

THE MEDICINES POLICY

Version Number 10

*Medicines Act 1968
Misuse of Drugs Act 1971
Human Medicines Regulations 2012*

<i>Post Holder responsible for Policy:</i>	<i>CHIEF PHARMACIST</i>
<i>Contact details:</i>	<i>Steve Bleakley, Chief Pharmacist Salisbury District Hospital</i>
<i>Date written:</i>	<i>November 2004</i>
<i>Date revised:</i>	<i>November 2018</i>
<i>Approved by:</i>	<i>Drugs and Therapeutics Committee</i>
<i>Ratified by:</i>	<i>Clinical Management Board</i>
<i>Date approved:</i>	<i>December 2018</i>
<i>Next due for revision:</i>	<i>December 2020</i>

CONTENTS

1	INTRODUCTION.....	1-5
1.1	Purpose of the Medicines Policy	1-5
1.2	Responsibilities	1-5
2	GENERAL GUIDANCE.....	2-7
2.1	Pharmacy Staff	2-7
2.2	Ward and Departmental stocks.....	2-7
2.3	Prescribing of Medicines.....	2-7
2.4	Administration of Medicines	2-7
2.5	Nurses in Training.....	2-7
2.6	The Prescription Chart.....	2-7
2.7	Controlled Stationery.....	2-8
2.8	Medicine Labels	2-8
2.9	Intravenous fluids.....	2-8
2.10	Risk Management including reporting defective medicines and medication incidents.....	2-8
3	MONITORING PROCESSES AND AUDIT	3-9
3.1	Medicines formulary and related activities	3-9
3.2	Medicines safety, risk management and related activities	3-9
3.3	Reporting of incidents involving medication	3-9
4	PRESCRIBING OF MEDICINES	4-11
4.1	Responsibilities	4-11
4.2	Drug formulary	4-11
4.3	Function of the drug chart and administration record	4-11
4.4	Allergies and drug intolerances.....	4-12
4.5	VTE Risk Assessment and Prophylaxis indicated	4-12
4.6	Initiation of Treatment.....	4-12
4.7	Prescribing by Medical Students and Non-Medical Prescribers (NMP) in training.....	4-12
4.8	Prescribing on the drug chart and administration record (in-patient chart).....	4-12
4.8.1	Once only medicines	4-12
4.8.2	As required prescriptions.....	4-13
4.8.3	Additional Medication Given.....	4-13
4.8.4	Regular prescriptions.....	4-13
4.8.5	Amendment of treatment.....	4-15
4.8.6	Valid signature	4-15
4.8.7	Anti-infectives.....	4-15
4.8.8	Variable Dose section.....	4-15
4.8.9	Continuous epidural infusion or local anaesthetic infiltration	4-15
4.8.10	Continuous parenteral infusions	4-15
4.9	Special prescriptions	4-16
4.9.1	Oral Anticoagulants	4-16
4.9.2	Cytotoxic therapy.....	4-16
4.9.3	Diabetic therapy (3 charts)	4-16
4.9.4	Dialysis fluids	4-17
4.9.5	Nutrition	4-17
4.9.6	Other infusions.....	4-17
4.9.7	MRSA	4-17
4.9.8	Dressings	4-17
4.9.9	Medical Gases	4-17
4.9.10	Resuscitation drugs	4-17
4.10	Benzodiazepines.....	4-17
4.11	Complementary medicines	4-18
4.12	Limited list medicines (Black list).....	4-18
4.13	Remote orders	4-18
4.14	Investigations involving the administration of medicines.....	4-18
4.15	Incidents involving prescribing	4-19
4.16	Discharge and hospital transfer	4-19
4.17	Licensing of medicines and prescriber liability	4-19
4.17.1	Prescribing licensed medicines used outside their licensed indications (off-label use).....	4-19
4.17.2	Prescribing Unlicensed medicines	4-19

4.18	Clinical Trials.....	4-19
4.19	Prescribing for Outpatients	4-20
4.20	Prescribing for day attenders	4-20
4.21	Prescribing for private patients.....	4-20
4.22	Self Prescribing.....	4-20
4.23	Prescription Modification by Pharmacists	4-21
5	DISPENSING OF MEDICINES	5-23
5.1	Dispensing procedure.....	5-23
5.2	Labelling of Medicines	5-23
5.3	Nursing/midwifery and medical staff.....	5-23
5.4	Supply of patient packs for inpatient use	5-23
5.5	Supply of medication on discharge.....	5-23
5.6	Special arrangements for supply of discharge medication (during pharmacy working hours) on named wards/departments only.....	5-24
5.7	Incidents involving dispensing.....	5-24
5.8	Procedure for dispensing urgent discharge medication at ward level when pharmacy is closed.....	5-25
6	ADMINISTRATION OF MEDICINES.....	6-27
6.1	Responsibilities	6-27
6.2	Nurses and midwives authorised to administer medicines.....	6-27
6.2.1	Registered nurses/midwives	6-27
6.2.2	Student nurses/midwives.....	6-27
6.3	Authorisation to Administer	6-27
6.4	General Guidelines for Drug Administration.....	6-27
6.5	Checking Procedure.....	6-28
6.6	Preparation of medicines in advance.....	6-29
6.7	Nil by Mouth (NBM)	6-29
6.8	Swallowing difficulties.....	6-29
6.9	Measurement of liquid medication.....	6-29
6.10	Anticoagulants	6-30
6.11	Security of medicines	6-30
6.12	Missed/late doses.....	6-30
6.13	Administration of discretionary medicines by registered nurses and midwives	6-31
6.14	Additional Medication Given.....	6-31
6.15	Administration of medicines by doctors	6-31
6.16	Administration of medication by nursing associates or assistant practitioners	6-31
6.17	Remote Orders (previously known as 'verbal orders')	6-31
6.18	Guidance on the administration of Intravenous Drugs	6-32
6.18.1	Strong Potassium Chloride.....	6-33
6.18.2	Cytotoxic drugs	6-33
6.18.3	Bolus Injections.....	6-33
6.18.4	Flushing Intravenous Lines.....	6-33
6.18.5	Intermittent Infusions	6-34
6.18.6	Single use only.....	6-34
6.18.7	Further information	6-34
6.19	Guidance on administration by subcutaneous and other parenteral routes.....	6-34
6.20	Line Labelling.....	6-35
6.21	Covert administration of medicines.....	6-35
6.22	Administration records.....	6-35
6.23	Incidents involving administration of medicines.....	6-35
6.24	Self-medication by staff in clinical areas	6-35
7	RECONCILIATION OF MEDICINES (ALL PATIENTS ON ADMISSION).....	7-37
7.1	Definition.....	7-37
7.2	Staff with responsibilities for medicines reconciliation	7-37
7.3	The process	7-37
7.4	Responsibilities	7-39
7.4.1	Prescriber's responsibilities:	7-39
7.4.2	Pharmacy staff's responsibility during medicines reconciliation:	7-39
7.4.3	Nurse's responsibilities during medicines administration.....	7-40
7.5	Documentation.....	7-40
8	LOCALLY AGREED CLINICAL PROCEDURES.....	8-45

9	PATIENT GROUP DIRECTIONS	9-45
9.1	Patient Group Direction Development/Amendment	9-45
9.2	Approval procedure	9-46
10	Stock Medicines	10-46
10.1	Non stock medicines/named patient items	10-47
11	Labels	11-47
12	Medicines on discharge	12-48
12.1	Samples and Clinical Trial Materials	12-48
12.2	Delivery of medicines	12-48
12.3	Unused medicines	12-48
13	Out of hours	13-49
13.1.1	Emergency Cupboard	13-49
13.1.2	Borrowing of Medicines	13-49
13.1.3	Decanting of Medicines	13-49
13.1.4	Controlled Drugs	13-49
14	STORAGE OF MEDICINES	14-50
14.1	Ward/department medicine storage facilities	14-50
14.1.1	Internal Medicines	14-50
14.1.2	Controlled Drugs	14-50
14.1.3	External Medicines	14-50
14.1.4	The medicines trolley	14-50
14.1.5	The reagent cupboard	14-50
14.1.6	Sterile fluids	14-50
14.1.7	Refrigerator (2-8°C)	14-51
14.1.8	Resuscitation Trolley	14-51
14.1.9	Cleaning Materials Cupboard	14-51
14.1.10	Patients' own drug lockers	14-51
14.2	Closure of a Ward	14-51
15	DISPOSAL OF MEDICINES NO LONGER REQUIRED	15-53
15.1	Pharmaceutical waste	15-53
15.2	Hazardous Waste	15-53
15.3	Non-Hazardous waste (General pharmaceutical waste)	15-53
15.4	Controlled drugs	15-53
15.5	Medicines no longer needed or out of date	15-53
15.6	Medicines returned via the mortuary	15-54
16	MEDICINES SECURITY	16-55
16.1	Pharmacy Premises	16-55
16.2	Wards and Departments	16-55
16.2.1	Controlled Drug Cupboard keys	16-55
16.2.2	Keys for Medicine Cupboards/Medicine Trolley and refrigerators	16-55
16.2.3	Reagent Cupboard	16-55
16.2.4	Keys for patient's own drug lockers (see also chapter 13)	16-55
16.2.5	Loss of medicine cupboard keys	16-55
16.3	Controlled Stationery	16-56
16.4	Losses	16-56
17	CONTROLLED DRUGS (CDs)	17-57
17.1	Controlled Drug Prescribing	17-57
17.2	Ordering controlled drug ward stocks	17-57
17.3	Delivery and receipt of controlled drugs	17-58
17.4	Storage of Controlled Drugs	17-59
17.4.1	Controlled Drug Cupboard keys	17-59
17.4.2	Records	17-59
17.5	Administration (including self-administration)	17-59
17.6	Stock checks and maintenance of records of CDs	17-60
17.7	Weekly checking procedure for CDs	17-60
17.8	CDs no longer required	17-61
17.9	Patient's own CDs	17-61
17.10	Obtaining CDs when Pharmacy is closed	17-62
18	PATIENTS' OWN DRUGS (PODs)	18-63
18.1	On admission	18-63
18.2	Consent	18-63
18.3	Assessment of PODs	18-63
18.4	Suitability criteria	18-63

18.5	Patients' own controlled drugs	18-64
18.6	Administration of patients own drugs.....	18-64
18.7	Discharge of patients own drugs	18-64
19	SELF ADMINISTRATION OF MEDICINES (SAM).....	19-65
20	CLINICAL TRIALS	20-67
20.1	Legislation.....	20-67
20.2	Role of the pharmacy service in relation to clinical research is:	20-67
20.3	Study Set-up.....	20-67
20.4	Investigators Delegation	20-67
20.5	Storage.....	20-67
20.6	Clinical Trials Prescriptions.....	20-68
20.7	Clinical Trials Prescription charges.....	20-68
20.8	Authorisation.....	20-68
20.9	Duty of care	20-68
21	ADVERSE REACTIONS.....	21-69
22	DEFECTIVE MEDICINES	22-71
22.1	Medicinal Products (or dressings) excluding IV fluids.....	22-71
22.2	Intravenous Fluids.....	22-71
22.3	Examples of product defects include:	22-71
23	OPERATING DEPARTMENTS.....	23-73
24	X-RAY DEPARTMENTS.....	24-73
24.1	General.....	24-73
24.2	Administration of Radioisotopes.....	24-73
25	MEDICINES FOR CHILDREN AND YOUNG PEOPLE 16 YEARS AND UNDER.....	25-75
25.1	Standards	25-75
25.2	Prescribing, dispensing and administration of medicines for children and young people.....	25-75
25.3	Specific issues relating to administration of medicines to children and young people	25-75
25.4	Staff involved in administering medicines to children or young people	25-76
25.5	Outreach nurses.....	25-76
25.6	Self-administration.....	25-76
26	MIDWIVES	26-77
26.1	General provisions for supply/administration of medicines by Registered Midwives	26-77
26.1.1	Specific legislation relating to supply and administration of medicines by midwives	26-77
26.2	Supply and administration of medicinal products outside of their license.....	26-77
26.3	Controlled Drugs	26-78
26.3.6	Midwives working in the community.....	26-78
26.4	Midwives Exemptions legislation parenteral.....	26-78
26.5	Midwives Exemptions legislation other medicines.....	26-79
27	OCCUPATIONAL HEALTH SERVICES	27-81
28	MEDICAL REPRESENTATIVES	28-83
28.1	Medical Representatives	28-83
28.2	Visits.....	28-83
28.3	Samples.....	28-83
28.4	Introduction of New Products	28-83
28.5	Clinical Trials and Clinical Assessments.....	28-83
28.6	Casual Gifts, Hospitality and Commercial sponsorship.....	28-84
28.7	Collaborative agreements.....	28-84
28.8	Breaches of Policy.....	28-84
29	CODE OF PRACTICE FOR WORKING WITH PHARMACEUTICAL COMPANIES	29-85
30	BIBLIOGRAPHY	30-87
31	Appendix 1: Prescription for urgent medication required to keep medical staff on duty .1	
32	Appendix 2: Medicines unavailable guideline	1
33	Appendix 3:Sources of Information about Medicines for Professional Staff.....	2

1 INTRODUCTION

1.1 Purpose of the Medicines Policy

This Policy provides guidelines aimed at safeguarding patients and staff from error when involved with medicines. It aims to ensure and enable safe practice in the prescribing, ordering, storage, administration, recording and disposal of medicines throughout Salisbury NHS Foundation Trust and covers the following classes of medication:

- Controlled Drugs (CDs): medicines included in, and controlled under, the provisions of the Misuse of Drug Acts 1971.
- All other medicines and medical preparations: any substances prepared and intended for administration to patients. They are controlled under the Medicines Act 1968 and Human Medicines Regulations 2012 and may be Prescription Only Medicines (POM), Pharmacy only medicines (P) or General Sales List medicines (GSL). They include lotions, applications, oral preparations, intravenous infusions, injections, medicated and interactive dressings and medical gases etc.
- Other pharmaceutical preparations: These include disinfectants, reagents and other products not used **directly to treat patients and some medical devices**.

1.2 Responsibilities

The Chief Pharmacist is responsible for establishing and maintaining appropriate systems for the safe and secure handling of medicines across the Trust.

All procedures involving the prescribing, ordering, storage, administration, recording and disposal of medicines are described in, or signposted within, this Policy. In all cases, staff involved in these activities (including medical, nursing, midwifery, Allied Health Professional (AHP) and pharmaceutical disciplines) are required to undertake these duties with due diligence and in accordance with this policy.

Registered staff of all disciplines are personally accountable for their actions and omissions. In prescribing, dispensing or administering medicines each profession must abide by the standards/code of conduct laid down for these activities by their professional body. Each individual is required to exercise their professional judgement and apply up to date knowledge and skills in all situations involving medicines.

In accordance with the principles of Clinical Governance staff must:

- Always act in such a manner so as to promote and safe guard the interest and well being of patients.
- Ensure that no action or omission on their part or within their sphere of responsibility is detrimental to the interest, condition or safety of patients.
- Maintain and improve their professional knowledge and competence.
- Acknowledge any limitation in their knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner.

The Trust also has a legal responsibility for ensuring that it meets essential standard of quality and care in order that patients will -

- Be involved and told what's happening at every stage of their care
- Have care, treatment and support that meets their needs
- Be safe
- Be cared for by qualified staff
- Know the Trust constantly checks the quality of its services.

All staff must be aware of these essential standards and implement them in the course of their work.

Newly appointed medical, nursing, midwifery, AHP and pharmaceutical staff must read the Policy, acquaint themselves with the procedures described within it and act upon them.

The ward/department leader is responsible for ensuring that ward/departmental staff, including bank and agency staff, carry out the safeguards referred to in this document and abide by Trust Policy at all times.

Consultant medical staff are responsible for ensuring that their teams, including locum staff, are aware of the safeguards referred to in this document and of their individual responsibility to abide by their professional standards and Trust Policy at all times.

The Director of Nursing is responsible for ensuring that all nurses and midwives within the Trust are aware of the safeguards referred to in this document and of their individual responsibility to abide by their professional standards and Trust policy at all times.

The Chief Pharmacist and the professional leads of AHP staff are responsible for ensuring that all pharmacists and AHPs within the Trust respectively are aware of the safeguards referred to in this document and of their individual responsibility to abide by their professional standards and Trust policy at all times.

Throughout this document the generic term 'nurse' is used for nurses, midwives and health visitors and is defined as those registered with the Nursing and Midwifery Council. Aspects of this policy relating solely to midwives are clearly indicated.

A copy of the Medicines Policy is available on ICID.

Comments/suggestions regarding this Policy should be made via email to the Chief Pharmacist (steve.bleakley@salisbury.nhs.uk)

All staff involved in the prescribing, dispensing, preparation and/or administration of medicines must undertake regular training and be able to demonstrate competence in respect of their roles towards medicines. Records of training and competency assessments must be retained. Minimum mandatory training for junior doctors on prescribing is identified in the Trust's Training Needs Analysis. All other professional training and development for all staff dealing with medicines is as per professional requirements and may be identified via their annual appraisal.

2 GENERAL GUIDANCE

2.1 Pharmacy Staff

Pharmacy staff are responsible for stocks of medicines held in the Pharmacy and for the supply of medicines ordered by wards and departments. They are also responsible for advising on the storage of medicines and will provide information on any aspect of medicine formulation and administration. Pharmacy staff can inspect ward, departmental and midwifery stocks at any time to ensure that medicines are in date and stored under the proper legal and environmental conditions. The pharmacy is the only procurement point for medicines within the Trust¹.

2.2 Ward and Departmental stocks

The registered nurse or midwife with 24 hour responsibility for the clinical area is ultimately accountable for the stock of all medicines held in his/her ward or department and is responsible for ensuring that the systems and procedures detailed in this Policy are followed correctly and that the security of medicines in the clinical area is maintained at all times.

The registered nurse with 24 hour responsibility for the clinical area may decide to delegate some of the duties but the responsibility always remains with the registered nurse who holds 24 hour responsibility.

2.3 Prescribing of Medicines

All prescribers have a responsibility to elicit an accurate medication history, including information about allergy status from the patient and to document this clearly in the patient record. For inpatients the prescriber is also responsible for completing the patient's drug chart fully and accurately in the light of the medication history and the patient's presenting condition.

Where discrepancies are identified these must be resolved as soon as possible and at the latest by the end of the next working day after admission.

On discharge the prescriber must prescribe the discharge medication and inform the GP via the discharge summary or equivalent, of all changes to the patient's medication list, together with the clinical reason for those changes.

2.4 Administration of Medicines

The correct administration of medicines is the responsibility of the individual registered practitioner, (e.g. nurse, midwife or doctor) administering the medicine.

The nurse in charge of the shift is responsible for ensuring that medicines are administered correctly and on time and that doses are not missed or delayed. The nurse in charge of the shift is also responsible for ensuring that nurses administering medicines, including intravenous products, have the relevant training and experience to take on this responsibility.

Within maternity services each midwife is responsible and accountable for her own practice with the support of the local Supervisor of Midwives.

Where medicines are administered by staff other than nurses, e.g. by Allied Health Professionals, the correct administration is the responsibility of the individual practitioner. The relevant head of profession is responsible for ensuring that the AHP has the relevant training and experience to take on the responsibility for medicines administration.

The mechanisms through which medicines may be administered within the Trust are set out in the [Authorisation of Medicines](#) document available on ICID.

2.5 Nurses in Training

Pre-registration student nurses/midwives should be given every opportunity to become proficient in the administration of medicines (including controlled drugs) with appropriate supervision. The registered nurse or midwife supervising must accept full responsibility for the correct administration of medicines. (See [chapter 6](#)).

2.6 The Prescription Chart

Prescription charts are essential documents. The prescription chart must be an accurate, unambiguous and comprehensive description and record of medicine treatment. The purpose of the prescription chart is to provide clear instructions on medicines to be administered and a history of previous drug treatment. It is the prescriber's responsibility to ensure that all prescriptions comply with these requirements.

¹ Except for X-ray contrast media which are managed by Radiology

If there is any doubt about the legibility of a prescription, or if it is ambiguous or unclear in any way, the prescriber or covering on-call doctor must be contacted and any ambiguity or doubt resolved before the medicine is administered.

There are specific prescription charts for some medicines e.g. anticoagulants, intravenous fluids, parenteral nutrition, diabetes and palliative care. These should be kept with the master prescription chart. The master prescription chart should include a reference to any other chart in use. Alternative arrangements may be made in specialist areas, e.g. Intensive Care; they should be consistent with the principles set out in this policy.

2.7 Controlled Stationery

Prescription charts, outpatient prescription pads, FP10HNC Forms (previously known as FP10 (HP) pads), and CD requisition books must be treated as controlled stationery. Controlled stationery is defined as any stationery which, in the wrong hands, could be used to obtain medicines fraudulently. The registered nurse with 24 hour responsibility for the clinical area is responsible for ensuring that such items are stored securely and access by unauthorised individuals is prevented. In particular, prescription forms/charts should not be left unattended in ward/clinic areas or at reception desks and CD order books must be locked away. Responsibility for security of FP10HNC pads issued to named consultants rests with the relevant consultant. When registered non-medical prescribers are prescribing via an FP10HNC they will require their own, registered pad.

2.8 Medicine Labels

The label on the container must be clear and distinct. Labels must not be altered. If a label becomes damaged or obliterated or does not properly relate to the medicine prescribed, the container should be returned to pharmacy for replacement.

It is essential that the labels of all medicine containers are carefully read and checked against the prescription prior to administration. It is not acceptable to select and/or administer medicines by reliance solely on the appearance of the packaging or of the medicine itself.

If the appearance of the medicine varies in any way from that which is expected, or the appearance is queried by the patient, the advice of a pharmacist or pharmacy technician must be sought before the medicine is administered to the patient.

2.9 Intravenous fluids

Advice on the administration of intravenous fluids (IV) and the addition of medicines to intravenous fluids is given in the British National Formulary (BNF) (kept on all wards/departments) and via MEDUSA, database for IV drugs accessible via ICID. Advice is also available from the pharmacy department and from the on call pharmacist.

Intravenous fluids are medicines: they should be kept in secure storage and only administered in accordance with a prescription written by a registered prescriber. (NB some intravenous fluids may be administered by relevant practitioners under midwives exemptions legislation – see [chapter 21](#)).

2.10 Risk Management including reporting defective medicines and medication incidents

Appropriate prescribing, dispensing, storage and administration of medicines are essential elements of the Trust's risk management agenda. All staff involved with medicines **MUST** understand their responsibilities with regard to medicines and ensure that their practice is in accordance with current legislation, Trust Policy and their professional body.

It is important that on suspecting any defect in a medicinal product the agreed medicine defect reporting procedure is followed (see [chapter 17](#)).

All incidents involving medicinal products arising from prescribing/dispensing or administration must be reported as per the Trust incident reporting policy. Specific guidance on reporting incidents arising from prescribing is given in this policy in [chapter 4](#), for dispensing in [chapter 5](#) and for administration in [chapter 6](#).

3 MONITORING PROCESSES AND AUDIT

The application of the Trust Medicines Policy throughout the Trust is monitored by the following groups and committees:

3.1 Medicines formulary and related activities

- Trust Management Board (TMB) Drugs and Therapeutics Committee (DTC)
- Antibiotic Reference Group (ARG)
- Intravenous Immunoglobulin Panel (IVIgP)
- Increasing Access to Medicines Panel (IATMP)

3.2 Medicines safety, risk management and related activities

- Clinical Governance Committee (CGC)
- Clinical Risk Group (CRG)
- Medicines Safety Group (MSG)
- Medical Gases Group (MGG)
- Clinical Management Board (CMB)

The following tools managed and co-ordinated by the structures identified above are used to monitor adherence to this policy:

- Pharmacist intervention reports via datix
- Trust incident reports via datix
- Formulary compliance rates
- Internal audit
- External audit
- Self-assessment
- Prescription monitoring
- Complaints
- Clinical reviews/SII
- Patient survey results
- Usage trends/data
- NHS Benchmarking data
- Model Hospital dashboard

Medicines Governance issues are reported regularly to the Clinical Governance Committee and the Drugs and Therapeutics Committee reports monthly via its minutes to the Trust Management Board (TMB). Other reports are prepared (e.g. audit reports) and distributed as appropriate.

3.3 Reporting of incidents involving medication

The following list of Medication Errors has been identified by the Medicines Governance/Safety Group as always requiring reporting and investigating.

Important note: This list is not exhaustive but provides a minimum requirement which should serve as a guide for all staff. It is important that all staff feel able to report any error which has the potential to cause harm.

- Prescribing Errors: e.g. incorrect patient or inappropriate route, dose, frequency, drug chart, or prescribing of a contraindicated drug.
- Dispensing Errors which leave the pharmacy: e.g. wrong patient, strength, drug, quantity, formulation, wrong directions on the label.
- Administration Errors: e.g. wrong patient, drug, strength, diluent, rate, formulation, route, time. Administration of a contraindicated drug, an expired product, or non-administration of medicines without reasonable justification.

- Monitoring Errors or high risk medication: e.g. failure to monitor levels (e.g. with digoxin, warfarin, lithium, gentamicin, vancomycin etc.), failure to maintain the patient within therapeutic range which has the potential to lead to an adverse outcome/ does lead to an adverse outcome requiring medical intervention.
- Transcribing Errors: e.g. incorrect transfer of information from one drug chart to another.
- Any medication error which causes actual harm to a patient
- Any medication error involving a critical medicine (see Critical Medicines list on ICID)
- Any medication error involving a controlled drug (schedule 2&3)
- Legibility: e.g. inability to interpret drug name and/or direction for prescribed medication.

