Barts Health NHS Trust

TRUST CORPORATE POLICY
MEDICINES MANAGEMENT

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RELATED DOCUMENTS	Injectable Medicines Policy Controlled Drug Policy Consent Policy Patient Identification Policy Patient Group Direction Policy Self Administration Policy Adverse Incident Policy Cytotoxic Drug Prescribing Policy Non Medical/Supplementary Prescribing Policy		
STANDARDS	Medicines Act Controlled Substances Duthie Report NPSA Alerts		
OWNER	Pharmacy Governance Team		
AUTHOR/FURTHER INFORMATION	Medicines Safety Nurse		
SUPERSEDED DOCUMENTS	Medicines Management Policies		
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CONSULTATION	Barts Health	Medicines Safety Team
	Other	Medicines Safety Team (legacy BLT) Medicines Management Group (legacy NUH) Clinical Improvement Group (legacy WX)

Scope of application and exemptions	**Included in policy:** For the groups listed, compliance with this policy is a contractual requirement and failure to follow the policy many result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for trust employees, and other action in relation to organizations contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement. *Individuals exempt from this arrangement include staff employed by the Trust's private sector partners (or seconded to them under the Retention of Employment arrangement) providing Facilities Management services (Capital Hospitals Limited and its Service Providers).*

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WeConnect Digital Programme

In October 2019, every Barts Health NHS Trust clinical policy was reviewed to determine if it would be impacted due to the We Connect Digital Programme and the digital development of nursing documentation, electronic prescribing and physician documents.

This policy is one such policy which has been changed accordingly

Therefore, please note that information regarding the patient will be entered into the individual electronic patient record on Millennium. In the event of downtime to Millennium, the Trust will revert to downtime procedures as defined in individual department business continuity plans.

MEDICINES MANAGEMENT

1 INTRODUCTION AND AIMS OF POLICY

1.1 This policy lays down rules for safe and secure handling and administration of medicines. It covers responsibilities, how medicines are supplied to clinical areas and patients, how medicines must be stored, who has authority to prescribe. It details what needs to appear on a prescription and how medicines should be administered. It covers the loss and disposal of medicines, the recall of defective medicines and the reporting of adverse drug reactions.

1.2 The policy is based upon the elements of a structured 'Medicines Trail', as described by the Duthie Report, which covers all aspects associated with the management and physical handling of medicines.

1.3 Core operational Standard Operating Procedures (SOPs) must be developed in all areas where medicines are handled. The Drugs and Therapeutics Committee must approve local procedures or may delegate this to a sub-group of the Committee. The person accountable for any activity should be specified in the written document this is the most senior member of staff within the Trust who should be aware of the procedures. The member of staff responsible either does or oversees the task. Persons who may accept responsibility for any activity should be defined in the SOP.

1.4 The definition of a medicine according to 'The Medicines Act 2003, the medicines for human use regulations 2005' is 'any substance or combination of substance presented for treatment or preventing disease in humans or animals. Any substance or combination of substances, which may be administered to humans or animals with a view to making a diagnosis or restoring, correcting or modifying physiological function in humans or animals, is likewise considered a medicinal product.

1.5 All staff must appreciate the importance of involving the patient in their treatment as much as possible. This includes ensuring that the patients understands and agrees to the proposed treatments and understanding as far as possible, any potential side effects. This is particularly important for clinical trials where the trial organiser must ensure that informed consent is given by the patient. All trials must have approval of the Drugs and Therapeutics Committee and for the patient to give written consent to treatment with them. Appropriate communication and language support will be provided for patients whose first language is not English in these circumstances. Appropriate provision will also be provided for patients with disabilities, although older children should be involved in decisions as far as possible.

2 Responsibilities

Medical Director	Holds lead organisational responsibility for medicines management for the Trust.
Chief Nurse	Accountable Officer for controlled drugs.
Director of Pharmacy	To establish and maintain systems for medicines management across the trust to include: • Maintenance of policies and procedures • Safe and Secure handling of medicines • Incident reporting and action planning on medicine related issues • Provision of Trust wide support from Pharmacy staff • Advice on training and accreditation for all staff groups involved in the medicines use process • Cost-effectiveness with medicines
Directors of Nursing/ Heads of Nursing/ Matrons/ Sisters & Charge Nurses	• To ensure that medicines' systems are followed and that the security of medicines are maintained. The senior sister/charge nurse may decide to delegate some of these duties but the responsibility always remains with him/her.
Senior Nurse/ Manager of Clinical Area. Community service/team	• To ensure staff are suitability trained in the handling and use of medicines. The senior sister/charge nurse may decide to delegate some of these duties but the responsibility always remains with him/her.
Medical, Nursing and Pharmacy staff and other staff authorised to deal with medicines in any procedures approved by Barts Health NHS Trust	• Staff who are authorised to undertake tasks to comply with legal regulations and/or local or national requirements. The person assuming responsibility or accountability for a task should ensure that any registration or training requirements are met. Tasks should not be delegated to a member of staff who is not legally entitled, authorised or appropriately trained to carry out these tasks • To follow the policy at all times

3 The System for Security of Medicines

3.1 All clinical areas should have standard operating procedures (SOPs) covering each of the activities concerned with medicines' use, to ensure the safety and security of medicines stored and used in them. Appropriate pharmaceutical advice must be sought in the development of systems for the safe and secure handling of medicines. The procedures for handling Controlled Drugs should take account of the additional legal and good practice requirements for this category of medicines.

3.2 Throughout this document the term 'senior nurse' will be used to describe the nurse in charge of a ward, department of clinical area e.g. Ward Sister, Charge Nurse, Clinical Ward Manager, Adult Community Nursing Clinical Leader etc.

3.3 In community health clinics and bases e.g. sexual health, family planning, the title 'Designate Person' will also be used; this is a person who has been identified as being suitable for, and therefore given responsibility for a specific duty, by the person having overall responsibility for the security system. The designated person does not have to be a member of nursing staff. The designated person in a clinic should control access to the medicines for each clinical area e.g. family planning, child health or district nursing stocks held on the site. The designated person has responsibility for ensuring the system is followed and that the security of medicines in each clinical area is maintained. The designated person may decide to delegate some of the duties but the responsibility always remains with them. In the absence of a nurse team leader, the nurse in each clinic should bear the responsibility individually.

3.4 This policy does not apply to 'internal' pharmacy policies that only affect the Pharmacy Department. These are kept within Pharmacy and not published Trust wide.

4 Medicines Brought into Hospital by Patients

4.1 Patients may bring their current and/or old medicines with them on admission. It is Trust policy to encourage them to do this so health care staff can see what treatment regimen the patient is following. Trust policies should be drawn up in consultation with an appropriate pharmacist and should take into account the current guidance on consent. These medicines are the property of the patient, and should not, therefore, be destroyed or disposed of, without the agreement of the patient or the patient's agent.

