MEDICINES POLICY

To be read in conjunction with: Antimicrobial Prescribing Policy; Clozapine Policy, Controlled Drugs Policy (see also section 25.2), and Medical Gas Cylinders and Medical Pipeline Services Policy.

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<td>Date issued:</td>
<td>July 2017 (minor changes December 2017, September 2018, April 2019)</td>
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<td>Review date:</td>
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<tr>
<td>Applies to:</td>
<td>All staff working within the Trust who are involved in any way with the use of medicines. This includes locum and agency staff.</td>
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This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000
**Amendments**

Revised and updated May to April 2015.
Jan-16: update to reflect BNF changes, clarify policy on homeopathic medicines and OPD clinics medicines.
Jun-17: Various amendments and additions to correct technical errors, reflect changes in national guidance and best practice, Trust operational changes, learning from incidents, and comments on Trust policy and procedures by the CQC (Feb-17 inspection).
Nov-17: Amendments to enable enactment of SmokeFree Policy v3, and facilitate self-administration of medicines on inpatient wards. Revision of Appendix E Annex 1.
Sep-18: Minor amendments and Appendix M (Red Drug Pathway) updated.

**Document objectives:** This policy defines the policies and procedures to be followed within the Trust for the management of medicines and includes obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

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<tr>
<th>Approving body</th>
<th>Medicines Oversight Group</th>
<th>Date: June 2017 April 2019</th>
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<td>Contact for review</td>
<td>Chief Pharmacist</td>
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<td>Lead Director</td>
<td>Chief Medical Officer</td>
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**CONTRIBUTION LIST** Key individuals involved in developing the document

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<td>Deputy Chief Pharmacist – Head of Medicines Safety</td>
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Legal and Human Rights

Mental Health Act 1983
MHA Form T2 or Form T3
Deprivation of Liberty Safeguards (DoLS)

Administration of Medicines

Newly appointed and newly qualified staff
Midwives, paramedics and podiatrists
Pre-registration student nurses
Role of non-registered staff in medicines administration
Role of patient relatives or carers in medicine administration
Administration Process
Checks before administering medication
Measuring Doses
Omitted and Delayed Medicines
Missed administration of antipsychotic depot injections
Administration of Controlled Drugs
Self-Administration on inpatient wards

Adverse Drug Reaction Monitoring

Dispensing and Supply of Medicines

Dispensing
Supply of pre-labelled packs (over-labelled packs)
Issue of dispensed medication

Monitored Dosage Systems

Patient Medicines Information

Medication Untoward Events

Controlled Stationery

Trust Day Hospitals / Day Centres

Community Teams

Medicines reconciliation in Community Teams
Prescribing in Community Teams
Storage of and access to Medicines in Community Teams
Ordering medicines in Community Teams
Palliative Care Drug Administration for Community (District) Nursing Teams
Patient collection of medication from Trust sites
Using Patient's own drugs in Community Teams
Controlled drugs in the community teams
Administration in Community Teams
Transportation of Medicines by Community Teams
Disposal of Medicines by Community Teams
School Age Vaccination Service

20 Primary Care Dental Service

21 Managing Medicines in a Section 136 Suite – Mental Health
   Routinely prescribed and as required medication for symptom control

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24 Monitoring Compliance and Effectiveness

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Appendix B Patient’s Own Drugs Disposal Form Inpatient/Community
Appendix C Algorithm for the use of Patient’s Own Drugs (PODs)
Appendix D Safety Alerts and Recalls
Appendix E Pharmaceutical Products Temperature Monitoring Guidance
Appendix F Amending Medicines Administration Record Charts
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Appendix P Drugs Administration in Inpatient Wards – Clinical Audit Standards
Appendix Q Safe and Secure Handling of Medicines – Clinical Audit Standards
1. **INTRODUCTION**

1.1 All NHS Trusts are required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner.

1.2 Staff should ensure the patient is able to understand the information given to them and is able to give their informed consent. This may necessitate the use of a professional interpreter and the translation of written information. A capacity assessment should be considered for those patients who are unable to consent to the procedure and reference should be made to the relevant Trust policy Consent and Capacity to Consent to Examination/Treatment Policy.

2. **PURPOSE & RATIONALE**

2.1 This policy defines the policies and procedures to be followed within the Somerset Partnership NHS Foundation Trust for the management of medicines in accordance with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This includes prescribing, obtaining, transporting, recording, handling, safe keeping, dispensing, safe administration and disposal of medicines.

2.2 Where appropriate this policy refers to other Trust Policies which are linked to the use of medicines. It should be read in conjunction with those policies, which are listed in Section 25.

2.3 All staff working within the Trust who are involved in any way with the use of medicines must familiarise themselves with the correct procedures contained in this policy. Managers must ensure that all staff are familiar with this policy before they are involved with the use of medicines. This is especially important for all new starters, locums and agency staff as procedures may differ from elsewhere.

2.4 This policy recognises the following statutory and advisory publications and should be read in conjunction with:

- Antimicrobial Stewardship: “Start Smart –then Focus” ARHAI Antimicrobial Stewardship Subgroup. November 2011
- Control of Substances Hazardous to Health (Amendment) Regulations 1997 (COSHH)
- CQC Outcome 9
- Guidelines for records and record keeping, Nursing & Midwifery Council (NMC) 1998
- Health Service Circular HSC 2000/026 Patient Group Directions
- The Medicines Act 1968
- The Human Medicines Regulations 2012
- The Health Act 2006
• The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2006
• Mental Capacity Act 2005
• Mental Health Act 1983
• Misuse of Drugs Act 1971
• NMC Standards of proficiency for nursing associates (current version)
• The Prescription Only Medicines (Human Use) Order 1997
• Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society & Royal College of Nursing 2019).
• Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
• Safe and Secure Handling of Medicines (SSHM) (Revision of the Duthie Report) (Royal Pharmaceutical Society 2018)
• Safer Management of Controlled Drugs: (1) Guidance on Strengthened Management Arrangements January 2007
• Safer Management of Controlled Drugs: a guide to good practice in secondary care (England) (DH 2007)
• Somerset CCG Prescribing Formulary – current edition
• Standards for Medicines Management: Nursing and Midwifery Council (2008)
• Professional Standards for Hospital Pharmacy Services: Royal Pharmaceutical Society July 2014

3. DUTIES AND RESPONSIBILITIES

3.1 The Chief Executive is ultimately responsible for ensuring the trust complies with legal requirements and national recommendations for medicines management.

3.2 The Trust Board has a responsibility to ensure training and competency assessment is available to all relevant staff.

3.3 The Chief Medical Officer is the Executive Lead responsible for this policy covering safe medicines practice within the trust, but will delegate authority for the operational implementation and ongoing management of this policy to the Chief Pharmacist.

3.4 The Chief Pharmacist is the nominated ‘Accountable Officer’ for Controlled Drugs in the Trust and has delegated authority for the operational implementation and ongoing management of this policy.

3.5 Each registered healthcare professional is accountable for their own practice and will work within the Code of practice of their professional body.

3.6 All staff should appreciate the importance of involving the patient and/or carer in their treatment as much as possible. This includes ensuring the patient or carer understands and agrees to the proposed treatment and appreciates as far as possible any risks of side effects. In order to fully
understand, patients may need the support of a professional interpreter or translation service. Information on medication and its side effects should be made available in a range of formats and languages to meet patient need. Please contact the Medicines Management Team for advice on how to access.

3.7 **All registered healthcare professionals** involved in the medication process:
- must acquaint themselves with this policy and other related policies
- will be aware of the action that should be taken if their practice or their patients safety is compromised
- will be aware of the safe dose range, frequency, route, administration technique, side effects, contra-indications, interactions and monitoring requirements of the drugs used
- will observe the patients for side effects and adverse reactions and manage them appropriately
- will monitor the outcomes of the treatment against identified treatment goals
- will be aware of their limitations and seek advice or support from appropriate health professionals when in doubt
- will avoid delegation to others who may not be qualified or experienced to carry out that task

3.8 **All non-registered healthcare staff** involved in the medication process:
- must acquaint themselves with this policy and other related policies
- will be aware of the action that should be taken if their practice or their patients safety is compromised
- will only undertake tasks in the medication process where suitable policies and procedures are in place, a clear process for delegation and escalation of medicines related tasks has been identified, the staff member has been suitably trained for the specific task and competencies have been assessed as appropriate, and the scope of the staff members involvement in medicines related task is defined within the staff members job description.
- will be aware of their limitations and seek advice or support from to an appropriate health professionals when in doubt
- must not delegate medicines-related tasks to others

3.9 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies before they are involved in any drug administration or ordering of medicines and that they are trained and competent to undertake that role. Line managers are responsible for ensuring that staff attend mandatory training in line with the Staff Mandatory Training Matrix.

3.10 **Consultants** are responsible for ensuring that all medical staff in their team are competent to prescribe and that they follow this policy.
3.11 The Chief Medical Officer is responsible for ensuring that all other medical and dental staff are competent to prescribe and that they follow this policy.

3.12 The Chief Nurse is responsible for ensuring that non-medical prescribers are competent to prescribe and that they follow this policy.

3.13 All practitioners will be required to demonstrate their necessary knowledge and competence to prescribe and administer medicines.

3.14 Pharmacists and Pharmacy Technicians

3.14.1 The Trust recognises the use of the specialist knowledge and medicine management expertise of pharmacists and pharmacy technicians working in collaboration with other healthcare staff and patients in the implementation of this policy.

3.14.2 Clinical pharmacists and pharmacy technicians provide a broad based clinical advisory and medicine management service for Somerset Partnership NHS Foundation Trust. This service includes:

- Prescription review
- Medicine optimisation
- Pharmaceutical education and training.
- Implementation and monitoring of policies and related protocols
- Information and advice on all aspects of the use of medicines for staff and patients
- Implementation and use of Medicine Management systems for ordering, storing, administration and supply of medicines.

3.15 The Medicines Incident Group is responsible for reviewing Medicines incidents and disseminating lessons learned.

3.16 The Medicines Oversight Group will make recommendation based on Audit Reports on all aspects of this policy. It is also responsible for ensuring that this policy is reviewed at least every three years or sooner in line with local and/or national requirements.

3.17 Operational managers are responsible for the implementation of any clinical audit recommendations.

3.18 The Medicines Oversight Group is responsible for approving this policy. The Group is responsible for the overall monitoring of the Clinical Audit plan in relation to this policy.

3.19 Learning and Development Facilitators are responsible for ensuring attendance records are signed by each participant and forwarded to the Learning and Development Department.

3.20 The Learning and Development Department is responsible for entering all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and reporting non-attendance to Local Managers.

4 DEFINITIONS

4.1 Medicinal Product: A Medicinal Product is ‘Any substance or combination of substances presented for treating or preventing disease in human beings.
or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product.’ Council Directive 65/65/EEC

4.2 **Controlled Drug:** Those drugs defined in the current Misuse of Drugs Regulations 2001 (as amended). The Misuse of Drugs Regulations classifies the drugs in five schedules according to the different levels of control required. See Controlled Drug policy.

4.3 **Authorised Prescriber:** A registered doctor, dentist, or registered independent/supplementary or Community Practitioner Nurse Prescriber who is authorised by the Trust to prescribe to patients in the care of the Trust and has provided a specimen signature to the Trust supply pharmacy.

4.4 **Prescribing:** The preferred way for patients to receive medicines is for an appropriately qualified healthcare professional to prescribe for an individual patient on a one to one basis.

4.5 **Patient Specific Direction:** A patient specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine (including the dose, route and frequency), or appliance to be supplied and administered to a named patient e.g. an instruction on a medication administration chart.

4.6 **Patient Group Directions:** a specific written instruction for the supply, sale and/or administration of named medicine or vaccine in an identified clinical situation (HSC2006/026). It applies to a defined group of patients who may not be individually identified before presenting for treatment (see the Trust Patient Group Direction Policy for details).

4.7 **Transcribing:** the act of making an exact copy, usually in writing. In the context of this policy, transcribing is the copying of previously prescribed medicines details to enable their administration in line with legislation (i.e. in accordance with the instructions of a prescriber) without further intervention of a prescriber.

4.8 **Medicines Reconciliation:** the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician’s admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points in a patient’s treatment. See Medicines Reconciliation Policy.

4.9 **Dispensing:** To prepare a clinically appropriate medicine for a patient for self-administration or administration by another professional. It includes checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient.

4.10 **Administer:** To give a medicine by either introduction into the body e.g. orally inhaled or by injection, or by external application e.g. cream, ointment or application of a patch. The process involved may be:

- Administration – drugs are fully administered by staff
• Supervised administration – patients exercise varying degrees of responsibility for the administration of their own drugs short of self-administration and staff will provide varying degrees of assistance short of full administration.
• Self-administration – the patient manages their own drugs with appropriate monitoring by staff.

4.11 Medicines Administration Record (MAR) chart: These are not a prescription but a direction to administer and record administration of medication. If the MAR chart is also to be used as a prescription for the supply of named-patient medicines the MAR chart must be signed by a registered prescriber who authorises the administration of medication on their behalf. When administering medication the registered nurse is accountable for their actions and for raising any concerns about the direction to administer with the prescriber. Only Trust approved medication charts may be used (Exceptions: for inpatient and Community Nursing services see paragraph 9.45; for Ambulatory Care Services please refer to local service protocols).

4.12 Supplementary chart: additional ‘paper’ charts approved by the Medicines Oversight Group for recording the administration of specific drugs.

4.13 Red drugs: Drugs categorized under the Somerset Prescribing “traffic light” system as appropriate for specialist prescribing only. Please see “Principles of prescribing across the primary and secondary care interface” (Appendix L) for further explanation.

4.14 Cold Chain - The system used for maintaining temperature sensitive medicines in good condition is called the cold chain. This consists of a series of storage and transport links, all of which are designed to keep the product within the correct temperature range until it reaches the user.

5 ACQUISITION OF MEDICINES

5.1 This section applies to inpatient and community settings, where it should be read in conjunction with section 19.

5.2 The Ward/Team manager or Community Hospital Matron is responsible for the ordering, stock control, rotation, expiry date checking and reconciliation of any discrepancy of medicines. On a day to day basis, the responsibility may be delegated to a nominated Registered Nurse.

5.3 The Trust does not have an in-house medicines supply service (pharmacy). Medicines supplies are outsourced to a single provider by commercial tender in accordance with procurement legislation.

5.4 The only other authorised supply route is by means of FP10 forms which may be dispensed at any registered pharmacy holding an NHS community pharmacy contract when supply can be obtained from pharmacy within an acceptable time for the circumstances.

5.5 Other medicines suppliers may be used for regular supply of medicines by exception but only after approval by the Chief Pharmacist.

5.6 Medical gases are licensed medicinal products. Procedures for ordering, storing and controlling movement of medical gas cylinders and for piped...
gases are contained within the Medical Gas Cylinders and medical Pipeline Services Policy.

5.7 E-cigarettes will not be prescribed, purchased or supplied by the Trust except in accordance with the Trust Smoke Free Policy. E-cigarettes use must not be prescribed on MAR charts or via RiO EP. See the Smoke Free Policy for details on permitted use of E-cigarettes by patients on Trust property.

5.8 Homeopathic, herbal, probiotics or alternative medicines will not be prescribed for purchase or supply at Trust expense (also see paragraphs 9.67 to 9.73) unless explicitly approved for use in the Trust formulary, the Somerset CCG Formulary or under the Somerset Traffic Light Guidance.

5.9 Orders should be in the form of a permanent record and any requisition sheets or books must be stored securely when not in use (see paragraphs 5.11, 5.12, and 5.14).

Ordering and Receiving Stock and Non-stock Medicines

5.10 All locations that order medicines will have an agreed list of stock medicines that will be reviewed regularly by the Trust pharmacy staff in consultation with ward or department staff.

5.11 Stock items for inpatient wards are ordered from the supplying pharmacy. Electronic ordering is being phased in to replace existing paper order books. Non-stock items must be ordered using the Trust approved paperwork. Orders must be signed and dated by a registered nurse and sent to the pharmacy in line with the agreed schedule.

5.12 Only one requisition book / sheet should be in use at any time.

5.13 It is important that a check is made of the medicines cupboards and of any previous orders not yet received, before an order is placed.

5.14 Controlled Drugs must be ordered and received following the procedures in the Controlled Drugs Standard Operating Procedures 1 and 2 (see Controlled Drugs Policy).

5.15 All medicines must be delivered in a secure tamper-evident transit container and these must be brought to the attention of a registered nurse on arrival.

5.16 The container must be locked in a secure place. Containers must not be left unattended or accessible to patients and visitors and unauthorised staff.

5.17 As soon as practicable a registered nurse must check the medicines received from pharmacy against the computer printout from pharmacy and against the order. Any drugs supplied in error or complete packs ordered in error must be returned to the supplying pharmacy for reimbursement within five days of receipt accompanied by appropriate paperwork. Forms are available on the Medicines pages of the intranet.

5.18 The medicines must be locked in the medicines cupboard.

5.19 Items that require cold storage must be locked in the medicines refrigerator.

5.20 Any delays in obtaining medicines should be investigated and a Datix Untoward Event Report Form completed if appropriate.
5.21 All wards, units or departments that order and receive medicines must have a system in place for tracking and auditing medicines ordering and stock control.

**Ordering Discharge or Leave Medicines**

5.22 Medicines for patients to take home should be requested well in advance to avoid delays on the day of discharge.

5.23 The discharge and /or leave prescription written and signed by an authorised prescriber, may be faxed to the supplier but note that prescriptions for Controlled Drugs cannot be released from the pharmacy until the complete original discharge prescription has been received.

5.24 For wards using paper MAR charts facsimile copies should be faxed or emailed with the discharge and / or leave prescription to allow the supplying pharmacy to perform an accuracy check.

**Access to Medicines and Advice outside Pharmacy Hours**

5.25 If a medicine is required urgently when the pharmacy departments are closed, medicines may be obtained by one of the following routes:

- transfer from other wards (see paragraphs 5.26 to 5.34).
- FP10 prescriptions may be used to obtain medicines from a community pharmacy (see paragraph 5.3 and the FP10 Prescription Form Policy)
- the doctor or nurse in charge may telephone the on-call pharmacist following the arrangements for the pharmacy supply service (see Medicines pages on the intranet).

**Transfer of Medicines**

5.26 Somerset Partnership units, services and wards cannot legally supply stock medicines to any service or provider outside the Trust. However, in exceptional circumstances where it is in the best interest of the patient and after prior authorisation by the Chief Pharmacist, Deputy Chief Pharmacist, or on-call Director and a Datix Untoward Event Report Form must be completed.

5.27 Stock Medicines should not be transferred from one Trust unit, service or ward to another Trust unit, service or ward when a supply can be obtained from pharmacy within an acceptable time for the circumstances.

5.28 Transferring stock medicines between wards should only occur in exceptional circumstances under the direction of ward manager / hospital matron, head of MIUs, the on-call manager, a pharmacist or pharmacy technician. When stock medicines are transferred without prior authorisation of the Chief Pharmacist, Deputy Chief Pharmacist, or Deputy Chief Pharmacist a Datix Untoward Event Report Form must be completed.

5.29 When transferring stock medicines the complete container must be transferred to the receiving location. Medicines must not be transferred into another container.

5.30 The transfer of stock medicines between wards must be recorded on a ‘Stock Medicines Transfer Form’ (Appendix A).
5.31 The Registered Nurse in Charge of both wards/departments must keep signed records of the transfer of stock medicines and a copy sent to the Chief Pharmacist.

5.32 Stock Controlled Drugs must not be transferred between wards. Single doses may be administered to a patient on one ward from stock on another. The necessary record must be made in the Controlled Drugs record book of the supplying ward in accordance with the Controlled Drugs Policy (CD Standard Operating Procedure 12).

5.33 Patient’s own Controlled Drugs should be transferred from ward to ward with the patient in a safe manner in line with all other medicines and property belonging to that patient. Entries must be made in the Controlled Drugs record books on both wards.

