## 6. PROCESS

**This is a summary of the processes described in the appended body of the Policy, together with the numbers of the relevant sections thereof:**

**6.1 Prescribing:** All prescribing of medicines throughout the Trust will comply with agreed, consistent, safe, legal and professional standards given in **Appendix, sections 2 and 12.**

**6.2 Authorised Stationery:** Only official stationery will be used for the ordering, supply and prescribing of medicines, and for recording their administration. Issue, storage and use of such stationery will comply with the protocol given in **Appendix, section 3**

**6.3 Procurement, Storage and Stock Control of Medicines:** The procurement, distribution, storage, security and accountability medicines (and quantities held by wards/depts) will comply with the protocol given in **Appendix, sections 4 and 6**

**6.4 Dispensing of Medicines:** All pharmaceutical dispensing will be carried out in the Trust pharmacies, under the supervision of a registered pharmacist. Prescription charges will be collected in accordance with NHS legislation. **See Appendix, section 5.**

**6.5 Administration and Checking of Medicines:** Medicines will be administered to patients only by healthcare professionals who are suitably qualified, trained and experienced (see **Appendix, section 12**). All such administration will be performed and recorded in accordance with **Appendix, section 7**

**6.6 Disposal of Unwanted and Expired Medicines:** Pharmaceutical waste (including empty primary packaging) will be disposed of in accordance with Trust policy, as described in **Appendix, section 8.**

**6.7 Personnel, Education and Training:** education and training of all those who prescribe, handle, supply or administer medicines (including NHS Professionals staff) will follow the guidance given in **Appendix, section 9.** For professional groups, this includes Continuing Professional Development. Guidance on the responsibilities of professional healthcare groups is given in **Appendix, section 12.**

**6.8 Risk Management:** The reporting of adverse incidents concerning medicines, adverse drug reactions, reporting of defective pharmaceuticals (and acting on receipt of such reports emanating from outside the Trust) will be in accordance with the protocol given in **Appendix, section 10**

**6.9 Clinical Trials:** Any proposed clinical trials involving medicinal products or medical devices will be first submitted to the Local Research Ethics Committee for approval. The process of conducting the trial will be in accordance with the protocol given in **Appendix, section 11**

## DUTIES AND RESPONSIBILITIES

See above, including appendix references.
Please note that throughout the appendix, the imperative "must" is used to imply legal requirements, whilst "should" is used to imply agreed practice

Ward/Clinical Department Managers

**Ward/Clinical Department Managers are responsible for ensuring adequate dissemination and implementation of policies.**

All ward staff
All ward staff must comply with their responsibilities when undertaking their duties involving medicines.

Pharmacy Staff
All pharmacy staff will carry out their duties in accordance with the relevant law(s) and current departmental Work Instructions.

**TRAINING**

All Ward and Clinical Department Managers will need to be aware of the contents of this policy and ensure that their staff are aware of and understand the procedures, roles and responsibilities given. Support and advice will be available from the Pharmacy Department to anyone requiring assistance. See 6.7 above

**AUDIT**

The pharmacy service carry out an annual process on medicines management audits to ensure compliance with the elements of this policy. The audit report is reported annually to the Medication Safety Committee.

**ASSOCIATED DOCUMENTATION**

See **Appendix 1, section 14**

**APPENDICES**

Appendix 1: Policy document
Annex 1: Medicines Administered at the Discretion of Nurses

Portsmouth Hospitals NHS

NHS Trust

**(Ministry of Defence Hospital Unit)**

**The Royal Hospital, Haslar**

**Portsmouth City Primary Care Trust**
**Hampshire Primary Care Trust (South East)**

# MEDICINES POLICY

# Contents

# 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: Hampshire PCT (South East) and 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.

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

Storage and security requirements may be increased locally at the discretion and direction of the Nursing Management.

There is a separate policy describing the specific requirements and procedures for the management of **Controlled Drugs.**

There are separate policies describing the specific requirements and procedures for the management of **cytotoxic and intrathecal chemotherapy.**

There is a separate policy for dealing with suspected or known possession or use of **illegal substances** on Trust premises.

There are separate policies and clinical guidelines describing the specific requirements and procedures for **intravenous therapy.**

**See also section 14 Affiliated Documents for other important medicines-related supporting resources.**

# 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
Pharmacy Technicians
Operating Department Practitioners
Radiographers
Podiatrists
Dietitians

CLINICAL SUPPORT STAFF include the following:

Dental Nurses
Dialysis Assistants
Health Care Support Workers
Nursery Nurses
Pharmacy Assistant Technical Officers
Medical or Clinical 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 (BNF) http://www.bnf.org/ as the first-line source of information for adults and BNF-C or 'Medicines for Children' for children.

## 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.

Within Portsmouth Hospitals NHS Trust, responsibility 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-group, the Patient Group Directions Steering Group), on behalf of the Professional Advisory Committee and the Trust Board. See PHT Production of drug Therapy Guidelines Policy.

In the case of PCTs, this is via the relevant Medicines Management Committee(s), Pharmaceutical Advisors, and with the support of the District Medication Safety Committee.

Responsibilities 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.

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.

# 2. PRESCRIBING

## 2.1 Scope

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. Wherever possible, prescribers should have access to a pharmacist capable of giving advice about a patient's treatment plan. Ideally, this will include the pharmacist's involvement in reviewing the patient's medication on admission, during their stay in hospital and on discharge.

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 Protocol. Alterations made under this policy should be treated as equivalent in authority to the original prescription.
- Suitably trained and qualified and registered non-medical prescribers working within primary or secondary care are legally allowed to prescribe as Independent Prescribers or as Supplementary Prescribers, 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 for Community Practitioners (see Non-medical Prescribing Policy).
- The supply and/or administration of prescription only medicines under Patient Group Directions is dealt with in section 7.5.

## 2.2 Responsibilities

Prescribers should be trained and assessed as competent before being required to prescribe, and have access to the current British National Formulary. Those involved in prescribing for children should have access to an approved up-to-date paediatric formulary,(BNF-C??) and their competence in using it assessed.

The prescriber is responsible for:

- Prescribing for a patient within the context of his or her treatment plan, with due regard to responses to any previous therapies, as recorded in the Multi-disciplinary Health Record.
- Taking or having read an accurate, up-to-date medication history of the patient, before writing a prescription.

- Checking for and recording patient allergies and sensitivities (named drugs / latex / others), in the medical notes and on the Prescription Record Chart, before writing a prescription. 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 National prescribing standards should be followed whenever possible.
- 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. See also Blood and Blood Products Policy
- Providing a legal, legible, signed prescription giving all the detail necessary to enable the medicine to be supplied and administered safely, correctly and lawfully.
- Ensuring the accuracy of dosage calculations, particularly where they are for children's medicines and/or where they are complex. The calculations themselves should be documented for children's medicines. If the calculation involves calculating the dose from the patient's weight or body surface area, the intended dose in mg per kg (or per sq. metre) or microgram per kg (or per sq. metre) should be stated.
- Discussing with the patient or his/her representative, where possible, the aims and the side-effects of drug treatment

### 2.2.1 Non-medical Prescribers

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

- Notify the trust of their prescriber status
- Agree their role and scope of duties with their line manager and the Clinical Director of the Directorate in which they work
- Prescribe in accordance with the District Prescribing Formulary
- Prescribe only within their professional capabilities

For further detail refer to current Non-Medical Prescribing Policy

### 2.2.2 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/ interface through EL(91)127 –"Responsibility for prescribing between hospitals and GPs". 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". Where a shared care agreement is not already in place, individual proposals for shared care should be discussed, in the first instance, with the patient's General Practitioner and, if necessary, the appropriate PCT prescribing advisor or prescribing committee. The legal responsibility for prescribing lies with the doctor who signs the prescription.

In particular, communications with GPs, patients, carers and community pharmacists about discharge medication should be timely and comprehensive.

## 2.3 Prescription Writing Requirements

**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.**

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 outpatients, their address.**

b) **Patient's Hospital / Case note / or NHS Number**

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

d) **The patient's weight in kg**

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 or brand 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 ciclosporin, lithium and theophylline, and certain modified release products, because the various brands differ in bioavailability (refer to BNF).

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
PV = Vaginal
NG = Via Naso-gastric tube
SL = Sub-lingual

**NB:** ***Intra-thecal*** must always be written in full – See PHT Intrathecal Policy

For inhaled medicines the administration device should also be stated, e.g. Turbohaler, Aerochamber / spacer, Accuhaler 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 never be used)**

**Use of the phrase "as directed" is not acceptable. Explicit dosage instructions, including route of administration, should be stated.**

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

Outpatients & Day Hospitals – usually provide a minimum 14 days and maximum of 28 days (or sufficient to complete a course of treatment).

Longer duration supplies are given by some specialist clinics where treatment monitoring and clinical responsibility are ongoing or when hospital only medicines are used. See also Policy for Unlicensed Medicines.

