Medicines Policy

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Purpose of Agreement	This policy sets outs the standards for care and control, prescribing, ordering, supply and administration of medicines within Solent NHS Trust.
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Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
1	Nov 16	8	Addition of Physiotherapists to Healthcare Professional list	
2	Nov 16	11	In some settings a patient's treatment will also include or previously included, P and GSL medicines bought OTC. These items may be included in a patient's treatment but must be considered as part of the patients overall care and included within the formal process, e.g. added to prescription chart and signed records made.	
3	Nov 16	15	Addition of electronic of paper	
4	Nov 16	18	Addition: Prescribing and dispensing should be by exception. It is acceptable to prescribe and dispense in some instances where medicines are required urgently or an FP10 prescription is not possible, in these circumstances having a second checker when dispensing is best practice.	
5	Nov 16	23	Clarification: lockable medicine cupboard, medicines trolley not exceeding 25°C.	
6	Nov 16	31	Addition: or MAR chart	
7	Nov 16	43	Addition: including Children's Community Nursing)	
8	Nov 16	46	Addition: **23.13 School Nursing** Administration of medicines by a registered nurse or health care support worker (HCSW) is part of the role the special school nursing service. School Nurses should ensure that they follow the relevant SOPs with regard to the Administration of Medicines.	
9	Nov 16	70	Addition: or with the express written consent of parent/carer, in accordance with the Solent NHS	
10	Aug 17	19	Addition regarding staff required to receipt medicines	
11	Aug 17	26	Revision of section 13.	
12	Aug 17	56	Addition of nicotine replacement therapy to discretionary medicines list for nurses.	
24	Nov 17	39	Addition to the carriage of medicines by nursing staff	
24	Nov	26	Addition: administration of medicines under the mental health act and mental capacity act and cover t administration	
24	Nov	29	Addition: staff who can receive medicine deliveries	

13	Feb 2018	5	List of definitions moved to Appendix 6	
13	Feb 2018	3	Amended wording to 'all staff have a responsibility to highlight where new guidance may conflict with this policy' (removed word 'identify')	
13	Feb 2018	65	MAR chart definition added before medicine in Appendix 6	
13	Feb 2018	39	Amended title to 'Special School Nursing'	
13	Feb 2018	34	PGD Paragraph removed section 19.4	
13	Feb 2018	21	Lone working policy caveat added 11.3	
14	May 2019	73	Covert administration form added as Appendix 7	
15	August 2019	39	Add New Section – 24 'Research'	
Version 10	August 2020	34,35 71	Addition of points 19.5-19.8 regarding adrenaline injections in an emergency Addition of Appendix 8 – Emergency Adrenaline Advice	
Version 11	March 2021		Extension via Policy Steering Group to allow time for approval of January 2021 revisions	
Version 12	March 2021		Commenced January 2021. Multiple updates throughout the policy to include (not an exhaustive list): Electronic prescribing and administration (EPMA) references, Nursing Associates, STOMP, Remote prescribing, Treatment by post, Pandemic and National Protocols, Anti-biotic stewardship, Blood products, Modifications following Gosport Enquiry.	

Review Log:

Version Number	Review Date	Lead Name	Ratification Process	Notes
4	October 2016	Sarah Nolan	Medicines Management and Safety Committee	
5	April 2017	Sarah Nolan	Medicines Management and Safety Committee	
6	August 2017	Sarah Nolan	Medicines Management and Safety Committee	
7	November 2017	David McCann	Medicines Management and Safety Group	
7	February 2018	David McCann	Policy Steering Group	
8	May 2019	Luke Groves	Medicines Management and Safety Group	
9	March 2020			Extension agreed
10	August 2020	Luke Groves		Chair's action agreed

11	March 2021	Luke Groves	Extension agreed at March 2021 PSG – to extend current policy by one month, to allow time to finalise and ratify updated policy on the back of review at March 2021 PSG	Extension agreed at Policy Steering Group
12	March 2021	Luke Groves	Policy Steering Group, Clinical Executive Group	

SUMMARY OF POLICY

This policy sets out the standards which the organisation expects directly and indirectly employed staff to adhere to in relation to the care and control, prescribing, supply, storage and administration of medicines.

The policy takes account of current legislations, official guidance, recommendations and professional codes of practice. These, however, change with time and all staff have a responsibility to highlight where new guidance may conflict with this policy.

This policy lays out the key principles for the care and control of medicines. Individual services may develop local procedures within this framework in consultation with the Chief Pharmacist. Any local procedure must be approved by the relevant service-line clinical director, senior practitioner or other suitable professional and the Chief Pharmacist via the Solent NHS Trust Medicines Management Group.

Contents

1. INTRODUCTION & PURPOSE

1.1 This policy sets out the standards which the organisation expects all directly and indirectly employed staff to adhere to in relation to the care and control, prescribing, supply and administration of medicines.

1.2 The policy takes account of current legislations, official guidance, recommendations and professional codes of practice. These, however, change with time and all staff have a responsibility to identify where new guidance may conflict with this policy.

1.3 This policy lays out the key principles for the care and control of medicines. Individual services can then develop local procedures within this framework in consultation with the Chief Pharmacist. Any local procedure must be approved by the relevant service-line Clinical Director, senior practitioner or other suitable professional and the Chief Pharmacist via the Solent NHS Trust Medicines Management Group and must adhere to both regulations and professional body standards/requirements.

2. SCOPE & DEFINITIONS

SCOPE

2.1 This policy applies to locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), bank staff, volunteers, Non-Executive Directors, and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 This policy covers all aspects of ordering, prescribing, dispensing and supply, administration, storage and disposal of medicines and is an important aspect in the treatment of all clients receiving care provided by the organisation. Where prescription records are referred to throughout this policy this applies to both paper prescriptions and administration records and electronic prescriptions and administration records unless specifically stated otherwise.

DEFINITIONS

2.4 See Appendix 6 for a full list of definitions.

2.5 Example of term defined in section 6

Administration of Medicines
To give to a patient a medicinal product, dressing or medical device, by introduction into the body (e.g. by injection or orally) or by external application (e.g. application of an ointment or dressing). This covers all situations where a member of staff removes a medicinal product, dressing or medical device from its packaging including (a) using the preparation for a procedure, (b) giving medication to someone who is unable to open a packet or to tell staff what medication they need or (c) to in-patients where the person is not self administering.

3. CONTROLLED STATIONERY

3.1 Solent NHS Trust intends to use Electronic Prescribing and Medicines Administration (EPMA) wherever possible however prescription stationary will still be maintained for some purposes, including business continuity in the event of EPMA system failure. Wherever possible the available EPMA system must be used and users must only use their own account to prescribe and administer medicines. Passwords must not be shared.

3.2 Prescription forms are valuable items and their theft and misuse can represent significant financial loss for the NHS. Prescription forms must be treated as 'blank cheques'. Individual prescribers are responsible for the security of prescription forms once issued to them and must ensure that they are locked away securely when not in use.

3.3 Any person issued with a blank prescription form/pad will be held accountable for its security. Arrangements for security must be documented and comply with the Standard Operating Procedure (SOP) for Ordering, Supply and Security of FP10 Prescription Pads .

3.4 All services must maintain clear and unambiguous records of FP10 prescription pads ordered, received, distributed, or destroyed, and check stock levels regularly in line with the Trust SOP for Ordering, Supply and Security of FP10 Prescription Pads. As a matter of best practice prescribers must keep a record of serial number of prescription forms issued to them.

3.5 Blank prescriptions must never be pre-signed.

3.6 The Trust SOP for Ordering, Supply and Security of FP10 Prescription Pads must be followed where one or more prescriptions are believed to be lost or stolen. An incident form must be completed and reported.

3.7 Inpatient medication charts should be regarded as 'Controlled Stationery' and the appropriate prescription chart must be used in agreement with pharmacy service.

3.8 Electronic controlled drug registers implemented as part of the Trust medicines WellSky electronic medicines stock control system are the preferred form of recording controlled drug usage. Wherever available electronic controlled drug registers should be used. Paper Controlled Drug Order Books and Controlled Drug Registers are types of Controlled Stationery and must be ordered and stored securely to prevent Controlled Drug fraud or diversion.

4. PRESCRIBING/INITIATION OF TREATMENT

4.1 A patient's treatment must be initiated, changed or stopped through a formal process, which may be the production of a prescription chart or form or electronic prescription by an authorised prescriber (these are all patient specific directions), by an approved Patient Group Direction (PGD) or in rare circumstance via a nationally approved protocol from the Secretary of State for Health (such as vaccines in a pandemic situation). Some staff e.g. doctors, non-medical prescribers, midwives, podiatrists, dentists, may administer medicines on their own authority. This does not remove the need for an electronically authenticated or signed record to be made. In some settings a patient's treatment will also include or have previously included, Pharmacy Only Medicine (P) and General Sales List (GSL) medicines bought over the counter (OTC). These items may be included in a patient's treatment. They must be considered as part of the patient's overall care and included within the formal process, e.g. added to prescription charts and signed/authentication records made.

4.2 Patients, including children and young people and their parents or carers, should be helped to be active partners in discussions about their medicines. Risks and benefits of treatment must be discussed, taking into account differing values and beliefs in order to support concordance.

4.3 Solent NHS Trust has taken the STOMP (Stopping over-medication of people with a learning disability, autism or both) pledge:

- We will actively explore alternatives to medication
- We will ensure people with a learning disability, autism or both, of any age and their circle of support are fully informed about their medication and are involved in decisions about their care
- We will ensure all staff within the organisation have an understanding of psychotropic medication including why it is being used and the likely side effects
- We will ensure all people are able to speak up if they have a concern that someone is receiving inappropriate medication
- We will maintain accurate records about a person's health, wellbeing and behaviour
- We will ensure that medication, if needed, is started, reviewed and monitored in line with the relevant NICE guidance
- We will work in partnership with people with a learning disability, autism or both, their families, care teams, healthcare professionals, commissioners and others to stop over medication

4.4 **Specimen Signatures**

In addition to the use of electronic prescribing software wards/services must keep an up to date list of specimen signatures/initial's to be able to identify who has prescribed and administered medicines when paper records are used. An example sheet to be used at ward/service level is attached in Appendix 3.

4.5 **Prescription Writing Requirements**

When hand-written prescriptions must be clear and unambiguous giving full details necessary to enable staff to select and administer the correct medicine by the appropriate route at the right time. When writing a prescription the current guidelines for prescription writing, as documented in the British National Formulary (BNF) must be followed.

4.6 **General Prescriptions requirements:**

- Written legibly in black or blue ink (unless otherwise instructed by the Medicines Management Team for temporary periods for prescription security) or otherwise so as to be indelible or produced on an approved EPMA system.
- Must be dated.
- Must state the full name and address of the patient except for GUM patients where a unique identifier will be used. An addressograph should be used where available.
- Must be signed electronically as authenticated by EPMA system or in ink by the prescriber and have the name of the prescriber printed.
- Must state the date of birth of children under 12. It is good practice to state the age and date of birth of all patients.
- For children the prescription must state the child's weight in kg. Where dosing is based on weight or another unit it is recommended the intended dose in mg/kg (or other units) is stated on the prescription also.
- Independent non-medical prescribers must prescribe within any service formularies or guidelines, and supplementary prescribers under clinical management plans (individualised for each patient) and within their scope of practice. Further guidance is available in the Non-Medical Prescribing Policy.
- Patients must be informed of any changes in their medication and receive appropriate information about the new therapy.
- If treatment is being initiated for administration or supply under a Patient Group Direction (PGD) then the requirements of that PGD must be adhered to as a legal document authorising medicines use under the Medicines Act (and amendments). The PGD allows the specified professionals to supply or administer medicines according to certain defined criteria as specified within the PGD. For further details see section 14.

4.7 **Specific Prescription Writing Requirements**

All prescriptions must comply with the following requirements:

- They must be written on an approved prescribing document or EPMA system.
- Give the form of the medicine, its dose and route, the date and time of administration and where appropriate the rate (e.g. for infusions and medical gases) and site of administration (e.g. for injections).
- Instructions must be in English. Only abbreviations used in the BNF shall be used.
- Where a medicine is prescribed for use 'when necessary' it must clearly state the indication, minimum intervals between doses and the maximum number of doses in 24 hours. Prescribers should also avoid dose ranges wherever possible.
- Where the medicine is administered by continuous infusion the prescription must state the rate of infusion or in the case of continuous subcutaneous infusions, the duration for use of the syringe driver (usually 24 hours).
- Written prescriptions must not be altered or amended later by a prescriber. Subsequent changes in dose require the drug to be re-written.
- Due regard must be taken of any known hypersensitivity.
- If there is any doubt about the legibility of the prescription, or a practitioner does not understand it, the prescriber must be asked to re-write or clarify the prescription. If the prescriber is unwilling to do so, the prescriber must administer the medicine. The nurse must not, under any circumstances

administer the medicines but must inform his/her manager and complete an incident form.

- Repeat prescriptions for outpatients must be reviewed at least every 6 months.
- Unlicensed medicines may be prescribed and licensed medicines may be used for a condition or a dose outside of the product licence. However, this should be in accordance with the trust's Unlicensed Medicines Policy.
- All prescribers are expected to adhere to the District Medicines Formulary applicable to their area of work, which can be accessed via the Medicines Management Section of the Trust's website or via the Pharmacy Service. This includes the Wound Formulary. If a prescriber wishes to prescribe a non-formulary medicine for a patient admitted on that medicine or to prescribe a new previously unauthorised non-formulary medicine there is a Trust approved Formulary request process that must be followed. The prescriber concerned will need to contact the Chief Pharmacist to commence this process for authorisation – See the separate document 'Solent Non-formulary request process'.

4.7.1 **Name of product/medicine**

- Use the Recognised International Name (rINN)
- This should be clear and not abbreviated
- The trade name (proprietary or brand name) should also be used for combination products that have not been given a 'co-' title by the BNF
- Some drugs should be prescribed by brand to prevent confusion e.g. buprenorphine patches.
- Some brands of the same drug vary in length of action or bioavailability (eg. Ciclosporin, lithium, check with BNF or eBNF) so these should also be prescribed by brand.
- The CHM advises prescribers to ensure that when prescribing the following antiepileptics (when used for the treatment of epilepsy), the patients are maintained on a specific manufacturers product to avoid potentially serious consequences of therapeutic failure due to narrow therapeutic index. (see CHM Advice updated 2017):
    - Phenytoin
    - Carbamazepine
    - Phenobarbital
    - Primidone

NB. If the prescribed product is unavailable, it may be necessary to dispense a product from a different manufacturer to maintain continuity of treatment.

4.7.2 **Dose**

- The unnecessary use of a decimal point should be avoided e.g. 3mg and not 3.0mg.
- Where decimal points are unavoidable there must be a zero must in front of the decimal point where there is no other figure e.g. 0.5ml and not .5ml.
- Quantities less than 1mg should be in micrograms e.g. 500 micrograms and not 0.5mg.
- 'Micrograms' and 'nanograms' must be stated in full and not abbreviated to mcg or µg.
- 'Units' must be written/typed in full and never abbreviated to iu or u.
- Medicine names must be written in CAPITAL letters or displayed in type and not abbreviated.

