The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Ref: FOI-062023-00099

Date: 5/7/23

Address / Email:

Dear

Request Under Freedom of Information Act 2000

Thank you for requesting information under the Freedom of Information Act 2000.

Request

Please can you provide me with a copy of your policy or procedure relating to the management of Central Alerting System (CAS) and MHRA notifications.

Response

Please see attached and please note that names have been redacted, also where there are links in the documents to internal documents at the Trust the links will not work

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ
Email: dgft.dpo@nhs.net

Should you disagree with the contents of our response to your appeal, you have the right to appeal to the Information Commissioners Office at.

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
www.ico.org.uk

If you require further clarification, please do not hesitate to contact us.

Yours sincerely

Freedom of Information Team
The Dudley Group NHS Foundation Trust

The Dudley Group
NHS Foundation Trust

CENTRAL ALERT SYSTEM (CAS) POLICY		
	DOCUMENT TITLE:	**CENTRAL ALERT SYSTEM (CAS) POLICY**
	Name of Originator/Author /Designation & Specialty:	[redacted] Head of Clinical Effectiveness
	Director Lead:	Medical Director
	Target Audience:	All staff involved in actioning a CAS alert
	Version:	1
	Date of Final Ratification:	
	Name of Ratifying Director Lead/Sponsor:	[redacted]
	Review Date:	
	Registration Requirements Outcome Number(s) (CQC)	All outcomes
	Relevant Documents /Legislation/Standards	
	Contributors: ***Individuals involved in developing the document*.**	Senior Clinical Effectiveness Facilitator Patient Safety Specialist
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
V1		Document converted from a guideline to a policy

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

1 Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

CENTRAL ALERT SYSTEM (CAS) POLICY

1 INTRODUCTION

NHS England through analysis of patient safety incidents and safety information develops advice for organisations that can help ensure the safety of patients. This is done via the Central Alert System (CAS) which is a web-based cascading system developed by the Department of Health and is a key means to communicate and disseminate important safety and device alerts information within the NHS.

The CAS facilitates distribution of safety alerts, emergency alerts, National Patient Safety Alerts (NatPSA), Chief Medical Officer, CAS Helpdesk Team (CHT) messages and Dear doctor letters.

This policy is designed to ensure a consistent approach for dealing with the management of alerts received through the CAS. This relates to NPSAs, MDAs and Estates alerts (EFNs, EFAs and DHs) (for the purpose of this policy CAS will relate to these only). It is important that all Trust personnel are aware of their roles and responsibilities with regard to dissemination and actions required in complying with these alerts.

2 STATEMENT OF INTENT and PURPOSE

This policy sets out the structures and processes at The Dudley Group NHS Foundation Trust that ensures the safety of patients, including the identification of any areas of non-compliance and/or risk.

3 DEFINITIONS

Central Alerting System (CAS) – The Central Alerting System is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Chief Medical Officer (CMO) Alerts
These are emergency alerts along with MHRA drug alerts and Dear Doctor Letters. This type of alert can be issued 24/7 with a need to be cascaded immediately in extreme cases. No response to CAS is currently required due to the potential difficulties this could cause out of hours.

National Patient Safety Alerts (NatPSA) – NatPSA alerts provide guidance on preventing potential incidents that may lead to harm or death. They are identified using the national reporting system to spot emerging patterns at a national level, so that appropriate guidance can be developed and issued.

4 DUTIES (RESPONSIBILITIES)

4.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that there is an effective framework in place for the distribution, implementation and monitoring of compliance to CAS alerts.

4.2 Medical Director

The Medical Director is the executive lead and has delegated responsibility to ensure that CAS alerts (as pertaining to this policy) are appropriately managed across the Trust and that the Board of Directors are made aware of any issues that may impact upon the organisation's ability to do so.

The Medical Director is responsible for working with the Clinical Effectiveness to ensure that all Patient Safety Alerts are embedded and that we have assurance of compliance.

4.3 Trust Response Lead

The Trust response lead is responsible for ensuring that the alert is actioned within the agreed timescales ad notifying the Clinical Effectiveness Team of any potential delays in completion and any identified risks.

4.4 The Clinical Effectiveness Team

The Clinical Effectiveness Team is responsible for supporting the Trust Response Lead in ensuring that the Trust Response Lead completes the alert on time. The team also act as CAS officers for the responding to the CAS system . To provide coordination of the NatPSAs process from the initial notification. The role will be required to acknowledge the NatPSA on the CAS system on behalf of the Trust and notify the Medical Director, and ensure all the actions are documented on AMaT. Once approved by the Medical Director to update the CAS system with the outcome.

4.5 **Patient Safety Specialist – PSS**

To support the Medical Director/Executive Lead with the NatPSAs and ensure the governance process is followed and followed up with assurance.

4.6 **Clinical Effectiveness Group - CEG**

All NatPSAs will be reported to CEG with full assurance of closure to complete closure on the CAS system.

5 PROCESS

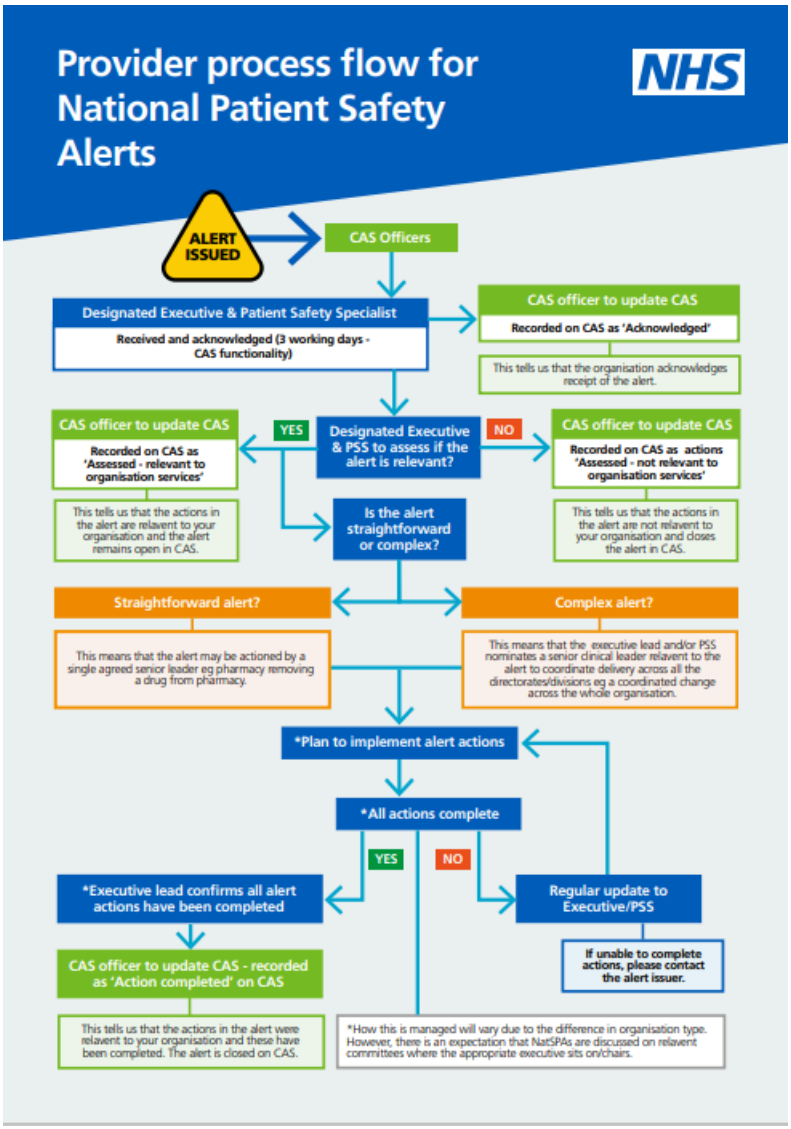
5.1 All safety-critical information that meets predetermined, nationally agreed thresholds and standards, and requires coordinated implementation of trust-wide actions by providers, will be issued as a National Patient Safety Alert (NatPSA).

These thresholds and standards include working with patients, frontline staff and experts to ensure alerts provide clear, effective actions to reduce the risk of death or disability. The thresholds include an assessment of whether the patient safety issue is 'more likely than not of one or more potentially avoidable deaths or disability in healthcare in England in a year'.

This is to ensure that National Patient Safety Alerts:

- are only issued for safety-critical issues (those that have a risk of death or disability) that need organisations to act
- clearly and effectively explain the identified risk
- include actions that have been assessed for feasibility, safety, efficacy, and cost-effectiveness
- can be quickly recognised and actioned by senior personnel
- have actions that are SMART (specific, measurable, achievable, realistic, and timely)

Diagram 1: Provider process flow for National Patient Safety Alerts.



5.2 **Alert issued: Summary:**

- The alert is uploaded to AMAT automatically and received in the CAS system dedicated email account. The entry will include, title of the alert, a link to the actual alert, details of actions required and publication date.
- Sent to the designated Executive and Patient Safety Specialist within 3 working days.
- Clinical effectiveness Team to record as acknowledged on the CAS system.
- Designated Executive and PSS to assess if the alert is relevant?
- If YES, this is recorded on CAS/AMaT as assessed - relevant to organisational services.
- If NO it will be recorded on CAS/AMaT as actions assessed – Not relevant to organisation services (This will close the alert)
- A Straightforward alert means that the alert can be actioned by a single agreed senior leader e.g., pharmacy removing a drug from pharmacy.
- A complex alert means that the executive lead and/or PSS nominates a senior clinical leader relevant to the alert to coordinate delivery across all the directorates/divisions e.g., a coordinated change across the whole organisation.
- The alerts will be managed centrally and will be sent to the Lead (avoid blanket emails and ensure any information sent out contains a plan).
- Executive lead confirms all alert actions have been completed, the clinical effectiveness team update CAS – to Action completed. If the actions have been unable to complete the regular updates will be required for the executive lead and PSS. An update will need to be given to the alert issuer.

5.3 **Process to manage the alert:**

5.3.1 If the alert is applicable to the Trust, the alert Trust Lead will undertake a compliance review in the statements tab of AMAT detailing status and providing evidence to support any assessment of compliance. The Trust Lead then ensures that the compliance review is saved prior to progressing with the alert.

5.3.2 The Lead will then click on the documents tab and upload any supporting evidence that will provide assurance of completion. This may include reports, procedural documents, emails, presentations, audits etc.

5.3.3 The Clinical Effectiveness Team will provide advice and support regarding completion of the alert, to the Trust lead, if required.

5.3.4 Once all actions have been completed, the Trust Lead will present a report to the oversight Group which is most relevant to the alert i.e. Medicines Management Group for Medication Alerts, Medical Devices Group for Medical Device Alerts.

5.3.5 The alert must be completed within the deadlines set by CAS. The National Patient Safety Alerts (NatPSA) states 'Actions to be completed by…' and a NatPSA can be closed when they are completed. If you are unable to complete the actions, this needs to be communicated to the issuer and the executive lead/ PSS to discuss your concerns about the individual NatPSA e.g., not feasible etc. Where you are unable to close an NatPSA within the required timescale, ensure that the reasons for being unable to close the NatPSA is clearly articulated in a Board reporting meeting. If you are ever challenged by commissioners or CQC as to why a NatPSA has not been closed, you have a clear governance trail outlining the rationale.

5.3.6 Once the oversight group has approved the report and has determined that the actions have been completed (evidenced by minutes uploaded onto AMAT), a summary report is submitted to the Medical Director with a request to close the alert on the CAS system.

5.3.7 Once approved by the Medical Director, the Clinical Effectiveness Team close the alert on the CAS system.

5.3.8 A compliance report is submitted to the next Clinical Effectiveness Group for information, and a copy sent to the PSS.

5.3.9 All alerts will be reviewed by the Trust lead on a regular basis (dependant on the level of risk the alert presents to the Trust) to determine whether the level of compliance has changed. High risk alerts that have poor compliance, serious incidents or are on the risk register will be reviewed every 6 months. All other active alerts will be reviewed every 12 months. Once an alert is deemed to be fully embedded then it will be archived on AMAT.

5.3.10 If it has been determined that there is a reduction in the level of assurance, the Trust Lead for any NatPSA Alert will be asked to consider whether a risk needs to be raised on the risk register. The lead will also present actions to address concerns at the next Clinical Effectiveness Group meeting. Any concerns raised through Clinical Effectiveness Group will be escalated to the Risk and Assurance Group. The Trust will seek to ensure that the alert is fully embedded within the organisation and that compliance is maintained.

6 TRAINING/SUPPORT

There is no specific training for CAS Alert Management. Guidance and support is offered and available from the Clinical Effectiveness Team on request.

7 PROCESS FOR MONITORING COMPLIANCE

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
All CAS alerts will be reviewed in the specified time scales and the organisation does not incur any breaches to compliance	Risk and Standards Team	CAS alert position report	Monthly	Clinical Effectiveness Group Report up to Risk and Assurance Group	Medical Director Directorate / Divisional Directors Deputy Directors	Escalation of areas of concern with the aligned Directorates/ Divisions and Risk and Assurance Group
	Directorate /Divisional Leads	CAS Alert Position Report	Monthly	Directorate/ Divisional Risk Meetings	Deputy Directors and Governance leads	• Shared good practice, Assurance of Compliance • Recommendations within the CAS Alerts. • Escalation of areas of concern

8 EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

The Dudley Group
NHS Foundation Trust

Policy Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

During the development or review of the Policy, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity.

What is the title of the procedural document:			
Date of Submission:		**Author**	
Director Lead and Date Signed off as Approved.	**Name:**		**Date Approved:**
Is there a similar/same document already in existence? Please state which document this will replace. If the document has a different title or has been merged with another document, please provide details of relevant documents.			
Please detail under which folder on the Procedural Documents Hub Page that the document is to be stored. Procedural documents can only be stored on the central procedural documents page. If you require the document link to be stored on another page outside of this, please contact IT and ask them to put a link on.			
Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:			
Name	**Designation**	**Date confirmed agreement (mm/yy)**	
SPECIALISTS / GROUP/S (if no Specialists Groups consultation identify the reason why)			
DIVISIONAL MANAGEMENT CONSULTATION (if no Management consultation identify the reason why)			
PHARMACY CONSULTATION (if applicable)			
OTHER			

Check List

The Dudley Group
NHS Foundation Trust

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Prior to submission of the Policy please ensure you can answer yes to all of the questions below.

	Y/N
1. Title	
Is the title clear and unambiguous?	
Is the title the same in the Document Title, banner and footer?	
2. Front Sheet Completion	
Is the colour banding strip blue?	
Is the Author identified (name and designation)?	
Is the Director Lead identified (designation only)?	
Is the target audience identified?	
Is the document version controlled?	
Is the version recorded on the front page reflected in the change history and the footer?	
Have the CQC registration requirement outcomes been recorded?	
Have relevant documents/legislation standards been recorded if applicable and hyperlinked?	
Have the identified contributors been documented (name and designation)?	
Has the change history been fully completed?	
3. Body of the document	
Has contents page been fully completed and the numbering reflects document content pages?	
Is there a footer on each page recording; document title, month / year of issue, version number, page number and total number of pages?	
Is the document written in Arial 12pt font?	
Does the document contain individual designations and NOT names?	
Does the numbering run in sequence?	
Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Duties, Process, Training/Support, Monitoring, Equality and References for the main body?	
The meaning for any definitions or abbreviations used is clearly stated?	
Is there identified training or support clearly cited?	
Are any references to Appendices in the main body of the document in Blue text?	
Are procedural documents relating to /supporting this document hyperlinked?	
Is the table for Monitoring Compliance fully completed?	
Are references cited in full and comply with the Harvard referencing?	
4. Consultation	
Is the consultation form completed including details of people / groups consulted?	
Has the Director Lead been consulted and accepted the document?	
If the document includes prescribing/administering of medicines, has pharmacy been consulted?	
Has a representative of all staff / teams affected by this policy been consulted?	
Has appropriate specialist group been consulted?	

The Dudley Group NHS Foundation Trust

MEDICINES MANAGEMENT POLICY		
	DOCUMENT TITLE:	**MEDICINES MANAGEMENT POLICY**
	Name of Originator/Author Designation & Specialty:	[redacted]- Chief Pharmacist
	Director Lead:	Medical Director
	Target Audience:	All hospital and community staff handling medicines in DGNHSFT
	Version:	7.0
	Date of Final Ratification:	26th September 2022
	Name of Ratifying Director Lead/Sponsor:	[redacted]
	Review Date:	31/08/2025
	Registration Requirements Outcome Number(s) (CQC)	CQC Outcome 9 – Management of Medicines
	Relevant Documents /Legislation/Standards	The Medicines Act 1968 The Misuse of Drugs Regulations 2001 Medicines, Ethics and Practice, Royal Pharmaceutical Society (2021) Professional Guidance on the Safe and Secure Handling of Medicines, Royal Pharmaceutical Society (2018) Good practice in prescribing and managing medicines and devices, General Medical Council (2021)
	Contributors:	Deputy Heads of Pharmacy Chair, Drug and Therapeutics Group Principal Pharmacists Senior Specialist Pharmacists
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
1	2006	New Policy
2	August 2009	Full Review
3	October 2010	Full Review
4	October 2012	Full Review
5	April 2016	Full Review
6	October 2018	Full Review
7	August 2022	Full Review

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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THE DUDLEY GROUP NHS FOUNDATION TRUST

MEDICINES MANAGEMENT POLICY

1. INTRODUCTION

Medicines are used in all areas of the Trust and are the responsibility of all healthcare professionals. The importance of appropriate procedures to ensure the safe, effective, and economic use of medicines is paramount and is a key component of clinical governance. All members of staff dealing with medicines need to contribute to maximising their effective use, minimising medicine related morbidity for our patients and using Trust resources effectively.

2. STATEMENT OF INTENT/PURPOSE

This Medicines Management Policy and appendices defines the role and responsibilities to be followed within Dudley Group NHS Foundation Trust (DGFT) for the prescribing, ordering, dispensing, storage, and administration of medicines of all staff groups.

Exemptions to medicines legislation
In the event of a major incident or National Crisis e.g., flu pandemic or other circumstances deemed to be equivalent to a major incident the Trust recognises that it may not be possible to adhere to all aspects of this document. If the Clinician in Charge deems that their circumstances are exceptional and that a deviation from this policy is necessary, they should contact the Responsible Pharmacist or on-call pharmacist. The circumstances should be documented, and appropriate plans made to mitigate this need and ensure that it is temporary.

Deviation from this policy should be for as short a time as possible and for no more than 72 hours without further agreement from the Chief Pharmacist or a Deputy Chief Pharmacist.

All possible action must be taken to maintain ongoing patient and staff safety.

3. DEFINITIONS and ABBREVIATIONS

ACE: Area Clinical Effectiveness Group

Administer: To give to a patient a medicinal product, dressing or medical device, by introduction into the body, orally, by injection, inhalation or by external application (e.g., application of an ointment)

Adverse Drug Reaction (ADR): A response to a medicinal product which is noxious and unintended (response in this context means that a causal relationship between a medicinal product and an adverse event is at least a reasonable possibility)

Advanced Electronic Signature: An electronic signature that is:

a. uniquely linked to the person (“Prescriber”) giving the prescription.
b. capable of identifying Prescriber.

c. created using means that Prescriber can maintain under Prescriber's sole control; and
d. linked to the data to which it relates in such a manner that any subsequent change of data is detectable.

