Fareham and Gosport NHS
Primary Care Trust

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Your ref: RF/EP/31829/2/9922
Our ref: Ripley/Lit/Misc/CH

16 May 2003

Dear Sirs

Re: Code A

Thank you for your letter dated 29 April 2003.

Please find enclosed the following documents as requested in your letters of 25 March 2003 and clarified in your letter of 29 April 2003:

1) Code A **medical records**. Please note these records have been printed from a CD Rom as the Police currently hold the originals. You have a copy of every page that was printed, however, there are a number of pages which are not legible which are the computer's attempt at reading handwriting.

2) **Copy of the Complaints correspondence**:

i. Letter from Code A handed to the Chief Executive of Portsmouth & South East Hampshire Health Authority in June 2000 (passed to Portsmouth HealthCare NHS Trust)

ii. Letter of acknowledgement from Portsmouth Health Care NHS Trust dated 4 July 2000

iii. Letter of response from Portsmouth HealthCare NHS Trust to M Code A (June) letter, dated 1 August 2000

iv. Letter from M Code A to Hampshire Police dated 31 September 2002 (query correct date, may have been 31 August 2002

v. Letter of response from Hampshire Police dated 11 September 2002 to Mrs Ripley's (September/ August) letter

vi. Letter from Hampshire Police to Portsmouth Hospitals Trust Chief Executive, dated 11 September 2002 (passed to Fareham & Gosport Primary Care Trust for response)

vii. Letter of acknowledgement from Fareham & Gosport PCT, dated 12 October 2002

viii. Letter of response from Fareham & Gosport PCT to Code A dated 2 December 2002

3) Copy of the **Administration of medicines Policy (1997)** in place at the relevant time.

4) Copy of the **Prescription writing Policy (July 2000)** in place at the relevant time.

The **British National Formulary (BNF) 2000** would also have been in place at the relevant time, and would have been a reference source available to staff.

An invoice for photocopying charges will be sent separately.

Yours faithfully

Code A
Risk & Litigation Manager

Enc.

Alexander Harris solicitors

Our ref: RF/EP/31829/2/9922
Your ref: Ripley/Lit/Misc/CH
Please ask for: Code A
Direct dial 0121 7115111

Code A
Risk & Litigation Manager
Fareham & Gosport NHS Primary Care Trust
Unit 180 Fareham Reach
Gosport
PO13 0FH

FAREHAM AND GOSPORT
30 APR 2003

29 April 2003

Dear Madam

Re: Code A

We thank you for your letter of 23rd April received on the 28th.

Code A was admitted to Gosport War Memorial Hospital on the 4th April 2000. He became drowsy and non communicative until by the 9th he was unrousable. He was diagnosed as having suffered a stroke prior to being transferred to Hasler Hospital where it was decided that he had not had a stroke but was in an analgesic coma.

Specifically then, without prejudice to the generality of the request made, we want to see protocols or guidelines in relation to analgesia.

Yours faithfully

Code A

PARTNER
ALEXANDER HARRIS

Code A

PRESCRIPTION WRITING POLICY

THIS IS A JOINT POLICY WITH PORTSMOUTH HOSPITAL TRUST

APPROVED BY THE MEDICAL DIRECTORS OF BOTH TRUSTS AND THE FORMULARY AND MEDICINES GROUP

Approved by the Medical Directors of both Trusts and Formulary & Medicines Group March 1998

JOINT TRUST POLICY

PRESCRIPTION WRITING

1.0 PURPOSE

1.1 The primary purpose of this policy is to have an agreed, consistent, safe and professional standard of prescription writing across both Trusts.

1.2 The Policy should also be used for:

a) Teaching or reminding prescribers of the standards expected.
b) Auditing prescriptions and assessing risk management.
c) Resolving prescription writing queries.

2.0 SCOPE

This policy covers all prescriptions written by doctors and nurses, but excludes some specific issues which are handled separately:

b) Pre-printed Prescriptions (individual directorate policies in force).
c) Intravenous Drugs (see Administration of Intravenous Drugs Policy).
d) Self Medication (see separate guidance document in this compendium).