4 PRESCRIBING OF MEDICINES

4.1 Responsibilities

It is the responsibility of **all prescribers** to prescribe in accordance with statutory and local rules and with guidance issued by their professional bodies. Where prescribing is undertaken by fully or provisionally registered doctors, this policy must be read in conjunction with:

- Good Practice in Prescribing and managing medicines and devices 2013 ,¹²

For non-medical prescribers, this policy must be read in conjunction with:

- Trust Non-medical prescribing policy and clinical governance framework (available on ICID)

ALL prescribers are reminded of their responsibility to elicit accurate medication histories from patients, to document these appropriately and for inpatients, to complete the patient's drug chart fully and accurately in the light of the medication history and the patient's presenting condition, resolving any anomalies as soon as possible and at the latest by the end of the next working day. See [Chapter 7](#)

4.2 Drug formulary

The Trust operates a local (South Wiltshire wide) MANDATORY DRUG FORMULARY. All prescribing must be in accordance with this policy (available on ICID) Clinicians wishing to introduce a new medicine into the Trust must follow the processes set out in the New Drug Form (available on ICID). . Where this involves collaborative working with a pharmaceutical company the principles set out in the Code of practice for Working with Pharmaceutical Companies must be followed. See [Chapter 24](#).

4.3 Function of the drug chart and administration record

- To provide a permanent record of the patients' medication.
- To facilitate the provision of the correct medicine from the Pharmacy.
- To direct the administration of the medicine to the patient.

There may be more than one current prescription form in use at any one time for any one patient. There should be at least one general chart plus specialist prescription charts as appropriate. Multiple charts should be attached together with a plastic treasury tag or secured in a patient specific folder.

Specialist prescription charts in use within the Trust include those for total parenteral nutrition, cytotoxic therapy, intrathecal cytotoxic therapy, total dose iron infusions, anticoagulants, MRSA topical treatment, dressings and diabetic therapy (3 charts). The main drug chart and administration record **must** include a reference to any therapy indicated on such a specialist prescription chart.

The main drug chart and administration record must include:

- Patients' name
- Date of birth or age
- Weight (for paediatric patients and those requiring weight adjusted dosing) and the date the weight taken
- Weight and height (where relevant to prescription e.g. chemotherapy regimens) and the date the weight taken
- Ward name or department
- Patient's hospital number/NHS number
- Allergies or drug intolerances and their nature (or none known, as appropriate)
- Consultants' name
- Date prescription written
- Signature of Prescriber and contact number
- VTE risk assessment and prophylaxis indicated (or reason for contraindication, as appropriate)
- Record of medicine administration

4.4 Allergies and drug intolerances

The prescriber is responsible for entering relevant allergies and drug intolerances in the appropriate section on the front of the drug chart and administration record and for transferring these to subsequent charts and discharge prescriptions.

- Prescribers should ascertain whether patients are reporting a true allergy, in which case it should be clearly documented, or simply a side effect. Where an allergy is judged to be 'real' details should be provided e.g. 'rash'.
- If there are no allergies or drug intolerances this must be stated as NO KNOWN ALLERGIES.
- The allergy section should always be completed, signed and dated and checked before new drugs are prescribed or administered.
- In cases where the allergy box is not completed pharmacists, midwives and nurses may complete the allergy box if they can responsibly establish the allergy status.
- No drug to which the patient is known to be allergic should be prescribed, dispensed or administered. The allergy box should be checked prior to prescribing, dispensing or administering each medication.
- If a patient develops an allergy during their hospital stay the attending doctor must update the patient record and all other relevant documents to reflect the current allergy status.
- All patients with a known allergy MUST wear a red wristband

4.5 VTE Risk Assessment and Prophylaxis indicated

This section of the drug chart and administration record MUST be completed and all relevant action taken (e.g. prescription of LMWH) for all patients on admission, including those attending for day surgery. See [VTE Prophylaxis Policy](#) on ICID.

4.6 Initiation of Treatment

Prescribers are reminded of the need to explain to and discuss with patients what medication is being proposed and why, and to ensure that the patient is aware of all significant risks associated with the medication.

Prescribers are also reminded of the need to ensure that prescription charts accurately reflect current treatment decisions (initiation of new medicines/dose modifications/discontinuation of therapy) at all times. In addition, the treatment plan, including how the response to the drug therapy is to be monitored, should be clearly documented in the patient's medical record.

Prescribers must ensure they are aware of the allergy status of the patient before prescribing any medicines and ensure that any potential interactions between medicines or drug-disease interactions for a given patient are considered and avoided. The patient's medical record should always be checked before a new prescription is written.

All prescriptions for children should include the child's age and, where the dose is weight dependent, or the medicine high risk, or with a narrow therapeutic index, or being used in unusually high or low doses or to be given by infusion, the child's weight in kg and the intended dose in mg/kg/dose should be stated.

4.7 Prescribing by Medical Students and Non-Medical Prescribers (NMP) in training

Medical students and trainee NMPs are allowed to write prescriptions but these must be signed by a registered prescriber before they are valid. Administration of medicines should not take place until the prescription has been appropriately validated and authorised.

4.8 Prescribing on the drug chart and administration record (in-patient chart)

4.8.1 Once only medicines

This section of the inpatient prescription chart is used for:

- Treatments needed at once
- Pre-operative medication
- Other drugs given once only such as vaccines or test doses of medicines
- Depot preparations
- Medication needed before X-ray or laboratory investigation.

Prescribers should ensure that nurses are informed when a stat dose has been prescribed to ensure that it is given in a timely manner.

4.8.2 As required prescriptions

This section should be used for prescribing medication to be given as required. The drug name, dose, frequency, route and start date must be stated and where appropriate the maximum dose to be given in 24 hours and the indication of when the drug should be given e.g. anxiety, seizure, pain relief. All prescriptions must be signed by the prescriber and a bleep/contact number provided.

The 'as required' section should be used only for those medicines to be given according to the clinical needs of the patient.

'As required' prescriptions must be reviewed on a regular basis, which should not normally exceed a period of 48 hours. Medicines originally prescribed 'as required' but which are needed regularly, as indicated by the administration record, should be reviewed and rewritten in the regular prescription section if appropriate.

Medicines which are meant to be given as a single dose should be prescribed in the *once only* section.

Sodium Chloride 0.9% IV flushes should be prescribed using the space reserved for this in the top left-hand box of the 'as required' section of the drug chart and administration record.

4.8.3 Additional Medication Given

Details of any additional medication given to the patient under the provisions of a Patient group Direction (PGD), Locally Agreed Clinical Procedure (LACP) or the Discretionary Medicines List (found on ICID as "Administration of discretionary medicines by registered nurses and midwives") must be recorded in this section together with the date, time and signature of the person administering the medicine.

4.8.4 Regular prescriptions

The good practice described here for regular prescriptions also applies in principle to other sections of the chart.

Full details must be supplied for each prescription and the drug name, dose, frequency, route of administration and start date must be stated. All prescriptions must be signed by the prescriber and a bleep/contact number provided.

Previous treatments, adverse reactions, hepatic or renal disease should be noted.

Care must be taken to avoid confusion between patients with similar names or personal characteristics.

The regular prescription section should be used to prescribe medicines to be given by **intermittent IV infusion** and **subcutaneous syringe drivers**.

Where a patient requires oxygen either continuously or when required, this **MUST** be prescribed using the oxygen prescription in the regular medicines section of the drug chart.

4.8.4.1 Date

Consecutive dates of the hospital admission are entered into the top row of boxes in the administration record. The start date box in the medicine section should record the date on which the treatment is to begin. **NB** when re-writing a prescription chart the **original start date** for a given medication should be entered onto the new prescription chart.

For treatments prescribed in advance of the date treatment is to commence, the intervening boxes on the administration record should be crossed through.

4.8.4.2 The Medicine Name

All medicines must be prescribed by the approved or generic name. This must be written clearly and legibly in indelible black ink. The use of block capitals may aid legibility and should be encouraged. Approved names for drugs should be used unless a formulation with a specific brand name is essential. Lithium, clozapine and modified release preparations of ciclosporin, tacrolimus, aminophylline, diltiazem, nifedipine and theophylline, should be prescribed by brand name in addition to the generic name to avoid problems with bio-availability. In these cases the appropriate brand will be dispensed.

Use of a brand name in all other circumstances does not imply that the brand written will be dispensed. The pharmacy service will supply the most appropriate product meeting the prescription and in line with the local formulary.

If the medicine is a combination of two or more medicines then a brand name may be used except where the preparation has an approved 'co-name' in which case the latter must be used.

Prescriptions for Phenytoin should specify tablets, capsules or suspension.

4.8.4.3 Dose

Doses of medicines must be prescribed using the metric system. Quantities such as *units*, *micrograms* or *nanograms* MUST be written in full and not abbreviated. Solid quantities of less than 1 gram should be written in mg, for example 500mg, not 0.5g. Quantities less than 1mg should be written as microgram, for example 100microgram, not 0.1mg. Decimal points should be avoided wherever possible by using whole units, for example 125micrograms rather than 0.125milligram. If a decimal cannot be avoided a zero must be written before the decimal point. (See also guidance on prescription writing provided in the BNF).

Care is needed where prescribing requires calculation of the dose, for example where the dose is based on weight. In such situations it is considered good practice for prescribers to specify the dose per kg **AND** the total dose required.

Care is also needed with drugs of narrow therapeutic index such as gentamicin or lithium where the prescription carries an obligation to monitor drug levels at appropriate intervals.

Rate of administration of medication should be clearly stated to avoid misunderstandings over drops/min, micrograms/min, micrograms/kg/min, milligrams/litre or the equivalent doses per hour or day.

4.8.4.4 Route of administration

The route of administration should be clearly specified. If this is changed the original prescription should be cancelled and a new prescription written. For the topical route the type of preparation e.g. ointment should be included with the approved name.

The following abbreviations are recognised within the Trust as a standard means of indicating the route:

IV	intravenous	Neb	per nebulizer
IM	intramuscular	PV	per vagina
PR	per rectum	PO/Oral	by mouth
SC	subcutaneous	Inhal	by inhalation
SL	sublingual	Top	topical
Buc	Buccal	TD	transdermal
NG	Nasogastric	PEG	via gastrostomy tube

All other routes of administration must be written out in full.

The prescriber should ensure clarity of dose and route required.

The dose, frequency and route of administration should be checked, particularly for drugs like *metronidazole* where oral and intravenous schedules are different.

4.8.4.5 Frequency of administration

The frequency of dosing should be specified in the box and the times ticked or circled. Consideration and care should be exercised when choosing times of administration i.e. with regard to achieving optimal therapeutic response, to the patient's normal routine and to nursing workload.

If medication is required to be given at specific times, these should be clearly stated in the "add times" column.

4.8.4.6 Unusual dose intervals

Where a medicine is prescribed at unusual intervals such as alternate days or 3 days weekly, the doctor must state this on the prescription. The administration record boxes for days when medication is not required must be crossed through as soon as the prescription is written.

4.8.4.7 Duration of treatment

Prescriptions should be reviewed at least daily by the doctor. The doctor should ensure that medicines are prescribed at the lowest effective dose, by the most convenient route and are stopped as soon as they are not needed.

When treatment is for a specific period, such as a course of steroids or antibiotics, the duration of treatment should be stated on the prescription

Prescriptions (other than those for antimicrobial agents) remain valid for a period of 28 days. Before the administration record is full a new drug chart should be filled out by the prescriber.

4.8.5 Amendment of treatment

Change of treatment implies cancellation of previous treatment.

PRESCRIPTIONS MUST NOT BE AMENDED. RATHER THE REQUIRED ITEM MUST BE PRESCRIBED AS A NEW ENTRY AND THE PREVIOUS TREATMENT CANCELLED.

labelling and rewriting prescription

It is essential that cancellation of treatment is shown clearly and unambiguously. The discontinued drug must be crossed out as shown (i.e. ~~TETRACYCLINE~~) and a line drawn through the unused recording panels on the drug chart and administration record. The cancellation should be dated and initialled, and where appropriate the reason for cessation stated.

4.8.6 Valid signature

Inpatient and outpatient prescriptions (including those for controlled drugs) can be signed by fully registered doctors within the meaning of the Medicine Act 1968, or by provisionally registered doctors such as Foundation Year 1 Doctors. Provisionally registered doctors are not allowed to prescribe for their own use, for people who are not patients of the Trust or for his/her own private patients. FY1 doctors are not allowed to sign FP10HNC scripts. 'Prescriptions' written by medical students are not valid without the signature of a registered medical practitioner or Foundation Year 1 Doctor.

Inpatient and outpatient prescriptions may also be signed by supplementary and/or independent non-medical prescribers who have the appropriate designation against their name on the relevant professional register and who are named on the local SFT register maintained by the Chief Pharmacist. (See [Non-medical prescribing policy](#) on ICID)

Recognisable valid signatures are required for all items prescribed. A full signature is mandatory for controlled drugs. Unsigned prescriptions are invalid.

All prescribers must provide the Trust with a specimen of their signature.

Prescribers are encouraged to provide their bleep/contact no. on the prescription.

4.8.7 Anti-infectives

Antibiotic prescribing must comply with the 'Start smart, then focus' methodology. [Guidance](#) on this and which antibiotics should be used in which circumstance are available on ICID. Antibiotic prescriptions must state the indication for and duration of therapy.

4.8.8 Variable Dose section

Where a medicine needs variable dosing, e.g. chlordiazepoxide and oral potassium supplements the variable dose section should be used and completed for each date, time and dose required, signed by the prescriber and a bleep/contact number stated. This section should also be used for the gentamicin prescription sticker.

4.8.9 Continuous epidural infusion or local anaesthetic infiltration

Prescriptions for continuous epidural infusions or local anaesthetic infiltration should be written in the section reserved for this purpose.

A pre-printed label, if available may be used on the drug chart and administration record provided it is fully completed and with the prescribers signature overlapping the main chart and label.

Where the dose is prescribed as a range, the actual dose given must be recorded.

4.8.10 Continuous parenteral infusions

Subcutaneous and IV replacement fluids should be prescribed on the back page of the medicines chart and administration record (headed 'continuous parenteral infusions').

Medicines to be given by continuous IV infusion should be written, together with the required IV fluid, in the 'continuous parenteral infusions' section on the back of the drug chart. The dose of drug and rate of infusion must be clearly stated.

4.9 Special prescriptions

4.9.1 Oral Anticoagulants

Vitamin K antagonist anticoagulants

All vitamin K antagonist anticoagulants must be prescribed in the regular medication section of the drug chart and administration record AND on the yellow vitamin K antagonist anticoagulant chart. The dose section of the anticoagulant prescription on the drug chart and administration record should be annotated 'as per yellow chart'.

The indication for anticoagulation and target INR range must also be completed on the yellow chart.

The dose given should be signed for on the yellow card and the dose given noted on the main drug chart.

It is important that concomitant medication is recorded on the yellow chart, in the box provided, so that potential interactions may be identified and monitored. This section should be updated with changes to drug therapy during admission for each INR request.

On discharge, the anticoagulant must be included in the take home prescription with the dose section left blank. The dose will be advised by the Anticoagulant department.

Thrombin/Factor Xa inhibitors

These anticoagulants must be prescribed on the main section of the drug chart and endorsed 'oral anticoagulant' by pharmacy. Patients on these agents must be notified to the Anticoagulant Service using the appropriate referral form or via the whiteboard.

4.9.2 Cytotoxic therapy

Cytotoxic therapy may be used to treat cancer and non-cancer conditions. Cancer treatments must be prescribed by a chemotherapy prescriber that may be a consultant/registrar/NMP for Haematology, Oncology or Paediatrics. For the purposes of this document, cytotoxic drugs for the treatment of cancer will be defined as all drugs with direct anti-tumour activity; this includes both classical cytotoxic drugs and targeted therapies but not hormonal or anti-hormonal agents. Cytotoxic drugs for haematology/oncology will be prescribed by a chemotherapy prescriber using the network-wide e-prescribing system. If e-prescribing is not used cytotoxic drugs and associated therapy for adults attending the designated chemotherapy facility as day patients must be prescribed on the white cytotoxic treatment sheet usually kept in green plastic sleeves. If e-prescribing is not used for in-patients and paediatrics the normal in-patient prescription chart should be used, except where the white cytotoxic treatment chart or pre-printed sheet is appropriate.

If e-prescribing is not used, oral chemotherapy and cytotoxics for patients attending haematology outpatients should be written on hospital outpatient prescriptions.

5FU used in eye surgery is prescribed on DSU prescriptions

Special procedures apply to the prescription, preparation and administration of cytotoxics for intrathecal and intra ventricular administration. It is essential that all staff prescribing and administering these products are aware of and abide by these procedures. The relevant procedure document available on ICID.

Further guidance on administration of cytotoxics and associated products is provided in the Trust policy for the [Administration of Prepared Anti-cancer Medicines](#), and [Guidelines for the Management of Oral Cytotoxic Chemotherapy](#) for cancer patients available on ICID. In-patient prescriptions for oral cytotoxics or targeted treatments should be endorsed with the word(s) 'cytotoxic' or 'handle as cytotoxic' respectively together with a reminder that each dose must be checked/signed for by two nurses (or two appropriate healthcare professionals) to highlight the nature of the medication and as a reminder of the Trust checking procedure.

4.9.3 Diabetic therapy (3 charts)

Three prescription charts are in use for diabetic treatment.

Chart 1: Variable Rate Insulin Infusion (VRII) must be prescribed on the 2-day IV insulin infusion and monitoring chart.

Chart 2: Oral hypoglycaemics and subcutaneous anti-diabetic medications (insulin, GLP-1 inhibitors) must be prescribed using the 2 week prescription and monitoring chart designed for this purpose. Reference MUST be made on the standard chart to indicate existence of diabetic therapy chart(s).

Chart 3: Diabetic Ketoacidosis in adults - management chart - fixed rate intravenous insulin infusion. Only to be used in the management of Diabetic Ketoacidosis in patients 18 years and over in conjunction with the national guidelines.

NB: 'UNITS' of insulin MUST ALWAYS BE WRITTEN IN FULL AND NEVER ABBREVIATED.

4.9.4 Dialysis fluids

Dialysis fluids should be prescribed in the as required prescriptions section of the drug chart, except in specialist areas for example Intensive Care Unit (ICU) where specialist fluid charts are in use.

4.9.5 Nutrition

Enteral nutrition. This must be prescribed in the regular prescriptions section of the normal in-patient drug chart and administration record. It may be prescribed by a doctor or registered dietician. Products include those for sip feeds, percutaneous endoscopic gastrostomy (PEG), percutaneous endoscopic jejunostomy (PEJ) and nasogastric use.

Parenteral nutrition. Total Parenteral Nutrition (TPN) for adults and neonates should be prescribed on the special prescription sheet available for this purpose.

4.9.6 Other infusions

Total dose iron infusions must be prescribed on the chart reserved for this purpose

Potassium infusions. Wherever possible, pre-mixed potassium infusions should be used. Only on Sarum and NICU may potassium chloride be added to intravenous fluids. Great caution must be exercised in all such instances.

(The policy for [Storage, Handling and Administration of Intravenous Potassium Chloride Injection](#) available on ICID)

Heparin preparations. See Trust policy on [Safe use of heparin preparations](#) on ICID.

4.9.7 MRSA

A separate pre-printed prescription chart exists for use when prescribing topical products for use in Methicillin Resistant Staphylococcus Aureus (MRSA).

Where systemic treatment is required, this should be prescribed in the anti-infectives section of the normal prescription chart.

4.9.8 Dressings

The dressing prescription sheet should be used for prescribing interactive dressings.

4.9.9 Medical Gases

Medical gases are regarded as Prescription Only Medicines.

Oxygen must be prescribed on the drug chart, using the oxygen prescription in the regular medicines section of the chart. The prescription must include the target oxygen saturation and where possible the device, flow rate etc. The nurse must check that oxygen is being administered and record administration on each drug round.

For other medical gases e.g. entonox, these must be prescribed in the as required prescription section of the drug chart and administration record¹. Instructions on flow rates should be written across the administration section. (See also Trust Medical Gases Policy).

4.9.10 Resuscitation drugs

All drugs administered during a resuscitation procedure should be recorded in the resuscitation record and signed by the team leader.

4.10 Benzodiazepines

The prescribing of long term benzodiazepines is discouraged. When benzodiazepines are prescribed long term physical and psychological dependence and tolerance may occur. This can lead to profound withdrawal problems (e.g. seizures) in some patients after just a few weeks of regular use. Benzodiazepines should be prescribed at the lowest effective dose, ideally only short term use and with clear and documented discussions with the patient over the risks and benefits of use. See [benzodiazepine policy](#) for guidance available on ICID.

¹ This requirement does not apply in midwifery.

4.11 Complementary medicines

Patients admitted to hospital on complementary medicines (eg herbal preparations) may continue to take them provided:

- i) A medical assessment is made of their safety and appropriateness for the patient concerned.
- ii) There are no drug interactions
- iii) The preparation(s) are written on the PRN or regular section of the drug chart and administration record as appropriate
- iv) The patient has their own supply.

The Pharmacy Department does NOT stock complementary medicines. Prescribers should note that patients using such products in hospital will be expected to make their own arrangements for ongoing supplies.

4.12 Limited list medicines (Black list)

Certain medicines are no longer available on NHS prescriptions and cannot be prescribed on FP(10) or FP(10)HNC forms. The pharmacy does not stock these blacklisted items.

Patients admitted to hospital on black listed medicines may continue to use them if they are prescribed on their inpatient prescription and if they bring their own supplies with them (subject to the usual safety checks made on patients own drugs). Supplies will not be provided through the pharmacy department.

4.13 Remote orders

IN NO CIRCUMSTANCES ARE REMOTE ORDERS ACCEPTABLE SOLELY IN VERBAL FORM OR FOR CONTROLLED DRUGS.

Only in **very exceptional** situations where the requirement for the prescriber to attend the ward to provide a written authorisation would result in significant deterioration of a patient's condition is a remote instruction acceptable within the Trust. (See [chapter 6](#)). In agreeing to accept a remote order for urgent and essential medication the nurses or midwives involved should be aware of the NMC guidance on remote prescriptions or authorisations to administer.

Remote orders may cover amendments to previously prescribed items where changes in dose are considered essential or the initiation of a previously un-prescribed medicine.

In both cases a fax or secure NHS net e-mail **MUST** be used to confirm the change to the original prescription/the new prescription before the medicine is administered. The fax or e-mail prescription or direction to administer must be stapled to the patient's drug chart and administration record and be followed up by a new prescription within 24 hours and signed by the prescriber who sent the fax/e-mail.

NB: IN NO CIRCUMSTANCES ARE REMOTE ORDERS ACCEPTABLE SOLELY IN VERBAL FORM OR FOR CONTROLLED DRUGS.

NB: Appropriately trained nurses, midwives and other healthcare professionals may administer Epinephrine injection (Adrenaline) 1 in 1000 (1mg/ml) by INTRAMUSCULAR INJECTION without authorisation by an appropriate practitioner for the purpose of saving life.

4.14 Investigations involving the administration of medicines

When radiography, laboratory tests or other investigations involve the administration of medicines, the prescription should include the date, name, dose and route of administration of the medicine, a valid signature and a reference to the instructions supplied by the department concerned.

The prescription should accompany the patient to the department where the investigation is performed.

Nurses and doctors involved in the administration of such drugs should complete the time given, given by and checked by boxes.

A separate policy applies to the use of contrast media in the X-ray department. See also [chapter 19](#) of this policy.

4.15 Incidents involving prescribing

Incidents involving the prescribing of a medicine to a patient include:

- i) Inappropriate drug/confusion over drug name
- ii) Inappropriate dose, frequency, route
- iii) Prescription of drug despite known intolerance/allergy
- iv) Significant interaction
- v) Inadvertent omission of a critical drug (see “Critical list of omitted or delayed drug” on ICID)

Whenever such incidents in the prescribing of medicines are found or observed then:

- The incident should be brought to the attention of the prescriber.
- An adverse event report via datix must be completed including immediate actions taken and results of the local investigation

4.16 Discharge and hospital transfer

Discharge medication should be prescribed 24 hours before discharge to avoid unnecessary delay.

Discharge prescriptions for controlled drugs **MUST** comply with all legal requirements (see BNF guidance on controlled drugs).

Prescriptions for medicines to be taken home on discharge are usually supplied using patient packs and provide a minimum of 14 days unless stated otherwise, e.g. to complete a course of antibiotics or cytotoxic drugs¹. Discharge prescriptions should be clearly prescribed via the Trust Electronic Discharge Summary (EDS) system or written in full on the paper discharge summary if the EDS system is unavailable. An electronic copy of the EDS should be sent to the GP within 24 hours of discharge.

On discharge or transfer to another hospital, all prescription charts should be filed in the patients' notes.

4.17 Licensing of medicines and prescriber liability

The majority of medicines used in SFT have a Product Licence for use in the U.K. issued by the Medicines & Healthcare Products Regulatory Agency (MHRA) or European Medicines Agency (EMA). The licence allows the product to be marketed and is an indication that the medicine is considered safe and effective for the uses indicated in the product licence. If harm arises to patients because of problems of safety or quality then the manufacturer is liable for any problems associated with his product.

4.17.1 Prescribing licensed medicines used outside their licensed indications (off-label use)

The Trust will generally accept liability in the event of untoward events happening in connection with the use of a licensed medicine for an unlicensed indication (so called “off label” use) provided that the unlicensed use would command peer group support and the Trust policy for ‘off label’ use of medicines has been followed.

Clinicians intending to use a licensed medicine outside its product license should follow the requirements set out in the [unlicensed medicines policy](#) on ICID.

4.17.2 Prescribing Unlicensed medicines

Medicines that have no Product License for use in the UK are also sometimes used within the Trust. The Trust will accept liability for their use if used in accordance with the Trust procedure for the use of [unlicensed medicines policy](#) on ICID.

4.18 Clinical Trials

Medicines that are prescribed for inpatients as part of a clinical trial must be prescribed on the normal drug chart and administration record or e-prescribing system in the same way as other medicines. There may also be a paper trial-specific prescription which is to be completed as well as the inpatient prescription. Similarly, administration of such medicines must be recorded in the usual manner on the drug chart and administration record or e-prescribing system.

