Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document level: Trustwide (TW)
Code: MP1
Issue number: 10

Medicines policy

Lead executive	Medical Director
Author and contact number	Chief Pharmacist - 01244 397379

Type of document	Policy
Target audience	All clinical staff
Document purpose	The policy provides guidance on all aspects of medicine legislation set out in the various steps of the Medicines Management Process i.e. prescribing, ordering, supply and transport of medicines, safe storage, administration and disposal as they apply to the inpatient and community settings.

Approving meeting	Medicines Management Group	27-Sep-12
Implementation date	Oct-12 followed by annual review Full review postponed with agreement from MMG (September 2017) to await revised Duthie Report, anticipated for early 2018.	

CWP documents to be read in conjunction with	
HR6	Trust-wide learning and development requirements including the training needs analysis (TNA)
MP18	High dose antipsychotic therapy guideline
MP19	Medicines reconciliation policy
MP20	Policy for the reuse of patient's own drugs
GR1	Incident reporting and management policy
CP10	Safeguarding adults policy
CP40	Safeguarding children policy
MH	Mental health act policies

Document change history

Changes made with rationale and impact on practice
1. Information added regarding administration of paracetamol at the Urgent Care Centre.
2. Transfer to updated template and removal of NHSLA requirements

Training requirements	There **are** specific training requirements for this document. Medicines management mandatory training in accordance with training needs analysis

Financial resource implications	No

External references

References
1. The safe and secure handling of medicines: a team approach (RPSGB, 2005)
2. Safer management of controlled drugs: Guidance on strengthened governance arrangements (DH, 2007)
3. Safer management of controlled drugs: Guidance on standard operating procedures for controlled drugs (DH, 2007)

References
4. The Medicines Act 1968 5. The Misuse of Drugs Act 1971 6. Misuse of Drugs (amendment 2) regulations 2006 7. Shipman Inquiry 2005/6 8. The Medicines labelling Regulations 1976 9. The Royal College of Psychiatrists 1994: Consensus statement on "The Use of High-Dose antipsychotic Medication" Thompson (1994) *B. J. Psych*; 164; p.448-58 10. Audit Commission. (2001). *A Spoonful of Sugar - Medicines Management in NHS Hospitals*. London: Audit Commission. 11. Department of Health. (2000). *Pharmacy in the Future - Implementing the NHS Plan*. London: Department of Health. 12. Department of Health. (2003). *Medicines Management in NHS Trusts: Hospital Medicines Management Framework*. London: Department of Health. 13. Department of Health. (2004). *Building a Safer NHS for Patients: Improving Medication Safety. A Report by the Chief Pharmaceutical Officer*. London: Department of Health. 14. Department of Health and NHS Practitioner Programme. (2006). *Medicines Matters - A Guide to Current Mechanisms for the Supply, Prescribing and Administration of Medicines*. London: Department of Health. 15. Department of Health. (2006). *Final Guidance Safer Management of Controlled Drugs (CDs) Changes to Record Keeping Requirements*. London: Department of Health. 16. *Health Act 2006 (c1)*. London: The Stationery Office. 17. *Health and Social Care Act* 2001. London: The Stationery Office 18. The Controlled Drugs (Supervision of Management and Use) Regulations 2006. SI 2006/3148. London: The Stationery Office. 19. Department of Health, Royal Pharmaceutical society of Great Britain (May 2007). Safer Management of Controlled Drugs: a guide to good practice in secondary care (England). London: Department of Health. Found at www.rpsgb.org 20. Healthcare Commission. (2007). *Talking about medicines; the management of medicines in trusts providing mental health services*. London: Commission for Healthcare Audit and Inspection. Available at www.healthcarecommission.org.uk 21. University of Manchester. (2006). *Avoidable Deaths Five year report of the national confidential inquiry into suicide and homicide by people with mental illness.* University of Manchester. Available at: www.medicine.manchester.ac.uk/suicideprevention/nci/

Equality Impact Assessment (EIA)

Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative?	No	
• If so can the impact be avoided?	N/A	
• What alternatives are there to achieving the document without the impact?	N/A	
• Can we reduce the impact by taking different action?	N/A	

Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.	
Was a full impact assessment required?	No
What is the level of impact?	Low

Contents

1. Introduction

This is the eighth edition of the Cheshire and Wirral Partnership NHS Foundation Trust's "Medicines Policy for the safe and secure handling of medicines". This policy will supersede edition six. All Partnership Trust staff and those staff contracted to work within the Partnership Trust either as locums, agency staff or staff working with the Trust under Service level Agreement (SLA) arrangements must adhere to this policy.

This edition of the policy now incorporates the principles of the safe and secure handling of medicines relevant to all staff working across Community Care Western Cheshire (CCWC) Service Unit and as such the policy has had a major update across most chapters in order to incorporate those principles. Generic principles which are applicable to all areas of the Trust are covered in the main chapters of the policy (chapter 3-11) and any differences or specific duties are covered in the chapters on Community Care Teams (CCWC), community mental health teams and controlled drugs.

The policy provides guidance on all aspects of medicine legislation and is set out as chapters, which constitute each step in the process of how medicines are managed. The medicines management process includes the following steps:

- Prescribing;
- Ordering;
- Supply and transport of medicines;
- Safe storage;
- Administration;
- Disposal.

New professional practices concerning the use of medicines have developed and continue to develop. As a result the policy goes beyond the six principle steps and looks at guidance for managing medicines within the community teams, which is an ever-developing area within mental health and learning disability. The Trust has a separate strategy for non-medical prescribing and a stand alone policy that goes into the detail of non-medical prescribing which is found in the suite of medicines management policies on the Trust intranet. The chapter on Controlled Drugs takes into account the amendments set out in "Controlled Drugs (supervision of management and use) Regulations 2006". This also includes a set of standard Operating Procedures for handling controlled drugs within the inpatient units and the out of hour's services for Community Care.

All staff working within the Trust, who are involved in some way with the use of medicines, must familiarise themselves with the contents of this policy. Those in charge of wards, departments or teams are responsible for ensuring that their staff; especially new starters, agency staff and locum staff follow procedures within this policy, the procedures within this policy may differ slightly from procedures in other Trusts where staff have worked previously. Copies of this policy should be made available on all wards and in community teams and can be accessed via the Trust Intranet.

This policy will be reviewed again within the next 5 years to take into account any changes in medicines legislation and ratified by the Trust's Medicines Management Group. In the meantime, all comments and suggestions should be forwarded to the Trust Chief Pharmacist.

2. Definitions

Throughout this policy, certain specialist titles describe healthcare staff who have defined responsibilities regarding the management of medicines. In general only staff with contracts (or honorary contracts) of employment to work across the Trust are assessed as having any involvement with medicines. However certain regular bank staff may be considered competent to administer medicines. All nurses or practitioners who are either new or unsure about certain practices should administer in pairs.

Throughout, the term **"Practitioner" is used. This is a general term used to describe a qualified medical practitioner, nurse, pharmacist or other authorised healthcare employee.**

Appointed Practitioner in charge
The senior practitioner appointed in charge of a ward, department, team e.g. ward manager, team leader.

In situations where the person in charge is not from a professional background appropriate to take such responsibility (e.g. community team leader with a social work background) another member of the team must undertake the role of appointed practitioner in charge.

Assigned practitioner in charge
The senior practitioner on-duty for the ward or department, who has been rostered as the professional in charge for that shift.

Designated practitioner
Any registered practitioner identified by the Appointed Practitioner in Charge as competent and appropriate to perform a specific function. The designation as such has been communicated to and accepted by the Designated Practitioner. If the practitioner is based in the community the term used is Designated Community Practitioner.

Authorised pharmacy staff
Any qualified pharmacist or pharmacy technician authorised by the chief pharmacist as competent and appropriate to perform a specific function.

Pharmacist
Usually the ward / locality based pharmacist covering the pharmaceutical duties of that area.

Chief pharmacist
This refers to the chief pharmacist of the trust who has overall responsibility for the medicines management process within the organisation.

The chief pharmacist has overall responsibility for the provision of the pharmacy service in the various localities of the Trust and the pharmacy (supply) service contract.

Authorised health employee
A member of staff who has following training, been authorised by the trust to undertake specific duties in relation to medicines.

Bank / agency staff
Agency or bank staff unfamiliar with the policies of the Trust should not undertake to administer medication. Regular bank or agency staff confident in Trust practices may administer alone with approval of the appointed practitioner in charge. Bank and agency staff should be made aware before agreeing to work a shift, that they will be expected to administer medication alone. They should NOT be pressurised into working in an area where they will need to administer medication if unconfident in doing so.

Non – registered nursing staff
Health care workers, support workers and nursing assistants who assist in medication management. Some of these staff may have NVQs allowing them to undertake certain functions with respect to medicines administration.

Runner
An untrained, non-registered member of staff who takes medication, prepared by another practitioner, to a patient for administration. This practice is not to be used at CWP.

Supplementary / non medical prescriber
A registered nurse or pharmacist who has completed a recognised non-medical prescribing course and whose qualifications are recorded by the Nursing and Midwifery Council (NMC) for nurses and the General Pharmaceutical Council (GPhC) for pharmacists and the register annotated accordingly.

Authorised Witness for Controlled Drugs
In accordance with the Misuse of Drugs Regulations legislation the Trust Accountable Officer for controlled drugs has to nominate responsible members of staff to witness the destruction of schedule 2 Controlled Drugs that are no longer required by patients within the Trust premises. The approved witnesses must not be involved in any way with the daily handling of such medicines.

Medicine
Any substance or combination of substances presented for treating or preventing disease. Any substance or combination of substances which may be administered with a view to making a medical diagnosis or restoring, correcting or modifying physiological or psychological functions.

Prescribe
To authorise in writing the supply of a medicine.

Dispense
To prepare a clinically appropriate medicine for a patient for self-administration or administration by another. The act of dispensing includes supply and also encompasses a number of other cognitive and practical functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product). These functions are usually performed under the supervision of a pharmacist.

Supply
To supply a medicine to a patient/carer for administration.

Administer
To give a medicine by either introduction into the body, (e.g. orally or by injection) or by external application (e.g. cream or ointment).

Supervision of administration
To observe a patient administer their own medicines

Patient group directions
A specific written instruction for the supply and administration of named medicines in an identified clinical situation in the absence of a written prescription. It must be drawn up within the Trust by doctors, pharmacists and other professionals and approved by the Medicines Management Group.

Standard Operating Procedures (SOPs)
Procedures that outline the process of carrying out a specific task. E.g. Pharmacy SOPs for dispensing, Controlled Drug SOPs.

3. How medicines are prescribed

3.1 Consent and capacity

General Principles of Consent

"Consent is the voluntary and continuing permission of the patient to receive a particular treatment based on an adequate knowledge of the purpose, nature, likely effects and risks of the treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not 'consent'" *(Code of Practice for the Mental Capacity Act, Chapter 23.31)*.

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.

- For consent to be valid it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

- If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected.
- Consent should be sought for each aspect of the person's care and treatment.

For guidance on the Consent to Treatment under the MHA, see trust policy MH13 Consent to Treatment.

All patients should be educated about changes to their medicine and about their discharge medication. A range of leaflets for patients are available from the wards and community teams. Specifically the "choice and medication leaflets" and various Trust information leaflets are available on the Trust internet for staff and patients. Local arrangements should be made for the issue of these leaflets, so as to ensure that the patient receives the appropriate information.

Patients should be given a copy of the patient information leaflet associated with their medicine(s) they receive on discharge.

Treatment of those without capacity to consent
When a patient is incapable of consent to treatment, medicines can be prescribed for them in their best interests under the Mental Capacity Act. The treatment must be:

- Necessary to save life, or prevent a deterioration of, or ensure an improvement in, the patient's physical or mental health;
- Be in accordance with the practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question.

Treatment of those detained under the Mental Health Act 1983 (as amended 2007)
The Mental Health Act 1983 (as amended 2007) and additions should be followed by practitioners where it relates to medication consent.

3.2 How the organisation makes sure that all prescription charts are accurate

It is the responsibility of the doctor and nursing staff admitting a patient to ensure a faxed copy of all medication usually prescribed by the patient's GP is received as soon as possible (on the same day for Monday to Friday 9-5, next working day for nights and weekends) and filed in the prescription section of the patient's notes. This should form the basis of the medicines reconciliation process which must be completed within 24 hours for patients admitted Monday-Friday and within 72 hours for patients admitted Friday 5pm-Sunday. See the CWP Medicines Reconciliation Policy MP19 for full requirements, process and monitoring. An ongoing check of the prescription chart is undertaken by the Lead Pharmacist and via clinical audits conducted.

3.3 How medicines are prescribed

Medicines must only be prescribed by suitably trained and qualified healthcare professionals according to the terms of their qualification, and acting within their skills, knowledge and competence. In CWP this includes registered Doctors, Independent Non-medical Prescribers and Supplementary Non-medical Prescribers.
Dieticians may prescribe dietetic products in CWP.

Community care staff should also refer to the following in conjunction with this policy:

- The non-medical prescribing policy;
- The safe use of McKinley syringe pump policy.

Non-medical prescribers should also refer to the non-medical prescribing policy.

Any authorised Prescribers of medicinal products are required to check medicinal products for suitability of use, contra-indications and allergies that patients may have.

3.3.1 Choice of medication

Local regulations and guidelines that limit the choice of medicines available, the length of prescribing period, format and style of the information and records should be followed. These include (the full list is found on the website medicine management section on policies):

- CWP medicines formulary;
- Antibiotics formulary;
- Rapid tranquillisation guidelines;
- Guidance on use of psychotropic medication in pregnancy and lactation.

Hospital doctors will be guided by the decision of the Trust medicines management group and the relative joint Acute Trust / Primary Care Trust medicines management committees with regards prescribing of medicines both within the Trust, on Fp10s and then on transfer of care of patients to their respective GPs.

A defined procedure must be followed in order to request a new medicine or named-patient medicines for use within the Trust. Details of the procedure can be found in MP6.

Community Care Western Cheshire prescribers should refer to sect 14.1 for further information on local prescribing policies and guidelines.

3.3.2 Prescribing 'off label, unlicensed or above BNF limits

If any medicine is unlicensed, used 'off-label' or on a named patient basis, its prescription and procurement must comply with the relevant policy or Standard Operating Procedure.

All prescriptions for medication should be within BNF limits. Any prescribing above BNF maximums should be discussed by the multi-disciplinary team and ideally involve the locality mental health pharmacist. The prescriber should indicate on the prescription chart under additional instructions that the dose is above BNF limits.

3.3.3 Medical staff prescribing for self and families

Medical staff should not prescribe for themselves or their families, in line with current General Medical Council (GMC) recommendations.

3.3.4 Function of the prescription sheets / charts

3.3.4.1 Inpatient chart

- To provide a permanent record of the patient's treatment with medicines;
- To indicate the patients' sensitivity to medicines;
- To facilitate the provision of the correct medicine from the pharmacy;
- To direct the administration of the medicine to the patient.

All medicines must be written on the prescription sheet, including details of OXYGEN therapy. It should only be necessary for each patient to have one current prescription sheet. Where more than one prescription sheet is required cross-reference must be made where indicated.
For example:

- Clozapine or Antipsychotic Cross Titration Charts;
- SC. fluids and additives;
- Insulin Chart;
- Depot cards;
- ECT charts;
- Anticoagulant Charts;
- MHA Forms 38/39 T1 & T2;
- Nicotine replacement therapy administration charts;
- Alcohol detoxification charts;
- On more medicines than the prescription sheet will facilitate –the sheets should be annotated "*1 of 2 sheets*".

As soon as possible multiple prescriptions should be condensed onto one sheet.

When a new prescription sheet is needed, all currently prescribed medicines must be transcribed by the doctor onto a new sheet and the old entries cancelled. Under these circumstances the date when the medication was originally prescribed should be entered onto the new prescription sheet. The date that the prescription sheet was re-written should be clearly noted on the front of the prescription sheet.

3.3.4.2 Patient administration chart

A **Patient Medicine Administration Chart** is not a prescription **but is a direction** to administer medication (NMC 2008). It must be signed by an authorised prescriber and authorises the delegation to administer medication on the prescriber's behalf. However, in so doing the staff administering the medicinal product are accountable for their actions and for raising any concerns about the direction with the prescriber.

The documentation in use in Community Care Western Cheshire (CCWC) for prescribing medication in Community Nursing Services is The Medication Authorisation Form (excluding controlled drugs).

Please note that there is separate End of Life Care Pathway medicines documentation. See the Safe use of McKinley Syringe Pump Policy.

3.3.5 Standard for entries on a medication authorisation form or prescription form

The name of the medicine should be written using black indelible ink pens, writing legibly using BLOCK CAPITALS and approved medication names. Proprietary names (i.e. brand names) must not be used. The only exceptions to this rule are multi-ingredient preparations with no approved names or products whose proprietary name defines a specific formulation (e.g. slow-release theophylline preparations).

Where non proprietary (generic) titles are given they must be used in prescribing. This will enable any suitable product to be dispensed thereby saving delay to the patient. The only exception to this is where bioavailability problems are so important that the patient should always receive the same brand and in such case the brand name or manufacturer should be stated e.g. Priadel (lithium) Epilim (sodium valproate).

The following must be entered in BLOCK CAPITALS.

- Patients name;
- NHS Number;
- Date of Birth;
- Date and where applicable, time on which a treatment and or medication is to commence;
- Drug;
- Dose;
- Frequency;
- Route of administration;
- Full signature of authorised prescriber;
- Date drug discontinued.

3.3.5.1 Use of decimal points

- The unnecessary use of decimal points should be avoided, for example: 3mg not 3.0mg;
- Quantities of 1 gram or more should be written as 1g;
- Quantities less than 1g should be written in milligrams, for example: 500mg not 0.5g;
- Quantities less than 1mg should be written in micrograms, for example: 100 micrograms not 0.1mg;
- When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, for example: 0.5ml not.5ml;
- Use of the decimal point to express a range for example: 0.5 to 1g is acceptable;
- Micrograms, Nanograms and units must not be abbreviated particularly as a poorly written "u" can be misinterpreted as a number leading to insulin over dosage;

- The term ‘millilitre' (ml or mL) is used in medicine and pharmacy, and cubic centimetre, c.c., or cm^3 should not be used.

3.3.5.2 Use of abbreviations

Only the following abbreviations when prescribing dosage are acceptable:

- mg milligram
- g gram
- kg kilogram
- l litre
- ml millilitre
- mmol millimole

Route of Administration – use of abbreviations

The following abbreviations are only acceptable when prescribing route of administration:

- I.M. intramuscular
- INHAL for inhalation
- I.V. for intravenous
- I.D. intradermal
- NEB for nebulised
- PO or O for oral
- P.R. for rectal
- S.C. subcutaneous
- PV for vaginal
- TOP for topical

Other routes of administration must be written in full, for example: Sublingual, Buccal. Only one route of administration may be specified for each medication, for example: METOCLOPRAMIDE O/IV is not acceptable.

3.3.5.3 Dosage of medication

The dose required must be included by the authorised prescriber. The dose must not be expressed in terms of the dosage form for single ingredient preparations, for example: Zomorph 2 capsules is not acceptable and should be written as ‘Zomorph capsules 20mg’.

When doses other than multiples of 5 mL are prescribed for oral liquid preparations the dose-volume will be provided by means of an oral syringe.

3.3.5.4 Dosage frequency

- For regular medication the times of administration must be indicated by the authorised prescriber using the 24 hour clock;
- Depot injections should be prescribed with the time interval expressed using the term “every”, e.g. every 3 weeks rather than 3 weekly which can be misinterpreted. This can be abbreviated as 3/52;
- For “regular medicines” the prescribing times should be in accordance with regular medicine rounds wherever possible. A 6am dose should only be ordered if there is a good therapeutic reason;
- For antibiotics the prescribing times should be in accordance with regular medicine rounds wherever possible and should also be equally spaced to ensure effective treatment. The indication and course length appropriate to the treatment should be written against the antibiotic e.g. 5 days for UTI;
- Some medicines may be prescribed according to written protocols agreed by the Medicines Management Group These medicines may be prescribed ‘as protocol’ or “see chart” e.g. Clozapine, Chlordiazepoxide;

- For paper prescriptions complete the 'Other Charts in current use' section on the front of the prescription chart when starting or discontinuing an additional chart (including ECT prescription).

3.3.5.5 As required medication

"As required" medicines the times for administration must be written by the prescriber, using the 24 hour clock, where relevant, for example: hypnotics. The maximum frequency must be stated as well as the maximum dose in 24 hours. In the case of preparations to be taken 'as required' a minimum dose interval must be specified.

- The as required section of the prescription sheet must only be used for those medicines to be given at the practitioner's discretion according to the needs of the patient. Prescribing medicines on an as required basis provides a useful method of assessing the patient's requirements for medicines such as anticholinergics, analgesics and hypnotics;
- **The prescriber must write the frequency of administration and indication for use. A maximum dose in 24 hours must be stated and this must include any regularly prescribed doses. Abbreviations such as 4 º should not be used; 4 hourly should be written in full;**
- Dose ranges are usually only used for Rapid Tranquillisation (RT) administration in line with the Trust policy and algorithm MP10. If a dose range is prescribed the maximum daily dose must not be exceeded. A dose range enables the prescriber and the nurse administering the medicine to see clearly what has been given over a period of time and this should be reflected in the careplan in terms of what dose has been effective;
- The 'as required' prescription must be reviewed regularly by the prescriber to determine its clinical need. Good practice indicates that no more than 6 doses should be given without a review. Medicines originally prescribed 'as required' but which are needed regularly as indicated by the administration record should be rewritten in the regular prescription section;
- To prevent the accumulation of unnecessary 'as required' prescriptions the following guidelines should be observed:
  - Any PRN that has not been required for 3 months should be cancelled;
  - No more than one medicine from any BNF therapeutic category should be prescribed as a PRN at the same time;
  - No more than two medicines should be prescribed as a PRN for any one indication.

Care must be taken not to duplicate medicines being taken regularly and thus overdose the patient. Combination analgesics frequently contain paracetamol, which may already be prescribed in the regular section of the prescription chart. Rapid dose escalation using combinations of PRN and regularly prescribed antipsychotic drugs is one of the most common causes of neuroleptic malignant syndrome and sudden death in schizophrenia.

3.3.5.6 Once only doses (stat doses)

Medicines that are intended to be given once only must be prescribed in the 'once only' section of the prescription sheet.

