Medicines Management Policy and Standard Procedures

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<td>February 2021</td>
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**Purpose**

The purpose of this policy is to set the standards for the correct management of medicines, i.e. prescribing, procurement, production, ordering, storage, distribution, preparation and administration of medicines.

**Who should read this document?**

Trust Wide dissemination.
All Medical, Pharmacy and Nursing staff.
All other healthcare professionals involved in the management of medicines – e.g. radiographers, physiotherapists, optometrists etc

**Key messages**

The Medicines Management Policy provides a framework for the safe use of Medicines across the organisation and includes all aspects of medicines use including prescribing, procurement, production, ordering, storage, distribution, preparation and administration.

**Accountabilities**

- **Owner**  
  Sally Mayell, Assistant Director Pharmacy
- **Review**  
  Medicines Assurance and Utilisation Committee
- **Ratification**  
  Phil Hughes, Medical Director
- **Dissemination (Raising Awareness)**  
  Sally Mayell, Assistant Director Pharmacy
- **Compliance**  
  Medicines Assurance and Utilisation Committee

**Links to other policies and procedures**

- Medicines Reconciliation in Adults Policy
- Procedures for administering injectable drugs
- Policy for the Safe Prescribing, Dispensing and Administration of Oral and Parenteral Anticoagulants
- Procedure for the setting up and maintaining variable rate IV insulin infusions
- Non-Medical Prescribing policy
- Policy for the Procurement, Prescribing, Supply and Administration of Unlicensed Medicines
- Policy for Self administration of Medicines by Patients (Adult and Paediatric)
- Procedures for the safe handling and administration of injectable cytotoxic drugs
- Policy for the Safe Administration of Intrathecal Cytotoxic Drugs
- Policy for Reducing Dosing Errors with Opioid Medicines in Adults
- Policy for Safe Sedation during Healthcare Procedures in Adults
| Version History |
|-----------------|-------------------------------------------------|
| **V10.1 October 2017** | 1. Change second check required for “Administration of all injectable medicines” to “Administration of all injectable medicines except for 20mg and 40mg doses of enoxaparin for venous thromboembolism prophylaxis in accordance with Trust policy”. Administration of any medication, by any route, by an Assistant Practitioner”. On the Neonatal ICU (NICU) and Transitional Care Ward (TCW) the second-check of selected medicines given to neonates and infants by registered nurses and midwives, can be undertaken by Assistant Practitioners who have been trained and assessed as competent (Sec 9)
2. Change made to locking/clamping Totally Implantable Venous Access Devices (TIVADs) in adult patients - When in use with the needle in, flush with at least 10ml of 0.9% sodium chloride using a push pause technique. Clamp line under positive pressure. (In paediatric patients only lock the device with the appropriate volume of 10 units/ml heparin). (Sec 9.3.1)
3. Main Theatres no longer keep ampoules of Strong Potassium Chloride Injection. Instead they keep a small stock of Potassium Chloride 50mmol in 50ml (7.5%) pre-filled syringes for IV infusion. Penrose and Pencarrow now predominantly use the same pre-filled syringes, but still have occasional need for 10ml ampoules of Strong Potassium Chloride Injection. Technically, the 50mmol in 50ml (7.5%) prefilled syringes are not covered by the NPSA/DoH definition of “Strong” potassium. However, the local controls for the pre-filled syringes are the same as those for the ampoules of Strong Potassium Chloride (Sec 9.2)
4. In Main Theatres, level 4, the stock of pre-filled potassium chloride syringes will be kept in a dedicated locked cupboard beside the CD cupboard close to Main Theatres Reception (Sec 9.2)
5. In Cardiothoracic Theatres the supply of potassium chloride ampoules for use by the anaesthetists will be kept in a dedicated locked cupboard in the head ODP’s office. The Perfusionists’ supply is kept in a dedicated locked cupboard in the Perfusionists’ office (Sec 9.2)
6. Operating Department Practitioners and Assistant Practitioners have been added to the list of staff groups allowed to issue TTA packs to patients in accordance with discharge prescriptions (Sec 3.2.1)
7. Definition of Staff Group No. 8 Assistant Practitioners added to section 8.10
8. “When a prescriber chooses to draw up and administer medications by themselves without a second check, they must understand this practice is at odds with this policy document, and they are wholly responsible for the consequences of any error that occurs” has been added to Section 9
9. High Dose/Strength Opioids now also includes Oxycodone 50mg/ml ampoules, Oxycodone 10mg/ml oral solution and morphine 20mg/ml oral solution. Strength of high-strength alfentanil corrected to 5mg in 1ml (Sec 12.3.12.2)
10. In certain approved areas, Oxygen can be administered by Assistant Practitioners who have received appropriate training (Sec 9.9).
11. Cardiothoracic ODPs are now permitted to pre-draw syringes and prepare infusions in advance of procedures, in accordance with a specific SOP and predefined lists of preferred anaesthetic drugs for each cardiothoracic anaesthetist (Section 9.3)

| **V10.2 February 2018** | 1. The policy now makes reference to Clinical Technologists who may administer and second-check a selected number of medicines and radiopharmaceuticals in accordance with the Nuclear Medicine Department protocols (Sections 8, 8.9).
2. For adult patients, sodium chloride flushes can be administered using pre-filled syringes of sodium chloride 0.9%, licensed as a medical device (eg. PosiFlush®) without the need for a signed prescription (Sections 8.9, 9.3.1). |

| **V10.3 October 2018** | 1. Addition of requirement for liquid medicines expiry (section 9.4)
2. Addition of Critical Medicine TTA process and ward template (appendix 4) |
1. Addition of section 9.3.1 – Risk Assessment of injectable medicines
2. Addition of statement about supply of medicines for discharge in section 3.2 Medication for discharge
3. Addition of Appendix 4: procedure for dealing with critical TTA medicines that have not been supplied on discharge.

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.
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1 | Introduction

The purpose of this policy document is to set the standards for the correct management of medicines, i.e. prescribing, procurement, production, ordering, storage, distribution, preparation and administration of medicines. The policy covers all clinical areas and all medicinal products as defined in the glossary (annex A). This policy is based on relevant evidence based national guidance on medicines management. Other products or devices requiring pharmaceutical control are also considered as medicines for the purposes of this document.

THE PROCEDURES DESCRIBED IN THIS POLICY ARE MANDATORY. ALL STAFF ARE REQUIRED TO OBSERVE AND COMPLY WITH THE POLICY AND WILL RECEIVE TRAINING ON INDUCTION TO THE TRUST.

Procedures have been standardised within the Trust to avoid confusion when staff move from one ward or department to another. Your immediate manager or Pharmacist will advise if there is any doubt.

All drug related protocols must be agreed when additional policies are required to address the needs of specific departments/ Directorates and the changing role of health professional staff. In all cases, prior to implementation, full discussion and agreement must take place with the Director of Pharmacy who will determine whether the policy requires ratification by other bodies within the Trust (e.g. Medicines Assurance and Utilisation Committee, Clinical Effectiveness Group), or can be approved by the Director of Pharmacy.

2 | Responsibilities

The Trust Board has the responsibility for establishing, documenting, maintaining and monitoring an effective and economical system by which medicines are managed safely, securely and legally including formal reporting mechanisms and a commitment to promote the significance of this system. The Director of Pharmacy is accountable for the management of this system.

3 | Prescribing / Initiation of Treatment

A patient’s treatment with any medicine must be initiated through a formal process, in accordance with current legislation (Medicines Act 1968).

a) Prescribing by an authorised prescriber:
   i. Registered medical or dental practitioner
   ii. Non-medical prescriber (supplementary or independent) – see separate Trust Non-Medical Prescribing policy.

b) In accordance with a Trust-approved Patient Group Direction (PGD) in specified clinical circumstances.

c) Administration of a pre-defined range of medicines by a registered midwife

d) In certain cases (e.g. during surgery) or life-threatening events, the process may not be formally initiated in full but retrospective records must be made; these
must cover the treatment given, be made at the earliest opportunity and certainly before the prescriber leaves the clinical situation. The authorisation and record of administration of medicines forms an integral part of the patient’s total health records and must be treated as such.

3.1 Inpatients / Day Cases

A prescription for these patients is, legally, an authority to administer medicines and will be made in writing on the approved Trust-wide Drug Prescription and Administration Record (DPAR - also referred to as prescription chart) or Trust approved specialist DPAR (see below). Currently there are a number of DPAR’s in use in the organisation:

- Adults DPAR
- Paediatric and neonatal DPAR and intravenous prescription booklet
- Ophthalmology DPAR
- Day case DPAR

The full requirements for Prescription Only Medicines and Controlled Drugs are not required in these cases as they do not involve individual supply to patients, unlike prescriptions for outpatients and on discharge from hospital (see below).

The DPAR’s will cover the needs of the majority of patients within the Trust, but there may be a need for supplementary specialised or complex prescription and administration records, such as critical care infusions or sliding-scale insulin. In these cases, the existence of the supplementary record should be indicated on the front of the main DPAR. Similarly, the number of medicines associated with current evidence-based treatment means that, occasionally, there is a need to use more than one DPAR at any point in time and this should be made clear on the front of the active documents.

The prescriber must cancel all DPARs and supplementary documents when completed or no longer required, and retain in the patient’s medical record.

The Drug Prescription and Administration Record MUST:

- Clearly indicate the patient’s name, hospital number and/or NHS Number, date of birth (or age), responsible clinician and current ward/unit.
- The patient’s weight (and date weighed) and height (or body surface area) should be included where this information is needed to calculate dosage.
- Clearly indicate Allergies and Drug Sensitivities with the type of reaction when known or if the patient has no known drug allergies or sensitivities then document as NKDA or Nil Known. Allergies and Drug sensitivities should also be documented on the green allergy chapter card kept at the front of the medical notes. The allergy status must be confirmed within 24 hours of admission otherwise the authority to administer medicines ceases.

All individual medicine prescriptions must:
- Be legible, unambiguous and clear and written in block capitals (if not pre-printed or computer-generated). The legal and professional responsibility for incorrect administration due to ambiguity or illegibility rests jointly with the relevant prescriber, supplier and/or person administering the medicine.

- Include the date treatment is to commence. This date should be carried forward to the new DPAR if it is re-written.

- Be signed by an authorised prescriber

- For regular medication on the DPAR, circle and state the time of administration

- Use the `approved name ' (generic, International non-proprietary names) of the medicine. The exceptions are:
  - Preparations where a change in brand or preparation may result in a change in bioavailability as recommended in the BNF. This includes brand name for beclomethasone inhalers
  - Compound preparations for which there is no approved name, for example “Seretide” or “Cosopt”.
  - Oral contraceptives and HRT
  - Slow release opioid preparations, i.e. Oxycontin, Zomorph, MST
  - Topical preparations, for example Diprobase or Dermol 500.
  - Nutritional products, for example, Jevity.
  - Biosimilar medicines

- Clearly express the dose to be administered, using the metric/S.I. systems, wherever appropriate. The unnecessary use of decimal points should be avoided, e.g. 3mg, not 3.0 mg. Similarly, decimal fractions should be avoided e.g. 500 mg not 0.5g, 250 micromoles not 0.25 mmoles.

  N.B. Micrograms, nanograms, intrathecal and units should be written in full to avoid confusion or errors.

I. Combination products e.g. Burinex A - the dose should be expressed as the number of tablets/capsules.

II. Liquid Formulations – the dose in milligrams (or other unit) must be indicated unless inappropriate, i.e. lactulose, Gaviscon.

III. Nebuliser Solutions should specify the dose in milligrams or micrograms. Variable doses - eg. warfarin, prednisolone, clomethiazole or alternate day therapy etc, requirements must be clearly indicated.

IV. For medical gas therapy, the duration, concentration, flow rate, delivery device and, where appropriate, target saturation required should be stated.

V. Unusual doses should be written in both words and figures –e.g. very small doses used for highly sensitive patients.

VI. Insulin – The term ‘units’ (all in lower case) is used in all contexts and there must be a clear space between the numeric value and the word ‘units’. Abbreviations, such as ‘U’ or ‘IU’, are never used. Use of abbreviations has led to misinterpretation of the intended dose, resulting in significant overdoses of insulin and thereby harm to patients. The insulin device being used by the patient, i.e. Solostar, Flexpen, penfill, etc; must also be specified.

VII. Specify the inhaler device being used, i.e. Easibreathe, Turbohaler, Handihaler, Respimat, etc.
Clearly express the route of administration required. The following are acceptable abbreviations for routes of administration; others should be specified in full:

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<td>S/L</td>
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<td>Inhaled</td>
<td>Inh</td>
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<tr>
<td>Nebulised</td>
<td>Neb</td>
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<tr>
<td>Naso-gastric Tube</td>
<td>NG</td>
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<tr>
<td>Naso-jejunal Tube</td>
<td>NJ</td>
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<td>Rectal</td>
<td>PR</td>
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<tr>
<td>Topical (please specify e.g. Right Eye)</td>
<td>TOP</td>
</tr>
<tr>
<td>Intra-venous injection</td>
<td>IV</td>
</tr>
<tr>
<td>Intra-muscular injection</td>
<td>IM</td>
</tr>
<tr>
<td>Sub-cutaneous injection</td>
<td>SC</td>
</tr>
</tbody>
</table>

Prescribing PO/IV is only acceptable where the relative IV and PO potencies are known by the prescriber to be equivalent.

Clearly express the frequency of administration required. Times of administration may be indicated, if so ensure these correspond to the frequency prescribed.

Acceptable Latin abbreviations are listed in the BNF; note, however, that abbreviations may be used differently by prescribers from other countries, e.g. QD is used for ‘daily’ in USA.

The indication, minimum dose interval and maximum total daily dose for `prn’ medicines should be indicated.

The abbreviation for ‘hourly’ (o) has great potential for confusion with a zero and must be avoided.

Express an intended duration of therapy where appropriate, eg all antibiotic courses, corticosteroid courses.

In most cases the anticipated duration of antibiotic should be noted when the prescription is written. Changes to the duration of treatment must be noted on the drug chart when moving to oral treatment from IV i.e. after 2 days IV of a 7 day course, the new oral prescription should have a 5 day review.

If the patient's treatment is to be modified (e.g. change of dose, route or frequency) this MUST be done by re-writing the prescription, e.g. IV crossed through and amended to PO is not acceptable.

Prescriptions must be checked against any allergies or sensitivities to avoid adverse reactions.

Medicines that have been cancelled must be clearly indicated by drawing a line across the drug details and the remainder of the drug administration record - this must be initialled and dated.
Prescriptions should be written in full to avoid possible errors or confusion due to unfamiliarity of abbreviations. The following are to be avoided:

- Abbreviations such as μg (micrograms), u (units).
- Abbreviation of drug names e.g. AZT could be Azathioprine or Azidothymidine, ASA could be acetylsalicylic acid (aspirin) or Aminosalicylic acid (mesalazine).
- Chemical formulae.

Prescribing is reviewed on a continuous basis by pharmacists on daily visits to wards and at the point of dispensing. The Pharmacist may amend the prescription at any time for the purpose of clarification to assist safe administration, e.g. endorse the approved name (or proprietary name) as appropriate, clarify the dose or duration following confirmation with prescriber or patient's notes, clarify the site of injection or rate etc. The only exceptions to daily ward visits are maternity and day case as these are deemed to be low risk areas for medicine related issues. Where complex cases do arise or advice is needed, a referral can be made to an appropriate Pharmacist.

Authorised prescribers must not permit other staff to write up or rewrite prescription charts. Responsibility for prescriptions rests with the authorised prescriber and cannot be delegated. The only exception is for 5th year medical students, who as part of their training, are authorised to transcribe medication on to a DPAR under the direct supervision of a medical doctor who is involved in the care of that patient. The supervising doctor must thoroughly check the prescription before signing each drug entry.

3.1.1 Medicines Reconciliation
Medicines reconciliation is a process designed to ensure that all medication a patient is currently taking is correctly documented on admission and at each transfer of care. It encompasses:

- Collection of the medication history from a variety of sources (usually a minimum of two)
- Checking that medicines prescribed on admission for the patient are correct. The ‘checking’ step involves ensuring that the medicines and doses that are now prescribed for the patient accurately reflect the sources consulted. Discrepancies may be identified at this stage and these may be intentional or unintentional.
- Communicating any changes in medicines so that they are readily available to the next person(s) caring for the patient. Communication must include reasons for the change(s) and any follow-up requirements. Although the process and outcomes may be verbally discussed with other members of the healthcare team there must also be a written record in the patient’s medical record and/or on the prescription chart.

See separate Policy for Medicines Reconciliation in Adults

3.1.2 Enabling Protocol – IV to oral antimicrobial switching
An enabling protocol authorises pharmacists to amend prescriptions in the following circumstances,:
• Adult patients, excluding patients in ED, critical care areas and haematology / oncology (where the patient has mucositis).
• Patient is able to take the antibiotic orally.
• Patient is prescribed:
  o Fluconazole
  o Levofoxacin
  o Linezolid
  o Metronidazole

When enacting this switch the pharmacist will:
• Rewrite the prescription for oral drugs to commence in 24 hours’ time.
• Cross through the administration record of the IV prescription in 24 hours’ time to avoid duplication of administration
• Document the changes in the medical notes
• Annotate the prescription chart to communicate the change has been made in line with Trust policy.

3.2 Outpatient (OP) and Discharge (TTA) Prescriptions

See also Controlled Drugs – Section 12

Outpatient prescriptions will normally be written on Lloyds Pharmacy hospital outpatient prescription form, unless the patient is being seen in a satellite clinic; in these cases, prescriptions may be written on FP10HNC forms.

Use of FP10 prescriptions
FP10 prescriptions must not be used to prescribe non-formulary medicines or issued to in-patients upon discharge (except in emergency situations).
Prescriptions pads will only be issued to areas approved by the MUAC to hold FP10 prescriptions.
FP10 prescriptions are controlled stationary and as such there needs to be a full audit trail from receipt to patient.
Pads must be stored securely in a locked cupboard and the keys held by the member of staff in charge in the area (or delegated to an appropriate individual).
A tracking sheet is issued with each pad and must be completed to account for every prescription issued.
The tracking sheet must be checked against the prescription number when the pad is issued and returned, if any scripts are missing enter the details onto datix and notify the Pharmacy Governance Technician or Director of Pharmacy.

Ordering further supplies of FP10s
New pads will be supplied by pharmacy upon receipt of a completed tracking sheet and an order form.

Monitoring of FP10 prescriptions.
Individual clinical areas are responsible for ensuring the tracking sheets are completed appropriately.
The pharmacy department will monitor the use of the tracking sheets and store completed documents for 2 years.
The pharmacy department will review e-PACT data on a monthly basis to ensure the appropriate use of FP10 prescriptions. Any concerns will be escalated as appropriate.
Discharge Medication
Medicines to be taken on discharge must be prescribed on an e-discharge proforma accessed via Corporate Services secure IT system or, where the system is not available, on handwritten multi-part discharge summary sheet, which forms the basis of accurate and timely communication with primary care. Prescribers must ensure that all handwritten copies are legible. One medicine only must be prescribed on each line of the prescription section of this form in the interest of clarity and safety; a second form must be used if the number of medicines required exceeds the number of lines.

The use of the copies is as follows:

- One copy is retained in the Pharmacy department. In the case of Controlled Drugs, this copy must also have the prescribers original signature.
- One copy is retained in the patient’s hospital notes.
- One copy is sent to the patient’s general practitioner.
- The patient for emergency use, if necessary, by health professionals, retains one copy.
- For e-discharge prescriptions, there is also a copy for the patient’s community Pharmacy listing medication on discharge.

Hospital attendance for medicinal treatment in some specialist units, e.g. oncology, haematology or paediatrics, may involve frequent and complex prescribing on an inpatient, day case and/or outpatient basis. These units may use specialist prescription documentation, which has been approved by the Health Records Committee, but the requirements set out below still apply. The same applies to systems being developed for electronic prescribing.

All prescriptions for medicines to be supplied directly to patients’ leaving Trust premises MUST:

- Clearly indicate the patient’s name, address, hospital number and/or NHS Number, date of birth (or age), responsible clinician, and current ward/unit/outpatient department.
- The patient’s weight (and date weighed) and height (or body surface area) should be included where this information is needed to calculate dosage.

All prescriptions for Prescription Only Medicines and Controlled Drugs must comply with all relevant legal requirements. Refer to the current BNF for guidance - or discuss with a pharmacist.

All prescriptions must have the prescriber’s original signature (either electronic or handwritten), date and contact telephone number or pager number. The latter is important if there is a query regarding the prescription; these may arise some hours or days after the prescription is written and from pharmacists or doctors outside the Trust in the case of FP10HNC forms.

The patient will normally be given 28 days supply of those medicines intended for chronic therapy. When a shorter / specific “course” of a drug is required the full duration will be provided (e.g. antibiotics, steroids etc.).
New supplies of medicines will not usually be made where patients have sufficient supplies of long-term medicines at home and no changes to their medicines have been made during their stay in hospital.

Under these circumstances it is not necessary for the discharging doctor to complete a full discharge prescription – an appropriate annotation will be made to the e-discharge TTA by the prescriber.

In wards where a one-stop dispensing for discharge scheme is in operation, 28 days is issued on admission and a further supply of 28 days is issued if the remaining supply is 14 days or less at the time of discharge. The prescriber must indicate the duration of treatment if short, specific or variable dose treatment is intended e.g. antibiotics or corticosteroids.

If a referral is made for a district nurse to administer medication at home a Community Prescription Chart (COM 65 form) must be completed by the prescriber and given to the patient to allow the district nurse to administer the prescribed medication.

### 3.2.1 Procedure for issuing TTA Packs

This procedure is to be followed where TTA packs are issued:
- To complete discharge supplies by members of the pharmacy department
- To patients from clinical areas when pharmacy is closed
- In selected departments which have been authorised to use TTA packs during normal Pharmacy business hours.

For nurses, assistant practitioners (APs) or operating department practitioners (ODPs) to undertake the issue of TTA packs they must have completed the training programme available from the pharmacy department.