4.7.3 **Inpatient Medicine Charts and Medication Administration Record (MAR) Charts**

- It is the prescriber's (or transcriber's) responsibility to complete all relevant patient details on an in-patient medicines chart or MAR chart whether this is electronic or paper-based, including the hospital/NHS number. (See also separate Trust SOP for writing and using a Medicines Administration Record (MAR)).
- The allergies box on the chart must always be complete. Where the patient is not allergic to any medicines, the words 'nil known' must be stated rather than the box left blank. For hand-written: the allergy box must be signed and dated after each entry. It is good practice to also state the nature of the reaction and the source where this information was obtained from e.g. GP records, patient.
- Ideally when paper charts are used only one medicine chart (unless the total number of medicines prescribed is greater than can be accommodated on one chart) should be in use at any one time for any one patient. If more than one chart is in use, they must be labelled 1 of 2, 2 of 2, etc. When the end of a chart is reached all current prescriptions must be cancelled, and current medication must then be re-entered on a new chart.
- Continuation sheets for paper-based recording of administration of medicines must not be used as this is associated with the risk of error. To cancel a handwritten prescription chart, a diagonal line must be scored through the whole card; this must be signed, dated and filed in the patient's notes. When cancelling a handwritten prescription chart, care must be taken not to obliterate important records on the chart.
- Prescriptions for inpatients must be reviewed at least every 2 months.
- Where a dose is to be given once a week the prescriber must strike out the six days when a dose must not be administered on the administration side of the chart with a 'X' and state "weekly" on the prescription side.
- VTE risk must be assessed for all inpatients and documented and any chemical prophylaxis prescribed as per the Trust's VTE Policy.
- Care must be taken when copying a chart (eg. to scan into primary care record or to send to another provider) to keep the chart as a whole. If the record of administration is separate from the prescription errors will occur.

4.8 Self-prescribing or prescribing for people that the prescriber has a close relationship to.

It is considered poor practice to self-prescribe or prescribe for people for whom there is a close personal relationship. Guidance in relation self-prescribing has been tightened following an increase in fitness-to-practice cases featuring allegations of self-prescribing, self-treatment or informal treatment of family and colleagues. GMC Good Medical Practice Guidance updated in 2016 now states the following:

GMC Guidance: Good practice in prescribing and managing medicines and devices
1. Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship (family, friends or colleagues)
2. Controlled medicines present particular dangers, occasionally associated with drug misuse, addiction and misconduct. You must not prescribe a controlled medicine for yourself or someone close to you unless:

- *no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient's, life or health at risk or cause unacceptable pain or distress, and*
- *the treatment is immediately necessary to:*
  a. save a life

b. avoid serious deterioration in health, or
c. alleviate otherwise uncontrollable pain or distress.

3. If you prescribe for yourself or someone close to you must:
a. make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe, and why there was no other alternative. b. tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object.

The regulatory body for nurses (NMC) advises in the Standards for Proficiency for Nurse and Midwife prescribers:

Practice Standard 11.

- *You must not prescribe for yourself*
- *You should never prescribe for anyone with whom you have a close personal or emotional relationship, other than in an exceptional circumstance.*
- *If a prescription is necessary you should refer this to be undertaken by another registered prescriber wherever possible*

Practice Standard 16:
- *You must not prescribe a controlled drug for yourself*
- *Prescribing controlled drugs for someone close to you:*
  You may only prescribe a controlled drug for someone close to you if:
  a) No other person with the legal right to prescribe is available
  b) And only then, if that treatment is immediately necessary to:
    i) Save life
    ii) Avoid significant deterioration in the patient/client's health
    iii) Alleviate otherwise uncontrollable pain
- *You must be able to justify your actions and must document your relationship and the emergency circumstances that necessitated your prescribing a controlled drug for someone close to you.*

The General Dental Council provides guidance on prescribing medicines:
- Dentists must not prescribe medicines for themselves
- Other than in emergencies, dentists should not prescribe medicines for anyone with whom they have a close personal relationship.

4.9 Prescribing Antibiotics

Antibiotics must be prescribed in line with local guidance to minimise the development of resistance and the risks of C. difficile and MRSA. This includes stating the indication for antibiotic prescription when prescribing and ensuring a finite course length is prescribed. All prescribers of antibiotics must be familiar with and adhere to the relevant local antibiotic policies and guidance relevant to their clinical area.

4.10 Prescribing under the Mental Health Act.

Patients prescribed medicines under the Mental Health Act must comply with T2 and T3 forms. (see section 13).

4.11 Prescribing cytotoxic medicines

All cytotoxic medicines for oncology and haematology uses should be checked with Oncology/Haematology Unit responsible for the patient before prescribing. This is to ensure there are no current contraindications to the medicine and to ensure the correct dosage is prescribed for the patient.

4.12 Prescribing controlled drugs

Full guidance regarding prescriptions for controlled drugs can be found in the Controlled Drug Policy.

4.13 Medicines and Topical Preparations Administered at the Discretion of Nursing Practitioners (Nurses and Nursing Associates)

Registered practitioners can be approved to administer certain medicines and topical preparations at their own discretion for a limited period of time. The Medicines Administered at the Discretion of Nursing Practitioners and Topical Preparations Administered at the Discretion of Nursing Practitioners can be found listed in appendix 4 to this policy. The list provides the indication for which they may be administered, the dose and frequency of administration and the maximum duration. Appendix 5 lists medicines that may be administered to children at the discretion of children's community nurses. The procedures also indicate which practitioners may be approved to administer discretionary medicines. Medication initiated at the discretion of a registered practitioner must be reported to the prescriber when they next visit the ward, or earlier, if indicated by the condition of the patient. All medication administered at the discretion of a registered practitioner must be recorded on the patient's prescription in the section reserved for such medicines and in the patient's notes. Practitioners needing to administer medicines at their discretion for patients who have an electronic or paper Medication Administration Record (MAR) should use the 'once only' section of the MAR.

5. ORDERING AND SUPPLY OF MEDICINES

5.1 Nominated staff, with appropriate qualifications and competencies may order medicines using approved prescriptions and/or order forms (as agreed between each service and the Medicines Management Team) from a number of sources including:

- The local Hospital Pharmacy
- A local community pharmacy
- A pharmaceutical wholesaler
- Directly from a manufacturer

5.2 Medicines received from the pharmacy for use in inpatient areas and clinic based services should be checked against any delivery note provided or the prescription by a registered practitioner before storage or administration. Unregistered staff must not complete requisitions, although they may assist qualified staff in preparing requisitions for certain products such as dressings but these must be countersigned by registered staff.

5.3 In the patient's own home and in other community settings the patient themselves, or their carer, are generally responsible for ensuring medicines are ordered in good time. In some cases Trust staff may feel it appropriate to provide a reminder. For

dressings, Trust Community Nurses who will apply the dressing will order appropriate supplies.

5.4 **Stock Medicines used on wards and in departments/clinics**

5.4.1 Stock medicines must be acquired by using stock requisition sheets as generated by the local pharmacy computer system, which must be completed, signed and dated by a designated practitioner and sent to the relevant pharmacy distribution. Some wards and departments/clinics will have their ward stock medicines topped up by pharmacy staff. For medicines used in resuscitation bags/trolleys the MyKitCheck web-based system is used to stock-check and order items, this is overseen by the Solent Pharmacy on the St Marys Community Health Campus site.

5.4.2 The range and quantity of all medicines, controlled drugs and sterile fluids to be held must be agreed in writing between the practitioner in charge/ ward manager/ team leader and the responsible pharmacist or pharmacy technician in the form of a stock list. Each stock list should reflect current prescribing patterns and should be reviewed at least annually.

5.4.3 Each ward and department/clinic should have a copy of their stock list available to all registered practitioners.

5.4.4 Stock medicines must not be purchased by ward/department staff for the treatment of patients under their care; these must only be obtained from Solent pharmacy distribution (as described above), a Solent approved third party pharmacy such as an NHS Hospital or Wholesaler or in exceptional circumstances these can be ordered from a different pharmacy wholesaler (e.g. where deliveries cannot be made by a hospital pharmacy).

5.5 **Dispensed Medicines for Individual Inpatients**

5.5.1 Wards receiving a clinical pharmacy service (as determined by the Medicines Management Team) should, wherever possible, allow the ward pharmacist or pharmacy technician to initiate the supply of non-stock inpatient medicines and to arrange on-going top-up of these medicines. However, the responsibility for ensuring the medicines are ordered remains with the registered practitioner administering the medication.

5.5.2 For medicines required before the next pharmacy visit, within normal opening hours, the electronic prescribing system should be used to transmit a request or an inpatient chart should be sent to the relevant pharmacy department. For sites at a distance from the supplying pharmacy (i.e. when transport rather than portering services are used) request for inpatient items may be made by secure email such as via nhs.net email. The entire prescription sheet should be scanned and emailed together with a request sheet.

5.5.3 Outside of normal pharmacy hours, supplies should be obtained from the on call pharmacist at the local acute trust via the respective switchboard. The on call pharmacist may assess the need for the medicine as a low priority and advise an alternative course of action.

5.5.4 Samples of medicines obtained from drug companies/drug reps (including dressing and topical medicines) must not be used to treat patients unless this is part of an approved practice change/service change evaluation – this must not be done

without the approval of the Chief Pharmacist and consultation with the Trust research team.

5.6 **Medicines to Take Home (TTOs)**

5.6.1 Medicines for patients to take home can only be dispensed when a pharmacist has clinically checked the doctor's written or electronic prescription. This can either be the ward pharmacist or the dispensary pharmacist if the drug chart or a copy of the drug chart is sent with the TTO, or by accessing an electronic TTO. The supplying pharmacy must endorse what has been supplied on their copy.

5.6.2 Within pharmacy hours:
Where possible the inpatient prescription record will remain on the ward and the clinical pharmacist will check the TTO against the inpatient prescription record. The TTO will then be used to dispense the medication. Otherwise, the TTO form or electronic TTO plus the inpatient prescription record (or copy) must be sent to the pharmacy for supply of the TTOs. For legal reasons, the supplying pharmacy must be in receipt of the original paper TTO or a printout of an electronic TTO signed in ink when controlled drugs are dispensed. TTOs with controlled drugs can be prepared against a scanned/email copy of the TTO but will not be released until the original/signed copy is received. It is the ward's responsibility to ensure that the original is received by pharmacy in a timely manner.

5.6.3 Some areas (e.g. Sexual Health Services), TTO medicines may be supplied directly to patients by registered healthcare professionals as pre-packed items (pre-dispensed into packaging other than that supplied by the manufacturer e.g. with clinic specific directions pre-printed onto the label). A selection of pre-packed medicines is agreed with the pharmacy department and is held at various locations throughout the Trust for supply via organisation approved PGDs or supplied directly by a doctor or dentist.

5.6.4 An essential part of any discharge planning is ensuring that discharge medicines are available on the ward in adequate time. Occasionally, though, there will be a genuine reason for discharge medication to be needed or altered at the last minute. If requesting TTOs via the normal mode would result in an unacceptable delay, then the forms may be taken directly to Pharmacy or sent via secure email e.g. nhs.net. In all cases, the doctor must complete the TTO in line with this policy. If the TTO has missed the routine transport then it will be the ward's responsibility to arrange ad hoc transport.

5.6.5 Discharge medicines should always be dispensed from a pharmacy. In exceptional circumstances, when a patient is to be discharged outside of normal pharmacy hours, the doctor may dispense from ward stock if available. It is illegal for doctors to dispense CDs (including temazepam, pregabalin and gabapentin) from ward stock. The medication must be labelled to include the patient's name, date of dispensing, address of unit, name and strength of drug, quantity and directions. The doctor who prescribes and dispenses medicines is responsible for ensuring that these requirements are met and that the correct medicine is supplied. Medicines should be dispensed in their original pack or suitable medicine container, if this is not possible, an FP10 should be considered. Prescribing and dispensing should be by exception. It is acceptable to prescribe and dispense in some instances where medicines are required urgently or an FP10 prescription is not possible, in these circumstances having a second checker when dispensing is best practice.

5.6.6 Supply to community patients for treatment at home will be via an FP10 collected from a community pharmacy, or via an outpatient prescription dispensed by a hospital pharmacy.

5.6.7 It is the responsibility of the healthcare professional discharging the patient to ensure that:

- The TTO prescription used to discharge the patient with is up to date. The TTO should be checked to ensure that it has been signed or electronically verified by the pharmacist within the last 7 days and that there have been no changes by prescribers to the inpatient chart since that date.
- All the medicines prescribed on the TTO prescription are given to the patient on discharge with directions that match the TTO prescription and they are dispensed for that patient i.e. they have that patient's name on.
- At least 14 days-worth of regular medicines are given to the patient on discharge, or the specific quantity documented on the TTO prescription.
- No other medicines are given to the patient other than those on the TTO (including medicines that have been dispensed during the current hospital admission but are not on the TTO prescription). An exception to this can be made for:
    - Non-prescription medicines that a patient or carer has purchased.
    - Prescription medicines, that the patient brought into hospital with them, that have been stopped **only** if the patient has been advised that the medicines have been stopped and the staff have offered to dispose of them safely but in spite of this the patient requests to take the medicines home. In this circumstance the discharging healthcare professional must advise the patient not to take the medicine without consulting an appropriate prescriber and document this in the notes.
- If a patient is discharged with a Monitored Dose System (MDS) tray the patient is not given the same medicines in other containers (that may have been used for administration while the patient was on the ward).
- Where patients are taking warfarin or an oral anticoagulants they are:
    - given the appropriate anticoagulant book, completed by an appropriate prescriber with doses up until their next blood test
    - told when their INR test is next due if they are on warfarin.
- The patient is given a copy/print-out of the TTO.

5.6.8 Patient's discharged on warfarin:

- The doctor that signs the TTO prescription is responsible for ensuring:
    - A patient on warfarin has an INR test booked at their GP surgery at a clinically appropriate time that the patient can attend, the patient's dose up to the date of their INR blood test is written in a completed anticoagulant book and the patient is given verbal directions about how much to take until the blood test.

5.7 **Posting medicines**

Medicines may be sent to patients by post in certain circumstances. Departments who propose to send medication by post should have a robust process in place that has been discussed in their clinical governance meeting.

- The risks associated with mailing medicines should have been clearly identified and mitigated where possible. The benefits of mailing medicines should have been identified.

- The patient should have given their consent to the medicines being mailed to them. The patient should know when to expect the medicine to arrive, and who to contact if they do not arrive.
- The medicines should be safely packaged to prevent damage in the post, and be in discrete packaging. There should be a clear return address in case of misdirection. The return address should be a department within the Trust where there are appropriate staff on duty to receive returned medicines. Recorded delivery should be used for the posting of medicines.
- When agreeing to send medicines by mail, the member of staff must check that the address (including the post code) is correct. Should a patient ask for medicines to be sent to a different address to their registered address (eg whilst staying with friends or family or asking for medicines to be left with a receptionist in a Solent NHS Trust department) the alternative address should be recorded clearly in the notes and the person eg. Receptionist receiving the delivery informed.
- Liquids may not be sent through the post. Controlled drugs may not be sent through the post.
- These same principles should be followed when a prescriber choses to post an FP10 prescription to a patient or community pharmacy for dispensing outside of the Trust Pharmacy Services.

5.7 **Emergency Medicines required outside normal Pharmacy hours.**

Outside of normal Pharmacy open hours, emergency medicines may be obtained from:

- The Pharmacy On-call Service can be contacted via
    - Southampton General Hospital switchboard for Solent West
    - Queen Alexandra Hospital switchboard for Solent East. This service does not include the dispensing of discharge medicines.
- Medicines may be borrowed from another Solent ward with the exception of controlled drugs. If a medicine is borrowed from another ward, a whole original container should be borrowed. Never transfer individual doses in temporary containers

  Ensure the transaction is noted for the attention of the pharmacist or pharmacy technician on their next visit so the item can be replaced or correctly re-costed.

- If supply isn't obtainable by the above methods then an FP10 can be written for dispensing in a community pharmacy. In the community, a small number of pharmacies are open extended hours to cover most eventualities.

