Forms can be obtained by the patient from any community pharmacy. They cannot be dispensed by the hospital pharmacy. These prescriptions should only be used for urgent commencement of treatment when the hospital pharmacy is closed. Again the 28 day rule should apply.

These forms should not be used for patient’s routine medication supplies (they should be obtained from the G.P) nor for non-formulary items.

Patients should be advised to take the prescription to the community pharmacy of their choice. Please note that the full cost of all drugs prescribed on FP10(HNC) forms plus a dispensing fee are borne by the directorate issuing the prescription.

Both outpatient prescriptions and FP10(HNC)s will attract prescription charges for each item dispensed unless the patient is exempt. Classes for exemption or pre-payment are printed on the reverse of the prescription form.

Application forms for exemption or prepayment can be obtained from hospital or community pharmacies or from the Post Office.

**Security of the Blank FP10(HNC) Forms** is the responsibility of the Medical Officer concerned, including safe (locked) storage but may be delegated to the trained nurse in charge of the department).
DRUGS AND THERAPEUTICS COMMITTEE

TERMS OF REFERENCE

ACCOUNTABLE TO: Safety Committee

OVERALL AIM: To develop medicines management strategy and policy; To take an overview of medication safety; To monitor medicines management performance against standards and agree action plans; To commission relevant audit or other work; To hear the views and needs of stakeholders; To educate and inform professionals who use medicines.

KEY DRIVERS: Learning from incidents and risk NHS LA Safety and Governance

ACCOUNTABILITY & SCHEME OF DELEGATION

The Drugs and Therapeutics Committee is chaired by one of its members, normally a Medical Consultant with a particular interest in medicines choice and use, and is directly accountable to Safety Committee. The Clinical Director of Pharmacy (or nominated deputy) will deputise for the Chairman in their absence. The Drugs and Therapeutics Committee is where the major decision making process regarding multidisciplinary Trustwide Medicines Management will take place.

The Drugs and therapeutics Committee delegates responsibility for specific aspects of performance to a number of sub-Committees

The sub-Committees and their frequency of reporting are:-

- The locality-wide Formulary Working Group (monthly),
- Trust Chemotherapy Group (quarterly),
- Trust Antimicrobial Committee which also reports to Infection Control Committee (quarterly)
- Trust Immunoglobulin Group (annually)
- Medical Gas Committee (six monthly)
- Non-medical Prescribing Group (quarterly)
• Safe Medication Practice Group (monthly)
• Trust Anticoagulant and Thrombosis Committee (quarterly)

Assurance to external committees is provided to:

• South Staffs PCT Area Prescribing Group

**FREQUENCY OF MEETINGS:**

Meets every month on the second Wednesday lunchtime, usually at Heartlands Education Centre.

**RESPONSIBILITIES**

**A.** The monitoring of all aspects of Medicines Management, Trustwide, including but not limited to:

- The Medicines Management policy and policy development,
- The Medicines Management risk register,
- The Medicines Management business plan, and progress of agreed actions,
- The Medicines Management audit plan, and audits of practice against the Medicines Management Policy,
- Evidence based practice (drugs Formulary, treatment guidelines and protocols),
- Safe handling of medical gases,
- Medication safety, including adverse reactions, patient safety incidents, errors and near misses, trends in incidents, external reports, medicines defects, Modernisation, and extended practice (e.g., non medical prescribing, and Patient Group Directions),
- Rational prescribing, including trends in drug choice and use,
- Investment in drugs budgets to meet anticipated clinical need,
- Response to national standards and guidance (NICE, NPSA, National Service Frameworks, Healthcare Standards),
- Unlicensed medicines,
- Medication technologies,
- Medicines clinical research.

