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NHS Trust

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FOI REF: 23/641

24th October 2023

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

I request that a copy of the following documents (or documents containing the following information) be provided to me please:

- **All Trust policies that include information on the checking of medicines when they are being administered to patients, and any associated documents e.g. medicines policy, specific medicine/ clinical area policies, codes, appendices to the relevant policies etc.**

Please see that attached documents.

Please note that it is East Sussex Healthcare NHS Trust's FOI policy to only provide the names of Senior Staff, therefore we have redacted the names of staff below this level from the attached documents.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Cont…/

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The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
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Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
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East Sussex Healthcare NHS Trust

Authorisation, Assembly and Issue of Discharge Medication (TTA / TTO) [Medicines Code]

Document ID Number	852
Version:	V3.3
Ratified by:	Medicines Optimisation Group
Date ratified:	July 2017
Name of author and title:	Jonathon Palmer, Deputy Chief Pharmacist
Date originally written:	June 2012
Date current version was completed	September 2019
Name of responsible committee/individual:	Medicines Optimisation Group
Date issued:	29th October 2019
Review date:	30 April 2022
Target audience:	All staff involved with medicines
Compliance with CQC Fundamental Standard	Regulation 9 Person Centred Care Regulation 12 Safe Care and Treatment
Compliance with any other external requirements (e.g. Information Governance)	RPS: Keeping patients safe when they transfer between care providers – getting the medicines right
Associated Documents:	▪ Procedures for accessing medicines in acute hospital sites [Medicines Code] ▪ Procedures for the Use of Patients Own Medicines on Admission, During Inpatient Stay and at Discharge [Medicines Code] ▪ Medicines Policy [Medicines Code] ▪ Hospital pharmacy procedures NMC Standards for Medicines Management

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
1.0	01/07/2012	Jonathon Palmer	New format and to improve process	Discharge processes have been improved and streamlined in response to incidents related to poor medicine management. New procedure reduces operational burden on clinical staff whilst improving understanding of responsibilities
2.0	12/12/2013	Jonathon Palmer	Response to incident recommendation and integration of community services processes	Clarification that patient must be identified at the point of discharge and only their medicines given/returned to them.
2.1	20/07/2016	Jonathon Palmer / Iwona Ward	Inclusion of supplying delivery paraphernalia with liquid medicines	New statement at point 5.3.4 and update of flowchart
3.0	16/11/2016	Jonathon Palmer	Inclusion of eSearcher (ICE) discharge process	New Overview and inclusion of all the processes relating to the recording TTAs on the eSearcher system. Inclusion of pharmacy role in discharges.
3.1	22/10/2019	Jonathon Palmer	Amendment to allow electronic discharge summaries to be used as a TTA in short stay surgical units	Rewording of note in 5.2.3 to include special dispensation for surgical short stay units.
3.2	12/11/2020	Jonathon Palmer	Extension required on review date as this needs a review	Extended the review date from September 2020 to 30th April 2021
3.3	18/05/2021	Jonathon Palmer	Extension required on review date as this needs a review	This document is awaiting the roll out of the new electronic prescribing system across the Trust and can then be updated. Moved from May 2021 to May 2022

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Emma Jones Davies	Medicines Management Nurse	
Beth Attwood	Lead Medicines Management Technician EDGH	
Marie O'Mara	Lead Medicines Management Technician Conquest	
Benjamin Clark	Lead Pharmacist for Medicine	
Maria Andrade	Lead Pharmacist for Surgery and Theatres	
Peter Symons	PMO	
Hayley Barron	PMO	

Jane Starr	Medicines Safety Officer	
Simon Merritt	Division Lead for Medicine	
Angela Colosi	Deputy Director of Nursing	
James Wilkinson	Assistant Medical Director	
Simon Badcott	Chief Pharmacist	
Rosie Furner	Community Health Services Pharmacist	
Medicines Optimisation Group		

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

Nationally the transfer of information about patients' medicines continues to be a significant risk to patient safety. The Royal Pharmaceutical Society (RPS) guidance, *'Keeping patients safe when they transfer between care providers – getting the medicines right parts 1 and 2*' suggest that between 30 and 70% of patients can have either an error or an unintentional change to their medication when their care is transferred.

Reducing medication errors causing harm has already been identified as an improvement area in the NHS Outcomes Framework under Treating and Caring for People in a safe environment and protecting them from avoidable harm. The Health and Social Care Act 2008 (Regulated activities) Regulations 2010 require that the registered person must protect service users against the risks associated with the unsafe use and management of medicines, and cooperate with other providers.

As the NHS restructures, with more providers and new commissioners, the RPS standards imply that the risk to patient safety related to inaccurate transfer of information about medicines is likely to increase. It is crucial therefore that ESHT actively develops safe systems that support, and continuously improve the processes for reducing medications errors and safe transfer of information about medicines when patients transfer to other care providers.

2. Purpose

The aims of this document are to:

- Ensure that ESHT processes for supplying medicines and information at discharge are safe, patient orientated and outcome focussed.
- Utilise nursing and pharmacy staff efficiently to realise the benefits of dispensing for discharge.
- Provide a safe framework for allowing the use of medicines that may be manipulated at ward level to fulfil a discharge prescription [for example 'gun-labelled' pharmacy only or TTA packs].
- Describe the process for ensuring accurate information about the patient's medication is provided to them on discharge and to the provider responsible for their ongoing care.

2.1. Rationale

These procedures cover the processes that must be followed before and at discharge to ensure medicines are provided safely to patients from the hospitals of ESHT. It is important from a patient safety perspective to ensure that the medicines and discharge information provided to patients and the provider responsible for ongoing treatment correctly represent the intentions for the patient's expected ongoing treatment.

The Care Quality Commission (CQC) considers that managing medicines when a patient transfers from one setting to another is central to safe, high-quality care. This document therefore supports two CQC essential standards on quality and safety; Outcome 9: Management of Medicines and Outcome 6: Co-operation.

Improving the transfer of information about medicines across all care settings should reduce incidents of avoidable harm to patients, and contribute to a reduction in avoidable medicines related admissions and readmissions to hospital. These desired outcomes are clearly linked to the Quality, Innovation, Productivity and Prevention (QIPP) programme.

2.2. Principles

Health care professionals transferring or discharging a patient should ensure:

- Medicines are assembled in accordance with the discharge instructions
- All necessary information about the patient's medicines is accurately recorded and transferred with the patient
- Responsibility for ongoing prescribing is clear

Patients (or their parents, carers or advocates) should be encouraged to be active partners in managing their medicines when they move, and know in plain terms why, when and what medicines they are taking.

Information about patients' medicines should be communicated in a way which is timely, clear, unambiguous and legible; ideally generated and transferred electronically.

2.3. Scope

This document applies to all prescribers, qualified registered nurses and approved pharmacy staff that may provide medicines to patients at discharge or transfer to another care provider.

3. Definitions

Within this policy the following abbreviations and definitions are used:

Abbreviation	Full Name	Meaning
TTA / TTO	'To Take Away', 'To Take Onwards'	Medicines supplied to a patient to use after discharge
P	Pharmacy only	A medicine that may be supplied to a patient under the supervision of a pharmacist or other authorised practice – designated by a 'P' on the medicine packaging.
POD	Patient Own Drug / Medicine	Patients own drugs (PODs) are defined as any medication used by the patient whilst at home that they have brought into the hospital with them. This also includes any discharge medicines from a stay at an acute trust. They may be prescribed medications or those which the patient themselves have purchased from a pharmacy or supermarket etc. They may include oral, topical, inhaled or injected preparations. [Note medicines dispensed during a stay by the ESHT pharmacies for acute hospital sites or by contracted suppliers for community bedded units do not become patient's property until they are discharged from hospital. All medicines dispensed on FP10 remain patient property regardless of origin]
CD	Controlled Drug	A medicine that is defined by the Misuse of Drugs Act 1971 and regulated by the Misuse of Drugs Regulations 2001. See Medicines Management Policy 8: The Management of Controlled Drugs.
FP10 FP10HP		Types of NHS prescription stationery for

FP10CDF		dispensing/ordering from community pharmacies.
MMS	Medicine Management Service	The service provided by pharmacy technicians to ward areas that concentrate on medication histories, patients own medicines, one stop dispensing, non-stock top-up and supporting medicines reconciliation.
	Medicines Reconciliation	The process for ensuring that a patient's medication history prior to admission is obtained and is used to assess the patient's current medication regime within the clinical context of the admission.
	Medicines Optimisation	Medicines optimisation is an approach that seeks to maximise the beneficial clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement. Medicines optimisation is likely to be one of the key focuses of the NHS Commissioning Board.
MedCA	Medicines Compliance Aids	Medicines Compliance Aids within the context of this document includes monitored dosage systems that are filled by community pharmacies or purchased by patients or carers to aid adherence with a medication regime. These include Manrex, Venolink, Nomad, and Dosette boxes.
MRC	Medicines Record Chart	A medicines record chart is a compliance aid that ensures additional information is provided to a patient in a form that is understandable by them. Please refer to Medicines Management Policy 10: Providing Patients with Information about their Medicines
MOAC	Medication Order and Administration Chart	Trust documentation used for inpatients to provide an order for medicines to be administered, it also allows recording of administration. Other commonly used names are prescription chart or drug chart.

4. Accountabilities and Responsibilities

4.1. Medical Staff

Medical staff are responsible for:

- Planning discharges well in advance so as not to create pressure on nursing and pharmacy staff or preventable delays at the point of discharge [i.e. write discharge prescriptions before 4pm on the day before discharge].
- Collaborating with nursing and pharmacy staff to ensure that prescribing intentions on discharge and for ongoing care are clear and unambiguous.
- Accuracy of the discharge prescription by ensuring medication records on discharge summaries is maintained, corrected and up-to-date.
- Discussing new medication or changes to existing medication with patients at the point of prescribing to ensure they are active partners in their care.

4.2. Nursing staff

Nursing staff are responsible for:

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- Encouraging medical staff to plan discharges well in advance so to reduce pressure on nursing and pharmacy staff at the point of discharge.

- Collaborate with medical and pharmacy staff to ensure that issues with prescribing intentions or medications at discharge are clarified or corrected.
- Discussing existing, new medication or changes to existing medication with patients at the point of administration to ensure they remain active partners in their care.
- Ensuring medication and written information provided to a patient at the point of discharge has been correctly assembled and given to the patient in accordance with this procedure.
- Verbally discussing and checking that a patient (or their carer) understands the prescribed medication regime at discharge.

[Note: It is the responsibility of the discharging nurse to check that the medication handed to a patient on discharge has been dispensed or supplied for them. The patient's identity must always be confirmed.]

4.3. Pharmacy staff

Pharmacy staff are responsible for:

- Ensuring medicines have been dispensed in accordance with prescriptions or medicine orders.
- Supporting ward areas when possible to expedite discharges.
- Help identify potential pharmaceutical care problems on discharge and provide expert support to overcome these.

Pharmacists are responsible for:

- Ensuring the safety of prescriptions and medicine orders through regular review of medicine charts at ward level.

Pharmacists should be involved directly in clinically screening patient discharges when the service allows.

5. Procedures and Actions to Follow

A qualified registered nurse / midwife, a pharmacist, medicines management technician (MMS technician), or accredited rehabilitation support workers in joint health and social care facilities (e.g. Firwood House) may supply 'To Take Away' (TTA) medicines to a patient from a clinical area providing the following are met:

Any dispensed medicines for the patient have been:

- Labelled for them
- Met the criteria for the re-use of patients own medicines if applicable
- Provided in an acceptable form for discharge for example 'gun labelled' pharmacy only (P) medicines and purposely packaged TTA packs that have space to annotate patient's name, date and administration instruction.
- Correspond to the patient's current intended prescription as detailed on the inpatient medication administration chart.

For all acute patients and elsewhere when available a discharge summary must have been generated that corresponds to the intended prescription on the inpatient medication order and administration chart. For intermediate care areas, particularly those without a discharge summary in use, a medicine record chart must be generated to correspond to the inpatient medication order and administration chart and the medicines supplied.

All medicines that have been dispensed to a patient from the acute hospitals pharmacies will have been screened by a pharmacist for safety. These medicines will comply with the medicines act. Dispensed medicines that patients have brought into hospital with them (Patient's Own Drugs or PODs) will normally comply with the medicine act; however because these medicines may be altered whilst in the possession of patients they must be assessed for suitability for re-use within the hospital. This assessment must be undertaken in accordance with Procedures for the Use of Patients Own Medicines on Admission, During Inpatient Stay and at Discharge. For complex discharges it may be advisable to involve pharmacy in normal working hours. Contact the ward / unit based pharmacy team.

In order to minimise risk all TTA prescriptions whether dispensed through pharmacy or assembled on the ward must be handled exactly the same way at the time of discharge. This is in accordance with the NMC standards.

5.1. Authorising a TTA in readiness for discharge

5.1.1. Planning for discharge begins at the point of admission. Medicines reconciliation is an important step in validating a patient's current medication regime and has consequences on the quality of discharge information about medicines.

5.1.2. Medicines Reconciliation is covered in detail within the Medicines Code Document: Medicines Reconciliation on Admission.

5.1.3. Where patients have been admitted for less than 24 hours and medicines reconciliation has not been carried out, consideration must be taken to the risk of the possibility of providing inaccurate information on a discharge summary to those responsible for ongoing care.

5.1.4. For any unscheduled urgent admissions to hospital it is the **only** allowed option for not providing a full list of medicines that a patient is on, with reference made to those that have been changed or stopped. In this case it is appropriate to put in the free text section of the discharge summary that a full medication history and reconciliation was not possible prior to discharge due to length of stay.

5.1.5. Where a medicines reconciliation has not been achieved on admission it is also appropriate to put a note in the free text section of the discharge summary to highlight that to those responsible for ongoing care.

5.1.6. The current system involves eSearcher (ICE) to record the TTAs on the discharge summary. In other areas TOMCAT is used; however with all discharges the main principle is that the record of TTAs on the discharge summary must reflect the patient's current medication regime.

5.1.7. Pharmacy cannot currently support the validation of discharge summaries written outside of eSearcher.

5.1.8. Where medicines reconciliation has been completed and recorded on the front of the chart the doctor should review any outstanding 'Prescription Review Notes' and amend the existing medicines regime accordingly. If action is not required a decision should be recorded in the decision section e.g. stopped on admission and signed.

5.1.9. In the Acute Hospital service ESHT utilises a MOAC that has a built in TTA section.

5.1.10. For each drug in the insulin, complex and variable dose sections should check that the entry is valid, make amendments and complete the TTA section of the drug chart indicating in the section 'For TTA' and if appropriate 'GP to review'. Any additional details required to complete a prescription should be added to the special instructions / dose and instructions sections (For example 'INR in xx days for warfarin' and 'to be reduced every 7 days by 5mg and then stop for steroids).

5.1.11. For each drug on the regular medicines section the doctor should check that the entry is valid, make amendments and complete the TTA section of the drug chart indicating in the section 'For TTA' and if appropriate 'GP to review'. Any additional details required to complete a prescription should be added to the special instructions section (such as for 7 days).

5.1.12. In the 'as required section' the doctor should review ongoing needs for medicines in this section and highlight those for continuation 'TTA', those for 'GP to review' and those with limited duration.

5.1.13. At the bottom of the chart the doctor should sign the 'TTA Sign' box and date the 'TTA Date box' to authorise the prescription on the last applicable page of the 'regular' and 'as required' sections.

5.1.14. Controlled drug prescriptions for supply on discharge must be completed on the front of the drug chart

5.1.15. The doctor must indicate to the nurse who is looking after the patient that they have authorised the TTA for assembly.

5.1.16. To arrange assembly of the TTA the nurse can do one of three things:

- Where there is an agreement in place to support discharge and regular pharmacy services on the ward the nurse should discuss with/bleep/contact the pharmacy technician or pharmacist for that ward to arrange for the discharge to be clinically screened and supplies checked and organised.
- Out of hours or where there is no agreement for pharmacy to support the assembly of discharge medicines (e.g. elective short stay wards). The TTA can be assembled by two nurses following the procedures described in section 5.5.

5.2. Recording of the TTA medicines on the discharge summary

5.2.1. TTAs must be recorded on the discharge summary within eSearcher prior to a patient leaving hospital. The only exception to this is when special arrangements are put in place due to operational or major incidents that affect the availability of doctors to write discharge summaries.

5.2.2. The procedures for the completion of this are covered in the eSearcher training handbook.

5.2.3. In normal pharmacy hours ideally the TTA section of the discharge summary should be submitted for checking by pharmacy when completed by the doctor.

- Where there is an agreement in place to support discharge and regular pharmacy services on the ward the doctor should 'submit to pharmacy' for review.
- Out of hours or where there is no agreement for pharmacy to support discharge medicines (e.g. elective short stay wards). The TTA section should be authorised by the nurse after they have triangulated the MOAC, discharge summary and medicines.

Note: It is important to note that under normal circumstances the MOAC performs the legal function of the discharge prescription. The TTA discharge summary is intended to provide information to those responsible for ongoing care and therefore must always correspond to the prescription on the drug chart. The exemption to this is where Short Stay Surgical Units do not use MOACs and it is problematic to obtain a 'wet' signature. In these areas the discharge summary can be used as a discharge prescription with the prescribers electronic signature, provided the discharge does not contain schedule 2 and 3 controlled drugs

5.3. Pharmacist screening of TTA and discharge summary checks

5.3.1. In Pharmacy hours when the discharge prescription has been authorised by the doctor via the MOAC the pharmacist should be notified to screen the TTA prescription.

5.3.2. The pharmacist will indicate the screen has taken place by signing and dating the 'Discharge Screen' box on page 1 of the MOAC.

5.3.3. During the screening process the pharmacist will identify, query and clarify any clinically significant issues with the prescription.

5.3.4. As all supply is taken off of the drug chart this would form the basis for a 'conditional screen' for pharmacy technicians to organise supply without further input from pharmacists in the process.

5.3.5. If the discharge summary has been written and submitted to pharmacy at the same time as the drug chart has been authorised for TTA it is appropriate for the pharmacist to do the clinical screen and authorisation of the TTA section of the discharge summary at the same time.

5.3.6. If the discharge screen box has been signed and dated by a pharmacist either a suitably trained pharmacy technician or pharmacist can authorise the TTA section of the discharge summary.

5.4. Supported TTA assembly by pharmacy

5.4.1. It is recognised that pharmacy has an important role in ensuring that they are involved in the processes regarding the assembly and provision of discharge medicines.

5.4.2. Pharmacy also has a role in supporting medicines optimisation, which may include the counselling or patients and referral of patients for follow-up review during admission and the point of discharge.

5.4.3. Pharmacy technicians in particular are highly skilled in the assessment and assembly of medicines at discharge and can influence nurses with respect to their own practice.

5.4.4. In short involving pharmacy as early as possible in the discharge pharmacy will support a safer, more efficient and productive discharge process throughout the organisation.

5.4.5. To support these important roles it is essential that a multi-disciplinary approach to the organisation of discharge medicines is taken at ward level with every member of the team fulfilling their part.

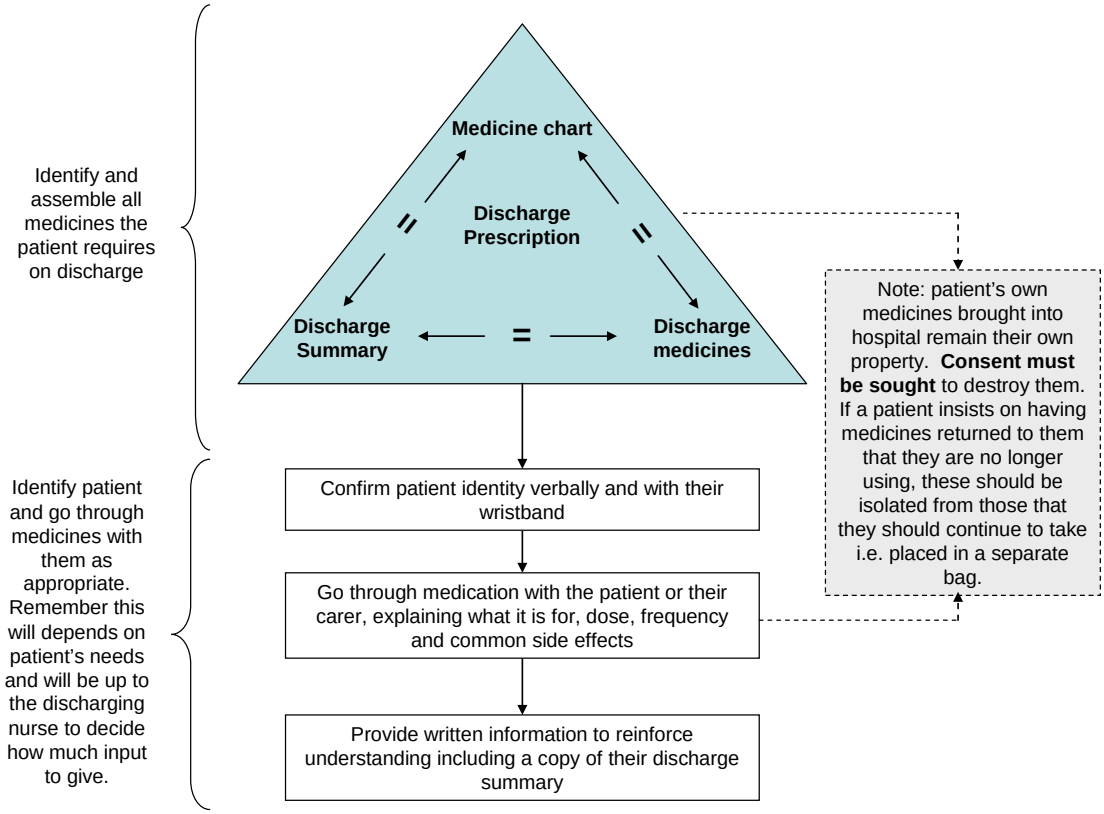
5.4.6. Pharmacy will always attempt to be actively involved in discharges where the service allows.

5.4.7. To maximise the impact when pharmacy cannot be involved i.e. outside of working hours, assembly of TTAs at ward level by pharmacy will be completed with nursing staff wherever possible.

5.5. Assembly of TTAs in readiness for discharge

5.5.1. The underlying principles of assembling a TTA ready for a patient are summarised by the diagram below. If used properly the consolidation of the three elements; drug chart, discharge summary (or medicine record chart in some intermediate care areas) and medicines will ensure the discharge medicines and discharge information match and are accurate before it is given to the intended patient.

Summary of Process



5.5.2. Remove all medicines from the patient's medicine locker. Do not forget any patient's own CD drugs that may be locked in the ward CD cupboard or items that may be in the drug fridge.

5.5.3. When applicable (see 5.1.4) check that a discharge summary has been completed by the doctor ensuring

- It is legible and has a date
- It has been generated or signed by an authorised doctor
- Allergies are noted either in the space provided in the summary or documented elsewhere and complete

Ensure the discharge summary corresponds **exactly** to the inpatient medicine administration chart. Any anomalies should be highlighted to the doctor for clarification and amendment to the discharge summary or inpatient chart (both must match exactly).

5.5.4. For intermediate care areas that do not have access to a discharge summary a completed medicine record chart should be generated in accordance with the 'Guidelines for the Completion of Patient Held Medication Record Charts'.

5.5.5. Check each dispensed medicine or POD corresponds to the inpatient medicine administration chart and discharge summary / medicine record chart by ensuring it is correctly labelled by:

- Ensuring the medicine contents are as labelled
- The label corresponds to the patient details

- The directions on the medicine label correspond to the directions on the discharge summary / medicine record chart and medication order and administration chart

5.5.6. Check each dispensed medicine or POD:

- Is within an expiry date if specified, or was dispensed in the previous 3 months if none specified
- That have a shortened expiry date when opened, e.g. GTN spray, tablets or eye drops, is still in date
- Is in good condition
- Is intact within the original dispensing container
- Has at least one week's supply for acute hospitals or fourteen days supply for community bedded areas of regular drugs and sufficient number of doses to complete the course, e.g. Antibiotics or Steroids. If a Pre-pack is used, ensure the patient knows the duration of the course and it is stated on the label. The patient should be told to discard any remainder by returning the surplus to a community pharmacy after they have completed the course.

5.5.7. Unless a TTA pack is available (see section 5.2) for acute hospitals and community bedded areas, any anomalies with dispensed medicines should be highlighted to the pharmacy team for relabeling or re-dispensing in pharmacy hours. For community bedded areas or acute hospitals out-of-hours this may be rectified with an FP10. A record of the issue of the FP10 prescription including patients name and X number, date, prescription serial number and medicines prescribed should be maintained on the ward for audit purposes.

5.6. Over-labelling / providing TTA packs on discharge

5.6.1. When available medicines may be supplied on discharge in the form of TTA packs or 'gun' labelled medicines providing they comply with the Medicines Act.

5.6.2. On discharge the nurse should ensure that the following are added to the label:

- Patient Name
- Date
- Directions (not necessary for P medicines as directions are part of the pack)
- Duration for courses of medicines e.g. antibiotics or steroids
- Initials of the over-labeller and checker in the space provided when present on the label or on the discharge summary if no space is provided.

5.6.3. Note for safety reasons and assurance purposes these supplies must be checked with a 2nd qualified nurse, Doctor, Pharmacist or approved Pharmacy Technician.

5.7. Giving patients or their carers discharge medicines

5.7.1. All patients must be identified prior to giving them their TTA medicines i.e. confirm the patient name and check their identity / wristband.

5.7.2. Provided that the above procedures in 5.1 and 5.2 are undertaken correctly the medicines may be supplied to the patient.

5.7.3. Medicines patients have brought into hospital with them remain their own property even when discontinued by a doctor. If discontinued medicines are identified during the assembly process permission should be sought to destroy them. If this is not possible they should be returned to the patient isolated from their regular medication e.g. in a separate bag marked 'these medicines no longer form part of your treatment'. It is good practice to document any actions taken.

5.7.4. For each liquid medication ensure that patients receive an appropriate oral syringe (purple enteral syringe), spoon or measuring cup and that patients and / or carers are instructed on their use.

5.7.5. Ensure that the patient receives any additional information regarding their medications, the side effects leaflet and medicines helpline leaflet as well as all patient Information leaflets supplied with the medicine and steroid cards.

5.7.6. Ensure that the patient and / or carer is aware of the basic information about drugs, in particular, drug name, directions for use, indications for drugs and important side effects. Directing to the patient information leaflet in the boxes, side effects leaflet and medicines helpline if further advice necessary.

5.7.7. Staff should recognise that patients with difficulties in understanding information such as learning disabilities or where English is not their first language will need additional time and support.

5.7.8. Refer to the medicines information service if leaflets are required in alternative formats such as community languages, easy read or large print. It may be necessary to refer to interpretation services to aid discharge for patients whose first language is not English.

5.7.9. Where there are duplicate packs of a particular medicine, the person issuing should emphasise that one pack should be finished before starting another.

5.7.10. For patients taking warfarin or other coumarin anticoagulants, ensure the dosage is written in the yellow anticoagulant book and the patient knows when and where to come back for INR blood check.

5.7.11. Remind patients that any other supplies of discontinued medications that they have at home should be returned to the community pharmacy.

5.8. Supporting documents and algorithm

5.8.1. The processes in this document must be used alongside those specified in the following medicines code and policy documents:

- Procedures for Accessing Medicines in Acute Hospital Sites
- Procedures for the Use of Patients Own Medicines on Admission, During Inpatient Stay and at Discharge
- Medicines Management Policy 10: Providing Patients with Information about their Medicines
- Guidelines for the Completion of Patient Held Medication Record Charts

5.8.2. The algorithm in appendix A is a useful checklist for reducing delays at discharge and for improving safety.

6. Equality and Human Rights Statement

Clinicians must ensure they consider religious observances, equality, human rights and the promotion of dignity and respect in relation to prescribing, administering and handling medicines. The principles of informed consent and the Mental Capacity Act should be followed. Refer to the full statements within the Medicines Management Policy: Policies Overview.

ESHT has equality impact assessed this policy.

People who do not have English as their first language may need translation services. These are available on request. Disabled people that may have an impaired ability to understand the principles laid out within this document or during informed consent may require additional support. Clinicians must therefore consider a patient's or carer's capacity for understanding and make attempts to include them in the decision making process by explaining the treatment in a way that is meaningful for the patient or carer.

7. Training

Training on this procedure will be facilitated by pharmacy staff within the clinical environment in accordance with the training needs analysis for medicines management (nursing).

