# Medicines Policy

**Version:** 17

<table>
<thead>
<tr>
<th>Summary:</th>
<th>To provide staff with the up to date policy and procedures on prescribing, administration and control of medicines in Southern Health Foundation Trust (SHFT).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Keywords (minimum of 5):</strong> <em>(To assist policy search engine)</em></td>
<td>Prescribing, medicines, ordering, security, storage, transport, administration, dispensing medicines, controlled drugs, medication errors, CMPs, PGDs, Mental Health Practitioners (MPs), Competency</td>
</tr>
<tr>
<td><strong>Target Audience:</strong></td>
<td>All staff working in clinical areas involved with medicines use</td>
</tr>
<tr>
<td><strong>Next Review Date:</strong></td>
<td>September 2020</td>
</tr>
<tr>
<td><strong>Ratified by:</strong></td>
<td>Medicines Management Committee</td>
</tr>
<tr>
<td><strong>Date issued:</strong></td>
<td>January 2019</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Steve Mennear, Principal Pharmacist (Policies), East ISD</td>
</tr>
<tr>
<td><strong>Accountable Executive Lead:</strong></td>
<td>Dr Karl Marlowe, Medical Director.</td>
</tr>
</tbody>
</table>
## Amendments Summary:

<table>
<thead>
<tr>
<th>Amend. No.</th>
<th>Issued</th>
<th>Page</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, V2</td>
<td>April 2007</td>
<td>31</td>
<td>New point 7.4 Re: The Mental Capacity Act 2005 added. Following points renumbered.</td>
</tr>
<tr>
<td>1, V3</td>
<td>June 2008</td>
<td></td>
<td>Policy rewritten to take account of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- the changes in law resulting from Shipman and the associated requirements of standing operating procedures for all activities processes involving Controlled Drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- the amalgamation of the MHP policy within the main trust policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- The update of the NMC standards for meds administration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- The requirements resulting from the NPSA alerts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Learning from experience from error reports, litigation at both trust and national level</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Problems associated with e prescribing system at Melbury lodge. Reflecting and cross referencing other trust policies.</td>
</tr>
<tr>
<td>1, V5</td>
<td>Sept 2009</td>
<td>6&amp;11</td>
<td>Reference to Townhill Way deleted</td>
</tr>
<tr>
<td>2, V5</td>
<td>Sept 2009</td>
<td>33</td>
<td>Addition re non provision of a chemotherapy service.</td>
</tr>
<tr>
<td>3, V5</td>
<td>Sept 2009</td>
<td>46, 99</td>
<td>Updating of MHA Form numbers</td>
</tr>
<tr>
<td>4, V5</td>
<td>Sept 2009</td>
<td>92</td>
<td>Addition to Appendix P – Flumazenil injection</td>
</tr>
<tr>
<td>5, V5</td>
<td>Sept 2009</td>
<td>103</td>
<td>Additional Appendix - T – Competency Pathway for Medicines Management for Nurses</td>
</tr>
<tr>
<td>1, V6</td>
<td>Dec 2009</td>
<td>6</td>
<td>Section 1.3.3. updated to reflect need to assist patients make informed choice around medicine</td>
</tr>
<tr>
<td>1, V7</td>
<td>Jan 2010</td>
<td>15</td>
<td>New point 2.9.4 – retention of medicines in case of patients death</td>
</tr>
<tr>
<td>2, V7</td>
<td>Jan 2010</td>
<td>46</td>
<td>Addition to point 9.1 – inpatients self-administration by exception</td>
</tr>
<tr>
<td>3, V7</td>
<td>Jan 2010</td>
<td>63</td>
<td>Additional Appendix C – Medicines administered at the discretion of Nurses for Patients age 12-18</td>
</tr>
<tr>
<td>1, V8</td>
<td>Apr 2010</td>
<td>44</td>
<td>6.12.2 – correction (ref to section 7.3 amended to section 8.4)</td>
</tr>
<tr>
<td>2, V8</td>
<td>Apr 2010</td>
<td>93</td>
<td>Appendix Q – MHPs to administer depot antipsychotics by gluteal route only</td>
</tr>
<tr>
<td>1, V9</td>
<td>Sept 2010</td>
<td>22</td>
<td>Sentence added to end of 6.2.2 re patient’s cultural and religious beliefs to bring in line with CQC.</td>
</tr>
<tr>
<td>2, V9</td>
<td>Sept 2010</td>
<td>54</td>
<td>New Section 18 Drug Recall and Drug Alerts. Drug Recall Form added as Appendix U</td>
</tr>
<tr>
<td>3, V9</td>
<td>Sept 2010</td>
<td>55</td>
<td>New Section 19 Clinical Trials</td>
</tr>
<tr>
<td>4, V9</td>
<td>Sept 2010</td>
<td>57</td>
<td>Policy Compliance Monitoring (was Section 18) renumbered Section 20. Following sections renumbered</td>
</tr>
<tr>
<td>1, V10</td>
<td>Jan 2011</td>
<td>44</td>
<td>Section 8.8 Omitted/Delayed Doses – addition of paragraphs (d) and (e).</td>
</tr>
<tr>
<td>1, V11</td>
<td>April 2011</td>
<td>All</td>
<td>Changes throughout - Integration of SHFT and HCHC medicines policies and updating of reference and resource documentation.</td>
</tr>
<tr>
<td>2, V11</td>
<td>April 2011</td>
<td></td>
<td>Deletion of App J - Medicines Assessment Questionnaire. Appendix letters reallocated. New App U – Process for obtaining an urgent prescription for an inpatient when a prescriber is not on site at Melbury Lodge (extracted from body of policy) New App V - Process for Recording Email Prescription on RiO</td>
</tr>
<tr>
<td>V12</td>
<td>June 2012</td>
<td>P56</td>
<td>Training Requirements/Policy Compliance Monitoring</td>
</tr>
<tr>
<td>V13</td>
<td>March 2013</td>
<td>P68</td>
<td>Topical applications at nurse discretion: Add lidocaine cream or gel (e.g. EMLA) for surface anaesthesia before venepuncture or IM injections.</td>
</tr>
<tr>
<td>V13</td>
<td>July 2015</td>
<td>100</td>
<td>Updated TNA (Appendix R)</td>
</tr>
<tr>
<td>V14</td>
<td>August 2016</td>
<td></td>
<td>Thorough review and update by Medicines Management Team, Review to eliminate repetition and improve clarity. Update to reflect current best practice, e.g. medicines transport, electronic prescriptions and their transmission, FP10 prescription handling.</td>
</tr>
<tr>
<td>V15</td>
<td>September 2017</td>
<td></td>
<td>Additions: Canceling a completed drug chart ,Pt's own CDs on ward to ward transfer, Anticipatory prescribing Appendices: Expiry date guidance, Controlled drug disposal, Appendix C amended to include NRT, Appendix W, medication consent form added. Removal of references to TQtwentyone. Appendix N updated.</td>
</tr>
<tr>
<td>V15</td>
<td>November 2017</td>
<td>81</td>
<td>Covert section reviewed as per CQC Action Plan. Reviewed in conjunction with OPMH, LD and Mental Health Act teams.</td>
</tr>
<tr>
<td>Amend. No.</td>
<td>Issued</td>
<td>Page</td>
<td>Subject</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>V16</td>
<td>May 2018</td>
<td>12 &amp; 22</td>
<td>Change to management of One Stop Dispensing and “Named Patient” medicines no longer required or expired.</td>
</tr>
<tr>
<td>V17</td>
<td>December 2018</td>
<td>1, 19, 11, 24, 31, 27, 43, 45, 51, 53, 61, 63, 89, 108, 114, 116</td>
<td>Policy name changed to Medicines Policy Medicines management during ward closure/transfer clarified (3.5) Nurses’ responsibilities on patient discharge clarified (2.5), “Consent to Treatment” Assessment Record forms added (8.2.3), Missing / stolen FP10 process updated (8.3.2), Remote prescribing updated to reflect electronic system use &amp; inclusion of CD remote prescribing in exceptional circumstances (8.2.7) CD administration authority expanded (10.12.1), CD liquid reconciliation process clarified (10.12.2), Best interests “meeting” to “discussion” (10.14.3), Trust prescription card changed to PSD (16.5), record patient consent if medicine prescribed outside guidelines (18.6), CD audit by pharmacy team updated (Appendix A), Magnesium Trisilicate removed, Paracetamol suspension added (Appendix C1), TNA (Appendix N) updated, MDS use on wards included (Appendix R6), Missing FP10 report form updated (Appendix U), Creams/ointment expiry date updated (Appendix V). Chair approval</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Version Reviewed &amp; Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Management Team</td>
<td></td>
<td>V14 - August 2016</td>
</tr>
<tr>
<td>Alex Weston</td>
<td>Principal Pharmacist for R&amp;D and OPMH</td>
<td>V15 – November 2017</td>
</tr>
<tr>
<td>Steve Mennear</td>
<td>Senior Clinical Pharmacist</td>
<td>V16 – May 2018</td>
</tr>
<tr>
<td>Steve Mennear</td>
<td>Senior Clinical Pharmacist</td>
<td>V17 – December 2018</td>
</tr>
</tbody>
</table>
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>1 Staff Groups</td>
<td>6</td>
</tr>
<tr>
<td>2 Acquisition of Medicines</td>
<td>6</td>
</tr>
<tr>
<td>3 Storage of Medicines</td>
<td>15</td>
</tr>
<tr>
<td>4 Transportation of Medicines</td>
<td>20</td>
</tr>
<tr>
<td>5 Disposal of Medicines</td>
<td>21</td>
</tr>
<tr>
<td>6 Patient and Carer Information</td>
<td>22</td>
</tr>
<tr>
<td>7 Transcription</td>
<td>23</td>
</tr>
<tr>
<td>8 Prescribing</td>
<td>23</td>
</tr>
<tr>
<td>9 Patient Group Directions (PGDs)</td>
<td>31</td>
</tr>
<tr>
<td>10 Administration of Medicines</td>
<td>32</td>
</tr>
<tr>
<td>11 Self-Administration of Medicines</td>
<td>46</td>
</tr>
<tr>
<td>12 Compliance Aids</td>
<td>47</td>
</tr>
<tr>
<td>13 Legal and Human Rights</td>
<td>47</td>
</tr>
<tr>
<td>14 Medication Errors</td>
<td>48</td>
</tr>
<tr>
<td>15 Infection Control and Control of Substances Hazardous to Health (COSHH)</td>
<td>49</td>
</tr>
<tr>
<td>16 Community Teams</td>
<td>49</td>
</tr>
<tr>
<td>17 Dispensing</td>
<td>51</td>
</tr>
<tr>
<td>18 Use of Unlicensed Medicines</td>
<td>52</td>
</tr>
<tr>
<td>19 Drug Recalls and Drug Alerts</td>
<td>53</td>
</tr>
<tr>
<td>20 Clinical Trials</td>
<td>53</td>
</tr>
<tr>
<td>21 Training Requirements</td>
<td>55</td>
</tr>
<tr>
<td>22 Policy Compliance Monitoring</td>
<td>56</td>
</tr>
<tr>
<td>23 References</td>
<td>57</td>
</tr>
<tr>
<td>24 Glossary of Abbreviations</td>
<td>57</td>
</tr>
<tr>
<td>25 Signposting to other relevant policies</td>
<td>57</td>
</tr>
<tr>
<td>26 Appendices Index</td>
<td>59</td>
</tr>
</tbody>
</table>
Medicines Policy

This policy defines the policies and procedures to be followed within Southern Health NHS Foundation Trust for the prescribing, administration, supplying, dispensing, storing and recording of medicines. This policy covers all areas of the Trust. For the purpose of this policy, medicines are defined as any therapeutic, diagnostic or preventative substances administered to patients/clients or self-administered.

This policy has been developed to manage the roles and risks associated with medicines management. These have been assessed as:

- The Trust may be found non-compliant with national guidance and legislation
- Staff may be unaware of optimum practice in relation to the prescription, administration, storage, control and safe disposal of all medicines (including Controlled Drugs) resulting in adverse health outcomes for patients

This policy provides clear guidance/instruction to staff to manage these risks by addressing

- Safe Prescribing
- Safe Administration
- Safe Storage and Control of Medicines including Controlled Drugs
- Roles and Responsibilities of members of staff with respect to medicines
- Legislation Relating to Medicines

Senior staff must ensure that their staff who are involved in any way with the use of medicines are familiar with the appropriate sections, and have completed the appropriate competency assessment before they are involved with medicines.

The Chief Pharmacist has lead responsibility for the content and practices described in this policy. Pharmacists practice within their professional guidance and promote and uphold standards for safe medicines use within this policy.

The policy has been drawn up in consultation with professional groups across the Trust and is designed to facilitate best practice.

The faxes used within the framework of this policy must agree with the Trust's requirements for safe haven faxes.

Any instances where there is a suspicion of unauthorised administration or supply of medicines to anyone other than a Trust patient, e.g. a member of Trust staff or other third party, must be referred to either the Police or the Trusts Counter Fraud Service for investigation.

Where staff have any suspicion that medicines are being taken or used by either another member of staff or a third party they have a duty to report this to either their line manager or in confidence to the Trust Local Counter Fraud Specialists. Further details of the Trust’s Counter Fraud Policy, and means of reporting your suspicions, is available on the Trust intranet.
1. **Staff Groups**

1.1 A Health Professional is a member of one of the following staff groups, UK registered with their professional body:

- Dentists
- Dietitians
- Doctors
- Operating department Practitioners
- Nurses
- Clinical Psychologists
- Speech and Language Therapists
- Radiographers
- Pharmacists
- Occupational Therapists
- Podiatrists
- Pharmacy Technicians

1.2 Each registered health professional is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence in the ordering, prescribing, storage, transportation, administration and recording of medicines; and work within the Code of Practice of their professional body.

1.3 **All staff** involved in the medication process:

1.3.1 Must acquaint themselves with this policy and associated policies for the area in which they work.

1.3.2 Will be aware of the action that should be taken if their practice or their patient’s safety is compromised.

1.3.3 Will be aware of the safe dose range, frequency, route, administration technique, side effects, contra-indications and interactions of the drugs used and provide information to service users on their medicines and possible side effects to enable them to make an informed choice around their medicines.

1.3.4 Will observe the patient for side effects and manage them appropriately.

1.3.5 Will monitor the outcomes of the treatment against identified treatment goals.

1.3.6 Will be aware of their limitations and seek advice or support from appropriate health professionals when in doubt.

1.3.7 Will avoid delegation to others who may not be qualified or competent to carry out that task.

1.4 Local service or departmental managers, modern matrons, consultants and medical staff are responsible for ensuring all staff are conversant with this policy and related policies before they are involved in any drug administration, prescribing or ordering and that they are competent to undertake their role.

*Any reference to Mental Health Practitioners (MHPs) within this policy refers only to those who have been assessed as competent to administer medicines.*

2. **Acquisition of Medicines**

2.1 **Ward and department stocks**

2.1.1 A ward/department manager is responsible for the ordering, stock control, rotation, expiry date checking and reconciliation of any discrepancy. This may be delegated on a day to day basis to a nominated person who must be a registered nurse or MHP or may be undertaken by a member of pharmacy staff where such a service is provided.
2.1.2 Where the ward/team manager is not a registered nurse, the manager is responsible for ensuring that a named member of nursing staff has this role delegated to them and that it is reflected within their job description. The ward manager is responsible for ensuring this policy is implemented. For the purposes of this policy, the named nurse or nurse in charge of the ward will be referred to as the nurse in charge of medicines (NICM).

2.1.3 All medicines received from pharmacy must be checked against the order/prescription before storage or administration. This responsibility lies with the registered nurse/MHP/designated member of the pharmacy staff, but may be delegated appropriately. Non-registered staff (except MHPs) must not complete requisitions. Any discrepancy should be reported to the supplying pharmacy and an incident form completed. Requisition forms must be stored securely to avoid unauthorised use.

2.1.4 The range and quantities of all medicines, controlled drugs and sterile fluids held as stock should be agreed between the NICM, the ward or department, clinical pharmacist/technician and the pharmacy. Each list should reflect current prescribing patterns and include medicines for use in emergencies, and controlled drugs and be reviewed every six months.

2.2 Requisitioning of Controlled Drugs (CDs)

2.2.1 The NICM for each ward is responsible for CDs under current legislation. The NICM can delegate the task of preparing a requisition to another registered nurse but the legal responsibility remains with the NICM.

2.2.2 CDs for use on the ward/unit must be acquired using the CD Order book and signed by a registered nurse, along with their printed name. Pharmacy will maintain a system to enable the checking of signatures. The NICM is responsible for authorising and providing the supplying pharmacy with a list of signatures of current staff. In addition a Home Office CD Requisition Form must be completed and accompany requisitions.

2.2.3 Requisitions must contain the following:

- Name of Ward/Department/Hospital
- Drug name, form, strength, ampoule size if more than one available Total quantity and date
- Signature, printed name and qualifications of registered nurse
- If the CD is ordered from an external organisation - A second signatory of pharmacist or, if pharmacist not available, doctor working in the Trust

The pharmacist/doctor signature is the independent verification that the CDs ordered are to be used in the requesting ward. If the request is for an unusual item, they should take any necessary action to assure themselves that a patient on the ward has been prescribed that drug. The second signatory is not responsible for management and accountability of the CDs in the ward. Spoilt or cancelled orders must be clearly marked VOID and remain in the order book.

2.2.4 There must be a complete audit trail for CDs from supplying pharmacy to ward. All CDs must be delivered to wards or departments in a tamper evident package. The porter/driver will sign either the CD Order Book as accepted for delivery or the CD Order Book and a transport sheet or only the transport sheet depending upon local arrangements. If a driver hands over the tamper evident package to a porter for delivery, the porter must sign the delivery sheet and the driver retains a copy of the delivery sheet. When the driver/porter hands over the tamper evident package to a
registered nurse on the ward, the transport sheet is signed in the appropriate section by the nurse confirming that the seal is intact. The relevant section of the transport sheet is returned to pharmacy. On no account should the CDs be left unattended. As a matter of good practice the receiving person should not be the same person who ordered the controlled drug. If there is no registered nurse present on the ward, a registered nurse must be bleeped to attend. On no account may anyone other than a registered nurse accept the controlled drugs. They must be returned to the supplying pharmacy if a nurse is not available.

2.2.5 After the registered nurse accepts delivery of the CDs they must immediately check the contents of the package containing CDs against the requisition. Any discrepancy must be reported to pharmacy immediately. If correct, the registered nurse must sign the requisition in the received by section. The registered nurse must enter the new stock into the CD register on the appropriate page witnessed by either another registered nurse, a health care support worker, MHP or authorised member of pharmacy staff. The following details should be recorded:

- Date received
- Time received (24 hour clock)
- Name of pharmacy making supply
- Quantity received
- Serial (page) number of the order
- Signature of registered nurse completing the entry
- Signature of witness
- New resulting total balance (checked against actual stock)

The witness’s role is to check the:

- Name and strength of drug
- Form
- Quantity
- New stock level balances tally with the quantity stored in the CD cupboard.

The medicines must then be IMMEDIATELY LOCKED IN THE CONTROLLED DRUG CUPBOARD. Morphine and diamorphine ampoules of 30mg or more should be physically segregated from lower strength ampoules within the CD cupboard. This can be done by placing them on a separate shelf.

2.2.6 Boxes sealed by the manufacturer should be assumed to be correct and not opened until required for use. If when the seal is broken the contents do not match the expected amount stated on the pack, the registered nurse must contact the supplying pharmacy. Appropriate records must be made in the CD register and all necessary action taken to resolve the discrepancy. An incident form must be completed and the CD Accountable Officer informed.

2.2.7 Controlled drug register books (CDR)

2.2.7.1 The CDR should be bound (not loose-leaf) with sequentially numbered pages and it should have separate pages for each drug and each strength, so that a running balance can be kept easily. Entries should be made in chronological order, in ink or be otherwise indelible.

2.2.7.2 All entries should be signed by a registered nurse and must be witnessed by a second registered nurse. If a second registered nurse is unavailable the transaction must be witnessed by another Health Professional or competent MHP, student nurse or health care support worker.
2.2.7.3 On reaching the end of a page in the CDR, the balance should be transferred to a new unused page. The new page number should be added to the bottom of the finished page and the index updated. This transfer should be witnessed.

2.2.7.4 If a mistake is made it must not be crossed out. It should be bracketed in such a way that the original entry is still clearly legible. If clarification is necessary the brackets should be annotated with a * or similar mark and details of the error entered at the bottom of the page. This should be signed, dated and witnessed. The witness should also sign the correction.

2.3 Ordering Stock Medicines other than Controlled Drugs

2.3.1 Ordering methods:
- A computer requisition, generated by the pharmacy service, is signed by a registered nurse or MHP and sent to the pharmacy department in line with the agreed schedule. The requisition must be stored securely when not in use.
- E-mail from registered nurse to supplying pharmacy requesting medicines on agreed stock list
- Pharmacy staff undertake the ordering role (Top Up service)
- Vaccines for the school immunisation programme: immform website
- Urgent Items
  - Items required urgently outside the schedule should be ordered on the requisition sheet and sent to pharmacy if the unit is on site
  - Offsite units should fax or e-mail a request using the appropriate form.

2.3.2 All medicines must be delivered to wards/departments in a lockable drug box for main stock orders or tamper evident container for small quantities. These must be brought to the attention of the registered nurse or MHP on arrival on the ward/department.

2.3.3 The registered nurse or MHP must:
- a) Check for items which require cold storage, these should be checked and placed in the fridge as soon as possible after receipt on the ward
- b) Lock the container in a secure place. Boxes and tamper evident containers must not be left unattended or accessible to patients and visitors and unauthorised staff.
- c) As soon as practical the registered nurse or MHP must:
  - (i) check the medicine against the delivery note
  - (ii) sign the note and keep it for two years
  - (iii) lock the medicines in the medicine cupboards immediately
  - (iv) report any discrepancies to the supplier immediately

2.4 Method of Supply for individual patients

2.4.1 Wards receiving a regular clinical pharmacy supply service:
- (a) Initial Supply - An authorised member of the clinical pharmacy team will initiate the supply in accordance with the prescription. If medicines are required urgently before the pharmacist’s next visit, a medicine request slip should be completed by a registered nurse/MHP and a request sent to the pharmacy if there is no pharmacy on site. Each request must include the appropriate prescription chart(s), including PRNs, to enable the supplying pharmacy staff to undertake pharmaceutical checks. If the pharmacy is on site the prescription is taken to the pharmacy.
  Parklands Hospital: all supplies must be ordered on a non-stock ward sheet which has been countersigned by a member of the clinical pharmacy team.
With the exception of inhalers, eye drops, creams etc. urgent items will only be issued as temporary stock and not for a named patient.

(b) Repeat Supplies - These should be ordered by the clinical pharmacy team. Where a patient’s own drug (POD) scheme is in operation the initial and repeat supplies will include instructions on the label.

2.4.2 Wards not receiving a clinical pharmacy service that day: For all medicines, a medicine request form must be completed by a registered nurse or MHP who is authorised to order medicines and send to the pharmacy department with the prescription chart. For units where there is no pharmacy on site, both the request and the whole prescription chart must be sent. The registered nurse/MHP should telephone the pharmacy before sending the prescription. (for North – see above)

2.4.3 Melbury Lodge Site: Requests for supplies of non-stock medicines prescribed using the JAC electronic system should be made via phone call from the ward to the dispensary.

2.5 Ordering Discharge or Short Term Leave Medicines

2.5.1 Wherever possible, medicines for patients to take home (TTO) should be requested well in advance (e.g. 24 hours in advance) of patients’ discharge/leave to avoid delays on the day of discharge. Where this is not possible the time of the patient’s discharge/leave should be entered onto the TTO request form to give the pharmacy department an indication of the urgency.

2.5.2 Medication supplies in monitored dosage systems (MDS) should be processed as stated in the Trust MDS Procedure on Filing and Checking a Compliance Aid, SH CP 170. Where the hospital pharmacy service does not provide this service, FP10HPs may be used to obtain MDS systems from a community pharmacy. Liaison with the community pharmacy is essential. Under the Equality Act 2010 community pharmacists are required to ensure patients are assessed for any reasonable adjustment to medicine containers before dispensing. It is the community pharmacist’s responsibility to decide on need and they can refuse if they do not consider an MDS appropriate (see also Section 12).

2.5.3 Medicines for patients to take home can only be dispensed when a pharmacist has seen the registered medical practitioner’s prescription or when an authorised pharmacist has transcribed an order from the inpatient prescription chart (see section 2.5.4). Pre-packed medicines and Patients Own Drugs (PODs) may also be issued against a TTO prescription.

2.5.4 Pharmacy department on site:

(a) Where there is a clinical pharmacy supply service the prescription chart will remain on the ward and the clinical pharmacist will arrange for medicines to be supplied. The TTO prescription must be sent to the pharmacy for endorsing what was subsequently supplied. A copy of the TTO should be returned to the ward with the patient’s medication.

(b) If there is no clinical pharmacy supply service or a delay in waiting for the next visit would be unacceptable, all prescription charts together with the TTO prescription must be sent to pharmacy along with any PODs.

(c) Lymington Hospital site: A print out of the e-Docs discharge summary should be sent to the pharmacy.
2.5.5 No pharmacy department on site:

(a) Where there is a regular clinical pharmacy supply service - 2.5.4 (a) applies

(b) If there is no clinical pharmacy service or waiting for the next visit would cause an unacceptable delay, the TTO prescription must be sent along with a complete copy of all prescription charts. If sending for TTOs via the normal mode of transport would result in an unacceptable delay and affect patient care, then the TTOs may be sent to pharmacy via fax or nhs.net e-mail. The registered nurse endorses the TTO form with date & time sent and signs and dates it before sending it. A copy of the TTO prescription form from which the items were dispensed including all annotations must be sent back to the ward with the TTO medicines. Copies of this are then kept in the notes and sent to the GP.

NB prescriptions containing CDs, including temazepam, cannot be released from pharmacy until the original TTO prescription has been received.

(c) Electronic Prescribing sites: TTO requests are generated by the prescriber using the JAC electronic system which sends requests to the HHFT dispensary.

(d) Fordingbridge Hospital: A complete copy of all prescription charts must be saved onto the shared drive to enable dispensary staff to reconcile the TTO prescription (e-Docs discharge summary) with the charts.

(e) Romsey Hospital: A complete copy of all prescription charts must be sent to the Royal South Hants Hospital dispensary to enable dispensary staff to reconcile the TTO prescription (e-Docs discharge summary) with the charts.

2.5.6 Outside Pharmacy Hours:

Nurses (unless they are prescribers) cannot supply or authorise the supply of medicines for patients to take home. If a patient is discharged when pharmacy is closed and the discharge medicines have not been prescribed and dispensed in advance, the doctor or Non-Medical Prescriber who prescribed them is responsible for their supply. In these circumstances the doctor may issue an FP10 for dispensing at a community pharmacy. It is illegal for CD ward stocks to be used for discharge medicines. PODs and CDs may be returned to the patient provided that they fulfil the POD criteria (see Appendix R).

2.5.7 The registered nurse/MHP should go through all the discharge medicines with the patient and/or carer and answer any questions which may arise. The patient should know the purpose of the medicine, how to take it, and how long for. The registered nurse/MHP is also responsible for checking the discharge medicines against the discharge prescription and ensuring that any discrepancies are resolved before the patient leaves the ward. As PODs are the property of the patient, any PODs that are no longer prescribed for or required by the patient may be retained for destruction if the patient agrees.

