South London and Maudsley NHS
NHS Foundation Trust

TRUST MEDICINES MANAGEMENT POLICY

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Responsible Committee:	Trust Executive
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Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
1	October 2005	N/A	N/A	D. Taylor
2	March 2008	Required full review and new NHSLA Standards	Major	D. Taylor
3	February 2010	New NHSLA Standards	Major	D. Taylor
4	June 2012	Required full review and new NHSLA Standards	Major	D. Taylor

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes Made as a Result of Consultation
CAG Clinical Directors & Heads of Nursing	Entire review process via email	
Standards Team	06.03.12	Development of monitoring section and cross reference to associated documents
Trust Executive	20.06.12	Minor amendments to monitoring table

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
Nurses, Doctors, Pharmacists and Pharmacy staff, Clinical staff, Audit staff	Publication to the Trust Policies Intranet site and announcement on SLAM e-News	Electronic	Head of Pharmacy

Contents

1. Introduction

This Medicines Management Policy has been developed over the period 2002-2005. Originally a **Core Medicines Policy** was developed and approved by the Trust Policy Making Committee in 2003. Amendments and additions were made and the updated policy with supplements was approved by the trust in July 2005. The **Non-Medical Prescribing Policy** was separately approved by the trust (Policy Making Committee and Governance Executive) in November 2004. In September 2005 these two policies were combined (with minor further additions) to form this **Medicines Management Policy**. **The standard operating procedures for Controlled Drugs** were approved by the Governance Executive in May 2007 and are included in this policy. This policy is required by numerous NHS directives, including the NHS Litigation Authority standards.

This updated Medicines Management Policy supersedes the old Medicines Management Policy (2010)

Medicines Management Committee (MMC)

The trust has a Medicines Management Committee whose Chair is the director of pharmacy and secretary is the deputy director of pharmacy. The Committee has representation from different professional groups across the trust. The Committee meets every 3 months and is accountable to the trust board. See appendix 1 for the Committee's Terms of reference and membership.

2. Definitions

For the purpose of this policy and local policies throughout SLaM, the definitions are:

- **Administer/Administration** - To give a medicine by either introduction into the body, (e.g. orally or by injection) or by external application (e.g. cream or ointment). This includes removal of medication from labelled packaging for patient to take.
- **BNF** - The British National Formulary.
- **Carer** - A person who assists a client/patient in personal care, whether paid or unpaid, and may or may not be related to the client/patient.
- **Client/patient/service user** - A person receiving services from the trust.
- **Clinical Unit** – A trust clinical facility eg, ward, clinic, resource centre, day centre, community mental health team, Home Treatment Team
- **Clinician** – person with responsibility to provide a clinical service to a patient e.g. doctor, nurse, pharmacist and key worker.
- **CPN** - Community Psychiatric Nurse/Community Mental Health Nurse.
- **Dispensing of medication** - Medication is prepared by pharmacy staff for a named patient according to a legal prescription which has been clinically screened by a pharmacist.
- **Homely remedies** - An agreed list of medicines which give symptomatic relief and may be administered without individual prescription at the patients request for an agreed time limit or a specified number of doses. Staff must ensure that there are no existing factors which contra-indicate the use of the medicine.
- **Issue/supply of medication** - To provide patient (or carer) with medicines which have been dispensed for the individual patient and labelled with full instructions for self administration, or to supply medicines to a clinical unit as stock or non-stock items. Note: this is not the same as administration. See above
- **Medication** - Any medicines or drugs prescribed for the purpose of treatment or prevention of any condition or disease or illness, including herbal treatments, homeopathic medicines, over-the-counter medicines, vaccines and homely remedies.

- **Off-label use** - Unlicensed use of licensed medicines**.** See appendix 11 for the trust unlicensed medicines policy.
- **Pharmacy** - Departments providing a service to clients of the trust.
- **Prescribe** - To authorise in writing the supply or administration of a medicine.
- **Prescription chart** - The chart or form used to prescribe medication. May also be known as a prescription form, medication chart or drug chart.
- **Qualified nurse** - A registered nurse currently registered with the NMC and holding a current PIN.
- **Self-administration** - See appendix 9 for the trust self-administration policy.
- **Supervised administration** - Where staff observe self administration.
- **Supply/issue of medication** - To provide medication labelled with patient details and directions for use or to provide unlabelled medication in the manufacturer's original containers for a ward or clinical unit
- **Team leader** - The responsible person in charge of a service area, ward or department. The title actually used may differ in individual areas.
- **The Trust** - South London and Maudsley Foundation NHS Trust.
- **Unlicensed Medicines** - Drugs without a formal Product Licence or used beyond recognised indications.
- **Ward manager** - The person in charge of a service area, ward or department. The title actually used may differ in individual areas.

3. Purpose and Scope of the Policy

Purpose of the Policy

- This document forms the overall Medicines Management Policy for South London and Maudsley NHS Foundation Trust.
- This policy provides the basis for any local medicines policies for individual service areas.
- This policy will be reviewed every 2 years and revised as necessary by the Medicines Management Committee in consultation with all relevant parties.
- It is the responsibility of all managers employed by the trust to ensure that staff in their services know how to access the policy and that staff are familiar with the parts of the policy which covers their practice.
- All staff must ensure that, having read and understood the policy they are in a position to work in accordance with the policy.
- Any failure to adhere to this policy, if it is deemed to have been health- or life-threatening, jeopardised safety or had other serious consequences, may lead to enquiries and, if necessary, to disciplinary action.
- Specific monitoring requirements are detailed throughout the text of this policy. Adherence to this policy will be subject to regular audit.
- The aim of the policy is to ensure that the medicines management process is safe and secure and complies with clinical governance and legal requirements.

Objectives of the policy are to:

- To define procedures and set standards for the medication process based on current legislation and professional standards.
- To direct where possible to the appropriate policy for specific or local issues.
- To take into account the needs of service users.
- To define the responsibilities of all staff involved in the medication process working within South London and Maudsley Foundation NHS Trust, whether employed directly or indirectly.

Scope of this policy

This policy covers all aspects relating to the procurement, dispensing, prescribing, administration and destruction of medicines in the trust. The policy also includes the trust's non-medical prescribing policy, self-administration policy and the standard operating procedures for controlled drugs.

Targeted audience
All staff who have any involvement with medicines use in the trust
Audit staff

Targeted patient/client/user group
This policy is relevant to all service users who are prescribed medicines.

4. Roles and Responsibilities

4.1 The Chief Executive and Trust Board

The Chief Executive and Trust Board will bear ultimate responsibility for this policy and will authorise implementation of the Medicines Management Policy and appendices into the working arrangements of the Trust. They will maintain an overview of significant risks via the Medicines Management, Drug and Therapeutics, and Clinical Risk Committees and by monitoring the trust Assurance Log.

4.2 Accountable Officer

The medical director is the designated Accountable Officer who will have overall responsibility for all aspects of the safe and secure management of Controlled Drugs.

4.3 Director of Pharmacy

The Director of Pharmacy has statutory responsibility as superintendent pharmacist under the Medicines Act 1968. He is responsible for Medicines Management throughout the Trust on behalf of the Chief Executive.

4.4 Deputy Director of Pharmacy

The Deputy Director of Pharmacy will hold the master copies of the Medicines Management Policy and will be responsible for ensuring the accuracy of content and will act as a source of information for enquiries related to the policy content.

Members of Pharmacy staff will promote use of the Medicines Management Policy in Pharmacy and in relevant clinical areas.

4.5 Executive Directors and CAG leads

Executive directors and CAG leads will ensure that the medicines management Policy and its appendices are implemented throughout their divisions with the aim of minimising risks associated with medicines use.

4.6 Clinical directors and heads of nursing

Clinical directors, heads of nursing and service managers will ensure the policy is implemented to achieve its aims

4.7 Team leaders

Team leaders will ensure staff are aware of how to access the policy and ensure day-to-day adherence to the policy.

4.8 Clinical staff

All clinical staff will ensure they are familiar with all relevant sections of the medicines management policy and its appendices and will follow the correct procedure when undertaking any medicine-related task.

All clinical staff involved in the daily use of medicines must attend mandatory medicines management training as described in the trust's mandatory training needs analysis policy.

All clinical staff health professionals involved in the daily use of medicines are expected to act in accordance with their professional standards and codes of conduct with respect to medicines use.

4.9 Education and training department

The trust education and training department will advise CAG leads of the training requirements in relation to this policy. Records of attendees will be collated by the trust E&T department.

4.10 Role of professions in relation to this policy

a) The role of the pharmacist

See minimum clinical standards (appendix 22)

- To ensure that medication received by all patients is safe, effective and appropriate.
- To ensure that a supply of the correct medicine is available for the right patient at the right time.
- To ensure that all prescriptions are complete, clear, unambiguous and safe and appropriate for the patient.
- To ensure allergy status of the patient is documented on the prescription before any medication is supplied
- To review patient medication on in-patient units and in Home Treatment Teams at least once a week
- To review medication in community teams every 3 to 6 months.
- To provide patients and healthcare staff with medicines information.
- To provide training for other health care professionals.
- To work at all times in a professional manner, following procedures and acting in the best interests of service users e.g. by following the Royal Pharmaceutical Society of Great Britain Medicines, Ethics and Practice – A Guide for Pharmacists.
- To ensure that safe and secure systems for the handling of medicines are established and followed.

b) The role of the nurse

- To practice within the NMC Code of Conduct and Standards for Medicines Management
- Qualified nurses to complete mandatory training and undertake the competency assessment relevant to clinical area
- To administer medicines to the patient
- To be aware of the patient's allergy status and co-morbidities before administration of medicines
- To issue medicines to the patients
- To observe the clinical effects (benefits and side effects) of medication in the patient

- To have an up-to-date knowledge of the drugs s/he administers including route, dose range, indications, contraindications and side effects.
- To provide information on medication to patients and their carers. Nurses should be able to reinforce information about medication given to patients by medical staff.
- If the nurse is in any doubt s/he should consult an up-to-date reference source, e.g. Prescribing Guidelines, formulary, BNF, or a colleague or pharmacist for clarification prior to making a judgement about administration. If any doubt remains the nurse should contact the prescriber.

c) The role of social workers, occupational therapists, psychologists and support workers (see appropriate supplements)

- To issue (see definition above) medication to patients and their carers. The role of these occupational groups in relation to medication concerns the issuing of dispensed medication to clients, for self-administration by the client. To support this role the staff involved must be familiar with the trust policy and local procedures for issuing medication to clients. Staff should have received training and feel confident to perform this duty.
- Support workers in care homes may administer or support the service user to self administer medication only in strict accordance with trust and local policy. (See appendix 15 for the Medicines Management in (non-nursing) registered Care Homes and Supported Housing) The medicines may only be administered to the person that they were intended for and in accordance with the directions specified by the prescriber. The medicines must have been dispensed by a pharmacy for that individual patient and the label must include the specified directions for use. Staff performing this duty must have received formal training and obtained a proficiency certificate. A proficiency certificate is only valid for administration of medication in that specified home/project Service.

5. Course of Action Required

Ongoing actions in relation to this policy are outlined in the annual Medicines Management Report and programme and the Chief Executive's Performance Management Reviews.