8. Monitoring Compliance with the Document

Compliance will be monitored reactively through the Trust incident reporting system, with medicine related incidents being reviewed fortnightly by the Director of medicines management and pharmacy and subsequently by the relevant Directorate risk management groups

There are no exceptions to compliance

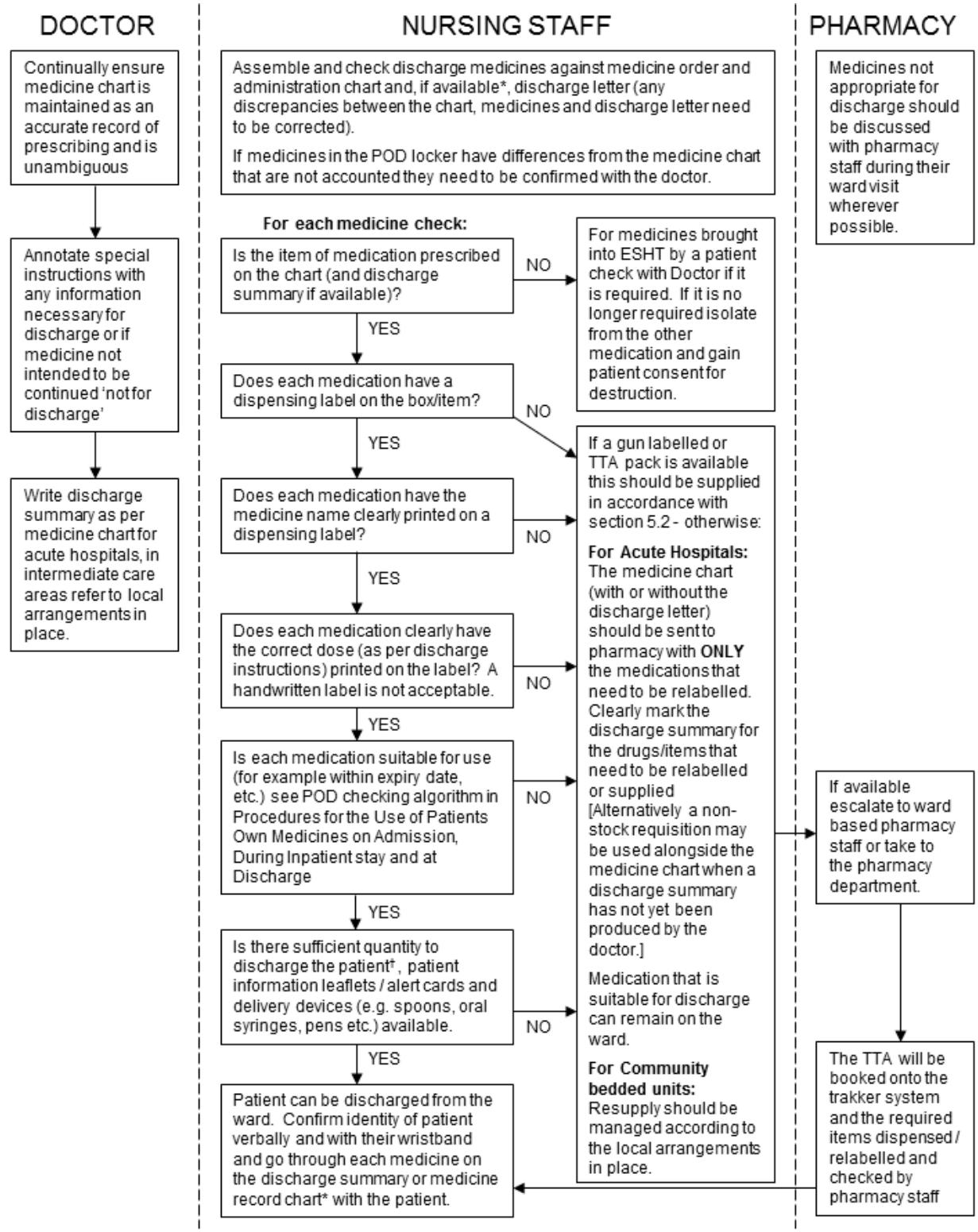
Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Policy Document	Chief Pharmacist	Senior Pharmacy Team review	Every 3 years	Medicines Optimisation Document and Service Development Subgroup	Medicines Optimisation Group	Pharmacy/Division Management Teams
Incidents	Chief Pharmacist	Datix	Ongoing	Medicines Quality Subgroup/Division CG groups	Medicines Optimisation Group	Pharmacy/Division Management Teams

9. References

- NMC, Standards for medicines management, Nursing and Midwifery council, 2010
- Royal Pharmaceutical Society (2011), Part 1; Keeping patients safe when they transfer between care providers – getting the medicines right, Good practice guidance for healthcare professions, available at: http://www.rpharms.com/current-campaigns-pdfs/1303---rps---transfer-of-care-10pp-professional-guidance---final-final.pdf
- Royal Pharmaceutical Society (2011), Part 2; Keeping patients safe when they transfer between care providers – getting the medicines right, A guide for all providers and commissioners of NHS services, available at: http://www.rpharms.com/current-campaigns-pdfs/1303---rps-transfer-of-care-10pp-organisational-guidance---final-final.pdf
- Royal Pharmaceutical Society (2012), Final report; Keeping patients safe when they transfer between care providers – getting the medicines right, available at: http://www.rpharms.com/current-campaigns-pdfs/rps-transfer-of-care-final-report.pdf
- National Institute of Health and Care Excellence (NICE) (2009), CG76 Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence, available at http://publications.nice.org.uk/medicines-adherence-cg76

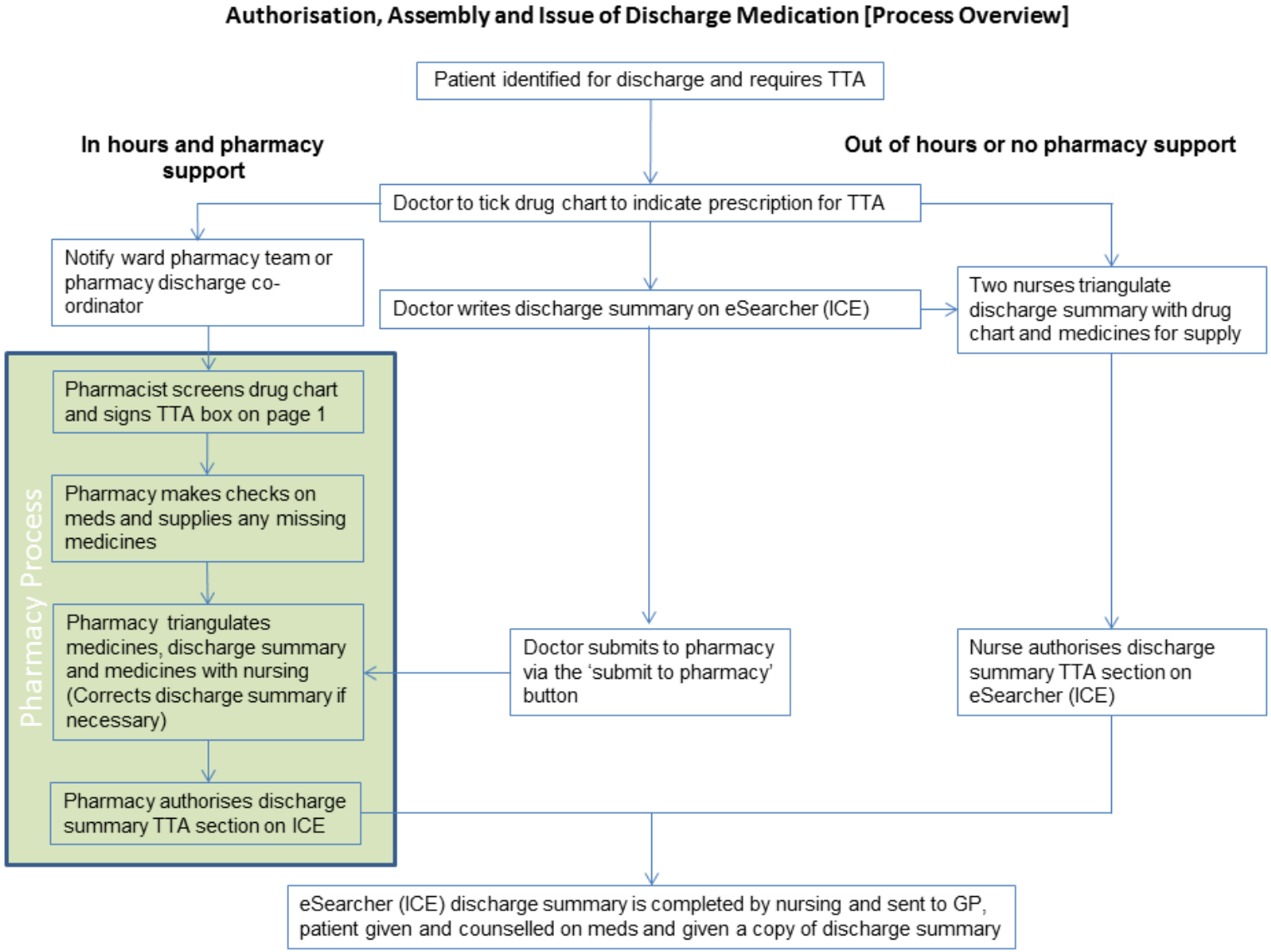
Appendix A: Discharge Prescription Decision Tree



*Discharge letters are available in all acute hospitals and some community health care facilities. A record of the medication given to a patient on discharge must be provided via a medicines record chart to all intermediate care patients and acute patients when appropriate to support discharge.

†Seven days supply in acute hospitals, fourteen days in intermediate care areas or a complete a course of antibiotics / steroids

Appendix B: Overview



Appendix C – EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

East Sussex Healthcare NHS
NHS Trust

Due Regard, Equality & Human Rights Analysis

Title of document: Authorisation, Assembly and Issue of Discharge Medication (TTA / TTO) [Medicines Code]
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.
Please include a brief summary of intended outcome: Patients get medicines on discharge safely

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	(Ensure you comment and link to main policy with page/paragraph number)
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	None	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	See section 6.5.8, 7 and 11. Staff are directed to leaflets for those with learning difficulties and there is an extensive section on equality and human rights.	
5.	**Please evidence how this work / policy seeks to "advance equality of**	This work provides technical guidance.	

	opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?	
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	As above
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	As above
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	Consultation
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No

East Sussex Healthcare NHS Trust

Policy for the Management and Administration of Injectable Medicines

Document ID:	1484
Version:	V2.1
Ratified by:	Medicines Optimisation Group
Date ratified:	4 July 2017
Name of author and title:	[redacted], Lead Nurse. Lisa Redmond, Senior Infection Control Nurse Specialist [redacted], Practice Educator. [redacted], Practice Educator. Rosie Furner, Lead Pharmacist, Out of Hospital Division Jane Starr, Medication Safety Officer
Date Written:	May 2017
Name of responsible committee/individual:	Medicines Optimisation Group
Date issued:	July 2017
Issue number:	2017148
Review date:	31 March 2021
Target audience:	All ESHT Staff
CQC Fundamental Standard:	12
Compliance with any other external requirements (e.g. Information Governance):	NPSA
Associated Documents:	Medicines Policy [Medicines Code] Prescribing Standards [Medicines Code]

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V4.2	January 2010		Changes in line with updated national guidance, new patient information leaflet, updated information on training, clarification on clinical setting for second dose administration of antibiotics, incorporating comments from Medicines Management Committee	
V4.3 2012253	March 2011		Includes policy & SOP for IV flushing	
V4.4 (Community Document - Policy for the Administration of Intravenous Medications within East Sussex Community Health Services)	July 2011		Incorporated relevant elements from the procedure for prescribing, preparing and administering injectable medicines in near-patient areas	
V1.0 2013256	December 2013		Changes in line with updated evidence base and around anaphylaxis probability.	Reformatted in new Trust procedural document format EHRA undertaken New policy statement regarding administration of first doses.
V1.0 2014258	December 2014		To provide a single Trust wide document.	Merging of current Acute and Community policies. Full content of Acute policy exists within the revised policy. Full content of community policy exists within revised policy except that updating competency is via peer review rather than attending an update training day. Reference has now been made to prefilled saline syringes.
V2.0	May 2017	J Starr		Appendix C- double check flow chart for admin and prep of products. Update in line with

				other procedures Include Patient Safety Alert around restricting use of open systems for injectable medicines
V2.1	11 November 2020	J Starr	Extension requested for the review date	Extended the review date from June 2020 to 31 march 2021

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Christina Short	Chief Pharmacist Community Health Services	November 2013
ESHT Medicines Management Group		December 2013
Rosie Furner	Pharmacist, community services	November 2013
Jonathon Palmer	Clinical Pharmacy Manager	November 2013
Steve Rochester	Resuscitation Officer	
Jonathan Palmer	Clinical Pharmacy Manager	November 2014
Practice Educators		November 2014
Rosie Furner	Pharmacist	October 2014
Lisa Redmond	Senior Infection Prevention & Control Nurse Specialist	June 2017
[redacted]	Nurse Specialist, Vascular Access team	June 2017

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

The use of injectable medication has many healthcare benefits for patients. The complexities associated with the prescription, preparation and administration of injectable medicines means that there are greater potential risks for patients than for other routes of administration. Weak operating systems increase the potential risk of harm, and safe systems of work are needed to minimise these risks.

The National Patient Safety Agency (NPSA) circulated an alert in 2007 as they had received around 800 reports a month to its National Reporting and Learning System (NRLS) relating to injectable medicines between January 2005 and June 2006. This represents approximately 24 per cent of the total number of medication incidents with the majority of these resulting in no or low harm to patients. However, as this represents the total number of incidents reported, there may be many more unreported. There have been reports of death and severe harm associated with injectable medicines.

Research evidence indicates that the incidence of errors in prescribing, preparing and administering injectable medicines is higher than for other forms of medicine. In one study, at least one error occurred in 49 per cent of intravenous medicine doses prepared and administered on hospital wards; 1 per cent were judged to be potentially severe errors; and 29 per cent potentially moderate errors.

2. Purpose

2.1. Rationale

The rationale for these procedures are to provide a reference source for clinicians involved in the administration of injectable injections in community settings and as a guide to good practice. This guidance is intended to support training. It is not intended to replace assessment of competence or professional responsibilities related to the administration of medicines.

2.2. Principles

Practitioners must refer to the Medicines Policy [Medicines Code] and NMC Standards for Medicines Management. The overarching principle for the use of injectable medicines is that practitioners should only use injectable routes when it is in the patient's best interests to do so. The risks associated with injectable medicines mean that generally they are the less preferred route within a range of clinical situations; however in certain circumstances the injectable route will be the preferred if not the only option.

It is therefore important that practitioners have the confidence and competency through adequate training to be empowered to make the clinical decisions related to the use of injectable medicines for their patients.

2.3. Scope

This policy is intended to be used by staff within ESHT when patients require administration of injectable medicines.

3. Definitions

Aseptic technique (non-touch technique)

Handling technique designed to minimise the risk of microbial contamination of a sterile medicine during preparation.

Bolus (push)

Administration from a syringe of a small volume of a single dose of a sterile solution directly into a tissue, organ or vein, over a short time of, usually, between 30 seconds and 10 minutes.

Clinical areas

Wards, clinical departments, operating theatres, clinics and GP surgeries. In the context of homecare, the term may also be considered to include the patient's home.

Diluent

Any sterile injection solution, such as water for injection or sodium chloride 0.9%, commonly used to dissolve (reconstitute) or dilute a medicine immediately before administration.

Flush, flushing solution

A sterile solution of diluent such as sodium chloride injection 0.9%, used to purge (flush) access devices (e.g. cannulae) before and/or after injection of a medicine or between injections of different medicines.

Hazard

Any factor (such as a difficult procedure or a complex calculation) with the potential to cause harm if carried out incorrectly.

Infusion

Administration, from a syringe or other rigid or collapsible container e.g. plastic bag, of a volume of sterile solution of an injectable medicine directly into a tissue, organ, vein or artery, at a constant rate, under gravity or by means of an electronic or mechanical pump or other means of rate control, over a defined period usually of at least 10 minutes.

Injectable medicines

Sterile medicines intended for administration by bolus injection, perfusion or infusion by any of the following routes: intravenous, intramuscular, intrathecal, intra-arterial, subcutaneous, intradermal, intraventricular, epidural, intravesicular, intravitreal, intrapleural, intraocular and intraosseus.

Licensed medicine

Medicines (medicinal products) placed on the market in the UK require a Marketing Authorisation formerly called a Product Licence. Marketing Authorisations are granted under European Community Council Directives and Regulations by the Medicines and Healthcare products Regulatory Agency (MHRA) and the European Medicines Evaluation Agency (EMEA). Licensed medicines are manufactured or assembled by commercial organisations that have a Manufacturing Licence and operate Good Manufacturing Practice.

Risk

Risk can be defined as 'the possibility of incurring misfortune or loss,' (Oxford English Dictionary) for example through an unexpected event happening that may either cause harm or have an impact upon patients, staff, visitors, partner organisations, strategic objectives, assets and/or reputation.

4. Accountabilities and Responsibilities

Trust standards apply to all practitioners involved in the administration of injectable medicines.

4.1. Managers

The senior manager for each individual professional group is responsible for ensuring that:

- Education and skills training is available and meets the criteria for the profession and the Trust.
- Suitable arrangements are available for training and assessing agency and bank staff.
- Information on the administration of intravenous drugs and the equipment in use is accessible to all clinical areas where this procedure is undertaken.

It is the responsibility of line managers/ Matrons to ensure that staff involved in the administration of medicines are competent to do so before any preparation or administration is commenced. Evidence of competence should be checked by Temporary Workforce Staff and line managers/ Matrons.

4.2. Practitioners

Practitioners are responsible for undertaking appropriate training, working within their professional constraints, maintain their own competence, and ensure that they decline any tasks which they are not able to undertake in a safe and skilled manner.

5. Procedures and Actions to Follow

5.1. Prescribing of Injectable Medicines

All prescriptions must be written in accordance with Prescribing Standards [Medicines Code]. All prescriptions for injectable medicines must specify the following:

- Patient's name
- Prescriber's signature
- Approved medicine name

- Dose and frequency of administration
- Date and route of administration
- Allergy status of the patient

Where relevant, the prescription, or a readily available local protocol, must also specify the following:

- Proprietary name and formulation of the medicine
- Concentration or total quantity of medicine in the final infusion container or syringe
- Rate and duration of administration
- Stability information to determine the expiry date of the final product
- The age and weight of any patient under 16 years of age, and weight of all patients where relevant for specific medication (especially if considered outside of normal adult weight ranges).
- Date on which treatment should be reviewed
- Arrangements for fluid balance or clinical monitoring should be made on an individual patient basis and according to local protocol and clinical need

5.2. Preparation of Injectable Medicines

Practitioners must check all prescription details carefully and confirm that they relate to the patient to be treated.

The area in which the medicine is to be prepared must be as clean, uncluttered and free from interruption and distraction as possible.

In 2007, the National Patient Safety Agency (NPSA) issued the alert Promoting safer use of injectable medications. This stipulated that injectable medicines must be drawn directly from their original ampoule or container into syringes, and then either administered immediately or, if they are not for immediate use, the syringe is labelled and checked before later use. The 2007 alert was issued in response to errors that occurred when injectable medication was decanted into an 'open system' before administration. 'Open systems' include gallipots or other types of open container such as moulded plastic procedure trays. This practice risks one medication being confused with another, and medication intended for injection being confused with other substances, such as skin antiseptics, that are routinely contained in gallipots or other open containers. Additionally, an 'open system' can become contaminated by bacteria. Only closed systems must be used for preparation of injectable medicines ('Open systems' include gallipots or other types of open container such as moulded plastic procedure trays and are not permitted)

All materials and equipment should be assembled prior to preparing an injectable medicine and include:

- Sharps bin for waste disposal
- The medicine ampoule(s)/vial(s) for preparation
- Diluent
- Syringe(s)
- Safety Needle(s) or blunt fill drawing up needles(s)
- Disinfectant wipes
- Disposable protective gloves (if appropriate)
- ANTT Tray.

The practitioner must check the following:

- Expiry dates
- Damage to containers, vials or packaging
- That medicines were stored as recommended, e.g. in the refrigerator

Practitioners should be aware of the risk of confusion between similar looking medicine packs, names and strengths and make sure they read all labels carefully to avoid risk. Practitioners must 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 and no previous history of anaphylaxis requiring critical care.
- They understand the method of preparation

Care must be taken to calculate the volume of medicine solution needed to give the prescribed dose. It is good practice to write the calculation down and if possible obtain an independent check by another qualified healthcare professional

All prepared medicines must be labelled; it is good practice to do this prior to preparing the injectable medicine.

Hands must be cleansed prior to preparing the medicine in accordance with Trust policy.

Disposable protective gloves should only be worn when directly preparing the medicine and unless the medicine is being drawn up next to the patient, a new clean pair of gloves must be worn for administration of the medicine.

Aseptic technique (a 'non-touch' technique) must be used to avoid touching areas where bacterial contamination may be introduced, e.g. syringe-tips, needles, and vial tops.
NB: Never put down a syringe attached to an unsheathed needle.

Injections must be prepared by following the manufacturer's product information or local guidelines, and the relevant technical procedures contained in section 5.8.

5.3. Administration of Injectable Medicines

5.3.1. Training and Competency

All registered staff that prepare or administer intravenous medications must have completed the competency assessment for administration of intravenous medications. Preparation and administration of intravenous medicines must be in line with professional limitations.

A Registered Nurse who has undertaken training recognised by the Trust and assessment in practice can perform the administration of Intravenous (IV) Medication.

Competency is self-assessed after a period of supervised practice in accordance with the **code**: professional standards of practice and behaviour for nurses and midwives (NMC 2015). Any Nurse who administers IV should evidence competency via documented peer review at least 2 yearly [RCN 2013].

5.3.2. Second Checking (see Appendix C for guidance)

It is the Nursing & Midwifery Council's recommendation that, in the majority of circumstances, a first level registered nurse, a midwife or a second level nurse, each of whom has demonstrated the necessary knowledge and competence, should be able to administer medicines without a second person. It should be noted, however, that double checking is preferable where possible.

In the exceptional circumstance where this is not possible, IVs should be checked by one registrant with another competent person who knows the patient. This could be a parent, a carer or the patient. At a minimum, any dose calculation must be independently checked.

It is considered best practice where practical for the second person to witness the whole procedure from preparation to administration.

A second practitioner checking the medicine and the patient must be competent and confident in their own ability to do this. This second check is to confirm the details of the prescription, the identity of the patient, the identity of the drug, route, strength, dose to be administered and expiry date of the product.

The ultimate responsibility remains with the administering practitioner.

5.3.3. A student nurse under the supervision of a trained nurse is permitted to replace fluid only bags, if the trained nurse is satisfied with their competence.

5.3.4. Agency and bank staff are not permitted to administer or second check injectable medicines unless the ward/department manager has deemed the staff member competent, and this has been appropriately documented. Appendices B and D must be used to support the competency assessments.

5.4. Administration of first doses

The first and subsequent doses of IV therapy may be safely administered by a Medical or Nursing Health Care professional, who has undergone Resuscitation Training, including airway management and anaphylaxis training with the following equipment available:

- Anaphylaxis kit
- Airway management equipment.
- Or a Resuscitation trolley / bag which will contain these

The patient must be under the care of a medical practitioner in both acute and community settings.

A Medical Practitioner must agree to take medical responsibility for the patient.

5.5. Administration of sodium chloride 0.9% as a flush

Sodium chloride 0.9% injection is a prescription only medicine unless provided in the format of a pre-filled device when it is classified as a medical device. However, where practitioners have successfully undertaken additional education in either IV drug administration or cannulation, they may administer sodium chloride 0.9% as part of this practice.

5.6. Administration of medicines in an emergency situation without a prescription

The legislation provides that no-one may administer a parenteral prescription only medicine otherwise than to them self, unless they are an appropriate practitioner or are acting in accordance with the directions of an appropriate practitioner.

The following medicines, likely to be available for use by parenteral administration, are exempt from this restriction when administered for the purpose of saving life in an emergency:

Most commonly used in acute and community	Mainly used in acute care setting
Adrenaline injection	
Chlorphenamine injection	Atropine sulphate and pralidoxime chloride injection
Glucose 50% injection	Atropine sulphate, pralidoxime mesilate and avizafone injection
Atropine injection	Pralidoxime chloride injection
Glucagon injection	Promethazine hydrochloride injection
Hydrocortisone injection	Snake venom antiserum
Naloxone injection	Sodium nitrite injection
Atropine sulphate injection	Sterile pralidoxime

In the event of emergency administration of any of the medicines listed in 5.6 it is always necessary to inform the doctor who must review the patient.

5.7. Patient monitoring

Administration of some intravenous drugs requires particular or constant patient monitoring. When this is the case, treatment should only be initiated in situations where such monitoring can be sustained through the availability of appropriate equipment, and adequate levels of staff with appropriate competencies.

The administration of vancomycin and gentamicin in patients own homes is not routinely undertaken.

Patients receiving sympathomimetic inotropic drugs should preferably be nursed on ITU, CCU or acute areas where appropriate monitoring can be carried out and by staff who have competence in the monitoring of these agents.

In the event of the above treatment areas not being available the patient should be referred to the Consultant Anaesthetist covering ITU, who will advise on safe management and placement of the patient. Similarly if the patient's team believes that it is in the patient's best interests to be nursed elsewhere, despite the need for these agents, the case should be reviewed by the Consultant Anaesthetist covering ITU.

In both cases the nurse bleep holder should be asked to advise on the nursing implications of any plan in respect of the care and monitoring needed.

5.8. Administration of Immunoglobulins

The batch number and expiry date of each individual product must be recorded in the patient's notes. Many products attach a removable section to assist in this.

5.9. Technical procedures for preparing and administering injections

For technical Procedures for preparing and administering injections refer to Appendix C and Medusa for individual monographs.

6. Equality and Human Rights Statement

Note: Equality and human rights issues need to be considered in respect of procuring unlicensed medicines. Informed consent underpins prescribing of unlicensed medicines and as such a patients religious observances (blood or animal derivatives) or disability-related requirements in terms of the preparation of that drug-related to its administration (oral versus intravenous), are taken into account when prescribing unlicensed medicines. The provision of interpretation services during informed consent should also be considered for non or less capable English speaking patients.

7. Training

7.1. Educational requirements

In order to administer drugs by the intravenous route, authorised personnel, with the exception of registered medical practitioners and registered midwives, are required to undertake additional education as deemed appropriate for the specific professional group to which they belong.

In order to meet ESHT requirements, on completion of the educational programme personnel must be able to:

- Access information on the administration of any prescribed drug, in relation to rate, route, volume, vehicle and rate control
- Calculate drug dosage and administration rate
- Understand how to prevent and manage line related complications including infection.
- Prepare and administer drugs using aseptic non touch technique (ANTT)
- Understand drug compatibility/ incompatibility
- Recognise situations in which giving intravenous drugs is contra-indicated
- Recognise and manage adverse reactions to intravenous drugs
- Administer intravenous drugs using an appropriate route and technique
- Select equipment for administration and be able to use it (e.g. Volumetric pumps, Syringe Drivers

Access to Education and Training will be provided by the Learning and Development Department with oversight from Assistant Director of Nursing (Education and Workforce). Guidance on frequency of training and dates available will be listed in the L&D training opportunities brochure.

Appendix B provides a work competence statement, which includes a procedure for preparation, administration and monitoring of injectable medicines with supporting

information, an associated log of practice, and a statement of competence, to provide a record for the staff member.

8. Monitoring Compliance with the Document

It is the responsibility of lead practitioners and line managers to ensure that staff who inject medicines are trained appropriately. Training records will be held and monitored by the learning and development department.

Clinical units are responsible for monitoring compliance; however incidents will be monitored reactively through the Trust incident reporting system, with medicine related incidents being reviewed fortnightly by the Director of Medicines Management and Pharmacy and subsequently by the pharmacy and relevant Risk Management Groups.

9. References

- Nursing & Midwifery Council. Standards for Medicines Management. Accessed via: https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-medicines-management.pdf 2015 edition.
- Nursing & Midwifery Council. The Code- Professional Standards for practice and behaviour for Nurses and Midwives. Accessed via: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf March 2015.
- National Patient Safety Agency. Promoting safer use of Injectable medicines. Accessed via: http://www.nrls.npsa.nhs.uk/resources/?entryid45=59812. March 2007.
- NICE. Drug allergy; Diagnosis and management (CG183). Accessed via: https://www.nice.org.uk/guidance/cg183/chapter/Introduction. September 2014.
- Royal College of Nursing. Competences- An education and training competency framework for administering medicines intravenously to children and young people. Accessed via: https://www.rcn.org.uk/professional-development/publications/pub-003005. August 2013.
- NHS Improvement. Patient Safety Alert- Restricted use of open systems for injectable medications. September 2016. Accessed via: https://improvement.nhs.uk/uploads/documents/NHSI_Patient_Safety_Alert_-_Restricted_use_of_open_systems.pdf

Monitoring Table

Element to be Monitored	**Lead**	**Tool for Monitoring**	**Frequency**	**Responsible Individual/Group/ Committee for review of results/report**	**Responsible individual/ group/ committee for acting on recommendations/action plan**	**Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented**
Incidents	Medication Safety Officer and HoN for Divisions	Datix	Every 2 Weeks	Pharmacy and divisional risk groups. Medication Safety Group	Pharmacy / Clinical Division Management Team	Clinical Division Management Team
Guidelines and Procedure	Medication Safety Officer and Vascular Access team	Review	Every 3 years	Medicines Optimisation Group	Senior Pharmacy Team. Vascular Access team	Clinical Division Management Team
Staff training	Ward Matrons/lead Nurses	Training records	One off training with updates accessed as appropriate via appraisal process	Learning & development compliance coordinator/Assistant Director of Nursing (Education and Workforce)	Learning & development	Clinical Division management Team

Appendix A – EHRA Form
Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

East Sussex Healthcare NHS
NHS Trust

Due Regard, Equality & Human Rights Analysis

Title of document: Policy for the Management and Administration of Injectable Medicines
Who will be affected by this work? Patients and staff
Please include a brief summary of intended outcome: This document is to ensure medicines management procedures are followed to ensure safe prescribing and administration of injectable medicines at ESHT.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	Patient Safety may be affected as high risk injectable medicines may not be obtained or used appropriately.	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	N/A- no one excluded or treated differently	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	N/A	
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected**	N/A	

	characteristic and those who do not" as per the Equality Act 2010?	
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	N/A
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	N/A
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No

Appendix B - Competency Based Assessment Tool for second checking of Intravenous Medication by Temporary Staff

This list of key competencies is designed as a tool to assist with assessing that a temporary member of staff (bank, agency) is competent in second checking intravenous medications.

Name: …… Assessor name: ……..

Date of assessment ……..