2.5.8 Controlled Drugs as discharge medicines:

Controlled drugs (CDs) to take home must be stored in the ward/department CD cupboard. These medicines should be clearly marked and segregated from the ward CD stock. The CD should be recorded in the POD section of the CD register or separate POD CD register and witnessed as outlined in 2.2.4. On discharge the CD must then be booked out by a registered nurse and witness who both sign and date the register. The following must be checked:
• Patient Name
• Date
• Drug name + strength + form
• Quantity
• The patient’s identity must also be confirmed

The patient/carer/driver should also sign the register for the receipt of the CDs. If the driver refuses to sign, then a second ward witness should be a third signature. The rest of the discharge procedure is identical to 2.5.7.

2.6 “One Stop” Dispensing

2.6.1 Medicines dispensed to wards with labels containing full instructions in accordance with the inpatient prescription chart are usually supplied in the manufacturer’s original container with a patient information leaflet. This supports the self-administration of medicines and a more efficient patient discharge process.

2.6.2 If the prescriber changes the dose or frequency from that stated on the label a new supply must be ordered or the medicines relabelled by a pharmacist. Any supply remaining with previous directions should be returned to the supplying pharmacy for full credit where this is possible. If the supplying pharmacy will not accept the container for credit it must be destroyed.

2.6.3 Where one stop dispensing is in operation, or PODs are being used during the inpatient stay these may be used for short term leave or discharge provided:

• Staff follow, and medicines comply with, Appendix R of this policy
• Consideration is given to the amount of medication supplied and a risk assessment undertaken by medical and ward staff. The outcome of this should be documented in the notes
• The practitioner checking the medicines for use is deemed competent to check one stop dispensed medicines or PODs for discharge
• A discharge/short term leave form detailing the medicines issued has been completed and retained in the notes

2.7 Emergency Medicines and Advice Required Outside Pharmacy Hours

2.7.1 Outside pharmacy hours emergency medicines may be obtained by the prescriber or senior registered nurse using one of the following routes:

(a) borrowing from neighbouring wards (see 2.8 below)

(b) The local emergency duty pharmacist service contactable via switchboards at:

(i) Royal Hampshire County Hospital for Mid Hants
(ii) Southampton General Hospital for Southampton City, Lymington and other New Forest localities (e.g. Tatchbury site)
(iii) Queen Alexandra Hospital for Fareham & Gosport and East Hants localities and Ravenswood
(iv) North Hampshire Hospital for North Hants locality
(v) Salisbury Hospital for Fordingbridge

Local procedures are available. The service does not cover discharge medicines.

(c) A local community pharmacy using FP10s. The ward manager is advised to keep an up to date list of pharmacies providing extended opening hours.
2.7.2 The ward manager is responsible for reviewing the use of emergency supply procedures and ensuring these do not become the norm.

2.8 Borrowing Medicines from other wards/units/services

2.8.1 Medicines should not normally be borrowed from another ward or department when a supply can be obtained from pharmacy within an acceptable time for the circumstances.

2.8.2 In urgent circumstances ward STOCK drugs may be borrowed. Named patient medicines or PODs must not be used for another patient.

2.8.3 The decanting of medicines into another container is forbidden. The original container must be transferred to the borrowing ward/service. If only one container is available and the drug is needed on the original ward, the full container must be taken and the dose administered from it. The container is then returned to the original ward.

2.8.4 Controlled Drugs cannot be borrowed. If a Controlled Drug is required but supply is only available on an adjacent ward, a nurse working on that ward should take the supply and CD register to the ward requiring the CD. Administration of the dose required is then recorded in the CD register and witnessed. If no supply is available on site a duty pharmacist at the local acute Trust must be contacted.

2.9 Patients’ Own Drugs (PODs): Procedure for their use at admission and during inpatient stay

2.9.1 Definition

Every medicine that is brought into hospital by a patient and is either prescribed for them by their registered medical practitioner or purchased by or for them is a POD.

2.9.2 Procedure on Admission

(a) Patients will be encouraged to bring in their medicines from home, using a green bag if available. All patients should be asked if they have brought in their medicines from home and if they consent to using their PODs whilst they are in hospital or for them to be destroyed where necessary. Document destruction on RiO or in the patient medical record as part of the medicines reconciliation entry.

(b) Any medicines remaining at home should, if possible, be brought in by relatives as soon as possible. If consent for their use is granted, they should be locked in the locally agreed POD storage area for assessment by the pharmacist, pharmacy technician or POD trained member of nursing staff (for Controlled Drugs see section 2.9.5).

2.9.3 Consent

(a) PODs remain the patient's property and verbal consent for their use or destruction must be obtained by the admitting nurse/MHP, pharmacist or pharmacy technician. A best interest decision may have to be made if consent is not possible. At Leigh House good practice dictates that parents or carers should, where possible, be involved in such decisions. This should be documented in the patient’s records.

(b) If the patient does not consent to using the PODs on the ward, the medicines must be stored on the ward in a locked medicines cupboard and either
returned to the patient on discharge (if appropriate, with clear instructions as to their use) or destroyed according to the Handling and Disposal of Healthcare Waste Policy, SH NCP 47. If any drugs are considered unsatisfactory for use the registered nurse, pharmacist or pharmacy technician should inform the patient/carer of the risks associated with poor quality medicines or poor labelling, and seek permission to destroy them. This should be documented in the patient’s medical notes.

2.9.4 POD Assessment

(a) Only medicines that can be positively identified and have passed the algorithm (Appendix R1) will be accepted for administration to inpatients. However POD trained staff may authorise the use of unlabelled inhalers, eye drops, MDS (blister-packed medication) and loose blister strips providing the appropriate guidelines are followed in Appendices (R) to (R6). The pharmacist, pharmacy technician or registered nurse/MHP must be satisfied with the general condition of the product and its packaging and labelling. Even if the medicine passes the algorithm, professional discretion should remain the over-riding factor in assessing suitability. PODs which are not currently prescribed should be stored in the POD cupboard or other secure drug storage cupboard i.e. not on medicines trolleys or in POD lockers. Any discontinued items should be removed immediately.

(b) Any unlabelled PODs should have an addressograph or similar label attached stating the patient’s name, DoB and NHS number. Unsuitable medicines will be documented on RiO in progress notes or patient medical record and if the patient consents, be destroyed on the ward according to the Handling and Disposal of Healthcare Waste Policy. If there is any doubt about using a particular medicine then it can be left in the agreed locked storage location on the ward for assessment by pharmacy staff and if necessary a new supply organised by the pharmacist or pharmacy technician.

2.9.5 Controlled Drugs (CDs) Brought into Hospital by Patients

Criteria for use of Patients’ Own CDs, including temazepam

(a) CDs brought into hospital by a patient may be used for that patient provided that the following criteria are met:

(i) The use of patients’ own CDs will be limited to those items where there is no evidence of tampering to enable nursing and medical staff to positively identify the medicines and check expiry dates and batch numbers. The drugs should appear in a reasonable condition (Appendix R).

(ii) The CD is entered into the CD Register on a page used solely for the use of patients’ own CDs.

(b) If the criteria above are not met or where it is not practical to use CDs brought into hospitals by patients, the drugs may be sent home with relatives or destroyed on the ward by a registered nurse and must be witnessed by a Trust pharmacist. All CDs on the ward must be stored in the CD cupboard and documented in the CD register.

2.9.6 Recording of patients’ own CDs

The drug name, strength and form and patients’ name should be stated on top of the page. Each drug strength should be entered on a separate page.
2.9.7 **PODs Storage**
(a) Bedside medicine lockers, medicines trolleys or cupboards
(b) Patients' own CDs must be stored in the ward CD cupboard.
(c) All PODs must be locked in the locally agreed POD storage area which complies with this policy.

2.9.8 **Staff Roles in the POD Scheme**
The registered nurse or MHP who has undergone POD training:
(a) To obtain consent from patient regarding the use or destruction of PODs on admission and document this in the patients notes
(b) To ask relatives to bring in other medicines that the patient may have at home
(c) To be responsible for the safe and secure storage of PODs
(d) To complete all paperwork related to the scheme and legal documentation required for patient’s own CDs (registered nurses only)
(e) To check PODs for new admissions against the algorithm and inpatient prescription chart

The pharmacy technician/pharmacist (within normal pharmacy working hours)
(a) To check PODs against both the algorithm and the inpatient prescription as part of the medicines reconciliation process
(b) To ensure safe custody of the PODs
(c) To endorse relevant prescriptions as "POD", initial date and quantity
(d) To remove all medication inappropriate for use
(e) To obtain permission for POD use and complete the documentation where appropriate
(f) To identify and resolve adherence issues
(g) To provide counselling and complete the medication reminder card where required

2.9.9 **Medical Staff**
(a) To encourage patients to bring in their medication from home
(b) To inform nursing staff and, where possible, patients of changes in drug therapy
(c) To check PODs if appropriate and obtain consent for use

3. **Storage of Medicines**

3.1 All medicines stored in a ward, clinic or department must be stored in a locked cupboard, medicine trolley or medicines refrigerator as specified below. No other substances or articles may be stored in these cupboards/refrigerators which must be reserved strictly for the storage of medicines. Clinic rooms where drug cupboards are situated must be kept locked. Access to clinic rooms where drugs are stored must be controlled.

The only exceptions to this requirement are:-

(a) Storage of intravenous fluids and sterile topical fluids which because of their bulk are stored in designated clean areas, as agreed between the ward manager and pharmacy department. Storage should be raised from the floor and the ambient temperature should not exceed 25°C.

(b) Medicines for Medical Emergencies and Resuscitation: See Medical Emergencies and Resuscitation Policy SH CP 30
3.1.2 The NICM is responsible for custody of medicines stored in their clinical area and must ensure that no unauthorised person has access to them. Advice can be obtained from the Trust Chief Pharmacist. The NICM is also responsible for ensuring regular expiry date checks are undertaken.

3.1.3 A Trust pharmacist will formally monitor the storage arrangements on each ward or department as part of the Trust ongoing audit programme. This will include a full check of all CDs and the entries within the register in line with Appendix A. All changes to storage arrangements and arrangements for new medicines storage facilities must be discussed with and approved by the Principal Pharmacist or Chief Pharmacist.

3.1.4 Medicines must not be transferred from one container to another nor must they be stored in any container other than that supplied by the supplying pharmacy.

3.2 **Keys**

3.2.1 The following keys must be kept together on one key ring and held by a registered nurse/or MHP at all times or they may be kept locked in a key safe to which only the registered nurse/MHP/or authorised pharmacy staff has access.

- Medicine Trolley
- Lock securing medicine trolley to wall
- Medicine Cupboards
- Medicine Refrigerator
- Pharmacy ward stock box

If an MHP is responsible for the medicines and the ward is storing CDs, the MHP may hold or have access to all the keys except the CD cupboard key. This key must be held by a registered nurse. If there is no registered nurse on the ward there must be a local Standard Operating Procedure (SOP) for handing them to a suitably qualified nurse on an adjacent ward or department. This procedure must be fully auditable and must be approved by a Trust pharmacist. If the unit currently has no CDs in stock, the MHP may hold the CD cupboard key.

As the CD cupboard keys may only be held by a registered nurse it is good practice to have them on a separate key ring or on a ring that allows them to be easily separated.

3.2.2 Should a key or set of keys be lost, every effort must be made to find it or retrieve it from off duty staff. A spare set of keys must be securely held in a key press in the senior nurse’s office. The senior nurse and bleep holder each hold a key to the key press. The bleep holder also has a key to the senior nurse’s office. In hours the senior nurse (or nominated deputy when on leave) must be contacted. Out of hours the bleep holder will be contacted. It is the responsibility of the ward manager to ensure that a full set of spare keys is available. If the missing key(s) is not recovered quickly (i.e. by the next working day) the locks must be replaced and a Trust adverse incident form completed. A full check of CDs should be undertaken as per Appendix A. All other medicines should be checked to see if there are any obvious losses discernible. The Accountable Officer and Principal Pharmacist must be informed.

If duplicate keys are issued, the date and time of issue of duplicate keys must be recorded together with the names of people handing over or receiving them.

If the original keys are found, the duplicates must be returned and a record with the same details above recorded.
Extra vigilance must be observed in the period before the lost keys are found or new locks fitted.

3.2.3 A separate set of keys other than the duplicate is held by pharmacy staff when a POD or top up service is provided.

3.2.4 Access by any other member of staff other than those described above can only be allowed under the direct supervision of the registered nurse or MHP.

3.2.5 Patients self-medicating from medicines stored in patients’ own medicine cabinets must be made aware of the importance of keeping it locked and retaining the key on their person. The key given to the patient must only be able to open a cabinet containing medicines for their use and not other patients’ lockers. The key must remain on the ward at all times i.e. returned to the nurse in charge when the patient leaves the ward or is assessed as incapable of self-administering their medicines. See SH CP 168 Self Administration guidelines.

3.2.6 Community Team Keys. Keys held by nurses, MHPs or other authorised trained and competent staff should not be identifiable by any marking. Any loss must be reported immediately and action taken as above.

3.3 Storage Area

3.3.1 Controlled Drugs Cupboard
All medicines listed in schedule 2 and most in schedule 3 of the Misuse of Drugs Regulations must be stored in a lockable cupboard complying with Controlled Drugs, Misuse of Drugs (Safe Custody) Regulations. (Contact the Trust Chief Pharmacist for advice and a list of the more frequently used products). This cupboard must be reserved solely for the storage of Controlled Drugs. The safe custody of Schedule 3 and schedule 4 CDs may vary from time to time and on a site specific basis as required by the CD Accountable Officer.

3.3.2 Medicines Trolley
A medicines trolley may be used for the storage of orally or subcutaneously administered preparations which are in current use and which require neither special storage conditions nor have special procedures for preparation/administration. The trolley must not be left unattended during medicine rounds. When not in use, a medicine trolley must be locked and immobilised by locking to the wall or by some other means which prevents its unauthorised removal. The trolley must be designed to provide adequate space to facilitate the safe selection of medicines. Advice can be obtained from the Trust medicines management team http://www.southernhealth.nhs.uk/knowledge/clinical-support-services/medicines-management/

3.3.3 Patients’ Own Medicine Cabinets
If patients’ own medicine cabinets are used, consideration must be taken to their siting and a full risk assessment undertaken. Please seek advice from the medicines management team.
Patients’ own medicines cabinets must be kept locked and the key held by the registered nurse in charge of the ward unless a patient has been assessed as safe and appropriate to self-administer when the patient may hold the key.

3.3.4 Medicines Cupboards
Medicines cupboards are for the storage of medicines such as oral, parenteral, topical and rectal preparations. These must comply with the latest British Standard
BS2881 and must be kept locked. Internal and external preparations must be stored separately either in different cupboards or on a separate shelf to minimise the risk of incorrect selection.

3.3.5 **Medicines Refrigerator**

Used for the storage of medicines labelled “Store in Refrigerator” or which indicate that they should be stored at 2°C to 8°C. It must be an approved design for the storage of medicines with an integral thermometer or temperature recording device or maximum and minimum thermometer. The fridge should be kept locked and used only to store medicines. Temperature should be recorded at least once each working day. Refer to the Temperature Management of Medicines: Storage and Transport policy SH CP 87 for full standards of practice.

3.3.6 **Disinfectant Cupboard**

Preparations that are neither administered nor applied to patients must be stored in this cupboard which must be clearly labelled and locked.

3.3.7 **Sterile Fluids for Topical Use**

It may not be practical to store these in a cupboard. In this case storage should be in clean conditions in a designated area.

3.3.8 **Site of Medicines Storage**

3.3.8.1 The ward manager is responsible for ensuring that suitable storage conditions are available for all preparations and that any preparations in storage are in a suitable condition for use. Information and advice may be obtained from the medicines management team or the Chief Pharmacist’s office.

3.3.8.2 If any medicine is found to have been improperly stored, e.g. refrigerator found to be not working or ordinary medicines being subject to extreme high temperatures, the items should be placed in quarantine in a suitably labelled container and the medicines management team should be contacted for advice. Medicines should not be administered to a patient until advice is gained. If urgent the out of hour’s pharmacist at the local acute Trust may be contacted.

3.3.8.3 Storage accommodation should be sited in a locked room away from public areas wherever possible. Medicines should not be stored near sources of heat e.g. radiators or windows, or humidity e.g. near sinks. Storage facilities should always be kept locked.

3.3.8.4 Room temperature must be recorded at least once each working day at the hottest time of day e.g. between midday and 2pm using Appendix 3 of the Temperature Management of Medicines: Storage and Transport policy, SH CP 87 (medicines refrigerator temperature chart). Room temperature recordings outside of 10-30°C must be reported to the ward/service manager for risk assessment and appropriate action.

Staff should lock the door of the storage room when opening cupboards/trolleys to access medicines both for personal safety and that of service users and visitors.

3.4 **Storage and Handling of Flammable Liquids, Gases and Aerosols**

3.4.1 **Medical Gases**

3.4.1.1 Gas cylinders should be stored in a dry, clear and well-ventilated area and secured in a safe position where they cannot fall over. Cylinders must never be used or stored where there are naked flames or high temperatures. Where necessary, the
Fire Officer should be consulted on the safe use and storage of gas cylinders, ‘No Smoking’ signs and signs in accordance with HTM 02-01 Part B Chapter 8 must be displayed where oxygen is in use or being stored near areas where smoking is allowed.

3.4.1.2 Cylinders should be held in specifically designed trolleys or wall racks to prevent them from falling over. Their storage position on the ward should be agreed with the Trust Fire Safety Officer.

3.4.1.3 Staff involved in the handling and administration of gases should receive approved and documented training regarding the safe use of equipment including checking, maintenance and storage of gas cylinders.

3.4.1.4 When not in use the cylinders should be closed at the cylinder head (with the appropriate spanner) as well as at the flow meter.

3.4.1.5 Flow meters seals (‘O’ rings) must be replaced every 2 years to prevent leakage which is a fire risk.

3.4.1.6 When changing cylinders hands must be clean as the mixture of oil or grease e.g. butter or white soft paraffin with oxygen is combustible.

3.4.1.7 The general provision for safe handling of gases in piped systems (HTM02-01 (MGPS)) apply for gas systems

3.4.1.8 A local written procedure should be available which details the ordering, receipt, handling, storage, issue and use of medical gases. This should comply with the Medical Gas and Medical Gas Pipeline Systems Policy SH NCP 65.

3.5 Ward/Department Closures or Transfers

3.5.1 Ward / department closure: the ward manager is responsible for making adequate security arrangements to ensure that there can be no unauthorised access to medicines. For isolated units, the medicines must be returned to the pharmacy department for storage on all occasions. For other wards/departments, medicines may stay on site for short term closures (up to 5 days) provided a risk assessment has been completed. If longer term closure is expected, arrangements must be made with pharmacy to return the medicines for storage or return to pharmacy stock. For CD management see Appendix K.

3.5.2 Ward/department transfers: When a ward moves to another location, the ward manager should liaise with the principal pharmacist to agree how medicines will be transferred safely and securely to the new site. When CDs are transferred to another site as part of a ward move, all CDs must be reconciled with the CD register prior to transfer and again immediately on arrival at the new site. Any discrepancies should be reported immediately.

3.6 Recording balances, losses and discrepancies

3.6.1 Controlled Drugs (CDs)

(a) The NICM is responsible for ensuring that the records and stock balances reconcile at all times. Checks must be carried out weekly. (see Appendix A – Procedure for Auditing Controlled Drug Stocks and Record Books). Wards with a high use of CDs should check daily.

(b) Where discrepancies are identified, the procedure outlined in Appendix B – Procedure for Managers when Discrepancies in Controlled Drug Stock Levels are identified - must be followed. Where the medicines remain unaccounted for, counter fraud and the CD Accountable Officer must be contacted on 02380
874023 and an internal investigation commenced. A Trust Incident Report must be submitted.

3.6.2 Any Other Medicines

Where there is a suspicion of medicine misappropriation or abuse

(a) The nurse manager and locality manager, Principal pharmacist and Chief Pharmacist must be informed. The medical director and consultant must be informed if medical staff are involved

(b) If the above requires ongoing monitoring of one or more drugs a stock balance must be recorded within the CD register and the drug temporarily treated for recording purposes as a CD.

4. Transportation of Medicines

4.1 Medicines must only be transported within hospitals by members of staff (including third party service providers) or between sites by authorised or contracted transport providers (e.g. taxi service). Staff transporting medicines must hold a valid identification badge at all times.

4.2 If under exceptional circumstances ad hoc transport / taxi services are used the driver should be asked for an approximate time of arrival at the required destination and the receiving ward/unit informed.

4.3 Medicines must be transported in locked boxes or individual tamper-evident secure containers designed solely for that purpose and labelled with the final destination. All such containers must be kept securely or under surveillance whilst awaiting collection or on receipt at designated areas. Whilst in transit medicines must not be left unattended or unsecured. They must be handled in a way that maintains their security and integrity.

4.4 A documented full audit trail must be maintained to ensure medicines security.

4.5 Controlled drugs must be transported in sealed bags or tamper evident containers with uniquely numbered tamper evident seals with the number recorded in the CD requisition book and the top copy kept in the pharmacy.

4.6 Refrigerated medicines should be transported in validated cool boxes to maintain the integrity of the medicine (see Temperature Management of Medicines: Storage and Transport policy SH CP 87).

4.7 When a patient is transferred from one hospital site to another via authorised transport or taxi, their medicines must accompany them in secure packaging labelled with the destination. Ambulance or Trust staff escorting such patients are responsible for medicines security and integrity between sites.

4.8 Transportation of medicines by Community Staff

4.8.1 Patients or their carers are expected to collect their medicines from a community pharmacy or dispensing doctor surgery wherever possible. Where this is not possible many community pharmacies operate a delivery service.

4.8.2 Community nursing staff may deliver medicines to patients in their own home where clinical need dictates i.e. a patient would clearly benefit from receiving medication at home.

4.8.3 Vaccines may be transported in validated cool containers by school nurses, community nurses and health visitors to administer in the community as part of the
school immunisation programme or other national vaccination schedules. See Temperature Management of Medicines: Storage and Transport policy SH CP 87.

4.8.4 Medicines not requiring refrigeration must be transported in a discrete bag, out of sight e.g. boot of the car and handed to the patient or carer on arrival.

4.8.5 If medicines cannot be delivered they should be either stored securely at the community team base or returned to the pharmacy.

4.8.6 On no account should medicines be posted through the door / letter box or left with another person.

4.8.7 Health visitors are permitted to transport Healthy Start Vitamins within the Trust via the internal post using a secure, locked bag.

5. **Disposal of Medicines**

Staff must read this in conjunction with the Trust Handling and Disposal of Healthcare Waste Policy SH NCP 47.

To minimise medicines waste, use stock medicines with the shortest expiry date before any others. Do not use them after their expiry date. See Appendix V for guidance on expiry dates of opened medicines containers.

5.1 **Controlled Drugs (CDs) – ward stock**

5.1.1 CD’s must not be returned to pharmacy in the ward box or by a messenger. Surplus stocks of CDs must be notified to the clinical pharmacist or the pharmacy supplying the site. Those that can be returned for reuse and credit will be collected from the ward by a pharmacist. An entry must be in the ward Controlled Drug Record book and signed and dated by the pharmacist and registered nurse. See Appendix L.

5.1.2 Expired CDs must be rendered irretrievable on the ward before disposal using a DOOP kit by a registered nurse and witness authorised by the CD Accountable Officer (CDAO). Refer to Appendix L for detailed procedure. The authorised witness will also complete a Destruction of Controlled Drugs Record to inform the CDAO of all CDs destroyed.

5.1.3 An individual CD dose, or part of a dose, which is prepared and not used must not be returned to stock. It must be destroyed on the ward by two registered nurses or by a registered nurse and pharmacist or registered nurse and MHP or registered nurse and approved Health Care Support Worker. The destruction of CDs must be recorded in the CD register with both staff signing, following the procedure in Appendix L.

5.2 **Controlled Drugs brought into hospitals by patients**

5.2.1 If a CD supply exceeds the expiry date or is deemed inappropriate or unsuitable for return to the patient when discharged from the ward it should be rendered irretrievable on the ward before disposal using a DOOP kit, subject to patient consent. See Appendix J for further information. Destruction should ideally be performed by two registered nurses, one acting as witness. If not practically possible the witness may be an approved witness.
5.3 Ward Stock Medicines

5.3.1 Surplus stock medicines used routinely on the ward should be used up on the ward. Exceptionally excess stock may be returned to the pharmacy in the ward box if agreed with the pharmacy.

5.3.2 Expired medicines should be disposed of in a medicines waste container, Tablets/capsules should be removed from outer packaging i.e. boxes no longer required by individual patients may be returned to the pharmacy for credit, in the ward box.

5.4 Patients’ Own Drugs (PODs)

Patients’ consent will be obtained for their disposal where practically possible. Where this is not possible, a risk assessment must be undertaken and clearly documented in the notes and the medicines will either be:

(a) Sent to pharmacy for destruction, subject to patient consent
(b) Stored in a designated place on the ward for return to the patient on discharge when a further risk assessment should be undertaken
(c) Destroyed on the ward

5.5 “Named Patient” Medicines

All ‘named patient’ medicines (labelled with the patient’s name) supplied during the inpatient stay should be destroyed on the ward in the appropriate waste container or returned to pharmacy when the patient is discharged.

5.6 Faulty Medicines

Details of medicines that appear to be faulty, e.g. cloudy liquid, wrongly coloured tablets, or changed in some way from normal appearance, should be quarantined and reported to the supplying pharmacy/clinical pharmacy team and on the Trust incident reporting system.

6. Patient and Carer Information

It is important that the patient (or carer if appropriate) receives adequate information about their medicines prior to discharge unless their care plan deems it inappropriate. All original containers should contain a Patient Information Leaflet.

The patient should know as a minimum:

(a) The purpose of the medicine
(b) How to take it
(c) How long it is to be taken for
(d) What side effects they may experience.

This is the responsibility of the prescriber who may choose to involve the medicines management or nursing team in this process and the actions taken should be documented in the patient’s notes. Discharge medicines should contain manufacturers Patient Information Leaflet (P.I.L). P.I.L.s can also be obtained from the eMC website http://www.medicines.org.uk/emc/ . In addition, further information on mental health drugs can be accessed on the Choice & Medication website http://www.choiceandmedication.org/southernhealth/.

Medication reminder charts can be completed from the Forms section of the medicines management intranet.
7. **Transcription by Pharmacists and Pharmacy Technicians**

The above staff may order supplies of medicines from contracted pharmacies by transcribing from inpatient drug charts onto Trust drug order sheets.

Pharmacy Technicians must have completed the in-house transcription competency or be Accredited Medicines Management Pharmacy Technicians. Orders may be sent to pharmacies provided that the following requirements are met:

- ALL items on the drug chart have previously been clinically screened by a pharmacist.
- All prescriptions are clearly written and unambiguous

When ordering medication, the transcription should be an accurate match of what is written on the drug chart, e.g. if the prescription is written as Co-careldopa 12.5/50, this must also be transcribed onto the order form – do not shorten by writing the brand name unless that is what's prescribed.

**NB See also Appendix S**

8. **Prescribing**

8.1 **Prescription Charts/Forms**

8.1.1 Functions of the Prescription Chart:

(a) To provide a permanent record of the patient's treatment with medicines
(b) To indicate the patient's sensitivity to medicines
(c) To facilitate the provision of correct medicine from the pharmacy
(d) To direct and record the administration of the medicine to the patient
(e) To record when treatment commenced in relation to the Mental Health Act
(f) To ensure accurate records of expenditure on medicines are maintained

8.1.2 All blank prescription chart / forms are controlled stationery and must be stored in such a manner to avoid use by non-appropriate persons.