4.2 Medicines brought in by the patient should only be used in the Trust when they are positively identified, meet defined quality criteria and are appropriately labelled. They should be approved for use by the appropriately trained staff i.e. qualified nurses for immediate use, and then by the ward pharmacist or pharmacy technician on the next working day. Where they are judged unfit the patient should be advised accordingly.

4.3 One of the following procedures should be followed:

4.3.1 The medicines may be retained on the ward, for the sole use of the patient. Responsibility and arrangements for security are the same as with all ward medicine stocks.

4.3.2 The medicine may be securely stored on the ward until returned to the patient prior to or upon discharge.

4.3.3 If the medicines are not appropriate for use (i.e. unfit for use or discontinued) and the patient or the patient's agent agrees, medicines may be sent to pharmacy for destruction. The pharmacist or pharmacy technician takes responsibility for their destruction and the patient must sign for this in the designated space on the inpatient prescription record or a note made that the patient consent has been gained.

4.3.4 If the patient insists, the medicines may be returned home via an identified adult. Responsibility for security is given to that adult. The patient or patient's agent should be advised if the medicines are not safe or appropriate to use.

4.3.5 If the patient is admitted with their medication in a compliance aid, it is essential that the medicine regime prescribed matches the contents of that aid and that all the medicines can be identified before it is used. If this is not appropriate then new medication will be issued.

4.3.6 If a patient dies, their drugs must be returned to pharmacy for destruction. The medicines are the property of the patient only and cannot become the property of the next of kin. If the next of kin wishes to keep the medicines for analysis, they will be kept sealed in pharmacy and handed over to the legal advisor of the next of kin.

5 Medicines Supplied by the Pharmacy Department

5.1 All medicines used in the Trust must be ordered by the Pharmacy Department (other than patient's own supplies from home). Devices e.g. corsodyl mouthwash are ordered through supplies.

5.2 The pharmacist, pharmacy technician and the senior nurse, in consultation with appropriate medical staff, should decide a stock list of medicines kept in the clinical area. Pharmacy staff should decide on the amount of each stock medicine at any time from usage patterns, including medicines that might be needed urgently. This amount should be stated on the record of orders. This list should be subject to regular review between pharmacy and the senior nurse, in consultation with medical staff, at least yearly.

5.3 The Pharmacy Department will supply all other medication that a patient is prescribed as an individual supply. This may be a supply for in-patient use only i.e. the label for the medicine states the drug, form, strength, quantity supplied, expiry date and the patient name. Individual medicines may be dispensed labelled for discharge as TTAs, these are usually original manufacturer's packs of medicines labelled with directions for use, so that they can be used on the ward and given to the patient on discharge if they are to be continued.

5.4 It is critical that some medicines are administered as soon as possible. During Pharmacy opening hours wards should bleep the link pharmacist to obtain supplies of non stock medication. Where they do not have a link pharmacist, a request slip and the prescription chart should be taken to the dispensary. Requests for stock items should be directed to the pharmacy stores.

5.5 The pharmacy dispensary at the Royal London Hospital is open 24 hours a day and can accessed for any urgent items that cannot wait until the following day. Please use the appropriate order forms, fax them to the dispensary and contact the oncall pharmacist. Whipps Cross, St Barts and Newham all retain their Emergency Drug Cupboards. If the drug is not available in these cupboards then the drug can be ordered from the dispensary at the Royal London using the appropriate fax order forms and contacting the oncall pharmacist. The drug will be sent in a taxi to the requesting site.

6 Ordering and Records

6.1 The senior nurse, designated person or a member of the pharmacy staff (e.g. top-up technician or assistant) should be responsible for ordering medicines for stocks and for individual in-patients. Orders should be in a permanent record. Electronic ordering systems should be designed in such a way that a permanent record of orders is kept as stated in the Barts Health Records Retention and Disposal Policy. Where order books, top up sheets, requisitions or prescription pads are used, they should be considered as controlled stationery and stocked only in the pharmacy department. Their issue should be limited to authorised pharmacy staff. Access to electronic ordering systems should be similarly secure e.g. via password. Where ordering is done using computer technology, access to passwords should be restricted to pharmacy staff.

6.2 Where a pharmacy stock top-up service is in operation, technicians will restock clinical areas on a regular basis. The senior nurse remains responsible for identifying fluctuations in requirements and ordering appropriately.

6.3 Where a pharmacy top-up is not in operation, computer generated stock sheets or requisitions are completed, signed by a registered nurse or authorised deputy and sent to the pharmacy department.

6.4 Nurses and ODPs ordering Controlled Drugs must be permanent members of Trust staff. CDs should be ordered using the appropriate requisition form. If the drug is not routinely stocked in the clinical are, it is good practice for the pharmacist to screen the prescription first and validate the requisition by signing it in the appropriate section.

6.5 All used for medicines e.g. prescription charts, must be approved by the Drugs and Therapeutics Committee.

7 Restricted Drugs

7.1 Some other drugs, which are not classified as full Controlled Drugs (Schedule 2) but which may be liable to misuse e.g. midazolam and temazepam are treated in the same way for requisition and storage as full Controlled Drugs. Senior nursing and pharmacy staff must agree on this and these restrictions can apply to the entire Trust or to individual areas.

7.2 The use of high strength midazolam injection 5mg/ml (2ml and 10ml ampoules is restricted to operating theatres, level 2 and 3 clinical areas, and agreed palliative care locations and in other areas agreed following formal risk assessment. In areas where it is used for sedation, flumazenil injection must be available.

7.3 Strong potassium solution for injection (e.g. in ampoules) are treated in a similar way to controlled drugs reduce the risk of them being mistaken for sodium chloride or water for injections.

7.4 Epidural injections if stored, must be stored in a designated locked cupboard, separate from other drugs. This is to avoid the risks of confusion with intravenous medication and is a requirement of the National Patient Safety Agency.

8 Transport of Medicines

8.1 Only staff that are appropriately trained, identified and authorised by pharmacy, porters or transport shall transport medicines. Staff should be aware of the necessary security and handling arrangements involved with the handling of medicines.

8.2 Medicines must be transported in a secure or sealed container. It is the responsibility of the person sending the medicines to ensure that the container is sufficiently secure.

8.3 A system should be in place that records all orders, dispatches and receipts. The person responsible for delivering the medicines should sign to accept the delivery when orders are collected and deliveries should be handed to a designated member of staff at the destination point and a signature collected where possible. The signed receipt should be returned to the distribution point. Transfer of medicines outside the Trust should always be authorised and a receipt acknowledged by the receiving body.