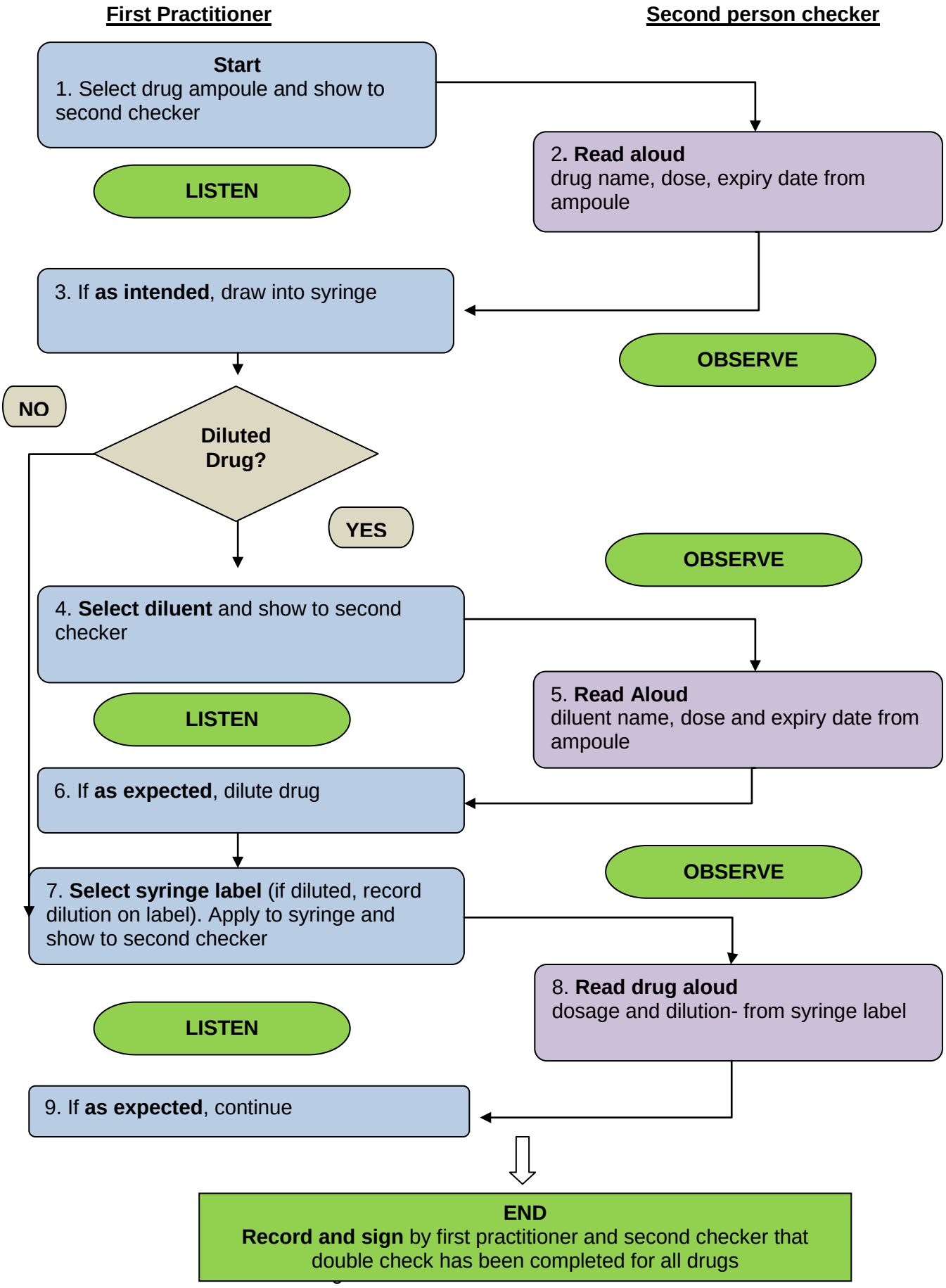
Signed: …… Assessor Signature …….

1.	**Training and Specific Knowledge**	
	The practitioner	
1a.	Is a qualified Nurse or Midwife with current NMC registration	
1b.	Has read the ESHT **"Policy for the Management and Administration of Injectable Medicines"** (available on extranet).	
1c.	Practices within their own competency.	
1d.	Demonstrates knowledge of correct procedure for calculating drug doses and selecting appropriate volume of medicine to administer.	
1e.	Demonstrates knowledge of intravenous catheter site assessment tools including Vascular Infusion Phlebitis Score and Infiltration Scale	
2.	**Effective Troubleshooting and Risk Management**	
2a.	States the correct procedure for managing infiltration /extravasation of a drug.	
3.	**Accountability, Behaviour and Attitudes**	
3a.	Understands and observes patient confidentiality.	
3b.	Communicates and cares for patients in a professional manner.	
3c.	Has an awareness of the implications surrounding accountability issues and consent of patients and an awareness of the mental Capacity Act 2005.	
4.	**Infection Control and Risk Management**	
4a.	Understands ESHT sharps injury policy.	
4b.	Understands the need for effective hand washing techniques, the use of gloves and other Personal Protective Equipment (PPE) as appropriate.	
4c.	Is aware of the need to minimise contamination through adherence to effective aseptic non touch technique during administration of medication and the need for needlefree connectors.	
4d.	Demonstrates knowledge of correct disposal of materials and sharps safely in adherence with ESHT policy.	

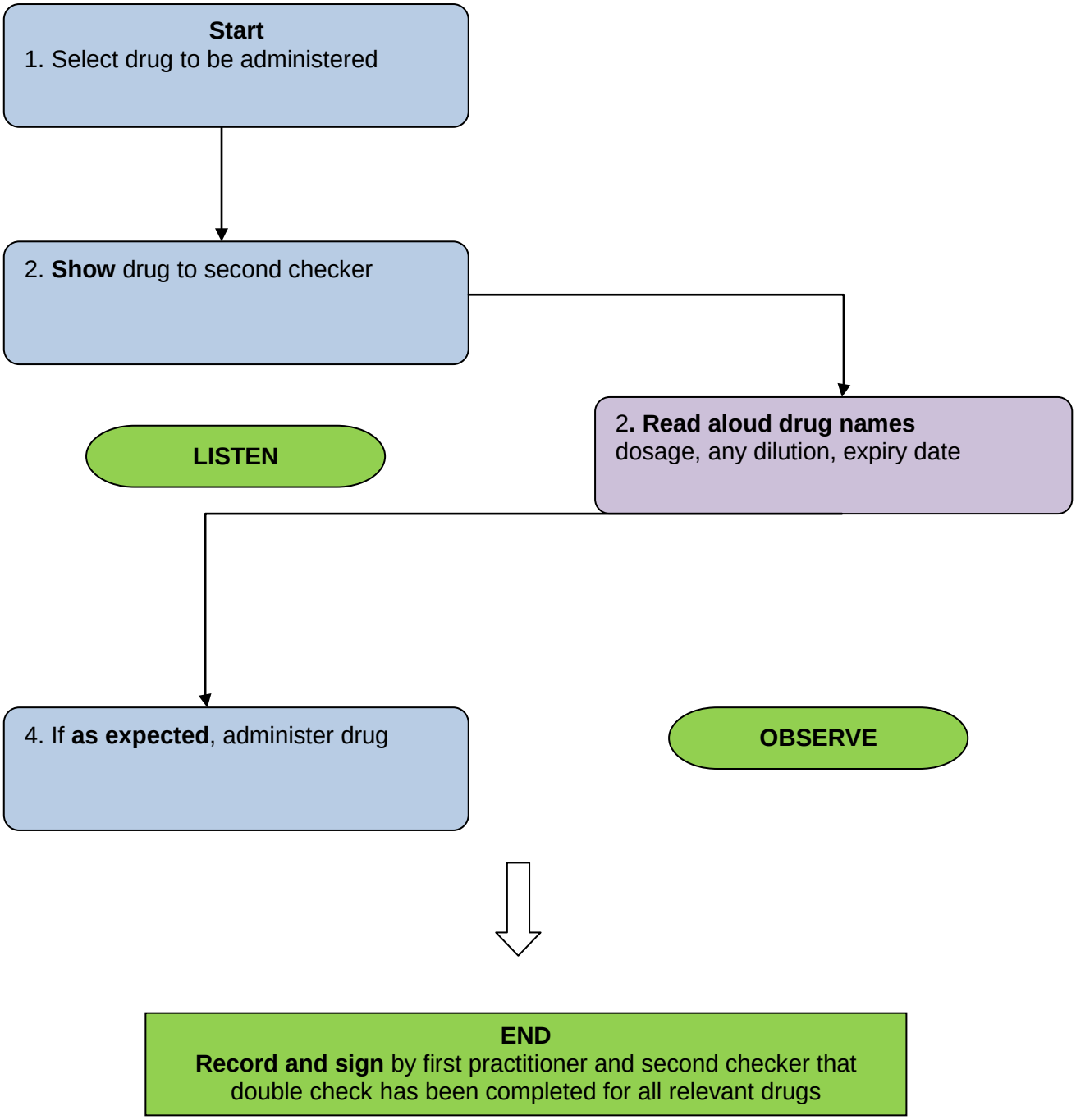
4e.	Demonstrates knowledge of ESHT infusion pumps.	
4f.	Can discuss the risks and hazards/complications of IV medication and take appropriate action in the event of adverse reaction.	
4g.	Recognises when it is inappropriate to administer intravenous medications.	
4h.	Demonstrates knowledge of Trust Incident Reporting procedure	
5.	**Administration of intravenous medication procedure.**	
5a.	Demonstrates correct identification of the patient in accordance with ESHT policy.	
5b.	Obtains appropriate consent prior to administration.	
5c.	The practitioner must check expiry dates, damage to vials/ampoules/bags/infusers or packaging, and that the medicines have been stored as recommended.	
5d.	The practitioner must ensure that infusion labels, where needed, are in use and accurately completed.	
5e.	The practitioner must ensure that closed systems are used. 'Open systems' include gallipots or other types of open container such as moulded plastic procedure trays and MUST NOT be used.	
5f.	Check the formulation, dose, diluent, infusion fluid and rate of administration.	
5g.	Check the patient's allergy status to confirm they have no known allergy to the prescribed drug, or related drug classes. .	
5h.	Take care when calculating the volume of medicine solution needed to give the prescribed dose. Write this down and confirm with colleagues.	
5i.	Confirm with a second check the following: the prescription details, identity of the patient using the wrist band, identity of the drug, route, strength, and dose to be administered, and expiry date of the product.	
5j.	Clean hands prior to preparation and wear gloves for administration.	
5k.	Aseptic non touch technique must be used to avoid touching areas where bacterial contamination may be introduced, e.g. syringe tips, needles and vial tops.	
5l.	Flushes cannula with 0.9% Sodium Chloride (prefilled) prior to and following administration.	
5m.	Dispose of equipment safely in waste/sharps bins.	
5n.	Document procedure correctly on patient's prescription chart/record of administration.	
5o.	Uses needle-less connectors and needle free systems as appropriate in line with manufacturer's instructions	

Appendix C- Flow charts for double checking administration and preparation of drugs (based on NPSA/ Royal College of Anaesthetists)

Double-checking process for drug preparation (Repeat for each drug)



Double-checking process for drug administration (Repeat for each drug)



Appendix D - Work Competence statement

Preparation, administration and monitoring of injectable medicines

Summary	**This practice competence is directly applicable to healthcare professionals who undertake the preparation, administration and monitoring of injectable medicines in clinical areas or the homes of adults or children. It includes** • The interpretation of the prescribed instruction • Reviewing indications and contraindications for use • Calculation of volume and rate of administration plus the amount needed to deliver the required dose • Preparation and labelling of injectable medicines in readiness for administration • Preparation and administration of injectable medicines • Assessment of the patients fitness for treatment • Checking of the medicines against the prescription and patient information • Education of the patient/carer with regards to benefits and side effects • The initiation and delivery of a monitoring regimen
Indicative links to KSF Dimension & level	Health & Wellbeing HWB7: interventions and treatments level 3: Plan, deliver and evaluate interventions and/or treatments
Origin	This is a new workforce competence proposed and developed by the national patient Safety Agency (NPSA) and adapted for use in ESHT
Activity scope	**Key words and concepts** **Prescription** The document, which describes the medication determined by a properly authorised individual for an individually named patient. It includes the medication to be used, the dose, dilution, mode of delivery and time period for delivery. **Monitoring regimen** A systematic plan for observing the physiological impact of prescribed medication therapy, enabling subsequent adjustment to maintain or improve the health of a patient. Communication with professional's colleagues includes communication within and between appropriate members of the teams.

	Appropriate members of the team Include: registered nurse, midwife, doctor, pharmacist, laboratory scientific officer and phlebotomist or any other member of the health or social care team. Adverse reactions related to any fluid or drugs given through a cannula Include: neurogenic, anaphylactic and hypovolaemic shock, cardiogenic shock, septic shock & allergy.
Performance criteria	**Preparation of injectable medicines** **You need to:** 1. Read the patient's notes, prescription and relevant protocol or clinical guideline and identify any special instructions, investigations (including abnormal blood test results), baseline parameters such as weight, or issues for which you need to seek advice. 2. Confirm that the prescription has been written clearly and fully to enable accurate and safe interpretation of the therapeutic instruction intended by the prescription, and also safe preparation. **The prescription should include the following:** • Patients name, hospital/NHS number, date of birth or address; • The allergy status of the patient; • Date and time; • The approved name of the injectable medication (in full, do not abbreviate); • The dose and frequency (ensuring, where necessary, that recent parameters have been used to calculate dose, for example, weight and laboratory test results); • The route of administration, for example, intravenous, sub-cutaneous, epidural; • Date and time for reassessment of the prescription; • Start and finish date/time or maximum number of doses; • Prescriber's signature • Where relevant, the prescription or a readily available local protocol must specify the following: • Brand name and formulation of the medicine; • Concentration of the total quantity of medicine in the final infusion container or syringe;

- Name and volume of diluent or infusion fluid;
- Rate and duration of administration;
- Stability information concerning the medicine to help determine the correct expiry date and time;
- Type of rate control infusion device or pump required;
- The age and weight of all children under the age of 16 years;
- Arrangement for fluid balance or clinical monitoring should be made on an individual basis and according to local protocol and clinical need.

3. Confirm that the parenteral route is the most appropriate route for administration of medication to the patient (i.e. consider and exclude oral or other routes of administration).
4. Assess the appropriateness of the intended treatment against the patient's current health status and concurrent medication
5. Check the medication against the treatment plan, prescription, patient information and local protocol with regard to:

- Patient's identification on prescription chart and on labelled medication;
- Allergy status (where relevant for the medication involved);
- Critical test results (including blood results);
- Regimen and individual medication name;
- Name of medication;
- The medication's fitness for administration (assessed by appearance and condition);
- Diluent and dilution volumes;
- Dose;
- Administration route and duration;
- Type of infusion control device or pump;
- Expiry date/time of the medication.

6. Assemble the required materials in a clean location designed for the task. This area should be uncluttered and free from interruption and distraction. Materials will include; medication ampoules/vials, diluents, needle(s), alcohol wipes, disposable protective gloves, clean re-useable plastic tray and sharps bin for disposal of waste.
7. Check that the medication selected matches with the product described. Check packaging and containers for damage and ensure that the materials have not passed their expiry date. Check that storage up to this point has been as required, for Example, in the fridge.

8. Calculate the volume of medication required to give the prescribed dose. Make a record of the calculation in the patient's notes and arrange for an appropriate co-worker to check the calculation.

9. If require, prepare the label for the prepared medication.

10. Cleanse hands according to local policy and put on a pair of disposable gloves. Disinfect the surface of the plastic tray in which preparation is to be undertaken.

11. Prepare and arrange the medication, diluents and needles on the tray and using a 'non-touch technique' (i.e. avoid touching areas where bacterial contamination may be introduced), prepare the medication according to prescription requirements, with reference to relevant technical information, NPSA guidance on safer use of injectable medication and health and safety procedures.

12. Immediately label the prepared medication (if not used immediately). Do not leave unlabelled syringes or infusion bags unattended or in the presence of other unlabelled medications, as this may lead to error.

13. If multiple preparations of injectable medications are being undertaken, or if there is a delay between preparation and administration, syringes and infusion fluids should be labelled immediately, according to local policy.

14. Place the final syringe or infusion, the empty ampoule/vial and prescription chart in a clean tray for transportation to the patient for immediate administration.

15. Where a monitoring regimen has been prescribed, ensure that appropriate documentation for recording monitored parameters is made available, for example, fluid balance chart.

16. Record the reason(s) for any deviations from the clinical guideline the patient's notes.

17. Communicate with local professional colleagues as required by local guidelines.

18. Recognise when you need help and seek advice and support from an appropriate source when the needs of the individual and the complexity of the case are beyond you competence and capability.

19. Only closed systems must be used for preparation of injectable medicines ('Open systems' include gallipots or other types of open container such as moulded plastic procedure trays.)

Administration of injectable medicines

You need to:

1. Read the patient's notes, prescription and relevant regimen protocol and identify any special instructions, investigations (including abnormal blood test results) or issues for which you need to seek advice.

2. Greet and accurately identify the patient.
3. Introduce yourself and any colleagues involved in the procedure to the patient and/or carer.
4. Assess the patient's physical condition and their fitness for treatment, and seek advice from an appropriate team member if required.
5. Check the medications against the treatment plan, prescription, patient information and local protocol with regards to:
   - Patient's identification on prescription chart and on any labelled medication;
   - Allergy status (where relevant for the medication involved);
   - Critical test results (including blood results);
   - Regimen;
   - Name of medication;
   - The medication's fitness for administration (assessed by appearance and condition);
   - Diluents and dilution volumes;
   - Dose (ensuring where necessary, that recent parameters have been used to calculate dose, for example weight and laboratory test results);
   - Administration route, rate and duration of treatment;
   - Expiry date/time of the medication;
   - Arrangements for fluid balance and clinical monitoring should be made on an individual basis and according to local protocol and clinical need.
6. Explain the treatment and the potential side effects/adverse reaction and their management to the patient and/or carer and accurately answer any questions at a level and pace that is appropriate to:
   - Their level of understanding;
   - Their culture and background;
   - Their preferred ways of communication;
   - Their needs.
7. Check that the patient and/or carer understand the treatment to be given and any potential side effects together with their management.

	8. Prepare the dose, carrying out calculations, dilutions etc in accordance with local policy and with reference to technical information provided for the medication 9. Undertake a final check of the medication against the prescription and the patient's identity before administration, according to local checking procedures. 10. Give the required medication via the prescribed route, at the prescribed rate, according to local medicines administration guidelines or appropriate reference sources, eg Medusa, BNF, eMC, local control of infection and control of substances hazardous to health (COSHH) guidelines. 11. After administration, observe the patient and the site of administration to monitor for immediate adverse effects. 12. Record the administration in the patient's notes, prescription chart and/or patient-held records, as appropriate, according to local guidelines. 13. Dispose of waste materials (sharps etc) in accordance with local guidelines.
	Monitoring the administration of injectable medicines **You need to:** 1. Read the patient's notes, prescription and relevant protocol or clinical guideline and note any previously identified special instructions, investigations (including abnormal blood test results), baseline parameters such as weight, or issues for which you need to seek advice. The arrangements for fluid balance or clinical monitoring should be made on an individual basis and according to local protocol and clinical need. 2. Assess the appropriateness of the intended treatment against the patient's current health status and concurrent medication. 3. Refer to the technical information relating to the injectable medication being prescribed and identify any monitoring recommendations for which you need to seek advice. 4. Determine the appropriate regimen for the patient and include both type and frequency of monitoring activity. Give consideration to fluid balance, potential effect of interaction between concurrent medications, adverse reactions, access site, laboratory tests and physical parameters, for example, weight. 5. Record requirements for monitoring the patient's response to treatment and record the reason(s) for any deviations from the clinical guidelines in the patient's notes. Communicate requirements to professional colleagues.

	6. Explain the treatment and potential side effects, monitoring regimen and their management to the patient and/or carer and accurately answer any questions at a level and pace that is appropriate to: • Their level of understanding • Their culture and background • Their preferred ways of communicating • Their needs 7. Check that the patient and/or carer understand the treatment to be given and any potential side effects together with their management. Communicate the role that the patient and/or carer can play in the early alert of staff to adverse reactions to medication therapy and how this assists the monitoring process. 8. Ensure that local arrangements are in place to deliver the monitoring regimen requested according to local policy. 9. Record the results of monitoring in the patient's notes, on the prescription chart, or on the monitoring chart according to local policy. 10. Communicate results of monitoring to members of the clinical team and ensure that any deviations from expected monitoring results are communicated in a timely way to appropriate members of the team so that action can be taken. 11. Modify any subsequent prescriptions in light of the patient's tolerance, side effects, adverse reactions, complications and response to treatment.
	Adapted from the National Patient Safety Agency Competency Tool formulated using skills for health and KSF frameworks (2007)

Registered Healthcare Practitioner Training

Intravenous Drug Administration Log with Reflection

Date	Details (what I did well, what could have been done better)	Successful? (√)	Number

NAME……

PERSONAL RECORD OF SUPERVISED PRACTICE I.V DRUGS

DATE	VENUE	DRUG GIVEN	SUPERVISOR

IT IS RECOMMENDED AT LEAST 3 I.V. DRUGS TO BE SUPERVISED AND 10 RECORDED

Assessment of competence for registered Health Care Practitioner

Clinical Skill: Intravenous Drug and Fluid Administration

Name: **Ward/Dept:**

_____ **_____**

Aim: Safe Preparation, Administration and Monitoring of Intravenous drugs and fluids

Objectives: The practitioner will be able to: demonstrate competence in preparing for and performing the procedure, and monitoring the therapy.

Training: Attendance at an approved training session(s) or evidence of attendance of training elsewhere and demonstration of knowledge of trust policy

Assessment: Using the performance criteria overleaf. A competent colleague will assess practitioners. Practitioners will be supervised until they can demonstrate the competence to perform independently and safely

Update: Competence to be reviewed annually at annual appraisal

I confirm that the Registered Healthcare Practitioner named overleaf has completed the Assessment competently

Date:	**Assessor Signature:**	**Print name:**

Assessor Comments:

Candidate comments:

Declaration:
I confirm that I have had theoretical and practical instruction on how to safely administer intravenous drugs and fluids, and agree to comply with the policy and procedures of the Trust.

Appendix E - Assessment and Referral Form for ACUTE to COMMUNITY step down IV therapy

Attach the completed HSCC referral form and/or Background Information and Contact Assessment (BICA) form.

To be completed by the referring Medical or Nursing Health Care professional.

Section 1

REFERRAL CRITERIA, RISK ASSESSMENT AND PATIENT INFORMATION			
The Patient	YES		NO
Aged 18 or over?	☐		☐
Suitable for intravenous therapy at home?	☐		☐
Fully informed, understands, consents to home intravenous therapy and has been given the patient information leaflet?	☐		☐
Known to have a history of anaphylaxis requiring critical care treatment?	☐		☐
Known reaction to medication (if yes please specify)…… Referring doctor to be contacted for advice where there are concerns.	☐		☐
Known to have a history of drug abuse?	☐		☐
Known to have a history of poor compliance?	☐		☐
Known to have a history of dementia/confusion?	☐		☐
Has adequate venous access? (if longer than 2 weeks, consider PICC line) N.B. Peripheral cannuale **MUST** be changed just prior to discharge	☐		☐
Immunocompromised, receiving immuno-suppressive treatments, or otherwise have an increased vulnerability to infection?	☐		☐
The home setting	YES		NO
Has access to a telephone	☐		☐
Has running water and electricity in the house	☐		☐
Is the environment a suitable place to conduct clinical care (e.g. in relation to pets, infection control, health and safety, space, cleanliness, access to hand washing facilities)	YES	Not known	NO
	☐	☐	☐
The Medicine	YES		NO
Can be administered by any other route that is as effective	☐		☐
Maximum frequency of administration of IV Therapy acceptable to service provider (Check community capacity to do this via HSCC)	☐		☐
Drug infusion time to be no more than 30minutes depending on service provider.	☐		☐
Capacity for all doses to be administered by a resus and airway management trained practitioner who has access to anaphylaxis kit and airways at each visit	☐		☐
Confirmed with HSCC that the service provider have the capacity and capability to receive patient on caseload for treatment	☐		☐
Medical responsibility for the patient has been identified	☐		☐
Has no special monitoring or safety requirements ***(if 'YES' go to Section 2)***	☐		☐

Ticks in any of the shaded boxes exclude the patient from domiciliary IV therapy. Consider a community intermediate care bed, or contact community duty phone via HSCC to discuss

Section 2

Patient's name:	**Date Of Birth:**
Intravenous drugs to be administered:	
Date and Time IV Therapy commenced:	
Date of review of IV Therapy / treatment, if needed:	
Blood Monitoring – only relevant for In-Patient	
Is blood monitoring required? Y/N If 'yes', what monitoring is required and how often?	
Peak or trough levels required? Who will review these results?	
IV Access	
Type: Complications with line/access? Yes/No If 'Yes', consider insertion of PICC line	
Date of insertion: Comments:	
Anaphylaxis Risk Assessment	
Patients who have suffered previous anaphylactic reaction needing critical care treatment must not be accepted for IV Therapy in the community	
Known allergies:	
If the patient has a previous allergic reaction, what type of reaction was it?	
Is there any cross-sensitivity between the medicine to be administered and the substance that caused a previous reaction?	
Has the patient had the prescribed medication? (Orally or IV) Y / N	
How many doses of the current regime have been administered?	
Referring doctor to be contacted for advice: Contact numbers: Bleep number: Doctor's signature: Print: Date:	

Appendix F - Assessment and Referral Form for COMMUNITY IV therapy – cellulitis pathway

Attach the completed HSCC referral form and/or Background Information and Contact Assessment (BICA) form.

To be completed by the referring Medical or Nursing Health Care professional.

REFERRAL CRITERIA, RISK ASSESSMENT AND PATIENT INFORMATION			
The Patient	YES		NO
Aged 18 or over?	☐		☐
Suitable for intravenous therapy at home?	☐		☐
Fully informed, understands, consents to home intravenous therapy and has been given the patient information leaflet?	☐		☐
Known to have a history of anaphylaxis requiring critical care treatment?	☐		☐
Known reaction to medication (if yes please specify)…… Referring doctor to be contacted for advice where there are concerns.	☐		☐
Known to be allergic to penicillins and/or cephalosporins?	☐		☐
Known to have a history of drug abuse?	☐		☐
Known to have a history of poor compliance?	☐		☐
Known to have a history of dementia/confusion?	☐		☐
Systemically unwell (e.g. feverish, vomiting, hypotensive, tachycardia, etc)	☐		☐
Presenting with cellulitis of the leg only?	☐		☐
Presenting with cellulitis covering more than half the limb?	☐		☐
Presenting with a rapidly deteriorating cellulitis, or with necrosis?	☐		☐
Known to have severe renal failure (eGFR <10 ml/min)?	☐		☐
Known to have a history of MRSA infection or colonisation?	☐		☐
Known to have a history of C. difficile associated diarrhoea?	☐		☐
Has adequate venous access? (if longer than 2 weeks, consider PICC line)	☐		☐
Known to have a history of multi resistant enterobacteriaceae?	☐		☐
Known to have had a recent acute admission for treatment of cellulitis?	☐		
Immunocompromised, receiving immuno-suppressive treatments, or otherwise has an increased vulnerability to infection?	☐		
Capacity for all doses to be administered by a resus and airway management trained practitioner who has access to anaphylaxis kit and airways at each visit	☐		☐
Confirmed with HSCC that the service provider has the capacity and capability to receive patient on caseload for treatment	☐		☐
Medical responsibility for the patient has been identified	☐		☐
The home setting	YES		NO
Has access to a telephone?	☐		☐
Has running water and electricity in the house?	☐		☐
Is the environment a suitable place to conduct clinical care (e.g. in relation to pets, infection control, health and safety, space, cleanliness, access to hand washing facilities)	YES	Not known	NO
	☐	☐	☐

Ticks in any of the shaded boxes exclude the patient from this pathway. Please arrange acute admission.

Appendix G - Assessment and Referral Form for COMMUNITY IV therapy – pneumonia pathway

Attach the completed HSCC referral form and/or Background Information and Contact Assessment (BICA) form.

To be completed by the referring Medical or Nursing Health Care professional.