6. Consultation

This is an update of the original formally agreed policy developed by the Medicines Management Committee. A full consultation process has been undertaken including the trust Nursing, Medical, Pharmacy and Clinical risk directorates.

7. Prescribing

7.1 Who can prescribe in the trust?

- Registered medical practitioners employed by the trust, which could include GPs employed via SLA
- Healthcare professionals employed by the trust who are approved as independent or dependent (supplementary) prescribers.
- Legal responsibility for a prescription lies with the practitioner signing that prescription.

7.2 The role of the prescriber

- Before prescribing, to determine (and document in ePJS and on the prescription where necessary)

  - the patient's allergy status. To note any drug allergies or sensitivities and make a record on the front of each prescription chart and on the front of the patient's notes and in ePJS
  - the patient's history of adherence with prescribed medication.
  - the patient's regular prescription before admission/transfer

- To select and prescribe medication according to the clinical needs of the patient, in line with local, regional and national guidance.
- To be satisfied that the prescription is appropriate for the individual patient. By signing the prescription the prescriber is taking legal responsibility for the prescription,
- To make a record in the patient's notes (Patient Journey System) when medication is started, changed or discontinued, giving reasons for the choice of treatment or change in treatment.
- To inform the patient and/or carer of the reason for the prescription, the expected outcome and length of treatment, possible side effects and what to do if they occur, and when medication will be reviewed.
- To review patient medication on in-patient and Home Treatment Teams at least once a week
- To review medication in community teams every 3 to 6 months.
- To monitor and document in ePJS the effects of treatment (clinical benefits and side effects, including physical health monitoring)
- To refer to GP when appropriate.
- To refer to specialist/acute services when appropriate.

7.3 Self prescribing and administration of medicines by staff (for personal use)

- Clinical staff are not permitted to take any medication for themselves or another person for whom it is not prescribed.
- Prescribers are not permitted to prescribe, using trust prescriptions or an FP10, any medication for themselves or another person who is not a SLAM patient. Staff requiring 'prescription only medicines' must see their GP.
- Staff requiring treatment for minor ailments must be referred to occupational health or purchase medicines from a local pharmacy.
- Medicines can only be supplied legally to patients with an NHS hospital number**.**

7.4 Prescription writing

In-patients

Prescriptions must be written on the trust in-patient chart. Supplementary prescriptions used must be attached to the in-patient chart. All medications, including any prescribed on supplementary charts, must be prescribed on the in-patient chart

Outpatients and community patients

Trust community prescriptions and FP10s (FP10HP, FP10SS and FP10 MDA) can be used

See appendix xx for details of the FP10 policy

Prescriptions must comply with legal and professional requirements as well as local regulations and guidelines.

- Prescriptions will be handwritten by the prescriber on a Trust approved prescription pro-forma, or in an electronic format on a Trust approved computerised prescribing system.
- If prescriptions are not written legibly or legally, or are felt to be unsafe, they are referred back to the prescriber for clarification.
- Prescriptions may only be written for patients registered as patients with the trust
- Prescribers should follow local and national prescribing policies. These include NICE guidance and The Maudsley Prescribing Guidelines.
- All prescriptions for children should include the child's age and weight.
- Prescriptions for controlled drugs for supply to patients must comply with the legal requirements of the Misuse of Drugs Regulations 2001 and subsequent amendments.
- Investigational medicines, or medicines being used as part of a research study, may only be prescribed following approval of the clinical trial protocol by appropriate research and ethics committees.
- Research Ethics Committee and have Regulatory (MHRA) and R&D approval.

7.5 Prescription writing standards

- All medicines must be prescribed according to BNF guidelines and local prescription writing standards

Trust in-patient and community prescriptions must

- Be written legibly in ink and be indelible
- Be dated
- State the name and the hospital number (trust ID) of the patient
- Be signed in ink by the prescriber
- Include the patient’s date of birth
- Include the patient’s allergy status. It is the responsibility of the person signing a prescription to ensure that the patient’s allergy status is noted on the prescription.
- Include a valid start date

Medicines must be prescribed using the approved drug name. Brand names should not be used unless specific drug products are required

Abbreviations must not be used.

The drug dose and frequency must be stated as metric or international units.

7.6 Drug discontinuation

- When medicines are discontinued the prescription for that medicine should be cancelled by crossing it through with a single line.
- The prescription should not be obliterated in such a way that the original prescription cannot be read.
- The date and reason for stopping the medicine must be documented in the patient notes and on the inpatient drug chart.

7.7 Changes to prescription

- Once written a prescription must not be altered in any way. It must be discontinued and a new prescription written
- Correcting fluid e.g. Tippex must not be used on prescriptions
- Pharmacists may make amendments to prescriptions following discussion with the prescriber. The pharmacist should record on the prescription the name of the prescriber with whom the amendments have been agreed and details of the amendments. If such an amendment results in the drug being rewritten on the hospital inpatient chart the new prescription must countersigned by the prescriber
- Any additions or changes to prescribed medication must be entered in the patient's record (ePJS) under the medication section. Any discontinuation of medication must also be clearly documented.

7.8 Prescriptions on transfer between trust clinical units

- When patients are transferred between trust clinical units the existing prescription should be transferred with the patient and continue to be used.
- Medications should also be transferred

7.9 Destruction of old prescriptions

- A prescription should be cancelled by drawing a bold line diagonally across all pages of the chart The cancellation must be dated and signed in full by the prescriber.
- The old prescription should be scanned into the correspondence section of the patient's ePJS record. The paper copy should be shredded.

7.10 Allergy status determination and documentation

- Before prescribing any medication for a patient the prescriber must accurately determine the patient's allergy status.
- A note of any drug allergies or sensitivities must be made on the front of each prescription chart and in the alert section of ePJS. This must include the drug and the suspected/known reaction to the drug.
- The prescriber must ask the patient about any allergies, adverse reactions or sensitivities to any previously prescribed (or non-prescribed) medications as well as consult the patient's medical notes. It may be necessary to corroborate the information using other sources. See appendix 18 for the Medicines Reconciliation Policy.
- The prescriber must complete, sign and date the allergy section on the front of the prescription.
- The prescriber must record any allergies (or the absence of them) in the alert section of ePJS.
- The known absence of any allergies must be denoted by NKDA or No known drug allergies. The record must be signed and dated by the prescriber.
- Under no circumstances must the allergy section on the prescription be left blank. Pharmacy will not supply medication for a patient if the allergy section on the

patient's prescription is not filled in. Nursing staff should not administer medication unless the allergy section is completed.

- On discharge from or transfer to another service the patient's allergy status must be communicated to the onward team.

7.11 Medicines reconciliation

See appendix 20 for the trust medicines reconciliation policy

- When a patient is admitted to a trust service or transferred between trust services the prescriber must ensure that the patient's regular medication is not inadvertently omitted from or changed on the prescription. The patient (or their carer) must be asked for a list of medications (and doses) the patient was taking before admission to the service. In addition, the patient's notes must be consulted. Other sources of information include the patient's GP, community team and any other specialist services.
- The patient's allergy status must also be determined and documented on each admission. See above.

7.12 Medicines Adherence

- Before prescribing any medication the prescriber must determine the patient's previous history of adherence with prescribed medication and willingness to take current medication as prescribed.
- When choosing a medication above factors must be borne in mind.
- Patients must be involved, as far as is reasonable, in the choice of their medication.

7.13 Information for patients on prescribed medicines

- The patient should be informed of the following when medication is prescribed:
  - The reason for the medication choice
  - The aims of treatment
  - The likely duration of treatment (i.e. short or long term)
  - The commonly recognised adverse effects of treatment and who to contact if they experience any
  - Any serious adverse effects of which the patient should be aware
  - Monitoring requirements
- A summary of the conversation should be made in ePJS.
- The patient should be asked about any concerns they may have about currently prescribed medication (including any medications that are being considered).
- In addition, the patient should be given a Patient Information Leaflet for the medications prescribed. These are available from pharmacy or on the trust intranet.
- The patient should have the opportunity to speak to a pharmacist about prescribed medications within 2 weeks of starting a medication and thereafter.

7.14 Discharge or transfer from the service

- On discharge from or transfer to another service the following patient information must be communicated to the new service:
  - diagnosis
  - current medication
  - changes to medication whilst in the service (including any treatment stopped or started)
  - Intended treatment duration
  - Monitoring requirements
  - Any problems with adherence
  - Allergy status

- Statutory regulations regarding the prescriber, the medicine and the prescribing

7.15 Prescribing PRN (when necessary) medication

- All PRN prescriptions should be individualised in the same way that regular prescriptions are written for individual patients: there should be no routine PRN prescribing of any drugs.
- All PRN prescriptions should specify indication, dose (not a range of doses), frequency, maximum daily dose, a single route of administration and precise circumstances in which the drug is to be given.
- All PRN prescriptions should be reviewed at least once a week by the prescribing team. Any prescriptions for PRN antipsychotics should be time-limited, preferably to a week or less.
- The reason for administration must be clearly stated by the nurse administrating.

7.16 Prescribing and use of patients' own drugs (PODS)

On admission to an in-patient unit, patients are encouraged to bring with them any prescribed or non-prescribed medication that they take whilst in the community. Please refer to appendix 2 for more information

a) PODs may be used whilst the patient is an in-patient provided:

   - The medicine is prescribed on the in-patient medication chart.
   - It can be easily identified from the backing on the strip pack or markings on the tablet/capsule.
   - The medicine has not expired and appears to be in good condition.
   - Local policy requirements on PODs are satisfied.

b) If the medication is a Controlled Drug, it must be stored in the Controlled Drugs cupboard and appropriate records made in the Controlled Drugs register.
c) Medicines not appropriate for use on the in-patient unit must be removed from the ward as per PODS procedure.

7.17 Prescribing complementary medicines

- Complementary medicines are therapies that may be used in conjunction with orthodox medical, nursing and paramedical treatments to enhance patient well-being, quality of life and symptomatic relief. These may include herbal and homeopathic medicines as well as essential oils.
- If a patient is admitted to hospital and is already taking complementary therapies then these therapies should be brought to the attention of the multidisciplinary team and a decision taken as to whether these therapies should continue.
- The administration of any alternative/complementary substance (by ingestion or topical use) must follow this medicines policy, unless a specific approved policy for that particular therapy is available.
- The pharmacist should be asked to investigate whether there are any interactions or contra-indications with conventional medication, and whether the substances can be positively identified and assessed as suitable for use (see use of patients own drugs). If a substance cannot be identified, it may not be prescribed.
- Items that have been purchased by patients for their own use (i.e. items not obtained via a prescription) will not normally be supplied by the hospital pharmacy. If therapy is to continue then the patient remains responsible for the continuation of supply.
- All complementary medicines must be prescribed on the patient's medication chart and recorded according to usual policy.

- Generally speaking, pharmacy will not procure or supply complementary medicines. Limited supplies may be provided against a prescription in exceptional circumstances.

7.18 Prescribing medicines for use in clinical trials

See appendix 27

- All trials have a specifically designed prescription form. For in-patient trials an in-patient trust medication chart must also be used. The prescription must make clear that the medication is intended for clinical trial use.
- Medicines must be prescribed in the usual way in accordance with the Trust Medicines Management Policy.