Stat doses are valid for a maximum of 24 hours. They are prescribed with the intention that it is needed to be given immediately. If not given within that timeframe stat doses should be discontinued by the prescriber.

3.3.5.7 Discontinued medications

The date when a medicine is discontinued must be entered on the date drug discontinued box on the Medication Authorisation Form/Prescription Chart beside the prescriber's full signature. On inpatient charts the reason for discontinuation should also be stated.

A diagonal line must be drawn through the prescription so that cancellation is obvious, but the prescription is not obliterated. This is important to know exactly what was taken by the patient and when.

3.3.5.8 Incorrect entries

Incorrect entries must be scored through and the word cancelled written against it by the prescriber.

3.3.6 Validity of prescriptions

All prescriptions are valid for a maximum of six months (this applies to inpatient, outpatient/clinic and FP10 HNC prescriptions). The exception being for controlled Drugs (see section 12). After this period, treatment must be re-written if it is to be continued.

If an inpatient prescription becomes ambiguous or unclear at any time, the practitioner responsible for the administration of the medicine or the pharmacist checking the prescription must request the prescriber to rewrite it.

3.3.7 Prescribing by telephone / verbal orders

In the interests of patient safety, prescriptions must not be given or accepted over the telephone, except in an emergency.

A verbal order may result in the administration of a medicine without a prescription written by the responsible medical officer.

In an emergency, or where waiting for a Doctor is considered detrimental to patient care, that Doctor may prescribe medicines (excluding controlled drugs) over the telephone. The prescription must be dictated clearly to the senior nurse in charge of the ward or CPN and repeated to a second registered nurse / bleep holder. The doctor is advised to record the verbal prescription contemporaneously.

For all such verbal requests:

- The drug, dose, date and time must be written in the “once only” section of the prescription sheet by the nurse who takes the message; clearly indicating that it was a “telephone message” and recording the name of the prescriber and the signature of the nurse;
- The drug, dose, indication, date and time of administration must be written in the multidisciplinary notes;
- The reason for administration on telephone request must be written in the multidisciplinary notes;
- The prescription must be signed by the doctor within 24 hours. If this does not occur the senior nurse manager / team manager or modern matron should be informed;
- When a community designated practitioner receives a verbal order to alter the dose or time interval of a depot medicine the prescription must be signed within one week. After one week the verbal order is no longer valid;
- Crisis / home treatment team staff or inpatient staff that are working on a remote site for which there is no doctor presence 24hrs a day may use verbal orders for the supply of medication when it is not viable for a doctor to assess the client at that moment in time;
- It is unacceptable for a verbal message to be given for a controlled drug;
- The designated practitioner retains the right to refuse to take a verbal message to administer a medicine.

Where possible the prescriber should be encouraged to make required amendments to prescriptions in person and original prescriptions should be presented for dispensing.

Where an urgent prescription has been telephoned to a pharmacy, the FP10 must be with the pharmacist within 72 hours. This is a legal requirement.

3.3.8 Standards for prescribers in community clinics

- A prescription must be completed by an authorised prescriber, signed and dated on the approved secure and controlled prescription stationery;

- Order pads and prescriptions (controlled stationery) must be stored securely in a locked receptacle, drawer or room, when not in use;
- Repeat prescriptions must be reviewed regularly, and annually as a minimum;
- The issue of a prescription must be documented in the patient's clinical records;
- The correct route of administration must be selected;
- The correct patient has been identified;
- The correct medicine and formulation have been selected;
- The audit trail should be traceable;
- Appropriate steps to control these procedures must be in place regardless of whether they are undertaken using a paper or electronic communication system;
- Prescriptions must be clearly written in ink or printed by machine and signed in full.

3.4 Medication for CWP outpatients

Changes to Medication for outpatients should be communicated to the GP within 2 weeks either using fax template as per contract or in a clinic letter so that the patient medication record can be updated and a new prescription issued. If medication is required within 2 weeks for an outpatient then a CWP FP10 HNC prescription must be written. FP10HNCs will also be used for those medicines subject to shared care agreements e.g. lithium, Circadin. They are more expensive for the Trust due to the greater cost of certain medicines in the community and should therefore only be used as above. Consultants will be monitored on their and their team's use of these prescriptions through the locality mental health pharmacists.

3.5 Prescribing and ordering Depot or Risperidone long acting injection or clozapine for patients in the community

As per pharmacy Standard Operating Procedures (SOP) with the preferred supplier. These are now stand alone from this policy and found on the intranet as the joint operational policy for pharmacy services.

4. Ordering

Medicines procured for use by CWP must be obtained from approved sources. This includes any registered or any other pharmacy specifically approved by the lead pharmacist medicines governance to meet local needs. In the case of mental health wards and units this means the preferred pharmacy supplier.

Review of the ward / clinic stock list should occur periodically, the time interval having been agreed with the pharmacy clinical team. Any changes must be agreed with the pharmacy clinical team.

A list of staff authorised to order medicines should be held in the ward/clinic and a copy sent to the preferred pharmacy supplier.

4.1 Inpatient units

Medicines should be ordered from the preferred supplier using approved order forms for stock and non stock medicines. The standard operating procedures for ordering medicines should be followed.

4.1.1 Stock medicines

- A Designated Practitioner or shall be responsible for ordering medicines from the pharmacy for the purposes of maintaining ward stocks;
- A copy of the current ward stock list is held on each ward. When changes have been made to the list all outdated copies should be destroyed;
- Stock medicines are supplied to a ward in their original container. Such medicines are not labelled up for individual patient use and so many patients can have their medication issued from the same stock box during medicine administration rounds;

4.1.2 Named patient medicines

- A Designated Practitioner shall be responsible for ordering named patient medicines from the pharmacy when that medicine is not available as a ward stock item. The designated practitioner should be informed if a new medicine is prescribed;

- A clinical check will be performed either by CWP pharmacist or preferred supplier pharmacist before supply;
- Named patient medicines are supplied to the ward in an original pack;
- The medicine will be labelled with the patient's name, date of dispensing, the name (approved (rINN)), strength and quantity of medicine supplied. Sometimes it may also have the proprietary name of the medicine on the label, particularly when prescribing by brand is recommended e.g. Lithium –Priadel, Camcolit;
- The medicine will come labelled with directions on how to take it;
- Medicines should be ordered promptly and stocks checked regularly to ensure that there is no delay in patients receiving prescribed medication. If a critical medicine (see appendix 3) is prescribed this should be ordered urgently.

4.1.3 Use of patients own drugs

- See policy for the reuse of patients own drugs (pod's).

4.1.4 Medicines for clinical emergencies

Medicines for Clinical Emergency must be readily accessible and in a position to afford supervision to prevent unauthorised access. They must not be stored in a locked cupboard:

- Need to read in conjunction with CPR policy. Basic Life Support does not involve the use of medication;
- Emergency situations could also include treatment of anaphylaxis, reversal of the effects of benzodiazepines and opiates. Therefore each inpatient ward should have access to hydrocortisone injection, Adrenaline injection 1:1000, Chlorphenamine injection, Flumazenil injection and Naloxone injection;
- There is an agreed list of medicines to be stocked for emergency use for CWP;
- All items on the list must be kept at each locality although the presentation may differ depending on which resus team responds to the crash call;
- Nursing staff should check the expiry date of the medicines kept for emergencies each week;
- The pharmacy will replace any expired or used boxes and items for replacement can be ordered as for other stock items;
- Due to arrangements with the resus teams some of the emergency medicines may come from the acute trust pharmacies and not from the CWP designated supplying pharmacy;
- ECT suites have their own stock list as per the ECT policy, which includes medicines used in emergency situations along with a resus trolley;
- At each locality, emergency medicines are stored in different locations, all nursing and medical staff should be aware of local arrangements.

4.1.5 Ordering TTOs / TTHs and prescriptions for periods of leave

- Doctors are responsible for ordering medicines for discharge and completing the prescription section on leave cards. Nursing staff may then order medicines for periods of leave of absence from the ward;
- Leave/discharge prescriptions should be clinically checked by a pharmacist before sending to the pharmacy supplier. In exceptional circumstances when a pharmacist is unavailable then a copy of the prescription chart needs to be sent;
- The discharge/leave prescription along with a copy of the inpatient prescription card, if required, should be received in the pharmacy in sufficient time for the pharmacy team to dispense the medication and have it returned to the ward in advance of the patient going on leave/discharge. This ideally should be 24hours in advance and is planned in as part of the acute care pathway;
- Quantities of medicine to be supplied will be dictated by the duration of the leave from the ward. For discharge, all patients should be supplied with the quantity agreed in accordance with the local arrangements with the PCT, this normally equates to a minimum of 14 days supply. (See section 2.10 from discharge policy). The pharmacy will usually supply original packs (one months supply) unless advised otherwise e.g. If there are self-harm issues, then a maximum of 14 days would be given;

- Child-resistant containers (CRCs) are used routinely on discharge items. If a member of the ward staff feels that CRCs would be difficult for the patient to open, plain tops will be fitted provided that the doctor annotates the prescription with a statement to that effect. The likelihood of children coming into contact with the medicines should be considered;
- Nurses should never "dispense" from ward stock/medicine trolley for patients going home or out on leave as this is specifically prohibited within the terms of The Medicines Act 1968. The Trust will accept no responsibility should a medicine related incident occur;
- Patient's own drugs may be issued from the trolley as part of a discharge after the discharge prescription has been checked and annotated with 'on ward' by the pharmacy team.

4.1.6 Obtaining medicines out of hours and the role of the emergency duty pharmacist

- Each locality has an out of hours cupboard which can be accessed when the pharmacy is closed. (Also see the Standard Operating Procedures – these include the Pharmacy opening hours and alternative pharmacies which can be used after 5pm and at weekends);
- The supply of the majority of medicines will not be urgent and can be left to the next time the Pharmacy is open. The emergency duty pharmacist will assist ward staff to determine what is clinically urgent;
- It may not always be possible to have individual medicine supplies available from the pharmacy for the next medicine administration round. Nursing/practitioner staff must make maximum use of patients' own medicines and ward stock during out of hours situations;
- Medicines can be borrowed from another ward if they are a stock item (see section 4.1.7);
- If the medicines have been ordered and have not yet been supplied by the pharmacy the Designated Practitioner must record "OS" (out of stock) on the medicine administration chart, and enter the reason in the patients' notes;
- If a critical medicine (see appendix 3) is prescribed the process for obtaining critical medicines out of hours must be followed (see SOPs);
- The appointed practitioner in charge or the duty doctor can contact the emergency duty clinical pharmacist via any of the four acute hospital switchboards for clinical advice out of normal working hours;
- If in exceptional circumstances urgent leaves or discharge prescriptions are required out of hours the on call pharmacist should be contacted for advice.

4.1.7 Borrowing of medicines

- Medicines must not be borrowed from a ward or department unless a supply cannot be obtained directly from the pharmacy during normal working hours. Only stock medicines may be borrowed and the complete container must be transferred to the receiving ward;
- In the circumstances when medicines are borrowed, transferring medicines into another container is forbidden. The complete container must be transferred to the receiving ward;
- Controlled Drugs must not be borrowed except in an extreme emergency. Records of the dose of a borrowed Controlled Drug must be made in the Controlled Drugs Record Book of the ward or department who has provided the medicine; i.e. the dose must be booked out directly to the patient in the receiving ward. Stocks of controlled drugs cannot be transferred from one ward to another. The pharmacy must be informed as soon as possible after a borrowed supply of a Controlled Drug has been made (see section 12).

4.1.8 The use of faxes for ordering medicines

- When fax machines are used staff should adhere to the following procedures for faxing which are governed by Caldecott guidelines concerning safe faxing:
  - Use a safe haven fax;
  - Double check the number before sending;
  - Tell the recipient to wait by the fax;
  - Ask them to phone you when it has arrived.

Where supply of a medicine is required from the pharmacy without a valid prescription being presented to the pharmacy, a copy of the prescription should be faxed to the pharmacy to confirm that

a valid prescription card is in place and supply will be made against the fax. The original prescription should be forwarded to pharmacy within 24 hours of the supply, this in the main applies to all discharge and leave prescriptions. If controlled drugs are ordered for leave or discharge the original copy must be received by the pharmacy before the medicine can be supplied.

4.2 Community clinics

- The list of medicines and quantities held by Community Care Western Cheshire services will be approved by the Lead Pharmacist Community Services;
- For medicines not previously stocked a request will be made to Lead Pharmacist Community Services prior to ordering;
- The request will include details of the medicines to be ordered, its place in therapy, the patient group it will be used for and whether it will be in addition to the existing list of stocked medicines or in place of and item on the list;
- Medicines stock order pads and prescription forms (controlled stationery) must be stored securely in a locked receptacle, drawer or room when not in use;
- Ordering must be done by an authorised employee or by a person under their direct supervision;
- Electronic ordering must be password protected;
- Any stolen and misplaced order books will be notified to the line manager. This should be reported on the Datix Incident Reporting System as set out in the Incident Reporting Policy.
- Paper copies of orders will be retained for 2 years. Electronic copies will be retained for 7 years;
- Records of medicines ordered must be stored in the relevant secure location.

5. Dispensing

Items ordered will be dispensed by the preferred pharmacy supplier. It is the responsibility of the dispensing pharmacy to ensure that SOPs are in place for safe dispensing.

Items that need re-labelling for a leave or discharge may be labelled by a member of the pharmacy team following the CWP Standard Operating Procedure for Dispensing Medication.

6. Transport and receipt

6.1 Transport and delivery of medicines within inpatient areas

- The Pharmacy supply service will deliver medicines to wards, departments and clinics at specified times throughout the day in sealed bags or boxes;
- Medicines must not be left unattended at any time during transport;
- When medicines are received at their final destination they must not be left unattended or unsecured. The staff receiving the sealed container should hand this to a Designated Practitioner, who will lock it away in the medicine cupboards at the earliest opportunity;
- The Designated Practitioner receiving these supplies must ensure the bags are emptied completely. Immediately after opening, the identity of the drugs should be confirmed and the medicines stored securely and appropriately in the ward / department as soon as possible after receipt;
- On receipt of stock medicines the Designated Practitioner must:
  - Check the medicine against the delivery note;
  - Sign the note and keep it (for 6 months) as a record that the supply was complete;
  - Lock the medicines in the medicine cupboards immediately;
  - Report any discrepancies to the Pharmacy immediately.

6.2 Process for transportation and receipt of medicinal products in CCWC

- Medicines must not be transported unless it is absolutely necessary to do so and transfers should be initiated through a system in which all orders and dispatches are recorded;

- All goods are despatched in a tamper evident container and checked against the delivery note placed inside the tamper evident container or tamper evident document wallet;
- Records of medicines returned to the supplier must be maintained at the site;
- Medicines in transit must not be left unattended even in a locked vehicle;
- The name of the person transporting the medicines must be recorded;
- The transport of medicines must comply with health and safety law (see http://www.hse.gov.uk/);
- Cold chain storage conditions will be checked for effectiveness. For the Clinical Guideline for Maintenance of Vaccines within Recommended Storage Temperatures. Cold Chain; time out of fridge should be recorded and sent with the goods. Every effort should be made to reduce the time out of the fridge for each cold chain item transported;
- Transport will always be in a suitable "cool box". Time in a "cool box" should be counted as time out of a fridge. Ice packs in cool boxes should not be allowed to come into contact with the products;
- Delivery notes and records: paper copies retained for 2 years and stored on site. Electronic copies retained for 7 years;
- Any products not received in a tamper proof container or including a delivery note will be returned to the supplier;
- All medicines received will be checked against the consignment and delivery note to confirm product identity and quantity;
- The delivery note will be signed on receipt of goods and the checkers name will be recorded;
- All discrepancies will be notified to the supplier using the supplier's process and recorded within the service;
- Handling of goods to be undertaken with due regards to Control of substances hazardous to health (COSHH) risk assessment. See http://www.coshh-essentials.org.uk;
- Storage in a secure place, or rarely administration, will immediately follow receipt;
- For cold chain products the time out of the fridge will be noted as the time since the delivery left the supplier.

7. Storage

7.1 Security and storage of medicines

- In all locations medicines must be stored securely. An authorised employee will know at all times who holds the keys or has access to the medicines stored under their control. Also keys to cupboards, fridges, rooms and the site that contains medicines are securely locked away;
- Community mental health teams (CMHTs) may find alternative methods to ensure safe storage of keys such as a cupboard with key pad with code known only by authorised staff;
- Any incident must be reported immediately using appropriate documentation (DATIX clinical incident forms) and investigated by the Appointed Practitioner in Charge together with an Authorised member of the Pharmacy Staff. In community clinics incidents must be reported to the service head as soon as practicable following discovery;
- Medicines will be stored separately for each service within a building or clinic. There will be a record of the maximum and minimum temperature of each storage facility made on a daily basis for cold storage and on a weekly basis for ambient (below 25°C) storage (if there are extremes of temperatures then monitoring should be increased);
- Medicines for emergency use will not be locked away but will be stored with the necessary accessibility in a tamper evident container;
- Professional advice from the Lead Pharmacist Medicines Governance or locality pharmacist should be sought if the conditions of storage, in particular temperature, vary from those recommended by the manufacturer. If unavailable efforts should be made to contact the manufacturer direct;
- Medicines not stored correctly should be quarantined prior to destruction;

- There should be separate storage for internal medicines, external medicines, intravenous fluids, sterile preparations, medical reagents, medical gasses, flammables and items awaiting return or destruction;
- Rooms where medicines are stored have a locked solid door with fitted security locks. Any windows shall be lockable;
- Medicines are stored in locked cupboards secured to a wall. All cupboards should comply with BS2881: 1989 (Security Level One) Specification for Cupboards for the Storage of Medicines in Health Care Premises;
- Expiry dates will be strictly observed and recorded. Stock rotation shall ensure the shortest dated stock is used first. Short dated stock shall be clearly identified;
- Expired stock shall be clearly identified and quarantined prior to destruction.

7.2 Losses or discrepancies with medicines

- Any loss of medicines other than Controlled Drugs must be reported to the Appointed Practitioner in Charge of the ward or department and the Designated Pharmacist, who can then decide on a further course of action;
- A clinical incident form (on DATIX) should be completed where deemed appropriate by the appointed practitioner in charge;
- For controlled drugs see section 12 and SOPs.

7.3 Storage of Controlled Drugs (see also chapter 12)

No ward or department must store Controlled Drugs unless there is an Appointed Practitioner in Charge responsible for their storage and use:

- The Key for the controlled Drug cupboard should be held separately from all other keys;
- The appointed practitioner in charge is legally responsible for the CD key;
- If CD keys cannot be found then the trust accountable officer should be informed, depending on the circumstances the police may be contacted.

7.4 Internal and external medicines

- Internal medicines must be stored separately from other medicines;
- Under no circumstances must medicines be transferred from one container to another, nor must they be taken out of their container and left loose.

7.4.1 Medicine trolley

The medicine trolley (where one is available) is for the storage of **all oral medicines in use** on the ward. The medicines trolley must be kept locked and immobilised when not in use (by securing to the wall). If unlocked, it should be kept under constant observation. Under no circumstances are medicines to be stored on the open shelf under the medicine trolley (only externals in current use can be kept here). If no medicine trolley is available then a designated cupboard should be used instead.

7.4.2 Controlled Drug (CD) cupboard

The Controlled Drug cupboards are reserved solely for the storage of Controlled Drugs and secured to the wall. These cupboards may be separate from others or be inside other locked medicines cupboards used to store internal medicines. Where possible they should be fitted with a red warning light/alarm to identify when the door is open, this is a recommendation not a legal requirement. The lock must not be the same as any other lock in the hospital.

7.4.3 Internal medicine cupboard

The Internal Medicine cupboard is for the storage of tablets, liquid medicines, injections, etc. that are not in current use in the medicine trolley.

7.4.4 External medicine cupboard

The External Medicine Cupboard is for the storage of creams, lotions etc. If an external cupboard is not available then these preparations should be segregated from the internal medicines by storing on separate shelves.

7.4.5 Disinfectant cupboard
For preparations which are not used for patients.

7.4.6 Reagents cupboard
Contains urine testing and blood testing strips and litmus paper. This cupboard is situated in an area where urine testing is carried out. Some wards may not require a separate cupboard if urine testing is only rarely carried out. In these circumstances there should be a ward agreement about where such testing is to take place.

7.4.7 A clean storage area / room
This area or room is designated to contain intravenous fluids and sterile topical fluids, if no suitable cupboard is available.

7.4.8 Potassium containing fluids
No wards or departments will be allowed to stock either concentrated or diluted potassium chloride. This follows an alert by the National Patient Safety Agency. Should a potassium chloride replacement be required, pharmacy will dispense ready prepared, diluted infusion bags on a named patient basis. This is in the interest of patient safety.

7.4.9 Storage of refrigerated medicines
- If refrigeration is required, only refrigerators designed for the storage of medicines between 2-8°C must be used;
- Accidental interruption of the electricity supply can be prevented by using a switchless socket or by placing notices on plugs and sockets;
- The refrigerator must be positioned away from direct sources of heat such as radiators. They must not be over filled to ensure the air inside is free to circulate. Defrosting must be done regularly and recorded;
- Products must not be stored touching the cold plate or adjacent to the freezer compartment;
- Daily maximum / minimum fridge temperatures must be recorded at least once each working day. The records of recording temperatures must be readily accessible for easy reference and retained;
- Refrigerators must be maintained and defrosted in line with the manufacturer's guidelines. An approved cool box or alternative refrigerator must be used during defrosting of the main refrigerator;
- Fridge doors should be lockable;
- Service Heads should monitor vaccine stocks in order to avoid over ordering or stock piling;
- Expiry dates on all medicinal products must be strictly observed and recorded. Stock rotation must ensure the shortest dated stock is used first. Short dated stock will be clearly identified;
- Food, drink and clinical specimens must not be stored in the medicines fridge;
- Medicines must not be stored in a food fridge;
- Expired stock or medicines which have been exposed to temperatures of above 8C must be clearly identified and quarantined.

7.5 Review of storage of medicines and stock levels
- Every 3 months pharmacy technicians are required to visit wards and departments to check storage, security and safety of medicines (see clinic room checklist in pharmacy procedures);
- In addition ward pharmacists will inspect controlled drug (CD) record books and requisition books and check the controlled drug stocks every 3 months.

7.6 Medicine samples from pharmaceutical representatives
- No samples (of medicines or dressings) may be left on wards, departments, clinics or in CMHTs.