REFERRAL CRITERIA, RISK ASSESSMENT AND PATIENT INFORMATION			
The Patient	YES		NO
Aged 18 or over?	☐		☐
Suitable for intravenous therapy at home?	☐		☐
Fully informed, understands, consents to home intravenous therapy and has been given the patient information leaflet?	☐		☐
Known to have a history of anaphylaxis requiring critical care treatment?	☐		☐
Known reaction to medication (if yes please specify)…… Referring doctor to be contacted for advice where there are concerns.	☐		☐
Known to be allergic to the proposed antimicrobial agent(s)?	☐		☐
Known to have a history of drug abuse?	☐		☐
Known to have a history of poor compliance?	☐		☐
Known to have a history of dementia/confusion?	☐		☐
Systemically unwell (e.g. feverish, vomiting, hypotensive, tachycardia, etc)	☐		☐
Presenting with pneumonia CURB-65 score 1 or 2 (moderate severity)	☐		☐
Presenting with a rapidly deteriorating pneumonia?	☐		☐
Known to have severe renal failure (eGFR <10 ml/min)?	☐		☐
Known to have a history of MRSA infection or colonisation?	☐		☐
Known to have a history of C. difficile associated diarrhoea?	☐		☐
Has adequate venous access? (if longer than 2 weeks, consider PICC line)	☐		☐
Known to have a history of multi resistant enterobacteriaceae?	☐		☐
Known to have had a recent acute admission for treatment of pneumonia?	☐		
Immunocompromised, receiving immuno-suppressive treatments, or otherwise has an increased vulnerability to infection?	☐		
Capacity for all doses to be administered by a resus and airway management trained practitioner who has access to anaphylaxis kit and airways at each visit	☐		☐
Confirmed with HSCC that the service provider has the capacity and capability to receive patient on caseload for treatment	☐		☐
Medical responsibility for the patient has been identified	☐		☐
The home setting	YES		NO
Has access to a telephone?	☐		☐
Has running water and electricity in the house?	☐		☐
Is the environment a suitable place to conduct clinical care (e.g. in relation to pets, infection control, health and safety, space, cleanliness, access to hand washing facilities)	YES	Not known	NO
	☐	☐	☐

Ticks in any of the shaded boxes exclude the patient from this pathway.
Please arrange acute admission

East Sussex Healthcare NHS
NHS Trust

Appendix H- COMMUNITY NURSING ADMINISTRATION CHART (PAGE 1 OF 2)

GP:			**NHS No:**			**DISTRICT NURSE:**	
Name:			**Date of Birth:**	**Weight (kg):**		**Contact Number:**	
Address:				**Allergies/Hypersensitivities:**			
Name of Medication (to include drug, diluent, flush, infusion fluid)	**Dose/Range**	**Route of administration**	**Frequency of administration**	**Date**	**Length of treatment**	**Prescriber's signature**	**Prescriber's name**

East Sussex Healthcare NHS
NHS Trust

COMMUNITY NURSING ADMINISTRATION CHART (PAGE 2 OF 2)

Date	Time	Name of Drug	Dosage Given	Route and Site	Stock Left	Batch Number & Expiry date	Signature

Administration record for medicines other than syringe drivers and their bolus doses

- Community Nursing Administration chart

Appendix I - Community Nursing Administration chart – Ceftriaxone

GP:	**To be used for ceftriaxone administered by Community Nursing Staff**		**LEAD NURSE:**
Name:	**Date of Birth:**	**Weight:**	**Contact Number:**
Address:			**Allergies/Hypersensitivities** / **Weight/kg**

Name of Medication	**Dose/Range**	**Route of administration**	**Frequency of administration**	**Date**	**Length of treatment**	**Prescriber's name**
CEFTRIAXONE	1 gram/2gram* *Delete as applicable – as per age and weight dose selection criteria	Intravenous	Once a day			
SODIUM CHLORIDE 0.9%	10ml	Intravenous	Once a day – Flush cannula before administration of			
SODIUM CHLORIDE 0.9%	10ml	Intravenous	Once a day – Flush cannula after administration of			

Ceftriaxone dosage criteria by age and weight
1 gram - all patients 60 years or older, also younger patients weighing 80kg or less
2 gram – patients under 60 years AND weighing more than 80kg

Ceftriaxone reconstitution instructions
1 gram – reconstitute vial with 10ml water for injection, mix thoroughly and administer over 4 minutes.
2 gram – this is brand specific - reconstitute the vial contents as directed by package insert/summary of product characteristics.

East Sussex Healthcare NHS Trust

Medicines Policy [Medicines Code]

Document ID Number:	1508
Version:	V2.7
Ratified by:	Medicines Optimisation Group
Date ratified:	21st October 2021
Name of author and title:	Jane Starr, Medication Safety Officer
Date originally written:	May 2015
Date current version was completed:	October 2021
Name of responsible committee/individual:	Medicines Optimisation Group
Date issued:	2 November 2021
Review date:	October 2023
Target audience:	All staff involved in handling medicines within ESHT
Compliance with CQC Fundamental Standards:	Safe Care and Treatment Good Governance
Compliance with any other external requirements (e.g. Information Governance):	N/A
Associated Documents:	All Medicines Code Documents Management of Controlled Drugs Policy Counter Fraud and Bribery Policy Management of Security Policy

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2015101	May 2015	Jonathon Palmer, Deputy Chief Pharmacist	Improvement of medicines management systems within the Trust and the creation of a single overview and policy document that signposts users to relevant procedural documents and guidelines	Merger of existing medicines management policy statements into the medicines management overview document to create a single reference source for delivering medicines management. Replaces the following Medicines Management Policies: ▪ 1: Procurement, Acquisition and Receipt of Medicines ▪ 3: Storage and Security of Medicines ▪ 4: Transfer and Transportation of Medicines ▪ 5: Administration of Medicines ▪ 6: Homely and Alternative Remedies ▪ 9: Cytotoxic Drugs ▪ 10: Providing Patients with Information about their Medicines ▪ 13: Unlicensed Medicines, Clinical Trials and Medicines used 'Off-Licence' ▪ 14: Supply and Dispensing of Medicines to ESHT Patients ▪ 15: Disposal of Medicines [Renamed] ▪ 16: Verbal Orders for Medicines ▪ Policy on the Pharmaceutical Management of Patients with Drug, Solvent or Alcohol Problems
V1.1 2017075	March 2017	Jane Starr Medication Safety Officer	Addition of 2nd checking by nurses	Amendment of section 5.5.10 and addition of Appendix C
V2 2017170	June 2017	Rosie Furner Lead Pharmacist – Out of Hospital Division	Updated to reflect extended services in community setting provided by non-registered staff.	Activities undertaken by non-registered staff in the community setting as part of the Integrated Community Service, in the absence of registered staff, have been added to the following sections: 5.3.8.2; 5.5.1; 5.5.11; Appendix B
V2.1	March 2019	Jane Starr MSO	Recommendations from incidents/ safety alerts	Add in weights of patient and fire risk with paraffin containing products. Update shared care/ outpatient prescribing.
V2.2	May 2020	Jane Starr MSO	Unlicensed medicines	Clarify unlicensed and off label governance and responsibility due to

				recent incident
V2.3	November 2020	Jane Starr	Additional sentence	Under Section 5.3.8.3 It is the responsibility of the ward manager to ensure that medicines are stored appropriately and are within the expiry date and there should be a process in place for regular expiry date checking on each ward or unit where medicines are kept as stock
V2.4	17 June 2021	Jane Starr	Extension to Review date this needs to be reviewed and approved	Extended review date from May 2021 to 30 September 2021
V2.5	09 September 2021	Jane Starr	Extension to Review date this needs to be reviewed and approved	Extended review date from 30 September 2021 to September 2022
V2.6	20/10/2021	Jane Starr	Additional information regarding nebulised meds	To add assurance that trust policies comply with NatPSA/2021/003/NHSPS-Eliminating the risk of inadvertent connection to medical air via a flowmeter
V2.7	11 April 2023	Jane Starr	Extension from September 2022 to October 2023	Extended review date to allow time to update the policy

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Alice Webster	Director of Nursing	October 2014
Amanda Isted	Pharmacy Operations Manager	October 2014
Angela Colosi	ADN (East)	October 2014
Brenda Lynes O'Meara	ADN (Safeguarding)	October 2014
David Hughes	Medical Director	October 2014
Deidre Connors	Head of Nursing (Specialist Medicine)	October 2014
Emma Jones-Davies	Medicines Management Nurse	October 2014
Ian Bourns	Chief Pharmacist	October 2014
James Wilkinson	Assistant Medical Director - Quality	October 2014
Lead Pharmacists Group		October 2014
Lindsey Stevens	Deputy Director Nursing / Midwifery	October 2014
Lucy Scragg	ADN (West)	October 2014
Medicines Policy and Procedure Group		January 2015
Melanie Adams	Pharmacy Governance Manager	October 2014
Nick McNeillis	Assistant Medical Director - Operations	October 2014
Simon Walton	Consultant Anaesthetist	October 2014
Éanna McKnight	Head of Legal Services (Solicitor)	March 2015
Tina Lloyd	ADN (Infection Prevention and Control)	October 2014
TNMAG		March 2015

Medicines Optimisation Group	July 2017
Medicines Optimisation Group	March 2019
Medicines Optimisation Group	May 2020

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

This policy provides a clear framework within East Sussex Healthcare Trust (ESHT) for all medicine management processes that are designed to lead to the safe, efficient and cost-effective use of medicines. Together with other medicines policies, working procedural or guidance documents, grouped collectively together as the medicines code, it provides the ESHT interpretation of the current legislative framework. This approach is aimed at delivering good practice in the safe and secure handling of medicines within ESHT and ensuring that the process driven medicines management agenda is aligned with the objectives of medicines optimisation.

The scope of policies can be broad and therefore not always address all circumstances related to medicine management in a specific clinical area. The combination of the underpinning principles of the policies, specific systems and procedures in place for common and high risk practice, professional standards, leadership of staff, training and governance processes such as audit, provide a framework for achieving the aims of ensuring patient safety and gaining the optimal clinical outcomes for patients. The importance of reflecting and learning from medication related incidents both personally and organisationally is a fundamental requirement for ensuring this framework and the organisation functions at its best.

2. Purpose

2.1. Rationale

The expectation for the Management of Medicines in ESHT is set with the requirement to comply with legislation within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Under Regulation 13: The Management of Medicines, the registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Because of the volume and variation of medicine use and the complexities often involved in medication incidents they are one of the commonest types of error reported nationally. Whilst part of the rationale for this policy is to provide the framework for medicines management within the Trust to comply with the legislation and CQC requirements, principally the desired outcome of this policy is to ensure that patient safety is assured within ESHT through good medicine management practices.

2.2. Principles

The underlying aim for the medicine management documents within ESHT is to ensure that patients receive safe care. This can be achieved by ensuring the following:

- A governance framework exists for medicines management within the Trust.
- Staff are clear of the expectations on them with respect to their role within medicines management
- Staff are adequately informed and trained to undertake their role and expectations within medicine management.
- The organisation, teams and individuals learn from clinical incidents related to medicines and proactively change processes and practice as a result.
- A programme of providing assurance of compliance exists to identify and proactively reduce risk and patient safety incidents related to medicine use.

Within ESHT medicines management is focussed on the patient journey. Our responsibilities begin when the patient is referred to or access our services for the first time and often continue beyond discharge. The diagram in Appendix A provides an overview of the patient journey, where the risks lie and how the main principles of medicines management apply to them. These principles, listed below, are used to group the medicine management policy statements and therefore provide a clear link back to how the organisation manages the risk present from medicines.

The principles are:

- Patients are kept safe because we follow processes to ensure their medication regime is accurate, up to date and appropriate.
- Patients are actively encouraged, through shared decision making, to be involved in the decisions about the medication they are prescribed and therefore help optimise their own treatment outcomes (medicines adherence).
- Patients are kept safe because we follow processes that ensure medicines we provide are handled correctly and in line with national recommendations and best practice.
- Patients are kept safe because we follow processes that mean patients can access the medicines they need in a safe and timely way.
- Patients are kept safe because we follow processes that mean patients are administered medicines in a safe and timely way.
- Staff respect patients and carers role in shared decision making by ensuring information about the medicine being prescribed or administered is made available to them or others acting on their behalf whenever possible.
- ESHT and its staff act with openness within a learning culture that adapts processes as a result of medication incidents and errors to ensure that patients are kept safe.

2.3. Scope

Whilst the scope of this policy applies to all staff working within ESHT who have contact with patients, it is recognised that the detailed and technical aspects of medicines management may not be applicable to all staff groups; however a basic awareness of and referral to this document when necessary is expected for all members of ESHT clinical staff.

As a subgroup of medicines management the use of controlled drugs within the Trust is a high risk area that has legislative requirements requiring firm control. A separate document, 'Controlled Drugs: Safe Use and Management [Medicines Code]', exists to cover the practices.

Clinical staff that regularly come into contact with medicines must have a working knowledge of both medicine policies and use them together with the other medicines management documents as a primary reference source when dealing with medicine use within ESHT. Additionally staff with professional responsibilities with respect to medicine use e.g. medical staff, registered nurses and midwives, pharmacists, pharmacy technical staff and other non-medical prescribers will be required to have more than the superficial depth of understanding that the documents provide as required by their professional regulators.

3. Definitions

Throughout the document the term "Practitioner" is used. This is a general term used to describe a qualified medical practitioner, nurse, midwife, pharmacist or other authorised

healthcare employee. A glossary of terms and abbreviations used within this policy and throughout medicines management is in Appendix B.

4. Accountabilities and Responsibilities

4.1. Chief Executive

The **Chief Executive** is the registered person and has overall accountability for the safe and secure handling of medicines under regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

4.2. Chief Pharmacist

The **Chief Pharmacist** has a delegated responsibility for all aspects of the safe and secure handling of medicines and is the Accountable Officer for controlled drugs.

4.3. Medical Director (Governance)

The **Medical Director (Governance)** is the Board member with responsibility for the safe and secure handling of medicines.

4.4. Medicines Optimisation Group

The **Medicines Optimisation Group** is responsible for providing oversight to medicines issues within the Trust.

4.5. Heads of Nursing or Midwifery, Matrons and Clinical Service Managers

Heads of Nursing or Midwifery, Matrons and Clinical Service Managers are responsible for ensuring:

- Staff working in areas under their control are aware of how to access this policy via the extranet.
- Monitoring and ensuring the policy is implemented in clinical practice by all professionals involved and for reporting any deficits to the Medicines Policy and Procedure group.
- All clinical staff attend appropriate medicines management training.

4.6. Team Managers and Senior Nurses/Midwives

Team Managers and Senior Nurses/Midwives are responsible for ensuring staff have read understood and adhered to the chapters of the policy relevant to each individual's scope of practice especially any matter which may differ from procedures elsewhere.

4.7. All Staff

All Staff must familiarise themselves with the correct procedures contained in this policy, if they are in any way involved in the use of medicines. Each individual's responsibility with respect to prescribing, ordering, dispensing, storing and administration of medicines are detailed within the text of this document.

4.8. Pharmacy

The role of the **Pharmacy** is to:

- Advise on and monitor the safe, effective and economic use of medicines.

- Procure and ensure the quality of medicines.
- Arrange supply of and/or dispense medicines.
- Undertake medication review
- Provide medicines for discharge.
- Advise patients on their use of medicines when appropriate.

5. Procedures and Actions to Follow

5.1. Ensuring Accuracy and Safety with a Patient's Medication Regime

Principle 1: Patients are kept safe because we follow processes to ensure their medication regime is accurate, up to date and appropriate.

5.1.1. Sensitivities, Allergies and Other Observances

Information on allergies and sensitivities is relevant to all aspects of the safe use of medicines within patient care. This information should not be confined to medicine sensitivities or allergies as some other potential allergens, such as latex, peanut oil, egg protein or soya may be present in a medication or a formulation.

Prescribers are responsible for ensuring that any history of allergies or sensitivities is recorded in the appropriate section of the patient record, medicines order and administration chart (drug chart) and discharge information.

Patients' allergy status must be checked before administering any medicines and when this is missing from the patient records, e.g. the allergy status section on drug charts has not been completed; the healthcare staff administering medication must take steps to ensure it is updated. This can involve referral back to the medical team or physically updating the record themselves.

Conversations about allergies and sensitivities with patients must be fully documented in the notes to ensure that the nature and history of the allergy is present, particularly as this may affect the medicines a patient can be treated with in the future.

It is the responsibility of all healthcare staff involved in a patient's care to ensure patients with documented allergies have the correct wristband (or other locally agreed procedure if appropriate) for identification in line with the Policy for Identification of Patients.

Pharmacy staff when conducting medicines reconciliation, clinical screening and checking of medication order and administration charts or discharge summaries must take steps to ensure that the appropriate sensitivities and allergy section is complete.

Religious and cultural observances can impact on choices about medicine use for an individual patient. Staff must take steps to ensure that these are discussed with patients as part of the option appraisal for choosing drug treatment. Advice and assurance can often be sought from local religious leaders on behalf of concerned patients as to their interpretation of the observance and these can be accessed through the equality and human rights service. Medicines which should be avoided due to religious preferences or beliefs should be documented with an explanation in the patients notes and on the drug administration chart. The pharmacy Medicines Information Service can provide advice on medication origin and potential alternatives that can be used during option appraisal.

5.1.2. Medication History Taking and Medicines Reconciliation

It is essential that prescribers and other healthcare workers have access to the most up to date records of medicines a patient is taking. This is to ensure that the decisions made

about a patient's ongoing treatment are based on accurate information and that only intentional changes are made to the medication regime.

Prescribers must make efforts to obtain an accurate medication history prior to prescribing at the point of accessing our services (this is basic Stage 1 medicines reconciliation) and refer to Pharmacy for help when this is technically difficult. Pharmacy will endeavour to confirm or check the medicine history as soon as possible after admission and have internal targets set for achieving this in a timely way and as the service allows.

In bedded areas Medicines Management Pharmacy Technicians have a role to support and provide a safety net with stage 1 medicines reconciliation; however prescribers should not assume that this will take place, particularly when a patient is admitted out of hours, at weekends or over bank holidays.

Stage 2 medicine reconciliation requires clinical judgement and involves taking the basic reconciliation information (stage 1) and comparing it to the list of medicines that is most recently available for that patient (e.g. for an inpatient that would be their medicine order and administration chart). Getting medicines reconciliation right at the beginning of a patient's journey as they access ESHT services is a core requirement of medicines optimisation. The medicines code document Medicines Reconciliation on Admission provides procedures and further guidance which must be referred to.

5.1.3. Prescribing

All prescriptions must be written by registered healthcare professionals who are authorised to prescribe within ESHT; this includes registered medical practitioners, dentists, nurse prescribers and other non-medical prescribers with a prescribing remit within their ESHT job description. Prescribers MUST be covered by an employment contract or Service Level Agreement with ESHT. The exception is for patients in community units or their homes where the patient's own or a designated GP is authorised to prescribe.

All health professionals are under an obligation to provide care within their area of specialist competence. They should have available sufficient information about the patient's history and condition to be assured that any treatment they may wish to provide is safe and appropriate.

In order to ensure that others involved in the patients care are similarly informed, they should ensure that any investigations, diagnosis and treatment are recorded in the patient's medical record.
Accurate weights of patients must be obtained and this should be recorded on the drug chart before prescribing any medicine. If the patient is not able to be weighed (e.g. if the patient is non-weight bearing) the most recent weight should be used from the patient/ carers information and this should be documented as an estimate on the drug chart. Scales should be calibrated regularly to ensure accuracy.

Health professionals should be able to act objectively, avoiding conflicts of interest especially when prescribing for staff or family members (see 5.1.8 below).

Patients seen outside of normal NHS arrangements are, almost without exception, considered to be 'private patients'. As such they are not entitled to receive NHS prescriptions and any prescribing must be undertaken on a private prescription only.

As a general rule, a consultation that is not recorded in the patients (NHS) hospital clinical notes or on the hospitals patient administration system must be considered to be a private consultation. Any resulting prescription will, by definition, also be private. A prescriber who issues an NHS prescription to a private patient is potentially defrauding the NHS. A number

of hospital doctors have been prosecuted for the fraudulent use of hospital prescription forms for non-NHS purposes.

ESHT requires prescribers to take into account the best available evidence when prescribing medicines for patients. All prescribers have an obligation to consider NICE Technology Appraisal Guidance and consider the implications when stepping outside of the guidance for their patients and the Trust. Deviations from best practice guidance should be fully documented within the medical notes and discussed with the patient.

When NICE guidance does not apply prescribers should only prescribe according to locally approved health economy formulary and local ESHT prescribing guidelines to ensure cost-effective and evidence-based prescribing. All patients within EHST (including those under the care of external contractors) should be prescribed antimicrobials in accordance with the Trusts Antimicrobial Prescribing Policy for Adults and Children or East Sussex Health Economy Formulary.

Statutory regulations regarding the prescriber, the medicines and the prescribing of medicines must be adhered to. All prescriptions must be in writing as a form of patient specific directions, written either on ESHT approved drug administration charts, within the patient's medical notes or on an FP10 prescription form. It is the responsibility of the prescriber to verbally inform nursing/midwifery staff that they have prescribed a 'stat' medicine or loading dose, to enable the medicine to be administered in a timely manner.

Under the rules of their provisional registration, pre-registration House Officers are permitted to prescribe only for those NHS patients registered with, and being treated by, their employing hospital.

Medical students must not prescribe medicines on any inpatient drug charts or on any other documentation where this would constitute a prescription.

All orders, including verbal orders, on medicine administration charts and prescriptions must be in accordance with the medicines code document Prescribing Standards.

5.1.4. Transcribing

Nurses, care workers or pharmacy staff can only transcribe the patient's own medication onto another document to act as medicine administration record (MAR) where procedures allow. At their next visit the responsible doctor / prescriber must review all medicines on medicine administration charts and countersign transcriptions. Refer to: Procedure for Transcribing Information about Medicines by Nursing and Social Services Staff (Community Bedded Services).

5.1.5. Prescribing by Non-Medical Prescribers

Prescribing by Non-Medical Prescribers in ESHT is allowed provided this is covered by the individual's job description. For the Trust policy and further information refer to the Non-Medical Prescribing Policy.

5.1.6. Prescribing on FP10 Forms

FP10 prescription forms are controlled stationery which, if stolen, may be used to illegally obtain drugs of abuse and other items. Prescribers (both medical and non-medical) are responsible for ensuring they follow the Medicines Management policy statements when prescribing for ESHT patients. Pre-printed stickers must not be used for patient details or for medicine names and directions on FP10 prescriptions. Prescribers are responsible for ensuring the security of prescription forms whilst they are in use and in their possession e.g.

during patient contact. Refer to: ESHT Procedure for the Management of FP10 Prescription Forms.

5.1.7. Outpatient Prescribing

Prescribing for patients in outpatient clinics should only occur when treatment must be started urgently, when 'hospital only' medicines are needed, for cytotoxic chemotherapy or in other circumstances when clinical responsibility is retained by the Consultant.

A two week period between consultation and initiation of therapy by the GP is required by the CCGs to provide notice of intent to start treatment. In cases where a delay of 14 days is not acceptable (due to the urgency of treatment) a maximum of 14 days treatment can be prescribed, except in the following circumstances*:

- Patients attending A&E (maximum one week's supply)
- Hospital only products; (prescribe full quantity in outpatient script (white))
- When clinical responsibility is retained by the Consultant, including drugs deemed unsuitable for prescribing by GPs as determined by the East Sussex Area Prescribing Committee or other similar committee (supply full quantity)
- Where a drug is associated with a shared care guideline which requires the dose to be stabilised prior to handing over prescribing responsibility to the GP (see individual shared care guideline for stabilisation period)
- Products dispensed in original packs (e.g. inhalers, ointments)
- Complex regimes where transfer of prescribing responsibility could result in confusion (supply full course)

*It is expected that the majority of outpatient appointments will not be urgent and therefore the need to prescribe reserved for exceptional circumstances.
**An outpatient attendance should be raised for each prescription written to cover all/some of the costs of medicines.

- Any medicines recommended to a GP, or prescribed to a patient should be approved for use on the local formulary** (see 'Clinical' links: East Sussex Health Economy Formulary). [**In exceptional circumstances non-formulary medicines are prescribed or recommended, the reasons for this action must be explained to the GP.]
- All prescribing must use **generic names**, except for those medicines where the BNF suggests otherwise.
- **Unlicensed (specials)** medicines used by the Trust are supplied by the Pharmacy Department [in accordance with the Guidelines for the Prescribing, Supply and Use of Unlicensed Drugs].
- All Homecare medicines must be ordered via the pharmacy department.
- High Cost Medicine (HCM) PbRe and commissioner reimbursed medicines must be ordered via the pharmacy department in accordance with the ESHT Complex Drugs & Homecare Methotrexate Injections in Specialist Medicine

5.1.8. Prescribing for Family Members

All medical and other staff that are entitled to prescribe should ensure that:

- They and their families are registered with a GP through whom they should obtain all routine NHS care.
- With the exception of minor ailments and in a medical emergency, they do not prescribe for themselves or for their families.
- They only prescribe for staff and colleagues in exceptional or emergency cases,

unless those staff and colleagues are under NHS care.
- They only issue private prescriptions for patients that are not receiving NHS care.

With just a few exceptions, UK law allows UK registered medical practitioners to prescribe medicines for anyone to whom they are providing care. As a result there are no statutory restrictions that prevent doctors from prescribing for themselves, for their families or for friends and colleagues; however prescribing at NHS expense may only be undertaken for NHS patients. In the hospital context, this includes patients who are registered as in-patients, outpatients or day-cases, and who are being treated as part of an episode of hospital care.

On the specific issue of prescribing for family members, the General Medical Council has issued advice to doctors[1] and the Department of Health has also published guidance on nurse prescribing[2].

5.1.9. Prescribing for Staff

There may be occasions when it is in the best interests of the Trust and its staff to allow for immediate access to medicines (for example, a member of staff who suffers an exacerbation of their asthma and who has left their inhaler at home might request a prescription for an inhaler rather than go off-duty). The Trust therefore considers it acceptable to permit the issue of a prescription for a small supply of medicine at the Trust's expense in exceptional or emergency cases.

Medical staff may not, at NHS expense, prescribe for other staff or colleagues unless:

- The patient is receiving formal and recorded NHS care in the usual way, or
- The prescribing is for exceptional, emergency or urgent care.
- The prescription is endorsed by the prescriber so that the pharmacist and Trust management are aware it is being provided and funded under the 'staff' scheme'.

The quantities to be supplied will normally be limited to 1-3 days supply, and certainly no more than is required to allow the patient to obtain further supplies via the usual GP arrangements.

The staff member's GP should be informed of the action taken.

5.1.10. Unlicensed, Clinical Trial and 'Off-Licence' Medicines

Unlicensed and off-label medicines should only be used when no pharmaceutically equivalent licensed product or suitable alternative licensed product is available for use at the time the patient requires it.

The Medicines Optimisation Group is responsible for the governance arrangements for the use of unlicensed and 'off label' medicines and may request supporting information for these prescribing decisions. Prescribers will maintain responsibility for any unlicensed prescribing unless this has been formally approved within the Trust. A risk assessment should be

[1] General Medical Council (2013), Good practice in prescribing and managing medical devices, http://www.gmc-uk.org/static/documents/content/Prescribing_guidance(1).pdf, last accessed (06 May 2014

[2] Nurse & Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers, http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-proficiency-nurse-and-midwife-prescribers.pdf, last accessed (06 May 2014)

completed when an unlicensed medicine is prescribed in the Trust or when a medicine is to be prescribed outside of its licensed use (off label). Both these risk assessment templates can be found with further guidance in the Policy for the Prescribing, Supply and use of Unlicensed Medicines. The Pharmacy Medicines Information Department can be contacted for advice on all medicines.

Clinical trials should be undertaken in accordance with local procedures and clinical trial protocols.

For patients who are admitted into ESHT units on clinical trial medicines, consideration should be made by clinicians about any potential risks associated with a trial medicine that may have contributed to admission. Further advice should be sought from the research department or Pharmacy if necessary. Refer to the Research Governance – Standard Operating Procedure Manual with further information being obtained from the Sussex NHS Research Consortium http://www.sxrc.nhs.uk).

5.1.11. Shared Care Agreements

ESHT encourages prescribers to enter into shared care agreements with primary care when appropriate. Appropriateness can only be established properly when all commissioning and contracting arrangements are referred to in the decision making process. Where specialist commissioning arrangements with other providers are in place, e.g. neurology services, these arrangements need to be recognised when deciding if the shared care model is acceptable to ESHT. A specialist commissioned provider will often receive a higher income tariff for the service than ESHT to cover additional costs incurred, such as those often seen with specialist drug expenditure. Practically this means that any new service, of which a shared care agreement would be one, needs thought as to the financial implications as associated drug costs can easily be more than the income received. Shared care decisions must always include pharmacy and contracting. Where the local service is not viable patients must be referred to the tertiary centre for specialist treatment.

Shared care agreements with specialist (tertiary) service providers may also be set-up under a service level agreement as part of network arrangements for delivering care closer to patients' homes. In this case contracting must be involved to ensure that ESHT charges for the service via the correct route. In these cases NHS England commission the services direct from the tertiary centre and will challenge invoices not raised via the correct route.

Some drugs, as determined by the Health Economy Medicines Group, will require a shared care agreement to be provided when a GP is asked to participate in the prescribing and care of a patient receiving these drugs.

Within ESHT the following principles should be applied to any shared care agreement:

- The decision to share care should be agreed between the GP and the hospital consultant.
- The arrangement for prescribing should be evaluated as to whether it represents the optimum solution for that patient (for example is the medicine actually available within primary care).
- The GP should have sufficient information and support to feel confident in managing the patient.
- The GP and the hospital consultant should agree their respective responsibilities.
- An agreed communication flow should be established so that it is clear what information should be exchanged between the GP, hospital consultant and patient.
- The referral criteria should be agreed between GP and hospital consultant.

An example of a shared care agreement in place is Shared Care Agreement for Azathioprine.

5.2. Shared Decision Making

Principle 2: Patients are actively encouraged, through shared decision making, to be involved in the decisions about the medication they are prescribed and optimise their treatment outcomes (Medicines Adherence).

5.2.1. Involving Patients in Decisions about Medicines

NICE states that between a third and a half of medicines that are prescribed for long-term conditions are not used as recommended. This represents a health loss for patients and an economic loss for society. In terms of ESHT this can manifest as re-admissions or dissatisfaction because of treatment failure.

Non-adherence to a medication regime usually results from a failure to fully agree the prescription with the patient in the first place and to support the patient once the medicine has been dispensed.

Non-adherence falls into two overlapping categories: intentional (the patient decides not to follow the treatment recommendations) and unintentional (the patient wants to follow the treatment recommendations but has practical problems).