This procedure does not apply to the issue of medication within a Patient Group Direction (PGD). In this case the specific PGD should be followed. N.B. APs and ODPs can issue TTA packs to a patient in accordance with their discharge prescription, but they cannot legally issue medications using a PGD.

### TTA Packs

Supplies of medicines issued to patients must fulfil legal labelling requirements, therefore if no suitable TTA pack is available supply cannot be made from the ward and the TTA should be forwarded to pharmacy. It is prohibited to issue medicines loose without appropriate packaging and labelling, i.e. loose in an envelope.

For the Emergency Department, Surgical Assessment Unit or Paediatric Assessment Unit, when a medicine is required that is not available as a TTA pack and there is no alternative, it may be prescribed on a FP10HNC form.

An agreed limited range of TTA packs appropriate for a specific clinical area will be supplied as stock by the pharmacy department. The range and stock levels will be reviewed regularly by the appropriate pharmacist/pharmacy technician.

### Storage

TTA Packs will be kept in a locked cupboard separate from other ward/clinic stock.

### Writing prescriptions for TTA packs
A prescription must be written in advance of any TTA packs being dispensed. All prescriptions must be written and signed (electronically for e-discharge) by the prescriber on either the e-discharge system or an outpatient prescription form or the appropriate medications must be signed on an agreed pre-printed discharge form.

The prescription must include the following patient details:
- Patient’s name
- Hospital number
- Date of birth/age
- Weight if the prescription is for a child
- Address

The prescriber should ensure that the wording of the prescription is compatible with the label on the required TTA pack and should include the following drug details:
- Drug name – the approved generic name must be used except for combination products (e.g. contraceptive pill)
- Dose
- Frequency and whether PRN dosing is intended
- Length of course if appropriate (e.g. for antibiotics)

**Dispensing TTA packs on the ward**
The person dispensing the TTA pack must check that the dose prescribed is appropriate, using either the BNF, BNF-C or approved local guidelines. Pharmacy technicians must get the TTA clinically screened by a pharmacist before TTA packs are given to the patient.

Before dispensing the TTA packs checks must be made to ensure that:
- The patient requires each item
- The patient is not allergic to any of the medication (refer back to the prescriber if concerned)
- The medication is appropriate to be taken with the patient’s existing medication (e.g. avoid duplication of paracetamol containing products or NSAIDs).

The TTA pack will contain standard information (i.e. drug name, form, strength, dose and frequency). Before being given to the patient it will require the addition of the following details:
- Patient’s name
- Date
- If the directions contain blanks the quantity to be taken, e.g. number of tablets/volume of liquid), frequency and/or duration

This additional information will be added to the TTA pack by a pharmacist, pharmacy technician, doctor, registered nurse, assistant practitioner (AP) or operating department practitioner (ODP) who has completed the training program provided by the pharmacy department.

The manager of the ward or clinical area will hold a list of signatures of the nurses, APs and ODPs from that area who have completed the training program.

Medicines must not be transferred from their original pre-pack to any other container. The quantity in the pack must not be altered.
The label must not be altered in any way other than the addition of any missing information. Liquid antibiotics must be reconstituted as per manufacturer instructions using sterile water. A click-loc lid and expiry date must be added to the bottle.

The person dispensing the TTA packs must annotate the TTA prescription with the quantity and strength supplied and “TTA”. Also sign and date in the “dispensed by” space on the prescription.

**Checking the TTA pack dispensing**

If a pharmacist or doctor has dispensed the TTA pack, they are authorised to supply them to the patient without obtaining a second check. However, it is good practice to obtain a second check whenever possible.

If a pharmacy technician, nurse, AP or ODP has dispensed the TTA pack a second check must be obtained to ensure that:
- The dose prescribed is appropriate
- The TTA pack selected contains the medication specified by the prescription
- The label complies with the prescription and has been fully completed
- The quantity supplied is appropriate

An accredited pharmacy checking technician may perform the second check provided the prescription has been clinically screened by a pharmacist or a pharmacist may provide the second check.

A registered nurse or a registered ODP who has completed the training program may perform the second check for TTA packs dispensed by:
- a pharmacist
- a doctor
- a nurse, ODP or AP who has completed the training program.

The person performing the second check must sign the prescription in the checked by box.

The items should then be placed in a TTA bag, with any other medication required, labelled with the patients name.

If a TTA prescription is completed by a nurse, ODP or doctor, the pharmacy copy must be retained and given to the ward pharmacy staff on their next visit.

**Supply to the patient**

When the TTA is given to the patient (or patient’s carer/parent) they must be counselled about the purpose of the medication and how it should be taken.

The training pack for each clinical area will include information about any other checks or counselling required for each TTA pack stocked in that area.

It is the responsibility of the nurse, pharmacist or pharmacy technician handing the TTA to the patient to ensure that all appropriate counselling or checks take place.

**Re-supply of TTA Packs**

The stock levels TTA packs will be monitored by a member of pharmacy who will top up the packs as and when required.
3.3 Prescribing for Self / Family

All authorised prescribers and their families are encouraged to register with a general practitioner and/or relevant NHS clinic (e.g. family planning) in order to obtain the medicines they require. Any medicines required as a result of their work in the Trust (e.g. needle-stick injury prophylaxis) will be provided through the Occupational Health arrangements applying to all staff.

It is forbidden for any staff member to “help themselves” to medicines, either for personal use or for passing onto family or friends.

It is forbidden for any staff member to use Trust prescription forms (Outpatient, FP10HNC, DPAR or Discharge Medication forms) in order to obtain medicines for themselves or their families.

A limited supply of medicine(s) can be supplied to medical staff to treat an acute episode of illness occurring whilst on duty, if prescribed on a Trust OP prescription by a fully registered Trust medical practitioner colleague; this can be dispensed in the Pharmacy department with normal NHS prescription charges applying.

Prescriptions for psychotropic drugs or Controlled Drugs will not be dispensed under this arrangement.

Alternatively, staff should present / register with the Emergency Department or when simple / over the counter remedies are required these can be purchased from the on-site community pharmacy.

In each of the above circumstances it is the responsibility of the “patient” member of staff to report the receipt of the medicine(s) to their general practitioner.

1.4 Patient Group Directions (PGDs)

A PGD is a written instruction which authorises the supply and/or administration of a licensed medicine, without a prescription, to a group of patients who may not be individually identified before presentation or treatment.

A PGD permits a single administration / supply and must not be used for repeat administrations / supplies.

PGDs will be reviewed and authorised for use by the Medicines Utilisation and Assurance Committee, in line with best practice (as defined by NICE guideline – MPG2).

Before a health care professional supplies or administers a medicine under a PGD they must have completed the e-learning package and signed the relevant PGD signature sheet to which they are working.

Unit or Ward managers are responsible for:
Maintaining a list of authorised users, which must remain available for inspection at any time.
Ensuring all PGD(s) reflect best practice
Ensuring only the latest versions are available for staff
4 Supply of Medicines to Wards and Departments

The Pharmacy department is responsible for the procurement/acquisition, receipt and storage of all medicines supplied from external suppliers prior to issue to the point of use. The only exception is for some of the specialised medicinal products, e.g. radiopharmaceuticals, blood fraction products.

Wards, clinics, departments or individual members of staff must not order medicines directly from manufacturers / suppliers.

4.1 Ordering Medicines for Use/Administration on Wards/ Departments

There is a basic stock list for each ward/department that defines the range of stock held. This will comprise the minimum required to meet reasonable demand for the selected products, with regard to their storage requirements, and agreed by the pharmacist, appointed nurse in charge and appropriate senior medical staff. Certain medicines may be restricted to specific clinical areas e.g. concentrated potassium injections in accordance with local or national policy.

The Hospital Pharmacy must supply all stock medicines that are used in wards/departments.

- Wards, Theatres and specified departments medicinal supplies will be topped up to the agreed levels by the Pharmacy department weekly or twice weekly depending on the level of usage. For all other areas:
- the ordering of stock drugs is the responsibility of the appointed nurse in charge but may be delegated to another registered nurse, or medical practitioner (e.g. anaesthetist) or to an Operating Department Assistant (ODA) or Operating Department Practitioner (ODP). In the Operating Department, ordering will be centralised and medicines must be promptly distributed to individual theatres.
- Medicines will normally be issued to wards and departments in tamper-evident sealed containers and delivered to the ward by the Pharmacy porter(s); in the case of bulk products, such as parenteral fluids a sealed container is not practical. Pharmacy staff delivering medicines must inform a member of nursing staff that a delivery has been made. Identified member of staff may collect from the Pharmacy after prior arrangement and upon presentation of a Trusts identification badge.
- Non-stock medicines are obtained as required either during the Ward Pharmacist's or Pharmacy Technician's visit; or, direct from the Pharmacy, by sending the Drug Prescription and Administration Record (DPAR) to the dispensary together with a non-stock requisition request slip. There are separate and specialised arrangements for ordering Controlled Drugs (see Controlled Drugs section), Parenteral Nutrition, Intravenous and Intrathecal Cytotoxic preparations.
• Medicines Management systems are in place on some wards and to varying degrees involve the use of Patients' Own Drugs (PODs), Self-administration of medicines, dispensing medicines ready for discharge (One-Stop supply) and/or use of stock medicines for individual patients. These systems are subject to separate procedures (see Medicines Management section) but the principles remain the same.

• The Pharmacy computer system records all issues from the Pharmacy to wards and departments.

4.2 Medicines Management

Systems have been introduced into some clinical areas that utilise pharmacists and pharmacy technicians to assess the medicines requirements of patients. This involves checking the identity, availability and suitability of using the Patients' Own Drugs (PODs), arranging the supply of any medicines needed for their inpatient stay only and, wherever possible, any medicines that may be needed when the patient is discharged from the hospital (One-Stop supply).

In clinical areas where this system is in place, each patient bed will be supplied with a specific locker for use with that patient. This locker can be used for the storage of all medicines prescribed and supplied for that patient and deemed to be suitable for use after assessment. These lockers must not be used for the storage of any other items. Prior to discharge, the medicines will be assessed for continued suitability against the discharge prescription and sufficient quantities will be provided to ensure that at least 2 weeks treatment is available for those items that are used regularly. The keys for these patient lockers are held by the Registered Nurse looking after the patients along with the medicine trolley that may be needed for stock medicines.

4.3 Obtaining medicines for in-patients when Pharmacy is closed (excluding schedule 2 & 3 controlled drugs – see section 12.3.14)

All supplies of medicines are to be ordered from the Pharmacy in a timely manner. Should it be necessary to obtain medicines outside of the Pharmacy’s opening hours then these can be obtained from the pharmacy emergency cupboard located on level 5 or by “borrowing” from a neighbouring ward. If the required medicine can not be obtained by either of these two routes then the on-call pharmacist must be called.

A flow diagram is available on all wards to aid the location of medicines out of hours.

The following process must be used.

Step 1 Confirm if the item is routinely stocked on the ward/unit or if it has already been supplied for the patient. Always double check stock cupboards, trolleys, fridge, unopened pharmacy deliveries, treatment room and individual patient drug locker. Check any previous wards the patient has been on and confirm if the patient has brought in any of their own supply; if still unavailable proceed to step 2:

Step 2 Ascertain if the medicine is kept in the Pharmacy Emergency Cupboard. An up to date list of available medicines is available on the Pharmacy website (on Healthnet under departments) and by the night co-ordinator. Contact the night co-ordinator if access to the emergency cupboard is required. If a medicine is still unavailable proceed to step 3:
**Step 3** Ascertain if the medicine is kept as stock on another ward. This can be checked by accessing the pharmacy IT system - Ascribe (details available on the Pharmacy website). If it is, contact the other ward to arrange a supply. Proof of the clinical need for the drug (i.e. a valid prescription) and identification (hospital ID card) must be produced when borrowing any medicine. Borrow only the minimum required and contact pharmacy for further supplies as soon as possible.

If the drug is on the **restricted list** of medicines below, a record must be made on a dedicated page at the rear of the controlled drugs register of the lending ward documenting the following:

- Date
- Medicine, form and strength that is being borrowed
- Quantity borrowed
- For which patient
- Ward borrowing
- Countersigned by both the nurse lending and the nurse borrowing the medicine.

A record of the receipt of the borrowed drug must be entered on a dedicated page at the rear of the controlled drugs register of the receiving ward documenting the following:

- Date
- Medicine, form and strength that has been borrowed
- Quantity borrowed
- For which patient
- Ward lending
- Countersigned by both the nurse borrowing and the nurse receiving the medicine/nurse in charge.

The borrowing records for each ward will be reviewed every three months as part of the routine CD audits.

**Borrowing restricted list**

<table>
<thead>
<tr>
<th>Schedule 4 Controlled Drugs</th>
<th>All benzodiazepines:</th>
<th>Anabolic steroids:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlordiazepoxide</td>
<td>Somatropin</td>
</tr>
<tr>
<td></td>
<td>Clonazepam</td>
<td>Stanozolol</td>
</tr>
<tr>
<td></td>
<td>Clobazam</td>
<td>Oxymetholone</td>
</tr>
<tr>
<td></td>
<td>Diazepam</td>
<td>Testosterone propionate injection (Sustanon®)</td>
</tr>
<tr>
<td></td>
<td>Flurazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lorazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loprazolam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lormetazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nitrazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxazepam</td>
<td></td>
</tr>
</tbody>
</table>

| Schedule 5 Controlled Drugs | | |
|-----------------------------|-------------------|
|                             | Migraleve®        | Co-dydramol       |
|                             | Co-phenotrope (Lomotil®) | Co-codamol (8/500 & 30/500) |
|                             |                   |                   |
|                             | Codeine            |                   |
|                             | Dihydrocodeine     |                   |
|                             | Morphine Sulphate solution (10ml/5ml) Oramorph® | |
|                             |                   |                   |

<table>
<thead>
<tr>
<th>Other</th>
<th>Zopiclone</th>
<th>Zolpidem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sildenafil</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cyclizine</td>
</tr>
</tbody>
</table>
**Step 4** If the medicine is still unavailable, bleep the on-call Pharmacist via the night co-ordinator Bleep 355 (17.30 – 20.00 & Weekends 08.00 – 20.00) or Hospital @ Night (Between 20:00 – 08:00).

See section 12.3.14 for the emergency transfer of stock of schedule 2 & 3 controlled drugs from one ward to another.

### 5 Supply of Outpatient or Discharge Medication

#### 5.1 Outpatients, Accident & Emergency Attendees, Day Case Patients

Issues will only be made on receipt of a suitable prescription by an authorised prescriber.

In all cases, the correct identity of the patient will be established before issue of dispensed medicines to the patient or their representative. In cases of doubt, Pharmacy staff may seek confirmation of identity. In the case of Controlled Drugs the identity must be recorded. See Section 12

Medicines will be supplied in a suitable container along with a patient information leaflet.

A limited range of suitably labelled patient packs for routine short-term or symptomatic treatment (TTA packs) may be provided for direct issue by specific unit medical or nursing staff either in accordance with a prescription or a Patient Group Direction (P.G.D.) – see separate section.

#### 5.2 Discharge Medication (TTAs)

Discharge prescriptions are to be written electronically, using the e-discharge system. The patients DPAR must be sent to Pharmacy where the discharge prescription will be clinically checked by a pharmacist against the inpatient DPAR, including the patient’s allergy and drug sensitivity status.

All medicines supplied to the patient and any of the patients own drugs must be returned to pharmacy for checking by a pharmacist or accredited checking technician before resupplying to the patient on discharge.

If the discharge prescription was sent to Pharmacy to be processed, the dispensed medication will be securely returned to the ward on a Pharmacy porter round and given to a Registered Nurse.

In wards and units utilising the Medicines Management systems, medicines for the discharge prescription(s) may be available on the wards as Patient’s Own Drugs or One-Stop supply. A pharmacist or suitably qualified pharmacy technician must check these products in order to ensure accurate, appropriate and sufficient continuation and/or short-term symptomatic treatment.

A limited range of suitably labelled patient packs for routine short-term or symptomatic treatment (TTA packs) may be provided (see below) for direct issue by specific unit medical or nursing staff either in accordance with a prescription or a Patient Group Direction (P.G.D.) – see separate procedure.
Under no circumstances must loose tablets, capsules etc be placed in envelopes or similar packaging and be given to a patient / relative.

In all cases, the correct identity of the patient will be established before issue of dispensed medicines to the patient or their representative.

Patients or their representative will be provided with relevant information regarding their medicines and will be counselled regarding their correct use by the member of staff discharging the patient.

To safeguard against patients returning home without their TTAs a daily check must be completed on each ward and unit using the template in appendix 4. If a critical medicine TTA is identified (see section 9.2.1.5 for critical medicine list) the following actions must be completed:
1. Attempt to contact patient
2. If unable to contact patient, inform GP
3. Return TTA’s to pharmacy with note informing pharmacy of actions taken.
4. Complete Datix form

5.3 Assessment and Provision of Monitored Dosage Systems (MDS)

MDS systems can be used for patients with poor compliance. However other aids for compliance may be more suitable and careful review of the patient is important before initiating MDS.

5.3.1 Continuation of an MDS Brought into Hospital by a Patient

- Ward Pharmacist must endorse on the front of the prescription chart that the patient is on an MDS and record the details of who fills the device in the medicines reconciliation section of the prescription chart.
- Ward Pharmacist should ascertain who fills the MDS and if the present system is satisfactory.
- If the patient has been admitted from a nursing home or residential care home and are being discharged back to them, we do not dispense their medication in an MDS as staff are trained and competent to administer medicines.

If Patient or Relative fills the MDS:
For example Dosettes, Medidoses, or seven-day pill reminders. If this is the case the Ward Pharmacist may arrange for either:
- The system to be filled and labelled as a TTA to ensure continuation of supply, along with a minimum of 7 further days supply dispensed in original packs/normal containers;
- Or the medicines to be dispensed in original packs/normal containers and the MDS to be filled by the patient or relative.
- And a compliance card to help the patient or relative to fill the MDS

If the Community Pharmacist fills the MDS:
For example Venalink/Nomad systems or Dosettes. In this case, the following procedure should be followed:
- Ward to give pharmacy at least ONE working day notice of discharge.
- Ward Pharmacist to inform Community Pharmacist and GP of intended discharge to insure continued supply
• The hospital pharmacy will supply sufficient medication in a monitored dosage system until the community pharmacy can continue the supply. (Maximum two weeks)

5.3.2 Starting a New MDS in Hospital
• The Ward Pharmacist must be involved in any decision about starting a new MDS. Pharmacy needs at least 24 hours notice to assess a patient.
• Pharmacy Procedure for Starting a New MDS
  • Assess the patient to see if an MDS would be appropriate for them (see SOP DIS530 – Filling of monitored dose systems)
  • If a Community Pharmacist is to refill the monitored dosage system, phone them to confirm they are willing to continue supply and fax them a copy of the patient’s discharge prescription
  • Fax a copy of the patient’s prescription to the GP and inform the GP of the name of the Community Pharmacy who will continue the MDS
  • Place a copy of the assessment form in the patient’s notes.

6 Receipt and Storage of Medicines in Wards and Departments

See also Controlled Drugs – Section 12

The receipt and storage of stock drugs is the responsibility of the Nurse in Charge but may be delegated to a registered nurse or a designated person.

On receipt of all medicines, a registered nurse should check the contents and transfer them to appropriate storage at the earliest opportunity, as shown below. Any discrepancies must be notified to the Pharmacy department immediately. Ensuring fridge items are stored appropriately immediately upon receipt.

Receipt of bags or syringes of medication for epidural infusion will require an ODP, nurse or midwife to sign Pharmacy form DISP29 to confirm that they have put this stock away in the storage place assigned for epidural products to avoid them being mixed up with intravenous infusions. This is in accordance with the Trust policy arising from NPSA Alert 21 – ‘Safer practice with epidural injections & infusions’.

In the case of medicines dispensed for individual patients, the registered nurse should ensure these are transferred to the appropriate medicines trolley, approved patient medicines cabinet or refrigerator at the earliest opportunity. N.B. Special arrangements are required for hazardous material such as injectable cytotoxic preparations.

All medicines belonging to, or having been dispensed for, the patient should be stored in the patient’s own drugs (POD) locker, with the following exceptions;
  • Controlled drugs
  • Medicines which require storage in a refrigerator or freezer
  • Medicines which may be needed urgently, e.g. reliever inhalers, GTN sprays – these may be stored at the bedside, but should be out of sight of other patients.

The POD locker must be checked when a patient leaves the bed space, e.g. is discharged or transferred to another ward
Where a Pharmacy topping-up or medicines management service is in operation the nurse in charge retains responsibility for receipt and storage of drugs.

Any medicines kept in a ward or department of a hospital or clinic must be stored in a locked cupboard, locked refrigerator or locked medicine trolley. The security level required for the medicine cupboards will vary depending on the siting; level 1 is suitable for permanently manned clinical units, whereas level 3 may be required for units or clinics that may not be manned for one or more days. All medicine trolleys must be secured to an immovable fixing whenever not in use for medicines administration purposes. No other substances or articles, e.g. staff food and drinks or pathology specimens, may be stored in these places. With the exception of bulk fluids and intubation kits, all medicines must be stored in their original containers, i.e. not stored as loose blisters of tablets or loose ampoules of injections.

The following different categories of storage cupboard should be used:

- Cupboard for Controlled Drugs (see Controlled Drugs Section).
- Cupboard for Internal Medicines.
- Cupboard for External Medicines and Reagents.
- Lockable refrigerator/freezer for Internal or External Medicines marked for refrigeration.
- Disinfectants or antiseptics for topical use may be stored either in a separate cupboard, or in a separate section of the cupboard for external medicines.
- Cupboard for flammable liquids

The following are exempt from the above, although attention should be paid to the security and safe storage of these items and where possible they should be out of sight of the general public.

