

PROCEDURAL GUIDELINES FOR THE SAFE AND SECURE HANDLING OF MEDICINES IN MENTAL HEALTH SERVICES

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POLICY SUMMARY	
<p>The purpose of this procedural guideline is to ensure Essex Partnership University NHS Foundation Trust has operational procedures in place to minimise the risks associated with the management and use of medicines. It defines the systems that are in place for the safe and secure handling of medicines, including ordering, supply, storage, transportation, prescribing, dispensing, administration and disposal.</p>	
<p>The Trust monitors the implementation of and compliance with this policy in the following ways:</p>	
<p>This policy and procedural guidelines will be monitored by the Medicines Management Team according to a three yearly rolling, medicines management audit programme.</p>	

Services	Applicable	Comments
Trustwide		
Mental Health & Learning Disability	✓	
Community Health Services		

The Director responsible for monitoring and reviewing this policy is the Executive Nurse

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PROCEDURAL GUIDELINE ON THE SAFE AND SECURE HANDLING OF
MEDICINES IN MENTAL HEALTH

1. INTRODUCTION

- 1.1. Essex Partnership University NHS Foundation Trust is required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner. This document and its associated appendices define the operational procedures for the ordering, prescribing, supply, storage, transportation, dispensing, administration and disposal of medicines needed to achieve this. The document is laid out in the chronological order that medicines are managed.
- 1.2. In order to achieve this, it is necessary for the Trust to comply with a variety of legislation and best practice guidance. This document is based upon statutory requirements and guidance issued by various official bodies. These include:
- The Medicines Act (1968) as consolidated by the Human Medicines Regulations 2012 as amended
 - The Misuse of Drugs Act (1971) as amended
 - Misuse of Drugs Regulations (2001) as amended
 - Royal Pharmaceutical Society / Royal College of Nursing *Professional Guidance on the Safe and Secure Handling of Medicines* (update to the 'Duthie Report') (2018)
 - General Pharmaceutical Council *Standards for pharmacy professionals* (2017) and *Standards for registered pharmacies* (2018)
 - General Medical Council *Good Medical Practice* (2014)
 - General Medical Council *Good Practice in Prescribing and Managing Medicines and Devices* (2013)
 - Nursing and Midwifery Council / Royal Pharmaceutical Society *Professional guidance on the administration of medicines in healthcare* (2019)
 - Health Education England *Advisory Guidance on Administration of Medicines by Nursing Associates* (2018)
 - Nursing and Midwifery Council () *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates* (2018)
 - Professional Standards for optimising medicines for people in secure environments (Royal Pharmaceutical Society February 2017)
 - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC Fundamental Standards)

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- 1.3. Although primarily directed at nursing and medical staff who are responsible for the prescribing and administration of the majority of medicines, references are also made to the many other professions who may be involved in these activities. The requirements of this procedural guideline apply to all staff who handle medicines.
- 1.4. For convenience and by custom the feminine pronoun is used throughout to refer to nurses and the male pronoun to doctors and patients. All statements can refer equally to men and women.
- 1.5. This document is intended for use in conjunction with the current edition of the British National Formulary (BNF), British National Formulary for Children (BNFc) and the EPUT 'Formulary and Prescribing Guidelines'.
- 1.6. Where wards or services develop local protocols for any element of the pathway relating to medicines they must conform to the requirements of this procedural guideline and be authorised by the Lead Clinical Pharmacist for the relevant area of the Trust. If there is any doubt about the appropriateness of such local protocols they will need to be discussed by the Medicines Management Group (MMG)

2. SCOPE

- 2.1. All staff working within EPUT and are involved in the prescribing, ordering or administration of medicines are required to familiarise themselves with the contents of, and practice within, this procedural guideline, its appendices and related documents.

3. DEFINITIONS

- 3.1. For the purpose of this document:
 - 3.1.1. The term 'medicines' encompasses the following
 - All medicines and medicinal products prepared for administration to patients and which are subject to the requirements of the Medicines Act, 1968 as consolidated by the Human Medicines Regulations 2012. This includes all products designated as 'prescription-only' (POM) medicines 'pharmacy' (P) medicines, and 'general sales list' (GSL) medicines. It also includes products such as vaccines, medical gases and X-ray contrast media.
 - Controlled Drugs (CDs), as defined within the Misuse of Drugs Act, 1971 (as amended).
 - Complementary medicines, e.g. aromatherapy oils, herbal remedies and homeopathic preparations.
 - Medicated dressings, disinfectants, reagents and similar products.

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- 3.1.2. A Controlled Drug is any substance controlled by the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001 (as amended). Certain drugs may be designated locally to be treated in the same way as controlled drugs, where authorised by the Chief Pharmacist.
- 3.1.3. The term "Appointed Nurse in Charge" is a registered nurse who is shown to be competent in the administration of medicines as determined by the competencies laid down by the Trust, and carries overall responsibility for a ward, unit or community setting (e.g. ward sister, charge nurse, clinical ward/team manager).
- 3.1.4. The term "Nurse in Charge" is the senior nurse on duty for the ward or department who has been identified as the Nurse in Charge at a particular point in time (e.g. for that shift).
- 3.1.5. The term "Manager" refers to managers of wards, units and community teams.
- 3.1.6. The term "Nurse" is used in its generic sense to include a registered nurse, on all parts of the register. The term "associate practitioner" is a qualified practitioner approved by Essex Partnership NHS Foundation Trust and universities with which the Trust contracts to provide such training, having achieved the competencies outlined in the curriculum.
- 3.1.7. The term "First Level Nurse" is a nurse whose name appears in Part One of the register.
- 3.1.8. The term "Clinical Area" means a ward or department in which patients are treated or a group of such wards or departments which form a single management unit. This includes residential units operated by the Trust and community team bases and prison wings.
- 3.1.9. The term "Prescriber" means a registered medical doctor or dentist, or a nurse, pharmacist or other allied health professional, who have undergone a specified training course in supplementary and independent prescribing and have been registered by their professional body. (See Appendix 19 *Non-Medical Prescribing*).
- 3.1.10. The term "Pharmacist" means a registered pharmacist employed directly by EPUT or providing pharmaceutical services to EPUT under the terms of a service level agreement (SLA) or contract.
- 3.1.11. The term "Community Pharmacist" refers to a pharmacist working in primary care in a pharmacy providing pharmacy services defined in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

4. RESPONSIBILITIES

- 4.1. Responsibility for reviewing this document in relation to medicines management rests with the Chief Pharmacist working through the Medicines Management Group.
- 4.2. Responsibility for establishing and maintaining a system for the secure and safe handling of medicines rests with the Chief Pharmacist in consultation with appropriate medical, nursing and administrative staff.
- 4.3. **Responsibility of Prescribers**
 - 4.3.1. All prescriptions shall be written by a suitably qualified practitioner. See also section [7.0](#).
 - 4.3.2. A record listing the name, position and specimen signature of all prescribers, including locums, must be notified to the Trust Chief Pharmacist (or designated senior pharmacist) by the Medical Staffing Department using the form shown at Appendix 1. Any changes to this list must also be notified.
- 4.4. **Responsibilities of Line Managers and New Staff**
 - 4.4.1. It is the responsibility of the line manager to identify all new staff whose duties include the prescribing, handling or administration of medicines, and to provide such staff with a copy of the medicines policy and this procedural guideline to read during their induction period.
 - 4.4.2. It is the responsibility of the line manager to identify to new staff the key aspects of this procedural guideline that relate to their areas of work.
 - 4.4.3. It is the responsibility of the line manager to ensure that members of staff whose duties include responsibility for medication-related procedures have received relevant training and experience and are competent to undertake these procedures.
 - 4.4.4. A record listing the name, position and specimen signature of all nurses authorised to order medicines, including controlled drugs, must be notified to the Trust Chief Pharmacist (or designated senior pharmacist) by managers using the form shown at Appendix 2.
 - 4.4.5. It is the responsibility of a new member of staff to read and familiarise themselves with this procedural guideline prior to dealing with medication for the first time in their new role, and to adhere to it as it applies to their duties.

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4.5. Responsibilities of the Appointed Nurse in Charge

- 4.5.1. All wards, units and other Trust sites shall designate a member of staff who at all times assumes overall responsibility for the ordering, storage and administration of medicines at that site. This will be the Appointed Nurse in Charge, although another member of staff may be the designated person if more appropriate.
- 4.5.2. The Appointed Nurse in Charge carries responsibility for the security of, and access to, medicines held at the site, for ensuring that stocks of Controlled Drugs (CDs) correspond with the CD record book, for the appropriate disposal of medicinal waste, and for ensuring that the medicines policy and procedural guideline is followed by all members of staff.
- 4.5.3. The process of medicines administration and other medicines-related activities may be delegated by the Appointed Nurse in Charge to another suitably trained member of staff. The tasks that may be delegated, and the grades of staff who may undertake such tasks, are indicated within this document. All members of staff, including locums, agency staff and bank staff, must be aware of the tasks that they may or may not perform.

4.6. Responsibilities of Nurses

- 4.6.1. All Registered Nurses, Midwives and Health Visitors are personally responsible for their own actions and omissions, and shall adhere to the current NMC Code of Practice.
- 4.6.2. In administering any medication, or assisting or overseeing the self-administration of medication, nurses must exercise their professional judgement and apply their knowledge and skill in the given situation.
- 4.6.3. Where conditions arise in which staff are unable or have difficulty complying with this procedural guideline or its associated appendices, or any component thereof, they shall notify the senior person on duty, with the reasons, and the Lead Clinical Pharmacist at the earliest opportunity.

4.7. Responsibilities of Pharmacy Staff

- 4.7.1. Responsibility for establishing systems for the safe and secure handling of medicines rests with the Chief Pharmacist in consultation with appropriate medical, nursing and administrative staff.
- 4.7.2. Pharmacy staff working for, or on behalf of, the Trust have a responsibility to ensure that the requirements set out in the medicines policy and procedural guidelines are followed. Pharmacists and Pharmacy Technicians are required to carry out

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their duties in accordance with the standards for pharmacy professionals set out by the General Pharmaceutical Council (GPhC).

- 4.7.3. Pharmacy staff are responsible for the stock of medicines held in the pharmacy departments, their procurement, manipulation and preparation into user-ready presentations, and for their supply to wards, departments and outpatients. This includes advising on suitable solutions when a medicine is unavailable for purchase on a long term basis. In some services pharmacists and pharmacy technicians will also be responsible for administration of medicines on wards.
- 4.7.4. Pharmacists and Pharmacy Technicians are also responsible for monitoring prescriptions and for advising on the safe, effective and economic use of medicines. This includes advising practitioners on the storage of medicines in clinical areas.
- 4.7.5. Pharmacy staff may inspect the stocks of medicines held on wards, units and at other Trust sites (and at non-Trust sites where Trust staff are responsible for care provision) at any time, to ensure that the medicines are in date and are being stored under the correct legal and environmental conditions. Stocks of medicines in clinical areas will be checked by a member of pharmacy staff at regular, frequent intervals not exceeding twelve months. **Note: Controlled drugs are audited at 3-monthly intervals.**

4.8. Workforce Development and Training

- 4.8.1. Workforce, Development and Training are responsible for ensuring appropriate medicines management training is available to all appropriate staff and for recording attendance/course completion and following up on non-attendance/non-compliance.

5.0 MEDICINES SAFETY

- 5.1. The Trust is committed to the safe management of medicines and takes a lead from the National Patient Safety team at NHS Improvement. NHS Improvement leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. It issues Patient Safety Alerts as safety issues with medicines arise.
- 5.2. CQC Key Line of Enquiry S3 expects arrangements for managing medicines to keep people safe. This includes obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal and would also include actions required by patient safety alerts disseminated by NHS Improvement to be acted upon within specified timescales. The Francis report reiterated that compliance with existing NPSA guidance should be maintained.
- 5.3. Guidance is reproduced in the Pharmacy and Medicines Management section on the intranet. All staff involved in the management of medicines must be familiar with these publications, and ensure that they follow current policy, procedural guidelines and operational procedures implementing the actions recommended within them.
- 5.4. **Medicines reconciliation**
- 5.4.1. When a patient is first admitted to a ward, a medicines history must be completed in accordance with the procedure set out in Appendix 18.
- 5.4.2. This is to ensure that medicines prescribed correspond to those that the patient was taking prior to admission and to reduce medication errors commonly associated with the transfer of patients from one area to another.
- 5.4.3. On admission to inpatient services the medication of high priority patients will be reconciled by the pharmacy team. (See Appendix 18 section 4.2) Basic reconciliation will take place for all patients via the clerking process.
- 5.4.4. When taking over the care of a patient, the healthcare professional responsible should check that information about the patient's medicines has been accurately received, recorded and acted upon.
- 5.5. **The pharmacological treatment of acutely disturbed patients (“Rapid tranquilisation”)**
- 5.5.1. The pharmacological treatment of acutely disturbed patients (rapid tranquilisation) shall be undertaken in line with RMPG05 *Procedural Guidelines for Restrictive Practice*, CG52 *Pharmacological Management of Acutely Disturbed Behaviour Procedure*, and the Trust Formulary and Prescribing Guidelines.

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5.6. Treatment of anaphylactic shock

- 5.6.1. All clinical areas will hold a stock of adrenaline for the treatment of life-threatening anaphylactic shock. All inpatient nursing staff are expected to have undertaken training in enhanced emergency skills. Staff must be familiar with CG27, *Clinical Guidelines for the Treatment of Drug Allergy and Medical Emergencies*

6.0 PROCUREMENT AND RECEIPT OF MEDICINES

- 6.1. Medicines may only be purchased and received from manufacturers and wholesalers by pharmacy staff acting in accordance with local standard operating procedures, or ward staff where arrangements have been made by the pharmacy team for direct delivery to a clinical area. No other staff are authorised to order or receive medicines on behalf of the Trust. Medicines will be obtained from a reputable source and due diligence applied to ensure quality and minimise the risk of falsification.
- 6.2. Investigational material for clinical trials may be accepted only by a pharmacy department, for issue as appropriate.
- 6.3. Samples and free stock may be accepted only by the pharmacy department, for issue as appropriate. Representatives wishing to leave samples must be directed to the appropriate Trust pharmacy department. If left in a clinical area by a company representative such medicines shall be sent immediately to the pharmacy department. Samples must not be used for the treatment of patients. (See also policy CLP51 *Policy on Hospitality and Sponsorship provided by the Pharmaceutical Industry, and contact with Representatives*).
- 6.4. Receipts of controlled drugs from external sources (i.e. wholesalers and manufacturers) must be recorded in a designated Controlled Drug Register within a pharmacy department (i.e. not in the CD record book of a clinical area). Therefore, Controlled Drugs must not be received by anyone other than the pharmacy department from external sources.
- 6.5. **Shortages in the supply of medicines**
- 6.5.1. Shortages of medicines vary from short term unavailability requiring no action other than waiting for supply to be resumed, to long term unavailability of vital medicines requiring a change in clinical practice with the prescribing of alternative medicines. Where a shortage has been identified by the supplying pharmacy (either a Trust Pharmacy or a pharmacy providing a service under an SLA), an assessment shall be carried out to determine the appropriate action necessary.

7.0 PRESCRIBING

7.1. Authority to prescribe

- 7.1.1. Medicines will be prescribed by medical staff and non-medical prescribers according to their professional registration restrictions and competency.
- 7.1.2. Nurses, pharmacists and certain other professional groups who have successfully completed an accredited non-medical prescribing course, and have been annotated to the appropriate professional register, may prescribe certain medicines provided they have been approved to do so within their employment setting (see Appendix 19 *Non-Medical Prescribing*).
- 7.1.3. Provisionally registered medical staff may prescribe for in-patients including prescriptions for leave or discharge. They may not prescribe for out-patients. Unregistered medical locums (e.g. medical students) do not have the authority to prescribe.
- 7.1.4. If a prescriber considers it unwise for a patient to receive medicines in accordance with a Patient Group Direction, that fact shall be recorded in the patient's healthcare record and on the prescription chart.
- 7.1.5. All staff who are authorised to prescribe shall provide a specimen of their signature to the pharmacy department of each clinical area in which they may work (see Appendix 1 Specimen Signatures - Prescribers).
- 7.1.6. In certain circumstances a pharmacist may alter the formulation or dose of a prescribed medicine to clarify the correct meaning and facilitate administration. A pharmacist may also alter a prescription written by a prescriber in accordance with therapeutic substitution which has been agreed by the Medicines Management Group (See Trust *Formulary and Prescribing Guidelines*).
- 7.1.7. In some clinical areas, nurses and members of other professions may have the authority to administer and supply certain medicines at their own discretion. This is not prescribing and the precise circumstances in which this is permitted will be defined in a Patient Group Direction (see section [8.0](#)) or other protocol approved by the Medicines Management Group.