8.4 When the transportation is under personal control throughout e.g. a porter delivering medicines to a ward, tamper- evident and preferably, secured containers should be used. When the transportation is not under personal control throughout, secured containers in secured vehicles should be used. Arrangements for transport of CDs must comply with current legal requirements. Cold chain control, within the limits appropriate to the individual product, should be maintained for items requiring refrigeration.

9 Receipt and Records

9.1 Staff members in clinical area or pharmacy staff who receive stock medicines in the clinical area must check these supplies against the requisition, and record that the check has been made. Any discrepancies should be reported to pharmacy.

9.2 Receipt and record keeping for Controlled Drugs should follow the agreed local procedures that comply with the current legal framework. Pharmacy staff are responsible for devising such local procedures.

9.3 Supplies of medicines for in-patients should be: signed for whenever this is possible; by a member of the ward staff and locked away immediately, either in the patient's bedside medicines locker, drug trolley, drug cupboard or fridge where appropriate.

9.4 Medicines intended for patients to take home on discharge and which have been obtained directly from the Pharmacy on a prescription should be securely stored on the ward (usually in the bedside medicines locker) in a way that allows them to be readily identified and separated from ward stocks. If there is 'one-stop' dispensing procedure in operation, then these items are also used for inpatient treatment.

9.5 Certain wards and clinics have a limited range of preparations e.g. analgesics, oral contraceptives and antibiotics. Ready packed and labelled for giving to the patient as a TTA or from clinic. These packs must be issued only on a prescription written by an authorised prescriber or by a member of staff authorised to use an approved PGD. At the time of issue must be endorsed with the patient's name, date of issue and dose, if needed.

10 Samples and Clinical Trial Materials

10.1 Only a member of pharmacy staff should receive samples of medicines and clinical trials from the manufacturer or his representative. They should not be accepted in a clinical area, if found there they should be sent to the pharmacy department. Clinical areas may participate in clinical trials with appropriate staff and training.

10.2 Properly labelled clinical trial medicines brought in by a patient on admission, as part of current medication, can be checked by an authorised prescriber and a pharmacist in the ward setting, noted, prescribed and administered as directed.

10.3 All clinical trials within the Trust must be approved by the research and development department at Barts Health who will liaise with pharmacy in regards to medication and ensure good clinical practice is (GCP) adhered too.

11 Security of Medicine Stocks and Storage of Medicines

11.1 This section describes the requirements for storage of medicines, including patients' own medicines, in all clinical areas including, but not limited to, all:

- Wards
- Theatres
- Outpatient facilities
- Day care areas
- Emergency Departments and associated departments

11.2 Within clinical areas, the responsibility for the safekeeping of medicines rests with the nurse in charge. On the clinic site the responsibility for safe keeping of medicines rests with the designated person. The nurse in charge or designated person is responsible for controlling access (by keys or other means) to any areas in which medicines are stored e.g. the medicine cupboards, medicines

fridge and trolley. The responsibility remains with the nurse in charge / delegated person even if he / she decides to delegate the duty.

11.3 The nurse in charge of a clinical area is ultimately accountable for practice in their area. They must ensure all staff are aware of their responsibilities in regards to the safe and secure storage of medication and that the environment is appropriately maintained and monitored. Operationally, the nurse in charge of a clinical area assumes responsibility for the safe and secure custody of any medicines supplied by pharmacy.

11.4 All staff must be aware of the need to maintain the security of medicines and should not compromise this in any way. Ward/departmental staff should not hand over cupboard keys, give access codes to, or open doors or cupboards where medicines are stored for others unless they are clear that the person to whom they are giving access is authorised to handle medicines within Bart's Healthcare NHS Trust. Equally, staff must not display the code for keypad locks in places where unauthorised persons may see them or leave cupboard keys and open trolleys unattended.

11.5 Any detected breaches in medicines related security must be reported to the nurse in charge / designated person, and pharmacy in a timely fashion, (clinical incident report (Datix) form must be completed where appropriate).

11.6 All medicines issued by Pharmacy, or brought into the hospital by patients, must be stored in wards and departments in the appropriate cupboards **which must be kept locked when not in use;** Cupboards should conform to BS2881 or be of a standard approved by pharmacy. Doors to medicines storage rooms, refrigerators and freezers **must also be kept locked at all times** when not in use.

11.7 Medicines in all dosage forms must be stored in the original packs supplied and labelled by pharmacy; they **should not** be decanted into unlabelled containers or single strips removed from the labelled box and stored in any other area (e.g. drug trolley).

11.8 The ward/department Medicine Trolley should only contain medicines that are in current use. The trolley must be **locked when unaccompanied** and securely anchored to the wall when not in use.

11.9 Keys for the medicines cupboards should be kept on one key ring, no other cupboard keys should be kept on this key ring to prevent unauthorised access to medication. CD keys must be kept separate from other medicine keys. Only pharmacy and nursing staff are allowed to hold or use these keys and the bunch of medicine keys must be on the person of a registered nurse/ODP at all times. A second set of keys should be kept in an appropriate secure location. Pharmacy staff needing frequent access to the cupboards may keep a master key for patient bedside lockers. No other category of staff should have access with the exception of Operating Department Practitioners who are registered with their profession, who work in theatres and have the approval of the senior nurse.

11.10 Missing keys must be reported to the senior nurse and pharmacy. A Datix incident form must be completed and security informed.

11.11 At each stage where a medicine changes hands, it is the responsibility of the person handing over the medicine to do so in such a way that there is no 'loss' of stock. Ideally, written records and receipts should be made.

11.12 Pharmacy staff should carry out inspections of the security and storage of stock medicines, with reconciliation where necessary. All supplies of medicines in clinical areas must be checked, those that are 'stock; are within expiry and are stored correctly.

11.13 Unless specified otherwise, all medicines must be stored between 8 – 25^{O}C. It is the responsibility of the nurse in charge of a clinical area to ensure that minimum and maximum ambient temperature monitoring is completed in all clinical areas storing medication. The values of these readings must be recorded in the agreed record and any reading outside of designated range must be reported to pharmacy at the earliest opportunity.

11.14 For items that require refrigeration or freezing, the storage equipment used should conform to MHRA guidance and kept clean and defrosted according to manufacturer specifications. Details of suitable refrigerators and freezers for medicines can be obtained from NHS logistics and the pharmacy department. Refrigerator and freezer temperatures should be measured at least once daily using a calibrated maximum/minimum thermometer, recorded and the entry signed. Any reading outside of designated range must be reported to pharmacy at the earliest opportunity. The senior nurse for the clinical area should retain copies of the monitoring documentation until this is checked by pharmacy during an inspection visit, or as part of the CD / Safe & Secure Medicines Storage audit process for clinical areas.