Where there are trial specific chemotherapy regimens or treatments set up on the e-prescribing systems, these must be used instead of the standard prescription.

¹ Actual quantity may vary depending on Trust policy at the time.

All medicines used for patient care including clinical trial medicines must be procured by and dispensed² by the Pharmacy Service.

See also [chapter 15](#) on Clinical Trials.

4.19 Prescribing for Outpatients

Patients requiring immediate initiation of treatment

Prescribing for outpatients should only be done when patients require immediate or urgent initiation of treatment. All non-urgent prescribing should be referred back to the patients regular GP.

For patients seen in Outpatients requiring immediate initiation of treatment the hospital doctor should prescribe, and the pharmacy dispense, 28 days' supply of treatment unless the required course is shorter.³ Trust prescription forms should be used for this purpose except when prescribing at outreach clinics or when pharmacy at Salisbury District Hospital is closed when hospital FP10 prescriptions should be issued for patients to take to a community pharmacy. On occasions outpatient clinics may be asked to switch to FP10 prescriptions when the dispensary is unable to process outpatient prescriptions.

The above is also applicable to the emergency department however prescriptions are generated using the Lorenzo template.

Patients NOT requiring immediate initiation of treatment.

Where immediate commencement of treatment is not required, the hospital doctor should write to the GP and request that the GP consider initiating or continuing treatment, giving sufficient information to allow safe and effective prescribing. The patient should be advised to make a **non-urgent** GP appointment which allows time for receipt of written information by the GP.

Exceptions: Consultants should retain prescribing responsibility where:

- i) There is a need to retain responsibility for monitoring the effect of treatment or adjusting the dosage in which case a supply to see the patient through to the next outpatient appointment should be prescribed and dispensed.
- ii) The prescribed preparation is designated as a "hospital only" or "red drug" medication by the Medicines and Healthcare Products Regulatory Agency (MHRA) or by the Drugs and Therapeutics Committee (see medicines formulary on ICID)
- iii) The prescription forms parts of a clinical trial for which the Consultant is responsible.

4.20 Prescribing for day attenders

Where appropriate, 'stat' doses of medication for administration to day attenders or patients attending outpatient clinics may be prescribed in the patient's healthcare record. The entry must state the name of the drug, strength, form, dose, route, date and signature of the prescriber. Staff administering against such a direction should record the date and time of administration and sign the entry.

4.21 Prescribing for private patients

Where consultants are prescribing on Trust stationary for private patients, the private status of the patient MUST be clearly marked on the prescription by the prescriber.

4.22 Self Prescribing

It is recognised that there may be instances when it is in the best interest of the Trust and of 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. In such circumstances the Trust will allow the managed supply of small quantities of medicines in emergency or urgent situations, in order that key staff may remain on duty.

All hospital staff and their families should be registered with a G.P. through whom they will obtain all routine NHS care. In line with GMC advice, Trust medical staff may not, at NHS expense, prescribe for themselves and for their families. Prescribers wishing to prescribe outside this guidance must do so on a private basis.

Forms for self-prescribing in emergency or urgent situations as described above are available from the pharmacy department, in [Appendix 1](#) or alternatively a hospital outpatient prescription form may be used. The prescription should be written in the normal way and

² Dispensing requirements do not cover medical gases or X-ray contrast media.

³ Actual quantity may vary depending on Trust policy at the time.

signed by either an occupational health physician or consultant working with the Trust who is not the intended recipient of the medicine.

Items will only be supplied if they are consistent with emergency/urgent use in order for the member of staff to remain on duty. A maximum supply of 14 days will be made, unless the prescription specifies less. Where an original pack containing more than 14 days supply is prescribed and no other pack exists, one original pack shall be supplied (e.g. inhalers). Items supplied will attract the standard prescription charges. Normal exemptions will be allowed.

See [Supply of medication for Doctors Self Use or for Family/Colleagues/Friends](#) on ICID.

4.23 Prescription Modification by Pharmacists

Pharmacist interventions

Where pharmacists identify prescriptions which are incomplete, misleading, and inappropriate or potentially damaging the pharmacist has a professional duty to intervene. This intervention is likely to require modification of the prescription. Modification includes the addition of supplementary information to the original prescription, in addition to changes agreed after verbal discussion with the Prescriber.

Pharmacist modification of Prescriptions

Prescription modification may be applied to in-patient, discharge (TTOs) and outpatient prescriptions under the following circumstances:

Without contacting the prescriber

- i) Endorsements of the Approved Name when the drug has been prescribed by its trade name or abbreviated e.g. ISMN should be endorsed isosorbide mono-nitrate.
- ii) Addition of additional information in line with BNF guidelines eg 'to be taken with or after food'.
- iii) Addition of additional directions eg 'for pain'
- iv) Addition of maximum daily dose when drug is prescribed 'when required'.
- v) Alteration of dosage frequency where appropriate (e.g. amoxicillin prescribed QDS instead of TDS).
- vi) Alteration of administration timings to avoid drug interactions, minimise side-effects or maximise clinical effect: e.g. magnesium hydroxide and ciprofloxacin – allow 2 hours, between doses isosorbide mononitrate BD – last dose before 16.00 hours to provide nitrate-free period, simvastatin 20mg OD – administer at night for maximum effect.
- vii) Strength clarification in line with BNF guidelines e.g. 0.1mg, should be endorsed '100 micrograms'.
- viii) Rationalisation of Paracetamol-containing preparations, if the 4g maximum daily dose could be exceeded by combination of regular and 'when required' prescriptions.
- ix) Substitution of the following non-formulary drugs for the approved formulary drug only:-
 - x) Oral ampicillin, substituted by amoxicillin (TDS).
 - xi) Gaviscon advance substituted by gaviscon (10-20ml QDS).
 - xii) Cefaclor 250mg TDS, substituted by cefaclor MR 375mg BD.
 - xiii) Movicol substituted by Laxido
- xiv) A pharmacist can amend minor typographical errors on a controlled drug prescription e.g. if it specifies the quantity only in figures the pharmacist can add the words
- xv) Addition of a documented drug allergy to the 'Allergies and Drug Intolerance' section of the drug chart. The 'Allergies and Drug Intolerance' section of the drug chart should always be completed with either 'no known allergies' or the addition of a known or documented allergy and its form.

After contacting the prescriber

Wherever possible contact should be made with the original prescriber, except where circumstances necessitate contact with another doctor.

- i) Discontinuation of a drug (eg antibiotic)
- ii) Substitution of a non-formulary drug by one included in the formulary

- iii) Alteration of the route and/or frequency of administration of a drug prescribed as a TTO.
- iv) Addition of an item to a prescription, eg a drug omitted from a TTO but prescribed as part of in-patient treatment (not applicable to Controlled Drugs).
- v) Alteration of dose when discrepancy between POD/GP information identified.
- vi) Substitution of a non-formulary 'combination' drug by the individual components. The individual components should be prescribed separately and each prescription signed by a doctor.

The modification should be made, initialled and dated by the pharmacist and the prescription endorsed 'PC' (Prescriber Contacted) and annotated with the prescriber's name. The modification will not be routinely countersigned by the prescriber. Where modification has been so extensive as to require rewriting of the prescription, the prescriber must sign this new prescription as soon as possible.

Verbal prescription telephoned by Prescriber

Addition of a drug to in-patient treatment when the patient's prescription chart is in Pharmacy for some other reason.

The Prescriber is required to sign the prescription when the chart is returned to the ward. The dose must not be administered until the prescription has been duly authorized.

NB The above list is not exhaustive of all situations in which pharmacists' professional judgement indicates that modification of the prescription chart is required. In such situations the pharmacist will at all times be guided by the requirement to safeguard patient safety and the broad principles outlined above.

5 DISPENSING OF MEDICINES

5.1 Dispensing procedure

Only prescriptions that fulfil legal requirements and are in accordance with the procedures outlined in this policy may be dispensed within SFT. In all cases drug allergies and intolerances must be checked before any item is dispensed. The dispensing procedure must ensure that the prescriber's intentions are accurately interpreted, that the medicine is correctly dispensed and that an appropriate container and correct label are used.

5.2 Labelling of Medicines

By law, all medicines dispensed to patients for self-administration within the hospital or to take home must have a label on them which includes the following:

- The name of the patient
- The name and address of the hospital
- Directions for use
- The date of dispensing
- The name and strength of the product
- The quantity dispensed
- Keep out of sight and reach of children
- Other warnings/information relevant to the product

New medication supplies must also be supplied with a patient information leaflet (PIL)¹.

5.3 Nursing/midwifery and medical staff

If, under exceptional circumstances, nursing, midwifery or medical staff are required to dispense medication, there is no legal barrier to this practice. However, this must be in the course of the business of a hospital and in accordance with a prescriber's written instructions.

Dispensing includes:

- Checking the validity of the prescription,
- Checking the appropriateness and safety of the medicine for an individual patient,
- Assembling the product accurately and safely,
- Labelling in accordance with legal requirements and
- Providing information leaflets for the patient.

Dispensing by registered nurses or midwives represents an extension to normal professional practice. The patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist. See guidance issued by NMC.

5.4 Supply of patient packs for inpatient use

Nurses/midwives may issue patient pre-packs for use by inpatients without the issue being checked by a second nurse or a doctor. The issuing nurse/midwife must complete the dispensing label with the patient's name and date of issue, and appropriate dose/frequency instructions if these are not already stated on the label and lock the supply into the patient's bedside POD locker.

This facility is available for nurses/midwives at all times on participating wards.

5.5 Supply of medication on discharge

Supply of medication on discharge constitutes 'dispensing'.

Only when pharmacy dispensing is not possible or circumstances dictate the need to discharge a patient where pharmacy has not already dispensed the discharge medication should dispensing be carried out by ward staff.

¹ Where insufficient leaflets are available, pharmacists must use their best endeavours to obtain extra supplies in order to ensure that patients receive the information to which they are legally entitled

Nursing/midwifery and medical staff may issue patient packs of medicines, 'one-stop' medicines dispensed by pharmacy and/or reissue PODs to patients on discharge in accordance with a legal written discharge prescription signed by a registered prescriber. In all cases, the Trust procedure for issue of patient packs, 'one-stop' dispensed items and/or reissue of PODs on discharge must be followed. (See [flow chart in 5.8](#)).

All such issues must be labelled in accordance with the legal requirements set out above ([5.2](#)). All such issues must be checked by 2 nurses or a nurse and a doctor.

THIS FACILITY EXISTS FOR USE ONLY WHEN THE PHARMACY IS CLOSED. In all other circumstances discharge prescriptions should be filled by a pharmacist or suitably trained and accredited pharmacy technician on the ward or sent to pharmacy for dispensing/checking. On NO ACCOUNT should ward stocks or medicines dispensed for nurse administration to inpatients, i.e. medicines without appropriate legally compliant directions on them, be given to patients to take home.

Wards have a responsibility to ensure that prescriptions are written in a timely manner which allows dispensing by pharmacy.

5.6 Special arrangements for supply of discharge medication (during pharmacy working hours) on named wards/departments only

In certain circumstances wards/departments have standard requirements for discharge medication where the involvement of pharmacy in the medication supply adds little value to the process for the patient. Where this is the case and is approved by the Trust, appropriately trained and assessed nursing and midwifery staff on the named wards/departments may supply standard discharge prescriptions (TTOs) at ward level during pharmacy opening hours .

Standard TTO items are specific to the ward/department concerned. Each participating clinical area will have an agreed list of medications that are considered standard TTO items for their area. The medications must be available as pre-labelled packs for discharge and be specifically agreed and documented for each area.

In undertaking this activity, nurses/midwives are reminded of the NMC guidance on dispensing of medications and the contents of para [5.3](#) above. See Policy for supply of standard discharge prescriptions (TTOs) at ward level by registered nurses and midwives during pharmacy working hours (named wards only) available from the Chief Pharmacist.

5.7 Incidents involving dispensing

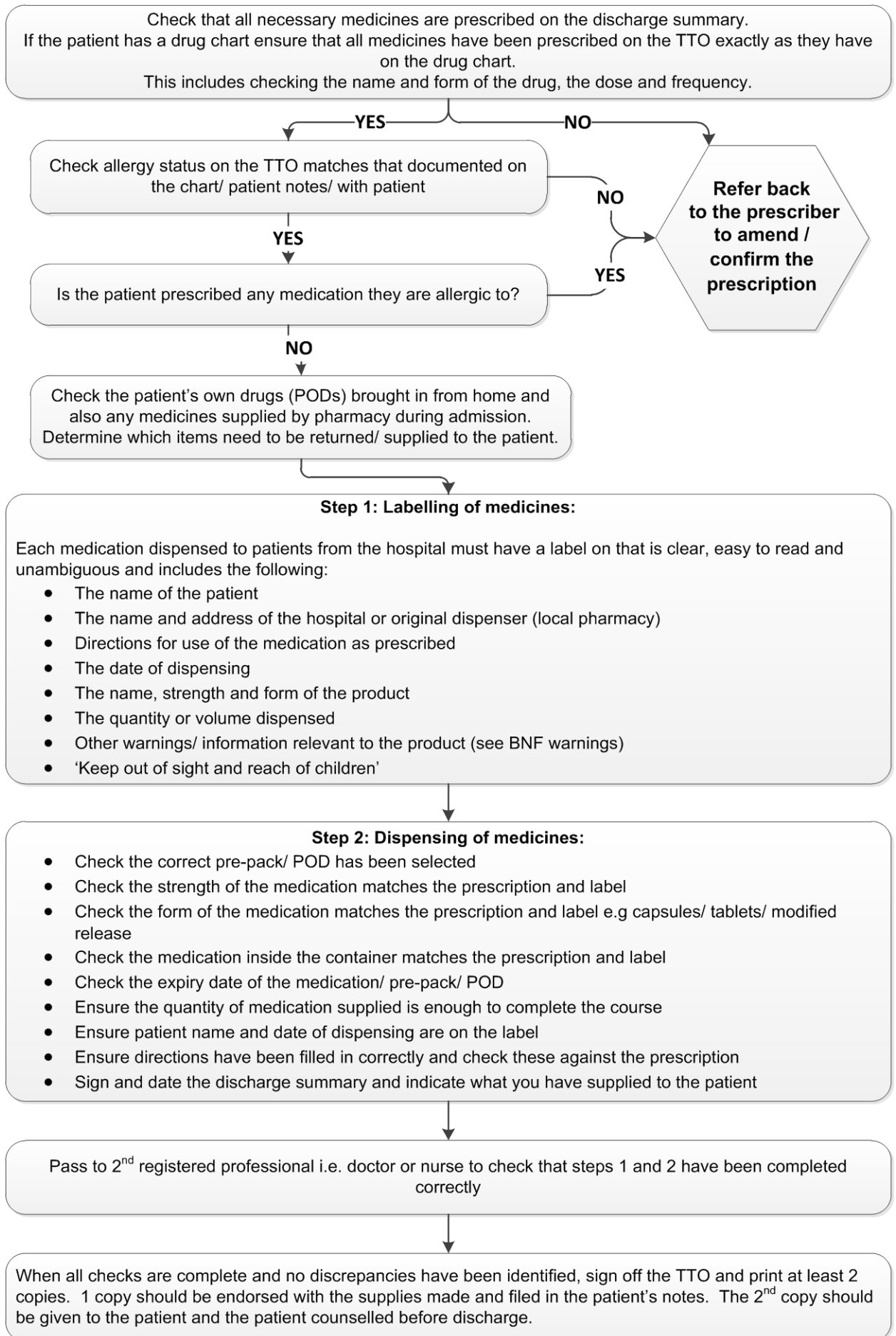
Incidents involving dispensing of a medicine to a patient may include:

- i) Wrong drug
- ii) Wrong strength/form/dose
- iii) Wrong patient's name
- iv) Wrong patient

Whenever a dispensing error is identified after the medicine has left the pharmacy department, ward or hospital then:

- If the patient has received a dose, the appropriate doctor in charge of the patient should be contacted and when necessary, remedial action taken to ensure the safety of the patient.
- Any incident involving pharmacy staff should immediately be reported to and investigated by the Chief Pharmacist or a person delegated to act on their behalf.
- An Incident form via datix must be completed and fully investigated . Support statements may be required from all staff concerned.

5.8 Procedure for dispensing urgent discharge medication at ward level when pharmacy is closed



6 ADMINISTRATION OF MEDICINES

6.1 Responsibilities

It is the responsibility of nurses/midwives and other relevant practitioners including doctors administering medicines to do so in accordance with statutory and local rules and guidance issued by their professional bodies.

The administration of medicines is an important aspect of professional practice irrespective of the discipline involved. It is not solely a mechanistic task to be performed in strict compliance with the written prescription or protocol. In exercising professional accountability in the best interests of patients, nurses and midwives must ensure the “principles for the administration of medicines” as described in this medicines policy are followed at all times.

6.2 Nurses and midwives authorised to administer medicines

6.2.1 Registered nurses/midwives

Registered nurses and midwives may generally administer medicines on their own provided they are experienced in the clinical area in which they are working.

It is Trust policy that only nurses who have demonstrated the necessary knowledge and competency and who have an active Personal Identification Number (PIN) may administer medicines including Controlled Drugs. Newly qualified nurses awaiting their PIN may be permitted to administer medicines at the discretion of the registered nurse with 24 hour responsibility for the clinical area/lead midwife for the shift.

Bank and Agency nurses are individually responsible and accountable for their practice and should only administer medication if they are competent to do so. The nurse in charge of the shift is responsible for determining competence with the nurse as soon as he/she reports for duty.

Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations, it is recommended that a second practitioner checks the calculation 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.

6.2.2 Student nurses/midwives

Student nurses/midwives are subject to the supervision of a registered nurse/midwife at all times.

6.3 Authorisation to Administer

The written authorisation is required before medicines can be administered to patients¹. The authorisation may take the form of:

- The Trust policy for the administration of Discretionary Medicines as found on ICID:- [Administration of Discretionary Medicines by Registered Nurses and Midwives - Salisbury NHS Foundation Trust](#)
- A Trust approved Locally Agreed Clinical Procedure
- A Trust approved Patient Group Direction
- A prescription signed by a registered medical practitioner.
- A prescription signed by a registered supplementary and/or independent non-medical prescriber (NMP).

6.4 General Guidelines for Drug Administration

All staff on or visiting the ward must be made aware that a nurse/midwife should not be interrupted whilst administering drugs.

Where an interruption is essential, the nurse/midwife carrying out the drug round must ensure that he/she completes the administration for the patient being dealt with at that time.

The nurse/midwife responsible/accountable for a group of patients should administer the drugs to those patients and wherever possible should discuss the medicines including the purpose of the medication and any likely side effects with patients or their representatives at the time of drug administration.

¹ Special rules apply to the supply and administration of medicines by midwives see [chapter 21](#).

Where a drug trolley is in use it must be kept tidy. Medication no longer in use should be removed from the trolley and the nurse/midwife undertaking the drug round should ensure that he/she stocks up on essential items before starting.

The entire drug chart and administration record must be reviewed at each medicine round. Staff are reminded that ALL pages of the drug chart must be checked including anti-infective medicines and continuous parenteral infusion sections. Staff are also reminded of the need to check additional specialist charts e.g. diabetes and anticoagulant charts.

6.5 Checking Procedure

When administering medicines nurses and midwives and other relevant practitioners, including doctors, MUST adhere to the following procedures:

- Carefully read and understand the prescription. Check its validity (prescriber's signature, the prescription date and time of administration) and that it is completed in accordance with [chapter 4](#) of this Policy.
- NB. It is very important to check the administration time carefully. Do not be distracted by previous signatures in the administration columns: if an error was made previously it may be continued.
- Ensure the prescription including the dose, form and route of administration can be clearly read and fully understood.
- NB Prescriptions must be legible. If the prescription is not clear in any detail, it must be checked with the prescriber. Staff administering the drug should not proceed until they are completely satisfied (if doubts persist contact the pharmacist or nurse manager).
- In addition, the nurse/midwife should have knowledge of the medicine and be able to calculate the dose. Doses requiring calculation, or those based on patient's weight or those which are prescribed according to physiological measurements should be checked independently by a second practitioner.
- Ensure that they are aware of the patient's current assessment and planned programme of care.
- Note any contra-indication or change in the patient's clinical condition which might require a medicine to be withheld. Seek medical advice should the unplanned withholding of a medicine be indicated.
- Check allergies and drug intolerances associated with the medicine to be given.
- Consider carefully whether any of the prescribed medicines will or might interact dangerously with each other.
- Check to see if the prescription has been annotated (either by the pharmacist or doctor) giving further guidance concerning its administration.
- Check that the patient has not already received the dose which is about to be administered.
- NB. There may be changes in the presentation or appearance of a medicine as the pharmacy department routinely uses more than one source of supply. If the appearance of the medicine gives cause for concern or is queried by the patient, a pharmacist must be contacted before it is given.
- Select the medicine and check the following aspects to ensure that the selected medicine is correct and is administered according to the prescription:
 - Ensure you have the correct patient (ask the patient their name and check their wrist band)
 - Medicine name
 - Dose form
 - Strength of preparation
 - Quantity to be administered
 - Expiry date (if available)

- Check each part of the packaging of the medication is correct e.g. are the individual blister strips of medication the same as the outer box and label?
- Additional instructions on container label and prescription
- Appropriate setting of infusion device (where used)
- Correct drug through correct line (where appropriate)
- If there is any substantial interruption during the process it may be necessary to discard the medicine and start again.
- Confirm the patient's identity by checking the patient's identification name band.
- Administer the medicine and immediately record the administration on the appropriate documentation. Where the medication given is oral the nurse should ensure the dose(s) have actually been taken before signing the administration record. Where the prescription allows for a range of doses to be given e.g, Paracetamol 1-2 QDS, the dose given should be stated in the administration record.
- Wherever possible draw the attention of patients to information concerning their prescribed medicines including the purpose of the medication and any likely side effects as patient education is an important aspect of care and helps improve compliance and reduce drug related adverse events.

6.6 Preparation of medicines in advance

Medicines for injection must not be routinely prepared at ward level in advance of their immediate use. Individuals must not administer medicines prepared by another practitioner when not in their presence unless the product is an already established infusion which has been instigated by another practitioner in accordance with their professional code of practice or products that have been prepared and supplied by the pharmacy department.

When taking over a patient with an established infusion/PCA etc. from another ward/department the receiving nurse must ensure appropriate checks are made.

6.7 Nil by Mouth (NBM)

Patients who take essential medication must not on any account have their medication withheld when NBM (eg when being fasted in preparation for theatre). [See [fasting guidelines](#) and associated guidance available on ICID].

All essential medication must be administered, with a small amount of water (60ml) if necessary unless specifically instructed by a member of the medical team not to give the medication. In such cases this must be clearly documented and written on the drug chart. If the oral route is contra indicated an alternative must be used.

6.8 Swallowing difficulties

For patients with swallowing difficulties or those being fed via nasogastric, PEJ or PEG tube, liquid medication may be available for use instead of a solid dosage form. However, formulations may not be directly equivalent and the nurse must check with pharmacy before substituting one for the other.

NB. Solid dosage forms are not always suitable for crushing to aid administration e.g. those in slow release formulation. In all cases of uncertainty, advice should be sought from a pharmacist or from the NEWT guidelines website available on ICID.

6.9 Measurement of liquid medication

Where doses of oral liquids of 5ml or more are to be administered orally, 5ml spoons or calibrated medicine pots must be used to measure the required dose. On no account should IV syringes be used.

Where the dose of oral liquid is less than 5ml, an oral syringe must be used.

Where oral liquids are to be administered via a nasogastric tube, PEJ or PEG, the required dose must be measured and administered via a clean oral/enteral syringe. (See Trust policy for the [measurement and administration of liquid medicines via oral and other enteral routes](#) on ICID).

Where oral liquids are to be administered via a jejunostomy tube a sterile enteral syringe should be used to measure and administer the dose. (See policy as above).

6.10 Anticoagulants

Wherever possible, warfarin doses will be determined by the Anticoagulant service and written on the yellow anticoagulant chart. Warfarin will also be written in the regular medication section of the patient's drug chart and administration record. When administering the dose as indicated on the yellow anticoagulant chart the nurse/midwife must document the administration on the main drug chart/administration record and STATE THE DOSE GIVEN.

On discharge, for patients new to anticoagulation, the nurse/midwife must:

- Give the patient an Oral Anticoagulation Therapy (OAT) pack
- Give the patients their trifold printed warfarin dosing document
- Make an appointment for counselling with the anticoagulant nurse.

It is the responsibility of the nurse discharging the patient to ensure that he/she has been issued with the relevant information and that the patient knows the dose to take and when the next blood test is due.

6.11 Security of medicines

Medicines must not be left unsecured in any area of the ward including the treatment room and in the patients' bed area. The nurse/midwife (or nursing assistant supervised by registered nurse) must stay with the patient until the medication has been taken by the patient.

Self-medication by the patient is encouraged in some settings. Medicines must be kept locked in patient's own drug cabinets and Trust procedures must be followed.

Drug cupboards and treatment rooms must be kept locked at all times. Drug trolleys must be locked and secured to the wall when not in use. Unlocked drug trolleys or unsecured medicines should not be left unattended during a drug round.

Medicines fridges must be kept locked at all times.

6.12 Missed/late doses

Missed or late doses may pose a significant risk to the patient's continued wellbeing and should be avoided at all times. Where a drug is not immediately available it is the responsibility of the nurse or midwife concerned to **secure a supply of the medication, either as soon as possible (for urgent treatment e.g. antibiotics) or by the next due dose for routine medication.**

When a prescribed medication is not administered to a patient (eg because the patient refuses, or is absent from the ward at the time) this omission must be recorded on the prescription sheet in the relevant box using the appropriate numerical code as follows:

List of Codes:	
1	Patient refuses
2	Patient not present on ward
3	Medicine not available (if using this code please ensure the supply is being sourced from pharmacy)
4	Clinical reason/professional judgement - specify reason in the patient's notes
6	Nil by mouth
√	Patient self-administered medication
X	Prescribing doctor's instruction to omit dose

Where doses have been omitted it is not sufficient to continue writing codes in administration boxes. It is the responsibility of the nurse or midwife concerned to seek medical review if a dose has not been given. Where appropriate the doctor should amend the patient's prescription (e.g. change route of administration in patients nbm) to allow treatment to continue.