- Medicines required for immediate use in emergencies, i.e. cardiac arrest, resuscitation or emergency anaesthesia.
- Ampoules of sodium chloride 0.9% and water for injection, Intravenous infusion fluids and sterilised bulk topical fluids.
- Non-Pharmaceutical items, i.e. sip/NG feeds, dressings, emollients (aqueous cream, chap-sticks etc)
- Medical gases

Medicine storage audits are carried out by Pharmacy on a rolling 3 monthly basis on all wards, departments and clinics (on-site and off-site) that routinely hold medicines in accordance with SOP D35. If existing wards or departments undergo refurbishment or relocation or a new clinical area is built requiring the installation of medicine storage lockers, the Director of Pharmacy (or his deputy), must be informed to ensure the medicine storage facilities meet the required standards.

The Nurse in Charge shall be responsible for controlling access (by keys or other means) to the cupboards and trolleys.

The responsibility remains with the Nurse in Charge even if he/she decides to delegate the duty to another member of staff.

Keys to the Controlled Drugs cupboards must be kept on a separate key ring and must be held by the registered nurse in charge.
All staff handling medicines must be security conscious:

- Anyone discovering an apparent loss of medicines, a medicine cupboard that has been tampered with, or suspecting misuse of medicines, must report the matter at once to the Nurse in Charge. **Pre-existing records must not be altered in order to reconcile the apparent loss.**

- The Nurse in Charge must notify the Ward Manager, Night Co-ordinator or Modern Matron for the clinical area, as appropriate, who will investigate the apparent loss as soon as possible. A Trust Incident Form must be completed when a loss is confirmed. The nurse manager involved must assess whether the loss is due to error or whether a criminal offence has occurred. In the latter case, in consultation with the Director of Pharmacy (or his deputy) and Legal Affairs/Security, the matter should be reported to the police.

**6.1 Expiry date checking of ward medicines**

Date checking of ward stock will be undertaken by pharmacy top-up staff on a regular basis, although this will not include medicines stored in the CD cupboard. Registered nurses are responsible for ensuring that medicines stored in the CD cupboard are date checked as part of the regular CD cupboard checks.

Liquid medicines have a shorter shelf life once opened. Registered nurses must record the date a bottle is opened using the date of opening/expiry date labels provided. These stickers must be placed directly on to the bottle.

All expired medicines will be removed immediately and returned to pharmacy for destruction.

It is the responsibility of all staff administering medicines to check the expiry date of the medicine immediately prior to giving it to a patient.

**6.2 Storage of Products in Refrigerators and Freezers**

- Medicines are not to be stored together with food or pathological specimens, but in a separate locked fridge/freezer. Medicines requiring storage below room temperature will be marked: "Store between 2ºC and 8ºC, in a refrigerator", or "Store below -10ºC, in a freezer".

- The ward kitchen refrigerator should never be used for the storage of medicines.

- Total Parenteral Nutrition (TPN) should be stored between 2 and 8 degrees. Ideally it should be kept in an appropriate medical fridge which is properly monitored and with an alarm system. (The exception is for adult TPN bags with no additives (vitamins/minerals) which are stored at room temperature.)

- Oral food supplements (e.g. drink cartons such as Fortisip) may be stored in the ward kitchen fridge.

- Where medicines are intended for storage in a fridge they should be kept well away from the exposed elements and NEVER placed in the freezer compartment.

- Fridge temperature should be monitored by nursing/department staff every 24 hours and the temperature recorded on the Trust wide online Temperature Monitoring Database – see below
• Ensure all refrigerators used for storing medicines are of Pharmaceutical Grade and meet the MHRA guidelines on ‘Control and Monitoring of Storage and Transportation Temperatures of Medicinal Products’ i.e.
  • Maintain an air temperature of 2-8 °C with the minimum of intervention.
  • Are not sited in an environment where extremes of temperature (<10 °C or >32°C) will affect their performance.
  • In secure locations
  • Allow sufficient space to be maintained between the goods and the internal surfaces to allow adequate air flow i.e. is the fridge large enough for the wards needs?

6.2.1 Temperature Monitoring of Refrigerators and Freezers

The registered nurse in charge is responsible for ensuring that refrigerator and freezer temperature monitoring is carried out and recorded on a daily basis. It is recommended that this monitoring is carried out at the same time as the daily CD stock check.

The temperature displayed on the front of each refrigerator, or freezer, should be recorded on the temperature monitoring database (http://temperaturemonitoring/).

1. Select the correct location and fridge/freezer
2. Enter the current temperature.
3. If there is a thermometer inside the fridge/freezer which gives a minimum and maximum temperature then this should also be recorded.
4. Reset the thermometer after the temperatures have been recorded and tick the Thermostat Reset box.
5. If the temperature displayed is outside of the normal temperature range the database will prompt you to document any actions taken.
6. Once all required information is present click on ‘+ Add’
   If the temperature is found to be outside of the normal range at any other time, or if the fridge/freezer is alarming then the temperature displayed must be recorded on the database along with corrective actions taken.

What to do if a refrigerator is not working correctly

Temperature less than 2 °C

• Check the temperature again.
• If the temperature of the fridge is less than 2 °C the fridge may not be working correctly.

Temperatures greater than 8 °C

It is normal for a fridge temperature to rise above 8 °C when the door is opened to access the contents. Do not panic at this point…..

• If the temperature of the fridge is recorded as 9 °C or greater recheck the temperature after 15 mins, ensuring the fridge is not opened / accessed during this period of time.
• If the fridge temperature remains greater than 8 °C the fridge may not be working properly.
• The Ward / Department must report the malfunctioning fridge to the Estates / Facilities department immediately for the fridge to be accessed.
• All stock in the malfunctioning fridge must be relocated to an alternative working refrigerator.
• Contact the Pharmacy Quality Control Department (ext: 53428) (or if outside normal hours the on-call Pharmacist via switchboard) for advice regarding the stability / suitability of the medicine.
• Make a note of the deviation
  • e.g. When was the deviation noticed?
  • The temperature range reading on the thermometer
  • Was the fridge temperature too high?
  • Was the fridge temperature too low?
  • According to the daily monitoring form when was the fridge last working correctly?
• Arrange for replacement of urgently required medicines.

6.3 Responsibility for Medication Cupboard / Trolley Keys

See section 12 for CD cupboard keys

The registered nurse or midwife in charge is legally responsible for the medication cupboard / trolley keys.

• Key-holding may be delegated to other suitably trained, healthcare staff (HCAs, +APs or ODPs), but the responsibility rests with the registered nurse or midwife in charge.
• In off-site clinics, where registered nurses are not always present the keys may be held by suitably trained HCA staff, in-line with the policy of the hosting organisation.
• On occasions, for the purpose of stock checking, the keys may be handed to an authorised member of pharmacy staff (e.g. a pharmacist or pharmacy technician).
• In the event of the keys going missing, urgent efforts should be made to retrieve the key as speedily as possible e.g. by contacting the responsible staff members who have just gone off duty. The senior nurse on duty and the ward or on-call pharmacist should be contacted as soon as appropriate if the keys cannot be located in order that suitable arrangements can be made to make sure patient care is not impeded and the security of the medication stocks is maintained.

6.4 Patients’ Own Medicines

Department of Health (DoH) guidance requires that Information Booklets which are issued to patients, (before or on admission), advise patients to bring with them any medicines they may have been taking at the time of admission.

N.B. Medicines dispensed for a patient are the property of that patient and wherever possible must not be retained or destroyed by the hospital.

Medicines brought in by patients cannot be taken back into hospital stock since their quality cannot be guaranteed.

Patient’s own medication can be used if the following criteria are met:
• The packaging is intact and the expiry date has not been passed.
• The label is clearly readable and contains the following information (except for insulin pens which may not be labelled):
  o Name and strength of medication
  o Patient’s name
  o Date dispensed (must be within the last 6 months)
  o Name and address of dispensing chemist or doctor
• The medicines are intact, dry and not broken, they appear to be of good quality and match up with the label.
• Eye drops have been opened less than 4 weeks ago.
• Insulin vials/cartridges/disposable pens have been opened less than 4 weeks ago.
• The packaging contains only those medicines identified on the label.

Patient’s own medications can be checked by the registered nurse responsible for drug administration at ward level, using the above criteria. If there is any doubt, pharmacy staff (ward pharmacist or technician) can be asked to assess the suitability of the medications.

Medicines brought in by patients must never be used for other patients.

See Section 12 for Controlled Drugs brought in by patients.

When a patient is admitted, the Nurse in Charge must ensure that the patient understands the need to tell hospital staff of all medicines he/she is taking or has recently taken. This includes medicines bought over the counter (OTC) and herbal medicines. An accurate record of the patient's medicines should be made in the medical notes by the Doctor.

If the Doctor considers the medicines are no longer indicated, the patient, or their carer, should be encouraged to agree to their destruction in Pharmacy.

Following the death of a patient, medicines held in safe custody should not be returned to relatives but returned to Pharmacy for destruction.

It is the responsibility of all staff to seek immediate advice from the line manager or professional advisor if medicine abuse is suspected.

### 7 Preparation of Medicines for Administration

The Pharmacy department will supply medicines in a ready for use form whenever possible. However, many medicines do require manipulation prior to administration to the patient for reasons of stability, unusual route of administration, dose and rate of administration, patient characteristics or other reasons.

Preparation of doses in accordance with the Summary of Product Characteristics (SPC) will normally be done by the person administering the medicine, at the bedside or in the clean treatment area of the clinical unit, and maintains the licensed status of the product.

Doses of specific medicines are prepared in the Technical Services section of the Pharmacy department because of their hazardous nature (e.g. cytotoxic or products
derived from non-human sources) or the need for strict asepsis (e.g. parenteral nutrition). These are supplied to the clinical unit in ready for use containers.

Manipulation of medicines e.g. crushing tablets, not in accordance with the SPC, is often required when artificial methods of feeding are needed (e.g. NG, NJ, PEG or PEJ feeding) or if there is other patient characteristics (e.g. children) that preclude normal administration. In these cases, the person administering the medicine must be sure of the suitability of the proposed manipulation and consult the pharmacist if there is any doubt. For further information refer to the White and Bradman reference text.

The Trust’s Injectable Drug administration guide together with the product literature must be consulted for the preparation of injectables in order to ensure suitable diluents, concentration, rate of administration and equipment are used. There is restriction to the use of particularly hazardous preparations, e.g. concentrated intravenous Potassium solutions, and the relevant Trust policy must be followed.

### 7.1 Monoclonal Antibodies

Monoclonal Antibodies (MABs) are highly active biological agents which affect wide range of biological functions. Those staff involved in handling them must be aware of potential risks of each individual product.

MABs are not conventional cytotoxic agents and do not damage DNA or RNA but they still cause cell death and may be potentially hazardous to staff. As MABs may contain products of animal origin they must be treated as potential biohazard.

The manipulation and potential hazard to staff posed by each MAB must be individually risk assessed. All MABs assessed as high risk must be prepared in pharmacy aseptic facilities where practical. Products which are to be prepared in aseptic facilities must be segregated from other products using normal levels of process control and validated procedures.

MABs assessed as medium to low risk may be manipulated at ward level. Any staff involved in such manipulation must be aware of potential risks of individual drugs. All staff involved in manipulation of MABs must use personal protection equipment and as a minimum must include gloves, gowns and face masks.

### 8 Personnel Authorised to Administer Medicines

See Section 12 for Controlled Drug Procedures.

The personnel listed below are authorised by the Trust to administer medication (**or a restricted range of medicines) against a valid written prescription. The underlined groups of personnel may also administer medications using patient group directions (PGDs).

- Registered Nurses and Midwives
- Registered Radiographers**
- Registered Operating Department Practitioners
• Registered Medical Officers (Foundation Year 2 – FY2 or above)
• Pre-registration Medical Officers (Foundation Year 1 – FY1)
• Registered Physiotherapists**
• Registered Podiatrists**
• Registered Orthoptists**
• Assistant Practitioners**
• Healthcare assistants**
• Clinical Technologists**

It is the responsibility of line managers to ensure that staff participating in administration of medicines, are competent to do so.

**Practitioners also bear a responsibility to maintain their own competence, and ensure that they decline any tasks that they are not able to undertake in a safe and skilled manner. The essence of the philosophy of “duty of care” must be observed at all times.

8.1 Registered Nurses and Midwives

Registered Nurses and Midwives must be currently registered with the UK Nursing and Midwifery Council, they will practice according to the standards laid down by the NMC. Particular attention will be given to: NMC Standards for Medicines Management (2007) and NMC standards of conduct, performance and ethics for nurses and midwives (2008)

Registered Nurses and Midwives by virtue of their education and qualification and assessment in accordance with Trust policy are deemed competent to administer medicines by the oral, intramuscular, subcutaneous, topical, rectal, vaginal and inhaled routes and to infuse manufacturer prepared standard intravenous fluids and blood products. Appropriately trained and competent registered nurses may also administer medicines in to an implantable pump for intrathecal administration.

In order to administer drugs by the intravenous route authorised personnel, (with the exception of registered medical practitioners), are required to undertake additional IV Training and education as deemed appropriate for the specific professional group to which they belong. In the acute hospital setting, the acquisition of skills in undertaking intravenous administration of medicines should be seen as an essential core development component for all registered nurses and midwives.

Registered Nurses and Midwives will provide evidence to demonstrate theoretical knowledge and practice competency in the administration of intravenous drugs prior to undertaking this role within the Trust. It is the responsibility of line managers to clarify if newly appointed staff possess the relevant knowledge and skills, before they undertake this role. The ward sister will assess whether new employees of the Trust will undertake supervised practice. However, midwives are able to administer (by virtue of their training) oxytocic agents in post partum emergencies and opiate
antagonists in neonatal emergencies (when the mother has been given an opioid and is not a substance misuser).

Registered Nurses and Midwives, following completion of IV training, who have received further education and undertaken supervised practice are authorised to administer patient controlled analgesia (see policy).

Registered Nurses and Midwives who have received further education and undertaken supervised practice are authorised to administer medicines by the epidural route.

The Trust is providing a programme of update training for Registered Nurses and Midwives, covering the correct methods and dangers of administering liquid oral medicines via enteral feeding tubes or devices (see Section 14)

8.1.1 Medicines Used By Midwives

- See section 12 for Supply, possession and use of diamorphine by Midwives
- A midwife in the course of her practice in the community may need to carry antiseptics, analgesics, local anaesthetics, oxytocic preparations and approved agents for neonatal and maternal resuscitation. The particular medicines which a midwife may use will be determined locally in collaboration with the supervisor of midwives and medical and pharmaceutical staff and should be listed in written local policy. A midwife should obtain details from her supervisor of midwives
- When administering medicines in the NHS, midwives must comply with locally agreed Trust policies and procedures. A standing order signed by a consultant registered medical practitioner and a supervisor of midwives authorising the administration of medicines for the use by the midwife exists. The standing order is subject to biannual review by the Supervisor of Midwives, consultant and pharmaceutical staff. These medicines will be similar to those carried by a midwife in her practice in the community.
- All medicines and inhalation analgesia must be recorded in the midwives’ Statutory Register of Cases and the patient's case notes. This record must include name and dosage of drug, time and method of administration or application.
- Supervisors of midwives should periodically audit the records of medicines kept by midwives. Any discrepancies must be investigated.
- In certain circumstances where a patient is cared for in or transferred to a hospital/institution, the community midwife may NOT use her own supply of drugs.
- Drugs obtained by a patient prescribed by her general practitioner are her own property. If no longer required they should not be removed by the midwife, but the woman should be advised to return them to a Pharmacist for destruction

8.1.2 Community Psychiatric Service and Community Child Health (CN’s Employed by this Trust)

Carriage of Medicines

Where the patient's or carer mental state permits, he/she should be encouraged to accept responsibility for the collection and storage of his/her medication. If the patient or carer is ill or poorly motivated, then the Nurse may accept responsibility for collection. This should be documented in the patient’s care plan.
The community Nurse must carry an identification card issued by the Trust, this confers the right to carry medicines.

The only medication to be carried by the community nurses must be that prescribed by the patient's General Practitioner, hospital Specialist, nurse prescriber or Psychiatrist. The medicines so carried must be delivered to the patient (carer) as soon as possible after issue from a Pharmacy (hospital or community).

If medicines are obtained from the hospital Pharmacy as a stock issue, then a record book, detailing all medicines issued to and returned from community nurses, should be maintained at the nursing base. This book should be examined and verified at six monthly intervals by the appropriate Senior Nurse and Pharmacist.

Security of medicines is the responsibility of the Community Nurse carrying them. Nurses are advised that, ideally, medication must be kept and carried in a locked case issued by the Trust. In some circumstances this may not be appropriate, but the Nurse should ensure best possible practice is followed.

The community nurse must accept responsibility for the safety and security of the medication at all times, and should not leave the case unattended.

The case should be kept out of sight when carried in the car.

If the community nurse has occasion to hold the medicines at home, they must be stored in as secure a place as possible.

**Administration of Medicines to Patients**

The Community Nurse/ Health Visitor is administering a medicine that has been dispensed for an individual patient in the community. It is recognised that double-checking of drugs is not feasible. The responsibility lies with the individual Nurse in accordance with NMC guidelines.

The exception is for administration of controlled drugs to children under 16, for which double-checking is mandatory.

When medication to be administered is from stock supplies i.e. it has not been dispensed for a named patient, the Nurse must carry with him/her the patient's prescription and administration record sheet.

The General Practitioner, Hospital Specialist, Psychiatrist, or Nurse Prescriber must provide a full written and signed prescription at the start of treatment and subsequently when changes of medication are made.

The prescriber must regularly review the treatment sheet, at intervals dependant upon the service provided/patient’s care plan.

The Community Nurse must record on the sheet the fact that the medicine has been administered. This also applies if a community nurse administers a medicine to a
patient who has been admitted to a hospital ward, when the hospital prescription sheet should also be signed.

**Patient’s own drugs**

Community Psychiatric Service
- Patient’s own medicines for disposal should be returned to a Pharmacy by the patient or his/ her relatives or carers. The Community Nurse should encourage this practice.
- In exceptional circumstances where there is a clinical indication that current or expired medication owned by the patient, is harming the patient or where serious abuse is threatened, the medicine may be removed by the Community Nurse, taken to a Pharmacy and the appropriate doctor informed immediately.
- **NB:** This does NOT apply when an “illegal substance” is found.

Community Child Health
- Patient’s own medicines for disposal will routinely be brought to the hospital for destruction by the community nurse.

### 8.2 Pre-Registration Student Nurses and Midwives

Pre-registration student nurses and midwives should be encouraged to undertake a role in the administration of medicines in support of a registered nurse or midwife as part of an educational experience.

Any medicines that they administer must be fully checked and their administration supervised by a registered nurse(s)/ midwife(ves). The route of administration of the medicine must fall within the scope of pre-registration nurse education as specified above. All opportunities should be used to encourage learning about the therapeutic benefits and risks of medicines.

### 8.3 Registered Radiographers

Radiographers holding a ‘Statement of Competency for Undertaking New or Extended Clinical Roles’ may administer Contrast Media by the intravenous route, in accordance with local policy. Registered radiographers can also become supplementary prescribers.

### 8.4 Operating Department Practitioners (ODPs)

ODP’s registered with the Health Professionals Council may administer medicines by the following routes:
- oral, rectal, inhalation / nebulisation, topical, intramuscular, subcutaneous.

ODPs who have completed the additional unit in intravenous drug administration may administer by this route.

### 8.5 Medical Officers

Pre-registration (FY 1) and registered medical practitioners, by virtue of their training and qualification, are deemed competent to administer medicines by any route when their competence has been demonstrated, assessed and documented. Specific training is required for high risk routes of administration e.g. Intrathecal or Epidural.
8.6 Registered Physiotherapists

Physiotherapists by virtue of their professional education and registration are deemed competent to administer specified medicines by the topical, oral, subcutaneous, intra-articular or inhalation routes, as governed by their rules of professional conduct and working within agreed local protocols eg Patient group direction. Registered physiotherapists can also become supplementary prescribers.

8.7 Registered Podiatrists

Podiatrists registered with the Healthcare Professions Council (HPC) who are appropriately qualified can administer certain local anaesthetics and supply certain prescription only medicines in the course of their practice. In order to have these entitlements they must have successfully completed training in these areas and have the entitlement marked (“annotated”) on the HPC register. The HPC register indicates where a podiatrist can administer local anesthetic (annotated by LA) or supply prescription only medicines (annotated by POM). Registered podiatrists can also become supplementary prescribers.

8.8 Registered Orthoptists

Orthoptists by virtue of their professional education and registration are deemed competent to administer specified eye drops, as governed by their rules of professional conduct and working within agreed local protocols.

8.9 Assistant Practitioners (APs), Clinical Technologists (CTs) and Health Care Assistants (HCAs)

Appropriately trained and competent Assistant Practitioners (APs) are authorised to administer a range of prescribed medicines to patients. The range of medicines permitted will be authorised by the MUAC after a risk assessment of the requested medicine. All medicines administered by an AP must be double checked by a registered member of staff.

Appropriately trained and competent Clinical Technologists (CTs) are authorised to administer a selected range of medicines and radiopharmaceuticals, and to double-check each other without the involvement of a registered member of staff in accordance with practice detailed in the Nuclear Medicine Department’s protocols.

Health Care assistants with Level 2 qualification are authorised to administer Glycerin suppositories and those with Level 3 are authorised to administer Phosphate enemas under the supervision of a Registered Nurse or Midwife, once the Registered nurse or Midwife, who will sign the record of drug administration, has checked the medicine and patient identity.

Unregistered staff e.g. HCAs and MAs who have received formal training in cannulation are permitted to administer up to 10mls 0.9% Sodium Chloride as a flush to confirm patency of the cannula they have placed.
Unregistered HCAs working within the Acute Care Team, who have received formal training in taking blood specimens from Central Vascular Access Devices and Midline Catheters are permitted to administer up to 10mls 0.9% Sodium Chloride as a flush to clear the catheter lumen of blood following blood sampling.

Sodium chloride 0.9% from ampoules (Prescription-Only-medicine) can only be given against a signed prescription and it must be checked and signed for with a Registered Health Care Professional who is competent at IV drug administration. However, for adult patients, a signed prescription is not required to administer a saline flush using a prefilled syringe of saline licensed as a medical device (eg. PosiFlush®).