7.7 Closure of a ward/department

- If a ward or department is due to close, the Controlled Drugs must be handed over by an Assigned Practitioner in Charge to an Authorised member of the Pharmacy Staff who will sign the appropriate section of the CD record book and return the Controlled Drugs to the supplying pharmacy for safekeeping;
- If a ward or department is to close for **more than** a few days, all other medicines must be returned to the pharmacy;

- If a ward is to close for **only a few** days, the medicines (other than Controlled Drugs) may, with the agreement of the Authorised member of the Pharmacy Staff and the Appointed Practitioner in Charge; stay on the ward provided there is adequate security to prevent unauthorised access to the cupboards.

8. How medication is administered, including patient identification

8.1 Authorisation for administration of medicines

Generally only medicines that have been approved for use by CWP–Medicines Management Group (MMG) should be administered to patients. Special arrangements maybe necessary when a patient is admitted on a non formulary medicine. The authorisation of a suitably qualified practitioner should be obtained before medicines can be administered to patients. This authorisation is given in one of three ways:

- An instruction written by a medical practitioner / authorised prescriber on an official chart;
- In accordance with locally-agreed clinical procedures;
- In accordance with Patient Group Directions.

8.2 Who can administer medicines to patients?

Medicines must only be prepared, checked or administered to a patient by the following categories of healthcare staff:

- A Designated Practitioner;
- A Medical Practitioner;
- Authorised Pharmacy Staff;
- A practitioner in training, but only under the direct supervision of a Designated Practitioner. The Designated Practitioner remains responsible for ensuring that the correct procedure takes place;
- Other Authorised Health Service employees.

In general, the administration of medicines to patients under the care of the Trust should be by:

- A designated practitioner;
- A second check of the administration should be carried out by another designated practitioner;
- If an authorised nurse is not available then the check should be made by another authorised service employee (this can be a health care assistant or student nurse).

A record of administration should be made, and the administering nurse identified, by initialling the prescription chart. Medication refused or wasted should be recorded. Where a second nurse checks the administration of a medicine, the checking nurse should also initial the prescription chart. The ultimate responsibility remains with the administering nurse.

It is good practice that, wherever possible, all medicines be prepared and administered in the presence of another practitioner.

Runners (see definition in section 2) must not be used for administration of medicines in CWP.

8.3 Single nurse administration

Single nurse administration may be carried out by a registered nurse. Single nurse administration does not apply:

- To controlled drugs;

- Where the dose required a complex calculation (not usually applicable to depots);
- Where the dose is weight related;
- To any area of IV therapy including IV infusions;
- To Rapid Tranquillisation;
- Under Section 62;
- For telephone prescriptions.

In the cases where single nurse administration does not apply, medicines should be administered by two registered nurses OR one registered nurse and either a doctor, pharmacist, 3rd year nursing student or a healthcare worker who has completed sufficient training to assist a registered nurse as in 6.11. The administration must be recorded on the prescription chart.

In these instances (listed above), a second Authorised Nurse or other health employee should check all aspects of administration.

Runners (see definition in section 2.3) must not be used for administration of medicines in CWP.

8.4 Preparation of medicines

It is frequently during the preparation of medicines for administration that errors occur, particularly where some form of dose calculation is involved. Wherever possible, medicines must be presented to ward areas from the Pharmacy Supplier in a ready-to-use form, where no further dilution or dose calculation is required.

Where the preparation of medicines is performed on the ward or in clinical areas the following points must be observed:

- Read the prescription carefully. Determine the name, dose, diluent, route for administration and expiry date;
- If a dose calculation is required this information must be included as part of the prescription either by the doctor or the pharmacist, so that the Designated Practitioner administering the dose is clear about the actual amount to administer. It is recommended that the Designated Practitioner checks all calculations with a second practitioner or pharmacist before administration;
- Where a calculation is involved and where the medicine product is intended for intravenous administration, a second practitioner must check all aspects of the preparation of the medicines and sign and date the entry;
- If the practitioner is unclear as to the correct medicine diluent or precise method for medicine preparation, he/she must obtain this information from a clinical pharmacist before proceeding;
- Where liquid medicines are to be administered an appropriate size medicine container such as a plastic measuring pot, spoon or oral syringe should be used to measure out the correct volume of liquid. In the main medicine spoons come in two sizes, 2.5ml and 5ml measures. The purple oral syringe can be 1ml or 5ml graduated in 0.1ml and 0.5ml measures respectively, the plastic pots can hold up to 60ml and are graduated in 5ml increments. One of these devices should be used for all small volume liquid measures. The correct volume is obtained by reading the bottom of the meniscus.

The practice of medical staff obtaining a second practitioner check when calculating, preparing and administering medicines is considered good practice.

8.5 Principles of administration of medicines by clinical staff

The Assigned Practitioner in Charge is responsible for ensuring that prescribed medicines are administered within 60 minutes either side of the prescribed time.

Before administration of a medicine, a practitioner must:

- Read the prescription carefully;
- Check the date (some are written in advance e.g. Increasing doses of a titration);

- Be competent with the principles of administration of Medicines (as outlined in the Nursing and Midwifery Council (*NMC) guidelines on administration*).

8.5.1 NMC guidelines on administration of medicines

In exercising your professional accountability in the best interests of your patients, you must:

- Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications;
- Be certain of the identity of the patient to whom the medicine is to be administered;
- Be aware of the patients care plan;
- Check that the prescription, and the label on the medicine dispensed by the pharmacy, are clearly written and unambiguous;
- Have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies;
- Check the expiry date of the medicine to be administered;
- Check that the patient is not allergic to the medicine before administering it;
- Contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable;
- Make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring that any written entries and the signature are clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine;
- Where supervising a student nurse or midwife in the administration of medicines clearly countersign the signature of the student.

8.5.2 Additional administration checks and process for patient identification

In addition the following should be checked:

- Check authorisation of administration (Forms T2 or T3) if the patient is detained under the Mental Health Act 1983;
- Ascertain from the record of the administration of medicines that the prescribed dose has not already been given;
- Select the medicine required and check the label against the prescription;
- The practitioner must then check the identity of the patient using the patient's wristband or other method approved by CWP and administer the medicine. Extreme care is required to ensure that the patient's identity is confirmed by visual recognition and verbal questioning before proceeding to administer the dose;
- Medicines dispensed for an individual patient must be administered only to that patient (**supplies labelled for individual patients must not be shared**);
- When administering as required (prn) medication the practitioner must check the amount given in the previous 24 hours to ensure that the maximum daily dose is not exceeded. If a variable dose is written the practitioner should use their clinical judgment and follow any relevant guidelines (e.g. Rapid Tranquillisation Guidelines) to ascertain the appropriate dose. The maximum dose in 24 hours must not be exceeded.

Patients must be observed to have taken their medicines by the Designated Practitioner. Prepared medicines must not be left unsupervised.

8.6 Recording of medicines that have been administered

The practitioner who has administered or supervised the administration of the medicine must, at the time of administration, sign with initials in the appropriate column of the official prescription sheet.

For PRN medications the time of administration must be recorded and the reason for use documented in the clinical notes. If a variable dose is written the dose used must be recorded.

8.7 Non- administration of medicines

If a medicine is omitted the following codes must be entered in red on the prescription sheet:

- Omission for clinical reasons is marked by 'X' and the reason for the omission written in the clinical notes;
- If the patient is 'nil by mouth' and the practitioner has been given clear instructions to omit the oral doses 'N' must be recorded;
- 'L' must be recorded when the patient is on leave;
- "SELF" must be recorded when a practitioner supervises patient self-medicating;
- An adverse drug reaction is marked by 'ADR' and the reasons recorded in the clinical notes;
- If the patient refused treatment it is marked by 'R';
- If the patient is drowsy or asleep and the medication is omitted it is marked by 'D';
- If the patient is unavailable it is marked 'A';
- If the medicine is unavailable it is marked by 'OS' (out of stock);
- In all cases an explanation for the omission of medication should be written in the clinical notes. Every effort should be made to ensure that patients receive their medication at the prescribed time;
- FAILURE TO RECORD THE ADMINISTRATION OF A MEDICINE OR AN OMISSION CODE CONSTITUTES A MEDICATION INCIDENT AND MUST BE REPORTED. THE SCRUTINY OF SUCH RECORDS WILL BE THE SUBJECT OF REGULAR AUDIT;
- If the patient is absent from the ward, or has missed a dose for some other reason, the delayed dose can be administered at a later time provided a doctor or pharmacist has confirmed that it is appropriate to do so or that it is according to an agreed protocol. The actual time of administration must be clearly recorded in the administration record by the Designated Practitioner and an appropriate entry into the patient's record is made;
- Patients classified 'Nil by Mouth' prior to a diagnostic procedure or receiving an anaesthetic must have all their prescribed oral medicines administered to them at the prescribed time unless specifically advised otherwise. For patients undergoing ECT, please refer to the ECT policy (CP16) regarding nil by mouth status. If medicines are to be administered they should be taken with a small amount of water to enable them to swallow these medicines. **Only medicines that have been clearly marked on the prescription sheet may be omitted.** It is the responsibility of the prescriber to provide clear written instructions to the nursing staff concerning the omission of prescribed doses.

8.8 Administration of medicines without a prescription

No medication should be administered to a patient in the absence of a valid written prescription. There are currently some exceptions:

1. A registered nurse may administer 'homely remedies' such as laxatives, analgesics and antacids to adults provided that the drug(s) are contained on the "Discretionary List" which has been approved by the Medicines Management Group for the indications and doses listed. The CWP Trust has approved those medicines that are on the Prescription chart under this section. A doctor must authorise the use of the homely remedies by signing the chart.
2. In extreme circumstances, a drug may be given on verbal instruction from the doctor to two nurses, provided that the name, dose, and route of the drug are recorded on the prescription sheet and nursing care plan by the nursing staff, and countersigned by the doctor within 24 hours (see section 3.3.8).
3. Two Community Nurses may receive a verbal instruction from a doctor as in (2). They should ensure all documentation as above and that a prescription is written within 24 hours. This may involve the patient's GP.
4. CWP employed registered nurses working in the Urgent Treatment Centre at Countess of Chester hospital may give a single dose of paracetamol, where appropriate. This dose of paracetamol will be recorded in the patient's notes.

8.9 Administration of Medicines in accordance with Patient Group Directions (PGDs)

All medication must be prescribed by a member of the medical staff or by a practitioner authorised to prescribe with the exception of those medicines that named staff individuals can administer following locally agreed Patient Group Directions. All such directions must be ratified by the Trusts Medicines Management Group.

A Patient Group Direction is a specific written instruction for the supply and administration of a named medicine to a group of patients in an identified clinical situation.

The majority of clinical care should be provided on an individual, patient specific basis. The supply and administration of medicines under Patient Group Directions should therefore be reserved for those limited situations where they offer advantages for patient care without compromising patient safety.

The qualified health professionals who may supply or administer medicines under a Patient Group Direction are:

- Nurses;
- Midwives;
- Health Visitors;
- Optometrists;
- Pharmacists;
- Chiropodists;
- Radiographers;
- Orthoptists;
- Physiotherapists;
- Ambulance Paramedics.

They can only do so **as named individuals**.

The Patient Group Direction must be signed by a senior Doctor (or, if appropriate a Dentist) and a senior pharmacist, both of whom should have been involved in developing the direction with a member of the professional group expected to supply medicines under the direction. Additionally, Patient Group Directions must be authorised by the Trust's Medicine Management Committee and the Trust's Clinical Governance lead before being signed by the practitioners who will be using them.

The following should not normally be included in Group Directions:

- New drugs under intensive monitoring and subject to special adverse reaction reporting requirements (the Black Triangle scheme);
- Unlicensed medicines;
- Medicines used outside their licensed indications;
- Medicines being used in clinical trials.

The law specifies that each Patient Group Direction must contain the following:

- A description of the medicine(s) to which the direction applies;
- A description of those patients included and those excluded from treatment under the direction;
- A description of the circumstances in which further advice should be sought from a doctor (or dentist, as appropriate) and arrangements for referral;
- Details of appropriate dosage and maximum total dosage, quantity, pharmaceutical form and strength, route and frequency of administration, and minimum or maximum period over which the medicine should be administered;
- Details of any necessary follow-up action;
- Relevant warnings, including potential adverse reactions;
- The date the direction comes into force and the date it expires;
- Class of health professional who may supply or administer the medicine;
- Signature of a doctor or dentist, as appropriate, and a pharmacist;

- Signature of the Trust's Clinical Governance lead;
- A statement of the records to be kept for audit purposes.

In addition The Trust requires

- Signature on behalf of the Trust's MMG;
- Patient Group Directions should be reviewed every two years.

Further guidance is contained in HSC 2000/026 Patient Group Directions (England only) The British National Formulary (BNF) patient group directions policy.

8.10 Administration of Medicines by Medical Staff

Should the need arise for medical staff to prescribe and administer medicines themselves:

- These must be prescribed on the prescription sheet;
- The normal checks for dose, drug compatibility and allergies must be undertaken (as in 8.4 and 8.5);
- Medicines must be checked with a registered nurse prior to administration.

8.11 Medicines related duties performed by non registered nurses such as health care workers and Assistant Practitioners

With the addition of Cheshire West physical health services, the district nursing, continence and other community teams have had to adapt as is identified in The Cavendish Review 2013 An Independent Review into Healthcare Assistants and Support Workers In the NHS and Social care settings. The Cheshire and Wirral Partnership has invested a significant amount of time and effort to help some of our health care assistants re-train to become Assistant Practitioners. The role of the assistant practitioner has become extremely useful in the community setting and has helped to alleviate the work load that was previously managed by district nursing staff.

Assistant practitioners working in community services are staff members who have attained a foundation degree qualification in healthcare and have been signed off as fit to practice against their framework by a nurse mentor, can administer all medicines except for those noted in section 8.11.1

Staff that have successfully completed NCFE Level 2 Certificate 'Understanding the Safe Handling of Medicines,' may be authorised by the Trust to assist a Designated Practitioner to perform the following:

- Check the medicine label with the prescription sheet as a second check
- Administer oral and topical medicines (including inhaler, eye and ear drops) to a patient once prepared and checked by a Designated Practitioner;
- Check Controlled Drugs with a Designated Practitioner;
- Check the patient's name and hospital number against the prescription sheet with a Designated Practitioner;
- Check discharge medicines with a Designated Practitioner against a discharge prescription;
- Witness the self-administration of medicines either in a ward or in a patient's home following patient specific assessment and training by a Designated Practitioner.

8.11.1 Duties that cannot be performed by non-registered nurses

- Preparation and supply of medicines;
- Administration of Controlled Drugs;

- Supply of discharge medicine

8.12 Medicine allergy

This should be read in conjunction with section 3.5.7 and 5.5:

- Prior to a medicine being administered, the 'drug allergies / reaction' box must be re-checked by the nursing staff.

8.13 Covert administration of medicines

8.13.1 When is it necessary and legal considerations?

Treatment may be given to adults who lack mental capacity to consent to treatment if it is considered to be in their best interests under the Common Law Doctrine of Necessity which is now codified in sections 5 and 6 of the Mental Capacity Act 2005.Treatment must be:

- Necessary to save life or prevent a deterioration or ensure an improvement in the patient's/client's physical or mental health;
- In accordance with the practice accepted at the time by a reasonable body of medical opinion skilled in that particular form of treatment in question (Ref 1990) and Part IV of the Mental Health Act 1983 (see Code of Practice paragraph 15.8);
- Although there is legal support under certain circumstances to prescribe medication to adults who mentally cannot consent to treatment there are no nationally agreed protocols or standards for the administration of such medication in food or drink. It is left to local Services to develop their own protocols and standards.

It is clear that offering medication in food or drink could still be perceived as being deceitful and could be open to abuse and requires particular guidelines to be established locally to ensure that when this practice happens it has been properly considered, proper consultations have been made and that the practice is transparent and open to public scrutiny and audit.

8.13.2 Principles of covert administration

- This Policy applies to the administration of medication to inpatients / clients who cannot give consent to treatment who are refusing to take tablets or syrup when openly presented to them and for whom administration of medicine disguised in food or drink is then considered. The decision to administer covertly should not be considered routine;
- Covert administration should not be confused with the administration of medicines against someone's consent. This policy must be read in conjunction with Policy MH13 Consent to Treatment;
- Administering medicines covertly to clients in the care of this Trust should be carefully considered and there should be adherence to this policy;
- The capacity of the patient in relation to medicines should be assessed. If the patient has capacity to consent and refuses medication it cannot then be given covertly. If a patient has not got capacity to consent and refuses medicines then it may be appropriate to administer some medicines covertly;
- Patients / clients who are refusing or unable to take treatment because they:
  - Find it difficult to swallow the size or shape of the tablet / capsule;
  - Find the taste of the liquid is unpalatable;
  - Have swallowing difficulties - should be discussed with the Clinical Pharmacist as a different formulation that is suitable may be available. These patients / clients may not be actively refusing to take treatment but find the treatment difficult to swallow and if presented with medication in the appropriate form will consent to take it.

- It is important to remember that the Mental Health Act only applies to those medicines used in treatment of mental illness. Other medicines, even though their administration may be considered in the patients best interests cannot be given against the patient consent under the Mental Health Act. The Mental Health Act does not give guidance on administering medication covertly. Any medication to be given covertly should be in line with this policy;

- If the patient is detained under a section of the Mental Health Act then the use of covert administration should be discussed with the Second Opinion Appointed Doctor (SOAD). A second opinion should be sought for informal patients for whom covert administration is being considered, as a principle of good practice;
- A review of the importance of the medication and whether it is essential to continue with it should also be made. A judgment about the importance of the treatment to the patients /client's quality of life and general health should be formulated to decide whether to give the treatment or to discontinue it;
- Although it is acknowledged that nobody can consent for another adult the views of the nearest relative/carer or a patient's advocate should be sought;
- The decision to use covert medication must be made by the Multidisciplinary Team (including the clinical pharmacist) including the views of the relatives and carers and any advance statement/directive made by the patient. The pharmacist will consider ethical, cultural or religious beliefs that could affect the choice of medicines. The method of administration should clearly be recorded on drug prescription and administration chart. The second opinion should be sought before this discussion is held.

8.13.3 Care plan discussion and actions required

The discussion and actions taken as a result of deciding to use covert administration should include the following:

- Which medicines are considered essential? Remembering that treatment with the medication must be in the patient's best interest and necessary to save life or prevent deterioration or ensure an improvement in the patient's / clients physical or mental health;
- Considerations to the taste of the medicines as some are so unpleasant tasting as to be impossible to disguise;
- The stability of the medicine when mixed with food (e.g. available in solution, crushing of tablets, effects of temperature). You must ask the Pharmacist regarding mixing any medication in food or drink;
- Limit the number of medicines given covertly to one or two or food will taste unpleasant and be refused. Other medicines can still be offered in the conventional manner;
- Clarification of the aims to giving a particular medication covertly. If aims not met then the medication and its covert use should be reviewed;
- Medicines should be offered in the conventional manner on a regular basis. With covert administration the patient may come to accept medication and it is well known that mental state and therefore consent can fluctuate;
- Consider the kind of food the patient favours;
- Best to mix medication in a small amount of food e.g. jam, yogurt (some medication is bitter tasting) rather than whole dinner in case it isn't eaten;
- Administration needs to be closely supervised so that only the intended patient gets the medicated food, should be cleared away and disposed of immediately the patient has finished eating;
- The prescribing doctor must mark the medicines chart 'for covert administration' in the Additional Instructions box;
- The decision should be documented in a care plan including all parties involved in discussions. See example care plan (appendix 6);
- A decision to administer medication in food or drink must be clearly entered into the case notes. Details of the condition being treated and the likely benefits of treatment, results of assessments indicating the nature of the patient's / client's difficulty in taking medication openly, and indicating who else has been consulted, particularly referring to consultations with the Multidisciplinary Team and nearest relatives / carers.

8.14 Compliance aids (sometimes referred to as concordance aids)

Non-compliance with medicines is a major cause of relapse and admission to hospital. There are many factors that can lead to non-compliance with medicines. These include:

- A poor understanding of the need for medicines;
- A poor understanding of how to take the medicines;
- Forgetfulness;

- Inability to open the containers;
- Poor sight;
- A complicated regime of medicines.

For some people a compliance aid may assist a person to continue self-medication and remain out of hospital.

Before there is any agreement to provide medicines in a compliance aid a full assessment of the reason for non-compliance should take place. It may be that the provision of a compliance aid may not be of benefit.

Compliance aids vary but most require to be replenished on a weekly basis. Before compliance aids are issued and the patient trained to use them arrangements must be made for their regular replenishment. This should be discussed with the pharmacy team and decision conveyed to the pharmacy supplier.

The act of filling a compliance aid involves re-dispensing. Only Authorised Pharmacy Staff are allowed to re-dispense medicines. Other practitioners may:

- Assist patients to fill their own compliance aids;
- Train patients to use a compliance aid as part of a ward based training scheme.

Refer to the pharmacy policy on the assessment for and supply of compliance aids.

8.15 Clinical trials

In addition to the need to follow all the procedures in this policy, attention is drawn to the need to observe special additional requirements when medicines are administrated in connection with a clinical trial.

Clinical trials are only undertaken after careful consideration. All clinical trials have to comply with the Medicines for Human Use (Clinical Trials) Regulations, 2003 and with the Research Governance Framework for Health and Social Care, 2005. This includes approval by the Ethics Committee and the Trust's evidence based practice centre. Information about trials of medication that have been approved will be forwarded to the MMG. The MMG will then make recommendations for the clinical trial in discussion with the pharmacy, where they need to be involved in the supply of trial material. Patients must always give informed consent, in line with the patients' Charter right number 7. Supplies are issued by Pharmacy only as agreed in the trial protocol and pharmacists continue to supervise the use of medicines in the trial.

Refer to the following documents:

- Consultation Letter on the Medicines for Human use (Clinical Trials) Regulations 2003, Medicines Control Agency, February 2003;
- Research Governance Framework for Health and Social Care, Department of Health, April 2005.

9. Patients self-administration

The definition of Self Medication for the purposes of this procedure is when a service user takes responsibility for the administration of their medication which has been prescribed by their doctor and dispensed by a pharmacy.

Self medication of the whole medication regime is done as part of a comprehensive rehabilitation package on rehabilitation wards only. On other wards patients may self administer specific medications such as insulin, inhalers and topical preparations? This will be documented in their diabetes care plan in the case of insulin and in the general care plan for other medications.