The nurse/midwife should document the action taken in the patient's notes and complete a Trust Incident form where non-administration of a dose is clinically significant.

For a dose given significantly later than intended (i.e. later than 2 hours) the actual time should be written into the initials box of the administration record by the prescribed time. The entry should be signed.

See [coding system for missed doses available](#) on ICID and [Appendix 3](#) to this policy – Medicines unavailable guidance flow chart.

Some critical drugs are essential to the immediate health of the patient. Any missed doses of critical medicines (Critical list of omitted or delayed drugs available on ICID) must be investigated immediately and reported on datix.

6.13 Administration of discretionary medicines by registered nurses and midwives

See [Trust policy](#) on ICID

6.14 Additional Medication Given

Where authorised by a Trust approved written Patient Group Direction, Locally Agreed Clinical Procedure or the Trust policy for administration of Discretionary Medicines a nurse, or other relevant practitioner, may administer relevant medicines in accordance with the terms of the written authorisation.

In all such instances a record must be made of this administration on the patient's drug chart and administration record, or, if this is not appropriate (eg for outpatients), in the patient's health care record. Where a record is made on the drug chart and administration record this should be in the Additional Medication Given section. All records of medicines given in this way must include the name of the product, dose, date and time given and the signature of the person administering the medicine and state the authority under which it was given (eg PGD).

The requirements for recording medication given by midwives in the absence of a prescription are set out in [chapter 21](#).

6.15 Administration of medicines by doctors

Medical staff are reminded that administration of medicines by relevant professionals (eg nurses) within the Trust may only take place in accordance with the appropriate authorisation to administer as detailed in [chapter 6.3](#).

Where an individual prescription is required this should always (except in exceptional circumstances eg cardiac arrest / anaphylaxis) be written and signed before the medicine is administered.

The doctor administering the medicine must ensure that the administration is clearly documented on the appropriate documentation eg drug chart and administration record or, where outpatients are concerned, in the clinic notes.

6.16 Administration of medication by nursing associates or assistant practitioners

In some circumstances and following a robust competency and training framework band 4 nursing assistants are allowed to administer a defined range of medication. A strict policy is in place outlining the training and education requirements before this can be considered and a trust wide register is in place to support the individual. See "Medicines Administration by band 4 assistant practitioners / Nursing Associates" available on ICID <http://icid/MedicinesManagement/Guidance/Generalguidance/Pages/MedicinesAdministrationbyBand4AssistantPractitionersNursingAssociates.aspx>

6.17 Remote Orders (previously known as 'verbal orders')

IN NO CIRCUMSTANCES ARE REMOTE ORDERS ACCEPTABLE SOLELY IN VERBAL FORM OR FOR CONTROLLED DRUGS.

Only in very exceptional situations where the requirement for the prescriber to attend the ward to provide a written authorisation would result in significant deterioration of a patient's condition may a remote instruction to administer a medicine (or to vary details of an existing prescription) be accepted by a nurse/midwife. All of the following conditions must be met:

- The nurse/midwife must be trained and competent in the administration of medicines and
- Must be able to account for his/her actions and
- Must be satisfied that by accepting the remote order the patient will not be put at risk and
- The situation corresponds to an emergency where the requirement for the prescriber to attend the patient would result in significant deterioration in the patient's condition
- The order is being given by a registered medical practitioner

In agreeing to accept a remote order for urgent and essential medication the nurse or midwife involved should be aware of the NMC guidance on remote prescriptions or authorisations to administer.

Remote orders may cover amendments to previously prescribed items where changes in dose are considered essential or the initiation of a previously unprescribed medicine.

In either a fax or secure NHS e-mail) **MUST** be used to confirm the change to the original prescription/the new prescription before the medicine is administered. The fax or e-mail must be stapled to the patient's drug chart and administration record and be followed up by a new prescription within 24 hours and signed by the prescriber who sent the fax/e-mail.

NB: Appropriately trained nurses, midwives and other healthcare professionals may administer Epinephrine injection (Adrenaline) 1 in 1000 (1mg/ml) by INTRAMUSCULAR INJECTION without authorisation by an appropriate practitioner for the purpose of saving life.

Where the conditions justify a remote order being accepted the instruction must be immediately written on to the patient's drug chart and administration record in the Once Only section by the nurse/midwife receiving the instruction. The fax/e-mail must contain clear and unambiguous instructions and the nurse/midwife must be certain that he/she is fully conversant with the medicine and has fully understood the prescribing details. If there is any doubt about the drug, its dose, its route, etc., the nurse/midwife concerned must contact the prescriber. It will then be the responsibility of the prescribing doctor to attend the ward to administer the drug if he/she insists that it must be given.

The nurse/midwife must write "REMOTE ORDER" with the date and time of the order, the name of the prescriber and his/her own signature.

Only ONE dose may be administered on a remote order.

In the case of inpatient prescriptions, the prescriber must countersign the order at the earliest possible moment; this must be within 24 hours. The pharmacist may only dispense sufficient medication for one dose. The prescription must be signed by the doctor before further supplies are dispensed.

If the medication is to continue a properly written and signed prescription must be in place before supply/administration occurs.

In an emergency situation where the prescriber is physically present/attending to the patient concerned but unable to give the required medication themselves (e.g. emergency intubation) a nurse/midwife/ODP may administer essential medication (including controlled drugs) on the verbal instruction of the prescriber. As soon as the emergency situation is resolved the medication given must be prescribed by the doctor issuing the verbal request and signed as given by the relevant staff.

6.18 Guidance on the administration of Intravenous Drugs

Intravenous medicines can be administered by qualified medical staff, suitably trained medical staff in training and by registered nurses/midwives/ODPs with evidence of competence to administer intravenous products.

The first dose may be given by either a member of the medical staff or a registered nurse/midwife who has received appropriate training in the administration of intravenous drugs.

Wherever possible there should be two registered nurses/midwives or one registered nurse and a doctor present on the ward/department when the first dose of an IV drug is being administered.

If there is any doubt about the drug, its dose, its route, etc., the nurse/midwife concerned must contact the prescriber. It will then be the responsibility of the prescribing doctor to administer the drug if he/she insists that it must be given.

Hands must be decontaminated, with an alcohol-based hand rub or by washing with liquid soap and water if soiled or potentially contaminated with blood or body fluids, before and after any contact with the intravascular catheter or insertion site.

All nurses/midwives must be fully aware of the possibility of reactions which may result following the administration of intravenous drugs. It is incumbent on all nurses/midwives to ensure that they continually keep themselves updated about all such reactions. Anaphylaxis is the most extreme of reactions. There are some categories of drug where anaphylaxis is more likely to occur. These include; antibiotics, total dose iron infusions, chemotherapy, vaccines, vitamins and X-ray contrast media. Each ward/department must keep a pack of

Epinephrine 1 in 1000 together with syringes and needles within the medicine cupboard or an orange anaphylaxis box designed for this purpose. These should be readily available to be accessed quickly in the event of an anaphylactic reaction. The Medicines Act allows the INTRAMUSCULAR administration of Epinephrine (Adrenaline) 1:1000 (1mg/ml) without prescription for the purposes of saving life.

Drugs given intravenously to infants will be given by trained and competent nursing and midwifery staff. (See [chapter 21](#)).

All registered nurses/midwives competent in administration of drugs can, without further training and assessment, set up infusion fluids containing additives (EXCEPT CYTOTOXICS) which have been commercially produced or prepared in the pharmacy and for which the rate of administration has been prescribed.

The pharmacy contains a suite of clean rooms with HEPA filtered isolator cabinets for the aseptic preparation of injectable medicines under exemption 10 of the Medicines Act and audited under EL (97) 52. These aseptic facilities are used to prepare parenteral nutrition bags, cytotoxic drugs as syringes and infusions for chemotherapy and other high risk intravenous drugs eg PCA syringes, epidural infusions and intrathecal syringes.

If medicines are to be added to Intravenous Fluids, the following precautions should be taken:

- **CHECK FOR INCOMPATIBILITIES:** The addition of more than one medicine to a fluid should be avoided. However certain common combinations are known to be compatible. IV compatibility data is available in the BNF and the on-line injectable Medicines Guide (Medusa – see ICID) Strict aseptic procedures should be used in adding medicines to IV fluids to avoid the possibility of bacterial contamination.
- Certain fluids containing additives are available from Pharmacy as ready prepared solutions eg Glucose with Potassium. Ready made products should be used wherever possible. Certain high-risk solutions are available from Pharmacy on request, eg cytotoxic preparations.
- When using mechanical equipment to administer IV medicines, care should be taken to achieve the correct flow rate, in accordance with the manufacturer's instructions. Nurses must have undergone training and ensure that they are competent to use the infusion pump in question. Any calculations involved in setting up an infusion device should be checked by a second qualified person.
- The IV additive label must be attached to the FRONT of the intravenous fluid bag. On no account should it be placed on the reverse side.

NB On no account should additions be made to Parenteral Nutrition bags at ward level due to risk of microbial contamination and chemical instability.

6.18.1 Strong Potassium Chloride

Strict rules apply to the administration of intravenous potassium preparations: see Policy for Storage, [Handling and Administration of Intravenous Potassium Chloride Injection](#). See policy on ICID

6.18.2 Cytotoxic drugs

Strict rules apply to the preparation and handling of cytotoxic products. All parenteral cytotoxics **MUST** be reconstituted in the pharmacy aseptic suite except where:

- The medication is available as a kit
- Or involves the use of a reconstitution / administration kit (e.g. mitomycin made using a kit)

6.18.3 Bolus Injections

Where IV drugs are appropriate for Bolus administration, this is the method of choice.

6.18.4 Flushing Intravenous Lines

Once intravenous access has been established it should be flushed before and after IV medicines with 5 ml of Sodium Chloride 0.9% unless contraindicated (see below). Larger volumes should be used for long lines eg 10ml for PICC. Smaller volumes, for example 0.5ml should be used for neonates and infants. Sodium Chloride 0.9% injection flushes should be prescribed using the pre-printed box at the top left-hand side of the as required medication section of the drug chart and administration record. **Only when this instruction has been completed and signed does this become a valid authorisation to administer a flush.**

Exceptions:

- a) Specific risk of blockage, for example some central lines, when the appropriate volume of Heparinised saline 10 units per ml may be used, which must be independently prescribed.
- b) There is a need to adjust volume of cumulative fluid if sodium overload is a potential problem.
- c) Incompatibility with Sodium Chloride 0.9%, for example Amphotericin, must be flushed with 5% dextrose. Check compatibility in product information sheet or BNF or Medusa on-line IV Guide.

6.18.5 Intermittent Infusions

This is relevant to patients who do not otherwise require intravenous fluids and where consideration can be given to removing the giving set between drug administration times, allowing the patient freedom of movement.

The intravascular device should be flushed before and after the intermittent infusion (see above). The volume of the flush solution should be equal to at least twice the volume of the catheter and add-on devices – usually 5-10ml.

All solution sets used for intermittent infusions, for example, antibiotics, should be discharged immediately after use and not be allowed to hang for reuse.

Peripheral vascular catheter insertion sites should be inspected on every shift and a Visual Infusion Phlebitis (VIP) score recorded. This evaluation should include a gentle palpation over the dressing on the insertion site. If the site exhibits redness, warmth, pain, drainage or tenderness, the site and the entire IV system should be changed immediately.

Peripheral vascular catheters should be re-sited when clinically indicated and not routinely, unless device specific recommendations from the manufacturer indicate otherwise. The date of insertion must be documented in the clinical records as a matter of routine.

Transparent, semi-permeable polyurethane dressings should be changed every 7 days, or sooner if they are no longer intact or if moisture collects under the dressing. A single application of 2% chlorhexidine gluconate in 70% isopropyl alcohol (or povidone iodine in alcohol for patients with sensitivity to chlorhexidine) should be used to clean the peripheral venous catheter insertion site during dressing changes and allowed to air dry.

When the next drug is due, injection ports, connections and caps should be disinfected with alcohol swab or chlorhexidine, and the new infusion set up using aseptic technique before injecting the required medicine.

A bolus of 10ml Sodium Chloride 0.9% injection should be administered via the cannula prior to switching on the administration set. This is to ensure patency.

Administration sets for blood and blood components should be changed when the transfusion episode is complete or every 12 hours (whichever is sooner).

Administration sets used for lipid-containing parenteral nutrition should be changed every 24 hours.

Administration sets in continuous use do not need to be replaced more frequently than every 96 hours, unless device-specific recommendations from the manufacturer indicate otherwise, they become disconnected or the intravascular access device is replaced.

Any intravenous device/cannula should be removed in line with Trust policy as soon as it is no longer clinically indicated.

6.18.6 Single use only

Most vials of injectable products are for **SINGLE USE ONLY**. They **MUST NOT** be used as multidose containers or used for subsequent doses unless specifically stated as multidose on the label or package information.

6.18.7 Further information

Further information on IV drug administration is available in the BNF, pharmacy, and MEDUSA, the on-line injectable medicines guide which can be accessed via ICID.

6.19 Guidance on administration by subcutaneous and other parenteral routes

Guidance on the administration of chemotherapy drugs by various routes is given in the Trust Policy for the [Administration of Cancer Chemotherapy](#) and Trust [Protocol on Intrathecal Chemotherapy](#) (both available on ICID).

Guidance on the administration of fluids by subcutaneous infusion is given in the Trust [Protocol on Administration of Subcutaneous Fluids](#) (Available of ICID).

Guidance on administration by intrathecal, intra-muscular, intra-articular, intravitreal, intrapleural and epidural is available from pharmacy.

6.20 Line Labelling

All lines giving venous, arterial or epidural access must be labelled in accordance with the Trust [Line Labelling](#) Policy available on ICID.

6.21 Covert administration of medicines

The Trust policy for [covert administration of medicines](#) is available on ICID. Nurses/midwives are reminded of the NMC guidance on this topic.

6.22 Administration records

The person administering a medicine is responsible for completing the administration record immediately afterwards. The relevant initials box adjacent to the prescription should be signed. For 'as required' medication, the date, time, dose and given boxes should be filled in.

Before the drug chart and administration record is full, a new prescription chart should be made out by the prescriber. In this situation the date medication was initiated should be taken from the completed chart and entered onto the new chart. Previous charts should be filed in the patient's healthcare record.

6.23 Incidents involving administration of medicines

Incidents involving administration of medicine to a patient include:

- i) A medicine is given which has not been prescribed.
- ii) An incorrect dose of medicine is given.
- iii) The correct medicine is given but at an incorrect interval.
- iv) All unplanned omissions or delay in administering a drug
- v) An incorrect person receives a medication
- vi) .

Whenever incidents involving administration of medicines are found or observed then:

- The appropriate doctor in charge of the patient should be contacted immediately and, when necessary, remedial action taken to ensure the safety of the patient.
- Any incident involving nursing/midwifery staff should immediately be reported to and investigated by the appropriate Ward Manager or a person delegated to act on their behalf.
- An on-line Datix form must be completed and the appropriate investigation and actions added
- The relevant ward pharmacist should be informed if appropriate.
- The Chief Pharmacist should be informed of any incidents involving controlled drugs

6.24 Self-medication by staff in clinical areas

A supply of Paracetamol and ibuprofen is available on wards and in clinical departments for specific use by staff in exceptional situations when staff feel unwell but do not need medical or nursing assistance, or to visit Occupational Health AND are unable to leave their clinical area to obtain their own supply.

A supply of Paracetamol and Ibuprofen for use by staff unable to leave the clinical area will be supplied to wards by Pharmacy on request. Wards are requested to record receipt of this stock from Pharmacy. Records of tablets issued to individuals should be kept by the nurse/midwife in charge in a book and include details of the place, date, time and number of tablets issued, together with the names of the persons receiving medication and the signature of the person issuing medication.

Individuals are not expected to use this provision to access medication on a regular basis.

Nurses/midwives may not dispense any other form of medication to any member of staff.

Nurses/midwives who hold the drug cupboard keys remain responsible for all ward medication. Keys must not be released to **any** other staff member, not authorised to possess them, and particularly not to allow self medication.

Medications must not be released from ward stocks for the purpose of staff administration.

The provisions contained within this policy relate only to staff working in clinical areas. They do not extend to staff working in non-clinical environments.

The availability of Paracetamol and Ibuprofen is intended to help staff that become mildly indisposed. It is NOT intended to replace or supplement personal medication privately purchased by staff for their own use nor to encourage staff to stay at work when they are unfit for duty.

Staff may not receive any form of prescription only medication from another member of the hospital staff, other than in an immediate and life threatening situation.

Staff are reminded of the importance of reading the label of all medication. Always note contraindications and never exceed the stated dose. Staff with a history of gastrointestinal problems and/or asthma should not take Ibuprofen.

7 RECONCILIATION OF MEDICINES (ALL PATIENTS ON ADMISSION)

7.1 Definition

The process of medicines reconciliation can be thought of as 'harmonizing' the patient's drug history, the patient's drug chart and other sources of information about their medication to ensure they are consistent with each other. Through this preventable medication errors on admission, on transfer between hospital units or on discharge to primary care can be reduced.

The process aims to:

- To enable the most accurate list of a patient's medication to be compiled.
- To ensure that medicines prescribed on admission correspond to those that the patient was taking before admission, where this is clinically appropriate.
- To ensure that the details of medicines stopped, started or altered during a patient's stay are accurately communicated to any relevant health professional on patient discharge, transfer to another hospital or transfer within SFT.
- To ensure that a comprehensive history of a patient's medication allergy and sensitivity status is available.
- To determine, if possible, an estimate of a patient's concordance with their prescribed medication and the details of any previous therapeutic failures and side-effects.

7.2 Staff with responsibilities for medicines reconciliation

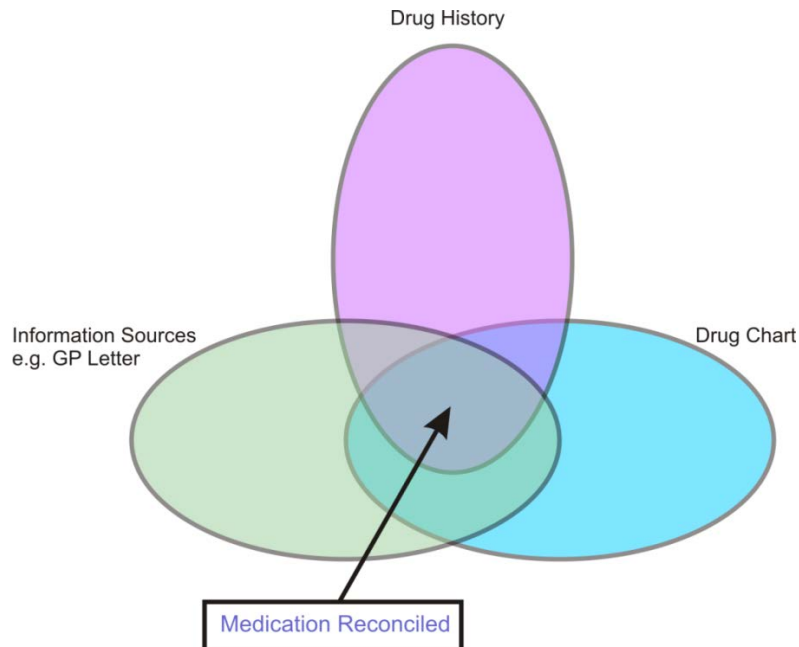
Registered doctors (including F1 level)

Registered non-medical prescribers (independent or supplementary prescribers)

Registered pharmacists

Pharmacy technicians with accreditation in medicines management (drug history taking module or local equivalent)

Registered nurses having undertaken competency assessment e.g. surgical nurse practitioners, medicines management nurses¹



7.3 The process

The process consists of 3 steps:

- **Collection**
- **Checking**
- **Communication**

¹ Registered nurses who have undertaken the medicines management course for pharmacy technicians and are accredited and authorised by the Chief Pharmacist to undertake medicines management roles including medicines reconciliation.

STEP 1: Collection

All patients must have a medication history taken on admission (or for elective surgical patients, at the pre-operative assessment visit), by the admitting clinician (or nurse practitioner respectively). Other relevant information about the patient's medicines should also be collected and documented on the Trust's medicines reconciliation form.

The following information must be collected and documented:

- Medication allergy and sensitivity status with the clinical details of all reactions
- Significant adverse drug reactions or events with clinical details
- All regular medication used (dose, route, frequency, brand (if the specific brand is clinically important)) including eye drops, oral contraceptives, HRT, once weekly medications, oxygen therapy, insulin etc
- Topical therapy, occasional ('prn') medication, and any medication bought 'over the counter' at community pharmacies or shops
- Herbal, homeopathic or other complementary medications used
- Any recent changes in prescription and why
- Any use of recreational substances.

The following must also be documented:

- Details of all medication altered or stopped on admission and on the post take round must be recorded on the medicines reconciliation form together with the clinical indication for these changes.
- The name and signature of the healthcare professional taking the medication history, date of the drug history and date of any amendments to the original history
- The source(s) used to compile the drug history. NB: as many sources of information as possible should be used to compile the drug history.

The following information sources should be used to ascertain the medication history:

- A review of the GP clinical records system (SystemOne or SCR).
- The tear-off side of a patient's repeat prescription request
- Verbal information from the patient, their family or a carer
- Medical notes from a patient's previous admission to hospital
- Medicine containers brought into hospital by patients (Patient's Own Drugs - PODs).
- Where appropriate discussions with the regular community pharmacy or external agencies such as the local mental health trust or addiction service.

Medication histories should involve collection of information from at least 2 up to date sources (e.g. the patient or their carer and their repeat prescription request form). In all cases the information should be collected using the most recent and reliable sources. If there is any doubt about the validity of the source (e.g. the patient is confused) alternative sources **MUST** be checked.

NB: If a patient's medication history was taken during a pre-admission clinic it is essential to check with the patient for any recent alterations as it may have changed in the interim.

Wherever possible, information should be cross-checked and verified. In the case of an apparent discrepancy between what the patient is currently prescribed and what the patient is actually taking, this must be recorded on the front of the drug chart, and where these can be established, the reasons for any variations.

Patients with communication difficulties may require additional assistance in order to provide a full and accurate medication history. This may necessitate the use of an interpreter or carer, ensuring that their hearing aid is working etc.

STEP 2: Checking

The medicines and doses prescribed for the patient on admission must be checked and reconciled against the medication history as documented on the medication reconciliation form to ensure that they are correct, or where changes have been made, that these are documented clearly on the prescription.

National guidelines recommend the check/reconciliation of patients' inpatient medication to their medication history should be undertaken by pharmacy staff within 24 hours of admission or at the earliest opportunity. .

If the medication history is confirmed by pharmacy staff indicates discrepancies/errors to that of the admitting doctor, it is the responsibility of the ward pharmacist to act on this in discussion with the medical/surgical team and to document this on the front of the prescription chart (prescription review notes section) and in the health care record.

At the point at which the discrepancies have been resolved the medicines are classed as having been reconciled and the drug chart will be annotated in the medicines reconciliation box with MR next to the prescription review notes section with the date, time and initials of the member of pharmacy staff.

STEP 3: Communication

Provision of accurate and up to date medication information is essential on discharge. The GP or destination hospital must be informed of all changes to each patient's medication list, together with the clinical reasons for those changes, and any relevant instructions for the ongoing monitoring of those medications or instructions as to length of treatment.

The following details should be provided as a minimum standard¹ on discharge :

- Complete and accurate patient details (full name, date of birth, NHS number, consultant, ward discharged from, date of admission, date of discharge)
- The diagnosis of the presenting condition and co-morbidities
- Procedures carried out during the admission
- A list of all the medicines prescribed for the patient on discharge (and not just those dispensed at the time of discharge which are in addition to the regular medication)
- Dose, frequency, formulation and route of all the medicines listed
- Medicines stopped and started, with reasons
- Lengths of courses where appropriate (e.g. antibiotics, clopidogrel)
- Details of variable dosage regimens (e.g. oral corticosteroids, warfarin etc)
- Known allergies, sensitivities and previous significant adverse drug reactions.

7.4 Responsibilities

7.4.1 Prescriber's responsibilities:

- **During clerking:** to elicit an accurate medication history from the patient and to document this on the medicines reconciliation form or as part of the clerking proforma. Any decision to change the patient's medication must also be recorded on this form.
- The prescriber is also responsible for completing the patient's drug chart fully and accurately in the light of the medication history and the patient's presenting condition.
- **Resolving discrepancies:** to resolve discrepancies identified by pharmacy staff and to document their decisions. This must be completed within 24 hours of the patient's admission or end of the next working day.
- **At discharge:** to prescribe the discharge medication and inform the GP of all changes to the patient's medication list, together with the clinical reasons for those changes, and any relevant instructions for the ongoing monitoring of those medications or instructions as to length of treatment.

7.4.2 Pharmacy staff's responsibility during medicines reconciliation:

To verify the patient's medication history, within 24 hours of admission or end of next working day. It is recognised by the Trust that not every patient will be seen by a pharmacist following admission to the hospital for the purposes of medicines reconciliation but that this task may be instead undertaken by suitably trained and accredited pharmacy technicians.

¹ Suggested minimum dataset required in primary care. Medicines reconciliation – a guide to implementation, National Prescribing Centre, 2008

7.4.3 Nurse's responsibilities during medicines administration

To ensure that where patients raise concerns about the medicines they are prescribed, or have been asked to take, that these concerns are resolved and/or brought to the attention of the patient's medical team or pharmacist at the earliest opportunity.

