Policy Number CL16

Portsmouth Hospitals NHS

NHS Trust

(Ministry of Defence Hospital Unit)

The Royal Hospital, Haslar

East Hampshire Primary Care Trust
Fareham and Gosport Primary Care Trust
Portsmouth City Primary Care Trust

MEDICINES POLICY

29th January, 2004

Introduction

The purpose of this document is to set out policy on all aspects of the management of medicines, comprising the acquisition, storage, prescribing, dispensing/provision, administration and disposal of medicines.

The policy aims to achieve a consistent approach to the management of medicines across the local health economy. It is therefore written jointly to cover Portsmouth Hospitals (including the Ministry of Defence Hospital Unit) and the local Primary Care Trusts, namely:

East Hampshire PCT
Fareham and Gosport PCT
Portsmouth City PCT

Portsmouth Hospitals extends a pharmaceutical service to a number of provider functions of Primary Care Trusts.

Throughout this document, unless stated otherwise, the term "Trust" applies to Portsmouth Hospitals NHS Trust **and** the Primary Care Trusts named above.

The imperative, "must" is used in the policy to indicate legal requirements. In other circumstances, "should" is used to indicate agreed practice.

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Section 1

ACCOUNTABILITY

1.1 Staff groups

- A HEALTH PROFESSIONAL is one of the following staff groups, UK-registered with their respective professional body:

  Dentists
  Doctors
  Nurses/Midwives
  Pharmacists
  Radiographers
  Podiatrists

- VOLUNTARILY REGISTERED HEALTH PROFESSIONALS

  Operating Department Practitioners (See section 12.4 for detailed information)

- CLINICAL SUPPORT STAFF include the following:

  Dental Nurses
  Dialysis Assistants
  Health Care Support Workers
  Nursery Nurses
  Pharmacy Technicians

1.2 Individual Accountability

Each registered health professional is accountable for his/her own practice, and:

- should acquaint him/herself with the contents of this policy
- will be aware of their legal and professional responsibilities relating to their competence in the ordering, storage, prescribing, administering and recording of medicines; and work within the Code of Practice of their professional body.
- will be aware of the action that should be taken if their practice or their patients' safety is compromised.
- will be aware of the safe dose range, frequency, route, administration technique, side effects, contra-indications and interactions of the drugs used (Use the British National Formulary http://www.bnf.org/ as the first-line source of information for adults and 'Medicines for Children' for children).

- will monitor the patient for response to the medication, including potential adverse reactions and observe the patient for actual adverse reactions, following administration.
- will know the mechanism for reporting errors in prescribing, or administration incidents or adverse reactions, and how to manage them.
- will be aware of their limitations and seek advice or support from relevant senior health professionals when in doubt.
- will avoid delegation to others who may not be adequately qualified or experienced to carry out that task.

1.3	**Managerial**

The Chief Executive of each Trust has lead responsibility for ensuring the appropriate policies and procedures are in place to guarantee effective medicines management, including the safe and secure handling of medicines.

In the case of PCT's, this is with the support of the Pharmaceutical Advisor, via the medicines management committee for that Trust

Within Portsmouth Hospitals NHS Trust, it is through the Pharmacy Services Manager. All policies, procedures and protocols regarding medicines management and guidelines for medicines usage will be agreed and approved by the Formulary and Medicines Group (or its sub-groups, e.g. the Patient Group Directions Steering Group) on behalf of the Clinical Governance Committee and the Trust Board.
http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.23.doc

These include:

- providing material facilities and adequate levels of staff who are suitably qualified/experienced in the relevant clinical area(s), so that these procedures may be carried out safely.
- ensuring that adequate training is provided to all members of staff requiring such training.
- ensuring that systems are in place for ensuring that all registered health professionals have their registration checked on appointment and at regular intervals (agreed with HR departments) thereafter.

Section 1

ACCOUNTABILITY

Local service or departmental managers are responsible for:

- ensuring that all staff are informed as to which members of the team are competent in the various modes and routes of administration of medicines, to enable tasks to be delegated safely.
- ensuring that facilities and resources are available to allow staff to meet required competencies for the administration of medicines.
- ensuring that Patient Group Directions are used according to the guidelines within each Trust.

PRESCRIBING

The primary purpose of this policy section is to provide an agreed, consistent, safe and professional standard of prescribing and prescription writing throughout all the Trusts.

2.1 Scope

This policy section covers all prescriptions written by doctors/dentists and administered by health professionals, but excludes some specific issues which are handled separately:

- Pre-printed prescriptions within PHT (individual directorate policies in force which have been agreed by the Formulary & Medicines Group).
- Prescriptions written by pharmacists within PHT under their Enabling Policy. Alterations made under this policy should be treated as equivalent in authority to the original prescription.
- Nurses working within primary or secondary care are legally allowed to prescribe as Extended Formulary Nurse Prescribers or as Supplementary Prescribers, provided they have undergone the necessary training, and their prescribing status is recorded on the NMC register. In addition, Community Nurses who have undergone the requisite training (and whose prescribing status is noted on the NMC register) may also prescribe a limited range of medicines contained in the Nurse Prescribers' Formulary (see nurse prescribing policy).

See section 7.5 for supply and/or administration under Patient Group Directions.

2.2 Responsibilities

The prescriber is responsible for:

- taking an accurate patient medication history.
- checking for and recording patient allergies and sensitivities (named drugs / latex / others). Allergies should also be recorded on **red** patient wrist bands.
- stating the drug (including certain pharmaceutical criteria, such as "modified release" etc.), dose, route, rate of administration and duration of treatment.
- checking to ensure that each item prescribed is listed in the District Prescribing Formulary http://nww.ports.nhs.uk/drugform/default.asp
- checking for clinically significant drug interactions and for intravenous drug incompatibilities (drug-fluid, drug-drug), including ensuring that no drug is added directly to any blood product.
- providing a legal, legible, signed prescription giving all the detail necessary to enable the medicine to be supplied and administered safely, correctly and lawfully.

2.2.1	**Shared care**

With rapid advances being made in the areas of therapeutics and drug development, it is becoming increasingly important to recognise the specialist skills and experience that are necessary for clinicians to manage drug treatments safely and effectively.

The NHS Management Executive issued its guidance on prescribing at the hospital/GP interface through EL(91)127 –"Responsibility for prescribing between hospitals and GP's". This guidance:

- reinforces the basic premise that prescribing should be undertaken by the doctor who has clinical responsibility for a patient
- focuses on the concept of shared care, emphasising the need for proper hand-over procedures from hospitals.

Agreements for "Shared Care" prescribing between secondary and primary care should be made according to the guidelines of the Area Prescribing Committee, "The development and content of shared care guidelines". Any shared care agreement not already in place, should be firstly discussed with the patient's General Practitioner and if necessary the PCT's prescribing advisor or prescribing committee. The legal responsibility for prescribing lies with the doctor who signs the prescription.

2.3 Requirements for Prescription Writing

Warning: Failure to comply fully with these requirements is liable to result in the prescription being sent back to the prescriber, since it could not be dispensed safely/lawfully.

General requirements

Prescriptions will be written **legibly, in indelible ink** and will state the following **(use patient identification sticker whenever possible):**

a) **Surname and first forename of the patient, and for out-patients, their address.**

b) **Patient's Hospital Number for inpatients.**

c) **Patient's date of birth.**

d) **The patient's weight.**

e) **Name of product.** Use rINN, i.e. recommended international non-proprietary name (except for *adrenaline* and *noradrenaline,* which are the correct current British Approved Names).

- This should be written clearly and **not** abbreviated.
- The trade name (proprietary name) should be used for multiple-active-ingredient products that have not been given a [*co-*] title by the BNF.
- The trade name should be used for cyclosporin, lithium and theophylline, and certain modified release products, because the various brands differ in bioavailability.

f) **The dose:**

- In particular, the **unnecessary** use of **decimal points** should be **avoided** (e.g. 3mg **not** 3.0mg).
- Quantities less than 1 gram should be written in milligrams (e.g. 500mg **not** 0.5g).
- Quantities less than 1 milligram should be written in micrograms (e.g. 500micrograms **not** 0.5mg).
- Quantities of less than one litre should be written in millilitres (e.g. 15mL, **not** 0.015L).
- When decimal points are unavoidable, a zero should be written in front for values less than 1 (e.g. 0.5mL **not** .5mL).
- **Abbreviations of units** should always be written in the **singular**, e.g. 10mg, **not** 10mgs.
- For **liquid oral medicines**, the dose should be prescribed by mass (e.g. milligrams) whenever possible. With some drugs, however, e.g. magnesium hydroxide, there is no mg dose and 'mL' is acceptable.
- For **mixed "compound" preparations,** which are supplied as a unit dose, the number of tablets (or other units) to be given should be stated (e.g. co-dydramol tablets).
- The words: **micrograms**, **nanograms,** or **units** should **not** be abbreviated.

g) **The route of administration**

This should preferably be stated in plain English, but the following

abbreviations are acceptable:

O or PO =Oral

IM	=	Intramuscular injection
SC	=	Subcutaneous injection
IV	=	Intravenous injection
PR	=	Rectal

For inhaled medicines the administration device should also be stated, e.g. Accuhaler, Volumatic, etc.

h) **Frequency of administration.**

In the case of preparations to be taken 'as required' a **minimum dose interval** should be specified, and an **indication** (reason for administration) if not obvious. Although directions should preferably be in English, without abbreviation, the following Latin-based abbreviations are allowed:

stat. = immediately

o.d. = once a day

b.d. = twice a day

t.d.s.= three times a day

q.d.s.= four times a day

o.m. (or mane) = each morning

o.n. (or nocte) = each night

p.r.n.= when required (as a minimum requirement, please state maximum dose allowed in 24 hours)

('qd' should <u>never</u> be used)

i) **Minimum quantity to be supplied.**

<u>Outpatients & Day Hospitals</u> - minimum 14 days and a maximum of 28 days (or sufficient to complete a course of treatment).