5.8 **Storage of Self-Administered Emergency Medication**

It may be appropriate for some patients to have immediate access to certain medicines to be able to administer them if required, for example if they suffer from an acute angina or asthma attack. The following medicines may be administered in this way:

- Salbutamol or terbutaline Inhalers for treatment of acute asthma
- Glyceryl trinitrate sublingual tablets or spray for treatment of acute angina

There must be a valid prescription for the medicine on the patient's record.

The prescriber or patient's trained nurse must assess the patient to ensure that the patient understands the purpose of this medication and is willing and able to communicate to the trained nurse when a dose has been taken or used. The patient

must also be capable of administering the medicine correctly. If this is not the case, the prescriber should be informed and advice from a pharmacist considered. It is the responsibility of the patient's trained nurse to encourage the patient to tell her/him when a dose has been self-administered, to record this on the prescription and to review these records to ensure the medicine is being taken appropriately.

The medicines can be kept with the patient and not locked away unless there is a hazard to other patients. If the medicine to be used has been brought in by the patient it must meet the PODs suitability criteria.

6. DISPENSING OF MEDICINES

6.1 Medicines will be dispensed in such a way as to support the safe, effective and appropriate supply and use of medicines and the safety of patients. Dispensing will usually only take place within the premises of an approved pharmacy. Occasionally, however, dispensing will occur at ward or clinic level by/supervised by pharmacy staff.

6.2. The approved pharmacy supplier must have SOPs in place to support the safe, effective and appropriate supply of medicines. Medicines must not be transferred from one container to another except when completing Monitored Dose Systems (MDS) or in a designated dispensary area.

6.3 Providers of dispensing services are expected to monitor and investigate any dispensing errors and to provide details to the Chief Pharmacist as requested.

6.4. The following are general expectations for the length of supply of dispensed medicines. There may be clinical reasons for smaller amounts to be prescribed and in such cases requirements for medicines shall be specified appropriately. Also, certain clinical areas have individually agreed lengths of supplies.

- TTOs: patients should generally receive one month supply - 14 days minimum and 42 days maximum (depending on patient's own supply (PODs) or sufficient to complete a course of treatment)
- Outpatients: At least 28 days. Where secondary care retain responsibility for prescribing a longer duration may be supplied up to a maximum of 6 months.
- Leave medicines: patients going on leave shall be supplied with enough medicines to cover the whole period of their leave. If appropriate patients will take their own drugs from the ward. After short term leave, on return from leave, the drug supplied from the ward can continue to be used by the patient providing the PODs have been assessed for suitability.

7. TRANSPORT OF MEDICINES

7.1 All medicines will be transported in such a way as to take account of the safety of staff and the storage requirements of the medicines. All orders and dispatches must be recorded and tamper evident containers shall be used where possible. Dispatches from St Mary's Pharmacy are recorded on individual transport sheets which are signed by the delivery driver/porter and upon receipt. A copy of the transport sheet is retained by the pharmacy.

7.2 Medicines in transit shall only be left unattended if they are placed out of sight in a locked vehicle and only for the period of delivery to another unit or specific patient (e.g. community nurses). Medicines must never be left in a vehicle overnight.

7.3 Cold chain control, within the limits appropriate to the individual product, must be maintained for items requiring refrigeration (see the Trust Temperature Management of Medicines SOP). Validated cool bag or box arrangements must be used when transporting vaccines.

7.4 The dispensing pharmacy shall be contacted to give appropriate advice on any special action to be taken if accidental spillage occurs.

7.5 Arrangements for the transport of controlled drugs must comply with the current legal requirements and as specified in the Controlled Drugs Policy. This includes all schedules of controlled drugs e.g. diazepam, gabapentin, midazolam.

7.6 Where it might be needed for emergency treatment of anaphylaxis in the community, Trust staff may transport a single portable oxygen cylinder (size CD) in their vehicle. Each cylinder must be fixed securely during transportation. There is no requirement to display a HAZChem Notice. Transport of any other medical gases, other sizes of oxygen cylinder or non-emergency, routine use must be done in specially designated vehicles and is restricted to medical gas delivery companies and Trust nominated transport service.

8. RECEIPT OF MEDICINES

8.1 Upon delivery, some suppliers will ask the ward or department/clinic to sign for the delivery. If staff authorised to handle medicines are not available when the department/clinic receives a medicines delivery the staff present should accept the sealed delivery and store it securely until an authorised member of staff can unpack and securely store the medicines (deliveries cannot be left in reception areas overnight).

8.2 A delivery note shall accompany each delivery of stock medicines. The authorised member of staff receiving the order shall check the medicines against the delivery note and sign for receipt. Discrepancies shall be notified to the supplier as soon as possible and an incident form completed. The signed delivery notes must be kept as a record of receipt for a period of 2 years.

8.3 Two members of staff, one of whom must be a registered practitioner, are to receive and unpack stock medication delivered to the ward/clinical area and the stock delivered added to the stock record. The second member of staff can be another registrant or a HCA. Any variance to this must be authorised by the Chief Pharmacist and documented.

8.4 Products such as vaccines must have an additional quality check to ensure that storage requirements through the cold chain have been maintained. Other products such as controlled drugs will require confirmation of compliance with legal and/or local requirements.

8.5 Generally, patients must be encouraged to take their prescribed medicines with them when admitted to hospital and the integrity of these medicines will be checked, in so far as it is practical to do so, before they are used or returned to the

patient. As a minimum, the quality and accuracy of the labelling and the expiry date will be checked.

9. STORAGE AND SECURITY OF MEDICINES

9.1 At any time there will be a nominated person responsible for the safekeeping of all medicines stored in the health care setting. This will usually be the registered practitioner in charge of the ward or department. They must ensure that no unauthorised person has access to medicines.

9.2 All medicines including sterile fluids, with the exception of medicines for emergency use, and non-prescription-only wound care products, must be stored in a robust, lockable medicine cupboard or medicines trolley not exceeding 25°C. Medicines cupboards should be securely fixed to the floor or wall. Medicines that are for internal use (e.g. oral, injectable) and external use (e.g. medicated dressings, topical preparations) must be stored separately from each other in different medicines cupboards or different parts of the same cupboard. Medicine cupboards must be reserved solely for the use of medicines and must not be used for any other product.

9.3 Adequate provision must be made to enable access to named medicines in an emergency. The local storage arrangements must take account of the need for quick access versus the risks associated with misappropriation.

9.4 A medicines trolley may be used for the storage of all administered preparations which are in current use and which require neither special preparation nor special procedures for administration. When not in use, a medicine trolley must be locked and immobilised by locking to the wall or by some other means which prevent unauthorised removal.

9.5 Medicines requiring storage between 2 and 8^{o}C or labelled 'Store in a Refrigerator' must be stored in a dedicated locked medicines refrigerator specifically designed for storage of medicines with an integral thermometer or temperature recording device (see the Trust Temperature Management of Medicines SOP and Medicines Refrigerator Specification). Refrigerator temperatures must be monitored on a daily basis. They must have their current, maximum and minimum temperature recorded every day and the recording device re-set for the following day.
If an item requires refrigeration but is not a medicine and there isn't another fridge or capacity for another fridge then this should be discussed with the Chief Pharmacist. In these circumstances, each item will be considered individually, taking into account alternative storage solutions, infection control risk and any risk of inadvertent administration. Any items approved must be stored in a separate container within the fridge appropriately labelled. Documentation detailing the authorisation by the Chief Pharmacist will be kept with the items.

9.6 If it is discovered that the medicines refrigerator has deviated from the above range then stock should be quarantined and the Medicines Management Team should be contacted for advice. Outside of normal working hours, the relevant on-call pharmacist should be contacted. Further detail can be found (including the management of a medicines refrigerator failure) in the Trust Temperature Management of Medicines SOP.

9.7 Preparations used for cleaning and disinfecting must be stored away from medicines in a separate Disinfectants Cupboard which must be clearly labelled and locked.

9.8 Urine/Blood testing reagents must be clearly labelled and kept in a locked cupboard.

9.9 All medicines must be stored in their original containers or the container in which they were dispensed by the pharmacy. They must not be transferred from one container to another. Injection ampoules and vials must be stored in the outer packaging in which they are supplied. It is good practice only to remove ampoules from their outer packaging at the time they are required and to avoid returning ampoules to boxes.

9.10 Patient's own medicines may be stored in one of the following ways:

a. in a designated area within the medicines cupboard, or a designated 'patient's own' medicine ward cupboard, or
b. an individual 'patient's own' medicine cabinet or
c. in an individual container within a trolley specially designed for the purpose

9.11 Where there is a clinical need to store oxygen cylinders or nitrogen cylinders, refer to the Medical Gas Policy.

9.12 The keys to the medicines cupboards, medicines refrigerator, medicines trolley, lock securing medicines trolley, pharmacy ward stock box and individual patient own drug (POD) cabinets (if available on wards) must be kept on one key ring and are the responsibility of a registered practitioner, normally the practitioner in charge of the clinical area to which the keys relate. It is usual practice for the registered practitioner in-charge of the clinical area to hold the keys themselves. In some exceptional areas keys can be kept in a specific locked cabinet where access is controlled by the registered practitioner in-charge of the unit. Where controlled drugs are held, the controlled drug cupboard key must be kept on a separate key ring and must be held by the practitioner in charge. If both sets of keys are held by one practitioner it is acceptable to attach the CD key ring to the main bunch with a carabiner – it **must** be separated when handing to member of staff who either doesn't require the CD keys or who is unauthorised to hold the CD keys. Any loss of keys must be reported to the designated manager immediately, who must then investigate (including consideration of notifying the police) and follow the incident reporting procedure.

9.13 The practitioner in charge / ward manager / team leader is responsible for ensuring that all preparations on his/her ward or department are currently in date, and that regular checks are carried out to remove out of date items. Wards / teams are encouraged to order conservatively to avoid unnecessary waste. It is also essential, that when putting stock away, stock is rotated appropriately. Community practitioners are responsible for checking the expiry dates on any medicinal products that they either use or carry. Liquid/topical medications may have shortened expiry dates once opened (refer to packaging or to pharmacy for advice if uncertain) and the practitioner in charge will be responsible for ensuring these items are not used beyond their expiry date.

9.14 The manager of the clinical area or the Chief Pharmacist may require a detailed record of stocks of some non-controlled drugs to be maintained in the interest of security.

9.15 Self-administration must include arrangements for the secure storage of medicines as detailed in the Self-Administration Policy (section 15).

9.16 Staff in any supervisory position must be aware of the signs that may indicate abuse or diversion of medicines e.g. changes in an individual's behaviour, regular unexplained absences from the work area, and loss of stock or excessive ordering and take appropriate action as defined locally.

9.17 For controlled drugs (CDs) the Misuse of Drugs (Safe Custody) Regulations apply as detailed in the Controlled Drugs Policy. These Regulations state that CDs must be stored in a CD cabinet or safe, locked with a key. It must be made of metal, with suitable hinges and fixed to a wall or the floor with rag bolts that are not accessible from outside the cabinet. Additional recommendations, e.g. NPSA advice on separating high and low strength Diamorphine injections, must also be adhered to.

9.18 **Restrictions on Medicines Held on Wards**
Certain high risk medicines are not permitted as stock, whilst some are allowed to be held only at a very limited range of locations under set conditions. These high risk medicines currently include:

Medicine	Restriction
Oral methotrexate	**Not permitted as stock.**
Concentrated solutions of potassium salts for injection	**Not permitted on Solent NHS Wards**
Neuromuscular blocking agents	**Not permitted on Solent NHS Wards**
High strength midazolam • **5mg/ml (2ml and 10 ml amps)** • **2mg/ml (5ml amps)**	**Restricted to palliative medicine and clinical areas/situations where its use has been formally risk assessed, for example, where syringe drivers are used.**
The use of concentrated heparin sodium products (over 1000 units/mL)	**Use should be minimised, and wards and departments should normally only stock heparin sodium products of 1,000units/ml or less**

10. MEDICINES RECONCILIATION

10.1 **Reconciliation of Medicines on Admission to Inpatient Areas or Transfer to/from Inpatient Areas**

10.1.1 Medication errors occur most commonly on transfer between care settings and particularly at the time of admission to hospital.

10..1.2 Medicines must be checked and reconciled with the patient's current prescription when patients are admitted to hospital, transferred to other units within a hospital or to another hospital, or discharged from hospital. The Standard Operating Procedure for Medicines Reconciliation includes the specification for collecting and documenting information about current medications on admission, including:

a. Name of medicine(s)
b. Dosage
c. Frequency
d. Route of administration
e. Any specific high risk medications and appropriate consents or risk assessments e.g. valproate medicines in women of child-bearing potential.
f. Checking that a patient has the required alert cards for any specific high-risk medicines e.g. Steroids, Lithium etc.

Establishing these details may involve discussion with the patient and/or carers and the use of records from primary care. Ideally more than one source will be used to ascertain a patient's current medication.

10.1.3 A pharmacist or medicines management technician must review a patient's medication within 48 hours after admission. In some circumstances, though, this time period may vary and will be agreed between the head of service and the Chief Pharmacist.

10.1.4 When transferring a patient from our care the healthcare professional organising transfer must consider the requirements of the accepting organisation or department in terms of medicines administration and medication supplies and ensure sufficient supplies and any medicines administration record/written direction to administer and/or other information to ensure continuity of care is transferred with the patient e.g.:

- Transfer from a Solent inpatient ward to another hospital – ensure the drug chart and medications are transferred. Sufficient supplies must be transferred to last until the receiving ward can obtain further supplies from their pharmacy.
- Transfer from a Solent community team to an inpatient ward – ensure the medicines administration chart and any medications the patient has been using at home are transferred.
- Transfer from a Solent team to a care home – ensure appropriate information required for the care home to create a medicines administration record is transferred (if this is what they do when accepting patients) e.g. TTO prescription form and appropriate supplies of medications (a care home would normally require at least 14 days-worth).

10.2 **Medicines Reconciliation in Outpatient/Community Settings**

10.2.1 Even in settings where a patient will not be admitted into inpatient care, it may still be clinically important for the Clinician/Service to have an understanding of the patient's medication history. This may help in choice of any further prescribing, understanding of possible medicines interactions, or in identifying possible adverse drug reactions or potential side effects and Services are responsible for understanding how a patient's medication history will impact on their overall care.

10.2.2 Ideally, medication history should be checked with more than one source wherever possible.

10.2.3 Practitioners should ensure they ask about high risk drugs as applicable to their clinical areas. The risk associated with particular drugs may be different depending on what Service/clinical speciality the patient is being seen by, but examples to consider may include:

- Anticoagulants
- Systemic corticosteroids
- Opiates

- Cancer treatments
- HIV medicines (check drug interactions if unsure)
- Antipsychotics
- Antiepileptics

11. ADMINISTRATION OF MEDICINES

11.1 No person should administer any medicine unless they are competent to do so and are acting within their sphere of practice.

11.2 Standard operating procedures may be used within individual services to supplement the information in this Policy to specify in detail the preparation, administration and monitoring of medicines in that service particularly injectables, in line with NPSA safety alert 20 – Promoting safer use of injectable medicines. Refer to the Overarching Policy for the Safe Management of Intravenous Medicines.

11.3 Authorised staff may administer some medicines without a second check. IV medication within inpatient areas must receive a second check. All services are expected to undertake a local risk assessment and to clearly state where a second check prior to medicines administration is required. It is good practice to seek checks in the following circumstances:

- where a calculation of a dose volume is involved.
- administration of oral cytotoxic medication
- changing of an insulin cartridge

In these circumstances the person checking shall make any calculations independently. The presence of a person checking does not reduce the responsibility of the person administering the medicine. The person administering a medicine may request a check in any situation for the safety of the patient. Where a second check is not possible, there must be a robust procedure for self-checking. For the administration of Controlled Drugs – refer to the Controlled Drug Policy. However, where there is a lone worker policy the above should not delay patient treatment where appropriate.