7.5 Documentation

The medicines reconciliation form provides a structured format for the recording of a medication history and enables documentation of medicines reconciliation and must be used wherever possible on admission. The form should also be referred to when transferring patients between wards, between hospitals and on discharge. This will allow full reconciliation of any changes to a patient's medication to be communicated to the next care provider.

Specific information and guidance on completing the medicines reconciliation form is given in below.

The first person to take the patient's medication history will usually be the admitting doctor or nurse practitioner in the pre-operative assessment unit.

The medicines reconciliation form should be completed as follows:

- Complete the **Allergy** box, tick '**NKDA**' if no known drug allergies (NKDA)
- List the medicines the patient was taking on admission. Include dose, route and frequency. ALL medications must be listed even if they are to be changed or discontinued on admission.
- For each medicine, tick the appropriate box:

continued	where the medicine is to be continued as on admission
hold	if the medicine is temporarily on hold and will be reviewed, write the reason next to the medicine, to ensure restarting or permanently stopping a medicine at a later date as appropriate
stopped	if the medicine is to be stopped on admission, and write the reason for stopping next to the medicine
changed	if the medicine dose, route or frequency is to be amended, and write the change next to the medicine in the comments section.
- **Any queries** with the patient's medicine list (e.g. unsure of a dose, or whether a medicine is still current) should be noted in the 'any further action required' section of the form. Pharmacy staff will help to resolve any queries.
- **Information Source;** tick in the 'history' column as appropriate to indicate the information sources used to establish the drug history. These can include:
 - ◆ **Patient or patient's carer / relative**
 - Delete as appropriate, and state the carer or relative if used as a source (obtain consent from the patient to discuss their medication if possible)
 - Ask about allergies and items that may not spring to mind such as eye-drops, injections, inhalers and creams
 - Wherever possible, use this as an opportunity to discuss medication with the patient. If they have their medicines with them, show them each medicine and discuss how the patient is taking it. Patients may take their medicines differently to the instructions stated on the label.
 - ◆ **GP surgery**
 - This may be a history taken over the phone, or a faxed list of medications
 - Check whether medicines have been recently issued, to ensure they are still current
 - Ask about any acute medicines and allergies
 - Some patients receive medication from hospitals rather than their GPs because those medicines can only be prescribed in secondary care. These may not be included in a GP's list
 - ◆ **Medicines brought in from home**

- Patient's own drugs (PODs)
- Ensure that the medicines belong to this patient (and not one of their relatives)
- Check that these have been recently dispensed, old medicines may no longer be current
- Where the patient has a weekly tray of medicines, consider that there may be medicines that cannot be put into the tray. If filled by a community pharmacy, phone the pharmacy where possible, and document this (see 'Other' below)
- ◆ **Nursing Home records**
 - Medication administration records (MARS), these are similar to in-patient drug charts, and should give a good indication of which medicines the patient has actually been receiving
- ◆ **GP letter**
 - Hand-written or typed referral letters noting current medicines
- ◆ **GP repeat prescription**
 - This may not be a complete list of current medicines as acute prescriptions are not listed and there may be pages missing
 - Some medicines listed may not have been issued to the patient recently, always check with the patient where possible
- ◆ **Previous chart / TTA**
 - Recent discharges are a useful source on current medicines, but ensure another prescriber (e.g. GP) has not amended any medicine since discharge
 - Note the discharge date for the medicine list used on the "Medicines Reconciliation" form.
- ◆ **GP printout**
 - This information usually contains medical history as well, and is commonly issued at a GP emergency referral
 - Information on drug sensitivities and allergies can be found on GP patient summaries
 - Recent verbal dose alterations from the GP may not have been changed on their computer
 - Note when a medicine was last issued and how many were issued. This will indicate if something is current. If last issues were some time ago then either the drug has actually been stopped or the patient has not been ordering any. This in turn may indicate a concordance issue; discuss these with the patient if possible
 - Prescriptions issued for 7 days at a time suggest that the patient uses a compliance aid at home
- ◆ **Other sources**
 - The above list is not exhaustive, other appropriate sources for a drug history may be apparent e.g. clinic letters, transfer notes / charts from other hospitals, drugs and alcohol teams, community pharmacies, patient's own list of medicines / medicines information card
- When the medicines reconciliation form is complete, the person taking the drug history will print their name, bleep, date and time of completion in the box at the bottom of the page
- As soon as possible after admission (and certainly no later than 72 hours after admission) the medication history will be checked. In most cases this will be a pharmacist, pharmacy technician or other appropriately qualified member of the pharmacy team. The 'Information Source' section will be completed by the person checking the history in the same way as by the

person taking the history in the first place and a tick entered into the confirmed column against relevant sources.

- Pharmacy staff will question any discrepancies between the list of current medications found by the history taker and history check with the medical / surgical team. If it is not possible to contact them directly then a record will be made on the Medicines Reconciliation form under the medication history documented by the doctor/pre-admission nurse. (A blank line will be left to separate the two entries and the pharmacy entry will be clearly headed 'Pharmacist' followed by a record of any omitted drugs or queries e.g. wrong dose). These discrepancies will also be written on the prescription review notes on the front of the drug chart by either a medicines management technician (MMT) or pharmacist, and in the patient's healthcare record by the pharmacist.
- The pharmacist/MMT will also check the prescription chart to ensure that it matches the medicines reconciliation form and if any transcription errors have occurred the medical/surgical team will be informed.
- When all the discrepancies have been resolved and the medicines are classed as reconciled, the pharmacist/MMT will annotate the drug chart next to the prescription review notes section with MR in the medicines reconciliation box with the date, time and their initials.
- Any changes to the medication regimen, either at admission or during the patient's stay, should be recorded, documented and dated. Medications stopped should be indicated on the prescription review notes section of the drug chart, and if stopped on admission, on the medicines reconciliation form. Any changes in dose/frequency can be indicated in the 'other directions' box for the individual drug e.g. dose ↓. New drugs started during the inpatient episode will be annotated as 'new'. Wherever possible the pharmacist/MMT should ensure that this information is added to the TTO if not done so by the discharging doctor.
- When taking/checking a drug history specific information should be collected about the following drugs:
 - ◆ **Warfarin:** the following points should be recorded on the anticoagulation chart for patients taking warfarin:
 - Indication, duration of treatment and target INR
 - Patient's usual or most recent dose
 - Whether patient has an anticoagulant "yellow" book
 - ◆ **Steroids**
 - It is important to obtain an accurate history particularly for patients with asthma or COPD, IBD or arthritis.
 - Ask about any recent courses (within past 6 months) and if so, how many and for how long (whether they were short 5-7 day courses or reducing courses).
 - For those on long-term steroids this should be annotated on the drug chart so that treatment is not abruptly stopped. Patients' usual maintenance dose should be recorded.
 - ◆ **Insulin**
 - The type (human, bovine or pork), brand, administration device and dose should always be checked and annotated on the diabetic chart.
 - For those patients that say that they have an insulin pen, clarify between a pre-filled disposable pen and a penfill cartridge.
 - ◆ **Oral contraceptives /HRT**
 - These are not always considered as medicines by the patient and should therefore be asked for.

- Additional counselling may also be needed, if antibiotics are started, for the oral contraceptive pill

- ◆ **Methotrexate**
 - This is prescribed once weekly so the day of administration, strength and number of tablets taken should be confirmed with the patient.
 - Check that this is correct on the drug chart and that the six days of the week when the dose is not to be administered are crossed off.
 - Any concomitant folic acid prescriptions should also be asked about.
 - Ask to see the patient's monitoring booklet.

- ◆ **Bisphosphonates**
 - The day of administration should be confirmed with the patient and annotated on the drug chart.
 - Ask the patient whether they take calcium preparations and confirm which brand.

- ◆ **Inhalers:** It is important to confirm the name, strength and type of inhaler.

- ◆ **Methadone**
 - Check whether doses have been confirmed with the ADAS, patient's GP or community pharmacy.
 - Contact the community pharmacist to alert them of the patient's admission and determine the normal dispensing schedule and when the patient last collected their methadone.
 - Ensure methadone is prescribed by number of milligrams and not number of millilitres (as two different strengths of solution are available).
 - Patients do not usually get a supply of methadone on discharge.
 - The GP and relevant healthcare professionals need to be contacted before discharge to agree a plan of action.

- ◆ **Nebulisers.** Identify whether the patient has own nebuliser and nebulisers at home and document on drug chart.

- ◆ **Oxygen:** check also whether the patient uses oxygen at home and document on drug chart

- ◆ **Patches:** check whether the patient uses medication administered via patch. Check particularly the dose, delivery rate and frequency of patch change and ensure this is clearly documented on the chart.

8 LOCALLY AGREED CLINICAL PROCEDURES

Locally Agreed Clinical Procedures (LACP) may be drawn up to meet specific needs in some specialist areas, eg theatres. These must, at all times, remain within the parameters laid down in the Medicines Policy. Such LACPs must be located with this policy and be readily accessible for all staff members to refer to.

LACPs should be drawn up using the LACP Trust template. The development and authorisation process for LACPs is the same as that for Patient Group Directions (see [chapter 9](#)). LACPs are indicated for use where the full requirements for Patient Group Directions cannot be met but where patient care can be enhanced or facilitated safely by drug administration in accordance with clear protocols.

Specialist areas considering the authorisation of drug administration via LACPs must follow the "[Framework for Developing Expanded Practice Protocol](#)".

Advice on the use of LACPs is available from the Chief Pharmacist.

9 PATIENT GROUP DIRECTIONS

A Patient Group Direction (PGD) is a specific written instruction for the supply and/or administration of a named licensed medicine in an identified clinical situation.

PGDs are drawn up locally by doctors, pharmacists and other appropriate health professionals, and must be approved by the Trust before implementation.

PGDs can only be used by the following registered healthcare professionals, acting as named individuals:-

Nurses, midwives, health visitors, paramedics, optometrists, chiropodists and podiatrists, radiographers, orthoptists, physiotherapists, pharmacists, dieticians, occupational therapists, prosthetists and orthotists, and speech and language therapists.

A PGD can include a flexible dose range so the healthcare professional can select the most appropriate dose for the patient.

Medicines can be used outside the terms of their Summary of Product Characteristics (SPC) (so called 'off-label' use), provided such use is supported by best clinical practice. The PGD must state when the product is being used outside the terms of the SPC and why this is necessary.

It is essential that the development, approval and implementation of PGD is properly controlled so as to ensure quality of care and patient safety at all times.

The legislation that legitimises the use of patient group directions came into force in 2000. This section outlines the particulars which must be included in a PGD as laid down in Statutory Instrument 2000 No 1917, The Prescription Only Medicines (Human Use) Amendment order 2000.

9.1 Patient Group Direction Development/Amendment

An intention to develop a PGD must be submitted using the Framework for [Expanding Practice protocol](#) in the first instance. Once approved for development, all PGDs must follow the [proforma](#) available in the medicines management section on ICID.

Development of a Patient Group Direction must involve a doctor, nurse/midwife or AHP and a pharmacist.

All Patient Group Directions must

- i) Recognise that discretionary administration and supply must only be delegated to approved practitioners where there are clear benefits of improved patient care or organisational advantages without any reduction in patient care.
- ii) Specify the additional training process and competency for approval a practitioner must undergo before authority is granted to that individual to supply and/or administer under a Patient Group Direction, as an approved practitioner. This will be agreed between the consultant(s) giving directions under the Patient Group Direction, the head of the professional group and the Chief Pharmacist.
- iii) Specify the mechanism and time scale for regular updating of knowledge and review of relevant skill and knowledge of approved practitioners.
- iv) Identify the person/job role responsible for training staff in the use of the PGD, maintaining an up to date list of staff assessed as competent and authorised to operate under the PGD and reviewing the PGD
- v) Specify the review date (to a maximum of 3 years).

Any proposed changes to an existing Patient Group Direction must be submitted to the Increasing Access to Medicines Panel for approval in the same way as for newly developed ones.

9.2 Approval procedure

Draft Patient Group Directions should be supported and signed by the Clinical Head of Service, a directorate/senior pharmacist and the Senior Clinical Nurse or relevant professional lead before submission to the Increasing Access to Medicines Panel for review. Once reviewed and any changes made, draft PGDs will be forwarded to the Drug and Therapeutics Committee for ratification. Once approved the PGDs will be signed by the Chief Pharmacist, Director of Nursing, and Medical Director before being put into clinical use.

A copy of the Patient Group Direction will be:

- i) Held in Pharmacy
- ii) Held by the individual responsible for managing the PGD
- iii) Available within the area of practice
- iv) Available to each approved practitioner

If the approved PGD is an amended version of one already in operation it will immediately supersede the previous one. The relevant Clinical Lead should ensure that the amended PGD is substituted as soon as possible for the previous version and that all relevant staff are made aware of the change and sign the departmental copy of the new version. All copies of the previous PGD for that area of practice should be destroyed. (Original copies will be retained by Pharmacy).

Each Patient Group Direction must be reviewed at least every 3 years by the relevant Clinical Lead and submitted to the Improving Access to Medicines Panel (IAMP) for re-approval.

The Trust accepts responsibility for the actions of the approved practitioner, properly acting in the course of his/her duties and in accordance with the current Patient Group Direction in force in his/her area of practice. However the Trust accepts no responsibility for an approved practitioner who attempts to act/acts outside the scope of the approved Patient Group Direction.

In working under a PGD the nurse or other health professional must act within their own expertise and competence.

For each approved PGD the relevant department manager must maintain a list of the relevant individual registered healthcare practitioners named as competent to supply and/or administer under the direction. Appropriate individuals will be identified by a senior person in each profession within the relevant speciality who will ensure that only fully competent, registered and trained professionals operate within directions. Named individuals will be required to sign the declaration in the PGD to confirm that they have read, understood and agree to act within the parameters of the PGD.

A PGD does not allow a named healthcare practitioner to direct another practitioner not named within the PGD to supply/administer on their behalf. Supply or administration of a medicine under a PGD IS NOT prescribing but an allowance to order and supply medication under very specific guidance.

10 STOCK MEDICINES

Each ward/department will have a list of medicines which are to be held on the ward/department as stock items. The list of stock medicines will vary with the nature of the ward. The list shall be decided by the ward pharmacist or Medicines Management technician in consultation with the registered nurse with 24 hour responsibility for the clinical area or supervisor of midwives. The amount of each medicine to be kept on the ward will reflect current usage and will be specified on the list. The list and amounts must be reviewed when necessary and at least once a year.

The registered nurse with 24 hour responsibility for the clinical area is responsible for ordering medicines from Pharmacy and for maintaining ward stocks and stocks for individual patients¹. The registered nurse with 24 hour responsibility may be assisted in ordering ward stock drugs by the pharmacy department where 'top-up' arrangements exist. A pharmacy 'top-up' service, linked to a clinical Pharmacy service, is the preferred method and should be adopted wherever possible. If this is not possible then a nurse or suitably qualified person

¹ In midwifery, this responsibility is held by the lead midwife for the shift.

can order stock items using a pre-printed requisition sheet or duplicate book provided by the pharmacy

If a ward/department runs out of **stock** medicines, additional supplies can be obtained from the Pharmacy by:

- Telephoning pharmacy (stores section, ext. 4277) to request a supply. (Preferred option).
- Contacting the ward pharmacist via the ward pharmacy book or bleep system and requesting a supply.
- Presenting a dispensing request slip to the pharmacy department indicating the stock required.
- For Main Theatres only, presenting a duplicate requisition book with a requisition, dated and endorsed by a valid signature.

Stock medicines delivered to wards should be received by a designated person, usually a registered nurse. Portering staff will notify the registered nurse of the arrival of the 'stock box' and any medicines for individual patients. Boxes/bags containing fridge items will be clearly labelled and should be dealt with immediately. The registered nurse should check stock drugs against the delivery note and inform pharmacy immediately of any discrepancy. Delivery notes will not be issued for non-stock or discharge medicines. Records of issue will be retained by pharmacy for two years.

Where an enhanced "stock top up service" is in place pharmacy staff will be responsible for delivering and putting away stock medication.

Stock lists on the ward or department should be reviewed at regular intervals by the registered nurse with 24 hour responsibility for the clinical area/supervisor of midwives together with the ward pharmacist to ensure that stock medicines remain appropriate. In addition stock levels need to be reviewed by the registered nurse with 24 hour responsibility/supervisor of midwives with pharmacy technical staff to ensure that stocks are kept to a minimum and are not out of date.

Wards/Departments are reminded that the following items should be returned to pharmacy:

- Containers with damaged or defaced labels
- Medicines no longer required
- Date expired stock
- Excessive amounts of stock ordered in error

10.1 Non stock medicines/named patient items

Medicines not kept as stock on the wards are classed as 'non-stock' medicines or 'named patient items'. These include items dispensed for individual patients.

Non stock or named patient medicines will be supplied by pharmacy as part of the ward pharmacy service. Continuing supplies should be routinely ordered via the ward pharmacist or pharmacy technician by writing them in the ward pharmacy book/form together with the patient's name. **Nursing staff have a responsibility to ensure that there are sufficient stocks of named patient medicines on the ward at all times.**

Only in exceptional circumstances, eg where an item is required **urgently** should the ward need to present the appropriate drug chart to Pharmacy to secure a supply.

Medicines for named patients will only be dispensed by pharmacy on receipt of a valid prescription. In the event that the prescription cannot be presented to pharmacy (e.g. if the prescription is in theatres) and a lack of supply would be detrimental to patient care pharmacy may supply a minimum quantity as temporary stock.

Discharge medicines, on receipt from Pharmacy, should be securely stored either in the drug cupboard or the drug locker at the patient's bedside until discharge. If the discharge prescription contains a CD, this should be treated as patient's own supplies and entered in the "patient's own" CD book and stored in the CD cupboard. The identity of the patient must be checked and confirmed as correct before discharge medicines are issued.

11 LABELS

All medicines issued by pharmacy are labelled to indicate their approved name, strength, storage conditions, and, if applicable, an expiry date. Labels should not be altered or amended by nursing staff. Nurses may add additional information where indicated (eg date opened) and the patient's name and date on pre-packed medicines with labels designed for

this purpose. Containers with defaced, damaged or illegible labels should be returned to the pharmacy.

12 MEDICINES ON DISCHARGE

Wherever possible medicines for discharge will be issued by pharmacy at ward level. In all cases, the discharge prescription (TTO) should be written in good time, preferably at least 24 hours before discharge.

In the event that the TTO prescription has to be sent to pharmacy for processing it is ESSENTIAL that all drug charts for the patient (including diabetes charts etc.) AND all medicines, including fridge items, which have already been dispensed for the patient and those that have been brought in by the patient (ie patients own drugs) are sent to pharmacy with the TTO/discharge form.

All drugs which the patient is to be discharged on, including those on which the patient was admitted and which have not been altered, should be prescribed on the TTO prescription.

TTO medication processed in Pharmacy will be sent to wards/departments as soon as possible. Patients should not attend pharmacy to collect TTO medication. It is the responsibility of the nurse/midwife discharging the patient to ensure that the correct medicines are issued to the patient and that the patient understands how to take their medication.

Patients for whom Medicine Information Cards (MICs) are considered essential should be identified to the ward pharmacist. A copy of the [MIC card](#) is available on ICID together with guidance on completing MICs for both discharge and self administration whilst in hospital [chapter 16](#)

12.1 Samples and Clinical Trial Materials

Medicines used for patient care must be issued by pharmacy¹. Samples from the manufacturers or sales representatives for possible use by patients within the Trust should be received only by a pharmacist. Samples of medicines must not be accepted by a ward or department. Any such materials found on a ward or department must be returned to pharmacy. The trust policy on Medical Representatives is given in [chapter 25](#).

All medicines for clinical trials must be received and issued through Pharmacy. (See also [chapter 17](#))

12.2 Delivery of medicines

All medicines must be transported in secure transit bags or containers unless delivered by pharmacy staff or collected personally by a member of a ward or department.

If there is a delay in supply of an item, the ward or department will be notified, the delay explained and an alternative item will be offered, if appropriate.

Goods must be checked on receipt, e.g. against computer generated delivery notes where available. All discrepancies must be reported to the pharmacy department immediately. All items received should be placed in appropriate and secure storage immediately. Deliveries containing fridge items will be clearly marked.

Medicines (excluding Controlled Drugs, liquids etc.) may be transported to and from pharmacy in the pneumatic air tube system in **GREEN** canisters only. See Pneumatic Air Tube System Operational Policy for detailed guidance relating to this system. Bulky items, glass bottles or liquids or controlled drugs will not be delivered via the pneumatic air tube system.

12.3 Unused medicines

All medicines no longer needed or out of date (except Controlled Drugs) should be returned to the pharmacy in a secure box or transit bag. Medicines awaiting return to pharmacy must be stored securely, e.g. locked cabinet or ward box in secure area.

In some circumstances the ward pharmacist or technician may choose to dispose of expired medicines on the ward (in the appropriate clinical waste bin) – this exception does not include controlled drugs.

Unused, expired or no longer needed controlled drugs should be removed from the ward by a pharmacist or authorised pharmacy technician and returned to pharmacy. The pharmacist or technician must sign the CD record book and amend the balance in the presence of a

¹ Except medical gases and X-ray contrast media.

registered nurse/midwife. Nurses/midwives/medical staff must NOT return Controlled Drugs, either from ward stock or brought in by patients, in the pharmacy ward box.

See also [chapter 12](#) on Disposal and [chapter 14](#) on Controlled Drugs.

Where medicines have been put out for use in clinical areas but remain unused and in their original container or wrapping, e.g. ampoules, vials, suppositories, minims etc., great caution must be exercised in returning these to stock for subsequent use. Wherever possible sufficient quantity and no more should be removed from storage for use. THE RETURN OF UNUSED PRODUCT BACK IN TO STORAGE IS STRONGLY DISCOURAGED because of the potential for error caused by returning the wrong product to the wrong box.

13 OUT OF HOURS

13.1.1 Emergency Cupboard

If medicines are required out of hours the doctor/registered nurse/midwife should first attempt to obtain a supply from the Emergency Drug Cupboard (EDC). The emergency drug cupboard is located near the pharmacy. The key can only be obtained from the hospital switchboard outside of pharmacy working hours. A list of [EDC contents](#) is available on ICID.

The individual requesting the key must be a registered nurse or doctor working in SFT. (Healthcare support workers from the hospital at night team are also authorised to access the EDC out of hours)

The individual must show a Salisbury NHS Foundation Trust ID or a current agency ID badge when signing for the key.

The key should be signed out and then returned to switchboard immediately after use. It is essential that staff remember to lock the door behind them when they leave the EDC.

Staff using the EDC must clearly record items removed from the cupboard using the paperwork provided. This is to ensure that items can be routinely replaced and avoid out of stock situations occurring.

In the event that the item is not available in the EDC the doctor/registered nurse should attempt to borrow the item from another ward. NB see paragraph below on borrowing. Additional options for obtaining medication are given in [Appendix 3](#) flowchart – medicines unavailable guidance.

In the event that it is not possible to secure a supply of the item via any of the routes given in the guidance flow chart the registered nurse/midwife should contact the site manager for assistance. If the problem cannot be resolved, the site manager should contact the on-call pharmacist via switchboard.

NB The on-call pharmacist is available for information /advice and where necessary supply of medicinal products in emergency situations only.

13.1.2 Borrowing of Medicines

Borrowing of medicines from other wards should be necessary only in exceptional circumstances and only when the pharmacy is closed and when the medicine or a suitable alternative is not available in the Emergency Drug Cupboard. When borrowing is unavoidable wards/ departments may borrow a minimum quantity of medicine provided the medicine is clearly identifiable on arrival on the ward where it is intended to be used.

Registered controlled Drugs (schedules 2 and 3) MUST NOT be borrowed or supplied from another ward. See 9.10.4 for details on administering an out of stock controlled drugs in an emergency.

13.1.3 Decanting of Medicines

The decanting of medicines into other containers is **FORBIDDEN**. The original labelled container should be transferred to the ward requiring the medicine if the situation described above applies.

13.1.4 Controlled Drugs

Controlled Drugs **must not** be supplied by one ward to another. Under the provisions of the Misuse of Drug Act 1971 nurses/midwives/ODPs are authorised to possess controlled drugs for the purposes of administration within their ward/department: they are **not authorised to supply Controlled Drugs to other wards/departments**.

In cases of emergency however, a registered nurse/midwife may attend another ward with the urgent prescription and, with a registered nurse/midwives from the second ward, may

sign out one dose of the necessary medication from the CD register for that patient making sure that all details are recorded clearly and take it back to the original ward for immediate administration to the patient concerned.

The registered nurse/midwives obtaining a dose in this manner MUST be accompanied throughout by a second member of staff who will witness the transaction on the second ward and the administration of the dose to the patient. Both members of staff must sign the administration record box on the patient's drug chart.

14 STORAGE OF MEDICINES

The registered nurse/midwife with 24 hour responsibility for the clinical area is responsible at all times for the safekeeping of all medicines stored on his/her ward/department

ALL internal and external medicines, disinfectants and reagents must be stored in locked cupboards, trolleys or other secure receptacles at all times. The only exceptions to this requirement are the storage of intravenous fluids and sterile topical fluids which because of their bulk are stored in a secure clean area (as agreed between the registered nurse with 24 hour responsibility for the clinical area and pharmacy department). Internal medicines must be stored separately from all external medicines.

Medicines must always be stored in their original container. Under no circumstances should medicines be transferred from one container to another, nor should they be taken out of their container and left loose.

14.1 Ward/department medicine storage facilities

Medicines should be kept in locked cabinets or rooms which are constructed and maintained so as to prevent unauthorised access to the medicines.

Cupboards and trolleys should be sited where it is most convenient for nursing staff, allowing adequate space and permitting surveillance, to afford maximum security against unauthorised entry. Medicine cupboards should generally be sited in a clean treatment room to which the general public does not have access. Cupboards should not be sited above or near radiators or major sources of heat, nor above sinks where they may be subject to higher than average humidity. Reagent cabinets should be sited in areas where testing is carried out.

Advice on placement of drug cupboards and drug security in general is available from the Pharmacy Department.