Take Out Prescriptions : 20 to 28 days (depending on patient's own supply) or sufficient to complete a course of treatment. Except Adult Mental Health and Elderly Mental Health patients who are provided with 14 days supply.

Where a suitable pack size exists, a manufacturer's original pack will be dispensed.

Inpatients – quantity will vary as per individual treatment / ward / patient needs. In many instances 28 day original packs will dispensed labelled ready for discharge.

j) **Signature of the prescriber.** This should be recognisable and the prescriber identifiable. Wherever possible, the prescriber's bleep or contact number should be provided to facilitate any clarification necessary.

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

## 2.4 Inpatient Prescriptions - Additional requirements

### 2.4.1 General

a) **Ward.**

b) **Consultant's name.**

c) **Drug allergies / sensitivities** section must be completed. State the agent, nature and severity of any reaction or write "not known" or "history unobtainable" if these are the case. If history unobtainable on admission this should be obtained as soon as possible.

d) **Times of administration** for **regular** and **once only** drug therapy. Use 24 hour notation (e.g. 16.30hrs).

e) **When required**, 'p.r.n.' prescriptions also should include:

- If the dose is a range, guidance on how to choose the dose to 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").

f) 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.

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

### 2.4.2 Stopping a prescription

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 Changing drug doses

When a dose needs to be changed, the Trusts require doctors to completely rewrite the prescription to avoid misinterpretation. Remember to cancel the original entry as described in 2.4.2 above.

### 2.4.4 Dose deliberately withheld by 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 Prescribing Controlled Drugs

Full guidance on Controlled Drugs (CDs) including prescription writing is given in the District CD Policy and see also current BNF http://www.bnf.org/ "Controlled Drugs and drug dependence"

### 2.5.1 Prescribing Controlled Drugs for Outpatients or Patients being Discharged

To meet legal requirements the following criteria must be satisfied. The prescription must specifically state:

- **the name and address of the patient.** Patient identification stickers are now acceptable. If a sticker is used it is recommended that the prescriber signs across the sticker to render it tamper-proof))
- the **drug and dosage form** (e.g., capsules, modified-release capsules, oral liquid, injection, patch etc.), even when it is implicit in the proprietary name.
- the **strength.** 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 to be supplied** in both **words and figures.** This should be expressed in multiples of dose units e.g. the number of tablets, capsules, patches or millilitres of liquid, rather than milligrams of drug. For proprietary liquid medicines, the quantity should be adjusted to allow dispensing of whole container/s only.
- the **dose and frequency** directions
- bear the **signature of prescriber and date**

| **Example A** |
|---|
| Patient's name & address |
| Morphine sulphate M/R capsules 40 mg bd. |
| Supply 56 (fifty-six) 10mg caps |
| and 56 (fifty-six) 30mg caps |
| Dr's signature, date |

| **Example B** |
|---|
| Patient's name & address |
| Fentanyl patch "50" |
| Apply 1 patch every 3 days |
| Supply 10 (ten) patches |
| Dr's signature, date |

### 2.5.2 Prescribing Controlled Drugs for administration by community nurses

CDs must be administered only in accordance with the written directions of a doctor. Thus, a community nurse must have written direction on an official Prescription Record Chart from a medical practitioner stating:

a) name of drug.

b) dosage and frequency, route / method of administration, dated and signed by a medical practitioner.

c) any special precautions/instructions.

### 2.5.3 Controlled Drugs for administration by Midwives

Midwives are specifically exempt from the requirement for a doctor's prescription and there are provisions in law permitting Midwives to possess and administer certain drugs including CDs in the course of their professional practice.

## 2.6 Pharmacists' Addition or Amendment of Prescriptions

Pharmacists may continue a patient's existing drug therapy or adjust or correct dosages / frequencies, in accordance with their Pharmacists' Enabling Protocol.

The pharmacist will sign and date any entries and annotate with their title and whether the prescriber was contacted (p.c.) or not (p.n.c.). An entry in the Multi-disciplinary Health Record may be indicated and/or a conversation with the prescriber out of courtesy or for education depending upon the circumstances.

Prescriptions added to or amended by pharmacists should be held in the same authority as that of a doctor, i.e. they are valid for administration by other health professionals and dispensing purposes.

## 2.7 Discharge Medicines

- For the purpose of this policy document, discharge medicines means the following: dispensed medicines, (including dressings) supplied 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 and 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 record chart, unless previously screened and 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:
  - prior arrangement has been made **and**
  - 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 PHT Discharge Policy.

## 2.8 Verbal Orders

**The prescribing of medicines over the telephone is not recommended by the NMC and is NOT normally allowed within PHT.**

However, verbal orders may be accepted during a resuscitation/emergency situation.

Telephone orders are permissible within PCTs to authorise the administration of a "once only" prescription e.g. in the case of Peripheral Units, where the prescribing doctor (GP) is unable to attend the ward.

The following procedure should be followed:

- The order/ message can be accepted by a health professional, and should be confirmed and repeated (read back) by a second registered health professional.
- The prescription should be written in the 'once only' section of the Prescription Record Chart.
- The entry should have the date and time written and signed by the registered health professional, stating that this is a verbal order.
- The doctor's name should be recorded in the prescription entry 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 order should be recorded in the Multi-disciplinary Health Record.

- Verbal orders **may not** be taken for Patient-Controlled Analgesia (PCA) or for Controlled Drugs (schedules 2 or 3).
- Changes to an existing prescription **may not** be made over the telephone. The use of information technology, such as fax or e-mail is the approved method. A copy of the fax or e-mail should then be filed in the patient's Multi-disciplinary Health Record and a new prescription confirming the changes should be written within 24 hours of the verbal order.
- Pharmacists are allowed to receive verbal messages and thereby make prescription alterations or additions as agreed in their Enabling Protocol. See also Section 2.6.

## 2.9 Self Prescribing

- Doctors may prescribe certain medicines for their own use providing the following conditions are met:
  1. The doctor is known to pharmacy staff or can provide current, valid hospital identification
  2. the medicine prescribed is for the prescriber's own use only
  3. Their reason for being unable to visit their own GP should be provided
  4. Only formulary medicines may be prescribed
  5. A maximum of 7 days supply, or the smallest original pack (whichever is less) will be dispensed.
  6. The standard NHS dispensing fee must be paid
  7. Items that may not be self-prescribed include:
     - oral contraceptives (irrespective of indication)
     - hypnotics including benzodiazepines
     - controlled drugs (Schedule 2 or 3)
     - vaccines
     - otherwise inappropriate requests – at the discretion of a senior pharmacist
- Any request not meeting the above criteria may be treated as a private prescription with costs added to fully reflect the cost to PHT.
- This facility is intended to enable staff to obtain ongoing medication or treatment for acute conditions. It does not replace the need for individuals to seek the advice, diagnosis and care of their GP or specialist.
- FP10 (HP) prescriptions are strictly for the treatment of legitimate registered patients under the care of a PHT consultant. Misuse of these for self, family or other persons is fraud.

## 2.10 Medical gases

- Medical gases are Prescription Only Medicines therefore they should be prescribed on the Prescription Record Chart.

# 3. STATIONERY

## 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<br>Infusion Therapy sheet<br>Pre-printed therapy specific charts e.g. IV heparin, insulin, thrombolysis/chest pain pathway |
| | Theatres | Anaesthetic record sheet |
| | Discharge | Discharge summary |
| | Out-patients & Day Case | Day case record chart WWG500 (MR 601)<br>FP10 HNC |
| | 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 record chart PMP 457 or Long stay<br>Prescription Record Chart PMP 458<br>Infusion Therapy sheet |
| | Discharge (elderly care) | Discharge summary |
| | The Rowans Hospice | Prescription record chart PMP 457<br>Discharge summary |
| | Mental Health Units | MH inpatient chart<br>Short term discharge chart<br>Discharge summary FP10 HNC |
| | District Nurses, Health Visitors | FP10 HNC |
| | Peripheral Units | Prescription record chart PMP 457 or Long stay<br>Prescription Record Chart PMP 458<br>FP10 HNC |

The design or issue of any other prescribing stationery in PHT should be designed and agreed in consultation with a senior pharmacist and subsequently approved by Formulary and Medicines Group or other specialist meeting, if relevant. Final ratification and Trust endorsement is granted by information governance Committee. In PCTs discuss requirements with the Pharmaceutical Advisor. Prescribing stationery should be original printed materials Photocopies are not valid. Computer-generated versions are acceptable but must be individualised and signed.

## 3.2 Controlled Stationery

### 3.2.1 Obtaining controlled stationery

- CD stationery (namely Ward/ Department CD Order Books and CD Record Books) will be issued from pharmacies or from the Pharmacy Support Services office
- Issue of FP10(HP) prescription pads for dispensing in community pharmacies will be from Pharmacy Support Services office but they can be ordered through the dispensaries at QAH, SMH or SJH as appropriate. Prescriptions are now purchased pre-printed to identify clinical directorate and name of Trust. Details of issues will be recorded, and written receipts obtained from recipients.