Take Out Prescriptions : 20 to 28 days or sufficient (depending on patient's own supply) to complete a course of treatment (exception is Adult Mental Health and Elderly Mental Health patients [14 days]). Where a suitable pack size exists, a manufacturer's original pack will be dispensed.

j) **Signature of the prescriber.** This should be recognisable and the prescriber identifiable. The prescriber's bleep number should be used for additional identification wherever possible.

k) **Date (including year) of prescription.**

2.4 Inpatient prescriptions (additional requirements)

a) Ward.

b) Consultant's name.

c) Patient's identification number.

d) Completion of **drug allergies / sensitivities** section. State "not known" or "history unobtainable" if these are the case. If history unobtainable on admission this should be obtained as soon as it practical.

e) Times of administration for **regular** and **once only** drug therapy. Use 24 hour notation (e.g. 1630).

f) When required, 'p.r.n.' prescriptions should include:

- dose. If the dose is a range, guidance on how to choose which dose should be given.
- administration frequency (or minimum interval between doses).
- maximum dose over 24 hours (if relevant).
- indication (reason) for administration (e.g. "for pain relief").

g) Stability/compatibility data should be checked when contemplating the dilution of drugs in infusions. The period of administration should not exceed the "life" of the infusion or the manufacturer's recommendations. Contact the pharmacy for guidance if necessary.

h) The use of continuation sheets is **strictly forbidden**. If a chart is full, continue on another, remembering to fill in patient details, and state chart number and number of charts in use.

2.4.1	**Changing drug doses**

When a dose needs to be changed, the Trusts require doctors to completely rewrite the prescription to avoid misinterpretation.

2.4.2	**Stopping a medicine**

When a medicine is discontinued, prescription should be deleted with a large 'Z' across drug name, dose and administration sections, countersigned and dated by the doctor.

2.4.3	**Dose deliberately withheld by the prescriber**

The dose administration box should be filled with a code 1 (see 7.2.1) and countersigned. The reason for the decision should be documented in the health record.

2.5 Controlled Drugs for outpatients and for patients being discharged.

To meet legal requirements, the entire prescription must be written in the **doctor's own handwriting,** including **the name and address of the patient.** Patient identification stickers alone are **not** acceptable.

The **drug and dosage form** must be stated (e.g., capsules, modified-release capsules, oral liquid, injection, patch etc.), even when it is implicit in the proprietary name.

The **strength** must be stated. This is particularly important where the dose is not the same as the unit strength (see example A below). [In example B, the figure "50" is actually the release rate in micrograms per hour, but this legally defines the medicine required].

The **total quantity of the preparation** (e.g. number of tablets, millilitres of liquid, or number of dose units) must be written in both **words and figures.** For proprietary liquid medicines, the quantity should be adjusted to allow dispensing of whole container/s only.

The **dose and frequency** must be stated.

PRESCRIBING

Full guidance on CD prescription writing is given in the "Controlled Drugs and drug dependence" section of the current BNF http://www.bnf.org/

Example A (all to be written in Dr's handwriting)

Patient's name & address

Morphine sulphate M/R capsules
40 mg bd. Supply 14 (fourteen) 10mg caps
and 14 (fourteen) 30mg caps
Dr's signature, date

Example B (all to be written in Dr's handwriting)

Patient's name & address

Fentanyl patch "50"

Apply 1 patch every 3 days

Supply 10 (ten) patches

Dr's signature, date

2.5.1 Prescribing Controlled Drugs for administration by community nurses

A community nurse must have written direction on an official drug card from a medical practitioner stating:

a) name of drug.

b) dosage and frequency, dated and signed by a medical practitioner.

c) route / method of administration.

d) any special precautions/instructions.

2.6 Pharmacists' continuation of drug therapy

Pharmacists may continue a patient's existing drug therapy, and record this on the in-patient prescription chart for administration by other health professionals, in accordance with their Enabling Policy.

2.7 Discharge Medicines

- For the purpose of this policy document, discharge medicines means the following: To dispense medicines, (including dressings) upon discharge, for the patient to use until seen by their General Practitioner. (**At RHH, dressings** are supplied from Stores, **not** by the pharmacy dept.).
- Discharge medicines should be ordered and delivered to the ward or department on the discharge date, but preferably 24 hours before discharge, whenever possible.

- Discharge medicines should be stored on the ward/department in accordance with the legal class or with due regard to storage requirements of the medicines supplied. For example, Controlled Drug cupboard, locked cupboard or refrigerator.
- Discharge medicines **should not** be made up from ward stock.
- On arrival at the pharmacy department, the discharge prescription should always be accompanied by the prescription chart, unless previously screened (& signed) on the ward by a pharmacist (as indicated on the discharge form). Within peripheral units, there are local arrangements for obtaining discharge medicines.
- Any member of staff or volunteer (with valid identification) may collect discharge medicines from pharmacy. Patients may also collect discharge medicines providing:
  - 3 prior arrangement has been made **and**
  - 3 proof of identification is shown i.e. wristband in situ.
- Upon each patient's discharge, the discharging health professional will check to ensure that any patient's own medicines returned to him/her are currently prescribed at the correct dosage. Medicines no longer required will be disposed of by the discharging health professional in accordance with the current policy, as described in Section 8. Prior to destruction of a patient's own medicines, his/her permission should be sought.
- Supply of discharge medicines from wards should be in accordance with agreed protocols and using pharmacy-dispensed pre-packed medicines. Ward stock should be used only in **exceptional** circumstances (in which case a risk event form report should be completed). A patient's name should always be present on the label, as well as dosage and administration directions. A patient information leaflet should always be supplied.

See:http://pompi/Governance/Policies/Clinical%20and%20Nursing/Section%207.%20Discharge%20Planning1.doc

2.8 Prescriptions for Outpatient, Accident and Emergency, Day Case Surgery or Day Attenders

- Patients should be made aware **prior to admission** if possible, that when they attend as day patients, for day surgery, (or for accident and emergency treatment), they are liable for prescription charges (tax) for any medicines supplied to take out.
- Arrangements should be made in each dispensary and relevant clinical area so that patients sign a declaration to state why they do not have to pay, or how much they have paid. This will normally be done using the designated Trust stationery (see section 3) or by arrangement with the Principal Pharmacist Operations (QAH).

2.9 Medical gases

- The prescription of these should be entered on the prescription record chart.

3.1 Permitted prescribing stationery

Prescriptions may be written using only the following stationery:

Sector	Area	Stationery
Portsmouth Hospitals	**In-patients**	**Prescription record chart, PMP 457 IV fluid chart**
	Theatres	**Anaesthetic record sheet**
	Discharge	**Discharge summary**
	Out-patients & Day Case	**Day case record chart WWG500 (MR 601) FP10(HP)**
	Accident & Emergency	**WNV1068 A/E**
	Theatres	**Peri-operative record**
	Post-operative areas (recovery).	**Pre-printed post-operative analgesic charts**
Royal Haslar Hospital	**Military Out-patients**	**F Med 296**
	Civilian Out-patients	**As Portsmouth Hospitals**
	In-patients	**As Portsmouth Hospitals**
Primary Care	**In-patients (elderly care)**	**Prescription sheet IV fluid chart**
	Discharge (elderly care)	**Discharge summary**
	The Rowans Hospice	**Prescription record chart PMP 457 and discharge summary**

	Mental Health Units	**MH inpatient chart** **Short term discharge chart** **Discharge summary** **FP10(HP)**
	District Nurses, Health Visitors	**FP10(HP)**
	Peripheral Units	**Prescription chart** **FP10(HP)**

The design or issue of any other prescribing stationery in PHT should be agreed first with the Principal Pharmacist (Clinical Services), or in PCT's by the Pharmaceutical Advisor. Prescribing stationery should be original printed materials. Photocopies or computer-generated versions are not acceptable.

3.2 Controlled stationery

- Controlled stationery will be issued from pharmacies (CD stationery) and from the Pharmacy Support Services office (FP10(HP)'s).
- Issue of FP10(HP) pads will include ink-stamping each form with the prescribing authority details, immediately prior to dispatch. Details of issues will be recorded, and written receipts obtained from recipients.
- The ink stamps used as above should themselves be regarded as controlled stationery, i.e. they should be stored under lock and key.
- Dispatch of controlled stationery from pharmacies/pharmacy office to users, must be by means of sealed transit systems, similar to those used for dispatch of medicines (see section 6.2).
- All controlled stationery, including Controlled Drug order books and FP10(HP) prescription pads, must be kept in a locked cupboard (or other secure place) when not in use.
- Any instance of loss or theft of any controlled stationery from any location must be reported to the Pharmacy Services Manager (023 9228 6415) and to the local manager via the incident reporting procedure as soon as possible.

3.2.1 Storage

Controlled Drug record books and registers, when full, should be sealed (with adhesive tape) after the final entry and kept in a secure place on the ward for 8 years after the date of the last entry. This is to prevent further use or alteration. After this period, they should be disposed of as confidential waste.