14.1.1 Internal Medicines

The internal medicines cupboard should contain stocks of internal medicines such as tablets, capsules, mixtures and injections, with the exception of those needing special storage or refrigeration.

On no account should external medicines be stored in this cupboard.

14.1.2 Controlled Drugs

The controlled drugs cupboard should contain only those medicines controlled by the Misuse of Drugs Act 1971 and marked Controlled Drug, plus others as deemed necessary by Pharmacy from time to time.

14.1.3 External Medicines

The external medicines cupboard should contain all applications for external use such as ointments and creams.

On no account should internal medicines be stored in this cupboard.

14.1.4 The medicines trolley

If a medicines trolley is in use it should contain medicines in current use on the medicine round and when not in use should be locked and secured to the wall. The trolley must not be left unattended during the medicine round.

14.1.5 The reagent cupboard

This should be situated in the area where urine testing is carried out (usually the sluice). It contains all reagents, strips and tablets used in testing.

14.1.6 Sterile fluids

It may not be practical to store large volumes of sterile fluids in cupboards. In this case there should be designated secure clean storage areas in wards, theatres and departments.

14.1.7 Refrigerator (2-8°C)

The medicines refrigerator should be reserved solely for the storage of medicines marked 'store in a refrigerator'. Medicines must not be stored with food or pathological specimens. The fridge must be lockable with an indicator of internal temperature. The registered nurse with 24 hour responsibility for the clinical area is responsible for ensuring that fridge temperatures are monitored and recorded on a daily basis. Where evidence is found of temperatures falling outside the normal range, this must be reported to the registered nurse in charge of the shift and appropriate remedial action taken immediately – which will usually involve contacting pharmacy for advice.

See the policy “Pharmaceutical Fridge Management in Clinical Areas available on ICID for further information. [Pharmaceutical Fridge Management in Clinical Areas - Salisbury NHS Foundation Trust](#)

14.1.8 Resuscitation Trolley

This should be readily accessible in an emergency and kept in a prominent position to prevent unauthorised access. Emergency resuscitation drug boxes with tamper evident seals are available in designated wards and departments. They should be stored in their sealed container, ideally secured in the resuscitation trolley. When the seal is broken or the drugs are near their expiry date, the box should be returned to pharmacy for replacement.

14.1.9 Cleaning Materials Cupboard

This is for use by domestic staff. It must be a locked cupboard or a cupboard in a room with a door capable of locking.

14.1.10 Patients’ own drug lockers

These are cabinets/drawers fitted to bedside lockers or located in bed spaces for the purpose of storing patients’ own drugs and hospital medicines dispensed with instructions, for use by the patient on the ward and on discharge. Each cabinet has its own lock. The cabinets must be kept locked at all times. Where patients are competent to administer their own medication, access is provided by way of a key/key card. Where patients are not competent, access is confined to nursing staff only. See [chapter 15](#) for further guidance on patients own drugs.

14.2 Closure of a Ward

When a ward/department is closed for a prolonged period (greater than 7 days) all medicines (including Controlled Drugs) must be returned to the Pharmacy. The Controlled Drugs must be handed over by the registered nurse/midwife personally to the pharmacist/MMT. The pharmacist/MMT must sign the appropriate sections of the CD register.

When a ward closes for a short period (7 days or less) , the medicines (including Controlled Drugs) may, with the agreement of the responsible pharmacist and registered nurse with 24 hour responsibility for the clinical area, stay on the ward provided there is adequate security to prevent unauthorised access to the cupboards.

15 DISPOSAL OF MEDICINES NO LONGER REQUIRED

15.1 Pharmaceutical waste

Pharmaceutical waste is classified as Hazardous, Non-hazardous or not pharmaceutically active.

15.2 Hazardous Waste

Hazardous waste is waste that contains cytotoxic and/or cytostatic products ie those which have one or more of the following properties – toxic (H6), carcinogenic (H7), toxic for reproduction (H10) or mutagenic (H11).

Items that contain or are contaminated with cytotoxic and cytostatic products must be segregated from other medicinally contaminated items by placing them in the appropriate cytotoxic/cytostatic sharps bins with a purple lid.

15.3 Non-Hazardous waste (General pharmaceutical waste)

Items that contain or are contaminated with drug residues (eg medicines vials, blister strips, etc) from products other than those identified as cytotoxic or cytostatic are classified as non-hazardous medicinal waste and must be disposed of in sharps bins with yellow lids and sent for incineration in accordance with Trust Waste Management Policy.

Type of container	Disposal method
Glass bottle contaminated with medicine ¹	Place in LARGE sharps bin with yellow lid OR yellow rigid bin
IV giving set and empty/part used infusion bags (NB for bags/cassettes containing Controlled Drugs – see below)	Place in LARGE sharps bin with yellow lid OR yellow rigid bin
Empty blister packs/foil strips of medicine	Place in any size sharps bin with yellow lid
Inhalers, creams/ointments, patches, dropper bottles,	Place in any size sharps bin with yellow lid

15.4 Controlled drugs

Controlled drugs which have been administered but no longer needed may be disposed of on the ward / department by a registered nurse/ midwife or OPD. They must be witnessed by a second competent person.

Controlled drugs which have expired or are no longer required (unused patients own or stock CDs) must be removed from the ward by a pharmacist or authorised pharmacy technician.

Small (under 50ml liquid) unused doses/part-doses of controlled drugs must be rendered irretrievable by emptying the contents of the ampoule/vial or syringe into a sharps bin. The emptied ampoule/vial or syringe must also be placed in the sharps bin.

Larger quantities of part used CDs eg more than 50ml liquid, discontinued epidural infusions, PCA syringes or morphine cassettes, should be disposed of as above, using an absorbent pad or granules in the base of the bin to absorb the liquid if required.

All destruction must be documented appropriately in the Controlled Drug record book. It should be witnessed by a second competent professional such as a registered nurse, midwife or ODP. Both persons should sign the CD record book. This requirement applies to all areas of the Trust including operating theatres.

15.5 Medicines no longer needed or out of date.

All medicines no longer needed or out of date (except controlled drugs) should be returned to pharmacy in a locked box or handed directly to a member of pharmacy staff for processing in accordance with the Trust Waste management Policy.

Controlled Drugs should be removed from the ward by a pharmacist or authorised pharmacy technician. See [chapter 14](#). Controlled Drugs, whether from ward stock or brought in by patients, MUST NOT be returned to pharmacy in the pharmacy ward box.

¹ Including X-ray contrast media

In some cases (for small volume patient's own liquid CDs and CD syringes/infusion bags pre-prepared for named patients) it may be appropriate for controlled drugs to be destroyed on the ward or department by a pharmacist, in the presence of a registered nurse/midwife. Details must be recorded in the CD record book and signed by the nurse and pharmacist.

15.6 Medicines returned via the mortuary

Upon receipt of pharmaceutical products in the Mortuary from any source the mortuary staff will document each item in the Mortuary Pharmacy Disposal Record Book. Wherever possible this will be undertaken by 2 members of staff. Once it has been established by the pathologist that there is no further need for the medicines to remain in the mortuary arrangements will be made with the pharmacy department for their transfer. See mortuary procedure document CP-SOP-M-030 for details of process.

16 MEDICINES SECURITY

16.1 Pharmacy Premises

A member of the Pharmacy Department will be present whenever the Pharmacy is open.

Access to the pharmacy is restricted to personnel authorised by the Chief Pharmacist

16.2 Wards and Departments

The registered nurse with 24 hour responsibility for the clinical area is responsible for the safekeeping of medicines in the ward or department¹. All staff handling medicines must be security conscious.

Anyone discovering apparent or suspected unauthorised access to medicine storage areas must report the matter immediately to a senior colleague and the Chief Pharmacist.

16.2.1 Controlled Drug Cupboard keys

The controlled drugs cupboard must be kept locked at all times. The keys should be kept on a separate key ring which can be unclipped from the medicines keys. Legislation dictates that only ONE set of CD keys is allowed to be in use at any one time. The keys should be kept on the person of the registered nurse in charge of the ward / unit. The CD keys can be handed to a designated other (registered staff nurse or midwife) for the purpose of administering medicines but should be returned to the nurse in charge of the ward / unit when practically possible. The nurse in charge of the ward / unit should be aware where the CD keys are at all times. No person should have access to the controlled drugs cupboard unless directly designated by the nurse in charge. The key must not be handed over to medical staff or students but may be given to pharmacists or pharmacy technicians for the purpose of auditing or stock control.

16.2.2 Keys for Medicine Cupboards/Medicine Trolley and refrigerators

Cupboards, trolleys and refrigerators containing medicines must be kept locked at all times when not in immediate use.

Medicine cupboards and trolley keys must be kept together on clearly identified ring(s) and separate from all other non-drug keys and if not in immediate use, must be held on the person of the registered nurse with 24 hour responsibility for the clinical area¹ or on the person of a designated registered nurse or midwife competent in the administration of medicines².

Where spare keys to medicine cupboards exist, they must be held securely and only used whilst keys mislaid are located.

16.2.3 Reagent Cupboard

The key to the Reagent Cupboard shall be kept separately, and in a place designated by the registered nurse with 24 hour responsibility for the clinical area¹.

16.2.4 Keys for patient's own drug lockers (see also [chapter 13](#))

Where patients are assessed as competent to self administer their own medicines (see [chapter 13](#)), the patient takes possession of the individual locker key/key card. The patient is then responsible for storing this key/key card securely.

A master key for all POD lockers on the ward should be held on the medicine key ring by the nurse in charge, or designated key holder.

16.2.5 Loss of medicine cupboard keys

Every effort should be made to find the key or retrieve it from off duty staff. If unsuccessful the Directorate Senior Nurse, or if out of normal hours the Site Manager must be informed. If they are available duplicate keys should be obtained. If duplicate keys are not available the nurse in charge should arrange for the cupboard to be broken open. In either situation, a new lock must be fitted. The pharmacy department should be notified.

¹ In midwifery, this responsibility is held by the lead midwife for the shift.

² In situations where a registered nurse/midwife is unable to hold the drug keys (eg in certain outpatient clinics) this must be discussed with the Chief Pharmacist and a risk assessment completed.

The nurse with 24 hour responsibility for the ward must instigate an investigation into the loss of the key(s) to ascertain the potential level of the security breach. A Trust datix form should be completed.

16.3 Controlled Stationery

Controlled stationery is that which could be used in the wrong hands to obtain medicines fraudulently. It includes FP10HNC forms (previously FP10(HP) forms), outpatient, discharge and inpatient prescription sheets, controlled drug order books, and other stationery used for requisitioning medicines.

FP10HNC prescriptions are only issued to designated areas for use in defined circumstances.

The following procedures are used for ordering and issuing controlled stationery:

- Controlled drug order books and controlled drug registers issued by the pharmacy are marked with the date of issue and the name of the ward or department to which they belong.
- FP10HNC pads are issued from the finance department following approval from the Chief pharmacist.
- Drug charts, outpatient prescriptions and duplicate books (where used) are ordered via Oracle/Procurement Dept.
- Once it is in a ward or department, the security for controlled stationery becomes the responsibility of the nurse with 24 hour responsibility for the clinical area.
- Only limited quantities of controlled stationery should be held at any time.
- All controlled stationery should be stored securely.

16.4 Losses

Great care must be taken at all times to safeguard the security of medicines and controlled stationery within the Trust. This is a responsibility of **all** involved in handling these items.

Any member of staff discovering or suspecting a loss or abuse of medicines of any kind must notify their Head of Service, Directorate Senior Nurse and senior pharmacist.

In some situations it may be appropriate to record a stock balance and implement regular stock checks. If this shows discrepancies, the matter should be discussed urgently with the Chief Pharmacist. Depending upon the circumstances it may be appropriate to treat the medicine in accordance with the procedures for Controlled Drugs and entries made in the CD register whenever the medicine is administered. In either situation a Trust Datix form should be completed by the ward.

Alternatively, the situation may be so serious as to warrant involvement of the police. Such a decision will be taken by the Chief Pharmacist in conjunction with the relevant Head of Service and an Executive Director,. If the case involves suspicion of fraud, then an Executive Director shall be informed immediately and they will be responsible for deciding at what stage the Police should be notified. (Ref Salisbury NHS Foundation Trust Standing Financial Instructions).

17 CONTROLLED DRUGS (CDS)

17.1 Controlled Drug Prescribing.

Preparations detailed in the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001 are controlled by procedures additional to those that apply to other medicines. Drugs listed as controlled drugs (CDs) are often the most harmful to society, through addiction and drug seeking behaviour, and the individual via potential toxicity. Additional rules and regulations exist to protect individual patients and healthcare practitioners when dealing with CDs.

The prescription should state clearly the dose, maximum frequency and route of administration.

Prescriptions for controlled drugs on discharge, for outpatients and on hospital FP10s forms need to satisfy legal requirements for style and content.

- The prescription must be SIGNED and DATED by the prescriber.
- The prescribers ADDRESS must be stated.
- The prescriber must state in the **PRESCRIBERS OWN HANDWRITING** in ink or so as to be otherwise indelible:
 - The name and address of the patient.
 - In the case of a preparation, the form and where appropriate, the strength of the preparation. (NB. The dosage form (e.g. tablets) must be included on the CD prescription irrespective of whether it is implicit in the proprietary name (e.g. MST Continus) or of whether there is only one form available).
 - The **total quantity** of the preparation to be supplied **MUST be expressed** as the number of dosage units (not the total number of milligrams) **in BOTH WORDS and FIGURES** (e.g. 14 tablets (fourteen)). If the CD is a liquid, the total quantity must be expressed as total number of millilitres (dosage unit) (eg One hundred (100) ml) rather than milligrams.
 - The dose and frequency.

Prescriptions for controlled drugs are valid for TWENTY EIGHT days only from the date of the prescription. The MAXIMUM length of supply for any CD is legally capped at 30 days.

Supply of drugs for replacement therapy e.g. methadone should be avoided and referred instead to the local addiction service. In only exceptional circumstances after discussion with a senior pharmacist will 1-2 days of methadone be dispensed on discharge.

17.2 Ordering controlled drug ward stocks

Orders for controlled drugs must be made in the controlled drug order book. A separate requisition is needed for each medicine and should be signed in full by a registered nurse/midwife or Operating Department Practitioner (ODP) authorised to do so by the registered nurse with 24 hour responsibility for the clinical area/local Supervisor of Midwives.

The registered nurse with 24 hour responsibility for the clinical area/local Supervisor of Midwives must maintain a list of nurses/midwives/ODPs authorised to order and administer controlled drugs. This list must include specimen signatures of relevant staff and use the following headings:

Name in capitals	Designation	Signature	Date	Signature ward sister/local supervisor of midwives	Date
------------------	-------------	-----------	------	--	------

The registered nurse with 24 hour responsibility for the clinical area/local Supervisor of Midwives must review this list WEEKLY to ensure it is up to date. All relevant staff that have joined the clinical area must be added and entries for those who have left must be crossed through. All changes must be notified to pharmacy and a photocopy of the revised list provided.

Staff may not order or administer CDs unless their name and signature appear on the signature sheet and has been countersigned by the registered nurse with 24 hours responsibility for the clinical area/local Supervisor of Midwives or nominated deputy.

The signature list may be kept secured inside the cover of the CD record book or in the controlled drugs cupboard for the relevant clinical area.

The CD requisition book is an item of controlled stationery and must be stored securely in a locked drawer/cupboard when not in use (e.g. in the outer CD cupboard).

Some medicines e.g. temazepam and midazolam belong to a separate CD classification. Trust policy requires that these should be ordered via the CD order book and be stored in the CD cupboard. There is, however, no requirement to maintain a record of administration in the CD record book.

Tramadol (pregabalin and gabapentin from 1st April 2019) also have unique regulations owing to their status as a schedule 3 CD. They must be ordered via the CD book but do not need to be stored or recorded as a CD. They are stored safely and securely as per other medication on the ward (see 9.11).

All other CDs including barbiturates and buprenorphine require records of administration to be kept in the CD record book.

All requisitions for Controlled Drugs must comply with the legislation as set out in the Misuse of Drugs (safe custody) Regulations 1985 and contain:

- i) Ward or department name and address.
- ii) Description of Controlled Drugs required including the form.
- iii) Total quantity to be supplied ("one box" is not sufficient).
- iv) Signature of registered nurse in charge of the shift (or other authorised signatory).
- v) Signature of supplier.
- vi) Signature to receive goods for transit (or security seal number).
- vii) Signature for receipt at ward or department.
- viii) Date.

17.3 Delivery and receipt of controlled drugs

Controlled drugs are transported in sealed black bags. Each bag is sealed with a numbered security tag.

Controlled drugs are generally delivered to wards by members of the portering staff, although this is not always the case. Ward staff (including nursing assistants and volunteers) are permitted to collect CDs from pharmacy if required.

Porters delivering stock CDs are required to:

- i) Ensure that the closure of the CD bag is intact,
- ii) Sign the CD delivery sheet (which records the ward against the security bag number),
- iii) Transport the sealed bag in a secure manner,
- iv) Deliver the sealed bag to the ward or department to which it is addressed,
- v) Obtain the signature of the registered nurse in charge of the shift, or a designated deputy, on the delivery sheet at the point of delivery and
- vi) Return the signed delivery sheet to pharmacy.

The registered nurse/midwife in charge of the shift or ODP, on receipt of the sealed bag containing controlled drugs, must verify that:

- i) The bag is being delivered to the correct ward,
- ii) That the security seal is intact and
- iii) That the tag number corresponds with that on the CD delivery sheet.

The nurse/midwife/ODP must then sign and print his/her name and designation on the CD delivery sheet (which the porter must return to pharmacy). Nurses/midwives/ODPs operating under this procedure are signing for receipt of an intact, sealed CD bag; there is no requirement for the nurse/midwife/ODP to inspect the contents of the bag before signing the CD delivery sheet.

Once the CD delivery sheet has been completed (at which point the porter may leave the ward), the registered nurse/midwife/ODP, in the presence of a second member of staff¹, must immediately open the CD bag and check the contents against the CD requisition book. Any discrepancies/breakages should be reported immediately to pharmacy. In the event that immediate checking of the bag contents is not possible the sealed bag should be locked in the CD cupboard to be opened at the soonest possible opportunity.

¹ On Hospice and Clarendon Suite only, this may be a suitably trained and authorised Nursing Assistant when the shift has only 1 registered staff member on duty.

The receiving nurse/midwife/ODP and witness must sign for receipt of the CDs in the CD requisition book, make the relevant entries in the CD record book (including the CD requisition number) and lock the CDs away in the CD cupboard.

Controlled Drugs for patients to take home (TTOs) may be collected from pharmacy as described above. Where they are delivered to the ward, the receiving nurse/midwife and witness should store the TTO securely in the CD cupboard and enter the TTO into the "patients own" section of the CD register, until the patient is discharged. On discharge the CD TTO must be removed from the CD cupboard and issued to the patient by 2 members of staff. The register must be completed to reflect issue of the TTO.

17.4 Storage of Controlled Drugs

Controlled Drugs must be stored in a secure area usually within an inner locked compartment, within an internal medicines cupboard, assigned to the storage of Controlled Drugs or, for fridge items, in a locked refrigerator. All storage facilities for Controlled Drugs should be permanently fixed to an appropriate surface. If Controlled Drugs are stored in other secure areas these must be approved by the Chief Pharmacist.

Only Controlled Drugs and the CD order book may be kept in the Controlled Drugs cabinet/cupboard except for other specified medicines deemed necessary by the Trust from time to time.

17.4.1 Controlled Drug Cupboard keys

The controlled drugs cupboard must be kept locked at all times.

The keys should be kept with the ward keys. Only ONE set of CD keys is permitted to be in use at any one time.

The ultimate responsibility for the CD keys rests with the nurse with 24 hour responsibility for the area/lead midwife. This individual may delegate responsibility for holding the keys to others (e.g. to the nurse in charge of the shift). The person with delegated responsibility is responsible for ensuring the security of the keys and knowing their location at all times, they are permitted to hand the keys to other trained registered nursing / midwifery staff on the shift in order to allow access to CDs to meet patient needs but the keys MUST be returned to the safekeeping of the person with delegated responsibility once this has occurred.

The CD keys must not be handed over to medical staff.

17.4.2 Records

Details of receipt, administration and disposal of Controlled Drugs must be entered in the ward/department Controlled Drug Record Book. There must be separate sections/record books for recording hospital CDs and those brought in by patients. The Record Book must be kept in a secure place. Completed Record Books will be retained securely by the registered nurse with 24 hour responsibility for the clinical area for a period of two years from the last entry and then destroyed.

17.5 Administration (including self-administration)

Administration of Controlled Drugs must be undertaken with the utmost care at all times.

Two members of staff must be involved throughout the process of dose preparation and administration. These staff may be either a registered nurse/midwife/ODP or a designated learner (i.e. a 2nd or 3rd year student nurse on placement). In addition specific nursing assistants, on specified wards may provide the second check only in conjunction with either, the Trust Protocol for the

- [Safe Custody of CDs and the Role of Nursing Assistants](#)
- Medicines Administration by band 4 assistant practitioners / nursing associates who are qualified and deemed fully competent (policy available on ICID) [Medicines Administration by Band 4 Assistant Practitioners / Nursing Associates - Salisbury NHS Foundation Trust](#)

BOTH members of staff must sign the CD record book AND the patient's drug chart to indicate that the whole process from drug selection to administration has been witnessed in accordance with Trust policy.

Self-administration of controlled drugs is discouraged due to considerations of security of the medication and risk of overdose. In the event that self-administration of controlled drugs is considered clinically appropriate this must be discussed with a senior pharmacist before

implementation. In the event that self-administration is agreed with pharmacy as appropriate the following must be in place:

- The patient must have their own supply of the correct medication (NB ward stock MUST NOT be used for self-administration)
- The drug must have been prescribed on the drug chart for the patient whilst in hospital
- The doses taken by the patient must be clearly documented on the drug chart and the register of patients own CDs updated accordingly
- The patient must store the medication securely in a locked POD locker at all times.

17.6 Stock checks and maintenance of records of CDs

The registered nurse with 24 hour responsibility for the clinical area/local midwifery supervisor is required to implement a system to record the names and specimen signatures of all staff working in the ward/department including bank and agency staff. This is essential for audit trail purposes and to allow reconciliation to staff rotas in event of incident.

The registered nurse with 24 hour responsibility for the clinical area¹ must ensure that full signatures are used in the CD record book: Initials are not acceptable.

17.7 Weekly checking procedure for CDs

The CD record book must be checked and reconciled at least once in every 7 day period by two appropriately qualified authorised members of staff. The check must include all CDs held within the clinical area including Patient's Own CDs.

It is essential that the stock check is undertaken diligently as follows:

- i) The stock level of every item in the CD cupboard (including patient's own and TTOs awaiting issue) must be reconciled with the relevant page in the CD record book.
- ii) The stock level indicated on every page of the CD record book (including patient's own and TTOs awaiting issue) must be reconciled with appropriate items in the cupboard.
- iii) The check must include a review of patients' names, dates and doses and staff signatures in addition to the stock balance check.

When checking a liquid controlled drug a weekly visual check (and marking on the label) of the amount on the bottle is sufficient. Avoid pouring the liquid out of the original bottle to check the liquid volume as losses can occur during the measuring.

A record indicating that the check has been carried out must be made in red ink or red stamp underneath the last entry on the relevant page for a given product in the CD record book. The entry should confirm the stock is correct, where that is the case and that the entries made on each line of the CD record book since the last check make sense. Staff should be alert to the possibility that the stock balance may reconcile but that fraudulent entries may have been made in the record book in an attempt to cover up acts of misappropriation and must undertake the weekly check with this in mind.

ALL discrepancy in stock balances or other anomalies MUST be reported to the registered nurse in charge of the shift, the directorate senior nurse and the ward pharmacist immediately. A trust incident form must be completed and the chief pharmacist must be informed of the discrepancy.

Where concerns about Controlled Drug stocks exist, or instances of discrepancy are found, increased checking procedures/frequency may be required, following consultation with the ward pharmacist or chief pharmacist.

Ward and departmental stocks of Controlled Drugs are checked and audited regularly by the pharmacy department together with a trained nurse/midwife/ODP. A report detailing findings is provided for the nurse with 24 hour responsibility for the clinical area/local Supervisor of Midwives, the Directorate Senior Nurse and forms part of the Clinical Governance monitoring arrangements with the directorates.

The ultimate responsibility for ordering, receipt and custody of Controlled Drugs rests with the registered nurse with 24 hour responsibility for the clinical area or lead midwife for the shift.

¹ In midwifery, this responsibility rests with the lead midwife for the shift.

17.8 CDs no longer required

On no account may CDs be returned to pharmacy in the pharmacy ward box.

17.8.1.1 Ward stocks and patients own CDs

All CDs issued from pharmacy as ward stock and CDs brought in by patients that are date expired or no longer needed must be brought promptly to the attention of the ward pharmacist/technician for return to pharmacy.

The pharmacist/authorised technician must return the CDs in a sealed bag and document the return in the ward CD record book and duplicate book held by each ward solely for this purpose and stored in the CD cupboard. This process must be witnessed and documented on the ward by a member of the nursing/midwifery/ODP staff.

The Pharmacist/authorised technician and ward nurse will complete the following details in the CD duplicate book:

- Date
- Ward
- Drug name, form and strength
- Amount returned
- Patient's name (if POD) or 'Stock'
- For Destruction or Credit
- Nurse name and signature
- Pharmacist/authorised technician name and signature

The returned item and top copy from duplicate book will be placed in a sealed bag.

On arrival in the Pharmacy the pharmacist/technician will open the sealed bag in the presence of another authorised person who will check the contents against the details on the returns slip. The returned item will be locked in the CD cupboard as stock for re-issue or to await destruction, and the computer stock record will be updated as soon as appropriate. Details of the returned item will be entered in the appropriate section of the Controlled Drugs register (in-date returned stock) or the Destruction Register (unusable/expired stock, PODs). The authorised person who makes the entry will mark the slip 'entered' and file it to be retained for two years from the date of entry.