The Trust recognises 'advanced electronic signatures' by this definition as the only valid and legitimate electronic authorisation for independent and supplementary prescribing. This excludes the prescribing of controlled drugs.

Approved/registered prescriber: Individuals identified within the "Summary of prescriber types and prescribing restrictions" with the Medicines Ethics and Practice guide

BNF: The British National Formulary (latest edition).

CCG: Clinical Commissioning Group

Clinical Support Worker: Individuals not registered with a professional body employed to assist healthcare professionals in the delivery of patient care.

Controlled Drugs (CDs): Medicines liable to misuse, that are subject to higher levels of regulation under the Misuse of Drugs Act, 1971.

Controlled Stationery: Any stationery which if held or possessed by the wrong person or group could be open to abuse to obtain medicines fraudulently.

Dispense: To prepare and/or give out a clinically appropriate medicinal product to a patient for self-administration or for administration by another, usually a healthcare professional. Dispensing must be in response to a legally valid prescription. The act of dispensing should be accompanied by the provision of advice to the patient on safe and effective use of these products.

Dispensing for discharge (DfD): A scheme in which medicines prescribed in hospital are supplied in advance in preparation for discharge

Electronic Prescribing and Medicines Administration System (ePMA): Digital systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration, and supply of a medicine through knowledge and decision support; provides a robust audit trail for the entire medicines use process

General Medical Council (GMC): regulator of medical doctors in the United Kingdom

General Pharmaceutical Council (GPhC): regulator of Pharmacists and Pharmacy Technicians in the UK

Healthcare Professional (HCP): A registered practitioner in an occupation which requires specialist education and training in practical skills in health care. The professions concerned are self-regulating and are expected to satisfy their profession's accepted standards of practice and conduct. For the purposes of this policy, these practitioners are accepted to include:

- Medical Doctors
- Dentists

- Dental nurses
- Dieticians
- Nurses
- Nursing associates
- Midwives
- Pharmacists
- Pharmacy Technicians
- Operating Department Practitioners
- Occupational therapists
- Optometrist
- Orthoptist
- Paramedics
- Physiotherapists
- Podiatrists
- Radiographers
- Speech and language therapists

Health and Care Professions Council (HCPC): regulator of a specific list of health and care professionals in the United Kingdom e.g., paramedics, podiatrists, radiographers

Medication error: Any preventable event that may cause or lead to inappropriate medication use and/or patient harm while the medication is in the control of the healthcare professional, patient, or carer.

Medicine order: A written direction provided by a prescriber or authorised transcriber for a specific medicinal product or medical device to be administered to an individual.

Medicinal product: Any substance or article (not being an instrument, apparatus, or appliance) which is manufactured, sold, supplied, imported, or exported for use wholly or mainly by being administered to one or more human beings for a medicinal purpose and/or use as an ingredient in the preparation of a substance or article which is to be administered to one or more human beings for a medicinal purpose. The term also includes over the counter and complementary medicines.

Medicines reconciliation (MR): process of accurately listing and communicating an individual's current medication

MHRA: Medicines and Healthcare Products Regulatory Agency

Nursing and Midwifery Council (NMC): Regulator of nurses, nursing associates and midwives in the United Kingdom and nursing associates in England

Patient Group Directions (PGD): A specific written instruction for the supply or administration of medicines to clinical groups of patients who may not be individually identified before presentation for treatment.

Physician Associates (PAs): Unregistered, medically trained, generalist healthcare professionals, who work alongside doctors, including surgeons to provide medical care as part of the multidisciplinary team. PAs are dependent

practitioners working with a dedicated medical supervisor and are NOT authorised to prescribe medicines or administer a medicine under a PGD.

Patients' Own Drugs (POD): medicines that are a patient's own property, brought into NHS premises for treatment of that patient.

Prescribing: To order in writing (or electronically) the supply of a medicinal product (within the meaning of the Medicines Act, 1968, this means a Prescription Only Medication) for a named patient (see "Prescription").

Prescriber: A healthcare professional that is legally authorised to prescribe a medicinal product, including medical and non-medical prescribers.

Prescription: An order for the dispensing of a medicinal product. The order is presented to a professional who is legally authorised to dispense. The order must be either:

a) in writing in a legally prescribed format and signed by the person authorised by law to prescribe.
b) made, using a Trust-agreed electronic prescribing system, by the person authorised in law to prescribe medicinal substances, and who has been provided with a secure, individual computer access password.

Prescription Record Chart: Authorised drug chart for recording inpatient prescriptions and administration. Speciality specific prescription record charts are available in Day Case and In-patient areas, e.g., maternity, mental health.

Prescription Amendments (by Pharmacists): The act of amending an error or omission within a medicine order or prescription by a pharmacist to reflect the prescriber intention, to improve safety, medicines management and enable prescription optimisation to support medicines supply and patient flow, or to ensure compliance with legislation. Amendments within the electronic prescribing and administration system will require the original order or prescription to be cancelled and re-entered by the pharmacist (and by doing so, gives the impression of prescribing). This activity is fully auditable.

Quality and Safety (Q&S) Committee:

RCN: Royal College of Nursing

RPS: Royal Pharmaceutical Society

Self-administration: The process of patients administering their own medicines.

SOPs: Standard Operating Procedures

Transcribing: The act of making an exact copy into a written or electronic record. For the purposes of this policy, transcribing is the copying of previously prescribed medicine details to enable their administration in line with legislation (i.e., in accordance with the instructions of a prescriber). Transcribing is not covered by the by the Human Medicines Regulations 2012 and as such is not a legally recognised activity.

Transcriber: A healthcare professional that is authorised to transcribe a medicinal product or medical device.

To take out (TTO) medicines: dispensed medicines, (including dressings) supplied upon discharge, for the patient to use until seen by the General Practitioner

4. DUTIES AND RESPONSIBILITIES

4.1 All staff

All staff handling medicines will ensure they are familiar with all relevant sections of the Medicines Management Policy and appendices and will follow correct procedures when undertaking any medicine-related task. All staff handling medicines will act within their competence and relevant legal and organisational boundaries of practice. They will report any concerns relating to medication risk to their line manager or pharmacist so action can be taken. Staff are required to report any medication incidents or near misses using the Trust Incident Reporting processes.

The specific responsibilities relating to the prescribing, administration, storage and supply of medicines and community practice are covered in the Appendices to this policy.

4.2 Board of Directors / Chief Executive (CEO)

The Board of Directors, through the CEO, will seek assurance that the Trust has robust arrangements in place to manage medicines and identify and learn from medication errors. They will maintain an overview of significant risks through the Risk and Assurance Committee and by monitoring the risk register.

4.3 Chief Operating Officer (COO)

Executive with responsibility for Medicines Management

4.4 Head of Pharmacy Services (Chief Pharmacist)

The Head of Pharmacy Services has statutory responsibility as Superintendent Pharmacist under the Medicines Act 1968. The post holder is responsible for establishing approved systems for the safe and secure handling of medicines and all medicines optimisation activity. They are required to ensure staff and medicines are managed in line with relevant legislation and regulations, and that national and professional guidance on medicines governance is followed within their organisation on behalf of the Chief Executive. They are also responsible or the operation of the Trusts' Medicines Management Groups.

4.5 Chief Clinical Information Officer (CCIO)

The CCIO is responsible for managing the health informatics platform and working with clinical IT staff to supporting efficient design, implementation, and usage of healthcare technologies.

4.6 Clinical Directors and Medical Heads of Service

Clinical Directors and Medical Heads of Service will oversee the application of this policy in their service areas and ensure it is implemented and complied with within their management structure. They will be familiar with the policy, and promote the policy to consultants, and they, in turn, to their teams.

4.7 Controlled Drugs Accountable Officer (CDAO)

The Controlled Drugs Accountable Officer (CDAO) is responsible for all aspects of controlled drugs management within the Trust. See Controlled Drugs Policy

4.8 Medication Safety Officer (MSO)

The Medication Safety Officer is responsible for improving medication incident reporting and learning, managing medication incident reporting, being a member of the National Medication Safety Officers Network and acting as the main contact for NHS England and the MHRA. They will Chair the Trust's Safe Medicines Practice Group to deliver these responsibilities.

4.9 Ward/ Departmental Managers and Matrons

Ward and Department Managers will ensure that staff have an understanding of the policy, and that they practice in line with the policy. Ward and departmental managers are responsible for the safe and secure handling and storage of medicines in their areas.

4.10 Registered healthcare professionals

Must have a working knowledge of their personal responsibility and accountability in relation to current national legislation and guidelines relating to the safe storage, dispensing, prescribing administration, and destruction of medicines.

Registered Healthcare professionals are accountable for their own conduct and must practice in accordance with the relevant codes and professional standards set by their UK regulatory body (refer to individual registered professional roles for further information)

4.11 Student Healthcare Professionals

For the purpose of this policy the term 'student healthcare professional' refers to an individual who is enrolled on a training or educational course that, upon successful completion, will result in their name being listed on the relevant UK professional register.

It also includes Registered Healthcare Professionals who are undertaking continuous professional development to extend their role and competence to suit their working environment e.g., independent prescribing qualification (refer to individual registered professional roles for further information).

4.12 Radiographers

Radiographers are permitted to administer medicines such as contrast media to patients, in accordance with a doctor's or dentist's prescription, or in accordance with an authorised PGD on which they are named.

4.13 Clinical Support Staff

A Clinical Support Worker, Nursery Nurse, Dental Nurse, Medical or Clinical Technician who has undertaken suitable specific training for specific tasks and **has had their competency assessed and recorded**, may assist in the administration of medicines in specific areas, **with proper delegation being the responsibility of the registered nurse or midwife.** Whilst their competency is being assessed, candidates should be under the direct and constant supervision of the registered nurse or midwife. Approval for medicines

administration by Clinical Support Staff must be sought from the Chief Nurse and Chief Pharmacist before this can be enabled.

4.14 Doctors (medical)

Each doctor is responsible for prescribing and administering medications correctly in accordance with this policy.

4.15 Dentists

Dentists having sole General Dental Council registration, whilst working in the hospital setting can prescribe from the Dental Practitioners' Formulary in the current BNF.

Oral and maxillofacial consultants and registrars are registered with the GMC and therefore they practice as any other medical doctor would (rather than as a dentist).

4.16 Pharmacists

Each registered pharmacist is accountable for their own conduct and practice in accordance with the GPhC standards and supporting guidance and RPS professional standards, guidance, and frameworks.

Pharmacists within The Trust hold a variety of roles. The list below outlines the key professional responsibilities of all Pharmacists, but the list is not exhaustive:

- Optimising therapy with medicines to ensure the safe, clinically appropriate, and cost-effective use of pharmaceutical products through involvement at all stages of patient medicines usage and management (including prescribing).
- Providing up-to-date information and guidance to other healthcare professionals on all pharmaceutical aspects of drug therapy, pharmaceutical care, and medicines management.
- Conforming to legal requirements.
- Advising on the individualisation of patient therapy.
- Advising on patient monitoring of drug effects and side effects.
- Education and consultation with patients, carers, and hospital staff on the safe and correct use of medicinal products.
- Advising on drug-drug and drug-fluid interactions and compatibilities in parenteral medication.
- Advising on the pharmaceutical requirements and proper undertaking of clinical trials.
- Contribution and advice on governance processes concerning medicines use such as policy and procedure writing, including the requirements for PGDs and groups of staff such as non-medical prescribers.
- Advising on and managing medicines audits.

4.17 Non-Medical Prescribers

Registered Healthcare Professionals who have undertaken training and qualified as independent or supplementary prescribers will also:

- Notify the trust of their qualification and annotation as a prescriber on the register of the relevant professional body.
- Agree their role and scope of duties with their line manager and the Medical Mentor
- Prescribe in accordance with the applicable formularies.

- Prescribe only within their professional competence and clinical knowledge in area of practice.

For further details see the Non-Medical Prescribing Policy.

4.18 Nursing Associates

Each registered Nursing Associate is accountable for her/his own conduct and practice in accordance with the NMC professional standards of practice and behaviour for nurses, midwives and nursing associates (2018).

Nursing associates should exercise professional responsibility in ensuring the safe administration of medicines to those receiving care. They should adhere to the NMC procedural competencies required for administering medicines safely and any local policy relating to medicines administration.

4.19 Trainee (Student) Nursing Associate

During each practice placement the mentor should assess the trainee's proficiency in the administration of medicines in accordance with the expectations stated in their Assessment of Practice portfolio. Trainee's must never administer or supply medicine products without direct supervision.

Trainee nursing associates may observe the administration of medicines and assist in the administration of medicines as specified below, under the direct and constant supervision of a qualified nurse, midwife, or medical practitioner.

- oral, topical* and inhalation routes
- subcutaneous and intramuscular routes
- enteral routes
- enemas and suppositories

Trainee nursing associates may administer a ready-to-use pre-filled sodium chloride 0.9% flush, to ensure the patency of a peripheral cannula. This activity must be carried out under the direct and continuous supervision of a qualified nurse, midwife, or medical practitioner.

4.20 Members of the Pharmacy Team

Members of the Pharmacy Team will promote the operation of the Medicines Management Policy and supporting others in their undertaking of medicines related activities.

4.21 Drug and Therapeutics Group (D&T)

The Drug and Therapeutics Group (D&T) will oversee the development and implementation of the Medicines Management Policy in conjunction with The Medicines Management Group, on behalf of the Trust Board.

The group has a broad range of duties and responsibilities, which are summarised in its Terms of Reference.

4.22 Safe Medicines Practice Group

The Group responsibilities include the following:

- Improving reporting and learning of medication error incidents in the organisation.
- Analysing and reviewing incident data, audit, and other data to identify, prioritise and address medication risks to minimise harm to patients.

- Identifying, developing, and promoting best practice for medication safety. This will include supporting the implementation of external patient safety guidance from NHS England, MHRA, NICE and other organisations –
- Coordinating and supporting education and training support to improve the quality of medication error incident reports and safe medication practices.
- Assisting in development and review of medication-use policies and procedure.
- Reviewing and assessing compliance with outcome 9 of CQC standards.

4.23 The Medicines Management Group

The Medicines Management Group has responsibility for all aspects of the management of medicines within the Trust, and its key duties include to agree and lead a medicines quality and safety programme in line with the Trust Quality Strategy.

The following groups report directly into the Medicines Management Group:

- Drugs and Therapeutics Group
- Safe Medicines Practice Group
- Non-Medical Prescribing Leads
- Antibiotic Steering Group.
- Medical Gases and Piped Systems Group
- Intravenous Immunoglobulin Panel
- Thrombosis Group
- Chemotherapy Multi-professional Group

The Medicines Management Group reports to Quality and Safety Committee and is required to comply with any reporting requirements set by the Committee as to format and frequency of meetings.

4.24 Quality and Safety (Q&S) Committee

This Trust Board receives regular reports from the Medicines Management Group via the Quality & Safety Group to assure itself that medicines are safely and securely handled.

4.25 EPMA User and Delivery Group

The Electronic Prescribing and Medicines Administration (e-PMA) User & Delivery Group will be established as a reporting group of Drug and Therapeutics Group. It will provide consensus-based direction to the Digital Trust by making clinical and operational decisions and recommendations regarding the use of the Sunrise e-PMA system.

5. SAFE AND SECURE STORAGE OF MEDICINES

This section applies to in- and out-patient facilities and other clinical settings where medicines are stored. It does not apply to patients' homes.

Medicines must be stored safely and securely. The level of security (to reduce theft, tampering and diversion) must be balanced with safety (risk of maladministration or urgency of need).

On any occasion where wards or departments wish to change their medicines storage facilities the Chief Pharmacist must be contacted for advice and approval.

All medicines storage areas should be locked when not in use. The registered professional in charge is accountable for ensuring all medicines are stored under in the appropriate condition in a locked facility. Digi-lock codes for and medicine storage facilities e.g., treatment rooms and bedside lockers should be changed every 6 months. The use of digital key safes is acceptable provided the combinations are changed every 6 months.

There must be appropriate segregation of medicines belonging to different categories to reduce the risk of mis-selection.

Medicines must remain intact in their dispensed packaging and must not be decanted into other boxes or strips of medicines left outside of their original container within the trolley. Medicines must not be left unattended at any time.

The safe and secure storage facilities for handling medicines is audited annually by the pharmacy department medicines safety and governance team. A summary of the outcome and action plan and is presented to the Trust Medicines Management Group.

Refer to Appendix 5 for further information.

Practice relating to the storage of medicines in the community setting is outlined in Appendix 6.

6. HOW MEDICINES ARE PRESCRIBED

6.1. The prescribing of medication and the prescription provide a permanent legal record of the patient's medication, facilitate the dispensing of the correct medicine and direct administration of the medicine to the patient.

6.2. Only *"bona fide"* and current patients of The Dudley Group NHS FT may be prescribed drug therapy at NHS expense.

6.3. The prescription must be an accurate and unambiguous description of medicine treatment. Only registered medical staff or registered and Trust approved non-medical prescribers may prescribe drugs for administration by other healthcare professionals.

6.4 The following prescribing systems are approved for use:

- Sunrise EPMA: in-patients 18 years of age and over
- Paper based systems i.e., drug charts and approved supplementary charts: in-patients below the age of 18 and all out-patients/Day Case patients
- IntelliSpace Critical Care and Anaesthetic Information System (ICCA)- in-patients 12 years of age and over on critical care areas
- JAC/ Well Sky- in-patients under the age of 18 for purposes of discharge
- ChemoCare- for chemotherapy and related treatments e.g., immunotherapy,
- Out-patient prescription form
- FP10 prescription forms

6.5 Prescribers should work in accordance with the RPS competency framework for all Prescribers, 2021. This competency framework sets out what good prescribing looks like and is designed to assist healthcare professionals to support their patients to enable them to get the best outcomes from their medicines.

Prescribers will undertake best practice prescribing in accordance with Department of Health, BNF, NICE and other relevant guidelines.

6.6 In addition to this policy all prescribers are expected to adhere to the:

- Dudley Joint Medicines Formulary
- Wound Care formulary and local prescribing guidelines available on the internet (http://www.dudleyformulary.nhs.uk/).
- Antimicrobial prescribing guideline available on the Hub or the Microguide App for smart phone use.
- Hospital only drugs advice is available on the BNF – links to adult and paediatric BNF's are available via the Hub

6.7 Key aspects for the prescriber to consider as part of the consultation process include but are not limited to:

- Patient age
- Medical, social and medication history
- allergies, adverse reactions, sensitivities, and intolerances (the nature of the reaction and source of the information should also be documented in the medical notes and prescription / inpatient treatment chart / EPMA system. The patient should be given a red wristband to indicate that the patient has an allergy as outlined in the Patient Identification Policy
- Any choice or preferences the patient has exercised relating to their medicines, including the right to refuse or limit treatment
- How their lifestyle may influence their compliance with or effect of likely regimens
- Any cultural and religious beliefs which may affect the patients approach to having their medicines prescribed for or given to them
- The potential for interactions between medicines and between medicines and disease

6.8 Prescribers should provide information to the patient/carer during the consultation, this includes:

- The reason for being prescribed their medicine
- How to use the medicine
- What the significant side effects are and how to report them
- The patient's understanding of and commitment to their management, monitoring, and follow-up
- Expected duration of treatment
- What to do if there are any concerns about the management of their condition if the condition deteriorates or there is no improvement within a specific time frame.