3.2.2	**Controlled Drug register entries**

- Entries in the Controlled Drug Record Book (ref. 90-501) must comply with the instructions inside the cover of the book, and with policy documents issued by pharmacy departments.
- Controlled Drugs must be requisitioned using the Ward Controlled Drugs Order Book (ref. 90-500).
- Each requisition must be separate from the preceding one, and the stock level should be balanced.
- Community nurses should record the administration of Controlled Drugs in the patient's nursing notes.
- Entries must be clear, unambiguous, contemporaneous and must contain no crossings out. Any errors in making entries must be bracketed, corrected and a notation made "Entered in error", in the margin, and initialled and dated.
- Any transactions concerning patients' own medicines ("POD's") that are CD's must be recorded in a separate Record Book. Within this book, there will be a separate page for each CD medicine of each patient. The records kept include initial receipt of POD CD's onto the ward, administration to the patient, and upon discharge, returning them to the patient or consignment of unwanted POD CD's to the pharmacy for subsequent destruction.
- In wards or departments where illicit Controlled Drugs need to be removed from clients, a dedicated book must be used to record receipt of these and their subsequent destruction via pharmacy. They should not be returned to a client under any circumstances.

Section 4

STOCK CONTROL AND STORAGE

4.1 Medicines procurement

- It is the responsibility of the Pharmacy Department to procure all agreed medicinal products and dressings, and to ensure that adequate records are kept to allow a defined audit trail of medicines usage. At RHH this is the responsibility of the MDC (Medical Distribution Centre).
- The Pharmacy Services Manager is responsible for ensuring that physical security in pharmacy departments complies with the requirements of chapter 9 of the latest NAHAT guidance document.
- Under certain circumstances, peripheral units may obtain medicines from a community pharmacy when the medicines are prescribed by GP's on FP10.

4.2 Medicine stock ordering by wards and departments

- The nurse in charge is responsible in each ward, unit or department for the ordering of stocks, stock control and rotation, expiry date checking, and reconciliation of any discrepancy. In all clinical areas, ward stocks will be checked at least once every 3 months.

a) In clinical areas **with Pharmacy top-up services**, the responsible person is the Pharmacy Distribution Manager, in accordance with the agreed service level agreement.

b) In clinical areas **without a Pharmacy top-up service**, the person in charge of the ward/department/unit is responsible. The duty of stock control and checking may be delegated to a nominated deputy, but the accountability still rests with the person in charge.

c) In pharmacy departments, the pharmacist manager in charge is responsible.

- All orders and requisitions should be signed by the person producing the order.

4.2.1	**Restrictions on medicines held on wards**

Medicines held in wards and departments are restricted by lists emanating from the pharmacy department.

Certain high risk medicines are allowed to be held only at a very limited range of locations. These high risk medicines currently include:

- Concentrated potassium salts for injection. Ordering, issue and use of these is strictly controlled according to the Trust policy for the use of potassium-containing concentrated solutions for intravenous administration http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.22.doc
- Neuromuscular blockers

4.2.2	**Controlled Drugs**

Controlled Drugs may be ordered only by the nominated registered nurse/midwife in charge of a ward or department at that time, using the Controlled Drug order book.

4.3 Storage

- All medicines, other than those identified below, should be stored under lock and key and in accordance with the manufacturers' or Pharmacy Department instructions.
- In departments where there is relatively unrestricted public access, for example, Accident and Emergency Departments, staff need to be particularly vigilant regarding security of medicines. In particular, careful consideration should be given to the location of emergency drug trays. They should be readily observed by and accessible to professionals, yet not obvious to the public. Also, care should be taken to keep patients' own medicines separate from departmental stocks.
- Locked facilities should be used for storage at ward/unit level. Bulk sterile fluids and topical, unmedicated dressings may be stored unlocked. All medicines trolleys should be locked and immobilized when not in use, normally by being secured to a suitable wall bracket. Drug cupboards should comply with the latest version of British Standard BS2881.

STOCK CONTROL AND STORAGE

- Medicines should be stored:
  - ✓ in a robust, lockable cupboard, refrigerator or freezer (depending on required storage conditions), used solely to store medicines. Cupboards should be securely fixed to the floor or wall. Injectable medicines, internal medicines, external medicines, diagnostic agents and flammables should be kept segregated from each other (e.g. separate shelves/drawers). Agreed lockers for the storage of patients' own medicines can be used, secured to a wall and/or to the patient's locker.
  - ✓ where they can be easily be supervised and observed.
  - ✓ away from sources of heat, strong light and moisture.
- Controlled Drug storage and records will be audited by pharmacy staff at regular intervals, not exceeding 3 months.
- Medicines will be stored in their original containers or in pharmacy-dispensed containers, and not decanted into other vessels or storage devices, or from one to another. Original containers should not be tampered with.
- **Medicines for the emergency management of patients**, e.g. Cardiac Arrest kits and Emergency Drug boxes, are **exempt** from the requirement for storage in a locked cupboard.
- All refrigerators should be fitted with a temperature monitoring device. This can be built-in, or a maximum/minimum thermometer can be used. These should be periodically calibration-checked, in accordance with pharmacy policy. Medicines refrigerators should be kept at between +2° and +8° C.
- Community nurses should **not** carry or hold a stock of medicines, **except for adrenaline.** The only exception to this is if the patient has no other means of obtaining the medicines and the nurse is travelling directly from a pharmacy to the patient's residence. Individuals should ensure that their own vehicle's insurance covers this eventuality. Learning Disability staffs have specific guidance for storage and transport of medicines.
- Medical gases should be stored in accordance with Trust guidelines. Particular care must be taken with Entonox. The cylinders should be stored horizontally, and repeatedly inverted before each use, to re-mix the liquefied component gases. [At RHH the storage of medical gases follows the requirements of the MHRA Wholesale Dealer's Licence. It is, therefore, deemed that the ward's stock of medical gases does not constitute storage]

STOCK CONTROL AND STORAGE

4.4 Stock control

4.4.1 Controlled Drug stock balancing

The ward or department stock of Controlled Drugs should be checked against the record book balance, and any discrepancies reconciled **at least once a week**. However, for many types of wards and departments, **the frequency of reconciliation may be considerably higher**, at the discretion of the responsible person in charge. Depending on security issues, including the number of Controlled Drug transactions per day, it may be daily, or more frequently, e.g. at the change of each nursing (or equivalent) working shift. **Each reconciliation should be recorded, signed and dated.**

4.5 Security

- The responsibility for the safekeeping of medicines in wards or departments rests with the appointed nurse in charge.

- The Pharmacy Services Manager is responsible for security of medicines within the pharmacy departments.

4.5.1 Drug cupboards

- In wards/departments, these should comply with the requirements of the latest version of British Standard BS 2881.
- Controlled Drug Cupboards should comply with design requirements contained in the Misuse of Drugs (Safe Custody) Regulations, 1973

4.5.2 Keys

- The appointed nurse in charge of the ward or department (or designated deputy) is responsible for controlling access (using keys or other means) to the medicines cupboards, refrigerators and trolleys.
- The responsibility remains with the appointed nurse, even if she/he decides to delegate the duty. In operating theatres at weekends or out of hours, the responsibility rests with the Operating Department Practitioner in charge, if there is no appointed nurse on duty.
- A second set of keys should be kept secure in a designated place and be available for access at all times if required.

4.6 Controlled Drugs

- The responsibility for the ordering, safe custody and supply of Controlled Drugs in hospital wards, theatres and departments rests with the nurse in charge or acting nurse in charge. Control of access may be delegated to another registered nurse/midwife, medical practitioner or operating department practitioner.
- A registered nurse or an operating department practitioner may remove Controlled Drugs from a Controlled Drug cabinet or return them to the cabinet only on the specific authority of either the nurse in charge, or a medical practitioner (i.e. a valid prescription). However, responsibility for the requisitioning, safe custody and supply of Controlled Drugs remains with the most senior registered nurse on duty in the department, even if that nurse decides to allow access by others.

4.7 Storage Error

a) Controlled Drugs

If a Controlled Drug has been accidentally left outside of the Controlled Drug cupboard, it must be replaced in the cupboard immediately and the stock balance of that medicine checked.

Any discrepancy should be dealt with as detailed in section 4.8.1, and should include the completion of a risk incident form, sending a copy to the Principal Pharmacist (Operations).

For PCT-managed services, a report should be submitted in accordance with the PCT incident-reporting procedure.

b) Medicines which should be refrigerated

If a medicine that should normally be stored between +2 and +8°C is left out of a refrigerator, or if the medicine has been exposed to a temperature below zero deg. C, the Medicines Information Centre should be contacted to determine the action to be taken.

If the medicine has been administered to a patient, the medical practitioner in charge of that patient should be informed immediately and a risk incident form completed. The Medicines Information Centre can be contacted for advice regarding any potential clinical consequences. A medicine which has been improperly refrigerated should not

be administered to a patient until the effect on the stability of that product has been established as being satisfactory.

c) Other medicines

If any other medicine has been improperly stored, the pharmacy department or Medicines Information Centre (023 9228 6632) should be contacted for advice.

4.8 Losses and Discrepancies

4.8.1 Controlled Drugs

When any discrepancy in a Controlled Drug stock quantity is discovered:

- this must be reported to the modern matron (daytime) or the clinical site manager (out of hours) as soon as possible and to a pharmacist on the next working day. They will jointly agree on the proper action to be taken.
- every practicable step should be taken to identify the cause of any loss of medicine.
- the General Manager / Divisional Nurse and Principal Pharmacist will discuss whether any further action is required, and whether to inform external agencies, such as Police. RHH may decide to alert the Service Authority or the MSA.
- A risk incident report form should be completed and sent to the Trust Risk Management Department (with a copy sent to the Principal Pharmacist (Operations) QAH/SMH, or to the Principal Pharmacist for the Trust relevant to a particular peripheral unit (or to the Dispensary manager at RHH).