7.2. Scope of prescribing

- 7.2.1. **Registered Medical Practitioners** are permitted to prescribe any medicines listed in the BNF, other than those marked as not allowable within the NHS.

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7.2.2. **Non-medical prescribers** are permitted to prescribe within their area(s) of competence and from their permitted range of medicines. Such practitioners are responsible for ensuring that they only prescribe within these requirements.

7.2.3. The following points should also be noted by all prescribers:

- For **mental health conditions** prescribing should be from within the range of products listed in the Trust *Formulary and Prescribing Guidelines*. Products that have not been approved by the Medicines Management Group for use within the Trust are not listed in the Formulary and should not be prescribed without gaining appropriate permission from the MMG (see below).
- **Non-psychiatric treatments** initiated by a patient's GP or hospital consultant may be prescribed as continuing therapy. If it is necessary to initiate inpatient treatment for a non-psychiatric condition, prescribing should be from within the formulary which applies at the local acute trust/CCG for the patient. Advice can be obtained from the pharmacy.
- When prescribing **Controlled Drugs**, additional requirements apply. Refer to Appendix 3 for further information:
- **Unlicensed medicines**, or licensed medicines for unlicensed indications (also known as 'off-label'), require approval from the Medicines Management Group. Prescribers shall refer to the Trust procedure for prescribing unlicensed medicines; see Appendix 4 for details.
- **New products** that have not previously been used within the Trust require approval from the Medicines Management Group before they can be purchased. The procedure for requesting a new medicine shall be followed; see Appendix 5.
- **Clinical trial drugs** must be prescribed in accordance with the trial protocol. For inpatients, the drug and dosage details on the pack label shall be transcribed onto the prescription chart. All clinical trials must be approved by the Trust Research and Innovation Group (RIG) as well as an NHS Research Ethics Committee (REC).
- **Complementary therapies** encompass a variety of *non-systemic* therapies such as aromatherapy, body massage, reflexology, head massage, etc. These therapies are intended to be used alongside (i.e. to complement) conventional medical and psychological therapies. Refer to the Trust's clinical guideline CG12 on complementary therapies for further information.

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- In contrast, the term **alternative therapies** is used to describe treatments that are used *instead of* conventional approaches, e.g. homeopathy. Any member of staff wishing to use an 'alternative' therapy instead of conventional treatments must seek prior authorisation from the Trust Medicines Management Group. The therapy must be an integrated part of the individual patient's care plan.
- 7.3. All prescriptions must be written on appropriate Trust stationery (Medicines Prescription and Administration Chart', outpatient prescription form, or FP10 prescription form), and be signed and dated by the prescriber. (See also section [20.0](#) on controlled stationery). Where a recognised electronic prescribing (EP) or electronic prescribing and medicines administration (EPMA) system is available this may be used for the purpose.
- 7.4. All prescriptions must be written by an authorised prescriber who works for the Trust or holds an honorary contract with the Trust.
- 7.5. All hand written prescriptions shall be written in block capitals with black ink, and must be legible.
- 7.6. Where a pharmacist or nurse/practitioner is unable to reasonably interpret a prescription then the prescriber shall re-write the prescription so it is legible.
- 7.7. *It is the responsibility of the prescriber to ensure that all prescriptions comply with the requirements detailed in this procedural guideline.*
- 7.8. **Prescribing for in-patients**
- 7.8.1. Prescriptions for in-patients shall be written on a Trust Medicines Prescription and Administration Chart (see Appendix 6). Supplementary cards are available to reduce risk in certain specialist situations e.g. for clozapine initiation, anticoagulants and insulin, and must be attached to the main prescription chart. Where these exist they shall be used. A new chart should be written each time a patient is admitted for a new episode of care.
- 7.8.2. It is essential that prescribers provide clear and complete written instructions to staff responsible for administering the medicines. These instructions shall be written in the appropriate section of the chart where used.
- 7.8.3. All prescriptions shall be dated and signed by the prescriber and endorsed with the prescriber's name in block capitals.
- 7.8.4. For inpatients, Controlled Drugs can be prescribed in the same way as all other medicines.

7.9. Completing a Medicines Prescription and Administration Chart

7.9.1. **Patient Details:** All sections on the front page of the Medicines Prescription and Administration Chart* must be completed. Addressograph labels shall be used whenever possible. Details required are as follows:

- Patient's full name and NHS number (required on all pages of the chart)
- Date of birth
- Name of patient's consultant
- Ward / unit name (required on all pages of the chart)
- Drug sensitivities (allergies)
- Consent to Treatment – Form T2/T3 in use

When more than seven medicines are being prescribed regularly, a second prescription chart will be required. In this event, both charts must clearly indicate that another chart is in use by marking them '1 of 2' and '2 of 2' on every page.

7.9.2. **Drug sensitivities/allergies:** The prescriber is responsible for entering any known drug sensitivities/allergies in the appropriate box on the front page of the chart. **This box must not be left blank.** If no allergies are known, the abbreviation 'NKDA' (no known drug allergies) shall be entered. If the patient has multiple charts, this box must be completed on all the charts, and must also be completed when a chart needs to be re-written.

Record the clinical effect caused by the causative drug or substance.

7.9.3. **Consent/Second Opinion:** When patients are subject to treatment under the Mental Health Act, all relevant consent documentation must be completed and reviewed as required by the Act (see also section 15.18). If a Form T2 or T3 is in effect, the relevant box on the front of the prescription chart shall be ticked, and a copy of the Form T2/T3 shall be kept in the folder together with the patient's prescription chart. The front of the chart should be signed by the Nurse in Charge.

All prescribing must be in accordance with the details contained in the T2/T3 form. This must be checked before additional items are prescribed.

Form 62 must only be used in line with the relevant legislation.

* * generally referred to as the 'prescription chart' 'drug chart' or 'chart'

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- 7.9.4. **Drug Name:** The full approved name of the drug (as per BNF) shall be written clearly in BLOCK CAPITALS. If the medicine is a compound product with multiple ingredients and has no BNF approved name, the brand name shall be written. Non-approved abbreviations, such as CBZ for carbamazepine, must never be used.

If the required drug has special release properties, this should clearly be indicated on the chart, in order to differentiate it from plain formulations of the same drug (e.g. venlafaxine MR, olanzapine orodispersible).

For drugs where there are important bioavailability differences between brands (particularly lithium and anticonvulsants), the brand name shall be written, e.g. Priadel rather than lithium carbonate MR.

- 7.9.5. **Dose:** Medication errors arising from incorrect interpretation of the intended dose are common. Whenever possible, doses shall be written in whole numbers rather than in forms that require decimal points. This particularly applies to doses in the form '0.xxx', and these shall always be converted to the whole number equivalent. For example:

- 0.125 mg shall be written as 125 micrograms
- 0.25 g shall be written as 250 mg

The word 'micrograms' must always be written in full, and never abbreviated to 'mcg', in order to avoid confusion with milligrams ('mg'). Only the following abbreviations may be used:

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

It is acceptable to write doses in a form which includes the decimal point if this is the convention for the drug, e.g. venlafaxine 37.5mg.

The word 'unit' shall always be written in full, and not abbreviated to 'u' or 'iu', e.g. 'insulin 20 units' rather than 'insulin 20u'. Insulin should be written on the dedicated insulin chart where the word 'units' is already included, not on the main prescription chart. If it is necessary to hand write a dose involving the word units a space shall be left between the numerals and the word to avoid the 'u' being misread as a zero (i.e. '10 units' not '10Units').

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If a medication does not have a strength (e.g. compound preparations), the dose shall be written in the form '1 tab', '2 caps', etc.

Roman numerals (e.g. i, ii) are a common cause of medication errors, and shall not be used.

Exact doses shall be specified for regular medications. Instructions such as '10-20mg' or '1-2 tabs' shall only be used for 'as required' medications (see also section [7.12](#)).

For liquid medicines and injections, the actual dose (in mg) must be written on the chart – the dose **MUST NOT** be written as a volume*. This is because a number of products are available in more than one strength (e.g. 5mg/ml and 20mg/ml), with the risk that an incorrect dose could be administered if the wrong strength product is used. Pharmacists will annotate the prescription chart with the appropriate strength and the volume to be administered in cases where there is potential ambiguity.

7.9.6. **Route:** The intended route of administration shall be specified in full or using only the abbreviations below:

- Oral PO
- Intramuscular IM
- Subcutaneous SC (ensure this is distinct from SL)
- Rectal PR
- Topical TOP
- Inhalation INH
- Sublingual SL (ensure this is distinct from SC)
- Nebuliser NEB
- Intravenous IV

Separate prescriptions shall be written if the same drug is to be given by two different routes. Instructions such as 'PO/IM' must not be used, as certain drugs have different doses depending on the route of administration.

7.9.7. **Frequency:** The interval between doses shall be specified, using conventional abbreviations such as BD, TDS, QDS or specifying in full, e.g. 'alternate days', 'every 2/52'.

7.9.8. **Prescriber's Signature:** Each prescription must be validated by the full signature of the prescriber. Initials or abbreviated

* except laxatives, antacids and simple linctus

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signatures alone are not acceptable, although these may also be included (in brackets) if they assist in identifying the prescriber.

7.9.9. **Pharmacy:** This box is intended for use by Pharmacy staff, and should not be used by the prescriber. Registered pharmacy staff may add such instructions to the chart (in green ink) where appropriate, for example when additional administration instructions are required, e.g. 'with/after food'.

7.9.10. **Times of Administration:** The intended time(s) of administration shall be clearly indicated. If the intended administration time is not pre-printed on the chart, the required time of the dose shall be written in by hand.

7.9.11. **Discontinuation of treatment:** When treatment is to be discontinued the prescriber must cancel the prescription by drawing a diagonal line through it and dating and signing the cancellation.

A vertical line shall also be drawn after the last signature in the administration recording boxes to ensure no further doses can be given. A 'cancelled' or 'discontinued' stamp may be used, but if so, it is important that the original prescription details are not obliterated.

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

7.10. Prescribing 'once only' medication

7.10.1. Medications that are intended to be given as a single dose shall be written in the 'Once Only Medicines' section on the front page of the chart.

7.11. Prescribing 'regular' medication

7.11.1. Medicines written in the 'Regular Medicines' section of the prescription chart will be given every day at the times specified, until the prescription is cancelled or instructions are given to the contrary.

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

7.11.3. If the drug is intended to be given for a fixed course, e.g. 5 days of an antibiotic, this must be specified and a vertical line drawn through the administration recording boxes at the end of this period to ensure no further doses can be given.

7.11.4. Prescriptions for systemic antimicrobial therapy should always state the period for which treatment is to be given. Pharmacists will automatically stop a prescription for antimicrobials after 7

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days unless specifically prescribed for longer. If treatment needs to be continued after this time, the prescription should be rewritten.

- 7.11.5. Prescription charts shall be rewritten by an approved prescriber once the administration record columns have been filled. Registered pharmacy staff may rewrite a prescription chart, but no doses may be administered until it has been signed by the prescriber.

7.12. Prescribing 'as required (PRN) medication

- 7.12.1. Prescriptions for 'as required' (PRN) medications shall be written in the 'As Required (PRN) Medication' section of the chart.

- 7.12.2. In addition to standard prescription writing requirements, the prescriber shall specify:

- the intended indication (e.g. 'for pain', 'for nausea'),
- the minimum interval between doses (e.g. '6-hourly')
- the maximum number of doses that may be given within 24 hours (e.g. 'max. 3 doses in 24 hours' or 'max. 4mg in 24 hours').
- Review date or duration of treatment.

- 7.12.3. Due consideration should be given to the BNF maximum daily dose for the drug, and the dosage instructions should normally ensure that this maximum cannot be exceeded. If it is considered necessary to prescribe a 'PRN' dose which could potentially exceed the BNF maximum daily dose, this must be discussed with the patient and/or their representative and the rationale documented in the patient's healthcare record.

- 7.12.4. Alternative routes of administration for the same drug shall be written as separate prescriptions – the practice of writing the route as 'PO/IM' or 'PO/PR' is not acceptable.

- 7.12.5. Prescriptions for 'PRN' medication should take into account any regular doses of the same medication that the patient has also been prescribed. If the combination of the regular dose and the maximum daily permitted 'PRN' dose exceeds the BNF maximum daily dose for the drug, this must be discussed with the patient and/or their representative and the rationale documented in the healthcare record (see also Appendix 7 on prescribing antipsychotic medication above BNF limits).

- 7.12.6. The maximum number of doses to be administered and/or maximum duration of treatment should be stated where allowed by the design of the drug chart.

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- 7.12.7. **Review of ‘PRN’ medications:** The administration records for ‘PRN’ medications, and the patient’s on-going need for these items to remain on the chart, must be reviewed at least every 7 days, or more frequently if clinically appropriate. The dates of such reviews must be documented in the patient’s healthcare record and on the chart. “PRN” antipsychotics should be reviewed after 7 days or 6 doses whichever is the shorter and recorded as above.

If the review of the administration record indicates that a ‘PRN’ medication is being given on a regular basis, the clinical rationale for the treatment should be reviewed. If appropriate, the treatment shall be re-written in the ‘regular medication’ section of the chart.

If the review of the administration record indicates that the patient has not required any doses of a ‘PRN’ medication, consideration should be given to cancelling the prescription for the item.

- 7.12.8. **Record-keeping for ‘PRN’ medications:** Every ‘PRN’ dose of medication administered must be recorded on the chart with the date and time of administration. A corresponding entry must be made in the patient’s healthcare record detailing the reason why the ‘PRN’ dose was given, and the date and time of administration.

7.13. Prescribing ‘Variable Dose’ and ‘Intermittent Dose’ medication

- 7.13.1. Prescriptions for medication requiring continuing changes of doses (i.e. chlorthalidone reducing regime) should be prescribed on the main chart in the ‘regular medication’ section with clear instructions about what doses are to be administered on which days. Administration record boxes for days on which the medication should not be given shall be crossed through on the administration side of the chart.

- 7.13.2. A Clozapine starting regime should be prescribed on the supplementary chart designed for this purpose.

- 7.13.3. Intermittent doses, i.e. those that are given on some but not all days during a period need to be clearly marked on the drug chart to avoid administration errors. Examples include methotrexate and bisphosphonates which are given weekly, and ketoconazole shampoo used twice weekly. The administration record boxes for days on which the preparation is not to be administered should be crossed through.

7.14. Prescribing medicines to take home

- 7.14.1. Medication for leave must be prescribed in the relevant section of the prescription chart. Medicines prescribed for patients to be discharged in Essex must be written on a separate multiple copy

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discharge prescription form. All copies of this form must be seen by a pharmacist when dispensing is requested. A copy should be scanned to the patient's healthcare record, one sent to the GP, one given to the patient and the remaining copy retained in the pharmacy.

Medication for leave and discharge from Robin Pinto and Woodlea should be prescribed on an outpatient prescription form or back of the prescription chart.