### 3.2.2 Security of controlled stationery

See District CD Policy

- All controlled stationery, including CD Record books, order books, FP10 prescription pads and FP57 Prescription Charge Refund forms, must be kept in a locked cupboard (or other secure place) when not in use.
- 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).
- Any instance of loss or theft of any controlled stationery from any location must be reported to the clinical Ward/ Department Manager and Pharmacy Services Manager Code A Principal Pharmacist Operations Manager as per CD Policy and an adverse incident report completed procedure as soon as possible.
- Full CD Record Books should be sealed after the final entry (with adhesive tape), dated and signed and kept in a secure place on the ward for 2 years after the date of the last entry. This is to prevent further use or alteration. After this period, they will be archived (physically or electronically by means of scanning) for a further 6 years.

### 3.2.3 Use of CD stationery

**For detailed guidance on the procedures and requirements of CD transactions and record-keeping see CD Policy**

- CDs must be requisitioned (only) using the Ward/ Department CD Order Book (ref. 90-500).
- Each requisition must be on a separate page and signed by a person authorised to Order CDs.
- Entries in the CD Record Book (ref. 90-501) must comply with the instructions inside the cover of the book, as described in the District CD Policy

- Entries must be made at the time of the transaction/ administration, be clear, unambiguous 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 ("PODs") that are CDs must be recorded in a separate Record Book or section. Within this book, there will be a separate page, or section for each CD medicine of each patient. The records to be kept include initial receipt of POD CDs onto the ward, administration to the patient, and upon discharge, returning them to the patient or removal of unwanted POD CDs to the pharmacy for subsequent destruction.
- If suspected illicit drugs are discovered (e.g. in the possession of patients) they should be removed from clients, in accordance with the "Illegal Substances Policy". A record of receipt describing the item(s) should be made in the back of the CD Record Book. Inform the Pharmacy Department at the earliest opportunity for advice and sign over and surrender the item(s) for destruction. Under no circumstances should suspected illegal drugs be returned to the client.
- Community nurses should record the administration of Controlled Drugs in the patient's nursing notes.

# 4. PROCUREMENT, STORAGE AND STOCK CONTROL

## 4.1 Medicines procurement

- It is the responsibility of the Pharmacy Department(s) to procure all agreed medicinal products and dressings, and to ensure that adequate records are kept to ensure an audit trail of all medicines supplied is maintained. At RHH this is the responsibility of the MDC (Medical Distribution Centre).
- The Pharmacy Services Manager is responsible for ensuring that the physical security in Pharmacy Departments complies with the requirements of chapter 9 of the latest NAHAT (National Association of Health Authority and Trusts) guidance document.
- Under certain circumstances, (e.g. peripheral units) medicines may be obtained from a community pharmacy when the medicines are prescribed by a suitably qualified prescriber on appropriate, valid prescription forms.

## 4.2 Medicine stock ordering by wards and departments

The Nurse/ Midwife in Charge of each ward, unit or department is responsible 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 by pharmacy staff at least once every 3 months.

- In clinical areas **with Pharmacy top-up services**, the responsible person is the Pharmacy Distribution Manager, in accordance with the agreed service level agreement.
- 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.
- In Pharmacy Departments, the Pharmacy 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 agreed by the Pharmacy Department and the Ward/ Department Manager.

Certain high risk medicines are not permitted as stock, whilst some are allowed to be held only at a very limited range of locations. These high risk medicines currently include:

- Doses prepared for Intra-thecal administration are subject to tight regulations on the training, competence and authority of personnel to carry out tasks pertaining to the use of these items. They are to be kept only in a designated refrigerator located in QA Pharmacy and may **not** be stored at ward level. See PHT Intrathecal Policy
- Oral methotrexate is not permitted as stock
- Concentrated solutions of potassium salts for injection are allowed only in designated Critical Care Areas. 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
- Neuromuscular blocking agents may only be kept as stock in areas where the equipment and expertise for ventilation are available.

### 4.2.2 Ordering Controlled Drugs

**For detailed guidance on the procedures and requirements of CD transactions and record-keeping see** District CD Policy

- CDs may be ordered only by authorised registered nurses/ midwives/operating department practitioners whose name and signature are listed on the Persons Authorised to Order CDs List for that ward or department held in Pharmacy.
- See also "Use of CD Stationery", Section 3.2.3 above.

## 4.3 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.
- where they can be easily be supervised and observed.
- away from sources of heat, strong light and moisture.
- 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.
- Injectable medicines, internal medicines, external medicines, diagnostic agents and flammables should be kept segregated from each other (e.g. separate shelves/drawers).
- in such a way that the risk of errors caused by selecting the wrong medicine are minimized.

### 4.3.1 Security and Safety

- The responsibility for the safekeeping of medicines (including CDs) rests with the appointed nurse in charge of that Ward/ Department.
- The Pharmacy Services Manager is responsible for security of medicines within the pharmacy departments
- All medicines should be stored under lock and key and in accordance with the manufacturers' or Pharmacy Department instructions. Locked facilities should be used for storage in Wards/ Departments. Exceptions are bulk sterile fluids and topical, unmedicated dressings which may be stored unlocked.

- In departments where there is relatively unrestricted public access, e.g. Accident and Emergency, staff need to be particularly vigilant regarding the 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.

### 4.3.2 Drug Cupboards and Trolleys

- 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
- Agreed lockers for the storage of patients' own medicines can be used, secured to a wall and/or to the patient's locker.
- 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.

### 4.3.3 Responsibilities for Drug Keys and Access

- The Nurse/ Midwife in Charge of the Ward/ Department (or designated deputy) is responsible for controlling access (using keys or other means) to the medicines cupboards, refrigerators and trolleys.
- Control of access may be delegated to another registered nurse/midwife, medical practitioner or registered operating department practitioner. The responsibility remains with the appointed nurse, even if she/he decides to delegate the duty.
- A second set of keys should be kept secure in a designated place and be available for access at all times if required.

**For detailed guidance on the procedures and requirements of CD storage and transactions see** District CD Policy

- A registered nurse or Registered Operating Department Practitioner (RODP) may remove CDs from, or return them to, the CD cabinet only on the specific authority of either the nurse in charge, or a medical practitioner (i.e. a valid prescription). The responsibility for the requisitioning, safe custody and use of CDs remains with the most senior registered nurse on duty in the department, even if that nurse decides to allow access by others.
- In operating theatres at weekends or out of hours, if there is no appointed nurse on duty, the responsibility rests with the RODP in charge.

## 4.3.4 Emergency Drugs

**Medicines for the emergency management of patients**, e.g. Cardiac Arrest Boxes, Peri-arrest Boxes and Emergency Drug boxes, are **exempt** from the requirement for storage in a locked cupboard, but are supplied with tamper-evident seal, which should remain intact

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 (i.e. delivering). Individuals should ensure that their own motor insurance covers this eventuality. Learning Disability staffs have specific guidance for storage and transport of medicines.

## 4.3.5 Temperature Control / Refrigeration

- 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°Cand +8° C.
- Each medicines refrigerator should have its temperature recorded at the same time each day (preferably at a time when the refrigerator has not been opened for the previous hour, or more). If the temperature falls outside the limits prescribed above, the pharmacy should be contacted for advice.
- Medical gases should be stored in accordance with Trust guidelines. Particular care must be taken with Entonox, especially at temperatures of 10°C or less. 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]

## 4.4 Stock control

### 4.4.1 Controlled Drug Stock Checking

**For detailed guidance on the procedures and requirements of CD transactions and record-keeping see** District CD Policy

- The ward/ department stock of CDs 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 CD 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,** in accordance with the Controlled Drugs Policy
- CD storage, balances and records will be inspected by pharmacy staff at regular intervals, not exceeding 3 months.

## 4.5 Storage Error

### 4.5.1 Controlled Drug

If a CD has been accidentally left outside of the CD 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)/pharmacy manager.

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

### 4.5.2 Medicines that should be refrigerated

If a medicine(s) that should normally be stored in a refrigerator, between +2 °C and +8°C, is left out of a refrigerator, or if the medicine has been exposed to a temperature below zero °C,

the Medicines Information Centre (023 9228 6632) should be contacted to determine the action to be taken.

In the case of refrigerator failure seek advice from the pharmacy department or Medicines Information Centre (023 9228 6632) providing details of the temperature reached, estimated duration and list of drug stocks affected

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.

### 4.5.2 Other Medicines

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.

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

## 4.6 Losses and Discrepancies

### 4.6.1 Controlled Drugs

**Refer to Appendix 2 of** District CD Policy (Flow Diagram for the Procedure to be followed on discovery of a CD Balance Discrepancy)

- 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
- the General Manager / Divisional Nurse and Principal Pharmacist will discuss the circumstances and decide what further action is required, and whether to inform external agencies, such as the Police. RHH may decide to alert the Service Authority or the MSA.
- An Adverse Event Incident report form should be completed and sent to the Trust Risk 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.