4.8.2 Other medicines

- Any unexplained losses of other medicines should be reported to the ward or departmental clinical manager and to the pharmacist responsible for that area.

4.9 Obtaining Medicines During Pharmacy Hours

4.9.1 Ward stock medicines

- For wards without Pharmacy Top-Up Services, all stock medicines should be ordered from the pharmacy department using the agreed order form or procedure. Verbal orders will be accepted for upto two items only. In addition, there are locally agreed procedures in place for ordering stock medicines within peripheral units.

4.9.2 Inpatient medicine which is not a ward stock item

- These medicines should be ordered by or via the ward pharmacist or by taking the prescription chart to the pharmacy department, or by faxing / telephoning the prescription in the case of peripheral units. Each acute ward is visited daily and it is preferable that, where possible, the prescription charts remain on the ward until the pharmacist visits.
- **At RHH**, medicines should be ordered by taking the prescription chart to the pharmacy department with a 'non-stock' requisition form.

4.10 Obtaining Medicines Outside of Pharmacy Hours

http://pompi/governance/Policies/Management/5.1.Issue%206.%20Sept%2003.doc

The following procedure should be followed:

- Try to obtain the medicine from the following sources (in order of preference):

  From the patient's own supply via relatives or carers, from the hospital's emergency cupboard or from a neighbouring ward.

- **Notes on the use of Hospital Emergency Drug Cupboards:** The cupboard(s) is/are located at strategic point(s) at each hospital. Most have a "satellite" refrigerator. The keys are held in a nearby, constantly manned ward/department. A key may be drawn from the nurse in charge by a registered nurse/midwife or medical staff, **provided** they are in possession of a valid Trust/RHH **identification** card. That person then proceeds to the cupboard, and draws the medicines required for their unit, if listed on the schedule displayed on/in the cupboard. It is **essential**

that the person completes the form found inside the cupboard to state what has been taken, the quantity, by which ward, the date and time, and gives a signature. This information is **vital** for reasons of stock traceability, and **to enable pharmacy staff to replenish the emergency stocks.** Pharmacy staff visit each emergency cupboard every working day to examine the form inside, to find out whether anything has been taken, and to re-supply. The contents of each emergency cupboard are checked by pharmacy every 3 months for completeness, and for any date-expired medicines.

- If a medicine is borrowed from another ward, a **whole original container** should be borrowed, **not** individual doses in temporary containers. This latter practice is dangerous and should **never** occur.

- Controlled Drugs may be "borrowed" from another ward. To use another ward's stock, that "lending" ward's register must be used in the normal fashion, administering and witnessing administration to the "borrowing" ward's patient, using the "lending" ward's stock.
- In Peripheral units, the nurse in charge should discuss the need for obtaining the medicine out-of-hours with the on-call doctor.
- **If none can be obtained from these sources, the on-call pharmacist should be contacted via the hospital switchboard, and the situation discussed.**
- **RHH: See separate on-call procedure.**

Section 4

STOCK CONTROL AND STORAGE

5.1	**Responsibility**

All dispensing should be undertaken by the Hospital Pharmacy Departments, under the supervision of a registered pharmacist. Medicines for patients in Peripheral units will, in an emergency be dispensed by a community pharmacy.

5.1.1	**Cytotoxic chemotherapy** (See separate Trust policy)

All cytotoxic chemotherapy should be reconstituted, prepared and dispensed in the pharmacy department (unless agreed with the Oncology Pharmacist for specific products/patients, in agreed clinical circumstances).

5.1.2	**Dispensing from ward areas**

- Dispensing by means of pre-packed and labelled medicines is allowed, using the approved Trust guidelines on dispensing pre-packs and if agreed with the relevant directorate pharmacist.
- Dispensing from ward stock is allowed **only** when the pharmacy department is closed, and **all other measures** are impracticable, and following a procedure agreed with the relevant Directorate pharmacist/Care Group.

5.2	**Provision of Medicines for Parenteral Administration** **(Centralised Intravenous Additives Service "CIVAS")**

- Wherever possible, the pharmacy department will provide medicines for administration by the parenteral route in a **ready-to-use form**. Usually, these will comprise pre-filled syringes, infusion bags or disposable pump devices.
- Parenteral cytotoxic chemotherapy medicines for administration at a patient's home and all such medicines for paediatric patients should be prepared in a pharmacy cytotoxics unit, and supplied in **a ready-to-use form**, wherever practicable.

5.3	Dispensing Error

- If a dispensing error has occurred which has led to an administration error, then the procedure outlined in section 10.2 should be followed.
- In all cases (whether a dose has been administered or not), an adverse incident form should be filled in and processed as soon as is practicable and the error reported to the manager of the department where the dispensing error originated.

5.4	Prescription charges

Prescription charges should be collected on all medicines (and on some dressings/medical devices) taken out of the hospital.

The only exceptions to this are:

- In-patients who are being discharged.
- Patients who are exempt or remitted from charges. Patients should sign a declaration to state why they do not have to pay.
- Prescriptions for contraceptives and for medicines used in the treatment of sexually transmitted diseases.
- Patients of certain clinical areas which have a written agreement with the Trust's Finance Director and the Pharmacy Services Manager.
- Service personnel (H.M. Armed Forces).
- Currently, medicines supplied in the following East Hants. PCT Minor Injuries Units: Petersfield Community Hospital, Havant War Memorial Hospital and Emsworth Victoria Cottage Hospital.

Section 6

DISTRIBUTION and DELIVERY

6.1 Distribution within the same hospital

All medicines that are transported between a pharmacy department and wards or departments should be transported using security-sealed containers (except those which are too bulky to be secured e.g. bulk fluids), via the pneumatic tube system, or transported in person.

6.2 Distribution between hospitals and peripheral units, surgeries and clinics

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

- sealed Envopaks or similar tamper-evident sealable bags, or
- locked transport containers or
- in person

Where motor vehicles are used (including taxis):

- the driver should not be in possession of the key to the transport container being carried.
- transport containers will be delivered directly to a secure area and checked upon arrival.
- unauthorised passengers will not be carried.
- vehicles will be locked when unattended (even if empty).

6.3 Chemotherapy (see also separate Trust policy)

Parenteral chemotherapy must be delivered to clinical areas, in recognisable containers, separately from non-chemotherapy. All chemotherapy for intrathecal administration is delivered to clinical areas, from pharmacy departments, **only on the signature of the health professional who accepts delivery.**

Chemotherapy for intrathecal administration must be delivered to clinical areas separately from other chemotherapy, preferably on a different day and in a container whose colour is distinct from that used for other chemotherapy.

Section 7

ADMINISTRATION and CHECKING of MEDICINES

7.1 Administration

- Any health professional listed in Section 1.1, who has demonstrated the necessary knowledge and competence may administer medicinal products. This also includes operating department practitioners and healthcare support workers who have undertaken training and have demonstrated such knowledge and competency.
- Health professionals should administer only those medicines with which they are completely familiar. They have a duty to maintain and update their knowledge and competency in drug developments relating to their own specialist area.

7.1.1 Ensuring safe administration

It is the responsibility of any health care staff administering medicines to ensure that they do so only if:

- the prescription is legal, valid, legible, unambiguous, and signed/dated by an authorised practitioner.
- the patient is the true intended recipient of the medicine.
- the drug, dose, route, pharmaceutical form, timing and frequency are correct.
- the prescription and/or administration is clinically appropriate, given the current circumstances of the patient at the due time. The allergy status of the patient should be checked before any administration takes place, for example, by reference to the allergy box on the drug chart or by a red "patient allergy" wrist band.
- all the required records are made and kept.

7.1.2 Administration of parenteral therapy

- Those who administer parenteral medicines have additional responsibilities, which are listed in the **Trust Parenteral Administration of Medicines Guidelines.**
- Health professionals should inject only into an **established** intravenous access point.
- All medicines that can be administered peripherally may be given via a central line **(but not vice-versa).**
- Whenever a drug is added to a container of infusion fluid, the "time added" and "added by" columns on the Infusion Therapy Sheet should be filled in. A label

(available from NHS Supplies) bearing the necessary details should be affixed to the fluid container or syringe, **not to the infusion pump or device.** The only exception to this is when the label cannot be read, or is so attached to obscure the calibration markings on a small syringe. In this case the label should be securely attached to the giving set and the set and syringe changed at the same time.

- Whenever administration of a fluid is commenced, the "Given by" column should be filled in by the health professional administering the fluid.
- Clinical support staff **should not** take part **any aspect** of the administration of parenteral therapy. The only exception to this is healthcare support workers who have undertaken training, have demonstrated the required knowledge and competency (completed Medication Administration IV Competency), and are acting in accordance with the Protocol on parenteral therapy.

7.1.3	**Consent to treatment**

When administering a medicine against a prescription, that prescription should be based, whenever possible, on the patient's informed consent and awareness of the purpose of the treatment. See Trust policy on Consent http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.8%20without%20appendix%20E%20Oct%2003.doc

7.1.4	**Timing of In-patients' first doses**

When a regular medication is newly prescribed, the first dose should be given without undue delay. Delays can potentially occur in cases where a new medication is prescribed several hours before the next ward "drug round".

In cases where this type of delay presents a clinical risk to the patient, prescribers should enter the first dose as a "once only" dose for immediate administration.