- 7.14.2. **Leave medication:** The period of leave must be specified in order to provide the correct quantity of regular medications. For 'as required' medication, the exact quantity to be supplied must be specified, e.g. 20 tablets, 200ml etc.
- 7.14.3. If a patient requires methadone or buprenorphine SL for leave this should be arranged with the relevant community drug and alcohol service where possible. Otherwise these medicines can be prescribed for dispensing by the Trust pharmacy if the Multidisciplinary Team (MDT) agrees that there will be no risk to either the patient or the public. A written record of this must be made in the healthcare record. The MDT must decide on the quantity and frequency of supply that is safe for the patient and write a leave prescription accordingly. If it is decided that a supply for less than the duration of leave is required the pharmacy should be consulted for advice. Arrangements for discharge should be made with the relevant community drug and alcohol service prior to the patient being discharged.
- 7.14.4. **Discharge medication:**
- Normal duration of supply of medicines to take home should be 28 days. Duration for less time shall be clearly specified by the prescriber.
- For 'as required' medication, the exact quantity to be supplied must be specified, e.g. 20 tablets, 200ml etc.
- Patients with a history of self-harm in the last three months, and considered to be at high risk of taking an overdose of medication should receive no more than 14 day's supply. In this event, the care co-ordinator must make arrangements for the patient to be provided with further supplies of suitable duration until such a time as it is considered safe for the GP to take over prescribing responsibility.
- 7.14.5. Administration instructions shall be given to the patient or their carer by the doctor, pharmacist or nurse. Information leaflets should also be offered to the patient. A manufacturer's Patient Information Leaflet (PIL) for all medicines to be taken home will be issued by the pharmacy.

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- 7.14.6. In some cases a period of training for the patient may be necessary prior to discharge.
- 7.14.7. **Monitored Dose Systems (MDSs):** Medicines may only be supplied in an MDS if their use has been agreed as part of the discharge planning process and the pharmacist is satisfied that adequate arrangements are in place for refilling (see also section [16.7](#)). The day and time of the first doses to be placed within the MDS must be stated to enable it to be correctly dispensed.
- 7.14.8. **Fixed Courses:** For fixed courses of treatment, e.g. antibiotics, the prescription shall specify the number of days treatment required to complete the course.
- 7.14.9. **Clozapine:** It is normal for clozapine to be issued as part of discharge medication in a quantity sufficient to last until the patient's next blood test is due. If the correct quantity of clozapine labelled with dosage instructions was supplied whilst on the ward this may be issued from the ward.

The pharmacy must be informed of discharge so that the patient's contact details can be updated and an outpatient prescription written. Arrangements must also be made with the patient, community team and pharmacy regarding future blood tests and medication supply.

- 7.14.10. **Controlled Drugs:** Leave and discharge prescriptions for Controlled Drugs must comply with the requirements of the Misuse of Drugs Act, which are more stringent than for inpatient prescriptions. See Appendix 3 for further details.

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

7.15. Remote prescription / direction to administer (verbal orders)

- 7.15.1. In exceptional circumstances, where medication is **currently prescribed** but where changes to the dose are considered necessary, the use of information technology, such as email is acceptable to obtain confirmation of a change to the original prescription.

A verbal order is not acceptable on its own. The email must be stapled to the patient's prescription chart until the prescriber can confirm and sign the change on the chart. It is the responsibility of the prescriber to amend the prescription as soon as possible and in any case within twenty-four hours of giving the verbal order. The fax or email providing confirmation of a verbal direction to administer must then be filed in the patient's healthcare record.

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In an emergency, when no other form of communication is possible (i.e. no email), a verbal order for dose changes may be accepted but, in an inpatient setting, must be witnessed by a second nurse. This shall be written in the “once only” section of the patient’s prescription chart in black ink by the nurse in charge, and then read back to the prescriber checking the patient’s full name and date of birth, the name of the medicine, dose and route.

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

If necessary, the doctor should also write up a new regular/PRN prescription for the medication. Under no circumstances should nursing staff write a new regular/PRN prescription for the drug on the patient’s chart in anticipation of the doctor’s signature. After the doctor has signed the patient’s chart (and if necessary, written a new regular/PRN prescription), the nurse should record that this has happened in the patient’s healthcare record.

- 7.15.2. Verbal orders for the administration of a **previously un-prescribed substance** are not normally acceptable. However, an exception may be made for short-acting treatment for highly agitated patients (e.g. lorazepam) that is required as a matter of urgency in a high risk situation, although a verbal order for such therapy can only be taken in exceptional circumstances and must be confirmed by either a fax or email from the prescriber before the dose is given. The email must be stapled to the patient’s prescription chart until the prescriber can confirm and sign the change on the chart. It is the responsibility of the prescriber to amend the prescription as soon as possible and in any case within twenty-four hours of giving the verbal order. The fax or email providing a verbal direction to administer must then be filed in the patient’s healthcare record.

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

The patient must be reviewed by the Consultant or their representative as soon as practicable.

- 7.15.3. **Schedule 2 and 3 Controlled Drugs and clozapine cannot be administered on a verbal instruction.**

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7.15.4. A verbal order to administer is valid for one dose.

7.15.5. **Text messages and confirmation of remote prescribing**

Confirmation by text messaging of a remote order to administer medication is a possibility, but should only be used in **exceptional circumstances**, as no record can be retained.

A second signature, when available (normally another registered practitioner but where this is not possible another person) – should sign to confirm the documentation agrees with the text message. It must be regarded as a patient contact and documented in the patient's notes. Ensure patient confidentiality and documentation of any text received

Records shall include:

- Name of registered prescriber
- complete text message,
- telephone number the message was sent from
- the time sent,
- any response given,
- date when the text message was received by the registered practitioner.
- the signature of the registered practitioner

The messages received shall be deleted from the receiving handset after all confirmatory documentation is received to maintain high standards of confidentiality.

7.15.6. Verbal orders are not permitted when the patient is under the age of eighteen years.

7.16. **Prescribing for out-patients**

7.16.1. When prescribing for out-patients, the following types of prescription forms shall be used within the Trust:

- 'In house' EPUT/ELFT prescription forms, FP10HNC prescription forms (green)
- Instalment FP10MDA forms (blue – only used within Substance Misuse Services)
- Community antipsychotic depot charts – to be used for administration of the injections by community nurses.

7.16.2. Prescriptions for out-patients shall contain all relevant information as detailed in section [7.9](#).

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- 7.16.3. A record should be made in the patient's healthcare record of what has been prescribed including the drug, dose, form and quantity.
- 7.16.4. **In-house prescription forms:** These can only be dispensed at the hospital pharmacy named on the form, and may be used for leave/discharge prescriptions by Robin Pinto and Woodlea. (Leave and discharge prescriptions in Essex must be written on the appropriate stationery).
- 7.16.5. The normal quantity to be ordered is 28 day's supply. If a shorter duration is required this should be specified by the prescriber. Patients with a history of self-harm in the last three months should receive no more than 14 days' supply.
- 7.16.6. **FP10HNC forms:** These prescription forms can be dispensed at any community pharmacy. It is essential that these prescriptions are completed correctly and in full to avoid inconveniencing patients. If in doubt, prescribers should check the section on prescribing in the British National Formulary.

The normal quantity to be ordered is 28 day's supply. If a shorter duration is required this should be specified by the prescriber. Patients with a history of self-harm in the last three months should receive no more than 14 days' supply. Larger quantities may be prescribed if the product is one that GPs are unwilling to prescribe.

Only medication pertaining to the patient's mental health condition should be prescribed; other medications should be obtained from the patient's GP.

The only drugs which should be prescribed are those listed in the Trust Formulary or ones that have been specifically approved by the Medicines Management Group for use (new and/or unlicensed products). **FP10HNC forms shall not be used to circumvent any restrictions on the prescribing of particular drugs.** Prescribing on FP10HNC forms will be audited on a regular basis. Any apparent inappropriate use of these forms will be brought to the attention of the relevant Clinical Director.

FP10HNC forms may not be used for private patients or for staff prescriptions.

- 7.16.7. **FP10MDA forms:** These forms are only available within Substance Misuse Services for use when clients are required to obtain their medication on an instalment basis, e.g. daily methadone. The forms may be computer generated and a copy should be kept in the patient's healthcare record.

Other non-instalment prescribing within these services should be undertaken on the normal FP10HNC form.

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7.16.8. **Controlled Drugs:** outpatient prescriptions for Controlled Drugs must comply with the requirements of the Misuse of Drugs Act, which are more stringent than for inpatient prescriptions. See Appendix 3 for further details.

7.16.9. FP10HNC and FP10MDA prescription forms are controlled stationery which must be kept securely. Refer to Appendix 8 for further information.

7.17. Prescribing for personal use

7.17.1. No prescriber shall issue a prescription for themselves, members of staff, or family and friends.

7.17.2. Members of staff, including medical staff, shall obtain any medication they require for their own treatment from their GP, or over the counter from a community pharmacy.

7.17.3. In the event of illness occurring whilst on duty, the Occupational Health Service should be contacted.

7.17.4. Medicines held on wards are for the treatment of Trust patients only, and must never be given to staff or visitors.

8.0 PATIENT GROUP DIRECTIONS

8.1. Patient Group Directions (PGDs) permit nurses and members of some other healthcare professions to supply or administer medicines in specific circumstances without the need for a valid prescription.

8.2. A PGD is a written instruction for the administration of named medicines in specified clinical circumstances. PGDs apply to groups of patients or other service users who do not need to be individually identified prior to presentation for treatment.

8.3. Development of PGDs

8.3.1. The Medicines Management Group is the recognised PGD Approval Group for the Trust. Approval from the Medicines Management Group must be obtained before proceeding to develop a PGD.

8.3.2. Patient Group Directions (PGDs) will be limited to those situations in which the use of a PGD offers an advantage for patient care, without compromising patient safety, and where there are clear governance arrangements and accountability.

8.3.3. The approval process should include the engagement of stakeholders, such as clinical groups, patients and the public and liaison with commissioning and finance colleagues, as appropriate.

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- 8.3.4. The PGD Proposal Proforma and Checklist (Annex 1 of **Appendix 9**) must be used in any application for development of a new PGD.
- 8.3.5. A PGD Working Group must be convened to develop the PGD proposal at service/directorate level and make an initial assessment and recommendation to the Medicines Management Group. The proposal must demonstrate that:
- A PGD is the most appropriate method to supply and/or administer the medicine.
 - Treatment cannot be delivered on an individual named basis either by prescription or Patient Specific Direction
 - The PGD is a legal method for supply and/or administration of the medicine in the proposed care setting
 - Local antimicrobial specialists have been consulted in the development of any PGD for an antimicrobial medicine
- 8.3.6. The PGD Working Group will consist of a lead author, supported by a doctor a pharmacist and a representative of any other professional group who will practise under the PGD.
- 8.3.7. The PGD Working Group will submit the PGD Proposal to the MMG for approval once they are satisfied that the necessary criteria have been met and there is sufficient information to support the proposal.
- 8.3.8. The Medicines Management Group will consider the following in relation to the PGD Proposal:
- all legal requirements have been met
 - robust local processes and clear governance arrangements are in place
 - the risks and benefits of all options for supplying and/or administering the medicine(s) have been explored
 - the PGD will deliver effective patient care that is appropriate in a pre-defined clinical situation, without compromising patient safety
 - the views of stakeholders, such as clinical groups, patients and the public, and the commissioning organisation have been considered
 - appropriate registered health professionals are available to use the PGD, and training and competency needs are addressed
 - people who are developing, authorising, monitoring, reviewing and updating the PGD are identified, and their training and competency needs are addressed

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- the need for appropriately labelled packs and safe storage can be met
 - adequate resources, such as finance, training, medicines procurement and diagnostic equipment are available for service delivery
 - adequate resources are available to ensure that processes are followed within any locally agreed timeframe
 - decisions are aligned with local clinical commissioning frameworks.
- 8.3.9. The MMG decision to accept or reject the proposal, including the rationale for the decision will be recorded in the Committee minutes and on the PGD Proposal Proforma. The Proforma will be returned to the proposer. The decision will be communicated to other appropriate stakeholders.
- 8.3.10. The MMG decision may be appealed against within 3 months of the date of the original decision. Appeals must be made in writing to the Chief Pharmacist. The Proposer must personally attend the MMC to appeal the case.
- 8.3.11. Once approval to develop the PGD has been granted, the Trust PGD Template (see Annex X) must be used to write the PGD.
- 8.4. Each Patient Group Direction shall be developed by a PGD Working Group involving a doctor, a pharmacist and a representative of any professional group expected to supply medicines under the PGD. (See Appendix 9). The PGD must be prepared using the Trust template (see Appendix 9 annex 2) which provides notes for completion. **Authorisation of PGDs**
- 8.4.1. The finalised version of the PGD must be presented to the Medicines Management Group for approval and ratification before being authorised. Any changes required by the Medicines Management Group must be completed and the amended PGD represented to the Medicines Management Group for final approval and ratification.
- 8.4.2. The Lead Author is responsible for making any changes required by the Medicines Management Group if it was approved subject to changes, before obtaining authorising signatures.
- 8.4.3. Authorising signatories must be appropriately competent to authorise PGDs on behalf of the Trust and include:
- A Senior Doctor
 - A Senior/Chief Pharmacist
 - The Executive Director level Clinical Governance lead

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- An appropriate Senior Professional representing the group working under the PGD
- 8.4.4. The authorising signatories should be appropriately competent to authorise PGDs on behalf of the Trust.
- 8.4.5. The doctor, and pharmacist signatory must establish that the clinical and pharmaceutical content is accurate and supported by the best available evidence
- 8.4.6. The Clinical Governance Lead must ensure that local processes and governance arrangements have been followed and all legal requirements have been met.
- 8.4.7. Expiry dates must be determined on a case-by-case basis and must not exceed 3 years.
- 8.4.8. The Lead Author of the PGD is responsible for submitting the final signed and authorised PGD in the appropriate format to the Chief Pharmacist, who will arrange for its inclusion on the PGD section of the Pharmacy and Medicines Management webpage of the intranet.
- 8.4.9. The master copy of each PGD will be held by the Chief Pharmacist.
- 8.5. Once a PGD has been re-authorised, the existing PGD ceases to be legal and will be removed from the intranet.
- 8.6. Staff working to the existing PGD must ensure that they are signed off as competent to work under the updated PGD before using it.
- 8.7. The senior person responsible for authorisation of named, registered health professionals to practice under the existing PGD must ensure that staff are competent to work under the updated PGD. Where that person is no longer with the Trust or has changed roles, the service must work with the PGD Working Group to identify another senior person within the profession locally who is appropriate to authorise staff to work under the updated PGD.
- 8.8. The lead pharmacists are responsible for identifying the need for unscheduled review and updating of a PGD in conjunction with clinicians working under the PGD. This should include responding to:
- changes in legislation
 - important new evidence or guidance, such as new NICE guidance
 - new information on drug safety
 - changes in the Summary of Product Characteristics
 - changes to the local formulary

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8.9. Use of PGDs

8.9.1. For each PGD, a senior responsible person from within the service locally should be identified to authorise named, registered health professionals. This person may vary according to locality, but should be made known to the PGD Working Group and to the Medicines Management Group before the PGD is authorised.

8.9.2. The senior person responsible for authorisation of named, registered health professionals to practise under the PGD will:

- ensure that authorised health professionals have signed the appropriate documentation
- maintain lists of authorised named registered health professionals to practise under the PGD who are currently employed by the Trust
- provide the lead pharmacists/Chief Pharmacist with a copy of the lists
- provide all authorised named registered health professionals with a copy of the PGD and a copy of their individual authorisation.
- ensure that only fully competent, qualified and trained professionals operate within the PGD.
- remove the names of any authorised practitioners from the registered list for any of the following:
 - Failure to provide relevant CPD evidence when requested e.g. for compulsory training such as CPR
 - Failure to successfully register with their professional body.
 - Audit results indicate poor professional standards
 - Professional voluntary request.
 - Practitioner moves from the department or leaves the Trust.
- inform any relevant members of staff about any removal of practitioners from that list.
- plan a programme of monitoring and evaluation of PGD use within the service, including clinical audit

8.9.3. Health professionals are responsible for ensuring that before practising under a PGD, they have:

- undertaken the necessary initial training and continuing professional development

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- been assessed as competent and authorised to practise under the PGD
 - signed the required section on the PGD to confirm that they agree to work under the requirements of the PGD
 - read and understand the context and content of the PGD
 - a copy of the most recent and in date final signed version of the PGD and are using this copy to practice.
- 8.9.4. When supplying and/or administering a medicine under a PGD, health professionals must follow Trust policies and act within their code(s) of professional conduct and local governance arrangements.
- 8.9.5. When practising under a PGD, health professionals should:
- not delegate their responsibility
 - ensure that they can determine that the patient meets the inclusion criteria as set out in the PGD
 - ensure that they can determine that no exclusion criteria apply
 - discuss alternative options for treating the patient's condition, when appropriate
 - assess each individual patient's circumstances and preferences
 - recognise when signposting or referral to another health professional or service is needed, as specified in the PGD
 - understand relevant information about the medicine(s) included in the PGD, such as:
 - how to administer the medicine
 - how the medicine acts within the body
 - dosage calculations
 - potential adverse effects and how to manage them
 - drug interactions, precautions and contraindications
 - storage requirements, including maintenance of the 'cold chain'
 - follow-up arrangements
 - be able to advise the patient or their carer about the medicine(s), as appropriate
- 8.9.6. Medicines supplied to patients must be appropriately labelled. Packs must not be split.