8.10 Staff Groups Permitted to Administer Intravenous Drugs

- The administration of any intravenous drugs must only be done under the authorisation of a legal prescription or PGD.
- All Registered Healthcare Professionals can check Intravenous medication, in accordance with their professional registration and in accordance with the information above, but they are prevented from administering this medication unless they have received additional Intravenous Drug Administration training.
- Registered Healthcare Professionals should only administer and check the administration of IV drugs within the specialist area for which they are trained.

Registered Healthcare Professionals

- All registered healthcare professionals must undergo additional training and be assessed as competent before administering ANY IV drug or infusion. Assessors must be clinically competent at giving IV drugs and able to critically assess staff in an objective manner, referring any problems or difficulties to the ward/department manager and/or Learning and Development Facilitator. IV drug administration training is available through the Plymouth Hospitals NHS Trust Preceptorship programme or Workforce and Organisational Development.
- Registered healthcare professionals appointed from outside the Trust, who regularly gave IV drugs in their last post, must do the following:
  - Show evidence of their competence from previous training and evidence of recent up-dating.
  - Read the Plymouth Hospitals NHS Trust IV procedures and all relevant policies relating to IV drugs e.g. Infection Control, Blood Transfusion and change their practice to meet Trust requirements.
  - Attend a Trust IV update session
  - Have their practice observed by their manager or someone nominated by their manager (providing this person is competent at this skill)
  - Complete and sign the IV drug assessment form, a copy of this should be placed on the individual’s personnel record.
- For those registered healthcare professionals appointed from outside the Trust who have not given IV drugs recently or would like to refresh their theoretical knowledge they should contact Learning and Development Facilitator.
- Medication must be administered under the guidance of the individual practitioner’s professional body e.g. NMC. The Code, standards of conduct, performance and ethics for nurses and midwives (2008) and NMC standards for medicines management (2008).

Newly Qualified Registered Healthcare Professionals
- Newly qualified staff will be given IV Drug Administration training if deemed appropriate as part of the Preceptorship programme.

**Registered Healthcare Professionals working for NHS Professionals (NHSP)**
- Registered Healthcare Professionals can check IV drugs if they are familiar with the drug they are checking and the Trust staff are satisfied with the level of understanding of the NHSP staff member.
- NHSP Healthcare Professionals can administer IV drugs if they fulfil the following criteria:
  - They complete the Trust’s IV training (or satisfy the criteria for new staff to the Trust) and have been assessed as competent.
  - They only administer IV drugs that they are familiar with.
  - Permanent employees who are working in their usual workplace, but are paid via NHSP/other agency, and normally administer IV drugs can continue to do so. If they work in another ward/department for the NHSP or agency they should only administer IV drugs with which they are familiar.

**Unregistered Healthcare Staff**
Unregistered staff e.g. HCAs and MAs who have received formal training in cannulation are permitted to administer up to 10mls 0.9% Sodium Chloride as a flush to confirm patency of the cannula they have placed.

Unregistered HCAs working within the Acute Care Team, who have received formal training in taking blood specimens from Central Vascular Access Devices and Midline Catheters are permitted to administer up to 10mls 0.9% Sodium Chloride as a flush to clear the catheter lumen of blood following blood sampling.

Assistant Practitioners (APs) and Clinical Technologists (CTs) in certain areas are authorised to administer a selected range of intravenous medications. All APs and CTs must undergo additional training and be assessed as competent before administering **ANY** IV drug or infusion.

Sodium chloride 0.9% from ampoules (Prescription-Only-medicine) can only be given against a signed prescription and it must be checked and signed for with a Registered Health Care Professional who is competent at IV drug administration. However, for adult patients, a signed prescription is not required to administer a saline flush using a prefilled syringe of saline licensed as a medical device (eg. PosiFlush®).

Unregistered healthcare staff must NOT prepare or administer any other IV fluid or IV medication.

**Pre-registration Healthcare Staff** e.g. student nurses, student midwives, student ODPs
In order to gain experience, pre-registration healthcare staff can prepare an infusion **UNDER THE DIRECT SUPERVISION** of a registered Healthcare Professional who is competent at this skill, but MUST NOT attach any infusion to the patient.
Definition of groups
The groups defined below refer to the drug tables in the Injectable Drug Administration guide, which identify which group(s) can administer each drug.

- **Group 1**
  Registered and Provisionally Registered Medical Practitioners. It is recommended that IV drugs are checked by a second person either another medical practitioner or a registered healthcare professional before administration.

**Responsibilities of Group 1**

- The Registered Medical Practitioner is responsible for the effects that IV drugs produce in patients, irrespective of whether the administration is undertaken by the doctor or delegated to another Registered Healthcare Professional.
- Medical Practitioners must provide a clear, legal, complete and unambiguous prescription to guide the practitioner involved in IV administration.

NB: The use or continuation of the IV route is justified only where there is a clear benefit to the patient.

- **Group 2**
  Registered Nurses, Midwives and Operating Department Practitioners (ODP’s) who have undertaken the Plymouth Hospitals NHS Trust IV drug administration training (or satisfy the criteria for new employees from outside the Trust), and have been assessed as competent. Group 2 can administer to adult patients only. Another Registered healthcare professional should check all aspects of the administration with this Nurse or Midwife.

  **Cytotoxic IV drugs are NOT to be administered by this group.**
  Exceptions are methotrexate and cyclophosphamide which in specific circumstances, identified in the Injectable drug administration guide, can be administered by this group if they have previous experience of administering parenteral cytotoxics.

- **Group 3**
  Nurses who qualify for Group 2, working in identified specialist areas, and have undertaken additional training and assessment to administer cytotoxic IV drugs.

- **Group 4**
  A Registered Sick Children’s Nurse (RSCN) or Registered Nurse (Part 15 - Child Branch) working in the paediatric field who qualifies for inclusion in Group 2. The exception is for staff who work regularly in the Emergency Department, Intensive Care Unit, Theatres, Maternity and Neonatal Intensive Care Unit, who can administer Group 2 drugs to paediatric patients, providing they are familiar with the drug and the calculation (if any) required.

- **Group 5**
  Nurses who qualify for Group 4 and have undertaken additional training and assessment to administer cytotoxic drugs.

- **Group 6**
  Named Individual Radiographers/Sonographers who have completed and passed an accredited training programme in the administration of IV drugs may administer named contrast media, Hyoscine Butylbromide, Sodium Chloride 0.9% and Glucagon via the IV or IM route according to the department’s authorised and signed patient group direction.

- **Group 7**
Named and authorised technical, scientific and delegated medical staff of the department of Nuclear Medicine who have the appropriate training required by IR(ME)R 2000 to administer radiopharmaceuticals and who have completed an accredited course in IV drug administration or equivalent. Such individuals may administer named drugs and radiopharmaceuticals by IV route according to the department’s authorised and signed patient group direction (PGD).

- **Group 8**
  Assistant Practitioners working within PHNT who have received the necessary additional local training on medicines provided by PHNT, and who have been assessed as competent to administer selected oral and parenteral medications in accordance with the Assistant Practitioner Drug Protocols.

All healthcare staff administering injectable medicines must be assessed as competent in the methods required for administration as advised in the Injectable Drug Administration guide. If they have not been assessed as competent with the administration method, e.g. using a central line, or aseptic non-touch technique they must not proceed.

All training and assessment of competency to administer intravenous medication should include training and assessment of aseptic non-touch technique and administration via central vascular access devices.

### 8.11 Administration of intravenous adrenaline and amiodarone without prescription to adults in an emergency involving cardiac arrest

Holders of a current Resuscitation Council (UK) ‘Advanced Life Support’ provider certificate can administer intravenous adrenaline (1:10,000 up to 1mg) and amiodarone without prescription to adults in an emergency involving cardiac arrest. This does not apply to children in cardiac arrest and does not include holders of certificates from 'in-house' ALS courses, European Resuscitation Council (ERC) courses, or Australian Resuscitation Council (ARC) courses.

### 9 Use of Medicines/Administration of Medicines

**N.B.** SEE SECTION 12 FOR CONTROLLED DRUG PROCEDURE

Medicines must be administered to patients in accordance with local procedures by one of the following:

- An Authorised Practitioner, as detailed above, who is trained and willing to undertake the procedure.
- Self-administration by an in-patient

Check that the identity of the patient corresponds with that on the prescription by checking the identity wristband that must be attached to all inpatient and day case patients. In the exceptional circumstances of a patient not wearing an identity band, practitioners must be especially careful to correctly identify the patient by confirming the patient’s name, date of birth and hospital number and/or NHS Number.
A system of full checking must be used. A second registered practitioner, Pharmacist or a Doctor must check all aspects of the administration, in the following situations:

- Administration to children under 16 years except for topical medicines that are classified as General Sales List (GSL) or Pharmacy only (P) medicines.
- Administration of Controlled Drugs.
- Administration involving any complex calculation e.g. weight-related doses, dilutions, infusion rates.
- Administration of all injectable medicines except for 20mg and 40mg doses of enoxaparin for venous thromboembolism prophylaxis in accordance with Trust policy.
- Administration of any medication, by any route, by an Assistant Practitioner.

All aspects of the administration MUST be checked, i.e. the second practitioner must not only check the preparation and the labelling of the medication but also the setting of the infusion pump, the prescription and the patient identification. A record must be made of each administration, and the administering practitioner (or practitioners) must be identified.

On the Neonatal ICU (NICU) and Transitional Care Ward (TCW) the second-check of selected medicines given to neonates and infants by registered nurses and midwives, can be undertaken by Assistant Practitioners who have been trained and assessed as competent.

- Where a second person checks the administration of a medicine, the ultimate responsibility remains with the administering practitioner.

When a prescriber chooses to draw up and administer medications by themselves without a second check, they must understand this practice is at odds with this policy document, and they are wholly responsible for the consequences of any error that occurs.

9.1 Prescription

Prescriptions must be legible. If the prescription is not clear in any detail, check with the prescriber and do not proceed until you are completely satisfied, (if doubts still persist contact the Pharmacist and your immediate manager at the earliest opportunity).

- Check that the patient's details have been correctly entered on the prescription sheet. The following must be present:
  Name, hospital number and/or NHS Number, age (or date of birth), weight (for all children, and where the dosage of medication is related to weight) surface area e.g. for cytotoxics as appropriate.
- Carefully read and understand the prescription. Check its validity (Prescriber's signature, the prescription date and time of administration).
- Check that the prescribed dose has not already been given and that any dosage interval is appropriate.
- Check that the patient does not have any allergy or sensitivity to the medicines or any of its ingredients. Cross reference to the green allergy chapter card which is at the front of the patient’s medical notes
- Check to see if the prescription has been annotated (by either the Pharmacist or Prescriber) to give you further guidance concerning its administration.
• Check that the medicine dose and/or formulation is appropriate for the route of administration selected by the prescriber (see below for liquid oral medicines).
• Check the prescribed medicine name with the medicine name on the container label.
• Check the prescribed strength with the strength on the label
• Check the expiry date of the medicine on the label and, where appropriate, the ‘in use’ life from the date of opening.
• Where a dose calculation is involved, both nurses must agree that the calculation and the quantity selected are correct.
• Check that the medicine conforms in appearance with dose units remaining in the original container.
• Check that administration is in accordance with any additional instructions that may be on the container label.
• Where any infusion device is involved check that this is correctly set. Check and countersign the details entered on the IV fluid sheet and/or the pump chart. See Trust IV Policy
• The medicine must be discarded and the nurse must start again, if there is any significant interruption to the process resulting in doubt about the preparation status prior to administration.

9.2 Omitted Doses

Medication not administered must be clearly documented on the DPAR using the following system with the actions taken:

1 Patient away from ward
2 Nil by Mouth
3 Patient refused
4 Drug not immediately available on ward (further action required)
5 Drug not available from own ward, pharmacy or other area
6 Omitted for clinical reasons

The specific reason for omission must be recorded on the “Record of doses not administered” page of the DPAR along with the action taken. It is not acceptable only to record the omitted drug without assessing / taking further action if required. If unable to obtain drug, contact the on-call Pharmacist or your ward pharmacist if necessary.

If a prescribed medicine has not been administered for 2 or more doses then inform the prescriber.

To avoid sending home critical medicines that are not readily available in the hospital, patients’ own current medications must not be sent home with the relatives/carer’s on admission until Pharmacy have been able to send alternative supplies.

9.2.1 Critical Medicines

The NPSA Rapid Response Report NPSA/2010/RRR009 “Reducing harm from omitted and delayed medicines in hospital” requires that hospitals identify a list of critical medicines where timeliness of administration is crucial.

9.2.1.1 Prescribing of critical medicines
Prescribing of critical medicines needs to be in a timely manner. Prescribers must inform nursing staff when a critical medicine is prescribed, that is not a stock drug for that area or needs to be given outside of normal medicines administration round times to enable the medicine to be obtained and administered in a timely manner.

9.2.1.2 Supply of critical medicines
- Stock supplies of critical medicines must be agreed by the pharmacist, appointed nurse in charge and appropriate senior medical staff.
- Resuscitation trolleys must be checked and replenished regularly.
- The Pharmacy must provide a responsive system for the supply of urgent medicines during normal working hours and out of hours.
- Every effort must be made to obtain supplies of critical medicines in a timely manner. If a problem arises contact the prescriber immediately to discuss alternative solutions.

9.2.1.3 Administration of critical medicines
Definitions for critical medicines:
- Omission is the failure to administer a dose before the next dose is due or in the case of once only doses failure to administer a drug within 2 hours of the time the dose is due.
- Delay is administration of a drug 2 hours or more after the time the dose is due.

These are broad definitions there will be some critical medicines or conditions where serious harm could occur in a shorter time period.

9.2.1.4 Action if Critical Medicine is Omitted or Delayed
- Record reason for omission or delay on the drug chart using the recognise codes on the DPAR.
- Notify the doctor so that the patient can be managed and alternative treatment can be promptly started.
- Record the incident on Plymouth Hospitals NHS Datix system which will then be used to report to the NPSA.

9.2.1.5 List of Critical Medicines

Critical medicines must never be unintentionally omitted or delayed as the timeliness of administration is crucial to patient care or safety.

<table>
<thead>
<tr>
<th>Drug Name or class</th>
<th>Reason for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation drugs and reversal agents including plasma expanders</td>
<td>Failure to treat medical emergencies with risk of patient harm</td>
</tr>
<tr>
<td>Oral and injectable antimicrobials (including antibiotics, antifungals, antivirals and antimalarials) including peri-operative anti-infectives.</td>
<td>Potential worsening of systemic infection and deterioration of condition, death.</td>
</tr>
<tr>
<td>Injectable anticoagulants (unfractionated heparin, enoxaparin)</td>
<td>Progression / Risk of thrombus and serious embolic episode</td>
</tr>
<tr>
<td>Antiplatelets and thrombolytics for an acute event</td>
<td>Increased risk of poor outcomes</td>
</tr>
<tr>
<td>Insulin – delayed administration in relation to food</td>
<td>Symptomatic hypoglycaemia</td>
</tr>
<tr>
<td>Medicine</td>
<td>Potential Risks</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Glucose</td>
<td>Failure to treat symptomatic hypoglycaemia (medical emergency) with risk of patient harm</td>
</tr>
<tr>
<td>Parkinson’s disease medications</td>
<td>Loss of symptom control</td>
</tr>
<tr>
<td>Antiepileptic agents when used to treat epilepsy</td>
<td>Injury or brain damage during prolonged seizures.  Loss of seizure control.</td>
</tr>
<tr>
<td>Benzodiazepines for convulsions</td>
<td>Risk of developing life-threatening dehydration and hypernatraemia (NHS/PSA/W/2016/001)</td>
</tr>
<tr>
<td>Desmopressin for cranial diabetes insipidus (includes all preparations; intranasal spray, oral and injectable desmopressin)</td>
<td>Requirement of NPSA/2010/PSA001 Safer Use of intravenous gentamicin for neonates</td>
</tr>
<tr>
<td>Gentamicin in neonates must be given within 1 hour of the time the dose is due</td>
<td>Requirement of NPSA/2010/PSA001 Safer Use of intravenous gentamicin for neonates</td>
</tr>
<tr>
<td>Pyridostigmine and Neostigmine for the treatment of myasthenia gravis.</td>
<td>Loss of symptom control. Increased muscle weakness.</td>
</tr>
<tr>
<td>Steroids</td>
<td>To avoid adrenal insufficiency</td>
</tr>
</tbody>
</table>

### 9.3 Injectables

Medicines administered by any form of injection must not be administered at the same time as other methods of administration (oral, rectal, inhaled etc). This is to reduce the potential for administration of products by an injectable route in error (see below – administration via enteral feeding tubes).

When injectable medicines are prepared on a ward, department or in a theatre the preparation must take place immediately before the drug is administered. The practitioner preparing any such solution must administer it, or be present at the time of starting administration.

The exception to this rule is in Cardiothoracic Theatres, where in accordance with a specific SOP and predefined lists of preferred anaesthetic drugs for each anaesthetist, Cardiothoracic ODPs are permitted to pre-draw syringes and prepare infusions in advance of procedures. These pre-drawn medications will be checked and administered by the anaesthetist.

All intravenous infusions must be suitably labelled with the following details:

- Patient’s name (and hospital number and/or NHS Number)
- Name of the drug added and the amount added
- Name and volume of diluent
- Time and date prepared
- Date and time of expiry
- Time of administration
- Identities of the practitioners preparing and checking the solution.

All syringes containing solutions (for example, antibiotics, sodium chloride 0.9%, contrast media, water for Injection, insulin, heparin) for bolus injection or perfusion by any route must be labelled with a minimum of drug/solution name and dose where the syringe leaves the hands of the practitioner.

The rate of administration (and any subsequent changes) must also be recorded on the IV prescription sheet or IV infusion pump chart.
Solutions prepared in the Pharmacy will be labelled with the following as a minimum:

- Name and amount of drug added
- Name and volume of the diluent
- Date of expiry (and time if appropriate)
- Appropriate storage conditions
- Batch number.

N.B. Details of ingredient batch numbers will be recorded on work sheets that will be kept in Pharmacy.

9.3.1 Risk Assessment of Injectable Medicines

- All injectable drugs administered within the organisation, except cytotoxic drugs and additions to parenteral nutrition solutions have been risk assessed by a clinical pharmacist to determine their site of preparation, which is either the Pharmacy Production Services or a clinical area. Injectable cytotoxic drugs and additions to parenteral nutrition solutions are not subject to the risk assessment process because they are always prepared within the aseptic unit or supplied in a ready to use presentation by the pharmacy department.


- The risk assessment for all injectable drugs is available in pharmacy. High, red risk items are entered onto the trust risk register and are reviewed annually by the pharmacy board.

- Injectable drugs identified for preparation within Pharmacy Production Services may be prepared in-house or outsourced and then supplied. A catalogue of these products is available at (insert hyperlink to web page). This is to help ensure these products are not inappropriately made in clinical areas and contains hyperlinks to product life cycle documents, detailing specifics of the product.

- Injectable drugs identified for preparation in clinical areas have an individual monograph within the UHP Procedures for Administering Injectable Drugs, detailing preparation and administration instructions in order to reduce risk.

9.3.2 Flushing and Locking Intravascular Lines

- All flushes (Bolus and infusions) and line/catheter locks should be prescribed.
- Administration of all flushes and line/catheter locks should be recorded on the prescription chart.
- Sodium chloride 0.9% from ampoules (Prescription-Only-medicine) can only be given against a signed prescription and it must be checked and signed for with a Registered Health Care Professional who is competent at IV drug administration. However, for adult patients, bolus flushes can be administered using pre-filled
syringes of sodium chloride 0.9%, licensed as a medical device (eg. PosiFlush®) without the need for a signed prescription.

- Always attempt to aspirate the heparin lock before use of the line. If unable to aspirate the heparin from the line, discuss with the duty consultant whether the heparin may be flushed into the patient.
- Heparin must not be used in a patient with recognised or suspected HIT, or at risk of HIT (Heparin-induced thrombocytopenia) without discussion with a Consultant Haematologist.

<table>
<thead>
<tr>
<th>Type of intravascular line, catheter or device</th>
<th>Maintenance of Patency, Flushing and Locking</th>
</tr>
</thead>
</table>
| Short-term Peripheral Venous Catheters (Adults and children)  
  - Cannula, venflon | Flush with 5 -10ml 0.9% sodium chloride |
| Arterial Lines (Adults and children) | Maintain patency with an infusion of 0.9% sodium chloride. |
| Central Venous Lines (Inpatient Adults)  
  - Tunnelled lines eg. Hickman or Broviac lines  
  - PICCs and Midlines  
  - Short-term CVCs  
  - Long Lines | Flush with 0.9% sodium chloride (at least 10ml for adult patients) and lock with 0.9% sodium chloride (volume stated on the line) using a positive pressure clamp technique. |
| Short-term Central Venous Catheters (Children) | All lines without a continuous infusion running should be flushed with 0.9% sodium chloride 6-hourly. To avoid blood flashing back into the lumen, “positive pressure” is applied at the end of the flush. |
| Long-term Central Venous Lines (Children) |  
  - **Hickman, Cook & Broviac Lines**: Flush with 0.9% sodium chloride and lock with 3ml of 10 units/ml heparin.  
  - **Groshong Lines**: Flush with 0.9% sodium chloride and lock with 5ml sodium chloride 0.9%. |
| Long Lines (Children) | Use 10 units/ml heparin to flush and lock Long Lines in children |
| Umbilical Arterial Catheters (Neonates) | Maintain patency with an infusion of 1unit/ml heparin, prepared by diluting 10 units/ml heparin, according to the Neonatal ICU protocol. |
| Vascaths (In General and Cardiotoracic Intensive Care) | Lock the catheter with 1,000 units/ml heparin (volume as stated on the catheter lumen). Before use, aspirate the heparin from the catheter and flush with 10ml of 0.9% sodium chloride. If unable to aspirate the heparin, discuss with the duty consultant whether the heparin may be flushed into the patient. |
| Renal-type large bore lines (On Adult Renal and Haemodialysis Units, and in Adult Haematology patients)  
  - Dialysis lines  
  - Vascaths | Flush the line with at least 10ml 0.9% sodium chloride then lock the line/catheter with trisodium citrate 46.7% solution (If no allergy). The locking volume will be stated on the catheter. Before use, aspirate the trisodium citrate 46.7% solution from the line/catheter. If this is not possible, the trisodium citrate 46.7% solution may be slowly flushed into the |
patient. Then flush with at least 10ml 0.9% sodium chloride.