**B.** Sponsoring and / or commissioning work in support of this, and monitoring performance - in particular the work of the health economy wide Formulary Working Group

**C.** Advice and educational support for prescribers through publications etc.

**D.** Forwarding to the relevant Commissioning departments or other appropriate body, locality decisions on drug use which cannot be implemented due to a financial or contractual barrier

**E.** Endorsing recommendations from Formulary Working Group on formulary review and new drug requests

**F.** Facilitation of cross boundary working, including endorsing of Essential Shared
Medicines Policy 2011

Care Agreements and prescribing affecting the interface
G. Controlling documents for the prescribing or administration of medicines, acting as the gatekeeper for requests for change. It is the guardian of these documents, and no changes can be made to Trust Medicines documentation without explicit permission.

The Drugs and Therapeutics Committee will oversee and monitor a programme of risk management activities in relation to its specialist responsibilities. This will include risk identification, review, management and progress / action monitoring.

The Drugs and Therapeutics Committee is the approving Committee for:
- Medicines Management Procedures
- Patient Group Directions
- Prescribing and Drug Administration Documents
- Essential Shared Care Arrangements
- Trust Formulary
- Antibiotic Prescribing Guidelines

REPORTING

The Drugs and Therapeutics Committee will report six monthly and with interim ad hoc issues to Safety Committee.
The Drugs and Therapeutics Committee will influence the Safety Committee and the clinical groups with the medicines management agenda and monitor the key risks in their area.

MEMBERSHIP and ADMINISTRATION

Chair: drawn from the core membership, by agreement
Lead Medical Representative – Clinical Group 1 (Renal Medicine, Cardiology, Emergency medicine)
Lead Medical Representative – Clinical Group 2 (Respiratory Medicine)
Lead Medical Representative – Clinical Group 3 (Diabetes)
Lead Medical Representative – Clinical Group 4 (Anaesthetics/Critical Care)
Lead Medical Representative - Clinical Group 4 (Microbiology)
Lead Medical Representative – Clinical Group 5 (Paediatrics/Neonates
Lead Medical Representative – Clinical Group 5 (Obstetrics / Gynaecology)
Independent or Supplementary Prescribing Lead
Senior Nurse/Matron/Consultant Nurse
Heads of Medicines Management of the locality PCTs
Clinical Director of Pharmacy / Trust Head of Medicines Management
Deputy Directors of Pharmacy
General manager
Senior Finance representative from Clinical Group 4 (as required)
Representative of Clinical Standards Committee / Formulary specialist
Representative of Formulary Working Group / Interface Prescribing specialist
Representative of Cancer Services
Pharmacy representatives of Solihull, Heartlands and Good Hope Hospitals
Head of Procurement (minutes only)
Representative of Safety and Governance

It is important to note that there is the expectation that lead medical representatives express views on behalf of their directorate/clinical group across all sites where appropriate.

1. Declarations of Interest will be required to be lodged with Trust Governance Department and declared at each meeting.
2. Alternates may be nominated

The Pharmacy Directorate services this group.

**Membership will be reviewed no less frequently than every three years.**

**MINUTES**

Minutes shall be produced for the transactions of the Committee. The minutes shall be concise and shall include all decisions made by the Committee. They shall refer to the papers as appropriate. The meeting papers will not be summarised / reproduced in the minutes.

**QUORUM**

A quorum comprises six members of whom one is a Trust Pharmacist, two are secondary care Medical specialists, and one is a Formulary / Interface specialist. The Interface Specialist may represent the local PCTs. A meeting of six or more members which is non quorate by virtue of the specialties of the attenders, may continue, and the minutes be submitted to the Chair as an informal record pending later ratification by the next quorate meeting. Deputies with full authority count towards the quorum.

Deputies are acceptable. Deputies must have full delegated authority. Deputies have to be approved by the Chair before the meeting unless there are exceptional circumstances in which case they may be approved at the meeting.

Non-members who are not deputies may be invited to attend the committee or Chair but they may not speak unless invited to and their attendance will be recorded in the minutes.

All papers submitted to the committee must be presented by a suitable member of the committee or a speaker invited by the committee.

**Date of last review: May 2010**
**Date for next review: No later than May 2013 (three years)**