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- 8.9.7. Manufacturers' Patient Information Leaflets must be supplied with all medication
- 8.9.8. Prescription charges for medicines supplied under a PGD must be collected from all patients who are not exempt from prescription charges.
- 8.9.9. Healthcare professionals working under a PGD must document the following information about the clinical assessment and supply and/or administration of the medicine(s):
- date and time of supply and/or administration
 - patient details, such as name, date of birth, allergies, previous adverse events and how the patient met the criteria of the PGD
 - details of medicine, such as name, strength, dose, frequency, quantity, route and site (if by injection) of administration (record the batch number and expiry date for vaccines, blood-derived products and other medicines if recommended by relevant national guidance)
 - a statement that supply or administration is by using a PGD
 - name and signature (which may be an electronic signature) of the health professional supplying or administering the medicine
 - relevant information that was provided to the patient or their carer
 - whether patient consent to treatment was obtained, in line with the Department of Health's advice on consent (2009).
 - Records may be paper-based or electronic.

8.10. Training and competency assessment

- 8.10.1. All people involved in the development, updating, and authorisation of PGDs need to be aware of the requirements of the NICE Competency Framework.
(<http://www.nice.org.uk/guidance/mpg2/resources>)
- 8.10.2. All registered healthcare professionals using a PGD must have undergone appropriate training and assessment of competency using the competency assessment in each PGD
- 8.10.3. All registered healthcare professionals using a PGD must have undertaken the appropriate mandatory OLM training
- 8.10.4. The Professional Lead for the service is responsible for ensuring that only fully competent, qualified and trained health professionals use PGDs.

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- 8.10.5. The Professional Lead for the service will ensure that adequate educational materials are available to enable individuals to deliver safe and effective services in which PGDs are used.
- 8.10.6. The Professional Lead will ensure that re-training of health professionals using PGDs incorporates a post-training assessment of competency.

9.0 SUPPLY OF MEDICINES BY PHARMACY

9.1. Stock items

- 9.1.1. Medicines and other pharmacy items that are regularly used in each clinical unit will be included on a stock list. This shall be agreed between the appropriate ward/team manager and pharmacy department. Each ward/unit should keep a copy of its current stock list in a readily accessible place such as the treatment room.
- 9.1.2. These medicines may only be administered to a patient by a nurse/ designated pharmacist or pharmacy technician and never issued to them to be self-administered. Stock items are retained on the ward/unit regardless of whether they are currently being used for the treatment of patients.
- 9.1.3. Patterns of medicines usage change over time, and stock lists should be reviewed at least annually. Alterations to the stock list and/or stock levels may only be implemented after discussion between the ward/unit manager and a pharmacist or pharmacy technician.
- 9.1.4. Where a pharmacy 'top-up' service is in operation, a member of pharmacy staff will restock clinical areas on a regular basis. The ward/team manager remains responsible for identifying fluctuations in medicines requirements, ordering appropriately and notifying pharmacy when it becomes necessary to review the current stock list.
- 9.1.5. Where a 'top-up' service is not in operation, computer-generated stock sheets will be completed and signed by the nurse in charge and sent to the pharmacy, by fax or preferably email. This system may need to be used for all wards in the event of an emergency such as a 'flu pandemic.
- 9.1.6. Inevitably, situations will arise where a ward/unit runs low on stock of an item before the next pharmacy 'top-up' visit is due. In this event, the product(s) required shall be requested in writing, and sent to the pharmacy orders inbox by email from the email account of a person authorised to order medicines.
- 9.1.7. A delivery note will be issued by the pharmacy when stock medicines are supplied. The nurse in charge/team manager or

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their deputy must check and sign this and notify the pharmacy of any discrepancies immediately. Delivery notes must be retained in a readily accessible place such as the treatment room for two years.

9.2. Controlled drugs

- 9.2.1. Stock Controlled Drugs shall be ordered by the nurse in charge or her deputy in the appropriate requisition book. A separate page must be completed for each preparation and the name of the drug shall be written in full.
- 9.2.2. Any nurse who is authorised to requisition controlled drugs shall provide a specimen of her signature to the pharmacy department of any hospital in which she may work.
- 9.2.3. On receipt, the nurse in charge shall check the drugs, sign the copy of the requisition and immediately record the receipt of Schedule 2 controlled drugs, and any locally required Schedule 3 drugs, in the controlled drugs record book (see Annex 1 of Appendix 3). The receipt shall be witnessed by a second nurse, who shall also sign the controlled drugs record book.
- 9.2.4. The controlled drug record book and order books must be retained in the clinical area for two years after the date of the last entry. If records of destruction have been made in the controlled drug record book it must be retained for seven years after the date of the last entry. It may be destroyed after this period.
- 9.2.5. Detailed procedures for the handling of controlled drugs are set out in Appendix 3. These must be followed at all times.

9.3. Items for individual patients

- 9.3.1. Medicines that are not used sufficiently frequently to warrant inclusion on the stock list will be supplied by pharmacy on an individual-patient basis or as 'temporary stock' items (usually where there is more than one patient on the ward requiring that medicine). These will be supplied in containers labelled with the name of the product, the patient's name or 'temporary stock', and the date of supply.
- 9.3.2. Non-stock items including items dispensed for individual patients and temporary stock will be endorsed as such on the prescription chart by the ward pharmacist.
- 9.3.3. These medicines should only be held on a ward/unit whilst there is a patient requiring treatment with them, although they may be retained on the ward for patients who are on short periods of leave. Once the patient has been discharged, any remaining temporary stock medicines will be removed by pharmacy staff

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(Essex) or disposed of as pharmaceutical waste on the ward (Robin Pinto and Woodlea).

- 9.3.4. Those labelled as 'temporary stock' may be used for other patients prescribed the same drug on the same ward. Items labelled with a patient's name may not be used for another patient.
- 9.3.5. If a patient is started on treatment with a non-stock medicine, it is the responsibility of the ward/unit to initiate a supply from the pharmacy (except for wards/unit that receive a daily ward pharmacist/pharmacy technician visit, when the pharmacist/pharmacy technician will usually initiate the supply). When items are required urgently, after a member of pharmacy staff has visited the ward/unit or where a pharmacist/pharmacy technician does not routinely visit, non-stock medicines should be ordered by emailing a copy of the original prescription chart to the pharmacy orders inbox, with a clear indication of which item(s) are required.
- 9.3.6. Prescriptions may be emailed from clinical areas on a site remote from a pharmacy. A copy of the entire prescription chart together with a requisition signed by the nurse in charge should be sent, including copies of every page of every chart, with the exception of any unused administration record pages. A copy of the 'as required' page must be included, even if no 'as required' medications have been given. Original prescriptions should be seen by a pharmacist within 7 days of supply, where possible.
- 9.3.7. Once a supply of a temporary stock medicine has been initiated, any further supplies that are required will usually be arranged by the pharmacy staff. However, if a patient runs out of a temporary stock medicine, the emailed copy of the prescription chart (should be sent to the pharmacy as described above, with a clear indication of which item(s) are required (see section [9.3.5](#)).

9.4. Patients' own medicines

- 9.4.1. Patients are encouraged to bring their own medication into inpatient settings at admission, as this can assist in the identification of the treatments they are currently taking. The Department of Health also encourages the continued use of patients' own medicines whenever appropriate, as this can help to reduce wastage in the NHS.
- 9.4.2. Medicines brought into hospital or other clinical areas remain the patient's property and all medicines retained on a ward/unit must be recorded in the patient's healthcare record by a member of the nursing or pharmacy staff, and as part of the patient's property.

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- 9.4.3. If the medicines are not required they may, with the patient's consent, be disposed of on the ward/unit in accordance with Appendix 10. Consent must be recorded in the patient's healthcare record using the form provided as part of Appendix 11. Alternatively, the medicines shall be stored in a locked medicines cupboard on the ward for return to the patient on discharge, or returned to an adult relative or carer for safe keeping.

When the medicines are removed from the clinical area details of disposal or onward transfer should also be recorded in the healthcare record.

- 9.4.4. Patients' own medicines may only be used when they can be positively identified and have been approved for use. This will usually be undertaken by a pharmacist or pharmacy technician.

- 9.4.5. In the absence of a pharmacist or pharmacy technician and where there is a need to administer a patient's own medicine, assessment may be made by a qualified nurse. This shall include checking that medicines are in appropriate containers and clearly labelled, following the algorithm in Appendix 11. The suitability of these medicines shall be recorded in the patient's healthcare records

- 9.4.6. If a patient's own medicines have been assessed as suitable for continued use, they may be used for the future treatment of that patient only, with their written consent. This should be obtained by using the form provided as part of Appendix 11). A patient's own medication must never be used to treat other patients.

Patients' own medicines that are being used for inpatient treatment will be endorsed on the prescription chart by the ward pharmacist. Patients' own medicines shall be kept in a locked medicines trolley or medicines cupboard.

If a patient is self-administering his medicines, he may continue to use his own medicines during an in-patient stay if the consultant agrees to this, and especially where a patient usually manages their own insulin regimen. If patients' own controlled drugs are to be used a record of each administration must be kept in the ward controlled drug record book. A separate page must be used for each drug held for an individual patient. As soon as these controlled drugs are removed from the ward a line shall be drawn through the remainder of the page to prevent it being used again. Refer also to Appendix 3 which explains the entries required in the CD Record Book for the receipt and administration of a patient's own CDs.

- 9.4.7. If a newly-admitted patient has not been seen by a prescriber before the time that a dose of their own medication is due, the

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patient should be permitted to self-medicate provided the nurse is satisfied that:

- the correct medicine has been brought in by the patient
- the medicine is in a suitable condition to use
- the treatment is still necessary for the patient's well-being

9.4.8. Before permitting self-medication the nurse should check with the prescriber responsible for the patient that the treatment is clinically appropriate, and record the prescriber's advice in the patient's healthcare record.

9.4.9. At discharge, a patient's own medicines may be returned to the patient provided the dosage instructions have not changed. If only a few days of medication are left, an additional supply should be ordered as part of the discharge prescription (see section [7.14](#)).

9.4.10. If a medicine has been discontinued, or the dosage changed, the patient's consent should be sought to retain their medicines on the ward/unit rather than returning them. Any such medicines should then be disposed of in accordance with Appendix 10.

9.4.11. A patient's own homeopathic, herbal and over-the-counter medicines may be retained on the ward and administered to the patient provided they have been prescribed on the prescription chart and have been assessed as fit to use.

Prescribers shall only prescribe such products if it is within their knowledge and competence to do so. Any such medicines must be clearly marked with the patient's name, and must never be administered to other patients. If the patient requires further supplies of such treatments, family or friends will need to be asked to purchase these on the patient's behalf.

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

9.4.13. Community teams may store medicines for patients who are at risk of self-harm. When a patient uses his own medicines during an in-patient stay or under the care of a community team, pharmacy or nursing staff must ensure that a reasonable quantity is supplied on discharge. This will normally be 28 days' supply but must be at least two weeks, unless the patient has a history of self-harm and the prescriber indicates that a smaller supply is required.

In situations where community staff are holding and administering medicines or supervising the administration of

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medicines, and decide that the patient will hold and administer their own medicines due regard needs to be given to the risk of self-harm and the quantities to be held by the patient. Staff may wish to take an approach similar to the Trust's self-administration scheme (see section 16.0).

Full details of medicines brought into a community team base and stored on behalf of a patient must be recorded in a book/folder and kept with the medication in a locked medicines cupboard. When the medicines are removed from the clinical area details of disposal or onward transfer should also be recorded in the same book/folder.

9.5. Medicines supplied for leave / discharge

- 9.5.1. Medicines for leave or discharge supplied by the pharmacy shall be locked in a medicines cabinet immediately upon receipt.
- 9.5.2. All medicines given to a patient on discharge, except patient's own drugs which they brought with them at admission which may be returned, shall be individually dispensed by the pharmacy department for that patient. It is not necessary to provide a new supply of any medicines, if the pharmacist considers that the patient has a sufficient quantity which is still appropriate to his needs.
- 9.5.3. If a patient is going on leave an individual supply of medicines shall be dispensed by the pharmacy for the duration of the leave. Where individual patients have a supply labelled with full directions, this may be issued to the patient for leave with the agreement of the multidisciplinary team. Under no circumstances must stock medicines ever be issued to a patient for leave. If patients' relatives or carers collect the medicines from the pharmacy or ward in the absence of the patient, ID must be confirmed.
- 9.5.4. Before the patient leaves the ward, the leave/discharge medication should be checked against the prescription chart to confirm that all details are correct, in case there have been recent changes to the treatment. Details to be checked include:
- the patient's name
 - the name and strength of the medicine
 - the dose
 - the directions
 - the quantity
- 9.5.5. This check should be done by a registered nurse in conjunction with the patient. Any discrepancies should be reported to the pharmacy immediately. It is also important that the patient

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receives adequate information about their medicines prior to discharge. The patient should know the purpose of their medicines, how to take them, and for how long they are to be taken. It is the responsibility of the nurse overseeing the discharge process for the patient to ensure that adequate information has been provided.

9.5.6. Healthcare professionals should ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for on-going prescribing is clear.

9.5.7. Ordering, delivery and receipt of Controlled Drugs for leave/discharge is the same as for other leave/discharge medicines (i.e. the CD Order Book does not need to be used). However, when the ward/unit receives a patient's leave/discharge medication which includes a CD, the medicines shall be stored in the CD cupboard until they are ready to be handed over to the patient. **NB.** Leave/discharge CDs shall be entered in the Patient's Own Drug section in the ward's CD Record Book.

9.5.8. With the agreement of the Chief Pharmacist, Consultant(s) and the Appointed Nurse in Charge, certain clinical areas may be issued with a limited range of preparations ready packed for patients to take home/use at home. These packs must:

- be provided by the pharmacy department
- be issued only in accordance with a prescription written by a registered prescriber
- have the label endorsed with the patient's name and the date of supply.
- be labelled with clear directions for use

No alteration may be made to the label or the contents.

9.5.9. A record must be kept of all pre-packs issued, and must be held in the clinical area at all times. Details to be recorded are patient's name, time, date, name of medicine, quantity issued and signature of two members of staff, one of whom shall be a first level nurse or registered prescriber.

9.6. Prescription accuracy checking

9.6.1. Prescription charts will be screened for accuracy and appropriateness by a pharmacist as part of their clinical pharmacy role, or at the time of dispensing. Clinical screening will involve the identification of pharmacotherapeutic problems through collation and evaluation of all relevant information, including patient characteristics, disease states, medication regimen and laboratory results, as appropriate.

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- 9.6.2. Endorsements shall be made to in-patient prescription charts to:
- clarify ambiguities or omissions by the prescriber
 - annotate the prescription with the approved name of the drug where the prescription does not already state this
 - ensure that that drug details on the prescription chart match the label details on dispensed items
 - provide additional administration instructions e.g. 'with/after food'.
- 9.6.3. Clinical screening, annotation and endorsement will be undertaken in line with the relevant Standard Operating Procedure (SOP) of the supplying pharmacy.