### 4.6.2 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.

## 4.7 Obtaining Medicines During Pharmacy Hours

### 4.7.1 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 by telephone will be accepted for no more than two items. In addition, there are locally agreed procedures in place for ordering stock medicines within peripheral units.

### 4.7.2 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 Record Chart (where more than one chart is in use, ensure all current charts are provided) to the Pharmacy Department, or, in the case of peripheral units, by faxing / telephoning the prescription. Each acute ward is visited daily and it is preferable that, where possible, the Prescription Record Charts remain on the ward until the pharmacist visits.

**At RHH**, medicines should be ordered by taking the Prescription Record Chart(s) to the pharmacy department with a 'non-stock' requisition form.

## 4.8 Obtaining Medicines Outside of Pharmacy Hours

Check the Pharmacy web page for information on Out of Hours provisions

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

- the patient's own supply via relatives or carers
- the hospital's Out of Hours cupboard
- contact the on-call Pharmacist for assistance
- a neighbouring ward.

### 4.8.1 Out of Hours Drug Cupboards

- The cupboard(s) is/are located at strategic point(s) on each hospital site. Most have a "satellite" refrigerator.
- The contents list for the Out of Hours Cupboard for each site are available on the Pharmacy Intranet site (link in 4.8 above) and are also displayed on/in the cupboard.
- 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 or RHH **identification** card.

- That person then proceeds to the cupboard, and selects and draws the minimum number of whole containers of the medicine(s) required.
- It is **essential** that the person completes the form found inside the cupboard to record what has been taken, the quantity, by which ward, the date and time, and provides 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 Out of Hours cupboard every working day to check the form to establish whether anything has been taken overnight, and they then cost the item correctly to the user and replace the stock. The contents of each Out of Hours cupboard are checked by Pharmacy staff every 3 months for completeness, and for any date-expired medicines.

### 4.8.2 Borrowing from another Ward

- Medicines may be borrowed from another ward. Information regarding medicines stocked on various wards can be obtained from the PHT Pharmacy Intranet site. If a medicine is borrowed from another ward, a **whole original container** should be borrowed. **Never** transfer individual doses in temporary containers – unidentified drugs are dangerous.
- Ensure the transaction is noted for the attention of the pharmacist on their next visit so the item can be to replaced or correctly re-costed
- Outside of normal hours, in exceptional circumstances, a single dose of a Controlled Drug may be administered to a patient by using stock from another ward. To use another ward's stock, the **supplying** ward's CD Record book must be used in the normal fashion, administering and witnessing administration to the other ward's patient. **Do not transfer CDs from one ward's record book to another.** See District CD Policy
- In Peripheral units, the nurse in charge should discuss the need for obtaining the medicine out-of-hours with the on-call doctor.
- **RHH: See separate on-call procedure**

### 4.8.3 Contacting the On-Call Pharmacist

- If the required medicine cannot be obtained from these suggested sources, the Nurse in Charge or a Medical Practitioner should contact the On-Call Pharmacist via the hospital switchboard to discuss the options, merits and urgency of the clinical situation.
- The On-Call Pharmacist may assist in negotiating borrowing from another ward e.g. if there is reluctance to lend or if transport/ delivery is necessary.
- If appropriate the On-Call Pharmacist will attend to supply a necessary treatment from the Pharmacy, or otherwise arrange a supply.

# 5. DISPENSING

## 5.1 Responsibility

All dispensing should normally be undertaken by the Hospital Pharmacy Departments, under the supervision of a registered Pharmacist.

Medicines for patients in Peripheral units may, on presentation of an appropriate, valid prescription, be dispensed by a community pharmacy.

## 5.2 Safe, Accurate Dispensing

Prescriptions will be dispensed only if they comply with the requirements of section 2 (Prescribing) of this policy.

All ambiguities or potential risks should be identified and clarified with the prescriber before dispensing.

Prescriptions should be checked for clinical appropriateness by suitably qualified staff prior to dispensing.

Formal checking procedures should be in place, including double checking of complex calculations by two suitably qualified, independent persons.

Persons who dispense and check dispensing should be suitably qualified and their competence and accuracy demonstrated.

All dispensed medicines must be labelled in accordance with the Medicines Act and Regulations, and with relevant current professional guidance.

Patient information leaflets should be provided with all medicines dispensed for outpatients and patients being discharged from hospital.

Each medicine should be checked with the patient when it is issued directly to them or their carer. Patients/their carers should be shown how to handle and administer their medicines safely and correctly. The patient/carer should be encouraged to ask questions about the medicines.

For oral medicines that need to be measured/presented in syringes, oral syringes should be used whenever possible.

## 5.3 Issuing of Discharge Medicines

"Dispensing" by means of issuing pre-packed and ready-labelled medicines is allowed, from Wards/ Departments as agreed with the relevant Directorate Pharmacist. Suitable packs can be provided as stock and the following protocol for issuing pre-packs must be followed.

Medication issued must be suitably labelled to comply with the Medicines Act.

Provision of medicines should be accompanied by instruction and advice to patients and/or their carers on how to handle and administer their medicines safely. A Patient Information Leaflet should be provided.

Only in exceptional circumstances, when the pharmacy department is closed, and all other measures are impracticable, may a doctor dispense from ward stock providing all the legal stipulations are fulfilled. It is recommended that the On-Call Pharmacist is contacted for advice on the most appropriate course of action since the (labelling) regulations are complex.

TTO packs are only to be issued against a legal prescription written by a registered medical practitioner or suitably trained non-medical prescriber, OR under the conditions as defined in a valid Patient Group Direction.

- Issuing of medication must be carried out, or directly supervised, by suitably qualified personnel i.e. registered nurses or medical practitioners.

- The prescription must be endorsed by the dispenser with the following details:

i. Amount supplied
ii. Date of dispensing
iii. Initials of dispenser

- To comply with legal requirements all dispensed medication must be labelled with:

i. Patient's name
ii. Date of dispensing
iii. Hospital address

TTO packs of tablets and liquids provided by the Hospital Pharmacy will be suitably labelled requiring only the minimum details to be completed by the issuer. Although not a legal requirement, it is good practice to include directions for the patient.

- Original packs as provided by pharmacy must be dispensed in all instances. Contents from one container must never be decanted or tipped into other containers. Where quantity greater than 1 pack is required the nearest quantity of complete multiple packs should be given. The patient should be instructed to return any remaining medication to a pharmacy for safe disposal. The pharmacy cannot be held responsible for the integrity or contents of split packs.

- In all instances a check should be made to ensure the medicine is in date.

- All dispensed items should be checked for accuracy by a second person and this person must then initial the prescription.

- The completed prescription must either be filed in the patients notes **or** returned to pharmacy depending upon which system has been agreed with the pharmacy department for the particular ward, unit or speciality.

- The TTO pack record form should also be filled in to keep a permanent record for the ward or unit.

## 5.4 Cytotoxic Chemotherapy

**For detailed guidance on the procedures and requirements in the provision and use of** Cytotoxic Chemotherapy **and** Intra-thecal Chemotherapy **see the specific Policies**

For the safety of staff and patients, all cytotoxic chemotherapy should be reconstituted, prepared and dispensed in the Pharmacy Department (unless agreed with the Oncology/ Haematology Directorate Pharmacist for specific products or patients, in agreed clinical circumstances).

## 5.5 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, **especially "high risk" medicines,** e.g. cytotoxics, strong electrolytes, strong opiates, 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.

## 5.6 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 Report 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.

Actual and potential dispensing errors should be recorded and reviewed regularly to raise awareness of risk issues.

Serious dispensing errors and near misses should be reported to the National Patient Safety Agency by the Risk Management team.

## 5.7 Prescription Charges

Prescriptions for supply of medication to patients from **Outpatient Clinics**, **Accident and Emergency**, **Day Case Surgery** or **Day Attenders** will attract prescription charges (tax) unless a valid exemption applies (see below), which must be declared.

Patients should be made aware **prior to admission** when attending as day patients or for day surgery that prescription charges are payable for any medicines supplied to take out.

Arrangements should be made in each dispensary and relevant clinical area for collection and record of payments of prescription charges and the declaration of valid exemption signed by patients. This will normally be done using the designated Trust stationery (see section 3) or by arrangement with the Principal Pharmacist Operations (QAH).

If, on attendance a patient is unable to pay the prescription charge due, the Pharmacy Department shall arrange for an invoice to be billed via the Finance Department.

### 5.7.1 Prescription Charges Exemptions

Prescription charges are payable and should be collected on all medicines (and on some dressings/medical devices) taken out of the hospital unless one of the following exemptions apply:

- In-patients who are being discharged.
- Patients who are exempt or remitted from charges. (e.g. on Income Support, Prepayment Certificate etc.) Patients should sign a declaration to state why they do not have to pay. A full list of reasons for exemption is available from the Pharmacy Department.
- Patients taking part in certain (not all) Clinical Trials of medicines.
- 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.
- Currently, medicines supplied in the following PCT Minor Injuries Units: Petersfield Community Hospital, Havant War Memorial Hospital and Emsworth Victoria Cottage Hospital.