17.8.1.2 Small volume liquid CDs/pre-prepared CD syringes/infusions bearing patients' names or part or unused doses

Unused doses/part-doses of controlled drugs must be rendered irretrievable by emptying the contents of the ampoule/vial or syringe into a sharps bin. The emptied ampoule/vial or syringe must also be placed in the sharps bin. When the bin is sent for destruction it should be labelled 'contains mixed pharmaceutical waste and sharps – for incineration'. Larger quantities (50ml or above) of part used CDs eg discontinued epidural infusions, PCA syringes or morphine cassettes, should be disposed of as above, using absorbent pads or granules such as the safetygel range) in the base of the bin to absorb the liquid..

All destruction must be documented appropriately in the Controlled Drug record book. It should be witnessed by a second competent professional such as a registered nurse, midwife or ODP. Both persons should sign the CD record book. This requirement applies to all areas of the Trust including operating theatres

17.9 Patient's own CDs

Where CDs are identified in a patient's belongings they must be counted and entered into the section of the CD register set aside for patients own drugs. Guidance on recording patients own CDs is available from ward pharmacists. This process must be witnessed by a second member of staff. They must be stored in the CD cupboard (unless otherwise agreed by a senior pharmacist – see [12.5](#) above). If the medication is reissued to the patient on discharge they MUST be prescribed on the TTO and the CD record book updated to reflect this.

Patient's Own CDs must be checked as part of the weekly CD checking procedures: see above.

Where Patient's Own CDs are no longer required that must be dealt with in accordance with the relevant paragraph above.

Patients' Own CDs should never be used to treat other patients.

17.10 Obtaining CDs when Pharmacy is closed

Controlled Drugs must **not** be supplied from one ward to another. Under the provisions of the Misuse of Drug Act 1971 nurses, midwives and ODPs are authorised to possess controlled drugs for the purposes of administration in their ward/department: they are not authorised to supply Controlled Drugs to other wards/departments.

In cases of emergency however, a registered nurse may attend another ward with the urgent prescription and, with a registered nurse from the second ward, may sign out one dose of the necessary medication from the CD register making sure that all details are recorded clearly and take it back to the original ward for immediate administration to the patient concerned.

The registered nurse obtaining a dose in this matter **MUST** be accompanied throughout by a second member of staff who will witness the transaction on the second ward and the administration of the dose to the patient. Both members of staff must sign the administration record box on the patient's drug chart.

In the event the CD is required for more than one dose or the CD is not available on another ward the on-call pharmacist should be contacted for advice and potential supply.

18 PATIENTS' OWN DRUGS (PODS)

Patients being admitted to hospital (elective and non-elective) should be encouraged to bring their medicines, in their original containers, into hospital with them whenever possible. This includes medicines which have been prescribed for them by a G.P. **AND** those they have bought over the counter at a pharmacy **AND** any herbal medicines. Where safe and appropriate to do so, these patient's own drugs should be used by the patient during their stay in hospital and taken home on discharge.

18.1 On admission

Patients should be encouraged to bring their own drugs in their original containers when admitted to hospital. Information to this effect will be supplied to all patients for planned admissions. Any drugs remaining at home should, if possible, be brought in by relatives/carers at the next visit. The drugs should be placed in a Green PODs bag and labelled with the patient's name and locked in the patient's POD locker, except for patient's own controlled drugs (eg morphine, diamorphine, oxycodone), which should be stored in the ward CD cupboard (see also para [12.5](#) above and para [13.5](#) below).

18.2 Consent

Drugs brought from home remain the patient's property. Consent for their use or destruction whilst the patient is in the care of the Trust, however, is considered to be implicit unless specifically directed otherwise by the patient.

Patients should be informed that the medicines they have brought in to hospital with them may be used as part of their treatment and will not be used by anyone else. If the patient needs any more the Trust will supply them and make sure the patient has suitable supply on discharge. If any of the medicines are out of date, or otherwise unsuitable for use, the Trust will replace them. If the hospital doctor decides that any of the medicines are no longer appropriate the Trust will assume that the patient is happy for them to be destroyed unless specified otherwise. This is done to help to avoid confusion when the patient goes home.

The medicines remain the patient's legal property and if they have any questions concerning the above, they should be encouraged to discuss them with the named nurse, midwife, doctor or pharmacist.

Patients have the right not to agree to the use or destruction of their medicines. When this occurs the medicines should not be used or discarded. They should be returned to the patient on discharge or sent home prior to this with a relative/carer. Where a patient's medication has been changed or discontinued or is considered unsuitable for use (e.g. out of date), staff should advise the patient accordingly that continued possession is medically inadvisable.

Patients own medicines no longer needed by a patient where consent to their destruction has been secured should be sent to pharmacy for disposal. Medicines of deceased patients may be sent to pharmacy for disposal after the relatives or carers collecting the effects have been informed.

18.3 Assessment of PODs

Patients' own drugs **MUST** be assessed prior to use following the suitability criteria in section [13.4](#) below. This can be done by a nurse, midwife, pharmacist, pharmacy technician or doctor. If the medicines are suitable for use the pharmacy box on the prescription chart will be endorsed "POD" with the quantity and date by the pharmacist or pharmacy technician.

Unsuitable drugs should be returned to the pharmacy for destruction (unless the patient has specifically stated that they do not agree to this, see section [13.2](#) above).

18.4 Suitability criteria

All of the following criteria must be met in order for PODs to be considered safe for use during the patient's stay and on discharge.

- The medicines (including controlled drugs) must be identifiable. Only medicines that can be identified will be accepted for ongoing use.
- Medicines must be in a suitable condition for use.
- Medicines must have been dispensed within the last six months, unless an expiry is stated on the container. Ophthalmic preparations must have been in use for less than one month.
- Medication must be correctly labelled with the patient's name, product name and strength, supplier's address and date of dispensing.

- Each container must hold only one preparation. Containers holding several different drugs or dosage strengths should be discarded or the products/strengths separated. (NB see bullet point below regarding use of PODs in compliance aid systems).
- Directions printed on the container must agree with the inpatient prescription chart or TTO prescription. If patient's own drugs are re-labelled by pharmacy with revised instructions, the POD must be positively identified and meet all suitability criteria. The label must include the words "Patients own medicine – relabelled". The new label must not obscure the original dispenser's name and address.
- Where medication is contained within a Monitored Dosage System (MDS) compliance aid, the medicines may be used provided that all reasonable measures have been taken to identify the medication, assure the suitability of the aid and its contents for continued use.

NB. The responsible pharmacist/technician or nurse, midwife or doctor must be satisfied with the general condition of the product and its packaging and labelling. Professional discretion should remain the overriding factor in assessing suitability.

18.5 Patients' own controlled drugs

Where patient's own controlled drugs are identified on admission they must be counted and entered into the section of the ward CD register or a separate register set aside for patient's own CDs.

A separate page must be used for each patient and for each medicine/form/strength. The patient's name together with the name, form and strength of the CD(s) must be stated together with the quantity received. The receipt and recording of patient's own CDs must be witnessed by a second qualified member of staff (or accredited HCA on specific named wards – see [protocol](#) on ICID).

Where patients own CDs are used during their admission, administration and recording procedures must be as for other CDs (see [chapter 12](#)).

If any remaining patient's own CDs are issued to the patient on discharge this must be witnessed by authorised staff and the register updated to reflect this.

18.6 Administration of patients own drugs

A nurse or midwife may administer patients' own drugs prior to them being assessed formally by pharmacy if he/she is satisfied that the drugs are suitable for use, in accordance with the above criteria.

Patients may begin self-administration with their own medicines (for self-administration of CDs see para 15.5 above) before formal assessment by pharmacy if the assessing nurse/midwife is satisfied that the drugs are suitable for use and correspond with the medication prescribed for the patient on the inpatient drug chart. However, the ward pharmacist or the pharmacy technician should check the medicines at their next visit.

Ward stock should be used until a labelled supply for the patient is available. However, ward stock should never be left in the PODs locker and patients must **never** self-administer from ward stock unless that stock is in the form of appropriately labelled pre-packs.

18.7 Discharge of patients own drugs

Patients' own drugs can be issued to the patient on discharge provided it is safe and appropriate to do so ([chapter 13.4](#) above). They must be checked against the prescription in the same manner as the TTO-labelled supplies from the hospital pharmacy. If there are insufficient supplies of any item, a fresh supply should be made of an original pack or at least 14 days.

19 SELF ADMINISTRATION OF MEDICINES (SAM)

The purpose of the self-administration schemes is to assist patients to take their medicines appropriately and safely in preparation for discharge, or to allow an inpatient to continue their therapy.

People at home usually administer medication to themselves. With the appropriate checks and controls it is therefore logical for hospital patients to have custody of and administer their own medicines. Wherever possible patients should be encouraged to administer their medicines themselves during their hospital stay.

See [Self administration policy, procedure](#) and forms available on ICID

20 CLINICAL TRIALS

20.1 Legislation

Practice guidance on pharmacy services for clinical trials was produced in 2005 jointly by the Institute of Clinical Research and the Royal Pharmaceutical Society of Great Britain⁽¹⁵⁾ and has since been reviewed by the National Pharmacy Clinical Trials Advisory Group in 2013¹⁷.

The Pharmacy Department has a clinical trials policy which applies to all clinical trials that are regulated by the Medicines for Human Use (clinical trials) Regulation 2004. This includes commercial and non-commercial clinical trials and investigator initiated clinical research.

20.2 Role of the pharmacy service in relation to clinical research is:

- a) To safeguard subjects, health care professionals and the Trust by ensuring that investigational medical products (IMPs) are appropriate for use and are procured, handled, stored and used safely and correctly.
- b) To ensure that IMPs are managed and dispensed to patients in accordance with the protocol and local Standard Operating Procedures (SOPs).
- c) To ensure that all pharmacy clinical trials procedures comply with relevant guidelines and regulations.

20.3 Study Set-up

Pharmacy should participate in the investigator meeting or the site selection visit and must participate in the initiation meeting. In order to assess the feasibility of the study and the impact it will have on the pharmacy department, the clinical trials pharmacist must review each protocol and will require the following information at the initiation visit:

- a) Sponsor/co-coordinator/CRA contact details
- b) Investigator and research nurse
- c) Number of patients, length of trial, start date
- d) Copies of clinical trial material labels
- e) Source of clinical trial material
- f) Storage conditions
- g) Ordering details
- h) Returns requirements
- i) Destruction details
- j) Pre-printed paperwork
- k) Code-break
- l) Any financial information including the pharmacy fee. (national fees agreed with NHS Trusts for commercial trials).
- m) Any other trial specific dispensing information

20.4 Investigators Delegation

The investigators must delegate responsibilities to the pharmacy department for the:

- a) Correct receipt and recording of deliveries of trial medicines
- b) Safe handling, storage and dispensing of trial medicines
- c) Return and disposal of unused products
- d) Reconciliation of delivery records with usage and return of unused stock
- e) Safe keeping of randomisation information including emergency code breaks
- f) Provision of information to trial subjects on how to take study medication
- g) When necessary, the compounding of study medication

20.5 Storage

When a clinical trial takes place at SFT all IMP should be stored and dispensed by the hospital pharmacy and managed to the same standards as licensed medicines. IMPs must not be stored in offices, clinics or ward areas unless by prior agreement with pharmacy.

20.6 Clinical Trials Prescriptions

Only registered and suitably qualified medical practitioners and healthcare professionals who are supplementary or independent prescribers (where Pharmacy has written confirmation of this arrangement signed by the Principal Investigator and the sponsor) may prescribe IMPs within SFT. The prescriber must be on the trial specific delegation log. On Aria, the chemotherapy e-prescribing system, trial specific regimens have been set up for each clinical trial and these must be used. The IMPs must be prescribed on a hospital drug chart or the e-prescribing system for administration and the study-specific clinical trial prescription forms should be used where provided for dispensing and accountability purposes. Study-specific prescriptions including those set up on the chemotherapy e-prescribing system, must be used to facilitate the prompt identification of the clinical trial and dispensing procedures and reduce the risk of dispensing errors.

It is essential that prescriptions for IMPs clearly identify the clinical trial, the subject and medication required. When an IMP is prescribed for an in-patient, the medicine chart should clearly identify the clinical trial and the IMP and include the words "Clinical Trial".

When a supply is being made, IMP doses should be validated by a pharmacist named on the delegation or training log before dispensing to ensure that the IMP is being prescribed according to the protocol.

Administration of such medicines must be recorded on the inpatient chart in the normal manner, where patients are discharged on clinical trial material this must be prescribed on the TTO prescription/electronic discharge summary. If the IMP does not appear on the electronic TTO system, ensure that the relevant information has been added to the GP notes section.

It is good practice for pharmacy staff to assess whether any IMPs brought into hospital by a patient are suitable for use. This includes all patients who present with clinical trial medication irrespective of whether they are taking part in a trial at SFT or any other trust or clinical trials unit. Where possible the pharmacy staff should notify the investigator and sponsor of any unplanned hospital admissions. If the patient is receiving trial medication under the care of another trust, the medical team looking after the patient at SFT should contact the research team at the other trust.

20.7 Clinical Trials Prescription charges

Prescription charges apply to clinical trial medicines unless the subject is exempt or the clinical trial is placebo controlled. A sponsor may choose to pay the prescription charges on behalf of the subjects in a clinical trial. These charges must be handled separately from clinical trial payments as per department policy.

20.8 Authorisation

Prior to the commencement of a clinical trial and the dispensing of any IMPs the pharmacy must be satisfied that clinical trials have:

- Appropriate regulatory documentation in place i.e. Clinical Trial Authorisation
- Been given a favourable opinion by the appropriate Research Ethics Committee(s).
- Been approved by the local R & D Department.

In addition, the pharmacy department must be in receipt of the final copy of the trial protocol and any amendments and the latest version of the investigator brochure prior to dispensing any IMPs.

20.9 Duty of care

Great care is needed when trial medicines are handled or used. They may be unfamiliar to medical and nursing staff and their identity may be obscured as a condition of the trial.

The clinical trials pharmacist should promptly notify all reported, possible adverse events experienced by patients in a clinical trial to the investigator and sponsor and a Trust adverse event form submitted in accordance with the Trust Adverse Events and Near Misses Policy.

21 ADVERSE REACTIONS

Any drug may produce unwanted or unexpected adverse reactions. Rapid detection and recording of adverse drug reactions is of vital importance so that unrecognised hazards are identified promptly and appropriate regulatory action is taken to ensure that medicines are used safely.

Doctors, pharmacists and nurses should notify definite and suspected adverse reactions to medicines including vaccines and X-ray contrast media directly to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme using the electronic form at <https://yellowcard.mhra.gov.uk/>. Alternatively prepaid yellow cards are available at the back of the current BNF.

Patients and carers may also self-report suspected adverse drug reactions to the MHRA using the web address above or by telephone. Advice on this is given in the current BNF.

Newer drugs and vaccines

Doctors and pharmacists should report **all** suspected reactions to newer drugs. These are identified in the BNF by the black triangle symbol (▼) and are monitored intensively by the MHRA.

An adverse reaction should be reported, even if it is not certain that the drug has caused it, or other drugs have been given at the same time.

Established drugs and vaccines

For established drugs, doctors and pharmacists should report all **serious** suspected reactions, including those that are fatal, life-threatening, disabling, incapacitating, or which result in, or prolong hospitalisation.

In addition, all suspected ADRs occurring in children should be reported.

Nurses and pharmacy staff must inform the prescribing doctor without delay if they observe or suspect adverse effects of a medicine. All such incidents must also be reported to via a Datix form.

22 DEFECTIVE MEDICINES

All suspected drug defects MUST be reported to Pharmacy and to the risk department via a Datix form as soon as they are suspected. The pharmacist will identify whether it is a possible defect or not. If a drug defect is suspected outside normal pharmacy opening hours, the emergency duty pharmacist should be contacted via switch board.

22.1 Medicinal Products (or dressings) excluding IV fluids

On suspecting a defect in a medicinal product (or dressing) the nature of the defect and the time and date of discovery should be recorded together with the manufacturer's name, name of product, batch number and expiry date (if any). The suspect product should be retained.

If the product has been administered to the patient, the doctor responsible for the patient must be informed.

The pharmacist must also be informed and provided with the information specified above. The pharmacist will, in conjunction with senior colleagues (including senior pharmacy manager, medical and nursing staff) determine the degree of patient risk associated with the suspected defective medicine and take local action to quarantine stocks as appropriate. The suspected defective medicine report will be classified by the senior pharmacist as hazardous, moderate or minor and action taken as set out in the regional defective medicines report procedure held in pharmacy.

The incident should be reported to the Ward Sister/Charge Nurse/lead midwife and the Directorate Senior Nurse and an incident form completed by the person identifying the suspected defective product.

22.2 Intravenous Fluids

On suspecting a defect in an intravenous solution or container the nature of the defect and date of discovery should be recorded together with the manufacturer's name, name of the fluid, batch number and expiry date. The suspect solution should be retained.

If the infusion has been set up, the administration set and infusion fluid should be replaced from a different batch. The solution and administration set must be retained for the pharmacist.

If the solution has been administered to the patient the doctor responsible for the patient must also be informed.

Inform the pharmacist who will then take charge of all reporting, recording and instigation of investigations. Be ready to provide the pharmacist with the information detailed above and retained items plus any supplementary containers/syringes, etc. in case of incidents in which IV additions are involved.

Report the incident to the Ward Sister/Nurse in Charge/lead midwife and the Directorate Senior Nurse and an incident form completed by the person identifying the suspected defective product.

22.3 Examples of product defects include:

- a) Particulate matter in IV fluids.
- b) Cracks in IV fluid bottles.
- c) Hairline cracks in ampoule.
- d) Labelling on container which does not correspond to the outer wrap.
- e) Different odour than normal.
- f) Unexpected clinical reaction.
- g) Quality of dressings lower than normal.
- h) Growth in IV fluids or in other injectable.
- i) Loss of vacuum in IV fluid bottles.
- j) Colour change.

23 OPERATING DEPARTMENTS

Procedures for the prescribing, administration and custody of medicines in operating departments are generally the same as for other wards and departments, but specific modifications apply as identified in the Management of Medicines in Operating Departments Policy found on ICID [Management of Medicines in Operating Departments - Salisbury NHS Foundation Trust](#)

24 X-RAY DEPARTMENTS

24.1 General

Medicines for the X-ray department are ordered from the Pharmacy department on a requisition signed by a consultant radiologist or specialist registrar in radiology or by one of the radiology nurses who is an authorised signatory.

Patients receiving any medicinal product (including radioisotopes and contrast media) must be asked if they have a history of allergy or if adverse reactions have occurred with a previous X-ray examination. Details must be recorded on the nurses check sheet and on the Radiology Information System under 'Patient Alarms' and brought to the attention of the consultant radiologist or specialist registrar in radiology.

Details of contrast media prescribed by the consultant radiologist or specialist registrar in radiology for in-patients will be recorded on the relevant prescription pro forma and following administration on the ward the administering nurse will complete the pro forma and place it in the patient's notes. Brand names may be used.

All requests requiring the administration of intravascular contrast media must provide details of the patient's renal function and in those patients with an abnormal renal function the latest estimated GFR will be required before the contrast is administered. This information must be supplied in the relevant box on the front of the X-ray request card.

Details of contrast media and drugs that are administered by the consultant radiologists, specialist registrars in radiology or radiographers under specific Patient Group Directions must be recorded on the radiology information system during post processing including the recording of any adverse reactions in the 'Patient Alarms'. The information recorded will include the date, time, the person administering the preparation and for intravascular preparations the batch number and expiry date.

All drugs that are administered in radiology as part of an interventional procedure will be recorded on the patient's drug chart in accordance with Trust policy.

Pre-packed, labelled bowel cleansing preparations are issued to patients as directed by the referring clinicians on the completed Bowel Cleansing Check List.

24.2 Administration of Radioisotopes

All Radiopharmaceuticals are obtained by a senior radiographer from the licensed Radiopharmacy Service at Southampton General Hospital.

Administration of these products must be undertaken by appropriately qualified Nuclear Medicine Radiographers who have been given written consent by an ARSAC Licence holder to perform this task, under the authorisation of agreed PGDs.

Details of the injection are recorded on the Radiology Information System during the post processing including the recording of side effects or discomfort following the administration of the Radiopharmaceutical. These details are also recorded in a log book as required by the Radiation Protection Advisor. Radioactivity in itself is not the cause of these rare occurrences but some patients may be allergic to the chemical ingredients of the Radiopharmaceutical.

All administered doses of Radiopharmaceutical must be recorded in a 'logbook' as required by the Radiation Protection Advisor.

Ward guidelines must be made available to the ward sister for all in-patients who have undergone Radiopharmaceutical investigation.

The administration of diuretic drugs, when appropriate, must be undertaken by appropriately qualified Nuclear Medicine Radiographers in accordance with the request card generated by a registered prescriber and which acts as the authorisation to administer. Details of such administration must be recorded on the Radiology Information System during the 'post processing' procedure.

25 MEDICINES FOR CHILDREN AND YOUNG PEOPLE 16 YEARS AND UNDER

25.1 Standards

Standards for the use of medicines for children and young people are set out in standard 10 of the "National Service Framework for Children, Young People and Maternity Services"¹⁶. These standards underpin the Trust's approach to medicines for children as described in this section.

The principles guiding the use of medicines for children and young people within SFT are as stated in the NSF as follows:

- All children and young people will receive medicines that are safe and effective, in formulations that can easily be administered and that are appropriate to their age, and that have minimum impact on their education and lifestyle.
- Medicines will be prescribed, dispensed and administered by professionals who are well trained, informed and competent to work with children to improve health outcomes and minimise harm and any side effects of medicines.
- Children and young people and their parents or carers will be well-informed and supported by healthcare professionals and others to make choices about their medicines and be competent in the administration of medicines.

ALL services and healthcare staff (including doctors, nurses, midwives, pharmacists, AHPs et al) providing care involving medicines for children and young people aged 16 years or under must ensure their practices conform to these principles at all times.

25.2 Prescribing, dispensing and administration of medicines for children and young people

See [chapter 4](#), [chapter 5](#) and [chapter 6](#) of Trust Medicines Policy and [20.1](#) above.

In addition individuals prescribing, dispensing and administering medicines for children and young people must be able to demonstrate competence in the use of medicines in children including:

- Dose and infusion calculations.
- An understanding of the potential for excipients in medicines to cause adverse effects in children, eg aspartame in children with phenylketonuria, lactose in individuals with lactose intolerance and colourings and preservatives in those with intolerance to these ingredients.
- An awareness of the availability of sugar free alternatives and the need to prescribe these in preference to other formulations.
- An understanding that unlicensed medicines must only be prescribed where the clinical needs of the child cannot be met by a licensed alternative.
- Provision of relevant information concerning medicines to allow the patient and carers to be informed about and competent in the use of their medicines.

Where prescriptions are written for medicines of high risk, narrow therapeutic ranges or in unusually high or low doses, or where they are to be given by infusion, the child's age, weight in kg and the intended **dose in mg/kg/dose** should be specified on the prescription to allow accurate double checks to be made.

Clinicians prescribing for children and young people with complex long term conditions should ensure that mechanisms are in place for regular review of the medicines used, and that support is provided to help children and young people and their parents or carers when changes to complex treatments are made.

25.3 Specific issues relating to administration of medicines to children and young people

All dose, volume and rate calculations must be carefully checked by 2 registered nurses/midwives and documented before administration of medicines.

Paediatric formulations must be used wherever possible. Extreme vigilance must be exercised when these are not available and adult strength preparations are used.

Oral syringes of appropriate size **MUST** be used to administer all liquid medicines when the volume does not correspond to a 5ml spoonful or multiple thereof.

In addition, where oral doses of less than 1ml in volume are required, these must be drawn up in a 1ml oral syringe graduated to 0.05ml.

If administration of a dose can only be achieved by crushing a tablet or opening a capsule (eg for administration through a feeding tube) the advice of a pharmacist should be sought.

25.4 Staff involved in administering medicines to children or young people

In **ALL** situations, medicines administered to children or young people, aged 16 years or under, **MUST** be undertaken by 2 registered nurses or midwives. Both nurses/midwives must check that it is the correct drug, the correct child or young person, the correct date and time, the correct route and correct dose or rate. This includes all medicines including intravenous fluids and blood and blood products.

In addition one of the nurses/midwives must have successfully completed an orientation period of not less than 4 months in the relevant work area (i.e. paediatric unit, NICU, maternity unit, ward or department).

On the paediatric unit one of the nurses above (referred to as the 'first checker') must be either:

- "a Registered Sick Children's Nurse" or,
- "a Registered Nurse (Child Branch) with at least one year's experience in children's nursing post qualification".

The 'second checker' can be any qualified nurse.

On NICU one of the qualified nurses above.1 must be either:

- A Registered nurse/midwife who holds the ENB 405, ENB904 or Neonatal Pathway qualification, or
- Has completed Band 5 foundation year or equivalent within the NICU service,

This nurse/midwife must have successfully completed an orientation period of not less than four months after their commencement date on the Neonatal Unit.

In all cases all drugs administered to patients on the Neonatal Unit must be checked by 2 registered nurses/midwives

In recognition of their previous registration, post-registration nurses undertaking a post-registration qualification on NICU may check and administer drugs to babies as a 'second' checker following appropriate orientation.

25.5 Outreach nurses

All medications administered by outreach nurses working in the home environment must have been prescribed by a registered medical prescriber and dispensed by either the hospital pharmacy or local chemist. These drugs may be administered without involving a second checker.

25.6 Self-administration

Where children or young people with long term conditions or their parents or carers are competent in managing their medicines', they should be allowed to do so during hospital stays. (See [Policy](#) – on ICID.

On NICU, parents of longer stay babies are encouraged to administer medicines under the supervision of Unit staff prior to discharge where appropriate.