6.9 All medications administered in the Trust must be prescribed, except:

- Sodium chloride 0.9% and glucose 5% intravenous flushes
- Medications included in the short-term treatment of pain, constipation, dyspepsia, and dry cough (minor ailments) for registered nurses standard operating procedure
- Medications administered or supplied under a DGNHSFT approved Patient Group Direction or midwife exemption.

Medical gases (e.g., oxygen and Entonox®) must be prescribed unless given in emergency circumstances or under the direction of a PGD.

6.10 Remote prescribing or direction to administer

6.10.1 The Trust expects all healthcare professionals with prescribing responsibility to follow the GMC principles of remote prescribing: https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-prescribing-high-level-principles

6.10.2 In exceptional circumstances, where medication (not including controlled drugs) has been previously prescribed and the prescriber is unable to issue a new prescription, but where a change or addition to the administration details is required and a delay in administering a medicine would compromise patient care a, the use of an appropriately secure electronic method (such as text message or email) may be used but must confirm any change to the original prescription.

6.10.3 A verbal order is not acceptable on its own. The text message or email prescription or evidence of the direction to administer must be stapled to the patient's existing medication chart or retained in the patient's medical records. This should be followed up by a new prescription signed by the prescriber who sent the text message or email confirming the changes within normally a maximum of 24 hours. In any event, the changes must have been authorised (via text message, email) by a registered prescriber before the next dose dosage is administered.

VERBAL INSTRUCTIONS VIA THE TELEPHONE MUST NEVER BE GIVEN OR ACCEPTED

6.10.4 Verbal instructions face-to-face

In an emergency, drugs (including Controlled Drug- not Schedule 2) may be given by medical/nursing staff prior to formal prescription on an approved prescription chart. It is the responsibility of the prescribing doctor to ensure that this is recorded on the approved chart, and for the administering staff to then sign as necessary within 24 hours

Verbal face-to-face instructions for administration of medicines are only permissible between a registered prescriber and a registered healthcare professional authorised to administer medicines

6.11 Completion of a prescription chart

All prescriptions must:

i. be completed legibly in black ink or otherwise to be indelible
ii. state the patient's full name, gender, weight on admission (if aged 16 or under), date of birth, ward/location, hospital number / NHS number and responsible Consultant (affix addressograph if available and appropriate)
iii. include information relating to drug allergies and sensitivities must be recorded in the appropriate section by the prescriber when completing a prescription. If none are known, then this should also be indicated. The reaction details and severity and source of the information should also be documented. As outlined

in the Patient Identification Policy the patient should be given a red wristband to indicate that the patient has an allergy.

iv. be authorised, verified (signed), prescribers printed name, registration number or stamp and dated by the prescriber who must be a registered prescriber employed by the Trust i.e., cannot be a medical student, clinical attachment, or Physicians Associate. A non-medical prescriber should add the annotation 'NMP' after their signature.

v. contain the contact details and registration number of the prescriber (paper prescription charts)

vi. state the approved generic name of the medicine or device (except where a proprietary name defines a specific formulation or combination or when the medicine or device should be prescribed by brand for patient safety e.g., biological, and biosimilar medicines).

vii. state the dose stated in terms of the quantity of active ingredient not, for example, the number of tablets or volume of liquid except in the case of compound preparations.

viii. state the formulation such as modified release, 'MR', slow release 'SR', extended 'XL' etc.

ix. state the route of administration and an indication of where the treatment (e.g., topically to leg) must be given. Combinations of routes are not acceptable, e.g., PO/IV/IM. For handwritten prescriptions, specified routes 'Intrathecal' and 'epidural' must be written out in full.

x. indicate clearly, by the prescriber, the time that each drug must be administered, utilising the 24-hour clock, and/or the EPMA system

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

xii. state the rate and/or duration of administration for parenteral infusions.

xiii. any alteration must result in the re-prescribing of that prescription apart from pharmacist annotation.

xiv. The duration of treatment must be clearly indicated by the prescriber where the intention is not to continue the medication long-term

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

xvi. When using abbreviations, the prescriber must ensure the initials used are clear and unambiguous. If abbreviations are used, only those on the following approved list are permitted: -

PO	by mouth	PV	vaginally
mg	milligram	SL	sublingual
IM	intramuscular	Neb	by nebuliser
G	Gram	OD	once daily
IV	intravenous	BD	twice daily
kg	kilogram	TDS	three times a day
SC	subcutaneous	QDS	four times a day
L	Litre	mane	in the morning
PR	rectally	nocte	at night
ml	millilitre	PRN	As required
Stat	Immediately	CSCI	Continuous subcutaneous infusion
NG	Nasogastric	PEG	Via percutaneous endoscopic gastrostomy tube

xvii. Prescriptions will be written to avoid, where possible, the use of a decimal point, e.g., 0.5 g should be written as 500 mg. If the prescription is ambiguous or illegible, then the drug must **NOT** be administered. The prescriber must be contacted immediately, and the prescription must be re-written.

6.12 Ensure that when new medication is prescribed this is communicated to the nursing / midwifery staff so that they can ensure medication is available and administered without delay.

6.13 Dietetic products can be prescribed by approved Dieticians in line with the Oral Nutritional Supplements provision to Adults in the Acute Setting available on The Hub.

6.14 Duration of supply of medication (excluding Emergency Department)
The Trust will provide a 7-day supply for outpatients or minimum 14 days discharge (unless course is shorter).

6.15 Duration of supply for out-patient prescriptions issued via the Emergency Department
All out-patient prescriptions issued by a prescriber based in the Emergency Department should be limited to a duration of 5 days or a treatment course e.g., for antibiotics, steroids. This is to ensure that patients receive the necessary treatment for their urgent and emergency care and seek medical advice from their GP or pharmacist in the event that their symptoms persist.

Prescriptions for opioids for acute pain e.g., codeine, dihydrocodeine should be limited to a 5-day supply to prevent excessive prescribing, whilst ensuring that patients have appropriate pain control.

6.16 Shared Care
In its guidelines on responsibility for prescribing NHS England has advised that legal responsibility for prescribing lies with the doctor or healthcare professional who wrote the prescription (NHS England 2018).

7. HOW THE ORGANISATION ENSURES THAT ALL PRESCRIPTIONS ARE ACCURATE

7.1 The accuracy of prescribing medicines is the responsibility of the prescriber at all times. This responsibility must not be delegated to others. Prescribers will self-check before requesting medication supply and administration.

7.2 Any HCP with responsibility for medicines administration **must** check medication appropriateness before administration and refer to the prescriber where there is ambiguity.

7.3 During their visits to ward areas, pharmacists review individual in-patient prescriptions. Pharmacists will also review individual patient prescriptions (including out-patient prescriptions) in the dispensary when a supply is made.

Hospital pharmacists check a prescriber's prescription by:

- Reviewing accuracy
- Reviewing legibility

- Reviewing safety
- Reviewing interactions
- Reviewing appropriateness
- Adding the generic name (where appropriate)
- Clarifying ambiguous prescribing.

7.4 Reducing the opportunity for error

i. Clinical Pharmacist Enabling

Hospital pharmacists may clarify prescriber's intentions and/or make amendments to a medicine order or a prescription to improve safety, medicines management and prescription optimisation to support medicines supply and patient flow.

Pharmacists must always act within their level of competence and consider the safety and wellbeing of the patient their prime concern.

All pharmacists are enabled to make the following amendments to medicines orders and / or prescriptions without contacting the prescriber to authorise the change:

- **Route of administration:** Inappropriate routes of administration may be changed to the appropriate one.
- **Timing of administration:** Appropriate times of administration may be added if these are omitted/timing changed.
- **Frequency of administration:** Frequencies may be amended according to BNF/local guidance, considering renal and hepatic function, and maximum frequencies added to "when required" doses.
- **Omission/incorrect dose:** Dose may be added having first verified the patient's usual dosage through medicines reconciliation and referring to the notes to confirm a dose change is neither intended, nor indicated. Where the prescribed dose is erroneous and the prescriber's intention clear, the pharmacist may amend the dosage, by re-writing the prescription item, and cancelling the incorrect item.
- **Duration of medication:** Items prescribed for a specified duration may be discontinued by the pharmacist when the prescribed duration has elapsed.
- **Form of medication:** If the patient has swallowing difficulties/requires a change in route to aid administration the formulation can be amended/re-written. E.g., paracetamol changed to soluble tablets, citalopram 10mg tablet changed to citalopram oral drops 4 drops.
- **Duplication of medicines:** One entry may be discontinued if a medicine is inadvertently prescribed twice. If the prescribed doses are different the pharmacist must first clarify which dose is intended.
- **Ambiguous prescribing:** The pharmacist may change or re-write an order to improve safety, for example to correct the misspelling of a drug name, or encourage prescribing by generic name as opposed to brand name

Pharmacists who are also suitably qualified registered non-medical prescribers (NMPs) within the Trust may also amend Controlled Drugs prescriptions provided that this activity is completed whilst working in their capacity as a Pharmacist Independent Prescriber.

Amendments to paper medicine orders or prescriptions must be made safely and legibly in such a way that the author is clearly identified as a pharmacist e.g., written in green ink and initialled. If the pharmacist deems that an amendment cannot be made legibly to an existing prescription, the pharmacist must re-write this item and cancel the original prescription.

Amendments within the EPMA system will require the original order or prescription to be cancelled and re-entered by the pharmacist (and by doing so, gives the impression of prescribing). This activity is fully auditable.

ii. Clinical Ward-based Pharmacy Service

The Ward-Based Pharmacy Service includes pharmacists and pharmacy technicians. A pharmacist visits all specified wards in the hospital every weekday and endeavours to see newly admitted patients and their prescriptions on each daily ward visit. Priority is also given to high-risk medications, medication changes and pharmacy referrals for advice. Remaining patients are reviewed at least twice a week. Where a Ward-Based Pharmacy Service is not provided or not possible due to lack of resources/ funding or staffing, this is highlighted by completing an entry on the risk register and ensuring a pharmacist is signposted to the clinical team as a point of contact to respond to any queries. Prescription professional checking is undertaken by a Pharmacist in the Dispensary.

A pharmacist is linked to all Directorates to provide operational, clinical and governance support.

At the weekend or on bank holidays the Pharmacy Service operates in areas of high patient flow e.g., AMU and SDEC and the dispensary. Therefore, at the weekend or situations where the Ward Pharmacy Service is not provided, the authorised member of ward staff requests a medication order from the Dispensary, and these are then professionally checked in the Dispensary as part of the dispensing process.

The key aim of the clinical ward-based service is to optimise the medicines each patient is prescribed to ensure the patient receives the best outcomes possible from their medication. This optimisation requires a number of key actions detailed further below:

- Medicines reconciliation on admission and transfer. There is a requirement under Patient Safety Alerts / NICE guidance to ensure that an accurate list of medicines that a patient is taking is compiled, to include over the counter pharmacy medicines and alternative therapies. Any discrepancies will be identified and resolved by pharmacy staff where possible or referred to a prescriber for clarification.

- The allergy status of the patient will be checked (or identified if not already done by the admitting prescriber or nurse), along with the nature and severity of any allergy.
- The pharmacist will review each prescribed medicine to ensure that it is correctly prescribed, safe, and appropriate for use in the individual patient. This review will take into account age, weight, race, allergies, renal or hepatic function and other factors where individualisation of therapy may be needed. Recommendations will be made where appropriate.
- The pharmacist or technician will look at the patient's own drugs and assess their appropriateness for continued use on the ward and at discharge.
- Advice will be given about administration of medicine e.g., with regard to mealtimes, compatibilities of parenteral medicines, safety requirements.
- The pharmacist will professionally check requests for discharge medication at ward level to ensure that the prescriptions are safe and appropriate. Medicines to take home will be dispensed at ward level or via the Pharmacy Dispensary, depending on the service provided in the individual clinical area.
- Pharmacy staff will advise on the safety and security of medicines in the clinical area, both at individual patient level and more generally relating to the ward.

Pharmacists record all prescribing interventions made using the pharmacy intervention form and these are uploaded onto The Dudley Group NHS FT incident reporting system Datix. Direct completion of the Datix system is also available. (Refer to the Incident Reporting and Management Policy (including Serious Incidents)

7.5 Transcribing medicines

Transcribing can be defined as "The act of making an exact copy, usually in writing….transcribing is the copying of previously prescribed medicines details to enable their administration in line with legislation (i.e., in accordance with the instructions of a prescriber)" (RPS & RCN, 2019, P.6).

As transcribing is the copying of medicines information for the purposes of administration it cannot be used in place of prescribing to issue or add new medicines or alter/change original prescriptions (RPS & RCN, 2019).

Transcribing should not be confused with prescribing. Transcribing is not covered by the by the Human Medicines Regulations 2012 (HMR, 2012), which does include legislation covering administration under the direction of a prescriber.

The absence of legal status means that transcribing may be carried out by any trained and competent individual. If transcribed information is used as a prescription it is a legal requirement that this is either countersigned (for paper prescriptions) or digitally authorised by a prescriber. The prescriber who countersigns or authorises the transcribed medicines accepts legal responsibility for the prescription.

Transcribing is also different to the practice of proposing prescriptions. Proposing prescriptions by PAs is not currently permitted at The Dudley Group Foundation Trust.

Within The Dudley Group NHS Foundation Trust, the following groups of staff who have been appropriately trained and assessed as competent to do so, may transcribe medicines to enable patients to be administered their prescribed medications in a safe and timely manner in accordance with a prescription originally written by an authorised prescriber:

Nurses enrolled on a post-graduate independent prescribing course.

- Senior Pharmacists (Band 7 or above) Physician Associates (PAs)

Examples of situations when staff may transcribe medicines include to prevent missed doses of medicines when a patient is admitted to hospital or to facilitate communication of medicines requirements at discharge.

The transcriber is accountable for their own decisions, including actions and omissions. They must act within their own personal expertise and competence.

Transcribing of high-risk medicines, including Controlled Drugs, is permissible, provided that the transcriber has completed a risk assessment in respect to the individual patient and is satisfied that this would protect the patient from risk of harm of a medicine related error.

The transcriber should refer to an appropriate prescriber if they deem that transcribing a particular medicine might be unsafe or outside their personal level of expertise or competence.

The person administering the medicine should perform the same checks on a transcribed medicine as they would for a prescription written by a prescriber as outlined in Section 9 and Appendix 2 of this policy.

8. SUPPLY OF MEDICINES

Pharmacy staff may only dispense prescriptions that comply with all legal requirements and are completed in accordance with the procedures outlined in this policy.

There is a full range of Standard Operating Procedures in Pharmacy relating to the supply of medicines. These are compliant with the requirements of the General Pharmaceutical Council.

TTOs should be sent to Pharmacy 24 hours in advance; at least 1 hours' notice is required.

The issue to a patient of pre-packed containers of medicine, supplied by The Dudley Group NHS FT (e.g., in ED), is the responsibility of the relevant medical & nursing staff in accordance with local procedures, which identifies the responsibilities of these staff. See the Supply of Pre-Labelled Medication Pre-Packs against a Prescription Standard Operating Procedure

9. ADMINISTRATION OF MEDICINES

9.1 The aim of administration is to ensure that the **correct drug** is given to the **correct person**, at the **correct dose**, at the **correct time** and via the **correct route**.

The person administering a drug will follow this policy, local procedures and be guided by the RPS and NMC Standards for Medicines Management. In addition, they will have completed their mandatory training, clinical skills training and be competent to administer medication, operating within their own scope of practice.

Where a prescription does not comply with the prescribing guidelines outlined in this policy the medicine must not be administered and the prescriber must be contacted.

9.2 Ensuring a patient centred approach to administering medicines

When medicines are being administered the nurse or appropriately trained healthcare professional will consider the patient, taking particular note of

- The patients' age
- Any choice they have exercised relating to their medicines
- How their lifestyle may influence their compliance with regimens
- Any cultural and religious beliefs which may affect the patients approach to having their medicines given to them
- Any appropriate allergies and intolerances as detailed below
- Any existing medical conditions and prescriptions the patient has and the opportunity for any interaction between medicines and disease
- Any previously occurred or potential adverse drug reactions

Before administering a medicine, the registered healthcare professional will check:

- the identity of the patient.
- the allergy status of the patient (*Appendix 3*) **Medicines must not be administered unless the allergy status information is completed**
- the drug label against the prescription.
- the drug name, dose form, strength, date, and time.
- the route of administration. The drug must not be administered by any other route than that prescribed. If the route is wrong for the formulation contact the prescriber to have them change the prescription **before** administration.
- any additional instructions, including safety considerations, start and finish times
- check that the drug has not already been administered.
- storage requirements have been adhered to (Section ***5***).
- the expiry date of the drug.
- calculate the dose if appropriate
- check that the patient understands
    - Why they are taking the medicine
    - The possible side effects
    - And how to properly take the medicine at home if appropriate

Administration must be completed and **signed on completion**. This means that the patient has received the drug. There are a few exemptions e.g., sub-lingual tablets, nebulised drugs, syringe drivers or patients self-administering drugs however a signature is still required.

For detailed guidance on the Administration of Medicines please refer to *Appendix 2*.

9.3 Enabling Bank and Agency registered healthcare professionals to administer medicines

The nurse in charge of a ward/department where NHSP/ Bank and agency nurses are deployed should ensure that all temporary staff receive orientation in the medicine's storage areas.

In the interest of patient safety for administration of medicines requiring a second check administration, the second signatory MUST be a substantive member of Trust staff who has completed the appropriate medicines management and medicines administration training and competency programme (Refer to *Appendix 2*).

9.4 Nursing associates

9.4.1 Registered nursing associates should adhere to the NMC procedural competencies required for administering medicines safely and local policy as detailed below:

- assess patients receiving care and their ongoing ability to self-administer their own medications. (See section A4.6)
- know when and how to escalate any concerns
- undertake accurate drug calculations for a range of medications
- exercise professional accountability in ensuring the safe administration of medicines to those receiving care
- manage and monitor effectiveness of symptom relief medication
- recognise and respond to adverse or abnormal reactions to medications, and when and how to escalate any concerns
- undertake safe storage, transportation, and disposal of medicinal products

Registered nursing associates can:

- Administer medications via oral, topical and inhalation routes. Topical refers to the application of a drug to a site where it is intended to have its effect e.g., eye, outer ear, nasal passages, skin preparations, transdermal patches.
- Administer medications via subcutaneous and intramuscular routes (excluding Controlled Drugs) and manage injection equipment
- Administer and monitor medications using enteral equipment
- Administer enemas and suppositories
- Act as an 'approved witness' (second registered healthcare professional) to sign and witness administration of Controlled Drugs requiring safe custody in a Controlled Drugs cupboard (excluding all parenteral formulations) when competence has been demonstrated and the task is

delegated to them by a Registered Nurse. The nursing associate accepts responsibility for performing the task correctly.

Nursing associates **must not** administer systemic anticancer chemotherapy and related monoclonal antibodies via any route.

Nursing associates must complete the necessary education and training for administration of medicines as specified in the Statutory and Mandatory Training (SMT) requirements for their role.

9.4.2 Ready-to-use pre-filled sodium chloride 0.9% flush syringes

Pre-filled flush syringes containing sodium chloride 0.9% e.g., PosiFlush, are a ready-to-use medical device. Nursing associates may administer a ready-to-use pre-filled sodium chloride 0.9% flush, to ensure the patency of a peripheral cannula.