8.1.3 All medicines for patients under the care of the Trust must be prescribed by registered prescribers on approved Trust prescription stationery or on a recognised electronic prescribing system.

8.1.4 Wherever possible only one chart should be in use for each patient to minimise any risk of duplicated prescribing and administration of medicines. If the number of prescribed items necessitates the use of additional charts, all charts must indicate the existence of additional charts, e.g. "this is 1 of 2".

8.1.5 When a subsidiary chart, e.g. warfarin or insulin chart, is required it must be cross referenced on the main prescription chart.

8.1.6 When patients are transferred from other hospitals/Trusts, on-going treatment should be prescribed within 24 hours on Trust approved prescription charts. This may be extended in exceptional circumstances up to 5 days if no prescriber is available. Before administering any medicines during this interval, the discharge letter and prescription chart from the transferring hospital must be reconciled and any discrepancies resolved. Medicines administered must be recorded on the original (or legible copy of) prescription chart from the transferring hospital and the admitting doctor informed during clerking.
8.2 Prescribers

8.2.1 The prescriber will be a registered doctor, dentist or registered supplementary or independent prescriber. Registered dieticians may give such directions for enteral feeds and food supplements. Medical students and staff undertaking the Independent and Supplementary Prescribing Course must not prescribe.

8.2.2 The prescriber should have all the relevant information required before prescribing for a patient and complete inpatient details essential for prescribing, i.e. name, date of birth, Mental Health Act (MHA) status, allergies, weight (when appropriate). Other details may be completed by ward staff. When patients are admitted prescribers must take steps to ensure that they have accurate information on the patient’s current medication. This may include checking with the GP practice, accessing the summary care record or checking medicines brought in by patient/carer in line with the Medicines Reconciliation Policy (CP SH 125). Certain medicines which require a higher level of monitoring, e.g. anticoagulants, methotrexate, insulin and opioids, will require special care. Prescribers must ensure that appropriate monitoring is undertaken in line with local prescribing guidelines and/or the product licence. Prescribers should take into account the patient’s cultural and religious beliefs in discussions with patients concerning possible treatment choices.

8.2.3 Inpatient and Community Prescription Charts
Prescribing instructions must be computer generated or legibly and indelibly hand written in black ink and include:

(a) Patient name in full, including aliases
(b) Patient’s Date of Birth
(c) Name of unit or home address
(d) Patient’s NHS number
(e) MHA status plus copy of 62/T2/T3/.CTO11/CTO12 and “Consent to Treatment” Assessment Record forms where applicable
(f) A record of all known allergies, where there is none known this should be recorded as ‘none known’ or “NKDA”
(g) Patient’s weight (where appropriate)
(h) Patient’s consultant/GP

8.2.4 If Addressograph labels are used on prescription charts or FP10s they must permanently adhere to the chart/FP10 so that they cannot be peeled off. If an error is identified on the label after applying it to the chart/FP10 this document must be destroyed as confidential waste and a new chart/FP10 generated.

8.2.5 Where a patient has a similar sounding name to another patient on the ward, a standard sticker warning staff must be attached to the charts.

8.2.6 The specific details of each medicine prescribed must include:

8.2.6.1 (a) The medicine name written in BLOCK CAPITALS. The generic name should be used wherever possible. The brand name should be used for:
• medicines with multiple active ingredients,
• clinically important differences in bioavailability between brands of the same medicine e.g. those with narrow therapeutic index (lithium, theophylline, ciclosporin, tacrolimus)
• important differences in formulation between brands of the same medicine e.g. strong opioids, some antiepileptic agents.
• modified release preparations which are not interchangeable e.g. nifedipine.
• patient familiarity with the same product/device is important e.g. inhalers, self-injection or insulins.

(b) The form where this provides specific pharmacokinetic properties e.g. modified release, soluble

(c) The strength:

(d) The dose:

i. Where a variable dose is required e.g. in dose titration of clozapine, the dose should be written in the appropriate section of the chart

ii. Where a steady dose regimen includes different doses during the day these may be written next to the times, this is indicated by stating “see times” or “variable” in the dose box, or as two separate prescriptions on the chart.

iii. Doses of 1 gram or more should be written using the abbreviation g or gram and a decimal point if required.

iv. Quantities of less than 1 gram should be written as milligrams. The abbreviation mg should be used for milligram.

v. Quantities less than 1 mg must be written as micrograms and in full.

vi. Where decimal points are unavoidable a zero should be written in front of the decimal point when there is no other figure e.g. 0.5ml

vii. Calculations should be double checked.

viii. The word “units” must be written in full and never abbreviated to “u” or “iu”.

ix. Where a dose is to be given less often than daily the prescriber should strike out the days when a dose should not be administered on the administration side of the chart and clearly state the frequency e.g. “weekly”, “two weekly”, “every 72 hours”. For weekly prescriptions the day of the week should be stated.

(e) The route: use the following abbreviations:

<table>
<thead>
<tr>
<th>Route</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
</tr>
<tr>
<td>PR</td>
<td>per rectum</td>
</tr>
<tr>
<td>PV</td>
<td>per vagina</td>
</tr>
<tr>
<td>Inh</td>
<td>inhalation</td>
</tr>
<tr>
<td>Oral or PO</td>
<td>by mouth</td>
</tr>
<tr>
<td>SC</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>SL</td>
<td>sublingual</td>
</tr>
<tr>
<td>NG</td>
<td>nasogastric</td>
</tr>
<tr>
<td>TOP</td>
<td>topical</td>
</tr>
<tr>
<td>Neb</td>
<td>nebulised</td>
</tr>
<tr>
<td>Nasal</td>
<td>intranasal</td>
</tr>
<tr>
<td>PEG</td>
<td>Percutaneous endoscopic gastrostomy</td>
</tr>
<tr>
<td>Patch</td>
<td>transdermal patch</td>
</tr>
<tr>
<td>R/L/Both Eyes</td>
<td>Eye drops</td>
</tr>
</tbody>
</table>

If there is a choice of routes e.g. oral or IM, a separate prescription should be written with a clear indication of there being a choice of either oral or IM.

(f) The administration time(s) using the 24 hour clock. Outpatient, discharge and FP10 prescriptions must also include the times of administration. OD (daily) or as directed should not be used but the most appropriate time e.g. om (morning) should be used. For medicines given every X weeks e.g. depots the prescriber should indicate a time either side of the due date when a medicine may still be given. If no such direction is given for each patient the nurse should contact the prescriber if a dose cannot be given on the due date.

(g) Where a medicine is prescribed for use “when necessary”, the purpose of the medicine should be stated. The minimum intervals between doses and the maximum number of doses in 24 hours should also be stated. If a dose range
is stated, it should be narrow with a clear rationale for movement within the range.

(h) Prescriptions must be signed in full, and then printed in block capitals, and dated by the approved prescriber.

8.2.6.2 For Injectable medicines, the Prescription must specify the following:

(a) name and formulation of the medicine
(b) concentration or total quantity of medicine in the final infusion container or syringe
(c) name and volume of diluent and/or infusion fluid
(d) rate and duration of administration
(e) stability information to determine the expiry date of the final product
(f) type of rate-control pump or device(s) to be used
(g) the age and weight of any patient under 16 years of age, where relevant
(h) date on which treatment should be reviewed
(i) arrangements for fluid balance or clinical monitoring should be made on an individual patient basis and according to local protocol and clinical need

8.2.6.3 Antimicrobial prescribing:

All prescriptions for antimicrobials must follow Trust approved guidelines. Prescribers should include the following in all prescriptions:

- Indication
- Course start date, duration or review/stop date
- An X in the administration section after the last dose is due, a vertical line through all administration times for the next day and a bold X across the remainder of the administration section

IV therapy should be reviewed every 48 hours and changed to oral as per local guidelines.

Prescriptions will be monitored and audited by the medicines management team.

8.2.6.4 Medical emergencies

All medicines prescribed and administered in a medical emergency must be recorded in the patient’s record i.e. drug chart (inpatients) or patient’s medical record (community).

8.2.6.5 Anticipatory prescribing

If the first dose of authorised drug is not required to be administered within 6 months of the date of authorisation it must be reviewed and re-signed by the responsible prescriber.

8.2.7 Remote Prescribing / Remote Orders *

Every effort should be made to obtain a written or electronic prescription for a patient. However, in exceptional circumstances i.e. where the need for the medicine is urgent and not to accept a remote order would compromise patient safety or care, remote instruction to a registered professional may be accepted by, fax, email, electronic prescribing system or RiO note for:

- a change in dose, route or frequency
- re-prescribing of a previously prescribed medication
- new medicines if conditions in 8.2.7.7 are fully met
*Prescribing by an independent prescriber who authorises administration of medicines to a patient without face to face assessment within the current episode of illness.

8.2.7.1 Where exceptional circumstances exist, the registered professional is required to inform the prescriber of the patient’s current drug regimen, symptoms and any other relevant information e.g. allergy status, path lab results. They should request information from the prescriber regarding any contraindications and side effects of the remotely prescribed medicine.

8.2.7.2 Trust staff must not request or accept a remote order for Schedule 2 and 3 Controlled Drugs unless previously prescribed and in a palliative care setting where it is in the patient’s best interest. If this occurs a Trust incident report must be submitted.

8.2.7.3 A remote prescribing order by telephone is not acceptable on its own. The prescriber must provide confirmation of the order using an electronic prescribing system or health record e.g. RiO note, fax or e-mail before drug administration. This confirmation must be entered in the patient’s electronic record where it is accessible to the prescriber and administering nurse or paper copy attached to the paper prescription chart. The confirmation must be read by the administering nurse before drug administration.

8.2.7.4 Only a registered healthcare professional may accept a remote prescribing order via fax or email. When this has been received the order must be immediately (a) attached to the inpatient paper prescription chart and (b) written on the relevant section of the patient’s prescription chart and endorsed ‘remote prescribing – email’ or ‘remote prescribing – fax’ or ‘remote prescribing - RiO’ and initialled by the registered healthcare professional.

8.2.7.5 When the above change is made to a paper prescription chart the prescriber must provide a newly written and signed prescription to confirm the changes within 24 hours or, when this is a bank holiday or weekend, the next working day. As part of the confirmation the prescriber must have reviewed the patient and the relevant notes.

8.2.7.6 An entry should be made in the patient record regarding the time of, and reason for, the remote prescribing.

8.2.7.7 Remote prescribing of new medicines for a patient may only be accepted if the prescriber has adequate information on which to base their decision to prescribe, sufficient to:

- Establish the patient’s current medical conditions and history and concurrent or recent use of other medications including non-prescription medicines;
- Carry out an adequate assessment of the patient’s condition;
- Identify the likely cause of the patient’s condition;
- Ensure that there is sufficient justification to prescribe the medicines/treatment proposed;
- Ensure that the treatment and/or medicine/s are not contra-indicated for the patient.
- Make appropriate arrangements to follow the progress of the patient;
- Monitor the effectiveness of the treatment and/or review the diagnosis;
- For patients detained under section 3/37 of the Mental Health Act, ensure that medication requested for administration is listed on Form 58/59 (after 3 months detention). If it is not listed on the form, the medication cannot be administered.
Where all these conditions cannot be satisfied remote prescribing should not occur. The prescriber is then required to carry out a full patient assessment in person before any medicines are prescribed.

8.2.7.8 Registered healthcare professionals can refuse to accept remote orders from prescribers if:

a) they do not feel competent to do so,
b) there are communication difficulties and the prescriber’s intentions are not clear,
c) they feel the request is not in the patient’s best interest, or
d) they feel the circumstances are not exceptional.

8.2.8 Prescription cancellation and alterations

(i) To cancel a single prescription on a chart
   (a) Draw a bold X across the drug name and dose, initial and date the cancellation
   (b) Draw a vertical line at the end of the last day that a drug is given and a bold X across the remainder of the administration section
   (c) If specific doses are to be omitted they should be cancelled individually by a X in the individual administration box
   (d) Prescriptions must not be altered. The old prescription must be cancelled as above and a new prescription must be written
   (e) Alterations to medications by prescribers MUST NOT be accepted as a mobile telephone text message.

(ii) Cancelling all prescriptions on an inpatient prescription chart
   (a) Draw two diagonal lines across the front page of the chart with “CANCELLED” in between them.
   (b) Sign and date the front page and file in patient’s notes away from the immediate clinical area.

8.2.9 Discharge Medicines (TTOS)

(i) Discharge medicines must be prescribed electronically or on approved Trust forms and conform to section 8.2.6.1.
(ii) Medicines intended for long term treatment should be prescribed for 28 days. Short term treatment should be indicated by writing “X days only then stop”. Patients for whom there is a risk of self-harm should be prescribed a quantity of medicines deemed acceptable by the prescriber. If a patient has a history of self-harm in the previous 3 months no more than 14 days should be supplied.
(iii) The discharge medicine form must contain all medicines being taken at the time of discharge with their dosage and frequency. Non-specific directions e.g. od (daily), as directed, should not be used, instead the most appropriate time e.g. om (morning) must be used. If patients have sufficient of their own supply of medicines the quantity should be endorsed POD (patient’s own drugs), (minimum of 14 days). This form is then the formal record of their medicines at discharge.
(iv) In certain circumstances an approved pharmacist may transcribe the medicines required on discharge/short term leave and these be dispensed. However, the prescription must be confirmed and signed by a registered medical practitioner before the patient is discharged/leaves the unit.

8.2.10 Outpatient Prescribing

(i) Outpatients requiring a non-urgent prescription should be referred to their GP using the approved proforma.
(ii) If an urgent supply is required – i.e. a drug that should be started immediately or within the next 14 days sufficient for up to 28 days treatment may be prescribed on an approved outpatient prescription or FP10HNC pads/FP10MDA/FP10SS forms (see section 5.3). A larger supply may be given if there are specific reasons e.g. the consultant is maintaining prescribing responsibility for the patient, rather than transferring it to the GP, or the medicine is not available in the community.

(iv) Outpatients and FP10HNC pads/FP10MDA/FP10SS prescriptions must include the times of administration. Nonspecific directions e.g. od (daily), as directed – **must not be used**, instead the most appropriate time e.g. om (morning) should be used.

8.2.11 Controlled Drugs Prescribing for Outpatients and TTOs

8.2.11.1 The Misuse of Drugs Regulations 2001 require that outpatient and TTO prescriptions for Controlled Drugs in Schedule 2 and 3 must:

a) Be signed with the prescriber’s usual signature and dated
b) Include the full name, address and date of birth of the patient
c) Include the form, even when only one form exists, and where appropriate the strength of the preparation
d) The dose (specified units, not “as directed”)
e) The total quantity of the preparation or the number of dose units to be supplied in both words and figures
f) Be in indelible blue or black ink
g) It is good practice to include the patient’s NHS number on the prescription
h) The use of any form of pre-printed sticky labels on prescriptions for CDs is not recommended. If they are used they must be tamper evident. Prescribers must also sign the sticky label

**NB.** It is an offence for a prescriber to issue an incomplete prescription and a pharmacist is not legally permitted to dispense a CD unless all the information required by law is stated on the prescription. A prescription falling short in these requirements may mean a failure to supply medication.

8.2.11.2 **NB.** At sites using electronic prescribing both a handwritten prescription and a prescription on the JAC system are required.

8.2.12 Receipt of CDs by outpatients

Patients or their representatives may be asked to provide evidence of identity when collecting CDs.

There is a legal requirement for persons asked to supply Schedule 2 CDs on prescription to determine whether the person collecting the medicine is the patient, their representative or a healthcare professional acting in their professional capacity on behalf of the patient.

Where the person is the patient or their representative, the dispenser:

(a) **May** request evidence of that person’s identity and
(b) **May** refuse to supply the medicine if he is not satisfied as to the identity of the person

Where it is a healthcare professional acting in his professional capacity on behalf of the patient, the dispenser:

(a) **Must** obtain the person’s name and address.
(b) **Must**, unless he is acquainted with that person, request evidence of that person's identity (the formal identification for health care professionals should be their professional registration number); but

(c) **May** supply the medicine even if he is not satisfied as to the identity of the person.

Any strengthening of controls has been balanced with ensuring that patients have access to medicines they need and have been prescribed for them. The requirement allows the dispenser discretion not to ask patients or patient representatives for proof of identity if, for example, they have concerns that to do so may compromise patient confidentiality or deter patients from having their medicines dispensed.

It is a requirement to record the following information in the CD register for Schedule 2 CDs supplied on prescription:

(a) Whether the person who collected the drug was (i) the patient, (ii) the patient’s representative or (iii) a health care professional acting on behalf of the patient.

(b) If (iii) above, that person’s name and address.

(c) If (i) or (ii) above, whether evidence of identity was requested (as a matter of good practice a note as to why the dispenser did not ask may be included but this is not mandatory).

(d) Whether evidence of identity was provided by the person collecting the drug.

### 8.3 FP10 Prescription Forms (FP10HNC and FP10PN)

#### 8.3.1 Supply

The supply of FP10 forms is strictly controlled. Supplies must be ordered via the Trust’s Chief Pharmacist’s office which orders a supply with the contracted NHS secure printer. Forms are issued only when a requisition has been received from an authorised signatory.

#### 8.3.2 Security

The number of FP10 forms held by a prescriber or ward/unit must be kept to a working minimum to minimise the risk of theft or potential assault on staff. Treat prescription forms like blank cheques and store them in a locked cupboard in a secure room or on your person during home visits. Patients, temporary staff and visitors must not be left alone with prescription forms.

(a) Immediately on receipt of FP10 forms, the receipt must be signed and returned to the appropriate authorised manager, or Chief Pharmacist office as appropriate

(b) A log must be held by the authorised signatory of all prescription forms received and issued. The following information is required:

**On Receipt:**

Date, Quantity and serial numbers, Signature of authorised signatory.

**On Supply:**

Date, Quantity and serial numbers, Signature of prescriber and authorised signatory.

**On Return:**

Date, Quantity and serial numbers, Signature of prescriber and authorised signatory.
(c) It is the responsibility of the prescriber to return unused prescription forms before leaving the Trust.
(d) All forms must be kept locked in the custody of the authorised signatory or their deputy.
(e) Missing, lost or stolen forms must be immediately reported together with form serial numbers to the Chief Pharmacist on 02380 874023 or 02380 874306. Complete Appendix U and send to local security management security@southernhealth.nhs.uk counter fraud specialists andrew.morley2@nhs.net and khampson@nhs.net, and Alerts.SCWCSU@nhs.net to inform local community pharmacies and CCGs. Complete an incident report. The prescriber or nurse in charge of the ward should contact the local police and an incident reference number obtained and given to the locality manager.
(f) If fraud is suspected also contact the NHS Fraud and Corruption Reporting Line: 0800 028 4060 or online at: https://cfa.nhs.uk/reportfraud .
(g) The prescriber must inform all prescribers in the team of the need to write in red on their pads for the next 2 months.
(h) If the prescription forms are recovered inform the contacts above by completing another Appendix U.

8.3.3 Private Patients

FP10 forms must not be used for private patients. The hospital doctor should either refer the patient back to the GP with the appropriate advice or give the patient a private prescription.

8.3.4 Self Medication

In line with GMC guidance, self-medication or prescribing for the prescriber’s own family is not allowed.

8.3.5 Cost: The cost of all FP10 forms is charged against the service/community team's budget.

8.3.6 Use of FP10HNCs: Outpatients requiring prescribed medicines should be given a Trust prescription for dispensing at the local hospital pharmacy. Where this is not practical, they may be given FP10HNC prescription forms, which they take to their local community pharmacy.

Prescribers are reminded that outpatient prescribing is subject to the same standards outlined in this policy for inpatients.

9. Patient Group Directions (PGDs)

9.1 The majority of clinical care should be provided on an individual, patient specific basis. Legislation enables registered health professionals to supply or administer licensed medicines under a PGD; nurses, midwives; health visitors; optometrists; pharmacists; chiropodists; radiographers; dietitians; orthoptists; orthotists and prosthetists; physiotherapists, speech and language therapists, occupational therapists and ambulance paramedics; dental therapists and hygienists.

9.2 PGDs are written instructions for the supply or administration of licensed medicines without involvement of a prescriber. The supply and administration of medicines under PGDs should be reserved for those limited situations when this offers an advantage for patient care (without compromising patient safety) and where it is consistent with appropriate professional relationships and accountability.
9.3 The legislation specifies the information which must be included. To assist staff developing PGDs a core template has been produced (Appendix G – Patient Group Direction (PGD) Proforma). Contact the Chief Pharmacist office on 02380 874023 for a PGD development form for submission to the PGD Forum. Clinicians should follow the Standard Operating Procedure for PGD development, review and approval.

9.4 It is important to ensure that the arrangements for the security, storage and labelling of all medicines used within a PGD are comprehensive and comply with Trust policies and the law. Wherever possible medicines should be supplied in suitably labelled/over-labelled prepacks supplied by the pharmacy department. In particular there must be a secure system for recording and monitoring medicine use from which it should be possible to reconcile incoming and outgoing stock on a patient by patient basis.

9.5 Use of any medicine should be consistent with the Summary of Product Characteristics for the relevant medicine and medicines practice guidelines from the National Institute for Health and Care Excellence (NICE).

9.6 Exemptions and Restrictions

Certain groups of medicines are excluded or have a restricted place under PGDs e.g. Antimicrobials

Microbial resistance is a serious public health matter and great care should be taken to ensure that their inclusion in a PGD is absolutely necessary. Staff wishing to develop a PGD which includes antimicrobials should in the first instance discuss it with the Chief Pharmacist – Tel No. 023 8087 4023

10. Administration of Medicines

10.1 General

The administration of medicines is not solely a mechanical task; it requires thought and use of professional judgement. All patients/clients have the right to have any proposed treatment including risks involved in that treatment and any alternatives clearly explained before they agree to consent.

Whether administering a medicine, assisting in its administration or overseeing self-administration, the practitioner must be satisfied that:

(a) The patient/carer has been given and understands the purpose and licensed status of the treatment and possible side effects.

(b) The patient has given their informed consent or is being treated under the M.H.A.

(c) The practitioner has an understanding of substances used and possible side effects.

(d) The practitioner is aware of any monitoring requirements and is satisfied these are being undertaken.

(e) The practitioner is able to justify any actions taken.

(f) The practitioner is prepared to be accountable for the action taken.

(g) The practitioner is aware of the patient’s current assessment and planned programme of care.

10.1.1 All registered practitioners and MHPs are expected to be deemed competent to administer medication by their line manager before administering any medicines independently. Clinical competency frameworks can be accessed from the Trust intranet to support this.
In the unlikely circumstances of someone requiring injectable chemotherapy whilst a mental health inpatient of the Trust, arrangements must be made to transfer the patient to an appropriate acute hospital.

If a patient is discharged from an Acute Trust to one of Southern Health’s community teams and it is agreed that our Trust is to support that patient’s care by disconnecting IV chemotherapy then the ‘Disconnection of continuous infusional chemotherapy from Central Venous Access Devices (CVADs) in the Community v1’ SOP is to be followed. This allows qualified nurses who have been suitably trained and competent to disconnect CVAD chemotherapy infusions. (see SH CP 192 Standard Operating Procedure; Chemotherapy discontinuation within the Community)

**10.2 Preparation and Administration of Medicines**

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

(a) Registered health professionals.
(b) Medical Practitioner.
(c) Mental Health Practitioner (MHP).
(d) Trainee MHPs who have undertaken the pharmacology and drug administration training within the post graduate diploma in Mental Health at the University of Southampton and been assessed as competent (see Appendix M).
(e) A practitioner in training or an employee training to administer medicines, but only under the direct supervision of a nurse or MHP. The nurse or MHP remains responsible for ensuring that the correct procedure takes place.
(f) Other individually authorised employees after formal competency assessed training.

All staff must be currently up to date with BLS/ILS training to administer adrenaline in the event of anaphylaxis.

**10.3 Administration by registered nurses**

10.3.1 A registered nurse is accountable for their actions and omissions. In administering any medication, or assisting or overseeing any self-administration of medication, they must exercise their professional judgement and apply their knowledge and skill in the given situation.

Medicines may only be administered by a registered nurse to a patient:

(i) in line with the directions of a registered prescriber (see section 8) who has completed a patient specific direction (PSD*)
(ii) following a patient group direction (PGD). See section 9.
(iii) in line with the Trust approved list for medicines to be used at the discretion of a registered nurse (see appendix C – Medicines Administered at the Discretion of Nurses - and Appendix D – Topical Applications Administered at the Discretion of Nurses). NB. This list cannot be used in conjunction with the JAC electronic prescribing and administration system. Units using this system must have all medicines prescribed on the when necessary (prn) section.(iv)

* In line with the Trust procedure on obtaining an urgent prescription for an inpatient when a prescriber is not on site. (see section 8.2.5.4).

* A PSD includes relevant patient specific information to enable safe and appropriate administration of a medicine. Examples include:

(a) hospital discharge letter
(b) inpatient drug chart
(c) community administration order
(d) a list of patient names
(e) A PSD generated electronically by a prescriber using a system compliant with Regulation 219(5) Human Medicines Regulations 2012.

All PSDs must state drug dose, route, duration & frequency of therapy and be signed and dated by an independent prescriber [electronic signature in (e) above]. PSDs can be generated, transmitted and stored in printed or electronic format within a framework of robust information governance.

10.3.2 A registered nurse may administer medicines on their own. The administration will be in accordance with the NMC standards. This includes CDs, when it is expected that a competent member of staff is sought to witness the dose being prepared and administered to an inpatient. If such a witness is not available this must be documented in the CD register by the registered nurse.

10.3.2.1 In Mental Health settings a second nurse or authorised person must be involved in the following situations: (In a community setting where it is recognised a nurse may be a lone worker the second check rule may not be possible. The administering nurse will take sole responsibility in line with NMC standards).

(a) All medicines given by continuous infusions, e.g. IV infusion, syringe drivers.
(b) All bolus injections, IV additives and injections via drip tubing.
(c) All injections taken from multidose vials. Where a patient demonstrates their competence to self-administer the medicine, e.g. insulin, the checking of administration need only involve one practitioner.
(d) When drug administration requires complex calculations to ensure the correct volume or quantity of medication is administered. In these situations it may be necessary for a second nurse to check the calculation in order to minimise risk.
(e) Children’s services - a second nurse must be involved.
(f) Administration of Controlled Drugs.

10.3.3 Student nurses can only administer medicines under the direction and direct supervision of a registered nurse. The registered nurse must clearly countersign the signature of the student who is being supervised. The registered nurse retains accountability at all times.

10.3.4 Mental Health Practitioners (MHPs) who have undertaken the Trust training and assessments may administer medicines:

(a) in line with the directions of a registered prescriber (see section 5)
(b) in line with the Trust approved list of oral medicines to be used at the discretion of a nurse/MHP (see Appendix C)
(c) in line with this Policy.

MHPs may only administer medicines

(a) by the following routes –
   - oral
   - topically – this includes eye, ear and nasal preparations and inhalers as well as creams/ointments
   - After further specific trust training and competency assessment MHPs may administer intramuscular injections of antipsychotic depots. This route is limited to antipsychotic depots and limited to the licensed route only. MHPs must NOT administer the first dose of any antipsychotic depots but may administer subsequent doses. Additional training and competency assessment is required before MHPs may administer antipsychotic depot injections - see appendix Q.

(b) To inpatients aged 16 years and over.
A Mental Health Practitioner, approved to administer medicines, may administer medicines on their own (NB. except Controlled Drugs, Schedules 2 and 3 – see Section 9).