26 MIDWIVES

26.1 General provisions for supply/administration of medicines by Registered Midwives

Special rules apply to the supply and administration of certain medicines by midwives. In all cases midwives should comply with all good practice guidance, in particular relating to Controlled Drugs, and must refer to this policy together with the appropriate, up to date NMC guidance, the Midwives' Rules and Standards and follow any local policy or procedures specified by the Local Supervising Authority or the Supervisor of Midwives.

Within Salisbury NHS Foundation Trust midwives may supply and administer medicines in accordance with the following:

- The Trust Policy for administration of Discretionary Medicines.
- A Trust approved Patient Group Direction (PGD) or Locally Agreed Clinical Procedure (LACP).
- A written prescription signed by a registered prescriber or
- The list of POMs specified by legislation for use by midwives without a prescription.

In each case the midwife must record such administration in the patient's notes except where the dose is given within the maternity unit when the record must also be made on the prescription chart. Where medication has been supplied or administered under a PGD/LACP or midwives exemptions, the relevant authority must also be stated in the record.

21.1.1 Specific legislation relating to supply and administration of medicines by midwives.

Registered midwives are able to supply and administer, as appropriate, on their own initiative and as part of their professional practice certain medicinal products covered by legal 'exemptions'. In addition, student midwives (from 1.7.11) may administer medicines on the exemption list (**except controlled drugs**) under the direct supervision of a registered midwife. The relevant pieces of legislation are as follows:

For pharmacy and general sales list medicines

The Medicines (Pharmacy and General Sale - Exemption) Order 1980 (SI 1980/1924) which allows registered midwives to supply and administer in the course of their professional practice all Pharmacy Medicines (P) and General Sales List Medicines (GSL) without a prescription form from a registered prescriber. Within Salisbury NHS Foundation Trust, midwives are expected to limit their use of P and GSL products to those specified within the Trust Policy for administration of Discretionary Medicines.

For Prescription Only Medicines (POMs)

The Medicines for Human Use (Miscellaneous Amendments) Order 2011 SI 2011/1327 which removes restrictions on the sale, supply and administration of certain specified POMs which registered midwives may use in the course of their professional practice without the need for a prescription given by a registered prescriber. The legislation also allows student midwives to administer medicines on the midwives exemption list (except CDs) under the direct supervision of a midwife.

Where midwives have occasion to administer a POM not specified as an exemption within current legislation they must only do so in accordance with a prescription signed by a registered prescriber or with a Trust agreed Patient Group Direction or Locally Agreed Clinical Procedure.

In all cases a practising midwife shall only supply and administer those medicines, including analgesics, in respect of which she has received the appropriate training as to use, dosage, frequency, precautions, contraindications and method of administration.

26.2 Supply and administration of medicinal products outside of their license

Medicine which is licensed but used outside its licensed indications (commonly known as 'off label') may be administered under the midwives exemptions list provided the following conditions are met:

- There is no appropriately licensed alternative
- There is sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy
- Midwives should explain to women and their families, in broad terms, the reasons why the medicine is not licensed for the proposed use.

26.3 Controlled Drugs

Current legislation allows midwives to order and hold stocks of pethidine, pentazocine, morphine and diamorphine for use in the course of their professional practice.

26.3.6 Midwives working in the community

Community midwives (CMWs) employed by Salisbury NHS Foundation Trust do not carry Controlled Drugs and do not promote their use for home births.

Controlled Drugs obtained by a woman by prescription from her doctor for use in her home confinement are her own property and are not the responsibility of the midwife. In the event that the CD is not used or only partly used, the woman should be advised to destroy the CD or to return it to the pharmacy from where it was obtained. A Supervisor of Midwives should be informed if a woman organises her own supply of a Controlled Drug from her GP to be used at a home birth.

CMWs may carry drugs as agreed locally by the Supervisors of Midwives and Pharmacy for use in their professional practice. These drugs are syntometrine, ergometrine, lidocaine, phytomenadione and entonox and administration is allowed under Midwives exemptions legislation.

The midwife must make a record of administration of all medication in the patient's notes.

Community midwives are responsible all medicines in their possession and must store them safely and securely at all times including during transportation. CMWs must check monthly that the drugs in their possession are in date and must keep a record that these checks have been done. CMWs must also record the exchange of out of date drugs/replacement of drugs used from the supply on labour ward. The Supervisor of Midwives should periodically audit and reconcile these records for each CMW. Any discrepancies should be investigated.

26.4 Midwives Exemptions legislation parenteral

Below are the prescription only medicines approved for parenteral administration by midwives employed by SFT without the need for prescription. (Authority to administer = Midwives Exemptions legislation)

(available at: <https://www.gov.uk/government/publications/rules-for-the-sale-supply-and-administration-of-medicines/rules-for-the-sale-supply-and-administration-of-medicines-for-specific-healthcare-professionals>)

Drug name	Use	Route	NMC advice for professional practice
Adrenaline 1:1000	Adult	IM	For use in anaphylaxis only. 1mg/ml
Anti-D immunoglobulin	Adult	IM into deltoid muscle	For routine antenatal and postnatal use to protect against haemolytic disease of the newborn. To be prescribed in case of an emergency e.g. APH
Cyclizine Lactate	Adult	IM	For management of actual or potential nausea and vomiting
Diamorphine	Adult	IM (in the arm)	Diamorphine hydrochloride for pain relief in labour 5 mg x 2 doses – 4hrly
Ergometrine Maleate	Adult	IM/IV	IV use with caution – risk of hypertension 1 amp (500 micrograms) - single dose only
Gelofusine	Adult	IV	For maternal resuscitation
Hartmann's solution (Compound Sodium Lactate)	Adult	IV	For maternal resuscitation
Lidocaine Hydrochloride 1%	Adult	SC/IM	For perineal infiltration Can use up to 20ml for perineal repair (usually only need 10ml)+ 5ml for perineal infiltration prior to episiotomy
Syntocinon	Adult	IM	10iu for prevention of PPH
Syntocinon	Adult	IV	30iu Syntocinon in 57ml Sodium Chloride 0.9% for the treatment of postpartum haemorrhage
Syntometrine	Adult	IM	I/M Syntometrine – 1 amp - can be repeated
Pethidine Hydrochloride	Adult	IM	For pain relief in labour

Drug name	Use	Route	NMC advice for professional practice
			50-150 mg – repeated 3-4 hourly (maximum of 2 doses only – then review pain relief options with obstetrician)
Prochlorperazine	Adult	IM deep	For management of acute or potential nausea and vomiting in labour – 12.5 mg: 1 dose only (repeated doses need to be prescribed or alternative anti-emetic considered)
Sodium Chloride 0.9%	Adult	IV	For maternal resuscitation and IV flush 5-10 ml as required
Naloxone Hydrochloride	Neonate	IM	For reversal of respiratory depression resulting from opioid administration to mother 200 micrograms – one dose only at birth (100mcg for pre-term babies)
Phytomenadione	Neonate	IM	Prophylactic use to prevent vitamin K deficiency bleeding (haemorrhagic disease of the newborn) 1 mg – single dose administered within 24 hrs

26.5 Midwives Exemptions legislation other medicines

Below is a list of the general sales list, pharmacy, and prescription only medicines approved for administration by midwives employed by SFT without the need for prescription. (Authority to administer = Midwives Exemptions legislation).

Drug name	Dose	Route	NMC advice for professional practice
Bradasol lozenges	1 prn	Oral	
Dequadin lozenges	1 prn	Oral	
Diclofenac	For postpartum pain relief up to 48 hours after birth 100mg PR x 1 dose 50mg tds – maximum 150mg in 24 hrs	Oral/PR	POM – midwives exemptions For Adult use only
Entonox	Prn	Inhalation	
Ferrous Suphate	200mg 1-3 times a day	Oral	
Fybogel sachet	1 bd	Oral	
Gaviscon	10ml prn	Oral	
Glycerin Suppository	4g daily	PR	
Lactulose	15ml bd	Oral	
Magnesium Trisilicate Mixt.	10ml tds in water	Oral	
Micro enema	1 daily	PR	
Oxygen	PRN	Inhalation	
Paracetamol suppos. 500mg ¹	1-2 up to qds	PR	
Paracetamol tablets 500mg ¹	1-2 up to qds	Oral	
Pregaday	1 OD	Oral	
Phytomenadione	Prophylactic use to prevent vitamin K deficiency bleeding (haemorrhagic disease of the newborn) 2mg x 1 dose within 24 hours of birth Arrange further 2 doses as TTOs for breast fed babies, to be given at 1 and 4 weeks of	Oral	POM – midwives exemption list For Neonatal use only

¹ Not to be given to patients already receiving preparations containing Paracetamol (eg benorylate, co-codamol)

Drug name	Dose	Route	NMC advice for professional practice
	age		
Simple linctus	5ml 3-4 times daily	Oral	
Cathegel/Instillagel	PRN for catheterisation NB. Contains chlorhexidine – contra-indicated in patients with sensitivity to chlorhexidine		

(See also, [administration of discretionary medicines by registered nurses and midwives](#) – on ICID)

Student midwives can only administer these medications (excluding controlled drugs) under the direct supervision by a registered midwife.

27 OCCUPATIONAL HEALTH SERVICES

Treatment provided by the Occupational Health Service of the Trust is carried out under the Occupational Health Schemes section of the Medicines Act 1968.

The Trust's Occupational Health Department provides a comprehensive immunisation service to remove the risk of staff acquiring or passing on work-related infectious diseases such as Hepatitis B, Tuberculosis, Varicella Zoster (chicken pox) or measles and rubella.

The majority of medicinal products are supplied to the Occupational Health Department from Pharmacy in response to a stock requisition.

Medicinal products can be administered by a doctor or nurse against a prescription or in accordance with a Patient Group Direction/Locally Agreed Clinical Procedure.

28 MEDICAL REPRESENTATIVES

28.1 Medical Representatives

Pharmaceutical representatives are welcomed by the Trust if they are ethical, well informed, and able to provide accurate current information for professional staff. They will be offered reasonable assistance but have no specific right as company representatives to be on Trust property.

They must adhere to the current code of practice for the pharmaceutical industry published by the Association of the British Pharmaceutical Industry. Representatives may be asked to leave Trust premises if they break its code of practice.

Trust staff should express any concerns about the behaviour of medical representatives to the Chief Pharmacist.

28.2 Visits

Representatives may see consultant medical and senior nursing staff only by appointment or invitation.

Visits to consultants should be made by arrangement through the department secretaries and should not take place during clinic times. Junior medical staff should only be seen on the direction of the appropriate consultant.

Appointments with hospital pharmacists should be made by telephone or via email to the Pharmacy Department. Information concerning drugs may be left for the relevant senior pharmacist usually without the need for a personal visit. .

Demonstrations to nurses must only be given after written permission has been obtained from the appropriate senior nurse.

28.3 Samples

Samples of medicinal products including dressings must not be left in wards, theatres or departments. All samples, goods for assessment etc., must be left at Pharmacy for issue through the normal procedures. Ward staff must not accept free supplies for assessment however generous such offers may seem.

Consultants requesting samples will be informed that any new drug being introduced into the Hospital is subject to the policy for entry of new drugs into Salisbury NHS Foundation Trust. No samples will be accepted by the Pharmacy until a Senior Pharmacist has discussed the request with the consultant requesting the samples and given his/her approval. Once it has been agreed to accept samples, they will be left in Pharmacy, and Pharmacy will contact the consultant when the supplies have arrived. These samples can only be supplied against the signature of the consultant who has requested the samples.

The requesting of samples by consultants for private use is discouraged. However, where samples of medicinal products are requested for a doctor's private use, these should be sent to their private address or given to the doctor concerned personally on the specific understanding that they will not be used within the Trust.

28.4 Introduction of New Products

The Trust operates a Joint Formulary in conjunction with local primary care providers.

Medical staff are expected to prescribe items within the Formulary (see [Policy on Formulary management](#) available on ICID).

Where a consultant wishes to introduce a new product to the hospital, specific procedures apply (see Policy on Formulary management available on ICID)..

28.5 Clinical Trials and Clinical Assessments

See [chapter 15](#) Clinical Trials.

All supplies for clinical trials and assessment should be sent to the Pharmacy.

A senior pharmacist should be involved in the planning of all clinical trials involving medical products and no trial material should be dispatched before suitable arrangements have been agreed. Such arrangements include a fee for participation where the trial is commercially sponsored.

The Trust does not approve of clinical trials or assessments which are poorly planned and controlled or which carry offers of free supplies as an inducement for future prescribing. Clinical trials must have the approval of the Trust Research and Development Committee and of an appropriate Ethics Committee.

28.6 Casual Gifts, Hospitality and Commercial sponsorship

The ABPI Code of Practice on these must be observed as well as any Trust policies which may be in force.

The Trust does not approve of offers to cut hospital prices substantially as an inducement to purchase while prices remain high for continuity of treatment in primary care.

This policy should be read in conjunction with the guidelines on Standards of Business Conduct contained in EL(96)12 and the associated Trust policy. Staff are reminded that NHS employees are not allowed to accept compromising offers of gifts, hospitality or travel from members of the pharmaceutical industry.

See also Trust Standing Financial Instructions

28.7 Collaborative agreements

Trust staff contemplating entering into a collaborative agreement with a pharmaceutical company must ensure they are familiar with and abide by the Trust Code of Practice for working with (Pharmaceutical) Companies. See [chapter 24](#).

28.8 Breaches of Policy

The Trust views breaches of these arrangements by representatives or hospital staff seriously and will not hesitate to take appropriate action when they are detected.

Medical representatives may be removed from Trust premises and their company and the ABPI will be informed of any breaches of policy or inappropriate conduct. Members of the Trust staff who do not conduct themselves properly will be dealt with through the disciplinary procedure.

29 CODE OF PRACTICE FOR WORKING WITH PHARMACEUTICAL COMPANIES

This code of practice relates to any proposed collaboration between a Pharmaceutical company and Salisbury NHS Foundation Trust. Collaboration or joint working can take many forms and can range from educational projects/programmes to provision of specialist nurses. Advice on the application of this code to specific projects is available from the Chair of the Drugs and Therapeutics Committee and the Chief Pharmacist. Where joint working with the pharmaceutical industry exists this code must be adopted.

The ABPI publishes a free to access and publically available database of doctors, nurses, pharmacists and other health professionals who have received financial incentives for working with organisations (Disclosure UK available at:- <https://www.abpi.org.uk/ethics/ethical-responsibility/disclosure-uk/>).

Any officers or other staff of the Trust taking part in collaborative working with the industry must in addition comply with their own professional code of conduct and complete the trust wide declarations of interest form found at:-

<http://intranet/website/staff/policies/standingfinancialinstructionsandorders/conflictsofinterestpolicyforsalisburyfoundationtrust.asp>

All proposals for joint working must abide by the following principles:

- **all joint working between the NHS and the pharmaceutical industry must be for the benefit of patients.**
- **the interests of individual patients must be protected.**
- **patient confidentiality must be respected and preserved.**

Each proposal for working with a company should initially be submitted to the relevant clinical director and subsequently to the Drugs and Therapeutics Committee for ratification. Any proposal to introduce a new drug to the Trust outside of a clinical trial should be accompanied by a completed Request for Addition to the Formulary Form for a new drug for consideration by the Drugs and Therapeutics Committee. The requesting clinician should disclose on the form what sponsorship if any has been offered by the drug company promoting the drug. In the case of research, best research practice should apply and approval should be sought from the Local Research Ethics Committee and the Trust Research and Development Committee. It may then be considered appropriate to send it to the Joint Board of Directors for approval.

Joint working should not undermine or conflict with the ethical requirements of healthcare professionals to provide clinically appropriate care for patients.

All collaborations should be on the basis of a prior written agreement. The agreement shall explicitly state what resources the company intend to supply; what outcomes the company expect including any proposals to publicise the collaboration; what resources are expected from the Salisbury NHS Foundation Trust collaborator; what outcomes are expected by the Salisbury NHS Foundation Trust collaborator .

Potential partners shall not advertise Salisbury NHS Foundation Trust's participation as an endorsement of their products, packages or company without the explicit written permission of the Trust. The Trust should agree the nature of any endorsement or linked publication.

Joint working should not be seen as an endorsement or promotion of a specific medicine or technology.

Reports or information relating to the joint working agreement should not be used or published without explicit permission given by all partners entering the agreement.

The pharmaceutical company will be expected to comply with the ABPI Code of Practice for the pharmaceutical industry at all times.

Clinical aspects must always be under local control. Development of guidelines or advice will be by a local group **not** including a representative of the Pharmaceutical company. Guidelines will recommend generic products or a class of agent, and not use trade names.

Pharmaceutical companies may offer to sponsor, wholly or partially, a post within the Trust. The Trust or its employees should not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Trust. Where such sponsorship is accepted, monitoring arrangements should be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement. **Under no circumstances should the Trust or its employees agreed to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.**

The company shall not be enabled to use Salisbury as a 'loss leader' site by providing free or very cheap drugs, materials or equipment, which subsequently needs to be provided out of Primary care resources. It may be appropriate for on-going supplies of medication/equipment to be made by Secondary care to patients as part of a research/evaluation project. In such cases a detailed proposal is to be provided and ethical committee approval gained.

If there is competition in the market space a tendering process shall be undertaken as defined by the standing orders of the Trust.

Work should proceed on a project by project basis, not on the basis of an ongoing formal relationship.

An 'opt out' clause should be part of each written agreement.

Each formal collaborative project with Pharmaceutical companies should be tested against the framework of this code of practice, and be the subject of a process and financial audit exercise.

The Trust employee involved in any collaboration with a Pharmaceutical company should inform their line manager of any sponsorship received from the company in question. In the case of study leave applications a record of any sponsorship received by a Pharmaceutical company should be documented on the application form. In addition the employee is responsible for completing a declaration of interest form which is available from the Trust Board Secretary. This form is returned to the Trust Board Secretary who is responsible for maintaining a confidential Register of these details.

See also:

Best Practice Guidance on Joint Working between the NHS and Pharmaceutical Industry and other relevant commercial organisations, DH

Moving beyond sponsorship – joint working between the NHS and Pharmaceutical Industry, DH, NHS & ABPI toolkit 2010

SFT Standing Financial Instructions 2013, section XXIII

30 BIBLIOGRAPHY

1. 'The Safe and Secure Handling of Medicines – a team approach' (A revision of the Duthie Report), RPSGB, London, March 2005.
2. 'Controls Assurance Standard Medicines Management (Safe and Secure Handling)', NHS Executive, London, 2003.
3. Building a safer NHS for patients – improving medication safety, DH January 2004.
4. Standards for medicines management NMC 2008
5. The Code. Standards of conduct, performance and ethics for nurses and midwives. NMC 2008.
6. 'Midwives rules and standards' NMC, London, 2004.
7. Record keeping, guidance for nurses and midwives NMC
8. 'The best medicine – the management of medicines in acute and specialist trusts' CC 2007.
9. 'Guidance on the management of controlled drugs in secondary care in England' DH 2007.
10. 'Medicine Matters – A guide to mechanisms for the prescribing, supply and administration of medicines' DH July 2006.
11. CQC Regulation 13, Outcome 9, Medicines Management. 2010
12. Good practice in prescribing and managing medicines and devices. GMC 2013. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices> .
13. Practice guidance on pharmacy services for clinical trials RPSGB June 2005
14. 'National Service Framework for Children, Young People and Maternity Services; Standard 10, Medicines for Children and Young People' DH October 2004.
15. Professional Guidance on Pharmacy Services for Clinical Trials – NPCTAG October 2013

31 APPENDIX 1: PRESCRIPTION FOR URGENT MEDICATION REQUIRED TO KEEP MEDICAL STAFF ON DUTY



**PRESCRIPTION FOR URGENT MEDICATION
REQUIRED TO KEEP MEDICAL STAFF ON DUTY**

Rx no:

DOCTORS NAME:.....

DOCTORS ADDRESS:.....

.....

AGE (if exempt):.....

Rx

NB. THIS PRESCRIPTION MUST BE SIGNED BY AN OCCUPATIONAL HEALTH PHYSICIAN OR ANOTHER CONSULTANT WORKING WITHIN THE TRUST. SELF-PRESCRIBING IS NOT PERMITTED.

CONSULTANTS

SIGNATURE:..... **DATE:**.....

CONSULTANTS

NAME (BLOCK CAPITALS):.....

ALL AREAS MUST BE COMPLETED BEFORE DISPENSING

PHARMACY USE ONLY

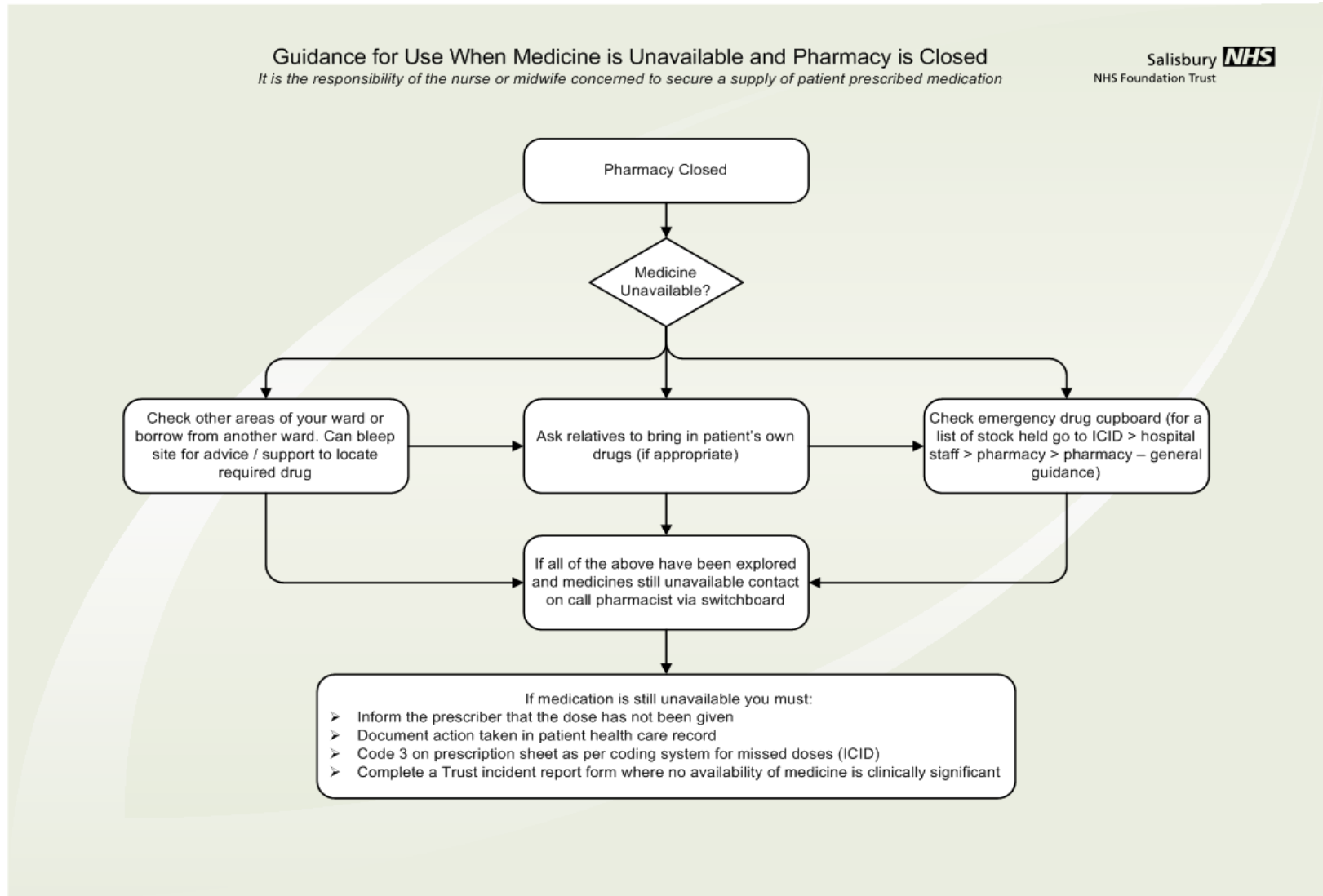
DATE DISPENSED:.....

DISPENSED BY:..... **CHECKED BY:**.....

FEE PAID:..... **ENTERED IN PRIVATE Rx BOOK: Y/N**

32 APPENDIX 2: MEDICINES UNAVAILABLE GUIDELINE

Medicines Unavailable Guidance



33 APPENDIX 3: SOURCES OF INFORMATION ABOUT MEDICINES FOR PROFESSIONAL STAFF

Information on medicines that can be accessed easily whilst working on the ward/ unit includes the following:

- The latest British National Formulary (BNF) available in hard copy on wards or clinics or via the intranet or app <https://www.medicinescomplete.com/#/> (hard copies of the BNF are available directly from the pharmacy)
- Package inserts in medicines
- The Electronic Medicines Compendium (EMC) containing the 'Summary of Product Characteristics' (data sheets) and patient information leaflets of branded proprietary medicines, via the intranet <http://www.medicines.org.uk>
- Medusa Injectable Medicines Guide: This provides information on the preparation and administration of intravenous medicines available at:- <http://icid/MedicinesManagement/Guidance/Generalguidance/Pages/InjectableMedicinesGuide.aspx>
 - The Newtguideliens for information on enteral feeding or medicines in people with swallowing difficulties available at:- <http://icid/MedicinesManagement/Guidance/Generalguidance/Pages/NEWTguidelines.aspx>
- Your ward pharmacist
- University Hospitals Southampton Medicines Information Centre (Mon. – Fri. 9.00am – 5.30pm) on 023 8120 6908/9
- For urgent and essential medicines information outside the local Pharmacy's opening hours contact the out- of- hours on-call pharmacist via switchboard.

For information on medicines management policies, procedures and guidance that has been issued by Pharmacy visit the Medicines Management intranet website on ICID