3.0 RESPONSIBILITIES

3.1 It is the responsibility of every member of staff involved in the medication process to acquaint themselves with this policy.

3.2 It is the responsibility of consultants, senior nurse managers and the pharmacy manager to ensure that their staff are aware of the policy.

3.3 SHARED CARE. The legal responsibility for prescribing lies with the doctor who signs the prescription.

4.0 REQUIREMENTS FOR PRESCRIPTION WRITING.

4.1 GENERAL REQUIREMENTS

Prescriptions should be written legibly and in ink and should state the following:

a) Name of the patient

b) Age of the patient.

c) Generic name of the medicine.
This should be written clearly and not abbreviated. The trade name may be used for multi-ingredient products not given a title by the BNF. The trade name must be used for cyclosporin, lithium and theophylline, because the various brands differ in bioavailability.

d) The dose. In particular:

- The unnecessary use of decimal points should be avoided (eg 3mg not 3.0mg).
- Quantities less than 1gram should be written in milligrams (eg 500mg not 0.5g).
- Quantities less than 1 milligram should be written in micrograms (eg 500micrograms not 0.5mg).
- When decimal points are unavoidable a zero should be written in front when there are no other figures (eg 0.5ml not .5ml).
- For liquid oral medicines other than laxatives, the dose should be prescribed by weight (eg milligrams) not volume (ie mL).
- For mixed compound preparations which come as a single dose, the number of tablets should be stated (eg co-proxamol).
- The words: micrograms, nanograms, units must not be abbreviated.

e) Route of Administration.
For inhaled medicines the device should also be stated.

f) Frequency of Administration.
In the case of preparations to be taken 'as required' a minimum dose interval should be specified, and an indication if not obvious. Although directions should preferably be in English without abbreviation the following Latin abbreviations are allowed:

b.d.	=	twice daily
o.d.	=	every day
o.m. or mane	=	in the morning
o.n. or nocte	=	at night
p.r.n.	=	when required
q.d.s.	=	four times daily
stat	=	immediately
t.d.s.	=	three times daily

g) Quantity to be Supplied.
Outpatients - minimum normally 14 days and maximum normally 28 days (or sufficient to complete a course of treatment).
TTOs - 7 days or sufficient to complete a course of treatment.

h) Signature of the Prescriber.

i) Date

4.2 INPATIENT PRESCRIPTIONS (Additional Requirements)

a) Ward.

b) Consultant's name.

c) Patient's Identification Number.

d) The Drug Allergies and Sensitivities section should be completed. State "not known" if this is the case.

e) The patient's weight for all children. For adults only where doses are weight related (eg chemotherapy).

f) Times of administration for regular and once only drug therapy.

4.2.1 Changing Drug Doses

When a dose must be changed, the Trusts encourage doctors to completely rewrite the prescription to avoid misinterpretation. However, it is acceptable to make one dose change, provided the new dose is clear, the old one has been clearly deleted, and the prescriber both signs and dates the change.

4.2.2 Stopping a Drug

When a drug is discontinued the prescription should be deleted with a large 'Z', countersigned and dated by the doctor.

4.2.3 Dose Withheld by Doctor

The dose administration box should be filled with an 'X' and countersigned. The reason for the decision should be documented in the medical record.

4.2.4 Dose Missed or Refused

In the Hospitals' Trust, the dose administration box should be filled with the appropriate code number or abbreviation as follows:

1 or "refused"	-	Patient refused dose
2 or "NBM"	-	Nil by mouth
3 or "N/S"	-	No Stock - drug unavailable
4 or "absent"		Patient not on ward
5 or "iv"	-	IV therapy precludes a dose
0	-	Other reason specify in nursing notes.

For Healthcare Trust prescriptions, nurses can either write 'X' in the box and give the reason in the Exceptions to Prescribed Orders Sections, or follow the convention above.

4.3 MEDICINES ADMINISTERED AT NURSES' DISCRETION

a) Directorates specify the medicines involved in any given clinical area.

b) Prescriptions should be in the "once only" section of the prescription chart.

c) Prescriptions must carry the nurse's signature and status and not "nurse prescribed".

d) The same nurse must sign for administration in the "given by" column.

e) Medicines which require administration on a frequent basis, should be referred to a doctor for prescribing.