ADMINISTRATION and CHECKING of MEDICINES

7.2 Administration records

All instances of administration of medicines to an in-patient or day-case patient should be recorded in the correct section of the prescription chart, peri-operative record, or special record charts for variable dose infusions. All of these should be placed in the patient's multidisciplinary health record.

7.2.1 Doses missed or refused

In Portsmouth Hospitals Trust, the dose administration box (Form PMP 457) should be filled with a code number or abbreviation as follows:

1 Dose withheld on medical orders (Prescriber to state reason in notes)

2 Patient refused dose

3 Medicine not available

4 Patient absent from ward

5 Unable to give oral dose due to patient's nausea/vomiting

6 Patient is "nil by mouth"

7 Medication not required

8 Instructions unclear or illegal

9 I/V access not available

10 Other (record on chart)

When using PCT prescriptions, nurses should write the appropriate code number in the box and record the reason in the 'Exceptions to Prescribed Orders' section.

If a medicine is not required, the prescriber should review the prescription.

7.2.2 Administration of blood, human albumin solution, immunoglobulin and other blood products

When any of these products is administered, the Trust Policy on Administration of Blood and Blood Products http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.18.doc should be followed. The time and date of administration should be recorded in the patient's health record, together with the batch number of each dose unit or product administered.

ADMINISTRATION and CHECKING of MEDICINES

7.3 Administration of Controlled Drugs

The administration of Controlled Drugs can be by a nurse, midwife, doctor or pharmacist. In Portsmouth Hospitals, this administration must be recorded in the Controlled Drug Register by two persons, one of whom should be the administering health professional. The second competent person should witness that the Controlled Drug has been administered.

Health Care Support Workers **may not** check Controlled Drug administration unless they have undergone a competency assessment, which includes a protocol, training pack and assessment package agreed with the Clinical Governance Committee or, in the case of PCT's, by the relevant committee.

It will remain the professional responsibility of the health professional to ensure that the medicine is administered correctly.

Any permanent member of staff (with identification) may act to deliver Controlled Drugs from the pharmacy department to the clinical area, but **may not** sign as a recipient for Controlled Drugs which have been delivered to that area.

Clinical support staff **may not** administer the CD medicine.

7.4 Administration of cytotoxic chemotherapy

Cytotoxic chemotherapy will be administered only by health professionals whose names are listed as those who have undergone competency training in this area. This is usually from accepted centres such as the Portsmouth Oncology Centre, Southampton or Guildford Hospitals.

7.4.1 Intrathecal chemotherapy (see also separate Trust policy)

The Portsmouth Hospitals NHS Trust policy on intrathecal chemotherapy must be followedhttp://pompi/Governance/Policies/Clinical%20and%20Nursing/Section%203.17%20Intrathecal.%20Issue%203.%20Feb%202003.doc

It must be administered only by senior registrars or consultants who have demonstrated competency in the intrathecal administration of chemotherapy, and whose names appear on the list on the Trust's Intranet website.

For a given patient, intrathecal chemotherapy should be administered on a separate day from other parenteral chemotherapy.

7.5 Administration of radiopharmaceuticals

- Radioactive pharmaceuticals may be administered to a patient only on the authority of a clinician who has an ASARC certificate for the diagnostic or therapeutic procedure concerned, as required by the Medicines (Administration of Radioactive Substances) Act, 1978. The clinician should also have undergone training that satisfies the core of knowledge requirements of the Ionizing Radiations Act, 1987 (Protection of Patients Undergoing Medical Examination or Treatment).
- The health professional administering the radioactive material may do so only if they have received sufficient training which satisfies the core of knowledge requirements for physically directing a radiation exposure as required by the Ionising Radiation Act, 1987 (Protection of Patients Undergoing Medical Examination or Treatment), or if they are acting under the **direct, personal supervision** of such a person. The health professional should **also** have completed the Trust competency training in the administration of intravenous medicines, if the dose is to be given by that route.

7.6 Supply and administration of medicines by Patient Group Directions

- Approved health professionals may supply or administer a medicine which has not been prescribed by a doctor or dentist only when following agreed Patient Group Directions, in accordance with the Trust Policy on Patient Group Directives.
- In the case of PHT these are approved by the Patient Group Directions Steering Group on behalf of the Formulary and Medicines Group.
- Patient Group Directions for use within PCT's are authorized by a doctor who is an expert in the relevant area (e.g. the Clinical Governance lead) and the PCT Pharmaceutical Advisor, in accordance with local procedures.

7.7 Verbal Orders

ADMINISTRATION and CHECKING of MEDICINES

The following actions are permissible, following Trust Clinical Guidelines on Verbal Orders:

- Telephone orders for administration of a "once only" prescription can be accepted by a health professional, only if the prescribing doctor is unable to attend the ward, or in the case of Peripheral Units, where the GP is unable to attend. Verbal orders may also be accepted during a resuscitation/emergency situation. Where changes to the dose are considered necessary, the use of information technology, such as fax or e-mail is the preferred method. A copy of the fax or e-mail should then be filed in the patient's medical record and a new prescription confirming the changes should be written within a maximum of 24 hours after the verbal message. The doctor's name should be recorded on the prescription and the doctor should sign it as soon as possible (NMC, 2002). The prescribing doctor's name and the name/s of the health professional/s taking the verbal message should be recorded in the medical record.
- **The order/message should be confirmed and repeated (read back) by a second registered health professional.**
- The prescription should be recorded in the 'once only' section of the prescription chart.
- This entry should have the date and time written and signed by the registered health professional, stating that this is a verbal prescription.
- Pharmacists are allowed to receive verbal messages and thereby make prescription alterations/additions as agreed in their Enabling Policy.
- **Verbal orders may <u>not</u> be taken for Patient-Controlled Analgesia (PCA) or for Controlled Drugs (schedules 2 or 3).**

7.8	Self-administration by patients or administration by carers

- Self-administration of medicines by patients or administration by carers is permitted only using protocols agreed by the PHT Formulary & Medicines Group. Where these agreements are in place, planned-admission patients should be informed about the self-medication scheme and asked to bring their medicines into hospital with them.
- A registered health professional will assess the ability of a patient to self-medicate, using an assessment form (an example form is available in the Drug Therapy Guidelines booklet). This will determine the level of supervision required.

7.8.1	**Home Care**

- Administration by patients, carers or Trust staff, as part of a home care arrangement, is permissible providing suitable procedures have been followed, which have been agreed by the Formulary & Medicines Group.

7.9 Use of Patient's Own Medicines ("PODs")

These will normally be assessed within 48 hours of admission, by a pharmacist or a pharmacy technician, who has gained the necessary competency. Other staff may assess their suitability by following the agreed guidance from the Formulary & Medicines Group.

A patient's own medicines may be used before being assessed provided the criteria within the Policy on the use of Patient's Own Medicines are met.

Upon discharge, for any POD's where the directions for use need to be changed, this will be achieved by re-labelling the medicine(s) in the pharmacy, or by dispensing them afresh.

7.10 Checking the administration of medicines

7.10.1	**Solo-checking of medicine administration**

- The administration of a medicinal product does not have to be checked by a second person, **unless** it is **any** of the following circumstances, when a **second** health professional should check the administration:

- the medicine is a Controlled Drug.
- The medicine is listed as a "High Risk Drug", requiring extra vigilance.
- the calculation of a drug infusion rate is required.
- the dosage is prescribed by patient weight or by body surface area.
- any other dosage calculation is required.
- the patient is under 12 years old.

Furthermore:

- **If mathematical calculations are required to determine any dosage or administration rate, these calculations should be checked by another health professional.**
- **Two health professionals must check <u>all</u> doses on the neonatal unit.**

ADMINISTRATION and CHECKING of MEDICINES

Whenever two people perform a drug-related calculation, this should be done **independently** of each other, and the results compared.

An exception to this is administration by Community Nurses (e.g. District Nurses and Health Visitors) who administer medicines without a second health professional being present. However, in the case of complex dose calculations, these should be checked with the prescriber.

Health professionals undertaking **solo-checking** of **any** medicine administration should follow a **rigorous process of self-checking** of all aspects of the treatment supplied.

7.10.2	**Nurses or Midwives assuming responsibility for care, which includes the administration of medicines previously checked by other practitioners.**

- This is acceptable practice only for an 'in-situ' ***established*** intravenous, subcutaneous or other infusion (continuous or intermittent), where a valid prescription exists. The container of fluid and any additive should have been signed for by a registered health professional. The label should clearly state the contents and be signed, dated, and bear an expiry date.

7.10.3	**Chemotherapy**

- Trust guidelines on the checking of chemotherapy should be followed (Policy for the safe handling of cytotoxic agents).

Policy Number CL16

Section 8

DISPOSAL OF UNWANTED AND EXPIRED MEDICINES

The Trust's waste handling policy should be followed
http://pompi/governance/Policies/Management/14.1..doc

8.1 General pharmaceutical waste

- This should be returned to the pharmacy department for disposal in accordance with the Trust Waste Handling Policy. This includes unwanted patients' own medicines ("POD's").
- Unwanted medicines should be returned to the pharmacy department. Small quantities (upto 20 units in total) of medicines (part-used ampoules or loose tablets) can be disposed of in a sharps bin prior to disposal in accordance with the Trust waste handling policy. It is not permitted to dispose of medicines in sinks or ablutions.
- Empty/used pharmaceutical containers should be disposed of in accordance with Trust guidelines, with due regard to the material from which they are made, e.g. glass, plastics, etc, whether or not there is a "sharps" hazard or blood-borne disease hazard.
- Community healthcare staff should encourage patients/carers to return unwanted medicines to their local pharmacy for disposal.