11.4 A practitioner must not administer medicines without the authorisation of a doctor, dentist, a non-medical prescriber, a patient group direction or national protocol unless they have legal exemptions during the course of their professional practice e.g. midwives, podiatrists. Competent and Trust authorised Health Care Support Workers are able to administer medicines in the community setting when those medicines are lawfully dispensed for an individual, the current instructions are clear either by the label attached to the medicine or the available MAR chart and remote supervision is in place (see section 11.10).

11.5 Individual services may enable qualified practitioners to administer a small number of non-prescription items, at their discretion. The list of such medicines and the situations when they can be given are clearly described in Appendix 4 - Medicines Administered at the Discretion of Nurses and Topical Applications Administered at the Discretion of Nurses . Where medicines have been lawfully dispensed for an individual and are labelled with instructions, practitioners can legally administer the medicines without separate authorisation. Local procedures need to outline where this may be undertaken within each specific service.

11.6 The identity of each medicine must be clear at all times up to and including the point of administration.

11.7 Before administration, the following must be checked, and any concerns referred to the prescriber before proceeding:

- Patient's name and Hospital/NHS Number on all pages of the drug chart or MAR chart.
- Date of birth and weight if appropriate
- Any allergies / hypersensitivities
- Section Treatment Order if appropriate
- Date and time the dose is due
- The maximum dose if the medication is an as required medicine
- Name of medicine, dose and frequency
- Time of previous dose if any
- Route of administration
- Signature of prescriber or requirements of a patient group direction or national protocol or evidence of a 'direction to administer', as described in the SOP for Writing a Medication Administration Record and section 11.4.

  Where medicines are dispensed with outer packaging it is important to check both the outer packaging and the inner container or tablet/ capsule strip.

11.8 When selecting the medicine, the following must be checked and any concerns clarified before proceeding

- Name of the medicine
- Strength
- Form
- Expiry date
  (eye drops, eye ointment, oral liquid meds, insulins in use should all be labelled with the date they were opened to ensure administration occurs within the expiry).
- That the dose has not already been given
  If there is any doubt regarding any element, the medicine must be referred to the supplying pharmacy.

11.9 When administering a medicine the following process must be followed:

11.9.1 Staff administering medicines must satisfy themselves of the patient's identity. Where identification bands are worn, the full name of the patient must be checked prior to administration of any medicines or therapeutic substance. If there is any doubt about the patient's identity, their NHS Number on the identification bracelet must be checked against the prescription sheet or MAR chart. In areas where identity bands are not worn and if there is continuing doubt regarding the patient's identity, medicines must be withheld until the patient's identity can be confirmed. In some areas, a photograph of the patient is fixed to the prescription to aid patient identification (see Consent to Examination and Treatment Policy).

11.9.2 Read the prescription or MAR chart carefully.

11.9.3 Check the time of last administration.

11.9.4 Select the medicines required, check the label with the chart and expiry date, noting any special instructions and any recorded sensitivities of the patient to medicines.

11.9.5 Prepare the medicines, one at a time, as described below by checking:-

- Name of the patient
- Drug, strength and route
- Dose
- Calculation if any
- Time of administration
- Additional instructions, e.g. after food etc.

11.9.6 Take the measured dose and prescription to the patient and administer the medicines.

11.9.7 The medicine is administered to the patient by the prescribed route. Staff must witness the administration of all medicines and satisfy themselves that it has been taken.

11.9.8 The administration of the medication is recorded on the electronic administration system or by initialling the appropriate section on the written prescription or MAR chart. If for any reason medication is omitted, this should be recorded by entering the appropriate code (as specified on the prescription sheet) in the administration record.

11.10 Health Care Support Workers may:-

- Assist with the identification of the patient.
- Help the patient to take the medicine.
- The registered practitioner is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task.
- In delegating the administration of medicinal products to unregistered practitioners, it is the registered practitioner who must apply the principles of administration of medicinal products. They may then delegate an unregistered practitioner to assist the patient in the ingestion or application of the medicinal product.

11.11 All injections must be administered separately from oral medicines. When preparing medicine(s) for injection, the practitioner must ensure that these are prepared on an individual basis for each patient. Exceptions would be pre-filled syringes, e.g. subcutaneous heparin and immunisations.

11.12 Any person administering a medicine shall be held accountable for his/her own actions. Anyone may refuse to administer a medicine after discussion with the prescriber if they consider that refusal is in the best interest of the patient. A record of any such instance shall be made in the patient's notes.

11.13 A record of each medicine administered to a patient must be made and the administering person identified. Medicines administered from a monitored dose system, where individual medicines cannot be easily identified, are simply recorded as 'all medicines administered'. All omitted, refused or wasted doses must also be recorded. Any dose prepared for administration and subsequently not given must be destroyed in accordance with the Trust's Waste Policy. Medicines shall not be returned to the container from which they were taken. Omissions and refusals must be reported to the prescriber if it is considered that the non-administration may affect the patient's condition.

11.14 Medicines may not in any circumstances be left out in a patient's absence, where they could be taken by another patient. Oral medicines must only be issued to a patient in a medicines pot immediately prior to administration. Medicines must always be locked inside the medicines trolley or medicines cupboard until the patient is available.

11.15 Administration of medication must be withheld if side effects or contra-indications are observed. A note of the withholding must be made in the Health Care Record and the appropriate code (as specified on the prescription chart) entered on the drug chart. A discussion must be held with the doctor as soon as possible. All changes in dosage relating to significant side effects must be entered on the patient's Health Care Records and signed by a doctor.

11.16 All service providers must ensure that staff are aware of the potential risks involved with the administration of oral and enteral liquid medicines via the wrong route. All oral liquid medicines MUST be administered with an oral syringe in line with NPSA Alert 19 – Promoting safer measurement and administration of liquid medicines via oral and other enteral routes.

11.17 Insulin must always be administered using an insulin pen device or withdrawn from an insulin vial using a subcutaneous insulin syringe and never an intravenous syringe. Insulin must NEVER be withdrawn from an insulin penfill cartridge.

11.18 Methotrexate prescriptions must be checked and endorsed by a pharmacist to ensure the prescription is clear and correct before administration. Methotrexate doses are given once a week. Where a dose is to be given once a week the prescriber must strike out the six days when a dose must not be administered on the administration side of the chart with a 'X' and state "weekly" on the prescription side.

11.19 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.

12. REMOTE PRESCRIPTIONS TO ADMINISTER MEDICINES

12.1 A remote prescription to administer a previously unprescribed medicine is not generally allowable. In a life-threatening situation or during a pandemic situation this may be permitted by exception. Additionally if an electronic prescribing system is not available and the medical practitioner is unable to prescribe in writing within an appropriate timescale in relation to the patient's condition this may be acceptable by exception. Responsibility for the decision remains with the doctor. Non-medical prescribers should not prescribe new previously unprescribed medicines remotely.

12.2 **A remote prescription to administer a previously prescribed medicine**.
In exceptional circumstances a remote prescription can be accepted:

- Where the medication has been prescribed previously and the prescriber is unable to issue an electronic prescription on the Trust's EPMA system or a new prescription in person

- Changes to the dose are clinically necessary

The remote prescription must be received by a registered practitioner providing that the practitioner is satisfied that the prescriber's absence is unavoidable and the remote prescription is essential. This can apply to both in-patient and community settings. The remote prescription must be received in the following way:

a. The practitioner in charge will call the prescriber and explain the situation.
b. If the prescriber feels that a further prescription is required, they must use the Trust electronic prescribing system if available, this should then be documented within the electronic medical record (SystmOne) or if an electronic medical record/prescription is unavailable they must send their directions to the practitioner via secure email e.g. nhs.net (if nhs.net is not used the prescriber must ensure they use and Trust IG/NHS IG approved alternative secure email/messaging system) including all the relevant prescription information.
c. If prescribing outside of the Trusts electronic prescribing system, the prescriber's instructions must be transcribed onto the once only area of the prescription form or MAR chart by a registered nurse, ideally this should be witnessed by a second registered nurse. A copy of the directions from the electronic medical record or nhs.net email must then be printed and attached to the chart. If the drug is already prescribed on the chart e.g. warfarin, or a different dose, then reference to the once only section must be made so as to avoid duplication.
d. For handwritten prescriptions the changes to the prescription must be completed in full in the usual way and signed by a prescriber attending the ward within 24 hours (72 hours maximum for bank holidays and weekends).

13. ADMINISTRATION OF MEDICINES UNDER THE MENTAL HEALTH ACT (1983) AND MENTAL CAPCITY ACT (2005) AND COVERT ADMINISTRATION

13.1 Individuals detained under a section of the Mental Health Act 1983

13.1.1 Where an individual is detained in hospital under a section of Part 4 of the Mental Health Act 1983, the Act allows treatment for the mental health disorder to be administered by any means (including covertly) in the absence of consent if it is done under the direction of the Approved Clinician in Charge of the treatment. The Clinician should try to obtain consent where practicable to do so or record why it is not practicable to do so and whether it is a necessary and proportionate step to take to administer medicines covertly to reduce risk to the patient.

13.1.2 For the first three months of an individual's detention, medication for the mental health disorder may be administered by nursing staff under the direction of the approved clinician in charge of treatment in question. There is no requirement for SOAD (Second Opinion Appointed Doctor) certification. The three-month period begins when medication is first administered and will continue even if the medication is changed or if it is not given continuously.

13.1.3 After three months, medication for the mental health disorder may be continued without the individual's consent, if the giving of the medicine is authorised by a second opinion appointed doctor ('SOAD').

13.1.4 Medicines to be administered to a patient for their mental health condition must be recorded on a statutory form in addition to the patient's drug chart (electronic or paper-based). For a patient who has not consented to treatment a Form T3 must be

completed by a SOAD. Where a patient has consented to treatment, Form T2 must be completed by the approved clinician in charge of treatment, or in his absence another approved clinician in charge of treatment The T2 or T3 Forms will represent the legal authority to administer medication to a detained patient. A copy of the T2 or T3 form will be kept with the medicine chart or be available electronically with an electronic medicines administration record, and nurses must refer to it when they administer to the patient any medicine for their mental health disorder, in order to ensure they are legally entitled to do so and that legal requirements have been met. For EPMA a suitable link to electronic T2 and T3 forms will be provided.

13.1.5 Once the initial three-month period has ended, all medication including PRN must be included on the Form T2 or the Form T3. If urgent treatment is required & the criteria under the mental health act are met the approved clinician in charge of treatment must complete a section 62 to allow medication to be administered until a new T2 or T3 is completed.

13.1.6 Where patients are detained under the Mental Health Act, the principles of consent continue to apply to any medications not related to the treatment of the mental health disorder for which they have been detained. Treatment of a physical condition can only be given under the Mental Health Act Part 4 if the condition is a symptom or manifestation of the mental disorder.

13.1.7 Before authorising the administration of medicines, a SOAD must interview the patient, discuss the treatment plan with the Approved Clinician in Charge of the treatment, and consult two other persons who have been professionally concerned with the patient's medical treatment. One of these 'statutory consultees' must be a nurse, and the other must be neither a nurse nor a doctor. Neither the patient's Responsible Clinician nor the Approved Clinician in Charge of the patient's treatment can act as 'statutory consultee', although of course the SOAD will wish to discuss the case with them.

13.1.8 Before administering medication for the mental health disorder, the nurse should:

i. Check the medicine chart and the medicine in the same way as for all other medicines, as laid out elsewhere in this policy. In addition:
ii. Check the date of the first administration, to ensure that the three-month period has not been exceeded.
iii. Where a patient has consented to medication beyond the three-month period, ensure that a Form T2 is in place and is correctly completed, and that the patient still consents.
iv. Where a second opinion has been obtained, ensure that the Form T3 is in place and is correctly completed, and, if the patient is certified as incapable of giving consent, that the patient remains incapacitated.

13.1.9 Further information is available in the organisation's Consent to Examination and Treatment Policy and the Deprivation of Liberty Safeguards and Mental Capacity Act Policy.

13.2 Wishes Expressed in Advance

13.2.1 A patient may have expressed an opinion about medical treatment that they do not want to have. This is known as an Advance Decision to Refuse Treatment (ADRT). A valid and applicable ADRT made by a person over the age of 18 is normally binding. Where the patient is detained and the ADRT concerns refusal of treatment for a

mental disorder, that refusal may if necessary be overridden by the Mental Health Act. However, due regard must always be given to the patient's expressed wishes to refuse the medication.

13.2.2 A patient may have expressed an opinion in an advance statement either verbally or in writing about their treatment preferences. This information is not legally binding but must be taken into account by the clinicians and should be done whether the patient is a patient who lacks capacity to consent or a patient who is subject to the Mental Health Act.

13.3 Individuals Lacking Capacity – Mental Capacity Act 2005

13.3.1 The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and a statutory Code of Practice that accompanies the Act provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack capacity to do things for themselves.

13.3.2 The Mental Capacity Act will apply to patients over the age of 16 years who lack the capacity to consent or to detained patients where the treatment is not for a mental disorder or one of its symptoms or manifestations. A clinician who reasonably believes that the patient lacks capacity to consent to treatment at the time that it needs to be administered may undertake treatment if it is in the patient's best interests.

13.3.3 Before consideration is given to covert administration of medicines, a mental capacity assessment must be undertaken. At this stage it is important to consider any ADRT and whether the patient is likely to regain capacity to consent.

13.3.4 A thorough review of all medications being taken by the patient must be undertaken. Any medicines that are not performing a function or contributing to health outcomes should be stopped. Only medicines essential to a patient's well-being should be considered for covert administration.

13. 4 Covert Administration of Medicines

13.4.1 The covert administration of medicines involves the disguising of medication in food or drink, or giving medicine by any other means, where the patient is being led to believe that they are not receiving medication when in fact they are.

13.4.2 At times a consenting patient will have difficulty in swallowing medicines or they find them unpalatable. In such circumstances it may be possible to give the medicine in food or drink with the patient's knowledge. This is not covert administration and the food or drink is acting as an aid to administration with the patient's consent. A pharmacists' advice must be sought before mixing medicines in food or drink to ensure drug compatibility and/or to consider alternative dosage forms. It may be appropriate to refer the patient to a speech and language therapist for further assessment.

13.4.3 Solent NHS Trust recognises and respects the autonomy of individuals to consent to or refuse treatment. However, there may be instances where a patient cannot consent to treatment because they lack the capacity to do so. In exceptional

circumstances, and with the appropriate processes having been followed, the patient's care plan might require that medicines are administered without the patient's knowledge in the least restrictive way possible.

13.4.4 Staff should be aware that crushing, opening capsule contents and mixing with food or flavoured drinks or otherwise tampering with a medical product renders its use unlicensed. However, the Trust supports this practice as long as it is in line with the covert administration of medicines process described above and that a pharmacist has confirmed the mixing is appropriate from a drug stability point of view.

13.4.5 A decision to covertly medicate should be taken at a patient's Best Interest Meeting and should involve the prescriber, a nurse or senior carer and a patient representative. The patient representative can be anyone named by the patient as appropriate to consult, or anyone who is appointed as personal welfare power of attorney. If there is no-one appropriate to consult other than professionals, an Independent Mental Capacity Advocate must be instructed. Covert medication must not be administered unless there has been a documented best interests meeting beforehand unless in urgent circumstances. As part of this decision making a Covert Administration Form from the Trust Mental Health Act Policy must be completed (see Appendix 6 in Trust Mental Health Act Policy)

13.4.6 Once a decision to administer medicines covertly has been taken, an appropriate care plan must be drawn up, following advice from a pharmacist, explaining exactly how medicines are to be offered to the patient and how they are to be disguised. The care plan must be included in multidisciplinary notes and must be regularly reviewed. For in-patients a covert administration form must be completed prior to administration (Appendix 7 at the end of this policy).