A second authorised person must be involved when complex calculations are required to ensure the correct volume or quantity is administered. If the approved Mental Health Practitioner is in any doubt about undertaking a calculation, they must involve a second authorised person.

10.4 Administration Procedure

10.4.1 Before administration of a medicine the nurse/MHP must:

(a) read the prescription carefully. The medicine must not be given if the practitioner has any concerns or if there is any doubt about the legibility of the prescription or other particulars, e.g. dosage, route, time or frequency. The prescriber must be contacted.

(b) check that the prescribed dose has not already been given. For “when required medicines” the size and timing of the previous dose should be checked before administering. A check must also be made to ensure there has been no duplication of prescribed drugs in any other section of the prescription, e.g. paracetamol within more than one product.

(c) check the patient’s identity. A patient's identity can be checked by use of photographs which are signed and dated with a statement saying “This is a true likeness of ....” Or by name and date of birth, or in the case of new staff or agency staff, using a regular member of staff to identify the patient, or by checking the patient’s identity bracelet.

(d) select the medicine required, checking the label against the prescription sheet.

(e) prepare the medicine as described below by checking:

- the name of the patient
- the name of the drug
- the strength of the drug
- the route
- the prescribed dose
- the calculation if any
- the time of administration
- the expiry date
- any documented or known allergies
- any clinical reasons for delaying not administering the dose
- any special additional instructions, e.g. with respect to food, swallow whole
- Form 62,T2 or T3 if appropriate
- The drug name and strength on the blister pack against the information on the label.
- Deal with one medicine at a time, only preparing the next medicine when the first has been returned to the cupboard/trolley/patient’s locker
- Take the measured dose and prescription sheet to the patient and administer the medicine. For oral liquids use oral dosing syringes for quantities less than 5ml or calibrated glass measures

(f) discuss with a prescriber if the patient appears to be intoxicated with alcohol or other substances,

(g) Administer the medicine.

(h) Registered nurses/MHPs must witness the administration.

(i) The registered nurse/MHP must initial or sign in the appropriate column of the prescription sheet at the time of administration.
Variable Doses - Where a variable dose has been prescribed, the registered nurse/MHP will use her/his judgement to decide the dose to be administered using the following guidelines:

- Give the lowest dose as first choice.
- Be clear that they understand the rationale for the variable dose and its indication.
- Record the actual amount given.

As required (PRN) medicines: The registered nurse/MHP must be sure of the indication for the medicines. Any ambiguity, or doubts for PRN medication should be discussed with the prescriber before administration occurs.

Preparation for this procedure should include measures to ensure medicines administration is performed with a minimum of interruptions and distractions to minimise potential for drug administration errors.

10.4.2 Injectable Medicines

All injectable medicines stored in clinical areas must be risk assessed to the standards described in Patient Safety Alert, Promoting safer use of injectable medicines, March 2007.

a) Read all prescription details carefully and confirm that they relate to the patient to be treated.

b) Ensure that the area in which the medicine is to be prepared is as clean, uncluttered and free from interruption and distraction as possible. Ideally, preparation should take place in an area dedicated to this process.

c) Assemble all materials and equipment: sharps bin for waste disposal, medicine ampoule(s)/vial(s), diluent, syringe(s), needle(s), alcohol wipes, disposable protective gloves, clean re-usable plastic tray.

Check the following:

- expiry dates
- damage to containers, vials or packaging
- that medicines were stored as recommended, e.g. in the refrigerator

d) Beware of the risk of confusion between similar looking medicine packs, names and strengths. Read all labels carefully.

e) Check that:

- the formulation, dose, diluent, infusion fluid and rate of administration correspond to the prescription and product information
- the patient has no known allergy to the medicine
- the method of preparation is understood

f) Calculate the volume of medicine solution needed to give the prescribed dose. Write the calculation down and obtain an independent check by another registered healthcare professional wherever possible.

g) Prepare the label for the prepared medicine (except for bolus doses).

h) Cleanse your hands according to local policy.

i) Put on a pair of disposable protective gloves.

j) Use a 70% alcohol wipe or spray to disinfect the surface of the plastic tray.

k) Assemble the syringe(s) and needles(s). Peel open wrappers carefully and arrange all ampoules/vials, syringes and needles neatly in the tray.

l) Use a ‘non-touch’ technique, i.e. avoid touching areas where bacterial contamination may be introduced, e.g. syringe-tips, needles, vial tops. Never put down a syringe attached to an unsheathed needle.

m) Prepare the injection by following the manufacturer’s product information or local guidelines, and the relevant guidance in 10.4.3 to 10.4.11.
10.4.3 **Withdrawing solution from an ampoule (glass or plastic) into a syringe**

a) Tap the ampoule gently to dislodge any medicine in the neck.
b) Snap open the neck of glass ampoules, using an ampoule snapper if required.
c) Attach a needle to a syringe and draw the required volume of solution into the syringe. Tilt the ampoule if necessary. Use ‘luerlock’ syringes where provided.
d) Invert the syringe and tap lightly to aggregate the air bubbles at the needle end. Expel air carefully.
e) Remove the needle from the syringe and fit a new needle or sterile blind hub.
f) Label the syringe.
g) Keep the ampoule and any unused medicine until administration to the patient is complete to enable further checking procedures to be undertaken.
h) If the ampoule contains a suspension rather than solution, it should be gently swirled to mix the contents immediately before they are drawn into the syringe.
i) The neck of some plastic ampoules is designed to connect directly a syringe without use of a needle, after the top of the ampoule has been twisted off.

10.4.4 **Withdrawing a solution or suspension from a vial into a syringe**

a) Remove the tamper-evident seal from the vial and wipe the rubber septum with an alcohol wipe. Allow to dry for at least 30 seconds.
b) With the needle sheathed, draw into the syringe a volume of air equivalent to the required volume of solution to be drawn up.
c) Remove the needle cover and insert the needle into the vial through the rubber septum.
d) Invert the vial. Keep the needle in the solution and slowly depress the plunger to push air into the vial.
e) Release the plunger so that solution flows back into the syringe.
f) If a large volume of solution is to be withdrawn, use a push-pull technique. Repeatedly inject small volumes of air and draw up an equal volume of solution until the required total is reached. This ‘equilibrium method’ helps to minimise the build-up of pressure in the vial.
g) Alternatively, the rubber septum may be pierced with a second needle to let air into the vial as solution is withdrawn. The tip of the vent needle must always be kept above the solution to prevent leakage.
h) With the vial still attached, invert the syringe. With the needle and vial uppermost, tap the syringe lightly to aggregate the air bubbles at the needle end. Push the air back into the vial.
i) Expel excess air from the syringe. Remove the needle and exchange it for a new needle or a sterile blind hub.
j) The vial(s) and any unused medicine should be kept until administration to the patient is complete.
k) If the vial contains a suspension rather than solution, it should be gently swirled to mix the contents, immediately before they are drawn into the syringe.

10.4.5 **Reconstituting powder in a vial and drawing the resulting solution or suspension into a syringe**

a) Remove the tamper-evident seal from the vial and wipe the rubber septum with an alcohol wipe. Allow to dry for at least 30 seconds.
b) Check diluent is appropriate for injection being reconstituted. Use the procedure above to withdraw the required volume of diluent (e.g. water for injections or sodium chloride 0.9%) from ampoule(s) in the syringe.
c) Inject the diluent into the vial. Keeping the tip of the needle above the level of the solution in the vial, release the plunger. The syringe will fill with air which has been displaced by the solution (if the contents of the vial were packed under a vacuum, solution will be drawn into the vial and no air will be displaced). If a large volume of diluent is to be added, use a push-pull technique (see above).
d) With the syringe and needle still in place, follow manufacturer’s recommendations in reconstituting as they may be specific, e.g. “gently swirl vial” as opposed to “vigorously shake”. This may take several minutes.
e) Follow the relevant steps above to withdraw the required volume of solution from the vial into the syringe.
f) Alternatively, the rubber septum may be pieced with a second needle to let air into the vial as solution is withdrawn. The tip of the vent needle must always be kept above the solution to prevent leakage.
g) If a purpose-designed reconstitution device is used, the manufacturer’s instructions should be read carefully and followed closely.

10.4.6 Adding a medicine to an infusion

a) Prepare the medicine in a syringe using one of the methods described above.
b) Check the outer wrapper of the infusion container is undamaged.
c) Remove the wrapper and check the infusion container itself in good light. It should be intact and free of cracks, punctures/leaks.
d) Check the infusion solution, which should be free of haziness, particles and discolouration.
e) Where necessary, remove the tamper-evident seal on the additive port according to the manufacturer’s instructions or wipe the rubber septum on the infusion container with an alcohol wipe and allow to dry for at least 30 seconds.
f) If the volume of medicine solution to be added is more than 10% of the initial contents of the infusion container (more than 50ml to a 500ml or 100ml to a 1 litre infusion), an equivalent volume must first be removed with a syringe and needle.
g) Inject the medicine into the infusion container through the centre of the injection port, taking care to keep the tip of the needle away from the side of the infusion container. Withdraw the needle and invert the container at least ten times to ensure thorough mixing before starting the infusion.
h) Do not add anything to any infusion container other than a burette when it is hanging on the infusion stand since this makes adequate mixing impossible.
i) Before adding a medicine to a hanging burette, administration must be stopped. After the addition has been made and before administration is re-started, the contents of the burette must be carefully swirled to ensure complete mixing of the contents.
j) Check the appearance of the final infusion for absence of particles, cloudiness or discolouration.
k) Label the infusion, with standard/approved infusion label (see 10.4.8 below).

10.4.7 Diluting a medicine in a syringe for use in a pump or syringe-driver

a) Prepare the medicine in a syringe using one of the methods described above.
b) Draw the diluent into the syringe to be used for administration by the pump or syringe-driver. Draw in some air (slightly more than the volume of medicine needed) and remove the needle.
c) Stand the diluent syringe upright. Insert the needle of the syringe containing the medicine into the tip of the diluent (administration) syringe and add the medicine to it. Alternatively, a disposable sterile connector may be used to connect two syringes together directly.
d) Check the following:

- The total volume of injection solution in the syringe is as specified in the prescription and that the infusion can be delivered at the prescribed rate by the administration device chosen
- The rate of administration is set correctly on the administration device and according to the manufacturer’s instructions
e) Fit a blind hub to the administration syringe and invert ten times to mix the contents.

f) Remove the blind hub. Tap the syringe lightly to aggregate the air bubbles at the needle end. Expel the air and refit the blind hub.

g) Carefully check the syringe to ensure there are no cracks, leaks, solution haziness or precipitate and then label it, especially noting the requirements specific to syringe drivers.

h) Check that the rate of administration set and starting the infusion device.

10.4.8 **Labelling injection and infusion containers**

a) All injections should be labelled immediately after preparation, except for syringes intended for immediate push (bolus) administration by the person who prepared them. Under no circumstances should an operator be in possession of more than one unlabelled syringe at any one time, nor must an unlabelled syringe be fitted to a syringe driver or similar device.

b) Labels used on injectable medicines prepared in clinical areas should contain the following information:
- Name of the medicine
- Strength
- Route of administration
- Diluent and final volume
- Patient’s name
- Expiry date and time
- Name of the practitioner preparing the medicine

c) Place the final syringe or infusion and the empty ampoule(s)/vials(s) in a clean plastic tray with the prescription for taking to the patient for administration.

10.4.9 **Administration of an injectable medicine**

a) Before administering any injection check all the following:
- Patient’s name, hospital/NHS Number or date of birth or address
- Prescriber’s signature
- The approved medicine name
- The dose and frequency of administration
- The date and route of administration
- The allergy status of the patient

b) Also check, where relevant:
- Brand name and formulation of the medicine
- Concentration or total quantity of medicine in the final infusion container or syringe
- Name and volume of diluent and/or infusion fluid
- Rate and duration of administration
- Type of rate-control pump or device(s) to be used
- The age and weight of any patient under 16 years of age, where relevant
- The date on which treatment should be reviewed

c) Check that the medicine is due for administration at that time and has not already been given.

d) Assemble everything you need including any flushing solution(s) needed.

e) Explain and discuss the procedure with the patient.

f) Check any infusion already in progress. It should be free of haziness, particles and discolouration.

g) Check that an appropriate access device is in place. Flush it immediately before and after administration of a medicine, and between doses of different medicines.
administered consecutively, according to local policy. Also check the administration site for signs of leakage, infection or inflammation.

h) For guidance on the procedure for administration of depot injections, refer to the Guidance on the Administration to Adults of Oil-based Depot and other Long-Acting Intramuscular Antipsychotic Injections, Feetam C, White J or Royal Marsden Manual of Clinical Nursing Procedures (via OpenAthens).

10.4.10 Administration of injections – general

a) Check infusions. They should be free of haziness, particles and discolouration.
b) Use aseptic (non-touch) technique at all times.
c) Attach administration sets to infusion containers carefully, on a flat surface and using the technique appropriate to the type of container.
d) Prime the access device according to local policy immediately before starting an infusion.
e) Before adding a medicine to a hanging burette, administration must be stopped. After the addition has been made and before re-commencement, the contents of the burette must be carefully swirled to ensure complete mixing.
f) Injection solutions must NEVER be added to whole blood, plasma infusions or opaque solutions. A separate infusion line must be used.

10.4.11 After Administration

a) After completion of an intermittent infusion, flush the access device according to local policy.
b) Ask the patient to report promptly any soreness at the injection site or discomfort of any sort.
c) Make a detailed record of administration. Discard the empty ampoules/vials from which the injection was prepared and any unused medicine. Ampoules or vials should never be used to prepare more than one injection unless specifically labelled by the manufacturer for ‘multi-dose’ use.
d) Re-check the administration site for signs of leakage, infection or inflammation and continue to monitor the patient, contents of the infusion container and the rate of infusion according to Intravenous Therapy and Peripheral Cannulation policy SH CP 137.
e) Check that arrangements for monitoring fluid balance or clinical parameters have been made. Ensure that relevant documentation is made available for subsequent regular monitoring to take place.

10.5 Administration of Medicines by staff other than prescribers or nurses

The Trust recognises that groups of staff other than doctors, pharmacists or registered nurses undertake duties which involve them in medicines. Where this occurs, the staff concerned MUST have undertaken Southern Health NHS Foundation Trust approved training and been assessed as competent in their particular context. They must follow the Trust policies and procedures around medicines developed for their specific area and approved by the Medicines Management Committee. These members of staff are referred to by their job title, e.g. Mental Health Practitioner (MHP), physiotherapists, medicines administration technician, as authorised staff within this policy.

10.6 The Mental Capacity Act

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who are not able to make their own decisions. A key principle of the law is that every adult has the right to make their own decisions and is assumed to have capacity to do so unless it is proved otherwise. Further guidance is available in the Trust’s Mental Capacity Act Policy and Guidance, SH CP 39.
10.7 Patient Refusing Medication

A patient lacks capacity to consent if she/he is:

- Unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question, and/or
- Unable to use and weigh up this information in the decision-making process

Before making a judgement that a patient lacks capacity, staff must take all steps reasonable in the circumstances to assist the patient in making their own decisions. This could involve explaining what is involved in very simple language, using pictures to communicate and decision-aids as appropriate. People close to the patient (spouse/partner, advocate, family, friends, and carers) may often be able to help, as may specialist colleagues such as speech and language therapists.

Capacity is ‘decision-specific’: A patient may lack capacity to make a particular complex decision, but be quite able to take other straight-forward decisions or parts of decisions.

A patient's ‘best interests’ are not limited to their best medical interests. Other factors which may form part of the best interests' decision include:

- The wishes and beliefs of the service user when competent
- Their current wishes
- Their general well-being
- Their spiritual and religious welfare

Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, staff should attempt to involve people close to the patient in the decision-making process. They are likely to know the patient much better than staff and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Where a medicine is refused by the patient or the carer refuses to administer or allow administration of that medicine, the Nurse/MHP must make a clear and accurate record of the decision. Consider whether refusal of that medicine compromises the patient's condition or the effect of other medicines, and assess the situation and judgement made as to whether to contact the prescriber. Out of hours this should be discussed with the site bleep holder. Never force the person to take their medication unless the patient is subject to treatment under the Mental Health Act.

A patient's views and wishes should be taken into account when administering medication. In the event of a patient declining medication, an assessment of risk and discussion with the multi-disciplinary team must take place. The decision must be documented in the patient’s case file and recorded on the prescription sheet.

If refusal becomes a regular occurrence, a care plan will be prepared by the multi-disciplinary team outlining an ‘acceptable’ level of non-compliance over a set period.

10.8 Omitted/Delayed Doses

(a) The approved Trust coding system must be used to record the reason for omission. If there is no appropriate code the reason for omission must be recorded on the prescription chart. In addition professional judgement should
be used to decide whether it is necessary to inform the prescriber. Out of hours this should be discussed with the site bleep holder before contacting the prescriber.

(b) Sites using electronic prescribing system: doses omitted must be entered “not given” on the JAC electronic system and reason for omission entered.

(c) If administration of a dose is delayed from prescribed time the actual administration time must be recorded under the signature. A prescriber or pharmacist should confirm that it is appropriate to give the dose at the delayed time.

(d) A check must be made for drug omissions at each nursing handover. Actions must be agreed and documented to ensure further omissions are prevented, e.g. follow up supply problems or request doctor to review if there is a consistent problem. For undocumented (blank) omissions, establish if the medicine was administered and document on the drug administration section of the prescription chart.

(e) Omissions should be identified as part of the medication review at ward rounds and reasons established. The clinical team should consider actions to prevent further omissions. All medication omission discussions and agreed actions must be documented in the patient notes.

(f) Blank administration boxes for critical medicines should be reported on Ulysses. A list of critical medicines is posted on the medicines management intranet.

10.9 Nil by Mouth

Patients classified ‘Nil by Mouth’ (e.g. those patients prior to a diagnostic procedure or receiving an anaesthetic and undergoing ECT) must have all their prescribed oral medicines administered to them at the prescribed time unless specifically advised otherwise and these omissions must be recorded on the drug prescription and administration chart. The medicines should be taken with a small amount of water to enable the patient to swallow these medicines. Only medicines that have been clearly marked on the prescription sheet may be omitted. It is the prescriber’s responsibility to provide clear written instructions to the nursing staff concerning the omission of prescribed doses.

10.10 Management of Side Effects/Adverse Effects

Practitioners must understand the expected outcome for any medication prescribed or administered.

Any adverse effects must be recorded in the medical records and the prescriber informed. The practitioner should consider withholding medication if serious side effects are observed. The prescriber must be contacted as soon as possible. Practitioners have a key role in explaining possible side effects, delays in onset of action etc. to patients. A Committee on the Safety of Medicines “Yellow Card” must be completed for adverse drug reactions to:

- New drugs – report all suspected reactions to new drugs, even if minor (new drugs are designated by a black triangle in the BNF)
- Established drugs - report only serious events requiring patient transfer/admission to an acute Trust hospital (following the above procedure) even if it is well known

Yellow cards can be found in the back of all BNFs or on website [http://yellowcard.mhra.gov.uk/](http://yellowcard.mhra.gov.uk/). Yellow cards can be submitted by a doctor, pharmacist, nurse and patients.
10.11 **Privacy and Dignity**

The practitioner should be aware of the need for privacy and the patient’s dignity when administering medication. The practitioner must exercise judgement in offering medication in a confidential manner.

10.12 **Controlled Drugs (CDs)**

10.12.1 The administration of all Schedule 2 and Schedule 3 CDs or drugs which are subject to local rules with respect to their recording within the CD Register, must only be undertaken by a registered healthcare professional and must be witnessed by another registered healthcare professional or competent member of staff, including student nurses, healthcare support workers or mental health practitioners. **Both practitioners must be present during the whole of the administration process.** Other members of staff may be trained to take on this role but only if approved individually by the CD Accountable Officer and Associate Director of Nursing.

It is recognised that where a nurse may be working alone the second check rule may not be possible. The administering nurse will take sole responsibility in line with NMC standards.

10.12.2 **In addition** to the procedure outlined in section 10.4.1 the following procedure must be followed before administering a CD:

(i) Check the total quantity of medicine corresponds to the entry in the CD register.

(ii) Enter the details in the CD Register together with the signatures of both the witness and the registered healthcare professional who will administer the drug. Details include: dose to be administered (and part dose destroyed where relevant), patient name, date and time of administration and remaining stock balance.

(iii) Oral liquid CDs: When a container is emptied or new container opened, if the actual quantity does not correspond to the quantity recorded in the CD register adjust the balance to reflect the actual quantity. If the adjustment is more than 10% of the container volume, inform a Trust pharmacist.

10.12.3 Where the witness is not a registered healthcare professional, the role of that person is limited to witnessing (a) the preparation of the CD to be administered, (b) that the drug is administered to the appropriate patient, (c) that the stock balance is correct and (d) the destruction of any surplus drug (e.g. part of an ampoule).

10.12.4 CD Registers must be kept locked in the CD or medicines cupboard.

10.12.5 CD Registers must be held for 7 years from the date of the last entry by the ward manager and then may be confidentially destroyed. If CDs are administered to a child under 17 the record must be retained until the child is 26 or until they are 27 if aged 17.

10.13 **Medicines Administered at the Discretion of Nurses and MHPs**

Treatment with certain specified medicines (not classified as prescription only medicines) may be initiated by nurses/MHPs without the authorisation of a prescriber provided:

(a) The medicine is listed on either the Trust approved lists (internal or external for adults or separate list for under 16 year olds). (Appendices C – Medicines Administered at the Discretion of Nurses and MHPs - and D – Topical Applications Administered at the Discretion of Nurses only).
(b) The treatment is recorded on the appropriate section of the Trust prescription chart.

Staff working in units using an electronic prescribing and administration system will have the list of discretionary medicines available for them to prescribe and administer as a STAT order. The details of frequency and conditions must be reviewed in the light of information in Appendix C.

10.14 Covert administration

10.14.1 Various bodies have highlighted the complexity of the issues and that it involves the fundamental principles of patient and client autonomy and consent to treatment, which are set out in common law and statute and underpinned by the Human Rights Act 1998.

10.14.2 Overview

(i) 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.

(ii) Disguising medication in the absence of informed consent may be regarded as deception.

(iii) A clear distinction should always be made between those patients who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity.

(iv) Where a person lacks capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medication, and others who would be aware if they were not deceived into thinking otherwise.

10.14.3 Procedure

(i) Establish that the patient does not have capacity to make a decision, or to consent to treatment in line with the Mental Capacity Act 2005.

(ii) Ensure that the treatment provided is deemed necessary and is the least restrictive option for the patient.

(iii) Hold a “best interests” discussion, where the best course of action for the individual is decided. The prescriber should conduct this discussion in conjunction with the multi-disciplinary team. The patient’s family/representatives must be involved and informed of decisions made. If the patient has an attorney appointed under the Mental Capacity Act for health and welfare decisions, this person should be present at the discussion.

In deciding what treatment may be reasonably considered as being in the best interests of a patient who lacks capacity to consent, the General Medical Council recommends that the following be taken into account:

- Options for treatment which are clinically indicated
- Evidence of the patient’s previously expressed preferences, including any advance statements or directives.
- Knowledge of the patient’s background, including their cultural and religious beliefs.
- Third party views about the patient’s preferences given by those who may have other knowledge of the patient, e.g., partner, relative, carer or advocate.
- Where more than one option (including non-treatment) seems reasonable and in the patient’s best interest, consideration should be given to that which least restricts the patient’s choice.
Only in urgent circumstances can covert administration be completed without a "best interests" discussion having been held.

(iv) Following the "best interests" discussion, agree a management plan and document this in the medical and nursing notes, including the names of all parties concerned. The timeframe or circumstances for review (for example changes to medicines) should be decided. The management plan, following advice from a pharmacist, must explain exactly how medicines are to be offered to the patient and how they are to be disguised. The need for covert administration must be reviewed regularly as capacity can fluctuate over time.

(v) Covert administration will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for decisions made lies with all staff involved in the patient's care. Clear documentation is essential. The actual method of covert administration must be recorded on the “Covert administration of medicines form” (Appendix I). Document when medicines have been administered covertly on the patient's medication administration chart. A full review of covert administration should be undertaken at least every two months, with mini reviews at least every fortnight. Document the outcomes of review meetings. At each review, attempts should be made to encourage the patient to take their medication.

(vi) 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.

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

(viii) 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. Registered nursing staff must remain aware of the NMC guidance on the administration of unlicensed and off-licence medication.

(ix) A pharmacist’s 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. Any medicine presented to a patient within foodstuffs must be witnessed as being consumed by the patient.

(x) Consideration must 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. The medical team should be informed.

10.14.4. Mental Health Act (MHA), Sections 58 and 63

(i) Before covert treatment for mental disorder is administered under ss 58 or 63 MHA the Responsible Clinician (RC) should consider:
• Why it is not practicable to seek the patient’s consent.
• Whether the giving of covert medication is a proportionate response to the aim of improving the patient’s health or reducing the risk posed by the patient.

The RC must be able to articulate and record why it is not practicable (e.g. feasible) for the medication to be given in another method, and why it is proportionate (e.g. why it does not go beyond what is necessary) to treat the patient.
(ii) Although it would be lawful to administer medication provided under s63 or s58(b) forcibly (if clinically possible), the RC might consider that the covert administration of the medication would be less invasive of the patient’s physical integrity and therefore would be deemed a proportionate response.

(iii) The issues considered and the reasoning behind any decision must be recorded in the patient’s notes. This will help protect from a challenge under the Human Rights Act (see paragraphs 23.37 – 23.41, Mental Health Act Code of Practice 2008).

(iv) If covert medication is being proposed under s58 then it is imperative that this is discussed and made clear to the SOAD so that this can be recorded on the statutory form completed by the SOAD to authorise the treatment. SOADs will look for evidence that the clinical team is aware of the RCPsych and related guidance, that alternatives to covert routes have been thoroughly considered, and that the clinical team have discussed the matter thoroughly between themselves and with any appropriate relatives, carers and advocates.

(v) Where a clinical team decide to resort to covert administration of medication that is authorised on an extant Form T3 (i.e. where that extant Form relates to a treatment plan that did not specify covert routes of administration), it is expected that a further Second Opinion to reconsider the authorisation is sought.

11. **Self (Carer) Administration of Medicines**

11.1 Self administration of medicines by patients, or administration by carers, should be seen as a key part of maintaining or enabling independence, an integral part of any recovery programme and an option within the delivery of routine care for all patients. Inpatients admitted to acute mental health inpatient areas will not be considered for self-administration except by exception. Patients in community hospitals will be considered for self-administration after assessment.

11.2 Self-administration should follow the Trust Self Administration of Medicines procedure SH CP 168

11.3 Consideration should be given to the following issues:

- **Patient selection**

  All patients considered for self-medication must be subject to a multi-disciplinary review and documented risk assessment

- **Training**

  The schemes should ensure that provision for patient/carer training is included in the scheme. This must include:

  (a) Knowledge of medicines and side effects
  (b) Correct storage of medicines
  (c) What to do if a mistake is made
  (d) How to obtain further supplies

- **Monitoring**

  Clear guidance on monitoring of the self-administration scheme must be given.

- **Storage**

  Medicines must be stored in line with section 3 of this policy. If individual medicine lockers are used, only the self-medicating patient and staff authorised to hold medicine keys may have access.
• Records
If administration is under the supervision of the registered nurse/MHP/or other authorised person, the latter is responsible for ensuring the correct drug, dose and time of administration and will record the administration on the prescription chart. If the patient/carer is responsible for administration, suitable records must be kept to allow the registered nurse/MHP/or other authorised person to monitor and comment on progress. Patients on self-medication schemes must have this clearly recorded on either the prescription chart or equivalent computer system. Doses administered by nursing staff/MHPs in addition to or instead of self-administration must be recorded in the normal way.