9.7. Obtaining medicines when pharmacy is closed

- 9.7.1. Whenever feasible, the medicines required by a ward/unit shall be ordered via a Trust pharmacy during normal opening hours. However, it is recognised that it may occasionally be necessary to obtain urgently-required medications when the pharmacy is closed.
- 9.7.2. In an emergency, a medicine, other than a controlled drug may be borrowed from another clinical area provided that it is transferred in the original, fully labelled pack, and the transfer has been authorised by the nurses in charge of both wards.
- 9.7.3. Such medicines must be transferred in their original packaging, as supplied by pharmacy, and not decanted into other containers. A signed record must be kept on both wards involved in any transfers of stock drugs, in the ward diary. Individual strips of medicines must not be removed from the original package and transferred. The nurse in charge must inform the pharmacy department as soon as it reopens, so that supplies can be replenished to the issuing ward.
- 9.7.4. Individually-dispensed medicines (including 'temporary stocks') must not be transferred between wards/wings unless the patient is being transferred (see section [9.8](#)),
- 9.7.5. If a Controlled Drug needs to be administered as a matter of urgency and the ward/unit does not have the drug in stock, a **single dose** may be obtained from another ward/unit that does have the drug, provided this is authorised by both the nurses in charge. The procedure set out in Appendix 3 MUST be followed.
- 9.7.6. Medicines may be obtained from the emergency drug cupboards at Basildon Mental Health unit, Brockfield House, Rochford Hospital, Derwent Centre, St Margaret's Hospital, Linden Centre, Crystal Centre, The Lakes, Kingswood Centre, Clacton, St Aubyn Centre or Thurrock Hospital. There is a stock list on the outside

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of each cupboard and the key can be obtained from the site officer/unit coordinator in South Essex and from the Ward Manager and their appointed deputy in North Essex. If a medicine is required urgently and is not available from another clinical area or the emergency drug cupboard, the doctor or nurse in charge should telephone the on-call pharmacist via the Contact Centre (0300 123 0808), who either will advise of a suitable alternative or make arrangements to dispense the medicine.

9.7.7. **Robin Pinto and Woodlea:** Pharmacy services are not provided by the Trust and the service level agreement does not include provision of an on-call service. In wholly exceptional circumstances, when all other avenues have been explored it may be possible to obtain any urgently needed medicines via the Essex on-call pharmacy service.

9.8. **Transfer of medicines when a patient moves ward**

9.8.1. If a patient moves from one ward/unit to another, medicines that have been individually dispensed for the patient (i.e. bear the patient's name) must be sent to the new ward along with his other property.

9.8.2. Stock items should not generally be transferred between wards, but this is permissible if the ward receiving a transferred patient does not keep the drug in stock and there is likely to be a delay in obtaining a supply from the pharmacy. In this event, the medicine must be transferred in its original packaging, as supplied by pharmacy, and not decanted into other containers.

9.8.3. The pharmacy must be notified at the earliest opportunity that medicines have been transferred with a patient, so that stocks can be replenished as necessary.

9.9. **Transfer of medicines when a patient moves to another healthcare setting**

9.9.1. If a patient is transferred to another healthcare setting, for example to an acute hospital, secure environment or care home, a copy of the prescription chart, discharge note or other record of current medication should accompany them. Healthcare professionals should ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for on-going prescribing is clear.

9.9.2. Wherever possible, medicines should also be transferred to ensure continuity of treatment. This will only be possible for medicines that have been dispensed specifically for that patient and are labelled with full directions for administration. Stock medicines, and medicines that are not labelled with full

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directions, must not be transferred to another healthcare setting. If a patient is prescribed clozapine advice should be sought from the pharmacy/on call pharmacy service before the medicines are transferred.

- 9.9.3. Where a transfer is planned, discharge medication should be ordered from the pharmacy to be transferred with the patient.

10.0 DISPENSING

- 10.1. Dispensing and the supply of medicines will be undertaken by a pharmacy department within the Trust or via a service level agreement with another appropriate organisation.
- 10.2. In-house pharmacy services will be provided in accordance with Standard Operating Procedures (SOPs) approved by the Chief Pharmacist. These will be regularly reviewed and updated in response to any event that may affect patient safety, or when new legislation or guidance is issued which affects what is included within a particular SOP.
- 10.3. When dispensing medication a pharmacist will check that:
- the prescription is clearly and correctly written to avoid misunderstanding and error
 - the medicines prescribed are appropriate for the patient
 - the dose prescribed is appropriate for the patient.
- 10.4. A prescription may be amended by a pharmacist following verbal consultation with the prescriber. Such alterations shall be initialled by the pharmacist and endorsed 'PC' ('prescriber contacted').
- 10.5. Amendments to the prescription which are made and signed by the pharmacist in accordance with procedures previously agreed by the Medicines Management Group are acceptable.
- 10.6. At the discretion of the pharmacist, and in the absence of facilities to email, a prescription may be dispensed following a verbal order from a prescriber. Full details must be given including drug allergies and concurrent medication, and the age and weight of the patient if a child. A signed prescription must be provided within twenty four hours.
- 10.7. Pharmacy staff are also responsible for:
- ensuring the quality, efficacy and safety of all medicines used within the Trust
 - advising on security and storage of medicines
 - procuring medicines in a form suitable for administration to the patient

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- annotating prescriptions to render them accurate and providing any relevant additional information on container labels, or in the form of a patient information leaflet.
- 10.8. Approved names shall be used for prescribing, dispensing and labelling of medicines. Pharmacists will normally supply the most appropriate branded or generic product bearing in mind the clinical needs of the patient, the quality, efficacy and safety of the medicine and any financial implications.
- 10.9. **Prescription Charges**
- 10.9.1. Prescription charges are payable in respect of drugs supplied to out-patients and day-hospital attenders.
- 10.9.2. Prescription charges are not payable in respect of drugs supplied on discharge to in-patients or in respect of any drugs administered whilst the patient is on health service premises. Patients treated under the terms of supervised Community Treatment Orders (CTO) are also exempt, provided they receive their medicines from a Trust pharmacy.
- 10.9.3. Prescription charges normally shall be collected by the pharmacy department, but staff who issue medicines from other departments, including supply under a PGD, are responsible for ensuring that the appropriate charge is collected.
- 10.9.4. If a patient requires medicines for immediate treatment and has no cash, staff may issue an invoice in respect of the prescription charge.
- 10.9.5. The prescription charge is not refundable unless it has been levied incorrectly or if no proof of exemption can be supplied. If this is the case an NHS receipt form FP57 can be issued by the pharmacy for reclaiming the prescription charge (only at the time the prescription charge is paid).
- 10.9.6. Credit is not possible in respect of medicines returned by the patient at a later date.

11.0 TRANSPORT OF MEDICINES

- 11.1. Medicines may only be transported by authorised courier/transport services, portering services or members of Trust staff.
- 11.2. Following a pharmacy 'top-up' visit, supplies of stock items will be transported to the ward/unit in a sealed pharmacy ward box or tamper evident bag. Small quantities of medications ordered on a day-to-day basis will be transported in sealed, tamper-evident bags. The courier/porter will be asked to sign for the collection of such containers from the pharmacy.

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- 11.3. A consignment note stating the number of sealed containers to be transported shall be completed by pharmacy staff and accompany each load. A signature shall be obtained each time the consignment changes hands.
- 11.4. Members of staff may collect medication from pharmacy. This task may be delegated to any member of staff by the nurse in charge, but the person collecting the medicines must be prepared to show their Trust ID card. The pharmacy may refuse to release medicines to staff who cannot produce identification.
- 11.5. Transport of Controlled Drugs
 - 11.5.1. Controlled drugs may be delivered to the appropriate clinical area by a member of Trust staff, Trust transport services or authorised courier services, in a tamper-evident package, provided that a signature is obtained on the appropriate document each time the package changes hands. The completed documentation will be archived in pharmacy. Upon delivery to the clinical area the package shall be handed to the nurse in charge who shall sign to acknowledge acceptance. The messenger must be a person employed by or contracted to the Trust. Refer to Appendix 3 for further information.
- 11.6. Any vehicle used to transport medicines shall be kept locked at all times.
- 11.7. Nursing staff shall carry medicines in their original container in a **locked** bag when transporting them in the community. This shall be transported in the **locked** boot of a vehicle and any remaining medicines must be returned to Trust premises at the end of a shift.
- 11.8. When a member of community staff delivers medicines to a patient's home they must be handed over in person to the named recipient or a nominated representative named in their care plan. They must not be put through a letter box.
- 11.9. Medicines must not be exposed to temperatures outside the recommended range for the individual medicine. Do not leave medicines in vehicles, especially in very warm or hot weather or during cold weather when there is a risk of temperatures falling below 2°C.
- 11.10. If a medicine is exposed to temperatures outside the recommended range, these shall be replaced at earliest opportunity
- 11.11. **Vaccines** shall be transported in a validated clinical cool-box in accordance with the manufacturer's instructions for use and local guidance / standard operating procedures on vaccine cold storage shall be followed. Domestic cool-boxes are **not** appropriate for the transport of medicines.
- 11.12. When medicines need to be returned by a ward or clinic to the pharmacy they must be transported in a tamper evident bag, sealed with a numbered seal. A consignment note stating the number of sealed containers to be transported shall be completed by ward/clinic staff and accompany each

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load. A signature shall be obtained each time the consignment changes hands. Numbered seals and consignment notes can be obtained from the pharmacy department.

Robin Pinto and Woodlea must not return medicines to the pharmacy departments of other organisations.

12.0 RECEIVING MEDICINES FROM PHARMACY

- 12.1. All medicines will be delivered from pharmacy in a sealed box or tamper-evident bag.
- 12.2. A registered nurse must check the medicines received against the delivery note and report any discrepancies to the pharmacy at the earliest opportunity. Delivery notes must be signed and retained for two years for audit purposes.
- 12.3. All medicines must immediately be transferred to a locked medicines cabinet or trolley.
- 12.4. Controlled Drugs must be signed as received in the CD Order Book, and immediately be entered into the CD Record Book. Refer to Appendix 3 for further information.

13.0 STORAGE AND SECURITY OF MEDICINES IN CLINICAL AREAS

- 13.1. The Appointed Nurse in Charge is responsible for the safe and secure storage of all medicines held on their ward/unit.
- 13.2. The design and location of all medicines cabinets and trolleys must be approved by the Chief Pharmacist or a designated senior pharmacist. Medicines should be stored in line with the requirements set out in "Medicines Storage in Clinical Areas" published by the Department of Health in *General design principles 6946:0.1: England, 2011*
- 13.3. The following general principles for medicines storage shall apply:
 - All medicines shall be stored in a secure area that is not accessible to patients or the public, such as a locked clinical room. If no such area is available for storing the medicines trolley, it must be securely chained to a wall whenever it is not in use.
 - All medicines cabinets, fridges and trolleys must be kept locked whenever they are not in use. Medicines cabinets must be securely attached to a wall and comply with the requirements of BS2881-1989.
 - All medicines (including dressings) shall be stored in conditions that minimise the risk of deterioration due to humidity, light, extremes of temperature or exposure to other substances.
 - Medicines packaging shall be checked for any special storage requirements, such as the need for refrigeration. Medicines suitable for storage at room temperature must be stored at or below 25°C.

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- The temperature of the room in which medicines are being stored must be monitored on a daily basis. If the temperature cannot be maintained at 25°C or below, the ward manager must contact the Estates Department to arrange for a temporary or permanent solution to be installed. Please refer to Appendix 12 for further guidance on temperature monitoring.
 - Items such as food, patients' valuables or personal property must not be stored in medicines cabinets or fridges under any circumstances.
- 13.4. All medicines shall be stored in one of the following locked cupboards, as appropriate: -
- 13.4.1. **Internal medicines cupboard:** To be used for the storage of internal medicines such as tablets, capsules, internal liquids, inhalers and injections, with the exception of Controlled Drugs and items that require refrigeration. Externally-applied medicines that are intended to have a systemic effect, e.g. hormone replacement patches, glyceryl trinitrate patches, should be treated as internal medicines.
- 13.4.2. **External medicines cupboard:** To be used for the storage of medicines intended for external application, e.g. creams, ointments, lotions etc.
- 13.4.3. **Reagent / disinfectants cupboard:** To be used for the storage of urine-testing products and antiseptic/disinfectant products
- 13.4.4. **Controlled drugs cupboard:** To be used solely for the storage of medicines subject to the Misuse of Drugs Act, 1971. The CD cupboard must meet the requirements of the Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007, and be securely attached to a wall with at least two rag-bolts. It must be separate from other medicines cabinets or located inside an internal medicines cabinet. All CD cupboards must have their own unique 7 lever, key-retaining mortice lock.
- 13.4.5. **Medicines refrigerator:** To be used only for the storage of medicines requiring refrigeration. Enteral feeding products requiring refrigeration may be stored in the medicines refrigerator if there is insufficient storage space in a general-purpose refrigerator.
- 13.5. Where separate cupboards are not available, internal and external medicines shall be stored on separate shelves in a locked cupboard. Any **new medicines cupboards** must comply with BS2881-1989 or the Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007, as relevant.
- 13.6. Medicines in current use may be stored in a portable, lockable medicine trolley. When not being used for a medicines administration round, the medicines trolley shall be kept locked and either securely chained to a wall or locked in a secure area such as a clinical room. The medicines trolley must never be left unattended at any time when unlocked.

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- 13.7. A limited range of medicines for life-threatening emergencies may be kept on a resuscitation trolley or in an emergency drugs box.
- 13.8. Medicines which have been individually dispensed for self-administration by a named patient or for those wards where “one-stop dispensing” takes place may be kept in a locked cabinet within the vicinity of the patient’s bed.
- 13.9. Medicines must never be transferred from one container to another. Once a dose of any medicine has been removed from its container it shall never be returned. If not required it must be discarded, by placing in a pharmaceutical waste bin. Where half a tablet from a blister pack is needed for a dose, the remaining half shall be discarded. (See special requirements for controlled drugs, Appendix 3).
- 13.10. Diagnostic reagents, monitoring devices and testing kits must be stored and used in line with the manufacturer’s specification, instructions and storage requirements.
- 13.11. Medicines belonging to individual patients and stored in the community team base for safety reasons, must be stored in a locked medicines cupboard. There must be a record of all medicines held in community team bases. This must include name, strength and quantity of each medicine and the date received / destroyed / issued / returned to the patient. If the medicine is the property of an individual patient then the patient’s name must also be included in the record.
- 13.12. **Custody of keys**
 - 13.12.1. The Appointed Nurse in Charge is entirely responsible for the custody of the medicines on their ward/unit, and this includes responsibility for the keys to medicines cabinets, trolleys, etc. This responsibility may be delegated to another registered nurse (e.g. the nurse in charge for a shift), but no other person shall have access to the medicines cabinets and keys unless authorised by the Appointed Nurse in Charge. The keys must not be handed over to medical staff.

In the prison the keys to the medicines storage areas in the wings are held in a cabinet on the healthcare wing or by the IDTS service. The healthcare professional in charge of medicating on that wing for the day will hold the keys on their person whilst on the wing and return them to the cabinet after use.
 - 13.12.2. All medicine cupboards and refrigerators shall be kept locked. The keys shall be held on the person of the nurse in charge of the clinical area or her designated deputy. The keys to medicines cabinets, trolleys, etc. must be kept together on a single key ring reserved solely for these keys, and each key should be clearly labelled.
 - 13.12.3. The keys to the controlled drugs cupboard shall be kept on a keyring entirely separate to the keys for other medicines storage

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facilities, and also be held on the person of the nurse in charge of the clinical area or her designated deputy.