The briefing from the Audit Commission 'A Spoonful of Sugar' Medicines Management in NHS Hospitals (www.audit-commission.gov.uk) states that only half of the people with chronic diseases

take their medication as prescribed and recommends self-medication as a way of tackling this problem.

The self-medication programme aims to:

- Allow the assessment of compliance;
- Retain skills and independence and promote service user autonomy with regard to their medicines;
- Prepare service users for discharge by teaching safe and correct administration of medicines;
- Provide education about medicines, including potential side effects and what to do if they occur;
- Provide medicines and regimen convenient for life after discharge.

Education, practice and alteration to drug regimen whilst an inpatient should help prevent readmission due to non-compliance.

Service user selection

Service users should be selected for self-medication by the multidisciplinary team including the service user's key worker.

Inclusion criteria

Include service users who:

- Will be responsible for their own medication at home including those who have some carer support;
- Will be in-patients for more than 7 days and are stabilised on medication;
- Have had a risk assessment completed;
- Have a discharge plan.

Exclusion criteria

- Self-medication is not suitable for service users who are confused or whose mental state is unstable;
- Service users with a history of drug or alcohol abuse need to be considered with caution by the multi-disciplinary team. Refer to the current risk assessment and consider the management of the service user's medicines on discharge;
- Controlled drugs, variable doses (except anticoagulants), injections (unless to self - medicate on discharge e.g. insulin) and stat doses are not suitable for self-medication;
- PRN doses of antipsychotics or benzodiazepines are not suitable for self medication.

Guidance for the 4 stages of self medication

- The procedure for self medication on the rehabilitation wards 4 stages which gradually increase the responsibility of the service user for taking their own medicines;
- The doctor must discuss any alterations that are made to medication with the service user. The medicine chart should be altered and sent to pharmacy along with the medicine for re-labelling and the compliance / reminder chart for amending;
- If at any stage the service user wishes to withdraw from the programme they may withdraw their consent. If it is felt that the service user is unable to cope they should drop back to a previous stage or be withdrawn from the self-medication programme;
- The self-medication assessment form must be kept up-to-date (see appendix 7);
- Discuss with the pharmacist any concordance issues identified during the scheme. He / she may be able to offer education about medicines, simplification to regimen, advice about treatment options or side effects, compliance aids or reminder charts;
- Consider other service users on the unit who may exert pressure on the service user to hand over their medication to them;
- If the level of risk changes during the self medication process the team needs to review whether it is safe for the service user to continue self medicating. This needs to be documented in the notes.

Preparation

- Service users identified for self medication should be discussed by the nursing, pharmacy and medical staff and the checklist on the consent form must be completed and signed by the pharmacist and named nurse;
- The programme of self medication is explained to the service user and they agree to self-medication before proceeding;
- The consultant and service user must sign the consent form before commencing self medication;
- The self-medication assessment form must be completed and kept with the prescription chart;
- Service user medication chart and self medication information sheet should be provided for the service user;
- A quiet place should be identified for the service user to take their medication in.

Stage 1

- Ensure that consent form has been completed by the doctor and the service user;
- Medication Chart is marked Self Medication Stage 1 in the designated box on the front of the prescription chart;
- Pharmacy requisition is checked by pharmacist and faxed to preferred pharmacy supplier. All medicines will be dispensed as original packs with directions on the labels;
- The medication is explained to the service user (the name of the drug, dose, frequency, reason for taking it and possible side effects) and written information provided;
- The medication is stored in the medicines trolley in a sealed plastic bag (as used for leave and discharge medicines);
-
- At the appropriate time the service user should present to the nurse and the bag of medication is given to the service user who will select and take the prescribed medicine(s). This procedure is observed by a qualified nurse who will intervene if a mistake is to be made;
- The supervising nurse signs the medication chart in the usual way and completes the Self-medication assessment form;
- If the service user does not present for their medicines after an agreed period of time has elapsed (usually 1 hour) then the nurse reminds the service user about their medication. For some medication the specified time is important and the nurse must remind the patient sooner e.g. insulin, medication for Parkinson's disease. This will be annotated on the medication chart by the pharmacist;
- In preparation for stage 2 random checks will be made 3 times a day to ensure the service user has locked the drawer in their room (in which their medication will be stored during stage2-4) and their room when they are not in it;
- Progress or difficulties are recorded on the self-medication assessment sheet. Problems may be overcome by the use of compliance charts, other compliance aids, altering the formulation, timing or frequency of medication for example. This should be discussed with pharmacy staff as to which is the most appropriate course of action;
- When stage 1 is successfully completed move to stage 2. The consultant must sign the consent form to move to stage 2.

Stage 2

- Medication chart is marked stage 2 in designated box on the front of the prescription chart. Assessment form 2b is used to record progress;
- Pharmacy requisition is checked by pharmacist and faxed to preferred pharmacy supplier. All medicines will be dispensed with directions on the labels. Advise requesting multiple 1 day supplies to avoid delays in patient receiving new supply each day;
- One days' supply of medication will be stored in the lockable drawer in the service user's room;

- Service user is instructed on keeping the drawer and room locked when they are not in the room;
- The nursing staff mark the chart 'self' instead of signing for administration (see codes on front of prescription chart) when the service user informs them that the medicines have been taken;
- If the service user does not inform the nurse that they have taken their medicines at the appropriate times the nurse will prompt them and record that intervention was necessary on the Assessment Form;
- Random checks will be made 3 times a week to ensure the service user has locked the drawer in their room and their room when they are not in it;
- The previous days containers must be handed in and the quantities remaining recorded (even if NIL remains) before the next supply is issued;
- The nurse may check progress at any time;
- When stage 2 is successfully completed move to stage 3. The consultant must sign the consent form to move to stage 3.

Stage 3

- Medication chart is marked stage 3. Order 3, 5 and then 7 days medication. This will labelled with directions as in stage 2;
- Annotate the prescription chart with how many days supplied (use the row after the 20.00-22.00 row to record this. Annotate the assessment form in Appendix 9 with the re-order date;
- Medication will be stored in the lockable drawer in the service user's room;
- Random checks will be made 3 times a week to ensure the service user has locked the drawer in their room and their room when they are not in it;
- The service user self-administers the medication and tells the nursing staff when they have taken the medicine;
- Nursing staff mark the chart 'self 'when the service user has informed them that medication has been taken;
- Containers from previous supply must be handed in and the returned quantities recorded before the next supply is issued;
- The nurse may check progress at any time;
- Service user must complete 3 and 5 days supply at least once successfully and 7 days supply at least twice successfully before transfer to stage 4;
- When stage 3 is successfully completed move to stage 4. The Consultant must sign consent form to move to stage 4.

Stage 4

- Medication chart is marked stage 4. The service user is managing one week's medication at level 3 satisfactorily. Assessment form 2b is used to monitor progress;
- Service user must request for new supply of medication to be ordered from pharmacy as they would for a GP repeat prescription. This involves ordering several days before the current supply has run out;
- One months supply in the original packs will be issued and the service user will collect from Pharmacy(if appropriate);
- Nursing staff mark the chart 'self 'when the service user has informed them that medication has been taken;
- A minimum weekly check on the number of tablets used will be made to assess progress. The nurse may check progress at any time;
- Random checks will be made 3 times a week to ensure the service user has locked the drawer in their room and their room when they are not in it;
- Can continue stage 4 until discharge unless the risk level changes;
- Contact will be made with the GP and community pharmacist to follow up progress with medicines at 1, 3 and 6 months post discharge.

10. Patient safety and how the side effects of prescribed medication are monitored

10.1 How the side effects of prescribed medication are monitored

Monitoring adverse effects of medication is the responsibility of the multidisciplinary team.

All patients should be advised about the potential of medicines to cause adverse / side effects before commencing treatment. Baseline observations and monitoring should be carried out before starting treatment as recommended in the Summary of Product Characteristics and clinical guidelines for individual drugs.

During treatment side effects should be monitored and advice given on their management.

Whilst on treatment, as part of the treatment plan review, patients should be asked if they are experiencing any side effects from their treatment and actions taken by the medical team to remedy these side effects as best they can. Side effect rating scales that have been approved for use within CWP (http://nww.cwp.nhs.uk/academicunit/assessmenttools/Lists/Assessment%20Tools/Service%20Line.aspx) can be used to measure the extent of such side effects and to measure improvements in the reduction of severity of stated side effects.

All the above should be clearly documented in the patients CareNotes.

The clinical pharmacy team can assist in side effect monitoring and on recommendations for alternative treatments that are less likely to cause such effects.

10.2 Medication error reporting

Definition

A medication error is a preventable incident associated with the use of medicines which may put a patient at risk. Such incidents may be related to any of the steps of the medicine use process. This includes prescribing, dispensing and administration of the medicine and the transfer of information.

This section should be read in conjunction with the Trust's incident reporting and management policy.

Monitoring and reporting system

It is acknowledged that errors may occur. It is essential that there is an open and honest approach to prevent and manage this. The well-being of the patient is of prime importance following a medication error. When an error occurs the member of staff will:

Report the error immediately to an appropriate member of the medical staff, who will decide if any further action is needed.

- Inform the Designated Practitioner in Charge, who will inform the Unit Bleep Holder;
- Inform the Authorised Pharmacy Staff when appropriate;
- Inform the patient and relatives of the error and subsequent clinical intervention if appropriate;
- Complete an Incident Report Form (on Datix);
- The Unit Bleep Holder may inform the second tier on-call manager outside normal working hours if there are critical implications.

How the organisation learns from medication errors

When a medication error has occurred a post-incident / reflective review will be arranged, depending on the severity of the incident, where all interested parties will be invited to attend. The purpose of which will be to learn from the error and to make recommendations to prevent such errors occurring in

the future. These recommendations may involve system redesign and improvement, education, training and competency.

- For “A” and “B” incidents the recommendations will be taken to Quality Committee via SUI reporting;
- “C”, “D” and “E” incidents are managed within the service unit;
- All medication incidents are reviewed at the Medicines Management Group (MMG) meetings every two months. Recommendations following this review are fed back to the service lines by their MMG representatives and fed in to the three times yearly Learning from Experience report. MMG requests assurance from clinical service units that these recommendations have been put into practice.

10.3 Adverse drug reaction reporting

An adverse drug reaction (ADR) is an unwanted or harmful reaction experienced following the administration of a medicine or combination of medicines and is suspected to be related to the medicine. The reaction maybe a known side effect of the medicine or it may be a new previously unrecognised ADR.

The Commission on Human Medicines (CHM) / Medicines & Healthcare products Regulatory Agency (MHRA) encourages the reporting of all suspected reactions to newer medicines and vaccines (those products that are indicated by the inverted black triangle symbol). For established drugs and herbal remedies report all serious adverse reactions in adults.

If you see the black triangle symbol ▼ against a product entry in the British National Formulary (BNF), MIMS, the ABPI compendium of Datasheets and Summaries of Product Characteristics and advertising material, this indicates that the MHRA are intensively monitoring that product.

A black triangle will be assigned to a product if the drug is a new active substance. However, a product containing previously licensed active substances may also be monitored if it meets one or more of the following criteria:

- A new combination of active substances;
- Administration via a novel route or drug delivery system;
- A significant new indication which may alter the established risk / benefit profile of that medicine.

The CHM/MHRA wish to receive all suspected ADRs associated with these products in order to confirm the risk / benefit profile established during the pre-marketing phase. The black triangle medicines are monitored closely for a minimum of two years and the black triangle symbol ▼ is not removed until the safety of the drug is well established.

The Scheme invites reports from doctors, dentists, coroners, pharmacists, nurses and patients.

Patients who suspect they have suffered an adverse reaction to their medicines should report these to their doctor, so that further action may be taken. Patients can now make the yellow card report themselves directly to the CHM by completing the Patient yellow card reporting forms which are available across the Trust and on the intranet.

10.4 Medicine defect reporting

The quality of medicines is of prime importance and is strictly controlled through the pharmaceutical drug contracts and purchasing procedures. New generic drugs are checked for quality prior to contract award and existing drugs are monitored throughout the period of contract, so that staff and patients can have complete confidence in their use. However if a problem arises as a result of poor quality it must be reported promptly to the Trust pharmacy supply provider or a member of the pharmacy clinical team so that corrective action can be taken. A national pharmacy network exists for reporting and disseminating drug defects to ensure patient safety.

The following procedure applies when a defect is found or is suspected in any medicine:

- Inform the Pharmacy who will advise on all reporting, recording and investigating on the defect;
- Retain any remaining product and any associated products or equipment (e.g. administration sets infusion devices etc);
- Record the details of the product and defect;
- If the product has been administered to a patient inform the doctor responsible for the patient and record the defects in the patients' notes;
- Report the incident to the Appointed Practitioner in Charge of the ward or department.

If a drug defect is suspected after the Pharmacy Department's normal opening hours contact the emergency duty pharmacist.

10.5 National Patient Safety Agency (NPSA) and Central Alerting System alerts (CAS)

NPSA and CAS alerts are issued in response to nationally collected incident reports that indicate a recurrent error occurring with a particular drug or clinical procedure. They are disseminated across CWP by means of a Medicine Alert from the Trust Health and Safety Advisor. Alerts should be kept on the ward or clinic and a system should be in place to ensure that all staff have read them.

All action plans and any procedures related to such alerts will be held on the trust intranet on the medicines management pages.

11. How drugs are disposed of safely

11.1 CWP wards and clinics

11.1.1 Out-of-date and non-stock medicines no longer required

All out-of-date medicines and any non-stock medicines that are no longer required should be disposed of in the ward pharmaceutical waste bins.

11.1.2 Medicines no longer required due to discharge of patient

- Except for controlled drugs (see section 12) medicines supplied for patients who have been discharged should be removed from the trolley as soon as possible and the non-stock medicines disposed of in the ward pharmaceutical waste bins;
- Stock medicines if not required should be returned to the stock cupboard.

11.1.3 Medicines no longer required due to death of the patient

- If a patient dies whilst on the ward and the death is unexplained and will be subject to a coroner's inquest, then all of their medicines must be removed from the trolley and kept to one side for a minimum of 7 days. This is because the medicines may be required as part of the evidence for an inquest;
- The medicines should not be destroyed until advised to do so by the coroner's office (cross-reference with Trust policy on unexpected death of a patient).

11.1.4 Disposal of medicine bottles/ containers

Drug residues, even in "empty" bottles and used needles are regarded by the environment agency as special waste. The following paragraph is derived from a statement by the environment agency:

"Any containers or sharps contaminated by POMs, irrespective of the amount, MUST be treated/ disposed of as Special Waste and not clinical waste. Please note a residual coating of POM is still contamination. There is no minimum threshold concentration of POMs. They are always special waste".

When empty, plastic bottles (almost exclusively used for film coated solids) may be disposed of in normal rubbish bags. Bottles with residual liquids (Not CD's) can be disposed of in the ward pharmaceutical bin. Empty glass bottles must be rinsed and may then be disposed of in the grey refuse sacks or glass bottle sacks. Hospitals routinely treat sharps as special waste and there is no requirement to separate those sharps contaminated with drug residues from other sharps.

11.2 Disposal for community care (CCWC)

- Appropriate handling requirements must meet with the Control of substances hazardous to health (COSHH) assessment. http://www.hse.gov.uk/coshh/index.htm and the Health Technical Memorandum 07-01: Safe Management of Health Care waste (2006);
- Medicines awaiting disposal must be kept separate from medicines in use but remain securely stored;
- Non cytotoxic / non cytostatic medicines must not be mixed with Cytostatic / Cytotoxic CTS/CTX) medicines;
- Patients who have non cytotoxic / non cytostatic medicines for disposal must be directed to community pharmacies;
- All containers used for non cytotoxic / non cytostatic waste should be clearly labelled with the category of waste in them plus the European Union waste code "EWC 18 01 09" and for those containers used to prevent infection i.e. sharps with "EWC 18 01 01";
- Medicines for disposal must not be transported by staff between sites. Disposal shall be undertaken by the contracted NHS Western Cheshire waste disposal carrier;
- A waste transfer note system is in place with the commissioned waste carrier to ensure the waste goes for high temperature incineration;

- Waste transfer notes will be retained for 2 years and will reflect the nature of waste removed from the premises and the name of the premises. Notes must be signed and the names printed of both the receiver of the waste and the responsible person within the service.

12. Controlled drugs

12.1 Legislation and good practice changes

A number of changes to the monitoring and inspection, prescribing, dispensing, record keeping and destruction of controlled Drugs (CDs) have been introduced in light of the implementation of the Health Act 2006 and the Controlled Drugs (supervision of management and use) Regulations 2006.

These are a mixture of legislative requirements and professional good practice guidance.

These changes to primary legislation and to the Controlled Drugs Regulations apply to Scotland, England and Wales. The changes as they apply to practice are incorporated within this chapter of the policy. In addition there are Controlled Drugs Standard Operating Procedures (SOPs) for the handling of such drugs within the inpatient units; these are detailed in appendix 1 and for community care; these are detailed in appendix 2 and should be read in conjunction with this chapter.

12.1.1 Accountable officer for controlled drugs

It is a statutory requirement as part of the monitoring and inspection legislation that all Trusts appoint an Accountable Officer for controlled drugs and a suitable deputy. This must be approved by the Board of Directors and listed in the Scheme of Delegation of the Trust's corporate governance manual (the deputy name does not require listing in the scheme of delegation but would be held by the Accountable Officer).

- The Accountable Officer will be responsible for ensuring the safe and effective use and management of controlled drugs within the organisation subject to their oversight;
- NHS Accountable Officers are accountable through their organisation's management to their SHA. This is a statutory duty of the organisation as laid down in the Health Act 2006;
- The Healthcare Commission will be the external agency responsible for monitoring our use of controlled Drugs within the organisation. This will be carried out by periodic self-assessment and declarations as well as using their existing self-assessment methods to assess whether the Trust is meeting national standards;
- Responsibilities of the Accountable Officer are detailed in http://www.dh.gov.uk/assetRoot/04/13/14/61/04131461.pdf;
- The Trust Board appointed the Chief Pharmacist as the Accountable Officer at its meeting in July 2006.

12.2 Prescribing of controlled drugs

All medical staff (except students and clinical observers) may prescribe controlled drugs, but may **NOT** prescribe diamorphine or cocaine for addicts unless licensed to do so. This license is granted by the Home Office.

All nurse independent prescribers are able to prescribe independently controlled drugs listed in the current BNF Nurse Prescribers' Formulary, solely for the medical conditions indicated. Up-to-date information and guidance on nurse independent prescribing is available on the Department of Health Website at www.dh.gov.uk/nonmedicalprescribing

Controlled drugs prescriptions for outpatients or discharges frequently present problems due to non-compliance with the regulations. Medical staff must ensure that all legal requirements are fulfilled.

12.2.1 For leave, discharge and out patient prescriptions:

- All standard, prescribing principles should be followed as in Section 3;

- Controlled drugs to take out should be ordered on a discharge / outpatient prescription which has been written up by a medical practitioner in accordance with current legislation summarised in the BNF (Prescribing of Controlled Drugs);
- Validity of prescriptions for Schedule 2, 3 or 4 medicines is for 28 days (which can either be from the date on the prescription or the date indicated on the prescription as the start date for treatment);
- If collecting Schedule 2 controlled drugs from Pharmacy, an Authorised Registered Nurse's Trust Photographic ID badge will be accepted as proof of identity;
- Quantity of medicine to be supplied for Schedule 2, 3 or 4 medicines is not to exceed 30 days supply. Exceptions to this may be dispensed provided the prescription is annotated by the prescriber as being appropriate for the needs of the patient. Prescribing of methylphenidate for CAMHS patients may be considered as an exception. In all circumstances no more than 3 months supply should be dispensed. When dispensing the prescription for a quantity exceeding 30 days supply the pharmacy may challenge the quantity with the prescriber;
- Controlled drug prescriptions for out-patients, discharge or leave patients **MUST** contain the following:
    - Full name and address of the patient;
    - Full name of the controlled drug;
    - Form of the drug (e.g. tablets);
    - Strength of the preparation, if several exist;
    - Dose;
    - Total quantity of the preparation, or the total number of dose units, in both words and figures;
    - Total number of dose units is the preferred option, as totals in mg etc, can get complicated if there are different strengths of preparations available;
    - The date – this can either be the date signed by the Prescriber or the date indicated as a start date for the treatment;
    - All the above details **MUST** be in ink either printed (computer generated), handwritten or combination of both. Across the Trust most CD prescriptions will still require writing by the prescriber in their own handwriting;
    - The prescription must be signed by the prescriber in his / her own handwriting.

- It is illegal for the pharmacy staff to dispense an incorrectly written prescription for controlled drugs. Errors in controlled drug prescriptions or take home prescriptions can lead to delay in discharge;
- The original prescription must be sent to pharmacy for dispensing. Upon completion of dispensing the top copy is kept in pharmacy and the other copies returned to the ward for filing;
- Delivery and receipt of controlled drugs for discharge purposes should be as detailed in Standard Operating Procedure 1 for controlled drugs (appendix 1). Storage on the ward / department should be in the controlled drug cupboard.

It is not necessary to enter the discharge prescription into the Controlled Drug Record Book. However, if leave or discharge is delayed and the medication has been sent to the appropriate ward then it is deemed good practice to enter details of the drug in the "patient's own" section of the ward controlled drug record book.

12.2.2 For inpatient use:

The responsibility for ordering, receipt and storage of Controlled Drugs is that of the Assigned Practitioner in Charge of the ward/department.

Controlled Drugs can only be ordered from the pharmacy by submitting a requisition from the official Controlled Drugs Requisition Book. Ordering is restricted to an Assigned Practitioner in Charge or an assigned practitioner authorised to order CDs.

All CD requests must be countersigned by an authorised Medical Practitioner. All assigned practitioners who may order Controlled Drugs must provide the supplying Pharmacy with specimen signatures.

Requisition books should be sent to Pharmacy as early as possible on weekdays. CDs should NOT be routinely ordered at the weekend; however, CDs will be supplied in an emergency via the out of hours pharmacy service. In this case the requisition book must be taken to the out of hours pharmacy by a member of staff who must wait for the controlled drug to be dispensed.
Please note that faxed orders for CDs cannot be dispensed by the Pharmacy.

12.3 Delivery of controlled drugs

The procedure for delivery of controlled drugs will always be within the following guidelines:

- The person signing the 'accepted for delivery' section must ensure security in transit;
- The top copy of the requisition will always be returned for filing in the pharmacy and kept for 2 years.

All Controlled Drugs must be delivered to wards or departments in a secure container.