11.4 Self Administration of Controlled Drugs (CDs)
Patients may self-administer CDs. Specific procedures must be in place and approved by the Chief Pharmacist and the CD entered as Patient’s Own CDs in the register. Self-administration of CDs on the unit must always be supervised by a registered nurse who must record that it has been given in the appropriate register.

12. Compliance Aids
12.1 Health professionals can employ a combination of strategies to promote patient adherence to prescribed medication. There should be a full multi-disciplinary assessment of the patient’s abilities and also a risk assessment of the possible outcomes of noncompliance. Approaches to improve compliance should be kept as simple as possible. Rationalising medication administration to once or twice a day when a carer could supervise or provision of a reminder card may be all that is needed. When all other approaches fail, a medication compliance device, e.g. Monitored Dosage System (MDS), may help. Contact your clinical pharmacist for advice. On discharge an MDS letter or copy of the discharge prescription should be completed and a copy sent to the GP and pharmacy who will continue the supply see

12.2 Wherever possible a pharmacist should fill the compliance aid. Check to see if the local pharmacy is able to provide this service.
Under the Equality Act, community pharmacists are required to assess individuals and provide a compliance aid if deemed necessary and the pharmacist has the capacity to undertake the work.
However, in the interests of patient care and where no pharmacy service is available, registered nurses, MHPs and OTs can support the patients in filling and using compliance aids as part of their role to support and instruct patients regarding their medication.

12.3 Staff must follow the Trust Guidance on Filling and Checking a Compliance Aid (Policy No SH CP 170).

13. Legal and Human Rights Issues
13.1 All clients have the right to have any proposed treatment, including any risks associated with that treatment and any alternatives clearly explained before they decide to agree to consent.

13.2 Mental Health Act 1983 - Section 58 Treatment Requiring Consent or a Second Opinion
If the patient is being treated under Section 58 this should be clearly indicated on the patient prescription chart and a copy of the statutory Certificate of Consent to Treatment or Certificate of Second Opinion, forms 62, T2, T3, T4, T5 or T6, must be
kept with the prescription chart when administering medication. The nurse/MHP must check that each drug being administered is included on the statutory form. Where electronic prescribing is used these forms are to be held so that they are easily accessible by the multi-disciplinary team.

Where patient/clients are detained under the Mental Health Act, the principles of consent continue to apply to any medication not related to the treatment of the mental disorder for which they have been detained.

14. **Medication Errors**

14.1 A medication error is a preventable incident associated with the use of medicines that may put a patient at risk. Such incidents may be related to one or more of the stages of the medicine use process:

a) Ordering  
b) Storage  
c) Prescription  
d) Dispensing  
e) Administration  
f) Recording  
g) Disposal  
h) Information / Advice

This section should be read in conjunction with the Policy for Managing Incidents and Serious Incidents (SIs) (SH NCP 16).

14.2 On discovering an error or a near miss, the member of staff must take immediate action to safeguard the wellbeing of the patient involved.

14.2.1 Assess current status of condition (overall presentation, level of consciousness, temperature, pulse, blood pressure, respirations).

14.2.2 In case of medical emergency, the usual procedures for obtaining immediate assistance and first aid should be followed.

14.2.3 Inform Doctor/Pharmacist/Professional Adviser/Line Manager dependent on nature of error or near miss. *When using a phone to discuss an error, always ensure any numbers are clearly understood by using “one” and, “four”, for 14, etc.*

14.2.4 Inform the patient/client/carer in line with the Duty of Candour Policy SH NCP 12

14.2.5 Follow advice of Doctor/pharmacist/Professional Adviser/Line Manager.

14.2.6 Inform Line manager/duty manager/bleep holder as appropriate to local arrangements.

14.2.7 Document the incident in the health records of all patients directly affected by the incident.

14.2.8 Report the incident using the Trust online reporting system, clearly stating:

- What should have occurred - the planned intention  
- What actually occurred  
- Names of medicines were involved  
- Doses of medicines  
- Administration routes involved  
- What actions were taken to safeguard the involved patients
14.3 The incident must be investigated to identify the cause(s) of the incident or near miss. The scope of the investigation will be dependent on the nature of the incident / near miss and should be determined by the Service/Locality Manager. For serious incidents, a full root cause analysis may be required. For any incident involving a Controlled Drug, the Accountable Officer must be notified and must agree the terms of reference and scope of any investigation. They must also agree any subsequent action plans. The Chief Pharmacist/Risk Services Manager should be contacted for advice/support if required.

14.4 An action plan must be formulated and implemented to address any issues identified by the investigation. The Service/Locality Manager will be responsible for ensuring action plans are implemented and reviewed.

14.5 The Service/area Manager is responsible for ensuring that any learning points identified are disseminated across the whole Directorate and copied to the Chief Pharmacist to ensure that Cross-Directorate learning occurs where appropriate.

15. **Infection Control and Control of Substances Hazardous to Health (COSHH)**

15.1 Hand washing is the single most important means of preventing the spread of infection. Hands must be washed before and after administering medicines. For details see Hand Hygiene Procedure, SH CP 12.

15.2 When applying topical liquids, pastes, ointments and creams, or administering suppositories, enemas or pessaries and when administering injections, practitioners must follow the Standard Precautions Procedure SH CP 19.

15.3 **Spills**

Staff must deal with any medicine spill as outlined in COSHH Policy SH HS 09 and Waste Policy SH NCP 47.

15.4 **Needle sticks Injuries**

In the event of a needle stick inoculation or contamination incident refer to the Sharps and Inoculation Management Procedure SH CP 14.

16. **Community Teams (includes Adult Mental Health and Assertive Outreach Teams)**

16.1 Medicines used by these teams must be managed (e.g. ordered, stored and administered) as outlined in sections 2, 3, 4, 5, 8 and 10.

16.2 **Individual Patient Items**

Most patients in the community will receive all their medicines from their GP and will store them in their own home. Exceptions to this practice include:

Medicines supplied through hospital pharmacy, e.g. Clozapine:

For patient convenience this can be delivered to a community team base. The nurse for each patient should decide whether the patient requires counselling on the medicine. If so the nurse should arrange to personally hand over the medicines and provide the necessary advice. If the nurse does not feel this is necessary a named member of administrative staff may hand the medicines to the patient. Administrative staff should be given a list of people who may be given their medicines in this manner and a record must be kept for each time a patient collects their medicines. The role of the administrative staff member is to give the correct bag of medicine to the correct person. They must not provide advice on the drug
and all such requests must be passed on immediately to the nurse. Staff who take on this role must be fully briefed and authorised by the Community Mental Health Team (CMHT) manager. A designated person(s) must ensure clozapine is collected for/by each patient and alert the appropriate team if this does not occur.

Clozapine awaiting collection must be held in a locked cupboard accessible only to authorised administrative staff.

If an error occurs the administrative staff must inform the CPN or manager immediately.

16.3 **Carriage (All Community Teams)**

16.3.1 It is not generally the responsibility of the community teams to obtain patient’s medication from the community pharmacy. However, registered nurses and other CMHT members may convey them to the patient’s home as an ‘agent’ of the patient.

16.3.2 When using stock medication the medicine must be taken to the patients’ home in the supplying pharmacy’s original container, i.e. the entire box must be taken.

16.3.3 Members of the community team authorised to administer medicines must keep medicines:
- In a discreet bag when visiting a patient
- In the locked boot of a car where the medicines are out of sight when travelling between visits
- Where practical the medicines should be returned to the base storage cupboard for overnight or weekend storage. Where this is not possible and by exception they may be stored in a locked cupboard/drawer/cash box at home for no longer than 72 hours. They must not be stored overnight in a motor vehicle.
- When removing patient’s own medicines from the home, team members are reminded that this is the patient’s own property and may only be removed with their consent and signatures obtained. Medicines must be returned to a community pharmacy for disposal. The pharmacist should be asked to sign and date the records for receipt of the medicines. A full record should be kept in the patient’s notes. This must include the name, strength and quantity of each drug. Disposal of stock drugs must be in line with section 5.3.2. When consent is refused, leaving the medicine in the patient/client’s home may endanger the patient/client. In such cases the registered nurse must take into account their duty of care and removal may be the most appropriate and responsible action to take. In all instances document actions and discuss with the line manager and the medical practitioner.

16.4 **Storage**

16.4.1 When medication is prescribed for a patient/client it should be stored in the patient’s own home and it is the registered nurses’ responsibility to teach patients and carers correct storage methods. Where risk assessment recommends that patient’s medicines are held in the team base, they should be stored in line with section 3.3. Medicines must not be stored in cars because of the extreme temperature variations which occur. Advice can be obtained from the supplying pharmacy, Trust pharmacist or Medicines Information Centre.

16.4.2 **Keys**

Only registered nurses, MHPs and authorised staff (i.e. Trust staff assessed as competent to administer medications) may access the medicines stock storage areas. Those authorised staff in the community teams will require access to the medicines cupboards at different times of day. Access can be gained by each
registered nurse/MHP/authorised staff having access to a key cupboard where the medicine cupboard keys are held. The team manager must keep a record of all keys held. Each key should be signed for when starting the role, and returned when leaving the role. Only registered nurses may have access to/administer/requisition schedule 2 or 3 Controlled Drugs.

16.5 **Administration Records**

A signed patient specific direction (PSD) must be in place for all medicines administered by authorised community team members which are not included on the discretionary medicines list. This includes medicines obtained on FP10HNC/FP10MDA/FP10SS forms.

16.6 **Medication Review**

The registered nurse must ensure all medication administered to patients is regularly reviewed by discussion with the patient/carer and the prescriber. Review should be in response to client needs but at least 6 monthly.

16.7 **Loss or theft of medication**

In the event of a loss or theft of medication whilst away from base the line manager must be informed immediately. Police must also be informed of the loss or theft. The incident must be reported using the Trust online reporting system.

17. **Dispensing Medicines**

Dispensing, the preparation of a clinically appropriate medicine for a patient for self-administration or administration by another professional, may only be performed by staff if it is included in their job description and is supported by their professional regulatory body. This should be performed by the local supplying pharmacy during routine opening hours. Medicines should be ordered from the supplying pharmacy in a timely manner to avoid delays in prescribed treatment and avoid missed doses.

Prepacks may be supplied to some wards to aid discharge:

A qualified nurse or MHP should select the correct pre labelled medication and check it against the prescription. They should fill in the name, date, and dosage instructions on the label. The items and labelling must be second checked by another nurse or member of staff. Directions should not be amended by ward staff.

17.1 **Dispensing / ordering for discharge (TTOs) on the ward**

TTO prescriptions must be completed by a prescriber as part of the discharge planning process. Medicines for patients to take home should be requested from the usual supplying pharmacy well in advance to avoid delays on the day of discharge and allow time for patient counselling.

17.2 Exceptionally, if a patient is discharged or wishes to discharge themselves outside of pharmacy hours and before to take out medicines (TTOs) have been arranged, the prescriber can consider the following options:

(a) Prescribe a supply on an FP10 for dispensing by a community pharmacy. The nearest community pharmacy may be found by searching [http://www.nhs.uk/service-search](http://www.nhs.uk/service-search)

(b) Contacting the local acute Trust on-call pharmacist via the hospital switchboard for advice

N.B. Patient’s Own Drugs (PODs) may be used as part of a TTO supply if the directions on the dispensing label match the TTO prescription.
17.3 If patients are discharged without timely access to required medicines this should be reported on the Trust incident reporting system.

18. **Use of Unlicensed/Off-Label Medicines**

18.1 The term “unlicensed medicine” is applied to a medicinal product which has no product licence but is accepted as effective in treating specific conditions by a recognised group of expert clinicians. Off-label medicines are licensed medicines being used for an indication which is not covered by an existing product licence (for example the use of some adult formulations in children).

The majority of medicines have a product licence granted by the Medicines & Healthcare Products Regulatory Agency (MHRA). The licence signifies that the product meets appropriate quality standards and is safe and effective for the use defined. If an untoward incident occurs with a licensed medicine that is a result of a product defect, or a problem with its use in an approved clinical situation, any liability arising may in part or whole be transferred to the licence holders.

The use of an unlicensed medicine is not illegal provided it has been prescribed by a prescriber or, in some cases, dentist for good clinical reasons. However a claim against either the pharmacist or the prescriber is less easy to defend should the patient suffer harm as a result of the effects of that drug.

18.2 For good clinical reasons, the use of such medicines is widespread in secondary care.

18.3 Doctors may legally:

- Prescribe unlicensed or off-label medicines
- Use, in a particular (“named”) patient, unlicensed products specially prepared, imported or supplied
- Use unlicensed drugs in clinical trials
- Use, or advises the use of, licensed medicines for indications or in doses or by routes of administration outside those stated in the product licence (i.e. off-label)
- Override the warnings and precautions given in the licence

18.4 The majority of medicines have a marketing authorisation granted by the MHRA. Should any problems arise because of defects associated with the quality of the medicine, or its use in an approved clinical situation, the Trust can transfer liability to the manufacturer.

18.5 The responsibility for prescribing any medicines falls on the prescriber. Doctors have a duty in common law to take reasonable care. If a doctor uses an unlicensed medicine, it would be deemed negligent if not used in accordance with practice accepted at that time by a responsible body of medical opinion as stated by the Bolam test.

18.6 In using an unlicensed drug or a drug in a way incompatible with the product specification, the doctor must act responsibly and with reasonable care and skill. When prescribing outside a license it is important that the doctor does so knowingly, recognising the responsibility that such prescribing entails and when obtaining consent to treatment should, where possible tell the patient of the drug’s license status and document all the above in the health record. If such prescribing falls outside local or national guidelines the patient’s consent must be recorded on Appendix W which should be filed in the patient’s notes. A copy of this should also be sent to the patient’s GP.
18.7 The Product Liability Directive and the Consumer Protection Act 1987 makes the producer or supplier liable for damage caused by a defect in the product. Accordingly the product can be considered defective on the basis of what the reasonable patient is entitled to expect. This may be affected by the verbal and written information and warnings given to the patient.

18.8 Recognising that the use of an unlicensed medicine is sometimes necessary in order to provide the optimum treatment, the Trust will accept liability on behalf of the prescriber / pharmacist provided that this procedure is followed:

(i) Wherever possible licensed products will be used
(ii) Any exception to this must be by approval of the Medicines Management Committee
(iii) If an unlicensed medicine is used, or one is used outside of its licensed indications, the Trust will accept liability providing such use would command the support of a reputable body of pharmacists or medical practitioners
(iv) Patients should be informed of the license status of the medicine wherever possible

18.9 Pharmacy staff providing unlicensed medicines will endeavour to alert, inform and advise, but it is the responsibility of each prescriber to be aware of the status of the medicines they prescribe.

19. Drug Recalls and Drug Alerts

19.1 The Medicines and Healthcare Products Regulatory Agency (MHRA) are responsible for notifying Trusts of defective medicines.

19.2 The supplying pharmacy has a responsibility to notify wards and units of any defective medicines they may have been supplied with and act on any specific instructions or advice detailed in alerts within the timescales prescribed.

19.3 If a ward or unit receives notification of a defective medicine, it must be immediately brought to the attention of the person in charge.

19.4 The person in charge must follow the instructions received regarding the identification and withdrawal of the defective product if this is advised. Detailed procedure and recording form is available in Appendix O.

19.5 Any withdrawn medicines must be quarantined in a locked medicines cupboard, sealed in a labelled bag/envelope clearly labelled 'Do Not Use'. Agree with the pharmacy how these medicines are to be returned to them.

19.6 If the total supply of a particular medicine is quarantined discuss alternative arrangements with the pharmacy team or on call pharmacist to ensure patients do not miss doses.

20. Clinical Trials Involving Pharmaceutical Products

20.1 Responsibilities for the Supply of Medication
The legal and indemnity issues surrounding supply of clinical trial materials are complex. Before a medicines trial has received Local Research and Ethics Committee and Trust Research and Development Committee approval, the Trust Research and Development Manager must ensure that appropriate arrangements are in place regarding the management and supply of trial medication. Assurance of this requires the signature of the Chief Pharmacist or nominated deputy. No trial is allowed to be dispensed until written authorisation is given by the clinical trials
pharmacist that pharmacy are ready to commence dispensing (green light- SOP CP R&D002).

20.2. Obtaining Trial Medication
Trial medicines are, in most cases provided by the sponsor. If medication is needed that is not provided by the sponsor, the senior pharmacy manager of the local acute trust must be approached and agreement sought for his/her department to facilitate the supply of clinical trial materials

20.2.1 Use of a Community Pharmacy
If, for whatever reason, the local acute trust pharmacy department does not agree to facilitate the management of medication for a particular clinical trial, or if that pharmacy’s location is not convenient for a significant number of the trial participants, a local community pharmacy may be approached to fulfil the role. The trust Chief Pharmacist will act as a liaison point between the trust and the community pharmacy if this is required. The community pharmacy’s responsible and/or superintendent pharmacist must have the capacity (and agree to) support the trial supplies. Where a community pharmacy is used, the responsibility for legal, indemnity and professional issues relating to medicines management will rest with the manager or superintendent of the community pharmacy.

20.2.2 Management of Clinical Trial Material on Trust Premises
Other than in exceptional circumstances, this may only take place in trust bases that regularly undertake clinical trial activity and that have been inspected and approved for such activity by the Chief Pharmacist or another member of the pharmacy team with delegated responsibility.

20.2.3 Bases that are considered as regularly undertaking clinical trials activity will be agreed by the Chief Pharmacist, the Trust’s Medical Lead for Research and Development, and the Commercial Trials Facilitator. Premises and operating procedures for medicines management (for each commercial trial) will be assessed (and approved) by the Chief Pharmacist or a named deputy.

20.2.4 All trials involving pharmaceuticals must involve a member of the medicines management team. The role of the pharmacy team member will include:

- Approving labelling and packaging of all trial material
- Assessing storage requirements
- Confirming that trial material has been manufactured in a licensed production unit, authorised by the MHRA, in accordance with Good Manufacturing Practice and released for use by a Qualified Person
- Assessing suitability of documentation provided
- Confirming whether the trial medication will be available to subjects when the clinical trial has finished
- Agreeing with the sponsor arrangements for disposal of used and unused trial material at the end of the trial
- Ensuring all regulatory documentation is in place before any dispensing occurs
- Developing standard operational procedures for dealing with the medicine. To include receipt, storage, dispensing, return and disposal, code breaks, reconciliation, maintaining a study file, training and archiving
- Only named staff authorised by the clinical trials pharmacy team may undertake dispensing or checking of trial medication if on the delegation log. Non-pharmacy staff will be expected to undergo regular revalidation by pharmacy to maintain competency to dispense or check.
- A member of the clinical trials pharmacy team reserve the right to prohibit any member of staff from undertaking any dispensing or checking activities at any time if, in their opinion, patient safety may be compromised.
• Signing the pharmacy authorisation for Trust Research and Development.

20.2.5 All nursing or other staff working with clinical trials material must work in accordance with a trial specific protocol or trial specific operating instructions:
• Non-pharmacy staff may only dispense clinical trial medication to patients if authorised to do so by a member of the clinical trials pharmacy team and on the trial delegation log. Containers must be fully labelled and clearly coded in accordance with the trial protocol. The role of staff is to add the trial participant’s name, the date of issue, a “dispensed by/checked by” sticker, the investigator’s name and the name and address of the trial centre, and any other information required on pre-printed labels provided by the sponsor to comply with the protocol. Staff may also add any pre-printed labels designed by the clinical trials pharmacy team and complete blank fields on such labels. Non-pharmacy staff are not permitted to amend any labels produced by the sponsor, or to amend pharmacy produced labels.
• The receipt of trial medication must involve an authorised staff member (as per trial delegation log) who is competent to receive medicine as per the protocol.
• The selection, issue and recording of trial medication must involve two members of staff (at least one of whom is a nurse, pharmacist or accredited checking pharmacy technician), who will have joint responsibility for the management of materials.

20.3 **Storage of Clinical Trial Materials**

• The general policy provisions for medicines management employed by the trust for its prescribed medication and its stock medication must also be applied to clinical trial materials.
• When trial materials are stored on trust premises, they must be stored in a locked medicine cupboard or medicine fridge that is reserved solely for the storage of trial materials.
• Facilities must be sufficient in size to allow tidy, uncluttered storage that allows materials to be easily identified. Materials for each trial must be clearly segregated and labelled in order to assist in accurate identification and selection.
• Trial materials should be stored separately to any associated items such as syringes, lancets and blood tubes etc.
• Access to trial material storage areas must be restricted to practitioners who are directly involved with the trial. Access to cupboard keys must also be similarly restricted.
• The temperature of trial material storage areas must be constantly monitored via a digital maximum/minimum thermometer or data device. A daily record of minimum and maximum temperatures must be maintained and be available for inspection by members of the medicines management team and by trial sponsors.

21. **Training Requirements**

The safe and secure handling of medicines in line with this policy requires all staff (dealing in any way with medicines at any level), to receive training appropriate to the needs of their work. Training support at various levels has been identified (Appendix N) and delivered by the pharmacy team in the published programme.

21.1 Please see the Training Needs Analysis at Appendix N.

21.2 Staff attendance (including those who fail to complete relevant medicines management training) will be managed in accordance with the Education and Development Policy SH NCP 26.
21.3. **Medicines Administration Competency Assessment**
Before administering medicines independently all mental health nursing staff and mental health practitioners must pass at least the core competencies stated in the Medication Administration Competency Assessment Toolkit which is posted on the clinical competencies section of the Trust intranet.

22. **Policy Compliance Monitoring**

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead Who will be responsible for monitoring compliance with this element?</th>
<th>Tool Which tool will be used to monitor compliance?</th>
<th>Frequency How often will compliance with this element be examined?</th>
<th>Reporting arrangements Who will the findings be reported to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties / responsibilities</td>
<td>Chief Pharmacist</td>
<td>Prescription Audit</td>
<td>As per audit plan</td>
<td>Medicines Management Committee (MMC) and Quality and Safety Committee</td>
</tr>
<tr>
<td>Documented process for how medicines are prescribed</td>
<td>Chief Pharmacist</td>
<td>Prescription Audit &amp; Intervention Audit</td>
<td>As per audit plan</td>
<td>MMC and Quality and Safety Committee</td>
</tr>
<tr>
<td>Documented process for how the organisation makes sure that all prescription charts are accurate</td>
<td>Chief Pharmacist</td>
<td>Prescription Audit &amp; Intervention Audit</td>
<td>As per audit plan</td>
<td>MMC and Quality and Safety Committee</td>
</tr>
<tr>
<td>Documented process for how medication errors are reported</td>
<td>Chief Pharmacist, Medication safety officer</td>
<td>Reporting via Ulysses and RCA process</td>
<td>Quarterly through Medicines Safety Group</td>
<td>Medicines Safety Group, MMC and Quality and Safety Committee</td>
</tr>
<tr>
<td>Documented process for how the organisation learns from medication errors</td>
<td>Chief Pharmacist, Medication safety officer</td>
<td>Reports generated from Ulysses and monitored for trends and issues of concern</td>
<td>Quarterly</td>
<td>As above and returned to divisions for actions and reports to remedy or address</td>
</tr>
<tr>
<td>Documented process for how the organisation trains staff, in line with the training needs analysis</td>
<td></td>
<td>The process for monitoring compliance with statutory and mandatory training requirements is outlined in the Trust Education and Development Policy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust has a responsibility to monitor its compliance with this policy, specifically with regards to:
- The prescribing responsibilities of staff
- The storage and administration of medication
- Process for service user self-administration
- Procedure for the safe disposal of controlled drugs
- Staff training requirements
- Annual audit of controlled drugs including prescribing, administering and storage; the contents of this audit changes to reflect the needs of the Trust
- Reports on training uptake gathered from information held by LEaD
• Compliance monitoring undertaken by clinical pharmacists and medicine management technicians as part of their regular duties
• Intervention monitoring by clinical pharmacists

23. References
Human Rights Act 1998
DOH 2001 Seeking Consent: Working with people with learning disabilities
Southern Health NHS Foundation Trust Consent Policy
Medicines, Ethics & Practice, Royal Pharmaceutical Society, July 2016
DOH Reference guide to consent for examination or treatment
Mental Capacity Act March 2015
British National Formulary August 2016
The Medicines Act 1968
NMC Standards for Medicines Management 2007
HTM 02-01 Health Technical Memorandum: Medical Gas Pipeline Systems Part A Design, Installation, Validation and Verification November 2006
Controlled Drugs (Supervision of management and use) Regulations 2013 Website link
Misuse of Drugs (Safe Custody) Regulations 1973
Controlled drugs: safe use and management, NICE guideline April 2016 (NG46)
Building a Safer NHS for Patients: Improving Medication Safety. DH.
Professional Guidance on Pharmacy Services for Clinical Trials October 2013 Website Link
Department of Health and Medical Research Council Clinical Trials Toolkit www.ct-toolkit.ac.uk
Institute of Clinical Research www.icr-global.org

24. Glossary of Abbreviations
Nurse in Charge of Medicines NICM
Mental Health Practitioner MHP
Controlled Drugs CD
Controlled Drug Register CDR
Patient’s Own Drugs POD
Discharge Medicines/Leave Medicines TTOs
Patient Group Directions PGD
Standard Operating Procedures SOP

25. Other Relevant Policies (found on the medicines management section of the website)

http://www.southernhealth.nhs.uk/knowledge/medicines-management/policies/
• Dealing with suspected possession of illegal substances by patient’s policy and procedure. http://www.southernhealth.nhs.uk/about/policies/?EntryId41=69468
- Management of seizures: What to do when an inpatient has a seizure SH CP3. 
  http://www.southernhealth.nhs.uk/about/policies/?EntryId41=70639
- Non-medical prescribing strategy document SH CP 179. 
  http://www.southernhealth.nhs.uk/about/policies/?EntryId41=71328
- Non-medical prescribing policy and guidelines S CP 179. 
  http://www.southernhealth.nhs.uk/about/policies/?EntryId41=71328
- Patients own drug use procedure
- Procedure for the delegation and administration of buccal midazolam 
  http://www.southernhealth.nhs.uk/search/?q=+buccal+midazolam&radio=
- Self-administration policy and guidelines 
  http://www.southernhealth.nhs.uk/about/policies/?EntryId41=70983
- Medicines Administration clinical competencies, ICS and MH
## 26. Appendices Index

| Appendix A | Procedure for Auditing Controlled Drug Stocks and Record Books | 60 |
| Appendix B | Procedure for Managers when Discrepancies in Controlled Drug Stock Levels are identified | 62 |
| Appendix C | (1) Medicines Administered at the Discretion of Nurses and MHPs | 63 |
| | (2) Medicines Administered at the Discretion of Nurses and MHPs for Patients age 12-18 | 64 |
| Appendix D | Topical Applications Administered at the Discretion of Nurses | 66 |
| Appendix E | Working in Partnership with the Pharmaceutical Sector | 68 |
| | NHS Standard of Business Conduct | 70 |
| Appendix F | Policy Governing Contact with Company Representatives | 71 |
| Appendix G | Patient Group Direction (PGD) Proforma | 73 |
| Appendix H | Verbal/Faxed Prescription Form | 81 |
| Appendix I | Covert Administration of Medicines | 82 |
| Appendix J | Guidance on the Legal & Trust Requirements for Controlled Drug Disposal on wards | 84 |
| Appendix K | Procedure For The Management Of Controlled Drugs For All Closures Of Isolated Units And Closures Of Other Units For More Than 5 Days | 85 |
| Appendix L | Procedure for disposal of Controlled Drugs (CDs) | 86 |
| Appendix M | Mental Health Practitioner Training | 88 |
| Appendix N | Training Needs Analysis | 89 |
| Appendix O | Drug Recall Form | 96 |
| Appendix P | Process for Obtaining an Urgent Prescription for a Inpatient when a Prescriber is not on site at | 97 |
| Appendix Q | Process for Recording Emailed Prescription on RiO | 98 |
| Appendix R | Procedure for use of Patients Own Drugs (PODs) | 99 |
| Appendix S | Transcription guidelines | 109 |
| Appendix T | Discharge Medication for patients using Compliance Aids at home | 113 |
| Appendix U | Missing/lost/stolen FP10 prescription notification form | 114 |
| Appendix V | Good Practice Guidance on Expiry Dates of Medicines | 116 |
| Appendix W | Medication Consent Form | 117 |
Appendix A:

Procedure for Auditing Controlled Drug Stocks and Record Books

1. Purpose

1.1 To confirm the quantity, identity and integrity of controlled drug stocks for which the Nurse in Charge of Medicines/Ward Manager is responsible.