It is assumed that no prescriber wishes a patient to be non-adherent to a medication regime that they have prescribed and therefore ESHT expects prescribers to follow these key principles as set out by NICE:

- Adapt their consultation style to the needs of individual patients so that all patients have the opportunity to be involved in decisions about their medicines at the level they wish.
- Establish the most effective way of communicating with each patient and, if necessary, consider ways of making information accessible and understandable (for example, using pictures, symbols, large print, different languages, an interpreter or a patient advocate).
- Offer all patients the opportunity to be involved in making decisions about prescribed medicines. Establish what level of involvement in decision-making the patient would like.
- Be aware that increasing patient involvement may mean that the patient decides not to take or to stop taking a medicine. If in the healthcare professional's view this could have an adverse effect, then the information provided to the patient on risks and benefits and the patient's decision should be recorded.
- Accept that the patient has the right to decide not to take a medicine, even if you do not agree with the decision, as long as the patient has the capacity to make an informed decision and has been provided with the information needed to make such a decision.
- Be aware that patient concerns about medicines, and whether they believe they need them, affect how and whether they take their prescribed medicines.
- Offer patients information that is relevant to their condition, possible treatments and personal circumstances, and that is easy to understand and free from jargon.
- Recognise that non-adherence is common and that most patients are non-adherent sometimes.
- Routinely assess adherence in a non-judgemental way whenever you prescribe, dispense and review medicines. Be aware that although adherence can be improved, no specific intervention can be recommended for all patients. Tailor any intervention to increase adherence to the specific difficulties with adherence the patient is experiencing.
- Review patient knowledge, understanding and concerns about medicines, and a patient's view of their need for medicine at intervals agreed with the patient, because these may

change over time. Offer repeat information and review to patients, especially when treating long-term conditions with multiple medicines.

Patient decision aids are a useful tool for aiding patients to make the right choices about their medicines; see the National Prescribing Centre website for more information: http://personcentredcare.health.org.uk/resources?f%5B0%5D=field_area_of_care%3A355

5.2.2. Provision of Patient Medicines Information from Prescribers

It is an essential requirement of care that patients, or others acting on their behalf, receive information about the medicine they are prescribed whenever possible.

To support this, consultation with patients during prescribing of medicines must involve:

- The indication and reason for prescribing
- The perceived risks and benefits
- Treatment duration, e.g. lifelong or limited course
- Relevant lifestyle implications e.g. effect on driving, alcohol consumption
- Interactions with other medications or substances e.g. warfarin and cranberry juice
- Risk Information: both short term and long term side effects e.g. postural hypotension with ACEI and weight gain with anti-depressant use

Discussions about medication should be set in the context of the individual care plan and should aim to address relevant issues raised by individual patients including, where appropriate, the clarification of possible treatment alternatives. If prescribers have difficulties in providing patients with information about their medicines it is appropriate to refer the issues to the Pharmacy team for support.

5.2.3. Informed Consent with Unlicensed / Off-licence Medicines

Health professionals must respect the right of patients, carers and parents to participate in discussions regarding the health care of the patient and to ensure that these decisions are properly informed.

The medical team should ask the patient to give their explicit, informed consent, which should be recorded in the medical notes. The prescriber should explain to the patient/representative in broad terms the reasons why the medicines are not licensed for their proposed use and note that any patient information leaflet for a licensed product will not state the “off label” use. The risks and benefits of the use of any unlicensed medicines should also be explained.

Where medicines are prescribed for ‘off licence’ use, the prescriber is accountable for ensuring that the patient understands the rationale and the directions for use and is aware of the limitations of the PIL contained within the medicine packaging.

5.3. Safe and Secure Handling of Medicines

Principle 3: Patients are kept safe because we follow processes that ensure medicines we provide are handled correctly and in line with national recommendations and best practice.

5.3.1. Procurement of Pharmaceuticals

To prevent counterfeit or poorly managed medicines entering the supply chain the procurement of medicines used within the service must be from an approved provider i.e. a registered community pharmacy, hospital pharmacy or from a recognised central distributor.

Within ESHT acute hospitals pharmaceuticals are purchased on behalf of wards and departments through the Pharmacy service. For some community health service units without an onsite dispensary, medicines are purchased on behalf of ESHT under service level agreements.

Medical, nursing/midwifery or other healthcare staff are not permitted to undertake contracting, tendering or purchasing of medicines intended for administration to patients of any ESHT service, unless it has been agreed through the Pharmacy service. This includes arrangements for homecare services related to medicines.

Sample medicines provided by pharmaceutical companies must NOT be administered to patients unless specifically organised through the Pharmacy service.

5.3.2. Non Formulary Medicines and Managed Entry of New Medicines

All prescribing must be undertaken in accordance with the East Sussex Health Economy Formulary. Where a non-formulary medicine is requested to be supplied for clinical reasons a non-formulary request form must be submitted to accompany the prescription (or monitoring form for FP10). A senior pharmacist must authorise the supply. When a non-formulary medicine is required frequently (i.e. more than twice) a new drug request for addition to the formulary must be submitted (Refer to: Application for a New Drug to be Added to the Prescribing Formulary).

Note: All applications for new drugs must be discussed with pharmacy prior to sending to the Area Prescribing Committee for addition to the formulary. Whilst the HEMC considers applications on the basis of patient care and benefits to the health economy as a whole, the decision for a medicine to be used within ESHT as part of a commissioned service must be made against the viability within the service from a contracting perspective. It may for example be more applicable for patients to be referred to a specialist provider or tertiary centre where their services are commissioned to take into account of the specialist nature and additional costs of treatment.

5.3.3. Controlled Drugs

Controlled drug management is a high risk area that has a legislative requirement that requires firm control. The management of controlled drugs within ESHT are covered by two documents. The document Controlled Drugs: Safe Use and Management [medicines Code] cover the governance arrangements within the Trust and the responsibilities and accountabilities of staff. All staff involved in controlled drugs must have knowledge of this document and refer to it when necessary and routinely in practice as the processes it relates to in controlled drug management require a high degree of familiarity by all staff involved in handling controlled drugs.

5.3.4. Cytotoxic Medicines

Cytotoxic drugs should not be kept as routine stock, except Mitomycin bladder instillation for some day surgery units. Refer to the Policy on Prescribing, Administration and Safe Handling of Cytotoxic Drugs and Policy for the Administration of Intrathecal Chemotherapy.

5.3.5. Other High Risk Medicines

There are separate procedures and guidelines in place for high risk medicines and medicine related practices; these can be located on the ESHT Document Database. The standards in each of the document apply for the scope of the document in addition to the standards laid out within this policy.

5.3.6. Storage and Security of Medicines

Medicines (including those brought into the hospital by patients) and other substances issued from a pharmacy must be stored securely in a locked patient medicine locker, locked cupboard, omnicell cabinet, locked refrigerator or locked trolley. Exceptions to this are intravenous fluids, sterile topical fluids and diagnostic reagents including test strips, which may be stored in a restricted access area, i.e. has a key pad or swipe card entry. Cardiac arrest packs must be accessible in case of emergency and are exempt from these requirements. Medicines stored on the Intensive Care Unit in permanently manned areas, which may be urgently needed for patient treatment, are also exempt from the requirement to be stored in a locked cupboard.

Staff must remain mindful when handling medicines and controlled stationery of the potential for medicines to be targeted for misuse, tampering, theft or fraudulent activity such as deception to obtain access to large quantities of medicines. Where there is suspected foul play this must be reported on DatixWEB and through the Trust security officers for investigation and escalation. Refer to the Counter-Fraud and Anti-bribery Policy and Management of Security Policy. Issues with controlled drugs must be managed in accordance with Controlled Drugs: Safe Use and Management [Medicines Code]. Suspected security/fraud issues may be identified through:

- Excessive use or ordering of medicinal products
- Changes in behaviour or deviation from SOPs
- Unexplained or regular losses of medicines or stationery
- Suspicious activity such as hidden empty boxes or blisters
- Regular data surveillance of DatixWEB reports, ePACT data and Ascribe
- Alteration of official documentation or records
- Inspections
- Audit
- Security surveys

Providing assurance of the cold chain of pharmaceuticals that are temperature sensitive, for example vaccines, is essential to ensure the efficacy of treatment and reduce risks of patient harm from treatment failure or harmful degradation products. Ward matrons and clinical area managers are responsible for ensuring that refrigerated medicines are stored in accordance with the manufacturers' instructions and for providing assurance of this through the maintenance of an audit trail. The medicines code document, Temperature control for the ambient and Refrigerator Storage of Medicines [Medicines Code], must be referred to and implemented in all areas that have refrigerated pharmaceutical products.

5.3.7. Fire Hazard with Paraffin Based Skin Products on Dressings and Clothing

Skin products containing paraffin based products, for example White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment, in contact with dressings and clothing are easily ignited with a naked flame or a cigarette. It is important that Health Care Staff do the following to minimise the risk of fire when patients are dispensed, or treated with, paraffin based products.

The following actions should apply to all patients in all settings being dispensed, or treated with, large quantities (100g or more) of paraffin based products:

- Information should be given about the potential fire risks of smoking (or being near to people who are smoking), or exposure to any open flame or other potential cause of ignition during treatment; and about regularly changing clothing or bedding impregnated with paraffin based products (preferably on a daily basis) as the paraffin soaks into the fabrics and can potentially be a fire hazard. **Patient information is included in Appendix F.**
- This information should be given on the first occasion that such treatment is prescribed, dispensed or administered by a healthcare professional and a record kept confirming that such advice has been given. A check should be made on healthcare professional and a record kept confirming that such advice has been given. A check should be made on subsequent occasions that the advice has been received previously and understood.
- Fire safety information should be displayed prominently in every clinical area where patients may be treated with large quantities of paraffin based products. **(See Appendix E).**
- If, against advice, a hospitalised patient intends to leave the ward to smoke, they should be informed of the risk and advised to wear a thick outer covering that has not been contaminated with paraffin based products.
- Relatives or carers should be informed if a patient does not comply with safety advice
- To implement the NPSA alert, patients who require large quantities of emollient (100g or more) should use a water based product (e.g. cream or lotion) rather than a paraffin based one (e.g. ointment) to reduce the fire risk.
- The Patient Information Leaflet or Instructions for Use and the Summary of Product Characteristics can be checked for warnings about the fire risk where healthcare professionals or patients are unsure.

Products on local formulary which contain paraffin and pose a potential fire risk:
Local Formulary

5.3.8. Stock Medicines

5.3.8.1. Stock Lists

Stock medicines must be provided against an approved list of medicines that are kept by the ward or clinical area. This is to reduce harm associated with having unsupervised access to high risk medicines, for example restricted antibiotics that should be authorised by a microbiologist. It also reduces waste by ensuring stock holding is kept rational and provides an audit trail for the medicines used. The stock list should be reviewed regularly and is an agreement between the ward or clinical area manager and pharmacy of stock items that may be kept readily accessible. Stock lists must be reviewed at least every two years. A list of critical medicines is maintained within the medicines code document, Procedures for Accessing Medicines, and should be used as a reference source when reviewing stock holding for a clinical area.

5.3.8.2. Acquisition of Stock

All orders for stock medicines must be on a pre-printed stock list or approved stationery designed for this purpose. These lists and stationery must be kept securely to avoid unauthorised access and diversion of medicines. Ordering of stock medications must only be undertaken by a member of staff authorised by the clinical area manager or a Pharmacy team member authorised through their job role (for example a Pharmacy assistant) to act on their behalf.

Healthcare professionals who order medicines must sign and date the order in the relevant section. Where the stock is to be supplied by a community pharmacy the order must be signed by an authorised doctor. Only in exceptional circumstances may stock medicines be administered to a patient other than those under the care of that ward or clinic. Where stock medicines are required from another area a note must be made of the drug, quantity taken, ward area, patient identifier and name of the requestor in the form of a signed requisition. The medicines code document Procedures for Accessing Medicines covers the practices for obtaining medicines within the Trust.

Stock items that are intended for issue to patients, for example gun labelled medicines or TTO packs may be issued under the direction of a prescription or a Patient Group Direction providing the medicine issued complies with the Medicines Act and Human Medicines Regulations 2012. The medicines code document Assembly and Issue of Discharge Medication (TTO / TTA) provides the system for assembling a patient's medications on discharge.

5.3.8.3. Receipt of Stock

All stock medicines received by a ward/department must be checked against the delivery note. The delivery should be signed, dated and retained for 6 months when obtained from an ESHT Pharmacy department and 2 years for outside suppliers (for example where a service level agreement applies).

Medicines that require refrigeration must be placed in the lockable medicines refrigerator as soon as possible to ensure integrity of the pharmaceutical product (refer to Temperature control for the ambient and Refrigerator Storage of Medicines [Medicines Code]. Other medicines should be placed in the appropriate locked cupboards. On occasions when it is not possible to empty the delivery box or bag immediately, the box or bag can be stored in a safe restricted access or locked room until placed in the appropriate cupboard.

It is the responsibility of the ward manager to ensure that medicines are stored appropriately and are within the expiry date and there should be a process in place for regular expiry date checking on each ward or unit where medicines are kept as stock.

5.3.9. Non Stock Items and Patient Labelled Medicines

5.3.9.1. Acquisition of Non Stock Items and Patient Labelled Medicines

Any medicine not listed on a ward stock list must be ordered as non-stock or 'patient labelled medicines'. The medicines code document Procedures for Accessing Medicines covers the practices for obtaining medicines within the Trust.

5.3.9.2. Receipt of Non Stock Items / Patient Labelled Medicines

For inpatient ward areas on the receipt of medicines labelled for a specific patient, a nurse must reconcile the labelled medicines against the requisition and must place it in the designated secure place. The checks necessary for supplying a discharge medicine are covered by the medicines code document Assembly and Issue of Discharge Medication (TTO / TTA) and additional information is provided within the Guidelines for the Completion of Patient Held Medication Record Charts.

For Firwood House, a joint health and social care facility, and community based services providing direct patient care in the patient's home included in the East Sussex Better Together initiatives, the receipt of a labelled medicine must be checked against the

medication administration record and a record of the quantity received must be recorded on the designated chart.

5.3.10. Transfer and Transportation of Medicines

All medicines must be transported in a locked or a sealed tamper-evident container using appropriate transport arrangements. Medicines must wherever possible be kept out of view during transit.

When a patient is transferred from one ward to another within acute areas of the Trust, the responsible nurse in charge of the patient must ensure that all dispensed medicines are transferred with the patient. In circumstances where expediency is necessary and patients are transferred without all their medicines the nurse in charge of the patient from the transferring ward must ensure suitable arrangements are in place to obtain the missing medicines as soon as possible.

For transfers within the Trust, in an emergency or out-of hours situation where care will be continued to be delivered by nursing/midwifery staff (i.e. not a discharge home) strips of medicines, part packs or full packs may be transferred provided the medicine and expiry date are identifiable from the packaging and the current acute chart is sent (with adequate space for the recording of administration until the next medical review is available). Loose tablets must not be supplied.

Healthcare professionals should not routinely transport medicines when delivering patient care (e.g. to and from the patient's home, or to a different location within the organisation). However, there are instances where this may be necessary. If medicines are transported by a member of staff it is their responsibility to ensure safe custody and storage in line with manufacturers' requirements and legislation.

Where a healthcare professional is storing medicines, for example overnight, the medicine must be placed in a secure place (out of reach of children) within the home (e.g. anaphylaxis packs). It is preferable that this practice is avoided and that medicines are stored within the appropriate lockable storage cupboards within ESHT facilities.

Where medicines are being transferred between sites within ESHT or between ESHT and an outside location there should be a system in place to ensure that the dispatch and the receipt of medicines are recorded.

5.3.11. Patient Own Medicines

Paramedics and trained ambulance staff should actively encourage patients to bring their medicines with them when admitted into care or transferred between areas at ESHT. This is to aid medicine reconciliation processes. Refer to Procedures for the Use of Patients Own medicines on Admission, During Inpatient Stay and at Discharge [Medicines Code].

5.3.12. Disposal of Medicines

The designated Pharmaceutical Officer (Chief Pharmacist) shall provide advice and guidance as required (or delegate responsibility if appropriate) on safe procedures for the handling and disposal of pharmaceutical waste materials regarded as clinical waste. Refer to An Organisation-Wide Policy & Procedure for the Management of Waste.

5.3.13. Management of FP10 Prescription Pads

The ordering and storage of FP10 Prescription pads within ESHT must be undertaken in accordance with ESHT Procedure for the Management of FP10 Prescription Forms.

Inappropriate use and diversion of FP10 prescriptions can constitute a risk to the organisation and patient safety. It is the responsibility of prescribers, clinical area managers and their staff, pharmacy and the organisation to ensure the security of FP10 prescription pads as controlled stationery.

5.4. Supply and Access to Medicines

Principle 4: Patients are kept safe because we follow processes that mean patients can access the medicines they need in a safe and timely way.

5.4.1. Supply of Medicines to ESHT Patients

Supply of medication directly to patients to take away (e.g. family planning, smoking cessation, podiatry, inpatients being discharged) must be carried out in accordance with the Medicines Act (1968) and Human Medicines Regulations (2012). All medicines must be in a labelled container bearing the name of the patient, date and place of issue, the name of medicine, full directions and "keep out of the reach of children".

5.4.2. Dispensing

All dispensing of medicines for patients of ESHT must be undertaken by an ESHT hospital pharmacy or pharmacy contractor under a service level agreement. Refer to pharmacy department procedures.

5.4.3. Using Patients Own Medicines

Patients Own Medicines should be used whenever possible and when they are of a suitable quality to do so. The medicine code document Procedures for the Use of Patients Own Medicines on Admission, during Inpatient Stay and at Discharge [Medicines Code] should be referred to as the primary reference source for assessing patients own medicines.

The underlying principal of using Patients Own Medicines is that they are and remain the patient's property at all times. The decision to re-use them during a patient's stay is subject to verbal consent wherever possible. Part of the consent requires that the medicines are taken off the patient and locked away for safekeeping. Where consent cannot be gained the medicines can be sent home with a relative for safekeeping; however it may constitute an additional risk if the relative has mental capacity or other issues. It is therefore essential that staff take a pragmatic approach to using Patient's Own Medicines and ensure they consider all the risks during the decision making. The risk assessment requires the following considerations:

- Mental capacity to give consent for use and safekeeping.
- Vulnerability of other patients on the ward and the risk posed to them.
- Risks the medicines pose if they are sent home with relatives or a carer e.g. controlled drugs.
- Willingness to give up the medicine for safekeeping.

Where a patient refuses to give up their medicines for safekeeping and storage and it constitutes a risk to other patients a discussion is required between the patient and nurse, with consultant and pharmacist input if necessary, as to the risks it poses and the options to be made in the best interests of patients on the ward e.g. removal of medicines without consent. The perceived risks and decision making should be documented in the individual patient record.

5.4.4. Supplying Medication to Patients on Discharge

No member of staff must alter, deface or remove labels from medicines containers. The Medicines Act (1968) and Human Medicines Regulations (2012) have exemption for supply and administration for certain professional groups; refer to the relevant professional body.

The handling of discharge medicines is covered by the medicines code document Assembly and Issue of Discharge Medication (TTO / TTA) [Medicines Code]. Patients will be issued with at least one week supply of medicines for discharge from acute hospital or at least two weeks supply for discharge from community bedded units and sufficient number of doses to complete the course, e.g. Antibiotics or Steroids. Where the discharge medication has not changed from the admission medication, the patient's own supply will be used, providing that these are suitable for use.

Patients can be discharged directly from wards and there is no need to send the medication back to an acute pharmacy department unless changes are required.

The planned time of discharge should be clearly indicated. Most medicines are dispensed ready for discharge; however where medicines are unavailable the ward based pharmacy team should be contacted in normal pharmacy working hours or sent to pharmacy on Saturdays. Discharge prescriptions required urgently will normally be ready as soon as possible or within two hours of receipt by pharmacy. If the ward based pharmacy team (contact via the bleep system) is organising discharge medicines normally it will be prioritised. However escalation of priority may also be initiated by the site management team.

5.4.5. Medication Compliance Aids (MedCA)

Medication Compliance Aids such as a medicines administration chart or blister packed medicine by a community pharmacy can support patients managing their own medicines by making reasonable and appropriate adjustments as assessed under the Disability Discrimination Act. The decision as to what adjustment is appropriate in each individual case is the responsibility of the community pharmacist, not that of carers, social workers or other providers.

For patients already receiving MedCA prior to admission, the community pharmacy should be informed of the admission and be contacted again prior to discharge to be advised of the patient's future requirements and date of discharge. Sufficient notice must be given where assessment or recommencement of any MedCA is needed.

5.4.6. Patient Group Directions

Patient Group Directions are a legislative mechanism for improving access to medicines for patients from an allowed trained health professional when access to prescribers is difficult. The basic principle for a PGD is that it is only applicable for a group of patients that meet the inclusion criteria of the PGD but were unknown to the service before they accessed it. Where a patient is known to the service a patient specific direction is applicable because a prescriber could review and authorise the selection of a medicine for the patient. Patient Group Directions are covered in detail within the Patient Group Direction Policy.

5.4.7. Patient Specific Directions

The commonest forms of Patient Specific Directions are prescriptions or medication orders for administration in the medical notes or on a medication order and administration record chart (drug chart). Other patient specific directions can apply and in some circumstances

may take the form of a direct verbal instruction to administer a drug or a signed intention to treat, for example a face to face direction from a prescriber, a clinic list or signed referral letter that authorises the administration of a standard set of drugs as part of the procedure. Protocols and procedures must always be set up to provide an audit trail for these other types of patient specific directions to ensure the responsibility and accountability for treatment is clear and fully documented.

The Patient Group Direction Policy covers patient group directions and reference to patient specific directions that are not covered under the umbrella of prescribing. The use of patient group directions and bespoke patient specific directions is a complex and potentially risky area that must include pharmacist support to ensure that current legislative requirements are met.

5.5. Administering Medicines

Principle 5: Patients are kept safe because we follow processes that mean patients are administered medicines in a safe and timely way.

5.5.1. Administration of Medicines

The Human Medicines Regulations (2012) prevents a person administering a parenteral Prescription Only Medicine (POM) to another person unless they are acting in accordance with the directions of an appropriate practitioner. Medicines legislation does not restrict who can administer non-parenteral POMs (i.e. oral, inhaled, topical or rectal dosage forms, etc). However, within ESHT, the person administering the medicine should only do so with the authority of a prescription, patient specific direction or patient group direction and should be appropriately trained. In practice ESHT requires authorisation for administration to always be clearly documented in the medical record and limits administration to individuals listed below.

Only ESHT staff who have followed appropriate training for parenteral medicines are allowed to administer parenteral medicines to patients. Appropriate training for parenteral medicines is defined in the Training Needs Analysis for medicines management.

The ESHT policy for the acute hospitals allows the following staff groups to be recognised as being authorised to administer non parenteral medicines:

- Registered nurses and Midwives
- Radiographers
- Operating department practitioners
- Medical officers
- Physiotherapists
- Podiatrists
- Orthoptists

The following staff groups may administer non parenteral medicines under the appropriate supervision of a registered practitioner listed above.

- Health Care Assistants and Nursing Auxiliaries
- Pre-registration Student Nurses and Midwives
- Unregistered nurses under the Return to Practice programme

Registered healthcare professionals remain accountable for all care delegated to students and unregistered nurses/midwives under the ‘Return to Practice’ programme. Students and these unregistered nurses/midwives must not undertake single-handed administration and the registered nurse supervising the administration of medicines must clearly countersign

their signature. Student and unregistered nurses/midwives under the Return to Practice programme must not:

- Add or check intravenous drugs
- Check any additives into intravenous bags of fluids
- Check bags of blood or blood products for transfusion

In care homes with nursing (e.g. Firwood House) it is considered best practice that medical or nursing staff administers medicine to patients.

Where community based services are supporting patients in their own home with medicine's administration, non-registered staff may only assist in administration where the following are all in place:
This task is specified in their job description;
The staff member has been assessed as competent;
The staff member is aware of, and works in accordance with, appropriate procedures;
The task is only undertaken as part of the community-based role where it forms an integral part of that service.

5.5.2. Covert Administration of Medicines

The covert administration of medicines is only likely to be necessary or appropriate in the case of patients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal. The decision to administer covertly must be made jointly between prescriber and nursing/midwifery staff and where possible the patient's representative.

The NMC recognises that there may be certain exceptional circumstances in which covert administration may be considered to prevent a patient from missing out on essential treatment. Under these circumstances and in the absence of informed consent the best interests of the patient must be considered at all times. Covert administration must always be documented fully in the patient's health record.

5.5.3. Administration of Medicines in the Absence of a Written Prescription

Wherever possible, medicines should be administered in accordance with a written prescription, medication order, patient specific direction or patient group direction. ESHT recognises that in some circumstances, particularly in community health care settings, access to prescribers is not always possible. Nurses/midwives therefore under these circumstances can administer medicines provided there is a prescription in place and is current; examples could be an acute trust drug chart or a patient's own dispensed medicine. The administering practitioner must be sure that the record is still current and relevant.

- For transfers within ESHT between acute and community hospitals an ESHT medicine chart may be used as a Medication Administration Record (MAR) until reviewed by a prescriber to whom the patients care has been transferred.
- Where a drug chart exists from a different trust it may, under these circumstances, be used as a MAR. There must be a clear record made of this on the drug chart and in the patients nursing/midwifery notes.
- Where a drug chart does not exist the preferred option is transcribing onto ESHT approved stationery where staff have been appropriately trained.
- Where there is no prescription chart or medicines administration record the administration should be recorded in the nursing/midwifery or medical notes.

A written record without the signature of an ESHT authorised prescriber can only be used to administer medicines which have previously been dispensed to the patient.

Refer to the Homely Remedy Procedures for responding to symptoms of a minor nature, e.g. mild pain.

5.5.4. Verbal Orders for Medicines

Within ESHT it is generally not considered normal or safe practice to administer medicines without a written authority to give the medicine (e.g. PGD, patient specific direction or prescription). Where direct supervision of the administration of the medicine is undertaken by a registered prescriber (e.g. an ODP under the direction of an anaesthetist in theatres, a nurse under the direction of a radiologist during an intervention or a registered practitioner under the direction of a medical practitioner in an emergency situation) the practitioner is technically working under a patient specific direction covered by the Human Medicines Regulations (2012). ESHT recognises this and under these circumstances stipulates that administration must always be documented as soon as possible and countersigned by the authorised prescriber. Where this practice is routinely undertaken procedures and protocols must be in place to cover the practice.

In circumstances where there is clear clinical evidence that it is in the patient's best interest, a verbal order may be accepted by a registered nurse or pharmacist from a medical prescriber.

In all cases it is up to each individual practitioner to use professional discretion to decide if they will accept and administer a medicine from a verbal order. Registered nurses/midwives must be familiar with standard for administering medication from a remote prescription/direction (NMC standard 11) see NMC Standards for medicines management.

Remote verbal orders, i.e. when they are not present, from an authorised prescriber for administration or supply of medicines may only be given in limited circumstances:

- To a registered nurse or midwife in a medical emergency (except as noted below)
- To a registered nurse on Michelham Ward and Community Bedded Units for changes in dose of previously prescribed medicines and to initiate or stop treatment.
- For supply when the doctor and nurse/midwife or pharmacist must agree that it is medically appropriate, safe, and in the interests of the patient to use a verbal order.
- To senior staff members of community-based services, to clarify an identified medicines discrepancy where all other steps have been unsuccessful, in accordance with the medicines procedures supporting this service, where the patient is already at home, and support is required in medicines administration.

Any person taking a verbal order must be satisfied that they are completely sure what is required and that the person giving the order is authorised to do so. In the event that the person is not satisfied with the verbal order they must refuse to accept it and the authorised prescriber must attend to write a prescription.

To accept a verbal order the nurse must be satisfied that they are competent to administer the drug and be prepared to account for their actions. The nurse taking the verbal order must ensure that any relevant medical histories and allergies are discussed with the medical prescriber providing the verbal order.

5.5.4.1. Obtaining a Prescribers Signature in an Acute Hospital

Doctors issuing a verbal order must, for legal reasons, countersign the order, whether this is an out-patient prescription, discharge prescription or inpatient treatment chart. Verbal orders must be signed as soon as possible, within four hours for a medical emergency, within a maximum of 24 hours in other cases. Any inpatient prescription not countersigned must no longer be used after 24 hours.

Doctors issuing a verbal order for in-patient treatment must make appropriate arrangements for the patient to be seen for assessment and review.

Verbal orders must be documented on the prescription, indicating that it is a verbal order, giving the name of the authorising practitioner and signed by the person taking the verbal order. Remote verbal orders cannot be given for controlled drugs and cytotoxic medicines.

5.5.4.2. Obtaining a Prescribers Signature in Community Practice

The nurse must inform the medical practitioner that the prescription must be signed within 24 hours (maximum 72 hours – bank holidays and weekends). The nurse must request a fax or email (via nhs.net) from the prescriber to confirm the verbal order. It is not acceptable within Community Health Service facilities to receive confirmation by text message. The fax or email must contain all information required for a prescription (see BNF for details).

The registered nurse taking the verbal order must confirm the details of the fax or the print-out of the email correspond to the verbal order. Any discrepancies in the information must be clarified with the prescriber. A copy must be attached to the drug chart. No verbal orders can be accepted for the initiation of intravenous medicines, the initiation of a syringe driver or any prescription for cytotoxic or controlled drugs.

5.5.5. Homely Remedies

Within intermediate care or community bedded units operating nurse-led administration of medicines for minor ailments or homely remedies, refer to the Procedures for the use of Homely Remedies.

Within acute hospitals at ESHT the supply and use of homely remedies without appropriate control and documentation may lead to clinical risk. It is therefore the ESHT policy for areas that have readily available access to prescribers that these medicines need to be provided under a patient specific direction unless a PGD exists.

Where PGDs exist within ESHT that cover products that could be classed as homely remedies it is advised that the implementation is discussed and agreed at clinical unit management level. The Patient Group Direction Policy covers the process for writing and implementing PGDs in detail.

5.5.6. Alternative Medicines

For the purpose of this policy a medicine or homely remedy may not exclusively be defined as a traditional pharmaceutical product but could also include other alternative, non-prescription medicines such as homeopathic, herbal or Chinese medicines.