13.4.7 Covert administration of medicines may add to a package of care that amounts to a deprivation of their liberty. The Mental Capacity Act includes a set of checks that apply to patients who lack capacity about their care and treatment. These checks, the Deprivation of Liberty Safeguards (DoLS), aim to make sure that any restrictions and treatments are both appropriate and in the patient's best interests.

13.4.8 There is no need to covertly administer medication to a patient who lacks capacity to consent but is not refusing treatment.

13.4.9 Any medicine presented to a patient within foodstuffs must be witnessed as being consumed by the patient in line with the Trust's Medicine Policy. Therefore consideration should be given to the volume of foodstuff within which the medication is concealed. Uneaten foodstuffs containing medication must be disposed of and a record made of approximately how much medication has been taken by the patient.

14 ADMINISTRATION AND OR SUPPLY OF MEDICINES UNDER A PATIENT GROUP DIRECTION (PGD).

14.1 A PGD is a specific written instruction for the supply or administration of named medicines in an identified clinical situation. A PGD allows specified healthcare professionals to supply or administer medicines to a well-defined group of patients without those medicines being prescribed. The PGD specifies exactly which patients can receive the medicine, who is excluded from receiving the medicine and which medicine they may receive and at what dose. All other criteria associated with the

supply and/or administration are specifically expressed within the PGD. PGDs developed for use within the organisation must follow the Trust's standard format. On rare occasions National PGDs may be employed within the Trust e.g. as part of national vaccination programmes. These PGDs are usually authorised by NHS England and will follow a National rather than a Trust format.

14.2 Legislation requires that PGDs must only be used by the following registered health professionals:

- chiropodists and podiatrists
- dental hygienists*
- dental therapists*
- dietitians*
- midwives
- nurses
- occupational therapists
- optometrists
- orthoptists
- orthotists and prosthetists
- paramedics
- pharmacists
- physiotherapists
- radiographers
- speech and language therapists*

Individual health professionals must be named and authorised to practice under a PGD.

NB: Those professional groups marked with a * may **NOT** supply or administer controlled drugs (Sch 1 – Sch 5) under a PGD.

14.3 Legislation requires that the following must not be included in a PGD:
unlicensed medicines, including:

- the mixing of 2 licensed medicines to form 1 new (unlicensed) product, unless 1 is a vehicle for administration, such as water for injection
- special manufactured medicines
- dressings, appliances and devices
- radiopharmaceuticals
- abortifacients, such as mifepristone.

14.4 Ensure that off-label use of a licensed medicine is included in a PGD only when clearly justified by best clinical practice. Clearly state that the medicine is being used outside the terms of the marketing authorisation on the PGD. Consider informing the patient or their carer that the use is off-label, in line with General Medical Council guidance.

14.5 Ensure that a black triangle medicine is included in a PGD only when clearly justified by best clinical practice. Clearly indicate the black triangle status on the PGD.

14.6 Do not jeopardise local and national strategies to combat antimicrobial resistance and healthcare-associated infections. Ensure that an antimicrobial is included in a PGD only when:

- clinically essential and clearly justified by best clinical practice

- a local specialist in microbiology has agreed that a PGD is needed and this is clearly documented
- use of the PGD is monitored and reviewed regularly

14.7 Do not include a medicine needing frequent dosage adjustments or frequent or complex monitoring in a PGD (for example, anticoagulants or insulin).

14.8 Do not make dose adjustments to a medicine supplied under a PGD when the medicine is already in the patient's possession.

14.9 Do not use PGDs for managing long-term conditions, such as hypertension or diabetes, or when uncertainty remains about the differential diagnosis.

14.10 Only certain controlled drugs are legally eligible to be included in a PGD, in accordance with The Misuse of Drugs Regulations (2001). (See 14.2 for which professional groups may not use PGDs to supply or administer controlled drugs).

Schedule	Controlled drugs that may be considered for inclusion in a PGD	Additional comments
2	Morphine Diamorphine	Use by registered nurses and pharmacists only, for the immediate necessary treatment of a sick or injured person (except for treating addiction)
2	Ketamine	
3	Midazolam	Note that gabapentin, pregabalin and tramadol may NOT be supplied or administered under PGD
4	All drugs, including benzodiazepines	Anabolic steroids and any injectable preparation used for treating addiction must not be included in a PGD
5	All drugs, including codeine	

14.11 Legislation requires that each PGD must contain the following information:
- 'the period during which the direction is to have effect
- the description or class of medicinal product to which the direction relates
- the clinical situations which medicinal products of that description or class may be used to treat or manage in any form
- whether there are any restrictions on the quantity of medicinal product that may be sold or supplied on any one occasion and, if so, what restrictions
- the clinical criteria under which a person is to be eligible for treatment
- whether any class of person is excluded from treatment under the direction and, if so, what class of person
- whether there are circumstances in which further advice should be sought from a doctor or dentist and, if so, what circumstances

- the pharmaceutical form or forms in which medicinal products of that description or class are to be administered
- the strength, or maximum strength, at which medicinal products of that description or class
- are to be administered
- the applicable dosage or maximum dosage
- the route of administration
- the frequency of administration
- any minimum or maximum period of administration applicable to medicinal products of that
- description or class
- whether there are any relevant warnings to note and, if so, what warnings
- whether there is any follow up action to be taken in any circumstances and, if so, what action and in what circumstances
- arrangements for referral for medical advice
- Details of the records to be kept of the supply, or the administration, of products under the direction'.

14.12 A PGD is drawn up locally by doctors, pharmacists and other appropriate professionals, and approved by the Chief Medical Officer, Chief Nurse and Chief Pharmacist on behalf of the organisation. All parties sign for developing and approving the PGD. The professionals signing the PGD are responsible for ensuring it is accurate, practicable and safe. PGDs apply to groups of patients or other service users who may not be individually identified before presentation for treatment. Once the PGD is finally approved, it should be sent to the Medicines Management team for filing and placing on the trust intranet.

14.13 Before administering medication under a PGD, suitably qualified health professionals must have received training in the use of PGDs and the specific medication / vaccine to be administered. Every healthcare professional acting under PGD must be individually authorised to do so by his/her service manager.

14.14 The person administering the medicines is responsible for ensuring that the criteria are met and for administering the medicines. The patient must fulfil the specific inclusion criteria, and be suitable to receive the medication through the relevant PGD in every aspect.

14.15 Ensure PGDs are consistent with the relevant summary of product characteristics, unless the medicine is being used off-label or relevant national guidance is being followed

14.16 Use the best available evidence, such as NICE guidance and other sources of high-quality information when developing PGDs. Include key references in an appendix to the PGD.

14.17 Final versions of the PGDs will be published on the Trust's intranet.

14.18 When practising under a PGD, health professionals should:
- not delegate their responsibility
- ensure that they can determine that the patient meets the inclusion criteria as set out in the PGD

- ensure that they can determine that no exclusion criteria apply
- discuss alternative options for treating the patient's condition, when appropriate
- assess each individual patient's circumstances and preferences
- recognise when signposting or referral to another health professional or service is needed, as specified in the PGD
- understand relevant information about the medicine(s) included in the PGD, such as:
    - how to administer the medicine
    - how the medicine acts within the body
    - dosage calculations
    - potential adverse effects and how to manage them
    - drug interactions, precautions and contraindications
    - storage requirements, including maintenance of the 'cold chain'
    - follow-up arrangements
- be able to advise the patient or their carer about the medicine(s), as appropriate.

14.19 When supplying a medicine(s), provide an appropriately labelled pack. Do not split packs.

14.20 Ensure that the patient receives a manufacturer's patient information leaflet with each medicine.

14.21 Document the following information about the clinical assessment and supply and/or administration of the medicine(s):

- date and time of supply and/or administration
- patient details, such as name, date of birth, allergies, previous adverse events and how the patient met the criteria of the PGD
- details of medicine, such as name, strength, dose, frequency, quantity, route and site (if by injection) of administration (record the batch number and expiry date for vaccines,
- a statement that supply or administration is by using a PGD
- name and signature (which may be an electronic signature) of the health professional supplying or administering the medicine
- relevant information that was provided to the patient or their carer
- whether patient consent to treatment was obtained, in line with the Department of Health's advice on consent (2009).

15 SELF ADMINISTRATION OF MEDICINES

15.1 There are a number of potential advantages to patients administering medicines to themselves where possible as part of a Self-Administration Scheme (SAM):

- Increased patient empowerment.
- Improvement in patient-education and concordance.
- Improved awareness of the patients' ability to cope with medication while they are on the ward and their needs after discharge.
- Better use of time in the ward environment by both nursing and pharmacy staff.
- Better communication between professionals and reduction in medication errors.
- Reduction of waste with corresponding savings in drug expenditure.

15.2 Prompting self-administration of medicines can be recorded in the case notes (unlike medicines administration which must be recorded on a MAR or drug chart).

15.3. For further guidance, refer to the Policy for the Self-Administration of Medicines on Solent Inpatient Wards.

16 PRESCRIBING AND ADMINISTRATION OF INTRAVENOUS MEDICINES

16.1 The methods of administration of intravenous medication are:

- By the addition of the drug to an intravenous fluid container.
- By injection of the drug through the injection port of an intravenous giving set.
- Intermittently through an indwelling needle or cannula.
- intermittently via central and PIC lines
- By a syringe driver, pump or other infusion device.

16.2 The Medicines Policy above should be followed when prescribing and administering intravenous drugs, but the additional steps and safeguards that must be followed for intravenous medicines, including the training/qualifications required by staff prior to administering intravenous medicines, are included in the Overarching Policy for the Safe Management of Intravenous Medicines.

16.3 Intravenous blood products are classified as biological matter/human tissue so do not fall under the remit of this policy. Blood products must only be checked and administered by registered practitioners who have undertaken additional training and competency assessment in the administration of blood products, this should include training and or assessment from a blood transfusion specialist.

17 RETURN AND DISPOSAL OF UNWANTED MEDICINES

17.1 Stock and individually dispensed medicines in inpatient settings, which are suitable for re-use by the supplying pharmacy, must be returned to the pharmacy with a visiting member of pharmacy staff or by alternative arrangement with the supplying pharmacy.

17.2 For patient's own medicines that are deemed unsuitable for use, the doctor, practitioner or member of the pharmacy team will seek the patient's permission for their destruction.

17.3 Patients own drugs for disposal must be stored in a separate designated cupboard or in a designated area within the medicines cupboard.

17.4 Specific regulations relate to the disposal of controlled drugs – refer to the Controlled Drug Policy and associated Standard Operating Procedures for more information. Only Authorised Persons are permitted to dispose of controlled drugs.

17.5 In Community Nursing Services, medicines dispensed for a patient are the property of that patient. Community practitioners should encourage patients / carers to return unwanted or obsolete medicines to their community pharmacy for the purpose of disposal. The community practitioner may, with the consent of the patient / relative, or where the practitioner believes they may constitute a risk, dispose of the medicines if they have appropriate medicines waste bins with them (if higher risk and/or small quantities), or return the medicines for disposal to a community pharmacy. A note must be made on the patients nursing records which

must include the date, name, strength and quantity of drug. The pharmacist should be asked to countersign the record wherever possible as best practice.

17.6 The disposal of pharmaceutical waste is governed by the Hazardous Waste Regulations 2005 and compliance must be ensured within each service / health service setting. Refer to the Trust Policy for the Safe Handling and Disposal of Healthcare Waste for further guidance.

17.7 All medicines waste must be separated into hazardous and non-hazardous waste. The majority of medicines used within the organisation will be non-hazardous. Refer to the *Safe Management of healthcare waste* (for an example list of cytotoxic and cytostatic medicines.

17.8 Medicines waste (both hazardous or non-hazardous) includes the primary drug packaging which comes into contact with the medicine, for example, empty blister strips and bottles containing syrup residues. It also includes used/unwanted medicines, e.g. patches that have been removed from a patient (must be folded in half to prevent drug leakage) and other formulations that have been dropped, spat out, or declined by the patient. An outer cardboard packet is not medicines waste and can be disposed of in a domestic waste bin provided it does not have any patient identifiable information on it. All waste containing a significant amount of drug must be stored in a locked cupboard/store while waiting for disposal. Empty blister strips and empty bottles do not have to be stored in a locked cupboard but must be stored securely, for example in a treatment room. Loose tablets and capsules must be wrapped in adhesive tape or in a paper administration cup before disposal in the designated clinical waste bins

17.9 Hazardous medicines waste (which includes any medicine which is cytotoxic or cytostatic) must be placed in purple lidded hazardous waste boxes. Anything placed in these boxes will have to be consigned separately so a full list of contents must be kept. When these boxes are three quarters full the box is sealed with postcode identifying tape and the label completed with date closed. The removal of the box is then arranged as per local procedure, along with the list identifying the contents. It will then await collection by the waste contractor.

17.10 Non-hazardous medicines waste including the primary drug packaging can be disposed of in blue lidded containers which are obtained from stores. They must be sealed when no more than three quarters full with postcode identifying tape and the label annotated with date closed. The removal of the box is then arranged as per local procedure. It will then await collection by the waste contractor.

17.11 Further information is available in the Policy for Safe Handling and Disposal of Waste.

18 INCIDENTS INVOLVING MEDICINES

18.1 If there is any risk of harm to an individual due to an incident involving medicines, priority must be given to the clinical care of that person(s).

18.2 Any incident or near miss in which medicines are involved must be reported in accordance with the organisation's incident reporting policy. The incident must immediately be reported to and investigated by the appropriate line manager, or person delegated to act on their behalf.

18.3 Where a drug administration error occurs, the appropriate prescriber must be contacted as soon as possible and when necessary, remedial action taken to ensure the safety of the patient. An entry must also be made in the patient's health care record.

18.4 As part of the incident investigation supporting statements may be required from all staff concerned and these are essential if there is any possibility of serious injury to the patient or of litigation.

18.5 Any drug may produce unwanted or unexpected adverse reactions. Detection and reporting of these is of vital importance. All staff are urged to report suspected adverse reactions to the Commission on Human Medicines using the Yellow Card Scheme. All suspected adverse drug reactions to "black triangle" drugs and any serious or unusual suspected reactions to established products should be reported.

18.6 During the manufacture or distribution of a medicine an error or accident may occur whereby the finished product does not conform to its specification. Any suspected defect in a medicine must be reported to the supplying pharmacy. Reports on suspected defective medicinal products must include the brand or the non-proprietary name, the name of the manufacturer or supplier, the strength and dosage form of the product, the product licence number, the batch number and the nature of the defect. If the defective medicine has been administered to a patient the prescriber must be notified and the incident reported in accordance with the organisation's incident policy.

18.7 All medication errors are reviewed by the Medication Safety Officer and common themes and shared learning are discussed at the Medicines Management Group as a standard item.

19 ALLERGIC EMERGENCIES AND ANAPHYLACTIC SHOCK

19.1 The most up-to-date organisation policy for The Management of Resuscitation must be used. This is available on the Trust website.

19.2 All staff who administer medication must be familiar with the particular protocol for the clinical setting in which they work, and must attend annual updates on recognising the signs and symptoms of anaphylaxis and its treatment.

19.3 All settings where medicines are administered, including in community nursing, must have access to Adrenaline 1:1000 Injection plus associated needles and syringes to administer the medicine intramuscularly.

19.4 In an emergency, Adrenaline can be administered intramuscularly without a prescription or PGD.

19.5 Clinical and non-clinical staff who have received relevant resuscitation training are able to administer adrenaline.