1.2 To reconcile the stock balance in the CD record with the amounts in the CD cupboard.

1.3 To ensure that stocks have not deteriorated or exceeded expiry date.

1.4 To ensure that entries in the Controlled Drugs record book are being made correctly.

1.5 To review the range and level of stocks in the light of current requirements.

2. Procedure

2.1 Stocks of the Controlled Drug must be audited weekly by the Nurse in Charge/Ward Manager or Deputy, with another nurse who may be either registered or a nurse undertaking pre-registration training. The staff undertaking this check should be rotated periodically.

2.2 Check each balance entered in the record book against the physical stock in the Controlled Drug cupboard, not the reverse to ensure all balances are checked.

2.3 Examine each ampoule and tablet and all liquids to check that they have not been substituted or tampered with. It is not necessary to open packs with intact tamper evident seals for stock checking purposes.

2.4 Stock balances of liquid medicines should be checked by visual inspection. Where there is concern volume checks should be made with the clinical pharmacist or medicines management technician. A calibrated glass measure should be used.

2.5 Check all expiry dates and labels for expired stock.

2.6 Review the range and levels of stock especially any preparation which is not in regular use, and arrange disposal with pharmacy.

2.7 Audit the record book to ensure that:

   (i) all entries have two signatures.
   (ii) any errors or wastage have been witnessed by two authorised people.
   (iii) all entries and signatures have been made in black ink in chronological order and are clearly legible.
   (iv) No entry has been obliterated and alterations and corrections have been explained by a marginal note or footnote which has been dated and signed.
   (v) All entries are complete.

2.8 Enter the date of checking on each current page of the record book with the signature of the Nurse in Charge/Ward Manager and witness.

2.9 If a discrepancy is found it should be investigated without delay.
3. CD Audit by Pharmacy Team

A Trust pharmacist or medicines management technician will perform an audit of CD security, ordering and administration records every six months. A record as per 2.7 will be made.

3.1 Procedure

(i) Check a sample of CD requisitions copies to ensure they meet policy requirements.
(ii) Check that the CD register and CD order book are stored in a locked cupboard.
(iii) Check that the list of authorised signatories for CD requisitions is up to date.
(iv) Check exceptional usage of CDs against orders and prescription chart to confirm medicines are prescribed and have been administered.
(v) Check physical security arrangements for CDs, CD stationery and that key adheres to policy.
Appendix B: Procedure for Managers when discrepancies in Controlled Drug (CD) Stock Levels are identified

Discrepancy in levels of Controlled drugs identified

CHECK: 1Staff to check controlled drugs register and work back through records to see if the error can be identified as being due to an error in previous calculations. (If possible seek assistance from staff on another ward). **Specific checks:**
- Look through CD register to ensure entry not written on wrong page
- Double check count of actual tablets/liquid/amps
- Staff to contact person who made the last entry to ensure missing drug not due to unrecorded waste e.g. broken ampoule
- Check all CD’s present at same time to check that there are no other discrepancies
- All requisitions received have been entered into the correct page of the register
- All CDs administered have been entered into the CD register
- Items have not been accidentally put into the wrong place in the cupboard.

Drug remains unaccounted for

- Contact Senior Clinical Nurse/Service Manager for unit concerned. Out of hours contact the Duty Manager Chief Pharmacist to be contacted next working day

- Contact Fraud Officer

- Local incident form completed

- Internal investigation commenced

Staff requested to make statements as appropriate. Missing drug noted in CD register.

Out of Hours Duty Manager completes On Call Log

Missing drug accounted for

- The registered nurse should make an entry in the Controlled Drugs Register Book clearly stating the reason for the entry and the corrected balance. This entry should be witnessed by a second nurse, pharmacist, medicines management technician or doctor. Both persons will sign the CD Register

- Incident Form completed

- Out of Hours Duty Manager completes On-Call Log

Report to Chief Pharmacist, Assistant Director of Nursing and Locality Manager who will agree action to be taken

1 Consideration needs to be given by the Senior Clinical Nurse/Service Manager as to whether the incident should be reported as a Serious Untoward Incident (see separate procedure). Factors that will be relevant here, for example, are: is it a single dose that cannot be accounted for, or a whole stock?
Appendix C1: Medicines Administered at the Discretion of Nurses and Mental Health Practitioners (MHPs)

The Medicines Management Committee has approved the following list of medicines whereby registered nurses, and MHPs who have been assessed as competent to administer medicines, are authorised to administer (or supply*) some medicines at their own discretion.

A registered nurse or MHP may administer any of the following medicines to ADULT patients.

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>DRUG</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>MAXIMUM TOTAL DOSE IN 24 HRS</th>
<th>MAXIMUM DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Magnesium Hydroxide mixture</td>
<td>25 – 50 ml</td>
<td>Once a day</td>
<td>50 ml</td>
<td>48 hours</td>
</tr>
<tr>
<td>Constipation</td>
<td>Senna tablets 7.5mg</td>
<td>1 – 2 tablets</td>
<td>Once a day</td>
<td>2 ml</td>
<td>48 hours</td>
</tr>
<tr>
<td></td>
<td>Glycerol 4 gram suppositories</td>
<td>1 – 2 Suppositories</td>
<td>Once or twice a day</td>
<td>4 suppositories</td>
<td>24 hours</td>
</tr>
<tr>
<td>Pain</td>
<td>*Paracetamol 500 mg</td>
<td>1 – 2 tablets</td>
<td>6 hourly</td>
<td>4g</td>
<td>48 hours</td>
</tr>
<tr>
<td></td>
<td>*Paracetamol suspension 250mg/5ml</td>
<td>10mL – 20mL</td>
<td>6 hourly</td>
<td>4g</td>
<td>48 hours</td>
</tr>
<tr>
<td>Cough</td>
<td>Simple Linctus</td>
<td>5 mls</td>
<td>6 hourly</td>
<td>20 ml</td>
<td>48 hours</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Thymol &amp; Glycerine throat pastilles</td>
<td>1 pastille</td>
<td>When required</td>
<td>8 pastilles</td>
<td>48 hours</td>
</tr>
<tr>
<td></td>
<td>(Strepsils for use in North Hants Locality)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigestion</td>
<td>Gaviscon Advance Suspension</td>
<td>5-10 mls</td>
<td>After meals and at bedtime</td>
<td>40 mls</td>
<td>48 hours</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Dioralyte</td>
<td>The contents of one or two sachets reconstituted as directions on sachet</td>
<td>After each loose bowel motion</td>
<td>As needed</td>
<td>Single dose then contact doctor for further advice</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy (smoking abstinence)</td>
<td>Nicotine Lozenges* (may be used in addition to a patch)</td>
<td>Dependency level: Low to moderate (up to 10 cigs / day): 1mg – Moderate to strong (10-20 cigs / day): 1mg or 2mg Strong to very strong (20 or more cigs /day): 2mg or 4mg</td>
<td>1-2 hourly</td>
<td>12 lozenges</td>
<td>72 hours</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy (smoking abstinence)</td>
<td>Nicotine patches</td>
<td>Light smoker (&lt; 10 cigs / dy): 14mg / 24 hours or 15mg / 16 hours. Moderate / heavy smoker (&gt; 10 cigs / dy: 21mg / 24 hours or 25mg / 16 hours</td>
<td>Once a day for 16 or 24 hours*</td>
<td>One patch</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

*Check patient not already prescribed paracetamol either within any other medication, or on its own.

Medication initiated by a registered nurse or MHP must be reported to the prescriber when he/she next visits 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 immediately. All such medication must be recorded on the front page of patient’s prescription sheet in the section headed “Medicines Administered under Protocol or Patient Group Direction” and in the nursing notes.
### Appendix C2:

**Medicines Administered at the Discretion of Nurses for Patients Aged 12-18**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Maximum Dose in 24hrs</th>
<th>Maximum Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigestion</td>
<td>Gaviscon Advance</td>
<td>5-10ml</td>
<td>After meals and at bedtime</td>
<td>40mls</td>
<td>48hrs</td>
</tr>
<tr>
<td>Constipation</td>
<td>Lactulose Syrup OR</td>
<td>15ml</td>
<td>Twice Daily</td>
<td>10mls</td>
<td>48hrs</td>
</tr>
<tr>
<td></td>
<td>Senna Tablets 7.5mg OR</td>
<td>1-2 Tablets</td>
<td>Once Daily</td>
<td>2 Tablets</td>
<td>48hrs</td>
</tr>
<tr>
<td></td>
<td>Senna Syrup 7.5mg/5ml</td>
<td>5 – 10 mls</td>
<td>Once Daily</td>
<td>10 mls</td>
<td>48 Hrs</td>
</tr>
<tr>
<td>Pain</td>
<td>Paracetamol 500mg OR</td>
<td>1-2 Tablets</td>
<td>Every Six Hours</td>
<td>4g</td>
<td>48hrs</td>
</tr>
<tr>
<td></td>
<td>Paracetamol Effervescent 500mg</td>
<td>1 – 2 Tablets</td>
<td>Every Six Hours</td>
<td>4g</td>
<td>48hrs</td>
</tr>
<tr>
<td>Cough</td>
<td>Simple Linctus</td>
<td>5mls</td>
<td>6 Hourly</td>
<td>20mls</td>
<td>48hrs</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>Strepsils</td>
<td>One Pastille</td>
<td>When Required</td>
<td>8</td>
<td>48hrs</td>
</tr>
<tr>
<td>Insect Bites or Hay fever</td>
<td>Cetirizine 10mg</td>
<td>1 Tablet</td>
<td>Once Daily</td>
<td>10mg</td>
<td>48hrs</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy (smoking abstinence)</td>
<td>Nicotine Lozenges* (may be used in addition to a patch)</td>
<td>Dependency level: Low to moderate (up to 10 cigs. / day): 1mg – Moderate to strong (10-20 cigs / day): 1mg or 2mg – Strong to very strong (20 or more cigs /day): 2mg or 4mg</td>
<td>1-2 hourly</td>
<td>12 lozenges</td>
<td>72 hours</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy (smoking abstinence)</td>
<td>Nicotine patches</td>
<td>Light smoker (&lt; 10 cigs / dy): 14mg / 24 hours or 15mg / 16 hours. Moderate / heavy smoker (&gt; 10 cigs / dy: 21mg / 24 hours or 25mg / 16 hours</td>
<td>Once a day for 16 or 24 hours*</td>
<td>One patch</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

* May disturb sleep.
### Topical Applications Administered at the Discretion of Nurses for Patients Aged 12-18.

<table>
<thead>
<tr>
<th>Topical Application</th>
<th>Approved Use</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone</td>
<td>Removal of nail polish</td>
<td></td>
</tr>
<tr>
<td>Alcohol Hand Gel</td>
<td>Hand disinfectant used in instances where routine hand washing is not possible or for disinfecting hands after washing with soap and water for more invasive procedures</td>
<td>Used on physically clean hands</td>
</tr>
<tr>
<td>Ametop</td>
<td>Local anaesthetic for topical application prior to venepuncture or venous cannulation</td>
<td>Although systemic absorption is low caution needed for patients who are epileptic</td>
</tr>
<tr>
<td>Diprobace Cream</td>
<td>Emollient for dry skin</td>
<td>Junior range available</td>
</tr>
<tr>
<td>Mouthwash Tablets (Pharmacy To Advise On Product)</td>
<td>Oral Hygiene</td>
<td></td>
</tr>
<tr>
<td>Alcohol Swabs (Sterets, Medi Swabs)</td>
<td>Skin cleaning</td>
<td>Alternatively ensure the area is cleaned with soap and water and then dried</td>
</tr>
<tr>
<td>Aqueous Cream</td>
<td>Dry skin (soap substitute)</td>
<td></td>
</tr>
<tr>
<td>Plaster Remover (CFC: Use Sparingly)</td>
<td>Removal of adhesive tape marks</td>
<td></td>
</tr>
<tr>
<td>Sudocrem</td>
<td>Barrier preparation for protection against urinary rashes</td>
<td></td>
</tr>
<tr>
<td>Oilatum Emollient</td>
<td>For dry skin conditions as bath additive</td>
<td></td>
</tr>
<tr>
<td>Calamine Lotion</td>
<td>Skin rashes / itching skin</td>
<td></td>
</tr>
<tr>
<td>Sunscreen Lotion Factor 30</td>
<td>Sun barrier</td>
<td></td>
</tr>
<tr>
<td>After Sun Lotion</td>
<td>Soothing relief from sunburn</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix D: Topical Applications Administered at the Discretion of Nurses

<table>
<thead>
<tr>
<th>Topical Application</th>
<th>Approved Use</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone</td>
<td>Removal of nail polish</td>
<td></td>
</tr>
<tr>
<td>2% chlorhexidine gluconate and 70%</td>
<td>Skin cleaning</td>
<td>Alternatively ensure the area is cleaned with soap and water and then dried.</td>
</tr>
<tr>
<td>isopropyl alcohol wipe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol hand gel (caution: flammable)</td>
<td>Hand disinfectant used in instances where routine hand washing with soap and water is not possible or for disinfecting hands after washing with soap and water for more invasive procedures</td>
<td>Used on physically clean hands</td>
</tr>
<tr>
<td>Anusol cream</td>
<td>Local pain relief from haemorrhoids</td>
<td></td>
</tr>
<tr>
<td>Aqueous cream</td>
<td>Dry skin (soap substitute)</td>
<td></td>
</tr>
<tr>
<td>Calamine lotion</td>
<td>Skin rashes/itching skin</td>
<td></td>
</tr>
<tr>
<td>Ocentisan</td>
<td>Indicated under prescription for the decolonisation of MRSA</td>
<td>Routine hand washing should be with soap and water.</td>
</tr>
<tr>
<td>Choline salicylate paste (Teejel, Bonjela)</td>
<td>Minor oral ulceration/teething</td>
<td></td>
</tr>
<tr>
<td>Drapolene cream</td>
<td>Barrier preparation for protection against urinary rashes</td>
<td></td>
</tr>
<tr>
<td>Diprobease cream</td>
<td>Emollient for dry skin</td>
<td></td>
</tr>
<tr>
<td>Hand cream</td>
<td>Hand protection/rehydration of hands when frequently cleaned</td>
<td>The hand cream should be compatible with the chosen hand hygiene products. Manufacturers should be consulted to ensure the products are compatible.</td>
</tr>
<tr>
<td>Lubricating Jelly (KY Jelly)</td>
<td>Lubrication for rectal catheters etc.</td>
<td></td>
</tr>
<tr>
<td>Lidocaine Gel 2% with Chlorhexidine</td>
<td>Local anaesthetic prior to catheterisation</td>
<td></td>
</tr>
<tr>
<td>Lidocaine cream or gel (e.g. EMLA)</td>
<td>Local anaesthetic prior to venepuncture or IM injection</td>
<td></td>
</tr>
<tr>
<td>Micro-enema</td>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td>Mouthwash tablets (pharmacy to advise on product)</td>
<td>Oral hygiene</td>
<td></td>
</tr>
<tr>
<td>Plaster remover (CFC – use sparingly)</td>
<td>Removal of adhesive tape marks</td>
<td></td>
</tr>
<tr>
<td>Sunscreen lotion (pharmacy to advise on product)</td>
<td>Sun barrier</td>
<td></td>
</tr>
<tr>
<td>Oilatum emollient</td>
<td>For dry skin conditions as bath additive</td>
<td></td>
</tr>
<tr>
<td>Sudocrem</td>
<td>Barrier preparation for protection against urinary rashes</td>
<td></td>
</tr>
<tr>
<td>Sodium Bicarbonate</td>
<td>Oral Hygiene</td>
<td></td>
</tr>
<tr>
<td>Sodium Chloride 0.9%</td>
<td>Mouth care</td>
<td></td>
</tr>
<tr>
<td>Spermicidal Jelly</td>
<td>Contraception</td>
<td></td>
</tr>
<tr>
<td>Zinc and castor oil</td>
<td>Barrier preparation for protection against urinary rashes</td>
<td></td>
</tr>
<tr>
<td>Topical Applications</td>
<td>Approved Use</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sodium Chloride 0.9% (Normasol sachets)</td>
<td>Routine use to clean and irrigate wounds</td>
<td></td>
</tr>
<tr>
<td>Chlorhexidine solutions</td>
<td>Should be used selectively where wound disinfection is indicated e.g. in the presence of MRSA. Further advice from tissue viability or control of infection staff should be sought.</td>
<td></td>
</tr>
<tr>
<td>Low adherent absorbent dressings (Mepore)</td>
<td>An absorbent pad with a low adherent layer</td>
<td></td>
</tr>
<tr>
<td>Soft silicone wound contact dressing (Mepitel)</td>
<td>Useful for wounds where dressing changes need to be kept to a minimum. Should be covered with an absorbent secondary dressing</td>
<td></td>
</tr>
<tr>
<td>Semi-permeable adhesive film (Opsite)</td>
<td>Suitable for protecting unbroken skin, or open wounds with a low exudate</td>
<td></td>
</tr>
<tr>
<td>Hydrocolloid paste/dressings (Granuflex, Comfeel)</td>
<td>Suitable for light to medium exudating wounds</td>
<td>Odour can be a concern to some patients</td>
</tr>
<tr>
<td>Alginates (Kalostat, Sorbsan)</td>
<td>Useful in wounds where there is moderate or heavy exudates. May require a secondary dressing to support the alginate and maintain a moist environment</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Working in Partnership with the Pharmaceutical Sector

1. Introduction

The Trust encourages all staff to work within “Best Practice Guidance on joint working between the NHS and pharmaceutical industry and other relevant commercial organisations”, Department of Health, 2008. Opportunities for joint working should be considered where the benefits that this could bring to patient care and the difference it can make to their health and well-being are clearly advantageous. Such partnerships should abide by the following criteria:

- Meet patient and NHS needs
- Be most accessible
- Provide sustainable clinical benefits
- Be highly cost effective

Collaborative partnerships with the pharmaceutical industry can have a number of benefits in the context of this obligation.

All joint working between the NHS and pharmaceutical industry should be conducted in an open and transparent manner. This applies to all staff, working under NHS terms and conditions, either directly employed by the Trust or as independent contractors and locum practitioners. Staff should also be aware of their own professional code of conduct in working with the industry. As a minimum, all staff should follow the code at Appendix F.

2. Principles for Working with the Pharmaceutical Sector

- The Trust will use available resources to generate the greatest benefit for our local population through the promotion of high quality, effective health care.
- The Trust wishes to work in partnership with the pharmaceutical sector on issues where there is a shared common aim and is in line with the Trust’s objectives.

These principles reflect a move away from the traditional relationship between the NHS and the pharmaceutical sector, which relied predominantly on ‘goodwill’ and product related sponsorship activity. In the future, relationships will be supportive of strategic education, training, professional and service developments.

3. Guidelines for Sponsorship / Partnership

The Pharmaceutical Company will provide a written proposal outlining the initiative in detail.

The proposal should be considered by the relevant clinicians, managers, Chief Finance Officer, Directorate General Manager and Chief Pharmacist and reference made to Appendix 3 of Standing Financial Instructions.

The following criteria must be explicitly addressed in any proposal for sponsorship/partnership:

- How it benefits the health of the local population especially in terms of quality of healthcare delivered on evidence based clinical practice
- How it links to the Trust objectives
- How it links with other local and national strategic priorities
- The operation of any partnership must be in accordance with the financial and other standing orders of the Trust
- How any purchasing decisions including those concerning pharmaceuticals and appliances, should always be taken on the basis of best clinical practice and value for money. Such decisions should take into account their impact on other parts of the health care system e.g. ongoing cost in primary care
- Ensure sponsorship arrangements permitting access to patient information is legally and ethically sound and that a contract should be drawn up which draws attention to obligations of confidentiality, specifies security standards that should be applied, limits use of the...
information to purposes specified in the contract and makes it clear that the contract will be terminated if the conditions are not met.

Agreement for sponsorship/partnership deals requires the approval of the Chief Executive.

4. **Hospitality and meetings**

Industry representatives organising meetings are permitted to provide appropriate hospitality and/or meet any reasonable, actual costs, which may have been incurred. Further guidance is available in Appendix 2 of Standing Orders.

Hospitality must be secondary to the purpose of the meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed that level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting.

Where meetings are sponsored by external sources, it must be disclosed in the papers relating to the meeting and in any published proceedings. Declaration of sponsorship of meetings, gifts etc. must be made by email to declarations@southernhealth.nhs.uk. Details and forms can be found in the Business Conduct for Staff Policy, SH NCP 55.

5. **Research and Development**

5.1 Exceptionally, in the case of non-commercial research and development (R&D) originated or hosted by NHS providers, commercial sponsorship may be linked to the purchase of particular products, or to supply from particular sources. This should be in accordance with the guidance at paragraph 28 of HSG (87)32 Responsibilities for meeting Patient care costs Associated with Research and Development in the NHS. Where there is industry collaboration in such studies, companies may alternatively make a contribution towards the study’s costs, rather than supply of product.

5.2 Any funding for research purposes should be transparent. There should be no incentive to prescribe more of any particular treatment or product other than in accordance with the peer reviewed and mutually agreed protocol for the specific research intended. When considering a research proposal, whether funded in whole or part by industry, NHS bodies will wish to consider how the continuing costs of any pharmaceutical or other treatment initiated during the research will be managed once the study has ended.

5.3 Separate Guidelines exist for pharmaceutical company Sponsored Safety Assessment of Market Medicines (SAMM) which remain in force.

5.4 Where R&D is primarily for commercial purposes, NHS providers are expected to recover the full cost from the commercial company on whose behalf it is carried but. (HSG (97) 32, paragraph 7). An industry-sponsored trial should not commence until an indemnity agreement is in place; see the guidelines in NHS HSC (96) 48. Indemnity, Arrangements for Clinical Negligence claims in the NHS. A Standard form of indemnity agreement, agreed with ABPI, can be found at Annex B of that guidance.

5.5 The NHS should benefit from commercial exploitation of intellectual property derived from R&D that the NHS has funded, or for which it has been funded, even where the intellectual property itself is owned by people outside the NHS. NHS bodies should ensure that an agreement to this effect is included in any contracts concerning R&D. The guidelines in HSC 1998/106 Policy framework for the Management of Intellectual Property within the NHS from R&D should be followed.

---

1 Paragraph 28 of HSG(97)32 states: At present, industry frequently contributes to the costs of pharmaceuticals (and other products) which are the subject of non-commercial R&D in the NHS. Although, by definition, such items constitute Treatment Costs, the NHS will continue, under the Partnership Arrangements, to look to researcher and non-commercial research funders to secure such contributions before approaching the NHS for support.
Appendix E1: NHS Standard of Business Conduct

Staff and independent contractors working in the NHS should follow existing codes of conduct.

Staff that are not covered by such a code are expected to:

- act impartially in all their work;
- refuse gifts, benefits, hospitality or sponsorship of any kind which might reasonably be seen to compromise their personal judgement or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused;
- make it a matter of policy that offers of sponsorship that could possibly breach the Code be reported to their board (NHS Trust or CCG) or to the NHS England (independent contractors);
- not misuse their official position or information acquired in the course of their official duties, to further their private interest or those of others;
- ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services;
- beware of bias generated through sponsorship, where this might impinge on professional judgement and impartially;
- neither agree to practice under any conditions which compromise professional independence or judgement, nor impose conditions on other professionals.
Appendix F:
Policy Governing Contact with Company Representatives

1. Introduction

The Trust recognises the role of pharmaceutical industry representatives in promoting and providing information on their products, whilst also recognising the need for sound management of medicines. This policy seeks to ensure the relationship between industry representatives and the Trust are maintained appropriately.

2. General

There is an expectation that representatives will have adequate training and skills to present information responsibly and accurately and will follow the guidance given within this policy. If breaches occur the Chief Pharmacist should be informed so that the matter can be raised with the company and/or Association of British Pharmaceutical Industry. Company representatives must be identifiable by a badge or similar at all times on Trust property.

3. Visits

3.1 Company representatives need to be aware of the demands on Trust staff time and should avoid causing disruption. Appointments are required for meetings. Ad hoc contacts are not allowed. Paging junior staff or other staff is forbidden.

3.2 To avoid disruption or inconvenience to patients, representatives should not enter clinical areas without prior appointment, for nursing staff this should be with the agreement of the appropriate nurse manager.

Samples

3.3 Samples will not be accepted by the Trust and must not be left on wards, in ECT suites, departments or offices.

3.4 Samples of products requested for the private use of doctors should be sent to their private address or given to the doctor personally on the specific understanding that they will not be used on Trust premises.

4. Introduction of New Drugs

4.1 The Medicines Management Committee adheres to the local health economy formularies (Portsmouth and South East Hampshire Area Prescribing Committee (APC) and Basingstoke, Southampton and Winchester District Prescribing Committee (DPC)) which restricts the range of medicines issued by hospital pharmacies. New medicinal products are not introduced automatically into stock but are treated as non-formulary until reviewed by the Appropriate Drugs and Therapeutics committee or Area Prescribing Committee. They are considered on the written request of a consultant. Doctors are asked to give the Committee published evidence that the proposed new product represents a significant advance in safety, efficacy and cost over others in the relevant therapeutic group. Application forms for new drugs are available from the Chief Pharmacist’s office – tel: 023 8087 4023.

4.2 Medical representatives may provide information to doctors to assist them in preparing a proposal for the introduction of a new product but all proposals are evaluated independently before presentation to the relevant committee.