<table>
<thead>
<tr>
<th><strong>Ports (Adults and children)</strong></th>
<th>When in use with the needle in, flush with at least 10ml of 0.9% sodium chloride using a push pause technique. Clamp line under positive pressure. (In paediatric patients only lock the device with the appropriate volume of 10 units/ml heparin). Before the needle is removed, flush with at least 10ml 0.9% sodium chloride then lock the device with the appropriate volume of 100 unit/ml heparin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totally implantable venous access devices eg. Portacaths</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Central Lumen of Intra-aortic Balloon Pump Catheter</strong></td>
<td>Use Heparin Sodium 2000 units/L in 0.9% Sodium Chloride IV Infusion, 500mL bags, REF Baxter B0953, as a continuous flush of the central lumen of the Intra-Aortic Balloon Catheter, as per protocol.</td>
</tr>
<tr>
<td><strong>Central Venous Lines (Outpatient or Day Case Adults)</strong></td>
<td>Flush the line with at least 10ml 0.9% sodium chloride then lock the line/catheter with trisodium citrate 46.7% solution (If no allergy). The locking volume will be stated on the catheter. Before use, aspirate the trisodium citrate 46.7% solution from the line/catheter. If this is not possible, the trisodium citrate 46.7% solution may be slowly flushed into the patient. Then flush with at least 10ml 0.9% sodium chloride.</td>
</tr>
<tr>
<td><strong>Tunneled lines eg. Hickman or Broviac lines</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Line lock in patients receiving TPN who have had a previous line infection</strong></td>
<td>Lock the line with the appropriate volume of Taurolock® (This contains taurolidine and sodium citrate).</td>
</tr>
</tbody>
</table>

### 9.4 Liquid Oral Medicines.

When oral liquid medicine is administered from the original manufacturer bottle from ward stock a 3 month expiry from date of opening (breaking of security seal) is required. Exceptions include those liquid medicines with a shorter than 3 month manufacturer expiry and those with a different expiry length once opened as per written instruction on the bottle. Apply appropriate label (sticker) to the bottle and complete expiry date details.

Administration of medicines via enteral feeding tubes (NG/NJ/PEG/PEJ tubes) pose a particular hazard with regard to their availability in suitable formulations and the possibility of administering them via an incorrect route. This is a particular danger in critical care and other areas where patients may have a number of parenteral as well as enteral lines. There are also risks attached to nebulised solutions being administered IV, and also enteral feed being attached IV (especially in neonatal care). Administration should be in accordance with Clinical Quality Alert Notice No. 36 ‘Safe Administration of Enteral/Oral Medicines’. In brief:

- **Do not** use syringes used for injecting medicines for the measurement or administration of liquid oral/enteral tube medicines.
- Use only **purple oral syringes** for liquid medicines administration via enteral tubes.
• Drugs to be given by the oral route and drugs to be given by the intravenous route should not be taken to the patient’s bedside together
• Enteral Feeds must not be delivered via IV or Epidural pumps. They should be administered via a suitable device that is clearly labelled ‘enteral’. Where the manufacturer does not label this as such, it is the responsibility of the healthcare professional to label the device with this information.
• Do not use 3-way taps connected to enteral lines in order to enable administration via injectable syringes.
• The crushing or breaking of tablets for administration via enteral feeding tubes may be outside a product’s licensed use. Many liquid pharmaceutical specials are also unlicensed. Clinicians administering/advising in accordance with the White and Bradman reference text will be considered to be working in accordance with Trust policy. See separate policy for the Procurement, Prescribing, Supply and Administration of Unlicensed Medicines for more information

9.5 Prescribing and Administration of Weekly Methotrexate

• For Rheumatological, Dermatological or Gastro-intestinal indications methotrexate MUST be prescribed and administered / taken as a SINGLE WEEKLY DOSE in accordance with NPSA Patient Safety Alert 13.
• Only 2.5 mg tablets are prescribed and dispensed for these indications with 10mg tablets being reserved for haematology and oncology patients ONLY.
• If the prescriber has any concerns with regard to the prescribing of methotrexate, they MUST seek appropriate advice before doing so.
• Decision to initiate methotrexate therapy is reserved for consultants only.
• When initiating therapy the patient must be given verbal and written information about Methotrexate and an “individual patient held monitoring and dosage booklet” (purple book). Confirmation of the patient’s understanding of the risks, benefits and the need for blood monitoring should be sought before commencing methotrexate treatment.
• All patients must be made fully aware that the drug is only to be taken on a once WEEKLY basis. Dosage must be clearly explained.
• The Plymouth (PAJF) shared care guidelines, which include responsibilities for monitoring, must be followed when methotrexate therapy is commenced. For out of area patients appropriate monitoring must be ensured by close discussion with the patient’s GP.
• Patients admitted to hospital on methotrexate should routinely have their FBC and blood chemistry checked.
• The prescriber cannot prescribe methotrexate without reviewing relevant medical notes and individual patient methotrexate booklet (and consulting patient). The prescriber must update medical notes and individual patient methotrexate booklet as appropriate. If relevant medical notes or up-to-date blood monitoring results are not available, methotrexate must not be prescribed.
• The day of the week must be specified on the inpatient prescription chart. On inpatient charts the administration boxes for other days must be crossed through. This is the responsibility of the prescriber.
• All oral methotrexate prescriptions on inpatient charts are endorsed by a pharmacist who must ask to see the individual patient methotrexate booklet, consult the patient or review the medical notes to confirm the correct dosage.
• If there is any doubt about dosage or the blood results pharmacists must not dispense methotrexate until the doubt has been resolved and documented in the medical notes.
• Inpatients will only be issued one weekly dose at a time.
• Ward nurses are not to administer oral methotrexate unless they have medical and pharmacist signatures on the prescription chart. The patient, where possible, should be asked to confirm dose and when the dose is due.
• Before a dose is administered check whether any new medications have been started since the last dose of methotrexate was administered. Information about drug interactions can be obtained from the BNF or PAJF shared care guidelines. If in doubt about a possible drug interaction do not administer the dose until confirmation it is safe to give is obtained from the prescriber and/or a pharmacist.
• Outpatient and discharge (TTA) prescriptions for oral methotrexate should identify the number of 2.5mg tablets in each dose e.g. 10mg dose should be written as “10 mg (4 x 2.5mg tablets) to be taken on the same day each week”. The day of the week must be stated. The direction “as directed” must never be used on prescriptions for methotrexate.
• A maximum of four weekly doses are to be supplied on discharge prescriptions.
• A maximum of four weekly doses are to be supplied on outpatient prescriptions, including FP10s, during initiation of therapy. Once treatment is stabilised, the total quantity may be increased to a maximum of 12 weeks at the prescriber’s discretion for RED indications. Prescribing responsibilities should pass to the patient’s GP at this time for all Amber indications.
• A 12 week supply can be dispensed by the clinical trials team for paediatric patients with ALL in line with the 12-week maintenance cycle.

• All incidents relating to methotrexate must be reported using The Trust’s incident reporting scheme.

9.6 Prescribing and Administration of Oral and Parenteral Anticoagulants

The National Patient Safety Agency (NPSA) issued a Safer Practice Notice in March 2007 (no. 18) titled “Actions that can make anticoagulant therapy safer” It provides guidance for all NHS staff involved in the prescribing, dispensing and administration of oral and parenteral anticoagulants.


9.7 Prescribing and Administration Low Molecular Weight Heparins (LMWH’s) for the Treatment of a Thromboembolic Event

Prescribed doses of low molecular weight heparins (LMWHs) for the treatment of a thromboembolic event are dependent on the weight of the patient and renal function.
• A patient’s weight MUST be used as the basis for calculating the required treatment dose of LMWH. The weight must be accurately recorded in kilograms (kg) on the Drug Prescription and Administration Record (DPAR) (when in use) and in the medical notes.
• Patients should be weighed and their renal function checked at the start of therapy and, where applicable, during treatment.
Essential information such as dose, weight, renal function, indication and duration of treatment is communicated at transfers of care (e.g. by discharge letters).

9.8 Safe Prescribing of Oral Anticancer Therapy for Adult Patients with Malignancies and Other Haematological Conditions

- Oral anticancer therapy for adult patients with malignancies and other haematological conditions with the exception of hydroxycarbamide must be prescribed by cancer specialists defined as Consultant Oncologists, Consultant Haematologists and Specialist Registrars who are working in these areas.
- Hydroxycarbamide may be prescribed by General Practitioners under the shared care guideline after specialist initiation.
- All oral anti-cancer medicines are prescribed in the context of a written protocol.
- Chemotherapy prescribed for patients in an outpatient setting must be prescribed on the designated oral chemotherapy prescription form or electronically using the Opmas program.
- Oral anticancer therapy for inpatients must be prescribed by the previously defined cancer specialists.
- All patients starting oral anticancer therapy receive verbal and up-to-date written information about their therapy. This information includes contact details for specialist advice, details of the intended oral anti-cancer regimen, treatment plan and arrangements for monitoring. It is the responsibility of the clinician to provide information or delegate this to the Cancer Services Pharmacist or Clinical Nurse Specialist. Patients discharged from hospital with oral anticancer therapy need to be made aware of their next clinic appointment.
- All staff dispensing oral anti-cancer medicines have access to the chemotherapy protocols to confirm that the prescribed dose is appropriate for the patient.

9.9 Administration of Oxygen

Registered Healthcare Professionals, and Assistant Practitioners who are permitted to administer oxygen, must ensure the following tasks and checks are performed when administering Oxygen to a patient:

- That the Oxygen is being administered in accordance with the prescription (matching: delivery device, flow rate and target oxygen saturation)
- That the Oxygen delivery device is correctly assembled and that the appropriate pre-use checks have been undertaken
- That the current 'Drug Prescription and Administration Record' is completed at every drug round (time, date, delivery device and flow rate to be recorded)
- The RHP must administer Oxygen within the boundaries of their professional scope of practice
- Completion and recertification of training that is appropriate and recognised by the Trust (such as the Medical Gases e-Learning module) will become mandatory for Trust employees
- Where Oxygen is administered: oxygen saturations as well as other vital signs must be measured, recorded and action taken when abnormalities occur
Assistant Practitioners, Health Care Assistants, Portering Staff and other Clinical Professionals may assist with the administration of Oxygen under the indirect supervision of a Registered Healthcare Professional (RHP) provided that they ensure the following tasks and checks are performed:

- That the Oxygen is being administered in accordance with the prescription and has been checked directly by a RHP
- That they are competent to do so and have completed (and are up to date with) training that is appropriate and recognised by the Trust (such as the Trust's Medical Gases e-Learning module)
- They must not alter the flow rate of a delivery device of the Oxygen. In emergency situations, this may be done, providing this is performed under the instruction of a RHP
- Only disconnect a patient from, or transfer an oxygen supply from one system to another (e.g. mains to cylinder supply) when instructed to do so by a RHP. The flow rate must be checked immediately by the RHP
- Bring to the attention of the RHP any problems identified with the supply, apparatus or it's assembly or the patient’s condition immediately

9.10 Prescribing of Lithium

- Patients prescribed lithium must be monitored in accordance with NICE guidance. Lithium should only be initiated by a specialist and full prescribing / monitoring requirements can be found in the Plymouth Area Joint Formulary Chapter 20 “Shared Care Information on the prescribing of Lithium”. The minimum ongoing requirement is for lithium blood level monitoring ‘normally’ every three months and thyroid and kidney (renal) function tests every six months.
- It is important that patients provide an accurate time between the last dose and when blood is taken. For consistent interpretation and reliability, this gap should be as close to 12 hours as possible. For this reason it is normal to prescribe lithium as a single dose at night.
- Lithium preparations are not bioequivalent, therefore should be prescribed by brand name. A change in brand would result in the need for weekly blood monitoring and adjustment of dose until stable.
- At the start of lithium therapy and throughout their treatment patients must receive appropriate ongoing verbal and written information and an NPSA record book to track lithium blood levels and relevant clinical tests. On issuing the NPSA information booklet, alert card and record book, the healthcare practitioner must complete the patient’s details, service providers’ details and current lithium therapy. The record book must be annotated with the patient’s current lithium blood level, the expected upper and lower lithium blood level range and healthcare tests results. The lithium blood level range may alter with time, and should be amended to reflect the current clinical expectation for safe and effective therapy.
- Prescribers and pharmacists must check that blood tests are being monitored regularly and that it is safe to issue a repeat prescription or dispense the prescribed lithium. However lithium should not be withheld due to lack of this information, as this could result in a worsening of the patient’s condition. Contact the patient's GP or specialist to determine the latest blood level.
- Monitor for any potential drug interactions.
9.11 The adult patient’s passport to safer use of insulin

- The NPSA Insulin Passport is a record of the patient’s current insulin products. It provides an additional check to make a patient’s use of insulin safer.
- All adult patients who are newly initiated on insulin must receive:
  - An NPSA patient information booklet and an Insulin Passport
  - Counselling, through the use of the information booklet, so they understand how and why their insulin passport can be used to minimise the risk of error and what can be done to make the use of insulin safer.
- Any existing adult patients on insulin, who have not already received the NPSA patient information booklet and Insulin passport, will receive these and the appropriate counselling when reviewed by a Diabetes Specialist nurse.
- When prescriptions of insulin are prescribed, dispensed or administered, healthcare professionals must cross-reference all available information to confirm the correct identity of insulin products. Where there is a discrepancy between the Insulin Passport, a patient’s notes or current understanding of insulin therapy, it should be reconciled and the information in the Insulin Passport updated.
- When there has been an amendment to a patient’s type of insulin therapy, the insulin passport must be updated
- If the patient, carer or responsible healthcare professional makes an informed choice that the patient is not to engage with this initiative, this must be clearly documented in the patient’s medical notes.

9.12 Strong Potassium Injection

- Maladministration of potassium-containing solutions is a “Never Event” as listed by the DoH (2015/2016), and can cause vein damage and even asystole and death. The Trust must comply with the NPSA Patient Safety Alert which requires that the handling and storage of strong potassium injection must be restricted to the Pharmacy Department and critical care areas, and that strong potassium injection should be treated like a Controlled Drug in terms of storage, ordering and record keeping. “Strong” potassium refers to concentrations of Potassium Chloride or Dipotassium Hydrogen Phosphate injection of 10-20%.

Main Theatres no longer keep ampoules of Strong Potassium Chloride Injection. Instead they keep a small stock of Potassium Chloride 50mmol in 50ml (7.5%) pre-filled syringes for IV infusion. Penrose and Pencarrow now predominantly use the same pre-filled syringes, but still have occasional need for 10ml ampoules of Strong Potassium Chloride Injection. The 50mmol in 50ml (7.5%) prefilled syringes are not included in the NPSA/DoH definition of “Strong” potassium. However, the local controls for the pre-filled syringes are the same as those for the ampoules of Strong Potassium Chloride.

- **Areas permitted to keep a stock of Strong (15%) Potassium Chloride Injection And Dipotassium Hydrogen Phosphate Injection**

<table>
<thead>
<tr>
<th>Cardiothoracic Theatres</th>
<th>Pencarrow</th>
<th>Penrose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torrington ICU and HDU</td>
<td>Children’s HDU</td>
<td>Neonatal Intensive Care</td>
</tr>
</tbody>
</table>
• Wards and Departments not listed above may not keep strong potassium injection as stock, and any stock remaining will be returned to Pharmacy.

• **Storage of Strong Potassium Chloride Injection and Dipotassium Hydrogen Phosphate Injection**

  • Where space allows, keep the stock inside the inner Controlled Drugs Cupboard. If this is not possible, the stock of these injections should be locked away inside the outer Controlled Drugs Cupboard. Where this is not possible the ward must keep the stock in another locked cupboard distant from stocks of ampoules of Water for Injection and Normal Saline.
  • In Main Theatres, level 4, the stock of pre-filled potassium chloride syringes will be kept in a dedicated locked cupboard beside the CD cupboard close to Main Theatres Reception.
  • In Cardiothoracic Theatres the supply of potassium chloride ampoules for use by the anaesthetists will be kept in a dedicated locked cupboard in the head ODP’s office. The Perfusionists’ supply is kept in a dedicated locked cupboard in the Perfusionists’ office.
  • In the Pharmacy Department strong potassium injection will be stored in the Controlled Drugs Room. Pharmacy Technical services will also keep a stock

• **Obtaining/Supply of Potassium Chloride Injection and Dipotassium Hydrogen Phosphate Injection**

  • The authorised wards and departments listed above must order strong potassium injection using a Controlled Drugs Ordering Book.
  • The wards and departments listed above must NOT supply wards and departments not listed above with strong potassium injection other than in exceptional circumstances when the ward pharmacist or the On-call Pharmacist authorises such a supply.

  When Pharmacy is not open a ward permitted to stock potassium strong injection may obtain stock from another ward permitted to stock strong potassium injection (a record of the transfer must be made in both wards’ potassium record books).

  When a ward not permitted to stock these potassium injections has a prescription for a non-stocked potassium-containing infusion or a non-stock phosphate-containing infusion, the ward should contact the ICU Pharmacist (Bleep 0460) or the On-call Pharmacist to discuss the prescription. (For phosphate replacement, a Phosphate Polyfusor can be prescribed and dispensed without restriction or the need for pharmacist advice).
  • If the pharmacist confirms with the prescriber that none of the pre-mixed potassium solutions available in Pharmacy are suitable then ideally the Pharmacy should prepare the solution.
  • If the request is made when Pharmacy is closed, the On-call Pharmacist should authorise the release of just sufficient potassium injection from one of the authorised areas listed above, for the ward to prepare the infusion.
• If Pharmacy is open but the potassium solution is needed urgently then the pharmacist should instruct the ward to order in their CD order book, only sufficient ampoules of strong potassium injection to make the first infusion.
• Pharmacy Technical Services should prepare any further non-stocked potassium infusions that are needed for the patient.
• Where the nurse is preparing a potassium infusion using ampoules of Strong Potassium injection, the nurse must mix the prepared solution thoroughly before use
• In exceptional circumstances, on specialist registrar or consultant request and after discussion with a pharmacist, Strong Potassium Chloride injection may be obtained by the Emergency Department on a CD order from Pharmacy or out-of-hours from Penrose or Torrington.

• Record Keeping

• Any area that obtains strong potassium injection will record receipts and issues in a Controlled Drugs Register in exactly the same way as for Controlled Drugs. The record will include the names of patients administered these injections, the signatures of the two registered practitioners preparing the IV, and a running balance.
• As with Controlled Drugs, the stock balance of strong potassium injections will be reconciled once every 24 hours.
• Pharmacy will have electronic records of the receipt and issues to wards of all strong potassium injections.

9.13 Verbal Orders

Verbal Orders, on their own, are not acceptable by Registered Nurses or Midwives in accordance with NMC standards.

• In an exceptional emergency, a verbal order to administer a medicine, apart from Schedule 1,2 or 3 (except phenobarbitone for the treatment of epilepsy) Controlled Drugs, may be accepted from a registered medical practitioner by a registered nurse/midwife, at their professional discretion, provided that:
  o The registered nurse receiving the verbal order must receive confirmation at the time that the details of the prescription are correct using information technology and agree that it is appropriate for the patient.
  o In this Trust, verbal orders must be confirmed by e-mail to the nurse in charge of the ward or by facsimile transmission, where this is available. This confirmation must be retained in the patient’s medical notes.
  o The instruction must immediately be written on the patient’s prescription chart in ink (once only section), it must be endorsed ‘verbal order’ and the following must be recorded:
    ▪ Date:
    ▪ Time:
    ▪ Medicine:
    ▪ Dose:
    ▪ Route of administration:
    ▪ Name of prescriber:
    ▪ Nurse’s signature:
- Registered nurse/midwife witnesses' signature:
  - The nurses receiving the verbal order must then administer the medicine. The authorised prescriber must countersign the prescription as soon as possible and before the end of their duty shift (at the latest within 24 hours).
  - The nurses involved in the administration of the verbal order should endeavour to get the prescription signed, preferably, before they finish duty. Where this is not possible, the nurses must inform the relevant nurse on the next shift and/or the Nurse in charge. A Trust incident form should be completed if the prescriber does not confirm the verbal order within 24 hours.

9.14 Self Administration of Medicines

The decision to allow self-medication by any patient must be by agreement of both Medical and Nursing staff based on the individual patient’s physical and mental ability to comply with the requirements of the scheme. Care should be taken to identify and exclude those who might endanger themselves or others. For more information refer to the policy for Self-Administration of Medicines by Patients (Adult and Paediatric)

10 Disposal of Surplus/Waste Medicines

10.1 Disposal/Removal of Surplus/Waste Medicines from Wards and Departments
Individual doses of medicines prepared for and subsequently not administered to a patient must be disposed of correctly. These must be placed in a sharps bin for subsequent incineration. Waste from cytotoxic or cytostatic drug administration must be disposed of in cytotoxic waste containers. Medicines must not be returned to the container from which they were removed.

Other medicines, that are no longer required, must be returned securely to the Pharmacy.

See the Controlled Drugs section for procedures for disposing of these products.

10.2 Disposal/Removal of Surplus/Waste Medicines from the Pharmacy/Trust

Pharmaceutical waste will be disposed of in accordance with the Health and Safety at Work and Environmental Protection Acts through authorised contractors. Some medicines, e.g. cytotoxics, will be segregated in order to allow appropriate final disposal. Controlled Drug medicines will be destroyed following authorisation by an approved person.

11 Principles for Controlling Medicinal Products within the Trust

11.1 Controlling the entry of new medicines into The Trust

MUAC controls the entry of all hospital only in-tariff medicines into The Trust. Prescribers wishing to introduce such medicinal products must obtain approval from the MUAC by completing the Trust-approved application form that is available from Pharmacy. Applications must be signed by a consultant or associate specialist clinician and include the required supporting documentation and information. New
medicines must not be prescribed until there has been clinical approval from the MUAC and financial approval has been given.