11.15 The Medicines Refrigerator must be used **only** for the storage of medicines. Food or enteral nutrition products (e.g. sip feeds) must not be stored in a medicines refrigerator.

11.16 In the event of a medicine being stored outside the normal temperature range the item should be quarantined and pharmacy advice sought in a timely fashion. The medicine must not be administered until advice has been given on the safety of use.

11.17 Ideally boxes of intravenous fluids and irrigation fluids must be stored off the floor, away from heat, and preferably in wall racking. Fluids must be stored securely and should never be decanted from their original boxes to reduce the risk of selecting the wrong bag. If for any reason, fluids are held in several locations on a ward or in a clinical area, these areas must be locked.

11.18 Clinical risk management arrangements and security monitoring that is consistent with Trust policy must be in place to monitor and review the safe and secure handling of medicines.

11.19 Some medicines that a patient may require urgently, usually for symptom relief, for example a salbutamol inhaler, glyceryl trinitrate spray or hypromellose eye drops, may be stored in an unlocked location, but not in open view. Large volume topical preparations, for example tubs of aqueous cream, or MRSA body washes

may also be stored in an unlocked location at the patient's bedside, however they must be stored in a place where a child or vulnerable adult cannot accidentally pick them up and swallow them. Where there is doubt then the product should always be locked away.

11.20 For clinical emergencies, e.g. cardiac arrests, all clinical areas should have a clearly identified source of urgent medicinal products. These should be held in resuscitation trolleys or in boxes clearly marked 'For Emergency Use Only'. Nursing staff / ODPs must be aware of the location of medicinal products for urgent use within their clinical area.

11.21 In community clinics, medicines for clinical emergencies e.g. anaphylaxis, kits should be stored in the correct packaging, clearly marked 'For Emergency Use Only'. These packs should be accessible to all practitioners during clinic sessions.

11.22 Packs containing medicines for emergency use should be tamper-evident and should not be held in a locked cupboard, but at strategic, accessible and observable sites.

11.23 Once an emergency drug has been used, a replacement must be obtained from pharmacy in a timely fashion.

11.24 Procedures should be in place to ensure that security is maintained in any storage area particularly where it is not continuously staffed. Some medicines may be stored overnight in a secured, unstaffed clinic location.

11.25 In clinical areas there should be separate lockable cupboards as follows:

a. Controlled Drugs Cabinet
b. Cytotoxic storage in designated areas, including separate fridge where required.
c. Internal Medicines Cupboard
d. Potassium High Strength Cupboard (for approved areas)
e. Epidural Cupboard (where required)
f. Individual Bedside Lockers
g. Medication trolley where in use with wall immobiliser
h. External Medicines Cupboard
i. Medication Refrigerator and medication freezer (where required)

11.26 Separate lockable storage should be provided for:

j. Diagnostic Reagents
k. Intravenous Fluids – these fluids should never be decanted from their original boxes to reduce the risk of selecting the wrong bag.
l. Sluice Rooms - storage of COSHH cleaning solutions and chemical reagents such as those used for urinalysis must be stored within a secure cabinet.

11.27 All medication must be put away promptly for security reasons and to ensure that items needing refrigeration are put in the medicines fridge.

11.28 Any loss of medicines from a clinical area must be notified to the Matron or Head of Nursing and pharmacy, out of hours to the site manager and on-call pharmacist. The manager must investigate the missing medication and complete a medication incident report (Datix) detailing actions taken. Loss of controlled drugs, a drug of abuse or a significant loss of any drug must be notified as above and the Accountable Officer (AO), Chief Nurse should also be notified at the earliest opportunity. Advice will be given by the AO on whether to inform the Metropolitan Police Drugs Liaison Officer.

11.29 If nursing or pharmacy staff discover evidence of tampering with medicines, they must quarantine the medicines immediately and any other medicine from the same batch and manufacturer. They must then contact pharmacy for further advice. Out of hours the on-call pharmacist should be contacted. A medication incident (Datix) report must be completed.

11.30 Staff in any supervisory positions should be aware of the signs that may indicate abuse or diversion of medicines and take appropriate action. A medication incident report (Datix) must be completed.

11.31 All staff collecting medication from pharmacy must show their identity badge. Without this, drugs will not be supplied.

11.32 Members of staff must never take any stock medicines or patients drugs for their own use, to do so will lead to disciplinary action being taken. If staff require medicines at work, the outpatient pharmacy department sell a variety of over the counter medications.

11.33 FP10 prescription pads are controlled stationery and should be kept securely in the controlled drugs cupboard. Pads logged out at the start of a clinic should be securely returned at the end and counted. Any suspected loss of prescriptions should be notified to pharmacy immediately so that if necessary the local Clinical Commissioning Group can be notified.

11.34 The security of individual prescription pads released to a qualified named prescriber remains their responsibility.

11.35 Subject to a formal risk assessment and documented agreement signed off by the site Director of Nursing and Pharmacy, certain clinical areas may be exempted from aspects of safe and secure medicines storage within this policy*.

- Critical Care
- Theatres
- Theatre Recovery
- Anaesthetics Rooms

Such areas may have restricted access, where patients are always escorted and visitors and other members of the public are generally excluded or very closely monitored e.g. theatres, theatre recovery, critical care etc.

12 Ensuring Accuracy of Prescriptions

12.1 The authorisation of a suitably qualified practitioner (frequently, but not always a doctor) must be obtained before medicines can be administered to patients. This

authorisation is usually given by a qualified and Trust accredited prescriber as an instruction written on an official chart e.g. the prescription chart. There are some restrictions on what medicines a doctor can prescribe within the Trust (Appendix 1).

12.2 The prescription must be written legibly on an authorised Trust prescription form in black or dark blue indelible ink and include the following details:

12.2.1 Patient's full name, NHS number and hospital record number

12.2.2 Approved name of medicine, or brand name if there is no approved name or where the bioavailability or release profile of a drug is relevant. No abbreviations should be used expect GTN.

12.2.3 Dose, where a liquid is prescribed the dose must be stated by weight and not volume i.e. 10mg (not 10mls)

12.2.4 Known drug allergies/adverse drug reactions recorded on drug chart and allergy sticker attached.

12.2.5 Initial allergy box on drug chart if present on the drug chart

12.2.6 Rate of administration for infusions

12.2.7 Timing and frequency of administration. Where the times for the regular administration of the drug need to be amended from those pre-printed, the revised items should be stated in the space available.