If the Controlled Drugs are to be collected by a Designated Practitioner, the appropriate part of the Controlled Drugs Requisition Book must be signed and the medicines transported back to the ward in a sealed package.

12.4 Receipt and Storage of Controlled Drugs on the ward

A Designated Practitioner must receive the pharmacy bag containing the CDs and sign for it. This will be by signing the requisition book, the delivery consignment sheet and CD record sheet as appropriate based on whether the pharmacy bag contains stock or discharge/leave CDs. The requisition order top copy is always returned to the supplying pharmacy as a record of the order. The Designated Practitioner is signing for receipt of the secure pharmacy bag. The detail of the procedure to be followed is covered in Standard Operating Procedure 1 for Controlled Drugs (appendix 1):

- A Designated Practitioner must check the contents of the pharmacy bag containing controlled drugs against the requisition. Any discrepancy must be reported to the pharmacy IMMEDIATELY. If correct, the Designated Practitioner must sign the requisition. The Designated Practitioner must enter the new stock into the Controlled Drugs Record Book on the appropriate page, witnessed by another Designated Practitioner, Authorised member of the Pharmacy Staff or an Authorised Health Employee who must verify the stock level and sign the Controlled Drugs Record Book. The medicines must then be immediately locked away;
- Where sealed packs of Controlled Drugs are supplied with tamper evident seals, there is no requirement to open these packs for stock checking purposes;
- Controlled Drugs must be stored in a locked medicines cupboard, approved by pharmacy and reserved for the sole storage of Controlled Drugs. Access must be limited to Designated Practitioners, Pharmacists or Authorised Pharmacy staff;
- Record Books and Requisition Books for Controlled Drugs are controlled stationery and obtainable only via the pharmacy team. Requisition books should be locked away;
- Orders and records must be in permanent ink and must be retained for two Years from the date of last entry in the book.

12.5 Checking of stock balance of controlled drugs

It is good practice to check stock balances of all Controlled Drugs with every shift change involving a change of Assigned Practitioner in Charge. The audit minimum standard is that the stock balance of all Controlled Drugs entered in the Controlled Drug Record Book must be checked once a week against the actual stock held in the ward/department. There is no need to open packs with intact tamper evident seals for stock checking purposes. Where possible there should also be verification of entries in the register against entries made on individual inpatient prescriptions.

Two Designated Practitioners, one of which is the Assigned Practitioner in Charge or one Designated Practitioner and one Authorised Heath care Worker must perform the check. A record indicating this check has been carried out must be kept in a separate record book / sheet or in the Controlled Drug Record Book and must confirm the stock is correct. The record must be dated and signed by both Practitioners. The Appointed Practitioner in Charge must ensure that these checks are carried out.

The Appointed Practitioner in Charge must undertake a random check of all Controlled Drug cupboards at least once a month and record it in the ward Controlled Drug Record Book.

It is recommended that stock balances of individual preparations be checked after every administration.

Liquid medicine stock balances can only be checked when the bottle is empty.

Any discrepancy must be reported to the Appointed Practitioner in Charge who must inform a locality CWP clinical pharmacist.

Any need for more frequent checks will be decided by the Appointed Practitioner in Charge in liaison with the Trust Chief Pharmacist.

A designated pharmacist must check the Controlled Drugs balance a **minimum of every three months** and when overall responsibility for the medicines change e.g. change of appointment of the Appointed Practitioner in Charge. Where possible there should also be verification of entries in the Controlled Drugs Record Book against entries made on individual inpatient prescriptions.

12.5.1 Checking stock balance of other medicines

Any need for checking stock balances of other medicines must be left to the discretion of the Appointed Practitioner in Charge. If, however, there is suspicion of abuse of medicines this must be reported to the Modern Matron/ General Manager and Locality Lead Clinical Pharmacist. In such cases it is advised that a stock balance must be recorded and regular checking introduced. If this shows discrepancies the medicine must be made subject to similar procedures as Controlled Drugs and Controlled Drug Record Book entries must be made whenever the medicine is administered.

12.6 Administration of Controlled Drugs (see appendix 1 - SOP 3)

The administration of all Controlled Drugs must be by a designated practitioner and witnessed by a second designated practitioner. The second person may be a nurse in training deemed competent in the Pharmacology of Medicines (usually Level 3) or a healthcare worker trained to NVQ level 2 in care as detailed in 5.11 who is competent to assist a designated practitioner.

An entry must be made in the ward or department Controlled Drugs Record Book, including:

- Date and time of administration;
- Name of patient;
- Dose administered;
- Full signature of both practitioners;
- Remaining stock balance must be checked. If cupboard and book agree then initial the balance figure, otherwise investigate why they differ by contacting the Pharmacist who is clinically responsible for your ward / department.

Any medicine prepared and not used, or only partly used, must be destroyed in the presence of a second practitioner. An entry must be made in the Controlled Drugs Record Book and signed by both practitioners.

12.6.1 Administration of controlled drugs via a syringe driver

When patients are commenced on the Final Days Care Pathway the documentation contained within the Care Pathway for prescribing, administering and controlled drug stock sheets must be used. For all other patients who are commenced on a syringe driver the prescribing, administering and controlled

drug stock form as set out in the Clinical Guidance for the completion of District Nursing documentation must be used.

12.7 Losses or discrepancies of controlled drugs: (see appendix 1 - SOP 4)

In the event of a discrepancy between the stock balance and register for Controlled Drugs, the Appointed Practitioner in Charge must immediately and thoroughly investigate the loss. A missing entry must be sought but, after an unsuccessful investigation, the discrepancy must be reported immediately to the senior manager responsible for the ward or department and the designated Pharmacist who can then further investigate the discrepancy. If a discrepancy is identified; the Trust Accountable Officer is to be contacted for further investigation and decide whether or not the police should be notified.

12.8 Patients own controlled drugs: (see appendix 1 - SOP 7)

Controlled Drugs brought into the hospital by the patient may be:

- Used by the ward staff for administration to the patient only when the pharmacy is closed until a fresh supply can be received from the pharmacy. The patient's own supply must be deemed suitable for use as checked by the designated practitioner;
- Stored for subsequent destruction.

In both of the above, the Controlled Drug must be stored in the Controlled Drug cupboard, and entered in the Controlled Drug Record Book either on a new page specifically allocated for "patient's own medicine" or on a page specifically identified for the recording of "Patients Own Medication for destruction". This entry **MUST** include the patient's name and the quantity and type of drugs, (tablets, ampoules, etc.) and be witnessed by another designated practitioner. When the drugs are released to a relative, the entry signing out the drugs should be countersigned by that relative or a designated practitioner.

12.9 Destruction of unwanted/out of date controlled drugs (see appendix 1 - SOP 5)

In general the following principles will apply:

- Controlled Drugs which are out of date or no longer required by a ward or department will need to be destroyed by the Designated Pharmacist. If the out of date or no longer required stock is a schedule 2 controlled drug the destruction must be carried out in the presence of a Trust Authorised Witness. The appropriate stock balance will be entered in the Controlled Drugs Record Book by the designated pharmacist and the entry signed by the Authorised Witness. For patient's own drugs destruction the transaction will be witnessed by a Designated Practitioner who will also sign the record book with the Designated Pharmacist;
- Any dose of a Controlled Drug that is prepared but not administered, including partly used syringes used in syringe driver pumps shall be destroyed on the ward or department / home. The destruction of the Controlled Drug must be in the presence of a second Designated Practitioner. The appropriate entry should be made in the Controlled Drug Record Book, which includes the signatures of the two practitioners involved in the destruction;
- Patients' own controlled drugs found in their own home are the patient's property and if no longer required/out of date the patient should be advised to return them to their local Pharmacy for safe destruction (see also section 12.12).

12.10 Obtaining controlled drugs for a ward in an emergency out-of-hours scenario

Controlled Drugs must not be borrowed except in an extreme emergency. Records of the dose of a borrowed Controlled Drug must be made in the Controlled Drugs Record Book of the ward or department who has provided the medicine; i.e. the dose must be booked out directly to the patient in the receiving ward. The Locality Lead Clinical Pharmacist must be informed as soon as possible after a borrowed supply of Controlled Drug has been made.

- Only single doses can be transferred in this way;
- In cases of difficulty or when borrowing a dose is not an option, the on-call pharmacist should be contacted via the hospital switchboard for advice.

12.11 Registered drug misusers admitted to inpatient wards

As soon as a patient who receives a prescription from the Drugs Service in the community is admitted to a ward**, the Drug Service must be informed immediately by the admitting designated practitioner.** This is to ensure that the prescription is cancelled at the community pharmacy / chemist whilst the client is an inpatient and to enable confirmation of the patient's dose before a regular inpatient prescription is commenced.

Similarly, the Drug Service must be informed when the client is discharged from hospital so that excessive supplies are not given on discharge and to enable contact to be made with the client's legitimate supplier in the community. This is the responsibility of the patient's named designated practitioner and should be undertaken as soon as a discharge date is agreed.

This section should be read in conjunction with Medicines Policy 8 "Guidance for Inpatient and Out of Hours Management of Drug Misusers".

12.12 Dealing with unknown substances found on patients

If a patient is admitted to hospital in possession of unknown substances and there are reasonable grounds for the designated practitioner to believe these substances are illegal, the patient should be advised that possession of the item is unlawful and asked to surrender the item voluntarily. This section should be read in conjunction with policies care and management of intoxicated service users - including management of risks associated with drug and alcohol use in inpatient settings and the management of illicit substances within CWP premises.

The police are reluctant to attend a unit for the disposal of small quantities of unknown substances.

In light of this all unknown substances handed in by / found on patients will be denatured by a designated pharmacist in the presence of an authorised witness in accordance with the controlled drugs SOP 5 (appendix 1) and treated as if they were a schedule 2 controlled drugs. The process to be followed by staff on receipt of an unknown substance is detailed in controlled drugs SOP 12 (appendix 1).

12.12.1 Contacting the Police about unknown substances

If it is suspected that there is drug dealing taking place within the Unit then the "Unknown Substance Intelligence Report", should be completed (appendix 1 – SOP 12(b)) and forwarded to the General Manager. The general manager will then make a decision as to whether the police need to be called in to investigate. If necessary the Accountable Officer for controlled Drugs may be consulted with on such an occasion.

For unknown substances disclosed to a community team practitioner, the practitioner should advise the service user / carer to hand the substance over to the police to deal with. The practitioner should not take custody of the substance.

12.13 Other substances liable to misuse

This may include drugs purchased by the patient which they may be misusing e.g. cough preparations, laxatives, alcohol etc.

There may also be other substances such as glue, which are being abused.

These substances are the patients' own property.

However, if the patient wants to take them on discharge from the hospital, the Doctor or nurse should counsel the patient on the potential harm and recommend that they not be used.

If it is felt that return of these items may cause harm or put their life or the lives of others at risk these items can be withheld from the patient when discharged and a designated Pharmacist contacted to carry out destruction.

This fact and the reasons why should be documented in the case notes.

12.14 Reporting concerns about controlled drugs

12.14.1 What is a concern?
A concern can be anything relating to the practice, storage, dispensing and destruction of Controlled Drug. The concern may be relating to inappropriate practice, record keeping and storage arrangements.

12.14.2 Why a concern would be raised:
A concern would be raised if it was felt that actions or outcomes of the concern meant that patients, staff and the wider public were at risk.

12.14.3 Who can raise a concern?
A concern can be made by any of the following groups:

- Accountable Officer for Controlled Drugs;
- Authorised Witness;
- Member of Primary Care Trust Staff;
- Member of External Organisation Staff;
- Patients.

12.14.4 How a concern can be raised
A concern can be raised by direct contact with either of the following:

- Lead Pharmacist Community services;
- Accountable Officer for controlled drugs (Chief Pharmacist);
- Medical Director Compliance, Quality & Regulation.

All contact numbers are held on CWP intranet / Trust board Offices.

13. Community Mental Health Teams (CMHT)

13.1 Overview of the chapter
This chapter refers to the following groups of staff who work from a community base and not a hospital in-patient base:

- Community Mental Health Teams (CMHTs);
- Home Treatment Teams (HTTs);
- Social Services staff, working within a CMHT;
- Community Learning Disability Teams.

Note: Learning disability respite houses where patient's own medication is used will follow local procedures

This chapter will need to be read in conjunction with other chapters of this policy as frequently it refers to various sections which are applicable to staff working in an inpatient and / or community setting.

This chapter should also be cross-referenced with the various local and Trustwide policies on medicines handling / storage for the Crisis / Home Treatment Teams.

13.2 The system for security of medicines

- Each clinical base for Community Teams, where medicines are stored and used, should have a system of Standard Operating procedures (SOPs) covering each of the activities concerned with medicines used to ensure their safety and security;
- The procedures for handling Controlled Drugs should take account of the additional legal and good practice requirements for this category of medicines (see Section 12).

13.3 Responsibility

- The responsibility for establishing and maintaining a system for the security of medicines should be that of a Senior Pharmacist in consultation with senior nurse managers and appropriate medical staff within the team base;
- The nurse team leader should be responsible for control of access to the medicines and should therefore have responsibility for ensuring that the system is followed and that the security of medicines in the clinical base is maintained;
- In the absence of a nurse team leader, the community nurses should bear the responsibility individually.

13.4 Supply of medicines

- Depot antipsychotics are supplied on a named patient prescription to each Team's clinical base. The Crisis / Home treatment teams are the only CMHTs that hold a selected stock of medicines to be used in a crisis situation;
- It is the responsibility of the pharmacy to ensure that there is a secure method of supply. It is the responsibility of the locality Clinical Pharmacy Team to ensure that there is secure storage of those medicines for Team clinical bases;
- A list of medicines to be held in stock by the CRHT should be decided by a pharmacist in consultation with appropriate medical staff and senior nursing staff;
- Pharmacy staff should determine the amount of each stock medicine to be held at any time from usage patterns;
- The list should be subject to a regular review at agreed intervals.

13.5 Ordering and records

- A Designated Community Practitioner within the team should be responsible for ordering medicines by sending a named patient's prescription to the pharmacy service provider;
- Orders should be in a permanent record, and any requisition book / sheets locked away;
- Where order books, pads of requisitions or prescription pads are used these should be treated as controlled stationery and kept under lock and key by an authorised employee. Their issue should be limited to Designated Community Practitioners only;
- It should be the duty of the supplying pharmacist to ensure that medicines are only supplied on the instruction of a Designated Practitioner (i.e. by confirming their authority to order);
- Where prescription pads are held in a unit their security should be the responsibility of qualified practitioners, who should keep them locked away;
- Some patients may need to have their medicines collected from a community pharmacy by a member of staff within the CMHT. The patient and team may need to identify a nominated community pharmacy to dispense the medicines. The patient will need to consent to the care co-ordinator or social worker and community pharmacist in ordering and collecting their medicines on their behalf. This consent should be documented within the care plan in the patient's case notes. The patient must provide proof of exemption from payment of prescription charges to a member of staff from the CMHT, if they are collecting the medicines on the patient's behalf. Medicines may be delivered from the community pharmacy, at a frequency based on patients need, to the CMHT.

13.6 Receipt and records

Medicines coming into the Team's clinical base should be checked against the consignment sheet by a Designated Community Practitioner for the correct number of boxes, the correct seal numbers and that the seals have not been broken. The consignment sheet is then signed and the name printed as a record for the pharmacy service provider. The contents of the boxes are then checked against the delivery sheet and if any discrepancies are noticed the pharmacy service provider should be contacted immediately. Individual patient's depot cards are then annotated to record receipt of medicines received with:

- Date received;
- Drug name and strength;
- Number and volume of ampoule / injections;

- Batch number;
- Signature of nurse.

The exception to this is Risperdal Consta. All the above needs to be annotated on the depot card except the batch number. This can be recorded on the depot card at a later date so as to not break the cold chain.

Where it is deemed to be in the patient's best interest for their medicines to be kept at the base for supervision/administration over a series of visits, these should be kept in a lockable cupboard, and used for that patient only. These medicines should be either in original boxes or compliance packs labelled up with the directions from the pharmacy that dispensed them. Medicines received from a patient must be recorded either in a bound book or on the 'Receipt of patient's own medicines form' (appendix 4) and kept in a separate folder for 'Receipt of patient's own medicines'. The record of receipt must contain:

- Name, strength, formulation of medicine;
- Number of dosages;
- Date;
- Signature of staff;
- Initial stock level of patient's own medicines.

Such medicines should be clearly labelled and kept separately from base stocks (or in a separate part of the same cupboard).

A record of the final balance when the medicines are given back to the patient must be recorded in the bound book or on the 'Balance of medicines returned to the patient form' (appendix 5) and kept within the same folder as the 'Receipt of patient's own medicines form' (appendix 4)

13.7 Consent for receiving, storing and managing patient's own medicines.

Consent MUST be received from the patient for the CMHT to take responsibility for the management of their medicines. This consent will be documented in the patient's case notes as part of the care plan.

If there are any concerns around capacity and consent this must be discussed with the team manager in accordance with the CWP Part IV & IVa MHA 1983 - Consent to treatment.

13.8 Security of unit medicine stocks

The security of medicine stocks should be checked by authorised pharmacy staff periodically, normally every three months, in accordance with locally agreed procedures. They should carry out inspections of the Unit stocks, with reconciliation where necessary.

13.9 Storage of Medicines at the Team base (see also section 5)

- In the clinical base the responsibility for the safekeeping of medicines rests with those holding means of access to the stock;
- It is recognised that for clinical bases having no continuous nursing presence it is impractical to have only one person with access to medicines. It is therefore important that records be maintained of all those having such access, by whatever means (e.g. keys, key cards, magnetic swipe cards etc). The team manager should ensure this is in place for the team;
- Lockable cupboards and medicine fridges should be used for storage of all medicines, which should at least comply with current British Standards or otherwise authorised as suitable. The current British Standard is BS2881 (1989) – NHS Estates Building Note No 29;
- All clinic rooms where medicines are stored must not exceed temperatures of 20-25ºc. All medicine fridges must have an external maximum and minimum thermometer in place and daily records must be kept of the fridge temperatures (read in conjunction with section 7.4.9). The temperature of the fridge should be maintained between 2-8 ºc.

13.10 Authorisation for administration of medicines

The authorisation of a suitable designated practitioner should be obtained before medicines can be administered to patients by a qualified registered practitioner. This authority is given in one of three ways:

- An instruction written by a medical practitioner or authorised prescriber on an official in-patient chart. The patient's administration record must be obtained by using the most recent and accurate sources of information to create a full and current list of medicines (see Medicines reconciliation policy for guidance). The administration record is kept within the patient's records. All medicines administered by a qualified registered practitioner must be recorded on the administration record;
- In accordance with locally agreed clinical procedures;
- In accordance with Patient Group Directions for new patients attending clinic or a Patient Specific Direction (a prescription) for patients who are returning for a further supply.

13.11 Record for supervision (concordance) of medicines

- A current list of the patient's medicines must be obtained by using the most recent and accurate sources of information to create a full and current list of medicines, (see MP19 Medicines reconciliation policy for guidance). This list is then kept within the patient's records. An entry in the patient's case notes must be completed for all medicines supervised by a member of the CMHT, documenting that the patient has received the medicines;
- Under no circumstance should medicines be administered to a patient unless point 10.9 is followed. They must only be prompted to take their medicines. If the patient is having problems in administering the medicines themselves then contact a community pharmacy to look at different concordance aids.

13.12 Domiciliary visits and carriage of medicines

- When medicines are issued to nursing staff for use in the community, these medicines become the responsibility of the person to whom they are issued. (i.e. the community nurses);
- All medicines carried by the community nurse should have been prescribed as a specific dose for a named patient by a qualified medical practitioner /authorised prescriber, or covered by the terms of a PGD under which the community nurse may supply or administer the medicine;
- Each medicine carried should be accompanied by the written prescription on the relevant medicines card or a prescription from the GP;
- A new prescription must be written by a qualified medical practitioner /authorised prescriber if any changes in medicines occur. The new prescription must be kept with the patient's record of current medicines and administration record;
- Any amendments to the medicines must be changed on the administration record by the qualified medical practitioner /authorised prescriber. In exceptional circumstances, where the qualified medical practitioner /authorised prescriber can not amend the administration record a verbal order maybe taken over the phone (refer to section 3.9) or a faxed copy from the qualified medical practitioner /authorised prescriber of the changes should be attached to the administration record and the changes clearly documented by them in the patient's case notes. The prescription must be signed by the qualified medical practitioner /authorised prescriber the next day. For any amendments to medicines that are supervised a faxed copy from the qualified medical practitioner /authorised prescriber of the changes should be attached to the concordance/supervision record and the changes clearly documented in the patient's case notes by them. A new prescription from the GP and a new labelled supply of medicines must be obtained from the nominated community pharmacy as soon as possible. Supply of medicines in-hours and outside normal working hours and dose adjustment of regular medicines will be carried out in accordance with Trust Procedure for the supply of specified medicines to adults after assessment by the psychiatrist for the crisis resolution and home treatment team (MP11);

- All medicines carried by the community nurse should be carried in the locked case which, for the limited periods when not in the personal possession of the nurse, should be locked in the boot of the car or out of sight. Any case which develops a fault preventing it from locking securely should be reported immediately and replaced. In situations where a locked case will bring unnecessary attention to the team member then the medicines should be carried in a suitable bag;
- Depot injections will be drawn on a daily basis in quantities in accordance with doses to be administered on that day only. On return to base, all medicines not administered should be returned to a locked place of safety in the base and recorded;
- The community nurse/ designated practitioner must carry a Trust staff identity card bearing a recent photograph which together with the prescription sheet is the authorisation to carry and administer medicines on behalf of the Trust. All Trust staff, be it nurses, occupational therapists, healthcare assistants, may as part of their job, be required to transport and handle prescribed medication. This should be limited to essential need only such that in the case where the client is unable to do so or as a direction from the prescriber. Provided this is carried out as part of the staff's duty the Trust will accept vicarious liability;
- The patient and their current prescription should be reviewed at least six monthly. All patients for whom medicines are prescribed on a long term basis should be reviewed by the Medical Officer;
- **The issue of all named patient depot medicine should be recorded on the patient's depot card. A local procedure should be in place to check the balance for the named patient stock;**
- **The community nurse should record administration, along with a note of all medicines refused, wasted or returned to stock, in the case notes / medicine chart and in the bound book at the Team Base on return as appropriate;**
- Whenever practicable unused medicines should be returned to the medicine cupboard at the team base for overnight and weekend storage. Where this is not possible, they may be stored in a locked cupboard or drawer at home but not for longer than 72 hours;
- Two members of staff should check that the correct medicines are removed from the Team base for supervised consumption/administration for that patient;
- Two members of staff or one member of staff and the patient must double check that the correct medicine is given to that patient;
- Community staff / designated practitioner must document in the patient's case notes that the patient has received their medicines.