### 5.7.2 Refund of Prescription Charges

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

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

# 6. DISTRIBUTION AND DELIVERY

**All transactions** should be initiated through a system in which all orders and dispatches are recorded.

## 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 Controlled Drugs

**For detailed guidance on the procedures and requirements of CD delivery and receipt see** District CD Policy

- Consignments of dispensed CD Orders are packaged in Envopak pouches sealed with numbered tamper-evident security tags. The numbers are recorded on collection or delivery and each package can be traced via the secure receipt and signing systems in place.
- Additionally, Off-site Units telephone the Pharmacy Department to confirm safe arrival and return the signed receipt.
- Any member of staff (with valid identification) may act to deliver CDs from the pharmacy department to the clinical area, but **may not** also sign as a recipient for CDs which have been delivered to that area.

## 6.4 Chemotherapy

**For detailed guidance on the procedures and requirements in the provision and use of** Cytotoxic Chemotherapy **and** Intra-thecal Chemotherapy **see the specific Policies**

- Parenteral cytotoxic chemotherapy must be delivered directly to clinical areas in recognisable containers, separately from non-chemotherapy.
- Chemotherapy for **intrathecal administration** is provided by pharmacy departments, **only to a named, suitably trained health professional who signs to accept receipt** of the item for 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.

# 7. ADMINISTRATION

## 7.1 Administration

- Medicines should be administered in accordance with the Procedure for Administration of Medicines. Any health professional listed in Section 1.1, who has demonstrated the necessary knowledge and competence may administer medicinal products. This also includes 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.
- Staff who are likely to encounter children as patients should demonstrate their competence in paediatric drug therapy, including dose and infusion rate calculations.
- Where possible, staff who administer medicines should do so within the context of each patient's treatment plan.
- Where possible and appropriate, medicines should be discussed with patients or their representatives at the time of administration.
- Medicines issued on discharge should be discussed with patients/carers to ensure that they understand fully how to use their medicines safely and correctly.
- In short, the aim of administration procedures is to ensure that the **right patient** receives the **right medicine**, in the **right dose**, by the **right route**, at the **right time**.
- To this end, staff who administer medicines should have access to appropriate reference sources to support safe administration, including local Medicines Information pharmacists and resources.

### 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.

- Devices for the administration of infusions and of feeds should be used only for the purpose for which they were intended.
- If liquid medicines for oral administration need to be measured in a syringe, an **oral** syringe should be used whenever possible.
- Particularly in seriously ill patients, liquid medicines to be given orally (including via nasogastric tube) and by injection should be given at **different times** from each other.

## 7.1.2 Administration of Parenteral Therapy

**For detailed guidance on the procedures and requirements of Parenteral therapy see IV Policy, Intravenous Therapy Guidelines and relevant Nursing Clinical Guidelines.**

Those who administer parenteral medicines have additional responsibilities, which are described in the above and associated documents.

Only Registered Nurses, Midwives and RODPs who have demonstrated the required knowledge and skills by successfully completing the PHT process for achieving competency in IV drug administration are permitted to administer intravenous drugs.

Some points of note include:-

- Health professionals should inject only into an **established** intravenous access point.
- All medicine preparations that are suitable for administration peripherally may be given via a central line **(but not vice-versa).**
- Parenteral drug lines should be labelled near each end to indicate the site of access/route.
- Wherever possible, guidelines should be put in place for the standardization of concentrations of infusion solutions of drugs.
- Infusion rate charts or validated computer software to aid calculation should be available in paediatric units, particularly for potent/high risk drugs.
- Infusions of **"high risk" drugs,** e.g. cytotoxics, strong electrolytes, strong opiates, should **not** be prepared in clinical areas, but should wherever possible be purchased or prepared centrally by pharmacy.
- Instructions/ procedures for administering medicines to patients with multiple parenteral drug lines should define the route of administration. e.g. peripheral or CVP line.
- 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 (this should be attached to or cross-referenced on the Prescription Record Chart). 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 together every time.

- Whenever administration of a fluid is commenced, the "Given by" column on the Infusion Therapy Sheet should be filled in by the suitably qualified person administering the fluid.
- Clinical support staff **should not** take part in **any aspect** of the administration of parenteral therapy. The only exception to this is specially trained Nursery Nurses in NICU and Medical/Clinical technicians who have undertaken training, have demonstrated the required knowledge and competency (successfully completed the IV Drug Administration Competency), and are acting in accordance with the relevant Clinical Guidelines and protocols on parenteral therapy

### 7.1.3 Infusion Devices

When considering purchasing medical devices refer to and follow the procedures on device evaluation and standardization and procurement as in the Trust policy for the Management of Medical Devices
This will ensure devices are chosen that are designed to be simple to use and have good safety features, such as alarms, and comply with national recommendations.

Staff should be trained in the correct use of devices, and have access to suppliers' user manuals.

The most appropriate device for the drug being administered, the rate and conditions should be selected and used. See Trust Policy for the Management of infusions with pumps

Staff should report actual or suspected damage or malfunction of an infusion device to clinical engineering support section fault report line Extn 6101 as soon as possible so that it can be taken out of use, checked and serviced (if necessary) to ensure its accuracy. Make a note of its serial number and the exact circumstances of the problem. **Mark the device as not suitable for use.** Retain and secure it.

### 7.1.4 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

### 7.1.5 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.

## 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 Record Chart, peri-operative record, or special pre-printed therapy-specific record charts e.g. for variable dose infusions. All of these should be filed in the patient's Multi-disciplinary Health Record.

As well as recording in the above documents that doses have been given, where appropriate, the patient's response to the drug should be noted in the Multi-disciplinary Health Record at intervals for the purposes of the treatment plan. In particular, allergic-type or adverse reactions should be recorded, and the prescriber informed as soon as possible. See section 10.3 Adverse Drug Reaction (ADR) Reporting.

### 7.2.1 Doses missed or refused

If a dose is missed or refused the dose administration box on the Prescription Record Chart (Form PMP 457) should be filled with a code number as follows:

1 Dose withheld on medical orders (Prescriber to state reason in Multi-disciplinary Health Record)

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 reason on panel on Prescription Record Chart)

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 Blood and Blood Products Policy 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.

## 7.3 Administration of Controlled Drugs

**For detailed guidance on the procedures and requirements of CD administration and associated balance checking see** CD Policy

- The administration of CDs can be performed by a nurse, midwife, RODP, doctor or pharmacist. The administration must be recorded promptly in the Ward/ Department CD Record Book by the administering health professional. In PHT, a second competent person should witness the CD administration and countersign the Record Book.
- Health Care Support Workers **may not** check CD 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 PCTs, by the relevant committee.
- It will remain the professional responsibility of the health professional to ensure that the medicine is administered correctly.
- Clinical support staff **may not** administer CDs.

## 7. 4 Administration of Anaesthetic Drugs

- Two health professionals should check all anaesthetic drugs one of these should be the anaesthetist.
- RODPs and anaesthetic nurses can draw up such checked drugs if the anaesthetist requests them to do so, after checking the drug together.
- The administration must be recorded promptly in the patient's records.
- Drugs drawn up but not used during the session should be destroyed by the anaesthetist e.g. by spraying onto absorbent hand towel and disposed of in medicines (POM) bin, in the presence of another health professional. Records accounting for wastages should be kept including identifying staff involved.

## 7.5 Administration of Cytotoxic Chemotherapy

**For detailed guidance on the procedures and requirements for the administration of** Cytotoxic Chemotherapy **and** Intra-thecal Chemotherapy **see the specific Policies**

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.

## 7.5.1 Intrathecal chemotherapy

**The Portsmouth Hospitals NHS Trust policy on intrathecal chemotherapy must be followed** *see link above*

Intrathecal chemotherapy 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 always be administered on a separate day from other parenteral chemotherapy.

## 7.6 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 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.

## 7.7 Supply and Administration of Medicines under Patient Group Directions

Approved health professionals may supply or administer a medicine that has not been prescribed by a doctor or dentist only when following agreed Patient Group Directions (PGD), in accordance with the Trust Policy on Patient Group Directions. Each person administering/ supplying must be named on the PGD.

In PHT all PGDs are managed and approved by the Patient Group Directions Steering Group on behalf of the Formulary and Medicines Group.

Patient Group Directions for use within PCTs 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.

Self-administration of medicines by patients or administration by carers is permitted in some Wards/ Departments. Protocols devised by the Clinical Ward/ Department Manager and the relevant Directorate Pharmacist, should be approved by the 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 to determine the level of supervision required. Refer to Drug Therapy Guideline which includes supporting resource documents, patient assessment tool and Patient dosing chart. Advice is available from the Pharmacy Department on request.