4.3 Medical representatives must always make the current status i.e. formulary/non formulary of the drug clear when discussing products with health professionals.
5. **Gifts, Hospitality and Declarations of Interest**

- The guidance given in the Trust’s Standards of Business Conduct must be followed. In particular, attention of clinicians is drawn to the following requirements:
  - For the purposes of this guidance commercial sponsorship is defined as including - NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises
  - In all these cases NHS bodies, members of NHS staff and independent contractors should use local arrangements to publicly declare sponsorship or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it
  - Declaration of sponsorship, gifts/interest etc., must be made via email to the declarations@southernhealth.nhs.uk. Details and forms can be found at http://www.southernhealth.nhs.uk/workday/policies/hospitality/

The above arrangements do not apply to:

- Personal gifts of less than £25 per gift e.g. gifts or post-it pads, pens etc. However gifts should be declared if several small gifts worth a total of over £100 are received from the same or closely related source in a 12 month period
- Income generation schemes will be logged separately at local level
- Discounts on particular pharmaceuticals
- Clinicians must declare and record financial or personal interest e.g. company shares, lecture fees, fees for chairing groups, advisory panel membership, research grants in any organisation with which they have to deal and be prepared to withdraw from these dealings if required thereby ensuring that their professional judgement is not influenced by such considerations http://www.southernhealth.nhs.uk/workday/policies/hospitality/

6. **Drug Pricing**

Staff are reminded that commercial information is confidential. This must be borne in mind especially when discussing rival firms and their products and prices. Guidance is given in the Trust’s Standards of Business Conduct (http://www.southernhealth.nhs.uk/EasysiteWeb/getresource.axd?AssetID=69074&type=full&servicetype=Inline). Representatives need to be aware that hospital costs should include V.A.T. where applicable. Care should also be taken when giving price comparisons since they may not be aware of rival comparisons.
## Appendix G: PGD Proforma

**PGD XXX** *(Number issued by Medicines Management Team)*  Medicine (generic) name Page 1 of 2  
**Issue Date:** For most up-to-date version see Trust website (Medicines Management)

### 1. Clinical Condition

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong> Define situation/condition</td>
<td><strong>A clear description of the clinical circumstances and symptoms for which the medicine would be administered or supplied and criteria for confirming circumstances and symptoms</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **1.2** Criteria for inclusion | **Who is eligible to receive the medicine e.g. age, sex**  
**Clinical criteria**  
**Any relevant evidence for inclusion e.g. CMO letters** |
| **1.3** Criteria for exclusion | **Who is not eligible to receive the medicine for all/any of the reasons below**  
**On basis of age**  
**Because of another concurrent condition**  
**Because of other concurrent treatment**  
**Severe local or general reaction to a previous dose of the medicine**  
**Hypersensitivity to the medicine or any component**  
**Pregnancy may be an exclusion**  
**Breast-feeding may be an exclusion**  
**Anything else stated in the SPC**  
**Limitations of commissioned service** |
| **1.4** Cautions | **As stated in the SPC** |
| **1.5** Action if excluded. | **Provide advice**  
**Refer to doctor if necessary**  
**Refer to local policy/ treatment guidelines** |
| **1.6** Action if patient declines treatment. | **Discuss potential consequences**  
**Provide written information on the risks / benefits.**  
**Inform GP or refer to local policy**  
**Document in patient’s clinical record** |

### 2. Description of Treatment

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong> Name, form and strength of medicine</td>
<td><strong>Generic Name of Medicine as stated in SPC, form (cream, tablet, injection) strength e.g. 5mg / ml</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.2</strong> Legal status</td>
<td><strong>e.g. Prescription only medicine (POM)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.3</strong> Licensed or unlicensed</td>
<td><strong>Should be licensed but may be used off label insert ▼</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.4</strong> Dose / Dose range / total maximum dose</td>
<td><strong>In line with the SPC and the views of the lead practitioners / authors</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.5</strong> Route of Administration</td>
<td><strong>This requires all the details of reconstitution, exact route e.g. oral/intramuscular etc</strong></td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>Frequency of Administration</td>
<td>In line with the SPC and the views of the lead practitioners / authors</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.7</td>
<td>Written/verbal advice for patient/carer</td>
<td>Most common side effects and how to minimise them. What to do if severe or unexpected side effects. Use manufacturer’s product information leaflet. How to continue therapy, if required</td>
</tr>
<tr>
<td>2.8</td>
<td>Potential side effects</td>
<td>In line with the SPC and BNF</td>
</tr>
<tr>
<td>2.9</td>
<td>Interacting medicines.</td>
<td>For some medicines need to consider the important interactions and need to state ‘See also the current BNF, Appendix 1: Interactions</td>
</tr>
</tbody>
</table>
Patient Group Directions
for the Supply and Administration
of
Therapeutic Group

This suite has been adopted by the following organisation:
(e.g. Trust, PCT or Practice)
Southern Health NHS Foundation Trust

*Authorised by……………………………
Name………………… Date………………
(Clinical Governance Lead or Similar within individual organisation)

*INVALID USE UNLESS AUTHORISED

Review Date
Month Year
The medicines to which this PGD suite relates are:

<table>
<thead>
<tr>
<th>Medicine name on PGD</th>
<th>PGD Number</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

1. Minor amendments for individual medicines are denoted by a change in version date of the PGD and are available from the Trust website.

2. Major amendments for individual medicines will result in the issue of a new suite with a new issue and review date.

3. **If a practitioner is asked to supply or administer a medicine not covered by this or any other Patient Group Direction (PGD) then a prescription or named written (patient specific) direction (PSD) is first required from a prescriber.**

PGD Suite: *Therapeutic Group © Year* Southern Health NHS FT Review Date: 2 yrs max from issue date
Rationale for Patient Group Directions for the supply or administration of Name of Suite

To enable suitably qualified health professionals, who have received specific training and who are deemed to be competent, to supply and/or administer medicines in accordance with recommendations issued by the following bodies:


HSC 2000/026: Patient Group Directions [England only] Department of Health (Link)

Department of Health 12 Key Points on Consent: The Law in England, DOH, March 2001 Link

Nursing & Midwifery Council, The Code: Standards of conduct, performance and ethics for nurses and midwives Link

Nursing & Midwifery Council, Standards for Medicines Management, Link

Nursing & Midwifery Council, Record Keeping Advice Sheet, Link

Health Professions Council, Standards of Proficiency, Link

Health Professions Council, Standards of conduct, performance and ethics, Link

**Authorised Staff Characteristics**

| Professional qualifications to be held by staff supplying medicines under these Patient Group Directions | Nurses with current NMC registration  
Allied Registered Health Professionals  
Pharmacists with current GPhC registration |
|---|---|

<table>
<thead>
<tr>
<th>Competence</th>
</tr>
</thead>
</table>

All registered practitioners are personally accountable for their practice and in the exercise of professional accountability there is a **requirement to demonstrate and maintain competence** in the following before undertaking administration and/or supply of medication under this patient group direction:

- An understanding of professional standards for the administration of medicines
- Familiarity with the local policies and procedures relating to medicines i.e. SHFT Medicines Policy
- Appropriate training to carry out the clinical assessment of a patient
- Basic training in the legal framework and use of Patient Group Directions for the supply and administration of medicines
- Understanding of pharmacology of drugs being issued to patients and relevant medical condition.
- Familiarity with the relevant information in the current BNF
  
**Include any specific competencies for the suite**

**For parenteral administration**

- Annual update on CPR and anaphylaxis (adult & children)

Competencies can be determined using some or all of the following methods:

- Multiple Choice Questionnaire (pharmacology and legal Framework)
- Objective Structured Clinical Examination (physical skills)
- Observation of practice and professional conversation
## Clinical Situation

### Patient Assessment

<table>
<thead>
<tr>
<th>Relevant history to include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standard demographics</td>
</tr>
<tr>
<td>• History of presenting problem</td>
</tr>
<tr>
<td>• Past medical history</td>
</tr>
<tr>
<td>• Family history</td>
</tr>
<tr>
<td>• Medicines history (including current and Over The Counter medicines)</td>
</tr>
<tr>
<td>• Allergies</td>
</tr>
</tbody>
</table>

### Consent

<table>
<thead>
<tr>
<th>Informed consent to be obtained from patient, parent or legal guardian. Follow professional codes of conduct for situations where adults do not have the capacity to consent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For young people attending without written consent the practitioner should ensure the young person is deemed “Fraser/Gillick competent”. Follow professional codes of conduct for complex situations.</td>
</tr>
</tbody>
</table>

### Patients Excluded from Patient Group Directions

<table>
<thead>
<tr>
<th>For all Complete as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No consent</td>
</tr>
<tr>
<td>• Consent declined or rescinded by parent or guardian, and treatment not considered to be in the best interests of the child to prevent grave and irreversible mental or physical harm, in accordance with professional codes of conduct.</td>
</tr>
<tr>
<td>• Anaphylaxis to the specific or class of medicine</td>
</tr>
</tbody>
</table>

### Action for excluded patients

| Advise and counsel patient, parents / guardian and or the young person accordingly |

### Referral arrangements for medical advice

| As per local service agreements |

### Facilities which should be available for use at site.

| Hand decontamination or washing facilities |
| Medicines to be stored and transported as specified in their summaries of product characteristics and Trust / Practice medicines storage procedures and temperature monitored and recorded. |

**In locations for parenteral administration:**

| Anaphylaxis pack including Epinephrine (adrenaline) (1 in 1,000) and a resuscitation face shield as a minimum. |
| Facilities for safe disposal of needles, syringes, vials and other clinical waste |

### General Advice to Patients, Parents or Guardians

| Consult a doctor/pharmacist or other identified health professional if concerned |

### Record Keeping

| A record of all patients supplied with medicines under this direction will be available for audit purposes |
| A full record must be kept of all stock received and issued, including pack size and expiry date. The following data must be included: |

**RECEIPT:** Date, Medicine name and strength, Quantity received, Signature of practitioner.

**ISSUE:** Date, Patient name, Medicine name and strength, Quantity, Signature of practitioner.

| Document any refusal and reasons why |
| Document supply or administration on relevant issue sheet. |
| Advise patient’s GP according to local procedure |
| Severe local and generalised reactions: Inform doctor and consider reporting to Medicines and Healthcare products Regulatory Agency (MHRA), especially medicines under intense surveillance (▼), on a Yellow card at the back of current BNF, telephone 0808 100 3352 |
Other Information

1. **Medicines Information**
   Medicines Information Services (For telephone numbers see inside the front cover of the BNF)
   Pharmaceutical Company Helplines (For contact details see BNF or Summary of Product Characteristics)

2. **Publications:**
   BNF for *Children* (also at [bnfc.org](http://bnfc.org) - Athens password required)
   Medicines for Children (Royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists Group)
   *Appropriate references*

3. **Web sites:**
   - Resuscitation Council (UK) [www.resus.org.uk](http://www.resus.org.uk)
   - Clinical Knowledge Summaries [Link](http://www.medicines.org.uk/)
   - Electronic BNF
   - Consent for examination or treatment [Link](http://www.library.nhs.uk/Default.aspx)
   - Fraser Guidelines & Gillick competence [Link](http://www.library.nhs.uk/Default.aspx)
   - Other appropriate references

**Authors:**

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Nurse</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please ensure that all earlier versions are retained on file, but removed from the areas of use in accordance with Divisional and Trust procedures.

**Authorisation of individuals to use this suite of PGDs**

<table>
<thead>
<tr>
<th>Location/Service where PGD used</th>
<th>Employing Organisation (where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of manager responsible for determining competency of individuals to use this PGD within the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>-----------</td>
</tr>
</tbody>
</table>
The following health professionals have been deemed competent and are authorised to supply the identified medicines in accordance with these Patient Group Directions.

<table>
<thead>
<tr>
<th>Name of Practitioner and Signature</th>
<th>Name of Competency Assessor and Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Initial column(s) to indicate PGDs authorised to use
Put a cross through columns which do not apply.
Appendix H: Verbal/Faxed Prescription Form (use a separate form for each drug)

Surname: ..........................  Date of birth: ........................................

First names: ................... ...  NHS No: ........................................

Known allergies: .................................................................

<table>
<thead>
<tr>
<th>Drug name (approved name)</th>
<th>Dose</th>
<th>Date</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber’s Name (PRINT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Signature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency (written in full)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Times of day

<table>
<thead>
<tr>
<th>Time</th>
<th>Minimum interval between doses for prn medication and clear indication for use</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800</td>
<td></td>
</tr>
<tr>
<td>1230</td>
<td></td>
</tr>
<tr>
<td>1730</td>
<td></td>
</tr>
<tr>
<td>2200</td>
<td></td>
</tr>
</tbody>
</table>

NB. Recorded Administration must be on drug chart.

Name of Nurse Contacting Doctor: ..................................................

Signature of Nurse: ............................................................................
Appendix I: Covert Administration of Medicines

Affix Patient Label Here

Patient Name..............................
Hospital/NHS Number..................
Date of Birth..............................

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

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?

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

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

What is the desired outcome?

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:

<table>
<thead>
<tr>
<th>Role</th>
<th>Print Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant/RMO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Named Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family member/ carer/advocate*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 ..........

<table>
<thead>
<tr>
<th>Date</th>
<th>Reviewed by</th>
<th>Date</th>
<th>Reviewed by</th>
<th>Date</th>
<th>Reviewed by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Original version from Sussex Partnership NHS Foundation Trust, July 2014
## Appendix J: Guidance on the Legal & Trust Requirements for Controlled Drug Disposal on wards

<table>
<thead>
<tr>
<th>Classification</th>
<th>Schedule 2</th>
<th>Schedule 3</th>
<th>Schedule 4 (part 1)</th>
<th>Schedule 4 (part 2)</th>
<th>Schedule 5</th>
<th>Patients’ own CDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples</td>
<td>Alfenantil</td>
<td>Buprenorphine</td>
<td>Chlordiazepoxide</td>
<td>Anabolic steroids</td>
<td>Codeine (tabs/oral liquid)</td>
<td>Schedule 2, 3 &amp; 4 (part 1) ONLY.</td>
</tr>
<tr>
<td></td>
<td>Dexamphetamine</td>
<td>Midazolam</td>
<td>Clobazam</td>
<td>Co-codamol</td>
<td>Co-lydranol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diamorphine</td>
<td>Phenobarbital</td>
<td>Clonazepam</td>
<td>Dihydrocodeine (tabs/oral liquid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fentanyl</td>
<td>Temazepam</td>
<td>Diazepam</td>
<td>Morphine oral liquid (not more than 10mg/5ml)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ketamine</td>
<td>Tramadol</td>
<td>Lorazepam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td>Nitrazeepam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td></td>
<td>Sativex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Morphine, (including oral liquid 20 mg/ml)</td>
<td></td>
<td>Zolpidem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxycodone</td>
<td></td>
<td>Zopiclone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pethidine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tapentadol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denatured before disposal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes*</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Authorised Witness required</td>
<td>Yes</td>
<td>Yes</td>
<td>No*</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Record Destruction: 1.CD Recording Book</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2.SHFT CD Destruction Form</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

1 Schedule 1 CDs have no therapeutic use. Pharmacists may destroy them (e.g. cannabis resin/oil, Khat, LSD) with the patients’ permission (refusals require police assistance).

* Destruction by 2 registered healthcare professionals competent in the management of CDs.

** Some units may choose to store, record administration and destruction as per Schedule 2 CDs.

Ω Authorised Witnesses include Trust senior nurse managers (e.g. matrons) and pharmacists.
Appendix K: Procedure For The Management Of Controlled Drugs for All Closures of Isolated Units and Closures Of Other Units For More Than 5 Days

(1) The nurse in charge of medicines must contact the supplying pharmacy and agree a mutually suitable time for a named pharmacist to collect Controlled Drugs.

(2) The nurse on duty must confirm the identity of the named pharmacist on arrival at the unit.

(3) The pharmacist will sign the stock out of the CD register, witnessed and countersigned by the nurse as described below:

- Date
- Time
- ‘Returned to pharmacy temporary closure’
- Quantity returned
- Zero stock balance entered
- Signatures of pharmacist and nurse

(4) The pharmacist will then remove the stock and return it to the pharmacy department.

(5) Depending upon the expected length of closure, stock can be returned into pharmacy stock or destroyed in line with the pharmacy department policy, or held together with a photocopy of the appropriate pages from the Controlled Drug Register within the pharmacy.

(6) The nurse in charge of medicines must arrange storage of the CD register in agreement with the Principal Pharmacist.

(7) Patients Own Drugs should be transferred with the patient. The member of SHFT staff who transfers the medicines must sign the CD register on the closing unit and on the receiving unit. The following details must be recorded:

On departure

- Date
- Time
- Name of patient transferred to
- Quantity transferred
- Zero stock balance
- Signature of nurse and SHFT staff member

On arrival

- Date
- Time
- Name of patient arriving from
- Quantity transferred
- New balance
- Signature of nurse and SHFT staff member
Appendix L: Procedure for disposal of Controlled Drugs (CDs)

1.1 All medicines must be disposed of in a safe and appropriate manner and in line with the Trust policy on Handling and Disposal of Healthcare Waste Policy (SH NCP 47).

1.2 All CDs awaiting disposal must be stored in the CD cupboard clearly labelled for disposal and separated from stock, e.g. in a labelled bag.

1.3 All CDs in schedule 2, 3 and 4 (part 1) must be rendered irretrievable by denaturing using a DOOP kit* and then placed into the designated bins with other non-hazardous waste medicines.

1.4 With the exception of spoilt doses (see 2.6 below) all expired CD stock must be destroyed by a registered nurse and an authorised witness, e.g. Trust pharmacist or matron, using a DOOP kit. The pharmacist must not be involved in the supply of CDs to that unit.

2. Procedure

2.1.1 Registered nurse and authorised witness check stock levels and sign to confirm they are correct.

2.1.2 Check and record amount of CDs to be disposed of. Checks to include:
- Drug name and strength
- Form
- Expiry date
- Patient’s name if applicable
- Quantity
- Where the CD is packaged in unit doses or ampoules each unit should be checked as well as the outer container.

2.1.3 Record the date and annotate as “expired stock”.

2.1.4 Record the balance. Both members of staff should sign the register confirming all details are correct.

2.2 Solid dose formulations

2.2.1 Staff should wear gloves.

2.2.2 Remove tablets and capsules from outer packaging and blister packaging.

2.2.3 After placing them in the *DOOP container activate it by following the instructions on the container. This should prevent whole tablets or capsules being recovered.

2.2.4 The *DOOP container may then be placed in the non-hazardous waste medicines container for disposal.

2.2.5 All packaging which has been in contact with the destroyed medicines must also be placed in the waste medicines container.

2.3 Liquid dose formulations

2.3.1 Staff should wear gloves.

2.3.2 Add liquid to the DOOP kit and deal with it as above.

2.4 Parenteral formulations

2.4.1 Staff should wear gloves.

2.4.2 Open liquid ampoules and empty content into DOOP kit. Dispose of ampoule in sharps bin.

2.4.3 Open powder ampoules and add water to dissolve the powder then pour into the CD DOOP kit.

2.4.4 Place empty ampoule in pharmaceutical sharps bin.
2.5 Fentanyl and Buprenorphine patch, including used patches (inpatient units only)

2.5.1 Staff must wear gloves.

2.5.2 Remove the backing and fold the patch over on itself, adherent surfaces face to face.

2.5.3 Place in a CD denaturing kit.

2.6 Procedure for disposal of individual doses or part doses of a CD prepared and not administered e.g. dose refused or dropped.

2.6.1 Individual solid dose preparations, e.g. tablets/capsules/suppositories, must be disposed of using a DOOP kit. The activated DOOP kit must then be placed in a non-hazardous (blue) medicines bin.

2.6.2 The CD stock balance must be checked against the register.

2.6.3. On all occasions, the following must be recorded:

- Date
- Time
- Quantity
- Reason for disposal
- Patient name
- Signatories of a nurse and other approved person
- Stock balance

*DOOP describes proprietary approved disposal system containing granular denaturing agent.
Appendix M: Mental Health Practitioner Training

Training on psychopharmacology, safe drug administration and use of the BNF is a component of the MHP course run by Southampton University. MHPs also receive in-house training and supervision on administration of medicines on their placements. Assessments are completed on wards/placements and undertaken by an approved sign off mentor from the Trust database.

Following additional Trust approved training provided by the SHFT Development and Training department and competency assessment by a registered nurse, MHPs may be approved to administer depot antipsychotics via gluteal route only. This role is an extended role and the training does not form part of the basic course run by Southampton University. Not all approved MHPs are required to administer depots. Approved MHPs must be in a role which will allow them to practice this skill and maintain their competency before undergoing the additional training. Once authorised to administer depots, if the practitioner at any point no longer feels competent to administer depots, or a period of twelve months passes without administering a depot, the practitioner must be reassessed by a registered nurse.

A record of the assessment and authorisation to administer depot antipsychotic drugs by gluteal route only will be held with the MHPs personnel record.
### Appendix N: Training Needs Analysis

#### Leadership, Education and Development (LEaD) Training Needs Analysis

If there are any training implications in your policy, please make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance on 02380 874091) to complete the form below **before** the policy goes through the Trust policy approval process.

<table>
<thead>
<tr>
<th>Topic/Subject</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management – Safer Use of Medication</td>
<td>Every 3 years</td>
<td>0.5 hours E-Learning 1 hour Face to Face (combined with High Risk Medicines)</td>
<td>E-Learning / Face to Face</td>
<td>Medicines Management Team</td>
<td>LEaD</td>
<td>Strategic – Medical Director Operational – Chief Pharmacist</td>
</tr>
</tbody>
</table>

#### Service

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Mental Health</strong></td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td><strong>Specialised Services</strong></td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td><strong>Learning Disability Services</strong></td>
<td>All registered nurses working in in-patient and community settings.</td>
</tr>
<tr>
<td><strong>Older Persons Mental Health</strong></td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td><strong>Adults (Business Units 1, 2, 3 &amp; 6)</strong></td>
<td>All registered nurses working in in-patient and community settings (excluding Continence Service).</td>
</tr>
<tr>
<td><strong>Childrens Services &amp; Quit for Life</strong></td>
<td>All health visitors and school nurses</td>
</tr>
</tbody>
</table>

#### Corporate

<table>
<thead>
<tr>
<th>Corporate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Director of Nursing</strong></td>
<td>All registered nurses in the Children in Care team</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Chief Executive</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Chief Financial Officer</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Development Director</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>People of Communications</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Property and Estates</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Medicines Management – High Risk Medicines</td>
<td>Every 3 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>All registered nurses working in in-patient and community settings.</td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td>Adults (Business Units 1, 2, 3 &amp; 6)</td>
<td>All registered nurses working in in-patient and community settings (excluding Continence Service).</td>
</tr>
<tr>
<td>Children's Services &amp; Quit for Life</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>Development Director</td>
<td>N/A</td>
</tr>
<tr>
<td>People of Communications</td>
<td>N/A</td>
</tr>
<tr>
<td>Property and Estates</td>
<td>N/A</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Medicines Management – Controlled Drugs</td>
<td>Every 3 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>All registered nurses and mental health practitioners working in in-patient settings</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>All registered nurses and mental health practitioners working in in-patient settings</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>All registered nurses working in in-patient settings</td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td>All registered nurses and mental health practitioners working in in-patient settings</td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td>Adults (Business Units 1, 2, 3 &amp; 6)</td>
<td>All registered nurses working in in-patient and community settings, Forest Assessment Unit, Medical Day Unit and MIU's.</td>
</tr>
<tr>
<td>Childrens Services &amp; Quit for Life</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>Development Director</td>
<td>N/A</td>
</tr>
<tr>
<td>People of Communications</td>
<td>N/A</td>
</tr>
<tr>
<td>Property and Estates</td>
<td>N/A</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Medicines Management – Psychotropics</td>
<td>Every 4 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>All registered nurses and mental health practitioners working in in-patient settings</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>All registered nurses working in in-patient and community settings.</td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td>All registered nurses and mental health practitioners working in in-patient and community settings.</td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td>Adults (Business Units 1, 2, 3 &amp; 6)</td>
<td>N/A</td>
</tr>
<tr>
<td>Childrens Services &amp; Quit for Life</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>Development Director</td>
<td>N/A</td>
</tr>
<tr>
<td>People of Communications</td>
<td>N/A</td>
</tr>
<tr>
<td>Property and Estates</td>
<td>N/A</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Medicines Management – Rapid Tranquillisation</td>
<td>Every 3 years</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td></td>
</tr>
<tr>
<td>MH/ LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td></td>
</tr>
<tr>
<td>Specialised Services</td>
<td></td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td></td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td></td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td>Adults (Business Units 1, 2, 3 &amp; 6)</td>
<td>N/A</td>
</tr>
<tr>
<td>Childrens Services &amp; Quit for Life</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>Development Director</td>
<td>N/A</td>
</tr>
<tr>
<td>People of Communications</td>
<td>N/A</td>
</tr>
<tr>
<td>Property and Estates</td>
<td>N/A</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Medicines Management – Immunisation Essentials</td>
<td>Once only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td>N/A</td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td>Adults (Business Units 1, 2, 3 &amp; 6)</td>
<td>N/A</td>
</tr>
<tr>
<td>Children's Services &amp; Quit for Life</td>
<td>All health visitors and school nurses</td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>All registered nurses in the Children in Care team</td>
</tr>
<tr>
<td>Medical Director</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>Development Director</td>
<td>N/A</td>
</tr>
<tr>
<td>People of Communications</td>
<td>N/A</td>
</tr>
<tr>
<td>Property and Estates</td>
<td>N/A</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Medicines Management – Immunisation Update</td>
<td>Annually following Immunisation Essentials</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td>N/A</td>
</tr>
<tr>
<td>ISD</td>
<td></td>
</tr>
<tr>
<td>Adults (Business Units 1, 2, 3 &amp; 6)</td>
<td>N/A</td>
</tr>
<tr>
<td>Childrens Services &amp; Quit for Life</td>
<td>All school nurses</td>
</tr>
</tbody>
</table>

| Corporate                                         |                                      |
| Director of Nursing                               | All registered nurses in the Children in Care team |
| Medical Director                                  | N/A                                  |
| Chief Executive                                   | N/A                                  |
| Chief Financial Officer                           | N/A                                  |
| Development Director                              | N/A                                  |
| People of Communications                          | N/A                                  |
| Property and Estates                              | N/A                                  |
### Appendix O: Drug Recall Form

<table>
<thead>
<tr>
<th>1) Name of Pharmacy Contact:</th>
<th>2) Tel No:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Date and Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Recall Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>i) Drug Name and Brand:</td>
</tr>
<tr>
<td>ii) Manufacturer</td>
</tr>
<tr>
<td>iii) Strength:</td>
</tr>
<tr>
<td>iv) Form:</td>
</tr>
<tr>
<td>v) Batch number(s):</td>
</tr>
<tr>
<td>vi) Nature of problem:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5) Required action (This should be noted and then read back to the pharmacy contact to confirm correct action)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6) Deadline for undertaking recall:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Name of ward/unit contact:</th>
<th>Designation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature: ……………………………………</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8) Name and signature of person responsible for checking all medicines (including patients own medication) on ward/unit if different to (7) – To be signed once all checks have been completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Name: …………………………………… Signature: ……………………………………</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9) Check list of areas – initial as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward trolley N/A</td>
</tr>
<tr>
<td>Ward cupboard N/A</td>
</tr>
<tr>
<td>POD lockers N/A</td>
</tr>
<tr>
<td>Fridge N/A</td>
</tr>
<tr>
<td>Drug box N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10) Immediate replacement medicines required – quantity, when ordered, expected delivery time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordered by ……………………………… Received on ward/unit by ………………………………</td>
</tr>
</tbody>
</table>

---

SH CP 01 Medicines Policy
Version: 17
January 2019
Appendix P: Procedure for Obtaining an Urgent Prescription for an In-Patient when a Prescriber is not on Site at Electronic Prescribing Sites

If a prescriber is not on site and both the prescriber and nurse consider that a medicine is required before a prescriber is next due to visit the unit and that neither the prescriber nor the nurse consider it essential for the doctor to attend, then in these circumstances the prescription can be written on the JAC prescribing system remotely.

This procedure only applies to those patients who have already been assessed by a doctor either on admission or following admission. The following procedure must be followed:-

The nurse must:
1. Describe the patient’s presenting symptoms.
2. Inform the prescriber of any relevant information on previous response to prescribed medication, e.g. “responded well to 1 mg Lorazepam”.