12.2.8 When a drug is not to be administered every day, the days when the drugs not administered must be crossed through, e.g. methotrexate

12.2.9 Date of commencement of the medicine at the current dose on admission

12.2.10 Duration of the prescribed dose or course of treatment (where appropriate)

12.2.11 Route

12.2.12 Site of application for topical medicines

12.2.13 Full signature and printed name of prescriber

12.2.14 Weight, height and body surface of patient: to calculate doses i.e. LMWH, cytotoxics

12.2.15 All prescribing of cytotoxic regimes for cancer should be carried out on ARIA

12.3 Discontinuation of a medicine must be clearly indicated by a line through the prescription, signed and dated by the prescriber.

12.4 A prescriber must inform a nurse when they have written a new prescription or amended a dose, so that the nurse can ensure that the drug is available for the next time the dose is administered.

12.5 If a medicine needs to be administered at a time other than the next drug administration round, the prescriber should prescribe a 'Once Only' dose in the appropriate section of the in-patient drug chart and inform the nurse that this has been prescribed.

12.6 Verbal orders are not permitted except in permitted emergency situations. In an emergency situation, medicines may be administered in accordance with the instructions of the prescriber. The prescription and administration must be recorded in the patient's notes and signed by the prescriber as soon as possible i.e. following the cardiac arrest or anaphylaxis. All staff authorised in the Trust to administer medication are expected to recognise and initiate the treatment of suspected anaphylaxis.

12.7 Any changes in dose or route must be initialled and dated by the prescriber making the change. In certain circumstances the pharmacist may amend the prescription but this must be written in green ink at (BLT & WXH) and red ink (NUH). Any pharmacist can add/delete or amend a prescription after confirmation with the doctor. The changed prescription should be endorses with 'as agreed with Dr……..' and signed by the pharmacist.

12.8 Pharmacists will check all prescriptions for safety, efficacy and appropriateness and endorse the prescription to ensure that it is clear and accurate. The endorsement will also show if it is a ward stock medication or a supply to the individual patient.

12.9 If a nurse has any doubts about any aspect of a prescription, clarification must be sought from the prescriber.

12.10 If a patient has/requires a Medicine Compliance Aid or MARS sheet this requires planning where possible 48 hours notice should be given.

12.11 All inpatient charts must be reviewed and rewritten every two weeks or every four weeks on long stay units using the extended drug charts. The old chart must be stored in the end of bed folder with the pages scored through. A pharmacist must screen all rewritten charts for transcription accuracy, and the appropriate section of the chart signed and dated to indicate that this has been completed. Once this check has been done the old charts should be filed in the patient's notes.

12.12 Abbreviations must not be used as they can lead to errors. Doses must be written in full i.e. micrograms and not mcg, units and nor u or iu.

12.13 Nurses must not transcribe prescription and medication charts except in the following services: Adult Community Nursing and Intermediate Care at Mile End Hospital. All transcriptions must follow the service transcription SOP.

12.14 Combination antibiotics must be prescribed by generic name to ensure that the constituents are clear i.e. piperacillin/tazobactam contains penicillin, the prescription charts should be endorsed 'contains penicillin'.

12.15 Antibiotics should have a review date or course length. Indication must be stated in the medical notes. Restricted antibiotics must be approved for use by microbiology, and the chart clearly endorsed 'microbiology approved'.

12.16 It is not permitted for doctors and independent prescribers to prescribe for themselves or for people that have a close personal relationship with. It is recognised on occasions a prescription may need to be written. For details of this framework refer to the Trust Policy on Prescribing for self and patients with whom you have a close personal relationship.

13 As Required Medicines

13.1 Maximum frequency should be specified

13.2 Maximum number of doses in 24 hours

13.3 Indication e.g. to treat nausea

13.4 If a choice of routes is stated, the dose of each must be the same. Where the dose varies by different routes, the two routes must be prescribed separately.

14 Discharge Medication

14.1 All discharge medication (TTAs) must be prescribed using the Electronic TTA system with the exception of (WXH, Maternity and SCBU)

14.2 'Initial Discharge Letter'. TTAs should be written as early as possible before discharge (at least 24 hours). The prescriber is responsible for ensuring that all details on the prescription are complete.

14.3 Medicines dispensed to be taken home must be checked, by the member of staff giving them to the patient, against both the inpatient prescription and discharge letter to ensure that nothing has been omitted and that doses have not been altered.

14.4 The assembly of discharge medication must be done by a registered nurse, a pharmacist, or a pharmacy technician and they must ensure the patient has been counselled on their medication where appropriate. The patient should have at least a two weeks supply of all their regular medication unless a compliance aid is being supplied then it will be one week supply.

14.5 For wards that use pre-packed discharge medication a record should be kept of medication supplied at time of discharged. At the time of issue, labels should be endorsed with the patient's name and date. A log of all mediation issued in this way should be held locally. The issue of a prepack medication should be double checked by another health care professional to ensure that one nurse is not selecting, labelling and supplying a medication.

14.6 It is essential that the nurse discharging the patient checks all locations that may have the patient's medication e.g. patient's bedside locker, controlled drugs cupboard, fridge and clinical rooms.

15 Administration of Medicines to Patients

15.1 Sufficient information about the medicine should be available to the staff and/or patient to enable identification and correct use of the product. A copy of the current BNF should be available in all areas and the Patient Information Leaflet (PIL) should be available for the patient to read. In the following situations a PIL must always be made available:

15.1.1 Anyone started on a drug since admission must have a PIL on discharge

15.1.2 Anyone started on a new drug in outpatients must have a PIL.

15.1.3 If a PIL is readily available in the stock box.

15.1.4 A patient requests one.

15.2 In areas where children are treated the 'BNF for Children' must be available.

15.3 For patients on specific high risk drugs e.g. warfarin, lithium, methotrexate or chemotherapy, at the start of therapy and throughout their treatment, patients must receive appropriate on-going verbal and written information and a record book where available to track blood levels and/or relevant clinical tests.

15.4 Administration to the patient should be in accordance with locally agreed procedures, and will be accomplished in one of the following ways:

15.4.1 Administration by an authorised nurse

15.4.2 Administration by a medical doctor

15.4.3 Administration by PGD by an authorised professional

15.4.4 Administration via a locally agreed policy i.e. emergency dept practitioners flushing cannula following insertion.

15.4.5 Self Administration by a patient or their carer/parent

15.5 Non registered staff cannot administer using a PGD.

15.6 Prior to administration the following should be checked.

15.6.1 Verify medication

15.6.2 Allergy status of patient

15.6.3 Dose

15.6.4 Frequency

15.6.5 Time of dose

15.6.6 Route

15.6.7 Expiry date

15.6.8 Check dosage calculation if appropriate

15.6.9 Check blood results/drug levels if appropriate

15.6.10 Contraindications of the medication e.g. digoxin, pulse below 60bpm

15.6.11 Prior to administration the administrator MUST cross check the identity of the patient with the drug chart, wristband and by asking the patient to identify themselves if able to do so. Staff must ensure appropriate communication and language support for patients whose language is not English, appropriate provision should be considered for those patients with disabilities including learning disabilities.