These medicines may have unpredictable effects and it should be noted that they have the potential to interfere with other medicines pharmaceutical responses through interactions or increased side effects. It is important therefore to check with the pharmacy team or medicines information the compatibility of these medicines if they are being administered alongside newly prescribed medicines.

It is good practice to note these types of therapy on any prescription and/or medication administration record chart to ensure all healthcare professionals involved with the patient's care are aware of this. Alternative medicines that the prescriber is aware of and wishes the patient to continue with must be prescribed; otherwise the medicine should be documented in the patients drug history within the medical notes.

5.5.7. Patient Self-Administration of Medicines

Patients should be encouraged to self-administer medicines when and where appropriate and in accordance with the relevant procedures. The Medicines Code document 'Procedures for the Self Administration of Medicines' defines the implementation, procedures and risks from this practice.

5.5.8. Records of Drug Administration

All drugs administered, intentionally withheld or refused by the patient, must be recorded clearly and accurately in black ink. The administration of medicines must always be recorded on the appropriate approved stationery.

5.5.9. Preventing Harm from Omitted or Delayed Doses

All medicines must be administered in an appropriate timely manner. High risk medicines should be administered at a time individualised to the patient, which may not coincide with established timing of medicines rounds. Staff should discuss these and other monitoring requirements, such as therapeutic levels (TDM), at clinical handover.
The Medicines Code document 'Procedures for Accessing Medicines' explains the processes involved in obtaining medication for patients in every care setting and contains a list of critical medicines that must be administered in a timely manner. This list is also kept for reference by the site team and pharmacists on the pharmacy shared drive.

5.5.10. Checking Administration

A person authorised to administer medicines must use professional judgement to determine the need to involve a second person to check administration. The exceptions, where it is usually preferable or covered by a different policy, are:

- Direct administration of Insulin (i.e. Insulins not given under 'supervised administration' or 'self-administration' by the patient/carer).
- Intravenous administration
- All controlled drugs in schedules 1, 2 and 3 that are subject to safe custody arrangements (These must be administered in accordance with Controlled Drugs: Safe Management and Use [Medicines Code])'.
- As required by an ESHT approved ward or department local procedure that overrides Trust Medicine Policy.

NMC standards for medicines management require that a second check of the administration of intravenous medication should be undertaken whenever possible. ESHT recognises this as its policy and requires that where a second person is used to check the medicine, they must be a practitioner authorised to prepare and administer that medicine. Pre-registration Student Nurses and Midwives may be second checkers if they have relevant skills and knowledge. Nursing Auxiliaries and Health Care Assistants must not be used for this purpose. In some community health care facilities a trained Health Care Assistant may be used if only 1 trained member of staff is available. The identity of the checker must be recorded; however the ultimate responsibility remains with the administering practitioner. In community settings i.e. patient's homes, the patient or carer may agree to provide a second check. Second checks are not essential in emergency situations.

It is good practice for intravenous medicines and essential for controlled drugs in schedules 1, 2 and 3 that are administered in secondary or intermediate care facilities that the second person witnesses the whole procedure from preparation to administration. In community practice within patients home the practitioner should follow locally agreed procedures.

Good practice for Second checking:

- Second checkers must be consciously engaged in the process and not distracted.
- Second checks should be done entirely independently
- Calculations should be done separately from the original administrator.
- Allergies should be checked

5.5.11. Administration of Nebulised Medicines

There is a significant risk when using air flow meters that patients may be inadvertently connected to medical air rather than oxygen and due to this risk there have been national and local alerts to minimise the use of air flow meters:
NatPSA/2021/003/NHSPS- Eliminating the risk of inadvertent connection to medical air via a flowmeter

British Thoracic Society (BTS) Guidance has stated that where gas is required to drive the administration of nebulised medication this should be driven via oxygen rather than air. This also reduces the risk of oxygen desaturation when air is used to drive nebulisers.
Where drugs are administered by electric powered nebulisers staff should be familiar with the devices in their area of work.

5.5.12. Administration of Unlicensed Medicines

Registered nurses/midwives may administer an unlicensed medicinal product with the patient's consent against a clinicians order or patient-specific direction. They should be satisfied that they have sufficient information to administer an unlicensed or off-label drug safely and wherever possible, that there is acceptable published evidence for the use of that product for the intended indication.
This is not applicable to non-registered staff administering pharmacy-labelled medicines in the patient's home.

5.5.13. Alcohol use by Inpatients

It may be acceptable in the context of the patient's overall care for them to drink small amounts of alcohol. This should be agreed by medical staff, and documented in the nursing/midwifery care plan and on the prescription chart (to avoid inadvertent drug – alcohol interactions). This policy should be made clear to patients.

It is not acceptable for patients to covertly drink alcohol, particularly when this represents a health risk to them, interferes with their treatment, or presents a danger or other problem for other patients or staff. If this happens the clinical team should jointly agree action which must include discussion with the patient, and the offer of appropriate help / support.

5.5.14. Suspected Illegal Drugs or Substances and Solvent use

The purpose of this section for Suspected Illegal Drugs or Substances brought onto ESHT premises by a Patient or Visitor is to ensure that members of staff are aware of their responsibilities to deal safely and legally with substances thought to be illegal when brought onto ESHT's premises. Whilst ESHT acknowledges that we may provide care for individuals with substance misuse problems, we do not tolerate the use, possession and supply of these substances on our premises. Please refer to the Trust **Policy for Illegal and Illicit Drugs.**

5.5.15. Management of Opiate Addicts during Hospitalisation

Admission

If prior information has not been received, attempt to confirm with the Community Drugs Team (CDT) Telephone 01323 749567, or Substance Misuse Service at Holmesdale Gardens (telephone 01424 710057), that the patient is a registered addict and the prescribed dose taken daily. Useful advice on a management programme may also be given.

During pharmacy opening hours, the ward pharmacist should be informed and asked to assist with local contacts.

If unable to contact the CDT/SMS, try the GP (with the patient's permission) or the patient's stated supplying pharmacy.

For advice on prescribing of analgesia contact the Acute Pain Team for advice.

Look for signs of drug abuse or withdrawal. The latter would include:

Pupil dilation	Raised blood pressure	Yawning	Goose flesh
Running nose	Vomiting	Raised pulse	Sneezing

If the patient shows signs of the above, these can be treated symptomatically or by giving a maximum of 20mg/20ml of methadone daily. Only give higher doses if these can be confirmed with the original prescriber.

Post-Operative Analgesia

Where possible, these patients should be identified pre-operatively to the relevant anaesthetist or acute pain team. If a patient is likely to be nil by mouth after surgery, it is sensible to plan to give their normal dose of methadone as close to the time of surgery as possible, to minimise the chances of withdrawal post-operatively. If a patient remains nil by mouth for more than 48 hours, contact Medicines Information (ext. (13) 3785 or (14) 7067), the Acute Pain Nurse Specialist, or the SMS for advice on an alternative maintenance regime.

When prescribing post-operative analgesia, consider using non-steroidal anti-inflammatories as first line agents, since these will not require dosage adjustment. Avoid using partial agonist opiates such as buprenorphine or pentazocine as these may precipitate withdrawal.

Discharge Planning

Prior to discharge contact the CDT/SMS and ensure that arrangements are in place for continuing supplies. It may be necessary to contact the patient's normal supplying pharmacy and apprise them of the situation. Enlist the aid of the ward pharmacist if available.

Only if the patient has to be discharged ahead of plans should a discharge prescription be written. This should be for a maximum of two days supply unless it covers a bank holiday. Again contact the CDT/SMS and the patient's stated supplying pharmacy if possible to inform them of supplies made on discharge.

5.6. Providing Information to Patients

Principle 6: Staff respect patients and carers role in shared decision making by ensuring information about the medicine being prescribed or administered is made available to them or others acting on their behalf whenever possible.

In order to encourage shared decision making and create a culture focussed on medicine optimisation, ESHT is keen to develop a strategic approach to how patient medicines information is managed organisationally and within the care setting to improve adherence and patient outcomes. This strategic approach is multi-disciplinary, mirrors NICE guidance and consists of:

1) Involving patients in decisions about medicines
2) Supporting adherence
3) Reviewing medicines
4) Improving communication between healthcare professionals as patients transfer between care settings

Provision of patient information about medicines during a patient's time at ESHT will support these strategic aims. The Medicine Code document ''Guidelines for the Completion of Medication Record Charts' support and facilitate the provision of patients' medicine information. The Medicines Information Department within Pharmacy have a direct role in supporting patients through the provision of a Medicines Helpline and can support clinicians and practitioners in obtaining good quality evidence based information sources for their patients.

5.7. Medicine Related Clinical Incidents

Principle 7: Staff act with openness within a learning culture that adapts processes as a result of medication incidents and errors to ensure that patients are kept safe.

All Medicines related incidents should be handled in accordance with the Trust policies for incident reporting. This document should be referred to when investigating incidents.

6. Equality and Human Rights Statement

Equality, human rights issues, dignity and respect need to be considered in the provision of information about medicines and the prescribing, procuring, dispensing, and administration of medicines. These considerations include the need for awareness of the temporary disabling effects a patient's condition may have on them, for example patients with swallowing difficulties may also have difficulty communicating or may be unconscious.

Informed consent underpins the use of medicines and is an essential part of the relationship and partnership between patients and clinicians. As such the following must be considered as part of the process:

a) The potential impact of a medicines origin on patient's religious or personal observances and empathising with those observances when prescribing or administering medicines, for example blood and animal derivatives for certain religious groups.
b) Disability-related requirements either in terms of the preparation of a medicine related to its administration, for example oral versus intravenous, or barriers to compliance, for example inhaler choice in a patient suffering with rheumatoid arthritis, or large label print for a partially sighted person. Steps should be taken to ensure all options are explored with patients to ensure they remain in control of choosing the most appropriate option for them.
c) Cultural barriers such as language or communication. Steps should be considered to maximise a patients understanding of medicines use wherever practicable, for example the provision of interpretation services during informed consent for non or less capable English speaking patients.
d) Learning disabilities that may be a barrier to understanding. Steps to overcome this may include the use of symbols on information leaflets or a patient advocate.

6.1. Mental Capacity Act

All staff prescribing, administering or advising on medicines should be aware of and take into consideration the requirements of the Mental Capacity Act in any decisions or actions they may take or recommend. This is especially the case in areas where the patient will not be aware of medicine administration for example where there is a need for covert drug administration, rapid tranquillisation, the patient is unconscious or unable to communicate.

Staff should refer to the Trust Mental Capacity Act guidelines and MCA 2006 Code of Practice for guidance when necessary.

6.2. Control of Substances Hazardous to Health (COSHH)

Medicines may be hazardous and therefore adequate safety protection should be worn when appropriate if handling medicines. Refer to the summary of product characteristics for a medicinal product and COSHH datasheets for information

7. Training

The staff groups who may administer medicine, their training requirements and the assessment of their competency will be determined by individual services through local policies and procedures. The web-site http://www.skillsforhealth.org.uk/ includes competency assessments for the administration of medicines or assisted administration of medicines.

It is the responsibility of line / department managers to ensure that practitioners involved in administration of medicines are competent to do so and all staff involved in administering medicines to patients should have this included in their job description.

Practitioners are responsible for:

- Undertaking appropriate and necessary training
- Working within their professional constraints
- Providing evidence of and maintaining competence
- Acting within their sphere of competence and professional obligations i.e. ensure that they decline any tasks which they are not able to undertake in a safe and skilled manner
- Acting in line with relevant policies and procedures

Contemporary evidence of training / competency to administer medication is required & should be included in the annual PR/PDP for all HC staff administering medicines

8. Monitoring Compliance with the Document

Compliance with this document will be assessed through the incident reporting process, within the East Sussex Healthcare NHS Trust and includes fortnightly review by the Head of Medicines Management and Pharmacy of medicine related incidents. Incidents are reviewed regularly by the Medication Safety Officer and bimonthly at Medicines Safety Group meetings.

The content of this document will be reviewed every three years by the Medicines Policy and Procedure Group.

Elements of Medicines management are audited on a rolling basis and SOPs are available that outline the processes.

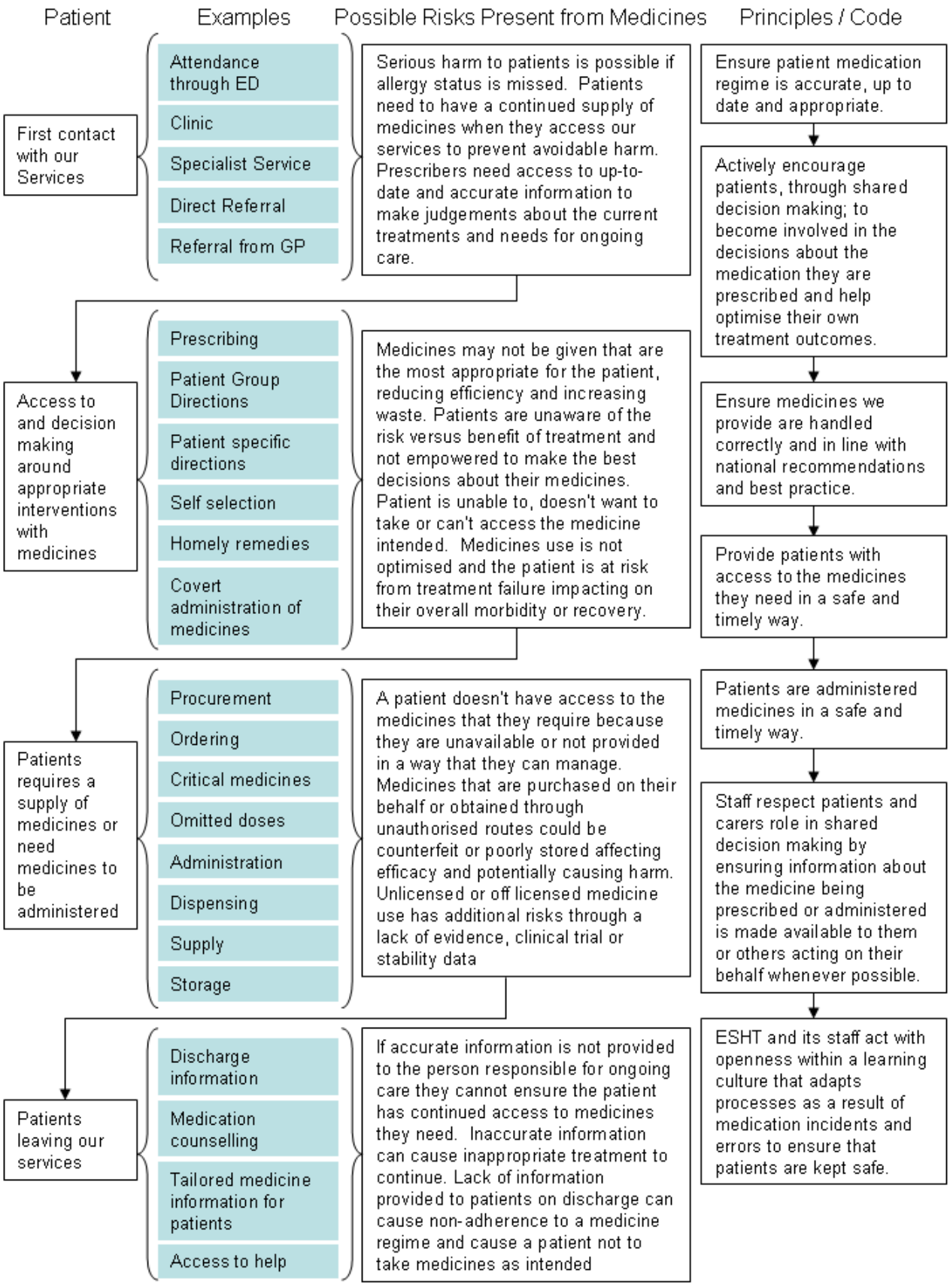
Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Medicines Policy [Medicines Code] Document	Chief Pharmacist	Medicines Optimisation Group	Every 3 years	Medicines Optimisation Group	Medicines Optimisation Group	Medicines Optimisation Group / Division Management Teams
Incidents	Medication Safety Officer	Datixweb	Continuous Review	Medicines Optimisation Group	Medicines Safety Group / Division Management Teams	Medicines Safety Group / Division Management Teams
External drivers	Medication Safety Officer	Medicines Safety Group Reports and Gap Analysis	Continuous Review	Medicines Optimisation Group	Medicines Safety Group / Division Management Teams	Medicines Optimisation Group / Division Management Teams
Audit and KPI Monitoring	Pharmacy governance Lead / Medication Safety Officer	Medicines Safety Group Reports and Dashboards	KPIs - Monthly Audits - bimonthly	Medicines Optimisation Group	Medicines Safety Group / Division Management Teams	Medicines Optimisation Group / Division Management Teams

9. References

General Medical Council (2013), Good practice in prescribing and managing medical devices, http://www.gmc-uk.org/static/documents/content/Prescribing_guidance(1).pdf, last accessed (06 May 2014)

Nurse & Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers, http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-proficiency-nurse-and-midwife-prescribers.pdf, (last accessed (06 May 2014)

Appendix A - Patient Focussed Medicines Management



Appendix B – Glossary of Terms and Abbreviations

Within this policy the following abbreviations and definitions are used:

Full Name	Abbreviation	Meaning
	FP10HNC FP10CDF	Types of NHS prescription stationery for dispensing and ordering from community pharmacies.
Administer		To give a medicine by introduction into the body, (e.g. orally, rectally, by inhalation or by injection etc) or by external application (e.g. cream or ointment).
Clinical Commissioning Group	CCG	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Community Nurse Prescriber		A Community Nurse or Health Visitor able to prescribe from the Nurse Practitioner Formulary.
Controlled Drug	CD	A medicine that is defined by the Misuse of Drugs Act 1971 and regulated by the Misuse of Drugs Regulations 2001. See The Management of Controlled Drugs.
Dispense		To prepare a clinically appropriate medicine for a patient for self administration or administration by another person. Dispensing is the term used to cover the act of manipulating a medicine in a form ready for supply or administration. In order to simplify the policy the term dispensing will only cover the activities undertaken by a hospital pharmacy or pharmacy contractor under an SLA. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product). These functions are performed under the supervision of a pharmacist (which may be delegated to staff working under SOPs).
Gun labelled Medicine		A pharmacy only or general sales list medicines that have the address of the supplying organisation attached to it to make it compliant with the medicines act when supplied as a dispensed medicine. The address is attached by a labelling gun.
Homely Remedy		A homely remedy is a product that can be obtained, without a prescription, for the immediate relief of a minor, self-limiting ailment.
Independent prescriber	IP	A practitioner responsible for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required who can prescribe any medication available from the NHS within their area of competence.

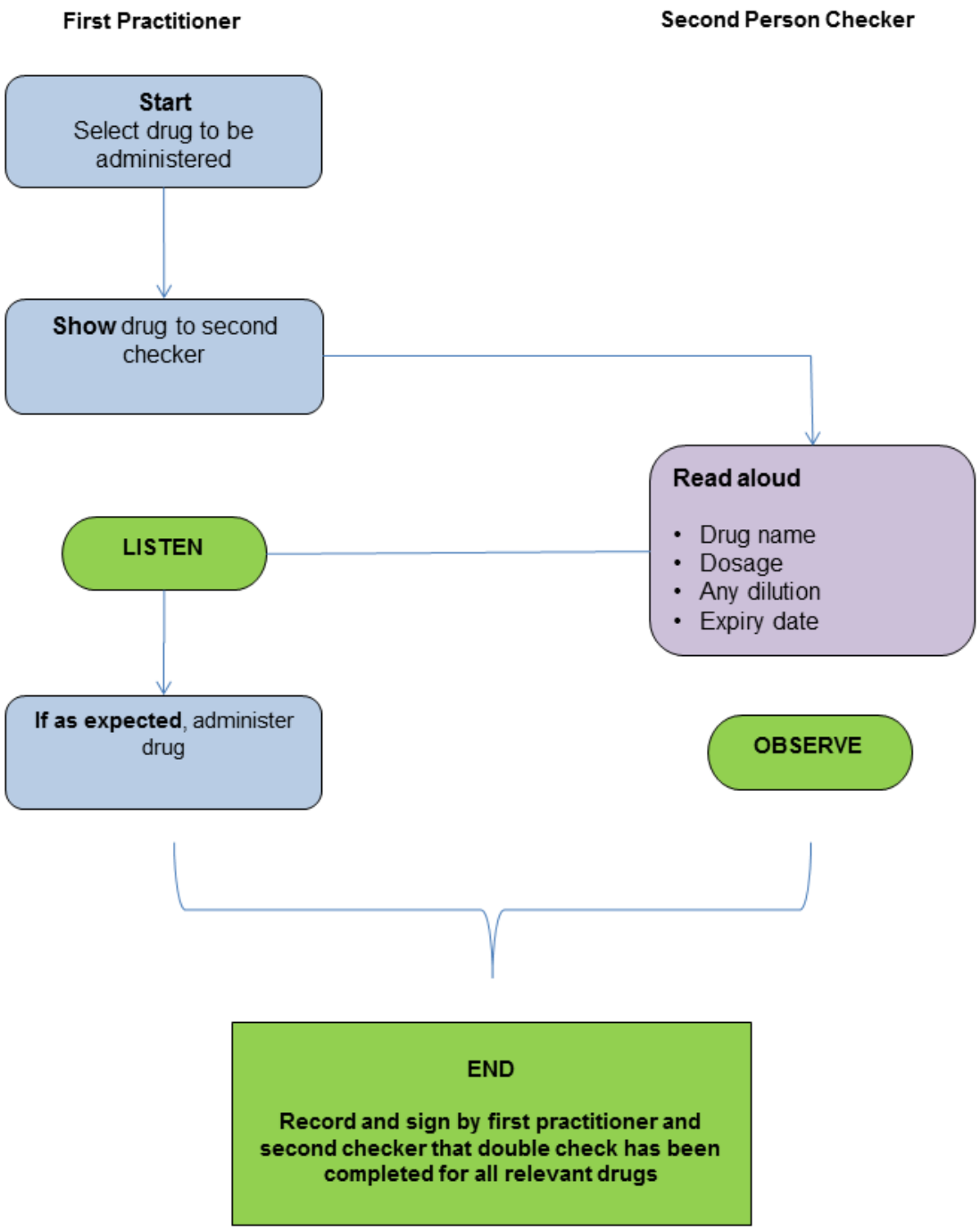
		Independent prescribers can be divided into medical (doctors and dentists) and non medical. Whilst medical prescribers can prescribe any controlled drug non medical prescribers are restricted to specific controlled drugs for specific conditions.
Medication Order and Administration Chart	MOAC	Trust documentation used for inpatients to provide an order from a prescriber for medicines to be administered, it also allows recording of administration (see MAR below). Other commonly used names are prescription chart or drug chart.
Medicine		Any substance or combination of substances presented for treating or preventing disease whose primary mode of action is pharmacological, metabolic or immunicological. Any substance or combination of substances which may be administered with a view to making a medical diagnosis or restoring, correcting or modifying physiological or psychological functions.
Medicine Management Service	MMS	The service provided by pharmacy technicians to ward areas that concentrate on medication histories, patients own medicines, one stop dispensing, non-stock top-up and supporting medicines reconciliation.
Medicines Compliance Aids	MedCA	Medicines Compliance Aids within the context of this document includes monitored dosage systems that are filled by community pharmacies or purchased by patients or carers to aid adherence with a medication regime. These include Manrex, Venolink, Nomad, and Dosette boxes.
Medicines Optimisation		Medicines optimisation is an approach to medicines use that seeks to maximise the beneficial clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement.
Medicines or Medication Administration Record	MAR	A Medication Administration Record or MAR is a legal record of medicines administered to a patient by a health care professional/worker and is part of a patient's permanent record. The health care professional/worker signs off on the record at the time that the drug or device is administered. MARs are often commonly referred to as drug or prescription charts; however as MARs may not contain the prescriber's physical medication order and may have medicines transcribed on them by someone other than the prescriber (e.g. nurse) the term MOAC is used to refer to drug charts (see below).
Medicines Reconciliation		The process for ensuring that a patient's medication history prior to admission is obtained and is used to assess the patient's current medication regime within the clinical context of the admission.
Medicines Record Chart	MRC	A medicines record chart is a compliance aid that ensures additional information is provided to a patient in a form that is understandable by them.
Off-licence / off-label medicine		Medicinal products, licensed but prescribed outside of their licence specifications (off-label).
Patient Group	PGD	A specific written instruction for the supply or

Direction		administration of named medicines in an identified clinical situation in the absence of a written prescription. It has been drawn up within the Trust by doctors, nurses/midwives, pharmacists and other professionals and reviewed by the Medicines Policy and Procedure Group and formally approved by the Trust.
Patient Specific Direction	PSD	A specific instruction given by an independent prescriber for the supply or administration of named medicines to identified patients. A prescription is an example of a patient specific direction.
Pharmaceutical equivalence		Products are considered pharmaceutically equivalent if they contain the same amount (or concentration) of the same active substance in the same dosage form, and meet the same or comparable standards considered in the light of the clinical needs of the patient at the time of its use. Such uses are informed and guided by a respectable and responsible body of professional opinion.
Shared Care Agreement	SCA	A shared care agreement involves the establishment of a partnership between primary care and secondary care for the management of a particular type of patient's medicine, for example azathioprine or methotrexate. The shared care arrangement must set out the responsibility of each care provider and make it clear where accountability lies. Shared care arrangements are useful in improving access to medicines for patients and improving their choice about where care is delivered. Shared care agreements also have the additional benefit in reducing the burden of follow-up appointments and the associated prescribing costs of chronic therapy.
Supplementary prescriber	SP	A practitioner who prescribes in partnership with an independent medical prescriber. (They may prescribe for the full range of medical conditions provided that they do so under the terms of a patient specific clinical management plan. The Plan will be drawn up, with the patient's agreement, following diagnosis of the patient's condition by the independent prescriber and following consultation and agreement between the independent and supplementary prescribers.)
Supply		To provide a medicine for administration.
Therapeutic Drug Monitoring	TDM	Therapeutic drug monitoring (TDM) is a branch of clinical chemistry and clinical pharmacology that specialises in the measurement of medication concentrations in blood. Its main focus is on drugs with a narrow therapeutic range, i.e. drugs that can easily be under- or overdosed. TDM aimed at improving patient care by individually adjusting the dose of drugs for which clinical experience or clinical trials have shown it improved outcome in the general or special populations.
To prescribe, prescribing or		To authorise in writing the supply and/or administration of a medicine.

medication order		
Unlicensed Medicine		Unlicensed medicinal products (often called "specials") that have been specially prepared by the holder of a Manufacturers Specials Licence or imported in response to or in anticipation of the order of a doctor or dentist to meet the special need(s) of the patient(s).

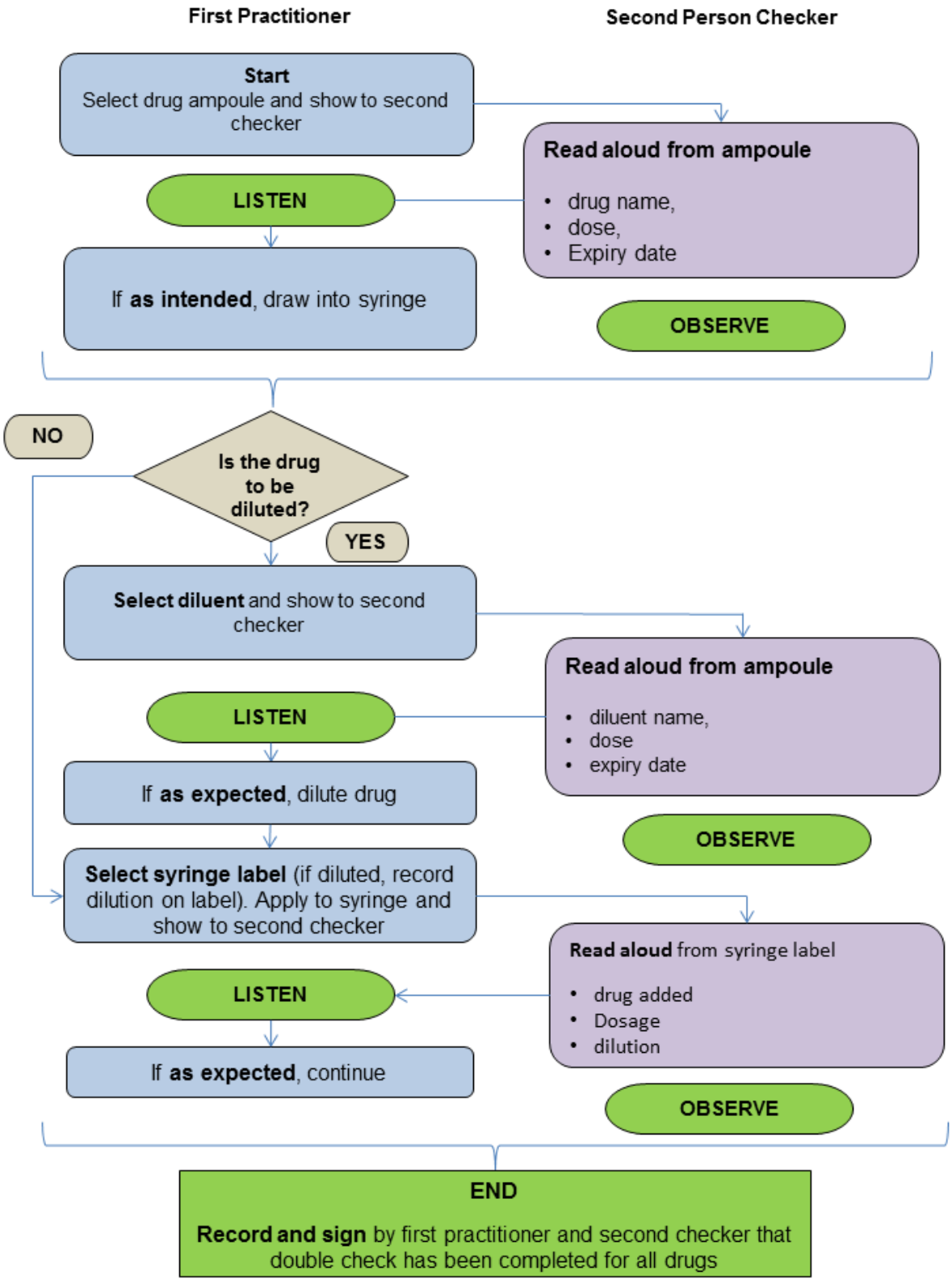
Appendix C: Double Checking Administration and Preparation of Drugs[4]

Double-checking process for drug administration (Repeat for each drug)



[4] Based on NPSA and Royal College of Anaesthetists guidance

Double-checking process for drug preparation (Repeat for each drug)



Appendix D – EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

Due Regard, Equality & Human Rights Analysis

Title of document: Medicines
Who will be affected by this work? staff, patients, service users, partner organisations
Please include a brief summary of intended outcome: Lays down the policies and procedures for medicines use in the Trust, including medicines management and optimisation. It is expected that staff following the document will achieve best practice in medicines legislation and best practice guidance.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	As a Trust policy the document has wide reaching impacts on all groups. The policy interprets current medicines legislation and the principle of shared decision making underpins the policy. As part of the policy patient views are held central to the decision about medicines are used and as such characteristics such as religion / disability etc. are widely referred to in the policy
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	(Ensure you comment and link to main policy with page/paragraph number)
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	No alternative legislative requirement	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	Minimises disadvantage by ensuring any patient who has the ability to manage their own medicines at home or in their normal care setting has the same opportunities. The policy allows children, all adults and people with disabilities to be involved in their meds without prejudice. Has statements to include equality and humans rights manager if advice needed. Any medicine management practices	

		must take in to account ability to communicate (race / age / disability) and any sensory or mental capacity factors (disability / age).
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	As above
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	As above, there is a requirement that if barriers / issues are identified that may cause problems in a patient being able to manage their medicines a pharmacist or pharmacy tech should become involved to provide help for example bold, large type labels (sensory disability) or compliance aids (physical disability). The use of a medicines record chart also allows support to be given to patients and this may be filled in by patients or carers to ensure it is meaningful to them.
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	Promotes fairness and equality by opening up the scheme to all patients irrespective of disability, race and sex. It promotes dignity and autonomy by allowing patients to self-medicate and effectively self-care in a risk managed process.
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	Work was undertaken with the equality group in 2012.
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No

Appendix E

NHS
National Patient Safety Agency

Fire Hazard

With Paraffin Based Skin Products On Dressings And Clothing

Skin products containing paraffin based products, for example White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment in contact with dressings and clothing are easily ignited with a naked flame or a cigarette.