The prescriber must:
1. Ensure they have adequate information on which to base their decision to prescribe which will be available on JAC e.g. administration chart on prescribed order entry (POE), path lab results.

Prescribing on JAC via laptop
   Refer to How To guides on the JAC e-Prescribing intranet page
**Appendix Q: Process for Recording an Emailed Prescription on RiO**

- Once the email has been received, the Nurse selects the text of the whole email including To, From, Subject and body text, by left clicking and dragging the mouse over the text
- Once all text is selected, click on File and select ‘Copy’
- Minimise the NHS Mail programme
- Log on to RiO
- Locate the appropriate client’s case record
- Select Progress Notes from the Case Record
- Click Add New Note
- Change the date and time of the progress note to reflect the date and time the activity/appointment occurred
- Nurse to Type their Team and Staff Profession, then type ‘Emergency NHS Mail Prescribing’.
- Then click File and select ‘Paste’.
- Mark the Progress Note as Significant Event (to indicate medication changes) and Validate the Note and click Save.

This will form part of the permanent record for that client.

A copy of the email must also be attached to the prescription chart.
Appendix R: Procedure for the Use of Patients’ Own Drugs (PODs) at admission, during inpatient stay and at discharge

1. Definition

Every medicine that is brought into hospital by a patient and is either prescribed for them by their registered medical practitioner or purchased by or for them is a POD.

2. Procedure on Admission

2.1 Patients will be encouraged to bring in their medicines from home. All patients must be asked if they have brought in their medicines from home. Record this on RiO.

2.2 Any medicines remaining at home should, if possible, be brought in by relatives as soon as possible. If consent is granted, the medicines should be locked in the locally agreed POD storage area for assessment by the pharmacist, pharmacy technician or POD trained member of nursing staff. (For Controlled Drugs see section 5.0).

3. Consent

3.1 Drugs brought in from home remain the patient's property and verbal consent for their use or destruction must be obtained by the admitting nurse/MHP, pharmacist or pharmacy technician. At Leigh House good practice dictates that parents should, where possible, be involved in such decisions. This should be documented in the patient’s records.

3.2 If the patient does not agree to using the PODs on the ward, the medicines must be stored on the ward in a locked cupboard and either returned to the patient on discharge if appropriate with clear instructions as to their use, or destroyed as per Trust guidelines. If any drugs are considered unsatisfactory for use the registered nurse, pharmacist or pharmacy technician should inform the patient/carer of the risks associated with poor quality medicines or poor labelling. This should be documented in the patient’s medical notes.

4. POD Assessment

4.1 Only medicines that can be positively identified using algorithm in Appendix R1 are accepted for use. However POD trained staff may authorise the use of unlabelled inhalers, eye drops, blister-packed medication and loose blister strips providing the appropriate guidelines are followed in appendices R2 to R6. The pharmacist, pharmacy technician, registered nurse/MHP must be satisfied with the general condition of the product and its packaging and labelling. Even if the medicine passes the algorithm, professional discretion should remain the overriding factor in assessing suitability. PODs which are not currently prescribed should be stored in the POD overflow cupboard or other secure drug storage cupboard. Any discontinued items should be removed immediately.

4.2 PODs will be checked against the algorithm by a registered nurse/MHP who has completed the POD training. Unsuitable medicines will be documented on RiO in progress notes and destroyed on the ward following Trust guidelines. If there is a
doubt about using a particular medicine then it can be left in the agreed locked
storage location on the ward for assessment by pharmacy staff and if necessary
a new supply organised by the pharmacist or by the pharmacy technician on their
next visit.

5. **Controlled Drugs (CDs) Brought into Hospital by Patients**

5.1 **Criteria for use of Patients Own CDs including temazepam**

CDs brought into hospital by a patient may be used for that patient providing that
the following criteria are met:

(i) The use of patients’ own CDs will be limited to those items where the
opportunity of tampering is evident, to enable nursing and medical staff to
positively identify the medicines and check expiry dates and batch numbers.
The drugs should appear in a reasonable condition.

(ii) The CD is entered into the Controlled Drug Register on a page used solely
for the use of patients’ own CDs.

If the criteria above are not met or where it is not practical to use CDs brought
into hospitals by patients, they may be sent home with relatives or destroyed on
the ward by a registered nurse or MHP and witnessed.

5.2 **Recording of patients’ own CDs**

In both cases the drug and patient’s name should appear on top of the page.
Each drug should be entered on a separate page.

5.3 **Storage of CDs**

Patient’s own CDs must be stored in the ward CD cupboard.

5.4 **Destruction**

Patient’s own CDs that fail algorithm R1 or are no longer required should be
destroyed on the ward by a registered nurse or MHP and a witness.

6. **Storage of PODs**

6.1 **Lockers, trolleys and cupboards**

All PODs must be locked in the locally agreed POD storage area which complies
with this policy.

6.2 **Keys**

The nurse in charge of the ward will hold master keys. The ward key for the POD
locker, trolley or cupboard must be held together with all other keys to medicines
storage containers.

7. **Supply of PODs**

PODs will only be used in hospital when they pass the POD algorithm or are
identified as one of the exceptions indicated in appendices R1 to R6. All other
regular medicines will be dispensed from the contracted pharmacy department.
Ward stock bottles or in-patient supplies must never be stored in the patient's cabinet unless labelled with full instructions for use.

7.1 **Discontinued medication**

Medicines that are no longer needed should be removed from the agreed storage area and must be either returned to the pharmacy department for credit, where suitable, or disposed of on the ward as per Trust policy.

8. **Administration of PODs**

The nurse should check the POD against using POD algorithm R1 before administration to ensure it is suitable for use. All other processes within the administration must be in line with sections 10.3 and 10.4 of this Policy.

9. **Nurse Guidelines for Discharging Patients ‘Out of Hours’ with Medicines from Individual Patient Medicine Cabinets**

Nursing staff may discharge patients with ready labelled medicines from their medicines cabinet/bedside locker providing the following criteria are met.

9.1. A discharge prescription has been completed and signed by the doctor

9.2. The medicines on the discharge prescription correspond to the medicines on the patient’s inpatient chart. Any discrepancies (e.g. additions, omissions or dose changes) should be confirmed with the prescriber and the discharge prescription amended by the prescriber if necessary.

9.3. The medicines in the patient’s bedside locker should then be checked against the discharge prescription ensuring that the directions on labels correspond completely with the directions on the discharge prescription (i.e. patient name, medicine name, dose and frequency of administration)

9.4. If there are any discrepancies between the labelled medicines and the discharge prescription (e.g. dose and/or frequency of administration) then the medicines should not be given to the patient. These medicines will need to be re-labelled or re-issued by the pharmacy department.

9.5. When there are new medicines prescribed on the discharge prescription, or when insufficient supplies are found the required items will need to be dispensed by the pharmacy department. Unlabelled ward stock supplies must not be given to the patient. However, it may be possible in some circumstances to utilise pre-labelled packs held as ward stock.

9.6. Only if the medicines in the patient’s locker correspond completely with the discharge prescription may they be given to the patient to take home.

9.7. The nurse issuing the medicines to the patient should sign and date the discharge prescription as ‘dispensed by’ box and endorse the prescription ‘supplied from ward’.

9.8. A second member of the nursing staff must double check all the above and then sign the prescription as ‘checked by’.
9.9. Any medicines that have been discontinued on discharge should be removed from the patient’s bedside locker and returned to pharmacy or destroyed as per Trust policy.

10. **Staff Roles in the POD Scheme**

10.1 The registered nurse or mental health practitioner who has undergone POD training:

- To obtain consent from patients regarding the use or destruction of PODs on admission and document this in the patients notes.
- To ask relatives to bring in other medicines that patients may have at home.
- To be responsible for the safe storage of PODs and keys.
- To complete all paperwork related to the scheme and legal documentation required for patient’s own CDs (registered nurses only)
- To check PODs for new admissions against the algorithm and inpatient prescription chart

10.2 The pharmacy technician / pharmacist (within normal pharmacy working hours)

- To check the new admissions PODs against both the algorithm, the inpatient prescription and as part of the medicines reconciliation process
- To ensure safe custody of the PODs
- To endorse relevant prescriptions as "POD", initial and date
- To remove all medication inappropriate for use
- To obtain permission for POD use and complete the documentation where appropriate
- To identify and resolve adherence issues
- To provide counselling and complete the medication reminder card where required

10.3 Medical Staff

- To encourage patients to bring in their medication for home
- To inform nursing staff and where possible, patients of changes in drug therapy.
- To check PODs where appropriate and obtain consent.
Appendix (R1): ALGORITHM FOR THE USE OF PATIENTS' OWN DRUGS (PODs) ON THE WARD

1. The patient’s name on the label of any prescribed medicine is the same as the patient. Any over-the-counter medicines are confirmed with the patient as being bought for their use only

2. In original dispensing container

3. Label, container and drug in good condition.

4. Within the expiry on the original manufacturer's container or within 6 months of the dispensed date on the container if no manufacturer's expiry exists. For eye drops/ointment see appendix (R4)

5. Are tablets or capsules in a bottle or box?

5a. Rogue tablets/capsules

5b. Positively identified by colours and markings

6. Drug name, form and strength on label agrees with the actual drug

Liquids, multidose injection vials, creams, ointments: Unopened or opened within last 3 months (1 month for insulin)

Is cold storage required?

NO

Do NOT use

Drug is safe to use

Contact the pharmacist / pharmacy technician, Medicines Information or on call pharmacist for advice

YES

See guidelines on the use of loose blister strips (Appendix R3)

NO

Do not use

Do not use

Do not use

Do not use
Appendix (R2): ALGORITHM FOR THE USE OF PATIENTS’ OWN DRUGS (PODs) OR ONE STOP DISPENSING AT DISCHARGE

1. Was the medicine dispensed prior to admission to the ward?
   - YES → Follow through POD algorithm first
   - NO →

2. Is there sufficient quantity to last 14 days on day of discharge?
   - YES → Order additional supply
   - NO →

3. Are the directions on the TTO form different from the inpatient drug chart?
   - YES → Discuss with Doctor
   - NO →

4. Are there any additions to the TTO?
   - YES → Are the pharmacy team available?
     - YES → Ward pharmacy team to arrange dispensing/re-label
     - NO → Request supplies from pharmacy or ask the doctor to re-label POD
   - NO → Drug can be given back to patient

Check patient has all drugs, packaged in green medicines bag before leaving ward.
Appendix R3: Guidelines on the Use of Loose Blister Strips

The use of loose blister strips under the Patients Own Drug scheme should only be used if:

- The drug was prescribed for the patient
- Each strip is within manufacturers’ expiry
- The dose written on chart corresponds with what patient is taking and is within BNF or current guidelines (if unsure check notes and/or contact prescriber)
- The drug name and strength is clearly visible on strip. (where it would aid identification the tablet/capsule may be popped out.)

If there is sufficient quantity to cover in a 14 day TTO supply the blister strip(s) must be relabelled.
Appendix R4: Guidelines on the Use of Eye Drops/Ointments

1. Check patient’s notes to ensure preparation, strength and dose is correct
2. Unopened containers should be relabelled, if necessary, and left on ward ready for use as discharge medicines.
3. If containers have been opened, efforts should be made to establish the opening date. Any bottles which have been opened longer than 4 weeks, or where a date of opening cannot be established, should be destroyed and a new supply should be issued. *
4. When supplying replacement antibiotic eyes drops, a bottle should be issued for each eye with an expiry date of one week.

* Opened containers may be used in the event of there being a delay in the issue of a new supply but must be destroyed once the new supply has been received.
Appendix R5: Guidelines on the Use of Unlabelled Inhalers

1. Check in the patient's notes and on the GP admission list that each Inhaler was prescribed for them.
2. If clarification is required confirm dose and strength with patient or carer, check notes or if necessary clarify with prescriber.
3. Notify ward pharmacist or doctor if there is any difference between prescribed dose/frequency and what the patient usually takes.
4. Check that the Inhaler is in date and that there is sufficient supply.
5. The pharmacist or pharmacy technician should complete a label with directions, patient's name, ward and date and attach to the inhaler. “POD relabelled” should be included on the label. Where this is done by a technician the label must be checked by a pharmacist, accredited checking technician, doctor or qualified nurse.
6. If the inhaler is a device other than a Metered Dose Inhaler, this should be endorsed on the prescription chart.
Appendix R6: Best Practice in the use of medicines packed in Monitored Dosage Systems (MDS) e.g. Nomad®, Venalink®, Medisure™

Medicines supplied in MDS systems (e.g. Nomad™) which contain mixed contents in each blister are not to be used unless:

(a) medicines are not stocked on the ward
(b) each capsule/tablet can be identified from the description on the container
(c) the container has been dispensed by a community pharmacy within the last 6 weeks
Appendix S: Transcription Guidelines

Appendix S.1: Transcribing from a Southern Health NHS Foundation Trust prescription chart

Transcribing information is copying from the inpatient prescription without any alterations or additions. Interpretations should only be as described in the following paragraphs. If the information on the prescription is unclear this should be clarified with, and countersigned by the prescriber. Changes may not be made based on information provided by the patient, family member or carer. Transcribing should take into account the abilities of the staff, patient or carer who will be following the instructions.

1. Write in black ink and use CAPITALS for all information being transcribed.
2. Ensure the order form corresponds to the ward that the item is being ordered for
3. Write the current date for all orders being made
4. The person ordering should print their name, qualification and signature for the first request on the sheet. Consecutive orders will only require the person’s signature/initials.
5. Write the name of the consultant or a recognised abbreviation
6. Write the name of the patient, their NHS number and date of birth
7. Ensure the patient is not allergic to the medication that has been requested by checking the allergy box on the SHFT prescription chart. If the allergy box has not been completed, please refer back to the prescriber or a SHFT pharmacist.
8. If this is a Non-Formulary Drug (NFD), then it should not be ordered from Pharmacy until approval is obtained
9. Write the drug name in its generic form unless the BNF advises that the drug should be prescribed by brand e.g. beclometasone inhalers, anti-epileptic medications, lithium, theophylline ciclosporin.

7. Write the strength of the drug and the units of measurement. Prescribers are advised to write as below and transcribers will need to follow this:
   a. g/G for grams
   b. mg for milligram
   c. ml for millilitre
   Micrograms and nanograms strengths should be written in full and not abbreviated to ‘mcg’ and ‘ng’, respectively. If the prescriber has not followed this advice and if there is any doubt about dose units then please check with the prescriber and write the dose units as above on the order form. Care should be taken when reading and transcribing decimal points. The advice to prescribers is to write a nought in front of a decimal point for clarification e.g. 0.25mg not .25mg; 0.5ml not .5ml. If the prescriber has not followed this advice then please check with the prescriber before transcribing and add the nought if appropriate.

9. Write the form of the drug. The following abbreviations may be used:
   a. TABS for tablets
   b. CAPS for capsules
   c. INH for inhaler if the device has already been specified previously in the ‘Drug Name’ section.
   d. INJ for injectable medication
10. Write the amount of the drug required. The abbreviation 'op' for original pack may be used where appropriate.

11. Write the instructions for items which will be labelled with instructions for the patient where appropriate. This may be used for inhaler devices, topical preparations for use on the skin, disposable insulin pens and cartridges, ear/eye drops, nasal drops, mouthwashes and other items. Prescribers may write frequencies in Latin abbreviations which should be interpreted by transcribers as follows:

a. OD / od = once a day
b. ON / on = once at night
c. BD / bd = twice a day
d. QDS / qds = four times a day
e. TDS / tds = three times a day
f. PRN / prn = when required

A full list of Latin abbreviations is in the back of the British National Formulary

12. Prescribers may use abbreviations for routes of administration which should be interpreted by transcribers as follows:

a. PR/ pr = rectally
b. PV / pv = vaginally
c. INH / inh = by inhalation
d. PO / po = orally
e. TOP / top = topically
f. SL / = sublingually
g. RE / re = right eye

13. The prescription which has been ordered must be endorsed with the quantity supplied and the date when the supply was made in the 'pharmacy' box on the SHFT prescription chart. If the strength of the medicine ordered is different from the dose which is prescribed, this information should also be included in the endorsement.
Appendix S.2: Accreditation process for SHFT pharmacy technicians to sign off non-stock order forms

1. On induction into the Trust, SHFT pharmacy technicians working as part of the medicines management team must become accredited to transcribe non-stock item requests from a SHFT prescription chart on to a non-stock order form and sign off non-stock order forms.

2. The accreditation requires a SHFT pharmacy technician to accurately transcribe 50 items from in-patient prescription charts (the transcription process is outlined in Appendix S1).

3. During the accreditation process, a SHFT pharmacist must check the SHFT pharmacy technician’s transcription and counter sign the non-stock order sheet.

4. The items can then be dispensed and checked from the order sheet.

5. A SHFT pharmacy technician must accurately transcribe 50 items with No major errors and no more than 3 minor errors. A major error or more than 3 minor errors will result in the SHFT pharmacy technician having to restart the 50 items. This may be repeated no more than 3 times.

6. **Major Errors**
   - Incorrect NHS number
   - Incorrect patient name
   - Incorrect drug name / brand specific not transcribed
   - Incorrect drug strength
   - Incorrect dose or frequency
   - Patient allergic to medicine

7. **Minor Errors**
   - Incorrect drug form
   - Incorrect quantity
   - Incorrect endorsement.
   - Spelling mistakes / unclear orders
   - Missing ward
   - Not intended for re-supply
   - Previously supplied
   - Wrong cost code

8. Any errors made must be discussed with a SHFT pharmacist and the technician and then any appropriate action taken.

9. If the SHFT pharmacy technician accurately transcribes 50 items they will be issued a certificate of accreditation valid for 2 years. However the final decision as to whether the SHFT pharmacy technician will be accredited is at the discretion of the supervising Pharmacist.

10. To be issued a new certificate after two years, the SHFT pharmacy technician will have to be re-accredited by accurately transcribing 50 items following the above guidelines.

11. Once accredited, the SHFT pharmacy technician may transcribe and sign off medication to be ordered from SHFT prescription charts without the counter signature of a Pharmacist.

12. The supervising Pharmacist reserves the right to rescind the SHFT pharmacy technician’s accreditation at any time if there is concern regarding their ability to transcribe orders accurately.
Appendix S3 Procedure for ordering non-stock items at Parklands Hospital

1. Non-stock items are those which are not listed on the stock list for a particular ward or they are stock items requested for the specific use by one patient e.g. inhalers, topical preparations.

2. Non-stock items must be ordered for a specific patient against an inpatient prescription written on a Southern Health NHS Foundation Trust (SHFT) prescription chart by a medical or non-medical prescriber.

3. Non-stock items are ordered on a non-stock order form by the transcription process detailed in Appendix A. The transcription of a prescription on to a non-stock order form can be completed by a qualified registered mental health nurse, SHFT Mental Health Practitioner, SHFT pharmacist or pharmacy technician.

4. All non-stock items requested at Parklands Hospital need to be signed off by a member of the SHFT medicines management team before they can be dispensed in the pharmacy at North Hampshire Hospital.

5. A pharmacist or an accredited SHFT pharmacy technician can sign off non-stock item requests. The accreditation process for SHFT pharmacy technicians is detailed in Appendix B.

6. The non-stock item being requested must be clinically screened by a SHFT pharmacist in the ‘Pharmacy’ section of the prescription (endorsement policy) before it can be signed off by a SHFT pharmacy technician on the non-stock order sheet.

7. If the prescription has not been screened by a SHFT pharmacist, the non-stock item request must either be signed off by a SHFT pharmacist or a SHFT pharmacist must screen the prescription before a SHFT pharmacy technician can sign off the non-stock item on the non-stock order form.

8. If a SHFT pharmacist is unavailable and a non-stock item is requested, all sides of all active prescription charts for the named patient must be photocopied and taken to North Hampshire Hospitals Pharmacy department along with the non-stock order form containing the non-stock item being requested. The non-stock order form can then be screened by a Hampshire Hospitals NHS Foundation Trust Pharmacist and supplied following the normal procedure.
Appendix T: Discharge Medication for Patients using Compliance Aids at Home

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>(use addressograph label)</td>
<td></td>
</tr>
</tbody>
</table>

| Date of birth |

| Hospital: | Ward: |

Dear Dr ____________________________ (GP) Your patient is due to be discharged on ______________________

□ He/she currently uses a medication compliance aid at home.
□ He/she requires a new medication compliance aid (see reasons below).

Assessments have shown that this patient needs to have his/her medication in a medication compliance aid for the following reasons (tick all that apply):

□ Physical/manual dexterity problems.
□ No relative/carer who can help the patient open boxes/bottles.
□ Patient is confused/forgetful.
□ No relative/carer who can help prompt the patient.
□ Medication reminder cards not helpful for this patient.
□ Patient’s confusion/disorientation is such that a compliance aid is necessary to enable carers to prompt/administer the medication to the patient.

We have arranged the following for the patient’s discharge:

□ We have issued an FP10HNC for _____ days medication compliance aids.
□ We have filled ______ days medication compliance aids (NOMADs).
□ The patient’s usual community pharmacy has medication compliance aids already made up ready for use.

Ongoing supply of medication compliance aids arranged with the following Community Pharmacy:

Community Pharmacy Address: ______________________________________________________________

Community Pharmacy Telephone number: __________________________________________________

Community Pharmacy Fax number: _______________________________________________________

Signed ____________________________ Designation ____________________________

PRINT NAME ____________________________ Contact Number ____________________________

Date ____________________________
### Appendix U  Missing/lost/stolen NHS prescription form(s) notification form

<table>
<thead>
<tr>
<th>Health body:</th>
<th>Date reported:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact name:</td>
<td>Contact telephone number:</td>
</tr>
<tr>
<td>Contact address:</td>
<td></td>
</tr>
</tbody>
</table>

The following numbered NHS prescriptions forms have been identified to us as lost or stolen:

<table>
<thead>
<tr>
<th>Date of theft/loss</th>
<th>Name of person reporting (GP, practice manager, nurse, trust pharmacist)</th>
<th>Telephone number</th>
</tr>
</thead>
</table>

**Full details of theft/loss (please fill in details below)**

Include the following information:
- date and time of loss/theft
- date and time of reporting loss/theft
- place where loss/theft occurred
- type of prescription stationery
- serial numbers
- quantity
- details of the LSMS to whom the incident has been reported.

Details of doctor/department/dentist/nurse etc from whom prescription form(s) have been stolen or lost:

<table>
<thead>
<tr>
<th>Name</th>
<th>Personal dispensing or identification code/number</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Serial number(s) lost or stolen</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>

Details of NHS prescription form type lost or stolen (tick appropriate box)
<table>
<thead>
<tr>
<th>Issue</th>
<th>Colour</th>
<th>Please indicate type lost/stolen</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP10NC</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>FP10HNC</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>FP10SS</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>FP10MDAS</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>FP10HMDAS</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>FP10MDASP</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>FP10MDASS</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>FP10PN</td>
<td>Lilac</td>
<td></td>
</tr>
<tr>
<td>FP10CN</td>
<td>Lilac</td>
<td></td>
</tr>
<tr>
<td>FP10SP</td>
<td>Lilac</td>
<td></td>
</tr>
<tr>
<td>FP10P</td>
<td>Lilac</td>
<td></td>
</tr>
<tr>
<td>FP10D</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>FP10PCDSS</td>
<td>Pink</td>
<td></td>
</tr>
<tr>
<td>FP10PCDNC</td>
<td>Pink</td>
<td></td>
</tr>
</tbody>
</table>

* updated current forms in use October 2006

<table>
<thead>
<tr>
<th>Has this incident been reported to the police?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and police station of investigating police officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please fill in details below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has an alert and warning been issued to all local pharmacies and GP surgeries within the area? (please tick box)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Please give details of any ink change or security measures and the effective dates of these measures (please fill in details below)

Name: ____________________________
Position: ____________________________
Signed: ____________________________
Dated: ____________________________

Please return this completed form by email to Alerts.SCWCSU@nhs.net and arrangements will be made for an alert to be issued.
Appendix V Good Practice Guidance on Expiry Dates of Medicines

Medicines must be stored as recommended by the manufacturer (read the label or container packaging).

They must not be used beyond the expiry date stated on the container as the medicine is no longer within an acceptable condition to be considered effective or has the potential to do harm.

Some medicines have a shortened expiry date after opening the container. For these medicines record the date opened and the calculated expiry on the container. Guidance for most of these is stated in the table below.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Expiry date after opening</th>
<th>Rationale / comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets / capsules in manufacturer's blister strip</td>
<td>Date on blister. If no expiry date visible, contact dispensing pharmacy for advice</td>
<td>To ensure expiry date not reached</td>
</tr>
<tr>
<td>Tablets / capsules in monitored dosage system (MDS) e.g. Nomad, Medidos™</td>
<td>8 weeks from date on dispensing label</td>
<td>Limited stability data when packaged into MDS. Some medicines are unsuitable for inclusion in MDS.</td>
</tr>
<tr>
<td>Tablets / capsules / liquids dispensed in medicine bottles</td>
<td>Contact dispensing pharmacy</td>
<td></td>
</tr>
<tr>
<td>Oral liquids in original containers</td>
<td>6 months from date of opening unless specified by manufacturer</td>
<td>Environmental exposure when measuring doses can introduce contamination</td>
</tr>
<tr>
<td>Insulins</td>
<td>Vials, cartridges &amp; pens: 4 weeks when stored at room temperature (under 30°C) unless otherwise stated. Pens: Record date opened and patient name on pen. Vials: Record date opened.</td>
<td></td>
</tr>
<tr>
<td>Creams</td>
<td>Tubes &amp; pump dispensers: 3 months (1 month if unpreserved) Tubs / pots: 1 month</td>
<td>Label all containers with the patient’s name when in use. The label should indicate the area of the body for use and how often it should be applied.</td>
</tr>
<tr>
<td>Ointments</td>
<td>Tubes: 6 months Tubs / pots: 3 months</td>
<td></td>
</tr>
<tr>
<td>External / topical liquids</td>
<td>6 months</td>
<td>Write the date opened on the label</td>
</tr>
<tr>
<td>Eye drops/ointment, ear drops, nose drops</td>
<td>1 month unless stated otherwise by manufacturer</td>
<td>Write the date opened on the label</td>
</tr>
<tr>
<td>Glyceryl Trinitrate tablets (GTN)</td>
<td>8 weeks</td>
<td>Close cap tightly after removing a tablet.</td>
</tr>
</tbody>
</table>
Appendix W Medication Consent Form

Tick applicable boxes:

I confirm that:

- The benefits and possible side-effects of using ……………………………………
  (medicine name) have been explained to me to treat my (diagnosis)
  …………………………………… and I have understood the explanation.

- I have been given a Patient Information Leaflet on this medicine

- The treatment options have been discussed with me, and also the consequences of not taking this medication.
  Treatment options discussed include:
  1. ………………………………………………………………………………………………………………………………
  2. ………………………………………………………………………………………………………………………………

- I have had enough time to consider my decision and ask questions

- I understand that this medication is being prescribed as:
  a licensed medicine used outside of its licensed indication (“off – label”) / or licensed route* or,
  an unlicensed medication

- I understand I can withdraw or give my consent at any time and I will inform the prescriber

Signed………………………………… (Patient)………………………………..(Print Name)
Date……………………………………………………………………………………………………

Signed…………………………………(Prescriber)………………………………..(Print Name)
Date……………………………………………………………………………………………………

Please file in the secondary folder (section 7) and upload into clinical documentation on RiO with a link entry in the RiO progress notes or file a copy in the PMR.