- 13.12.4. Ward, Unit and Team Managers should securely store a spare set of keys for each of the clinical areas under their management. Spare keys are not held by pharmacy or estates departments. In the prison the spare keys are held in the cabinet room next to the pharmacy.
- 13.12.5. At shift changeover, the nurse in charge must ensure that the keys are passed on to the nurse in charge of the incoming shift. In the event of no suitably qualified person being present on the ward/unit, the keys must be handed over for safe keeping to the nurse in charge on a nearby ward. This information must be made known to the staff on the ward.
- 13.12.6. In community team bases where the nurse in charge or her designated deputy is not permanently on-site the keys shall be stored in a locked combination key safe. Only qualified nurses will have access to the key safe and combination.
- 13.12.7. Where a department is not manned for 24 hours a day, e.g. ECT, the medicines and CD keys should be stored in a locked combination key safe when the department is closed.
- 13.12.8. Loss of medicine cupboard keys will be reported to the appropriate Manager and pharmacist immediately.

13.13. Temperature monitoring

- 13.13.1. The temperature of all areas where medicines are stored, including medicines refrigerators, shall be monitored on a daily basis and temperatures recorded. Temperatures above 25°C for rooms and outside the range 2-8°C for refrigerators shall be reported to the Matron or Team Manager and via Datix and the action taken documented on the record sheet. Pharmacy, will advise on the action to be taken.
- 13.13.2. Medicines refrigerators must be regularly defrosted (if not self-defrosting) and be kept clean and locked. Daily records of fridge temperature shall be maintained, using a maximum/minimum thermometer. Please refer to Appendix 12 for further guidance on fridge temperature monitoring.
- 13.13.3. If the fridge temperature falls outside the range 2-8°C, any medicines shall immediately be transferred to another medicines fridge until the fault has been investigated and rectified. The Estates Department should be contacted to investigate the fault, and advice should be sought from a pharmacist about the suitability for future use of any medicines that had been stored in the faulty fridge. Medicines shall be quarantined until this has

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been obtained and must not be administered until released by a pharmacist as suitable for future use.

13.14. Stock rotation and expiry dates

- 13.14.1. Stocks of medicines must be used in rotation and expiry dates checked regularly to avoid wastage. Nursing staff will inspect ward/unit medicines cabinets at regular intervals to ensure that medicines are in date and are being stored correctly. Cupboards shall be kept neat and tidy to facilitate this process.
- 13.14.2. Liquid medicines must have the date of opening and the resulting expiry date noted on the original container. This is generally six months from the date of opening, unless there are other instructions on the label stating that the medicine should be discarded sooner. Check the manufacturer's label as expiry dates once opened can vary between products and brands. Information on expiry dates once opened is provided by the pharmacy department.
- 13.14.3. There are two ways that pharmaceutical manufacturers express expiry dates:
 - "Use before/by" means that the medicine should not be used after the last date of the month prior to the date stated on the pack e.g. "use before June 2018" means that last day the medicine can be used is 31/05/18.
 - "Expiry" means use until the last day of the month stated on the pack e.g. "Expiry: June 18" means that medicines can be used until 30/06/18.
- 13.14.4. If there is any doubt nursing staff should check with the pharmacy department before administering medicines.

13.15. Controlled Drugs

- 13.15.1. All Schedule 2 and 3 controlled drugs, unless exempt from safe storage requirements, must be stored in a locked controlled drug cupboard. Any new cupboards must comply with the Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007. It is recommended good practice that all controlled drugs cupboards conform to these standards.
- 13.15.2. All stocks of Schedule 2 controlled drugs, and any drugs required locally to be recorded in the CD record book, shall be checked by nursing staff at least once a week. Refer to Appendix 3 for further information on the process required.

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13.16. Advice to patients

- 13.16.1. Nurses should advise patients on the safe storage of their medicines at home, seeking advice from pharmacy as necessary.

13.17. Losses and discrepancies

- 13.17.1. The loss of any medicines from a clinical area must be notified to the nurse in charge who will notify the appropriate senior manager and pharmacy manager. The manager and pharmacist will decide the appropriate action required.
- 13.17.2. If the missing items cannot immediately be found CPG3 *Adverse Incident Procedural Guidelines* shall be followed.
- 13.17.3. In the event of a discrepancy in the stock balance of a Controlled Drug, the nurse in charge must immediately investigate the reason for the discrepancy. An incorrect or missing entry in the CD Record Book must be sought, but if this is not found, the discrepancy must be reported immediately to the senior manager responsible for the ward/unit, to the pharmacy and to the Accountable Officer for controlled drugs. Refer to Appendix 3 for further information.

13.18. Actual or suspected theft of medicines

- 13.18.1. Theft of medicines is a serious criminal offence and will be dealt with accordingly by the Trust, professional regulatory bodies and the police.
- 13.18.2. Any member of staff who has reason to believe that medicines have been taken without authority has a duty to report their concerns to the Nurse in Charge of the clinical area.
- 13.18.3. All concerns will be treated in the strictest confidence regardless of whether the subsequent review substantiates their concerns and investigations will be carried out in a discreet manner.
- 13.18.4. The Nurse in Charge must take reasonable steps to ensure that medicines are in fact missing, for example by checking administration records, cupboards not normally used for storage of medicines and pharmacy delivery records.
- 13.18.5. If the Nurse in Charge is unable to satisfy herself that all medicines can be accounted for, she must report suspicions to the Deputy Chief Pharmacist and Service Manager at the earliest opportunity. If immediate action is required, consideration should be given to contacting the police.
- 13.18.6. Where a Service Manager / Deputy Chief Pharmacist has been informed of suspected / actual theft of medicines, he must inform

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the relevant professional lead, Chief Pharmacist / CD Accountable Officer and LSMS who will agree a course of action appropriate to the circumstances. This may include referring the matter to the NHS Counter Fraud Authority or the police.

13.19. Closure of a ward or unit

- 13.19.1. If a ward or unit is to close, arrangements must be made with a pharmacist for any Controlled Drugs to be returned to the pharmacy, destroyed or transferred to another ward/unit.
- 13.19.2. If a ward/unit is to close for only a few days, other medicines may, with the agreement of a pharmacist, remain on the ward provided there is adequate security to prevent unauthorised access.
- 13.19.3. If a ward/unit is to close for a longer period, arrangements should be made with a pharmacist for the stock of medicines to be returned to the pharmacy (Essex only), destroyed or transferred to another ward/unit.

14.0 PREPARATION OF MEDICINES FOR ADMINISTRATION

- 14.1. Wherever possible, medicines will be supplied by pharmacy in a form suitable for direct administration to the patient.
- 14.2. When medicines have to be measured, mixed or reconstituted in a clinical area prior to administration, this shall be undertaken in a designated clean area, i.e. clinical room.

15.0 ADMINISTRATION OF MEDICINES

- 15.1. Medicines shall only be administered in accordance with an official written order (a prescription chart or prescription form) which has been signed by a suitably-qualified prescriber, or in accordance with a Patient Group Direction (see section [8.0](#)). See section [7.15](#) for information on remote prescription or direction to administer (verbal orders).
- 15.2. Medicines may only be administered by suitably qualified nursing/pharmacy staff, or staff who have undergone appropriate training and assessment (see section [22.0](#)). Staff who are authorised to prescribe are also authorised to administer medicines.
- 15.3. Nursing/pharmacy staff who administer medicines are professionally accountable for their actions or omissions. The standards that apply to the administration of medicines are contained in:
 - Nursing and Midwifery Council / Royal Pharmaceutical Society *Professional guidance on the administration of medicines in healthcare (2019)*

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- Health Education England *Advisory Guidance on Administration of Medicines by Nursing Associates* (2018)
- Nursing and Midwifery Council () *The Code: Professional standard of practice and behaviour for nurses, midwives and nursing associates* (2018)
- General Pharmaceutical Council *Standards for pharmacy professionals* (2017)

A nurse/pharmacy staff member bears professional accountability for every action taken. She may therefore decline to administer a medication if she feels that to do so would be outside the limits of her knowledge or competence, and that to do so would be unsafe. However, she must be prepared to justify her reasons for taking such action.

- 15.4. Ward/unit managers have a responsibility to ensure that all staff who administer medicines are suitably qualified and trained to do so, and are familiar with the relevant sections of this procedural guideline.
- 15.5. Ideally, two people should be involved in the medicines administration process, but it is accepted that at certain times and in certain circumstances, this may not be feasible. Where two persons are involved the responsibility for the accuracy of the administration is attached to the senior registered nurse, who shall sign the administration record. However, both shall check each step of the administration process.
- 15.6. Medicines must be administered directly from the labelled container in which they were received from pharmacy and never transferred into another container prior to administration.
- 15.7. Medication shall normally be administered in the form in which it is supplied. If this is not possible for physical reasons then the advice of a pharmacist should be sought on appropriate alternatives.
- 15.8. Administration of liquid oral medicines
 - 15.8.1. A 2.5ml or 5ml medicine spoon or graduated plastic medicine pot should only be used to administer medicines such as simple linctus, antacids and cough medicines which do not need accurate dosing. Where accurate dosing is required (for example liquid lithium, anti-epileptics and controlled drugs) an appropriate oral syringe marked 'For oral use only' should be used.
 - 15.8.2. Under no circumstance must an intravenous syringe or domestic teaspoon be used for this purpose.
- 15.9. The administration of medication must be recorded on the patient's prescription chart immediately after administration. Failure to record administration will be considered an adverse incident and must be reported in line with CLP3. Non-administration must be recorded on the prescription chart using the appropriate reason code.

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15.10. If a patient has specific concerns regarding their medicines a summary of the discussion between them and a healthcare worker should be made in the patient's health care record.

15.11. Situations requiring specific care

15.11.1. **Anticoagulants:** If anticoagulants (e.g. heparin and warfarin) are to be administered the nurse/pharmacy staff must check that the patient's blood clotting (e.g. INR for oral anticoagulants) is being monitored regularly and refer to the patient's anticoagulant clinic card as appropriate. (See also NPSA Patient Safety Alert 18 *Anticoagulants: 'Actions that can make anticoagulant therapy safer'*) and CG83 *Management of Patients on Anticoagulant Medicines in Inpatient Units*.

15.11.2. **Insulin:** If insulin is being administered the nurse must check that the patient's blood glucose levels are being monitored regularly and refer to the patient's 'insulin passport' as appropriate. Many patients are very experienced at managing their insulin regimen, especially those used to "carbohydrate counting" to determine their insulin dose. Therefore, if it is considered safe to do so, patients should be encouraged to self-administer their insulin under the supervision of the nurse.

15.11.3. **Once weekly preparations:** Certain medicines are only administered once weekly. This includes **methotrexate**, which is used for rheumatoid arthritis and psoriasis. If administered daily when intended to be administered weekly methotrexate can cause considerable harm. (See also NPSA Patient Safety Alert 13 *Improving compliance with oral methotrexate guidelines*). Some bisphosphonate preparations for bone metabolism (including alendronate and risedronate) may be given once weekly. The prescriber must strike out the six days of the week when a dose must not be administered.

15.11.4. **Antibiotics:** penicillin allergy affects about 10 per cent of the population. It is important to check the allergy status of patients before administering antibiotics.

15.12. Nursing staff permitted to administer medicines

15.12.1. **Registered Nurses (first level):** May administer medicines alone, provided they are competent to do so, with the following exceptions which require a second person to be involved:

- Intramuscular and subcutaneous injections apart from depot antipsychotics, short-acting sedation, anticholinergics and subcutaneous insulin (see also section [15.15.3](#))
- Intravenous injections; intravenous and subcutaneous infusions such as insulin infusion pumps (see also section [15.15.4](#))

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- Any dose of medication which requires a calculation, e.g. doses based on body weight (mg/kg), where the dose has not already been calculated by the prescriber
 - Controlled Drugs (see also section [15.16](#))
- 15.12.2. **Registered Nurses (second level) / Associate Practitioners:** Subject to the exceptions listed in section [15.12.1](#), second level nurses may administer medicines alone provided:
- They have received additional instructions relevant to the medications likely to be encountered in the clinical area where they are working.
 - They have completed a practical assessment approved by the Trust and signed by the ward/unit manager (or have completed a similar assessment with an educational institution or another Trust).
- 15.12.3. **Agency nurses:** Agency nurses are registered nurses responsible for their own actions. Registered first level agency nurses may administer medicines alone provided they are familiar with the Trust medicines procedural guideline, subject to the exceptions listed in section [15.12.1](#). Second level agency nurses may not administer medicines alone unless they are familiar with the Trust medicines procedural guideline and have undergone assessment as explained in section [15.12.2](#).
- 15.12.4. **Student nurses:** Nurses in training should be given every opportunity to become proficient in the administration of medicines. Student nurses may administer medicines where accompanied and supervised by a registered nurse. In this situation, both the student and the supervisor shall sign the administration chart. Student nurses should not independently act as a witness in relation to controlled drugs but are encouraged to observe such activities as part of their training`.
- 15.12.5. **Support Workers:** In an inpatient setting where there is 24-hour nursing cover, nursing support workers who have successfully completed the Trust competency-based assessment* may be authorised by the Trust to assist a registered nurse to perform the following:
- Administer oral and topical medicines to a patient, including inhalers, eye and ear drops, once these have been prepared and checked by a registered nurse.
 - Check Controlled Drugs with a registered nurse (only if a second registered healthcare professional is not available).

* 'Learning Tool for Staff assisting the Administration of Medicines'

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- Check the patient's name and NHS number against the prescription chart with a registered nurse.
- Check discharge medicines against a discharge prescription with a registered nurse.
- Witness the self-administration of medicines following patient-specific assessment and training by a registered nurse.

Duties that cannot be performed by support workers:

- Preparation and supply of medicines
- Administration of medicines by injection or infusion
- Administration of Controlled Drugs
- Administration of 'as required' medication
- Administration to children
- Supply of discharge medication

15.12.6. **Pharmacists and Pharmacy Technicians:** May administer medicines alone, provided they are competent to do so, with the following exception which require a second person to be involved:

- Controlled Drugs (see also section [15.16](#))

15.13. Process for administering medication

- 15.13.1. All other sites, including day-hospitals, must administer against directions written on the Trust Medicines Prescription and Administration Chart, or supplementary cards (see section [7.8.1](#)).
- 15.13.2. Medicines should be administered in a quiet area to allow patients to discuss their medicines if necessary. The nurse administering medicines should ensure that she is not disturbed throughout the process. See also Appendix 13.
- 15.13.3. The therapeutic purpose of the patient's medication and its possible side-effects, interactions and contra-indications should be carefully considered. Reference should be made to the BNF for such information if necessary. If there are any concerns about drug interactions or contra-indications, contact the prescriber or a pharmacist.
- 15.13.4. If the dose that has been prescribed is above the BNF upper limit, the reason for doing so must be documented in the patient's healthcare record by the prescriber. If not documented the dose must be confirmed with the prescriber before administration.
- 15.13.5. If contra-indications to a medicine are observed, the dose shall be withheld and the appropriate prescriber informed without

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delay. A record should be made in the patient's healthcare record.

- 15.13.6. Always wash hands before administering medicines, or use an alcohol-based preparation if hand-wash facilities are not available, for example in a patient's home.
- 15.13.7. If a staff member is pregnant, thinks she may be pregnant or has sensitivities or allergies to particular drugs, contact pharmacy for advice before handling medicines.
- 15.13.8. Read the prescription carefully and ascertain that the dose has not already been given. If the patient has more than one prescription chart, ensure that all charts are available.
- 15.13.9. Check the entry for allergies on the first page of the prescription chart. If there is reason to suspect that the patient may be allergic to a prescribed medicine, refer to the prescriber or pharmacy.
- 15.13.10. Select the medicine required, check the label with the prescription and note the expiry date. If there is any doubt about the identity of the medicine, e.g. ambiguous / illegible wording on the chart or unclear labelling, withhold the medicine and contact the prescriber and/or pharmacy immediately.

For injections and liquid medicines (except laxatives and simple linctus) the dose must be written as milligrams, micrograms, grams or units and not as a number of millilitres (see section [7.9.5](#)). If this is not the case, contact the prescriber to verify what dose is intended.