Keep away from fire when using these products

For further information, go to www.npsa.nhs.uk

Appendix F

Skin products containing paraffin based products, for example White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment, in contact with dressings and clothing are easily ignited with a naked flame or a cigarette.

Keep away from fire when using these products

NHS National Patient Safety Agency

Fire Hazard

With Paraffin Based Skin Products On Dressings And Clothing

If you are being treated with a paraffin based product, for example White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment, which is covered by a dressing or clothing, there is a danger that smoking, or using a naked flame could cause your dressing or clothing to catch fire.

To stop this happening it is very important that you do the following:

1. *Do not smoke, use naked flames (or be near people who are smoking or using naked flames) or go near to anything else which may cause a fire whilst these products are in contact with your clothes, dressing or bandages.*
2. *Ensure that your clothes and bedding are changed regularly (preferably daily) as the paraffin soaks into the fabrics and can potentially be a fire hazard. You should also be careful to make sure that the paraffin does not soak into chairs, seating or other furniture.*
3. *Tell your relatives or carers about your treatment and show them this leaflet.*
4. *Tell your doctor, nurse or pharmacist if you normally smoke. They will be able to offer you help and advice to stop smoking.*

Your treatment is important, but it is essential that you are kept safe when you use these products. By following the advice in this leaflet, you will help us to make sure that you are treated safely.

Please speak to your doctor, nurse or pharmacist if you have any questions about the information in this leaflet.

East Sussex Healthcare NHS Trust

Controlled Drugs: Safe Use and Management [Medicines Code]

Document ID number	1576
Version:	V2
Ratified by:	Medicines Optimisation Group
Date ratified:	October 2021
Name of author and title:	Jane Starr, Medication Safety Officer
Date originally written:	July 2016
Date of current version was completed	September 2021
Name of responsible committee/individual:	Medicines Optimisation Group
Date issued:	22 October 2021
Review date:	October 2024
Target audience:	All ESHT Staff
Compliance with CQC Fundamental Standard	Safe care and Treatment Good Governance
Compliance with any other external requirements (e.g. Information Governance)	Misuse of Drugs Act 1971 Misuse of Drug Regulations 2001 NICE Guidance: Controlled Drugs; Safe Use and Management CQC Key Line of Enquiry requirement for safe administration of Medication. (KLOE S4)
Associated Documents:	Medicines Policy Medicines Code Documents

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
1.0	July 2016	Jonathon Palmer	New NICE guidance, amalgamation of Trust Controlled Drug Policy and Procedure into a single document	The new document has brought the two documents: Procedures for the Safer Management of Controlled Drugs [Medicines Code] and Medicines Management Policy 8: The Management of Controlled Drugs into a single document. The document has also been updated to include a more substantial prescribing section, risk assessments for schedule 3,4 and 5 CDs, alignment with current policy on illicit substances, bolstering of storage requirements to include temperature requirements and a general update in line with the new NICE guidance from April 2016.
1.1	Sept 2016	Jonathon Palmer	Clarification of record keeping in theatres	New section added (6.7.4) to cover record keeping in theatres.
1.2	March 2017	Jonathon Palmer	New accountable officer details	See section 5.9
1.3	July 2017	Jane Starr	Clarification of disposal of partially used ampoules or vials	Addition to include emptying part used vials or ampoules to ensure controlled drugs are irretrievable when disposed in sharps bin.
1.4	March 2018	Jane Starr	Update in line with NHS England advice- clear dosing instructions	Section 6- process updated for Prescribers and Pharmacy supply.
1.5	March 2019	Jane Starr	Clarification of governance around PCA bags	Updated governance, documentation and disposal of PCA bags included due to incidents reported.
V2	Sept 2021	Jane Starr	Review and update	Updated to include links to references and omnicells stock checks.

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Rosie Furner	Community Health Services Pharmacist	July 2016
Melanie Adams	Pharmacy Governance manager	July 2016
Simon Badcott	Chief Pharmacist	July 2016
David Hughes	Medical Director and CD Accountable Officer	July 2016
Alice Webster	Director of Nursing	July 2016
Angela Colosi	Assistant Director of Nursing	July 2016
TNMAG		
Medicines Optimisation Group		July 2016
Medicines Optimisation Group		March 2017
Medicines Optimisation Group		March 2018
Medicines Optimisation Group		March 2019
Medicines Optimisation Group		October 2021

Table of Contents

1. Introduction

Drugs defined under the 'Misuse of Drugs Act 1971' are subject to special legislative controls as there is a potential for them to be abused or diverted, causing possible harm. These drugs are termed 'controlled drugs'. The Misuse of Drugs Regulations 2001 defines the legislation for licensing of production, possession and supply of substances classified under the act. Department of Health guidance produced in 2007 and National Prescribing Centre in 2009 states that procedures must be established in all areas where controlled drugs are handled including clinics, inpatient areas and community settings. NICE also published guidance in April 2016; controlled drugs safe use and management.

There have been major advances in the therapeutic use of controlled drugs in the last few years. Controlled drugs are now an essential part of modern clinical care. It is recognised that the strengthened controls that have resulted from the Shipman enquiries must be implemented in a way that supports professionals and encourages good practice in the use of these important medicines when clinically required by patients.

This document has been developed to inform and support nursing staff and managers on the safe handling of controlled drugs (CDs) and needs to be read in conjunction with the relevant sections of the Medicine Policy.

2. Rationale

The rationale for this document is to interpret the overarching legislation and guidance to define the ESHT policy for how controlled drugs are managed across ESHT and to provide a resource to direct staff in the procedures to follow when handling controlled drugs.

The document provides the policy framework for procuring, storing, supplying, transporting, prescribing, administering, recording, and disposing safely of CDs, whilst at the same time helping to ensure appropriate and convenient access for those patients that require them. It is not designed to provide advice on the clinical choice or use of CDs. The risk posed by the security of controlled drug use differs between clinical settings. For that reason in areas where the minimum standards within this document cannot be met by default, action must be undertaken to risk assess and put local procedures in place to mitigate the risk.

3. Scope

All Acute and Community Staff involved in procurement, prescribing, administration, dispensing, destruction and handling of medicines at ESHT.

4. Definitions

4.1. Controlled Drug(s) (CD)

A medicine defined by the Misuse of Drugs Act 1971 and regulated by the Misuse of Drugs Regulations 2001.

4.2. Class

The Misuse of Drugs Act sets out three separate categories of controlled drugs, Class A, Class B, and Class C. Class A drugs represent those deemed most dangerous, and so carry the harshest punishments. Class C represents those thought to have the least capacity for harm, and so the Act demands more lenient punishment. Being found in possession of a drug on this list is dealt with less seriously than would be if it were deemed that there is intent to supply (even without payment) the drug to others.

4.3. Controlled Drug Register (CDR)

The term 'Controlled Drug Register' relates to the registers held within pharmacy departments for documenting the supply of controlled drugs. Currently the approved registers used in ESHT pharmacies are Controlled Drug Register Issues (Crown copyright) 0900520 and Controlled Drug Register Receipts (Crown copyright) 90-521

4.4. Controlled Drug Record Book (CDRB)

The Controlled Drug Record Book relates to the books used in clinical areas to record receipt and the administration of medicines to patients. Currently the approved stationery are Ward Controlled Drugs Record Book (Crown copyright) WOP105 (Previously 90-501) and Theatre Controlled Drugs Record book 0900502

4.5. Controlled Drug Order Book (CDOB)

The Controlled Drug Order Book relates to the duplicate books used to requisition CDs from pharmacy departments. Currently the approved stationery is Ward Controlled Drugs Order book WOP100 (Previously 90-500).

4.6. FP10 (CDF)

Dedicated controlled drug requisition form, the FP10CDF for schedule 2 and 3 controlled drugs, has been developed as part of the Government's actions to improve the safe management of controlled drugs. Following changes to the Misuse of Drug Regulations, pharmacy contractors are now required to submit the FP10CDF to the Prescription Pricing Department for audit.

4.7. Schedule

With regard to lawful possession and supply, a different set of categories apply which are set out in the Misuse of Drugs Regulations 2001 (as amended). This sets out five schedules each with their own restrictions. Schedule 1 contains substances which allegedly have no medicinal value such as hallucinogens and their use is limited primarily to research, whereas schedules 2-5 contain the other regulated drugs. This means that although drugs may fall into the category of Class A/B/C, they may also fall into one of the schedules for legitimate medicinal use. For example, diamorphine is a Class A drug under the Misuse of Drugs Act 1971, but when lawfully supplied falls under the category of a Schedule 2 controlled drug.

5. Accountabilities

5.1. All Staff

All staff have responsibility to ensure that they follow the applicable procedures within this document. Staff either directly or through their line manager **must** inform the Accountable Officer with information regarding any complaints, incidents and concerns in relation to controlled drugs.

This includes controlled drugs issues relating to independent contractors (e.g. general practitioners and community pharmacy) that will be forwarded to the respective CCG.

Note: If any staff within ESHT have any concerns about the management of controlled drugs inside or outside of ESHT then they should initially contact the Accountable

Officer. If any staff have any concerns about the practice of the Accountable Officer then they can approach either their line manager, the 'Speak Up Guardian', Medical or Nursing Directors, the Chief Executive Officer or the NHS England Local Area Team CD Accountable Officer.

5.2. Nurses, Midwives and Operating Department Practitioners

A Nurse, Midwife or ODP may only requisition, balance check, order, check and remove controlled drugs from the controlled drugs cupboard and return them to the cupboard on the specific delegated authority of either the registered nurse, midwife, ODP in charge of a ward / department or doctor. In practice this would be all registered duty staff who are deemed competent to handle controlled drugs.

Note: Agency Nurses are not eligible to sign requisitions for controlled drugs.

All registered nurses managing medicines (including CDs) and evaluating their effects are responsible for their own actions or non-actions. Nurses and ODPs have a responsibility to maintain their own competence and highlight any training and learning needs, including clinical supervision.

5.3. Registered Staff in Charge of a Ward or Operating Department

Responsible for:

- The safe and appropriate management of any controlled drugs held by that ward or theatre
- All supplies made from the controlled drugs cupboard on that ward or theatre
- The controlled drugs cupboard keys for that ward or theatre

Note: The registered nurse, midwife or OPD in charge can delegate control of access (i.e. key-holding) to the CD cupboard to another, such as a registered nurse or ODP. However, legal responsibility remains with the registered nurse, midwife or ODP in charge.

5.4. Clinical Service / Department Managers

Clinical service and department managers have direct responsibility for ensuring that processes are in place for the safe and appropriate management of Controlled Drugs (CDs) within the clinical areas under their control.

5.5. Assistant Directors of Nursing (ADNs)

ADNs have overall responsibility and oversight (including audit) for the safe and appropriate management of Controlled Drugs (CDs) within clinical areas under their control.

5.6. Pharmacy

Pharmacy staff are responsible for:

- Adhering to departmental procedures related to controlled drug management.
- Guiding and supporting other clinical staff with controlled drug management and destruction.

Pharmacy has responsibility to provide control assurance to the Trust through audit.

5.7. Authorised Person to Destroy Controlled Drugs

A member of staff, the Authorised Person, must have appropriate training, written authorisation and be accountable directly to the Accountable Officer to have authorisation for destroying stock controlled drugs.

5.8. The Controlled Drug Accountable Officer

The Accountable Officer responsibilities are set out in (part 2) of the legislation 'Controlled Drug (Supervision of Management and Use) Regulations 2006'. The Accountable Officer must be or report directly to an Executive Director.

The Accountable Officer should personally not be involved in routine prescribing, supply, administration or disposal of controlled drugs.

The Accountable Officer should not have any restrictions placed upon him/her by their regulatory body with regards to controlled drugs.

Individuals such as Chief Nurses, Medical Directors and Chief Pharmacists can be appointed as the Accountable Officer provided they meet these criteria.

It is desirable that the Accountable Officer has previous experience in the handling of controlled drugs and has a high degree of familiarity with controlled drugs legislation.

The Accountable Officer must be part of a regional Controlled Drug Local Intelligence Network (CDLIN) and ensure that the network receive quarterly updates on controlled drug incidents occurring at ESHT.

The Accountable Officer should have an outline job description that has been approved by the trust board. This job description should be reviewed annually to ensure it reflects any developments with this area.

The Accountable Officer is responsible for ensuring the development and implementation of systems for routinely monitoring the use of controlled drugs through pro-active analysis, identifying triggers for concern and taking appropriate action.

The Accountable Officer must ensure the use of controlled drugs is monitored through routine processes such as data analysis, audit and clinical governance, as part of an integral part of normal governance arrangements.

The Accountable Officer will routinely monitor the use of controlled drugs through these processes.

The Accountable Officer is responsible for authorising individuals or groups of people to witness the destructions of controlled drugs in compliance with the regulations. These authorised individuals or groups are referred to as "Authorised Persons".

The Accountable Officer should call on other Accountable Officers if a conflict of interest arises.

5.9. Organisation

The organisation is accountable for ensuring the safe management of controlled drugs through an appointed Accountable Officer.

NHS organisations have a statutory duty to nominate a specific individual as the Accountable Officer. The regulatory requirements for Accountable Officer are set out in full in the Controlled Drugs (Supervision and Management of Use) Regulations 2006.

The appointment or removal of an Accountable Officer should be notified to the Care Quality Commission.

The appointment or removal of an Accountable Officer should be included in the minutes of the board meetings to ensure support at board level for the Accountable Officer.

Note: The Accountable Officer for ESHT is currently:

Simon Badcott
Chief Pharmacist,
Pharmacy Department,
Eastbourne District General Hospital,
Kings Drive,
Eastbourne, BN21 2UD

Contact via simon.badcott@nhs.net (0300 1313455 / 0300 1314718) or pharmacy.
Contact pharmacy on-call out-of-hours

6. Process

6.1. Prescribing

CDs can be prescribed on the Medication Order and Administration chart. Requests for supplies of controlled drugs labelled for individual patient use must be prescribed on approved stationery or FP10.

Controlled drugs supplies required for discharge must also be prescribed on approved stationery or FP10.

Non-medical prescribers may prescribe controlled drugs in certain circumstances (refer to the NMP policy or latest Department of Health guidance).

FP10 prescriptions and other approved stationery for schedule 2 and 3 controlled drugs must fully comply with the legal requirements of the Misuse of Drugs Regulations 2001.

It is an offence for a prescriber to issue an incomplete prescription. A pharmacist is not allowed to dispense a controlled drug unless all the information required by law is given on the prescription.

The BNF has expanded advice on prescribing controlled drugs, including a full listing of which drugs fall into which schedule of the Misuse of Drugs Regulations 2001. See Appendix E for a list of frequently used controlled drugs at ESHT.

Verbal orders cannot be given for controlled drugs.

Where there is an inadequate supply of patients own controlled drugs or items have been initiated during the hospital stay, a prescription for discharge medicines will be required.
A specified amount (for acute areas minimum 7 days and community health services, Care homes and Nursing homes a minimum of 14 days) will be supplied at discharge.

Where the prescriber believes it is in the clinical interest of the patient to prescribe for more than two weeks and would not pose an unacceptable threat to patient safety, the prescriber should document the reasons in the patient's notes.

When prescribing controlled drugs the prescriber must document clearly the indication and regimen for the controlled drug in the patient's care record, check the patient's current clinical needs and if appropriate adjust dose until adequate control achieved.
The prescription must contain specific directions for the patient or administrator which include the appropriate dose (or defined dose range) and the frequency that the dose is to be given. "When required" or "as directed" should not be used without a specific direction of dose and time interval.

6.2. Transcribing of Controlled Drugs

Refer to the Procedure for Transcribing Information about Medicines by Nursing and Social Services Staff (Community Bedded Services).

Stock items cannot be administered to patients against a transcribed item. Stock can only be used if a prescriber has authorised the prescription.

6.3. Supply

The procedures for supplying controlled drugs will be covered by either the pharmacy departments or external pharmacy contractors operating procedures.

The principles are that the person supplying should:

- Follow relevant standards set by the GPhC
- Check with the prescriber about any safety concerns, such as whether the prescribed dose is safe for the person.
- Ensure that an appropriate dose and frequency is prescribed for each medicine.

Pharmacy procedures must include provision for reasonable steps to be taken for confirming the identity of the person or their representative when they are being supplied to. Refer to pharmacy department SOPs.

When the total quantity of a controlled drug in schedule 2, 3 or 4 cannot be supplied:

- Inform the person receiving the drug only a part supply is available
- Tell them when the rest will be available

6.4. Information and Advice to People Receiving Controlled Drugs

When prescribing or supplying (including as part of the discharge process) more than one formulation (for example immediate-release and sustained release formulations) of a controlled drug, the differences should be discussed with the patient, and their family members or carers if appropriate, and check that they understand what the different formulations are for and when to take them.

When supplying controlled drugs, advise people how to safely dispose of:

- Controlled drugs at a community pharmacy
- Used controlled drugs

The Trust patient information leaflet can be printed and given to the patient to reinforce this advice; https://www.esht.nhs.uk/wp-content/uploads/2019/12/0698.pdf

Both prescribers and suppliers of controlled drugs must be mindful of the potential for harm whilst driving under the influence of controlled drugs and the need to advise patients of the law. Prescribers, pharmacy staff and nurses should provide advice in accordance with DH guidelines found at:

https://www.gov.uk/government/publications/drug-driving-and-medicine-advice-for-healthcare-professionals

6.5. Administration

6.5.1. General Principles

Nurses and Midwives may administer controlled drugs to a patient in their care as long as they are acting in accordance with the written directions of a doctor, dentist or appropriate non-medical prescriber.

Only registered nurses who have been deemed competent may administer controlled drugs. Those qualified to administer controlled drugs must act according to their own competence and must comply with their own professional code of conduct.

The prescriber must be contacted before any drug is administered if there is any doubt about the prescribed drug. Advice may be sought from other health professionals, by telephone or e-mail to support clinical decision making (e.g. Medicines Information or on-call Pharmacist).

Verbal orders for controlled drugs must not be accepted.

Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. Where a calculation is required to obtain partial or complex doses it is good practice for these to be checked by another nurse, pharmacist or doctor where possible in order to minimise the risk of error. The use of calculators to determine the volume or quantity of medication should not act as a substitute for arithmetical knowledge and skill.

The principles for administering medicines are laid out in the Medicines Policy, individual professional body and RCN/ RPS Professional Guidance on the Administration of Medicines in Healthcare settings. In the case of controlled drugs, the following must also be undertaken:

- Check stock levels before any controlled drug administration against the last entry on the controlled drug stock record in the CDRB (or Omnicell stock level if relevant).
- Complete **ALL** appropriate documentation, which includes the administration record and CDRB if appropriate
- In the CDRB there must be separate pages for each drug and each strength and separate records for patients own CDs.
- Entries must be made in chronological order, made in black ink, and be indelible
- After every action involving CDs, the stock balance of that item must be confirmed to be correct.
- If a mistake is made then it must be bracketed in such a way that the original entry is still clearly legible.

When administering any controlled drug (including buprenorphine, diamorphine, dipipanone, fentanyl, hydromorphone, methadone, morphine, oxycodone, papaveretum and pethidine) the nurse should:

- ***Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient:*** This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records. Staff must confirm, as with any administered medicine, recent opioid dose, formulation, frequency and any other analgesic medicines prescribed for the patient.

- ***Ensure that where a dose increase is intended that the calculated dose is safe for the patient:*** A dose increase should not normally be more than 50% higher than the previous dose and the person administering the controlled drug must check that the calculated dose is safe for the patient (NPSA2008).

- ***Ensure that they are familiar with the following characteristics of that medicine and formulation***: Usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side effects

A controlled drug obtained on FP10 prescription or as discharge medicines from hospital or hospice is the property of the patient.

Patient's own controlled drugs may only be administered to the named patient to whom it was dispensed.

Refer to the following Policies and Procedures:

- Guidelines and Procedures for the Management of High Strength Opioids
- Guidelines and Procedures for the Management of Injectable Medicines

6.5.2. Acute Wards or Community Bedded Units

If stock or patients' own controlled drugs are administered to a patient then two registered staff must be involved, both of whom must be a registered nurse, midwife or ODP. In addition the second check is able to be carried out by a student nurse, student midwife or nurse associate if they are deemed competent by the lead nurse. Both must be present during the whole process surrounding the administration of the controlled drug.

In Community Health Service settings where a single trained member of staff is on duty Pre-registration Student Nurses and Student Midwives and Health Care Assistants may perform a second CD check.

In all other areas that deviate from this policy a risk assessment must be carried out with any local procedures approved by the appropriate ADN and Accountable Officer. Otherwise to perform a second check the practitioner must be authorised to prepare and administer that medicine.

Administration must be recorded in the controlled drug register/ Omnicell and the patient administration record by the nurse, midwife or ODP administering the drug and witnessed by the second person.

6.5.3. Joint Health and Social Services Settings

When patient's own controlled drugs are administered within a joint Health and Social Services setting, which is registered as a care home with nursing (e.g. Firwood

House and nurse-led units at Milton Grange), it is good practice for this administration to be witnessed by a trained nurse or suitably accredited staff member.

The witness should also sign the controlled drugs register.

Note: no patient should be deprived of prescribed medicine because there is only one member of staff on duty when he or she needs it.

6.5.4. Patient, Carer and Parent Administration of Controlled Drugs

Refer to Procedures for Self (Patient), Parent or Carer Administration of Medicines [Medicines Code]

6.6. Management in Inpatient Settings and Community Bedded Units

6.6.1. Controlled Drug Stocks

There should be a list of the CDs to be held in each ward or department as stock items which is agreed between the ward manager and pharmacy team. The stock list of controlled drugs to be held in a department must be reviewed annually and modified if practices change.

6.6.2. Requisitioning CDs from ESHT Pharmacies

A list of nurses / midwives / ODPs authorised to requisition controlled drugs must be maintained by the ward / department and lodged with pharmacy. This list should be updated when a new member of staff joins/leaves that clinical area to work and reviewed at least annually. The list should comprise of name, signature and PIN/Registration.

Requisitions for controlled drugs must be made in the Controlled Drug Order Book (CDOB), by the nurse, midwife or ODP under the direction of the registered nurse or midwife in charge.

Except in emergencies, requisitions should be sent to pharmacy before 11am from Monday to Friday. Controlled drugs will only be delivered if the order is received before 11am (i.e. ward will need to collect controlled drugs for orders received after 11am).

Community bedded units order CD stock items from ESHT pharmacies and will follow the local procedure for this.

Note: it may take up to three working days for the prescribing / receipt cycle to be completed for outside units.

6.6.3. Receipt of Controlled Drugs

On delivery CDs must be handed to a registered nurse, midwife or ODP who must sign for receipt of the CD and must not leave them unattended. Items received must be checked against the order placed.

If the order has been received in an acute hospital from the pharmacy department and a discrepancy found the order should not be signed for and sent back for amendment.

Delivery drivers usually sign for delivery of a locked box rather than the contents. When a box is unlocked after receipt by a community hospital and a discrepancy found then the receiving person should contact the contractor to arrange for return and / or amendment.

On receipt CDs must be recorded in the controlled drug record book (CDRB) by the registered nurse/ODP. This includes all stock and patient-labelled items.

Patient- labelled CDs should be kept separately to stock items.

Any tamper-evident seals on packs should be left intact and only broken when the pack is required for administration.

6.6.4. Transferring Stock Between Units

The controlled drugs stock held by the unit is for treatment of patients within that unit. Only in exceptional circumstances (see below) may stock medicines be administered to a patient other than those under the care of that unit. Stock should not be transferred between units without the involvement of a pharmacist.

Where Patient Controlled Analgesia (PCA) bags are transferred from Recovery to wards or units, two staff should document the transfer into the CD book of the receiving ward. Documentation should then be updated after administration to show how much controlled drug has been administered to the patient. Any remainder in the bag should be irretrievable and therefore should be squirted out of the infusion bag and into the sharps bin. Ideally the empty bag should then be put into the clinical waste bag (after removing sharps).

6.6.5. Obtaining Controlled Drugs Out-of-Hours

If controlled drugs are needed when pharmacy is closed and where the supply is needed for a specific patient attempt can be made to obtain a supply from another ward or department. A nurse / midwife from the receiving and supplying ward must administer and witness the administration (i.e. the supplying ward nurse / midwife should go with the receiving nurse / midwife and witness the patient being administered the medicine).

In non-urgent situations or if it is not possible to obtain from another ward, then contact the site management team who will contact the on-call pharmacist.
.
The supplying nurse / midwife and receiving nurse / midwife must carry out the whole process from start to finish to reduce chances of an administration error occurring

The supply must be recorded in the register of the supplying ward. Documentation of the supply being made from the supplying ward should be made in the patient record to aid investigation should a discrepancy occur.

6.6.6. Storage of Controlled Drugs

All controlled drugs, including those brought in by patients, must be stored in a controlled drug cabinet which complies with British Standard BS2881 Security level 2, with the Misuse of Drugs (Safe Custody) regulations 1973 and as amended by the Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007. The controlled drug cupboard must be locked when not in use.

Controlled drug cupboards must also be fit for purpose in the area they are to be situated i.e. large enough to cope with the demands for CDs in the ward / department. If the cupboard at any time is considered unfit for the ongoing needs of the ward it must be upgraded.

A nurse or ODP may only remove controlled drugs from the cupboard, and/or return them to the cupboard on the specific authority of the registered nurse or ODP in charge.

High dose diamorphine, morphine (≥30mg) and midazolam must be stored separately from low strengths (NPSA safer practice notice 2006/12: Ensuring safer practice with high dose ampoules of diamorphine and morphine).

Compliance can be achieved by segregating high strength products can be on a separate shelf or in a clear plastic bag. Refer to: Guidelines and Procedures for the Management of High Strength Opioids.

Ambient temperature (and refrigerator monitoring if applicable) must be undertaken in the area that the CD cupboard is situated. Refer to: Temperature Control for the Ambient and Refrigerator Storage of Medicines [Medicines Code].

6.6.7. Secure Storage of CD Stationery

CDOBs and CDRBs are controlled stationery and must be kept securely within the CD cupboard. Where it is not possible to comply with this requirement, for example due to size of cupboard, CDOBs and CDRBs may be kept in a locked cupboard or drawer. If this is not possible there must be a risk assessment and mitigation put in place to reduce risk.

Within clinical areas CDOBs and CDRBs must be kept, on the ward, for a minimum of two years after the date of the last entry. All completed CDRs and CDRBs with records relating to the destruction of CDs must be retained for seven years from the date of the last entry.

CDRs and CDRBs must be disposed of as confidential waste.

6.7. Key Holding and Access to Controlled Drugs

6.7.1. Controlled Drug Cupboard Keys

For areas that store CDs there must be arrangements for keeping the keys secure.

The registered nurse, midwife or ODP in charge of an area has personal responsibility for the CD key. That means that there should only be a single CD key in use on a ward or department for each CD cupboard held by the registered person in charge. Bunches of keys that are used for other purposes are not likely to satisfy safe custody requirements and therefore areas must separate the CD keys from those that are for other purposes.