5.34 Patient’s own drugs or medicines dispensed individually for a named patient must not be used for other patients. Patient’s own drugs and named patient supplies should be transferred with the patient if they transfer ward/hospital.

**Patient’s Own Drugs**

5.35 Patients are encouraged to bring their own medicines into hospital on admission. This will assist in the identification of their current treatment regimen.

5.36 Patient’s own drugs can be used on Trust wards operating a Patient’s Own Drugs (POD) system or dispensing for discharge scheme. Medicines used in these schemes must be stored in a lockable individual patient cupboard. Controlled drugs must be stored in the Controlled Drugs cupboard.

5.37 Patient’s own drugs remain their property and on transfer or discharge should be returned to them. If the medicines are no longer prescribed or there is any doubt regarding their suitability the patient should be advised of this and encouraged to sign the ‘Patient’s Own Drugs Disposal Form’ (Appendix B) to allow disposal of the medicines. A copy should be placed with the patient’s notes.

5.38 Medicines brought into hospital which are not suitable to be administered under a POD system should be:

- placed in a sealed bag clearly marked with the patient’s name and stored in a separate, designated area of the medicine cupboard or in an individual patient medicines locker, or
- disposed of following the Trust’s Procedure for the Disposal of Waste Medicines/Drugs and a ‘Patient’s Own Drugs Disposal Form’ (Appendix B) completed, or
- if the patient insists, the medicines may be returned home via an identified adult. Responsibility for security is given to that adult.

5.39 A patient’s own supply of medicines can be used for the named patient until a supply can be obtained from the pharmacy or if the pharmacy cannot supply. The medicines must pass the ‘Algorithm for use of Patient’s Own Drugs’ (PODs). (Appendix C).

5.40 If a patient does not have capacity to make decisions about their treatment their drugs may be removed for disposal without consent if a clinical decision is made that returning the drugs poses significant risk of serious
harm to the patient or others. The Trust will support clinical staff in making reasonable decisions in the balance between the legal duty of care to the patient and legal possession of the drugs. Full details of the identified risk and action must be documented in the patient record. A ‘Patient’s Own Drugs Disposal Form’ (Appendix B) should be completed.

5.41 Suspected illicit drugs and ‘legal highs’ not removed for analysis by the police should be disposed of following the Controlled Drug Standard Operating Procedure (see CD Policy) for dealing with illegal substances.

Clinical Trials

5.42 All clinical trials must have full Trust approval in line with the Trust Research and Development Policy before starting.

5.43 Clinical trials involving medication should be reviewed by the Medicines Oversight Group to provide input into decisions regarding Trust approval.

5.44 The requirements for the storage, administration or supply of Investigational Medicinal Products (IMPs) to patients by Trust staff and/or from Trust premises must be agreed with the Trust Chief Pharmacist.

5.45 Properly labelled clinical trial medicines brought in by a patient on admission, as part of current medication, can be checked by an authorised prescriber in the ward setting, noted, prescribed and administered as directed. The authorised prescriber has responsibility to inform the trial organiser that the patient has been admitted and to report any symptoms that could be a side effect of the medication.

5.46 Arrangements must be put in place at the point of care to prevent unintentionally compromising the patient’s participation in the clinical trial.

5.47 If further supplies of clinical trial medicines are required whilst the patient is an inpatient the relevant clinical trial pharmacy should be contacted or seek advice from the Medicines Management Team.

Samples / Free Stock

5.48 Pharmaceutical company representatives must not leave samples of medicines or dressings on any of the Trust premises nor give them out to Trust staff at meetings.

5.49 Medicines or dressings supplied free to the Trust must not be administered to, or used to treat patients except as part a clinical trial or an official product evaluation approved by the Medicines Oversight Group and the Clinical Effectiveness Team.

5.50 Where free samples of products designated as “ACBS” (Advisory Committee on Borderline Substances) in the Part XV of the Drug Tariff, e.g. oral nutritional supplements (‘sip feeds’) and baby milks, are provided to patients supply of samples should not be biased towards any particular manufacturer or supplier unless following Trust or Somerset CCG Formulary recommendations.

5.51 Any hospitality or sponsorship provided by pharmaceutical company representatives must comply with the Trust Ethical Standards and Code of Conduct Policy.
5.52 See also the Trust ‘Ethical Standards Policy’ and Commercial Representatives and their Dealings with SPNFT Policy for guidance on appropriate behaviour for pharmaceutical company representatives on Trust premises.

6 **DEFECTIVE MEDICINES**

6.1 All defective or suspected defective medicines must be reported immediately to the Trust Medicines Management Team and the supplier and an incident form completed. (see Untoward Event Reporting Policy and Procedure).

6.2 The Chief Pharmacist will advise on further reporting, and investigating of the defect.

6.3 Retain any remaining product and any associated products or equipment, pending information and advice from the Chief Pharmacist.

6.4 If the product has been administered to a patient inform the doctor responsible for the patient to ensure the patient is assessed and/or examined as appropriate. Record the defect in the patient’s notes.

6.5 Medicines recalls or Alerts should be handled as described in Appendix D

7 **STORAGE OF MEDICINES**

7.1 This section applies to inpatient and community settings where it should be read in conjunction with section 19.

7.2 A ward / team manager or community hospital matron is responsible for ensuring that the system for the security of medicines on the ward / team base is maintained. Some of the duties may be delegated but the responsibility always remains with the manager. No unauthorised person should have access to medicines.

7.3 All medicines stored on Trust premises must be stored in a locked medicine cupboard, locked medicines refrigerator, locked medicines trolley, locked individual patient own drug locker. These cupboards are reserved strictly for the storage of medicines - no other substances or article may be stored in them.

7.4 The only exceptions to this requirement are:

- medicines for resuscitation
- flammable liquids
- medical gases
- Patient own drugs – creams, ointments, inhalers (including glyceryl trinitrate) may be kept outside the POD locker following a risk assessment that takes account of patient capability and other patients on the ward.

7.5 Storage facilities should be situated in a locked room and should not be sited near sources of heat or humidity. The temperature of the room should be monitored to ensure it does not routinely exceed 25°C. Storage facilities should always be locked when not in use.
7.6 When a dispensing for discharge, patient’s own drugs system or a self-administration programme is operating on a ward, each patient involved should have a lockable receptacle which is not readily portable. Medicines must not be transferred from one container to another nor must they be stored in any container other than that provided by the supplier.

**STORAGE AREAS**

7.7 Medicines storage cupboards, including CD cupboards, Patient’s Own Drugs (POD) lockers and medicines refrigerators, must only be used to store the medicines relevant to the cupboards designated use. Medicines storage cupboards must not be used as a store for controlled stationary e.g. FP10 prescription pads, patient’s belongings or valuables or other items.

**Controlled Drugs Cupboards**

7.8 Storage arrangements for Controlled Drugs are detailed in the [Controlled Drugs Policy](#) and must comply with the Controlled Drugs Standard Operating Procedure 3.

**Medicines Cupboards**

7.9 Medicines Cupboards are for the storage of medicines such as oral, parenteral, topical and rectal preparations. These should be made of metal and comply with the relevant British Standards (BS 2881:1989) and NHS Building Note 29. Any other cupboards or storage facilities must be agreed with the Chief Pharmacist.

7.10 Internal and external medicines should preferably be stored in separate cupboards. If existing circumstances dictate that internal and external medicines are stored in the same cupboard (e.g. where space is at a premium), they must be stored on separate shelves to minimise risk of incorrect selection. The cupboards must always be locked.

**Medicines Refrigerators**

7.11 Medicines refrigerators must be used for storage of preparations labelled ‘Store in Refrigerator’ or those which indicate that they should be stored between 2°C and 8°C. See Appendix E for detailed information.

7.12 The temperature must be checked and recorded daily following the guidance in Appendix E – Medicines Refrigerator Monitoring Guidance. The refrigerator should be kept locked and used only for pharmaceutical products.

7.13 Further guidance for the handling of vaccines in community settings can be found in the Vaccination and Immunisation Policy.

**Medicines Trollies**

7.14 Where a medicines trolley is used, it should be reserved for orally administered preparations which are in current use and which do not require either special storage conditions or special procedures for preparation/administration.

See ‘Safe and Secure Handling of Medicines Clinical Audit Standards’ (Appendix Q) Standard 3 for exemptions.

7.15 The trolley must not be left unlocked unless in direct use and must not be left unattended during medicine rounds.
7.16 When not in use the trolley must be locked and immobilised and secured to an immovable object.

7.17 The trolley must be designed to provide adequate space to facilitate the safe selection of medicines.

7.18 Where Patient’s-Own Drugs (PODs) are administered patients may also need ‘PRN’ medicines for which they do not have a named patient supply. If a Medicines Trolley is no longer in use a ‘PRN’ medicines box or container containing stock medicines for ‘PRN’ administration may be used during medicines administration rounds.

7.19 ‘PRN’ medicines boxes must be stored securely in the Medicines Cupboard when not in use.

7.20 When in use ‘PRN’ medicines boxes must be under the direct supervision of the registered nurse and must not be left unattended at any time or in a position where a patient, carer or member of the public could access the contents.

**Keys for medicines storage**

7.21 On a ward the registered nurse in charge is responsible for controlling access to the medicine cupboards and trolley including custody of the keys for the Controlled Drugs cupboard. Key holding may be delegated to other suitably trained registered healthcare professionals but the legal responsibility rests with the registered nurse in charge. Keys should not be left unattended at any time. If there is no registered healthcare professional in other situations, for example, some out-patient departments, measures (including an audit process), must be in place to ensure that no unauthorised access to medicine keys or cupboards occurs.

7.22 The Controlled Drugs keys should be held separately from other medicines keys (in community hospitals a red fob should be used for controlled drugs and a blue fob for all other medicines storage related keys).

7.23 Access to medicines including Controlled Drugs is restricted to appropriate, designated and legally authorised personnel. On occasions for the purpose of stock checking, the keys including the Controlled Drugs key may be handed to an authorised member of the medicines management staff e.g. the pharmacy technician responsible for stock control of medicines on the ward.

7.24 If the keys are missing and cannot be found then urgent efforts should be made to retrieve the keys as speedily as possible e.g. by contacting nursing staff who have just gone off duty. A complete spare set of keys should be kept in an appropriate secure location.

7.25 Other staff groups who use medicines e.g. dental, physiotherapists, podiatrists should have their own storage cupboards and are responsible for the control and security of their medicines, including holding and securing keys.

7.26 Where patients are self-administering their medicines patients may be provided with a key or keycode for the specific Patient’s Own Drug (POD) locker where their medicines are stored. The POD locker key or keycode supplied must be unique to that locker on the ward / unit. POD lockers Master keys, or a POD locker key or keycode that open more than one POD
locker, within a particular ward or unit must not be supplied to patients (See also paragraphs 11.56 to 11.59)

**Storage and management of medicines on behalf of other organisations**

7.27 Where medicines stocks that are the property of other organisations for use by their clinicians on Trust premises and are within the custody of the Trust when not in direct use by relevant clinical staff procedures must be in place to ensure:

- An audit trail of receipt, storage and transfer to possession of the relevant clinicians is maintained.
- Only designated Trust personnel are allowed access to these medicines.
- Medicines that are the property of other Trusts are physically segregated from Trust stocks of medicines and patient’s own medicines.
- Medicines that are the property of other Trusts are stored in accordance with paragraph 7.8, 7.9, 7.10, 7.11 and 7.12
- If medicines are for use in Trust outpatient clinics these clinic areas must have dedicated facilities for medicines storage.
- Any unresolved losses or discrepancies identified are notified to the Chief Pharmacist as soon as practicable.

**Losses and discrepancies**

7.28 All staff handling medicines should be security conscious at all times. Anyone discovering an apparent loss of drugs, unauthorised access to medicine storage areas or suspecting the misuse, misappropriation or abuse of drugs must report the matter immediately to the Ward Manager or Community Hospital Matron or Service Manager or Senior District Nurse or Divisional Manager and Chief Pharmacist. An incident form must be completed.

**8 DISPOSAL OF MEDICINES**

8.1 Expired drugs, unwanted patient’s own drugs (with a completed ‘Patient’s Own Drugs Disposal Form’ see Appendix B) and any other unwanted medicines should be disposed of following the Trust’s Healthcare (Clinical) Waste Policy.

8.2 In use pharmaceutical waste bins must be stored in a locked cupboard in the treatment room. When pharmaceutical waste bins are sealed the bin can be stored to a designated secure area for waste in anticipation of uplift by a Trust approved waste carrier.

8.3 Medicines prepared for administration and subsequently not used or administered (including the remainder where the dose is half a tablet), must be disposed of in a pharmaceutical waste bin. They must not be returned to the container from which they were removed nor put in the sharps box. Controlled Drugs must be disposed of in the manner set out in Controlled Drug Standard Operating Procedure 7 (see CD Policy). They may not be returned to suppliers.
8.4 If any part of a Controlled Drug is wasted or if an individual dose is prepared but not administered it should be disposed of by the registered nurse and witnessed by a second registered nurse, other registered professional or healthcare assistant. This must be recorded in the Controlled Drugs Record Book. See CD Standard Operating Procedure 9 (CD Policy).

9 PRESCRIBING

9.1 This section applies to inpatient and community settings. It should be read in conjunction with section 19 ‘Community Teams’.

9.2 Medicines must only be administered where they have been authorised by a prescriber. The recognised exceptions to this are listed as follows:

a) In areas where there are no resident prescribers and in cases of clinical urgency a remote instruction may be acceptable (see paragraphs 9.74 to 9.82).

b) Certain medicines may be administered at the practitioner’s discretion against an agreed PGD. In each instance a record of the administration must be entered on the MAR chart in the appropriate section or recorded appropriately on RiO EP.

c) Specialist practitioners and Clinical Pharmacists involved in certain services may be authorised to modify dose regimens and, in certain instances, to initiate or stop medicines therapy in accordance with protocols approved by the Medicines Oversight Group or following prior agreement with individual prescribers and approved by the Chief Pharmacist.

9.3 The prescriber will be a registered doctor, dentist or registered independent / supplementary or community prescriber. Medical students and staff undertaking the Independent and Supplementary Prescribing Course may not prescribe.

9.4 All prescribers must, in addition, be authorised by the Trust to prescribe to Trust patients as part of their Trust employment or role.

(For Non-Medical Prescribers please refer to the Trust Non-Medical Prescribing (NMP) Policy for details of the Trust authorisation process.)

9.5 Funding for prescribing or medicines used within a service must be identified and necessary funds allocated to the Trust medicines budget. Where funding streams have not been identified and/or adequate funding allocated to the medicines budget the costs of prescribing will be recharged to the relevant service budget holder.

9.6 Foundation 1 grade (F1) doctors are not permitted to prescribe controlled drugs for patients being discharged or on FP10s, but may write them up under supervision by a more senior doctor on a Trust MAR chart or RiO EP. They are also not allowed to prescribe cancer medication, including cancer medication used for other indications, e.g. methotrexate for rheumatoid arthritis, under any circumstances.

9.7 Prescribers must advise the patient where possible and practicable of the reason for prescribing, the reasons for the particular choice of medication prescribed, the anticipated time course of condition progression / resolution and anticipated duration of the treatment course.
9.8 Clinical Pharmacists may amend prescriptions when necessary to assist safe administration or to follow agreed policies by using the Amending MAR Chart Procedure (see Appendix F).

9.9 The prescriber must have all the relevant information required before prescribing for a patient including details of the Medicines Reconciliation completed on admission (also see Medicines Reconciliation Policy).

9.10 The treatment plan, including changes to medication, reasons for these changes and how response and safety are to be monitored should be clearly documented in the patient’s notes.

9.11 The following principles should be applied at all times when writing prescriptions:

a) prescriptions must be clear and unambiguous.

b) all patient demographic details must be completed.

c) Most prescribed items must be written using the approved / generic except:

   o where there is a demonstrable difference in clinical effect between each manufacturer’s version of the formulation, or;
   
   o where national guidance or legal advice has been issued to use brand names eg some drugs for epilepsy, or;
   
   o where the Trust Formulary recommends a specific brand for a given generic medicine.

In these cases, the medicine should be prescribed by brand name.

d) prescriptions must indicate clearly the dose and frequency.

e) each prescription for a medicine must be individually signed and dated by the prescriber.

f) only an authorised prescriber or non-prescriber as defined in paragraphs 9.2c and 9.7 may alter a previously written prescription.

Formularies

9.12 Prescribers should follow national, local and Trust prescribing guidelines including the Somerset CCG ‘Somerset Prescribing Formulary’, and should follow the decisions of the Medicines Oversight Group. New drugs should not be used without the approval the Medicines Oversight Group. Recommendations for approval for mental health medicines must first be reviewed and approved by the Mental Health Drug and Therapeutics Group.

9.13 Trust prescribing guidance and formulary decisions take precedence over Somerset CCG Prescribing Formulary choices where applicable.

9.14 Trust guidance on prescribing is available on the Trust intranet: Medicines>Formulary.

9.15 Medicines that should not be prescribed, or that have restricted prescribing, within the Trust are listed on the ‘Approval Status of Drugs used for the Treatment of Mental Health Disorders’ page of the intranet (Medicines>Formulary>Approved Drug Status)
9.16 Opioid conversions should be in accordance with the conversion guidance defined in the End of Life Policy.

9.17 Dressings that are prescribed should be in line with the Trust Wound Formulary.

**Patient Group Directions**

9.18 The majority of clinical care should be provided on an individual, patient-specific basis. The supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care (without compromising patient safety) and where it is consistent with appropriate professional relationships and accountability.

9.19 The Patient Group Direction Policy should be followed for the introduction and use of any PGD.

**Prescribing for inpatients**

9.20 Medicines for inpatients may only be prescribed on the authorised Medicines Administration Record charts or electronically in the prescribing section of the patient’s electronic record.


9.22 Wherever possible only ONE main MAR Chart should be in use at any one time for any one patient. In exceptional circumstances, where the number of prescribed items dictates, a second chart should be used. Both charts must indicate the existence of a second chart.

9.23 A maximum of one medicines administration continuation sheet should be used with each MAR Chart.

9.24 When a second special chart e.g. warfarin or clozapine chart is required:

- Tick that there is a supplementary chart on the front of the MAR chart
- Write “drug name as per chart” on the inside of the MAR

9.25 Each chart should be fully completed and must clearly identify the patient’s full name (including aliases), hospital number, date of birth (or age), consultant (where applicable), ward and hospital.

9.26 Any known allergies or previous adverse reaction to a drug must be stated on the MAR Chart and if there are no known allergies, this must be recorded. For any allergy/adverse reaction, details should include causative drug/class of drug and type of reaction. No abbreviations should be used when recording allergy status. Allergy status should also be recorded in the patient’s records and inpatients should be identified either by a RED wrist band or red line around a photo identification.

9.27 When carrying forward prescribed medication to a new MAR Chart, the date the MAR chart is rewritten should be entered.

9.28 The dose of every drug must be written clearly and only the following abbreviations should be used:

- doses of 1 gram or more should be written using the abbreviation g or gram and a decimal point if required
- doses of less than 1 gram should be written as milligrams. The abbreviation mg should be used for milligram
- quantities less than 1mg must be written as micrograms and in full
- when decimal points are unavoidable a zero should be written in front of the decimal point where there is no other figure.
- For compound preparations (e.g. co-codamol) write the number of tablets e.g. two not as ii (which can be misinterpreted).

9.29 For liquid medicines, the dose must be stated in mg (or other units of weight if appropriate). Liquid medicines should only be prescribed in ml if no other dosage option is available.

9.30 The term units must be written in full and must not be abbreviated to ‘u’ or ‘iu’.

9.31 The times of administration for each prescribed medicine should be clearly indicated.

9.32 Prescriptions for “when required” medication must clearly state the indication for the medication. The dose, frequency and maximum number of doses in 24 hours must be stated. These should be reviewed at least once a month by a prescriber. Care should be taken to ensure end dates for courses of medicines are clearly stated on the chart.