7.19 Prescribing Controlled Drugs (CDs)

Please refer to appendix 3.
Prescriptions for controlled drugs for supply to patients must comply with the legal requirements of the Misuse of Drugs Regulations 2001 and subsequent amendments.

- CDs may be ordered on any trust prescription chart, an FP10HP or an FP10MDA.
- Prescriptions for CDs may be computer-generated or hand-written.
- The signature must be in the prescriber's own handwriting.
- The prescription must be dated. The prescription is valid for 28 days.
- The prescription must state the name and address (or hospital number/Trust ID) of the patient and the dose (and directions), form, strength and total quantity of the required CD. The total quantity of the CD to be supplied must be stated in words as well as figures. A total quantity need not be stated for CDs prescribed for administration to in-patients.
- A pharmacist may amend the prescription if it specifies the total quantity only in words or in figures or if it contains minor typographical errors. These changes need to be indelible and signed by the pharmacist.
- The supply quantity should not exceed 30 days. In exceptional circumstances where a supply of more than 30 days is necessary and not thought to pose a risk to the patient, the prescriber must make a note in the patient's medical records. The pharmacist must check that the prescriber intended the supply to be more than 30 days.
- Prescribing of CDs by non-medical prescribers (NMPs) – see appendix 4 for further details.

7.20 Prescription of unlicensed medicines or licensed medicines for unlicensed indications

See appendix 13 for the trust unlicensed medicines policy

- Unlicensed medicines have no product licence or UK marketing authorisation.
- Manufacturers have no liability for any harm resulting from the use of an unlicensed medicine.
- Only medical and dental practitioners can authorise the administration of unlicensed medicines

Licensed medicines may be prescribed for indications other than those listed in the medicines licence where there is acceptable evidence for the use of the medicine for the intended indication.

Prescribing unlicensed medicines or medicines outside the recommendations of their Marketing Authorisation increases the prescriber’s responsibility and potential liability.

The prescriber is responsible for the use of the medicine and any harm resulting from its unlicensed use.

The prescriber should be able to justify and be competent in using such medicines.

7.21 Process for ensuring the accuracy of prescription charts

It is the responsibility of all staff involved in the medicines process to ensure prescriptions are legible, legal and accurate prior to supplying or administering medicines.

Pharmacists review prescriptions for accuracy on regular ward visits, and before dispensing any medicines.

Where Trust approved pre-formatted prescriptions (e.g. clozapine prescription) are available to promote accurate prescribing these must be used.

8. Administration of Medicines in Clinical Areas

8.1 General principles

Medicines must only be administered in line with:

- A valid prescription written by a doctor or trust approved prescriber.
- An approved Patient Group Direction (PGD). The person administering the medicine must be approved to follow the PGD.
- Approved homely remedies list.

Note: A pharmacist or technician (band 5 or above) may take a verbal order for a prescription from the prescriber. The prescription must be written by the pharmacist or technician. The prescription must be annotated with VO and signed and dated by the pharmacist/technician. The name of the prescriber must also be noted on the prescription. The prescription must be signed at the earliest opportunity by the prescriber (except in the case of one-off outpatient prescriptions)

8.2 Who can administer medicines in the trust?

Medicines administration by any practitioner should be carried out in accordance with the Guidelines for the administration of medicines as published by the Nursing and Midwifery Council (NMC).

a) The administration of medicine by injection may only be carried out by:

- a medical or dental practitioner,
- a competent qualified nurse who has completed the trust competency assessment (see appendix 6 for competency assessment documents).
- support staff who have been trained to administer a specified medicine to a specified client.

b) Under normal circumstances, two qualified nurses should be involved in the administration of medicines. CPNs may administer depot injections alone.

- Student nurses should be given the opportunity to participate in the administration of oral as well as intra muscular and subcutaneous medicines by a supervising RN, who remains accountable for the student's practice.
- The student can act as the second checking person to the RN when administering generic medications. All medicine administration carried out by a student must be countersigned by the RN

Note
The qualified nurse who delegates this task to an unqualified colleague is responsible for ensuring that the individual has the skills and experience to complete the delegated tasks and that the qualified nurse delegating duties has the means to ensure that the delegated task has been completed appropriately.

c) In some clinical areas one qualified nurse may administer medicines after being assessed as per single nurse administration policy. The nomination of single nurse administration must be supported by the head of nursing of that particular clinical area.

d) Two qualified nurses must be involved in the administration of Controlled Drugs.

e) The manager of a service must ensure that staff carrying out the administration of medicines have received appropriate training.

f) The member of staff carrying out the administration of medicines must have been assessed by their manager or equivalent to be competent to do so.
g) Nurses in training may only participate in the administration of medicines under the direct supervision of a qualified nurse. (See appendix 7 for single nurse administration).

Under no circumstances must the medicine be given to an unqualified nurse to administer directly to the patient. If two trained nurses are jointly conducting the medication round, each is equally responsible and accountable for the medication administered.

8.3 Consent to treatment

Refer to the trust policy on consent to treatment

8.4 Aims of medicines administration

The aims of medicine administration are to ensure that:

- The right patient receives
- The right drugs and formulations
- In the right dose
- At the right time
- By the right route

Staff involved in medicines administration must ensure that they have sufficient knowledge of drug and patient to ensure these aims are achieved

8.5 Verbal messages

A verbal order to administer an un-prescribed medicine is not permitted other than in exceptional circumstances for the urgent and immediate treatment of a patient.

In exceptional circumstances changes in dose of existing prescriptions may be made by fax or e-mail message, followed by a new prescription within 24 hours of the original message.

8.6 Administration procedure

a) The accurate administration of medicines to patients remains the responsibility of the individual clinician administering. It is the responsibility of persons administering medicines to be familiar with the Medicines Management Policy.
b) Administration of medicines on behalf of the trust may take place in trust premises, in the client's home or other premises in which services are provided (schools, hostels etc).
c) Members of staff administering medicines must <u>always</u> check the following items prior to that administration.
    - Correct and legible completion of all details on the prescribing and recording chart.
    - The identity of the patient.
    - The name, form and strength of the medicine to be administered against the prescription chart.
    - The allergy status of the patient. Medication should not be administered until the allergy/drug sensitivity section of the prescription chart is completed.

- The validity of the prescription (check start and stop dates).
- The calculations of the correct dose to be administered.
- The time and frequency of the administration.
- The route of administration.
- Any special guidance relating to the dose offered, e.g. dilution with water, before or after food etc.
- The expiry date of the medicine.

d) If a label on a drug container is altered, damaged or obliterated in any way the container must be returned to the pharmacy.
e) The competent person administering or assisting with the administration of medicines must record on the prescribing and recording chart to indicate that the client has either received the due medication, or if not, the reason the dose has been omitted (e.g. refused, absent). Failure to do so may result in an administration error.
f) When making a record of administration the date line at the top of the medication chart should correspond with all the drugs on the chart.
g) It is recommended that oral syringes be used to measure small volumes of liquids.

8.7 Identification of the patient

- Patients must be positively identified prior to administering any medicines.
- Clinical staff must confirm the identity of the patient by asking the patient their name. If the patient is unable or not willing to give their name another staff member should confirm their identity.
- Medications must not be taken out their original package until the patient's identity has been confirmed and the patient is ready to take the medications.
- No drugs may be administered to a patient who cannot be positively identified.

8.8 Administering PRN (when necessary) medication

Medications prescribed on the 'prn' section of the medication chart are administered at the discretion of clinical staff. Two registered Nurses are required for administration of 'prn' medication

- Before administering any dose of 'prn medication' the RN must check that the maximum dose has not been exceeded
- After administration the RN must record on the prescription, for each 'prn' dose of medication administered, the indication, and the dose and route of administration.
- PRN medication must be reviewed at least once a week

Note: When calculating maximum dose allowance, a 24 hour period should be considered a continuous time period and not the beginning and end of a calendar day.

8.9 Administration of CDs to patients on the ward/unit/clinic

- Registered nurses and doctors may administer CDs to a patient. Two people must be involved in the administration.
- When a dose is administered to a patient, the patient's name must be entered in the CD register, together with the amount administered.
- The administered amount must be subtracted from the running balance and the new balance recorded. A margin of up to 2.5% (under or over) of the original volume may be allowed for liquids.
- Extreme care must be taken when measuring volumes of concentrated potent liquids (e.g. methadone 10mg/ml). Always read-off volumes from the bottom of the meniscus at eye-level to avoid parallax errors. It is recommended that an oral syringe with a bottle stopper (obtainable from Pharmacy or Supplies) be used to measure small volumes (less than 5ml).

8.10 Self administration of medicines by in-patients

See appendix 9 for details

8.11 Self administration of CDs by patients

- CDs for self administration by patients should be labelled with directions for use.
- A record of administration must be made in a CD register.
- Patients receiving CDs for self administration should sign for receipt of a specified number of doses.
- On the ward CDs for self administration must be stored in a non-portable locked metal receptacle next to the patient's bed or the ward CD cupboard.

8.12 Covert administration

See appendix 16 for the trust covert administration policy

8.13 Other administrations

- See appendix 8 for administration of medicines without a prescription (Homely remedies).
- See the relevant appendix for any local policies on administration.

8.14 Administration of medicines under a patient group direction (PGD)

See appendix 17 for the trust PGD policy

- A Trust approved PGD can act as a direction to a practitioner, authorised to operate under that PGD, to administer medicines to patients following assessment of that patient's need
- Administration of a medicine under a patient group direction must be documented in the patient's medical record and/or on their inpatient drug chart
- The authority to administer a medicine under a patient group direction cannot be delegated to another health care practitioner

8.15 Recording the medicine administered or omitted

- A record of all medicine administration must be made at the time of administration.
- The record must include the signature of the person administering the medicine
- Medication that is not given due to refusal, wastage, lack of availability or any other reason must be recorded on the drug chart or in the patient's notes. The reason for omission must also be noted.
- The omission must be reported to the prescriber so that alternative treatments may be considered.
- Where a second practitioner checks the administration of a medicine, the identity of the checking practitioner should also be recorded; however the ultimate responsibility remains with the administering nurse.

8.16 Omission of critical medicines

Critical medicines are those which must never be unintentionally omitted or delayed. They include anticonvulsant medications and insulins. Administration must occur within 2 hours of the prescribed time of dose, unless otherwise stated.

Below is a table of critical medicines commonly used in SLaM. The list is not exhaustive.

Drug name or class
Systemic antimicrobials (including antibiotics, antifungals, antivirals and antimalarials) within the first 48 hours of therapy
Antipsychotics
Mood stabilisers
Antidepressants
Antiretrovirals
Insulin
Oral hypoglycaemic agents
Glucose/glucagon
Opiates prescribed regularly for the management of severe chronic pain. Includes regular oral therapy, parenteral therapy and transdermal therapy
Naloxone
Corticosteroids
Anticoagulants (therapeutic)
Anticoagulants (thromboprophylaxis)
Antiepileptic agents
Anti-Parkinsonian agents
Benzodiazepines and parenteral vitamins for the management of acute alcohol withdrawal syndromes
Oxygen

8.17 Hazardous substances

Certain medicinal substances have specific handling requirements for example, wearing gloves. Clinical staff must check with pharmacy when handling a medicine with which they are previously unfamiliar or unsure of handling requirements.