## 7.9 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 approved by the Formulary & Medicines Group.

## 7.10 Use of Patients' Own Medicines ("PODs")

Patients' Own Medicines (Pts own drugs or "PODs") will normally be assessed for quality (physical condition), labelling accuracy and appropriateness within 48 hours of admission, by a suitably trained pharmacist or a pharmacy technician, according to the relevant Work Instruction. This task includes documenting details of the drugs, doses and quantities of medicines brought into hospital by patients on the Prescription Record Chart. Any discrepancies between the PODs, current prescribed regimen and Drug History (if available) are identified to the medical or nursing team.

If the PODs are required to be used before a member of pharmacy staff can perform the POD check, other staff may assess suitability and take responsibility for continued use.

Patients own drugs may be used for their treatment only if the following criteria are met:-

- All loose (i.e. non blister packed) solid dosage forms have been supplied within the preceding 6 months
- All items are within their expiry date, if shown.
- All blister packed and other medicines not in a labelled outer container are clearly identifiable, and within their expiry date
- Ophthalmic preparations, if opened, have been in use for less than 28 days, or less than the manufacturers recommended time. Date of dispensing is not considered as date of opening, due to advance or multiple dispensing of some products.
- All non sterile liquid medicines, if opened or decanted from the original pack, have been dispensed within the preceding 3 months, and are within the manufacturers original expiry date
- All items have satisfactory visual appearance
- All items which require refrigerated storage are found in the ward refrigerator

- All items, unless OTC preparation or blister packed/sachets not in labelled outer container, are labelled clearly and correctly with:
  - The name of the patient
  - The product name and strength
  - The suppliers name and address
  - The date of dispensing
  - The quantity dispensed
- There is only one medicine in each container
- The quantity in each container is not greater than the original quantity dispensed (as indicated on the label)
- Monitored Dose Systems are clearly labelled, and their contents are identifiable. These are usually best retained and left intact. Confirmation from a pharmacist should be sought to check and authorise the use of any of the contents of patients own monitored dosage systems.

PODs should be stored securely, preferably by means of individual POD-lockers, or if these are not available, by placing each patient's medicines in a suitable container, and storing in a locked medicines cupboard or trolley.

Upon discharge, suitable PODs may be re-issued to the patient. If necessary the directions for use can be updated by re-labelling the medicine(s) in the pharmacy, or by dispensing them afresh. (See also section 2.7 Discharge Medicines)

PODs remain the personal property of the patient. Permission should be obtained to remove and dispose of unwanted items. (See also section 8 Disposal)

## 7.11 Checking the administration of medicines

### 7.11.1 Solo-checking of medicine administration

The administration of a medicinal product does not have to be checked by a second person, **unless any** of the following special circumstances apply; then a **second** health professional should check the administration:

- If mathematical calculations are required to determine any dosage or administration rate, these calculations should be checked by another health professional. (e.g. infusion rate or a dosage is prescribed by patient weight or body surface area).
- Two health professionals must check all doses on the neonatal unit.
- the patient is under 12 years old and not being cared for on a specialist paediatric ward
- the medicine is a Controlled Drug - see CD Policy
- the medicine is cytotoxic chemotherapy - see Policy for the prescribing, handling and administration of cytotoxic drugs
- the medicine is an anaesthetic drug

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 have been qualified for more than 12 months, complete an annual Medicines Administration Update with calculation test (where available) and demonstrate competence. A **rigorous process of self-checking** of all aspects of the treatment supplied should be followed.

Nurses or Midwives may assume responsibility for care, which includes the administration of medicines previously checked by other practitioners, when they are handed-over patients.

The receiving Nurse or Midwife must be satisfied that::

- an ***established*** intravenous, subcutaneous or other infusion (continuous or intermittent), is 'in-situ'
- 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.

## 7.12 Administration Errors

- Actual and potential (near miss) administration errors should be recorded on a Adverse Event Form and submitted to the Risk Department. A database will be kept to review, assess and address regularly to increase awareness of risk.
- Administration errors and near misses will be reported to the National Patient Safety Agency by the Risk Management Team.

## 7.13 Medicines Administered at the Discretion of Nurses and Midwives

The Medicines Administered at the Discretion of Nurses and Midwives Protocol enables Registered Nurses and Midwives, on consideration, to administer simple remedies to adult patients in their care, which would otherwise need the prescription of a doctor. It should be noted that this is not considered "Nurse Prescribing" which now has a different context.

The range of medicines included the Medicines Administered at the Discretion of Nurses and Midwives Protocol is attached as Annex 1 of this policy. The medicine, route, maximum dose and frequency, indications and contraindications are listed in the Protocol.

The administration will be documented on the Prescription Record Chart as described in the Protocol.

If there is any concern about the patient's condition, they become unstable or deteriorate a medical opinion should be sought.

# 8. DISPOSAL OF WASTE

## 8.1 General pharmaceutical waste

The Trust's waste handling policy should be followed

**Unwanted medicines** should be returned to the pharmacy department. This includes unwanted patients' own medicines ("PODs"). Small quantities (up to 20 units in total) of medicines (part-used ampoules or loose tablets) can be disposed of in a sharps bin prior to disposal as clinical waste, in accordance with the Trust waste handling policy. It is not permitted to dispose of medicines in sinks or ablutions.

**Empty/used pharmaceutical packaging** 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.

**Prescription only Medicines**: The medicine itself, any container, packaging material, or used administration device that has come into direct contact with a medicine (even in a diluted form) must be regarded as hazardous waste, and placed in bins provided for this purpose. These are usually located in the sluice room, and marked "For residual contaminated Prescription Only Medicine Waste". No medicine or material that has been in direct contact with medicines may be allowed to enter the domestic waste stream.

**Broken glass contaminated with POMs** should be placed in a sharps container. Pieces of glass too large to fit in a sharps container should be wrapped in newspaper, or the like, and placed in a cardboard box. This should be marked "Broken glass contaminated with POM", and then placed in the nearest 820 litre Clinical Waste wheeled bin.

**Community healthcare staff** should encourage patients/carers to return unwanted medicines to their local pharmacy for disposal.

**Patient Confidentiality**: Pharmaceutical materials, packaging (or other things) that have been labelled with patient details should not be treated as domestic waste. These materials should be treated as clinical waste to ensure their proper destruction, avoiding possible breaches of confidentiality.

## 8.2 Cytotoxic and radiopharmaceutical waste

These must be handled according to the Trust waste handling policy (see link above).

## 8.3 Controlled Drugs

Accurate record-keeping is necessary on disposal of CDs to maintain legally required chains of accountability.

**For detailed guidance on the procedures and requirements of CD disposal see** CD Policy
Pharmacy Work Instruction PHPSWI03001 Controlled Drugs Transactions and Record Keeping

Pharmaceutical Support Services Work Instruction PSSWI016 Denaturing of Controlled Drugs

All date-expired CDs or any Patients' own unwanted CD medicines must be returned to the pharmacy department for destruction. They must be signed out of the Ward/ Department Record Book and the balance reconciled by a visiting pharmacist who will remove the items to the Pharmacy Department. This transaction should be witnessed by a registered health professional. In the pharmacy, the medicines will be entered into the destruction record book and ultimately undergo witnessed destruction.

### 8.3.1 Operating Theatres

Individual doses of CDs, 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, registered operating department practitioner, pharmacist or doctor.

The anaesthetist is personally responsible for properly and irretrievably 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 record book, stating 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, by taking them to a local community pharmacy. This disposal should be carried out as soon as possible, and recorded as per PCT policy.

# 9. PERSONNEL, EDUCATION & TRAINING

Medication safety should be covered comprehensively in induction programmes for all new NHS clinical staff (including medical, nursing, pharmacy, theatre, and any other staff who handle medicines), and regularly updated through further training and continuing professional development programmes. In accordance with the essential training matrix, all clinical staff are required to undertake an annual update of medicines management.

Personnel whose duties may expose them to security risks (e.g. porters, transport drivers, stores employees or those who carry medicines into the community) should be trained to be aware of the need for security and for following laid-down procedures. This should include what to do in the event of physical threat.

## 9.1 Administration of medicines (*except* by the intravenous, intrathecal and epidural routes)

The Procedure for Administration of Medicines should be followed

All health professionals who administer medicines to patients are required to maintain their competencies.

- Healthcare support workers can assist in the giving of medicines only after receiving competency training, and are certificated as competent in the Administration of Medicines (excluding intravenous, intrathecal and epidural routes).
- Medical and Dental practitioners cover this requirement during their undergraduate training.
- RODPs cover this requirement during their primary training.

## 9.2 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.

Medical and dental practitioners cover this requirement during their undergraduate training.

Nurses, Midwives and other health professionals are required to complete the PHT Process for Achieving Competency in IV Drug Administration.