9.33 Drugs prescribed for rapid tranquilisation should be annotated “For RT in accordance with RT policy” and should be reviewed every 7 days. Prescription of RT medication should not remain in place when they are no longer necessary (for further information see the Trust Rapid Tranquilisation Policy). (see paragraph 9.49)

9.34 The route of administration must always be stated. Different routes for the same drug must be written as separate prescriptions.

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

9.36 For antimicrobials, the duration of therapy must be clearly stated on the prescription sheet or a review date stated. An indication for use should be included in the patient’s notes. The Antimicrobial Prescribing Policy and “Start Smart Then Focus” principles should be followed.

9.37 Medication prescribed above the dose limit defined in the manufacturer’s MHRA product licence (as detailed in the relevant products Summary of Product Characteristics), is an off licence form of prescribing and it is therefore the prescriber’s responsibility to ensure that the treatment plans are well documented. (Note: the BNF contains a summary of prescribing information on individual products including maximum dose limits and limits of the product license).

9.38 If a medicine’s dose or frequency is changed the original prescription must be clearly crossed through and a new prescription written. Changes in dose or frequency must not be altered or amended by over-writing.
9.39 Prescriptions should be reviewed regularly and if no longer indicated should be discontinued.

9.40 When a medicine is stopped a line must be drawn through the prescribed medicine and the doctor must initial and date the discontinuation.

9.41 When a chart is no longer in use a diagonal line must be drawn across all pages and ‘cancelled’ written across it with a signature and date.

9.42 Nurses should not write or rewrite MAR Charts except:
   a) when following the Remote Prescribing procedure (see paragraphs 9.74 to 9.82 below)
   or
   b) when following ‘Discretionary Drugs Policy’. (Appendix G)
   or
   c) in accordance with the Trust transcribing policy and procedures (see paragraph 9.43)

9.43 Transcribing is permitted in accordance with the Professional Guidance on the Administration of Medicines in Healthcare Settings (RPS RCN 2019):
   - Creating a list of medicines for the purpose of medicines reconciliation on the ward is permitted because the process must be completed by a registered prescriber.
   - A registered healthcare professionals (including registered nurses) may list or note patient’s medications in care plans, patient notes or letters to other professionals.

9.44 When patients are transferred from one Somerset Partnership ward to another the prescription sheet does not need to be re-written, however for transfers between areas using differing charts it is advisable that the chart is rewritten.

9.45 If a patient is transferred from another NHS organisation to a Trust inpatient ward or to the District Nursing case load for medicines administration, the other organisation’s “prescription sheet” (but not a fax or photocopy) can be used for up to 24 hours (or until the next working day at weekends or Bank Holidays) before transferring to a Trust MAR chart or to the Trust electronic prescribing system. If a fax or photocopy only has been sent with the patient a Trust MAR chart or electronic prescription must be completed on admission.

9.46 If a patient is transferred from the Trust to an acute hospital, details of medication should be provided with the patient at the time of transfer.

9.47 ‘Stat’ doses for medication are only valid for 24 hours from date of signature (for exceptions see paragraphs 9.48 and 9.49). The prescriber should verbally inform nursing staff when a ‘stat’ medicine has been prescribed to enable the medicine to be administered in a timely manner.

9.48 ‘Stat’ doses prescribed under the Just In Case Protocol duration of validity is in accordance with that specified in the protocol.
‘Stat’ doses prescribed in anticipation of the need for Rapid Tranquilisation (RT) are valid for a period of seven days on condition that prescribing complies with paragraph 9.33 above and the Rapid Tranquilisation Policy.

**Clinical Check of Prescribed Medicines**

9.50 Medicines prescribed for inpatients where possible within the Trust clinical pharmacy resource will be checked for completeness, including prescriber’s signature and date, by a Clinical Pharmacist or an accredited Medicines Management Pharmacy Technician as part of their inpatient ward or unit visits. If necessary the Clinical Pharmacist or accredited medicines management Pharmacy Technician will annotate the prescription to guide practitioners when they administer medicines.

9.51 As part of the supply process, pharmacists check medicines prescribed for the dose regimen, the duration of treatment, the medicines formulation, the route of administration, allergy status and medicine interactions.

9.52 Further checks to consider the need for the medication, adverse reactions, the need for the medicine and whether the therapy is achieving the desired therapeutic end points may be carried out for specific patients as resource allows.

**Discharge / Leave Medication**

9.53 Medicines for discharge should be prescribed on the appropriate discharge prescription form if patients own drugs or those dispensed for discharge are not in use. They may be given to any patient responsible enough to use them safely.

9.54 A minimum of 14 days’ supply will be dispensed unless the prescriber specifies otherwise.

9.55 Controlled Drugs for discharge or leave must be written in accordance with the requirements of the Misuse of Drugs Regulations. Please refer to CD Policy.

9.56 When ordering and handing out medication for patients going on leave (including Section 17 leave), the quantity supplied should be checked against duration of planned leave, taking into account any potential risk.

9.57 It is essential as part of the discharge plan that the doctor, registered Nurse or medicines management staff go through the discharge medicines with the patient and/or carer and answer any questions which may arise. The patient should know the purpose of the medicine, how to take it, and for how long and should be provided with the appropriate Patient Information Leaflet. Staff handing out medicines should check them against the discharge prescription and any differences must be clarified.

9.58 Care should be taken with patients identified as being high risk of poor concordance with medication, with a view to encourage them to keep taking their medicines on discharge. Particular care is needed with certain mental health conditions where those that stop taking their medicines are known to be at greater risk of suicide. (Please see flow chart in Clinical Assessment and Management of Risk of Harm to Self and Others Policy).

9.59 The discharge notification to the GP must contain drug name and form, indication, route, dose; quantity supplied; duration of treatment (mandatory
for hypnotics, anxiolytics, antimicrobials and other fixed term items); whether the GP is to continue to prescribe and / or monitor the drug including specific requirements for high risk drugs and precautions e.g. risk of overdose requiring short supplies. Information on drugs discontinued whilst an inpatient should be provided.

9.60 All information concerning medication, contained within the discharge notification to the GP, must be reconciled with the discharge prescription and confirmed by an authorised prescriber.

**High Risk Medicines**

9.61 A number of medicines have been identified by the National Patient Safety Agency (NPSA) as high risk of causing potentially serious incidents and hence have been the subject of patient safety alerts and rapid response reports. Information on the key safety points and Trust protocols can be found on the Trust Intranet and these should be followed.

**NPSA High Risk Medicines**

- Warfarin
- Insulin
- High Dose Opiates
- Methotrexate
- Heparin (Including low molecular weight)
- Lithium
- Midazolam
- Injectable medicines

**Clozapine** has also been identified as a **high risk drug** within the Trust.

**Medical Gases**

9.62 Medical gases are licensed medicinal products. Oxygen should be prescribed in the appropriate section on the MAR chart, RiO electronic prescription or on a separate Trust supplementary oxygen chart. In an emergency, oxygen should always be given immediately and documented later.

9.63 Oxygen for discharge is ordered on a Home Oxygen Order Form (HOOF). A Home Oxygen Consent Form (HOCF) must be completed at the same time to allow personal data to be shared with the supply company.

The completed forms are faxed to the oxygen supplier and a copy sent to [Somerset Clinical Commissioning Group](http://www.somersetclinicalcommissioninggroup.org) and the patient’s GP.

For discharge from hospital at least 24 hours planned notice is required.

**Unlicensed Medicines**

9.64 The Medicines and Healthcare Products Regulatory Agency (MHRA) grant marketing authorisations for medicines in the UK. Medicines must have met the required standards of safety, quality and efficacy before they are granted this authorisation.

9.65 Current legislation gives some exemptions from full control to allow the use of medicinal products that are not licensed in order to fulfil special needs in individual patients on the direct personal responsibility of the prescribing clinician.
9.66 The use of such unlicensed medicines within the Trust is supported in accordance with the ‘Policy for the use of Unlicensed Medicines’ Appendix H.

**Herbal Medicines, Homeopathic Medicines and Other Complementary Medicines (‘Alternative medicines’)**

9.67 Products that fall into this ‘alternative medicines’ or ‘complimentary products’ category are not licensed medicines include products that may have a pharmacological effect such as:

- herbal medicines
- homeopathic medicines
- complimentary medicines
- pro-biotics
- nutraceuticals
- healthfood supplements
- cannabis oil (CBD oil)
- appetite-suppressing slimming products

Note: This is not an exhaustive list – seek advice from the Medicines Management Team if needed.

9.68 If a patient is admitted to hospital and is taking their own supply of alternative medicines or other complimentary products and wishes to continue this treatment whilst in hospital, the responsible prescriber must discuss with the patient whether or not this treatment should continue.

9.69 A record should be made of these alternative medicines or complimentary products in the patient record and the patient made aware if the taking of the medicines effects current or future prescribing so that the patient can make an informed choice of whether to continue taking the products.

9.70 If ‘alternative medicines’ or ‘complementary products’ are to be continued the following conditions must apply:

a) patients must be willing to and capable of self-administering the product

b) a risk assessment of the ability of the patient to self-administer safely and with consideration of the risks to other service users (Appendix K) must be completed

c) the product must be provided by the patient

d) the product must be as far as practicable verified as genuine and not adulterated with illegal substances / medicines of abuse

e) the product must be stored separately and securely in the clinic room as a medicine or the Patient’s Own Drugs (POD) locker

9.71 ‘Alternative medicines’ or ‘complementary products’ can only be added to the local drug file within the electronic prescribing system in exceptional circumstances by application through the medicines management team & following approval by the Chief or Deputy Chief Pharmacist.

9.72 The Trust will not provide supplies of herbal products, homeopathic medicines or other complementary products however prescribed (see paragraph 5.8) unless approved by the Medicines Oversight Group.
9.73 If these medicines are to be continued to be administered to, or taken by, the patient the registered HCP should only administer these medicines, or delegate administration of these medicines, if they can be positively identified using the ‘Algorithm for use of Patient’s Own Drugs’ (PODs) (Appendix C).

**Remote Prescribing / Remote Orders** (formerly known as ‘verbal orders’)

9.74 Every effort should be made to obtain a written prescription for a patient. However, in exceptional circumstances i.e. where the need for the medicine is urgent and not to accept a remote order would compromise patient safety or care, remote instruction to a registered professional may be accepted by telephone / text message / fax / email / RiO note:

- for a change in dose
- or re-prescribing of a previously prescribed medication

9.75 Where exceptional circumstances exist, the registered professional is required to inform the prescriber of the current drug regime and allergy status. They should request information from the prescriber regarding any contraindications and side effects of the remotely prescribed medicine.

9.76 Trust staff must not request or accept a remote order for **Schedule 2 and 3 Controlled Drugs unless** authorised by the **Chief Pharmacist** or the **senior on-call manager**. A [Datix Untoward Event Report Form](#) must be completed.

9.77 **A remote prescribing order is not acceptable on its own.** The prescriber must provide a faxed or email confirmation of the existence of a prescription or direction to administer. This confirmation can also be entered in the patient’s electronic record. The confirmation must be received prior to administration. A copy of the authorisation must be scanned into the patient’s RiO record. Where MAR charts are still used a copy of this written authorisation must be stapled to the patient’s existing MAR chart.

9.78 Only a relevant registered healthcare professional may accept a ‘remote prescribing order’ to be received via fax or email. Once the fax or email containing the prescription changes has been received the instruction must be immediately written on the patient’s prescription sheet and endorsed `remote prescribing – email` or `remote prescribing – fax` or `remote prescribing - RiO’ and initialled by the registered healthcare professional.

9.79 Any changes to a prescription by fax or email or progress note in RiO must be followed up by a prescriber with a newly written and signed inpatient MAR Chart prescription confirming the changes within 24 hours or when this is a bank holiday or weekend the next working day. As part of the confirmation the prescriber must have reviewed the patient and the relevant notes.

9.80 An entry should be made in the patient record regarding the time of, and reason for, the remote prescribing.

9.81 Remote instruction for items that are new for a patient may only be accepted if the prescriber has adequate information on which to base their decision to prescribe, sufficient to:
• Establish the patient's current medical conditions and history and concurrent or recent use of other medications including non-prescription medicines;
• Carry out an adequate assessment of the patient's condition;
• Identify the likely cause of the patient's condition;
• Ensure that there is sufficient justification to prescribe the medicines/treatment proposed;
• Ensure that the treatment and/or medicine/s are not contra-indicated for the patient.
• Make appropriate arrangements to follow the progress of the patient;
• Monitor the effectiveness of the treatment and/or review the diagnosis;
• For patients detained under section 3/37 of the Mental Health Act, ensure that medication requested for administration is listed on Form 58/59 (after 3 months detention). If it is not listed on the form, the medication cannot be administered.

Where all these conditions cannot be satisfied remote prescribing should not occur, and it will be necessary to carry out a full assessment of the patient in person before any medicines are prescribed.

9.82 Registered healthcare professionals can refuse to accept remote orders from prescribers if they do not feel competent to do so, if there are communication difficulties and the prescribers intentions are not clear, if they feel the request is not in the patient's best interest and if they feel the circumstances are not exceptional.

10 LEGAL AND HUMAN RIGHTS

10.1 Consent to treatment should always be sought from the patient or the parents if the patient is a child or other carers or family members for people with cognitive impairment or unable to communicate. Mental Capacity should be evaluated and appropriate actions taken.

10.2 A person must be assumed to have capacity unless it is proved otherwise and until all practicable steps have been taken to help someone make a decision without success they cannot be treated as lacking capacity. A perceived unwise decision does not in itself indicate a lack of capacity although treatment for mental disorders under the Mental Health Act 1983 is excluded).

10.3 For more information about the Mental Capacity Act 2005 and consent issues in relation to Part IV of the Mental Health Act 1983 refer to the Trust’s Consent and Capacity to Consent to Examination/Treatment policy, the Community Treatment Order policy and the ECT policy.

Mental Health Act 1983

10.4 Patients detained under the Mental Health Act (MHA) must be informed:
• of the nature, purpose and likely effects of the treatment which is planned
• of their rights to withdraw their consent to treatment at any time and of the need for consent to be given to any further treatment
how and when treatment can be given without their consent, including by the second opinion process and, when treatment has begun, if stopping it would cause serious suffering to the patients

10.5 There is a statutory duty to give this information to detained patients but this should be good practice for all patients.

10.6 Part 4 of the Mental Health Act refers to matters of consent in relation to detained patients and Part 4A to the treatment of patients subject to Community Treatment Orders. Detailed guidance may need to be sought in relation to:

- treatments requiring the patient’s consent and a second opinion (section 57)
- treatments requiring the patient’s consent or a second opinion (Section 58, the 3 month rule)
- withdrawal of consent
- urgent treatment (sections 62 or 62A)
- treatment of patients subject to Community Treatment Orders who have not been recalled to hospital (sections 64A to 64K)

**Mental Health Act Form T2 or Form T3**

10.7 In the case of patients subject to sections 57 or 58 (see paragraph 10.6) the relevant statutory forms (T2 and T3) must be available and accessible to the nurse at time of administration or supply of medicines to a patient.

10.8 Since September 2015 BNF numeric categories will no longer be used in the paper edition. Therefore T2 or T3 treatment plans must no longer be referenced to the paper BNF numeric categories.

10.9 From T2 or Form T3 must record the class of drug and route of administration, but rather than noting particular BNF sections, should either:

- State that the dose (when calculated together with frequency) is within BNF guidelines as to advisory maximum dose limits for that route, or state a maximum dose limit referenced to BNF guidelines such as, for example, 50% or 120%

OR

- State a named drug and its route & dose maximum.

In some circumstances it may be useful, indeed necessary, to specify a named drug and its purpose, especially when it is being used for an unlicensed indication, e.g. clonazepam when used for agitation.

10.10 Responsible / Approved Clinicians must ensure that only medication that is covered by a relevant Form T2 or Form T3 is prescribed for patients who fall within the scope of sections 57 or 58. If prescribing outside forms T2 and T3 occurs, a DATIX Untoward Event Report Form must be completed.

10.11 Nurses must not administer medication which is not covered by a relevant Form T2 or T3 for patients falling within the scope of sections 57 or 58.
10.12 If any medicine is administered that is not covered by a T2 or T3 form then this must be reported within the DATIX Untoward Event Reporting system as a drug error.

10.13 Before administering medication for mental disorder, the nurse should:
   a) Check the medicine card for the date of entry of a prescription for the medicine, for its dose, and for the route of administration.
   b) Check the date of the first administration, to ensure that the three-month period has not been exceeded.
   c) Where a patient has consented to medication beyond the three-month period, ensure that a Form T2 is in place and is correctly completed, and that the patient still consents.
   d) Where a second opinion has been obtained, ensure that the Form T3 is in place, is correctly completed and remains valid.
   e) If the administering nurse has any concerns about the validity of any T2 or T3 form in place, or of any medication being prescribed which is not authorised on a ‘T’ form, they must raise these concerns immediately with the approved clinician in charge of the patient’s treatment.

Deprivation of Liberty Safeguards (DoLS)

10.14 Where any medicines or combination of medicines covert administered are likely to alter the patient’s behaviour, mental state or is a sedative to such an extent as the treatment may be considered to be restricting the patient’s liberty the need for Deprivation of Liberty Safeguards (DoLS) assessment should be considered (see The Deprivation of Liberty Safeguards Policy). Also see Appendix J – Covert Administration of Medicines.

11 ADMINISTRATION OF MEDICINES

11.1 This section applies to all administration in both inpatient and community settings. It should be read in conjunction with Section 19: Community Teams.

11.2 Nurses on all parts of the Nursing and Midwifery Council (NMC) register and NMC registered Nursing Associates are authorised to administer medicines in accordance with relevant professional standards and proficiencies.

11.3 Other professional groups of registered healthcare professionals may also administer medicines to patients as part of their professional and service role if:
   a) undertaking such tasks is considered a core part of their professional role and competencies by the relevant professional regulatory body
      or
   b) under exemptions orders contained in the Health Act (see paragraph 11.21)
      or
   c) in accordance with the requirements set out in Section 22 below

11.4 Some pharmacy only or non-medicinal products may be administered by non-registered staff after appropriate training (see Section 22) as part of normal ‘nursing care’. These products are:
- Emollient or barrier topical preparations (creams, ointments, and lotions)
- Oral nutritional supplements (ONS) (e.g. ‘sip feeds’) and other ‘foods’.

When not prescribed administration of these products must be detailed as part of the patient’s documented care plan and each administration or application must be documented in the patient’s medical or nursing record.

11.5 Where administration of medicines is delegated (see Section 22) the supervising registered healthcare professional is responsible for ensuring the MAR chart or electronic medicines administration record is completed as appropriate (for exceptions see paragraph 11.4). Completion should be by the member of staff administering the medicine, however, if this is not possible for policy or technical reasons the supervising HCP should complete the record.

11.6 In administering any medication, assisting, delegating administration or overseeing any self-administration of medication, registered HCPs must exercise their professional judgment and apply their knowledge and skill in the given situation.

11.7 The responsibility for the administration of medicines rests with the relevant registered HCP. Each registrant is accountable for their actions and omissions when administering medicines.

11.8 Each administration of a medicine must be recorded on the patient’s MAR chart or electronic medicines administration record (for exception see paragraph 11.4). When a supplementary MAR chart is in use the administration must be recorded on the supplementary chart instead of on the MAR chart.

11.9 Staff should be aware of the needs for privacy and the patient’s dignity when administering medication. Staff will need to exercise judgement in offering medication in a confidential manner.

11.10 It is the registered HCP’s responsibility to ensure that he / she is able to give their full concentration to the administration of medicines and if this is not possible then the administration should be withheld until the correct environment is resumed.

11.11 In the inpatient setting, when the registered HCP undertakes the medicine round, measures must be taken to minimise interruptions. Recommended methods are wearing a tabard to highlight that they are undertaking a medicine round, or medicines must be supplied from the clinic room using a stable door, if fitted.