9.4.3 Nursing associates with extended scope

Registered nursing associates may extend their scope of practice for administering medicines by completing Trust approved training and competency assessment to include:

- Administration of intravenous fluids without drug additives e.g., sodium chloride 0.9%, glucose 5%.
- Administration of intravenous injections (excluding Controlled Drugs).

All stages of preparation, checking and administration must be carried out with a registered nurse who is trained and competent to administer medications via the intravenous route.

9.5 Student Nurses and Student Midwives

9.5.1 During each practice placement the mentor should assess the student's proficiency in the administration of medicines in accordance with the expectations stated in their Practice Assessment Document (PAD). Students must never administer or supply medicine products without direct supervision.

Student nurses and midwives may observe the administration of medicines and participate in the administration of medicines by the following routes under the direct and constant supervision of a qualified nurse, midwife, or medical practitioner:

- oral/ buccal/sublingual
- topical medicines (including eye /ear drops)
- inhaled / nebulised medicines
- subcutaneous (not via infusions)
- intramuscular
- rectal /vaginal

Student nurses and midwives must **not** participate in the administration of medicines by the following routes:

- intravenous lines (see below for IV fluids)
- peripheral lines/ central lines
- epidural
- medication given by any other route that requires a clinician to undertake further education and training (e.g., intrathecal).

Student nurses and midwives can, under the direct and continuous supervision by a competent substantive registered practitioner assist in the preparation of (but not administration of) intravenous medicines.

9.5.2 IV fluids: Administration of IV Fluids by student nurses and midwives

Student nurses may not participate in the initiation or alteration of administration by the above routes which involve infusion, mechanical pumps, or a patient-controlled device. As an exception, students may administer prescribed pre-prepared standard IV bags of 0.9% sodium chloride, 5% glucose or compound sodium lactate (Hartmann's solution) via an existing intravenous or subcutaneous line. This activity must be carried out only under the direct and continuous supervision of a qualified nurse, midwife, or medical practitioner. This is the only situation where the student can participate in the administration of intravenous or subcutaneous fluid. Students are not permitted to initiate or amend the settings of medical devices used in the administration of these devices.

9.5.3 Ready-to-use pre-filled sodium chloride 0.9% flush syringes

Pre-filled flush syringes containing sodium chloride 0.9% e.g., PosiFlush, are a ready-to-use medical device. Student nurses and midwives may administer a ready-to-use pre-filled sodium chloride 0.9% flush, to ensure the patency of a peripheral cannula. This activity must be carried out under the direct and continuous supervision of a qualified nurse, midwife, or medical practitioner.

9.6 Medical Students

9.6.1 During their clinical placements, the HCP should assess the student's proficiency in the administration of medicines in accordance with the expectations stated in their Clinical Passports. Students must never prepare, administer, or supply medicine products without direct supervision.

Medical students may prepare and administer medicines by the following routes under the direct and constant supervision of a one qualified nurse, midwife, or medical practitioner (with the exception of controlled drugs):

- oral/ buccal/sublingual
- topical medicines (including eye /ear drops)
- inhaled / nebulised medicines
- subcutaneous (not via infusions)
- intramuscular
- rectal /vaginal

Medical students may not participate in the administration of medicines by the following routes:

- epidural

- medication given by any other route that requires a clinician to undertake further education and training (e.g., intrathecal)

9.6.2 Medical Students and Administration of IV Medication

Medical students are expected to gain competency in the administration of IV medication, as part of their medical training. In their 3rd Year of Medical School students will attend theoretical and simulated practical training where they are assessed, and their clinical passports are signed. This will be delivered by a clinical skills trainer or someone who is qualified to teach and assess the skill.

In all cases, medical students can only be observed and signed off by a member of staff who has completed their training according to Trust processes and has been deemed competent and up to date with current practice to perform the skill of IV administration (*N.B.* Agency nurses and bank staff are not permitted to observe and sign off students in this area of practice). Prior to undertaking any of the above skills, the HCP supervising the medical student must confirm they have completed their theoretical and simulated practical training by checking their clinical passport.

With the exception of controlled drugs, medical students are permitted, under the direct supervision of two HCPs who are competent to administer IV medications, to undertake the following in the clinical environment:

- Preparing medication for parenteral administration.
- Setting up a fluid infusion.
- Administering an IV bolus.
- Administering IV medication via a central venous access device (5th Year Medical Students only, after appropriate training and simulated sign off)

In the event that a HCP has any concerns regarding the safe practice/competency of a medical student administering an IV medication whilst under their supervision they should undertake the following:

- Complete the procedure themselves with another competent HCP to ensure that the patient has safely received the prescribed medication. (The student can observe the procedure if appropriate to do so).
- Discuss with the student the concerns they have with their practice and explain that they should refrain from undertaking the skill until they have been contacted by their Clinical Skills Educator, who will formulate a plan of action.
- If an error or near miss has occurred, a DATIX must be completed.
- Contact the clinical skills department, explain their concerns to the appropriate Clinical Educator (this will depend on the student's year group)
- The HCP will also be asked to write a brief statement.
- The Clinical Skills Educator will contact the student and discuss a plan of action to support them with their practice.

10. HOW MEDICATION ERRORS AND ADVERSE DRUG REACTIONS ARE REPORTED

10.1 It is the responsibility of all healthcare professionals to report incidents/errors/near misses relating to the use of medicines using The Dudley Group NHS FT Incident Reporting and Management Policy (including Serious Incidents)

10.2 If a patient suffers a suspected adverse reaction to a medicine, vaccine, herbal or homeopathic medicine, the patient must be managed in the appropriate manner, depending on the nature of the reaction. The adverse reaction should be reported via the Yellow Card Scheme. Guidance on adverse reaction reporting and the Yellow Card Scheme are contained within the BNF or via the internet (https://yellowcard.mhra.gov.uk/).

10.3 Pharmacy staff, on their ward visits and as part of the medicines supply process, will review prescriptions and other issues pertaining to medicines management. They report as incidents any errors in the prescribing, preparing, dispensing, storing, administering, monitoring, or providing advice on medicines. This will include issues relating to the accurate assessment of patients' previous medicines on admission to hospital (medicines reconciliation).

All incidents will be reported in line with the process outlined in Incident Reporting and Management Policy (Including Serious Incidents)

11. HOW THE ORGANISATION LEARNS FROM MEDICATION ERRORS

11.1 Copies of all medication incidents are automatically forwarded to the Pharmacy team via the Trust Incident Reporting System. The Medication Safety Officer and Safe Medicines Practice Group oversee incident reporting and learning to ensure data quality for local and national learning and where necessary request further information and/ or investigation; gaps in assurance or poor compliance are identified and reported to Medicines Management Group.

The Safe Medicines Practice Group will identify trends and ensure reported incidents are used to reduce the likelihood of recurrence and minimise the risk of patient harm. An occurrence report is presented to the Medicines Management Group to highlight trends in practice. Medication and Prescribing incidents and occurrence reports are also presented to the Divisional Governance Groups to facilitate shared learning. Any risks identified are placed on the Trust Risk Register (refer to Risk Management Strategy*).* A Medicines Management Group meeting highlight report is then provided to the Quality and Safety Committee*.*

11.2 Action plans arising from Root Cause Analyses investigations and Risk Assessments form the basis of changes in practice and learning for the organisation. Please refer to the Incident Reporting and Management Policy and Risk Management Strategy for this process.

Changes in practice and lessons learnt are shared across the organisation via a variety of formats including:

- Mandatory and ward- based training
- Trust wide communications e.g., Patient Safety Bulletins, screensavers

- Communication through huddles and/or medicines link nurses in each clinical area and
- Senior and junior medical communication channels, providing the opportunity for individual practitioners to review their practice, improving it in line with the outcome of incident reviews.

12. HOW A PATIENTS' MEDICINES ARE MANAGED ON HANDOVER BETWEEN CARE SETTINGS

12.1 Transfer from home/community setting to the hospital setting

Medicines Reconciliation and Patient Own Medicines (POD) assessment must be undertaken as soon possible after admission in line with Appendices 3.5 & 4.

12.2 Transfer within the hospital setting

Any Patient's Own Medicine or individually dispensed drugs (non-stock supply or TTO supply) for a patient held on the ward **must** be transferred with the patient if they move to another ward. This includes Patient's Own Medicines that are Controlled Drugs.

A patient transferred temporarily. for special treatment e.g., chemotherapy or investigation must have their prescription transferred with them. Patient's Own Medicine or individually dispensed drugs (non-stock supply or TTO supply) required during the temporary relocation, must also be transferred with the exception of Controlled Drugs, which must be ordered from Pharmacy if required. Nursing staff must complete the Ward Transfer Checklist in line with the Transfer and Handover of Patient Care Policy

12.3 Transfer from hospital to community

Medicines for discharge (TTO) are provided in line with Appendix 4.4. The discharging nurse will check the discharge medication as outlined in Checking Medicines to Take Home (TTOs) by Nursing Staff Standard Operating Procedure. Two and competent practitioners must be involved in the final check of medicines dispensed as requested by the discharge letter, once of which must be the nurse responsible for the patient discharge. The discharging Nurse will discuss the medicines with the individual patient prior to discharge. Information relating to the medicines is available both in the discharge letter and in the information leaflet provided with the medicines.

Prior to discharge the patient must receive their medicines for discharge (TTO) and counselled by the nurse / pharmacist/ pharmacy technician to ensure the patient is provided with information about their prescribed medicines. Key points to consider during the consultation include:

- The patient's understanding of and commitment to their management, monitoring, and follow-up
- The reason for being prescribed their medicine
- How to use their medicine
- What the significant side effects are and how to report them
- Expected duration of treatment

- What to do if there are any concerns about the management of their condition if the condition deteriorates or there is no improvement within a specific timeframe.

Where delays in preparation or supply of the TTO are anticipated then the patient should be reviewed by the discharging nurse to assess the suitability of transferring the patient to the Discharge Lounge to await their medicines or referring the patient into the Pharmacy Department TTO Home Delivery Service.

TTO's must not be sent via a taxi or ambulance service.

Only in exceptional circumstances and where the doctor in charge of the patient provides written authorisation in the medical notes should patients be discharged without their TTO. Arrangements for the TTO to be provided to the Patient /Carer must be made to reduce delay and ensure the patient is counselled about their medicines.

13. CONTROLLED DRUGS

Controlled drugs are subject to additional legal and good practice requirements relating to prescribing, administration, supply, storage, and disposal. These requirements are described in the **Controlled Drug Policy**

14. TRAINING/ SUPPORT

All staff handling medicines **must**

- Have completed training and be assessed as competent to do so
- Operate within their own competence and scope of practice
- Undertake mandatory training relating to medicines management in line with the Trust Statutory and Mandatory Training Policy
- Line Managers are responsible for taking action in accordance with the Supporting Performance & Capability at Work Policy or Disciplinary Policy for staff who persistently fail to attend the required training.

Additional Support can be found on The Hub – Essential Links (BNF - adult, BNF- children, Medicines Management) or via the internet on www.medicines.org.uk or for more in-depth medicines related enquiries contact Medicines Information on Extension 2088.

15. PROCESS FOR MONITORING COMPLIANCE WITH THIS POLICY

To ensure that the health record keeping standards are fully embedded across the organisation, compliance with the Policy will be monitored in accordance with **Appendix 1.**

16. EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

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ROYAL PHARMACEUTICAL SOCIETY (2021) A COMPETENCY FRAMEWORK FOR ALL PRESCRIBERS

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PROCESS FOR MONITORING COMPLIANCE

Appendix 1

The Dudley Group NHS Foundation Trust

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Compliance to The prescription process: Reporting of medication errors	Head of Pharmacy	Trust Incident Reporting Database	Annual	Presented and reviewed internally within pharmacy and Safe Medicines practice Group. Themes and recommendations escalated to Medicines Management Group and Head of Pharmacy to identify leads to take actions forward	Lead identified from Safe Medicines practice Group to take action forward	Communication to clinical areas by inclusion in mandatory training and department training and via Ward Pharmacy Liaison, staff bulletins e.g. In the Know, Patient Safety and Experience
Compliance to The prescription process: Accuracy of prescription charts Administration and dispensing of medication Storage of medicines	Head of Pharmacy	Trust Incident Reporting Database	Ongoing	Report presented to the Reported to Safe Medicines Practice Group monthly who will monitor compliance to this policy, challenge areas of concern and identify leads to take actions forward. Recorded in the minutes of Medicines Management Group.	Lead identified from Safe Medicines Practice Group to take actions forward.	Changes in practice will be communicated via Matrons/Managers and communication to clinical areas by inclusion in mandatory training and department training, via Ward Pharmacy Liaison, staff bulletins e.g. In the Know, Patient Safety and Experience
		Audit as part of the medicines management audit programme (Safe and Secure Handling of Medicines: Pharmacy and Nurse Led) Audit of non-formulary prescribing on Sunrise EPMA	Quarterly	Report presented quarterly to the Medicines Management Group and escalated to Quality and Safety Committee Recorded in the minutes	Group will consider, challenge, agree and monitor poor compliance identified and actions from the report – identifying appropriate leads to take action forward	Changes in practice / areas of concern will be communicated via Matrons/Managers through Directorate Risk Management groups.

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Handover of medicines between care settings Community to hospital handover Hospital to community handover	Head of Pharmacy	Audit of medicines reconciliation Audit of the supply of discharge medicines	Ongoing Annually	KPI data presented to the Reported to Pharmacy Governance Group monthly. Audit findings reported to Medicines Management Group who will monitor compliance to this policy, challenge areas of concern and identify leads to take actions forward.	Groups will consider, challenge, agree and monitor poor compliance identified and actions from the report – identifying appropriate leads to take action forward	Changes in practice / areas of concern will be communicated via Matrons/Managers through Directorate Risk Management groups.
Patients understanding of their medicines	Head of Customer Relations and Communications	National Inpatient and Outpatient surveys.	Annual	Presented to Quality and Safety Committee, action plan agreed, delivered with oversight from Medicines Management Group	Group will consider, challenge, agree and monitor poor compliance identified and actions from the report – identifying appropriate leads to take action forward	Changes in practice / areas of concern will be communicated via Matrons/Managers from Patient Safety Group through Directorate Risk Management groups.
Organisation's expectations in relation to staff training	The Mandatory and Governance Training Manager	Electronic staff record (ESR) data base	Monthly	Mandatory Compliance report sent monthly electronically to managers/matrons/lead nurses	Managers/matrons/lead nurses Identify issues and act appropriately on findings and will investigate risk management issues.	Changes in practice will be communicated via Matrons/Managers from Patient Safety Group through Directorate Risk Management groups.
				Mandatory Compliance report sent monthly to the Finance and Performance Committee	Committee will review and monitor identified risks and instigate appropriate leads and actions to be taken	Changes in practice reported back to clinical areas by group representatives

The Dudley Group NHS Foundation Trust

ADMINISTRATION OF MEDICINES IN THE ACUTE SETTING

Practice difference relating to the administration of medicines in the **community setting** is outlined in Appendix 6

A2.1 HOW TO ADMINISTER MEDICINES

Where administration of a dose **involves any calculation** (not including number of tablets/capsules), it is required that another registered healthcare professional independently checks the calculation.

When administering any medication, the prescription must be **taken to the patient** to ensure that the medicine is administered appropriately.

Administration must be completed, and a record of administration/refusal made at the time of administration or as soon as possible thereafter and are clear, legible, and auditable.

Where a medicine is not administered or refused, details of the reason why (if known) are included in the record and, where appropriate, the prescriber multidisciplinary team is notified, and appropriate action is taken, as necessary.

Where the administration of liquid preparations involves the use of volumes other than 5ml spoonful's, then only oral/ enteral syringes must be used.

A2.2 WHO CAN ADMINISTER MEDICINES

Those administering medicines must be appropriately trained, assessed as competent and meet relevant professional and regulatory standards and guidance (RPS, 2019)

A registered **healthcare professional** can administer a medication, when trained and competent to do so, when it has been prescribed by an approved and registered prescriber, using an official prescription, provided by The Dudley Group NHS FT or Registered healthcare staff may where authorised, use Trust Patient Group Directions, or the Trust Standard Operating Procedure for short term treatment of pain, constipation, dyspepsia and dry cough

This also applies to drugs brought into hospital by a patient.

Other staff as described below can support administration of medicines with an appropriate witness.

Student nurses/ midwives and doctors may administer medication under the direct supervision of an experienced registered nurse. The supervising registered professional remains accountable for the administration. See Section 9: Administration of Medicines for further information.

Clinical Support Workers who have received training and are assessed as competent are authorised to administer enteral feeds provided, they have been

prescribed by a doctor, non-medical prescriber, or dietician. The competent Clinical Support Worker must then record the administration in the nursing notes and immediately inform the registered nurse to document the administration on EPMA. The supervising qualified nurse remains accountable for the administration.

Higher Clinical Support Workers and Ophthalmic Technicians working within the Ophthalmology Department who have received training and are assessed as competent are authorised to administer certain topical medicines to patients attending ophthalmology department in accordance with standard operating procedures.

A2.3 SINGLE AND SECOND CHECK ADMINISTRATION

A **single** individual administration system is used by non-medical healthcare professionals unless administration involves:

- An intravenous medicine
- An oral cytotoxic medicine
- Calculation of a dose (except numbers of capsules/tablets)
- Administration to children under 16 years of age (also see Appendix 2.8.1)
- Doses expressed by weight or surface area
- Administration of controlled drugs

Qualified Doctors must have a second check when administering to children.

See sections A2.8 (injectable administration), A2.9 (Cytotoxic Drugs) and A2.7 (Children)

A2.4 RECORDING MEDICATION ADMINISTRATION

A clear, accurate, and immediate record of administration must be made.

For areas using paper prescription charts, the individual must sign the relevant box on the administration section. Administration of medicines prescribed on paper based or anaesthetic record sheet must be recorded adjacent to the signed prescription including the date/time and the signature of the person who has administered the medicine.

Where a maximum number of doses to be given is stated or a specified maximum length of treatment, that number or length must not be exceeded, without a new prescription.

For digital systems e.g., Sunrise EPMA, Chemocare the person administering the medication should ensure that administration is recorded against the individual medication.

Where a check of the administration is required by a second person their signature must also be recorded on the paper or digital prescription.

Where Controlled Drugs are administered both administrator and witness must always sign the CD record book.

A2.5 OMITTED DOSES AND NIL BY MOUTH

If for any reason, and after due consideration of the risks and benefits of missing a dose, a medicine is not administered, a record of the omitted dose and the reason for omission must be made on the prescription, utilising non-administration codes when available. The patients' doctor should be kept informed of non-administration of prescribed medication.

Recording non-availability of a medicine as a reason for non-administration is only acceptable after full consideration of the impact of missing a dose on patient care.

Wherever doubt exists, contact the senior nurse or ward pharmacist/doctor, or on-call pharmacist out of hours, for advice. All details relating to such incidents must be recorded in the nursing notes.
Where a previous dose has not been given and a non-administration code is not included on either the prescription or in the medical notes the ward manager and pharmacy should be informed, an incident report completed, and the incident investigated.

Patients classified as Nil by Mouth (NBM)
Patients classified as NBM prior to a diagnostic procedure or operation should still have their prescribed oral medicines administered to them at the prescribed time unless specifically advised **AND DOCUMENTED** otherwise. It is the responsibility of the prescriber to provide clear written instructions to nursing staff concerning omission of prescribed doses.