The controlled drug cupboard keys should be returned to the nurse, midwife or ODP in charge immediately (or as soon as is practicable) after use by another registered member of staff.

In areas such as theatres, day surgery units and five-day wards, that are not operational at all times, the key must be held securely when not in use. Local arrangements should be put in place and agreed with the ADN following a risk assessment to mitigate risk.

On occasions, for the purpose of stock checking, the CD key may be handed to an authorised member of the pharmacy staff (e.g. pharmacist or pharmacy technician responsible for stock control of medicines on the ward).

6.7.2. Missing CD Keys

If CD keys cannot be found then urgent efforts should be made to retrieve the keys as speedily as possible e.g. by contacting nursing, midwifery or ODP staff who have just gone off duty.

The person who identifies keys are missing should ensure that the senior registered nurse, midwife or matron or the duty nurse or midwife manager is informed as soon as possible and the relevant duty pharmacist i.e. acute or community as soon as appropriate.

The advice obtained should specify the arrangements for preserving the security of CD stocks and for ensuring that patient care is not impeded e.g. by issuing a spare key.

If the keys cannot be found then the Accountable Officer should be informed.

Depending on the circumstances, it may also be appropriate to contact a locksmith and the police. Advice must be sought from the Accountable Officer.

6.7.3. Record Keeping

A CDRB must be available in each ward or department unless using an Omnicell exclusively. There must be separate pages for each drug and strength of drug. Entries must be made in chronological order, made in black ink, and be indelible.

All entries of receipt, administration, wastage etc. must be signed by a registered nurse or ODP and should be witnessed, preferably by a second registered nurse or ODP.

After every action involving CDs, the stock balance of that item must be confirmed to be correct and the balance recorded in the CD record book.

When at the end of a page, the balance is transferred to another page. The new page number is added to the bottom of the finished page, and the index updated.

If a mistake is made then it must be bracketed in such a way that the original entry is still clearly legible. This should be signed, dated and witnessed by a practitioner who is familiar with the controlled drug procedures. The witness must also sign the correction.

CDRBs and CDOBs are ordered by the individual units from the pharmacy departments. These must be ordered using a page from the current CDOB.

6.7.4. Record Keeping in Theatres, Endoscopy and for Elective Lists

If appropriate* areas that undertake a caseload (list), such as theatres and in endoscopy should use controlled stationery 0900502. All records should be completed as per the schedule below:

- Supply records must be signed and witnessed
- Administration records must be signed by the responsible person administering the controlled drug (and preferably witnessed)
- Disposal must be signed and witnessed

Block signing of records at the end of a list is not allowed.

*[To assess the correct stationery to use in a particular location and set of circumstances other than theatres there must be a risk assessment with the help of pharmacy that is agreed with the Head of Nursing and CDAO].

6.7.5. Stock Reconciliation Checks

It is the responsibility of the nurse, midwife or ODP in charge of the ward/department to ensure a controlled drug balance check is undertaken at an appropriate interval.

The default intervals for controlled drug stock reconciliation are:

- Theatres after a change of anaesthetist, a minimum of once a day (or approved locally by risk assessment)
- In other units a minimum of once a day (or approved locally by risk assessment)
- A locally approved interval for stock checks must not exceed 7 days.

A record of this reconciliation check must be made within the CDRB.

For checks at seven day intervals, a record of the check must be entered in each active page of the CDRB with the date and balance recorded, and signed by the two registered staff undertaking the balance check.

For daily balance checks the record of the check may be made on a dedicated page of the CDRB or recorded by the Omnicell stock check.

Controlled drug reconciliation checks should be undertaken with varied witnesses to ensure transparency within the process.

Where clinical areas are not able to undertake reconciliation checks in accordance with the default intervals specified a risk assessment must be undertaken and local procedure put in place to mitigate risk. In any case stock balances must be checked at least weekly.

Checks should be of the CDRB entries/ Omnicell stock checks against the contents to minimise the risk of items in the cupboard not having been entered in the CDRB/ Omnicell. The balances in the CDRB should always tally with the amount in the CD cupboard and Omnicell stock checks should be accurate.

Stock checks should be carried out by two registered nurses or registered health professionals. Where a second registered nurse/ODP is not available, the transaction can be witnessed by another practitioner who is familiar with the controlled drug procedures.

Any expired stock should be segregated and arrangements made for disposal.

The volume of oral liquid medicines can be estimated based on previous entries / length of time since a new bottle was opened. A balance check and amendment must be made for any overage/underage of existing stock before the new bottle is opened. The volume of the new bottle does not need to be measured.

Volume discrepancies >+/- 5% should be investigated and escalated if necessary.

It is not necessary to open tamper-evident packs.

6.7.6. Archiving of records

CDOBs, CDRs and CDRBs with records related to ordering and supply of controlled drugs must be kept by the ward or department for a minimum of 2 years.

Records relating to destruction of controlled drugs must be retained for seven years from the date of the last entry. This relates to the destruction records held within the acute hospital pharmacies and any CDRBs containing destruction records.

6.8. Patients Own Controlled Drugs

Any controlled drugs brought in by the patient must be entered in the CDRB and stored in the CD cupboard.

Patients own controlled drugs must be used only for the named patient and not for any other patient.

Patients own medicines should be assessed for suitability for use see Procedures for the Use of Patients Own Medicines on Admission, During Inpatient Stay and at Discharge [Medicine Code].

If a patient's own drug is used, each item should be given a separate entry in the CDRB. When administered to the patient, there must be a record made in the CDRB. A record must also be made when they are returned to the patient on discharge.

Patients own controlled drugs no longer needed or unsuitable for return to the patient or patient's representative must be segregated whilst awaiting disposal.

6.9. Disposal of Controlled Drugs

Individual doses of controlled drugs which are prepared but not administered or only partly used, should be destroyed on the ward by a registered nurse, midwife or registered ODP in the presence of another practitioner who is familiar with the controlled drug procedures. Small amounts of CDs can be destroyed and rendered irretrievable by emptying into a sharps bin. The emptied vial or ampoule should then also be placed in the sharps bin. When the bin is sent for destruction it should be labelled "*contains medical products and their residues*".

An entry should be made in the CDRB documenting the reason a dose or part dose was not used.

All other controlled drugs must be destroyed in line with the procedure for destruction of controlled drugs. This requires an authorised person to be present. The Accountable Officer confers this authorisation.

Drugs awaiting disposal or destruction must be clearly marked and segregated from drugs in use.

In either case an entry must be made in the CDRB, including the names of those involved in the destruction.

6.10. Destruction of Controlled Drugs

Controlled drugs that are obsolete, expired or unwanted must be kept segregated from other CDs in the CD cupboard. Stock CDs awaiting destruction must be clearly marked in order to minimise the risk of errors and inadvertent supply/administration to patients.

When acute clinical areas or a bedded unit within ESHT requires stock or patients own CDs to be disposed of or destroyed they must contact a member of the local pharmacy team or Community Health Services Medicines Management Team. An appropriate team member will then arrange a mutually suitable date and time for destruction or disposal to take place in accordance with pharmacy standard operating procedures.

All CDs in schedule 2, 3 and 4 (part 1) can be placed into pharmaceutical waste bins only after they have been rendered irretrievable (i.e. by denaturing).

With the exception of the denaturing of CDs, any process which involves de-blistering, emptying bottles, opening ampoule etc., is a licensable activity under the Waste Management Licensing Regulations.

All units must ensure that CD denaturing kits are available when the visit takes place.

From a Health and Safety point of view the appropriate team member and other Healthcare Professional involved in the destruction must ensure that they protect themselves, other persons within the premises and the environment when denaturing controlled drugs by taking necessary precautions.

6.11. Authorisation to Witness Destruction

Only the Trust Accountable Officer may authorise staff to witness the destruction of stock controlled drugs. To be allowed to witness destruction the person must not be involved in procuring, requisitioning or administering controlled drugs in the clinical area. The template for the letter of authorisation is contained in Appendix A.

Patient's own controlled drugs may be witnessed for destruction by a pharmacist.

6.12. Discrepancies

Balances in CDRs and CDRBs should always tally with the amounts of CDs in the cupboard. If they do not, the discrepancy must be reported, investigated and resolved. It is important to remember that a discrepancy can indicate misuse.

It is the responsibility of the nurse / midwife / ODP in charge to ensure that the procedure for dealing with discrepancies is followed. The reporting and investigation must follow:

- The Procedure for Dealing with Controlled Drug Discrepancies described below
- The Incident Reporting and Management Policy
- Policy for the Management of Nursing Staff involved in Drug Administration Errors

The Accountable Officer must always be informed.

In the first instance the following should be carefully checked:

- All requisitions received have been entered into the correct page of the register
- All CDs administered have been entered into the CDRB
- Items have not been accidentally put into the wrong place in the cupboard
- Arithmetic to ensure that balances have been calculated correctly

If the error or omission is traced, the registered nurse, midwife or ODP in charge should make an entry in the CDRB, clearly stating the reason for the entry and the corrected balance.

The entry should be witnessed by a second nurse, midwife, ODP, pharmacist, pharmacy technician or doctor. Both persons will sign the CDRB.

If no errors or omissions are detected then the discrepancy should be reported to the Accountable Officer without delay.

A local incident form completed in line with the Trust incident reporting procedures refer to: Incident Reporting and Management Policy.
The Medicines Safety Officer will routinely:

- Review CD arrangement regularly to reflect local and national learning
- Carry out risk assessment of incidents relating to CDs
- Share learning from CD incidents

6.13. Illicit Drugs and Substances

This section is covered comprehensively within the statements found in the Medicines Policy and the Illegal and Illicit substances Policy. This should be referred to as suspected illicit drug use is a complex and technically demanding situation to resolve. Advice should be sought from the Trust security officer and a pharmacist as soon as possible.

Following the Medicines Policy, attempts should be made to confiscate any remaining supplies. A qualified member of staff must witness this action.

Substances found and confiscated must be recorded as unidentified substances in the ward's CDRB, and be kept in the controlled drugs cupboard, until a decision is made by the clinical team on further action, including whether to involve the police.

If not required by the police, the substance must be given to a pharmacist for disposal. If a person known to be in possession of illegal drugs refuses to surrender them, the police should be called.

6.14. Controlled Drugs in Community Nursing

6.14.1. General Principles

This section of the procedure has been developed to inform and support community nursing staff and managers on the safe handling of controlled drugs (CDs) in the community setting.

Community Nursing Service includes Adult Nursing, Out of Hours Nursing, and other community based teams and for the purposes of this procedure excludes community bedded units.

6.14.2. Storage in Patient's Own Home

Good practice requires a record to be made of the receipt, administration and disposal of patient's own controlled drugs in patient's own home where a community nurse is involved in the administration of the drugs. This should be recorded in the patient's care record.

All CDs should remain in the original pack (as received from pharmacy).

As for all medicines when used in patient's own home, the medicines should be stored in a safe, appropriate location and out of sight of and reach of children.

Controlled drugs may be subject to abuse by the patient or others having access to the medicines.

In situations where this risk is a possibility, the Line Manager must be informed and measures must be taken to prevent diversion of the controlled drugs.

The Prescriber should be involved in risk managing the situation and the supplying Community Pharmacist involved as appropriate.

6.14.3. Stock Control and Audit Trail in Patient's Own Home

The Controlled Drug Stock Record must be used to record the amounts of injections of controlled drugs received and administered in the patient's home.

A separate page should be used for each drug or strength. This must be retained in the patients notes at all times.

When recording controlled drugs received into the home, the number of units received should be recorded in words not figures (for example ten, not 10) to reduce the chance of entries being altered.

Any tamper-evident seals on packs should be left intact when they are received from a pharmacy. Leaving the seals intact simplifies and speeds up routine checks.

A seal should only be broken when the pack is required for administration. If, when the tamper–evident seal is broken, the contents do not match the expected amount stated on the pack, the Community Nurse must contact the Pharmacy that dispensed the product.

When a practitioner finds that the amount of controlled drugs in the home does not agree with the balance figures on the Controlled Drug Record Sheet it is their responsibility to start to investigate the discrepancy.

Discrepancies must be investigated as detailed in section 6.9.

It is the responsibility of the Community Nurse to help the patient to maintain a supply of controlled drugs to ensure appropriate treatment is available for the patient.

Where the patient has unnecessarily large amounts of controlled drugs or where continuity of supply is an issue the Community Nurse may need to liaise with the GP, Community Pharmacist and other healthcare professionals to ensure the patient receives effective continuity of treatment.

Stock balance of liquid medicines may be checked by visual inspection but the balance must be confirmed to be correct on completion of a bottle. Any discrepancy should be reported to the Line Manager who should inform the pharmacist.

6.14.4. Administration within Patients' Own Homes

Any controlled drugs administered must be recorded in the nurse's and patient's notes stating the medicine and dose administered, the date of administration, the method of administration and the person who administered it.

In a patient's home, where a registered nurse is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

It is good practice for nurses administering parenteral schedule 2 controlled drugs (e.g. diamorphine or oxycodone) to keep full records of the number of ampoules stored and used within the patient's home.

The Prescriber must complete and sign the appropriate form before medicines can be administered to the patient by the Community Nurse.

Although normally a second signatory should be another registered health care professional (for example doctor, pharmacist, dentist) or student nurse or midwife, in the interest of patient care, where this is not possible, a second competent person may sign (which may be a carer). It is good practice that the second signatory witnesses the whole administration process. It is recognised that a second checker is not always available and so it is accepted that registered nurses may administer CDs alone under these circumstances remaining accountable for their actions.

6.14.5. Destruction of Patient's Own CDs by Community Nurses

Controlled drugs that have been prescribed to patients are the property of the patient and remain so even after death. In the first instance the patient/patient's relatives should be advised that all CDs no longer required should be returned to a Community Pharmacy for safe destruction.

A community pharmacy cannot legally accept prescription medicines for disposal from care homes registered to provide nursing care, or from care homes that provide both residential and nursing care.

It should not normally be the responsibility of community nurses to become involved in the disposal of unused CDs. However, there may be occasions when it is appropriate for nursing staff to facilitate the recovery/disposal of CDs, for example:

- A dose smaller than the total quantity in an ampoule or vial is required
- A dose is drawn up but not used
- The remainder of the contents of a syringe driver

To reduce the risk of small quantities of partially used controlled drugs being misappropriated the following actions should be taken (for example partially used ampoules, unused medication in syringes):

- CDs should be placed in the appropriate sized “controlled drugs destruction kit” as per instructions on container.
- Used container should then be placed in the appropriate sized sharps bin.
- Controlled Drug Stock Record should be completed to reflect correct stock balance.
- Sharps bin should remain in the patient’s home until CDs no longer required and then disposed of as per the Policy for Minimising, Handling, Storage and Disposing of Waste.

Destruction should be witnessed if possible

Empty vials/ampoules and empty syringes used in syringe drivers should be placed in a sharps bin.

Waste must be disposed of as stated in the Policy for Minimising, Handling, Storage and Disposing of Waste.

6.14.6. Transportation of Controlled Drugs by Community Nurses

Nurses should not routinely transport controlled drugs. This should only be undertaken in circumstances where there is no other reasonable mechanism available.

Controlled drugs should be kept out of sight during transportation and wherever possible transported in a sealed, tamper-evident container.

Nurses may transport controlled drugs, where carers/representatives are unable to collect them, provided the nurse is conveying the controlled drug to a patient for whom the medicine has been prescribed e.g. from a pharmacy to the patients home.

It should not normally be the responsibility of Community Nurses to become involved in the disposal of unwanted controlled drugs.

However in exceptional circumstances, if return of controlled drugs to a Community Pharmacy by relatives/next of kin is not practical or possible, then the nurse may transport the controlled drugs to the Community Pharmacy. In this circumstance the nurse must document the rationale for this decision.

The following details should be recorded on the Controlled Drug Stock Record when controlled drugs are returned to the pharmacy:

- Date
- Name, form, strength and quantity of drug being returned.
- Reason for return (comments column)
- Name and signature of pharmacist accepting the CDs (comments column)
- Name and signature of nurse witnessing the acceptance of the CDs

Annotate Controlled Drug Stock Record in comments column regarding any remaining stock and action taken / advice given.

If it is necessary for nurses to transport controlled drugs they should make this known to another colleague e.g. Team Leader, Line Manager, or GP etc.

6.14.7. Discrepancies

It is suggested that, before informing their Line Manager, the Practitioner should carry out the following checks:

- Check that all the doses administered are documented correctly
- Check that the correct numbers of dose units (e.g. ampoules) have been documented
- Check that the number of dose units has been correctly subtracted from the balance figure
- Check whether the patient has further supplies elsewhere in the house
- Check whether the patient has been administered 'extra' doses from, for example, other Community Nursing Staff, their own GP, Out of Hours Provider etc
- Check whether the patient has attended a Hospital, Clinic, Hospice etc where doses of their own medication may have been administered.

The Community Nurse must report any discrepancies in CD balances to their Line Manager who will investigate thoroughly.

If the investigation proves that an incident has occurred, the Line Manager and an ESHT community services pharmacist must be informed and an appropriate incident form completed (Datix). The Accountable Officer must also be informed soon after identifying the unresolved discrepancy.

7. Special Considerations

7.1. Risk Assessment of Controlled Drugs in Schedule 3, 4 and 5

Clinical areas under the direction of the Accountable Officer should undertake a risk assessment if controlled drugs in schedule 3, 4 and 5 should be handled in the same way as controlled drugs in schedule 2.

The risk assessment should include:

- Frequency and quantities of controlled drugs used
- Storage facilities available
- Whether the security setting is low, medium or high risk
- Checking discrepancies in stock balances at shift handover
- Frequency of staff handover
- Staff access to controlled drugs
- Any data from relevant reporting

Due to the complexities of undertaking risk assessments for the entire organisation on a central basis the current position is that controlled drugs in schedule 3, 4 and 5 will be treated in accordance with the safe custody requirements of the respected schedule. Where local intelligence suggests a change from the norm, for example a high number of CD discrepancy rates or active investigation into staff members; a risk assessment will be done for the clinical area and mitigation put in place as necessary. This may include safe storage enhanced record keeping and adoption of hand writing requirements for drugs in schedules that it would not normally apply.

8. Evidence Base/References

a) NICE (2008) NPSA Rapid response report: NPSA/2008/RRR05 Reducing Dosing Errors with Opioid Medicines. London: The Stationery Office
b) CQC (2012) Healthcare Commission Standards for Better Health: Essential Standard 9 Management of Medicines: Accessed from http://www.cqc.org.uk/content/regulations-service-providers-and-managers (1st July 2016)
c) Department of Health (2007) Safer Management of Controlled Drugs: a Guide to Good Practice in Secondary Care. London: The Stationery Office
d) Department of Health (2007) Safer Management of Controlled Drugs. London: The Stationery Office
e) Great Britain. Misuse of Drugs Act 1971. London: The Stationery Office
f) Great Britain. The Misuse of Drugs Regulations 2001. London: The Stationery Office
g) NPC (2009) A Guide to Good Practice in the Management of Controlled Drugs in Primary Care (England). London: The Stationery Office
h) Department of Health (2007) Safer Management of Controlled Drugs (CDs): Changes to Record Keeping Requirements. London: The Stationery Office
i) Department of Health (2007) Safer Management of Controlled Drugs (CDs): Changes to Record Keeping Requirements. London: The Stationery Office (February 2008 revision)
j) NICE (2016) Controlled drugs: safe use and management. NICE guideline, published 12th April 2016: Accessed from http://nice.org.uk/guidance/ng46
k) RPS and RCN Professional Guidance on the Administration of Medicines in Healthcare Settings. Jan 2019 Admin of Meds prof guidance.pdf (rpharms.com)

9. Competencies and Training Requirements

Foundation Year Prescribing doctors undertake a prescribing assessment when they start at ESHT. Foundation Year 1 and 2 doctors receive training on controlled drugs when they begin their year at ESHT. Nursing staff are assessed as competent in medicine administration and are expected to follow a training and validation process prior to undertaking injections.

10. Monitoring Arrangements

10.1. Process for Monitoring Compliance

The content of these guidelines and procedures will be reviewed a minimum of every three years by the senior pharmacy team and in accordance with audit or incident investigation recommendations related to controlled drugs.

It is the responsibility of lead practitioners and line managers to ensure that staff who handle controlled drugs in areas under their responsibility are trained appropriately. Clinical Divisions are responsible for monitoring compliance; however incidents will be monitored reactively through the Trust incident reporting system, with medicine related incidents being reviewed routinely by the Medicines Safety Officer and subsequently by the pharmacy, relevant Clinical Division Governance Groups and Medicines Optimisation Committee.

Pharmacy staff will proactively audit practice every 3-6 months in line with Safer Management of Controlled Drugs A guide to good practice in secondary care (England) October 2007. Overall monitoring of the audit recommendations and actions will be undertaken by the Medicines Optimisation Committee.

The pharmacy service has internal processes in place for monitoring supply and services; however the Pharmacy Leadership Group will provide a platform for staff to become engaged with pharmacy service managers.

10.2. Exceptions to Compliance

The Controlled Drug Management procedures within this document are in place to protect the general public, patients and staff from the risks associated with mismanagement.

All local exceptions must be risk assessed and locally agreed procedures put in place to mitigate risk and inform staff. Appendix B (template for locally agreed procedures) and C (generic risk assessment) are included to aid staff.

When exceptions are justified these must be risk assessed and approved by the Clinical Division Nursing Lead. The recorded deviations must be documented within a local procedure. Completed risk assessments and local procedures must be forwarded to the Accountable Officer and Associate Directors of Nursing for information. Common exceptions are for:

- The interval of Controlled Drug reconciliation checks
- The staff groups involved in reconciliation checks
- Process for securing controlled drug stationery when this cannot be achieved through storage within the controlled drug cupboard
- The segregation of high dose opioids
- In exceptional circumstances witnesses to controlled drug administration

10.3. Monitoring this Policy: Standards/Key Performance Indicators

See Table Below

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Document	Medication Safety Officer	Audit and incident reports	Every 3 years	Medicines Optimisation Committee	Pharmacy Risk group	Medicines Optimisation Group
Incidents	Medication Safety Officer	Datix	Ongoing	Medicines Optimisation Committee	Medication Safety group	Medicines Optimisation Group
Controlled Drug Management	Chief Pharmacist	Audit tool	3-6 months	Medicines optimisation Committee / Clinical Division Governance groups	Medicines optimisation Committee / Clinical Division Governance groups	Medicines Optimisation Group
Controlled Drug Pharmacy Audit	Chief Pharmacist	Pharmacy Dashboard	Monthly	Pharmacy Leadership Group	Pharmacy Quality and Financial Performance Meetings	Pharmacy Leadership Group

11. Equality, Human Rights and Health and Safety Statement

Equality, human rights issues, dignity and respect need to be considered in the provision of information about medicines and the prescribing, procuring, dispensing, and administration of medicines. These considerations include the need for awareness of the temporary disabling effects a patient's condition may have on them, for example patients with swallowing difficulties may also have difficulty communicating or may be unconscious.

Informed consent underpins the use of medicines and is an essential part of the relationship and partnership between patients and clinicians. As such the following must be considered as part of the process:

a) The potential impact of a medicines origin on patient's religious or personal observances and empathising with those observances when prescribing or administering medicines, for example blood and animal derivatives for certain religious groups.
b) Disability-related requirements either in terms of the preparation of a medicine related to its administration, for example oral versus intravenous, or barriers to compliance, for example inhaler choice in a patient suffering with rheumatoid arthritis, or large label print for a partially sighted person. Steps should be taken to ensure all options are explored with patients to ensure they remain in control of choosing the most appropriate option for them.
c) Cultural barriers such as language or communication. Steps should be considered to maximise a patients understanding of medicines use wherever practicable, for example the provision of interpretation services during informed consent for non or less capable English speaking patients.
d) Learning disabilities that may be a barrier to understanding. Steps to overcome this may include the use of symbols on information leaflets or a patient advocate.

11.1. Mental Capacity Act

All staff prescribing, administering or advising on medicines should be aware of and take into consideration the requirements of the Mental Capacity Act in any decisions or actions they may take or recommend. This is especially the case in areas where the patient will not be aware of medicine administration for example where there is a need for covert drug administration, rapid tranquillisation, the patient is unconscious or unable to communicate.

Staff should refer to the Trust Mental Capacity Act guidelines and MCA 2006 Code of Practice for guidance when necessary.

11.2. Control of Substances Hazardous to Health (COSHH)

Medicines may be hazardous and therefore adequate safety protection should be worn when appropriate if handling medicines. Refer to the summary of product characteristics for a medicinal product and COSHH datasheets for information

Appendix A – Letter of Authorisation for Witnessing Destruction of CDs

East Sussex Healthcare NHS
NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

[Insert Date]

To whom it may concern:

Letter of Authority to witness destruction of controlled drugs in accordance with the delegated authority of [Insert Name], Trust CD Accountable Officer, in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2013

Issued [Insert Date] valid until [Insert Date]

The following person whilst employed by East Sussex Healthcare NHS Trust is permitted to witness the undertaking of stock controlled drug destruction in accordance with the Trust procedures on behalf of the Trust on wards, clinics and departments within the organisational boundaries of the Trust.

Permitted Person: [Insert Name]
Registering Body: [Insert Registration Authority]
Registration Number: [Insert Registration Number]

Signed

[Insert Name]
ESHT Controlled Drug Accountable Officer
East Sussex Healthcare NHS Trust

Appendix B - Template for Local Procedures for Controlled Drug Management

These Procedures Only Apply to

[Insert Ward / Department]

1) Controlled Drugs must be managed under the principles laid out in Controlled Drugs – Safe use and management.
2) High dose opioids must be managed in accordance with the guidelines and procedures for high dose opioids.
3) Local exceptions to procedures can apply to:

   a) The interval of Controlled Drug reconciliation checks
   b) The staff groups involved in reconciliation checks
   c) Process for securing controlled drug stationery when this cannot be achieved through storage within the controlled drug cupboard
   d) The segregation of high dose opioids
   e) And in exceptional circumstances witnesses to controlled drug administration

   When these have been risk assessed by the ward/department manager and local procedures to follow agreed with the Clinical Division Nursing or Clinical Leads and forwarded to the Accountable Officer for information. Evidence of approval should be retained with this procedure.

Process	Local Procedure if an Agreed Exception
Key holding arrangements	
Interval of Controlled Drug reconciliation checks	
Staff Group who must undertake reconciliation checks	
Staff Group who must witness reconciliation checks	
Staff Group who must witness administration	
Process for storing controlled drug stationery	
Process for segregating high dose opioids	

If local procedures apply staff that handle controlled drugs must be made aware and the procedure attached to the controlled drug record book or controlled drug cabinet with evidence of approval.

Signature of Ward / Dept Manager:			
Approved by:			
Date of Approval:		Review Date:	

Appendix C - Controlled Drug Assurance Generic Risk Assessment

Hazard	Groups of people at risk	Controls required (list **all** controls that need to be in place)	Are Controls in place (Y/N)	**Local Procedures** Local procedures need to be written and approved by the Clinical Division Head of Nursing or Clinical Lead (Risk rating should reflect risk after local procedures have been put in place)	S	L	Risk Rating (S x L)
Access to controlled drugs is not adequately controlled – allowing the potential for unauthorised access, diversion and misuse	Patients, Public and staff	Keys are held by the qualified member of staff in charge and access is restricted when the unit is not in use. Keys should be adequately separated from other types of keys to prevent unauthorised access to the CD cupboard.					
Discrepancies in controlled drug management are not highlighted in a timely manner – allowing potential diversions and misuse to be undetected	Patients, Public and staff	Controlled drugs must be reconciled at an interval that is acceptable to prevent unnecessary risk e.g. at staff changeover, every 24 hours or as approved by local risk assessment. A local procedure must be in place when the default procedures within' medicines management policy 8: The management of controlled drugs' cannot be followed. Controlled drugs must be witnessed by a variety of authorised staff to retain transparency within the process.					
Controlled drug stationery is not adequately protected allowing the potential for obtaining, diverting and misusing controlled drugs	Patients, Public and staff	Controlled drug stationery to be secured within the controlled drug cabinet or otherwise secured to prevent unauthorised access.					

High dose opioids may be inadvertently used when stored alongside	Patients	High strength opioid preparations must be segregated from lower strength preparations to avoid inappropriate selection. Where possible high strength opioids should be ordered on a name patient basis and must be kept segregated from low strength products. Where this is not possible control measures must be in place to prevent selection errors, for example isolating within a plastic bag.					

Appendix D – EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

East Sussex Healthcare NHS Trust

Due Regard, Equality & Human Rights Analysis

Title of document: Controlled drugs – safe use and management
Who will be affected by this work? staff, patients, service users, partner organisations
Please include a brief summary of intended outcome: Lays down the policies and procedures for controlled drug management within the Trust. It is expected that staff following the document will achieve best practice in controlled drug legislation and best practice guidance.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	(Ensure you comment and link to main policy with page/paragraph number)
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	No alternative legislative requirement	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	It is a levelling policy / procedure. It does include an extensive section on protected characteristics and overcoming learning disabilities.	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	As above	
6.	**Please evidence how this work / policy will "Foster good relations between**	As above	

	people sharing a protected characteristic and those who do not" as per the Equality Act 2010?	
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	No
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	No
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No

Appendix E- Controlled Drugs frequently prescribed at ESHT (which require destruction by pharmacy):

- Alfentanil
- Buprenorphine
- Cocaine
- Codeine injection
- Dexamfetamine
- Diamorphine
- Fentanyl
- Gabapentin
- Hydromorphone
- Ketamine
- Lisdexamfetamine
- Methadone
- Methylphenidate
- Midazolam
- Morphine (Exception: Morphine sulphate oral solution 10mg/5ml- Oramorph)
- Oxycodone
- Pentazocine
- Pethidine
- Phenobarbital
- Pregabalin
- Remifentanil
- Tapentadol
- Temazepam
- Tramadol