8.2 Cytotoxic and radiopharmaceutical waste

These must be handled according to the Trust waste handling policy.

8.3 Controlled Drugs

- All date-expired Controlled Drugs must be returned to the pharmacy department. These must be removed from the ward/department register and the balance reconciled by a pharmacist. This transaction should be witnessed by another health professional. Within the pharmacy, the medicines will be entered into the destruction register and ultimately undergo witnessed destruction.
- Unwanted patients' own medicines ("POD's") that are Controlled Drugs must be sent to the pharmacy. These will be signed out of the ward register. In the pharmacy, these medicines are entered the CD register.
- Ultimately, the drugs will undergo witnessed destruction.

DISPOSAL OF UNWANTED AND EXPIRED MEDICINES

8.3.1	**Controlled Drugs In Operating Theatres**

- Individual doses of Controlled Drugs, which are prepared but not administered, must be destroyed in the department by a doctor in the presence of a second person, who may be a registered nurse, pharmacist or doctor.
- The anaesthetist is personally responsible for properly disposing of any unused drug in an open ampoule, a syringe, or diluted in an infusion bag.
- It is the responsibility of the anaesthetist to return any unopened ampoules to the nurse in charge.
- In all cases, an entry must be made in the theatre Controlled Drug register, including the names of those involved in the return or destruction.

8.3.2	**Disposal by Community Nurses in domiciliary settings/care homes**

In the community, Controlled Drugs are the property of the patient. However, where a Community Nurse has been directly involved in their administration, as in the case of syringe drivers, s/he should arrange for the destruction and disposal of the Controlled Drug(s) when they are no longer required. This disposal should be carried out as soon as possible, and recorded as per local policy.

PERSONNEL, EDUCATION and TRAINING

9.1 Administration of intravenous therapy

The administration of intravenous medicines, infusions, transfusions and their maintenance should be undertaken only by health professionals who have undergone specific training in this skill and have demonstrated their competence to do so. http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.12.doc

- Medical and dental practitioners cover this requirement during their undergraduate training.
- Nursing and other health professionals are required to complete the Trust intravenous competency training.

9.2 Administration of medicines (*except* by the intravenous and epidural routes)

All health professionals who administer medicines to patients are required to maintain their competencies. Healthcare support workers who administer medicines should do so only after receiving competency training.

- Medical and Dental practitioners cover this requirement during their undergraduate training.
- The administration of chemotherapy by the intrathecal route can be undertaken only by medical practitioners who have undergone the Trust training, and are certified as competent.
- Operating Department Practitioners cover this requirement during their primary training.

9.3 Administration of epidural therapy or epidural top-ups

All health professionals who administer epidural analgesia in post-operative situations or epidural top-ups are required to complete the prescribed Trust-agreed competency training. Only anaesthetists are permitted to *initiate* epidural therapy. http://pompi/Governance/Policies/Clinical%20and%20Nursing/Section%203.26%20Epidural%20guideline%20.doc

9.4 Continuing Professional Development

PERSONNEL, EDUCATION and TRAINING

All healthcare staff involved with medicines should undertake continuing professional development, which is aligned to clinical governance requirements and professional guidance. This is to ensure that their knowledge is up to date.

10.0 General

Portsmouth Hospitals NHS Trust, East Hampshire, Fareham & Gosport and Portsmouth City PCT's:

- examine the systems and circumstances surrounding adverse medication incidents.
- promote a learning environment through the development of an open and honest culture.
- expect health care professionals to be accountable and responsible for their actions.
- expect health care professionals to work within the guidelines of their professional bodies and to adhere to local policies and procedures, thereby promoting safe practice.

10.1 Avoidance of adverse incidents

An adverse incident is any event, error or omission, which could have led or did lead to unintended or unexpected harm, loss or damage. If harm, loss or damage did occur, it is an adverse event. If not, it is a near miss.

It is the responsibility of each registered health professional to ensure that his/her practice is safe, by adhering to agreed policies/guidelines. Note particularly section 7 of this policy (administration).

If the health professional is in any doubt as to the clinical appropriateness of any prescription with due regard to the patient's condition, advice should be sought from an appropriately experienced medical practitioner without delay.

10.2 Adverse medication incidents

As soon as it is realised that an adverse incident involving medicines has occurred, the following action should be taken:

a) Check the patient for any adverse reaction and immediately take any necessary action in response to any observed symptoms. Explain to the patient what has occurred, and reassure them. Continue to monitor the patient's condition.

b) Immediately inform the Medical Practitioner/Consultant in charge of the patient at that time, and take the correct clinical counter-measures, under medical guidance.

c) Immediately inform the ward/department manager and, in PHT, the modern matron (daytime) or the clinical site manager (at night), who will use professional judgement as to further action required.

d) Document the incident in the patient's records and inform others involved in that patient's care, including handover to the next shift of ward staff.

e) Complete fully an adverse incident form, following http://pompi/governance/Policies/Management/15.3.%20Adverse%20Incident%20Policy.doc Guidance given on the form regarding informing the Risk Management Department should be followed.

PCTs: East Hampshire, Fareham & Gosport, and Portsmouth City PCTs operate a risk event reporting scheme, common to them, which should be followed by staff employed by these organizations. In addition, it is important to consider whether it is necessary to notify other organizations which may be involved.

10.3 Adverse Drug Reaction (ADR) Reporting

An ADR is the occurrence of an unexpected significant adverse reaction or side effect to a medicine.

Within Portsmouth Hospitals, reports are filed via the Medicines Information Service, where they are logged and processed.

Within PCT's and Peripheral Units, a Committee on the Safety of Medicines 'yellow card' should be completed for adverse drug reactions for:

- new drugs: Report all suspected reactions to new drugs, even if minor (New drugs are designated by an inverted black triangle in the BNF).
- established drugs: Report any **serious** event, even if it is well known.

Yellow cards can be found inside every BNF book.

Yellow cards can be submitted by a doctor, pharmacist or nurse. However, pharmacists and nurses should discuss the case with the doctor before doing so.

10.4 Defective Product Reporting

RHH currently has a separate reporting procedure via RHH pharmacy.

10.4.1	**Reports originating within the Trusts**

If a defective (or suspected defective) product has (or is likely to have) affected a patient or member of staff, it should be reported to the person in charge of the ward or department, and an Incident Report completed.

All defective or suspect products should be retained and reported to the relevant parties below:

Medicinal products

Note the batch number and expiry date of the medicine and retain it, if possible. Contact the pharmacy department and report it to the ward pharmacist or dispensary manager. If outside of normal working hours, professional judgement should be used as to whether the Defective Product Procedure needs to be invoked immediately, via the on-call pharmacist. Otherwise, contact pharmacy the next working day.

Clinical disposables/medical devices (e.g. needles, syringes)

Report to NHS Supplies and the Supplies Department Liaison Officer as soon as possible. Where possible, within a safe system of work, retain the disposable and any other device attached to it. If a defective medicinal product is also involved, retain it and notify pharmacy. In cases where the Risk Management Department is involved, they will make the decision whether to inform the MHRA.

Infusion pumps

Notify the Equipment Library (or Medical Electronics) as soon as possible. Do not use the defective device. Make a note of its serial number or batch number, and the exact circumstances of the problem. **Mark the device as not suitable for use**. Retain and secure it, if safe to do so, and obtain a replacement.

10.4.2	**Reports originating nationally (usually via the MHRA)**

Medicinal products

It is the responsibility of the Pharmacy Services Manager to inform users of any defective medicinal product, product recall or other drug alert, in accordance with pharmacy procedures. Users should follow the guidance and instructions given out by the pharmacy alerting system. This will include an indication of the degree of urgency.

Infusion devices and disposables

It is the responsibility of the Health and Safety Advisor to inform users of any defective medicinal product or one subject to a product recall, in accordance with local procedures. Users should follow the guidance/instructions given.

10.5 Control of Substances Hazardous to Health Regulations (COSHH).

- The ward or departmental manager is responsible for implementing COSHH regulations in their area.

- COSHH assessments will be made on a regular basis according to the policy of each Trust. For PHT, see: http://pompi/OHsafety/safety%20policy%201.12cosh.pdf and http://pompi/Pharmacy/Publications/Policies/CSDCOSHHM01.pdf

10.6 Drug Abuse Vigilance

All staff should be aware of the potential for and possibility of drug abuse in any of their colleagues. They should look out for signs and patterns of unusual behaviour which may point to possible drug abuse. These include actual physical symptoms, or changes in a person's mood or personality, unusual tiredness or irritability, suspicious absences from their usual working area, or suspicious patterns of absence from work.

They should also be alert for clues which could indicate the possibility of theft of drugs, for example changes in ordering-patterns or in usage of certain medicines.

In such cases, staff should not be afraid to approach a trusted colleague (preferably their line manager) and discuss the matter in confidence.

Policy Number CL16

Section 11

CLINICAL TRIALS

Any proposed clinical trials involving medicinal products, medical devices or dressings should be submitted to the Isle of Wight, Portsmouth and SE Hampshire Local Research and Ethics Committee and the Academic Research and Development Support Unit (ARDSU). An important part of the approval process is to ensure that procedures are in place within each trial to obtain full consent of all patients taking part.

Once approval for a conducting a clinical trial has been granted, the Pharmacy Department should be informed in writing. This should occur **well in advance** of commencing the trial, to allow sufficient time for supplies to be acquired, and for administrative arrangements to be made.