Refer to the Perioperative drug management for adults undergoing elective surgery for guidelines for advice on specific drugs.

Refer to the 'Management of Parkinson's disease in primary and secondary care for patients with compromised swallow or those patients deemed nil by mouth (NBM) guideline'.

A2.6 ADVERSE DRUG REACTIONS

Adverse Drug Reactions reported via the Yellow Card Scheme should also be reported via the Trust incident reporting system (Datix).

A2.7 ADMINISTRATION OF MEDICINES TO CHILDREN

In the context of this policy, children will be defined as any patient under the age of 16 years. The policy will apply to any clinical area where children are cared for.

Where children's drug doses are calculated according to the weight of the child, it is essential that this is recorded in kilograms on the prescription. The child's weight must be checked at regular agreed intervals, according to their plan of care.

The date of birth of the patient must be stated. It is a legal requirement in the case of prescription-only medicines to **state the age for children under 12 years**.

A2.7.1 Checking of medicines to be administered to children

It is required that all drugs administered to children will have a second check including those administered by a doctor (whether a dose calculation is required or not).

The second check may be provided by:

- A registered nurse
- A Clinical Support Worker (higher level), student healthcare professional who has been assessed as competent in Clinical Assessment who has been assessed as competent in Clinical Assessment with regards to drug calculations and safe checking and administration of medicines.
- A doctor
- A Pharmacist

In exceptional circumstances a parent/guardian of a patient under 16 may be asked to perform the second check. This is only acceptable if none of the above are available, the drug administration does not involve a calculation **AND** the parent/guardian agrees to undertake the check.

Second checking is not required when administering the following drugs to children:-

- Oral paracetamol
- Oral Ibuprofen
- Oral Vitamin supplements
- Nystatin oral suspension
- Salbutamol nebules
- Inhalers
- Eardrops
- Dietary supplements
- Laxatives
- Emollients
- Topical local anaesthetic (Emla® cream or Ametop® Gel)
- Immunisations

All healthcare professionals have the unconditional right to request a second person to check the listed drugs if they consider this to be necessary.

A2.7.2 Children who refuse medication

All staff administering drugs to children should take into account their age and understanding.
Where it is considered that a child recognises the implications of refusing medication medical staff will be informed and the incident recorded in the medical records. If the child is considered incapable of recognising the implications of refusing medication, provided parental consent is given, medication should be administered.

Children under the age of 16 can consent to their own treatment if they're **believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment**. This is known as being Gillick competent. Otherwise, someone with parental responsibility can provide consent on their behalf.

A2.7.3 Self or Parent/Guardian administration to children

In the case of patients under 16 years, parents/guardians may administer the prescribed medicine to their child, but the Nurse must take the overall responsibility for ensuring the medication has been administered to the child.

Drugs given by the nebuliser route must be set up and the nebuliser treatment commenced by the Nurse. Parents/guardians can be left to hold their child during the administration of a nebulised medicine; however, parents/guardians must not be allowed to switch on the oxygen for the nebuliser treatment. When the nebulised medicine has been given the Nurse is responsible for turning the oxygen off.

Where appropriate and with appropriate assessment self-administration by children is permitted. This must be documented in the notes.

A2.8 ADMINISTRATION OF INJECTABLE MEDICINES

A2.8.1 Multiple Use of Injectable Medicines

This information refers to the multiple use of injectable medicines (vials, ampoules, infusion bags) in clinical areas. The term *multiple use* includes use of a single container of an injectable medicine

•To administer more than one dose to a single patient
and/or
•To administer one or more doses to more than one patient

For aseptic preparation of injectable medicines in aseptic dispensing units refer to the Yellow Cover Document "Vial sharing in Aseptic Services 1st Edition" (August 2014).

Multiple use of an unpreserved injectable medicine should be eliminated. Most injectable medicines are unpreserved and licensed for 'once only' use. Unless the manufacturer's Summary of Medicinal Product Characteristics (SmPC) specifically indicates that the injection contains a preservative, the container should only be used to prepare a single dose for a single patient on one occasion and then discarded.

There are a small number of vials that contain preservatives which are consequently intended for multiple use by a single patient, for example insulin and some heparin products. When injectable medicines intended for multiple use by a single patient are used multiple times for multiple patients the risk of cross-contamination is greater. In order to mitigate the risk of multi-use vials such as insulin, a patient label and the date opened should be added to the injectable medicine on first use and used only for that single patient.

In the instances where a preserved multi-dose vial is used, a risk assessment should be performed to determine if it is acceptable to use the multi-use vial for multiple patients. If a product is not used in accordance with its SmPC the use becomes "off-label". Therefore, the liability for that use transfers from manufacturer to the health care provider.

When considering the use of a multi-dose vial for multi-patient the risk assessment must consider the following factors as a minimum:

- Patient Factors (Such as age, condition, indication, immunocompromised etc.)
- Organisational (liability considerations, economic benefit vs risk assessment, etc.)
- Environmental (Such as preparation area, storage, distraction, training, patient throughput, transferring product with patient etc.)
- Microbiological risk (e.g., does "coring" occur, complexity of product preparation including number of aseptic manipulations)

Where it is necessary to use an injectable medicine without a UK Marketing Authorisation (unlicensed medicine) the product information from the relevant regulatory agency e.g. The Food and Drug Administration (FDA) should be reviewed to identify whether the product contains a preservative and action taken as above. Refer to Trust Unlicensed Medicines Policy.

Any departments that have reasons not to comply with this guidance must seek approval from the Drug and Therapeutics Group and Medicines Management Group and a record of the medication and situation in which it is to be used more than once should be made on the Trust risk register.

PRESENTATION	NUMBER OF PATIENTS - TYPE OF USE
IV BAG	SINGLE PATIENT - SINGLE USE ONLY
AMPOULE	SINGLE PATIENT - SINGLE USE ONLY
UNPRESERVED VIAL	SINGLE PATIENT - SINGLE USE ONLY
PRESERVED VIAL (CONTROLLED DRUG)	SINGLE PATIENT – MULTIPLE USE ONLY
PRESERVED VIAL	SINGLE PATIENT – MULTIPLE USE or RISK ASSESSMENT

Table 1: Summary of guidance on the multiple use of injectable medicines

A2.8.2 Principles of Intravenous drug administration

Also see the ADMINISTRATION OF INTRAVENOUS MEDICATION VIA A PERIPHERAL VENOUS ACCESS DEVICE (FOR ADULTS) and the Central Venous Access Device SOP STANDARD OPERATING PROCEDURE

A2.9 ADMINISTRATION OF CYTOTOXIC DRUGS

A2.9.1 Intravenous administration of cytotoxic drugs

The administration of cytotoxic drugs is not part of the routine administration of medicines within all areas of the Trust. The Trust policy 'Safe handling and administration of systemic anticancer chemotherapy and related monoclonal antibodies' and The Procedure for Prescribing, Safe Handling and Administration of Cytotoxic Chemotherapy and Related Monoclonal Antibodies must be followed in every instance of the administration of cytotoxic medicines.

Nursing staff **will not** be involved in the preparation and reconstitution of cytotoxic drugs. This is the responsibility of the Pharmacy Department. In the event of an urgent requirement, the consultant requesting the drugs will contact the on-call pharmacist for advice.

Cytotoxic drugs may only be administered in designated ward/department areas by staff who have who have completed the appropriate chemotherapy administration competencies to the required level as per the Safe Handling and Administration of Systemic Anticancer Chemotherapy and Related Monoclonal Antibodies Policy and Oral Chemotherapy Policy

A2.9.2 Intrathecal administration of cytotoxic drugs

Refer to Intrathecal Chemotherapy Policy

The procedure for intra-thecal chemotherapy must be followed each time a cytotoxic medicine is administered intrathecally.

A2.10 USE OF STRONG POTASSIUM CHLORIDE INJECTION

Strong potassium chloride injection is only available in limited clinical areas and pharmacy. It must be stored separately, securely and treated as a controlled drug.

Pre-prepared diluted parenteral potassium solutions should be used where possible.

Refer to Safety Controls for Strong Potassium Policy.

A2.11 DISPENSING LABELS

Prior to administration, If the dispensing label on any container is damaged, altered, or obliterated, the container must be returned to the Pharmacy for replacement.

Staff must not make any alterations to labels except to indicate the addition of a prescribed drug to a container of intravenous fluid or to mark the date of first use on a container. If the appearance of the product differs from normal, the

product should be quarantined, and the advice of a pharmacist should be sought.

A2.12 TRANSFER OF MEDICINES FROM ONE CONTAINER TO ANOTHER

Transfer of any medicinal item from one labelled container to another is not allowed, except by pharmacy staff. All medicines must be kept in their original container and not decanted into other boxes or drawers etc.

A2.13 EXTERNAL APPLICATIONS

External medicines (e.g., creams, ointments, lotions) must not be applied unless they have been either prescribed or specified in a written protocol or PGD.

A2.14 PATIENT GROUP DIRECTIONS (PGDs)

PGDs allow the supply or administration of medicines without a prescription in clearly and accurately defined situations. PGDs must be developed in the first instance by relevant senior medical, nursing, AHP and Pharmacy staff. The Trust PGD policy must be adhered to.

Pharmacy will maintain a record of all approved Patient Group Directions and will initiate their regular review.

Templates for completion of Patient Group Directions are available from Pharmacy and on the Hub.

It is the nurse or healthcare practitioners' responsibility to understand the PGD and operate within its directions.

Refer to the Patient Group Direction (PGD) Development, Implementation and Review Policy

A2.15 STAFF REQUIRING MEDICATION

Self-medication with drugs which are the property of The Dudley Group NHS FT by nursing, medical and all other staff is strictly prohibited.

Prescribers are referred to the RPS competency framework for all prescribers (2021) on prescribing for self, close family, and friends.

Emergency, short-term supplies for time limited indications may be made against a legal prescription at the discretion of the pharmacist. Normal prescription charges will apply.

Non urgent or routine medication will not be supplied via any process except as outlined in section A3.12

A2.16 ORAL LIQUID MEDICINES

Where oral liquid medicines require measurement of a dose that is not a multiple of 5ml an oral/enteral syringe will be used to measure the dose. Oral syringes are available as:

- Sterile, single use syringes for use in neonates, children under 6 months of age and immuno-compromised patients.
- Non-sterile multiple use syringes for use in all other situations. These can be washed and re-used for a single patient.

DO NOT USE standard sterile injection syringes for measuring oral liquid medicines.

The date of opening should be recorded on the bottle to enable shelf-life determination where this is affected.

A2.16.1 Design, supply, and use of oral/enteral syringes

An appropriate oral/enteral syringe should be used to measure oral liquid medicines if a medicine spoon or graduated measure (medicine measuring cup) cannot be used. Syringes should not be compatible with intravenous or other parenteral devices.

• only use labelled oral/enteral syringes that cannot be connected to intravenous catheters or ports to measure and administer oral liquid medicines.
• do not use intravenous syringes to measure and administer oral liquid medicines.
• make sure stocks of oral/enteral syringes are available in all clinical areas that may need to measure and administer oral liquid medicines in a syringe.
• when patients or carers need to administer oral liquid medicines with a syringe, supply them with oral or enteral syringes.

A2.16.2 Shelf life

If a shelf life once opened is not stated on the product, then then expiry date/shelf life of the product should be reduced to 3 months from the date opened or the expiry date of the bottle (if sooner).

A2.17 CRUSHING OF SOLID ORAL MEDICINES

Advice on the crushing of solid oral medication is available from the pharmacy department. Do not crush tablets without advice from pharmacy

Where patients are unable to swallow solid oral medicines, the pharmacy should be contacted about the availability of alternative liquid formulations.

Where a liquid is not available, tablets (safe to crush) may be crushed using a tablet crusher available from pharmacy.

To prevent cross contamination mortar and pestle must not be used.

A2.18 COVERT ADMINISTRATION OF MEDICINES

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

The covert administration of medicine is not to be confused with the administration of medicines against a person's will, which may be considered unlawful. All staff who administer medicines in this circumstance must refer to the NMC/ RPS Professional Guidance on the Administration of Medicines in Healthcare Settings

A2.19 ADMINISTRATION OF DRUGS TO PATIENTS WHO REFUSE TREATMENT

Medicines, as with all forms of treatment must only be administered with the patient's consent. A patient voluntarily taking prescribed medication would be seen as giving implied consent.

The only situation in which medicines may be administered without the patients consent is under the Mental Health Act 1983 – (refer to Policy on Assessing Mental Capacity , dealing with patients who lack capacity and complying with the mental capacity act (MCA2005)).

For detailed advice, the Safeguarding Team should be contacted via switchboard.

As a general principle, by disguising medication in food or drink, the patient is being led to believe they are not receiving medication, when in fact they are. The professional bodies would not consider this to be good practice. See A2.18 Covert Administration of Medicines.

A2.20 RECORDS OF NURSING STAFF SIGNATURES

To allow for tracing of staff ordering and/or administering medicines the Nurse in Charge/ ODP in Charge/ Service Head of each ward/department must maintain a list of staff signatures and initials used on drug charts and for ordering medicines. This signature list must be kept for the duration of the staff member's contract plus one year after an individual has ceased to work on that ward/department.

This signature list is not the same as that for Controlled Drugs as it must include ALL staff who are legally approved to administer or witness administration of drugs on a ward.

Staff signature lists must be reviewed by the Lead Nurse/Ward or Department Manager every three months and updated or re-authorised as appropriate. A copy must be held on the ward/department and a copy should be sent to the Pharmacy Department.

A2.21 ADMINISTRATION OF RADIOPHARMACEUTICALS

Radioactive pharmaceuticals may be administered to a patient only on the authority of a practitioner who has an ASARC certificate for the diagnostic or therapeutic procedure concerned, as required by Ionising Radiation (Medical Exposure) Regulations 2017.

The Employer is responsible for IR(ME)R protocols; the Chief Pharmacist should assure themselves that these are in place and contain the required details with respect to the administration of all medicines (radiopharmaceuticals and adjuvant medicines); For example, the medicine name, form, strength, and route of administration.

The referrer, practitioner and operator should also have undergone training that satisfies the core of knowledge requirements of IR(ME)R 17 schedule 3 as applicable.

The healthcare professional administering the radioactive material may do so only if they have received sufficient training which satisfies the core knowledge requirements for physically directing a radiation exposure required by or if they are acting under the direct, personal supervision of such a person.

The healthcare professional should also have completed the Trust competency training in the administration of intravenous medicines if the dose is to be given by that route.

The Chief Pharmacist must ensure that appropriate governance arrangements and roles and responsibilities for staff are clear and well documented. A Technical (Quality) Agreement should be in place between the Chief Pharmacist and the Nuclear Medicine Department as per the recommendations by the UKRG (The Responsibilities of Chief Pharmacists for Radiopharmaceuticals July 2020).

A2.22 LOST OR MISSING DRUG CHART PROCESS

If a paper drug chart is lost or missing on a ward or department the following process should be followed:

1) Check all nursing stations on the ward or department
2) Check all green bags on the ward (include a check of apparently empty bags as the drug chart may have been sent up alone in a bag)
3) If the patient has been transferred within the last 24 hours contact the previous ward as the new ward details may not have been updated
4) Check the pharmacy tracking system on the hub for your ward. This will have a date and time of any medicine requests for your patient.
5) In pharmacy core hours ring the Responsible Pharmacist (RP) or out of hours contact the on-call pharmacist with the patient's hospital number and pharmacy tracking details.
6) If confirmed that the drug chart is not in the pharmacy department or en-route with the porter, and you have been unable to locate the chart on the ward for more than 6 hours then request a drug chart rewrite.
7) The prescribing clinician (ward doctor/ NMP/ F1 on-call) should use the following recommended resources to rewrite the chart

- Medicines Reconciliation
- Summary Care Record (SCR)
- DB Motion

- Patient
- Patient's own drugs (PODs)
- Recent TTO/ discharge letter
- Any documented medicine changes

8) Complete a DATIX incident report and if out of hours refer to ward-based staff for follow up in core hours.

A3 PRESCRIBING MEDICATION

A3.1 Prescribing medication and the prescription form must:

a. Provide a permanent legal record of the patient's medication.
b. Facilitate the provision of the correct medicine from Pharmacy.
c. Direct administration of the medicine to the patient.

The prescription must be an accurate and unambiguous description of medicine treatment. Only registered medical staff or registered non-medical prescribers may prescribe drugs for administration by other healthcare professionals.

A3.2 Record Keeping

In writing prescriptions on paper drug charts, the following must be observed:-

a. The In-patient's prescription chart should always be available.
b. Not more than one prescription chart must be in use at any one time for any one patient, unless the number of items prescribed exceeds the available spaces.
c. Cross-reference must be made to drugs prescribed on specific charts, e.g., PCA & epidural infusions, TPN etc.
d. If a patient requires TWO or more drug charts the number of charts should be clearly identified on each chart. (e.g., 1of 2, 2 of 2 etc)
e. When the chart is full, all current prescriptions must be cancelled, and the cancellations must be signed and dated by an appropriate prescriber. The current therapy must then be entered by appropriate prescribing staff on the new chart. Cancelled charts must be retained with the patient's medical records.

A3.3 Discontinuing Medicines, Changing and Withholding Doses (Paper Charts)

Prescriptions will be cancelled by drawing a single bold line through the prescription and administration section

The cancellation will be signed and dated by the prescriber or pharmacist (see section A3.2.2.) AND the action and rationale recorded in the patient's medical records.

When medication dose alteration is required, the prescriber should completely rewrite the prescription to avoid misinterpretation, and make sure it is clear when the dose was changed and by whom. The original entry should be cancelled as outlined above to reduce the risk of administration.

When amending a TTO it must be ensured that all copies of the TTO or electronic discharge summaries are amended/ reprinted, and the pharmacy must be contacted to make sure the changes are screened and TTO medication changed or dispensed, as necessary.

Doses deliberately withheld by the prescriber should be clearly annotated on the in-patient medication chart. The dose administration box should be filled in with an 'X' and signed and dated on the chart. the reason for the decision should be documented in the medical notes.

Once weekly or other treatment frequency prescriptions e.g., methotrexate or fentanyl patches will require clear annotation of the medicines chart with the dose administration boxes marked with 'X' on days where treatment is not administered / reapplied.

A3.4.1 Allergy status

The Trust requires all healthcare practitioners to enter known drug allergies and sensitivities on medication prescribing documents together with their manifestations OR specify that there are no known allergies. Refer to the Patient Identification Policy.

Each prescribing document includes an allergy status section which must be completed. On paper records this entry should also be initialled and dated by the HCP who has obtained the information

Drugs must not be administered unless allergy status information is completed.

A3.4.2 **A true allergy** may be classified as one or more symptoms consistent with an immune reaction, including breathing difficulties, swelling, rash, itching, loss of consciousness or anaphylaxis.

A3.4.3 **Intolerance** may be classified as an adverse effect that may be predicted from the known side effect profile or pharmacological action of a drug or an idiosyncratic or unpredictable reaction to a drug, e.g., GI bleeding secondary to a NSAID or neutropenia with clopidogrel.