16 Safe Administration

16.1 Purple oral/enteral syringes, must be used for measuring and administering liquid medicines orally and through feeding tubes. IV syringes should never be used for drawing up these medicines due to high risk of wrong route errors.

16.2 All insulin MUST be double checked. Insulin must only be measured and administered using a designated insulin syringe or a commercially available insulin pen device. Intravenous syringes must never be used for insulin preparation or administration. An insulin syringe must always be used to measure and prepare insulin for an intravenous infusion.

16.3 Give all medication prescribed by one route before starting to administer medications prescribed by another route.

16.4 Check the patient is not allergic to the medicine. If the patient's allergy status is unknown, this must be determined and the chart endorsed, signed and dated in the appropriate section of the drug chart. When an allergy status cannot be assessed the chart should be endorsed 'not possible to ascertain'. The prescriber must check the allergy status on clerking in the patient on admission and then writing the prescription chart. If this is incomplete the prescriber must be called back to complete this section otherwise this is deemed as an incomplete prescription. Pharmacists and nurses must also check allergy status when assessing the patient and document any findings on the chart and sign and date the entry.

16.5 For inpatients, affix a red wrist band onto the patient where an allergy or significant previous adverse drug reaction is identified. Where the patient has a venflon, attach a red band onto the same arm as the venflon.

16.6 Check that the patient's condition does not warrant withholding the medicine. Consider if the patient is NBM for a procedure and check with the medical staff what medication should be withheld. Do not unnecessarily omit a dose, double check with the doctor or pharmacist whether a dose should be given.

16.7 Take all reasonable precautions to protect yourself from any harm resulting from administration e.g. wearing gloves when handling oral cytotoxic drugs or hormonal preparations. If staff are allergic to a medicine e.g. penicillin allergy, they should not handle this medication. If staff are pregnant they should refer to the pan London guidelines or occupational health for advice on handling.

16.8 The nurse shall take the measured dose of medication to the patient and remain with them to witness administration and to ensure all medication has been taken. Medicines must not be left on patient bedside lockers to be taken later. After witnessing the patient take the medication the nurse should:

16.8.1 Make an accurate record on the Trust prescription chart, by clearing writing their initials in the correct date column and if appropriate record the time of administration if out-with the prescribed time.

16.8.2 Tippex/liquid paper should never be used on drug charts.

16.8.3 If a nurse decides not to administer the medication the omission should be clearly documented using the relevant code and the actions taken clearly documented in the 'Drugs Not Administered' section on the chart. Medical staff should be informed.

16.8.4 The nurse should observe the patient for any side effects which might occur. Positive and negative effects must be reported to the appropriate prescriber and documented.

16.8.5 If a patient refuses medication, professional judgement should be used to determine the level of persuasion necessary to induce the patient to accept the medication. If unsuccessful, the refusal shall be documented on the chart and the prescriber informed.

16.8.6 The mechanics of crushing medicines may alter their therapeutic properties rendering them ineffective and are not covered by their product licence. Medicinal products should not be routinely crushed unless a pharmacist advises that the medicine is not compromised by crushing.

16.8.7 As a general principle, by disguising medication in food or drink, the patient is being led to believe that are not receiving medication, when in fact they are. The Nursing Midwifery Council would not consider this to be good practice. If a vulnerable adult or child is refusing their medication the relevant Safeguarding team can be contacted for advice.

16.8.8 It is crucial that some medicines are administered on time exactly as prescribed. Following the NPSA rapid response alert on omitted and delayed doses a 'critical list' of medicines where time-lines of administration are crucial. These are medicines that should be given within 1-2 hours of prescribing and which could lead to serious harm if not given as close to the prescribed time as possible. It should be remembered that all medication doses are important.

16.8.9 Medication that is not given due to lack of availability should be recorded, including the reason for non-administration. A supply should be obtained as soon as possible.

16.8.10 If the drug is not able to be administered because of lack of supply, access device etc, it is essential that this is communicated between nurses and midwives at shift changes. It should be clearly documented what drugs have not been given, what remedial actions have been taken, this should be documented in the 'Drugs Not Administered' section of the drug chart. The medical staff should be informed that the drug has not been given to ensure non administration does not comprise patient safety, or advice sought from the pharmacy department on an alternative drug or preparation. This should be clearly documented in the patients' health care records.

16.8.11 Details of drug name, strength, form and expiry date are always on the bottle or outer carton and original packs from pharmaceutical manufacturers are frequently used now. If the drug is blister packed, the name and strength of the drug, batch number and expiry date will be on the whole strip and should be checked. Pharmacy staff endeavour to dispense strips showing all the information but sometimes parts of strips need to be dispensed- the nurse should check the details against the outer box. It is essential that only one box of medication is open at a time and the strip is returned to the box after administration and not left loose in the drugs trolley.

16.8.12 Medicines must never be transferred from one container to another.

17 Administration to Children

17.1 When administering medicines to children, two staff should be involved, one of whom should be:

17.1.1 RSCN, RN (Child), RN/RM with relevant neonatal qualification.

17.1.2 Doctor

17.1.3 Patient/Carer using self administration policy

17.1.4 Agency nurses after working in the Trust for at least one month/and or at Senior Sister/Charge Nurse discretion, having been assessed as competent using the appropriate medication competency package.

17.1.5 Registered Nurses in areas outside designated children's areas who are caring for young people aged 14 and 16.

The other nurse may be:

17.1.6 An agency nurse

17.1.7 A third year student nurse who has passed their medicines management competency

17.1.8 For administration of medicines in walk in centres/urgent care, medication can be administered by one nurse/emergency nurse practitioner trained and assessed as competent using an appropriate PGD.

18 Administration by an Authorised Nurse

18.1 Where a system of single nurse administration is used, the nurse should follow full locally agreed checking procedures and ensure they are fully aware of the Nursing Midwifery Council guidance on medication administration.

18.2 Where a second nurse checks the administration of a medicine, the identity of the checking nurse should also be recorded.

18.3 Nurses are accountable for their actions and must be prepared to exercise professional judgement and substantiate their actions. 'When administering medicines the nurse must follow a sequence of steps to ensure the safety and well-being of the patient. He/she must understand the therapeutic effects and side effects, the usual doses, method of administration and rates where appropriate.

19 Competency to Administer Medication

19.1 All band 5 nursing staff who has not trained at City University or London South Bank University applying for a position in the Trust will be required to undertake a medications assessment as part of the selection process.