Pregnant staff must not handle hazardous substances.

Clinical staff must follow any specific guidance issued by the manufacturer for handling individual drugs.

9. Ordering Medicines from Pharmacy

9.1 General principles

- Medication is ordered from the local hospital pharmacy department or community pharmacies. Orders must be in the form of a permanent record, and any requisition book or order sheet must be kept in a secure place.
- Medicines may not be obtained directly from companies or company representatives.
- Community and outpatients should be assessed regularly for suitability of obtaining medication from their GP.

9.2 Pharmacy opening hours and out-of-hours services

See appendix 5 for details on obtaining medicines out-of-hours.

- Pharmacy opening times differ according to hospital site; contact your local pharmacy department for details.
- Outside normal working hours either the on-call or resident pharmacist may be contacted (via the hospital switchboard) to arrange the supply of any **urgently** required items or advice. See appendix 5 for further information.
- The Duty Nurse (Emergency Team Leader) may be contacted for access to out-of-hours cupboards.

9.3 Prescriptions used for ordering medicines

a) In-patient prescriptions

- Medicines must be labelled with the patient's details and medication name, form, strength quantity, batch number and expiry.

b) Community prescriptions/repeat out-patient prescriptions/Out-patient prescriptions

- Medicines must be labelled with the patient's details, drug name, strength, form and directions for use i.e. not 'as directed'.
- Prescriptions must be dispensed at trust hospital pharmacy departments.
- SLAM Community Prescriptions are valid for up to 6 months of repeat dispensings. Prescriptions must be reviewed and re-written every 6 months.

c) FP10HPs/FP10SS/FP10MDA

- FP10HP - forms are blank green prescription forms. Prescribers must handwrite these prescriptions.
- FP10SS forms are individual blank green prescription forms intended to be used with the PJS FP10 printing system.
- FP10MDA – Addictions prescription for dispensing in instalments

Some community/outpatients may receive an FP10 prescription which they can take to a community pharmacy for dispensing.

- Prescribers must ensure that the prescriptions are stamped/pre-printed with the appropriate unit/cost code.
- Medicines must be labelled with the patient's details, drug name, strength, form and directions for use.
- FP10 prescriptions should be used whenever appropriate.
- FP10 prescriptions are not usually dispensed by the trust pharmacies.

9.4 Ordering stock/Community clinic stock/Temporary stock items

- Stock items are commonly prescribed medicines that are kept on the ward/clinic/team whether or not they are currently in use.
- Community clinic stock items will usually consist of depot antipsychotic injections and procyclidine injection. Certain other medicines may be held as stock (preferably in the form of pre-packs) for emergency situations. All other medication should be dispensed for individual patients.
- The list of drugs that comprise "ward/clinic/team stock" will vary from one ward to another. This list will be agreed between the team manager and pharmacy and will be reviewed regularly (at least every 6 months) to accommodate changes in prescribing patterns.
- Stock items are regularly replenished by pharmacy.
- If an item of stock needs replacing before the next scheduled visit, it can be ordered from the pharmacy department.
- 'Blue' Emergency boxes are supplied automatically from pharmacy when the current box expires. If however, the box is opened in between those times it is the responsibility of the ward to contact pharmacy for a replacement box. There must be a box on the ward at all times.

  Note: procedures on Lewisham and Guy's and St Thomas's sites may vary

9.5 Ordering individual patient items (non-stock) for in-patients/out-patients and community patients

- Individual patient medicines (non-stock) must be prescribed by an approved trust prescriber on an appropriate trust prescription (e.g. out-patient/community/in-patient) or FP10HP.
- Individual patient medicines are supplied for the sole use of the patient whose name appears on the label.
- Out-patient and community prescriptions must also be labelled with the directions for use.
- A pharmacy technician will visit the ward regularly to replenish individual in-patient items.
- If any item needs replacing before the next scheduled visit or a new drug is prescribed (which is not ward stock) it can be obtained by sending the prescription chart to pharmacy.
- Clozapine is always supplied as an individual patient item as all patients who receive this drug must be registered with the clozapine patient monitoring service. Clozapine must never be administered to a patient whose name is not on the label without prior discussion with pharmacy.

  For off-site locations, prescription charts may be faxed to pharmacy unless a Pharmacy top-up service is provided. Contact local pharmacy departments to confirm whether this arrangement is in place. The prescription must be faxed each time a medicine is ordered.

9.6 Ordering take-away medicines for leave or discharge (TTAs)

- Leave and discharge medication must be labelled with the patient's details and directions for use.
- All discharge medication should be prescribed on the appropriate prescription form.

9.7 Planned leave or discharge

- TTAs should be ordered from pharmacy at least one day before the planned leave or discharge.

9.8 Unplanned leave or discharge

- Nursing staff must not dispense medication from ward supplies under any circumstances.

During Pharmacy opening hours:

- A prescription should be written and sent immediately to pharmacy.
- The discharged patient may only deliver and collect their own prescription from the pharmacy if prior agreement has been reached between ward staff and pharmacy.
- In all cases, no special priority can be given to the dispensing of TTAs for discharged patients. All patients sent to pharmacy must be informed that they will have to wait in turn for their prescription to be dispensed. An estimate of the waiting time can be obtained by contacting pharmacy first.

Outside Pharmacy opening hours:

- The duty doctor can be contacted and a TTA or discharge prescription written. The patient can present this prescription to Pharmacy when it is next open. The on-call pharmacist should **not** be contacted to dispense TTA medication.
- If it is not possible or inconvenient for the patient to return to the hospital pharmacy an FP10 (where available) for the TTA or discharge medication can be given to the patient. This can be dispensed at a retail pharmacy at the patient's convenience.
- If the patient requires TTAs or discharge medication immediately, the duty doctor may dispense labelled medication from the out-of-hours cupboard or ward (where available), or pre-packs (where available) against a valid prescription. Medication must be dispensed using boxes and labels provided in the out-of-hours cupboard.

9.9 Ordering Controlled drugs (CDs) from pharmacy

Note: procedures may differ on the Guy's and St Thomas' and Lewisham sites*:*

9.10 CDs for administration to patients on the ward/unit or in community clinics

- CDs should be ordered as 'stock' or 'temporary stock' not for individual patients.
- CDs must be ordered in the ward CD order book supplied for the purpose. Patients' prescription charts must also be sent to Pharmacy.
- The order must state the name, strength, form and quantity of the drug required.
- The order must be dated and signed (with a print of the name in block capitals) by an authorised nurse from the ward/unit/clinic/dept. The person signing the order must have previously supplied pharmacy with a sample signature. It is the responsibility of the ward/unit/clinic to supply pharmacy with up- to- date signatures. Orders signed by an "unknown" qualified nurse will not be supplied. The patient's prescription must also be sent to pharmacy.
- A pharmacist may amend the order on the request of the person ordering the CD. The pharmacist must sign and print their name on the order page.
- A duplicate of the order must be made in the order book, using the carbon paper provided. This duplicate must be retained (and be available for inspection) by the ward for two years.
- Any member of staff may deliver a CD order book to Pharmacy.

9.11 CDs for patients in community teams/TTAs or outpatients

- The prescription must be sent to pharmacy. The CD does not need to be ordered in the CD book in this case.

9.12 Ordering medicines for Clinical trial use

All medicines for use in clinical trials must be ordered from Pharmacy. Any alternative arrangement must be agreed with the Chief Pharmacist.

10. Receiving Medicines in Clinical Areas

10.1 General principles

- All medicines will be delivered from pharmacy in a sealed bag or locked box. Alternatively, an appropriate, clinical member of staff may collect medication in person from Pharmacy.
- Systems should be in place to record the receipt of all medicines on the ward/team base.
- All medicines should be checked against the requisition. Any discrepancy between the order and the delivery should be reported to the pharmacy as soon as possible.
- All medicines must be stored appropriately (see below) immediately (or as soon as is reasonably possible) after receipt.

10.2 Receiving Controlled Drugs (CDs) (see appendix 3)

Note: procedures may differ on the Guy's and St Thomas' and Lewisham sites

Collection of CDs from pharmacy

- If a CD is prescribed as a TTA or for a patient in a community team (i.e. the CD is labelled with directions for use), it may be collected by the person for whom it is prescribed. Alternatively, it may be collected by a carer with written permission from the patient.
- In all other cases, the CD must be collected from pharmacy by a qualified nurse (permanent or agency). Appropriate photo identification must be supplied (e.g. trust ID badge).
- Before leaving pharmacy, the nurse must check the supplied CD against the CD order or prescription.
- The collecting nurse must sign in the case of stock items, the section in the ward CD order book marked "accepted for delivery" and in the case of CDs dispensed for the patient, the CD register in pharmacy.
- Carers collecting CDs on behalf of a patient must sign the CD collection book.
- The top copy of a CD order will be kept by pharmacy.
- Copies of CD orders and the CD collection book must be retained (and be available for inspection) in pharmacy for at least 2 years.
- In the case of a TTA, community or out-patient prescription, a photocopy of the prescription should be kept by pharmacy. Copies should be retained in pharmacy for at least 2 years.

Receipt of CDs on the ward

- On receipt of CDs on the ward, two qualified nurses (one permanent) must check that the drugs received correspond to the order in the CD order book and sign the section marked "Received by".
- The CDs must be stored in the CD cupboard as soon as they are received on the ward.
- Details of the CD must immediately be entered into the ward CD register. Each CD must be entered under the name, form and strength of the drug provided.
- The requisition number must be recorded when entering the drug into the register.
- All entries into the CD register must be witnessed and countersigned by another registered nurse.
- Each strength and form of a CD preparation must be recorded on a separate page.
- For tablets and injections: If the balance of the CD is nil, simply enter the amount received into the balance column. However, if there is already an amount stated in the balance column, add the new amount to the outstanding balance to give a new overall total. The total should be expressed in numbers of tablets/capsules/ injections.

- For liquids only – A new page must be started for each requisition number/receipt (except on the Lewisham wards). The received volume must not be added to any existing volume in the register. The total volume must be expressed in millilitres not number of bottles.

11. Storage and Security of Medicines in Clinical Areas

11.1 General principles

- The overall responsibility for establishing and maintaining a system for the secure storage of medicines in a clinical unit lies with the manager of that unit or a designated deputy, in consultation with the senior pharmacist and appropriate medical staff. If the manager is not a nurse the responsibility must be devolved to the most senior nurse in the unit.
- The team manager/senior nurse is responsible for control of access to medication and medication keys and therefore has responsibility for ensuring that the system is followed and that the security of medicines in the clinical unit is maintained.
- In clinical areas without a team manager/senior nurse individual clinicians bear the responsibility.
- The pharmacist must ensure that there is a secure method of supply storage and disposal of medication in place. The pharmacist must report any failure to comply with the medicines management policy to the team manager/senior nurse.