A3.4.4 When taking a medical history, it is important to:

1. Verify the allergy status or drug intolerance.
2. Establish the length of time the patient has had the reported allergy/intolerance and whether there is a record of when the drug was prescribed or administered in the patient's notes.
3. Document the allergy/drug intolerance details clearly in the notes when taking the patient's history, indicating the type of reaction or intolerance described by the patient.
4. Apply the red allergy wrist band to the patient upon admission or if a new allergy is established.
5. Decide whether you would consider it appropriate to administer that drug or a drug in the same class to the patient based on the information available.
6. Document the allergy/drug intolerance details on the prescription chart providing sufficient information for other prescribers to be able to make appropriate prescribing decisions.
   e.g., Severe penicillin allergy (anaphylaxis) – this may be a warning to prescribers that they need to avoid all penicillin's and take great care with cephalosporins.

7. Acute renal failure or GI bleed with NSAIDS – avoid – this gives a clear message for prescribers to avoid NSAIDS.
8. Mild diarrhoea with erythromycin – if the antibiotic is needed, reassurance that the symptoms are a common side effect may be all that is needed.
9. In the event that a patient experiences a new suspected drug allergic reaction update the patient record and inform the patient and their GP. Refer to NICE guideline CG183.

A3.5 MEDICINES RECONCILIATION (MR)

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognition of any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated.

Medicines reconciliation enables the timely and accurate prescribing of medicines and is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer, and discharge of patients requiring medicines.

NICE Guidance (NG5/2015) recommends that organizations ensure medicines reconciliation is carried out by trained and competent health professionals – ideally a pharmacist, pharmacy technician, nurse or doctor – with the necessary knowledge, skills and expertise, including; effective communication skills**,** technical knowledge of processes for managing medicines and therapeutic knowledge of medicines use.

A3.5.1Summary of levels of medicines reconciliation

MR can be considered to occur at different stages or 'levels' which may in practice depend on the training and capability of the available staff, although ideally should be driven by the needs of the individual patient.

Level	Brief Description	Patient Groups	Referral Criteria to Next Level
First	Admission or transfer-led	All	No reliable information source
Second	Pharmacy consolidation	Defined	High risk or targeted patients

3.5.1.1 First level – admission/transfer-led

- Patient group – all adult admissions
- By: admitting doctor or other healthcare professional who has received appropriate training
- Collection method: Using a checklist, MR will include allergy/hypersensitivity history and medications taken prior to admission. Any concerns about the validity of the information is an indication for referral for Second Level MR (pharmacy consolidation)

- Sources: preferably 2, ideally 3 of the following more reliable sources of information: patient and/or carer, GP admission letter, recent printout from GP computer screen, repeat prescription slips; patients own drugs. Hospital out-patient visit notes; recent discharge prescriptions; verbal and written contact with care home; GP surgery or community pharmacy; district nurse, mental health team
- Time frame: within 6 hours of admission
- Communication: Patient medical notes, in-patient prescription chart

3.5.1.2 Second level – pharmacy consolidation*

- Patient Group – specific adult admissions and referred first level patients
- By: pharmacists and accredited members of the pharmacy team
- Collection method: Following a Pharmacy Department Standard Operating Procedure. MR will include allergy/hypersensitivity history and medications taken prior to admission
- Sources: At least 2 if not 3 of the more reliable sources available (See under first level)
  - Time frame: within 48-72 hours**
  - Checking: This involves ensuring that the medicines, doses, and formulations that are prescribed for the patient are correct. During the checking step discrepancies maybe identified as intentional or unintentional. The identified discrepancies, whether intentional or unintentional, need to be communicated as below
  - Communication: no confirmation of first level MR on drug prescription chart plus referral request***. Documentation of unintentional difference MR data added to the designated section of the in-patient drug chart or EPMA system. For wards/departments using paper prescription charts, this information will be included in the patients' medical notes with the insertion of the chart following writing up of a new chart or discharge of the patient.

*Although ideally all patients should receive Level 2 MR, it is acknowledged that this may not be possible in current circumstances and patients may have to be prioritised to receive this service.

**This should ideally be within 24 hours, and no longer than 72 hours, dependent on the capacity of the pharmacy team. This reflects the fact that information gathered after 72 hours may be less relevant to the patient's care

***Where accurate medicines reconciliation has not been possible at first level, and second level MR is not routinely offered, the admitting practitioner should highlight the need for verification and refer for a second level MR

A3.6 PRESCRIBING OF CONTROLLED DRUGS

For full details see the Trust Controlled Drugs Policy on the Hub.

A3.7 NON-MEDICAL PRESCRIBING (NMP)

For full details see the Trust Non-Medical Prescribing Policy on The Hub

If a non-medical prescriber is no longer carrying out prescribing duties because they have been suspended or removed from the register or they have left employment it is the clinical units' responsibility to inform pharmacy such that:

- Existing pads are destroyed where appropriate
- No further prescription pads are ordered
- All unused prescription forms issued to that nurse relating to that employment are recovered and returned to pharmacy.
- Their permissions within electronic prescribing systems are removed

The Trust NMP Lead will keep an up-to-date database of all non-medical prescribers their signatures and scope of expertise. Both full name signature and initial signature, if both are commonly used, must be held on the database. Pharmacy must have access to this database thus enabling pharmacists to check whether a prescription is bona fide.

Non-medical prescribers must provide a specimen signature to their Nonmedical prescribing Lead before commencing prescribing. If there is any change in signature due to name change or any other reason than a new specimen signature must be provided prior to using the new signature.

Independent non-medical prescribers and supplementary prescribers should prescribe on standard drug stationery and each prescription should be annotated with 'NMP' to indicate nonmedical prescriber.

A3.8 PRESCRIBING OF MEDICAL GASES

Medical gases are regarded as drugs and as such must be prescribed by authorised prescribers on The Dudley Group NHS FT approved stationery e.g., inpatient drug chart, Emergency Department notes or Anaesthetic record sheet.

The prescription must state:

- The medical gas required
- The delivery device i.e., mask, nasal cannula
- Rate
- Other instructions

Only Oxygen may be administered in an emergency (cardiac arrest or respiratory distress) without a prescription. See link:-
Prescribing, Administration & Monitoring Oxygen Policy

All staff handling and administering medical gases must only do so after they have completed medical gas safety training.

A3.9 PRESCRIBING DRESSINGS

The Dudley Wound Care Formulary should be used to guide staff on therapy for treatment and management of wounds.
http://www.dudleyformulary.nhs.uk/page/21/wound-care)

It is not necessary for dressings included within this document to be prescribed before use with the exception of silver preparations, iodine, medicinal honey, and antimicrobial dressings. It is however essential that ALL dressings used and the rationale behind their use are documented within the individual patient's nursing notes/care plan if the dressing is not prescribed.

A3.10 PRESCRIBING WITHOUT PATIENT CONSENT

Drugs for treating psychiatric disorders may be given without the patients consent if the patient is detained under the Mental Health Act 1983 which is in place to:
"…provide a means to compulsorily admit and detail people on psychiatric units and to sometimes administer treatment without consent when a patient is suffering from a mental disorder and needs to be detained in the interest of their own health or safety or for the protection of others"

A detained patient will have been admitted to hospital against their will and are said to be "on a section". There are three main groups of compulsory order which can be for assessment and/or treatment:

1) Admission for assessment (Sections 2, 4, 5,135,136)
2) Treatment orders (Sections 3, 7)
3) Admission and transfer of patients concerned with criminal proceedings (Sections 37, 41, 47, 49).

The most important are sections 2 and 3 which provide for admission and treatment without the patient's consent. Treatment can continue for 3 months after the start of a section order after this a second opinion must be sought. Further advice is available from the Mental Health Team via switchboard.

A3.11 PRESCRIBING STATIONERY

A3.11.1SECURITY OF CONTROLLED STATIONERY

Controlled Stationery is any stationery, which, in the wrong hands, could be used to obtain medicines fraudulently.

The security of such prescription forms is the responsibility of the ward/department manager and the prescriber.

The following stationery is considered controlled by The Dudley Group NHS FT and as such **must be stored in a secure manner**:-

- Controlled Drug order book.
- Controlled Drug registers
- Controlled Drug record books.
- Record of Controlled Drugs Brought into Hospital by individual patients (Patient's Own CD record book)
- ALL FP10 forms.

- Out-patient prescription form.
- Stock drug requisition books.
- Pink paper TTO forms (For use if e-prescribing system unavailable)
- Morphine Sulphate 10mg/5mL oral solution record book
- In patient treatment charts

For outpatient prescriptions (FP10 forms)

- The pharmacy will record the serial numbers of prescriptions received and subsequently issued to the individual prescriber.
- The prescriber should also keep a record of the serial numbers of prescriptions issued to them.
- Blank prescription forms must not be pre-signed
- Prescription forms must never be left unattended unless in a locked cupboard
- Pharmacy should be notified if prescription forms are lost or stolen.

Prescribers should be aware that they may need to be contacted by a Pharmacist who may wish to confirm an aspect of a prescription, recommend change or refrain from dispensing if they consider such action appropriate.

The prescriber's signature, printed name, registration number and an up-to-date bleep or phone number will be included on all outpatient prescriptions.

A3.11.2 For In-patients

Use the appropriate official Dudley Group NHS FT Drug Prescription Chart. Supplementary charts are available. Use of all supplementary charts, must be authorised by **Drug and Therapeutics (D&T) Group**

Chart/ Supplementary Chart	Ward/ Departments	Code
IP Drug Chart	ALL	DW9489
PGD Administration records	ALL using PGDs/ Midwives	DW9491
Infusion via syringe driver	Palliative care patients	DW9493
Neonatal chart	Neonatal unit	DW9494
PCA infusion	Theatres/ High dependency areas	DW9495
Epidural infusion	Theatres/ High dependency areas	DW9496
Maternity insulin sliding scale	Maternity & Obstetrics	DW9498

A3.11.3 For Discharge (commonly known as T.T.O.s (To Take Out))

Use the relevant electronic discharge process and only in exceptional circumstances where these are not available the paper Dudley Group NHS FT Discharge Prescription (WZZ7140) may be used. Authorisation from the Responsible Pharmacist / Pharmacist on call should be sought.

A3.11.4 For Out-patients/ GP Referral letter

Use the Dudley Group NHS FT outpatient prescription form/ GP Referral letter. A maximum of twenty-eight-day supply will be dispensed unless otherwise agreed. A full course of treatment such as antibiotics will be dispensed where appropriate.

For routine, previously supplied, or non-urgent medicines, the patient is to be referred to their GP to initiate or continue supply.

N.B. These forms can only be dispensed at a The Dudley Group NHS FT pharmacy; prescribers should ensure patients are notified of this fact upon issue. When out-patients do not require immediate prescriptions or GPs are requested to prescribe their choice of a particular class of agent ONLY individual drugs or classes of drugs approved within the Dudley Formulary are to be recommended.

For medication which the patient has received or which is not clinically urgent, the patients GP should be informed, and the patient asked to discuss with GP.

A3.11.5 For other patients

Patients in theatre have medication documented on the Trust approved anaesthetic records.

In units provided with the FP10 prescription pads, once written, these prescriptions may be dispensed at any community pharmacy with an NHS dispensing contract.

All Dudley Group NHS FT prescribing restrictions apply to FP10 prescriptions including the Dudley Formulary and restrictions as to duration of supply.

A3.12 SELF-PRESCRIBING OR PRESCRIBING FOR COLLEAGUES, FRIENDS OR FAMILY MEMBERS

The Royal Pharmaceutical Society (2021) advise that “it is generally considered poor practice to self-prescribe or to prescribe for persons for whom there is a close personal relationship”.

GMC (2021) advises that "Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with."

The Nursing and Midwifery Council advises within the document Standards of proficiency for nurse and midwife prescribers that nurses and midwives must not prescribe for themselves and, other than in exceptional circumstances, should not prescribe for anyone with whom they have a close personal or emotional relationship.

The GPhC advises pharmacist prescribers that 'Pharmacist prescribers must not prescribe for themselves or for anyone with whom they have a close personal relationship (such as family members, friends, or colleagues), other than in exceptional circumstances.'

In an emergency, after exercising professional judgement, a prescriber may decide that it is appropriate to self-prescribe a medicine or prescribe for persons with whom the prescriber has a close personal relationship.

The facility for prescribers to self-prescribe or prescribe for a colleague is to be used only in exceptional circumstances. It is intended to enable them to obtain on-going medication in an emergency or treatment for acute conditions. It does not replace the need for individuals to seek the advice, diagnosis and the care of their GP or specialist.

The following conditions should be met when considering self-prescribing or for a colleague:

- Foundation Year 1 doctors are not permitted to prescribe for themselves or a colleague
- The staff-member/patient must have a valid DGFT hospital number / NHS number
- The medicine prescribed is for the prescriber's own use only or for use by a colleague (i.e. not relatives or friends)
- Their reason for being unable to visit their own GP should be recorded or ascertained by the Pharmacist and documented on the prescription
- Only formulary medicines may be prescribed.
- A maximum of 7-day supply, or the smallest original pack (whichever is less) will be dispensed.
- The prescription will be costed in accordance with current NHS prescription charges, unless exempt.
- A single occasion for the prescribed item and self-prescribing is not routine practice.
- The prescriber should consider the abuse potential of the medicine. Items that may not be self-prescribed include:
- hypnotics including benzodiazepines
- Controlled drugs of any schedule

A4 SUPPLY OF MEDICINES

A4.1 PHARMACIST WARD VISITS

Each ward within the Trust (with the exception of Maternity) has an identified pharmacist who will visit the ward regularly at times agreed between the Pharmacy and the senior nursing staff.

Pharmacists will monitor prescriptions, both in the dispensary and on the ward, assessing prescribing for accuracy, legibility, safety, interactions, and appropriateness of therapy in line with department standards and evidence based clinical practice. Any clarification of a prescription made by a pharmacist will be documented in accordance with Pharmacy Department Standard Operating Procedures.

Pharmacy staff will assess the need for non-stock or DfD ('TTO supply') and arrange requisition on an 'individual named' basis from Pharmacy. All medication will be labelled with the approved 'generic' name of the preparation except where a proprietary name defines a specific formulation or combination.

Pharmacists will record interventions and near miss-errors prescribing errors using the pharmacy intervention note. All other incidents will be reported using The Dudley Group NHS FT Incident Reporting and Management Policy

A4.2 PHARMACY STOCK TOP-UP

Specific areas will be visited at a designated time each week by a member of the pharmacy team. This person will ensure stocks of pharmaceutical products for that area are replenished to agreed stock levels. The agreed timetable for visits, the actual visits and the personnel undertaking them are recorded in pharmacy. Unvisited areas will operate a system of self-top-up.

The stock list content and levels will be agreed after discussion between the relevant ward/Directorate pharmacist, senior for technician ward services or Lead Technician and appropriate medical and/or nursing staff. These levels will be reviewed at regular intervals by the staff concerned.

Pharmacy staff must be notified by if unusual amounts of any item are being utilised to allow stock levels to be re-calculated.

A4.3 DELIVERY OF DRUGS TO WARDS/DEPARTMENTS & COMMUNITY TEAMS

All medicines will be delivered to the ward/department/community base in a dedicated tamper evident container. Additionally, in-patient ward/department drugs for individual patient use (non-stock medicines and TTOs) will be labelled with a barcode to enable tracking by the pharmacy department.

The nursing/department staff are responsible for the security of this container on the ward/department and for transferring the contents of the container into the appropriate locked cupboards immediately upon receipt or on the day of receipt at the latest. Items requiring special storage conditions (e.g., refrigeration) will be clearly labelled and must be stored appropriately

immediately upon receipt on the ward/department. Medicines received must be reconciled against the delivery note immediately if possible and if not on the day of receipt. The delivery note should be signed and dated. All discrepancies must be addressed with the pharmacy immediately upon discovery. Delivery notes must be retained for a period of 3 months. Pharmacy staff will restock the automated medicines storage in AMU

For Controlled Drugs see the CD Policy

A4.4 DISPENSING FOR DISCHARGE

Medicines will be dispensed for individual patients labelled ready for discharge with the exception of medication for parenteral administration.

TTO supply will be issued in the event that the patient does not have a further supply at home and the medication is not held as stock on the ward.

Controlled Drugs cannot be included in the Dispensing for Discharge scheme.

The pharmacist will review the prescription for clinical appropriateness & will sign the prescription to authorise supply. Supply will be made by either:
The Medicines Management Technician, who will manage the supply of drugs to patients' once they are clinically checked.
The ward staff who will request supply from the pharmacy. DfD supplies will be stored in the locked part of the patient's bedside locker.

The ward technician will visit the ward each weekday at a pre-assigned time to manage the patients' stocks of drugs.

A4.4.1 Discharge from Hospital: (Handover from care setting)

Once the decision to discharge a patient has been made a Discharge Prescription (TTO) must be written. The medicines element of the TTO can be completed by a member of the medical staff or non-medical prescriber workers as agreed at Drug and Therapeutics Committee.

Ward DfD supplies will be checked by the ward pharmacist, accredited pharmacy technician or experienced registered nurse to ensure:

- That all prescribed medication is available.
- That more than 2 weeks supply is available.
- That the label directions are legible and match those of the current prescription.
- That the available medication is not damaged.

If pre-labelled TTO medicines are available for the patient to take home the TTO should be marked to indicate that DfD supplies are being used. The pharmacy department will re-label Patients Own Drugs that require the directions changing. The original supplying pharmacies label must not be obscured.

For those patients indicating they have sufficient medication and further supplies are not needed, the TTO will be endorsed MAH (medicines at home)

A4.4.2 Nursing Responsibilities:

To support safe and timely discharge nurses need to complete and submit the Pharmacy Discharge Medication (TTO) electronically within Sunrise request form.

Refer to the Checking Medicines to Take Home (TTOs) by Nursing Staff Standard Operating Procedure for further information.

A4.4.3 Pharmacy Team responsibilities

The pharmacy team must ensure that:

- The patient receives safe, effective, and clinically appropriate medicines.
- That relevant other standards are applied including:
- The Dudley Group NHS FT Patient's Own Drugs scheme procedure.
- The Dudley Group NHS FT Self Administration procedure.
- Existing clinical pharmacy standards are adhered to.
- Supplementary instructions are provided
- To ensure that any changes in medication are reflected in the DfD supplies (*i.e., changes in directions, drug additions or deletions*)
- To monitor the storage conditions particularly with relation to security.

Ward Medicines Management Technicians will review the contents of patient's lockers to ensure that adequate stocks are available. For TTOs that have been prescribed by a Pharmacist NMP, an accredited medicines management technician may also complete an accuracy check of the TTO in accordance with pharmacy department Standard Operating Procedures, to enable near patient dispensing of medicines and expedite discharge.

A4.5 USE OF PATIENT'S OWN DRUGS (PODs)

The Dudley Group NHS FT operates a system to support the use of PODs for inpatients.

A4.5.1 Patient Consent:

As soon as practical the patient should be asked whether they have brought any PODs into hospital.
Where patients have their own supply of medicinal products, whether prescribed, over the counter, or complementary/herbal therapy, the HCP has a responsibility to:

- ask to see the medicinal products
- check for suitability of use see A4.5.5.1
- explain how and why they will or won't be used
- ascertain if they meet the criteria for use if needed.

These medicinal products (PODs) including Controlled Drugs remain the patient's property and must not be removed from the patient without their permission and must only be used for that named individual.

The HCP must document in the patient's notes when a patient refuses consent to:
I) use their own medicines
II) hand their own medicines to nursing staff for secure storage
III) dispose of their own medicinal products no longer required or not suitable for use
iv) send their own medicinal products home with a relative or carer when in the hospital or care home setting.