North, East and West Devon CCG (NEW Devon) Clinical Prioritises Committee (CPC) control the entry of all other in-tariff medicines. Prescribers wishing to introduce such medicinal products must obtain approval from the CPC by completing the Trust-approved application form that is available from Pharmacy. New medicines must not be prescribed until there has been clinical and financial approval from NEW Devon CCG.

NEW Devon CCG and NHSE control the entry of all tariff-excluded drugs, either through the adoption of NICE guidance and / or the implementation of local policies.

Prior to the adoption of NICE guidance or NHSE policies a local Trust assessment will be undertaken to ensure that appropriate governance arrangements are in place to ensure that the medicine will be introduced safely. This local assessment will be undertaken by MUAC. New medicines approved via NICE / local policies must not be prescribed until there has been governance approval through MUAC.

11.2 Controlling the use of medicines within The Trust.

MUAC is responsible for ensuring medicines are used safely and in-line with local policies by promoting, monitoring, reporting and taking appropriate action to MUAC is also responsible for approving relevant medicines policies, protocols and patient group directions (PGDs) in order to achieve these objectives.

MUAC reports to The Clinical Effectiveness Group and into The Clinical Support Services Care Group.

11.3 Medicines Samples Policy

All medicinal products prescribed for in-patients or out-patients attending hospitals are supplied by the Pharmacy department or by a community Pharmacy.

The Consumer Protection Act 1987 confers liability for products supplied to patients which are later (up to 10 years) shown to be defective and to have caused damage. The Trust may incur liability unless the supplier can be identified from records of when and from whom that product was obtained. No centralised records can be kept of samples supplied directly to clinicians/clinical areas and the Trust is at risk in the event of a claim.

Products must also be stored under correct conditions to preserve integrity. Persons storing medicinal products incorrectly become liable.

11.3.1 Medical Staff

In the event that medical staff wish or have agreed to evaluate a product, approval must be sought from the Medicines Assurance and Utilisation Committee before proceeding. Deliveries of all medical samples must be processed through Pharmacy.

At educational meetings pharmaceutical samples may be available to medical staff. These must not be used for patients admitted to or attending hospital.
11.3.2 Wards and Departments

Nursing and Midwifery staff are not allowed to accept medicinal samples from representatives of pharmaceutical companies.

11.4 Representatives of the Pharmaceutical Industry

A Code of Practice that is laid down by the Association of the British Pharmaceutical Industry governs the activities of representatives of drug companies. One of these requirements is to observe the requirements of the Trust, i.e. not to promote non-formulary prescribing.

11.5 Injectable Drug Administration Guide

The Trust maintains an injectable drug administration guide that is updated as and when new information or procedures are agreed and is available in all relevant clinical areas. This guide covers the following sections:

- Injectable Drug Monographs
- Standard Operating Procedures for Preparing and Administering Intravenous Medicines and Fluids
- Standard Operating Procedures for the Management of Phlebitis, Infiltration, Air Embolism, Speedshock and Extravasation
- Standard Operating Procedures for the Safe Handling and Administration of Injectable Cytotoxic Drugs
- Choice of Infusion device
- PHNT Policy for maintenance of patency, flushing and locking of intravascular lines catheters or devices

11.6 Clinical Trials

A clinical trial may be defined as an investigation or series of investigations consisting of the administration of one or more medicinal products where there is evidence that they may be beneficial to a patient or patients, by one or more Doctors or dentists for the purpose of ascertaining what effects, beneficial or harmful the products have.

Medicinal products under investigation (IMPs) are generally unfamiliar to the staff involved in their handling and/or may be coded to prevent ready identification by either the investigator or patient. Extra precautions and diligence needs to be taken to ensure safety and security in their use.

All clinical investigators, before beginning studies using drugs either on human volunteers or patients, shall obtain the appropriate regulatory approval, ethics approval and approval from the Trust’s Research and Development Department. These must be presented to the Director of Pharmacy prior to the start of any clinical trial involving an IMP.

It is essential that prior to initiation of any clinical trial with any drug that a meeting be convened between the Investigators, Pharmacists, sponsoring pharmaceutical company representatives and any other concerned parties to ensure potential problems are discussed and solved promptly.
Procurement, storage, distribution and security of clinical trial medicines shall be handled by the Pharmacy. Separate stocks of trial medicines must not be maintained on wards, clinics or private offices unless there are exceptional circumstances that may impair the progress of the trial and with the prior agreement of the Director of Pharmacy.

All the trial specific Pharmacy Standard Operating procedures are approved by the Director of Pharmacy, who is responsible for the dispensing of medicines for clinical trials and will ensure that the labelling of any such medicines is in accordance with legal requirements. Pharmacy standard operating procedures allow other Pharmacy staff to dispense and check clinical trials.

The Pharmacy Department shall keep records of dispensing, issue and disposal of all clinical trials medicines and the identities of those concerned in dispensing and issue shall be recorded.

Administration of clinical trials medicines must be in accordance with procedures defined in this document.

All double blinded trials have a method of breaking the "code" to identify the exact treatment the patient has been receiving. These codes must only be broken for emergency reasons. Code breaks or code breaking methods (e.g. IVRS / IWRS systems) are kept in Pharmacy. If it is not life threatening, the consultant or doctor must request permission to break the blind from the sponsor via the Clinical Research Associate or Project Manager responsible for the trial. If the request is urgent, the code can be broken by contacting Pharmacy or if out of normal working hours by contacting the on-call Pharmacist (SOP CT10).

11.7 Unlicensed Medicines

The term 'unlicensed medicine' is normally applied to those medicines which do not have a UK Marketing Authorization (MA), formerly a Product Licence (PL), granted by the Medicines and Healthcare products Regulatory Agency (MHRA) or European Agency for the Evaluation of Medicinal Products (EMEA). The term is also applicable to licensed medicines when they are used for unlicensed applications.

See separate policy for the Procurement, Prescribing, Supply and Administration of Unlicensed Medicines for more information.

11.8 Specialised Medicinal Products

11.8.1 Blood Fraction Products

A number of blood fraction products, e.g. Factor VIII, are licensed medicines and are normally prescribed on the inpatient drug/infusion chart. However, there is a need for special tracking and recording of patients receiving these products that is consistent with the procedures for other blood products. These products are requisitioned, stored and supplied via the Blood Bank using the agreed Trust procedures.

11.8.2 Radiopharmaceuticals
These products require special procedures for their acquisition, generation, preparation, administration to patients and disposal of waste because of their radioactive nature.

The laboratory in the Nuclear Medicine department is approved by the MHRA as a Manufacturer (Specials) Licensed unit and the use of these products is restricted to special areas within the Nuclear Medicine department.

Standard Operating Procedures within the Nuclear Medicine department ensure compliance with the relevant national regulations and guidance concerning the quality assurance and medical use of radiopharmaceuticals within the Trust.

11.8.3 Medical Gases

Medical gases are licensed as Prescription Only Medicines. However, their use is somewhat different to other medicines either being delivered through piped systems or via portable pressurised cylinders where the use of the piped system is impractical.

The procedures for use and quality of the Piped Medical Gases must comply with the standards laid out in HTM 2022 Medical Gas Pipeline Systems – NHS Estates (1994). Further information is available from the Pharmaceutical Quality Assurance Manager.

Medical Gases in cylinders are stored in special areas and are requisitioned from the portering service due to their bulk and manual handling risks. Similarly, their storage in clinical areas must be in suitable stands or racks in order to ensure avoidance of injury. The transfer of valves and flow meters from one cylinder to another must only be done by staff with suitable training in the procedure. The Medical Equipment Maintenance Service (MEMS) can provide information about care of valves and flow meters, the use of cylinders must meet the national standards for the care and use of Medical Gas cylinders; further information is available from the Pharmaceutical Quality Assurance manager or the Estates department.

The movement of medical gas cylinders will be tracked across the organisation using a barcode scanning system. The use of the system will be monitored by the Medical Gases Group.

12 Controlled Drugs (CDs) Management

12.1 Legislative and Governance Arrangements

Guidance on strengthened governance arrangements for the Safer Management of Controlled Drugs has been issued by the Department of Health. This requires NHS Trusts (and all other healthcare organisations) to appoint an ‘Accountable Officer’ who will monitor and be responsible for the safe and effective use and management of CDs within the organisation as set out in the Health Act 2006. This Trust has appointed: Simon Mynes, Director of Pharmacy, as the Accountable Officer.

12.2 General Principles
• Patients have timely access to medicines prescribed for them.
• Current legal requirements for CDs are met within the Trust.
• Patients are partners in their treatment and should share decision-making with relevant healthcare professionals.
• Patients are adequately informed about their treatment.
• CDs are used and managed safely and securely.
• There is a clear audit trail for the movement and use of all CDs; this audit trail is tested and action taken where necessary.
• CDs are prescribed by professionals who are competent to do so and remain competent by receiving training and support in the safe management of CDs.
• Procedures and protocols are accurate and clear as possible for operational staff and do not impose an intolerable administrative burden.
• The stock levels and range of preparations of CDs held is appropriate to that which is routinely used in clinical areas.
• Healthcare staff should receive adequate training and are competent in the management of CDs appropriate to their sphere of activity and level of responsibility.
• Access to CDs is restricted to appropriate, designated and legally authorised personnel.

12.2.1 Management of CD incidents and concerns

• All incidents, balance discrepancies, suspected loss or suspected abuse of controlled drugs MUST be reported to the Accountable Officer for Controlled Drugs (AO-CDs) / Director of Pharmacy immediately upon identification.
• It may not be appropriate initially to record the event on DATIX – due to the wide dissemination of DATIX reports this could jeopardise any investigation.
• The AO-CDs will ensure a full and effective investigation takes place.
• In line with Controlled Drugs (Supervision of management and use) Regulations 2013 the AO must share any concerns and the outcome of any investigations with appropriate external bodies (i.e. NHSE Accountable Officer for Controlled Drugs and / or local police / Drugs Liaison Officers).

12.3 Management of CDs in Wards and Departments

12.3.1 Accountability and Responsibility

The ordering, receipt and storage of CDs on a ward or department are the responsibility of the registered nurse or midwife in Charge. This control of access may be delegated to another registered nurse, midwife or ODP but the legal responsibility remains with the nurse or midwife in charge.

12.3.2 Controlled Drug Stocks

A list of CDs to be held as stock items should be available in each ward or department.

The ward stock of CDs should be the minimum required to meet reasonable current patterns of usage.
12.3.3  Requisitioning of Controlled Drugs

- The ordering of controlled drugs is the responsibility of the Nurse in Charge and should be undertaken by her/him whenever possible. In the absence of the Nurse in Charge, a delegated Registered Nurse / Midwife/ODP may order them. However the legal responsibility remains with the registered nurse in charge.
- In **Main Theatres** the senior registered nurse on night duty will carry out routine ordering of stock controlled drugs following a check of the central CD stock cupboard against the ledger. When CDs are required to be transferred to the anaesthetic room from the central stock, the anaesthetic room Controlled Drug Record Book will be taken to the central CD stock cupboard and two registered practitioners will issue the required amount against the central stock ledger. The recipient will ensure the issued drugs are safely transferred to the anaesthetic room stock cupboard.
- All persons ordering controlled drugs must have previously provided a specimen signature to the Pharmacy as proof of authenticity. These are to be updated annually.
- A list of specimen signatures must be maintained on the ward to facilitate checking of the controlled drug Controlled Drug Record Book by the pharmacist.
- The order for controlled drugs must be written in indelible ink in the Ward Controlled Drug Order Book. Each order should be written on a separate page and specify the drug name (and brand name in the case of specific formulations such as transdermal or modified-release preparations), form, strength and quantity.
- Central CD stock levels in a theatre suite will be sufficient to ensure theatres are able to run at full capacity for three full days. In the case of Cardiothoracic Theatres this will apply to individual theatre stocks.
- Controlled drugs may be requisitioned privately by persons eligible to do so. However, confirmation from their employing body will be sought and approval obtained from the Accountable Officer for the Trust.

12.3.4  Receipt of Controlled Drugs

- Any stock controlled drugs or TTAs containing controlled drugs must be received by a registered nurse or an ODP (in theatres).
- A registered nurse/ODP and the member of staff delivering from Pharmacy, must immediately check and sign the delivery log. The medicine must then be checked against the order and, if correct, the 'receipt' portion of the order book signed by the registered nurse. Inform the Pharmacy immediately of any discrepancies (ext. No 53522).
  - For main theatres, controlled drugs will be received at one central point from which they will distributed to individual theatres suites.
  - As soon as the controlled drugs are received on the ward they must be entered in the Stock Controlled Drug Record Book or the TTA Controlled Drug Record Book.
- Check the balance of the ward stock against the controlled drug record book.
- Enter details of the medicine received in the Controlled Drug Record Book, to include:
  - Date
  - Amount of medicine received and the new balance
  - Controlled drug order book page number
- Full signatures of both Nurses
- Lock the medicines into the Controlled Drug cupboard

12.3.5 Storage of Controlled Drugs

Ward CD cupboards should conform to BS 2881 or be otherwise approved by the pharmacy department. A security cabinet that has been evaluated against the SOLD SECURE standard SS304 should be used in areas where large amounts of CDs are in stock at any given time, and/or there is not a 24-hour staff presence, or easy control of access.

Access to the CD cupboard must be restricted to a person who can lawfully be in possession of CDs, such as a registered nurse or pharmacist, or someone working under their authority. CD cupboards should only be used for the purposes of storing CDs including KCl and ketamine.

The general measures for the storage of CDs include:

- CD cupboards must be kept locked when not in use.
- The lock must not be common to any other lock in the Trust.
- CD cupboard keys must only be available to authorised staff.
- For main theatres, access to the CD cupboard will be restricted to two registered practitioners at any time.
- The CD cupboards must be used solely for the purpose of storing CDs or other drugs considered to have the potential for misuse or that pose a particular danger e.g. Strong (15%) Potassium Chloride Injection.
- CDs must be locked away when not in use.
- The CD keys must be kept secure. This is particularly important in clinical areas which are not operational at all times e.g. 5 day wards.

12.3.6 Responsibility for CD keys

- The registered nurse or midwife in charge is legally responsible for the CD keys.
- Key-holding may be delegated to other suitably trained, registered healthcare professionals or ODPs but the responsibility rests with the registered nurse or midwife in charge.
- Another authorised member of staff should return the CD key to the nurse or midwife in charge immediately after use.
- On occasions, for the purpose of stock checking, the CD keys may be handed to an authorised member of pharmacy staff (e.g. a pharmacist or pharmacy technician).
- The following best practice applies to Derriford Main Theatres (other theatre suites do NOT have a centralised CD store).
  - A senior registered practitioner will at all times hold the central CD stock cupboard keys.
  - Best practice dictates that a minimum number of people should hold the keys and avoid unnecessary passing of keys from one person to another.
  - Therefore, the central CD cupboard keys will be held by the team leader in charge of the suite on any given day.
  - All anaesthetic support staff must collect and sign for their keys from the central CD stock cupboard key holder at the beginning of the session/working day.
All anaesthetic support staff must return their keys to the central CD stock cupboard key holder at the end of the session/working day and sign for them.

- In the event of the CD key going missing, urgent efforts should be made to retrieve the key as speedily as possible e.g. by contacting the responsible staff members who have just gone off duty. The senior nurse on duty and the ward or on-call pharmacist should be contacted as soon as appropriate if the key(s) cannot be located in order that suitable arrangements can be made to make sure patient care is not impeded and the security of the CD stocks is maintained. The Accountable Officer should be informed if the key couldn't be found, who might, depending on circumstances, contact the police. If the key couldn't be found fill in a Trust Incident form.

### 12.3.7 Controlled Drug Order and Record Books

Controlled drug order books must be kept in the controlled drug cupboard. Each drug and formulation needs to be ordered on a separate page.

Controlled drug orders are received and entered into a controlled drug record book, each drug and formulation needs to be entered onto its own page.

**ENTRY IN A CONTROLLED DRUG RECORD BOOK MUST NOT BE OBLITERATED OR ALTERED** in such a way as to make it impossible to read what change has been made. Any correction must be made by placing brackets around the entry with an asterisk at the side of the incorrect entry and a margin note or footnote giving the details and the date on which the correction is made. All entries and corrections must be in indelible ink, clearly explained, attributable to an identifiable individual and witnessed.

The Controlled Drug Record Book must not be used for any purpose other than the recording of controlled drug transactions, or any other drug deemed by the Trust as necessary to be controlled.

### 12.3.8 CD Stock Checks

- The registered nurse in charge is responsible for ensuring that stock checks are carried out and recorded.
- A registered Nurse/practitioner must carry out the check. The check must be witnessed by a suitably trained second person – this may be another registered person or a suitably trained Assistant Practitioner / Healthcare Assistant.
- For all wards and departments (except theatres – see below) the stock balance of controlled drugs **must** be reconciled at least once every 24 hours when the ward/department is operational.
- For theatres, the stock balance of controlled drugs **must** be reconciled at the following times:
  - At the start of the session/working day
  - When there is a change in anaesthetic support staff
  - At the end of the session/working day
  - At any time when a practitioner decides it is necessary to do so
- The check must be recorded with both Nurses identified.
- Wards/departments/theatres: Guidelines for good checking practice:
  - Remove entire contents of CD cupboard
Check each page in the record book and check the balance when you come to the running total.

Ensure the drug name and dosage on the box are the same as the page in the Controlled Drug Record Book.

Reconcile the balance in the Controlled Drug Record Book against the contents of the CD cupboard, not the reverse, to ensure all balances and pages are checked.

Remove an ampoule at random from each opened box and check the details. Do not open sealed boxes where the tamper-evident seal is still intact.

Check the expiry date.

Ensure that all drugs from that session/day and the previous session/day have been properly signed and accounted for.

For theatres, perform a sweep of the work surfaces and anaesthetic machines for any unopened or half used ampoules and syringes that have not been properly returned or discarded.

Both practitioners must sign and date the check book.

Any CD, or part of, unaccounted for must be reported immediately to the senior person in charge of the theatre suite and treated as a serious untoward incident.

- Checking liquid balances:
  
  - The balances of liquids may be visually checked against the documented balance in the register.
  
  - Should the member of staff performing the check be concerned about the balance a measuring device is to be used to identify the correct balance, at this point the register is to be endorsed “Balance checked, measured with (e.g. syringe) x mls” and signed by both parties.
  
  - To facilitate estimation, prior to opening, it can be beneficial to mark the top of the liquid in the container with the nominal volume. An indelible marker or the top edge of an adhesive label can be used.
  
  - It is good practice to only have one bottle open at one time.
  
  - The balance must be confirmed as correct either upon receipt of a new bottle or when the amount in the running balance has been administered, and the amount in the bottle should have reached zero.
  
  - Managing A Suspected Volume Discrepancy:
    
    - Ensure the maths is correct and all doses have been recorded.
    
    - All discrepancies of 10% or greater must be recorded on datix.
    
    - If the container still contains liquid and the maths in the register is correct, this is overage. Overage must not be used for administration, the bottle must be endorsed with “Not to be administered” and should be returned to the Pharmacy by the ward pharmacist at the next opportunity.
    
    - If the bottle is empty and the balance suggests there should be liquid remaining this is underage. It is recognised small losses occur through natural wastage during the measuring process. Underage is to be endorsed in the register as “xml lost in administration” and it is the responsibility of the member of staff administering the last dose to ensure the balance is correct.
    
    - Should a spillage occur a second member of staff must be called upon to verify and help measure the spill. Should it not be possible to measure the spill, the remaining volume in the bottle must be measured and the register endorsed “Balance checked, measured with (e.g. syringe) x mls” and
signed by both parties. Under no circumstances must the spill be returned to the bottle.

- Should there be any concerns about the amount lost or the frequency the discrepancy must be raised initially with the ward pharmacist who will then raise the issue with the Accountable Officer or the Pharmacy Governance Technician. If the ward or department do not have a ward pharmacist then raise any possible concerns with the Accountable Officer or the Pharmacy Governance technician.

- Controlled drugs which are not in common use on the clinical area, ordered for a specific patient or out of date should be returned to the Pharmacy via the Ward/theatre Pharmacist when the patient no longer requires the medicine.

- The CD stock checks needs to be documented in the Controlled Drugs Record book. This MUST be signed and dated by both members of staff. This can be either as a separate entry for each individual preparation, or as a single declaration at the back of the record book.

**12.3.9 Archiving of Controlled Drugs Records**

All Controlled Drug Record Books, controlled drugs order books and documents tracking/monitoring CD usage in the Trust should be kept for a period of 2 years after the date of the last entry. These records should be kept securely in the ward or department to which they relate or are generated.

**12.3.10 Prescribing of Controlled Drugs**

Registered and provisionally registered medical practitioners and dentists are authorised to prescribe CDs as far as this is necessary for their work within the Trust.

Nurse Independent Prescribers can prescribe a limited range of CDs in certain clinical conditions (see current BNF) but only when they have been authorised to do so in accordance with the Trust’s Non-medical Prescribing Policy. Similarly, Supplementary Prescribers can prescribe and administer CDs if the CD is included within a patient’s clinical management plan signed by the relevant consultant.

**12.3.10.1 Prescribing CDs for Inpatients/Day Cases**

- The written requirements for CDs are the same as that for other medicines and can be written on the Drug Prescription and Administration Record or anaesthetic record (see Section 3).

- These orders are legally an authorisation to administer and do not need to meet the full legal requirements for prescriptions issued to individual patients (see prescribing for discharge patients and outpatients below).

- In theatres prescribers should use the colour-coded pre-printed opiate prescription labels provided by pharmacy to prescribe opiates on the main drug chart. These then match with the epidural, Patient Controlled Analgesia (PCA) and bolus opiate monitoring charts used in theatre and recovery.

- Naloxone should be prescribed on the “when required” section of the drug chart for all patients receiving opiate via PCA, epidural and/or bolus injections. A pre-
printed prescription label is available for this purpose. Any administration of naltroxone must be recorded on the drug chart.