- 15.13.11. Prepare the medicines and check the prescription and/or prescription chart with:
 - the name of the patient
 - the patient's NHS number where appropriate
 - the medicine including dose and route of administration
 - the calculation, if any (ideally with a second person)
 - the measured dose
 - the expiry date
 - the time of administration
 - the dosage instructions and compare with the label on the container
 - that the prescription has been signed
- 15.13.12. Take the measured dose and prescription chart to the patient, checking his identity. Care shall be taken to ensure that the

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patient's identity is positively confirmed by visual recognition and/or verbal questioning. If medicines are being administered by a nurse unfamiliar with the patient, a competent second person may need to assist with identification.

- 15.13.13. Ensure that the patient knows what the medicine is and has given valid consent. If the patient is detained under the Mental Health Act and a Form T2 or Form T3 is in effect, check that the prescribed medicine is in line with the details on the form. If there is any discrepancy, this should be brought to the prescriber's attention immediately, and the dose of medication withheld.
- 15.13.14. Administer or supervise the administration of the medicine. Remain with the patient until the medicine has been taken, or longer if required by the patient's care plan.
- 15.13.15. Immediately sign the prescription chart to confirm that administration has taken place. An entry shall be made on the prescription chart to indicate when doses are either refused or omitted using the numerical codes on the front of the card. The prescriber shall be informed and a record made in the patient's healthcare record. Where necessary, e.g. students under supervision, the prescription chart should be countersigned. *Failure to sign the prescription chart following administration may be regarded as an administration error – see section [15.20](#).*
- 15.13.16. If treatment is refused, professional judgement will be used to determine the level of persuasion necessary to induce the patient to accept.

15.14. Administration of medicines prescribed 'as required' (PRN)

- 15.14.1. These are medicines prescribed to be used only when necessary, in addition to the patient's regular medication. The minimum interval between doses and the maximum total daily dose should be stated on the prescription chart. The clinical indication for which the medicine is to be used should also be stated.
- 15.14.2. 'As required' medicines should be administered at the discretion of a registered nurse, e.g. for pain relief or to reduce anxiety. When administered a note should be made in the healthcare record stating the reason the medicine was given and the outcome.
- 15.14.3. It is essential to check whether an 'as required' drug has also been prescribed on the 'regular medication' section of the chart, to ensure that the maximum daily dose is not exceeded. This is particularly important with products such as paracetamol and compound analgesics, which are frequently prescribed as both regular medication and for PRN pain relief.

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- 15.14.4. If an 'as required' medicine is being given on a regular basis, it is the responsibility of the nursing staff to bring this to the attention of the prescriber. If appropriate, the prescriber should consider re-prescribing the medicine on the 'regular medication' section of the chart. The continuing need for 'as required' medicines should be reviewed on a regular basis (see section [7.12.7](#) for further information on the review of PRN medications).

15.15. Administration by injection

- 15.15.1. Injections are to be administered in accordance with the procedures for administration of injections (see Appendix 14). Before administering any medicine by injection, staff must be familiar with its contents on the preparation and administration of injections.
- 15.15.2. Practitioners must never administer any substance by injection that has been prepared in advance by another practitioner.
- 15.15.3. **Subcutaneous and intramuscular injections:** The administration of subcutaneous and intramuscular injections should be checked by two nurses whenever possible. However, the following products are exempted from the requirement for a second nurse to check:
- depot antipsychotics
 - short-acting sedation
 - anticholinergics
 - subcutaneous insulin
- 15.15.4. **Intravenous injections, infusions and subcutaneous infusions:** The administration of medicines by the intravenous (IV) route is associated with numerous risks, and should be avoided whenever a drug can be given effectively by an alternative route. Nursing staff should not administer injection by these routes unless they have undergone appropriate additional training and have a current and up-to-date IV certificate.
- 15.15.5. **Vaccines:** Nursing staff should not administer vaccines unless they have undergone appropriate additional training in immunisation and in the recognition and treatment of anaphylaxis.

15.16. Administration of Controlled Drugs

- 15.16.1. The administration of a controlled drug must be witnessed by a second practitioner, one of whom must be a registered nurse or doctor. In addition to the normal steps of the administration process described in section [15.13](#) an entry must be made in the CD Record Book, including:

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- the date and time of administration
 - the name of the patient
 - the dose administered
 - the **full** signatures of both the witness and the person administering the drug
- 15.16.2. The quantity of stock remaining shall be checked and recorded in the CD Record Book.
- 15.16.3. If the controlled drug is only partially used or wasted, it shall be destroyed by placing it in a pharmaceutical waste or sharps container in the presence of a witness and a record made in the CD Record Book. For more detailed information on the administration, recording and disposal of Controlled Drugs, refer to Appendix 3.

15.17. Delayed and omitted doses

- 15.17.1. There are a variety of reasons why a dose of medication may not have been administered. These include:
- Drug not available on ward/unit
 - Prescription illegible, illegal or ambiguous,
 - Patient not available
 - Patient asleep
 - Patient unable to take drug
 - Patient refuses to take drug
 - Prescribers must be informed of clinical reasons for non-administration as soon as possible, e.g. blood pressure low so antihypertensive omitted
- 15.17.2. It is essential that the reason for the non-administration of a medicine is documented. Codes for the above circumstances are listed on the prescription chart, and the appropriate code shall be entered on the chart in the box for the date/time that the medicine was due.
- 15.17.3. If no appropriate code is available, code 7 (other) shall be entered on the chart and the reason for the missed dose documented in the patient's healthcare record. *Failure to document the reason for a missed dose may be regarded as an administration error – see section [15.20](#).*
- 15.17.4. Following issue of an NPSA alert on delayed and omitted doses a list of 'critical medicines' has been drawn up. A short version is available on each ward and a longer version on the Medicines

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Management web pages of the Trust intranet. This provides advice on the action to be taken if a dose is delayed or omitted.

- 15.17.5. Blank administration record boxes will be considered to be a medicines incident and should be reported on Datix.

15.18. Administration of medicines to patients detained under the Mental Health Act

- 15.18.1. Medication for mental health disorders can be prescribed for, and administered to, certain categories of patients detained under the Mental Health Act without their consent, for a period of three months from the day on which such medication was first commenced (the 'three month rule').
- 15.18.2. Once the three month period has expired, such medication can only be administered to detained patients provided the safeguards referred to in Section 58 of the Act have been observed. These require that a Form T2 (patient consents to treatment) or Form T3 (patient does not or cannot consent to treatment) must be completed. These forms document what medications can be administered and need to be used in conjunction with the patient's prescription chart. A patient's T2 or T3 and prescription chart must be kept together at all times.
- 15.18.3. 'As required' (PRN) medication for the treatment of a mental disorder, or side effects of a treatment for a mental disorder shall be included on the Form T2 or T3.
- 15.18.4. In addition to completing Forms T2 or T3, the Responsible Clinician or Second Opinion Appointed Doctor (SOAD) should document in the patient's healthcare record the treatment plan and the process followed for considering consent.
- 15.18.5. The front page of the prescription chart contains a section which must be completed to indicate that a Form T2 or T3 is in effect, and signed by the Nurse in Charge
- 15.18.6. Section 62 of the Act provides for urgent treatment to be administered pending compliance with Section 58.
- 15.18.7. All administration must be in accordance with the details contained in the T2/T3 form. This must be checked before administration.
- 15.18.8. Further information is also contained in the Trust's Mental Health Act policies and procedures.

15.19. Covert administration of medicines

- 15.19.1. If it is felt that to disguise medication in food or drink can be justified in the best interests of the patient, the nurse must ensure before doing so that she:
- has made every effort to obtain the consent of the patient to receive the medicines in the normal way
 - has discussed the issue with other members of the health care team, including the pharmacist and, if possible, with the patients carers and relatives
 - document these discussions in the patient's healthcare record and provides a detailed account of the disguised administration.
- 15.19.2. If it is possible to obtain the written consent of carers and relatives this should be done and the consent retained with the records. Further information is provided in Appendix 15 including a checklist (**Annex 1**) and review form (**Annex 2**) for documenting the process.

15.20. Medication errors, incidents and near misses

- 15.20.1. A medication error is a preventable incident associated with the use of medicines which may put the patient at risk. Such incidents may be related to any step in the medicines use process, including prescribing, dispensing, preparation and administration. Examples include:
- administration of a medicine to the wrong patient
 - administration of the wrong medicine
 - administration of the wrong dose
 - the wrong route of administration used
 - failure to administer a medicine without due reason (i.e. no 'missed dose' code recorded on the chart
 - failure to record administration on the chart
 - a medicine incorrectly prescribed
 - failure to sign and/or date the prescription
 - a medicine incorrectly dispensed
- 15.20.2. In the event of an incident occurring, the well-being of the patient is of prime importance. The designated nurse in charge of the ward/unit must:
- ensure the patient is safe, and carry out any necessary physical observations

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- inform the ward/unit manager or on-call manager and the doctor responsible for the patient (or deputy).
 - conform with CPG3, *Adverse Incident Procedural Guidelines*.
 - document the incident in the patient's healthcare record
- 15.20.3. In the event of an error in administration, the nurse in charge shall inform the appropriate doctor, manager and pharmacist. The Consultant must be informed of the error at the earliest opportunity. In the case of a serious error the Consultant on-call must be informed.
- 15.20.4. Medication errors will be investigated in line with the CP3, *Adverse Incident Policy* and CPG3, *Adverse Incident Procedural Guidelines*. The Medicines Management Group regularly reviews statistics relating to medication incidents to identify trends and any lessons that need to be learnt. Common themes are considered for publication in the Medicines Management Bulletin.
- 15.20.5. Errors made within the pharmacy team are recorded and discussed at the Pharmacy Senior Management Team meeting. Pharmacy errors will be handled in line with the relevant Pharmacy Standard Operating Procedure.
- 15.20.6. Where there is a prescribing error either by a medical or non-medical prescriber the Royal Pharmaceutical Society (RPS) prescribing competency framework should be used.
- 15.20.7. The primary objective of the reporting system is improvement in care and not the disciplining of staff. It is only via the reporting of errors and near misses that managers can identify shortcomings in systems which need to be rectified.
- 15.20.8. Disciplinary action will only be taken in respect of a medication error where there is continual or general concern about a person's competence to practice. Punitive measures tend to create a culture of concealment, and operate against a spirit of openness, co-operation and mutual trust. Competency assessment of staff should be in line with the HR48 *Supervision and Appraisal Policy* and HRP48 *Supervision and Appraisal Procedures* in addition to individual professional standards.
- 15.20.9. **Near misses:** The Trust encourages the reporting of 'near misses', which are defined as medication incidents that are detected up to and including the point at which the medicine is handed over or administered to the patient, i.e. an error that could have occurred but did not, because of an appropriate intervention.

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Near misses should be reported in the same way as medication incidents. The purpose of 'near miss' reports is to use them as a learning tool and for identifying training needs.

- 15.20.10. Further information on the handling of medication errors is provided in Appendix 21.

15.21. Adverse drug reactions

15.21.1. Healthcare professionals must be alert to the possibility of adverse reactions to medicines, and all suspected reactions must be reported to the patient's doctor and pharmacist. These can be reported by the patient, nurse, doctor, carer or other health professional. All suspected adverse drug reactions should be documented in the patient's healthcare record giving details of the suspected adverse reaction and any action taken.

15.21.2. The detection of previously un-recognised adverse drug reactions depends largely on the receipt of reports when adverse drug reactions are suspected. The MHRA 'Yellow Card' system is designed to collect national data on suspected adverse drug reactions.

15.21.3. Hard copy 'Yellow Cards' for reporting adverse reactions can be found at the back of the BNF. Alternatively, they can be reported electronically via www.yellowcard.mhra.gov.uk. Medical, nursing and pharmacy staff are required to submit yellow card reports, especially for the following types of adverse reaction:

- unusual reactions to established medicines (including vaccines), i.e. reactions that are not listed in the BNF as recognised side effects of the drug.
- serious or potentially-life-threatening reactions, even if it is well-known that these may occasionally occur with the medicine.
- any suspected adverse reaction to a recently introduced 'black triangle' medicine (marked ▼ in the BNF), even if the reaction is already listed under 'side effects' in the BNF.
- any suspected adverse reaction involving a person under 18 years of age.

15.22. Defective Medicines

15.22.1. If a medicine is found to be defective, or is suspected of being defective, the following procedure should be applied:

- if the product has been administered to a patient, inform the prescriber responsible for the patient and record the defects in the patient's healthcare record.
- report the incident to the ward/unit manager.

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- inform the pharmacy department, who will advise on all reporting, recording and investigation of the defect.
 - retain any remaining product and associated packaging for inspection by a pharmacist.
- 15.22.2. Outside pharmacy opening hours the site officer must be informed and will notify the on-call pharmacist and senior clinical on-call person.
- 15.22.3. A local recall, or action required following receipt of a Drug Alert notifying of a defective medicine, will be instigated by the pharmacy department.

15.23. Duty of Candour

- 15.23.1. A medication error, adverse drug reaction or defective medicine which results in patient harm may need to be handled in line with 'duty of candour' requirements. Further information can be found in the Trust's Duty of Candour policy and procedure.

16.0 SELF-ADMINISTRATION OF MEDICATION

- 16.1. Self-administration of medication occurs when a patient on a ward or unit keeps and administers their own medication, which may be either brought in from home or dispensed by a hospital pharmacy.
- 16.2. The process is undertaken in the interests of improving patient care and should be consistent with the philosophy of care at the site where the scheme is operating. It should be made clear to the patient that inability to reach the later stage(s) of the scheme is not failure, and that any progress made is valuable.
- 16.3. The scheme must not be used as a response to staffing and other operational problems.
- 16.4. Patients wishing to take responsibility for their own medicines shall be entered on the Trust's self-medication programme. The programme may be started at any stage depending on the patient's ability. This must be recorded on the front of the prescription chart and dated.
- 16.5. Before any patient is started on the self-medication programme there must be agreement from the multidisciplinary team (MDT) that the patient is suitable for the programme and an entry stating this made in the patient's healthcare records.
- 16.6. Further details on operating self-administration are given in Appendix 16 including the risk assessment and monitoring forms to be used.
- 16.7. **Compliance Aids**
- 16.7.1. Non-adherence (also known as non-compliance or non-concordance) with prescribed medication is a major cause of

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relapse and admission to hospital. There are many factors which can lead to non-compliance, including:

- a poor understanding of the need for medicines
- a poor understanding of how to take medicines
- forgetfulness
- inability to open containers
- poor eyesight
- a complicated medication regimen

16.7.2. For some people, a compliance aid* may assist them to continue self-medication and remain out of hospital. The need for a compliance aid should be discussed and agreed by the multidisciplinary team, and this should include input from a pharmacist. The decision to use a compliance aid and the outcome of the assessment and evaluation must be documented in the patient's care plan.

16.7.3. A full assessment of the reason(s) for potential non-compliance should take place, as the provision of medicines in a compliance aid may not be of benefit in all cases. Patients should be assessed for their ability to:

- remember the time when medicines are due
- open the device
- select the right compartment
- remove medicines from the device

The assessment tool at Appendix 17 should be used.

16.7.4. Not all medicines will be suitable for inclusion in a compliance aid. Only medicines which are sufficiently stable may be used in a compliance aid, as exposure to other medicines, moisture and light may affect efficacy. A pharmacist should assess the suitability of a patient's medicines to be supplied in this type of container. Do not keep medicines in a device for longer than two weeks. The assessment tool at Appendix 17 should be used.

16.7.5. Most compliance aids need to be filled at a pharmacy with the appropriate equipment for dispensing, labelling and sealing the container. Compliance aids should only be considered if arrangements can be made for a community pharmacy to supply medication in a compliance aid on a continuing basis once the patient is discharged. Not all pharmacies provide this service, so

* also known as a Monitored Dosage System (MDS)

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it is essential to confirm that a local pharmacy is willing to provide a patient's medication in a compliance aid.