4.4 CONTROLLED DRUGS FOR TTOs AND OUTPATIENTS

The following are additional requirements for controlled drug prescriptions.

a) The prescription must be written in the doctor's own handwriting including the name and address of the patient. Addressographs are not acceptable.

b) The form must be stated (eg, tabs, elixir, Inj etc.), irrespective of whether it is implicit in the proprietary name (eg MST).

c) The strength must be stated where appropriate. This is not necessary where only one strength exists (eg Diconal), but is required where the dose is not the same as the strength. (See example A below).

d) The total quantity of the preparation (eg number of tablets, millilitres, or number of dose units) should be written in both words and figures.

e) The dose and frequency must be stated.

Example A	Example B
Morphine Sulphate M/R Tablets 40 mg bd Supply 14 (fourteen) 10mg tabs and 14 (fourteen) 30mg tabs	Morphine Sulphate Elixir 10mg in 5mls 15mls six times per day Supply 250ml (Two hundred and fifty ml)

4.5 VERBAL ORDERS

a) Telephone orders for single doses of drugs can be accepted by a registered nurse or midwife if the doctor is unable to attend the ward.

b) The prescription must be timed, dated and signed by the person taking the message, and endorsed "verbal order".

c) The doctor's name should be recorded, and the doctor should sign the prescription within 12 hours.

d) Pharmacists operate under a separate protocol (in this compendium).

File copy

POLICY NO:CLN/C3

PORTSMOUTH HEALTHCARE NHS TRUST

CLINICAL POLICY

CONTROL AND ADMINISTRATION OF MEDICINES BY NURSING STAFF

1 PURPOSE

The administration of medicines to patients is an area of nursing activity which can involve considerable risk to patients and to nurses themselves. This policy sets out what is expected of practitioners and what action they need to take in order to administer drugs safely.

2 SCOPE

The policy provides a general framework which applies to all registered nurses working within the Trust. However it is recognised that, because of the diversity of situations and client groups involved, there may need to be special arrangements which reflect local needs. For example for nurses working in the patient's home there may need to be some variations from this policy because of the particular circumstances. An addendum to this document setting out the particular requirements for community nurses is currently being prepared and will shortly be circulated to all Community Nursing Staff. Other requirements for nurses working with particular care groups are set out in the additional policies listed in the Appendix. No deviations from this policy are permissible unless they have been approved by the relevant Contract Lead Group.

3 RESPONSIBILITY

Registered Nurses are accountable for their own practice in the administration of medicines to patients including establishing their competence and are legally responsible for

- the correct storage, handling and safe keeping of all medicines and other pharmaceuticals in clinical areas
- the maintenance of records and registers

Registered nurses have a professional responsibility to adhere to the Code of Professional Conduct (UKCC June 1992), The Scope of Professional Practice (UKCC June 1992) and to the Standards for the Administration of Medicines (UKCC October 1992). Every nurse should ensure that he/she has a personal copy of these documents for reference purposes. A copy of the Standards for the Administration of Medicines is attached to this policy.

Service Managers are responsible for ensuring that nurses have the necessary resources for carrying out these functions safely and that the necessary guidance, training and updating is available to them particularly after any absence from practice.

4 REQUIREMENTS

The detailed requirements are set out in the UKCC document *Standards for the Administration of Medicines* with which all nurses should be familiar. Attention is drawn to the following points in particular:

4:1 The need for the nurse to exercise his/her professional judgement and to apply his/her knowledge and skill when administering a drug.

4:2 The importance of checking that the following are correct:
the drug
the concentration and the dose

the route of administration
the time
the patient's name

* *Attached for Community Nursing Staff only*

All of these should be clearly stated on the drug chart/prescription sheet.

4:3 The identity of the patient must be clearly established. This is particularly important where patients are confused or suffering from a mental disorder, or in situations where the nurse is not familiar with the patient. There must be a reliable system for identifying patients in all hospital settings.