11.2 Storage of medicines in clinical areas

- All medicines in clinical areas must be stored in a locked medicines cupboard or refrigerator approved for this purpose or a locked medicines trolley (or equivalent) attached to a wall (which may be removed from its fixings during medicine rounds).
- Medicines cupboards must be in a locked room with controlled access. Authorised staff are responsible for ensuring secure storage of medicines and keys. Cupboards must not be visible from external windows and should not display a red light or other obvious indication as to their content.
- Medicines should be stored at temperatures below 25 degrees Celsius.
- Fridge and clinic room temperatures should be monitored daily to ensure they are at the required temperatures. It is the responsibility of the unit manager to ensure that medicines are stored at the recommended temperatures.
- If the fridge or room temperatures are found to be outside those recommended the Works department must be contacted to report the problem. Pharmacy should be contacted for advice on medication storage
- Resuscitation drugs are the only exception to this rule. They should be stored inside a locked clinical room but not a locked cupboard within the clinical room. This ensures ease of access in an emergency situation.
- Medicines for external use must be stored separately from internal liquids, tablets and injections.

11.3 Keys

- The keys to the medicine trolley, medicine cupboards and bedside medicine lockers are the responsibility of the RN in charge of the shift/unit
- The keys to the individual bedside medicine lockers may be delegated to patients where they are part of an approved self-administration scheme.
- When the ward has CDs in stock the keys to the Controlled Drug cupboard must be kept on a separate key ring from the other medicine cupboard and be held by a second Registered Nurse. The main medication keys remain the responsibility of the designated registered Nurse in Charge.
- Health Care Assistants /Student Nurses must not hold any keys.

11.4 Borrowing and lending medicines between wards/departments

- Medicines must not be borrowed/lent between wards/departments during normal pharmacy opening hours other than in exceptional cases after authorisation by Pharmacy.
- If a non-stock medicine is required outside normal pharmacy hours the out of hours pharmacist should be contacted according to local policy.
- If a stock medicine is required outside normal pharmacy hours it may be borrowed from another ward that has the item as stock after agreement with the on-call pharmacist and the nurse in charge of the ward required to lend the drug
- The ward lending any medicine should inform pharmacy at the earliest opportunity.
- The ward pharmacist will note this and charge/credit the borrowing/lending ward as appropriate
- The borrowing ward should not replenish stock directly to the lending ward unless instructed to do so

11.5 Reporting the loss of medicine

- The person discovering a loss shall notify immediately:

  a) The appropriate ward/department manager via the Nurse in charge.
  b) The Ward Pharmacist or On-call pharmacist if out of hours

- After consultation together, the Nurse in Charge shall report the loss, in writing, to Ward Manager/Team Leader, the Head of Nursing and the Chief Pharmacist. A DATIX report should be completed.
- The Head of Nursing will inform the police where necessary.

11.6 Reporting the loss of the medicines cupboard keys

- If a Health Care Professional leaves the hospital with medicines keys it is their responsibility to return the keys to the ward/department immediately.
- If the key cannot be traced the nurse in charge concerned shall be informed immediately of the loss.
- After every effort has been made to find the key or have it returned the Nurse in Charge will obtain a duplicate key by contacting the Clinical Site Manager/Emergency Team Leader (refer to trust site procedures)
- If a duplicate is not available arrange for the cupboard to be broken open by Estates in the presence of a Registered Nurse and for a new lock to be fitted.
- A new set of duplicate keys must be given to the Clinical Site Manager for storage. A new lock must be fitted whenever a lost key cannot be found, regardless of whether a duplicate key is available.
- If a key to a Patient's Own Drug locker (POD locker) goes missing do not break the locker open or replace the lock. Pharmacy will arrange for the key or lock to be replaced. Spare POD locker keys should be kept in a locked cupboard on the ward. The key to this cupboard should be kept on main bunch and held by Nurse in Charge

11.7 Storage of Controlled Drugs in clinical areas

See appendix 3

- Controlled drugs must be stored in a separate Controlled Drugs Cabinet that complies with the Misuse of Drugs (Safe Custody) Regulations 1973
- If the ward has CD stock the keys must be kept on the possession of a registered nurse on a separate key ring from the other medicines keys.
- Controlled drug balance
- A running balance of controlled drugs must be maintained in the CD record book.
- The Controlled Drugs balance should be checked at least every 24 hours

- The balance check must be carried out by a Registered Nurse and witnessed by another Health Care Professional, both of whom should record the check on the assigned page of the Controlled Drug record book

Any discrepancies in the running balance should be reported to pharmacy

11.8 Storage of clinical trials medication in clinical areas

- All unlabelled stocks of medicines for use in a clinical trial must be stored in Pharmacy.
- Only medicines dispensed and labelled for individual patients may be stored in clinical areas outside Pharmacy.
- All medicines in clinical areas must be stored in a locked cupboard, fridge, or equivalent, in accordance with the trust Medicines Management Policy.

12. Dispensing and Supply of Medicines by Pharmacy

12.1 Dispensing and supply

12.2 Definition of dispensing

- Dispensing involves the supply of a medicine for administration to a patient in accordance with the prescriber's written instructions.
- Dispensing includes such activities as checking the validity of the prescription, checking the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient.

12.3 Who may dispense or supply

- Pharmacy is responsible for the dispensing/supply of all medicines used within the Trust except where there is an approved procedure in place for practitioners to issue pre-labelled medicines which have been supplied by Pharmacy for this purpose, or medicines which have previously been supplied by a pharmacy for that patient's use (e.g. patients' own drugs)
- Medicines must not be repackaged or 'dispensed' from ward or department stock cupboards other than by pharmacy staff as part of an approved procedure
- Nurses may issue medicines which have been supplied by a pharmacist to a patient against a signed discharge prescription which has been clinically confirmed by a pharmacist.
- The nurse issuing the medicines must ensure that the patient is supplied all items currently prescribed for the patient, and that they are accurately labelled, or confirm with the patient that they have correctly labelled supplies of currently prescribed medicines at home.
- For guidance on the supply of controlled drugs dispensed to patients as discharge medication refer to the Controlled Drug Policy.
- When the pharmacy is closed, duty doctors can dispense medicines using bottles, boxes and labels supplied by pharmacy in the out-of-hours cupboard.

12.4 Dispensed medicines

- Dispensed medicines are medicines that have been supplied and labelled for named patients against an individual patient prescription or patient specific direction. See stock medicines below.
- Patients may be inpatients, outpatients, community patients or patients being discharged from hospital.

12.5 Labelling of dispensed medicines

- All dispensed items must be labelled in accordance with the requirements of the Medicines Regulations 1994 (and amendments)
- Labels must be typewritten or computer-generated
- No amendments may be made to printed labels (other than completion of labels where required on certain pre-packed medicines).

12.6 Stock medicines

- Stock items are medicines supplied for use in a specific unit which are not labelled for individual patient use.
- Stock medicines are supplied to wards/ departments for use in patients being treated in that clinical area.

- Stock medicines are usually medicines frequently used within that clinical area or medicines which may need to be accessed in an emergency.
- The list of stock medicines held in a ward/ department should be decided by the pharmacist in consultation with medical staff and the Nurse in Charge.
- The amount of stock medicines held in a ward/department will be determined by usage patterns and reviewed at regular intervals.

12.7 Pre-packed medicines

- Pre-packed medicines are supplied as pre-labelled packs of agreed numbers of doses, labelled with standard dosing instructions.
- The patient's name and date of issue are completed when the medicine is issued to the patient.
- All medicines issued to patients must be recorded. The records must be available for audit purposes.
- No medicines may be added to or removed from pre-packed medicine containers.

12.8 Patient information leaflets

- All medicines supplied to patients for self administration in hospital or after discharge must include a patient information leaflet.

12.9 Supply of Controlled Drugs from pharmacy (see appendix 3)

Note: procedures may differ on the Guy's and St Thomas' and Lewisham sites

- The CD may be dispensed by a pharmacist (or pre-registration pharmacist under supervision) or a band 5 (and above) technician. The dispensed CD must be final checked by two people (either a pharmacist or technician but not the same person who dispensed it). A pharmacist must be involved in at least one stage of the process.
- When dispensing a CD, the following details must be recorded in the CD register:
  - either the name of the ward (for stock) or the patient's name (for TTA)
  - the CD requisition number from the order book (for stock) and the name of the nurse ordering the CD or the prescribing doctor (for TTA)
  - the CD name, form and strength
  - the quantity issued
  - the entry must be signed and dated
  - A record of who collected the CD and whether ID was requested and seen
- The stock balance must be checked and recorded in the register on each dispensing. The two people involved in the dispensing and checking must do this. Any discrepancy must be accounted for and clearly documented in the CD book.

12.10 Supply of medicines under a patient group direction (PGD)

See appendix 17 for the trust PGD policy

- A Trust approved PGD can act as a direction to a practitioner, authorised to operate under that PGD, to supply medicines to patients following assessment of that patient's need.
- Under a PGD medicines must be supplied to the patient by the practitioner who assessed the patient for that treatment.
- Supply of medicines under a PGD may not be delegated to another member of staff.

12.11 Supply of clinical trials medication from Pharmacy
See appendix 23 for clinical trials policy

- All clinical trial medication must be dispensed by Pharmacy.
- The medication must be labelled for use in accordance with the clinical trial protocol and the trust Medicines Management Policy.
- All relevant paperwork must be completed and kept in Pharmacy.

13. Disposal of Medicines in Clinical Areas

13.1 Disposal of medicines

- All out-of-date medication or medication that is no longer required should be returned to pharmacy. When patients are discharged all medication for that patient should be returned to pharmacy. All medicines no longer needed on the wards should be disposed of in pharmabins provided on the wards. The wards must ensure that these bins are collected directly from them. Please refer to the trust Healthcare Waste Policy for further guidance.
- Non-pharmaceutical waste e.g. sharps, empty bottles should not be returned to Pharmacy.
- Illicit drugs are not covered by this policy.

13.2 Disposal of Controlled Drugs in clinical areas (see appendix 3)

Note: procedures may differ on the Guy's and St Thomas's and Lewisham sites

Return to pharmacy

- If a CD has expired or is no longer needed (e.g. patient discharged, medication changed) the pharmacy must be contacted to arrange for the CD to be removed from the ward.
- CDs must be checked by a pharmacist on the ward before being returned to pharmacy.
- The pharmacist must sign the CD out of the ward CD register with a registered nurse acting as witness and deliver it to pharmacy. A record must be made in the ward CD register of the date, reason for return, name, strength, form and quantity removed.
- The balance must be adjusted accordingly in the ward CD book.
- CDs should not be returned to pharmacy by any ward staff or via porters.
- CDs which are not fit for re-use must be destroyed in pharmacy using the DOOP kit. Destruction must be witnessed by a pharmacist or a technician (band 5 or above).

13.3 Disposal of clinical trials medication in clinical areas

- Any unused medicines must be returned to pharmacy (not destroyed in clinical areas).

13.4 Hazardous substances

Please refer to the trust Healthcare Waste Policy.

14. Issuing Medicines to Patients and Their Carers

See appendix 3 for Controlled Drugs.

14.1 Definition

The delivery or handing over of medicine in person to a client or carer that is for self-administration by the client. The medication must have been dispensed by the pharmacy department, as a TTA (To Take Away) or outpatient medication, and clearly labelled with the client's details and instructions on how the individual client should take or use the medicine.