19.6 Adrenaline for use in anaphylaxis is available in an auto-injector administration device, where adrenaline is stored or carried for use in emergency an auto-injector device should always be used.

19.7 When adrenaline auto-injectors are not available such as in-times of national shortage, adrenaline in ampoules for intramuscular injection should be used. Staff attending a resuscitation incident where adrenaline may be required are to only draw up and administer injectable adrenaline from ampoules if they are competent to do so. If attending staff are not competent to draw up and administer adrenaline from ampoules, when the emergency services are called, they should be advised that an injectable form of adrenaline is not available.

19.8 For further information please see appendix 8 – Emergency Adrenaline Advice – March 2020.

20 USING MEDICINES OUTSIDE OF THEIR PRODUCT LICENCE

20.1 Whilst using medicines within their product licence should be the normal practice, the organisation accepts that this may not be possible in some circumstances. A medicine may be recommended by a prescriber that does not have a UK or EU product licence (an unlicensed medicine) or may be a medicine that has a product licence for an alternative condition or at an alternative dose to the one being recommended (off-label use).

20.2 Dosage recommendations produced by the pharmaceutical company making the unlicensed medicine must be strictly adhered to. The supplying pharmacy department must keep an accurate record of each named patient drug dispensed and ensure that sufficient medication is available for each patient on subsequent return visits, unless further supplies can be arranged via a community pharmacist.

20.3 Prescribers must complete all relevant documentation and undertakings with respect to named patient drugs obtained from a pharmaceutical company prior to prescribing and prior to the drug being released by the pharmacy department.

20.4 Where appropriate the patient or their parent/carer must be informed before prescribing that an unlicensed or off-label medicine is being recommended and the patient should understand that the product might be less well understood than a licensed product. They must also be informed that as many unlicensed medicines are imported, the standard of packaging of the medicine may not be as good as the usual packaging (e.g. may be in a foreign language).

20.5 A large proportion of medicines used in paediatrics and child health are not licensed for use in children. Children and, more appropriately, their parents / carers must be informed of this before prescribing.

20.6 Where a doctor prescribes an unlicensed or off-label medicine the practitioner signing the prescription accepts clinical responsibility and liability for the medicine's effects. The expectation is that a prescriber acts in accordance with appropriate current practice. A prescriber may be called upon to justify their prescribing by other professionals involved in supply and administration of medicines prescribed out-of-licence.

20.7 Where a prescriber recommends or advises the use of a medicine outside its product licence to another prescriber this shall be stated together with a justification of the unlicensed use.

20.8 Where a prescriber directs administration of a medicine outside its product licence the practitioner administering must be informed. Practitioners administering licensed medicines used outside the product licence must be satisfied they have sufficient information to administer the medicine safely and that there is acceptable evidence for the use of the medicine for the intended indication by actively seeking information from the prescriber and other appropriate sources.

20.9 Full guidance is contained within The Use of Unlicensed and Off-Label Medicines Policy.

21 MEDICATION FOR PERSONAL USE OF STAFF

21.1 It is not permitted for staff to use or take hospital medication from stock for their own personal use or to give to another person or member of staff. This constitutes theft and can lead to action being taken in accordance with the Trust improving and managing conduct procedures and/or legal action being taken.

22 WARD/DEPARTMENT CLOSURE OR TRANSFER

22.1 Any planned closure or transfer of a ward/department which holds medicines should be notified to the Medicines Management Team.

22.2 If the ward/department is closing, the supplying pharmacy should be informed of the date and arrangements should be made to transfer the medicines back to pharmacy securely via a registered member of staff or by designated transport.

22.3 If the ward/department is transferring to another site the all medicines stock held should be rationalised and the stock list updated to ensure all medicines are still required. The supplying pharmacy should then be informed so that stock lists can be updated.

22.3.1 The supplying pharmacy should be informed of the new destination so that ongoing transport can be rearranged.

22.3.2 The Medicines Management Team will provide advice on how to securely transport the medicines to the new destination.

22.3.3 If there is a time period between transferring, all medicines should be returned to the supplying pharmacy for secure storage. An inventory should be made of the medicines sent. The pharmacy will then quarantine the medicines in anticipation of the transfer. In the case of refrigerated medicines these should always be removed from any transported refrigerator prior to transportation. The refrigerated medicines may be returned to pharmacy (as 22.2 above) or transported in appropriate cold storage containers.

22.4 Any return or transfer of controlled drugs must be completed by a pharmacist.

23 COMMUNITY NURSING (including Children's Community Nursing)

23.1 While the general requirements of this Policy outlined above apply to Community Nursing Services, there are a number of processes that will differ in light of the community setting, as detailed below.

23.2 Prescribing/Initiation of Treatment

All medication must be prescribed for a named patient, and is the patient's own property. It is not generally the practitioner's responsibility to obtain patient's medication from the community pharmacy. However, in exceptional circumstances the practitioner may obtain medication via an FP10 prescription, and transport them to the patient's home as an "agent" of the patient (see section 7 Transport of medicines). In some areas where the service has been approved to receive stock medicines, authorised medicines will be issued via a stock list. These items must be prescribed on an organisation approved drug chart or electronic prescribing system by a medical practitioner, or administered under the Standard Operating Procedure for Medicines Administered at the Discretion of Nurses.

23.3 Storage

Medication must be stored in the patient's own home or community setting wherever possible and it is the practitioner's responsibility to teach patients and carers correct storage methods. Where it is inappropriate or unsafe to store medication in a patient's home but the medication is deemed to be essential, the medication must be stored in a designated area, e.g. practitioners office, health centre or day hospital in an appropriate medicines cupboard (see storage of medicines section 7 above).

23.4 Carriage

23.4.1 Delivering a medication to a patient (for instance if they cannot get to the practice), see section 23.2 above.

23.4.2 Medication carried by practitioners must be carried in a locked case or suitable alternative and where practicable remain in the possession of the practitioner.

23.4.3 Medication left in the car must be stored in a locked container and placed in the boot or stored unobtrusively. The car must be locked at all times when left unattended.

23.4.4 Practitioners should be aware that the shelf life and efficacy of medicines is affected by extremes of temperature.

23.4.5 Controlled Drugs must never be left unsecured. Ie. unless they are locked away in an appropriate and compliant storage/container they must be attended/supervised by a competent registrant at all times/.

23.4.6 Where Nurses or therapists will be administering medications under a PGD, or where they are NMPs and will be prescribing for the individual(s), it is acceptable to carry a stock of medication(s) for this purpose.

23.5 Record Keeping

The practitioner must sign on the appropriate prescription / administration sheet for medication which he / she personally administers. Medication wasted must be recorded in the same way. Following discharge or death, all records of medication/administration must be retained in the patient's Health Care Records.

23.6 Review of Medication

The practitioner must ensure that all medication administered to patients is regularly reviewed by discussion with the patient, doctor and pharmacist if

appropriate. The timing of these reviews depends on the area in which the practitioner is working but in any case should usually be at least every 6-12 months.

23.7 Loss or Theft

In the event of a suspected loss or theft of medication, or where there is suspicion that a medication container has been damaged or interfered with, the practitioner must ideally seek a double check from a colleague if practical and then inform their line manager immediately who will advise on the necessity to inform the police. A Trust incident form must be completed.

23.8 Drugs Administered Via a Syringe Driver

23.8.1 Community practitioners will follow the most recent standard operating procedure for the Administration of Medicines by continuous infusion via a syringe driver . Paediatric community practitioners will follow the most recent Syringe Driver Procedure for Paediatric Nursing Services.

23.8.2 In the event of using pre-loaded syringes which have been made up by the hospital pharmacy, these syringes must be clearly labelled stating:-

- Drug contained within the syringe
- Strength / dose contained
- Total volume
- Time period of administration (e.g. over 24 hour period)
- Batch number
- Date of manufacture
- Expiry date
- Patient name
- Special storage requirements

23.8.3 Drug administration records must be kept of all controlled drugs administered. These records must include the date, time, name of drug, dose, frequency and route of the drug administered. It is good practice to keep a running balance of the quantity of controlled drug received and administered. These Records provide an audit for all Controlled Drugs.

23.8.4 If a syringe driver is prescribed with an incremental increase in opioid dose as required, consider discussing the need for increasing the dose of the opioid with another senior community practitioner or doctor before making the prescribed incremental increase in medication. Document any changes in the patient's notes. Patients and/or their carers should always be involved in decisions taken regarding the decision to prescribe a syringe driver and the dosing method employed.

23.9 Adult Vaccination

As well as Solent NHS Trust PGDs, Patient Group Directions written on behalf of NHS England and approved for use within the Trust are used to cover the administration of vaccines within primary care and community settings as well as the Trust secondary care setting. Service managers and senior staff must ensure the correct and most recent versions are in use in service areas.

23.10 Children's Immunisation Programme

23.10.1 Separate Patient Group Directions are in place to meet the requirements for the childhood immunisation programmes. Community practitioners who are involved in administering vaccines must be provided with their own individual copies of PGD's

they are working to. Service managers and senior staff must ensure the most recent versions are in use in service areas.

23.10.2 National policies and procedures will be followed in accordance with the Trust's Immunisation Protocols.

23.10.3 Only practitioners who have received appropriate training may administer vaccines.

23.10.4 Practitioners must be appropriately qualified to administer vaccines and to recognise and treat anaphylaxis. The necessary drugs will be carried in a designated container. Documentation must be completed in accordance with Trust policy, including public and child health records.

23.11 Carriage of Medical Gases

23.11.1 Where it might be needed for emergency treatment of anaphylaxis in the community, Trust staff may transport a single portable oxygen cylinder (size CD) in their vehicle. The cylinder must be fixed securely during transportation. There is no requirement to display a HAZChem Notice. Transport of any other medical gases or other sizes of oxygen cylinder must be done in specially designated vehicles and is restricted to medical gas delivery companies and Trust contracted transport.

23.11.2 When a patient is discharged home and requires an oxygen cylinder to be transported to their home arrangements must be made with an approved oxygen carrier or as per above Trust staff may transport a single portable oxygen cylinder (size CD) in their vehicle. The cylinder must be fixed securely during transportation. There is no requirement to display a HAZChem Notice. Oxygen cylinders cannot be transported in taxis or the vehicles of patient's carers, friends or family.

23.12 Adjustments that may be required to support patients with their medicines

23.12.1 Health professionals can employ a combination of strategies to promote patient adherence to prescribed medication. There must be a full assessment of the patient's abilities and also a risk assessment of the possible outcomes of non-compliance.

23.12.2 The GP practice or community pharmacist will need to undertake an assessment of the patient to determine whether they are eligible under the Disability Discrimination Act for a reasonable adjustment (free on the NHS) to be made to help them with taking their medicines. Approaches to improve compliance should be kept as simple as possible, for example: rationalising medication administration to once or twice a day when a carer could supervise, recommending easy open tops, providing a reminder chart, or ordering and delivering medicines and use of monitored dosage systems (Nomad systems). Assessments made by pharmacists or pharmacy technicians are usually available within 4 to 7 days.

23.12.3 Where it is considered, after discussion with a pharmacist, that this time frame to obtain an assessment would put the patient at risk, and a pharmacist is unable to provide immediate support, then a practitioner may provide and / or fill a temporary compliance aid in the form of a monitored dosage system until a full assessment by a pharmacist can be made. This should only be necessary over a weekend / bank holiday break. Wherever possible a pharmacist must fill the compliance aid.

23.12.4 However, in the interests of patient care and where no pharmacy service is available, registered practitioners can support the patients in filling and using compliance aids as part of their role to support and instruct patients regarding their medication. The NMC guidance must be followed that "the patient has a right to

expect that the same standard of skill and care will be applied as if the patient receives the medication from a pharmacist. This includes the same standard of labelling and record keeping". Practitioners should be aware of the risk of errors if they choose to repackage dispensed medicines into a compliance aid.

23.13 Special School Nursing

Administration of medicines by a registered nurse or health care support worker (HCSW) is part of the role of the special school nursing service. School Nurses should ensure that they follow the relevant SOPs with regard to the Administration of Medicines.

24 RESEARCH

24.1 Any research involving medicines must conform to the regulations and guidelines outlined in the UK Policy Framework for Health and Social Care Research (and must have approval from the Health Research Agency (HRA) and the Medicines and Healthcare Products Regulatory Agency (MHRA). It must also be registered with the Solent NHS Trust Research Team, and conform with its Research Governance Policy. Research that has this approval does not require additional approval from the Medicines Management Committee.

Other innovation projects or evaluation projects that involve medicinal products that are not classified as healthcare research, and do not require HRA/ MHRA approval, should register their project with the Solent NHS Academy of Research & Improvement team and obtain local ethics approval. Projects that include a novel approach, or the use of a process not approved in this policy, should be brought to the Medicines Management Committee for discussion. MMC can authorise practise outside of this policy for the duration of the project so long as it has local or national ethics approval and is registered accordingly.

25 ROLES AND RESPONSIBILITIES

25.1 The Chief Executive has overall responsibility for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

25.2 The Chief Operating Officers, Chief Medical Officer and Chief Nurse and the Clinical Directors, on behalf of the Chief Executive, will ensure that clinicians and their practice comply with this policy.

25.3 Service managers, modern/clinical matrons and consultant practitioners will ensure that:

- The requirements of this policy are brought to the attention of all employees for whom they are responsible, i.e. new recruits and existing staff members.
- Employees are supported in the identification of training and development needs and have access to training if required.
- Staff involved in any aspect of medicines use understand their responsibilities and are competent to undertake those responsibilities.
- Facilities and equipment being utilised are provided and maintained to the required standards.
- Systems for routine audit, review of adverse events and patient complaints relating to the handling of medicines are in place.

25.4 The responsibility for monitoring this policy and advising on best and current evidenced-base practice is primarily vested in the Chief Pharmacist.

25.5 All staff must be aware of their roles and responsibilities under the current legislation and adhere to the safe practices outlined in this policy. Persons not complying with this policy will be subject to the Trust improving and managing conduct procedures and a safe-guarding referral considered. Staff must also make themselves familiar with local standard operating procedures for specific areas of work. Staff have a responsibility to ensure that their practice is current and up-to-date and that they are competent to fulfil their role in all aspects relating to medicines. Any breach of this policy is to be reported immediately to their service manager. Staff also have a responsibility to ensure working practices of colleagues or co-workers, students and trainees under their supervision are compliant with this policy.

25.6 The policy considers the processes associated with the physical handling of medicines. Each area is outlined in generic terms and must be supported by service / health care setting Standard Operating Procedures (SOPs) where further detail is required for local operational implementation.

25.7 It must be recognised that compliance with this policy does not override any individual responsibility of healthcare workers to ensure that:

- Their practice complies with current legislation.
- They follow guidance issued by the Department of Health, professional bodies (e.g. Nursing and Midwifery Council, General Pharmaceutical Council) or other government departments such as the Home Office.
- They manage the risks to patients, relatives, carers and staff arising from the use of medicines.

26 TRAINING

26.1 Individuals who prescribe, dispense or administer medicines must be trained to the appropriate level for their duties and must be able to demonstrate competence including in dose calculations.

26.2 All staff involved in the handling of medicines require appropriate training and some eLearning modules are mandated for these staff. Medicines Management training is provided by the Medicines Management Team in medicines training courses and updates, and on a one-to-one or one to a small group basis to address more individual needs. Specific Medicines Management courses are accessible by staff via the Learning and Development Department and the usual application process. More specific training to meet individual needs should be addressed directly to the Medicines Management Team. Attendance of staff at training must be recorded and monitored by service managers.

26.3 Staff require to be explicitly authorised by their line manager to carry out specific roles in medicines management and safety of patients is paramount. This must be reflected in the job description of the individual.