12.3.10.2 Prescribing CDs for Outpatients/Discharge Patients

Prescriptions for Schedule 2 and 3 CDs must contain the following details, written so as to be indelible and irremovable i.e. written by the prescriber's hand, typed or computer-generated. Addressograph labels MUST not be used. The prescription must:

- be signed by the prescriber
- be dated
- state patient's full name, address, hospital No. and, where appropriate, age.
- state the name and form of the drug
- state the strength of the preparation, where appropriate.
- specify the dose to be taken (a dose of "as directed" or "when required" is not acceptable, but "one to be taken as directed/when required" is acceptable
- specify the total quantity of the preparation, or the number of dose units, to be supplied in both words and figures. NB When the dose prescribed involves several strengths, the total quantity of each strength must be specified.

Electronically generated controlled drug prescriptions may be used, but they must be printed on paper and the hard copy signed by the prescriber.

Prescriptions which do not fulfil these requirements CANNOT be dispensed by pharmacy.

12.3.11 Administration of Controlled Drugs (Except Theatres – see below)

Controlled drugs must be administered by a registered nurse or doctor and must be checked by another Registered Nurse or Doctor.

BOTH THESE PERSONS MUST REMAIN PRESENT THROUGHOUT THE ENTIRE PROCEDURE of checking, preparation and the administration of the controlled drug.

Both persons must:

- Check the prescription sheet is legible and valid.
- Select the correct controlled drug and check that the drug has not expired.
- Check the stock balance of the controlled drug against the balance remaining in the Controlled Drug Record Book.

IF THE BALANCE IS CORRECT: - PROCEED
IF INCORRECT: -

Double check the stock balance, check you have selected the correct strength/form and investigate any possible subtraction errors, if balance is still incorrect, then:

- Enter details of loss in margin of controlled drug in the Controlled Drug Record Book.
• The senior nurse on duty must be informed of the discrepancy immediately and will contact the Pharmacy (contact on-call Pharmacist if deemed appropriate out of hours).

• Fill in a Trust Incident form.

The Pharmacy will take any appropriate further action, e.g. inform security/police.

THEN PROCEED.

• An entry is immediately made in the Controlled Drug Record Book with:
  - Date
  - Patient's first name and surname
  - Amount of medicine being administered
  - Route of administration
  - Stock balance remaining

• Prepare the medicine for administration and lock the remaining medicine away in the cupboard.

• If any portion of a controlled drug is to be wasted both persons must witness correct disposal, and record it in the Controlled Drug Record Book.

• Take the medicine and the prescription sheet to the patient. Both people must check the patient's identity and the medicine against the prescription sheet.

• Both Nurses/doctor administering the medicine must initial the patient's prescription sheet at the bedside. Both Nurses/doctor must ensure that the remaining necessary details are recorded in the Controlled Drug Record Book, namely:
  i) the time of administration
  ii) the full signature of both Nurses/doctor.

• If, for any reason, the controlled drug is not administered, a record of the reason for non-administration must be made in the left hand margin of the Controlled Drug Record Book and the entry signed in full by both Nurses.

12.3.11.1 Administration of Controlled Drugs in Theatres

• A record of all administrations must be made. The Theatre Controlled Drug Record Book must show issue, receipt, form of administration and ampoules/vials returned/disposed of.

• The nurse in charge is responsible for the recording of the amount of stock issued to the anaesthetist and recalculating the remaining stock balance, and for the return of unused ampoules to the stock balance. These tasks may be delegated to an authorised registered nurse or ODP but the responsibility remains with the nurse in charge.

• CDs must be issued to the anaesthetist for one case at a time.

• The amount issued should relate to a specific patient and surplus drug should be destroyed.

• Injectables should be treated as intended for single use only unless the label specifically indicates that they are licensed and intended for use on more than one occasion or to provide more than a single dose on any one occasion.

• The practice of issuing “active stock” to the anaesthetist then returning the unused portion to stock must be avoided.

• At the time of issue the balance in the anaesthetic room Controlled Drug Record Book must be checked against the amount in the box of that drug.
• At the time of issue the date and time, who issued the drug, who received the drug, the amount issued and the patient’s name must be entered in to the anaesthetic room Controlled Drug Record Book.
• The doctor/anaesthetist involved in the transaction is responsible for:
  o Signing for the number of ampoules received.
  o Recording the amount of the medicine administered on the anaesthetic record and drug administration sheet which will ultimately be incorporated in the patient’s notes.
  o Returning any unopened ampoules to the nurse in charge or the delegated authorised registered ODP or nurse.
  o Safely disposing of any unused medicine remaining in an open ampoule or in a syringe.

12.3.11.2 Record of Administration of Naloxone and Flumazenil

• Any use of naloxone or flumazenil must be recorded in the Controlled Drugs Record Book by a registered nurse or ODP. This record may be made retrospectively in the case of an emergency
• The reason for using either naloxone or flumazenil must be clearly documented, i.e. administered for opioid/benzodiazepine over-dose, drawn up in anticipation but not administered, etc.
• The record does NOT need to be checked by another Registered Nurse, ODP, accredited Health Care Assistant or Doctor
• Flumazenil and naloxone do NOT need to be stored in the Controlled Drugs cupboard

12.3.11.3 Supply, Possession and Use of Diamorphine by Midwives

• The possession and administration of diamorphine by midwives, for the relief of pain during the management of labour, is covered by the Misuse of Drugs Regulations 2001 and the Medicines Act 1968.
• The supply of diamorphine must be kept in a locked container. The security of all medicines issued to a midwife is her responsibility.
• A midwife is allowed to administer on her own responsibility a maximum of 15mg diamorphine in divided doses of up to a maximum individual dose of 10mg. Two hours MUST elapse between each dose.
• When attending a home birth the midwife must obtain the diamorphine from the Central Delivery Suite.
• Collection of Diamorphine from CDS for use in Community:
  • Following a request from the attending midwife at a home birth, a community midwife may take up to 2 ampoules of 5mg diamorphine or 1 ampoule of 10 mg diamorphine at any one time from the CDS CD cupboard.
  • The process will be:
    o The diamorphine ampoule/s must be checked out of the CDS CDRB and signed into Community CDRB at the same time. This must be signed by a CDS midwife as well as the community midwife.

<table>
<thead>
<tr>
<th>EXAMPLE</th>
<th>CDS CDRB</th>
<th>Diamorphine 10 mg ampoules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>Pt name</td>
</tr>
<tr>
<td>Amount</td>
<td>given</td>
<td>Given by</td>
</tr>
<tr>
<td>Witnessed by</td>
<td>Stock balance</td>
<td></td>
</tr>
</tbody>
</table>

TRW.MMA.POL.265.10.4 Medicines Management Policy 66
The ampoules of diamorphine must be carried in a locked container between the hospital and community setting.

The CDRB must be taken to the patient’s home together with the diamorphine. Once the diamorphine has been administered both community midwives must sign the CDRB and alter the stock balance accordingly. If the diamorphine is not used it may be returned to CDS, again by signing it out of the community and into the CDS CDRB. Any reconstituted diamorphine which is part/not administered to the patient can be destroyed and signed as such by both midwives in the community CDRB.

12.3.12 Use of High Dose/Strength Opioids (Diamorphine & Morphine ampoules (30mg or greater), Alfentanil 5mg in 1ml ampoules, Oxycodone 50mg/ml ampoules, Oxycodone 10mg/ml oral solution & Morphine 20mg/ml oral solution)

12.3.12.1 Use of High Dose Diamorphine and Morphine (30mg or greater) ampoules

- The prescribing of high dose diamorphine / morphine can only be undertaken by an appropriately qualified and trained medical officer, in line with the Trust’s approved therapeutic guidelines (Palliative Care Guidelines – 2nd Edition), End of Life Care available on Trust Net. The lowest clinically appropriate dose must be prescribed. Specialist advice can be obtained from the palliative care team and / or the acute pain service.

- Ampoules of 5mg and 10mg of either drug or 50ml vials of morphine 1mg/ml may be kept as routine ward stock. Higher dose ampoules of either drug must not be routinely stored in clinical areas, when they are they should wherever possible be segregated within the cupboard. Should a specific clinical need arise higher dose ampoules can be obtained from pharmacy by sending the prescription chart to pharmacy together with the CD order book and will be supplied on a named patient basis (e.g. for the management of a registered diamorphine addict or a palliative care patient requiring greater than 30mg diamorphine in 24 hours). When high strength ampoules have been supplied to a ward, but the clinical need for them has finished any remaining ampoules must be returned to pharmacy at the earliest practical opportunity.
• High dose ampoules of both drugs will be stored in a separate location in Pharmacy to lower strength formulations and a fluorescent sticker highlighting the high opiate content will be attached to every box. A record of all wards storing a high dose preparation will be maintained within pharmacy. The continuing need for these will be assessed on a weekly basis. Drugs no longer required must be removed and returned to pharmacy.

12.3.12.2 Use of High Dose/Strength Alfentanil 5mg in 1ml ampoules, Oxycodone 50mg/ml ampoules, Oxycodone 10mg/ml oral solution & Morphine 20mg/ml oral solution

• Although not included in the “high dose opiate” NPSA alert Alfentanil 5mg in 1ml amps, Oxycodone 50mg/ml amps, Oxycodone 10mg/ml oral solution and Morphine 20mg/ml oral solution will be controlled and restricted in the same way.

• High Dose/Strength Alfentanil 5mg in 1ml ampoules, Oxycodone 50mg/ml ampoules, Oxycodone 10mg/ml oral solution & Morphine 20mg/ml oral solution for patients on the End of Life Care Pathway can be obtained from pharmacy by sending the prescription chart to pharmacy together with the CD order book and will be supplied on a named patient basis. When high strength ampoules or oral solution have been supplied to a ward, but the clinical need for them has finished any remaining ampoules or oral solution must be returned to pharmacy at the earliest practical opportunity.

• High strength Alfentanil is licenced for the purpose of sedating patients on ventilators in intensive care. Any intensive care area requesting high strength Alfentanil will NOT have to supply the prescription chart.

12.3.13 Controlled Drugs Brought in by Patients

Controlled drugs brought in by patients remain the property of the patient.

12.3.13.1 Recording of Patient’s Own Controlled Drugs:

A record must be made in the Controlled Drug Record Book of any patient’s own controlled drug(s) received on the ward.

12.3.13.2 Administration of Patients’ Own Controlled Drugs

In exceptional circumstances (i.e. patients admitted after the Pharmacy is closed, in the evenings and weekends) patients’ own controlled drugs may be administered for a short period only:

• if they are prescribed
• with the agreement of the Doctor responsible for the patient
• if the medication is in date
• if the medication is identifiable.
In these circumstances the medicines must be transferred to a separate page of the Controlled Drug Record Book by the Nurse in Charge or authorised Nurse, plus a witness who must be another trained Nurse or Doctor.

The medicines are then administered using the same procedure as controlled drugs obtained from the Pharmacy.

Arrangements should be made to obtain a stock of the required controlled drug as soon as the Pharmacy opens.

Patients' own controlled drugs must not be administered to any other patient on the ward.

1.3.13.3 Patient's own drugs upon discharge

Upon discharge, patient’s own controlled drugs may be returned to the patient providing there is an on-going clinical need for the drug. The patient and registered nurse need to sign the CD register to maintain a full audit trail. In the absence of an on-going clinical need for the controlled drug the patient must be encouraged to hand over the drugs for destruction. Ensure the patient completes a “Patient's Own Medication – Consent to Destruction” form. The drugs should be returned to pharmacy for destruction, at the earliest opportunity.

If a patient dies whilst in hospital any patient own controlled drugs MUST NOT be returned to their next of kin / relatives. In such circumstances the drugs must be returned to pharmacy for destruction, making reference in the CD register to the fact that the patient passed away.

12.3.14 Emergency Transfer of Stock Controlled Drugs from One Ward to Another

All supplies of CD’s are to be ordered from the Pharmacy in a timely manner. Should it be necessary to obtain CD’s outside of the Pharmacies opening hours the following process can be used.

The emergency transfer of stock of schedule 2 & 3 controlled drugs must NOT occur during the opening hours of Pharmacy.

The nurse, ODP, anaesthetist or doctor caring for the patient must take the Controlled Drug Record Book and the patient's drug chart to the nearest ward holding a stock of the appropriate controlled drug.

An appropriate quantity of the required medicine may be transferred to minimise disruption to both wards, e.g. for overnight. The actual quantities transferred MUST be clearly identifiable to aid administration.

Both Nurses must enter details of the transfer into the Controlled Drug Record Books of both wards.
The Nurse must return promptly to the "borrowing" ward and administer the medicine as per prescription and procedure.
12.3.15 Procedure for Discharge (TTA) Controlled Drugs

All discharge prescriptions for controlled drugs must comply with the legal requirements for such prescriptions. Guidance can be found in the front of the current edition of the British National Formulary (BNF).

Prescriptions which do not fulfil these requirements CANNOT be dispensed by pharmacy.

The Nurse receiving the medicines must ask another trained Nurse to assist her and both Nurses should:

Check the controlled drug and amount received against the TTA prescription (GP letter).

Enter full details of the TTA controlled drug prescription in the Controlled Drug Record Book to include:

- Date
- Patient's name (Forename/Surname)
- Name of medicine
- Amount received
- Signature of both Nurses

The dispensed medicine must be stored in the controlled drug cupboard.

When the patient is ready for discharge two persons, one of who must be a Registered Nurse or Midwife, must check the controlled drugs out of the cupboard.

Medicines must be checked out to the patient using the copy of the prescription.

The registered Nurse must sign the Controlled Drug Record Book stating that the dispensed medicine has been given to the patient or carer. The patient or an identified carer must countersign the Controlled Drug Record Book to acknowledge receipt.

If the patient is unable to sign and no carer is available the discharge checks must be carried out by two registered nurses and the register must indicate why the patient has not signed (e.g. patient unable to sign – poor eyesight).

12.3.16 Disposal of Controlled Drugs

Controlled drugs on the ward or clinical area which are expired or no longer required must be returned to the Pharmacy by the Ward/Theatre Pharmacist or an authorised pharmacy technician for destruction. A Registered Nurse or midwife and the Pharmacist must sign the CDs out of the Controlled Drug Record Book into the designated Pharmacy controlled drug order book which has been adapted for CD returns with both the Registered Nurse or Midwife in Charge and a Pharmacist signing.

Individual doses of controlled drugs that are prepared, but not administered or only part administered, will be destroyed on the ward or in the department by a
doctor/anaesthetist, registered nurse or registered ODP and the destruction witnessed by a second registered person who may be a nurse, pharmacist, doctor/anaesthetist or ODP.

The CD to be discarded should be rendered irretrievable by emptying the contents of the ampoule/vial/syringe into a sharps bin. Larger volumes (100ml or more) of liquid waste should be denatured prior to disposal in the sharps bin. When the bin is sent for destruction it should be labelled “contains mixed pharmaceutical waste and sharps – for incineration”.

In addition for theatres:
- The anaesthetist is personally responsible for safely disposing of any unused drug remaining in an open ampoule or in a syringe.
- In the case of wastage from part doses the anaesthetic room Controlled Drug Record Book should show the name of the patient, the names of those and details of dose/wastage e.g. 5mg given/5mg wasted.
- In the case of a dose drawn up but not given the anaesthetic room Controlled Drug Record Book should show the name of the patient and the reason for non-administration.
- It is the responsibility of the anaesthetist to return any unopened ampoules to the Nurse in Charge.
- In all cases an entry must be made in the theatre Controlled Drug Record Book, including the names of those involved in the return or destruction.

Once returned to Pharmacy all controlled drugs will be stored and destroyed in-line with local standard operating procedures – see 12.5.

12.4 General processes and specific circumstances

12.4.1 Controlled Drug Stationery

Controlled drug order books must be kept in the controlled drug cupboard. CD stationary can be requested in the controlled drugs order book by the Registered Nurse or Midwife in charge. A record is made of the following for CD order books:

- Date
- Ward/department
- The serial number of the stationary
- Signature of the member of pharmacy staff supplying

Any loss or theft of CD stationary should be reported immediately to the Accountable Officer or the ward or on-call pharmacist. Only one CD Order Book or Record Book should normally be in use for one Ward/department.

When a new controlled drug record book is started the balance of Controlled Drugs should be checked and transferred into the new book promptly by ward staff. This may be more conveniently done before the last page is completely used. Another Registered Nurse or Midwife should witness this transfer and both to sign for each balance check.
12.4.2 Delivery/transfer of Controlled Drugs

Controlled drugs must be delivered in a secure, number-sealed, tamper-evident container.

At each point when a CD moves from authorised possession of one person to another, a signature and proof of identity should be recorded by the person handing over and the person receiving the CD.

In the case of issue to a patient or patient's representative from the pharmacy department, proof of identity or lack of it should be recorded on the receipt that the collecting person is required to sign. Discretion must be used if patient confidentiality may be compromised, or if patients may be deterred from having their medicines supplied.

In the case of messengers carrying CDs in a sealed or locked container, they should be made aware of the precise destination, be aware of safe storage and security, the importance of handing over the container to an authorised person and obtaining the relevant signature on the delivery document.

12.4.3 Clinical Trials

The requirements of the Controlled Drug legislation and Trust policy must be met in the protocol for any clinical trial involving Controlled Drugs in addition to that required for the clinical trial itself.

All clinical trial CDs must be stored separately from Stock CDs and entered onto a separate page of the Controlled Drug Record Book. In the case of double blind clinical trials all material must be treated as a CD.

12.5 Management of Controlled Drugs in the Pharmacy Department

The management of CDs in the pharmacy will be in accordance with the relevant legal requirements.

The pharmacy will maintain a comprehensive set of standard operating procedures covering all aspects of the management of controlled drugs.

In order to supply controlled drugs to organisations outside of Plymouth Hospitals NHS Trust the Pharmacy Department will hold and maintain a Wholesale Dealer’s Authorisation (Human) and a Home Office Controlled Drugs Licence.

12.6 Staff training

The Accountable Officer is responsible for ensuring that members of staff involved in the prescribing, supplying, administering and disposing of Controlled Drugs receive appropriate induction and regular update training to enable them to carry out their duties.

The Trust will develop this training programme in conjunction with the development of relevant Standard Operating Procedures for CDs that are included in this document.
Staff will be informed and, if necessary, receive additional training when policy or procedures are revised or amended.

12.7 Procedure for Dealing with Suspected ‘Illegal Substances’ Brought into Hospital by a Patient

The aim of the procedure is to ensure staff deal safely and legally with substances thought to be illegal when brought into hospital by patients.

The purpose of this guidance is to protect and ensure the safety of the patient concerned and to protect healthcare professionals.

It should be recognised that if a suspected ‘illegal substance’ is returned by a member of staff to a patient / carer then that person may be regarded in law as a ‘supplier’ and as such is committing an illegal act. The penalties for this type of offence are high and usually involve a custodial sentence. Staff involved must not contact the police, since this would be a breach of patient confidentiality. In the event a large quantity (a quantity exceeding personal use) of substance has been brought into the hospital the Accountable Officer / Director of Pharmacy for the Trust will discuss with the legal department whether to report the incident to the police.

12.7.1 Procedure

The member of staff finding the substance must notify the senior nurse in charge of the ward, A&E or department immediately.

12.7.1.1 Removal of Substance from Patient

- If at any point in time there is a potential risk to the safety of the staff involved Hospital Security must be involved.
- The nurse-in-charge must remove the substance from the patient and must lock it in the ward, A&E or department CD cupboard and notify pharmacy at the earliest opportunity.
- A record of the substance must be made in the ward’s Controlled Drug Record Book. The description of the ‘substance’ must not imply that the nurse has analysed it, e.g. “brown substance”, not “cannabis resin” or “allegedly cannabis resin”.
- If the patient refuses to relinquish the substance then the pharmacy must be informed at the earliest convenience. A pharmacist and nurse will interview the patient and explain the situation in order to obtain release of the substance. If the patient continues to refuse to release the substance Security must be involved. Should the situation still remain unresolved it may be appropriate to contact the police. This should first be discussed with the Accountable Officer / Director of Pharmacy.

12.7.1.2 Removal of Substance from Ward Area

- At the earliest opportunity during normal business hours a pharmacist (or a member of Pharmacy staff delegated by the Accountable officer) must visit the ward, clinic, or department and remove the ‘substance’ (see Pharmacy SOP).
- A ‘Patients Own Medication Consent to Destruction’ form must be completed—one copy is to be retained in the medical notes, one kept with the drugs and the
third copy given to the patient. Where a patient refuses to sign a ‘Patients Own Medication

- Consent to Destruction’ form, the pharmacist (member of Pharmacy staff) may
  witness the nurse in signing, if there is no other person to act for the patient.
- The substance must be booked out of the ward Controlled Drug Record Book by
  the nurse in charge and the pharmacist (member of Pharmacy staff).

12.7.1.3 Storage of substance in pharmacy

- The pharmacist must return to the pharmacy and enter the ‘substance’ in the
  designated police record book kept for this purpose.
- The description of the ‘substance’ must not imply that the pharmacist has
  analysed it, e.g. “brown substance”, not “cannabis resin” or “allegedly cannabis
  resin”.
- The ‘substance’ must be weighed with/out packaging and this must be noted
  alongside the description.
- The pharmacist must promptly inform the Accountable Officer / Director of
  Pharmacy (or deputy) of the occurrence, including the amount of ‘substance’
  involved (approximately).
- The Accountable Officer / Director of Pharmacy (or deputy) will de
  cide with
  support from the Caldecott Guardian / Legal Department / Security whether it is
  necessary to inform the police of the occurrence if a large amount of ‘substance’
  is involved.
- The ‘substance’ must be stored in the designated police safe in the CD Room.

12.7.1.4 Destruction of Substance

- The ‘substance’ will be collected for destruction at the next scheduled police
  visit.
- A full audit trail will be maintained of the substance. No patient details will be
  made available to the police, unless there is a specific request under the
  Prevention of Crime legislation. Details must only be released against a signed
  order from an appropriately senior officer within the force.