13.13 Clinics held by community nurses

- Sufficient information about medicines should be available to the Team Staff and / or patient to enable identification and correct use of the products (patient information leaflets, BNF);
- If there are any risks associated with handling or administration of a medicine, then there should be a procedure to minimise the risks (local policy on specific medicines). Clinical staff should also have undertaken the necessary training associated with each medicine;
- Patients should be encouraged, wherever possible, to store their medicines in their own homes, subject to appropriate risk assessments, and bring them to the clinic for administration;
- Where it is deemed to be in the patient's best interest to keep these medicines at the base they should be locked away, in a separate cupboard / or an area of the cupboard separated from medicines supplied by the pharmacy service provider;
- In the event of patients not bringing medicines with them, medicines must be obtained from the pharmacy service provider on a named patient prescription;
- The patient's treatment card should be annotated to show the amount that has been administered from base stocks;
- The base's record book should also be completed to show details of administration, along with the signature of the nurse administering the medicine;

- Where clinics are held away from the base where medicines are stored, medicines may be issued from an agreed list, in accordance with local policy, to an individual community nurse;
- These medicines should be the responsibility of that community nurse;
- Full record-keeping procedures should be followed.

13.14 Disposal of medicines (see also Section 8)

- All out of date medicines or unwanted medicines should be placed in the green pharmaceutical waste bin provided by the pharmacy service provider;
- All actions should be recorded in the base records and documented in the patient's case notes;
- Medicines obtained by patients for home use or by prescription from authorised prescribers are the patients' own property. When no longer required, the patient should be advised to return them to a local pharmacy for destruction. If this is not possible then it can be returned to the supplying community pharmacy for destruction or placed in the green pharmaceutical waste bin at the CMHT. The patient must consent to the destruction of the medicines and this should be documented in the patient's case notes. Appropriate records need to be completed to indicate that the patient's medicines have been destroyed. This should also be documented in the patient's case notes.

13.15 Risk management

Risk assessments should be carried out (in accordance with the local risk management policy) in connection with the medicinal products and procedures (including the use of delivery devices) to determine potential risks to patients and Trust staff.

A risk assessment should be carried out on each occasion when a new product or procedure is introduced to the clinic.

13.16 Social services staff

Social services staff working within CWP should follow the Trust's medicines policy.

13.17 Role of registered and non-registered Health/Social Services Staff

All team staff may deliver dispensed medicines and aid compliance with medicines by reminding and encouraging individuals to comply with treatment requirements.

Team staff should not re-dispense medicines into other containers or dosette /compliance packs.

All staff have a duty to provide information on medicines and report suspected side-effects back to the team and to the MHRA on the yellow card system.

13.18 Nurse dispensing

The Medicines Act 1968 clearly states that nurses should only dispense in exceptional circumstances. Community teams should make every effort to use community or hospital pharmacies to supply medicines once furnished with a valid prescription.

13.19 Supply of medicines upon assessment by the team if a client runs out of medicine

Throughout the Trust progress has been made to make a limited list of medicines available at the point of assessment by the Community Teams. In many areas this is via the availability of an FP10 HNC prescription pad or 'pre-labelled' medicine packs.

The current Trust system for supplying medication to clients upon assessment is as follows:

- All clients seen between 9am – 5pm (in hours) needing medicines should be facilitated by going through the client's GP. This is done by the assessing doctor faxing the GP a request for new / changed medicines;
- All clients seen between 5pm-9am (out of hours) needing medicines should be referred to the duty doctor for assessment;

- If a client presents to A&E the assessing doctor may issue a prescription;
- The assessing doctor is ultimately responsible for determining what medicine is necessary in all cases;
- All clients who are running out of their supply of medicines should access their GP for a repeat prescription as early as possible in order to avoid being without medicines. If this does occur, then a prescription should be obtained from the GP surgery during normal opening hours (most surgeries require 48 hours notice) and then dispensed at the pharmacy of the client's choice. If the client has run out of medicines and a prescription is not available from their GP an emergency supply of up to thirty days treatment can be made from a community pharmacy, for which a charge may be made;
- If pharmacies are closed and the FP10hnc prescription has been marked "urgent" by the doctor, then the police can be contacted for assistance. The police will then contact a community pharmacist to dispense the prescription, out of normal hours;
- If medicine is required by a client out of hours and none of the above points are fruitful, then the client should telephone their GP surgery. The call will be directed to the "Out of Hours service" or NHS Direct (depending on the time of the call) who will be able to assist the client in terms of assessment / provision of medicine.

14. Community Care Western Cheshire (CCWC)

Please read the Non-medical Prescribing Policy, Patient Group Direction Policy and the Safe use of McKinley Syringe Pump Policy in conjunction with this policy. Authorised Prescribers of medicinal products are required to check medicinal products for suitability of use, contra-indications and allergies that patients may have. Generic principles which are applicable to all areas of the Trust are covered in the main chapters of the policy (chapter 3-11) and any differences or specific duties are covered in this chapter and section 12.6.1 in chapter 12 on controlled drugs.

14.1 Prescribing

NHS Western Cheshire guidelines and formularies should be followed by all. These include:

- Current PCT / Countess of Chester primary care formulary;
- Management of infection guideline for adults in primary care (Antibiotics formulary);
- Wound management formulary and wound guidelines (2009);
- Continence prescribing formulary (2009).

Prescribing policies produced by West Cheshire Consortium (http://nww.wcheshirepct.nhs.uk) include guidance on:

- Esomeprazole;
- Gluten free products;
- Erectile dysfunction;
- Statins.

CCWC prescribers requiring further assistance with details of formularies and policies should contact the Lead Pharmacist Community Services.

14.2 Administration

The record sheets set out in the "Clinical Guidance for the completion of District Nursing documentation" must be used.

15. How a patients medicines are managed on handover between care settings

On admission to CWP ward or unit the medicines reconciliation policy should be followed as described in section 3.2.

On discharge from CWP ward or unit patients should be provided with 14 days supply of medicines unless a smaller supply is deemed to be necessary following risk assessment. The discharge prescription should be fully completed including a record of medicines discontinued during the hospital stay. A copy of this prescription should be faxed to the patients GP and Community Mental Health Team (if applicable) within 24 hours of discharge or next working day if discharged at the weekend.

If a patient is transferred to another NHS inpatient unit a copy of the complete, current prescription chart should be sent to the new unit on the day of transfer. Patients own medication which is labelled with name and directions should be sent with the patient.

16. Duties and responsibilities

16.1 Medical Director, Compliance, Quality and Assurance / Chief Pharmacist

The lead executive for this policy.

16.2 Chief Pharmacist

Overseeing the ongoing review of this policy in line with the Medicines Management Group business cycle, national guidance and changes in clinical practice.

16.3 Medicine Management Group (MMG)

- Ratifying medicines management related polices including this policy, its ongoing review (including review of duties) and receiving reports on the monitoring of this policy, through receipt of reports, work plans and action plans as detailed in this policy;
- Approving medicines for use;
- Approving the “discretionary list”;
- Receiving the list of clinical trial medications that have been approved by the Ethics Committee and Trust’s evidence based practice centre, and making recommendations;
- Ratification of patient group directions every two years;
- Receiving and reviewing reports on medicines related risks from incidents and agreeing a suitable action plan for addressing the risks;
- To ensure following review of reports that any recommendations are fed back to the clinical service lines via the MMG representative;
- Will request assurance from clinical service units that these recommendations have been put into practice;
- It is the responsibility of the Chair to ensure that the minutes of the meetings reflect the approval process and that all reviews of the policy are timetabled within the business cycle;
- Is responsible for approval, ongoing review (including review of duties) and receiving reports on the monitoring of this policy, through receipt of reports, work plans and action plans as detailed in this policy;
- Reports to the Patient Safety & Effectiveness Sub Committee.

16.4 Heads of Services (CCWC) and Managers

- Cascading information on the policy to all staff that they manage ensuring that any training required on the policy is included in staff’s personal development plan and clinical supervision;
- Ensuring only members of staff who have been appropriately trained and assessed as competent undertake any medicine related activities. They are also responsible for taking appropriate action should any breach of this policy occur;
- Ensuring that staff involved in medicine related activity have a current registration with the appropriate body;
- Ensuring that members of staff are aware of their roles and responsibilities in relation to controlled drug activities;
- Writing medicines management standard operating procedures where relevant;
- Auditing compliance with medicine management Standard Operating Procedures annually;
- Ensuring that the CQC safe and secure annual self-assessment declarations (outcome 9) are completed for their service including a nil return;
- Auditing the standard of Medication Authorisation forms six-monthly and reporting result to the MMG – CCWC only;
- Checking medicine stocks where relevant to avoid over ordering and stock piling.

16.5 CWP pharmacy team / Designated Pharmacist

Advising all trust clinical staff on systems and processes to ensure the safe and secure handling of medicines is in accordance with this policy and any supporting procedures and guidelines for good medicines management across the Trust. This includes dose calculation, developing patient group directions, discussing with staff management of patients with swallowing difficulties, authorised pharmacy staff can re-dispense medicines as outlined in this policy.

The designated pharmacist is responsible for destroying unwanted/out of date controlled drugs / patients own drugs that are no longer required, if it is a schedule 2 controlled drug this must be done in the presence of a Trust Authorised Witness. They should also enter the appropriate stock balance in the Controlled Drugs Record book.

16.6 Non-medical prescribing lead

Receiving assurances from line managers of NMPs that medicine management training is in place as set out in the Training Needs Analysis and Local Learning Plans and Continuous Professional Development for NMPs in order for them to maintain medicine management related competencies.

16.7 CWP Accountable Officer

- Ensuring that the organisation has robust arrangements for the safe and effective management and use of controlled drugs. This role is registered with the Care Quality Commission and is listed in the Trust scheme of delegation;
- Facilitating the use of the Incident Decision making tree for all Controlled drug incidents;
- Overseeing all of CWP Controlled Drug incidents;
- Reporting all controlled drug concerns to the local intelligence network.

16.8 Prescribers and Non-medical Prescribers (suitably qualified/ authorised practitioners/ prescribers) are responsible for:

- Being clinically and legally responsible for their prescribing actions;
- Prescribing medicines that they are competent to prescribe (knowledge of drug indication, action, dosing, side-effects and interactions);
- Prescribing medicines if they are necessary;
- Prescribing only if benefits of medication outweigh the risks;
- Discussing treatment medicines adherence options with service users;
- Discussing and monitoring side-effects/tolerability of medicines with service users;
- Seek informed consent from patients where required, including in clinical trials;
- Authorising administration of non formulary medicines;
- Being accountable for their own actions, being aware of the limits of their skills, knowledge and competence;
- Any discussion / monitoring / prescribing of medicines should be recorded in the patient record;
- Discussing covert administration with a Second Opinion Appointed Doctor if the patient is detained, and with the multi-disciplinary team and clinical pharmacist.

16.9 Non registered nurses such as healthcare workers

If authorised by the Trust, can either independently or assist a designated practitioner to undertake medicines related duties as detailed in the policy.

16.10 All healthcare/ CWP staff

This includes:

- Designated practitioners, including assigned practitioners in charge;
- Medical practitioners;
- Authorised pharmacy staff;
- Practitioners in training under the direct supervision of s designated practitioner;
- Authorised nurses / employees such as health care assistants and student nurses;
- Community nurses;

- Nurses;
- Midwives;
- Health visitors;
- Optometrists;
- Pharmacists;
- Chiropodists;
- Radiographers;
- Orthopists;
- Physiotherapists;
- Ambulance paramedics for which the policy describes their duties for preparing, checking and administering medicines to a patient.

This includes:

- The assigned practitioner in charge is responsible for ensuring that prescribed medicines are administered within 60 minutes either side of the prescribed time;
- All healthcare staff have a duty to ensure patients' identification is checked using methods approved by CWP before administration of medicines;
- Healthcare staff who are **named individuals** can supply or administer medicines under a patient group direction in accordance with the procedures outlined in the policy;
- Highlighting training needs in regard to the safe and secure management of medicines via a written record of these needs in their personal development review and one-to ones with line mangers;
- Attending medicine management training as appropriate;
- Ensuring that specific duties in relation to medicines are undertaken within their competence;
- Keeping up to date with changes in clinical practice related to medicines management if it forms part of their job role.

16.10 Doctor / Clinical governance lead/ Nursing Staff / Registered nurses

Doctors and/ or nursing staff are responsible for ensuring when admitting a patient that confirmation is received from the patients GP of their usual prescribed medication. This should be filed in the patient record. Ensure that this forms the basis of the medicines reconciliation process.

Doctors are responsible specific duties outlined in this policy, this includes dose calculation, developing patient group directions.

Clinical governance lead must authorise patient group directions, in conjunction with the Medicines Management Group, as outlined in this policy.

Registered nurses can carry out single nurse administration but only against the criteria detailed in the policy.

16.11 Dentist

Where appropriate, dentists sign patient group directions and provide advice in relation to them.

16.12 Patient Safety & Effectiveness Sub Committee

Receives reports from the Medicines Management Group.

16.12 Quality Committee

A summary of recommendations following medication errors from Category A and Category B incidents will be received by the Quality Committee.

16.13 Clinical Service Line

Are responsible for learning from medication errors for all category "C", "D" and "E" incidents. Will receive from the MMG recommendations following medication errors and are responsible for putting these into practice and then providing assurance back to MMG.

Appendix 1 - Controlled Drugs (CDs) Standard Operating Procedures (SOPs)

In light of the implementation of the *Health Act 2006* and *the Controlled Drugs (Supervision of Management and Use) Regulations 2006,* the Trust Accountable Officer, the Chief Pharmacist, has formalised the procedures for handling controlled drugs across the Trust by way of implementing Standard Operating Procedures for staff to follow and adhere to in practice.

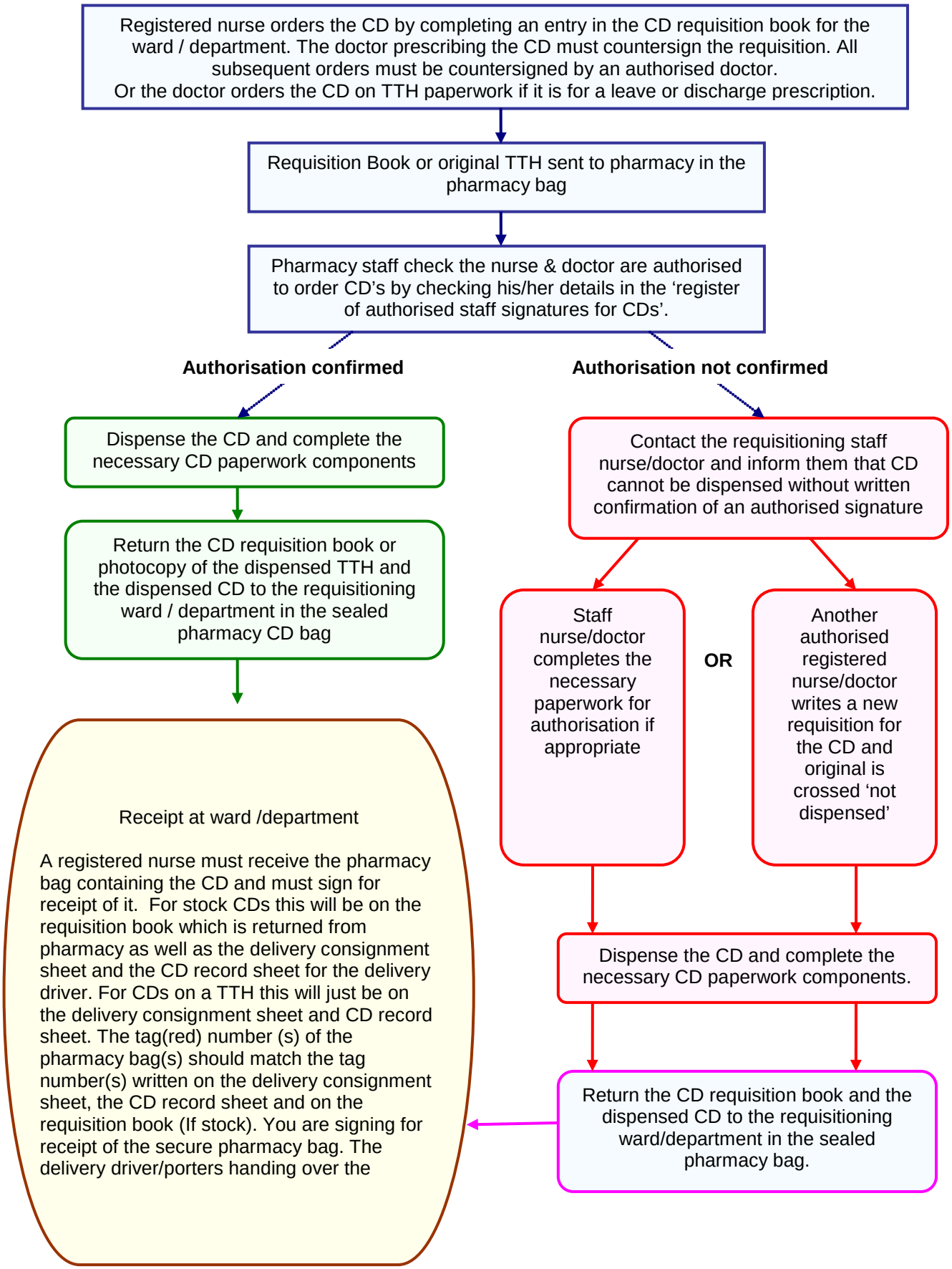
These SOPs apply mainly to inpatient settings, Drugs service staff are not directly affected as they don't tend to handle the drugs themselves. In community/respite/supported housing settings the controlled drugs are the property of the client and so Trust staff should have minimal handling. If there are circumstances where handling of controlled drugs is necessary then adherence to the SOPs should be carried out as part of good clinical practice.

The SOPs that are detailed in this appendix should be read and followed in conjunction with section 12 of the Medicines Policy. The Department of Health document "Safer Management of Controlled Drugs –A guide to good practice in secondary care (England), October 2007" should also be referred to when handling controlled drugs as part of clinical practice - http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_079591.pdf.

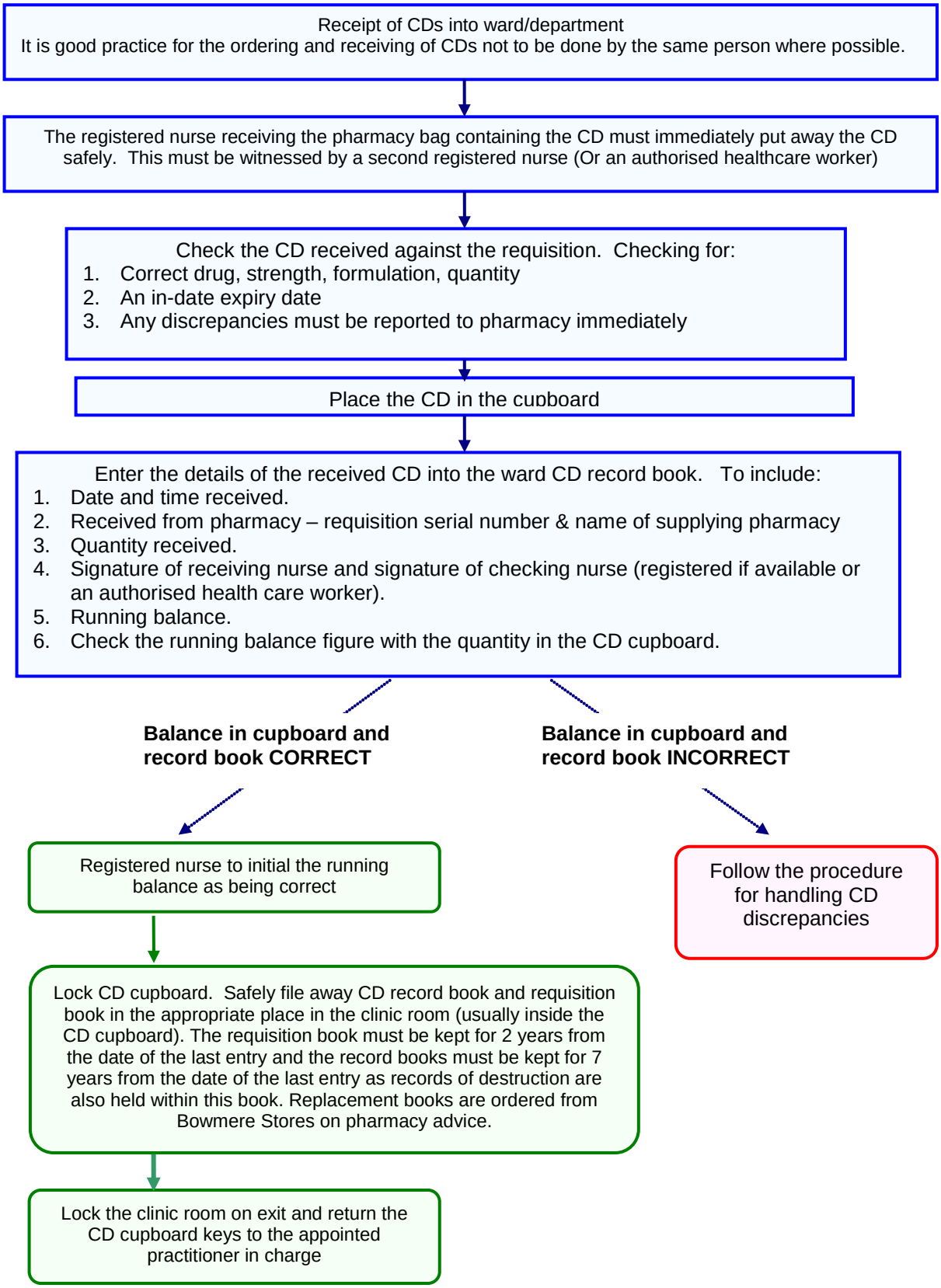
Each member of staff must complete the accountability Form (Appendix 1c) for each SOP acknowledging they have read the SOP and will be adhering to it in clinical practice. These forms must be kept with the ward manager in a folder and can be checked by the Accountable officer upon request.