26.4 Staff who may be exposed to risk from others or from medicines, including non-professionals (porters, drivers etc.) shall be trained by their line manager in the need

for security, what to do if spillage occurs (e.g. COSHH regulations) and transport of pressurised containers. Staff must undergo regular updating.

26.5 All supervisory staff shall be vigilant for signs that may indicate abuse or diversion of medicines and take appropriate action or discuss with their manager. Additional advice can be sought from the organisations Chief Pharmacist in the first instance.

26.6 All medicines training must be recorded on the Organisational Learning Module database against individual staff records.

26.7 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet.

27 EQUALITY & DIVERSITY AND MENTAL CAPACITY ACT

27.1 For the Equality & Impact and Mental Health Assessment conducted in relation to this policy refer to the Equality Impact Assessment Form (Appendix 1). There is no negative impact on any patient group or staff group as this policy is to ensure equality of practice across the organisation.

28 SUCCESS CRITERIA/MONITORING EFFECTIVENESS

28.1 The responsibility for monitoring this policy will be vested in the Chief Pharmacist.

28.2 Each service provider must have an audit programme in place to ensure compliance with this policy. A Medicines Management Processes and Stock Control Audit is available for services to complete on the Trust Intranet. This audit should be completed annually. The organisation's Chief Pharmacist will ensure annual assessment of compliance with this policy through this audit.

28.3 The Medicines Security Self-assessment Tool produced by NHS Protect will be completed annually by the Chief Pharmacist taking into account locally completed pharmacy and ward/department checklists.

28.3 The effectiveness of this policy will be reviewed by the Medicines Management Group and will be discussed prior to the stipulated review timeframe at the Medicines Management Group meeting. Details of these discussions will be documented in the minutes.

28.4 The policy will also be monitored through various other methods including adverse incident reporting, significant event review, other medicines management audits and clinical prescribing audits, as required and agreed on a regular basis. Audits will be completed on an annual basis.

28.5 The Assurance Committee will be responsible for overseeing risk management and clinical or corporate governance issues.

28.6 The policy will be assessed by the Policy Steering Group who will review the policy and any updates being presented to the Group to ensure that they conform to Trust procedures and format. This Group will determine subsequent ratifying groups that the policy should be presented to.

29 REVIEW

29.1 This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

30 REFERENCES AND LINKS TO OTHER DOCUMENTS

30.1 References

- Professional Guidance on the Safe and Secure handling of Medicines – December 2018
- Professional Guidance on the Administration of Medicines in Healthcare Settings – January 2019
- Advisory Guidance on the Administration of Medicines by Nursing Associates – December 2017

- Medicines, Ethics and Practice, a guide for pharmacists: The Royal Pharmaceutical Society of GB , Edition 43, July 2019
- Medicinal Products: Prescription by Nurses etc. Act 1992
- Health and Social Care Act 2012. London. The Stationery Office. Available at: www.legislation.gov.uk
- The Medicines Act (1968)
- The Human Medicines Regulations 2012
- The Misuse of Drugs Act (1971) and Regulations
- Misuse of Drugs Regulations 2001
- Misuse of Drugs (Safe Custody) Regulations 1973
- Misuse of Drugs (Supply to Addicts) Regulations 1997
- The Controlled Drugs (Supervision of Management and Use) Regulations 2006 (Came into effect in England on 1st January 2007)
- Safer Management of Controlled Drugs: a guide to good practice in secondary care (England) RSGB May 2007 Gateway Ref: 8157
- Safer management of controlled drugs: guidance on standard operating procedures for controlled drugs Department of Health Gateway Reference: 7585 January 2007
- DOH Destruction of controlled drugs in GP practices. Sept 2002
- National Prescribing Centre NHS A guide to good practice in the management of controlled drugs in primary care (England) Second Edition February 2007
- Human Rights Act 1998.
- Mental Capacity Act April 2005
- DOH 2001 Seeking Consent: Working with people with learning disabilities.
- Consent Policy
- DOH Reference guide to consent for examination or treatment
- The Royal Marsden Hospital Manual of Clinical Nursing Procedures online edition
- Patient Safety Alerts and Rapid Response Reports available at www.npsa.uk
- Patient Group Directions, Medicines Practice Guideline, NICE, 2 August 2013
- General Medical Council. Good practice in prescribing and managing medicines and devices (2013) available at http://www.gmcuk.org/guidance/ethical_guidance/14318.asp
- CSM Guidance: Antiepileptic Drugs: new advice on switching between different manufacturers products for a particular drug. 11 Nov 2013

- Professional Standards for Hospital Pharmacy Services, Royal Pharmaceutical Society of Great Britain, Version 2, July 2014. Updated 2017.
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE, March 2015.
- Infection & Control Policy for Aseptic Technique
- MHRA published advice on MLX356 – change of legislation to allow mixing of medicines to make unlicensed products
- The Control of Substances Hazardous to Health Regulations (1994)
- Review of Prescribing, Supply and Administration of Medicines – patient group directions, HSE 1998/051 (1998)
- Medicines Amendment Orders relating to Patient Group Directions (2000)
- Covert administration of medicines – disguising medicine in food and drink. Nursing and Midwifery Council November 2007
- The British National Formulary
- The Safe and Secure Handling of Medicines, A Team Approach; A Revision of the 'Duthie Report 1988', Royal Pharmaceutical Society of Great Britain, March 2005.
- 'The Green Book', Immunisation against Infectious Diseases 2021 The Stationery office ~~www.dh.gov.uk/greenbook~~
- Technical patient safety solutions for medicines reconciliation on admission of adults to hospital. NICE/NPSA/2007/PSG001
- Developing and implementing standard operating procedures for Dispensing RPSGB Nov 2007
- Nurses, the administration of medicine for mental disorder and the Mental Health Act 1983, CQC, September 2009.
- The Royal Marsden Hospital Manual of Clinical Nursing Procedures. 6th Edition
- NHS Security Management Service Security of Prescription Forms Guidance.
- Medicines and Healthcare products Regulatory Agency (MHRA).

30.2 Links to other documents

- Controlled Drug Policy
- Standard Operating Procedure for the Safe and Secure Handling of Controlled Drugs in Solent NHS Trust
- Adverse Event Reporting Policy
- Capability Policy
- Deprivation of Liberty Safeguards and Mental Capacity Act Policy
- Consent to Examination and Treatment Policy
- Safeguarding Children and Young People Policy
- Safeguarding Vulnerable Adults Policy
- Medicines Administered at the Discretion of Nurses
- Topical Applications Administered at the Discretion of Nurses
- Overarching Policy for the Safe Management of Intravenous Medicines.
- Policy for the Self-Administration of Medicines on Solent Inpatient Wards.
- Standard operating procedure for the administration of medicines by continuous infusion via a syringe driver as part of palliative care.

Appendix 1

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims		
Service Line / Department	Pharmacy and Medicines Management	
Title of Change:	2021 Update to Trust Medicines Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	To bring policy up to date with present legislation and provide updates to support current practice.	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	Policy is formed by circulating widely to service managers and various groups within the Trust such as Integrated Learning Disability Manager, Multiple clinical colleagues and the Medicines Management team.
Have you taken into consideration any regulations, professional standards?	Yes	See list of reference within the document.

Step 3: Review, Risk and Action Plans			
How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?	None there is no negative impact		
Who will be responsible for monitoring and regular review of the document / policy?	Chief Pharmacist		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Luke Groves – Chief Pharmacist*	*Date:*	*January 2021*

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

Appendix 2 – Medicines Management Processes and Stock Control Audit

- This audit tool is for the Medicines Management Team to help clinical teams reflect on all aspects of medicines handling and management.
- We are focussing our attention on wards or departments which keep a stock of medicines and/or controlled stationery such as prescription pads.
- The electronic audit tool can be found on the Trust Intranet at: ***https://forms.office.com/Pages/ResponsePage.aspx?id=wRwyQbnsfEaw1YVGRNlOO4o7Z1oEjSJCmdH12gmFkOxUN0E1VkQ0RVZENkxCUFZGNTI5UTNBUU5LTS4u***

Appendix 3 – Example Specimen Signature List

Ward/Department: ……

Date Added	Name	Signature	Initials	Date to be Removed or Ongoing

This list must at all times be kept up to date by the ward/department manager and must be a complete list of all signatures to be found on the ward/department.

Appendix 4

Medicines Administered at the Discretion of Registered Nursing Practitioners (Nurses and Nursing Associates)

Purpose of Agreement	**Standing order list to state medicines within Solent wards and units that registered nursing practitioners may administer without a prescription**
Document Type	Standard Operating Procedure
Reference Number	SH/protocol/MMT006
Version	6
Name of Approving Committees/Groups	Medicines Management Group
Operational Date	March 2021
Document Review Date	March 2024
Document Sponsor (Name & Job Title)	Chief Pharmacist
Document Manager (Name & Job Title)	Chief Pharmacist
Document developed in consultation with	Clinical Pharmacists and Ward Managers, Solent NHS Trust
Intranet Location	Medicines Management
Website Location	
Keywords (for website/intranet uploading)	Homely remedies, standing order list, medicines at nurses discretion, nursing associates discretion, nursing practitioner.

MEDICINES ADMINISTERED AT THE DISCRETION OF REGISTERED NURSING PRACTITIONERS TO ADULTS

All medicines shall be administered on the written prescription of a registered medical, dental or non-medical prescribing practitioner in accordance with the Solent NHS Trust Medicines Policy

EXCEPTION

The Medicines Management Group approves a "homely remedy protocol" whereby registered nursing practitioners are authorised to administer some medicines at their own discretion.

A registered nursing practitioner may administer any of the following medicines to ADULT patients and adolescents over **12 years** of age.

Drug	Indication or symptom reported	Dose	Frequency	Maximum duration
Gaviscon Advance	Heartburn or dyspepsia	5-10ml	Four times a day (after meals and at bedtime)	48 hours
Glucose gel (e.g. Hypostop/Glucogel)	Hypoglycaemia	1 oral ampoule (9.2g/23-g)	Once but may be repeated after 10-15 minutes	Two doses (one episode of hypoglycaemia)
Glycerol suppositories 4g	Constipation	1 suppository	Once	Once only
Magnesium hydroxide mixture	Constipation	25-50ml	Once a day	48 hours
Magnesium trisilicate mixture	Dyspepsia	10ml	Three times a day	48 hours
Movicol (or other brand of Macrgols)	Constipation	1-2 sachets (each sachet in 125ml water)	Once a day	48 hours
Nicotine patch	Nicotine Replacement Therapy (NRT) while an inpatient	16 hour patch – see NRT Guidelines	Daily as per NRT Guidelines	Daily patches for up to 5 days
Nicotine oral or nasal spray	NRT while an inpatient	Issue ONE bottle	As per NRT Guidelines for patient self-administration	72 hours with 1 repeat if needed
Nicotine lozenges	NRT while an inpatient	Issue ONE pack	As per NRT Guidelines for patient self-administration	72 hours with 1 repeat if needed
Nicotine inhalator 15mg	NRT while an inpatient	Issue ONE pack	As per NRT Guidelines for patient self-administration	72 hours with 1 repeat if needed
Paracetamol	Pain	500mg-1000mg	6 hourly	48 hours
Senna tablets	Constipation	2 tablets	Once a day	48 hours
Simple linctus	Cough	5ml	6 hourly	48 hours

Sodium citrate microenemas (Micralax, Microlette, Relaxit)	Constipation	One micro enema	Once	Once only

Medication initiated by a registered nursing practitioner must be reported to the prescriber when they next visit the ward or earlier if indicated by the condition of the patient. If the patient's condition does not respond to this treatment the prescriber must be notified as soon as reasonably possible. All such medication must be recorded on the patient's prescription sheet in the section headed "Medicines administered at the discretion of nursing staff" and in the nursing notes.

THIS LIST WILL BE REVIEWED EVERY THREE YEARS

Re - approved by the Medicines Management GroupMarch 2021

PLEASE DISCARD ALL EARLIER VERSIONS OF THIS LIST

Registered nursing practitioners wishing to administer medicines using this document should be named and sign the protocol.

By signing this homely remedy (nursing standing order) protocol the registered nursing practitioner is confirming they are

- **Competent to administer the medicines listed i.e. possessing the skills and abilities required for lawful, safe and effective professional practice without direct supervision (NMC: Code of Professional Conduct 31 March 2015).**

- **Accountable for their actions in administering medicines**

Name of registered nursing practitioner	**Signature** ***NB I understand that I am accountable for my actions in administering the medicines listed***	**Date**

Solent NHS
NHS Trust

Topical Applications Administered at the Discretion of Registered Nursing Practitioners (Nurses and Nursing Associates)

Purpose of Agreement	To state the topical applications that registered nursing practitioners within Solent Healthcare may administer without a prescription
Document Type	Standard Operating Procedure
Reference Number	SH/Protocol/MMT007
Version	9
Name of Approving Committees/Groups	Medicines Management Group
Operational Date	March 2021
Document Review Date	March 2024
Document Sponsor (Name & Job Title)	Chief Pharmacist
Document Manager (Name & Job Title)	Chief Pharmacist
Document developed in consultation with	Clinical Pharmacists and Ward Managers Solent Healthcare
Intranet Location	Medicines Management
Website Location	
Keywords (for website/intranet uploading)	Topical applications, standing order list, medicines at nurses discretion, nursing associates discretion, nursing practitioner.

TOPICAL APPLICATIONS ADMINISTERED AT THE DISCRETION OF NURSING PRACTITIONERS

The Solent NHS Trust Medicines Policy permits nursing practitioners to apply certain topical applications without a prescription written by a registered medical, dental or non-medical prescribing practitioner. The following may be applied by a registered nursing practitioners at their discretion for the approved use specified against each product, for the duration of the condition.

* An appropriate entry of all topical applications marked with an asterisk must be made in the nursing records after use.