## 9.3 Administration of Cytotoxic Chemotherapy

- 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.
- See Policy for the prescribing, handling and administration of cytotoxic drugs

## 9.4 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.

## 9.5 Continuing Professional Development

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. RISK MANAGEMENT

Portsmouth Hospitals NHS Trust, Hampshire PCT (South East) and Portsmouth City PCTs 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 complying with current policies, protocols and guidelines. Note particularly section 7 of this policy (administration).

If the health professional has any concern regarding 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 (including prescribing errors) has occurred, the following action should be taken:

1. 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.
2. Immediately inform the Medical Practitioner/ Consultant in charge of the patient at that time, and take the correct clinical counter-measures, under medical guidance.
3. 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.
4. 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.
5. Complete a (PHT) Adverse Incident Reporting Form.: Follow the guidance given on the form regarding the process and involvement of the Risk Management Department.

All incidents and "near misses" (including prescribing errors) should be reported to the National Patient Safety Agency (NPSA) via the risk management team.

Summary reports reviewing adverse incidents or potential incidents involving medicines should be circulated by the Risk Management Pharmacist to Divisional Clinical Governance forums, and annually to the Professional Advisory Committee (PAC). Further dissemination to staff groups to whose practice the details are relevant, or educational measures may be actioned.

In addition, it is important to consider whether it is necessary to notify other organizations that may be involved.

**PCTs:** Hampshire PCT (South East), and Portsmouth City PCTs operate a combined risk event-reporting scheme, which should be followed by staff employed by these organizations.

## 10.3 Adverse Drug Reaction (ADR) Reporting

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

See Drug Therapy Guideline for detailed advice on the reporting procedure

A 'yellow card' should be completed for adverse drug reactions for:

**New drugs:** (designated by an inverted black triangle in the BNF)

- Report **all** suspected reactions to new drugs, even if minor

**Established drugs:**

- Report any **serious** event, even if it is well known. Serious includes causing or prolonging a hospital admission. See definitions in Drug Therapy Guideline (link above)

Yellow cards to record all the necessary details can be found in every BNF book.

A yellow card may be submitted by a doctor, pharmacist or nurse. Out of courtesy, pharmacists or nurses should discuss the case with the doctor before doing so. Reports can also be made directly by patients themselves.

**Within Portsmouth Hospitals,** reports are preferably filed via the Medicines Information Centre, C level QAH ext 7700 6632, who will log and process. An Adverse Incident Reporting Form should be completed and forwarded to Risk Management for information.

**Within PCTs and Peripheral Units,** reports should be filed on line, at www.yellowcard.gov.uk , or by means of yellow cards available in the BNF.

## 10.4 Defective Product Reporting

Note: 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 Adverse Event Incident Form 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 PHT Supplies Team as soon as possible. They will report the defect to MHRA. 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 as above. In cases where the Risk Management Department is involved, they will make the decision whether to inform the MHRA.

**Infusion pumps**

Notify the Clinical Engineering support section fault report line Extn 6101 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/ Department 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: Health and Safety Policy and COSHH manual

## 10.6 Drug Abuse Vigilance

All staff should be alert to the possibility of drug abuse in any of their colleagues. They should look out for signs and patterns of unusual behaviour that may point to possible drug abuse. These may include:

- actual physical symptoms
- 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 that 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. The priority of managers will be the welfare and support of their staff.

# 11. CLINICAL TRIALS

## 11.1 Approval and protocols

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) for approval.

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.

## 11.2 Protocols and Processes

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

- The clinical trials pharmacist will check that the necessary exemption and/or certificate is in place **before** a trial starts.
- The trial protocol for all in-house trials should be agreed by the relevant Directorate Pharmacist or the Clinical Trials Pharmacist.
- Copies of the protocols for each trial should be held on the Ward/ Department where the patients are seen, and in the Pharmacy Department.
- The route of acquisition, distribution and storage of clinical trial materials should follow that of other medicines, except where there are special arrangements for supplies for commercial company trials of new medicines.
- Records should be kept of the receipt, dispensing, issue and administration of all medicines associated with each trial.
- All trial materials should be stored in the pharmacy department, unless a separate arrangement has been agreed with the relevant Dispensary Manager.
- All clinical trials using medicines without a full UK Product Licence for the patient groups or indication being treated will be conducted in accordance with current MHRA guidance on clinical trials, which includes the principles of Good Clinical Practice set out in EC Directive 2001/20/EC.

# 12. RESPONSIBILITIES OF PROFESSIONAL INDIVIDUALS

## 12.1 Nurses

### 12.1.1 Registered Nurses

Each registered nurse is accountable for her/his own conduct and practice in accordance with the NMC Code of Professional Conduct, 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.

### 12.1.2 Ward/ Department Managers

Ward/ Department 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.

### 12.1.3 NHS Professionals (NHSP) Nurses

Nurses working for NHS Professionals (NHSP) 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.

The nurse in charge of a Ward/ Department where NHSP nurses are deployed, should ensure that NHSP staff receive adequate orientation in relation to local practices regarding the administration of medicines and undertake the current training packages and competencies where reasonable to do so.

| 12.1.4 | **Student Nurses (other than Student Midwives)** |
|---|---|

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.

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.

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.**

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, 2002 ) 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.**

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

Midwives should adhere to the Nursing and Midwifery Council's Midwives' Rules and Codes of Practice **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/oxygen mixture (Entonox) via the Entonox apparatus.

## 12.2.1 Community Midwives

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 (phytomenadione)

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.

Midwives have provisions in law to possess and administer certain CDs in the course of their professional practice.

They are accountable for stocks issued to them and must keep detailed records of receipt, administration and return.

**For detailed guidance on the procedures and requirements of CD ordering, administration and record-keeping see** CD Policy **(Section 2.10)**

| 12.2.2 | **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 | **Registered Operating Department Practitioners (RODPs)** |
|---|---|

- RODPs will be registered with the Association of Operating Department Practitioners.
- RODPs should follow agreed Trust policies and procedures in dealing with medicines.
- RODPs are authorised to convey a CD to a doctor, registered nurse or to a patient for whom the drug has been prescribed and, providing they have completed the competencies required, may administer a CD to a patient, in accordance with the directions of a doctor.
- RODPs are now authorised to order or receive CDs

## 12.4 Radiographers

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

## 12.5 Clinical Support Staff

A HCSW, Nursery Nurse, Dental Nurse, Medical or Clinical Technician 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 CDs with a registered health professional.

## 12.6 Doctors

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

- Prescribing should follow the Portsmouth District Prescribing Formulary
- When a doctor is not confident of his/her own competence to prescribe or administer a particular medicinal product, s/he should not continue 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 resources on the managed introduction of new medicines guidelines available on the FMG Intranet page. http://pharmweb/FMG/

## 12.7 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 BNF 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.

| 12.8 | **Pharmacists** |
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Each registered pharmacist is accountable for her/his own conduct and practice in accordance with the Royal Pharmaceutical Society of GB's Code of Ethics.

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 the pharmaceutical requirements and proper undertaking of clinical trials
- advising on policy and procedure writing, including the requirements for Patient Group Directions.
- advising on medicines audits.

# 13. GLOSSARY and DEFINITIONS

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| 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:<br>Health Care Support Workers<br>Pharmacy Assistant Technical Officers<br>Nursery Nurses<br>Dental Nurses<br>Clinical/ Medical Technicians |
| Controlled Drugs (CDs) | 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 |
| GP | Medical General Practitioner |
| HCSW | Healthcare support worker (ward or clinical department staff who are not required to be registered with a professional body). |
| HR | Human Resources Department |
| 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.<br>For the purposes of this policy, these practitioners are accepted to include:<br>Registered nurses or midwives at grade D or above (or the equivalent)<br>Doctors (medical practitioners) |

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|---|---|
| Health (care) professional | Dentists<br>Dietitians<br>Pharmacists<br>Radiographers<br>Registered Pharmacy Technicians<br>Registered Operating Department Practitioners<br>Podiatrists |
| Infusion Therapy Sheet | Also known as IV fluid chart |
| 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). |
| Multi-disciplinary Health Record | Also known as Patient's Notes, Medical Notes, Casenotes |
| MSA | Medical Supplies Agency (Ministry of Defence). |
| 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. |
| NPSA | National Patient Safety Agency (a Special Health Authority of the DoH) |
| PAC | PHT Professional Advisory Committee |
| 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 |
| PHT | Portsmouth Hospitals NHS Trust |
| PODs | Patients' Own Medicines (or Drugs)<br>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 |

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|---|---|
| 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:<br>a) in writing in a legally prescribed format and signed by the person qualified by law to prescribe or<br>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. |
| Prescription Record Chart | Authorised Drug chart for recording inpatient prescriptions and administration. There are also "Long Stay" and Mental Health Unit versions. |
| 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. |
| TTOs | Medicines for a patient To Take Out (usually, discharge medicines) |

# 14. AFFILIATED DOCUMENTS

**This policy is to be used in conjunction with:**

- NMC Code of Professional Conduct.
- NMC Standards for the Administration of Medicines
- NMC Midwives Rules and Codes of Practice.
- 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'.
- The Safe and Secure Handling of Medicines: A Team Approach (Revision of 1988 Duthie report), R.P.S.G.B., March 2005
- Building a Safer NHS for Patients: Improving Medication Safety, Dept. of Health, January 2004
- 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 Drug Therapy Guideline: The Production of Patient Group Directions.
- Joint Trust Drug Therapy Guideline: Medication History Taking.