- 16.7.6. Patients should be encouraged to self-administer medication from their compliance aid.
- 16.7.7. Patients shall be monitored and re-assessed at least once every 3 months or when prescribed medicines are changed.
- 16.7.8. A nurse or pharmacist should explain to the patient the role of each person providing medication support to him or her.
- 16.7.9. A registered nurse may enable patients to fill and label their own MDS. In exceptional circumstances, where it is not possible to find a pharmacist to fill the MDS, the patient or carer is not able to fill it and the assessment of the patient has shown that a MDS is essential, a registered nurse may fill the device.
- 16.7.10. A device containing a maximum of one week's supply can be filled by a nurse. Ideally daily devices only should be filled by nurses. When filling the device care should be taken that it is filled in accordance with the directions on the boxes and bottles supplied by a pharmacist and in line with advice on whether each item is stable in this form of container.
- 16.7.11. Nursing or other non-pharmacy staff must not fill compliance aids from bulk or stock packs of medication.
- 16.7.12. A compliance aid must be labelled with:
 - Patients full name
 - Quantity, name and strength of medicine and prescribed dose.
 - The date filled
 - The name of the person filling it
- 16.7.13. The same details of filling must also be recorded in the patient's healthcare records.
- 16.7.14. The compliance aid shall be re-labelled each time there is a change in prescribed medication.
- 16.7.15. Medicines shall only be removed from the compliance aid at the time of administration.
- 16.7.16. If one medicine is no longer prescribed the whole contents of the compliance aid should be returned to the pharmacy and refilled with the correct medicine. A nurse must never attempt to identify and remove individual discontinued medicines.

17.0 DISPOSAL OF MEDICINES

17.1. A dose of a medicine prepared for administration within a ward or clinic and subsequently not used must be disposed of safely by placing in a pharmaceutical waste container or sharps container as relevant. It shall not be returned to its original container.

17.2. Due to differing arrangements for the provision of pharmaceutical services within Bedfordshire, Essex and Luton pharmaceutical waste must be handled differently in each area.

17.3. Essex

17.3.1. Spoiled doses and patient's own medicines which are not required should be disposed of on the ward.

17.3.2. Other medicines which are no longer required (including CDs) must be returned to the trust pharmacy as soon as possible. Medicines returned to pharmacy for disposal will be handled in accordance with the relevant pharmacy standard operating procedure.

17.4. Robin Pinto and Woodlea

17.4.1. **Stock drugs and individually-dispensed drugs (except CDs):** All out-of-date medicines and in-date medicines that are no longer required must be disposed of in accordance with Appendix 10.

Unwanted medicines must NOT be sent back to the hospital pharmacy for disposal. All Trust sites where medicines are handled must keep suitable pharmaceutical waste bins, which must be removed by the Trust's approved waste contractor when full.

17.4.2. **Controlled Drugs:** Unwanted Controlled Drugs held at inpatient sites must be denatured by an approved person in the presence of an "Authorised Witness" before they can be disposed of. Refer to Appendix 3 for further information on the disposal of CDs.

17.5. Patients' own medicines

17.5.1. All medicines brought into hospital by patients remain their own property, and should not be destroyed or disposed of without their permission (or if this is not possible, the permission of a family member or carer).

17.5.2. Medicines brought into hospital shall be reviewed by the admitting doctor, as part of the process of Medicines Reconciliation, who will decide whether the treatment(s) should be continued (see Appendix 18)

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- 17.5.3. If to be continued, the patient's medicines may be taken into the custody of the ward, and, if fit for use, used to treat the patient (refer to section [9.4](#) and Appendix 11).
- 17.5.4. If a patient's own medicines are not required because the admitting doctor decides to discontinue the treatment, permission should be sought for the medicines to be disposed. If such permission is not granted, the medicines should be sent home in the same way as any other property not required by the patient.
- 17.5.5. If a patient's own medicines are assessed as unfit for use (by application of Appendix 11), permission should be sought for the medicines to be disposed of. These should be disposed of in the same way as unwanted stock drugs (see section [17.4.1](#)).
- 17.5.6. In a community setting, patients' own medicines (including CDs) that have been dispensed by a community pharmacy can be taken to any community pharmacy for disposal. Annex 4 of Appendix 11 should be used to record medicines removed for disposal and to obtain consent from the patient. A copy of this should be kept in the patient's healthcare record.

18.0 DAY CARE FACILITIES

- 18.1. Patients attending day care / day hospital facilities will normally bring their own medicines with them if they require to take any during their time at the facility. Nursing staff should check with the GP or Consultant Psychiatrist the current medicines prescribed.
- 18.2. If the patient is able, they may keep their own medicines with them and self-administer at the appropriate times. Staff must ensure that the patient will store their medicines safely and not allow other less able patients access to the medicines.
- 18.3. If staff are not confident that the medicines are in a suitable condition for administration to the patient, or they are unsure of the identity of the medicines, then an alternative supply must be obtained from the trust pharmacy. This supply must be made against a trust outpatient prescription or prescription chart.
- 18.4. If it is felt that patients are not able to take their own medicines, then staff may administer them. The patient must bring their medicines with them fully labelled with name and directions for use. The medicines will be stored in a locked medicines cupboard for the duration of the patient's visit.
- 18.5. If staff are administering medicines to a patient then all medicines need to be prescribed on a prescription chart and all doses administered signed for. Omitted doses should also be recorded in the same way as for an inpatient.
- 18.6. There shall be a locked cupboard for the storage of medicines which complies with the requirements of section [13.0](#).

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19.0 MANAGEMENT OF MEDICINES BY SECONDED LOCAL AUTHORITY STAFF

- 19.1. This guidance must be used in conjunction with the individual policies and procedures of each Local Authority.
- 19.2. All local authority staff managing medicines on behalf of Essex Partnership University NHS Foundation Trust must have completed the Trust medicines management training for social care staff and nursing support workers.
- 19.3. Any medicines related tasks expected to be carried out by staff will be documented as part of the risk assessment and managed through the CPA care plan and be under the continuing supervision of a registered nurse.
- 19.4. Managing medicines will be limited to prompting patients to take their medicines correctly. This must be carried out with the permission of the patient, which must be recorded in the healthcare record. In cases of severe dementia staff may administer medicines in line with individual local authority guidelines.
- 19.5. Staff must not purchase or offer advice on non-prescribed medicines for the patient.
- 19.6. Any concerns relating to medicines, either raised by the patient, carer or staff member, should be reported to the CPA care coordinator.
- 19.7. Any interventions relating to medicines must be recorded in the patient's healthcare record.

20.0 CONTROLLED STATIONERY

- 20.1. All versions of FP10 prescription forms, Pharmacy requisition books, and outpatient prescriptions, shall be regarded as controlled stationery. All these shall be serially numbered.
- 20.2. Controlled stationery shall be kept in the pharmacy department or other designated area.
- 20.3. A record shall be kept of the date, ward or department and signature of the recipient whenever controlled stationery is issued.
- 20.4. FP10 pads are the responsibility of the prescriber to whom they were issued. No FP10 prescription forms shall be destroyed by prescribers or administrative staff. If spoiled the form shall be crossed through and retained with the pad/box of computer printed forms. These pads/forms shall be returned to the pharmacy of origin for destruction. See Appendix 8 for further information on the security and safe handling of FP10s.
- 20.5. White Trust prescription forms are used in outpatient clinics and by Robin Pinto and Woodlea for obtaining leave/discharge medication from the hospital pharmacy. They cannot be used to obtain medicines from community pharmacies, and can only be dispensed at the hospital of origin.

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- 20.6. For this reason, hospital prescription forms do not pose the same security risk as FP10 forms, and do not warrant the same level of record-keeping. Nevertheless, the good practice guidelines (section 13 of Appendix 8) should still be followed, and any losses or thefts should be reported to the Chief Pharmacist.
- 20.7. Prescription charts are not treated as controlled stationery. However, the following precautions shall be observed: -
- unused charts shall be kept securely in wards and departments and issued only to staff who have authority to prescribe medicines. They shall be kept in a locked cupboard or a staffed nursing office.
 - used charts shall be retained as part of the patient's healthcare records.
 - a file of specimen signatures of all staff authorised to prescribe shall be kept in each pharmacy department.
- 20.8. Other forms used for ordering medicines are not treated as controlled stationery but the following precautions shall be observed:-
- unused forms shall be kept securely and issued only to staff who have authority to order medicines.
 - used forms shall be retained in the pharmacy after dispensing.
 - a file of specimen signatures of all staff authorised to order medicines shall be kept in each pharmacy department.
- 20.9. Stationery used for ordering or prescribing medicines shall not be taken away from NHS premises except in the custody of an authorised member of staff who shall be responsible for its safe keeping.
- 20.10. FP10 prescription forms may be issued to an individual prescriber for their use. The prescriber must sign to accept responsibility for the forms. When a trainee doctor leaves the Trust or move to another part of the rota it is the responsibility of the consultant to make sure that any remaining FP10 forms are returned to the pharmacy department. Trainee doctors must not take prescription pads with them to their next placement.
- 20.11. Loss of FP10 forms should be reported immediately to the pharmacy department who will arrange for the NHS England Local Area Team to be informed. An Adverse Incident Report must be completed.

21.0 SUSPECTED ILLICIT SUBSTANCES

- 21.1. Where a suspected illicit substance is brought onto Trust premises by a patient, as soon as it is discovered it shall be removed from the area in which it was found, placed in a drugs evidence bag, sealed and placed in the drugs 'pod' within the unit.
- 21.2. The drugs evidence bag should be completed with a brief description of the item, (i.e. small quantity of brown substance) where and when it was found, who it was from and who found it.

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- 21.3. All incidents involving illicit substances should be recorded as an adverse incident using the Trust reporting system, including the serial number of the bag the substance was placed and sealed in.
- 21.4. The LSMS and/or the Police will attend at regular intervals to remove the substances from the drugs pod, and consider prosecuting patients for any offences relating to the substances. The Accountable Officer for Controlled Drugs should be informed if more than two doses are recovered.
- 21.5. Staff shall not transport suspected illicit substances from a service user's home to the team base unless police are contacted prior to transportation. This is to prevent staff from being in possession of a drug covered by the Misuse of Drugs Act and unwittingly committing an offence.
- 21.6. Under no circumstances shall any member of staff return suspected illicit substances to a service user as this may constitute a criminal offence i.e.: supplying Controlled Drugs.
- 21.7. Under no circumstances shall any member of staff assist patients in their own home in taking suspected illicit substances, even if they are known to be users, as this may constitute aiding and abetting a criminal offence.
- 21.8. Further details on the process for storing suspected illicit substances and completion of the information required on an evidence bag can be found in Appendix 3.
- 21.9. In the event of a suspected illicit substance being found on Trust premises which do not have a drugs 'pod' as soon as it is discovered it shall be removed from the area in which it was found, placed in a drugs evidence bag or if unavailable, a suitable container, e.g. sealed plastic bag or envelope, and labelled with:
- a brief description of the item
 - the quantity
 - where it was found
 - the date
- 21.10. Where such an item needs to be transferred from one site to another to take it to a drugs 'pod' the Police Control Room (Telephone: 101) should be contacted to advise that a suspected illicit substance is being transported, and an incident (STORM) reference number obtained. If the member of staff is stopped during that conveyance they should advise the officer the STORM reference number they have been given by the control room. These actions should provide a defence under section 5(4)(a) of the Misuse of Drugs Act.

22.0 TRAINING

- 22.1. Through the Trust analysis of training needs it has been agreed that medicines management is a core practice training requirement for all qualified nursing staff within mental health, learning disability, CAMHS and CDAS services. Staff are expected to attend medicines management training

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on a 3-yearly update cycle. All mandatory/core practice training is managed by the Workforce Development and Training Department.

Core Practice Training	Update Interval	Staff Category	Delivery Method
Medicines Management (including Rapid Tranquillisation) (Mental Health staff) <ul style="list-style-type: none"> • OLM medicines calculation test • Competency workbook 	Three yearly	Qualified nursing staff (Mental Health, Learning Disabilities CAMHS and CDAS)	Direct, e-learning medicines calculation test, and work book up to 3 months to complete

- 22.2. Training includes coverage of the Trust policy and procedural guidelines for the safe and secure handling of medicines, and the direct learning element is provided by the pharmacy team.
- 22.3. The Workforce Development and Training Department will report monthly on compliance levels for mandatory training to the Trust Executive Team, Workforce and Business Support Service Board and Health, Safety and Security Committees.
- 22.4. Staff who do not complete a Mandatory or Core Practice course will receive notification from the Information Department informing them of their non-compliance with mandatory/core training. Managers will receive a copy of this. Non-compliance will be recorded in the compliance statistics published on the Intranet. From this information non-compliant staff will be automatically re-booked onto another course by the Information Department.
- 22.5. If an individual fails to attend on the second occasion, the Service Director will be notified. Bank staff who are non-compliant with their mandatory training will receive a written warning and notification of when training must be completed. Failure to meet this will lead to individuals being removed from the bank database.
- 22.6. Line Managers will monitor the Mandatory/Core Practice requirements of the staff working within their areas through appraisal and the compliance reports

23.0 MONITORING

- 23.1. The prescribing and administration of medication on inpatient wards and units is monitored by pharmacists via regular reviews of all the prescription charts. The frequency of pharmacist monitoring is determined by the nature of the ward/unit.
- 23.2. Compliance with key elements of the safe and secure handling of medicines policy is monitored through a programme of regular quarterly and six-monthly audits conducted by the pharmacy staff. Additional medication-related audits are agreed via the Medicines Management Group as part of a three-yearly medicines management audit programme, as required by NHS Improvement patient safety alerts, or occur as part of the POMH-UK audit programme.

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- 23.3. Aspects of the procedural guidelines which may be audited via these programmes include:
- Controlled Drug storage and safekeeping, including stock reconciliation
 - Fridge temperature monitoring
 - Compliance with prescribing standards (prescription chart audits)
 - Medicines administration
 - Medicines reconciliation
 - Medication transfers
 - Transport of medicines
 - Supply of medicines to wards and departments
 - Self-administration
 - Disposal of medicines
 - High dose antipsychotic prescribing
 - Safe and secure storage of medications
 - Antimicrobial prescribing
- 23.4. The findings of these audits, and recommendations for action, are presented to the Medicines Management Group. Where re-audit identifies a lack of progress, the findings and recommendations are escalated to the appropriate senior managers and/or committees.
- 23.5. The Medicines Management Group is a sub-committee of the Clinical Governance & Quality Sub-Committee. The activity of the Medicines Management Group is reported in the Medicines Management Annual Report which is presented to the Quality Committee, a sub-committee of the Trust Board.
- 23.6. The Risk Management department collates details of all incidents involving the prescribing and administration of medication. Reports of these are available to the Chief Pharmacist and Medication Safety Officer (MSO). A summary report of medication-related incidents is a quarterly standing item on the agenda of the Medicines Management Group.
- 23.7. Compliance with training will be monitored by the Workforce Development and Training department as outlined in Section [22.0](#).

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Appendices

- Appendix 1 Prescribing Staff Specimen Signatures (Form)
- Appendix 2 Specimen Signatures for Nurses Authorised to order Medication Including Controlled Drugs (Form)
- Appendix 3 Procedures for the Safe Management and Use of Controlled Drugs (CDs)
- Appendix 4 Unlicensed Medicines
- Appendix 5 New & Non-Formulary Drugs
- Appendix 6 Medicines Prescription and Administration Chart
- Appendix 7 Prescribing Antipsychotic Medication above BNF Maximum Daily Dose
- Appendix 8 Procedures for the Security and Safe Handling of FP10 Prescription Forms
- Appendix 9 Patient Group Direction (PGD) Template
- Appendix 10 Procedures for the Disposal of Pharmaceutical Waste
- Appendix 11 Use of Patients' Own Medicines (PODs)
- Appendix 12 Monitoring the Temperature of Medicines Storage Areas
- Appendix 13 Procedure for the Administration of Medicines
- Appendix 14 Procedure for the Preparation and Administration of Injections
- Appendix 15 Mental Capacity and the Covert Administration of Medicines
- Appendix 16 Procedure for the Self-Administration of Medicines
- Appendix 17 Compliance Aid Assessment Tool
- Appendix 18 Medicines Reconciliation on Admission to Hospital
- Appendix 19 Non-Medical Prescribing
- Appendix 20 Intentionally blank
- Appendix 21 Procedure for Handling Medication Errors

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