A clear distinction should always be made between those patients who have refused access to their own medication and have capacity, and those who lack this capacity to understand the consequences of their refusal. Among those who lack this capacity, a further distinction should be made for those for whom it is necessary to access their medication. A patient who is refusing or unable to provide access to their own medication and who has been assessed as lacking capacity to understand the consequences of this refusal may have their own medication accessed, if it is thought that the prescribing of medication is in their best interests (following the principles within the Mental Capacity Act 2005, and the Trust's Consent Policy). The assessment of capacity is primarily a matter for the treating clinicians, but other practitioners involved in the patient's care retain a responsibility to participate in discussions about this assessment. For further information see the Assessing Mental Capacity, Dealing with Patients who Lack Capacity and Complying with the Mental Capacity Act (MCA) 2005 Policy.

There should be broad and open discussion amongst at least two members from the Doctor, Nurse, or Pharmacist teams responsible for the patient, before accessing the patient's own medication and the discussion with subsequent decision, including the names of all parties involved in these discussions, must be documented in the care records

A4.5.2 Selection:

PODs must be assessed by a registered nurse or nurse associate utilising the guidance for nursing staff given below. Pharmacy staff will provide additional assessments as required within 48-72 hours of admission. In areas without a regular clinical pharmacy service advice can be obtained by telephoning pharmacy if additional assessments are needed.

A4.5.3 Record Keeping:

All PODs administered must be prescribed and all requirements of this policy still apply. When the Clinical Pharmacy team assess PODs, they will endorse each individual medicine suitable for use on the prescription.

A4.5.4 Nursing Responsibilities:

Nurses must be aware of the correct procedure for patient selection.

- A nurse must be confident of his/her ability to initially assess the quality of the PODs

- Nurses must be aware of the correct procedure for obtaining drugs from pharmacy when the PODs are unacceptable for use
- Consent must be documented
- PODs must be stored in the patient's bedside locker, or another suitable locked storage unit as specified in Appendix 5.1.
- All PODs must be identifiable with the patient's name using an addressograph label. In the event that the medication has been removed from its primary packaging and the dispensing label is not available then the medication must not be used.

Patients' own Controlled Drugs are acceptable for re-use but MUST be stored in the Controlled Drug cupboard and recorded in the Patients' own CD record book.

A4.5.5 Process for checking of Patient's Own Drugs before use

It is essential that drugs brought into The Dudley Group NHS FT by patient's are assessed for appropriateness before use to ensure the patient's safety.

A4.5.5.1 Criteria for assessment:

I. **The PODs are intended for the patient who has them in their possession**

II. **The expiry date has not been exceeded** – If no expiry date is included the medication should not be used,

III. **The container is labelled** (with a typewritten label) where possible and includes the following information: drug name, strength, form, date, quantity. Label instructions should match the hospital prescription and the POD must be relabelled by Pharmacy if it is not the same.

IV. **The contents can be identified** i.e., are blisters packed with the drug name or are clearly marked individual tablets or capsules.

V. **The physical condition is satisfactory**

The tablets are NOT broken or discoloured, mixed with other tablets/capsules, or obviously been transferred from their original container.

N.B. Blister pack or equivalent patient compliance aids MUST NOT be used as the individual products cannot be identified except in exceptional circumstances. Pharmacy advice must be sought.

If drugs are unsatisfactory for use, then a supply must be obtained from ward stock, Pharmacy or borrowed from another ward/unit. This should be under the instruction of a Site Coordinator out of hours.

A4.5.6 Pharmacy Team responsibilities

The pharmacy team must ensure that:

- The patient receives safe, effective & clinically appropriate treatment
- The PODs they endorse for use have been assessed as being appropriate
- Clinical pharmacy standards are adhered to
- Supplementary instructions are provided where appropriate
- PODs are included within the discharge process.

A4.6 SELF ADMINISTRATION

The objective of self-administration is to ensure patients receive safe and effective treatment, whilst retaining and/or regaining responsibility and control over the administration of their medicines; it helps to develop the patient's own knowledge and understanding of their medicines and helps with medicines compliance upon discharge.

4.6.1 Staff Responsibilities

- Nurses must be deemed competent to support a patient to undertake self-administration
- Nurses are responsible for the initial and continued assessment of patients who are self-administering and have continuing responsibility for recognising and acting upon changes in a patient's condition with regards to safety of the patient and others
- At all times, the nurse jointly with other health care professionals has a duty of care to the patient to ensure that only medicinal products which are prescribed and meet the required criteria are used by the patient.
- Nurses must ensure patients are provided with the correct information and that this is tailored to individual patient need
- Nurses must ensure that patients meet necessary criteria for inclusion in the self-administration scheme as detailed below.

A4.6.2 Patient Inclusion Criteria

- The agreement of the consultant responsible for the patients' care has been given for the patient to self-administer
- The patient has capacity
- The patient can open the medicine containers or is offered assistance
- The patient is provided with the following information before commencing self-administration:
    - the name of the medicine
    - why they are taking it
    - dose and frequency
    - common side-effects and what to do if they occur
    - any special instructions
    - duration of the course or how to obtain further supplies
- When assessing a patient's suitability for self-administration of medicines, if the assessing nurse, in his or her professional judgement, is at all unhappy to let the patient self-administer, then the patient should be excluded and reassessed at another point

A4.6.2 Level of entry into the scheme

Patients meeting the criteria for self-administration may do so at one of two levels:

A4.6.2.1 Level 1

This is entry level for all patients initially assessed as appropriate for self-administration.

- All medication is securely stored in the patient bedside locker
- At usual "drug round" times the nurse visits the patient's bedside with the locker key and supports the patient in taking their medication, monitoring compliance & accuracy.
- The nurse will endorse the drug chart as self-administered and initial each dose as a record of supervision
- The nurse will record the patient's level of capacity to self-administer
- At any time, the patient may be taught about their medicines e.g., side effects, special instructions (e.g., when to take – after food).
- Fridge items & Controlled Drugs will be brought to the patient, as necessary.

A4.6.2.2 Level 2

Level 2 i**s not** an automatic progression from Level 1. Only patients who have been assessed as competent and are physically able to access their medication without nursing support will progress to completely manage their own medicines.

- All medication is securely stored in the patient bedside locker
- The patient accepts full responsibility for the storage and administration of their medicines
- Nursing staff will validate the patient's medication via questioning to ensure that the patient is compliant.
- Nursing staff will review a selection of self-administering patients each evening to ensure that medication taken appropriately – this will include visual inspection of dispensed medicines
- Any discrepancies will be discussed with the patient and documented
- At any time, the patient may be taught about their medicines e.g., side effects, special instructions (e.g., when to take – after food).
- If a self-administering patient has items that require controlled storage – e.g., fridge items or Controlled Drugs they must call a nurse at the required time and request these items

A4.6.3 Record Keeping

- Inclusion of a patient in the self-administration scheme must be documented in the patients' medical notes, and the level at which they are participating
- Patients must be assessed on a regular basis to ensure that they are still able to self-administer, and this should be documented in the medical notes
- Prescribed medication and self-administration of medicines will be recorded on the in-patient drug chart

- The top of each page of the in-patient drug chart must be clearly marked stating that the patient is self-administering in the nursing and medical notes.

A4.6.4 Storage Requirements for Self-administration

- Controlled Drugs requiring safe custody and record keeping in the hospital will be excluded from self-administration
- Items that require refrigerated storage should be assessed by a pharmacist or pharmacy technician to determine whether they are suitable for storage at the bedside.
- Only medicines that have been assessed for suitability by a registered member of staff, against the prescribed medicines on the in-patient chart and meet the criteria for patient's own drugs can be used for self-administration.
- Patient's consent should be sought for PODs to be used or destroyed, in line with local waste management processes
- Each patient must have all their medicines kept in a secure, lockable area to keep the medicines in e.g., bedside locker. If the locker has code access, this must be reset for each patient. If the locker has a key, this must not allow access to any other medicines storage areas on the ward. Locker keys must be retrieved from the patient prior to discharge from hospital.
- Patient's must be made aware of their responsibility to ensure that medicines are stored securely at all times. Patients who fail to secure their medicines on more than one occasion will be removed from the scheme.

A4.6.5 Documentation of administered doses

- Patients do not need to 'document' that they have administered their medication
- At each medication round the registered member of staff responsible for medicines administration should ask the patient about administration of their medicines and document this information on the in-patient medication chart.

A4.7 EMERGENCY/OUT OF HOURS SUPPLY

At Russells Hall Hospital an "out of hours" cupboard from which medicines may be obtained is provided. The Site Coordinator for the hospital must be contacted who will then access the cupboard.

When removing items from the emergency cupboard, the designated member of staff must record in the book provided the name of the items, the quantity, and the ward to which these medicines have been supplied. Only complete packs may be removed. Individual tablets or strips of tablets must not be supplied to wards/patients.

Stock drugs may only be borrowed from another ward/unit under the instruction of a Site Coordinator. Borrowing from wards must not occur whilst the Department of Pharmacy is open. It is the responsibility of the Site Coordinator to arrange the borrowing of drugs.

Drugs labelled for a specific patient may not be borrowed without the express consent of the on-call pharmacist.

Out of hours replacement cardiac arrest boxes for clinical emergencies are available.

For details on the emergency supply of medication for patients being transferred from another hospital see section 4.13.

A4.8 PHARMACY OPENING TIMES

The Department of Pharmacy at Russells Hall Hospital is open during the following times:

Monday to Friday:	9:00a.m.	to	7:00 p.m.
Saturday	9.30a.m.	to	5:00 p.m.
Sunday	9.30a.m.	to	5:00 p.m.
Bank Holidays	9.30a.m.	to	5.00 p.m.

Christmas day opening hours confirmed annually by Pharmacy Department.

Opening times at other sites is subject to change and are posted outside individual departments.

Out of hour's pharmaceutical service

The pharmacy provides an on-call pharmacist service through a team of pharmacists who, when on duty, will be able to initially respond to requests for information within 3 minutes of being bleeped and will be able to attend the department within 45 minutes for clinically urgent supply requests. Doctors and senior nursing staff requiring pharmaceutical advice or the supply of critical drugs in an emergency should contact the on-call pharmacist through the Trust switchboard.

Stocks of drugs that may be required urgently are available from the Out of Hours Medicines cupboard which can be accessed through the Site Coordinator (Duty Nursing Officer) via switchboard.

Discharge prescriptions are not available via the on-call service.

If urgent discharge prescriptions are required when the pharmacy is closed and they are not already available in the patient's locker, then a small number of pre-packed medicines are available in the Out of Hours Medicines cupboard under Emergency Discharge. In each case the Pharmacist on call should be contacted via Switchboard to assess the emergency need. The availability of additional pharmacy staff will be assessed to support the medicine verification, dispensing, and checking procedures.

A4.9 UNLICENSED MEDICINES

Refer to the Unlicensed Medicines Policy on The Hub.

The Unlicensed Medicines Policy describes the Trust Policy for the procurement and use of unlicensed medicines (also known as "specials").

Unlicensed medicines are those which have been specially prepared by the holder of a Manufacturers Specials Licence or imported in response to or in anticipation of the order of a doctor or dentist to meet the special needs of individual patients.

Unlicensed medicinal products should only be used when no pharmaceutically equivalent licensed product or suitable alternative licensed product is available for use at the time the patient requires it.

A4.10 PREPARATION OF "MEDIDOSE" TYPE PATIENT COMPLIANCE AIDS

Prior to admission patients may require compliance aids such as Monitored Dosage System (MDS/ Medidose) to help with compliance with their medicines. Patients with complex needs identified during their stay in hospital and requiring social care input at home may be assessed as requiring a MDS at discharge.

The pharmacy team for the ward should be contacted if information or support is required around the use of compliance aids.

A 4.11 CLINICAL TRIALS

Clinical Trials involving Investigational Medicinal Products (IMPs)
All research hosted by the Trust must have relevant regulatory, ethics and research and development (R&D) approval prior to conducting any trial related activity. Clinical trials involving IMPs (with a EudraCT number) must have pharmacy agreement to support. All work carried out on a trial must be in accordance with the International Conference on Harmonisation Good Clinical Practice (ICH GCP) Standards and Medicines for Human Use (Clinical trials) Regulations 2004. Pharmacy maintains detailed records of IMPs via accountability logs including receipt, dispensing, issue, and disposal. All activities are carried out according to clinical trial standard operating procedures.

Prescribing of IMPs
Outpatients: Prescribing must be on trial specific prescriptions. Only prescribers authorised on the trial delegation of duties log may prescribe. Each trial has its own individual prescription which includes the trial number and other trials specific details.

Inpatients: Prescribing should occur on standard prescription sheets after approval from the principal investigator to allow correct administration of IMPs. Only a prescriber authorised on the trial delegation of duties log may initiate an IMP on the prescription sheet. The prescription sheet must clearly state the following additional requirements: the words 'TRIAL MEDICATION', IMP name (in the case of double-blind trials; drug name/placebo), trial name, patients trial number and kit / box / bottle number that the patient has been assigned. A supply of IMP can only be made following the trial specific dispensing guide. A trial specific prescription will usually be required for supply of IMP. If the patient is an in-patient an entry on their electronic prescription will also be required to instruct the nurse to administer it. Prescribing and supply for IMP in COVID related trials may be different.

To Take Out (TTOs) / Electronic Discharge Letters (EDLs): These prescriptions must clearly state 'Clinical Trial Medication' and 'Patients own supply'. The GP should be informed NOT to continue supply. No dispensing can occur from this

prescription. The patient must be discharged with their own supply of clinical trial medication.

Returning IMPs
All returned clinical trial medication must be sent to the research team or supplying pharmacy.

Unblinding/ Code-break
In an emergency it may be necessary to determine which medication a patient has received during a blinded trial. Unblinding may be done via the investigator, pharmacy department or a trial specific telephone access number set up by the sponsor company. The procedure for unblinding is specific for each trial and is available to pharmacists out of hours > pharmacy >hidden channels>clinical trials>Summaries and code break information.

A4.12 PRESCRIPTION CHARGES

Prescriptions for supply of medication to patients from Outpatient Clinics and Emergency Department, will attract a prescription charge unless a valid exemption applies (as defined in the Drug Tariff), which must be declared.

Arrangements should be made in the relevant clinical area for collection and record of payments of prescription charges and the declaration of valid exemption signed by patients.

In exceptional circumstances in consultation with the Pharmacy Dispensary Manager, the Pharmacy Department can arrange for an invoice to be billed via the Finance Department on attendance if a patient is unable to pay the prescription charge due at the time of dispensing.

A4.12.1 Refund of Prescription Charges

In some circumstances, patients are required to pay prescription charges, but may subsequently be entitled to reclaim the charge, using Department of Health Form FP57 (0405). These include:

- Service personnel (H.M. Armed Forces).
- Persons who claim they do not have to pay prescription charges, but at the time of supply, are not in possession of the necessary documentation to prove that this is the case.
- Patients' representative who is unaware of the exemption status of the patient
- Persons such as refugees, who are unable to prove their status at the time of supply.

Appendix 5

A5 SAFE AND SECURE STORAGE OF MEDICINES

A5.1 STORAGE

Each ward/department requires storage accommodation where relevant as follows:-

Controlled drugs cupboard
Contain those drugs controlled by the Misuse of Drugs Act (1971) and subsequent amendments. Such storage MUST comply with the Misuse of Drugs (Safe Custody) Regulations 1973.

Internal medicines cupboards
Contain preparations for internal administration other than those, which are, controlled drugs. Such storage must comply with the British Standard specification for Cupboards for the storage of medicines in health care premises (BS2881:1989)

External medicines cupboard
Contain preparations for external use. Such Storage MUST comply with the British Standard specification for Cupboards for the storage of medicines in health care premises (BS2881:1989).

Electronic access cards
Electronic keys and appropriate electronic access cards may be used for medicines storage access.

Automated drug storage systems
Automated systems for the storage of medicines should be designed in line with the expectations and principles of the current BS 2881.

Digital Key Safes
For advice relating to digital key safes please contact pharmacy.

Medicine trolley
Contain those medicines in current use. Must be securely attached to a wall and locked when not in use.

Individual patient locked cupboards (lockers)
For the storage of medicines dispensed to individually named patients. These must be secure. These storage facilities must be kept locked at all times when not in use.

Intravenous and sterile topical fluids
All intravenous fluids must be locked when not is use using a keypad or key to secure the door of the storage area. In addition, clean conditions are required for the storage of intravenous and sterile topical fluids.

IV fluids should not be stored as singles

Individual bags of IV fluids should not be decanted from the original box

A5.2 MONITORING OF ROOM, REFRIGERATOR AND FREEZER TEMPERATURES OF MEDICINES STORAGE ROOMS

The ward/department manager or registered healthcare professional charge (nurse/ ODP) has overall responsibility for ensuring that the rooms, refrigerators, and freezers storing medicines are monitored and recorded daily. The task may be delegated but not the responsibility.

The temperature for rooms, refrigerators and freezers storing medicines in ward/departments will be continuously monitored by a digital temperature monitoring system.

If fridge, room or freezer temperatures fall outside the approved temperature range, this must be reported urgently according to the Fridge Temperature Monitoring Standard Operating Procedure

A5.3 CUSTODY OF KEYS

The registered healthcare professional in charge remains responsible for the safe and secure storage of medicines. This task may be delegated but not the responsibility.

Loss of medicine cupboard keys must be reported and investigated urgently to trace and recover. If keys leave the hospital building then the ward/department will be responsible for reporting this to the pharmacy and making urgent arrangements for locks to be changed by contacting the Helpdesk. An incident form must be completed.

A5.3.1 Wards

- Keys for controlled drug cupboards must be kept separately from other ward keys.
- The keys for the other drug cupboards must be kept separately from the keys to cupboards used to store other items.
- To ensure that Controlled Drugs are readily available, the designated person in charge of the ward/department may devolve responsibility to a registered nurse.

A5.3.2 Operating Theatres (including Day Cases)

- Keys for controlled drug cupboards must be kept separately from other theatre keys.
- The keys for the other drug cupboards must be kept separately from the keys to cupboards used to store other items
- The overall responsibility for these keys lies with the registered professional in charge of the Theatre who must be identified on the duty rota.

- To ensure that Controlled Drugs are readily available the registered person in charge of the Theatre may devolve responsibility to a registered nurse or qualified Operating Department Practitioner.
- During the working day drugs cupboards (NOT including Controlled Drugs) may be kept unlocked to facilitate safe clinical practice following the agreement of the Head of Pharmacy. When theatre is not in use then all drug cupboards and fridges must be locked, and keys placed securely into the key safe/cabinet: this is the responsibility of the Operating Department Practitioner.
- When the Theatres are not in use keys must be locked in the secure cabinet provided.

A5.3.3 Other areas: (Including Imaging)

It is the responsibility of other service leads to ensure the safety & security of drug cupboard keys within their area of responsibility.

Where Controlled Drugs are stocked the keys must be kept under the control of a registered designated practitioner.

Refer to the Controlled Drugs Policy for further details

A5.4 TRANSFER OF STOCKS

Only in exceptional circumstances may drugs supplied for Ward stock be used on another ward. This will be at the discretion of the designated Clinical Site Coordinator and must only occur when the pharmacy is closed.

Stock transfer forms must be completed to enable pharmacy staff to follow up the supply on the next working day

Controlled or other recorded drugs may only be transferred for administration to an individual patient. Refer to the **Controlled Drugs Policy**

Stocks of controlled or recorded drugs should only be transferred to another ward/theatre in exceptional circumstances and always with Pharmacy involvement. Pharmacy staff must be involved when a ward is opened, closed or during temporary closure.