11.12 All drugs (including topical preparations) should be administered according to a written prescription by an authorised prescriber except those covered by:
- a Patient Group Direction (PGD)
- the Discretionary Drugs Policy (Appendix G)
- the Remote Prescribing Procedure (see paragraphs 9.74 to 9.82)

11.13 For saving life in an emergency the Prescription Only Medicine (POM) restriction does not apply to the following medication. Administration of
these medications without a prescription is permitted.

- Adrenaline 1 in 1000 (1mg/ml) injection
- Chlorphenamine 10mg/ml injection
- Hydrocortisone 100mg/ml injection
- Glucagon 1mg injection
- Naloxone 400micrograms/ml injection

Please also refer to the Medical Emergencies Management (non-cardiac arrest) Policy and the Resuscitation Policy.

11.14 Sufficient information about the medicine should be available to the staff and/or patient, to enable identification and correct use of the product.

11.15 Medicines should not be assembled in advance of administration and doses should never be left out for a patient to take at a later time.

11.16 In exercising professional accountability in the best interests of patients staff must know the therapeutic uses of the medicines to be administered, their normal dosage, side effects, precautions and contra-indications.

11.17 The nurse must be aware of the patient’s treatment / care plan.

11.18 The nurse should educate patients regarding their medication where this is possible and appropriate.

**Newly appointed and newly qualified staff**

11.19 A newly appointed registered HCP who can demonstrate that they are competent in the administration of medication from their previous employment can continue to administer medication on appointment.

- It is expected that all new appointees would undertake and pass the Trusts medicines training as required in the Trusts training matrix within three months of taking up appointment.

- Advice and guidance will be sought from the Chief Nurse or nominated deputy if the three month time frame is not achieved.

11.20 Prior to a newly qualified registered HCP administering medicines independently they should be able demonstrate both evidence of a competency assessment from their training organisation and practically demonstrate safe administration of medicines to their line manager.

- It is expected that all new appointees would undertake and pass the Trusts medicines training as required in the Trusts training matrix within three months of taking up appointment.

- Advice and guidance will be sought from the relevant Head of Nursing if the three month time frame is not achieved.

**Midwives, paramedics and podiatrists**

11.21 Midwives, paramedics and podiatrists who are not trained as non-medical prescribers may administer or supply some specific named prescription only medicines under exemptions orders contained in the Health Act which allow certain groups of healthcare professionals to sell, supply and administer specified medicines directly to patients/clients as detailed in Schedule 17 of the Human Medicines Regulations 2012.

11.22 HCPs administering or supplying medicines to patient’s under the
Schedule 17 (Human Medicines Regulations 2012) (see paragraph 11.21) must be

Pre-registration student nurses

11.23 Pre-registration student nurses should be given every opportunity to participate regularly in medicines rounds and drug administration but this must be under the direct supervision of a registered nurse. The registered nurse retains accountability at all times. The registered nurse must clearly countersign the signature of the student who is being supervised. Where RiO EP is implemented the Registered Nurse must document in the RiO record details of medicines administered under supervision.

Role of non-registered staff in medicines administration

11.24 The non-registered staff can assist a registered healthcare professional with any or all of the following:
   - Assisting the patient to have drinks / food with prescribed medication
   - Observe the patient to avoid secretion / regurgitation of medicines
   - Observe patient’s physical state / take physical observations

11.25 Non-registered staff must not undertake medicines administration-related tasks (for definitions see paragraph 22.2) except in when the conditions set out in Section 22 have been met.

Role of patient relatives or carers in medicine administration

11.26 Patient relatives or carers may assist in medicines administration to patients under the care of the Trust in community services only. Administration by relatives or carers in the inpatient setting is not permitted.

11.27 Patient relatives or carers may only assist in medicines administration when the following has been completed:
   - A risk assessment has been completed
   - Consent has been received from the patient and agreement received from the prescriber and the Trust’s supervising healthcare professionals and relevant line management
   - All relevant agencies are informed of family or carer involvement
   - Training, support and competency assessment of family member, relative or carer regarding the administration of medication, and recording of administration has been completed and documented in the patient’s care plan and on the RiO clinical record
   - Monitoring and follow-up arrangements must be agreed between the patient, relatives or carer, and Trust supervising healthcare professionals
   - A record of all discussions, agreements, consent, training and competency assessments are detailed in the patient care plan and in the RiO clinical record

11.28 Monitoring and follow-up by Trust staff will be according to individual need and circumstances.
Administration Process

11.29 The date of first opening of liquid medicines, topical medicines and other medicines with a limited shelf-life after opening must be recorded on the product at time of first opening.

11.30 When administering Controlled Drugs the administration of drugs should be carried out by two registered health professionals (please refer to CD Policy). However, in exceptional circumstances where a second registered health professional is not available it is acceptable for one registered health professional to administer medication provided a second person has checked patient demographics, drug name and dose, and expiry date on condition that:

- The ‘exceptional circumstances’ have been agreed with a senior manager for the service or on-call manager
- Details of the ‘exceptional circumstances’ have been reported through the Datix Untoward Incident Reporting system
- When the second person is not a registered nurse the full name and designation (job title), and the professional registration number (if applicable) of the second person is recorded.

11.31 In all other circumstance single health professional administration of medication is normal practice. However, all registered health professionals should use their professional judgement when administering medication and consider utilising a two person check for the following instances. The name and role of the second checker should be clearly recorded in the progress notes.

- Where there is a complex calculation
- Administration of an unfamiliar drug
- Administration of drugs to a child (under the age of 18)

11.32 Where a two person check has taken place - the name and role of the second checker should be clearly recorded in the progress notes.

11.33 It is of paramount importance that the person undertaking the second check works independently and unprompted by the person requesting the check. The second checker is jointly accountable for all parts of the process.

Checks before administering medication

11.34 Before administration of a medicine the nurse must:

- read the prescription carefully. The medicine must not be administered if the nurse has any concerns or if there is any doubt about the legibility of the prescription or other particulars of dosage, route, time or frequency. If there are any doubts then the prescriber must be contacted.
- check that the prescribed dose has not already been given. For ‘when required’ medicines the dose and timing of the previous dose should be checked before administering. A check must also be made that there has been no duplication of prescribed drugs in any other section
of the prescription, e.g. Paracetamol with more than one product.

- select the medicine required, checking the label against the prescription.

11.35 The nurse responsible for administration of medication must also ensure that:

- they know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.
- they can clearly identify the patient/client to whom the medicine is to be administered. See the Patient Identification Policy.
- if there is a label on the medicine, they have checked that it is legible and corresponds with the prescription.
- they have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient, the patient’s care plan and co-existing therapies.
- they have checked the expiry date of the medicine to be administered.
- there is no previous history of sensitivities or allergies in association with the drug to be given recorded on the MAR chart. Inpatients in the Community Hospitals identified as having such sensitivity should be wearing a red ID bracelet that includes their patient identification details; mental health inpatients should have a red line around their photo identification.
- they have checked that the entries in every section of the MAR chart has been completed, and that the prescription is in date, with a valid start date. Any prescription using a "stop date" is valid on the stop date stated but not thereafter.
- they have recorded the weight of the patient on the prescription sheet for all children and where the dosage of medication is related to weight or where the clinical condition dictates recorded patient’s weight.
- they have attended relevant drug calculation training and are competent to calculate the amount to be given.
- any contra-indications (check the BNF monograph or Summary of Product Characteristics (SPC) for the drug) or change in the patient's clinical condition which may require a drug to be withheld are noted, and medical advice sought should the unplanned withholding of a drug be indicated.
- where combining the medication in a syringe driver confirm drug compatibility.
- the patient and/or carer are aware of the importance and implications of the prescribed treatment. The patient and/or carer have the information needed, including information leaflets where requested by the patient/carer, to understand and consent to the treatment. Patient concordance with their treatment should be encouraged at all times.
- if there are any special instructions eg with respect to food, swallow whole.
• in the case of patients subject to sections 57 or 58 of the Mental Health Act 1983 the relevant statutory forms (T2 and T3) correspond with the prescribed medicines.

**Measuring Doses**

11.36 For oral liquid medicines, if the dose cannot be measured accurately with a medicine spoon or pot, an oral syringe must be used. Intravenous syringes must not be used when measuring oral liquids.

11.37 Tablets must not be crushed routinely for patients with swallowing difficulties or for administration via a tube feed. Before crushing any tablet the registered nurse should ensure:

- they have confirmed the safety of crushing the tablet, having taken advice from the medicines management team.
- the appropriate prescriber has given approval, following consideration of alternative formulations.

Crushing tablets is an unlicensed use of a medicine so the Trust Unlicensed Medicines Policy (Appendix H) must be followed.

11.38 All regular and single insulin bolus doses must be measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used to administer insulin. Higher concentration insulins (U200, U300, U500) must be administered using the device they are presented in, not with a U100 insulin syringe.

11.39 For all injections, the Administration by Injection Policy should be followed.

11.40 Where a patient presents with signs or symptoms suggesting they are under the influence of alcohol, novel psychoactive substances or illicit drugs, medical advice should be sought before a decision is made to continue with any drug administration or to whether to delay the dose.

11.41 The registered nurse should administer the medicine to the patient and witness ingestion. If witnessing of ingestion has been delegated to a healthcare assistant the registered nurse must be satisfied that the patient has taken the medicine.

11.42 The registered nurse must immediately record clearly and accurately all medicines administered, refused or deliberately withheld.

11.43 If the drug is not administered the reason must be recorded.

11.44 A nurse should not administer a medicine unless he/she feels competent to do so or remains unsure about equipment that may be necessary for its administration.

11.45 In some exceptional circumstances, if the patient lacks capacity to consent to treatment, medication may be disguised. See ‘Covert Administration of Medicines Guidelines’. (Appendix J)

**Omitted and Delayed Medicines**

11.46 Medicine doses may be omitted or delayed in hospital for a variety of reasons such as medication not available; administration overlooked or inpatient chart lost or unavailable.

11.47 Whilst these events may not seem serious, for some critical medicines or
conditions delays or omissions can cause serious harm or death.

11.48 When any drug is going to be omitted or delayed for whatever reason or if it is discovered that a dose or several doses of a drug have already inadvertently been omitted, the senior nurse on duty should be informed.

11.49 The senior nurse on duty should decide whether the clinical risks warrant getting advice from a prescriber as soon as possible at any time of day or night.

11.50 Any omission of medicines that have been prescribed or authorised by a registered prescriber should be documented within the patient record and the patient medicine administration sheet annotated with the appropriate code.

11.51 Any omitted dose, where there has been no rationale for the omission documented, should be reported as a medication incident and a Datix untoward incident form completed.

11.52 Patients who are nil by mouth should have their route for medication assessed. Conscious patients who are being fasted in preparation for a procedure should continue to receive all their routine medications except those medicines expressly cancelled. Sufficient water may be given for the administration of medicines up to two hours before general anaesthesia.

11.53 At the end of every medicines administration round on inpatient wards the responsible nurse must check for apparent missed or omitted doses (i.e. ‘blank boxes’) and complete the administration record as appropriate

Missed administration of antipsychotic depot injections

11.54 In the event of a missed depot administration, the nurse should:

a) Record the reason why eg patient not available, shortage of medication etc in the electronic patient record and write ‘MISSED’ in the drug chart “Given By” section.

b) Have a discussion with the prescriber (or another suitably experienced prescriber in the absence of the original prescriber) and a subsequent plan recorded in the electronic patient record (eg give dose at an agreed alternative date, re-prescribe, review the patient, etc).

c) If the dose is to be given on an alternate date, this new date should be recorded in the ‘date next due’ part of the ‘long acting intramuscular injections’ section of the drug chart and countersigned by the prescriber.

Administration of Controlled Drugs

11.55 The procedures in the Controlled Drug Policy should be followed.

Self-Administration on inpatient wards

11.56 In some inpatient wards self-administration can be practised when appropriate. This can help maintain patient independence, improves compliance on discharge and increases patient’s awareness and participation in their treatment.

11.57 The transfer from nurse administration to self-administration should be agreed by the multidisciplinary team. See ‘Inpatient Self Administration Policy’ (Appendix K)
11.58 Self-administration by patients from Monitored Dosage Systems (MDS) (see Section 14) is permitted on inpatient wards / units. MDS supplied or filled from a non-Trust approved medicines supply service must meet the same criteria for re-use of patient’s own medicines for assessment of quality and safety in order to be used for self-administration.

11.59 Where a patient has previously been self-administering their medicines from an MDS but is no longer considered safe or competent to do so in exceptional circumstances nursing staff on the ward may administer the patient’s medicines from the MDS for a short time until a supply of named-patient medicines or stock medicines for that patient can be obtained. When medicines are required to be administered from an MDS permission to proceed is required from the person in charge of the ward or unit and a Datix incident report needs to be completed.

12 ADVERSE DRUG REACTION MONITORING

12.1 All inpatients must be monitored for side effects of medicines especially after starting a new medication or changing medication, including dose changes.

12.2 All outpatients / community patients should be provided with information on who to contact should they suffer any adverse reactions to or side effects from any new medication or following changes to existing medication.

12.3 Any possible side effects observed or complained of should be recorded in the patient’s record and action taken as clinically appropriate e.g. withholding or discontinuing medication.

12.4 Care plans should include details of how side effects will be monitored, including who is responsible for the monitoring. Side effects must be monitored at least annually by the prescriber.

12.5 Adverse drug reactions (side effects) must be reported to the MHRA on a yellow card for:
- all suspected reactions to new drugs, even if minor. New drugs are designated by a black triangle in the BNF
- all serious suspected reactions to established drugs

12.6 Yellow cards can be found in the back of all BNFs and are available online (yellowcard.mhra.gov.uk) and can be submitted by healthcare professionals or patients.

13 DISPENSING AND SUPPLY OF MEDICINES

13.1 All medicines supplied to patients to take away (TTO or TTA) must be labelled with a dispensing label detailing the name, form and strength or the medicine, the quantity supplied, the date of supply, the instructions for administration, relevant cautionary and advisory labels, the date of dispensing / supply, the name of the patient supplied and the name and address of the dispenser / supplier in accordance with the Human Medicines Regulations 2012. ‘Single doses’ of medicines supplied to patients for immediate administration, including those supplied under a patient group direction, do not need to be labelled with a dispensing label.
Dispensing

13.2 The contracted supply pharmacy will normally provide all stock medication or dispense all Patient Own Drugs administered on the ward and will also dispense leave and discharge medicines.

13.3 FP10 prescriptions may be used to obtain medicines from a community pharmacy when the supply pharmacy is closed or there is an urgent need for the medicine.

Supply of pre-labelled packs (over-labelled packs)

13.4 Pre-labelled packs can only be supplied if prescribed by an authorised prescriber or under the direction of a ratified patient group direction.

13.5 All pre-labelled packs supplied must comply with the labelling requirements for dispensed medicines and include the supplier’s name and address, patient’s name and date of issue.

13.6 The details of the medicine supplied must be recorded:
   - Patient Group Directions – as per PGD policy
   - Prescribed items – record details of supply including batch number and expiry date of pack on the prescription.

13.7 Where appropriate prescription charges should be levied for medicines supplied to all patients who have not stayed overnight in hospital. A form, outlining the payment procedure, should be provided to all patients who receive medicines who are liable for charges.

Issue of dispensed medication

13.8 When handing out dispensed medicines to a patient for discharge or leave check the identity of the patient and the dispensed items against the discharge or leave prescription. Any discrepancies should be queried with the prescriber or dispensing pharmacy as appropriate.

14 MONITORED DOSAGE SYSTEMS

14.1 Non-compliance with medication is a major cause of relapse and inpatient admission.

14.2 Monitored dosage systems (MDS) are only recommended for patients with genuine compliance problems and in whom a measurable benefit of use can be demonstrated. MDS are only recommended for the support of patients to self-administer their own medicines: MDS are not to be supplied for the benefit of carers.

14.3 The act of dispensing of medicines in to an MDS for a majority of medicines results in the medicines being supplied to the patient outside of the UK marketing authorisation (‘off label’ / ‘off licence’). Prescribers therefore must follow Appendix H: Policy for the use of Unlicensed or off-license medicines.

14.4 Before a MDS is considered for a patient the multidisciplinary team must consider the following:
   - review of the number of drugs and frequency of administration
   - alternative aids to compliance e.g. large print labels, patient reminder cards
weekly/daily dispensing in bottles/boxes
- detailed counselling and explanation of prescribed drugs
- When these other approaches fail the patient must be assessed as suitable for a MDS before it is used.

14.5 Before a patient is started on a MDS, nursing, medical or pharmacy staff should wherever possible ensure that the patient’s nominated community pharmacy is willing to provide the service in the long term.

14.6 Before a MDS is issued the patient should be instructed on how to use them and arrangements must be made for their regular replacement.

14.7 Some medicines are not suitable for inclusion in a MDS. Pharmacy staff will advise on which medicines should not be placed in a compliance aid. Oral anticoagulants should not normally be included in compliance aids.

14.8 Nursing, medical or other staff should not fill a MDS. The responsibility for filling an MDS lies with the dispensing pharmacist, patient or carer.

15 PATIENT MEDICINES INFORMATION

15.1 All patients should be given information, in a suitable format, on the possible side effects of a medication prior to it being prescribed, to inform their choice and make them aware of the side effects they may encounter.

15.2 All wards should be able to supply a wide range of medicines information leaflets and patients should be made aware of the availability of patient information leaflets.

15.3 The relevant patient information leaflet should be supplied to patients who are self-administering medicines whilst in hospital.

15.4 The contracted supply pharmacy is responsible for providing the appropriate patient information leaflets when dispensing leave or discharge medication.

15.5 The prescriber is responsible for advising patients on their medicines but may delegate this to pharmacy or nursing staff.

15.6 Information or advice provided to patients on alternative medicines including herbal medicines and homeopathy, must be objective and provide a balanced evaluation of the evidence, possible risks, and highlight lack of evidence of efficacy where applicable e.g. for homeopathy. In such circumstances staff should also ensure that patients do not stop taking their prescribed medication unless the patient has been advised to do so by an appropriate clinician.

16 MEDICATION UNTOWARD EVENTS

16.1 A medication untoward event is a preventable incident associated with the use of medicines that may put a patient at risk. Such incidents or near misses may be related to one or more of the stages of the medicines use process.

16.2 If a practitioner realises that an error has been made e.g. a drug has been omitted, given incorrectly or the procedure has failed, first check the well-being of the patient.

16.3 Depending on the nature of the incident, inform the doctor/pharmacist/line
manager/ward manager/service manager and seek advice and arrange immediate treatment or follow-up as necessary.

16.4 If a patient is directly affected explain to them what has happened and reassure them in line with the Trust’s Being Open and Saying Sorry When Things Go Wrong Policy.

16.5 Document the details of the untoward event in the medical records of all patients directly affected by the event.

16.6 A Datix Untoward Event Report form must be completed for all errors, near misses and any unexplained omissions.

16.7 For all untoward events involving medicines a local investigation will be undertaken and / or reflective account requested. All incidents rated as moderate or above and those where issues are highlighted will be reviewed by the Medicines Incidents Group and lessons learnt will be disseminated. The Medicines Incidents Group will also monitor incident trends.

16.8 See the Trust Medication Incident Handling Framework.

16.9 The Trust Medication Safety Officer is responsible for improving medicines incident reporting and learning within the Trust. Any learning as a result of incidents reported to the National Learning and Reporting System will be disseminated to appropriate staff within the Trust.

17 CONTROLLED STATIONERY

17.1 Any stationery which could, in the wrong hands, be used to obtain medicines fraudulently is deemed to be controlled stationery (Safe and Secure Handling of Medicines Revision of the Duthie Report 2005). It must be stored securely, access to it restricted and any loss or theft must be reported immediately to the Service/Locality Manager and a Datix Untoward Event Report form completed.

17.2 FP10 prescriptions are ordered and issued against strict procedures. When not in use these forms must be kept in a locked drawer/cupboard with strictly limited access. For further details refer to the FP10 Prescription Forms Policy.