14.2 Who can issue medicines to patients and their carers?

All trust staff, employed in a clinical role, are authorised to issue medication to individual clients. The issue of medication is part of the overall care of the client and each clinician has a responsibility to ensure that prescribed medication is dispensed and issued to their clients correctly and appropriately, and that accurate records are maintained. The CMHT/ward/team manager/senior nurse will determine local procedures for the issue of medication.

14.3 Responsibility

- The pharmacist is professionally responsible for ensuring that the medication dispensed for an individual client is correct and corresponds to the prescription.
- Medication will be dispensed by the hospital pharmacy against a valid prescription. The medication will be clearly labelled with the name of the client, the name, strength and form of the medicine, the quantity dispensed, the date of dispensing and instructions for use.
- Medication must always be issued in person to the client/carer except in pre-arranged exceptional circumstances.
- The medication must always be issued to the client in the original container as supplied by the pharmacy. The label must not be altered in any way and the medication must not be tampered with or transferred into any other container e.g. envelopes. The only exception to this is when it is necessary to transfer medication dispensed for an individual client into a compliance aid, and it is not possible for the pharmacy to fill the aid. In these circumstances a registered nurse may fill the aid following the SLAM Policy and Guidelines for Medication Compliance Aids. See appendix 10.
- The member of staff who hands out the medication to the client has a responsibility to ensure that the medication corresponds with the current prescription (i.e. that there have been no changes to the prescription since the medication was dispensed).
- The client should have the opportunity to ask any questions about their medication. The clinical worker may be able to answer these questions directly or may refer to another clinician.
- All clinical workers have a duty to acquaint themselves with the medicines that are prescribed for their clients. This is possible by attending training sessions, through discussions with colleagues and by reading current guidelines and literature e.g. British National Formulary, Patient Information Leaflets etc.
- Individual client risk must be assessed before determining the supply quantity of medication at any one time.

  Before issuing medication, staff should feel confident and able to do so. Where there is any doubt staff are expected to approach their team manager/colleagues for advice and assistance.

14.4 Documentation

- A system should be in place to record the issue of medication dispensed for individual clients. The issue of medication to the client should be recorded on the community prescription chart and a record made in the client's notes.
- A system should in place for recording/indicating when the next supply of medication is required.
- Details of any advice sought or given must be recorded in the patients notes (ePJS), including the names of the persons involved.

14.5 Issuing procedure

- Special care should be taken to confirm the identity of the client, e.g. by asking them to state their date of birth.
- The person issuing the medication should select the medication from the cupboard, taking care to ensure that the medication dispensed for that individual client is selected. Take extra care when there are clients with similar names.
- The person issuing the medication must check that the timing of the issue is in line with the instructions on the prescription chart. The client should not be given more than one instalment at a time or at intervals different from those directed, unless otherwise agreed by the prescriber or team leader/senior nurse.
- If an interval has lapsed when medication has not been collected and the client has been without medication during this time then clinical advice from the prescriber and/or pharmacy must be sought as to whether it is appropriate to issue the medication.
- The person issuing the medication must check the medication against the prescription. They must confirm that no changes have been made to the prescription since the medication was dispensed, and that the prescription is still valid. If there are any discrepancies between the prescription and the medication supplied, the member of staff must contact the pharmacy before handing out the medication.
- The person issuing the medication should ensure that the client/carer understands the following:-
    - the name of the medicine and the dosage.
    - the purpose of the medication.
    - the route, frequency and intended duration of use .
    - the correct use of special dosage forms and administration devices e.g. inhalers.
    - the actions to be taken in the event of a missed dose.
    - instructions on the storage of the medicine
    - advice on possible side effects and interactions (including OTC medicines) and what to do if they do occur.
    - how to obtain further supplies.
    - how to obtain further information.
- In addition, the person issuing the medication should check that the client/carer can read the label and open the container and measure the dose required. If they cannot, alternative arrangements should be made with the pharmacist, e.g. non-child proof tops, compliance aids etc.
- It is the prescriber's responsibility to ensure that the client/carer is informed about their medication at the time of prescribing.
- Staff have a duty to withhold the medication where there are any concerns that the administration of the medicines may lead to harm to the client e.g. hypersensitivity reaction, serious adverse reaction, pregnancy, risk of overdose. This must be discussed with the client's RMO or designated doctor immediately.
- The issue of medication to an individual client must be recorded immediately on the prescription chart and/or in the client's case notes.

14.6 Provision of medicines information to patients and carers

- Pharmacy will supply the manufacturer's Patient Information Leaflets (PILs) with dispensed medication. If the amount of medication supplied is less than that in the manufacturer's original pack, the pharmacist will ensure that a PIL is supplied the first time a medication is dispensed, and then at least once a month.
- The United Kingdom Psychiatric Pharmacy Group (UKPPG) Patient information leaflets provide information to supplement the manufacturer's information. These can be obtained from pharmacy or can be printed from the trust Intranet
- It is the key worker's responsibility to ensure that the client has access to information about medication.
- The client may ask to speak to a mental health pharmacist about their medication.

15. Ordering, Storage and Supply of Controlled Stationery (CD registers, CD requisition books, FP10HPs and FP10MDAs

15.1 Storage of Controlled Drugs (CD) registers and requisition books

- CD registers and CD requisition books for supply to wards/units/dept must be kept in a locked cupboard in pharmacy.
- CD registers and CD order books on wards/unit/dept must be kept in a locked cupboard.
- Only one CD order book must be in use per ward/unit/dept at any one time.
- The CD order book and CD register must be retained on the ward/unit/dept (and be available for inspection) for at least 2 years from the last entry.

15.2 Ordering CD registers and requisition books from Pharmacy

Procedures may differ on the Guy's and St Thomas's and Lewisham sites

- CD stationery may be ordered from pharmacy by a permanent qualified nurse using the CD order book.
- The date of issue must be recorded on the front of CD stationery supplied by pharmacy.
- CD stationery may be collected from pharmacy by a permanent qualified nurse.
- The following details must be recorded in the CD stationery issue book in pharmacy: date of issue, ward/unit/dept, name of person ordering and collecting and the type and quantity of stationery issued. The entry must be signed by the pharmacy member issuing as well as the staff member collecting.

15.3 Unused, lost or stolen CD registers and CD requisition books

- Any unused stationery must be returned to pharmacy. An entry of return must be made in the CD stationery issue book.
- All loss or theft of CD stationery must be reported immediately to the Chief Pharmacist.

15.4 Ordering FP10HPs/ FP10MDAs/FP10SS (See appendix 18 for FP10SS Security Policy)

The security of prescriptions and associated stationery is the joint responsibility of the trust and the individual prescriber.

- FP10HP - forms are blank green prescription forms. Prescribers must handwrite these prescriptions
- FP10SS forms are individual blank green prescription forms intended to be used with the PJS FP10 printing system.
- FP10MDA – Addictions prescription for dispensing in instalments

15.5 Ordering FP10 forms

- All blank FP10 forms should be ordered from the Maudsley hospital pharmacy 020 3228 2808
- All FP10 forms should be ordered two weeks in advance to ensure stocks are available – the team business manager should ensure stocks are replenished as necessary.
- Requisitions for new pads must be written on trust headed paper.
- FP10s should be collected in person by a member of team staff carrying trust ID.
- On the Guy's site, prescriptions will be sent to the teams in sealed bags or locked boxes. The receipt form must be signed and sent back to the Pharmacy.

- Prescription identifier numbers must be recorded by pharmacy (the first and last numbers of each pad) for those being supplied. The person collecting the forms should check the numbers are correct and sign for the forms. Pharmacy must keep the signed record of all FP10s collected.
- FP10HPs will be pre-printed with the hospital unit and identifier code.

15.6 Storage and use of FP10 forms

- FP10s forms must not be taken home by prescribers.
- All FP10s must be stored in a locked cupboard or drawer when not is use.
- FP10SS are supplied in large boxes of 2000 prescriptions. The team stock of blank FP10SS forms must be kept in a locked cupboard by the team leader/administrator.
- The business manager should designate a member of the administration team as responsible for the security of the team's FP10s. Only this member of staff should have access to the prescriptions and should issue to prescribers as necessary.
- Each time FP10s are issued to a prescriber the first and last serial numbers of the prescriptions must be recorded and signed for. The prescriber will be asked to sign for all prescriptions issued to them, and should check the identification numbers they are signing for. These records must be kept by the administration team.
- Once issued, prescribers should keep their FP10s in a secure, locked cupboard or drawer, and ensure they request a new batch of prescriptions before they have used all of their blank forms.

15.7 Responsibility of the individual member of staff

Prescribers should

- Record the number of the first and last prescription received.
- Keep prescriptions locked in a cupboard or drawer when not in use.
- Mark and cross-through as 'void' any incorrect/void prescriptions and destroy in confidential waste.
- Follow the above procedure for ordering and maintaining your own stock of prescriptions.
- Prescribers should only use their own issued prescriptions.
- Keep **FP10HP** pads with them whilst out of the office.
- Consider only taking one or two FP10HP prescriptions out of the office.
- Record the number of each FP10HP prescription used and the date of use.
- Notify the manager if any prescriptions go missing and follow the procedure below
- Return all unused forms if leaving the employment of the team.

Prescribers should not

- Pre-sign blank prescription forms
- **Use the blank FP10SS forms to handwrite prescriptions** on (they will be rejected by the pharmacy as the prescriber address and identification details are not complete) Leave any FP10 forms unattended in an unlocked place.
- Use prescription forms not authorised for them.
- Leave an FP10HP prescription pad in a car.
- Have more than one FP10HP prescription pad in use at any one time.

15.8 Responsibility of the trust

- To provide secure, lockable storage for prescriptions.
- To ensure the provision of new prescriptions as required.
- To minimise the risk of fraud by keeping clear and up to date records of the serial numbers of prescriptions received and issued.
- To retrieve unused prescription pads from clinicians leaving the trust.
- To ensure the procedure for dealing with lost or stolen prescriptions is followed.

15.9 Lost, stolen or fraudulent prescriptions

- The unit manager and pharmacy manager must be informed immediately if prescription forms are known to be lost, stolen or used fraudulently.
- The incident must be reported on a trust incident form or on DATIX
- The unit managers must inform the relevant PCT (see below for details) and the police as soon as possible. Any instructions given by them should be followed appropriately. There is a national procedure in place for all community pharmacies to be informed of lost of stolen prescription pads.

Lambeth PCT	020 3049 4444
Southwark PCT	020 7525 0400
Lewisham PCT	020 7206 3200
Croydon PCT	020 8274 6000

16. Risk Management

16.1 Recording allergies and adverse drug reactions

See appendix 20 for the trust medicines reconciliation policy

It is the responsibility of the prescriber to accurately determine a patient's allergy status before prescribing any medication for that patient.