Upon appointment the nurse will receive an induction to medicine management as part of the clinical and mandatory training week. It is an integral part of nurse training that they complete a medicines management module and assessment at undergraduate level.

19.1 It is the responsibility of the individual professional involved in the medication process to ensure they maintain their levels of competence and ensure they receive updates or additional education and training as required by the Trust. It is also their responsibility to ensure they are aware of the latest professional standards from their regulatory body in relation to medicines management.

Extended Practice	Training	Staff Group	How is competency assessed
Intravenous Drug Administration	1 day IV theory course	Nurses/Midwives	Skills book, competency assessments
Non Medical Prescribing	Approved external course	Nurses/ Pharmacists	Clinical Management Plan, ongoing supervisory contact with medical consultant
Cytotoxic Drug Administration	4 day chemo course	Staff working with chemotherapy	Clinical assessments
Parentral Nutrition	Self Directed Study Pack	Nurses/Midwives	Clinical skills assessment
Drugs Requiring handling like Cytotoxics	Face to face training session	Nurses/Midwives	Staff who have IV accreditation are deemed competent, following administration supervision

			x3

20 Student Nurses/Midwives

20.1 Are not permitted to prepare or administer to a patient except under the direct supervision of a registered nurse/midwife. They must have attained a level of knowledge agreed by City University and London Southbank University of Health Studies.

20.2 Student nurses/midwives must ensure that they have an adequate understanding of the drugs administered in a specific ward, therefore this should be written into the learning outcomes that must be achieved. It is the responsibility of both the authorised nurse/midwife and student to ensure that the student understands the safe administration of medicines.

20.3 May assist patients under direct supervision of a registered nurse/midwife to take their oral, inhaled/nebulised medicines and intramuscular and subcutaneous having participated in the entire checking procedure. However the registered nurse/midwife remains solely accountable and signs the prescription accordingly.

20.4 Students may assist in the preparation of intravenous and subcutaneous infusions under the direct supervision of an IV accredited nurse/midwife, but must not administer drugs until they are registered with the NMC. This includes changing/recommencing intravenous pumps, syringe drivers and infusions.

20.5 Third year students who have completed their medicines administration competency may act as second checker with controlled drugs and intravenous medication, (at the discretion of the senior sister/charge nurse for the clinical area). It is the responsibility of the supervising RN/RM to ensure that they have completed the competency before allowing students to undertake this role. This can simply be achieved by checking the student's documentation.

20.6 Student midwives on shortened courses must always follow the student guidelines. They are not permitted to give drugs unsupervised by virtue of their other registration.

21 Medication Errors

21.1 The systemic reporting of medication errors including near misses is designed to protect patients, staff and the Trust. It is also used to identify areas were improvements in practice need to be made.

21.2 Medication errors can be defined as an incident in which there has been an error in the process of prescribing, dispensing, preparing, administration (including omission), monitoring, or providing medicines advice, regardless of whether any harm occurred. (NPSA 2007)

21.3 A 'near miss' is an event or situation that could have resulted in harm, but through timely intervention did not actually occur.

21.4 Open and honest communication with the patient and/or relatives that an error

has occurred is fundamental to the ongoing relationship between staff and patient.

21.5 Should it be identified that a member of staff involved in a medication error requires an update on medicines management they should be directed to the elearning module.

22 Action to be taken by a member of staff in the event of a medication error or near miss

22.1 Assess the patient's condition, take any necessary action to maintain patient stability and report the error to the medical staff as soon as possible. Document actions in the patient's health care record.

22.2 Complete a datix online incident form.

22.3 Report error to nurse in charge/ consultant or educational supervisor (for doctors in training).

22.4 In the case of a dispensing error inform the pharmacy department, quarantine medication and arrange return to the dispensary.

23 Action to be taken by Nurse in Charge/ Consultant/ Educational Supervisor

23.1 Investigate the incident in line with the Trust policy on Adverse Incidents.

23.2 A systematic review of the root cause of the incident should be carried out involving those staff involved.

23.3 Complete the risk matrix on datix for scoring the incident and complete and sign off online datix.

24 Actions for specific staff groups

24.1 Midwives must discuss and reflect on the drug error with their Supervisor of Midwives. Where there are concerns regarding the practice a supervisory investigation will be carried out.

24.2 Consultants are accountable for the investigation of prescribing errors made by trainee medical staff and non-medical prescribers treating their patients. The consultant should also inform the appropriate educational supervisor or line manager in order to ensure that reflection and learning takes place. Clinical directors are accountable for investigating prescribing errors made by consultants.

25 Learning from Medication Incidents

25.1 Lessons learnt in relation to the practice of particular individuals and teams are shared with the individuals and teams concerned.

25.2 The following standard reporting approaches are used to share lessons across the Trust by the pharmacy department.

Information Shared	Report	Circulated to

Issue relating to a significant risk that requires action across teams.	Safety Alert/ Pharmacy Bulletin	Circulation as agreed depending on issue
Issue of general relevance to teams across the Trust.	Learning from incidents flyer.	All staff
Medication Incident Trends/Themes	Excel Report	Medicines Safety Team
Local trend reports	Trend Reports	CAG
MHRA alerts	MHRA bulletin	As appropriate
Annual Medication Storage Audit	Report	CAG Directors of Nursing

26 Cytotoxic Drugs

26.1 These drugs must only be administered by a doctor or nurse accredited in their administration. (Refer to the Pan London Guidelines for the Safe Prescribing, Handling and Administration of Systemic Anti Cancer Treatment Drugs, 2011).

27 Oxygen

27.1 Oxygen must be prescribed on the patient's drug chart. Appropriate target oxygen saturation should be specified (or if no target is required this should be stated), flow rate and oxygen delivery system/device to reach and maintain the prescribed oxygen saturation.

28 Mixing of Medicines

28.1 Medicines should not normally be mixed together as this creates a new unlicensed product e.g. Y site intravenous connection lines, nebulisers and syringe pumps.

28.2 For information on mixing palliative care drugs in syringe drivers refer to the subcutaneous monographs (see BH fileshare)

28.3 Medicines should only be mixed together for the purposes of administering them to meet the needs of a particular patient.

28.4 Prescribers must ensure that clear and unambiguous directions are available in writing for the person who will undertake preparation and administration.

28.5 Where the use of a mixture is not accordance with usual practice or policy, further advice should be sought from medicines information.

28.6 If the person administering is in any doubt about mixing or to see if there is an alternative commercial available preparation advice should be sought from pharmacy.

29 Community Health Services

29.1 Where medicines are issued to nursing staff for use in the community, these medicines become the responsibility of the person to whom they are issued.

29.2 All medicines carried by the nurse should be prescribed as a specific dose for a named patient by a doctor/non medical prescriber or covered by the terms of a PGD under which the nurse may supply or administer the medicine.