- Pharmacists' Enabling Protocol.
- Intravenous Therapy Guideline: Peripheral Intravascular (Intravenous) cannulation.
- Policy for the prescribing, handling and administration of cytotoxic agents (Adults).
- Trust Intrathecal Chemotherapy Policy
- Portsmouth Hospitals NHS Trust Policy: Consent
- Area Prescribing Committee Policy: The managed introduction of new drugs.
- Area Prescribing Committee Guidance: The development and content of shared care guidelines.
- Pharmacy Work Instruction PHPSWI03001 Controlled Drugs Transactions and Record Keeping
- Pharmaceutical Support Services Work Instruction PSSWI016 Denaturing of Controlled Drugs
- Portsmouth Hospitals NHS Trust Policy and Protocol for Waste Handling.
- PHT Discharge Planning Policy
- PHT Drug Therapy Guideline Policy
- PHT Epidural Infusion (Continuous) Management Policy
- PHT Potassium-Containing Concentrated Solutions for Intravenous Administration Policy
- Procedure for the Administration of Medicines (except via intravenous, intrathecal and epidural routes)

ANNEX 1: Medicines Administered at the Discretion of Nurses (MADON)
Portsmouth Hospitals NHS Trust
Portsmouth City NHS Primary Care Trust
East Hampshire NHS Primary Care Trust
Fareham & Gosport Primary Care Trust
Under normal circumstances, medicines should be administered on the written prescription of a registered medical or dental practitioner, or registered supplementary prescriber, in accordance with the Trust Medicines Policy. However, the Formulary and Medicines Group has approved the following list of medicines or homely remedies which registered nurses are authorized to administer at their own discretion, in accordance with the attached table, for the maximum times indicated.

A registered nurse may administer any of the listed medicines below to ADULT patients for the indications listed after first checking the cautions and contra-indications.

Any medication initiated by a registered nurse should be reported to the doctor when he/she next visits the ward, or sooner if indicated by the condition of the patient. If the patient's condition does not respond to this treatment, the prescriber should be notified immediately. Each administration must be recorded on the "once only" or "STAT" section of the Prescription Record Chart (i.e. not on the "as required" section), and in the nursing notes The drug, dose and time administered must be written clearly and must be signed both in the "prescriber's signature" column and the "given by" column by the nurse administering the dose.

Example:

| ONCE ONLY DRUGS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Date** | **Drug** | **Dose** | **Route** | **Time** | **Prescriber's signature** | **Given by** | **Time given** | **Pharmacy** |
| *21.12.05* | *Senna Tablets* | *2 tabs* | *PO* | *0745* | *Endorse "Nurse Administered" and full signature* | *FN* | *0745* | |
| | | | | | | | | |
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# Medicines Administered at the Discretion of Nurses (MADON)

Table 1: Dosages and Restrictions

| Medicine | Indication | Dose | Frequency | Maximum total daily dose over 24 hours | Maximum duration of nurse-led administration | Contra-indications |
|---|---|---|---|---|---|---|
| **Paracetamol** | Mild pain or pyrexia | 500mg - 1g | Every 6 hours | 4g in 24 hrs | 24 hours but 72 hours for community hospitals | Known hypersensitivity to paracetamol. Renal or hepatic impairment, alcohol dependence<br>CHECK PATIENT'S PRESCRIPTION CHART(S) BEFORE ADMINISTRATION to ensure not already receiving a paracetamol-containing medicine (e.g. co-codamol)<br><br>NB: Soluble tablets contain approx 30mmol of sodium in each 1g dose. Therefore do not use if hypernatraemic or on a sodium restricted diet. |
| 500mg tablets or 500mg soluble tablets | | 1- 2 tablets | | 8 tablets | | |
| 250mg/ 5ml suspension | | 10 - 20ml | | 80ml | | |
| 1g suppositories | | 1 suppository | | 4 suppositories | | |
| **Magnesium trisilicate mixture** | Dyspepsia | 10ml | Three times daily | 30ml | 48 hours | Patients on sodium-restricted diets. (contains approximately 6mmol of sodium in each 10ml dose).<br>Renal or hepatic impairment.<br>Caution in elderly/debilitated<br>Patients receiving interacting drugs listed in Appendix 1 of BNF (e.g. ciprofloxacin). |
| **Gaviscon Advance** | Dyspepsia/ oesophageal discomfort/ reflux | 5-10ml | After meals & at bedtime | 80ml | 48 hours | Patients on sodium-restricted diets (contains approximately 3.1mmol of sodium/ in each 5ml dose). |

| Medicine | Indication | Dose | Frequency | Maximum total daily dose over 24 hours | Maximum duration of nurse-led administration | Contra-indications |
|---|---|---|---|---|---|---|
| **Magnesium hydroxide mixture** | Constipation | 15 - 25ml | Once or twice a day | 50ml | 48 hours | Renal or hepatic impairment.<br>Caution in elderly/debilitated.<br>Patients receiving interacting drugs listed in Appendix 1 of BNF (e.g. ciprofloxacin)<br>Confirmed or suspected intestinal obstruction |
| **Senna 7.5 mg tablets**<br>**Senna syrup 7.5mg/5 ml** | | 1 - 2 tablets<br>5 - 10ml | Once a day | 2 tablets<br>10ml | 48 hours | Confirmed or suspected intestinal obstruction |
| **Glycerol 4 gram suppositories** | | 1 – 2 suppositories | Once or twice a day | 4 suppositories | 24 hours | Confirmed or suspected intestinal obstruction |
| **Bisacodyl 10 mg suppositories** | | One 10 mg suppository | Once or twice a day | 2 suppositories | 48 hours | Confirmed or suspected intestinal obstruction |
| **Micolette Micro-enema (sodium citrate)** | Faecal impaction | 1 enema | As required until impaction cleared | 2 enemas | 24 hours | Confirmed or suspected intestinal obstruction<br>Inflammatory bowel disease |
| **Glyceryl Trinitrate 400 mcg sublingual spray**<br>**300 mcg sublingual tablet** | Known angina chest pain | 1 – 2 sprays<br>1 – 2 tablets | Dose may be repeated once after 15minutes | 4 sprays<br>4 tablets | 1 hour | Patients already receiving IV or buccal nitrates<br>Uncertain diagnosis<br>Aortic stenosis, mitral stenosis, hypotension (systolic BP less than 100 mmHg) |
| | | | **Inform doctor if chest pain fails to resolve or if more than 2 doses of glyceryl trinitrate are needed within 24 hours.** | | | |

| Medicine | Indication | Dose | Frequency | Maximum total daily dose over 24 hours | Maximum duration of nurse-led administration | Contra-indications |
|---|---|---|---|---|---|---|
| **Simple Linctus BP (sugar-free)** | Irritable cough | 5mls | Every 6 hours | 20ml | 48 hours | |
| **Zinc and castor oil ointment BP** | Skin barrier to treat/prevent maceration or excoriation (including nappy rash) | Apply to skin where needed | As required | N/A | 48 hours | Allergy/hypersensitivity to zinc oxide, castor oil or other ingredients<br><br>Not to be used on open skin (wounds) but is suitable for superficial loss of skin integrity e.g. excoriation |
| **Liquid Paraffin 50% and White Soft Paraffin 50% oint** | Emollient for dry skin conditions | Apply to skin where needed | As required | N/A | 48 hours | Not to be used on broken skin.<br>Allergy/hypersensitivity to Liquid Paraffin/WSP 50/50 ointment |
| **Aqueous cream BP** | Emollient<br>Can be used as a soap substitute | Apply to skin where needed or as a soap | As required | | 48 hours | Not to be used on broken skin<br>Allergy/hypersensitivity to aqueous cream BP |
| **White soft paraffin BP** | Emollient | Apply to skin or lips where needed | As required | | 48 hours | Not to be used on broken skin<br>Allergy/hypersensitivity to white soft paraffin |
| **Diprobase cream** | Emollient | Apply to skin where needed | As required | | 48 hours | Not to be used on broken skin<br>Allergy/hypersensitivity to Diprobase |
| **Sun-block lotion, SPF 50 (E45 Sun)** | Drug-induced photo-sensitivity | Apply liberally to skin | As required, prior to sun exposure | N/A | N/A | Allergy/hypersensitivity to E45 Sun or its constituents. |

# INDEX – by section

**F**



**G**



**H**



**I**



**K**



**L**



**M**



**N**



**O**



**P**



**Q**



**R**