- The clinical trials pharmacists will **check** that the necessary exemption and/or certificate is in place **before** a trial starts.
- All in-house trials should have the trial protocol agreed by the directorate pharmacist or clinical trials pharmacist for that clinical area.
- Copies of the protocols for all trials should be held on the wards/departments where the patients are seen, and in the pharmacy department.
- All trial materials should be stored in the pharmacy department, unless a separate agreement has been made with the relevant Dispensary Manager.
- All clinical trials using medicines without a full UK Product Licence covering the patient groups/indication(s) being treated will be conducted in accordance with current MHRA guidance on clinical trials.

Policy Number CL16

Section 12

RESPONSIBILITIES OF PROFESSIONAL INDIVIDUALS

12.1 Nurses

Professional

Each registered nurse is accountable for her/his own conduct and practice in accordance with the NMC Code of Professional Conduct, http://www.nmc-uk.org/cms/content/publications/codeofprofessionalconduct.pdf and in exercising professional accountability will:

- always act in a manner as to promote and safeguard the interests and well being of patients and clients.
- ensure that no action or omission on their part, or within their sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients.
- maintain, update and improve their professional knowledge and competence.
- acknowledge any limitations in their knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe manner.
- report to a senior person or authority any circumstance in which safe and acceptable care for patients and clients cannot be provided.
- avoid any improper delegation to others, which compromises the interests, wellbeing or safety of patients and clients.

Managerial

Ward or departmental managers are responsible for ensuring that their staff meet required competencies for the administration of medicines. It is every manager's responsibility to ensure that all their staff are informed as to which members of the team are competent to accept delegation of duties.

First level nurses will have established basic competencies in pre-registration education and competency will be maintained. If evidence cannot be provided, then further training should be undertaken.

Section 12

RESPONSIBILITIES OF PROFESSIONAL INDIVIDUALS

12.1.1	NHSP Nurses

"NHS Professionals" nurses should adhere to the required standards for the administration of medicines. They should acknowledge any limitations in their knowledge and competencies, and decline any duties or tasks, unless able to perform them in a safe and skilled manner.

In wards or departments where NHSP nurses are deployed, the senior nurse on duty should ensure that NHSP staff receive adequate orientation in relation to local practices regarding the administration of medicines.

12.1.2	**Student Nurses (other than Student Midwives)**

Administration of medicines by students undertaking pre-registration training.

a) During the first academic year and summer period of any programme the student may observe the administration of medicines and **assist** in the administration of oral and topical medicines including eye and ear drops and inhaled medicines **under the direct supervision** of a qualified nurse, midwife or medical practitioner.

b) After the "Administration of medicines skills" teaching session in Nursing Unit 9 (3 & 4 year programme) or Nursing Unit E (2 year programme) or Medical and Surgical modules (B.Mid.(Hons) programme), which occur at the beginning of the second academic year, the student will have been prepared to **participate** in the administration of medicines.

c) Students may, subject to the discretion of the supervising practitioner, participate in the administration of medicines by any route ***EXCEPT*** via any peripheral, central, epidural or intravenous line or by any other route that requires a clinician to undertake further education and training. The student **may not** therefore participate in the **initiation** or **alteration** of administration by the above routes which involves infusion, mechanical pumps or a patient controlled device. ***As an exception,*** frequently administered maintenance intravenous fluids without additives, and not requiring any ward preparation, may be administered and/or checked by a student **but only under the direct supervision of a qualified nurse, midwife or medical practitioner.**

d) Registered Nurses undertaking programmes leading to a new registration retain their personal professional accountability, but in the learning context will, at times

need to acknowledge limitations in their knowledge (NMC Code of Professional Conduct,2002http://www.nmc-uk.org/cms/content/publications/codeofprofessionalconduct.pdf). Where they do not have a sufficient level of knowledge they should participate in the administration of those medicines, **only under the DIRECT SUPERVISION of a qualified nurse, midwife or medical practitioner.**

e) During each placement, a Clinical Assessor should assess the student as to their competence to administer the different medicines. Competency should be recorded on the Assessment of Practice document.

If further clarification is needed on students and the administration of medicines, please contact the link teacher for your clinical area.

12.2 Midwives And Midwifery Practice

Midwives should adhere to the Nursing and Midwifery Council's Midwives' Rules and Codes of Practice http://www.nmc-uk.org/cms/content/publications/midwives.pdf

Standing Orders

Midwives working within the Maternity Unit may give, without prior prescription, medicines listed on the 'Standing Order' form, which has been signed by each consultant Obstetrician and Supervisor of Midwives.

Epidural Top-Up

Competent midwives who have received the **requisite instruction on this procedure** may perform an epidural top-up. However,

- the strength of a medicine, its dose and frequency of administration should first be prescribed on the patient's Epidural Form, by the anaesthetist.
- These details should be checked by the midwife who is to perform the epidural top-up, and by one other person, either a registered midwife or a first level registered nurse.

Inhalation of analgesia

Midwives who have received instruction and have had their competence checked and recorded, may prescribe and direct the use of a nitrous oxide and oxygen mixture (Entonox) via the Entonox apparatus.

Community Midwives

Section 12

RESPONSIBILITIES OF PROFESSIONAL INDIVIDUALS

Midwives working within the GP Maternity Unit and in the Community may be in possession of a stock of medicines for use in accordance with the Operational Policy of the local Maternity Liaison Committee, or 'Standing Orders' if the client is under the care of a Hospital Consultant.

These may include:-

- local anaesthetics
- aperients
- analgesics
- a preparation of ergot alkaloids for intramuscular injection
- approved agents for neonatal and maternal resuscitation
- a preparation of Vitamin K

Community Midwives obtain their allocation of medicines from special stock in maternity units or community hospitals (e.g. Petersfield / Gosport). Stocks held in the GP Unit at St Mary's Hospital are issued and recorded by the midwife in charge.

Each Community Midwife is supplied on request with a drug box from the Pharmacy Department. The Pharmacy Department will also keep a record of the names of midwives who hold a drug box and drug box number, and for exchanging the box if used or has date-expired.

Pethidine at Home

Procedures for obtaining pethidine for home confinement from GP Units:

a) Pethidine administered to a patient must be recorded in the Community Midwife Personal Register / Controlled Drugs Book in the community unit.

b) A Community Midwife who practises from a community unit may obtain a total of pethidine 200mgs (in 2 x 100 mg ampoules) from a supply especially set aside at community units.

c) The pethidine must be signed out by two midwives (Community Midwife and Community Unit Midwife). If the pethidine is not used, it is returned to stock at the maternity unit and re-entered in the register.

d) An Inspector of the Home Office Drugs Branch may inspect the drugs and register of a Community Midwife at any time, as may the Supervisor of Midwives.

e) Should a Community Midwife experience difficulty with carrying out the above procedure, she should contact her Maternity Manager or Supervisor of Midwives.

Supply of Pethidine

A list of signatures of each Community Midwife is kept on the Controlled Drugs Book at each GP Unit, and countersigned by the Supervisor of Midwives once a year.

12.2.1	Student Midwives

Under the **DIRECT SUPERVISION** of a qualified midwife, Registered Nurse or qualified doctor, student midwives are allowed to:

- assist with cannulation and commence IV infusions
- check intravenous fluids (including blood)
- check prescribed additives, working with registered health professionals.
- change infusion rates in adherence with prescriptions or clearly agreed and defined protocols.
- discontinue IV infusions/decannulate.

Student midwives **MAY NOT**:

- give medicines via the epidural route.
- administer bolus intravenous drugs.

12.3	**Operating Department Practitioners**

- Operating Department Practitioners (ODPs) should follow agreed Trust policies in dealing with medicines.
- ODPs will be registered with the Association of Operating Department Practitioners.

RESPONSIBILITIES OF PROFESSIONAL INDIVIDUALS

12.3.1	Controlled Drugs

- **ODPs registered as above may administer to a patient, in accordance with the directions of a doctor, any Controlled Drug specified in schedule 2, 3 or 4 of the Misuse of Drugs Regulations 1985.**
- ODPs are authorised to convey a Controlled Drug to a doctor, registered nurse or to a patient for whom the drug has been prescribed.

12.4	**Clinical Support Staff**

- A HCSW /Nursery Nurse or Dental Nurse who has undertaken suitable training and has had their competency assessed and recorded, may take part in the administration of medicines, with proper delegation being the responsibility of the registered nurse or midwife. Whilst their competency is being assessed, candidates should be under the supervision of the registered nurse or midwife. Once assessed as competent the HCSW may check Controlled Drugs with a registered health professional.

12.5	**Doctors**

- Each doctor is responsible for prescribing correctly in accordance with this policy.
- Prescribing should follow the Portsmouth District Prescribing Formulary http://nww.ports.nhs.uk/drugform/default.asp
- When a doctor is not confident of his/her own competence to prescribe a particular medicinal product, s/he should not prescribe until s/he has sufficient working knowledge of it.
- Prescribers should adhere to Area Prescribing Committee policies.
- New medicines or service developments involving the use of medicinal products, and other changes to the District Formulary, should be managed through the Formulary & Medicines Group, using the Managed Introduction of New Medicines guidelines.

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12.6 Dentists

- Oral and maxillofacial consultants and registrars are on the GMC Register, and therefore they practice as would any other doctor (rather than as a dentist).
- Junior dental staff who are only dentally qualified, whilst working in the hospital setting, can prescribe from the Dental Practitioners' Formulary of the current BNFhttp://www.bnf.org/
- When a dentist is not confident of his/her own competence to prescribe a particular medicinal product, s/he must not prescribe it until s/he has sufficient working knowledge.