TOPICAL APPLICATION	APPROVED USE
Acetone	Removal of nail polish
Alcohol swabs (Sterets, Medi-swabs)	Skin cleaning
Anusol cream/ointment*	Haemorrhoids
Epaderm/Epimax	As a soap substitute.
Calamine lotion*	Skin rashes/itching skin
Choline salicylate paste (Teejel, Bonjela)*	Minor oral ulceration/teething
Diprobase cream/ointment*, Epimax* *(or alternative equivalent emollients in line with Skin Formulary and Ward stock list)*	Emollient for dry skin
Drapolene cream	Urinary rashes
E45 (Solent East only)	Emollient for dry skin – as per formulary
Flexible Collodion	Sealing skin following drain removal, lumbar puncture etc.
Hand cream	Hand protection/rehydration of hands frequently cleaned
Lubricating Jelly (KY Jelly or equivalent)	Lubrication for catheters etc.
Lidoocaine Gel 2% with Chlorhexidine*	Local anaesthetic prior to catherisation
Methylated spirit (70%)	Cleaning skin after iodine
Plaster remover (CFC – use sparingly)	Removal of adhesive tape marks
Povidone-iodine solution* (Betadine)	Skin disinfectant/superficial wound dressing
Povidone-iodine spray*	Skin disinfectant/superficial wound dressing
Benzoin compound tincture	Skin protection (undiluted) and antispetic Steam inhalation (in hot water)*
Sunscreen – high factor e.g. Uvistat or Sun 45 – as per local formulary	To prevent sunburn especially for patients at high risk due to adverse effects of medication
Sodium Chloride 0.9%	Mouth care
Sodium Chloride 0.9% bladder washout 100ml*	Removal of clots in indwelling catheter care – once only
White soft paraffin/Yellow soft paraffin	Sore/cracked lips
Zinc and castor oil	Emollient/barrier cream

WOUND CARE

For general principles in the treatment of wounds and further formulary information about specific wound care products see the booklet, Wound Formulary (Basingstoke, Southampton and Winchester District Prescribing Committee and South East Hampshire Area Prescribing Committee), updated April 2019

PRODUCT	APPROVED USE
Sodium Chloride (Clinipod®)	Cleaning wounds/eye care
Absorbant dressing (Zetuvit E® Sterile)	As a secondary dressing
Semi-permeable adhesive film (Hydrofilm)	To protect unbroken skin or open wounds with a low exudate
Autrauman non adherent dressing	See wound guidelines – Non adherent dressing of choice except patients with known coconut allergy
Hydrocolloid dressing (Comfeel Plus, Duoderm extra thin)	Pressure sores, ulcers (see wound guidelines)
Hydrofibre dressing (Durafiber Ag)	For infected/ heavily exudating wounds
Hydrogel (Intrasite Comformable)	For desloughing and debriding wounds
Povidone-iodine fabric dressings (Inadine)	Topical antibacterial agent
Foam dressings (Kliniderm, Biatain)	See wound guidelines for indications
Calcium alginate (Suprasorb A)	See wound guidelines

THIS LIST WILL BE REVIEWED EVERY THREE YEARS

Approved by the Medicines Management Group March 2021

PLEASE DISCARD ALL EARLIER VERSIONS OF THIS LIST

Registered nursing practitioners wishing to administer medicines using this document should be named and sign the protocol. (NMC Standards for Medicines Management 2015)

By signing this homely remedy (nursing standing order) protocol the registered nursing practitioner is confirming they are

- **Competent to administer & apply the medicines listed i.e. possessing the skills and abilities required for lawful, safe and effective professional practice without direct supervision (NMC: Code of Professional Conduct 31 March 2015).**

- **Accountable for their actions in administering medicines**

Name of registered nursing practitioner	**Signature** ***NB I understand that I am accountable for my actions in administering/applying the medicines listed***	**Date**

Appendix 5

Medicines Administered at the Discretion of Children's Community Nurses

Purpose of Agreement	**Standing order list to state medicines within the Solent Children's Community Nursing Service that registered children's nurses may administer without a prescription**
Document Type	Standard Operating Procedure
Reference Number	SOP/MMT/029
Version	2
Name of Approving Committees/Groups	Medicines Management Group
Operational Date	March 2021
Document Review Date	March 2024
Document Sponsor (Name & Job Title)	Chief Pharmacist
Document Manager (Name & Job Title)	Chief Pharmacist
Document developed in consultation with	Children's Community Nurses
Intranet Location	Medicines Management
Website Location	Medicines Management
Keywords (for website/intranet uploading)	Homely remedies, standing order list, medicines at nurses discretion

MEDICINES ADMINISTERED AT THE DISCRETION OF NURSES TO CHILDREN IN A COMMUNITY SETTING

All medicines shall be administered on the written prescription of a registered medical or dental practitioner or non-medical prescriber or with the express written consent of parent/carer, in accordance with the Solent NHS Trust Medicines Policy

EXCEPTION

The Medicines Management Group approves a "homely remedy protocol" whereby registered nurses are authorised to administer some medicines at their own discretion.

A registered children's nurse (defined in paragraph 2.4 of the policy) may administer any of the following medicines to children according to the protocols listed below:

Drug	Indication	Dose	Frequency	Maximum number of doses that can be administered under this protocol before medication must be prescribed for administration to continue.	Do not administer under this protocol if the child has any of the following medical conditions:
Paracetamol suspension/ tablets	Pain; pyrexia with discomfort	See table below.	See table below.	8 doses	
Ibuprofen suspension/ tablets	Mild to moderate pain, pain and inflammation of soft-tissue injuries, pyrexia with discomfort	See table below.	See table below.	6 doses	• Asthma (ibuprofen can be given if the child is known to tolerate NSAIDs and NSAIDs do not provoke an asthma attack) • Coagulation defects • Cardiac conditions • Hypertension • History of gastro-intestinal bleeding, ulceration of perforation. • Liver disease • Renal impairment
Chlorphenamine suspension/ tablets	Symptomatic treatment of allergy; treatment of mild urticarial rashes; pruritus, insect bites & stings	See table below.	See table below.	12 doses	• Porphyria • Urinary retention • Glaucoma • Pyloroduodenal obstruction

Parental consent should be obtained or consent of the child if he or she is deemed Gillick competent before administration.

Only medicines purchased by the parent/carer for the child or supplies obtained from the trust's agreed pharmaceutical suppliers (usually a local hospital pharmacy) should be administered under this protocol.

In all cases the dosage on the original packaging should be followed if available. Following-this refer to the BNF for Children. If either of the above dosage sources are not accessible or available follow the dosing advice listed below.

Paracetamol suspension/tablets			
Age of child	**Dose**	**Administer as:**	**Maximum frequency**
3 to 6 months	60mg	2.5ml of 120mg/5ml suspension	4 doses in 24 hours (leaving at least 4 hours between doses)
6 to 24 months	120mg	5ml of 120mg/5ml suspension	
2 to 4 years	180mg	7.5ml of 120mg/5ml suspension	
4 to 6 years	240mg	10ml of 120mg/5ml suspension	
6 to 8 years	250mg	5ml of 250mg/5ml suspension	
8 to 10 years	375mg	7.5ml of 250mg/5ml suspension	
10 to 12 years	500mg	10ml of 250mg/5ml suspension OR One 500mg tablet	
12 to16 years	500mg or 750mg	10 or 15ml of 250mg/5ml suspension OR One / One and a half 500mg tablets	
16 to 18 years	500mg to 1g	One or two 500mg tablets	

Ibuprofen suspension/tablets			
Age of child	**Dose**	**Administer as:**	**Maximum frequency**
3 to 6 months (weighing over 5kg)	50mg	2.5ml of 100mg/5ml suspension	3 times daily
6 to 12 months	50mg	2.5ml of 100mg/5ml suspension	3 or 4 times daily
1 to 4 years	100mg	5ml of 100mg/ml suspension	3 times daily
4 to 7 years	150mg	7.5ml of 100mg/5ml suspension	3 times daily
7 to 10 years	200mg	10ml of 100mg/5ml suspension	3 times daily
10 to 12 years	300mg	15ml of 100mg/5ml suspension	3 times daily
12 to 18 years	200mg to 400mg	Tablets	3 times daily

Chlorphenamine suspension/tablets			
Age of child	**Dose**	**Administer as:**	**Maximum frequency**
2 to 6 years	1mg	2.5ml of 2mg/5ml suspension	6 doses in 24 hours (leaving at least 4 hours between doses)
6 to 12 years	2mg	5ml of 2mg/5ml suspension	
12 to 18 years	4mg	10ml of 2mg/5ml suspension or 4mg tablets	

Medication initiated by a registered nurse must be documented on the Solent Medicines Administration Record so other practitioners are aware what has been administered. This should be documented in the 'One off prescriptions' section of the chart. In the Prescribed/Transcribed section state 'Homely Remedies Protocol' as in the example below. Administration must also be recorded in the nursing notes.

One Off Prescriptions										
Prescribed or Transcribed	Date			Time	Once Only Medication	Dose	Route	Signature	Batch No.	Given at and initials
	Day	Month	Year							
Homely Remedies Protocol	23	3	15	18.30	Ibuprofen	200mg	PO	EH	WF09 UZU	EH 18.30

Practitioners are reminded that it is critical other carers (who may not use the Solent MAR chart) are kept informed what has been administered to ensure the maximum daily dose is not exceeded.

If the patient's condition does not respond to this treatment the prescriber responsible for the patient must be notified as soon as reasonably possible.

THIS LIST WILL BE REVIEWED EVERY THREEO YEARS

Registered nurses wishing to administer medicines using this document should be named and sign the protocol. (NMC Standards for Medicines Management 2015)

By signing this homely remedy (nurse standing order) protocol the registered nurse is confirming they are

- **Competent to administer the medicines listed i.e. possessing the skills and abilities required for lawful, safe and effective professional practice without direct supervision (NMC: Code of Professional Conduct 2015).**

- **Accountable for their actions in administering medicines**

Name of registered nurse	**Signature** ***NB I understand that I am accountable for my actions in administering the medicines listed***	**Date**

Appendix 6 - Glossary

BNF
British National Formulary

CCG
Clinical Commissioning Group. Clinical Commissioning Groups are responsible for implementing the commissioning services as set out in the Health and Social Care Act 2012.

Controlled Drugs (CDs)
Medicines that are liable to misuse, that are subject to special controls under the Misuse of Drugs Act, 1971.

COSHH
Control of Substances Hazardous to Health.

Controlled Stationery
Any stationery which, in the wrong hands, could be open to abuse within the system to obtain medicines fraudulently.

Dispensing/Dispensed Medicines
Dispensing is the supply of a medicine to a patient on the signed instruction of a prescriber. Dispensing is usually carried out under the supervision of Pharmacists in line with GPhC standards, but if other healthcare professionals are dispensing medication (e.g. under a PGD) they must ensure the supply is made to the same standards that a patient could expect from a pharmacy.

GDC
General Dental Council

GMC
General Medical Council

GP
Medical General Practitioner

GPhC
General Pharmaceutical Council

GUM
Genitourinary Medicine

Healthcare Professional
A registered practitioner in an occupation which requires specialist education and training in practical skills in health care and is registered with a professional body. The professions concerned are self-regulating and practitioners are expected to satisfy their profession's accepted standards of practice and conduct.

For the purposes of this policy, these practitioners are accepted to include:

- Registered nurses or midwives

- Doctors (medical practitioners)
- Dentists
- Dental Therapists
- Dietitians
- Occupational Therapists
- Pharmacists
- Physiotherapists
- Registered Pharmacy Technicians
- Podiatrists
- Speech and Language Therapists

MAR Chart

A Medication Administration Record or MAR (eMAR for electronic versions) is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional. The MAR is a part of a patient's permanent record on their medical chart.

Medicine
Any substance or article (not being an instrument, apparatus or appliance) which is manufactured, sold, supplied, imported or exported for use wholly or mainly in either or both of the following ways:

(a) use by being administered to one or more human beings for a medicinal purpose
(b) use as an ingredient in the preparation of a substance or article which is to be administered to one or more human beings for a medicinal purpose

MHRA
Medicines and Healthcare products Regulatory Agency is an agency of the Department of Health.

Never Event
A Department of Health 'Never Event' is a serious, largely preventable patient safety Incident that should not occur if the available preventative measures have been implemented by healthcare providers. There are nine Medication related Never Events in the never event list (2018 update).

NHS England
(Known as the NHS Commissioning Board in the Health and Social Care Act 2012). NHS England is an organisation to support the NHS in improving the health outcomes of people within England.

NMC
Nursing and Midwifery Council (UK).

NPSA
National Patient Safety Agency (a Special Health Authority of the DoH) On Friday 1 June 2012 the key functions and expertise for patient safety developed by the

National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority which has since changed its name to NHS England.

Patient
People receiving medicines although individual services may refer to them, for example, as service users or clients or residents.

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

PODs
Patients' Own Medicines (or Drugs)
This term is used in the context of medicines that are a patient's own property, used by NHS staff and services for the treatment of that patient.

POM
Prescription only medicine (Medicines Act, 1968).

Practitioner
Practitioners whose names appear on one or more parts of the integrated Professional Register of the NMC.

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

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

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

Prescription Record Chart
Authorised drug chart for recording inpatient prescriptions and administration. There are also "Long Stay" and Mental Health Unit versions.

Prompting self-administration of medicines
Where the client/service user has the capacity to understand which medications they need to take but may require a prompt to remember to take their medication. Staff may or may not need to help the client/service user to remove medication

from the packaging but the client/service user is able to advise staff on what they need to take.

SOPs
Standard Operating Procedures

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 (including medicines and procedures) of a patient to prevent or cure disease or to ameliorate suffering and disability.

TTOs
Medicines for a patient To Take Out (usually, discharge medicines)

VTE
Venous Thromboembolism

Appendix 7 - Covert Administration Form (see also Trust Mental Health Act Policy. When applicable, Trust Mental Health Act Policy paperwork requires completion first)

Covert Administration Form Solent

To be completed and attached to the patient's drug chart* Outdated forms to be scanned or filed in the patient's notes

Name……..

Hospital/ NHS Number……..

Date of Birth……

Date of issue:.....

Full reviews must take place at least every two months. Mini reviews must take place at least fortnightly.

Please list the drugs to be given covertly, including the agreed method of administration.

When was the patient last encouraged to take their medication? What problems were encountered?

In what way are the medicines to be given covertly essential and in the patient's best interests?

What is the desired outcome?

What other medication options have been considered, e.g. different route?

Tick if the provisions of the Mental Health Act (1983) been considered ☐

Will regular attempts be made to get the patient to take their medication? If yes, how often?

The decision to covertly administer medication has been discussed and agreed with:

Role	**Print Name**	**Signature**	**Date**
Consultant/RMO			
Named Nurse			
Pharmacist			
Family member/ carer/advocate*			

*If no engagement by family, carer or advocate, please write 'No engagement' on the form.

A full review involving the family/carer/advocate will take place no later than

Date	**Reviewed by**	**Date**	**Reviewed by**	**Date**	**Reviewed by**

If all parties are NOT in support of the decision, please list names & objections/ concerns:

Appendix 8 - Emergency Adrenaline Advice

Supply problems with all Emerade pens (adrenaline auto-injectors) are set to continue indefinitely during 2020

Community Teams

All non-registered staff administering medications in the community should not be administering the first two doses of a medication to a patient.

Staff who are not registered but administer medicines to patients AND carry adrenaline auto-injectors in case of an anaphylactic reaction must ensure they check the adrenaline auto-injectors they carry and ensure they always carry two devices and that these are in-date. If they are unable to carry two in-date devices then they must not administer a medicine unless the patient has already had two doses of that medicine in the past and tolerated the medicine without any adverse symptoms.

Non-registered competency-assessed staff may administer medications from the third dose onwards.

Resus Bags

As an interim measure, when your Emerade pens for your resus bag expire they will be replaced by adrenaline ampoules *(please be aware, adrenaline ampoules have been added to your stock list so you need to order them as you would for all other meds in your resus bag).* Both adrenaline ampoules and Emerade pens will remain on the stock list for your resus bag, this is intentional as when Emerades return to supply their availability may be intermittent. Please ensure you have Emerade pens AND/OR adrenaline ampoules in your resus bag (we are aware this may show a degree on non-compliance on your stock list at times).

Who can give adrenaline ampoules?

Staff attending a resuscitation incident where adrenaline may be required are to only draw up and administer injectable adrenaline from ampoules if they are competent to do so. If not competent, when the emergency services are called, they should be advised that an injectable form of adrenaline is not available.

Anaphylaxis 'kits'

Please ensure all relevant needles and syringes needed to give the appropriate doses are present in your resus bag. 1ml syringes (to give paediatric doses) will automatically be sent out to the services that usually hold Emerade 150mcg and 300mcg pens in their resus bags.

Age Dose of adrenaline (epinephrine)*

Volumes stated are 1:1000 adrenaline

Under 6 months	150 micrograms IM (0.15ml)**
Over 6 months but under 6 years	150 micrograms IM (0.15ml)**
6 to 12 years	300 micrograms IM (0.30ml)
Over 12 years including adults	500 micrograms IM (0.5ml) (300 micrograms IM if patient is small or prepubertal)

*Dosing advice from Green Book Chapter 8 v4_0

** A suitable syringe for small volumes should be used.

If you do not understand any part of this advice or need further clarification please speak to your manager in the first instance. If necessary your manager will contact the resuscitation team or Head of Quality and Professions for your Service Line for further advice.

Advice Medicines Management and Chief Nurse – Solent NHS Trust. 1st issued March 2020, updated August 2020