17.3 Controlled Stationery should be kept for the periods stated in Records Keeping and Record Management Policy.

18 TRUST DAY HOSPITALS AND DAY CENTRES

18.1 Clients who attend Day Services may need to take medicines during their stay. It may be possible for the medication to be taken at a different time of day and this should be assessed by the prescriber.

18.2 The nurse in charge of the Day Hospital or the Day Centre co-ordinator has overall responsibility for the safe storage and supervision of any medicines within the day facility.

18.3 Clients will usually be responsible for bringing in their own medicines. The medicine must be for the use of that particular client only.

18.4 Medicines should always be brought in the original container, supplied and labelled by the community pharmacy or dispensing GP practice. Receiving medication in an envelope or bottle without any description of the contents is not acceptable. It has to be clear what the medication is and to whom it
has been prescribed.

18.5 The client or carer should hand the medication to the person in charge on arrival. Even if the client is deemed responsible to administer their own medication it must still be handed to the person in charge in case the medication is accidentally mislaid and taken in error by another client.

18.6 The medication must be stored safely in a locked cupboard or drawer. If medication is stored overnight then the drug cupboard must comply with the latest British Standards.

18.7 Clients may self-administer either unaided or with help. No administration records are needed, but an appropriate entry in the care plan should be made.

18.8 If there is any doubt or ambiguity about the medication clarification with the dispensing pharmacy or prescriber should be sought.

18.9 If a client needs medication during their stay and this has not been brought in with them, then normal prescribing, ordering and administration recording (using the MAR chart) will apply.

19 COMMUNITY TEAMS

19.1 This section should be read in conjunction with sections:

- 5: ACQUISITION OF MEDICINES
- 7: STORAGE OF MEDICINES
- 9: PRESCRIBING
- 10.14 Deprivation of Liberty safeguards (DoLS)

19.2 Community teams within the Trust community health include all staff who prescribe, administer and handle medicines and all teams who store medicines in community settings.

Medicines reconciliation in Community Teams

19.3 Following admission to a community team / community nursing caseload a patient’s medication should be reconciled as outlined in the Trust Medicines Reconciliation Policy

Prescribing in Community Teams

19.4 A single point of medication prescription and supply, for each patient, is desirable in the long term to prevent duplication, drug interactions, communication difficulties and blurring of monitoring responsibilities.

19.5 Most patients in the community will receive all their medicines from their GP. Exceptions to this practice include:

- Medicines that must be prescribed in secondary care – ‘red drugs’ (see Somerset CCG Traffic Light Guidance).
- Please refer to the principles of prescribing across the primary / secondary care interface (Appendix L) and Appendix M for advice on administration.
- Medicines prescribed by psychiatrists in an outpatient / community setting, for example during initiation or dose change of psychiatric
Medicines prescribed by an independent or supplementary non-medical prescriber or community practitioner nurse prescriber.

In the mental health teams a decision should be made on referral to the team as to whether medical responsibility for psychiatric care and / or prescribing responsibility remains with the GP or transfers to the consultant or a mixture of both is to be in place. The resulting decision should be recorded in the care plan and communicated to the GP who should also be informed of any subsequent changes in responsibility.

A Community MAR chart must be written for all medication that is administered by the team and any patient’s own drugs that are currently stored at the team base and subsequently supplied to the patient in aliquots.

Medicines prescribed by a patient’s GP that the patient self-administers are not recorded on the MAR chart.

Storage of and access to Medicines in Community Teams
(To be read in conjunction with section 7 above)

Within a shared community team base it is desirable that each team has their own locked cupboard in which to store medication for their clients.

All medicines must be stored in a locked cupboard of a defined standard (see paragraphs 7.8, 7.9, 7.10, and 7.11). The cupboard should be situated in a locked room and should not be sited near sources of heat or humidity. Storage facilities should always be locked when not in direct use.

The nurse team leader or designated nurse should be responsible for control of access to the medicines and shall therefore have responsibility for ensuring that a safe system for security of medicines in the clinical base is maintained.

Access to the keys should be restricted to registered nurses, doctors and authorised member of the pharmacy staff. Keys should be kept securely, preferably locked in a keypad controlled cupboard.

Following a decision by the Medical Emergencies Group (formerly the Resuscitation Group), adrenaline 1 in 1,000 must be carried within community team bags (mental and community health) for use in the event of an anaphylactic reaction to an administered medication.

Ordering medicines in Community Teams

Community team bases will normally hold a limited stock of medicines. A list of medicines to be held in stock should be reviewed regularly by the Trust medicines management team and the nurse team leader or designated nurse.

Medicines for stock must be ordered either on a pre-printed order list agreed with the Trust medicines management team or on a pharmacy order form, or using an agreed electronic system. Orders must be signed or electronically authorised by a registered nurse.

Palliative Care Drug Administration for Community (District) Nursing Teams

Palliative care patients may be supplied with a ‘Just in Case box’ for all
relevant medications for symptom control.

19.18 Arrangements for Palliative care drugs to be available in the patient’s home should be made in line with the Somerset Health Community ‘Just in Case Box Protocol – Standard Operating Procedure’ (see also the End of Life Care Policy and Syringe Driver Policy).

**Patient collection of medication from Trust sites**

19.19 If medication is collected from the team base or clinic it must be handed to the patient or their representative by a registered nurse, a doctor or a member of the pharmacy team.

19.20 The medication must be checked to ensure that the label on the medicine corresponds with the current prescription for the patient.

19.21 The patient or their representative should be asked to confirm the patient’s demographic details (if present on the prescription) before handing over the medication.

19.22 The receipt of dispensed items that have been delivered to the team base from the pharmacy must be recorded on the “Receipt & Issue of Leave / Discharge / outpatient Medicines Received from Supply Pharmacy” form (Appendix N).

19.23 The patient or their representative must sign the received by column on the form.

19.24 Policy and procedures for supply of clozapine directly from Clozapine Clinics, and forms to be used for this, are detailed in the Clozapine Policy.

**Using Patient’s own drugs in Community Teams**

19.25 Medicines dispensed (including dressings) for a patient are the legal property of that patient.

19.26 Medicines must only be used for the patient they have been prescribed and dispensed for and must not under any circumstances be used for another individual.

19.27 Patients routinely store medicines in their own home. Community nurses may be involved in advising patients or carers on the safe storage and use of their medicines.

19.28 Where it is deemed to be in the patient’s best interest for medication to be kept at the community base for example for patient safety reasons such as risk of overdose or to assist and / or monitor medicines adherence, this should be kept in the medicine cupboard and used for that patient only.

19.29 Medicines should be clearly labelled and kept separate from stock items within the medicines cupboard.

19.30 Medication placed in the cupboard should remain in the original container.

19.31 Storage at the community base should be recorded as part of the patient’s care plan.

19.32 Details of the medication stored should be entered on the “Receipt & Repeat Issue of Patient’s Own Drugs” form (see Appendix I) by the registered nurse and the form should be kept with the medicines within the cupboard. All entries should be dated and signed.
19.33 Any subsequent reissue or return of the medication to the patient must be recorded on the form and a running balance maintained.

**Controlled drugs in the community teams**

19.34 Controlled Drugs should be managed in line with the Controlled Drugs Policy and associated Standard Operating Procedures. Also see paragraphs 7.8, 7.22, 7.23, 8.3, 9.61 and 19.11 above

**Administration in Community Teams**

19.35 Patients will usually self-administer medicines in their own home. In these circumstances, nurses have a supportive, educational and monitoring role in relation to patient self-administration.

19.36 Some medication including injections and vaccines are administered by community nursing staff. It may also be deemed to be in the patient’s best interest for medication to be administered to them in their own home.

19.37 The registered nurse must pay special attention to the assessment of the environment e.g. privacy, dignity and hygiene issues, whilst administering medicines in the community setting.

19.38 A signed community MAR chart must be held for all medicines administered by Trust staff. This includes medicines obtained on FP10. A signed community MAR chart is not required for medicines administered under the direction of a Trust ratified Patient Group Direction.

19.39 Medication must not be administered by anyone other than a registered nurse, dentist or doctor unless they are a specified health professional working to a ratified Trust Patient Group Direction or the task has been delegated to them (see paragraph 19.40 and Section 22).

19.40 Within the Community / District Nursing Team, the team leader may delegate administration of named medications (see list below) to a non-registered staff on provision that conditions set out in Section 22 have been observed.

- Suppositories, Pessaries and Enemas
- Bladder Maintenance Solutions
- Eye drops
- Topical skin preparations
- Medicated dressings

Non-registered staff must record the administration of the medication delegated to them as below (see paragraphs 19.42 and 19.43). They may be allowed access to these categories of medicines.

19.41 Nurses should carry out assessment of all the patient’s own drugs prior to administration to ensure they are suitable for use. Please refer to Appendix C: Algorithm for the use of Patient’s Own Drugs (PODs).

19.42 The registered nurse should record administration on the community MAR chart. Additional information such as site of injection, if applicable, and any dilution or calculations made should be recorded in the nursing notes. For those items delegated to a HCA (see paragraph 19.40 and Section 22) the HCA is responsible for recording in the same way.

19.43 All medicines refused should be recorded on the MAR chart using the
appropriate code, documented in the patient’s records and the prescriber alerted.

19.44 Any wasted doses or returns of patient’s own drugs stored at the team base must be recorded on the “Receipt & Repeat Issue of Patient’s Own Drugs” form (see Appendix I).

19.45 As part of an individual care plan the HCA may observe a patient self-administer their medication. This should be recorded on the MAR chart using the appropriate code as stated on the chart. The same level of accountability for registered nurses applies here as set out in the administration section of this policy (see Section 22).

**Transportation of Medicines by Community Teams**

19.46 It is not generally the responsibility of the community team to obtain patients medication from the hospital or community pharmacist or deliver them from the community team base. However, registered nurses and other community team members may convey them to the patient’s home in exceptional circumstances or as part of their care plan as an ‘agent’ of the patient.

19.47 All medicines carried by the community team member should have been prescribed as a specific dose for a named patient by a qualified medical practitioner/authorised prescriber or covered by the terms of a PGD under which the nurse may supply or administer the medicine. Medication should remain in the original container.

19.48 Where a practitioner working in the community becomes involved in obtaining prescribed medicines for patients, he/she must recognise their responsibility for safe transit and correct delivery.

19.49 If medication is being delivered to the patient from the community team base it must be taken out of the drug cupboard by a registered nurse or doctor who is responsible for ensuring it is the correct medicine for that patient.

19.50 Members of the community team transporting medicines must:

- Keep the medicines in a suitable bag as agreed with the Trust Chief Pharmacist when visiting the patient.
- Lock the bag in the boot of the vehicle or otherwise ensure that the medicines are out of sight when travelling between visits. Ensure that access to the part of the vehicle where the medicines are stored is restricted (locked) to prevent access from outside the vehicle when temporarily stationary (e.g. waiting at traffic lights etc).
- Deliver medicines directly to the patient or carer and must not be left unattended or put through a letterbox.
- Not store medicines in cars, except during transportation and between visits, because of the extreme temperature variations which occur.

19.51 Any member of the community team transporting medication should ensure that they have informed their motor insurance company that they may undertake this activity.

19.52 In the event of a loss or theft of medication whilst away from base the line manager must be informed immediately. Police must be informed of the
loss or theft. An Untoward Event Report form must also be completed.

Disposal of Medicines by Community Teams

19.53 Medicines obtained by patients for home use, by prescription from authorised prescribers are the patient’s own property. When no longer required, the patient should be advised to return them to the community pharmacy for destruction.

19.54 Community team members should only remove medicines with the patient’s consent. A Patient’s Own Drugs Disposal Form (Appendix B) should be completed and signed by the patient. This form must be retained in the patient’s notes or scanned into the electronic patient record and retained only until it has been uploaded successfully. Medicines must be returned to a community pharmacy for disposal and this action should be recorded in the patient’s notes or in the patient's electronic record.

19.55 If permission is refused and the community team member believes the patient or others in the home are at risk, the line manager should be informed as soon as possible. If the patient lacks capacity to consent the medicines can be removed in the best interest of the patient. Evidence of a capacity test relevant to the decision to remove a patient’s medicines should be documented on RiO and the reason why this was thought to be in the patient's best interest. The Trust will support clinical staff in making reasonable decisions in the balance between the legal duty of care to the patient and legal possession of the drugs. Full details of the identified risk and action must be documented in the patient record.

19.56 Removal of patient’s own drugs, when appropriate should normally be carried out by a registered nurse or a doctor. In exceptional circumstances, for safety reasons, other members of the community team can remove the medicines.

19.57 Within mental health disposal of stock drugs must be in line with section 8 of this policy.

School Age Vaccination service

19.58 Medicines should be administered in schools according to the agreed Patient Group Directions and the Immunisation and Vaccination Policy.

19.59 Nurses working within the service may administer vaccines to children in school in accordance with the Patient Group Directions Policy, Immunisation and Vaccination Policy and following confirmation of parent/carer consent.

19.60 Vaccines should be stored and transported in accordance with the Immunisation and Vaccination Policy.

20 PRIMARY CARE DENTAL SERVICE

20.1 Medicines must be prescribed by a registered dentist

20.2 Storage of medicines should comply with the details in this policy in Section 7: STORAGE OF MEDICINES. The Senior Dental Nurse is responsible for the security of all medicines used in the departments

20.3 Administration of medicines should be recorded in the patient’s dental record

20.4 The training and competency of dental nurses will be monitored and
21 MANAGING MEDICINES IN A SECTION 136 SUITE – Mental health

21.1 This section should be read in conjunction with other relevant sections in this Policy.

21.2 Unless specific, approved medication storage is provided within the Section 136 suite, there must be a designated adjacent ward where any medication brought in by the person can be safely stored, including Controlled Drugs, if appropriate

**Routinely prescribed and as required medication for symptom control**

21.3 A Trust MAR chart, or RiO electronic prescription in areas of the Trust where EP has been implemented, should be completed by the prescriber for essential medication.

21.4 Information on the person’s need for routine medication may not always be available. In all circumstances the person’s medication should be confirmed as soon as practical (e.g. from GP if they have one and is known, or summary care record) even when the person or their carer provides information or brings in labelled medication as the information may be inaccurate or out of date.

21.5 Ward stock drugs should be used for administration. The patient’s own drugs should only be used if there is no stock on the ward and the drugs have been authorised for use by following the Algorithm for the use of Patient’s Own Drugs (PODs) (see Appendix C).

21.6 If there is no medication available a FP10 can be completed and dispensed for the person at a community pharmacy (see FP10 Prescription Forms Policy).

21.7 Medication that the person may have purchased ‘over the counter,’ and complementary medicines, must not be administered during their stay in the Section 136 suite.

21.8 If the person is subsequently admitted to an inpatient ward, any medication they brought in with them must be transferred, as part of their property, to the admitting ward.

21.9 If the person is subsequently released from the Section 136 suite without admission, any medication they brought in with them should be returned to them, unless it is felt that to do so would constitute unnecessary risk to the person or to others. In this case the person’s consent to the disposal of the medication should be sought and a Patient’s Own Drugs Disposal Form Inpatient/Community (Appendix B) completed and signed by the patient. If the person refuses to consent to the disposal of their medication return of their medication can be refused. In this case a full record must be made why this decision was taken by the practitioner taking responsibility for the decision.

22 DELEGATION OF MEDICINES ADMINISTRATION-RELATED TASKS TO NON-NMC REGISTERED HEALTHCARE PROFESSIONALS (HCPs) OR NON-REGISTERED STAFF

22.1 Delegation can be defined as the entrusting of a task to another person. The delegate has the following responsibilities:
agreeing to undertake the task in accordance with their competence and instructions from the person delegating;

- communicating changes and conditions which affect their competency - they have a right to refuse to undertake that delegated task;

- escalating untoward patient changes and circumstances

22.2 Medicines administration-related tasks for the purpose of delegation to non-NMC registered HCPs (see also paragraphs 4.10, 9.73 and 11.2-11.10) or non-registered staff are divided into the following five categories:

- **Assistance**: The patient defines and selects what medicine they require and the healthcare worker assists them with this task, for example, popping medicines out of packaging, measuring a dose, helping read labels. This process must be always directed by the patient.

- **Conveyance of medication**: Taking a medicine to a patient on behalf of another individual. This includes taking a medicine or medicines to a named-patient on behalf of a registered HCP with authority to supply or administer and may include the need to identify the patient to ensure the medicine(s) are supplied or administered to the correct patient.

- **Prompting**: Prompting is a question to ask if the person has taken their medication providing they have the capacity to refuse. For example “Have you had your medicine today?”, “Did you remember to take your medicine?”

- **Monitoring**: Monitoring means recording the response to prompts about medicines. Monitoring does not include physical verification of numbers, packets or amounts of any medicine however any obvious discrepancies noticed or other concerns regarding medicines must be reported.

- **Verification**: Verification is the checking the amount of medication remaining against the amount of medication used.

- **Administering medication**: Administration is to give a medicine by either introduction into the body or by external application.

22.3 In order for a medicines administration-related task or activity to be delegated the following rules must be applied:

a) Performance of the task or duty by delegation must be in the best interest of the patient: delegation of the task must not be detrimental to the patient’s care or safety.

b) Relevant delegating professionals and non-registered staff are fully aware they are individually accountability for their actions and that they have social, ethical and legal contractual accountability and are responsible delegated tasks undertaken.

c) The member of staff to whom the task is delegated must have been suitably trained and assessed as competent to perform the intervention.
d) There are full records of training given and evidence of competence assessment.

e) There should be clear guidelines and protocols in place to ensure:
   - the delegated tasks or activities are clearly defined;
   - staff to whom medicines administration tasks are delegated are not required to make a ‘stand-alone’ clinical judgement;
   - there is a clear process for escalation of the task or activity back to a suitable healthcare professional when the clearly defined boundaries have been reached.

f) The role is within the non-registered staff member’s job description.

g) The team and any support staff are informed that the activity has been delegated.

h) Necessary processes are in place to ensure that competency is maintained.

i) The service model must be assessed for the degree of risk.

j) For each instance of delegation to non-registered staff, the delegating healthcare professional remains professionally accountable and must be satisfied that:
   - the non-registered staff to whom the task has been delegated has been trained, has been assessed as competent, and remains competent to carry out the care required;
   - appropriate levels of supervision and support are in place;
   - the delegation is in accordance with relevant professional standards and the Trust’s policies, procedures and guidelines

23 TRAINING REQUIREMENTS

23.1 The Trust will work towards all staff being appropriately trained in line with the organisation’s Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

23.2 There is a mandatory requirement for a range of Medicines Management Training and Competencies for Nurses, Doctors, Pharmacists and all other professionals that handle medicines. Line Managers of staff should refer to the Staff Mandatory Training Matrix for specific details or contact the training department.

23.3 Additional training and competency assessment will be required for staff to participate in the following:
   - Drug calculations for administration
   - Insulin administration
   - Intravenous injection
   - Patients Own Drugs Scheme
   - Patient Group Directions
   - Rapid tranquilisation
   - Safe handling of Controlled Drugs
23.4 Additional training and competency assessment is advised for staff to participate in the following:

- Intramuscular and subcutaneous injection

23.5 The Learning, Development and Mandatory Training Policy describes how the Trust identifies and records training required by all permanent staff in line with the Training Needs Analysis and how non-attendance is followed up (including action to be taken in the event of persistent non-attendance)

24 MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring arrangements for compliance and effectiveness

24.1 The Medicines Oversight Group will be responsible for monitoring compliance with and effectiveness of this policy

24.2 Audit of this policy is incorporated into the Trust Clinical Audit plan and appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking audit and signing off key recommendations is held by the Medicines Oversight Group and is overseen by the Quality Assurance Group.

24.3 Methodology to be used for monitoring
- The Trust Board receives a Patient Quality and Safety Report on a monthly basis which includes medication incident trends.
- Medication incidents are reviewed by the Medicines Incidents Sub Group of the Medicines Oversight Group and lessons learned will be disseminated.
- Monitoring of incident reports relating to medication incidents will be undertaken by the Medication Safety Officer.
- Adverse drug reactions will be reported to the MHRA on a yellow card and a Datix Untoward Event Report form completed
- The Trust Accountable Officer for Controlled Drugs, registered with the Care Quality Commission, reports quarterly to NHS England Area Team and the Medicines Oversight Group.
- Monitoring of implementation of this policy will also be undertaken through the Trust Clinical Audit Plan. Medicines related audits are monitored by the Medicines Oversight Group.