29.3 Each prescribed medicine carried should be accompanied by the written prescription or copy of this, or a letter of authorisation from the patient.

29.4 The issue of all medicines from base stocks should be recorded in a record held at the base.

29.5 The nurse should record administration, along with a note off all medications refused, wasted or returned to stock.

29.6 Where it is necessary for a nurse to keep medicines in their control overnight, they should be placed in a secure lockable fixture. If necessary, this should be provided by the Trust. Medicines must not be kept overnight in a car.

29.7 Medicines in a patient's own home obtained on a prescription from authorised prescribers are the patient's property. When no longer needed, the patient should be advised to return them to a local pharmacy for destruction.

30 Medication No Longer Required

30.1 Medicines that are issued for specific patients that are no longer to be administered for whatever reason should normally be returned pharmacy for disposal. Local SOPs for the disposal of medicines should take account of the environmental protection regulations.

30.2 All out of date medicines can be destroyed on the ward by placing in the appropriately yellow bin with the correct coloured lid, general medicine waste should be disposed off in a yellow bin with a blue lid. Cytotoxic and cytostatic waste should be disposed off in a yellow bin with a purple lid.

30.3 Controlled drugs must always be returned to pharmacy for destruction.

30.4 Any stock no longer required should be returned to pharmacy, they will assess the suitability for reuse or it will be destroyed.

30.5 A dose which is prepared for administration but not used must be disposed of in the appropriately coloured waste bin (see point 30.2). The medicine must not be returned to its original container.

30.6 Wards should retain discharge medication for patients who leave hospital before they are ready for 48 hours, then return them to pharmacy if the patient does not return to collect them. The medication can remain longer on the ward if the patient has a prearranged collection time.

Appendix 1: Duties and Responsibilities

All staff working in the Trust	To adhere to the policy and to work within their professional regulatory bodies standards for practice
Managers	To ensure that all staff are aware of the policy, its contents and that staff within the area are working within the policy framework.
Other posts	Accountable officer to be notified of Controlled Drugs issues where a local solution cannot be resolved.
Committees	Medicines Safety Team to have oversight of all medication incidents, trends and variances and escalate as appropriate. To escalate unresolved issues or areas of concern to Drugs and Therapeutics Committee
Committees	Drugs and Therapeutics Committee to have overarching responsibility for the storage and control of medication in the Trust. To report and escalate concerns to Trust Board.

APPENDIX 2: Monitoring the effectiveness of this policy

Issue being monitored	**Monitoring method**	**Responsibility**	**Frequency**	**Reviewed by and actions arising followed up by**
Adherence to Storage Requirements	Audit of Clinical Areas	Medicines Safety Team/ Ward Sisters/Charge Nurses	Annually	Medicines Safety Team Quality and Safety Committee

Medication Incidents	Datix	Site Based Medication Governance Teams	Monthly	Medicines Safety Team
NPSA Alerts	Ad-hoc Audits	CAG Governance Teams	Ad-hoc when required	CAG Boards
Prescribing Audit	Audit	Pharmacy	Annually	Drugs and Therapeutics Committee

Appendix 3: Change Log

Change Log – Medicines Management Policy		
Substantive changes since previous version	**Reason for Change**	**Author & Group(s) approving change(s)**
Inaugural Barts Health Medicines Management Policy		

Appendix 4 – Impact assessments

Equalities impact checklist

MedicinesManagement Equality Analysis T

Organizational impact checklist

Organisational Impact Medicines Man

Appendix 5 – Additional guidance and information

Standards for Medicines Management, Nursing Midwifery Council, (April 2010) London

Standards of Conduct Ethics and Performance, General Pharmaceutical Council (July 2010) London

Good Medical Practice, General Medical Council (2013), London

Standards and Ethics Guidance for Doctors, General Medical Council (2013) London

The Safe and Secure Handling of Medicines (Revised Duthie Report), (2005) the Pharmaceutical Society of Great Britain, London

Appendix 6

RESTRICTIONS TO MEDICINES THAT CAN BE PRESCRIBED BY AUTHORISED PRESCRIBERS

Can the prescriber carry out the following activity?	**FY1**	**FY2**	**SpR**	**Consultant**	**Non Medical Prescriber (see Appendix …. for additional information)**
Outpatient prescribing	No	Yes	Yes	Yes	Yes-if included in agreed scope/CMP
FP10 prescriptions	No	Yes	Yes	Yes	Yes-if included in agreed scope/CMP
Cytotoxics for non cancer conditions- *see Trust Cytotoxic Policy use must be approved by the Trust*	No	No	Yes	Yes	Yes-if included in agreed scope/CMP
Cytotoxics for cancer-*see Trust Cytotoxic Policy*	No	No	Yes if received training and accredited by Trust via cancer services	Yes if received training and accredited by Trust via cancer services	Yes if received training and accredited by Trust via cancer services, and in agreed scope/CMP
Intrathecal cytotoxics	No	No	Yes-Named doctors working in Cancer Services who are registered with the trust as having attended training	Yes-Named doctors working in Cancer Services who are registered with the trust as having attended training	No
Prescriptions for self /family-*must be prescribed by an authorised colleague*	No	No	No	No	No

on trust letterhead					
Initiation of selected named drugs, (inc unlicensed and expanded access programs)	Restrictions apply to some drugs/indications for use –see Trust formulary/ New Drugs Group section on Pharmacy intra-net site for details				
Initiation of clinical trial drugs	No	No	Yes if named prescriber in trial protocol	Yes if named prescriber in trial protocol	Yes if named prescriber in trial protocol & in agreed scope/CMP

No= Not permitted to prescribe-restriction applies) Yes= Can prescribe-restriction does not apply

Appendix 7

Pharmacy Deptartment checking suitability of returns for reuse

1. Dispensed items from an outside source/supplier (for example a retail pharmacy) should always be disposed of as we cannot guarantee correct storage conditions have been maintained
2. Used liquids, eye drops, eye ointments, creams and ointments should be disposed of
3. Empty glass bottles that are intact should be placed in a strong cardboard box and labelled as "Glass". These are collected through general domestic waste stream
4. Dispose of any expired drugs
5. Drugs fit for purpose, but with short expiries should be distributed free of charge to major users were this is possible.
6. ALL TTA packs need to be expiry checked by a senior technician, before being returned to stock.
7. Using "item inquire" application check item is held in stock in MDU, for those drugs NOT held at MDU they should be sent to a Pharmacy location that does hold the item as stock
8. Using a permanent black marker pen or label, cover any patient details to ensure patient confidentiality. This applies to both items for disposal and to be returned
9. Use program to return items on the Pharmacy system before putting stock in correct locations