A5.5 DISCREPANCY OF STOCK BALANCE

Stock medicines received by the ward or department should be reconciled against the delivery note immediately or on the day of receipt at the latest.

TTO pre-packed medicine levels should also be reconciled at each dispensing episode.

In the event of a discrepancy in the stock balance at ward or department level, the registered professional in charge must be informed immediately who will inform a pharmacist during normal opening hours.

If a Controlled Drug is involved refer to the CD Policy. A pharmacist (or on call pharmacist) must be contacted immediately. If there is a suspicion of diversion

or misuse, then this should be reported to the Matron (or Site Co-ordinator– out of normal hours).

In all instances of stock discrepancy an incident form must be completed in line with the Trust Incident Reporting and Management Policy

A5.6 ACCIDENTAL LOSS

Any drug spilled or tablet dropped must be destroyed in accordance with the Waste Management Policy. Disposal of dropped/spilled/broken vials of controlled drugs must be carried out according to the Controlled Drug policy. An incident report must be completed in line with the Trust Incident Reporting and Management Policy. The drainage system must not be used for disposal of pharmaceutical products

A5.7 CLINICAL EMERGENCIES (i.e., Cardiopulmonary arrest)

All wards/departments have a source of urgent supplementary medicinal products. These boxes are tamper-evident and must not be held in a locked cupboard but at strategic and accessible points. Once a box has been opened, its seal has been broken or its expiry date has been reached a replacement shall be obtained from Pharmacy. The person in charge must check daily that these boxes are intact and in date.

A5.8 CONTROLLED DRUGS AND ILLEGAL SUBSTANCES BROUGHT INTO HOSPITAL

Refer to the **Controlled Drugs Policy**.

A5.9 DISPOSAL of DRUGS

All pharmaceuticals must be disposed of in accordance with Trust Waste Management Policy. Acute hospital stocks must be returned to the pharmacy. Patients own drugs should only be disposed of if verbal or written approval has been given by the patient or their parent/guardian or if a period of 7 days post-discharge has lapsed. In the event that verbal consent is given this must be documented in the patient's medical notes.

Hazardous Drugs (Cytotoxic or Cytostatic agents) are segregated within pharmacy and are disposed of as Hazardous Waste. All other drugs are destroyed by incineration via an approved waste contractor.

A5.10 MAINTAINING THE COLD CHAIN DURING DISTRIBUTION

Trust staff who perform duties away from their normal base must ensure that any pharmaceutical requiring refrigeration is stored in a validated temperature-controlled container (i.e., cool bag with ice packs). Items that require refrigerated storage and have risen above 8ºC must not be re-chilled and used without confirming acceptability with pharmacy. Particular care must be taken during summer months.

A5.11 Distribution and Delivery of Medicines

All medicines that are transported between a pharmacy department and wards/departments should be transported using:

- Tamper-evident containers e.g., Envopak® (except those which are too bulky to be secured e.g., bulk fluids).
- Transported in person
- Tracked barcode technology to ensure receipt of medicines bags to final destination.

A5.12 Distribution between Hospitals and Peripheral Units

All medicines that are transported between the Pharmacy department and off-site wards and units should be transported securely. In all cases, a tracking documentation system is employed, whereby a signature is given by the recipient at the destination; this is then returned to the sender as proof of delivery. The following means of carriage may be used:

- Sealed Envopak® or similar tamper-evident sealable bags, or
- Locked transport containers, or
- In person

Where motor vehicles are used (including taxis):

- The driver should not be in possession of the key to the transport container being carried.
- Transport containers will be delivered directly to a Pharmacy department or ward area and checked upon arrival.
- Unauthorised passengers will not be carried.
- Vehicles will be locked when unattended (even if empty).

Appendix 6

A6 COMMUNITY PRACTICE

This appendix identifies specific practices undertaken in the community setting by Trust staff. All other appendices apply to community practice unless the practice is described in this appendix.

A6.1 PRESCRIBING OF MEDICINES

A6.1.1 Clarity

The prescription form or medication record card must clearly state patient's:

- Name
- Age and Date of birth (if under 12 years of age)
- Address
- NHS number

Each item must be clearly written in black indelible ink, preferably using capitals. Prescriptions must be computer generated where possible.

A6.1.2 Generic Prescribing

Medicines should be prescribed using approved (generic) name where appropriate. Where bioavailability is important the patient should continue to receive the same brand: in such cases, the manufacturer's brand name should be stated. Examples are listed in the BNF e.g., anticonvulsants, lithium and theophyllines.

A6.1.3 Requirements for NHS Business Services Authority (NHSBSA) prescriptions e.g., FP10

Each item must include the following.

- Name of drug (generic name or brand name where appropriate)
- Metric dosage
- Frequency
- Form and strength
- Route to be used
- Clear directions as to any site of application of treatment must be present
    - Duration of treatment
    - The prescriber's signature and the date (NB name of the prescriber should be printed beside the signature)
    - Registration number of the prescriber

A6.1.4 Supply of prescription Pads

The prescription pad and forms are the property of the Trust. Prescriptions must only be issued to patients for whom Trust holds responsibility. It is the responsibility of the prescriber to ensure the security of the pad/form at all times.

A6.1.5 General Security

The prescription form must only be produced when needed and never left unattended. When not in use they must be placed in a locked drawer/secure stationery cupboard. When on patient visits the prescriber must keep the prescription pad on their person. Prescription forms should never be left in a car. If prescription pads are taken off Trust premises, they must be kept safe and secure from other family members and visitors.

Under no circumstances should blank prescription forms be pre-signed before use.

A6.1.5.1 In the event of loss or suspected theft.

If controlled stationary, including FP10s, under the care of a member of staff are lost or stolen then the member of staff MUST take action immediately.

Individual

- Inform the Community, Matron, Clinical Locality Manager and Cluster Lead
- Inform Police and give Pharmacy the incident report number. This information must be entered onto 'Missing/Lost/Stolen NHS Prescription Form(s) Notification Form' and the 'Prescription Cancellation Alert' (below)
- The incident must be logged on the Trust Incident reporting system.
- Prescribers will be asked to temporarily write/sign prescriptions in red or green coloured ink.

Pharmacy

- Forward the Prescription Cancelation Alert and the Missing/Lost/Stolen Prescription Forms to:
- Trust Controlled Drug Accountable Officer.
- Regional CDAO (england.westmidlandscd@nhs.net)
- Trust Security
- NHS England and NHS Improvement (england.westmidlandscd@nhs.net)
- Primary care England (RugeleyPrimaryCare-Alerts@nhs.net)

Trust Security

- Trust Security must complete "Missing/Lost/stolen NHS prescription form(s) notification form" (name of individual and signature)
- Completed form to be sent to prescriptions@nhsprotect.gsi.gov.uk

The Dudley Group
NHS Foundation Trust

Missing/lost/stolen NHS prescription form(s) notification form

Health body:	Date reported:
Contact name:	Contact telephone number:
Contact address:	
The following numbered NHS prescriptions forms have been identified to us as lost or stolen:	
Date of theft/loss	
Name of person reporting (GP, practice manager, nurse, trust pharmacist)	
Telephone number	
Full details of theft/loss (please fill in details below)	
Include the following information: • date and time of loss/theft: • date and time of reporting loss/theft: • place where loss/theft occurred: • type of prescription stationery: • serial numbers • quantity: • details of the LSMS to whom the incident has been reported.	
Details of doctor/department/dentist/nurse etc from whom prescription form(s) have been stolen or lost	
Name	
Personal dispensing or identification code/number	
Address	
Serial number(s) lost or stolen **From** **To**	

Details of NHS prescription form type lost or stolen (tick appropriate box)

Issue	Colour	Please indicate type lost/stolen
FP10NC	Green	
FP10HNC	Green	
FP10SS	Green	
FP10MDAS	Blue	
FP10HMDAS	Blue	
FP10MDASP	Blue	
FP10MDASS	Blue	
FP10PN	Lilac	
FP10CN	Lilac	
FP10SP	Lilac	
FP10P	Lilac	
FP10D	Yellow	
FP10PCDSS	Pink	
FP10PCDNC	Pink	

* Updated current forms in use October 2006

	Yes	No
Has this incident been reported to the police?		

Name and police station of investigating police officer
(please fill in details below)

Incident Log Number:
Incident logged by
Lost property no.
Police Station report passed to :

	Yes	No
Has an alert and warning been issued to all local pharmacies and GP surgeries within the area? (Please tick box)		

Alert sent to
bsbcALERTS England (NHS ENGLAND) [england.bsbcalerts@nhs.net] to activate local pharmacies.

Please give details of any ink change or security measures and the effective dates of these measures (please fill in details below)

Red ink for two months from today's date

Name:	
Position:	
Signed:	

Dated:	

Return this completed form by email to prescription@nhsprotect.gsi.gov.uk

PRESCRIPTION CANCELLATION ALERT			
Name and Organisation of Originator			
Address			
Telephone No			
Date Alert Issued		**Time Alert Issued**	
Details of Alert **IMPORTANT: PLEASE DO NOT INCLUDE ANY PERSONAL INFORMATION EG NAMES AND ADDRESSES**			
Prescription No OR Prescription Pad Numbers		**Type of Drug**	
Date of Prescription		**Dosage**	
Pharmacy Name and Address			
Additional Information			
If anyone tries to present the prescription(s): • ***Please DO NOT dispense*** ***AND*** • ***Contact the originator of the alert, as shown above***			
For information: • ***National NHS Fraud and Corruption Reporting Line – 0800 028 40 60***			

A6.1.6 Recording of prescription numbers

It is good practice at regular intervals to note the prescription number issued to a patient in the patient's notes so that should a prescription pad or individual prescription be stolen the prescriber is able to indicate how many forms have been taken.

A6.2 OBTAINING MEDICINES

Medicines may be obtained from the Hospital Pharmacy Service or a Community Pharmacy depending on the system in place for each Community Service.

A6.2.1 Obtaining medicines via the Hospital Pharmacy Service.

- Medicines may be obtained from the Hospital Pharmacy via Pharmacy top-up system or presentation of a signed written order.
- A signed written order may either be a prescription signed by a doctor or other authorised prescriber, or a stock requisition signed by the nurse in charge.
- All signatures must have the name of the prescriber in print next to .
- Staff collecting medicines must present their Trust identity badges.
- All order books and blank order forms must be stored in a secure location to prevent unauthorised access. Only one stock book may be in use and held by each clinical area at any one time.
- All drug requisitions must travel to and from the pharmacy department in sealed tamper evident containers or by a person authorised by the registered professional in charge.
- When requisitioning an order all remaining blank lines must be cancelled before signature. Completed requisition forms and requisition books must be retained by the requesting department for two years from the date of order or date of last entry.

A6.2.2 Obtaining Medicines from a Community Pharmacy

FP10 prescriptions may be used to obtain a supply of medicines to individual patients from community pharmacies who will deliver directly to the patients' home for use at home or within a community clinic.

A6.3 TRANSPORT OF MEDICINES

- All medicines will be transported in such a manner as to prevent loss or improper use.
- If a messenger service (e.g., porter, driver) is used the medicines will be contained in a sealed tamper evident satchel or other sealed container and kept under the control of the messenger until handed to the individual in charge.
- When items requiring refrigeration are transported, care must be taken to maintain the cold chain. If medicines are being transported by non-clinical members of Community staff or Social Services staff they must have received training in the safe transport of medicines.
- Community Nurses may act as the patient representative in collecting prescription medicines from a Pharmacy. This should only be done in circumstances where it is essential for the patient immediate treatment.

- A Community Pharmacy delivery service must be used, where available, when the patient has difficulty collecting their medication or returning items no longer required.
- Members of staff transporting medicines, including dressings, should:
  i) Carry the absolute minimum stock required.
  ii) Carry the medicines in such a manner as not to be obvious.
  iii) Whenever possible, travel direct to the place where the medicines are to be administered but in any case within that span of duty

  N.B. CDs (controlled drugs) must be delivered immediately once collected.
  Do NOT leave medicines unattended (overnight) in a vehicle.
  iv) Return directly back to the site of storage with any unused medicines.

Medicines or products prescribed for an individual patient on a NHSBA (Prescription Pricing Authority e.g., FP(10)) prescription form must be left with the patient since it is their property.

Used syringes, needles and any part used injections must be discarded into a suitable sharps container prior to transporting back to base.

A6.4 STORAGE AND SECURITY OF MEDICINES

For each area of Community services, the manager responsible for the service is responsible for the safe storage, custody and administration of all medicines used within their area, in accordance with this policy.

All medication on Trust property must be stored in a locked cupboard, drug trolley or refrigerator designated for the sole purpose of storing medication. These storage facilities must be kept locked at all times.

There should be a single key for each lockable storage facility with a duplicate key stored in a designated safe area or with a senior manager. Loss of keys must be reported to the line manager on duty who will arrange an investigation and change of locks or authorise temporary use of a second set of keys.

When drug cupboards and/or their locks are replaced, or new keys cut for drug cupboards this must be done only following verbal authorisation from the senior manager responsible for the service and the incident must be logged on Trust Incident reporting system.

The safe keeping and whereabouts of the drug cupboard keys is the responsibility of the most senior person on duty. Wherever possible the drug cupboard keys should be held personally by the senior officer in charge. If this is impractical the drug cupboard keys must be stored in a designated place of safekeeping and be managed in such a way (i.e., record signatures as key is issued and returned) to prevent unauthorised access.

Duplicate keys must be stored in a similar manner, preferably in a different designated place of safekeeping.

Preventing unauthorised access to keys is of paramount importance and the location of key storage (including the duplicate key) should be approved and documented by the manager responsible for the service.

When a unit where medicines are stored is temporarily not involved in the active treatment of patients or closed e.g., overnight or weekend, the drug cupboard keys must be returned to their designated place of safe keeping and secured in such a manner to prevent unauthorised access.

Where the duration of closure is longer than overnight or a weekend the advice of the manager responsible must be sought. All medicines shall be returned to lockable medicine cupboards when not in use except for emergency drug kits e.g., Cardiac Arrest Boxes, which shall be stored in a manner not obvious to the general public. Stocks must be checked on a monthly basis for out-of-date items.

All out of date medicines generated by healthcare professionals, must be disposed of in the waste container and transported to a pharmacy for safe disposal. Community staff and Pharmacy staff are responsible for ensuring that the stock is appropriate to the field of practice and that the stock remains in date.

The healthcare professional is responsible for ensuring that systems are followed the stock is kept tidy and clean and is stored in a way that facilitates ease of use. It is the healthcare professional's responsibility to ensure that any medications administered by them appear to be of suitable quality for use and have been stored according to manufacturer's guidance.

If items are required to be refrigerated then a lockable medicines fridge must be used for drug storage only. The temperature should be recorded regularly (daily or each time the area is used if less frequently than daily) with a maximum/ minimum thermometer on an audit sheet.

A6.4.1 Storage in the patient/ clients' home.

Healthcare professionals are responsible for advising patients/clients and/or their relatives or carers on security and safe storage of medicines to be administered at home. Where possible patients/clients and carers should be encouraged to store medicines in a locked cupboard, out of reach of children. Medicines should not be stored in a kitchen or bathroom area.

A6.5 ADMINISTRATION

Registered healthcare professionals will normally undertake the administration of medicines. Exceptions are Community Health Care Staff that have been trained in, and assessed as competent in, the administration of certain medication (e.g., eye/ ear drops). Documentation of training should be maintained by the Cluster lead/ Team Leader who has responsibility for ensuring such training is completed. A record of this training should be held in the staff member's personnel file.

A6.6 CONTROLLED DRUGS FOR COMMUNITY TEAM

Refer to the Controlled Drugs Policy and note the following additional points:

A6.6.1Transport

Community staff should **not** carry controlled drugs unless in exceptional circumstances or to deliver services to patients such as:

- Palliative patients receiving drugs via syringe drivers and anticipatory medicines.
- Community Pharmacy delivery services should be used wherever possible when the patient/client has difficulty collecting their medication.

On occasion it may be necessary for a nurse to collect an urgent prescription from the pharmacy. The medication must have been prescribed for a specific patient and the member of staff is collecting them under the direction of the patient for administration immediately. The nurse should go straight to the patient's home and must not leave the medicines in the vehicle unattended at any point.

When medicines are supplied out of hours, the OOH procedure should be followed.

A6.6.2 Records

Controlled drugs should be documented as follows.

A6.6.2.1 Patient held stock

A running balance should be kept in the patient's records to account for this stock. If a discrepancy arises then efforts should be made to account for this. If no reason can be found then the incident should be reported to the cluster lead/ team leader who is responsible for deciding on what further action should be taken. The Incident Reporting Procedure must be followed, and the incident recorded on the Trust incident reporting system.

A6.6.3 Destruction

6.6.3.1 Controlled Drugs no longer required by the patient

For all CDs the patient, their carer or representative should be advised to return it to their community pharmacy.

The nurse present should record all CD drugs not used (recording form, strength, and quantity) sign and date the record and ask a witness to sign that the record is true. A copy kept with the patient's notes. If there is no carer/relative to return drugs to a community pharmacy, all drugs should be destroyed as soon as possible.

These CDs can be destroyed by the healthcare professional at the patient's home, and witnessed by the patient, their carer or representative or another member of staff. A CD destruction/denaturing kit must be used for all liquid schedule 2 CDs. Once denatured, drugs may be disposed of in clinical waste

containers. A note should be made in the patient/client's records that must be signed by both parties.

In the residential home setting responsibility for destruction of CDs is handed over to the care manager of the residential home following a stock check of remaining CDs.

A6.6.3.2 Breakages and Damages

If any healthcare professional finds or accidentally causes a supply to be damaged or broken (e.g., ampoules/bottle) this incident shall be reported promptly to the cluster lead/ team leader. An entry on such incidents will need to be made directly in the patient records detailing the date, time, quantity of stock damaged or broken, the signature of the member of staff who found this, and the signature of the member of staff or other person present who witnessed the incident. The staff involved may wish to add additional information if thought necessary. If damaged or broken supply is discovered by a patient or carer then the same procedure should be followed noting who made the discovery.

An incident report MUST be completed via the Incident Reporting and Management Policy

A6.7 DISPOSAL OF MEDICINES (non-CDs)

Medicines once dispensed to a patient/client are their property. They should not be removed for disposal without the patient/client's consent. If any medication is not current therapy the patient/client or their relative/representative/carer should be encouraged to give their consent to the disposal of such medication.

Patients/clients, their relatives, representatives, or carers should be advised to take the medication to a community pharmacy. If a patient is utilising a community pharmacy delivery service then unused medication may be returned to the driver when they next make a delivery.

If it is felt unsafe to leave non-required medication in the possession of a patient, but the patient/client is unwilling to give consent for disposal, the registered nurse should contact the doctor in charge or patient/client's doctor to advise them of concerns. This action must be fully documented in the patient's record along with the name of the doctor contacted and an incident form completed via the Incident Reporting and Management Policy

A6.8 THEFT

If medicines under the care of a member of staff are lost or stolen then the member of staff must take action immediately to inform their Community, Matron, Clinical Locality Manager, Cluster lead, the police, and the Trust Head of Security. Contact the pharmacy department directly via switch and complete an incident form via the Incident Reporting and Management Policy