SOP1	Ordering and receipt of controlled drugs from pharmacy
SOP2	Storage and entry of controlled drugs into the controlled drug record book
SOP3	Administration of controlled drugs to patients
SOP4	Handling Discrepancies of controlled drugs
SOP5	Destruction of unwanted / out-of-date stock controlled drugs
SOP6	Disposal/destruction of prepared/partly-used controlled drugs not administered to patients
SOP7	Recording and administering of patients' own controlled drugs
SOP8	Security and transportation of controlled drugs from pharmacy to wards/departments and vice-versa
SOP9	Controlled drug stock and record checks
SOP10	Security of controlled drug keys
SOP11	Use of denaturing kits
SOP12	Procedure for the accepting and disposal of illegally held controlled drugs / unknown substances, found in the possession of in-patients.

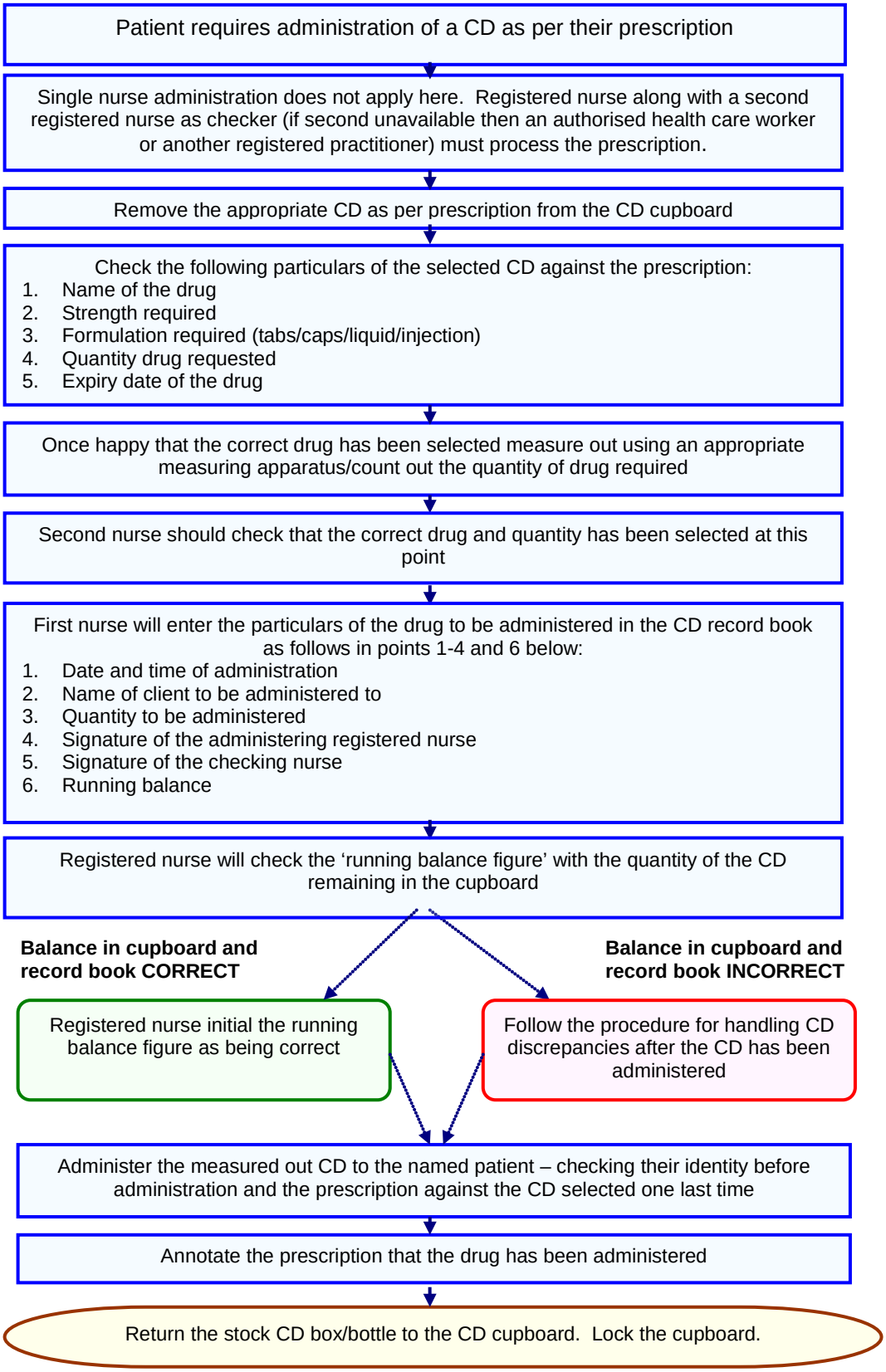
SOP 1 - Ordering of Controlled Drugs from Pharmacy and Receipt at the ward or department



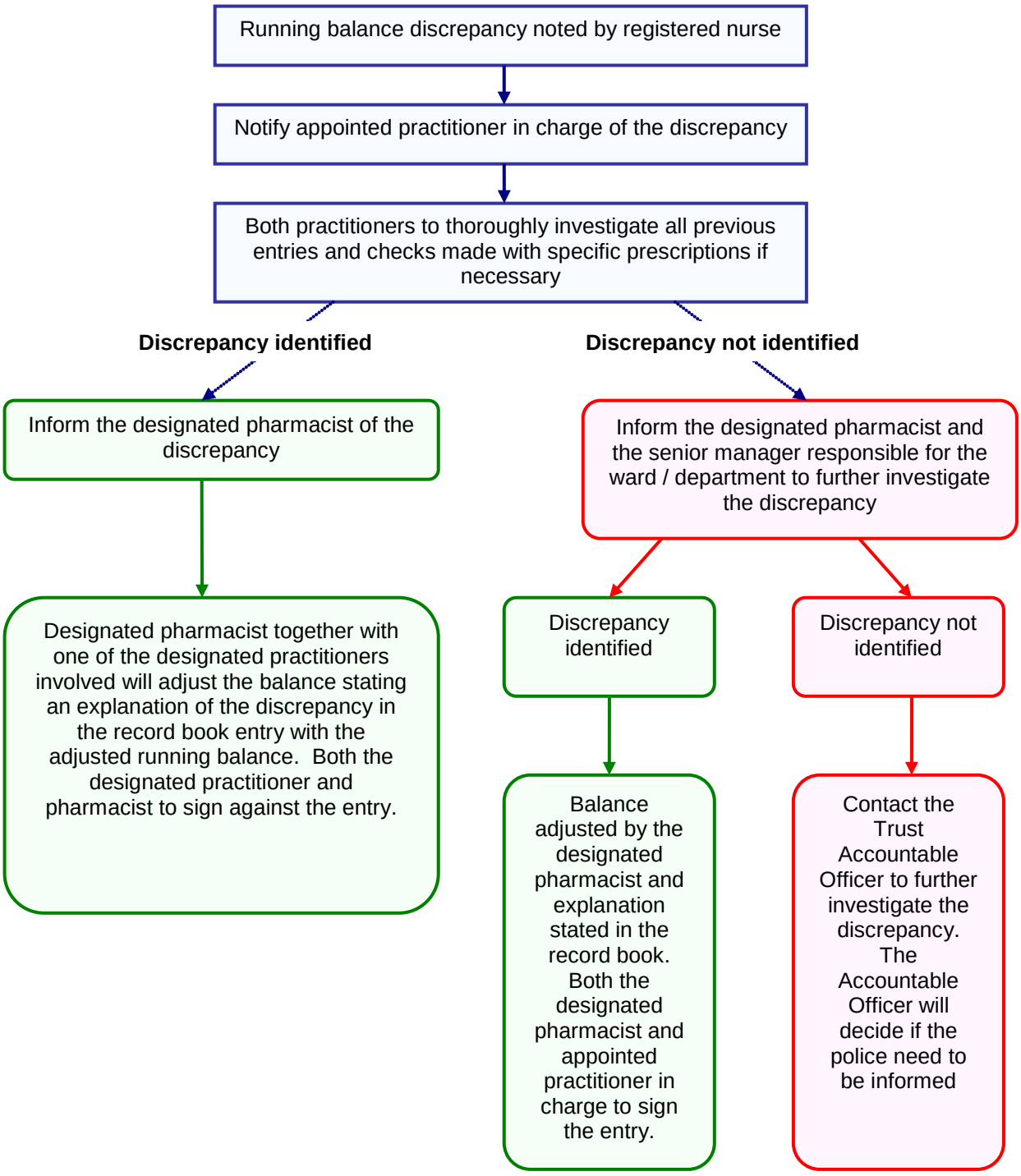
SOP 2 - Storage and Entry of Controlled Drugs into the CD Record Book



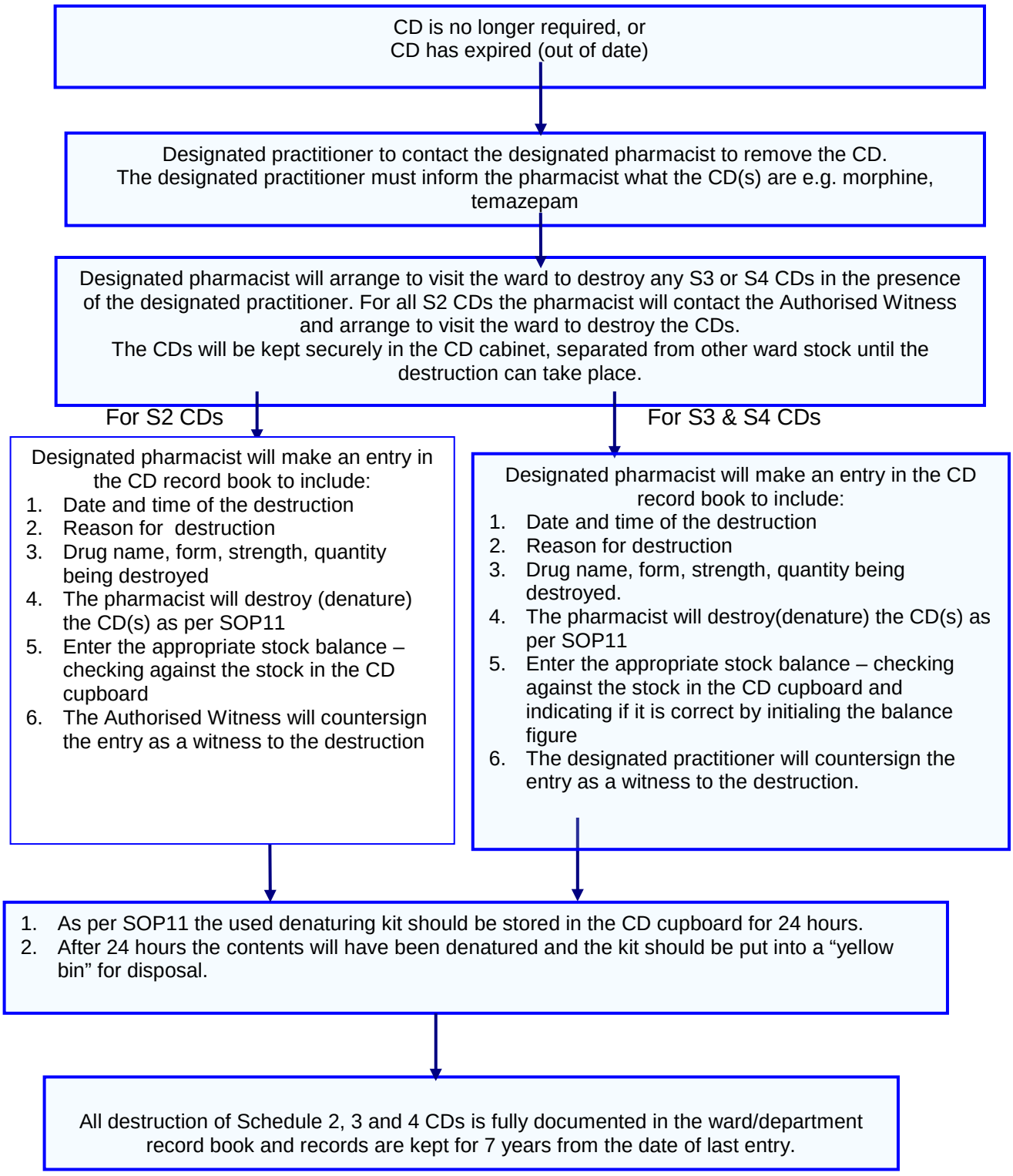
SOP 3 - Administration of controlled drugs to patients



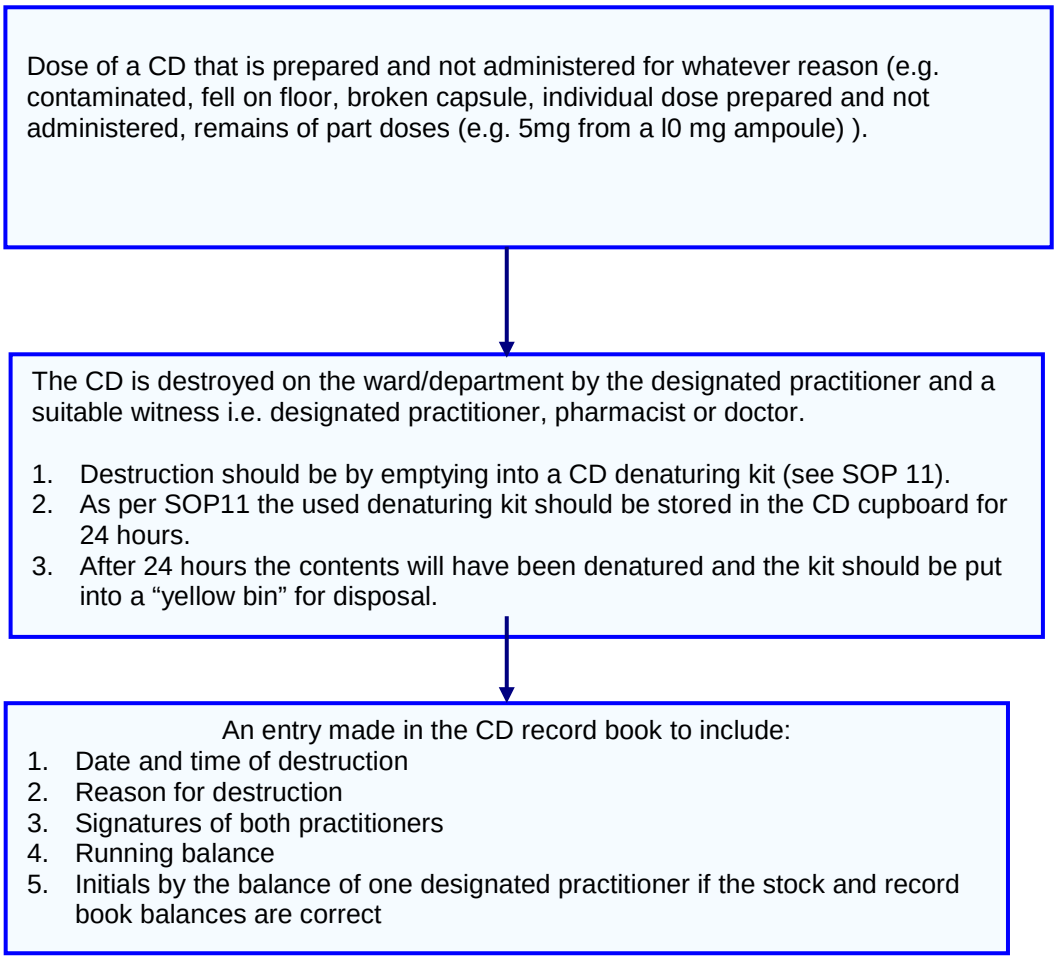
SOP 4 - Handling discrepancies of controlled drugs



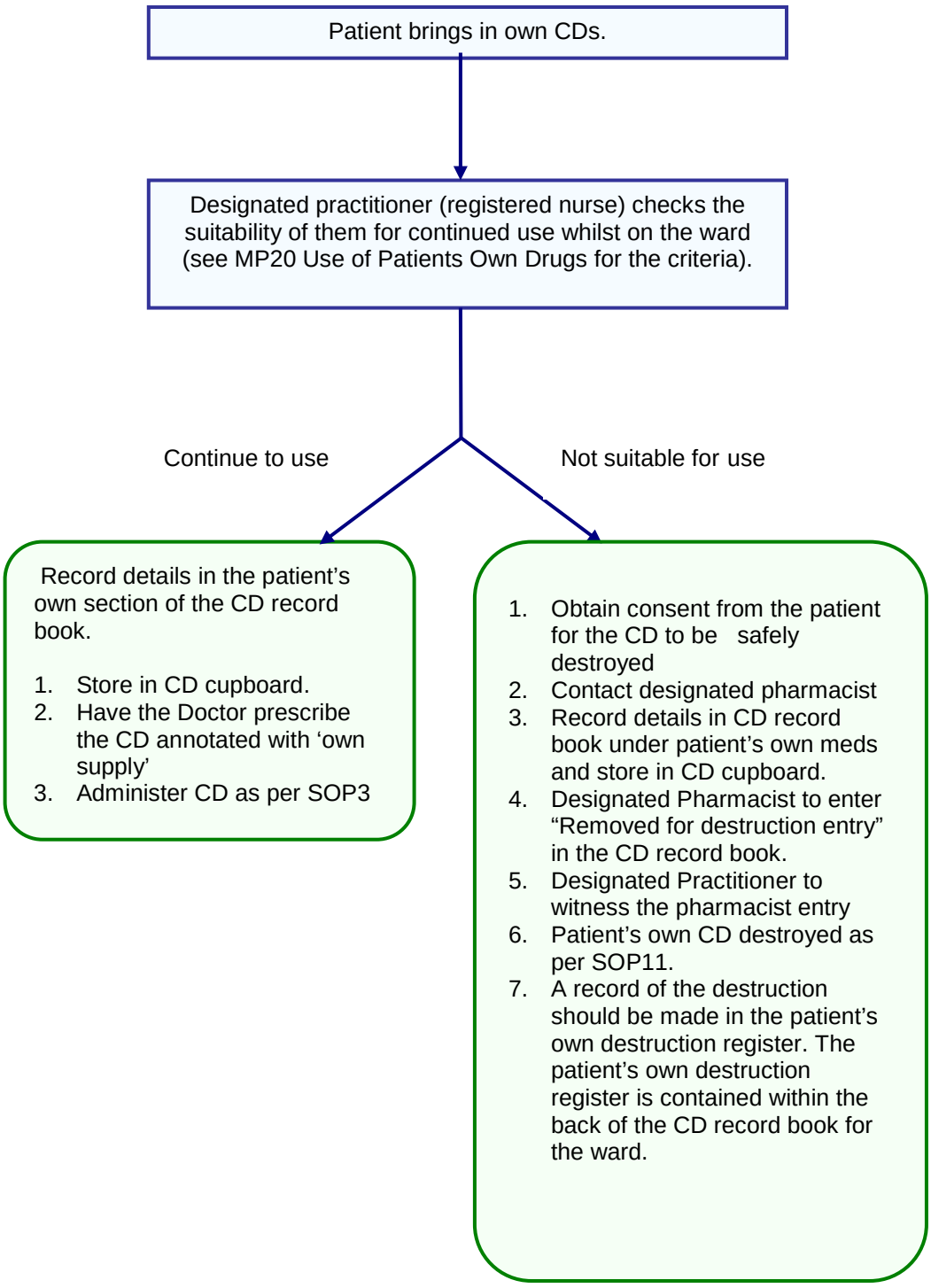
SOP 5 - Destruction of unwanted / out of date stock controlled drugs



SOP 6 – Disposal / destruction of prepared / partly-used controlled drugs not administered to patients



SOP 7 - Recording of patients' own controlled drugs (this covers continued use and destruction)



SOP 8 - Security and transportation of controlled drugs from pharmacy to wards / departments and vice-versa

Transportation of CDs from the pharmacy to the ward/department and back to the pharmacy will be covered under the pharmacy joint operational policy with the supplying Pharmacy (found on the medicines policies section of the intranet)

CDs should be transported in a sealed secure container which will be accompanied by the appropriate requisition book and delivery paperwork for signing for receipt of the container by the requesting ward/department (as in SOP 1).

When CDs are no longer required the designated pharmacist should be contacted and arrangements for destruction made with the designated practitioner to follow soon after. This is in accordance with SOP 5 and 7, depending on whether it is stock CDs or patient's own CDs.

If there is any breach of security in transportation this should be notified to the accountable designated practitioner requesting the CD to be transported and the designated pharmacist so that the situation can be investigated thoroughly. If necessary the Trust's Accountable Officer may become involved.

SOP 9 - Records of CD stocks and record checks

Wards/departments will carry out a CD balance check at the end of every shift change i.e. morning and evening. This should be conducted by the appointed practitioner in charge and another designated practitioner (if not available an authorised healthcare worker). This may also be a good point for the official handover of the CD keys

A record indicating that this check has been carried out must be entered in a separate record sheet/book or in the CD record book (appendix 1a). These records must be kept for two years from the date the last entry was made.

The entry must contain the date, two signatures of the staff involved and a statement confirming the stock is correct.

Appointed practitioner in charge must undertake a random CD stock check of the cupboards at least once a month and record in the CD record book.

A designated pharmacist must carry out a three-monthly CD check of all stock and CD record books and record this check in the record book. They should also cross check a random sample of CD record book entries against individual prescriptions and a sample of CD requisition copies to ensure they have been entered correctly in the record book. The proforma (appendix 1b) details the necessary checks that should be carried out. This should be completed and returned to the CWP Chief Pharmacist upon completion of the 3 monthly checks.

SOP 10 - Security of controlled drug keys

There must only be one set of keys providing access to controlled drugs in the clinical area. These keys must be supervised at all times.

The appointed practitioner in charge of each shift is responsible for controlling access to the controlled drug cupboard during that shift. Staff requiring access to the controlled drug cupboard must return the keys to the Appointed Practitioner in charge when they have finished with the keys.

Key-holding may be delegated to other suitably-trained designated practitioners but the legal responsibility rests with the Appointed Practitioner in charge.

The CD key(s) must be held separately from the other medicine keys on a separate key ring.

At the end of each shift the Appointed Practitioner in Charge for the shift is responsible for handing the controlled drug keys over to the incoming Appointed Practitioner in charge.

Healthcare assistants, nursing or midwifery Students and auxiliary staff are not authorised to carry any drug storage area keys.