12.7 Pharmacists

Pharmacists are responsible for:

- ensuring the safe, clinically appropriate and cost effective use of pharmaceutical products through involvement at all stages of medicines usage and management (including prescribing).
- providing up-to-date information and guidance to other health professionals on all pharmaceutical aspects of drug therapy, pharmaceutical care and medicines management
- conformance to legal requirements
- advising on the individualisation of patient therapy
- advising on patient -monitoring of drug effects and side effects.
- educating and counselling patients, carers and hospital staff on the safe and correct use of medicinal products.
- acting within the current Pharmacists' Enabling Protocol.
- advising on drug-drug and drug-fluid interactions and compatibilities in parenterals.
- advising on policy and procedure writing, including the requirements for Patient Group Directions.
- advising on medicines audits.
- advising on the pharmaceutical requirements of clinical trials.

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RESPONSIBILITIES OF PROFESSIONAL INDIVIDUALS

Administer	To give to a patient a medicinal product, dressing or medical device, either by introduction into the body, either orally or by injection, etc., or by external application (e.g. application of an ointment or dressing).
BAN	British Approved Name (of a drug). This is currently the recommended International Non-proprietary Name, except for adrenaline and noradrenaline. (In the EC States, the rINN for these two drugs was not adopted).
BNF	The British National Formulary (latest edition).
Bioavailability	The rate and extent to which a medicine releases its active ingredient(s) within the body, to become pharmacologically available at the site(s) of action.
CIVAS	Centralised Intravenous Additives Service
Clinician	A health care professional who is engaged in the direct examination, diagnosis, treatment and care of patients.
Clinical support worker	A clinical support worker is statutorily registered. They may be registered within the Trust. For the purposes of this policy these include: Health Care Support Workers — Operating Department Practitioners Operating Department Assistants — Pharmacy Technicians Nursery Nurses — Dental Nurses
Controlled Drugs (CD's).	Narcotic drugs or medicines liable to misuse, that are subject to special controls under the Misuse of Drugs Act, 1971.
Controlled Stationery	Any stationery, which in the wrong hands, could be misused to obtain medicines fraudulently.
COSHH	Control Of Substances Hazardous to Health
Dispense	To prepare and/or give out a clinically appropriate medicinal product to a patient for self-administration or for administration by another, usually a healthcare professional. Dispensing must be in response to a legally valid prescription. The act of dispensing should be accompanied with the provision of advice to the patient on safe and effective use of these products.
GMC	General Medical Council
HCSW	Healthcare support worker (ward or clinical department staff who are not required to be registered with a professional body).
HR	

GLOSSARY and DEFINITIONS

	Human Resources Department (formerly, "Personnel").
Health (care) professional	A statutorily registered practitioner in an occupation which requires specialist education and training in practical skills in health care. The professions concerned are self-regulating and practitioners are expected to satisfy their profession's accepted standards of practice and conduct. For the purposes of this policy, these practitioners are accepted to include: Registered nurses or midwives at grade D or above (or the equivalent) Doctors (medical practitioners) Dentists Pharmacists Radiographers Podiatrists Voluntarily registered Operating Department Practitioners are included in this category for some aspects of medicine control and administration – see individual policy sections and section 12.4.
MDC	Medical Distribution Centre (RHH)
Medication error	Any preventable event that may cause or lead to inappropriate medication use and/or patient harm while the medication is in the control of the health care professional, patient or carer.
Medicinal product	Any substance or combination of substances presented for treating or preventing disease in human beings. Any substance or combination of substances which may be administered to human beings with the view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings is likewise considered to be a medicinal product.
MHRA	Medicines and Healthcare products Regulatory Agency (Department of Health).
MSA	Medical Supplies Agency (Ministry of Defence).
NA	Nursing auxiliary (see HCSW).
NAHAT	National Association of Health Authorities and Trusts
NMC	Nursing and Midwifery Council (UK). (formerly UKCC)
NHS	National Health Service (UK)
NHSP	NHS Professionals. This is the public sector locum agency for NHS professional staffs. Each individual practitioner's professional credentials are vetted by NHSP before admission to the scheme. It is the only such agency that NHS organizations are allowed to use.
Patient Group Directions (PGD)	A specific written instruction for the supply or administration of medicines to clinical groups of patients who may not be individually identified before presentation for treatment.
PCT	Primary Care Trust.

GLOSSARY and DEFINITIONS

PHT	Portsmouth Hospitals NHS Trust
POD's	Patients' Own Medicines (or "Drugs") This term is used in the context of medicines that are a patient's own property, brought into NHS premises for treatment of that patient.
POM	Prescription only Medicine (Medicines Act, 1968).
Prescribe	To order in writing (or electronically) the supply of a medicinal product (within the meaning of the Medicines Act, 1968, this means a POM) for a named patient (see "Prescription").
Prescriber	A health professional who is legally authorised to prescribe a medicinal product
Prescription	An order for the dispensing of a medicinal product. The order is presented to a professional who is legally authorised to dispense. The order must be either: a) in writing in a legally prescribed format and signed by the person qualified by law to prescribe or b) made, using a Trust-agreed electronic prescribing system, by the person qualified in law to prescribe medicinal substances, and who has been provided with a secure, individual computer access password.
QAH	The Queen Alexandra Hospital, Cosham, Portsmouth
RHH	The Royal Hospital Haslar, Gosport.
Self-administration	The process of patients administering their own medicines.
SMH	St. Mary's Hospital, Portsmouth
Supply	To lawfully provide a medicinal product directly to a patient or to a carer for administration to patient/s.
Treatment	The management and care of a patient to prevent or cure disease or to ameliorate suffering and disability. A substance or procedure for doing so.
TTO's	Medicines for a patient To Take Out (usually, discharge medicines)

These definitions have been adopted or taken from

- The Medicines Act, 1968
- Guidelines for the safe and secure handling of medicines (the "Duthie Report"), Sept 1988
- Review of prescribing, supply and administration of medicines: Final report, March 1999.
- Medicines, Ethics and Practice. A guide to pharmacists. Royal Pharmaceutical Society of Great Britain, July 2003.

AFFILIATED DOCUMENTS

This policy is to be used in conjunction with:

- NMC Code of Professional Conduct.
  http://www.nmc-uk.org/cms/content/publications/codeofprofessionalconduct.pdf
- NMC Standards for the Administration of Medicines
  http://www.nmc-uk.org/cms/content/publications/guidelinesformedicines.pdf
- NMC Midwives Rules and Codes of Practice.
  http://www.nmc-uk.org/cms/content/publications/midwives.pdf
- The employment of operating department practitioners (ODPs) in the NHS. NHS Executive 2000.
- Code of ethics and professional standards. Royal Pharmaceutical Society of Great Britain (latest edition).
- Review of prescribing, supply & administration of medicines 'Crown report'.
  - 1. A report on the supply and administration of medicines under group protocols. 1998
  - 2. Final report. 1999
- Guidelines for the safe and secure handling of medicines 1988 'Duthie report'.
- HC (76) 9. Report of the working party on the additions of drugs to intravenous fluids.
- Medicines in Schools (1995). Hampshire County Council.
- Supporting pupils with medical needs (1996), Department of Health.
- Health and Safety at Work. Policy on administration of medicines in schools. Portsmouth City Council.
- NHS Controls Assurance Standard. Medicines Management (Safe and secure handling) Revision 01b (Feb 2000).
- Joint Trust Guideline: The Production of Patient Group Directions.
- Joint Trust Guideline: Medication History Taking.
- Joint Trust Policy: Pharmacists Enabling Protocol.
- Joint Trust Guideline: Procedure for dispensing TTO pre-packs

Section 14

AFFILIATED DOCUMENTS

- Joint Trust Guideline: Peripheral Intravascular (Intravenous) cannulation. http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.12.doc
- Joint Trust Guideline: Policy for the safe handling of cytotoxic agents.
- Trust Intrathecal Chemotherapy Policy http://pompi/Governance/Policies/Clinical%20and%20Nursing/Section%203.17%20Intrathecal.%20Issue%203.%20Feb%202003.doc
- Joint Trust Guideline: Infusion Devices Protocol.
- Portsmouth Hospitals NHS Trust Policy: Consent http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.8%20without%20appendix%20E%20Oct%2003.doc
- Area Prescribing Committee Policy: The managed introduction of new drugs.
- Area Prescribing Committee Guidance: The development and content of shared care guidelines.
- Portsmouth Hospitals NHS Trust Policy on Waste Disposal. http://pompi/governance/Policies/Management/14.1..doc
- PHT Pharmacy Emergency Facilities Policy http://pompi/governance/Policies/Management/5.1.Issue%206.%20Sept%2003.doc
- PHT Discharge Planning Policy http://pompi/Governance/Policies/Clinical%20and%20Nursing/Section%207.%20Discharge%20Planning1.doc
- PHT Drug Therapy Guideline Policy http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.23.doc
- PHT Epidural Infusion (Continuous) Management Policy http://pompi/Governance/Policies/Clinical%20and%20Nursing/Section%203.26%20Epidural%20guideline%20.doc
- PHT Potassium-Containing Concentrated Solutions for Intravenous Administration Policy http://pompi/Governance/Policies/Clinical%20and%20Nursing/3.22.doc

POLICY REVIEW GROUP

The Medicines Policy Working Group currently consists of:

Jeff Watling	Pharmacy Services Manager, PHT
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Lesley Shayler	Pharmacy Operations Manager, QAH
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Barbara Hamilton	Deputy Director of Nursing, PHT
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