24.4 Frequency of monitoring
- The Medicines Incidents Review Group monitors incidents and reports to the Medicines Oversight Group every second month.

25 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

25.1 References
As listed in paragraph 2.4 above
MHRA recommendations on the control and monitoring of storage and transportation temperatures of medicinal products
25.2 Cross reference to other procedural documents

- Administration by Injections Policy
- Admission, Transfer and Discharge Policy – Community Health
- Anaphylaxis Treatment Protocol (see Appendix C in the Medical Emergencies Management Policy)
- Antimicrobial Prescribing Policy
- Being Open and Duty of Candour Policy
- Clinical Assessment and Management of Risk of Harm to Self and others Policy
- Clozapine Policy
- Consent and Capacity to Consent to Examination/Treatment Policy
- Controlled Drugs Policy
- Community Treatment Order (CTO) Policy
- ECT (Electroconvulsive Therapy) Policy
- End of Life Care Policy
- Enteral Feeding Policy
- Code of Conduct and Managing Conflicts of Interest and Personal Conduct Policy
- FP10 Prescription Forms Policy
- Handover Policy (being developed as a Standard Operating Procedure)
- Healthcare (Clinical) Waste Policy
- Hypoglycaemia Policy
- Identification of Patients Policy
- Immunisation and Vaccination Policy
- Infection Prevention and Control Policy
- Insulin Management Protocol
- Somerset CCG Just In Case Protocol
- Learning Development and Mandatory Training Policy
- Medical Devices Policy
- Medical Emergencies Management Policy (being developed as a Standard Operating Procedure)
- Medical Gas Cylinders and Medical Pipeline Services Policy
- Medicines Reconciliation on Admission to Inpatients Wards Policy
- Non-Medical Prescribing (NMP) Policy
- Patient Group Directions (PGD) Policy
- Physiological Observations of Inpatients and Minor Injury Units Policy
- Rapid Tranquilisation Policy
- Records Keeping and Records Management Policy
- Integrated Care Planning Approach (ICPA) Policy
- Research and Development Policy
- Resuscitation Policy
- Serious Incidents Requiring Investigations (SIRI) Policy
- Somerset Treatment Escalation Plan (STEP) and Resuscitation Decision Policy (County Wide Policy)
- Subcutaneous Fluids (Hypodermoclysis) Administration Policy
- Substance Use Management on Trust Premises
- Syringe Driver Policy and Standard Operating Procedure in the Usage of McKinley T34
- Untoward Events Reporting Policy
- Wound Formulary
- Wound Management Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’).
APPENDICES

For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

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APPENDIX A

STOCK MEDICINES TRANSFER FORM

Complete this form when any stock medicines are transferred to another ward, department, MIU or community base and also when stock is received from another ward.

- Stock Controlled Drugs may not be transferred between wards or departments.
- Stock drugs must only be transferred in their original container.

The Registered Nurse in Charge is responsible for the safekeeping of medicines in their ward or department.

TO BE FILLED OUT IN BLOCK CAPITALS

DATE………………………..……….. TIME…………………………………………...

NAME OF SUPPLYING WARD/DEPT……………………………………………………

NAME OF DRUG…………………………………………………………………………

FORM…………………………………………………………………………………..
(tables/injection etc)

STRENGTH…………………………………………………………………………

QUANTITY………………………………………………………………………………

BATCH NUMBER………………………… EXPIRY DATE……………………

WARD/DEPT RECEIVING MEDICATION………………………………………………

Comments (including reason for transfer): …………………………………………..
……………………………………………………………………………………………
……………………………………………………………………………………………

REGISTERED NURSE NAME (Supplying medication) …………………………
SIGNATURE………………………………………………………………………………

REGISTERED NURSE NAME (Collecting medication)…………………………...
SIGNATURE………………………………………………………………………………

COPY MUST BE SENT TO THE TRUST CHIEF PHARMACIST
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

PATIENT’S OWN DRUGS (PODs) DISPOSAL FORM

INPATIENT / COMMUNITY

Patient’s Name: …………………………………………………………………………………………………………

I no longer require my medicines as stated below and wish them to be disposed of for me by the Trust or a Community Pharmacy

☐

Nurse certifies patient does not have capacity to consent and it is in the patient’s own interest to have medication retained for disposal

☐

Patient no longer on ward – no consent given

☐

Patient’s Own Drugs (Name, Form, Strength and Quantity) to be disposed of:

……………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………

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……………………………………………………………………………………………………………………………………

Patient’s signature (if applicable): …………………….. Date: ……………………..

Nurse’s signature: ………………………………………………………….. Date: ………………………

Ward/Team: …………………………………………………………………………………………………………………

Circle as appropriate:

Medication disposed of following the Trust’s Procedure for the Disposal of Waste Medicines/Drugs

YES/NO

Scan form and file in patient’s notes
ALGORITHM FOR THE USE OF PATIENT’S OWN DRUGS FOLLOWING MEDICINES RECONCILIATION

Assess each medication separately. Contact Meds Management Team if in any doubt or for further advice.

1. Is the medication on the patient’s current Medicines Administration Record (MAR)?
   - YES
   - NO

2a. Is the correct patient name on the label? see also 2b
   - YES
   - NO

2b. Unlabelled foil strips of medication – continue assessment process at stage 4
   - YES
   - NO

3a. Is the medication in the original dispensed container? See also 3b & 3c
   - YES
   - NO

3b. Monitored dose systems - only used in exceptional circumstances and AFTER discussion with medicines management team
   - YES
   - NO

3c. Loose tablets in a bottle or open container of liquid (or powder) – has the patient transferred direct from another NHS Trust?
   - YES
   - NO

4. Is the label, container and medication in good condition eg:
   - Container, contents & label clean & dry
   - Label clear & not been changed from another container
   - In date (check original container, dispensing label, or foil strips)
   - YES
   - NO

5a. Nose drops, eye/ear preparations
   - Is the medication unopened (go to 5d)
   - If opened was the medication dispensed within the last 28 days?
   - YES
   - NO

5b. Loose tablets in a bottle or opened bottle of liquid (see 3c)
   - No mixed tablets/capsules?
   - Contents not broken, crushed or damaged?
   - YES
   - NO

5c. All other medication
   - Do the drug name, form and strength on the pharmacy label match:
   - the medication in the container OR the manufacturer’s label?
   - NOT TO ANY
   - DO NOT

5d. Was medication dispensed in the last 6 months (Creams & Ointments only use if dispensed in last 3 months)?
   - YES
   - NO

6. Medication needing cold storage only: can you confirm that the product has been kept in appropriate cold storage conditions? *
   - YES
   - NO

7. Do the directions on the label (where present) match the directions on the MAR chart?
   - YES
   - NO

8. POD may be used
   - YES

---

Patient name
Hospital ......................... Ward .........................
NHS Number ........................ Nurse signature ........................ Date ........................

* Do NOT USE with exception of insulin vial in current use

Order new supply
Use POD until new supply arrives

APPENDIX C
Safety Alerts and Recalls

Safety Alert issued and sent to Chief Pharmacist & Medication Safety Officer

Forwarded onto the Medicine Management Admin Office to be actioned

Ensure YDH Pharmacy is aware of the alert and request confirmation it has been actioned

Update Database on Pharmacy shared drive

Send the alert/recall to the Pharmacy Team for their information so they can reinforce when on ward visits if necessary

Update DATIX report stating actions taken

Class 1:
Discuss with Trust Pharmacist

Class 2: ‘Patient & Pharmacy’
If patient level recall discuss with Trust Pharmacist
All others liaise with Suppliers

Class 3 & 4:
Liaise with suppliers
# MEDICINES POLICY: APPENDIX E

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<th>Title</th>
<th>PHARMACEUTICAL PRODUCTS TEMPERATURE MONITORING GUIDANCE</th>
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<tr>
<td>Purpose</td>
<td>To provide guidance on appropriate storage of pharmaceutical products to maintain their stability and integrity</td>
</tr>
<tr>
<td>Scope</td>
<td>This procedure covers the monitoring of storage temperatures for medicines/vaccines stored in Trust premises.</td>
</tr>
<tr>
<td>Responsibility</td>
<td>The senior nurse is responsible for ensuring that all medicines within his/her clinical area are stored in the appropriate conditions. The ward must have one trained individual with at least one trained deputy, responsible for the recording and monitoring of the ward environment.</td>
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</table>

## 1. INTRODUCTION

1.1 All healthcare practitioners are responsible for ensuring medicinal products are stored in accordance with the patient information leaflet, summary of product characteristics and in accordance with instructions on the label.

1.2 The majority of medicinal products can be stored under conditions of controlled room temperature without compromise to their stability and recommended shelf life. These products are usually labelled ‘do not store above 25°C’.

1.3 Managers should ensure that procedures/protocols are in place to ensure the correct storage of vaccines and other heat sensitive medicines within their area of management. They should ensure that staff have been appropriately trained in the use of the equipment and understand the importance of maintaining the cold chain.

1.4 There should be a system of stock rotation, so that stock with the shortest expiry is used first. Stocks should be monitored to avoid over-ordering or stockpiling.

1.5 All refrigerators used for storing medicines must meet MHRA guidelines on ‘Control and Monitoring of Storage and Transportation Temperatures of Medicinal Products’.

## 2. MONITORING ROOM TEMPERATURE

2.1 Room temperature where medicines are stored should be monitored and recorded daily using a maximum/minimum thermometer to demonstrate compliance with the designated temperature ranges.

2.2 If the temperature reaches above 25°C for more than seven consecutive days then advice must be sought from the Trust Medicines Management Team or the manufacturer.

2.3 Complete a significant event form.
3. **REFRIGERATORS FOR STORING TEMPERATURE SENSITIVE MEDICATION AND VACCINES**

3.1 All medicines requiring refrigeration must be stored in a lockable refrigerator.

3.2 Medicines refrigerators must be used solely for the storage of pharmaceutical products (no food or pathological specimens).

3.3 Integral temperature dials that only measure “actual” temperatures are not sufficient. The refrigerator must have a maximum and minimum internal thermometer irrespective of whether it has an integral temperature indicator or alarm system. A device that allows readings to be taken without opening the refrigerator door is preferred.

3.4 Check the accuracy of approved stand-alone maximum/minimum thermometers annually.

3.5 Do not site refrigerators where extremes of temperature (< 10 °C or > 32 °C), or nearby sources of heat will affect their performance. Keep adequate space between the compressor and the wall to allow air to circulate to cool the compressor motor.

3.6 Label the power supply to the refrigerator to discourage inadvertent disconnection.

3.7 Maintain refrigerators regularly according to the manufacturer’s instructions for cleaning, defrosting and record the date this is done. Stocks should be at a minimum whilst the refrigerator is being defrosted and the stock must be maintained in the cold chain throughout.

3.8 After cleaning or new installation, ensure the refrigerator has reached operating temperature before filling with medicines/vaccines.

3.9 Arrange stock systematically and allow sufficient space between medicines and the internal surfaces to allow adequate air flow.

3.10 Use a system of stock rotation so that stock with the shortest expiry date is used first.

4. **MONITORING REFRIGERATOR TEMPERATURE**

4.1 Temperature sensitive medicines and vaccines must be stored within the range of plus 2 and plus 8 degrees centigrade (+2°C and +8°C).

4.2 Measure the refrigerator daily in all refrigerators containing medicines (with the exception of those in patients’ own homes). Record the temperature at the time of the reading, and maximum and minimum temperatures reached during the preceding day using the Refrigerator Temperature Monitoring Chart in annex 1 below. Reset maximum/minimum thermometers after each daily reading.
4.3 Choose a time when the refrigerator has not been opened for a while to take temperature readings.

4.4 Place the probe of the maximum/minimum thermometer in the middle of the refrigerator in amongst the medicines. It will record load temperature rather than the air temperature which fluctuates more when the door is opened. The probe must not rest on or near the refrigerator light.

4.5 Temperature records should identify any temperature deviations and give details of corrective actions taken as a result. For instances where there has been a temperature deviation, best practice would be to take a further reading a few hours later to determine if the temperature is back within prescribed parameters.

4.6 Keep opening times of the refrigerator door to a minimum. If the door is open for an extended period record this on the temperature log, along with the reason, e.g. receipt of vaccine order, changing a faulty light bulb.

4.7 Temperature records should be kept for a period of 25 years (requirement for any medicines administered to babies and infants). They should be stored and archived as per the Records Management Strategy.

5. RECEIPT OF MEDICINES FOR REFRIGERATION

5.1 On receipt all medicines requiring refrigeration must be checked against the order and locked in the refrigerator IMMEDIATELY.

6. MANAGING OUT OF RANGE REFRIGERATOR TEMPERATURES

<table>
<thead>
<tr>
<th>POWER CUTS / ACCIDENTAL DISCONNECTION OF ELECTRICAL SUPPLY</th>
<th>REFRIGERATOR BREAKDOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refrigerator temperature inside the range 2-8°C:</td>
<td>• Make arrangements for repair of the refrigerator by contacting the Estates Maintenance department within your locality. If the refrigerator cannot be repaired and you need to order a new one, advice can be obtained from the Medicines Management Team.</td>
</tr>
<tr>
<td>• Reconnect the power supply. No further action required.</td>
<td></td>
</tr>
<tr>
<td>Refrigerator temperature outside the range 2-8°C:</td>
<td>• Transfer the medicines (in a bag marked DO NOT USE) to another refrigerator if possible, keeping them separate from other contents.</td>
</tr>
<tr>
<td>• Transfer the medicines (in a bag marked DO NOT USE) to another refrigerator if possible, keeping them separate from other contents.</td>
<td></td>
</tr>
<tr>
<td>• If this is not possible reconnect the power supply and keep the door of the refrigerator closed.</td>
<td>• If no other suitable refrigerator is available, keep the door of the malfunctioning refrigerator closed.</td>
</tr>
</tbody>
</table>
**THEN:**

- Note the refrigerator current maximum and minimum temperatures.

- Check the monitoring form to find out when the refrigerator was last working properly. Try and establish how long the drugs/vaccines have been stored outside the required range of temperatures.

- Record the drugs/vaccines and the manufacturer’s name. Contact the Trust Medicines Management Team or the manufacturer for the latest advice.

- If you are advised it is safe to use drugs/vaccines which have been exposed to higher than normal storage temperatures, mark the affected stock ‘use first’ and with the new expiry date (if applicable).

- Ensure the refrigerator has reached operating temperature before refilling with medicines (where applicable).

- Complete an Untoward Event Record of the incident.

### 7. RETURNING REFRIGERATED STOCK

7.1 If an item has been sent in error then inform Pharmacy immediately. Temperature sensitive items cannot be returned but credit can be given.
**REFRIGERATOR/CLINIC ROOM TEMPERATURE MONITORING CHART**

- Check the maximum and minimum fridge temperature every working day. Record time & initials of person undertaking check.
- If the temperature falls in either shaded area, **RESET THE THERMOMETER and test within 1 hour** – record and initial the new reading on the same date
- If the temperature still falls in either shaded area, further action **MUST** be taken to safeguard the fridge contents – see overleaf.
- Record the temperature of the clinic room in the bottom row.

| °C | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|----|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| >15|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 15 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 14 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 13 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 12 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 10 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  9 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  8 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  7 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  6 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  5 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  4 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  3 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  2 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  1 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|  0 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| <0 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Max room temperature |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
REFRIGERATOR TEMPERATURE MONITORING - When the temperature falls in the shaded area:

1. RESET THE THERMOMETER
2. Recheck temperature within 1 hour
3. Record new temperature and initial the new reading in the same date column
4. If temperature is still in the shaded area:
   a. Further action **MUST** be taken to safeguard the fridge contents. For example: bag contents, label and move to another ward medicine fridge, or if not available, a working fridge used for other purposes. Record actions in the grid below.
   b. Contact Estates to discuss options
5. If the fridge is broken, purchase a new fridge via Integra
6. Obtain advice from Medicines Management (contact details on Intranet) to find out if stock is fit to use.

ROOM TEMPERATURE MONITORING – For detailed advice, please refer to memo dated 21st June 2017
If room temperatures exceed 25°C you must take action to cool the room. If room temperatures exceed 25°C for more than 7 consecutive days, contact the Medicines Management Team.

<table>
<thead>
<tr>
<th>Date</th>
<th>Temperature recorded</th>
<th>Brief note of action, including persons informed.</th>
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</tbody>
</table>
### MEDICINES POLICY: APPENDIX F

<table>
<thead>
<tr>
<th>Title</th>
<th>Amending Medicines Administration Record (MAR) Charts</th>
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</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To describe the permitted interventions Pharmacists may make without referring individual decisions to a prescriber.</td>
</tr>
<tr>
<td>Scope</td>
<td>This procedure applies to pharmacists and working in the Trust Medicines Management Team.</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Pharmacists may make certain prescription amendments and continuations, after checking the patient’s medical records, as their professional judgement dictates.</td>
</tr>
</tbody>
</table>

**General:**

All new prescription of or discontinuation of medicines made by a pharmacist must be in ink, signed for and dated by the pharmacist.

All changes made to the chart according to this policy must be documented in the electronic patient record.

The following amendments are permitted:

1. **Timing of Administration**
   
   Change the timing of administration of medicines where appropriate to maximise the benefit of medication. For example:

   - When the mode of action demands.
   - To avoid interaction with food or other medication.
   - To ensure regularity of administration.

2. **Omission of Strength and Incorrect Strength**
   
   Where the strength has been omitted this can be added by referring to the electronic patient record (RiO), the patient’s own drugs or GP records or other suitable record.

3. **Nonsensical doses or units**
   
   Where nonsensical doses are prescribed and the prescriber’s intention is clear, the dose can be amended.

4. **Form of Medication**
   
   Frequently the pharmacist encounters patients who are receiving forms of their medication that are not best suited to their needs (e.g. patients requiring oral liquids rather than tablets, or a different presentation of inhaler). Such changes as are necessary can be made as long as the total daily dose is not significantly altered; in some cases this will necessitate a change in frequency.
5. **Duplication of Medicines**

Drugs may inadvertently be prescribed twice e.g. once by generic name, and again by brand name. In these circumstances one of them must be stopped.

6. **Amendments**

The following amendments can be made to prescriptions:

- Ambiguities or incomplete prescriptions may be corrected.
- Multi-ingredient preparations that the Trust does not stock may be re-prescribed as the separate ingredients in equivalent doses, so that the patient may continue to receive the medication.
- When medication that must be given regularly is written in the “when required” section of the prescription chart, it may be re-written on the regular section with the appropriate frequency indicated.
- To correct transcription errors occurring when prescription charts are re-written.

7. **Discontinuations**

Prescriptions can be discontinued in the following circumstances:

- Antibiotics where the prescriber has indicated a number of days for the course and the course length has been exceeded.
- Topical preparations that are no longer indicated.
- Items that have been transcribed from an old chart in error having previously been stopped.

8. **Continuation of a Patient’s Existing Therapy**

Continuation of a patient’s existing medication is not classed as a new prescription. The pharmacist can legally transcribe medication in the following circumstances:

- Continuation of regular medication onto a prescription for leave and discharge. If the patient is detained under the MHA ensure an up to date section 17 form exists to cover the leave period and that it has been approved in writing in the electronic patient record.