4:4 Registered nurses, in line with UKCC guidance, may administer medications without involving a second person. In the case of Controlled drugs, two people must be involved in the administration of the drug and in recording it in the Controlled Drug Register. One must be a registered nurse; the other is preferably another registered nurse, but may be a doctor or competent health care support worker.

4:5 Student nurses may administer drugs, except those given intravenously, under the direct supervision of a registered nurse.

4:6 Health care support workers may check Controlled drugs only if they have been assessed as competent. There is a recommended Trust package for teaching and assessing competence in checking Controlled drugs.

4:7 Medicines should not be administered without a written prescription which conforms to the Trust's requirements (Prescription Writing Policy CLN P2) The only exceptions are:

- Medicines which can be administered without prescription by a registered nurse. These are on Approved Lists agreed with the Lead Consultant for the specialty and must be recorded on the prescription sheet and signed by the administering nurse.

- Verbal order by the doctor which is recorded on the prescription sheet and signed by the nurse taking the message. The prescription must be signed by the doctor within 24 hours.

4:8 If a prescribed drug cannot be given as ordered the doctor should be informed. If the situation appears urgent, this should be done immediately. (There is a place on the prescription sheet for recording drugs not given as ordered)

4:9 The nurse should take all reasonable steps to ensure that the patient has taken the drugs administered to him/her. Medicines should never be left on lockers or elsewhere but given directly to the patient.

4:10 Where as part of a rehabilitation programme in a health care setting a patient is administering his or her own medicines there must be a written protocol setting out the detailed arrangements for administration and storage of medicines. The nurse retains responsibility for supervision to ensure that the medicines are being taken as prescribed.

4:11 Medication errors must be reported :-

i) immediately to the doctor in charge of the patient
ii) to the clinical manager or service manager
iii) to the patient (and/or his or her relatives where appropriate).

Risk Event form must be completed if a medication error recurs. The Trust's aim is to support the nurse and to ensure that the necessary action is taken to prevent a recurrence. Medication errors are very distressing for everyone involved but it is important that they are openly acknowledged.

4:12 There should be local arrangements, incorporated in care group policies and procedures, regarding supply and storage of drugs and how they can be obtained in an emergency.

4:13 A Register of Signatures should be kept in each clinical area where medicines are given to ensure that the identity of any person administering a medicine can be checked. Prescription sheets must be retained in the patient's records.

4:14 Patients who require medicines on discharge from hospital should be given seven days' supply, (or a complete course if this is shorter) in accordance with local Quality standards

4:15 Patients' own medicines are the property of the patient and should not be taken from him/her without permission. If their use is likely to be continued after discharge, a friend or relative may be asked to take them home. If medicines have to be returned to the dispensing pharmacist or destroyed because they are no longer prescribed for the patient and are not considered safe for use, the patient's permission must be obtained. In the hospital setting medicines are normally sent to the pharmacy for destruction. Nurses should be familiar with the local arrangements.

4:16 Any nurse in charge of a ward, administering medicines from a trolley or carrying medicines in the course of domiciliary visits is responsible for the security of those drugs at all times.

4:17 Nurses should not write out lists of patients' medicines for the patient, carer or GP. This should only be done by a pharmacist or doctor.

5 AUDIT STANDARDS AND REQUIREMENTS

The UKCC standards will be used as the basis for an audit tool to check practice.

6 REVIEW DATE

The policy will be reviewed in January 1998

CIRCULATION

Operational Management Group
Policy Holders

POLICY PRODUCED BY : Pam Grosvenor, Quality Director

POLICY PRODUCED ON : January 1997

APPROVED BY TRUST BOARD/OMG : January 1997

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PORTSMOUTH HEALTHCARE NHS TRUST

CLINICAL POLICY

APPENDIX TO POLICY ON ADMINISTRATION OF MEDICINES

Existing Care Group policies for the Administration of Medicines

- **Adult Mental Health/Substance Misuse Residential Services:** Policy and Procedure for the Prescribing Administration and Requisitioning of Medicines.
- **Department of Medicine for Elderly People:** Policy for the Control and Administration of Medicines
- **Administration of Medicine by Community Nurses** (Addendum to policy) in preparation by District Nursing Contract Lead Group.