Pharmacists and pharmacy technicians are authorised to borrow controlled drug keys from designated Practitioners for a specific task, provided that the keys remain in the clinical area and are returned immediately after the completion of the task.

Pharmacists and pharmacy technicians must ensure they notify their presence to the Appointed Practitioner in charge.

If the CD keys cannot be found, every effort must be made to retrieve these as speedily as possible e.g. confirm that a staff member has the keys and to retrieve them as soon as possible. If there are doubts about the security of controlled drugs in the interim, the locks should be changed at the discretion of the Appointed Practitioner in Charge using the Trust incident reporting process. A Trust incident form should be completed in such a case.

A spare CD key for each CD cupboard should be held in a designated secure key cupboard on the site of the inpatient unit. The spare key(s) must only be issued in an emergency in order to access the CD cupboard for patient care. No other sets of CD keys are permitted.

SOP 11 - Use of denaturing kits to destroy controlled drugs

If destroying patients own CDs details need to be recorded in patients own CD destruction register as in appendix 1d.

The process of denaturing Controlled drugs is classed as “waste processing” and may require a waste processing license. However, the Environment Agency/Home Office has agreed that denaturing of Controlled Drugs ONLY under the Misuse of Drugs Act is EXEMPT from this requirement.

Under NO circumstances should any process involving grinding, dissolving in soapy water or mixing with cat litter be used. The “DenKit CD destruction kit” should be used.

Remove all capsules/tablets from outer blister strips. Note: Hot water (not boiling) should be added to the kit to help in the denaturing of wax coated tablets.

Liquids should be poured directly into the kit. Note: thick, sugary liquids should be pre-mixed with warm water to lower the viscosity into the kit.

Parenteral formulations such as ampoules should be broken open and drug emptied into the kit. Care MUST be taken when ampoules are opened, gloves are recommended and the use of a tissue for glass ampoules.

Fentanyl patches should be rendered irretrievable by removing the backing and folding the patch over upon itself.

Shake to loosen granules and fill the kit to the level of the “White arrow” - the level is dependent on the size of kit used. Note: an appropriate size container MUST be selected to the amount being denatured.

Fill to the “Black arrow” in one filling. Note: If necessary use hot water (as indicated above). Securely replace the lid.

Shake thoroughly for 30 seconds. The kit will congeal in 3 to 5 minutes.

The date and time of the denaturing should be added to the kit lid by marker pen along with the initials of the staff performing the process.

The used kit should be stored in the CD cupboard for 24 hours

After 24 hours the contents will have been denatured and the kit should be put into a “green pharmaceutical waste” bin for disposal

SOP 12 - Procedure for the accepting and disposal of illegally held controlled drugs / unknown substances, found in the possession of in-patients

1. Designated practitioner receives the unknown substance from a service user

2. The designated practitioner Informs the appointed practitioner in charge

3. The assigned practitioner in charge plus the designated practitioner should place the item in an envelope labelled with the following details:
    - Found by or in possession of
    - Ward name
    - Date of receipt

The envelope should be sealed. Both members of staff should sign over the seal.

1. In the “patients own section” of the CD record book enter: ‘unknown substance’, ‘patient name’, “date of receipt,” in the same way as patients own CDs are recorded and store in the CD cupboard until it can be disposed of.

2. The relevant consultant should be informed at the earliest opportunity.

3. Fill in a Trust Incident Form (Datix) to report it ensuring it is logged as a potential controlled drug incident.

4. A designated Pharmacist should be contacted immediately to arrange a ward visit to dispose of the unknown substance(s) with an authorised witness.

5. Ensure that the assigned practitioner in charge is informed at handover.

6. The Designated Pharmacist, witnessed by the Authorised Witness, will dispose of the unknown substance(s) in the same way that any controlled drugs in schedule 2 are disposed of. This will involve following the CD SOP 5 for destruction of controlled drugs and in doing so complete the appropriate records in the “patient’s own section” of the CD record book.

Appendix 1a - Controlled drug stock and record check

Ward / clinic name	

Date	**Morning check** (2 signatures required)	**Is the stock correct?** Yes/No	**Evening check** (2 signatures required)	**Is the stock correct?** Yes/No

Refer to Medicine Policy Section 12 and standard operating procedure for CD records (SOP 9)

Appendix 1b - Proforma for ward controlled drug 3 monthly audits by pharmacists

Ward / Dept		**Date**	

1	Is the cupboard and lock in suitable condition	Y/N
2	Is there an official warning light or alarm? State which is present _____ Does this work?	Y/N Y/N
3	Do all balances in the register match stock held in cupboard? If N, detail discrepancies and attach copy of incident form.	Y/N
4 .1 4.2 4.3 4.4	Are all drugs in date? Does any stock need destroying? If Y can it be destroyed now with a designated practitioner? If N has the authorised witness for destruction of CDs been contacted to arrange destruction? Date agreed for Destruction (state) _____	Y/N Y/N Y/N Y/N
5.1 5.2	Does the ward stock high strength opiates? If Y, are they stored in an appropriately labelled section of the controlled drug cupboard? If N, explain……	Y/N
6	*For 6&7 refer to SOP 9, point 5 for 2 requisitions & 2 prescriptions.* Have the 2 controlled drug requisitions been reconciled with the ward controlled drug record book and entered correctly? State requisition numbers checked:……. If N, detail discrepancies and attach copy of incident form.	Y/N
7	Have the individual prescription entries been made correctly? If N, detail discrepancies and attach copy of incident form.	Y/N
8	Does the ward need a new Ward Controlled Drug Record Book? (if Y to be ordered via controlled stationery paperwork requisition)	Y/N
9	Is the list of authorised signatures up to date? Review with ward manager if N	Y/N
10	Is the CD key held in accordance with SOP10? (i.e. separate key ring)	Y/N

On completion of the inspection of each CD item, enter “Stock & running balance check complete and correct” and then sign the entry in the record book.

If incorrect, then make an entry detailing the correct balance and ask the appointed practitioner in charge to complete an incident form.

Check undertaken by		(Pharmacist Signature and Print name)

Witnessed by appointed practitioner in charge		(Signature & print name)

***Return completed form to CWP chief pharmacist**

Appendix 1c - Controlled drug SOPs accountability record

SOP (detail name and number)	

The undersigned have read and understood this SOP and will work to it and any future updates of this SOP.

Date	Name of member of staff	Signature

Appendix 2a - GP out of hours controlled drug standard operating procedure

Contents

1. Introduction

This Standard Operating Procedure will ensure that a robust system is in place for obtaining, storing, recording, transportation and the safe disposal of Controlled Drugs, whilst at the same time helping to ensure appropriate and convenient access for those patients that require them. It will not advise on the clinical choice and application of Controlled Drugs.

1.1 Purpose of the Standard Operating Procedure

To ensure that patients receive a safe and efficient service that complies with all legal and best practice requirements thereby ensuring the safe management of all controlled drugs stocked.

1.2 Aim of the Standard Operating Procedure

The aim of the Standard Operating Procedure is to define the roles and responsibilities for relevant 1829 clinic staff and Doctors

2. Community Care Western Cheshire responsibilities

The ultimate responsibility for Controlled Drugs lies with the Accountable Officer for controlled drugs (Chief Pharmacist)

- The Clinical Director Out of Hours (OOHs) will have overall operational accountability;
- Day to day responsibility will lie with OOH manager and the registered general nurses working for the service;
- Doctors prescribing or administering controlled drugs from emergency vehicle stock must follow this Standard operating procedure (and legal requirements);
- Registered general nurses with access to the controlled drug cupboard must follow this Standard operating procedure;
- OOHs vehicle drivers must follow this Standard operating procedure.

3. Legal basis

Controlled drugs that are subject to this Standard operating procedure are those classified as Schedule 2 Controlled Drugs under The Misuse of Drugs Act 1971. This includes the opiates such as diamorphine and morphine.

3.1 ☐Safe custody requirements apply (under the Misuse of Drugs Safe Custody Regulations1973). This means that Schedule 2 controlled drugs must be stored in a locked receptacle usually in an appropriate Controlled Drugs cabinet or approved safe which can only be opened by the person in lawful possession of the Controlled Drugs or a person authorised by him or her acting in his or her capacity as such.

3.2 A register must be kept for Schedule 2 Controlled Drugs and this register must comply with the relevant regulations.

3.3 Destruction of Controlled Drugs in Schedule 2 must be appropriately authorised. This requirement is set out in Regulation 27 (1) of the Misuse of Drugs Regulations 2001 and the person witnessing the destruction must be authorised to do so.

Controlled Drugs stock list for out of hours vehicles at 1829 building:

- Diamorphine 5mg/1ml, 10mg/2ml and 30mg.

4. Purchasing

4.1 Requisitions

The Ward requisition book must be used for all orders. Supplies of this should be ordered using the order form found on the intranet medicines management page and sent to Bowmere Stores, Chester.

Registered nurse orders the CD by completing an entry in the CD requisition book for the. All orders must be countersigned by the clinical director.

4.2 Stock levels

These should be reviewed by OOH manager and/or a registered general nurse employed by the service on a regular basis (weekly) and stock should be kept to a minimum and governed by previous requirements.

Expiry dates for all stock must be recorded and checked monthly.

The accountability for maintaining the correct balance of Controlled Drugs stock lies with the Clinical Director and not with the person to whom they may delegate the day to-day responsibility.

5. Recording

Legally a controlled drug record book (register) must:

Be bound (not loose leaved) or a computerised system.

The class of the drug its strength and form must be specified at the head of each page.

In the separate register or separate part of the register used for each drug a separate page shall be used for each strength and form of that drug.

Have the entries in chronological order and made on the day of the transaction or the next day.

Have the entries made in ink or otherwise indelible or in a computerised form in which every such entry is attributable and capable of being audited.

Not have cancellations obliterations or alterations; corrections must be made by a signed and dated entry in the margin or at the bottom of the page.

Be kept at the premises to which it relates and be available for inspection at any time. A separate register must be kept for each premise (for example not just the main surgery).

Be kept for a minimum of seven years after the date of the last entry once completed.

Not be used for any other purpose.

Good practice:

Wherever possible two members of staff should check all stock received or removed and both individuals should initial the entry in the Controlled Drugs register.

Controlled Drugs registers should be stored in a safe place away from patient areas.

Running balances of Controlled Drugs should be maintained. However as this is not currently a legal requirement this balance may have to be kept in a separate record book or on the computer system.

Controlled Drugs stock level of any particular item should normally be checked when such items are entered into stock or are dispensed or administered.

6. Receipt of controlled drugs

The delivery driver handing over the pharmacy bag containing the CD must inform the registered nurse that it contains CDs and wait whilst he/she checks the contents of the bag.
The registered nurse must receive the pharmacy bag containing the CD and must sign the:

- Receipt in the requisition book,
- Delivery consignment sheet,
- CD record sheet for the delivery driver.

The tag number(s) of the pharmacy bag(s) should match the tag number(s) written on the delivery consignment sheet, the CD record sheet and on the requisition book.

The controlled drugs must be placed in the controlled drugs cupboard as soon as is practicable.

7. Access to controlled drugs

7.1 Overall responsibility

OOH manager or the registered general nurse on duty will have overall day to day responsibility for the keys.

7.2 Sets of keys

The number of sets of keys to the controlled drugs cupboard and car safes and who holds them must be known at all times. The keys should always be kept in the controlled drug key safe and should only be accessible to OOH manager and/or the registered nurse on duty. The code to the key safe will be changed monthly. The spare key sets must not be stored with the set of keys in general operation.

7.3 Clinic cupboard access

The cabinet or safe should only be opened by the designated person or by a person authorised by them. The designated person (OOH manager) remains ultimately accountable for the management of the controlled drugs.

8. Start of shift (out of hours vehicles)

The Doctor is responsible for the controlled drug stock and vehicle safe key at all times and must ensure the OOH vehicle is stocked prior to shift commencement.

The registered nurse on duty must open the controlled drug key safe and both doctor and registered nurse must go to the controlled drug cupboard.

Both must sign the Controlled Drug Record Book which must have headings for:

- Date and time of stock issue
- Name and signature of registered nurse issuing stock and vehicle safe key
- Name and signature of doctor receiving the stock and vehicle safe key

Vehicle drivers are NOT responsible for holding vehicle safe keys at any time but are responsible for ensuring vehicle CD register present.

9. End of shift (out of hours vehicles)

The Doctor is responsible for the controlled drug stock and vehicle safe key at all times and must ensure the OOH vehicle safe is emptied prior to the shift end.

Prior to finishing the shift, the doctor must return the controlled drugs and the vehicle safe to the out of hours base.

The doctor with the registered nurse will return the stock of drugs to the controlled drug cupboard. The doctor must sign the Controlled Drug Record Book with the registered nurse on duty stating:

- Date and time of return
- Vehicle registration

10. Contingency

This contingency applies in the event of a patient requiring controlled drugs in the course of a visit when all the mobile vehicle controlled drugs have been used.

The visiting GP will take ampoules from the controlled drug cupboard at the out of hours base and will sign the controlled drug record book with the registered nurse on duty.

Any unused ampoules must be returned by that GP as soon as is practicable.

11. Destruction of out of date stock

11.1 Arranging a Visit

Responsibilities of the OOH manager are to contact an Authorised Witness to arrange a destruction visit, ensure they have a denaturing kit, segregate the controlled drugs to be destroyed and be present throughout the visit.

The authorised witnesses can be contacted on:

- Lead Pharmacist Community Services – contact details on CWP intranet
- Lead pharmacist medicines governance - contact details on CWP intranet

12. Reporting concerns

12.1 What is a concern?

A concern can be anything relating to the practice, storage, dispensing and destruction of Controlled Drug. The concern may be relating to inappropriate practice, record keeping and storage arrangements.

12.2 Why a concern would be raised:

A concern would be raised if it was felt that actions or outcomes of the concern meant that patients, staff and the wider public were at risk.

12.3 Who can raise a concern?

A concern can be made by any of the following groups:

- Accountable Officer for Controlled Drugs;
- Authorised Witness;
- Member of Primary Care Trust Staff;
- Member of External Organisation Staff;
- Patients.

12.4 How a concern can be raised

A concern can be raised by direct contact with either of the following:

- Lead Pharmacist Community services;
- Accountable Officer for controlled drugs (Chief Pharmacist);
- Medical Director Compliance, Quality & Regulation.

Contact numbers held on CWP website / Trust board Offices.

Appendix 2b - Out of hours controlled drug audit Q….201…

		1829 base	Car Reg *FCE*	Car Reg *WGD*
1	Is the receptacle and lock in suitable condition?	Y/N	Y/N	Y/N
2	Is there a working official warning light or alarm for receptacle? State which is present	Y/N	Y/N	Y/N
3	Do all running balances in each of the registers match stock held in cupboard?		Y/N	Y/N
4 4.1 4.2 4.3 4.4	Are all drugs in date? Are expiry dates checked monthly? Does any stock need destroying? If Y can it be destroyed now with a designated practitioner? If N has the authorised witness for destruction of CDs been contacted to arrange destruction? Date agreed for Destruction (state)……..	Y/N Y/N Y/N Y/N		
5	Record of administration made in patients Adastra record?	Y/N		
6	Have the controlled drug requisitions been reconciled with the controlled drug record book and entered correctly? State requisition numbers checked: ……	Y/N		
7	CD registers legal check		Y/N	Y/N
8	Is a new Controlled Drug Register need to be ordered? (if Y to be ordered via controlled stationery paperwork requisition)		Y/N	Y/N
9	Is the list of authorised signatures up to date? Review with Out of Hours manager if N	Y/N		
10	Is the code to the CD safe changed monthly?	Y/N		

On completion of the inspection of each CD item, enter “Stock & running balance check complete and correct” and then sign the entry in the record book. If incorrect, then make an entry detailing the correct balance and ask the appointed practitioner in charge to complete an incident form and attach to this audit report**. *Return completed audit form to CWP Chief Pharmacist***

Check undertaken by		(Pharmacist Signature and Print name)

Witnessed by appointed practitioner in charge		(Signature & print name)
Date completed		

Appendix 3 - Critical medicines list 2010

This list is intended to highlight those medicines whose omission is expected to cause serious harm to a patient. It is important that all medicines are identified, prescribed and obtained as soon as possible for every patient, however, the medicines below need particular attention for the reasons stated.

Medicines for emergency use	
Medicines for the treatment of cardiac arrest	These medicines should be readily available in inpatient areas
Medicines for the treatment of anaphylactic shock	
Medicines in rapid tranquilisation policy	
Actrapid insulin	
Glucagon and glucose gel	
Glyceryl trinitrate spray	
Salbutamol inhaler and nebules	
Medicines whose omission may cause serious harm	
Antibiotics and antifungals	These medicines should be prescribed, procured and administered as soon as possible
Anticoagulants (oral and injectable)	
Antiretrovirals	
Anticonvulsants prescribed for epilepsy	
Medicines for Parkinson's disease	
Antiarrhythmics, nitrates, betablockers Antiplatelet agents	
Immunosuppressants	
Steroids	
Oral antidiabetic medication	
Glaucoma treatment (topical or oral)	
Emergency hormonal contraception	
Medicines whose omission may cause withdrawal effects	
Paroxetine, venlafaxine, reboxetine	Although not life threatening omission of these may cause serious distress to patients
Opiates (see below for methadone)	
Drugs which need re-titration if doses are missed	
Clozapine	If doses have been missed for 48 hours or more then re-titration is required see MP5
Methadone	Follow guidance in MP8 Inpatient and out of hours management of drug misusers

Outside of Lime Avenue Lloyds opening hours medicines can be obtained by:

- Using the patients own medicines brought in from home (see Use of Patients Own Drugs policy);
- Borrowing from another ward (see Medicines Policy);
- Checking if the medicine is stocked in the Medi365 out of hours machine;
- Calling the clinical on-call pharmacist for advice and authorisation to order from Lloyds.

Appendix 4 - Receipt of patient's own medicines form

Patient's name		DOB	

Drug name	Strength	Form	Quantity	Date received	By whom (print name)

Appendix 5 - Balance of medicines returned to the patient form

Patient's name		DOB	

Drug Name	Strength	Form	Quantity	Date given back	By whom (print name)

Appendix 6 - Example care plan

Cheshire and Wirral Partnership NHS Foundation Trust Older Peoples Mental Health

Care plan for	……has been prescribed medication but he/she has not been able to accept medication consistently. The importance of taking medication on a regular basis has been explained to…… but he/she lacks the capacity to fully understand, their ability fluctuates, he/she is not always able to process or retain information given to him/her, which would then allow him/her to make an informed decision. Therefore a decision has been made in the best interest of……to proceed with the use of covert administration of medication if he/she will not accept it voluntarily.	Care plan No.
Goal	To ensure that policy for covert administration of medicines is followed. To aid compliance and ensure medication is taken as prescribed. To ensure the safety of other patients to prevent them from unintentionally taking the wrong medication.	Sign
Core plan	Second opinion has been sought. MDTM meeting was held with Consultant, Family, Nursing staff, Pharmacist to discuss the need for covert administration of medication. This issue will have to be reviewed regularly at MDTM. …….compliance fluctuates so medication to be first offered in the conventional way at the prescribed times. If he/she refuses then medication, which has been endorsed 'For covert administration' by the doctor, can be given in a small amount of food or drink. Staff to observe……during covert administration and ensure that food/drink containing medication is taken and cleared away to prevent other patients unintentionally taking the wrong medication. To liaise with the Pharmacist as to availability of liquid or soluble formulation or suitability of crushing tablets. Ascertain the most suitable medication on the basis of taste and possibility of disguising this in food/drink	
Date	**Additional information for individualised care planning**	**Sign**

Patient name		Patient Number	
Ward / hospital name			
Primary nurse signature			
Relative / carer signature			
Consultant signature			
Pharmacist signature			

Appendix 7 - Consent for self-medication programme

Service user name		Date	
Consultant		Ward	
Date discussed at multidisciplinary meeting			

Checklist

- ☐ Is the service user confused or have an unstable mental state?
- ☐ Is there history of overdose or substance misuse?
- ☐ Previous compliance problems, if so what?
- ☐ Can the service user open child resistant closures?
- ☐ Can the service user read labels? (Literacy, eyesight)
- ☐ Can drug regimen be simplified?

Nurse signature		Pharmacist signature	

Additional information

Approval for self medication

Approved for self-medication programme Stage 1 by			
	(consultant)		(date)

Approved for self-medication programme Stage 2 by			
	(consultant)		(date)

Approved for self-medication programme Stage 3 by			
	(consultant)		(date)

Approved for self-medication programme Stage 4 by			
	(consultant)		(date)

Consent by service user

I have had the self medication programme explained to me and I wish to take part. I have been given information about my medication and understand that I can withdraw my consent at any time.

Service user signature		Date	
Witnessed by			

Withdrawal of consent

I do not wish to continue with the self-medication programme & withdraw my consent.

Service user signature		Date	
Witnessed by			

Appendix 8 - Self medication assessment form – Stage 1

Service user's name		Date	
Ward			

Please record time medicines taken and any interventions necessary (e.g. prompting to take medicines, preventing wrong drug or dose being taken)

Days	Breakfast (1000)	Lunchtime (1400)	Teatime (1800)	Bedtime (2200)	Time checked locked door and drawer
Monday					1 2 3
Tuesday					1 2 3
Wednesday					1 2 3
Thursday					1 2 3
Friday					1 2 3
Saturday					1 2 3
Sunday					1 2 3
Recommendations following review of self medication assessment form and consideration of checklist					

Appendix 9 - Self medication assessment form – Stage 2-4

Service user's name		Date	
Ward			
Self medication phase			

Medicine / dose / frequency	**Quantity of medicine left**	**Date medicines due to be re-supplied**						
	Expected							
	Actual							
	Expected							
	Actual							
	Expected							
	Actual							
	Expected							
	Actual							
	Expected							
	Actual							
	Expected							
	Actual							
	Expected							
	Actual							
	Expected							
	Actual							
Time checked locked door & drawer	1		2			3		
Additional information								

Appendix 10 - Service user's medication chart

Medicine form & strength	Reason for taking medicine	Additional information	Breakfast	Lunch	Teatime	Bedtime

Name		Date	

Appendix 11 - Self- medication information sheet

Please remember

It is your responsibility to keep your medicines locked in your medicine cabinet and to keep the key in a safe place

Do not take more than the dose on the label

If you forget the number of tablets or when you need to take them, or if you have any questions about your medicines, please ask one of the nurses

Remember that medicines can be dangerous if not used properly

If any visitor or patient tries to take your medicine, please tell one of the nurses immediately