**Additional Information**

Each quarter all progress notes entered into the electronic patient record (RiO) by members of the medicines management team will be peer reviewed and used for learning purposes.
1. The Somerset Partnership NHS Foundation Trust has identified a list of preparations as “discretionary drugs”. (List A)

2. Discretionary drugs are for use for up to 48 hours only, not exceeding the maximum daily doses for each drug.

3. The preparations identified by the Trust may be administered subject to the following conditions:
   3.1 Only a registered nurse may take the decision to administer a “discretionary drug”.
   3.2 A doctor will indicate whether or not the “discretionary drugs policy” is to apply to a patient by signing an appropriate entry on the prescription sheet or in the electronic prescribing section. The use of discretionary drugs must be reviewed regularly with the rest of the patient’s prescribed drugs.
   3.3 Details of the preparation administered shall be entered in the appropriate section of the prescription by the registered nurse who administered it and in the patient’s clinical notes.
   3.4 If the patient’s condition does not respond to the dose administered medical advice must be sought.

4. Topical applications and wound dressings that can be applied by nursing staff without authorisation are included in the wound dressing formulary.

5. All other preparations must be prescribed for individual patients.
DISCRETIONARY DRUGS and GUIDELINES FOR USE

1. PARACETAMOL 500mg TABLETS

For the relief of mild to moderate pain and pyrexia

DOSE: One to two tablets every 4 to 6 hours. Maximum of 8 tablets (4g) in 24 hours.
CAUTION: Do not give if patient is prescribed other drugs containing Paracetamol. In cases of liver impairment or alcoholism contact doctor.

2. SENNA 7.5mg TABLETS

For the relief of constipation

DOSE: Two tablets to be taken at night.
CAUTION: Do not give if there is intestinal obstruction

3. GAVISCON ADVANCE SUSPENSION

Antacid for the relief of the symptoms of dyspepsia

DOSE: 5 - 10ml after meals and at bedtime.
CAUTIONS: Contains 2.2mmol sodium and 1mmol potassium and 1mmol calcium per 5ml dose. Do not give to patients on salt restricted diet or with high levels of calcium.

4. SIMPLE LINCTUS

For the relief of dry irritating cough

DOSE: 5ml three to four times a day.
CAUTION: Not suitable for diabetics unless sugar free version

5. GLYCERIN SUPPOSITORIES (Adult size 4g)

A laxative for rapid relief of rectal loading if oral therapy is not effective or contra-indicated (e.g. obstruction, NBM). It will exert an effect in 15-30 minutes

DOSE: A single dose of one 4g suppository. Moisten the tip of the suppository with water before use.
APPENDIX H

MEDICINES POLICY: APPENDIX H

<table>
<thead>
<tr>
<th>Title</th>
<th>POLICY FOR THE USE OF UNLICENSED OR OFF-LICENCE MEDICINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To describe the circumstances under which unlicensed medicines may be prescribed or medicines used outside their marketing authorisation status (off-licence).</td>
</tr>
<tr>
<td>Scope</td>
<td>To ensure that clinical staff are aware of their responsibilities.</td>
</tr>
<tr>
<td>Responsibility</td>
<td>All doctors and registered nurses</td>
</tr>
</tbody>
</table>

1. **INTRODUCTION**

1.1 The Medicines and Healthcare products Regulatory Agency (MHRA) grant marketing authorisations (previously ‘product licences’) for medicines in the U.K. Medicines must meet standards of safety, quality and efficacy before they are granted this authorisation.

2. **UNLICENSED MEDICINE**

2.1 Unlicensed medicines are those that do not have marketing authorisation in the U.K.

3. **“OFF-LICENCE” USE OF MEDICINES**

3.1 The off-licence use of medicines refers to the use of medicines with a U.K. marketing authorisation but where the prescriber intends them to be used outside the remit of their licence, for example outside the licensed dosage regimen or indication.

3.2 Where possible clinicians are advised to use licensed medicines within the remit of their marketing authority in preference to unlicensed medicines or off-licence use. The Summary of Product Characteristics (SPC) for a licensed medicine includes the licensed indication(s), dosage regimen(s), age restrictions and contraindications. Any use of a drug that is not in accordance with the SPC is considered off-licence.

4. **RESPONSIBILITY**

4.1 The manufacturer of a licensed medicine only takes legal liability if harm results from its use within the licensed recommendations. The manufacturer carries no legal liability for the unlicensed or off-licence use of a medicine, putting a greater responsibility on individual prescribers and the Trust. The ultimate responsibility for prescribing lies with the prescriber who signs the prescription and is professionally accountable for their judgement. Others could be held to be liable in part if they are shown to have acted negligently.
5. **RECOMMENDED CONSIDERATIONS (MHRA 2009 AND GMC GUIDANCE 2013: GOOD PRACTICE IN PRESCRIBING MEDICINES)**

5.1 Before prescribing an unlicensed medicine, prescribers should be satisfied that an alternative, licensed medicine would not meet the patient’s needs.

5.2 Before prescribing a medicine off-licence, prescribers should be satisfied that such use would better serve the patient’s needs than an appropriately licensed alternative.

5.3 Before prescribing an unlicensed medicine or using a medicine off-licence the prescriber should:
   - Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to show its safety and efficacy.
   - Take responsibility for prescribing the medicine and for overseeing the patient’s care, including monitoring and follow-up.
   - In the patient’s notes record the medicine prescribed and, where common practice is not being followed, the reasons for prescribing the unlicensed medicine and that this has been discussed with the patient or those authorising treatment on their behalf, information has been provided (see below) and that they have agreed to proceed.

5.4 Other Trust staff involved in the treatment of a patient with an unlicensed medicine or medicine off-licence should, where appropriate, be:
   - Made aware of its marketing authorisation.
   - Informed of any problems/risks involved and how to deal with them.
   - Be given sufficient information to administer/use the product safely and correctly.

6. **POLICY**

**Unlicensed medicines**

6.1 If a prescriber wishes to use a drug/preparation that is established as effective treatment, supported by research, and used in other countries but is not licensed in the UK a request should be made to the Drugs and Therapeutics Group for mental health treatments, or the Medicines Oversight Group for all other treatments. This request should be supported by an evidence based review of the literature which will then be reviewed at the next meeting of the relevant Group.

6.2 If approved, liaison with the supply pharmacy will be required and their procedure for procurement of unlicensed drugs followed.

7. **APPROVAL**

7.1 Approval will be granted if the relevant Group (see paragraph 6.1) is satisfied that the drug requested is necessary for patient care and that every
reasonable precaution will be taken to safeguard the patient. The overriding consideration in the use of unlicensed medicines is specific clinical need and safety of an individual patient. In an emergency situation where it is impossible to obtain the prior agreement of the patient or an advocate then the prescribed medicine may be administered if it is assessed to be in the best interests of the patient. This must be clearly documented in the case notes by the prescriber.

7.2 Drug treatment sometimes needs to be commenced at short notice and gaining the appropriate approval from the relevant Group (see paragraph 6.1) prior to treatment will not always be possible. At such times, an application can be considered by the Chair of the relevant Group and a decision taken, pending review by the relevant Group at its next meeting. However, a New Drug request should also be made to the relevant Group for consideration at the next meeting.

8. **OFF-LICENCE” USE OF LICENSED MEDICINES**

8.1 Medicines are sometimes used outside of their marketing authorisation. Use in these circumstances will be supported by the Trust provided that the following conditions are met:

- The unlicensed use of the medicine is clearly justified and the clinical benefit considered to outweigh the risks involved.

- The unlicensed use of the medicine is well established in clinical practice and/ or has a strong evidence base to support its use.

- The unlicensed indication for the drug and the dosage prescribed must be supported by a wide consensus in clinical practice or by strong research evidence.

- If the unlicensed use of the drug is not well established in clinical practice or the evidence for its effectiveness is relatively weak (for example small open studies) then the consultant must seek a second opinion from a consultant colleague or discuss the case with a peer group.

- If the medicine is new and is not already in use within the Trust, the prescriber may be asked to present a case to the Drugs & Therapeutics Group.

- Occasionally, the unlicensed use of a licensed medicine may be introduced on cost grounds. In such cases, the unlicensed use must have been approved by the relevant Group (see paragraph 6.1) which must have considered the potential effect on clinical effectiveness.

9. **INFORMATION TO PATIENTS (INCLUDING PARENTS AND/OR CARERS) AND PATIENT CONSENT**

9.1 The prescriber is responsible for informing the patient of the licensed status, the reason for the use of the medicine and for obtaining the agreement of
the patient. In situations where the patient is unable to give formal consent, someone able to advocate on the patient's behalf should be consulted. This should be clearly documented in the case notes. (Refer to Medicines Policy Section 9.1 and Trust's Consent and Capacity to Examination and Treatment Policy. In an emergency situation where it is impossible to obtain the prior agreement of the patient or an advocate then the prescribed medicine may be administered if it is assessed to be in the best interests of the patient. This must be clearly documented in the case notes by the prescriber.

9.2 Because of the greater risks and potential problems associated with the use of unlicensed or off-licence medicines, patients or those authorising treatment on their behalf, should be given sufficient information about the proposed treatment to enable them to make an informed decision. This should include:

- The reasons for prescribing an unlicensed medicine or a medicine off-licence where there is little evidence to support its use, or where the use of a medicine is innovative.
- Possible risks associated with the use of an unlicensed medicine or a medicine off-licence including known serious or common adverse reactions.
- Arrangement for continued supplies and appropriate awareness of problems that may be encountered.

10. RESPONSIBILITY FOR PRESCRIBING SECONDARY/PRIMARY CARE

10.1 The responsibility for prescribing unlicensed medicines should routinely remain with the specialist who initiated treatment and not be transferred to GPs.

10.2 In the case of drugs that are prescribed off-licence, the appropriateness of transferring responsibility will depend on the drug involved. For drugs that are not routinely used in primary care and are being used outside of licensed indications, responsibility should remain with the specialist who initiated treatment. In the case of drugs that are routinely used in primary care but are being used outside of licensed indications, general practitioners may feel clinically competent to prescribe, but reserve the right to decline accepting such responsibility. See also section 3, appendix L.

Administration

10.3 Nurses will on occasions be required to administer a prescribed unlicensed medicine or a medicine off-licence to a patient.

Nursing staff should:

- Be aware of the licensed status of any medicines they are administering.
• Only administer such a medicine if they have sufficient information and knowledge to safely administer the medicine.

• Record the batch number and expiry date of unlicensed medicines in the patient’s notes.

• Notify the medicines management team and/or the clinician looking after the patient if the labelling/any instructions supplied with the medicines are unclear or they are unsure about any aspects involved in the use/administration of the medicine, its quality, likely side effects or patient monitoring required.

• Notify a doctor immediately if the patient experiences any serious or unexpected adverse reactions.

**Monitoring**

10.4 Patients receiving an unlicensed medicine or a medicine off-licence should be closely monitored for signs of adverse effects.

10.5 Any suspected adverse drug reactions should be reported to the MHRA via the Yellow Card Scheme. Such reporting is equally important for unlicensed medicines or those used off-licence as for those that are licensed.
# APPENDIX I

## RECEIPT AND REPEAT ISSUE OF PATIENT’S OWN DRUGS FORM

**COMMUNITY TEAM:**

**PATIENT NAME:**

**MEDICATION:** (NB. One per sheet)

<table>
<thead>
<tr>
<th>RECEIPT</th>
<th>ISSUE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date medication received</th>
<th>Received from: eg GP practice / pharmacy name</th>
<th>Quantity</th>
<th>Name of Nurse (PRINT) receiving medication</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Qty issued</th>
<th>Name of Nurse (PRINT)</th>
<th>Nurse’s Signature</th>
<th>Remaining balance</th>
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1. INTRODUCTION

1.1 Covert administration – the administration of any drug or medical treatment to a patient without their knowledge, in a disguised or deceptive form. It must only be undertaken following a formal assessment of mental capacity to allow healthcare professionals to act in the best interests of the patient.

1.2 A competent adult has the right to refuse treatment, even if refusal will adversely affect their health, or shorten their life.

1.3 Covert administration, especially if the medicine alters the person’s behaviour, mental state or is a sedative may be restricting the person’s liberty. If a person’s liberty is restricted by the care or treatment a Deprivation of Liberty Safeguards (DoLS) assessment and authorisation may be required. Clinicians should seek expert advice from the Trust DoLS lead if needed before proceeding to consider the need for covert administration of medicines.

1.4 Patients who lack the capacity to give consent to treatment and who subsequently refuse it may be assessed as putting their physical and or mental health at risk. In such cases, the covert administration of their prescribed medication may be considered.

1.5 Clinicians must be able to demonstrate the decision made is the least restrictive alternative or intervention

1.6 Patients who lack capacity may have indicated consent or refusal at some previous time whilst competent, in the form of an advance statement, advance directive or living will. Where these wishes are known, all staff must respect them, provided these advance decisions are still clearly applicable to the patient’s present circumstances and there is no reason to believe that the patient has changed their mind.

1.7 Assessment of capacity should be made according to the statutory criteria within the Mental Capacity Act (2005). The ‘best interest checklist’ should also be applied. This should then be recorded in the Consent and Capacity assessment module within RiO. This module contains a structured form for recording the assessment of capacity and also a form for recording the application of the ‘best interest checklist’.
1.8 See ‘Consent and Capacity to Consent to Examination/Treatment Policy and Guidance’ and ‘Medicines Policy’ (Section 9.1).

2. **POLICY**

2.2 Every adult will be deemed to have capacity to consent or refuse treatment unless there has been a proper examination and assessment of the patient’s capacity (please refer to the Consent and Capacity to Consent to Examination and Treatment Policy for details and procedures).

2.3 The assessment of capacity with regards to medicines must be made as part of a multi-disciplinary process which includes the senior clinician responsible for the patient’s care; however the final decision on capacity rests with the prescriber and the individual healthcare professionals administering the medicine to the patient.

2.4 The wishes of patients who are competent to consent or refuse treatment must be respected.

2.5 Strategies to avoid covert administration must be considered and used in preference to covert administration.

2.6 Where any medicines or combination of medicines covert administered are likely to alter the patient’s behaviour, mental state or is a sedative to such an extent as the treatment may be considered to be restricting the patient’s liberty the need for Deprivation of Liberty Safeguards (DoLS) assessment must be considered.

2.7 If a DoLS authorisation is in place:

- the relevant person’s representative (RPR) must be involved in the best interest decision
- any use of covert administration must be clearly detailed in the DoLS authorisation
- If the DoLS authorisation is for more than six months there must be clear details of when the regular reviews should occur
- Any changes to the medicines covertly administered must be notified to the supervisory body and a review, involving the person’s RPR, of the authorisation triggered

2.8 Where it is considered that a patient lacks capacity and that a specified medication is considered **essential** for the patient’s health and wellbeing or for the safety or others, then disguise may be appropriate.

2.9 Medication must not be disguised for the convenience of the health care team.

2.10 The Consent and Capacity assessment module within RiO must be completed prior to the start of any regimen of covert administration.

2.11 The assessment for covert administration on RiO must be completed prior to the start of any regimen of covert administration.
2.12 There should be a broad and open discussion among the multidisciplinary team (MDT) and the patient's relative or carers, and agreement reached that this approach is required in the specific circumstances.

2.13 The ultimate decision to administer medicines covertly must be one that has been informed and agreed by the team, including the consultant or equivalent, caring for the patient.

2.14 The decision and action taken, including the names and designations (i.e. job role, relationship to patient if advocate, carer or relative of the patient) of all parties concerned with that process, should be documented in the clinical record.

2.15 Covert administration of medication must only be agreed for medication that is still indicated and required for the patient health & well-being, therefore a medication review is the first step to be carried out. The list of medicines agreed as being essential and therefore to be administered covertly must be documented in the patient's notes.

2.16 As part of the process of agreeing essential medicines (paragraph 2.14) and the relevant doses for covert administration the implications of any previous known or suspected non-compliance, poor compliance or partial compliance with the prescribed treatments must be considered and adjustments to the list and the doses made accordingly.

2.17 All interventions, and their outcomes, relating to how staff have attempted to administer medication, must be fully documented in RiO.

2.18 The Trust Medicines Management Team must be consulted for advice as to the appropriate formulation and suitable medium for disguising medication on a case-by-case basis and for all additions and changes of medicines. Medicines Management Team advice must be documented and followed:

2.19 Each medication usually has a different method of administration, based on its chemical and physical properties. If administered with food, medication should always be at room temperature and one tablet or capsule (whole or crushed or contents of capsule) should be administered per spoonful of food, prepared immediately before administration.

2.20 However, in some circumstances eg person has very limited intake of food and/or drink, and the patient's essential medication regime is complex and cannot be reduced or simplified it may not be possible to separate all medication required into separate dose administrations. In such circumstances, the Medicines Oversight Group has agreed that more than one medication can be given, this must be considered as part of the best interests assessment, clearly documented, and reviewed at regular intervals.

2.21 Staff need to be aware that if medicinal products are crushed, dissolved or otherwise administered in a way in which they were not intended then such administration will be considered ‘off licence’ (i.e. an unlicensed use of a licensed medicine.)
2.22 The decision and treatment plan should be reviewed at a specified time interval agreed by the multidisciplinary team.

2.23 It is important to recognise that mental illness might often cause temporary or fluctuating incapacity. In such cases, regular assessment (and record) of capacity will be required.

2.24 Even where an assessment for covert administration of medication has been undertaken, medication should always be offered overtly prior to administer covertly as it is important to recognise that mental illness might cause temporary or fluctuating incapacity. In such cases, regular assessment (and record) of capacity will be required.

2.25 There may be exceptional circumstances where offering medicines overtly prior to covert administration (see paragraph 2.21) may not be deemed clinically appropriate: in such circumstances this must be discussed and agreed as part of the MDT (see paragraph 2.11) and the reasons clearly documented in the patient record (see also paragraph 2.6).

2.26 It is the responsibility of the lead clinician undertaking the assessment to ensure that all relevant documentation is completed on RiO.
APPENDIX K

MEDICINES POLICY: APPENDIX K

<table>
<thead>
<tr>
<th>Title</th>
<th>INPATIENT SELF ADMINISTRATION POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To describe under what circumstances a patient may self-administer medication</td>
</tr>
<tr>
<td>Scope</td>
<td>To ensure the self-administration of medicines is accurate and safe</td>
</tr>
<tr>
<td>Responsibility</td>
<td>All inpatient registered nurses and doctors</td>
</tr>
</tbody>
</table>

1. **AIM**
   1.1 To secure the involvement of the patient in taking responsibility for self-administration of their medication.
   1.2 To establish a standardised approach for determining the ability of a patient to take their own medication reliably.
   1.3 To increase patient understanding of their medication and improve concordance with medication regimens.

2. **INTRODUCTION**
   2.1 Self administration occurs when a patient takes responsibility for taking/using medication as prescribed by a doctor and dispensed by a pharmacist for the patient.
   2.2 Self administration is only suitable for patients who will take responsibility for their medication on discharge. Patients deemed suitable will be encouraged to participate but refusal will be respected.
   2.3 Self administration will not be appropriate for all patients. Participation in the programme must be based upon criteria of assessment of suitability, safe systems of practice and informed choice and consent of the patient.
   2.4 Medicines Management Team must be involved in the decision to introduce self-administration and each ward should develop local guidelines. All self-administration schemes must be subject to monitoring, supervision and review and appropriate training must be available for the nursing teams.

3. **MEDICINES EXCLUDED**
   3.1 Controlled Drugs must be administered in the conventional way.

4. **POLICY**
   4.1 An assessment of the patient must be carried out by a nurse/doctor. This should include the physical and mental capability of the patient to self-administer and a risk assessment, including the risk to other patients.
   4.2 Agreement must be reached between the multidisciplinary team before self-administration is initiated and the team decision must be recorded in the patient’s records.
   4.3 A review of the patient’s medication should be undertaken to make the regimens as simple and rational as possible.
4.4 The self-administration programme must be fully explained to the patient and the responsibilities involved discussed. Written information must also be given to the patient.

4.5 Patients must agree and give written consent to participate in the programme. Such participation however does not mean that all responsibility for drug administration has been transferred from the nurse to the patient.

4.6 There are a number of stages to the self-administration programme and patients may commence at a stage assessed as appropriate. This must be recorded in the patient’s notes. The first stage is the patient asking for their medication at the appropriate time. The patient then takes their medication in front of a member of staff. The last stage is the patient being given 7 days’ supply to self-administer.