12.7.1.5 Return of Substance to Patient

It is possible that a patient may demand return of the ‘substance’ on discharge. In
such a scenario, the nurse discharging the patient should persuade the patient to
leave without the ‘substance’. If the patient refuses the nurse must call a hospital
security representative.

UNDER NO CIRCUMSTANCES CAN THE SUBSTANCE BE RETURNED TO THE PATIENT

12.8 Substance Misuse Patients, including opioid dependent patients, presenting in hospital that are prescribed Opiate Substitution Treatment (OST)

12.8.1 Procedure for prescribing opiate substitution treatment (OST), with the exception of diamorphine, dipipanone and cocaine, for the management of addiction
It is important to ensure that patients prescribed opiate substitution treatment, i.e. methadone, buprenorphine, for the management of addiction:

- On admission: have this confirmed through an appropriate systematic check, taking into account any necessary adjustments for clinical reasons.
- On discharge: ensure management is appropriately and safely transferred to primary care.

**Hospital medical practitioners**

When a patient is admitted on opiate substitution treatment (OST), i.e. methadone, buprenorphine, for the management of addiction (excluding diamorphine, cocaine and dipipanone), the hospital medical practitioner on the admitting team MUST

- Contact the appropriate prescriber to alert them of the patient's admission to hospital and to confirm:
  - the patient is prescribed opiate substitution treatment for addiction
  - the patient’s usual dosing schedule
  - when the last dose of substitute medication was taken or, at least, when the last prescription was issued and how many days have been supplied (this may also be confirmed with the patient's community Pharmacy)
  - a management plan for the duration of the patient's hospital admission
  - any modifications to be made because of the admitting condition

- A written management plan for the patient must be written in the medical notes following consultation with the OST prescriber.

- Any alteration or deviation from the agreed management plan MUST be discussed with the OST prescriber. Clear and unambiguous records must be maintained in the medical records of any changes.

**Ward Pharmacist**

When a patient is admitted on opiate substitution treatment (OST), i.e. methadone, buprenorphine, for the management of addiction (excluding diamorphine, cocaine and dipipanone), the ward Pharmacist MUST

**On admission:**

- To confirm patients prescribed on admission opiate substitution treatment, i.e. methadone, buprenorphine, for the management of addiction the treatment and doses prescribed
  - are clinically appropriately
  - in accordance with the patient's current management plan
- Contact the patient’s community pharmacist to:
  - alert them of the patient’s admission
  - confirm the patient's usual treatment and dosage
  - determine the normal dispensing schedule (daily, weekly, etc)
  - arrange for the patient’s normal supply to stop
- If the dose of opiate substitution treatment needs reviewing contact a specialist in substance misuse (see section 12.8.2 for contact details)
- Ensure that the ward has ordered the required Controlled Drugs.

**On discharge**

- Liaise with:
o OST prescriber and key-worker, to confirm:
  ▪ patients discharge
  ▪ arrange on-going prescription in community
  ▪ any other drugs that the patient is being prescribed.

o the patient’s community pharmacist to confirm when
  ▪ patient is being discharged
  ▪ the next dose is due to be dispensed/administered.

- Do NOT discharge patient with any psychoactive drug or opiates liable to misuse.
- Patients do not get a supply of opiate substitution treatment on discharge unless there are clear mitigating circumstances, i.e. discharge over a weekend when the patient’s usual community Pharmacy is closed.

12.8.2 Procedure for Prescribing and authorisation to administer or supply Diamorphine, Cocaine or Dipipanone for the management of addiction

When used for the management of addiction diamorphine, cocaine and dipipanone can only be prescribed or authorised for administration and supply by a medical practitioner licensed to do so by The Home Office, and in exceptional circumstances by a doctor authorised by the license holder (under an agreed clinical management plan). These restrictions are described in The Misuse of Drugs (Supply to Addicts) Regulations 1997 SI # 1001.

A consequence of this legislation is that hospital medical staff cannot normally prescribe or authorise the administration or supply of these drugs when used for the treatment of addiction. This includes the continuation of the drugs as part of an on-going addiction treatment plan, unless authorised to do so by the license holder.

The regulations do not specify the manner in which the authorisation of the hospital doctor is to be provided and do not specify that a named doctor needs to be nominated. It is considered best practice that this authorisation is provided on an individual patient basis through a named prescriber within Derriford Hospital and any verbal authorisation is confirmed in writing.

There are currently two licensed doctors covering Plymouth patients, two licensed doctors covering Devon and four licensed doctors covering Cornwall:

<table>
<thead>
<tr>
<th>Plymouth</th>
<th>Dr. Charlie Lowe</th>
<th>Tel: 01752 435222</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr. Hugh Campbell</td>
<td>Tel: 01752 435222</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tel: 01752 434297</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Harbour Centre</th>
<th>Tel: 01752 434343</th>
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</table>

Drs Lowe and Campbell are authorised to initiate therapy and continue prescribing for registered patients addicts.

Phone numbers updated Jan 15:

**Exeter**

(ENDAS) Exeter & North Devon Addiction Service Tel: 01392 208210

(RISE) Recover and Integration Support Service
Procedures to follow during normal business hours (Mon - Fri, 9am – 5pm)

Consultant or Registrar on the admitting team

- When a patient is admitted or an admission is planned and the patient is usually taking either diamorphine, dipipanone or cocaine for addiction, the Registrar or consultant on the admitting team must contact the appropriate licensed doctor to confirm:
  - the patient is prescribed diamorphine, cocaine or dipipanone for addiction
  - the patient’s usual dosing schedule
  - a management plan for the duration of the patient’s hospital admission
  - any modifications to be made because of the admitting condition

- These details MUST be confirmed in writing via a faxed letter signed by the licensed prescriber and filed in the patient’s medical notes. This is best practice and will also confirm the number of days supply authorised and who is authorised to prescribe.

- In the event that it is not possible to contact the licensed prescriber please see below.

- A written management plan for the patient must be written in the medical notes following consultation with the licensed doctor.

- Write the patient’s drug chart. Please note, only the authorised prescribers can write the drug chart. If the in-patient prescription chart is re-written, only an authorised prescriber can re-write the prescription. If the authorised prescriber is unavailable, a further authorisation letter from the licensed prescriber must be obtained.

- Inform the ward pharmacist of the patient including the name of a registrar/consultant delegated by the licensed doctor to subsequently prescribe for this patient.

- Any alteration or deviation from the agreed management plan MUST be discussed and confirmed in writing with the licensed prescriber. Clear and unambiguous records must be maintained in the medical records of any changes.

Ward Pharmacist

When a patient is admitted on diamorphine, dipipanone or cocaine, for the management of addiction, the ward Pharmacist MUST
- Confirm an authorisation letter has been faxed and signed by the licensed prescriber confirming the patient’s usual dosing schedule and any necessary dose modifications (see below if not available)

- Contact the patient’s community pharmacist to confirm usual dosing schedule and arrange for the patient’s normal supply to stop.
- Ensure that the ward has ordered the required Controlled Drugs.

- On discharge, the ward pharmacist will liaise with the patient’s community pharmacist and the licensed prescriber to confirm when usual prescriptions in community need to continue. No supply will be made as a TTA, except in exceptional circumstances and when approved by the Accountable Officer for Controlled Drugs (or nominated deputy).

**Procedures to follow when the licensed prescriber is unavailable (e.g. out of hours)**

- In the rare event that it is not possible to contact the licensed prescriber, and it is in the patient’s best interest to maintain their current addiction management programme, authorisation to a senior hospital doctor to continue any prescription for these restricted drugs may be provided in an “open letter” from the licensed prescriber, up until the time that a formal approval can be gained.

- It is essential that the “open letter” must only be used in exceptional circumstances when it is not possible to contact the current prescriber or an alternative license holder.

- If the licensed prescriber cannot be contacted then formal authorisation to continue the management of the patient must be sought at the earliest opportunity.

- An “open letter” authorised by Dr Lowe and Dr Campbell is in place for Plymouth based patients. No such authorisation is in place for NHS Devon or NHS Cornwall patients.

- For patients registered with Cornwall based services an on-call substance misuse doctor is available (see above). They should be contacted and formal authorisation obtained as described above.

- There is no on-call service for Devon patients and currently no “open letter” is available.

**Consultant or Registrar on the admitting team**

- When a patient who usually taking diamorphine, dipipanone or cocaine for addiction is admitted out of hours the Consultant or Registrar from the admitting team must contact the on-call pharmacist **before** prescribing any of the restricted drugs.

- For patients registered with Cornwall based services the admitting doctor will need to contact the on-call substance misuse doctor on the number above and obtain the necessary authorisation, as described above (procedure during normal working hours).
On-call pharmacist

- The on-call pharmacist will determine which substance misuse service the patient belongs to and give advice on the necessary steps that need to be taken to ensure the legal requirements are fulfilled.

- In all circumstances it is essential that the on-call pharmacist confirms the nature of the patient’s addiction and their current dosage regimen. The necessary confirmation can be gained from the following sources:
  - Contact the patient’s community pharmacist to confirm usual dosing schedule and arrange for the patient’s normal supply to stop.
  - Checking patients own medication brought from home which MUST be appropriately labelled from a Community Pharmacy with clear dosage directions (use as directed is not acceptable) – all patients
  - Contacting the on-call substance misuse doctor for Cornwall

- If the patient’s usual treatment / dose cannot be confirmed and / or it is not possible to obtain the appropriate authorisation to continue the patient’s current management plan contact the Controlled Drugs Accountable Officer, or if unavailable a nominated deputy for further advice.

13 Errors and Adverse Events in prescribing, dispensing, administration and monitoring of medicines

The following situations illustrate typical errors that occur during the administration of a medicine and require completion of an Untoward Incident Report in line with the ‘Management of Adverse Events Policy and Incident Management SOP’:

- A prescription error is found.
- A patient is given a medicine that has not been prescribed.
- An incorrect dose of a medicine is given to a patient.
- A patient is given the correct medicine but at the incorrect time.
- A medicine is administered via the wrong route.
- A medicine is administered in the wrong form.
- There is any unplanned omission of a medicine to a patient.
- The patient has an allergic/anaphylactic reaction to or demonstrates unforeseen/unpredictable sensitivity to a medicine. In these cases, the reaction should be documented:
  - in the medical notes
  - by completing the green allergy chapter card kept at the front of medical notes
  - by completing a MHRA Yellow card (in BNF) for all adverse events with new medicines (Black Triangle in BNF) and serious or unusual reactions with other medicines.

The person identifying a medicine-related incident must take immediate steps to ensure that no further harm occurs and seek advice from the Doctor(s) in charge of the patient’s care on further action to resolve the situation. The Nurse in Charge and the Pharmacist must also be informed.
In the case of a medication incident that may have resulted in serious /permanent harm, including death, the Serious Untoward Incident Procedure as documented in the Incident Management SOP must be followed. The Director of Pharmacy or his deputy must also be informed.

The person identifying a significant medicine-related incident or near miss must complete a Trust Untoward incident form as soon as possible after the incident. Statements from all those involved in the incident and action taken must be included as they will be required to support the investigation. The manager of the location where the incident occurred is responsible for investigating the incident and involving all relevant stakeholders.

Procedures in the Trusts Adverse Events Policy and Incident Management SOP must be followed.

Medicines-related incidents reported via the Trust Incident reporting system are collated by the Patient Safety pharmacist and reviewed by the MUAC on a monthly basis. All medicine related incidents rated as either medium risk or higher have a root course analysis completed by the Patient Safety Pharmacist and this is also reviewed by the MUAC. The MUAC will then nominate a committee member to resolve any identified issues, disseminating learning through the Medication Governance Bulletins and reviewing the Medicines management training packages.

Chemotherapy related incidents reported via the Trust Incident reporting system are collated by the Cancer Services Pharmacists and reviewed by the Chemotherapy Operations Group on a monthly basis. The Chemotherapy Operations Group will then nominate a committee member to resolve any identified issues.

14 Overall Responsibility for the Document

Overall responsibility for this document lies with The Director of Pharmacy.

15 Consultation and Ratification

The policy has been reviewed and ratified by the Medicines Assurance and Utilisation Committee.

16 Dissemination and Implementation

- Following approval and ratification by the Medicines Assurance and Utilisation Committee this policy will be rolled out across the Trust.
- Publication of this Policy will be publicised in Vital signs and in the weekly staff news brief. The Policy will be sent to all ward managers, doctors, Pharmacists and Pharmacy technicians, and a copy will be made available on the Trust-wide Shared Drive called Trust Document Drive

17 Training and Monitoring of this Policy

17.1 Training

All staff involved in the clinical use of medicines will receive education regarding this policy as part of their Trust induction through the medicines management e-learning
module and associated assessment. Following Trust induction, staff will receive training relating to policy updates through the e-learning medicines management statutory update module.

In addition to the above, junior doctors receive further medicine management training shortly after induction as part of their Foundation training programme. Further training is also provided to medical staff on rotation in to the admissions unit, paediatrics and oncology/haematology. All registered nurses, midwives and ODPs must undertake the Trust’s Intravenous Drug administration training and demonstrate competence and be certificated before undertaking this activity. Specific training is also required if administering certain medicines e.g. cytotoxic chemotherapy, Intrathecal medicines.

Non-Medical Prescribers must undergo specific training and be approved to prescribe within this Trust in accordance with the Trust’s Non-Medical Prescribing policy.

17.2 Monitoring Compliance with this Policy

- The Medicines Assurance and Utilisation Committee has the responsibility for reviewing, analysing and proposing changes designed to minimise risks from medicines.
- Medicines-related incidents reported via the Trust Incident reporting system are monitored by the Patient Safety pharmacist and reviewed by the MUAC on a monthly basis. All medicine related incidents rated as either medium risk or higher are reviewed and monitored by the MUAC. The MUAC will monitor implementation of any identified actions.
- The medicines management audit plan covers a wide diversity of areas and includes:
  - Pharmacists prescribing interventions are audited on a 6 monthly basis. This will include the accuracy of patient’s medicines on handover between care settings.
  - All NPSA alerts/RRR to confirm continued compliance
  - The Medicines Reconciliation in Adults Policy
Each audit has a lead nominated by the Associate Director of Pharmacy and the results are reported to and monitored by the MUAC.

Training:
- Individual training is monitored through the HR workforce and training records by the Workforce Development Team.

18 References

1. The Human Medicines Regulations 2012
2. Misuse of Drugs Act 1971
3. Misuse of Drugs Regulations 2001 SI No 3998
4. Misuse of Drugs (Safe Custody) Regulations 1973
5. Department of Health September 1988, Guidelines for the safe & Secure Handling of Medicines. A report to the Secretary of State for Social Services by the Joint Sub-Committee of the Standing Medical Nursing and Midwifery and Pharmaceutical Advisory Committees, chaired by Professor R B Duthie, CBE, MA, ChM, FRCS.
6. The Safe & Secure Handling of Medicines – A Team Approach – a revision of the above report by a working group chaired by Professor G B A Veitch. March 2005
10. NMC standards of conduct, performance and ethics for nurses and midwives (2008)
12. Review of Prescribing, Supply and Administration of Medicines, A report to the Secretary of State for Health, by a Review Team Chaired by Dr June Crown Final Report, March 1999

Annex A - Glossary

<table>
<thead>
<tr>
<th>Appointed Nurse-in-Charge</th>
<th>The most senior nurse appointment for the ward or department (e.g. ward manager)</th>
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<tr>
<td>Assigned Nurse-in-Charge</td>
<td>The senior nurse on duty for the ward or department who has been identified as Nurse-in-Charge for that shift/</td>
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<tr>
<td>Authorised Nurse</td>
<td>Any Registered Nurse who satisfies the criteria to enable him/her to administer medicines without supervision</td>
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<tr>
<td>Authorised Prescriber</td>
<td>A person who is authorised to undertake independent or supplementary prescribing according to the current legislation and Trust policy.</td>
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<tr>
<td>Controlled Drugs (CDs)</td>
<td>For the purposes of this document, any medicine or drug that is listed in Schedules 2 or 3 of the Misuse of Drugs Regulations. The Trust may treat other medicines as Controlled Drugs where a need is identified (e.g. Strong Potassium Solutions)</td>
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<td>Medicine</td>
<td>Medicinal product as defined in Section 130 of the Medicines Act: a substance administered by mouth, applied to the body, or introduced into the body for the purpose of treating or preventing disease, diagnosing disease or ascertaining the existence of a physiological condition, contraception, inducing anaesthesia, or otherwise preventing or interfering with the normal operation of a physiological function.</td>
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<td>Patient Group Direction (PGD)</td>
<td>A written instruction to enable a healthcare professional to supply and/or administer a licensed medicine to groups of patients who may not be individually identified before presentation or treatment.</td>
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<tr>
<td>Suitably trained person</td>
<td>For the purposes of this policy – someone trained in the administration of medicine(s) to a level of competence agreed by the Trust</td>
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### Core Information

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<th>Medicines Management Policy</th>
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<td>October 2017</td>
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<tr>
<td>Dissemination Lead</td>
<td>Matthew Brindley, Assistant Director Pharmacy</td>
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### Previous Documents

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### Dissemination Plan

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## Review and Approval Checklist

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<td>Human Resources/staff side committee</td>
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<td>Is there a plan to review or audit</td>
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<td>Is it clear who will be responsible</td>
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<td>for co-ordinating the dissemination,</td>
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<td>implementation and review of the</td>
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<tr>
<td>document?</td>
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### Core Information

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<tr>
<th>Manager</th>
<th>Simon Mynes</th>
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<tr>
<td>Directorate</td>
<td>Pharmacy</td>
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<tr>
<td>Date</td>
<td>31st May 2016</td>
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<tr>
<td>Title</td>
<td>Medicines Management Policy</td>
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### What are the aims, objectives & projected outcomes?

The purpose of this policy is to set the standards for the correct management of medicines, i.e. prescribing, procurement, production, ordering, storage, distribution, preparation and administration of medicines. The policy covers all clinical areas and all medicinal products as defined in the glossary (annex A).

This policy is based on relevant evidence based national guidance on medicines management. Other products or devices requiring pharmaceutical control are also considered as medicines for the purposes of this document.

The Trust will ensure, through the Director of Pharmacy, that appropriate systems are established and maintained in order to reduce the risk posed to patients, prescribers and pharmacists by the use of unlicensed medicines.

The medicines management policy is also a key requirement by the CQC relating to outcome 9 – Medicines Management

### Scope of the assessment

See names and contributors on page one of the policy

### Collecting data

<table>
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<tr>
<th>Race</th>
<th>Consideration will be made if information provided to patients/carers is required in a different language</th>
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<td></td>
<td>Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Religion</td>
<td>There is no evidence to suggest that there is an impact on religion or belief and non-belief regarding this policy.</td>
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<tr>
<td></td>
<td>Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Disability</td>
<td>Consideration will be made if information about medicines management is required in different formats for people with disabilities/learning disabilities</td>
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<td></td>
<td>Carers will be encouraged to participate in the management of medicines for those patients that require it.</td>
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<tr>
<td></td>
<td>Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Sex</td>
<td>There is no evidence to suggest that there is an impact on sex regarding this policy.</td>
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<tr>
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<td>Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Gender Identity</td>
<td>There is no evidence to suggest that there is an impact on gender identity regarding this policy.</td>
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<td>Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Sexual Orientation</td>
<td>There is no evidence to suggest that there is an impact on sexual orientation regarding this policy. Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Age</td>
<td>There is no evidence to suggest that there is an impact on age regarding this policy. Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>Socio-Economic</td>
<td>Consideration has been made for the management of medicines for addicts and a plan for the duration of their stay will be implemented.</td>
</tr>
<tr>
<td>Human Rights</td>
<td>Carers will be encouraged to participate in the management of medicines for those patients that require it. Data collected from Datix incident reporting and complaints will ensure this is monitored.</td>
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<tr>
<td>What are the overall trends/patterns in the above data?</td>
<td>No comparative data has been used to date which means that no trends or patterns have been identified</td>
</tr>
<tr>
<td>Specific issues and data gaps that may need to be addressed through consultation or further research</td>
<td>No gaps have been identified at this stage but this will be monitored via data collected from Datix incident reporting and complaints.</td>
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</table>

**Involving and consulting stakeholders**

**Internal involvement and consultation**
The Medicines Assurance and Utilisation Committee
Medical Director
Director of Pharmacy

**External involvement and consultation**
No external consultation has been undertaken

**Impact Assessment**

**Overall assessment and analysis of the evidence**
Consideration will be made if information provided to patients/carers is required in a different language
Consideration will be made if information about medicines management is required in different formats for people with disabilities/learning disabilities
Consideration has been made for the management of medicines for addicts and a plan for the duration of their stay will be implemented.
Carers will be encouraged to participate in the management of medicines for those patients that require it.

**Action Plan**

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Risks</th>
<th>Completion Date</th>
<th>Progress update</th>
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</thead>
</table>
## TTA Record

### Action if TTA with critical meds found of discharged patient:
1. Attempt to contact patient
2. If unable to contact patient, inform GP
3. Return TTA’s to pharmacy with note informing pharmacy of actions taken.
4. Complete Datix form

### Definition of Critical Medications (not exhaustive)
- Antimicrobials
- Anticoagulants
- Anti-platelets
- Insulin, glucose
- Parkinson’s medication
- Antiepileptic medication
- Desmopressin
- Gentamycin for neonates
- Steroids
- Pyridostigmine & Neostigmine

### Record of daily TTA cupboard check and record of TTA’s not taken by patients

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<th>Date daily check</th>
<th>Name of checker</th>
<th>Patient name</th>
<th>Patient hospital number</th>
<th>Date found</th>
<th>Name of person who found TTA’s</th>
<th>Name of staff member action handed to?</th>
<th>Reason not taken by patient</th>
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<th>What action taken when TTA’s found? By whom?</th>
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Ward-level actions in response to finding a potentially lost TTA

1. **Attempt to contact patient to repatriate TTA**

2. **If unable to contact patient on first attempt, inform GP**

3. **Return TTAs to pharmacy with note informing pharmacy of actions taken**

4. **Complete DATIX incident form detailing incident and actions taken**