4.7 Compliance should be checked as considered necessary for each individual patient.

4.8 Patients who self-administer must have their own individually dispensed supply of medication. It is not acceptable to use stock drugs.

4.9 Patients who self-administer must be given written patient information on their prescribed medication.

4.10 Secure storage must be available to the patient for the safe keeping of medication. This must be a lockable drawer or cupboard.

4.11 Access to the keys may be a staged process and will depend on the assessment process.

4.12 MAR charts or the Electronic Prescribing system must clearly indicate that a patient is participating in the self-administration programme.

4.13 If at any time it is found that the patient is not taking the medication as prescribed and is not coping with the training programme then self-administration should be reviewed.

4.14 It remains the registered nurse or ward manager’s responsibility to ensure that medication is stored, taken and disposed of safely. Any discrepancies must be reported.
APPENDIX L

PRINCIPLES OF PRESCRIBING ACROSS THE PRIMARY AND SECONDARY CARE INTERFACE

1. BACKGROUND
The NHS Executive issued guidance to GPs and hospital consultants in EL(91) 127 on the procedures to be adopted at the interface between prescribing in primary and secondary care. This guidance reinforces the basic premise that it is for the doctor who has clinical responsibility for a patient to undertake prescribing, and focuses on the concept of shared care, emphasising the need for proper handover procedures from hospitals. The guidance states that ‘where a consultant considers a patient’s condition is stable, he may seek the agreement of the GP to share the care’.

EL (94) 72 Purchasing and Prescribing further stated that where GPs accept prescribing responsibility, they should have all the information and support that they need to prescribe and monitor their patients.

Shared Care Guidelines are intended to provide clear guidance to GPs and hospital consultants regarding the procedures to be adopted when clinical (and therefore prescribing) responsibility for a patient's treatment with a shared care drug is transferred from secondary to primary care. The monitoring requirements and at what point further advice should be sought should be specified.

The Somerset health community operates a Traffic Light System for the classification of drugs, specifying where prescribing responsibility should lie. Drugs are reviewed by the Somerset Prescribing Forum and, if approved for use, are classified as red, amber or green. Red drugs are considered to be for specialist use and are to be prescribed by hospital clinicians only. Amber drugs are appropriate for shared care arrangements; treatment is initiated and stabilised by the hospital clinician who may then seek the agreement of an individual GP to take over prescribing responsibility. Green drugs can be initiated by secondary and primary care prescribers.

2. GENERAL PRINCIPLES
Prescribing for patients in the community should be transferred to primary care, taking into consideration the ‘traffic light’ classification of drugs.

When hospital clinicians prescribe or make recommendations about prescribing the GP should be provided with adequate clinical information and adequate information about the recommendations made and / or the prescription supplied. This applies to prescribing for patients discharged from inpatient care and to prescribing in outpatient clinics.

If medication is prescribed by a hospital clinician, and it is intended that prescribing and clinical responsibility is to be transferred to a GP, enough medication should be supplied to allow for the time taken to send a letter to the GP and for it to be processed within the GP surgery (7 to 14 days). This applies to prescribing for patients discharged from inpatient care and to prescribing in outpatient clinics.
Hospital clinicians should not ask GPs to prescribe red drugs. GPs would normally be expected to take on prescribing of amber and green drugs for outpatients. If there is disagreement which cannot be overcome by dialogue between the clinicians involved the issue can be investigated and resolved by the CCG prescribing advisor and the Chief Pharmacist for Somerset Partnership.

Where shared care guidelines exist, both the hospital clinician and the GP should adhere to the principles within them. GPs are expected to agree to take on prescribing of drugs under a shared care guideline, and hospital clinicians are expected to fulfil their responsibilities within the guidelines too. If there are specific instances where hospital clinicians do not fulfil their responsibilities under a shared care agreement (eg they do not follow the correct procedure for assessment and monitoring of the patient), and this cannot be overcome by dialogue between the clinicians involved, a PCT prescribing advisor can take the matter up with the Chief Pharmacist for Somerset Partnership who will seek to resolve the problem for the benefit of the patient(s) involved; the GP may refer the patient back to secondary care.

In most cases hospital clinicians will not be expected to continue prescribing amber and green drugs for outpatients. In most cases hospital clinicians should seek the agreement of a GP to take over prescribing responsibility.

In most cases hospital clinicians will not be expected to continue prescribing old drugs which have never been classified under the traffic light system. Exceptions will include selected cases requiring clinical monitoring. However, in most cases hospital clinicians should seek the agreement of a GP to take over prescribing responsibility.

Transfer of prescribing responsibility should not be to the detriment of the patient. However, there should be adequate systems in primary care to allow patients with mental health problems to have appropriate access to medications. These systems should be flexible enough to cater for the special needs of people with mental illness.

If a drug is not recommended in the hospital pharmacy formulary, secondary care healthcare professionals should not recommend their use to GPs or patients.

3. PRINCIPLES RELATING TO ‘OFF-LICENCE’ AND UNLICENSED DRUG USE

Unlicensed and off-licence medicines should only be used where there is no suitable licensed alternative.

The responsibility for prescribing unlicensed products should routinely remain with the specialist who initiated treatment and not be transferred to GPs.

In the case of drugs that are licensed but being used outside of the licensed indications or dose range (off-licence), the appropriateness of transferring responsibility will depend on the drug involved. For drugs that are not routinely used in primary care and are being used outside of licensed indications, responsibility should again routinely remain with the specialist who initiated treatment. In the case of drugs which are routinely used in primary care but are being used outside of
licensed indications, general practitioners may feel clinically competent to prescribe, but reserve the right to decline accepting such responsibility. The hospital clinician should present to the GP the case for using this medicine and justify its use in preference to licensed alternatives. It should be made clear whether the treatment recommended is a peer-supported option.

Any specialist who asks a GP to prescribe a medicine that is off-licence’ should clearly state the licence status of the medicine.

Prescribing responsibilities between the specialist and the GP must be clearly documented in correspondence between the clinicians involved and state the specific responsibilities of each party including arrangements for clinical review of the patient to assess benefit and adverse effects.

The specialist initiating therapy must inform the patient of the unlicensed / off-licence use of the drug and obtain their informed consent for its use. The specialist must ensure that the patient is aware of the known side-effects of the drug and that there may be other unknown side-effects.
APPENDIX M – REFERRAL PATHWAY FOR PATIENTS REQUIRING ADMINISTRATION OF RED DRUGS BY DN SERVICE

Request to administer Red Drug in community setting

Does the request to administer originate from TST?

Yes

Check list of TST Red Drugs for DN service admin. Available at http://intranet.sompar.nhs.uk/operational-services/community-services/district-nursing/medicines-management/

Is it on the list?

Yes

No

Does it require specialist skills?

No

Yes

District Nursing HUB nurse to discuss with Clinical Practice team and confirm training and competency requirements, competent to administer

District Nursing HUB nurse refers back to referrer with explanation

District Nursing HUB to ascertain if administration is appropriate as DN referral:
- treatment must be safe to administer in a community setting
AND
- relevant DNs / DN team must have necessary skills and competencies
AND
- staff have the capacity to undertake this role

Is it on the list?

Yes

No

Contact District Nursing HUB

Chief Pharmacist or Senior Clinical Pharmacist provides advice

1. Is clinical management plan* in place and agreed with Prescriber AND
2. Have appropriate primary care input and interventions been agreed between prescriber and GP?

Ensure step above has been completed

Refer to District Nursing HUB 48 hours before discharge to enable scheduling of visits

*Clinical Management Plan
- Referral letter
- Confirmation that patient consents and agrees to treatment plan
- Somerset Partnership MAR completed by prescriber and submitted
- Contact details of prescriber confirmed
- Drug treatment protocol supplied to include possible side effects and responding actions required
- Skills requirement confirmed
- Confirmation that GP aware and will provide primary care support
- Confirmation of drug supply by prescriber or by patient (FP10)
- Start date agreed
## APPENDIX N

### RECEIPT AND ISSUE OF LEAVE/DISCHARGE/OUTPATIENT MEDICINES RECEIVED FROM SUPPLY PHARMACY

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Receipt</th>
<th>Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date medication received</td>
<td>Name of Patient</td>
<td>No. of days</td>
</tr>
<tr>
<td></td>
<td>Name of Nurse/Doctor receiving medication</td>
<td>Name of Nurse/Doctor authorising issue of medicines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date medication collected/delivered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Received by (Client/Representative signature)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delivered by (If applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delivered Yes/No *</td>
</tr>
</tbody>
</table>

* If not delivered, please re-enter details on next available line

**IF MEDICATION IS NOT COLLECTED/ISSUED, PLEASE COMPLETE THE PATIENT’S OWN DRUGS DISPOSAL FORM**
APPENDIX O

All Audit Standards have been updated ie Appendix O, P, and Q

COVERT ADMINISTRATION OF MEDICINES
CLINICAL AUDIT STANDARDS

August 2014
<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patients detained under the Mental Health Act 1983 must not be assessed for Consent and Capacity under the Mental Capacity Act 2005 for medicines to treat a mental health condition</td>
<td>100%</td>
<td>Patients detained under the MHA 1983 may be assessed for Consent and Capacity under the MCA 2005 with respect to medicines to treat physical health conditions</td>
<td>RiO MHA status</td>
</tr>
<tr>
<td>2</td>
<td>The Consent and Capacity assessment on RiO must be completed prior to the start of any regime of Covert Administration</td>
<td>100%</td>
<td>None</td>
<td>Consent and Capacity Assessment on RiO</td>
</tr>
<tr>
<td>3</td>
<td>The specific assessment for covert administration on RiO must be completed prior to commencement of the intervention</td>
<td>100%</td>
<td>None</td>
<td>RiO Assessment</td>
</tr>
<tr>
<td>4</td>
<td>The decision to administer medication covertly must be taken by a multi-disciplinary team including consultant psychiatrist and, ideally, a relative, carer or advocate</td>
<td>100%</td>
<td>None</td>
<td>Record in RiO Assessment</td>
</tr>
<tr>
<td>5</td>
<td>The decision, action, names and designation (role) of all parties involved in the decision must be recorded</td>
<td>100%</td>
<td>None</td>
<td>Record in RiO Assessment</td>
</tr>
<tr>
<td>6</td>
<td>The list of agreed essential medicines to be disguised must be recorded</td>
<td>100%</td>
<td>None</td>
<td>Record in RiO Assessment</td>
</tr>
<tr>
<td>Ref No</td>
<td>Standard</td>
<td>Compliance</td>
<td>Exceptions</td>
<td>Definitions</td>
</tr>
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</tr>
<tr>
<td>7</td>
<td>The Trust Medicines Management Team must be consulted as to the appropriate method for disguising medication</td>
<td>100%</td>
<td>None</td>
<td>Recorded in RiO Assessment</td>
</tr>
<tr>
<td>8</td>
<td>Method of administration and all interventions and outcomes must be recorded</td>
<td>100%</td>
<td>None</td>
<td>The method of administration should be recorded in the care plan and the RiO Covert Administration form. The administration of medications will be recorded on the drug chart but any exceptions from the agreed method of administration should be recorded in the progress notes.</td>
</tr>
<tr>
<td>9</td>
<td>The decision and treatment plan should be reviewed at a specified time interval</td>
<td>100%</td>
<td>None</td>
<td>Recorded on Care Plan, and RiO Assessment</td>
</tr>
<tr>
<td>10</td>
<td>When there is a drug change the covert administration process must be repeated</td>
<td>100%</td>
<td>None</td>
<td>Recorded in RiO Assessment</td>
</tr>
<tr>
<td>11</td>
<td>A senior doctor must document the decision to change from covert to overt administration and a record of this decision and any discussions must be made in the patient record</td>
<td>100%</td>
<td>None</td>
<td>Recorded in RiO Assessment</td>
</tr>
</tbody>
</table>
# APPENDIX P

## DRUGS ADMINISTRATION IN INPATIENT WARDS CLINICAL AUDIT STANDARDS

**August 2014**

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All registered nurses must complete all administration process checks prior to the administration of medication.</td>
<td>100%</td>
<td>None</td>
<td>As defined within Section 11. of the Medicines policy. To include all routes of administration.</td>
</tr>
<tr>
<td>2</td>
<td>All wards are required to have specific measures in place to minimise distractions during Medicine Rounds, for example “Do Not Interrupt” vests.</td>
<td>100%</td>
<td>None</td>
<td>Red Tabard with “Do Not Disturb – Medication Round in Progress” printed on front and back. If “Do Not Interrupt” vests are not used, evidence of alternative specific measures used must be provided.</td>
</tr>
<tr>
<td>3</td>
<td>All medication must be administered to the patient by a registered nurse.</td>
<td>100%</td>
<td>Student Nurses may administer to the client under the direct supervision of a registered nurse.</td>
<td>Healthcare assistants must not be used as “runners” to transport medication to a client. Clients are brought to drugs trolley and drugs are not taken to the client by a nursing assistant out of sight of the Registered Nurse.</td>
</tr>
</tbody>
</table>
### DRUGS ADMINISTRATION IN INPATIENT WARDS CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Ref No</th>
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<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The identity of the patient must be confirmed before administration of medication.</td>
<td>100%</td>
<td>None</td>
<td>Identity must be confirmed using ID Bracelet or Photo ID. Where photo or bracelet not used open questions should be used to confirm name and Date of birth of patient.</td>
</tr>
<tr>
<td>5</td>
<td>All medication should be prepared at the time of administration.</td>
<td>100%</td>
<td>None</td>
<td>Medication that is prepared but not administered must be discarded. This might include clients that refuse medication at the point of administration.</td>
</tr>
<tr>
<td>6</td>
<td>The registered nurse must administer medication to one client at a time</td>
<td>100%</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>7</td>
<td>The medication trolley must not be left unattended during the medication round.</td>
<td>100%</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>8</td>
<td>Student Nurses only administer to the client under the direct supervision and direct observation of a registered nurse.</td>
<td>100%</td>
<td>In community health HCAs assessed as being suitably trained and competent may administer the following on behalf of a named registered nurse who is taking responsibility for the delegated task:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Suppositories, pessaries and enemas</td>
<td>HCA’s (including students working as bank HCA’s) must not administer medication (exceptions listed under Section 19.36 above).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Bladder maintenance solutions</td>
<td>HCAs administrating allowed medicines must record the administration according to the Trust policy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Eye-drops</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Topical skin preparations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Medicated dressings</td>
<td></td>
</tr>
</tbody>
</table>
## DRUGS ADMINISTRATION IN INPATIENT WARDS CLINICAL AUDIT STANDARDS

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</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Oral syringes are used for measuring liquids which cannot be measured accurately using a medicine pot or 5ml spoon</td>
<td>100%</td>
<td>None</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>10</td>
<td>Oral syringes are for single use only</td>
<td>100%</td>
<td>None</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>11</td>
<td>IV syringes are not to be used for measuring oral liquids</td>
<td>100%</td>
<td>None</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>12</td>
<td>All administration errors/incidents/near misses must be immediately reported using the Trust on-line untoward event system.</td>
<td>100%</td>
<td>None</td>
<td>Audit via analysis of Datix reporting rates compared to observed or expected error/incident/near miss rates</td>
</tr>
</tbody>
</table>
### SAFE AND SECURE HANDLING OF MEDICINES
### CLINICAL AUDIT STANDARDS

**August 2014**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicines are stored in a locked cupboard, which is metal and complies with current British Standards.</td>
<td>100%</td>
<td>Medicines for resuscitation. Flammable liquids. Medical gases. In use named-patient GTN sprays, inhalers, insulin, and topical emollients. None.</td>
<td>Cupboards should be: Made of metal, Locked</td>
</tr>
<tr>
<td>2</td>
<td>Internal and external medicines, if not exempted from storage requirements, must be stored in separate locked medicines cupboards</td>
<td>100%</td>
<td>Medicines for resuscitation. Flammable liquids. Medical gases. In use named-patient GTN sprays, inhalers, insulin, and topical emollients. None.</td>
<td>Cupboards should be: Made of metal, Locked</td>
</tr>
<tr>
<td>Ref No</td>
<td>Standard</td>
<td>Compliance</td>
<td>Exceptions</td>
<td>Definitions</td>
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<tr>
<td>3</td>
<td>Where a medicines trolley is in use storage shall only be for orally administered preparations which are in current use and which do not require either special storage conditions or special procedures for preparation/administration. Medicines are stored in a locked refrigerator which is used for pharmaceutical products only.</td>
<td>100%</td>
<td>Medicines for resuscitation. Flammable liquids. Medical gases. In use named-patient GTN sprays, inhalers, insulin, and topical emollients</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>4</td>
<td>Medicines trolleys must be lockable and must be locked and secured to a wall when not in use.</td>
<td>100%</td>
<td>None</td>
<td>Audit via inspection of lock and method of securing to wall and observation of practical use in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>5</td>
<td>Storage facilities should be situated in a locked room and should not be sited near sources of heat or humidity. The temperature of the room should not routinely exceed 25°C.</td>
<td>100%</td>
<td>None</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>6</td>
<td>Medicines are stored in a locked refrigerator which is used for pharmaceutical products only.</td>
<td>100%</td>
<td>None</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>Ref No</td>
<td>Standard</td>
<td>Compliance</td>
<td>Exceptions</td>
<td>Definitions</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Refrigerator monitoring should be carried out daily, recording the maximum and minimum temperatures from the internal thermometer. Digital thermometers must be reset after each recording of maximum and minimum temperature.</td>
<td>100%</td>
<td>None</td>
<td>The refrigerator should maintain an air temperature of 2-8°C with the minimum of intervention. Monitoring is to be recorded on the Medicines Refrigerator Monitoring Form.</td>
</tr>
<tr>
<td>8</td>
<td>The medicine keys are held by a registered nurse who is either the Nurse In Charge or who has been delegated this role by the Nurse In Charge.</td>
<td>100%</td>
<td>None</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
<tr>
<td>9</td>
<td>The Controlled Drugs keys should be held separately from other medicines keys (in the community directorate a red fob should be used for controlled drugs and a blue fob for all other medicines related keys).</td>
<td>100%</td>
<td>In Mental Health a red fob is not required.</td>
<td>Audit via observation in inpatient wards or staff questionnaire</td>
</tr>
</tbody>
</table>
| 10     | Controlled Drugs are stored in a locked controlled drug cupboard that complies with the Controlled Drug Safe Custody Regulations, which has a different lock to other cupboards.                                    | 100%       | None       | Cupboards should be:  
  ➢ Made of metal  
  ➢ Locked (different lock to the general medicine cupboard)  
  ➢ Have invisible hinges  
  ➢ Used only for controlled drugs |
## SAFE AND SECURE HANDLING OF MEDICINES CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Controlled stationary is stored securely and access is restricted.</td>
<td>100%</td>
<td>None</td>
<td>Controlled stationary includes any paperwork used to order medicines.</td>
</tr>
<tr>
<td>12</td>
<td>The Ward / Team Manager or Community Hospital Matron must have implemented a procedure for regular expiry date checking of all medicines under their jurisdiction</td>
<td>100%</td>
<td>None</td>
<td>Records of date checking showing details of dates of date checking activity, the relevant areas checked on what date(s) and by whom should be available to verify the process has been implemented and regular.</td>
</tr>
<tr>
<td>13</td>
<td>All date expired, spoiled, or unusable medicines must be segregated when identified and quarantined until appropriate disposal</td>
<td>100%</td>
<td>None</td>
<td>Segregation and quarantine may be in the form of a sealed bag or envelope clearly labeled to identify the contents as date expired or otherwise unusable.</td>
</tr>
<tr>
<td>14</td>
<td>Non nursing Health Professional who administer medicines (eg dental, physiotherapists, podiatrists) must store them in their own storage cupboards. Nursing staff are not responsible for the control and security of their medicines.</td>
<td>100%</td>
<td>Named-patient medicines prescribed on the patient’s MAR chart for nurse administration</td>
<td>Other Health Professionals may administer, or support or help patients to take their medicines as part of their agreed role in certain circumstances.</td>
</tr>
</tbody>
</table>