- All patients must be asked specifically for any history of drug allergies or hypersensitivities and previous adverse drug reactions on admission. These should be clearly documented in the medical notes and medication chart. All notations must be signed and dated by the prescribers.
- Where no allergies, hypersensitivities or adverse reactions are reported by the patient the patient record and prescription must be annotated with NKDA or no known drug allergies. Prescribers must sign and date all notations to this effect.
- Under no circumstances must the allergy section on the prescription be left blank
- On discharge all allergies must be included on any relevant discharge liaison forms.
- If a patient experiences an adverse drug reaction, the prescribing doctor or pharmacist or nurse should complete a yellow card (if appropriate) and send it to the Medicines and Healthcare Regulatory Agency (MHRA). Yellow cards can be found at the back of the BNF or the MHRA website www.mhra.gov.uk.
- Training in adverse event reporting must be included in induction programmes for all staff involved in medicines management.

16.2 Medicines reconciliation

See Appendix 20 for Medicines Reconciliation Policy.

16.3 Error reporting

See appendix 21 for guidance on the reporting of medication errors
It is the responsibility of all clinical staff to report any medication incidents.

All medication errors relating to the administration, prescribing and supply and disposal of medicines should be reported electronically on DATIX.

- Any serious error (i.e. health or life threatening) or potentially serious error (near miss) related to any aspect of medicine use must be brought to the attention of the immediate manager(s) and the relevant practitioners at the earliest opportunity.
- A DATIX incident form must be completed for all medication errors. The drug name, dose, strength and route of administration must be included in the report. The medical practitioner will decide upon the appropriate course of medical action (if any) and the immediate supervisor/service manager will decide upon the appropriate course of action in relation to the staff concerned.
- Minor errors must be reported to the immediate manager who will decide on the relevant action.
- Prescribing errors identified by other staff members should be brought to the attention of the prescriber and department manager.
- All prescribing errors (resulting in administration to the patient or not) must be reported on DATIX incident form. The prescriber and their manager must be made aware of the error.
- A DATIX incident form should be completed for all errors leaving the pharmacy.
- Errors in the supply of medicines must be reported to the pharmacy as soon as possible, but certainly within two working days, (within three working days at weekends and bank holidays). Out of hours - contact the on call pharmacist if necessary.

Learning from medication errors

- Medication errors will be monitored by medication error group every 3 months.
- A summary of the errors is sent to CAG clinical leads.
- Pharmacy produce an error bulletin once every 6 months with examples of trust reported errors and recommendations on minimising risk
- The trust Patient Safety Department will report all medication errors to the National Patient Safety Agency.
- Information on medication errors is shared with the Medicines Management Committee and partners across the interface.

16.4 Defective pharmaceutical products

- A defective pharmaceutical product is one which is unfit for use. This includes all products supplied by the pharmacy (tablets, mixtures, injections, dressings, etc.), whether manufactured commercially or by the hospital, and which are faulty by reason of manufacture, storage or handling.
- Defects noted **before a medicine is administered** must be reported immediately to the pharmacy (out-of-hours to the resident or on-call pharmacist contacted via the hospital switchboard) and fresh supplies obtained.
- Defects noted **after a medicine has been administered** must be reported immediately to:
  - the doctor
  - the pharmacist (on-call or resident pharmacist out of hours)
  - the operational manager/senior nurse
- If appropriate the pharmacist will initiate the notification process. **All products and equipment associated with the defective product must be retained for investigation**.
- If the defective product has been administered to a patient, record the manufacturer's name, the batch number and expiry date of the product in the patient's notes.
- Pharmacy will arrange collection of the defective product. **Do not send to pharmacy via ward boxes**.

16.5 Recall of defective pharmaceutical products

Hospitals are required to comply with notification procedures when pharmaceuticals products are found to be defective. The pharmacist in charge will arrange for the recall of any product that has been notified to them as being defective.

17. New Drugs, Clinical Trials and Unlicensed Medicines

17.1 Introduction of new drugs in the trust

See appendix 12 for new drug request form

- The trust Drug and Therapeutics Committee (DTC) will consider the place in therapy of any relevant new products and report its decision to the relevant PCT forum and to the trust board for ratification. The secretary of the DTC will disseminate information to relevant parties.
- The pharmacy will not purchase any new product until its place in therapy has been assessed by the Drugs and Therapeutics Committee.
- Medical representatives are not permitted to promote in the trust the use of any product that has not been approved by the DTC. See appendix 11 for the Medical representatives policy.

17.2 Drugs and Therapeutics Committee

The SLaM Drug and Therapeutics Committee meets every three months and is accountable to the trust board. The committee has a chair and the secretary is the Chief Pharmacist. The terms of reference are as follows:
See appendix 12 for the Committee's Terms of reference.

The DTC minutes and associated documents are available on the trust intranet.

17.3 Clinical Trials

- All trials must have the approval of the Research Ethics Committee R&D approval and regulatory (MHRA) approval

All clinical trials must have a protocol outlining medicines use.

17.4 Unlicensed medicines and off label uses of licensed medicines

See appendix 13 for the Unlicensed Medicines policy

- A list of trust approved unlicensed medicines and unlicensed uses of licensed medicines is contained in the unlicensed medicines policy.
- Medicines may be added to this list by application to the Drugs and Therapeutics Committee.

18. Local Policies

Local procedures may be developed which adhere to the principles of this policy but take into account differences in service provision/needs in local areas. Policies for local services not covered by this policy must be prepared in accordance with SLAM guidelines for clinical policies and be approved by the Medicines Management or Drug and Therapeutics Committees.

19. Dissemination, Implementation, Training and Monitoring of the Policy

Dissemination and implementation of the Policy

This is an update of previous policy and will replace the existing policy on the trust intranet once ratified. Implementation of the policy will be monitored through the Medicines Management Committee, Drug and Therapeutics Committee and the Chief Executive Performance review.

Training

All clinical staff on induction will be informed of the policy and how to access it. It is the responsibility of the individual and their line manager to ensure that they are familiar with the policy and competent to work within the framework of the policy.

Responsibility of clinical staff

All trust employees involved in any aspect of the use of medicines in the trust are responsible for ensuring that they comply with this policy.

Monitoring Compliance

What will be monitored i.e. measurable policy objective	**Method of Monitoring**	**Monitoring frequency**	**Position responsible for performing the monitoring/ performing co-ordinating**	**Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result**
a) how medicines are prescribed	Prescribing skills course for junior doctors (every 6 months on all training sites) *(new)* e-learning packages	Records of attendance and evaluation forms	Secretary of Medicines Management Committee	Medicines management committee
b) how the organisation makes sure that all prescription charts are accurate* *(addresses requirement (a) as well)*	'Snap-shot' audit of prescription charts on wards/HTTs and community teams to check that the necessary information is completed. Audit by ward managers Quarterly audit by Pharmacy of	Quarterly data analysis	Compliance team / Audit team	Medicines management committee

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
	prescriptions presented in pharmacy to ensure that necessary information is completed.			
c) how the side effects of prescribed medication are monitored	Audit of patients' notes (ePJS) for presence of a statement about assessment/management of side effects Annual POMH audit of monitoring of side effects in patients prescribed depots in the community	Annual	Performance team Secretary to Medicines Management Committee	Medicines management committee Medicines management committee
d) how the organisation learns from medication errors	Medication error group / annual medicines management report for trust board	Quarterly meeting Annual report	Secretary to Medicines Management Committee	Medicines management committee
e) how medication is administered, including patient identification	Nurse competency assessments Medicines management training e-learning packages	As recommended	Heads of Nursing Secretary to Medicines Management Committee Trust Education and Training Lead	Medicines management committee

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
	Medication errors	As recommended	Director of Patient Safety	
f) patient self-administration	Ongoing monitoring of pilot	TBC	TBC	TBC
g) how a patient's medicines are managed on handover between care settings	Managed by the Discharge and Transfer Policy	See Discharge and Transfer Policy	See Discharge and Transfer Policy	See Discharge and Transfer Policy
h) how drugs are disposed of safely	Managed by Management of Waste (including Clinical Waste) Policy	See Management of Waste (including Clinical Waste) Policy	See Management of Waste (including Clinical Waste) Policy	See Management of Waste (including Clinical Waste) Policy
i) how the organisation monitors compliance with all of the above.	Annual Report Quarterly medicines management meetings at CEO PMR At CAG clinical governance meetings See all of above	quarterly	CAG heads of nursing CAG clinical directors Deputy Director of pharmacy	Drug and therapeutics committee Trust Exec (Clinical Exec)

20. Associated Documentation

Medicines Management Annual Report
Medicines Management Committee Minutes,
Drugs and Therapeutics Committee minutes
Medicines Reconciliation
http://www.nice.org.uk/nicemedia/pdf/PSG001Guidance.pdf

Medicines Adherence
http://www.nice.org.uk/nicemedia/pdf/CG76FullGuideline.pdf

Clinical Waste Policy
Consent to Care and Treatment Policy
CPA Policy
Discharge and Transfer Policy
Mandatory Training Policy

21. References

The NMC 'Guidelines for the Administration of Medicines (2004)'

The NMC 'Code of Professional Conduct (2002)'

The Medicines Act (1968)

The 'Duthie Report' (2005)

Misuse of Drugs Act (1971)

NHSLA risk management standards for Mental Health and Learning Disability Trusts

Building a safer NHS for patients: improving medication safety (2004)

Healthcare Commission: Talking about Medicines (2007)

22. Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

APPENDIX 1

MEDICINES MANAGEMENT COMMITTEE – TERMS OF REFERENCE

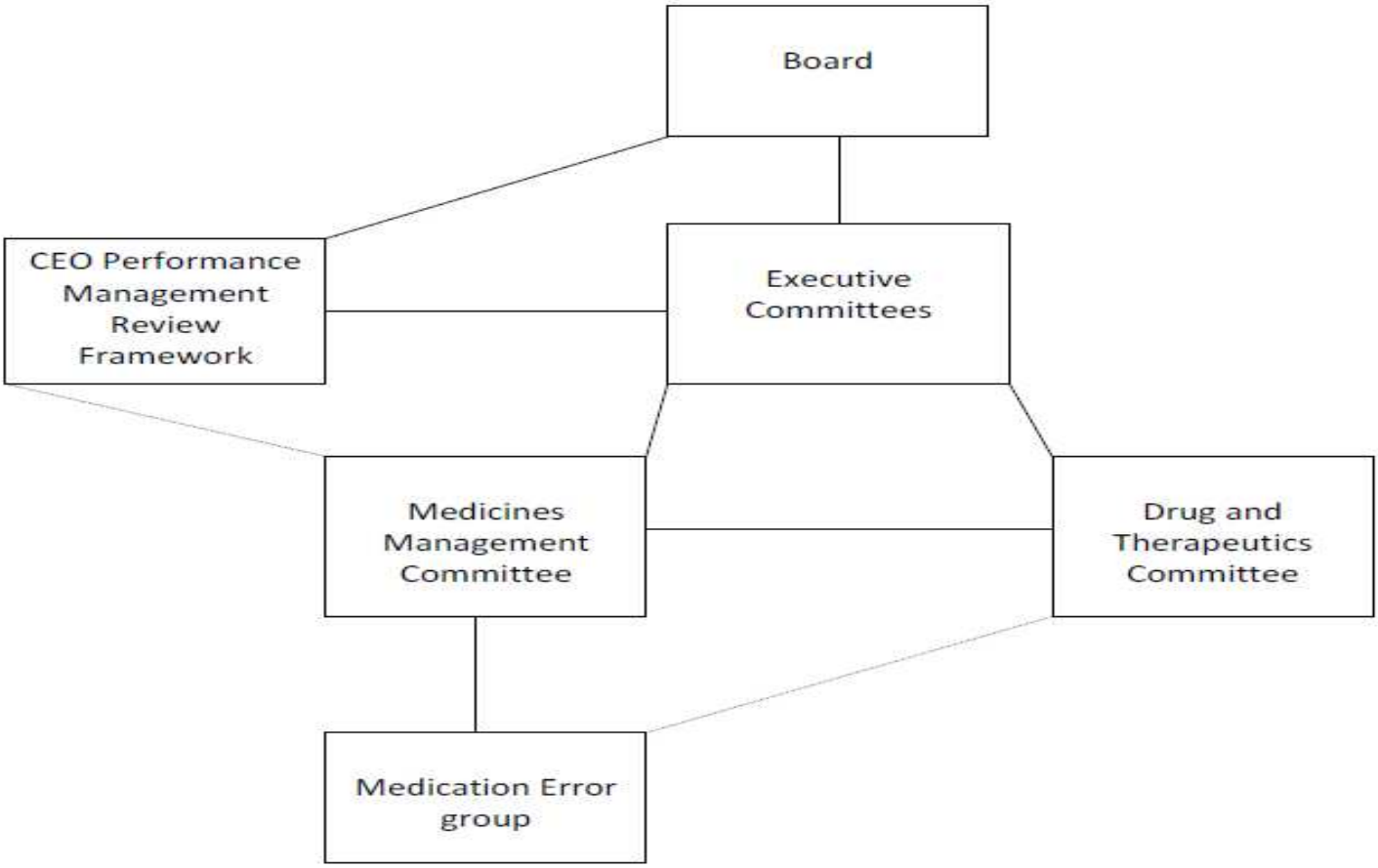
South London and Maudsley NHS Foundation Trust

Medicines Management Committee

Terms of Reference (updated February 2009)

- **To manage the trust Medicines Management Policy**
  - to update annually the trust Medicines Management Policy
  - to approve new or amended medicines management procedures or policies for inclusion in the trust Medicines Management Policy
  - to monitor adherence to the trust Medicines Management Policy
  - to inform individual services/directorates of non-adherence to the policy
- **To devise and manage the trust medicines management programme**
  - to update annually the trust medicines management programme
  - to monitor progress of the trust medicines management programme
  - to inform individual services/directorates of non-adherence to the programme
  -
- **To review trust-wide medication incidents (reported on trust SUI forms and DATIX)**
  - to feedback to individual services/directorates any themes of medication errors
  - based on analysis of the errors to make any necessary recommendations to the Governance Executive, Education and Training or the Service Quality Executive
- **To produce a quarterly Medicines Management Bulletin for the trust**
- **To liaise with the trust Patient Safety department**
- **To provide information for the directorate and corporate risk registers**

Relationship to other committees



APPENDIX 2

PATIENTS' OWN DRUGS (PODs)

1.1 Procedure on Admission

Consent should be obtained from patients or carers before medication can be assessed or destroyed. This can be obtained verbally and then documented on the additional information section of the inpatient drug charts or by pharmacy on medicines reconciliation forms.

During normal pharmacy opening hours the pharmacy should be contacted for staff to assess PODs. They will either go to the ward to check the PODs or ask for the medication and chart to be sent down for assessment.

When pharmacy is closed nursing staff can assess PODs using the Patients' Own Drug assessment form at the bottom of this policy. The pharmacy should be contacted when next open for them to check the assessment and obtain the completed assessment form. Pharmacy need to keep the completed assessment forms for financial costings and for records in the event of drug recalls.

1.2 Consent

The medicines bought in by the patient or carer remain the property of the patient; they may be retained by the ward and used **FOR THAT PATIENT only.**

The reason for consent should be fully explained to the client/carer by the Pharmacist, Pharmacy Technician or Nurse.

Patients not wishing to participate in the scheme will have their medication stored in the medication cupboards. These should be segregated from medicines in use and put in a bag clearly labelled 'PODs NOT CURRENTLY IN USE – FOR REVIEW ON DISCHARGE' these can then be returned to the patient/carer upon discharge. Alternatively they can be returned home with the carer.

However clients will be informed of medication changes and an offer made to dispose of unwanted medication in pharmacy.

This procedure also applies to medication that is not suitable for use in the POD scheme.

1.3 Assessment

The ward pharmacy team will assess the suitability of the patients' medication for use in accordance with a current prescription. Any medications the patient has brought in which have not been charted on admission should be queried with the medical team or patient to establish up to date medication regime.

The ward pharmacy team will endorse the medication chart with 'POD' and the quantity, signature and date. If the client has less than 7 days supply additional supplies will be dispensed by pharmacy.

When the ward pharmacy team is completely satisfied the medication meets the suitability criteria they will stick a 'POD assessed by pharmacy' label on the container.

This will indicate to the administering nurse the medication has been assessed by the ward pharmacy team and is ready to use.

The pharmacy team will remove any medication not suitable for use and return them to pharmacy for destruction. Medicine not suitable for patients' own use, but not for destruction must be stored separately and returned to the client on discharge this can include home remedies such as simple linctus.

The ward pharmacy team must be informed of all the medication the client brings into hospital.

Additional information

If obtaining the PODs will take longer than 24 hours a supply will need to be sent by pharmacy. The amount supplied will be at the discretion of the pharmacy team.

The client's medication must be locked in the trolley or lockable medication cupboards according to the trust medicine policy.

1.4 Assessment after pharmacy opening hours

If the client is admitted after pharmacy opening hours the administering nurse may provisionally assess medication following the set suitability criteria, and complete Patients' Own Drug assessment form.

The medication must then be checked by the ward pharmacy team, endorsed on the medication chart and the 'POD assessed by pharmacy' label applied on the next pharmacy visit. Pharmacy will also need the Patients' Own Drug assessment form to assess any clinical interventions, calculate financial savings and store for record in the event of a drug re-call.

1.5 Suitability Criteria

The following criteria must be assessed as suitable for the patients' medication to be approved by the ward pharmacy team.

- Medication must be prescribed on a current medication chart
- Medication in bottles must be identifiable as being the same as that indicated on the label
- Medicines must have been dispensed in the last 6 months
- Medication must be clearly labelled with:

  Name of the client — Date dispensed
  Name and strength of the drug — Name and address of supplier

- Medication in an original container has a batch number and expiry date on display.
- The patients' medication will be relabelled 'patients' own relabelled' if the directions have been changed upon discharge.

Additional information

Ophthalmic preparations must have been in use for less than 3 weeks, this will be indicated on the dispensing pharmacy label. On admission the Ward Pharmacy Team will add a 7-day expiry date to these preparations to comply with current dispensing standards.

Liquids maybe used if they are in the manufacturer's original container or at the discretion of the ward pharmacist liquids in amber bottles may be used. Formal identification of the liquid is required.

Fridge items must be assessed for suitability on the assumption they have been out of the fridge since the dispensing date unless fridge storage can be otherwise confirmed. If the medication can be kept out of the fridge for period of days or weeks a shorter expiry date should be attributed following manufacturer's guidance. If medication is not stable out of the fridge, new supplies should be ordered and the POD disposed of.

Clinical judgement should be applied in situations where patients may be without medication while new supplies are being ordered. In some situations returning PODs to the ward for use for a day or two to ensure continuity of treatment may be in the best interests of the patient.

1.6 Medication NOT suitable for use

The following Clients' own medication will NOT be suitable for use

- Not readily identifiable
- Medication in a poor condition
- Medication that has exceeded the expiry date
- Medication that is not in the original dispensed container
- Medication discontinued during admission – (follow guidelines stated in 1.2 Consent)
- Medication dispensed more than 6 months ago
- Ophthalmic preparations opened more than 3 weeks ago
- Containers should not hold more than one type of drug. Medicines contained in dosette boxes must not be used.

These items will be returned to pharmacy for safe disposal.

1.7 Storage of Patients' Own Drugs

Patients' Own Drugs that have been assessed by the ward pharmacy team as suitable for use must be stored in a locked medication cupboard or in the medication trolley.

Patients' Own Drugs that need to be assessed by the ward pharmacy team must be stored in a locked medication cupboard and a note made in the communications book.

It is good practice to store the patients' medication in separate containers e.g. plastic bags or storage bins, so that it does not get confused with stock medication.

Any patients' own Controlled Drugs must be locked in the controlled drug cupboard (as stated in trust Medicines Management policy).

The controlled drug must also be entered in the Controlled Drug register on a separate page labelled 'patients' own Controlled Drug' and documented according to the trust CD policy.

Patients' Own Drugs must not be administered to other patients

1.8 Discharge during pharmacy opening hours

Patients' medication can be issued upon discharge by the ward pharmacy team during pharmacy opening hours. Ensure that any patients' own drugs are brought to the pharmacy with TTO/prescription chart.

The ward pharmacist will sign the bottom of the TTO prescription when they are satisfied the TTO is both clinically and legally accurate e.g. correctly prescribed medication and correctly labelled.

A member of the ward pharmacy team can then check the patients' medication against the TTO and endorse the relevant items with 'POD', sign and date. Additional items can then be dispensed by pharmacy.

Each patient will receive a 14-day supply upon discharge as standard unless there are specific reasons for different quantities.

1.9 Discharge outside of pharmacy opening hours

Patients own drugs which are required for discharge outside pharmacy opening hours may be issued and signed by the doctor and a senior nurse providing it meets the set criteria.

The signatures of the staff issuing the medication must be on the TTO form. **Please note this must only be practised when pharmacy is closed.**

During normal pharmacy opening hours the ward pharmacist must clinically validate the TTO and issue to the client.

South London and Maudsley NHS Foundation Trust

Pharmacy Department

Patients' Own Drugs Assessment

Client Name…… Date……

Ward…… …. Directorate……..

Name and strength of Patients' Own Drug Quantity					
Suitability Criteria	Meets criteria Y/N	Meets criteria Y/N	Meets criteria Y/N	Meets criteria Y/N	Meets criteria Y/N
Is medication prescribed on a current medication chart?					
Is medication identifiable as being the same as indicated on the label?					
Has POD been dispensed in last 6 months?					
Is medication clearly labelled with • Name of client • Name and strength of the drug • Date dispensed • Name and address of supplier					
Manufacturer Medication is in date and batch number is on display?	Batch no: Expiry:	Batch no: Expiry:	Batch no: Expiry:	Batch no: Expiry:	Batch no: Expiry:
Medication is in overall good condition and suitable for use in PODs scheme?					

Signed **Position**

Date

This form must be sent to pharmacy. (Ward pharmacy team, Snr Nurse, Doctor)

APPENDIX 3

SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
STANDARD OPERATING PROCEDURES (SOPs) FOR CONTROLLED DRUGS (CDs)

Accountable Officer – Martin Baggaley
Chief Pharmacist – David Taylor

Note: procedures may vary on the Guy's and St Thomas's and Lewisham sites
Guy's, St Thomas' and Lewisham hospital pharmacy departments will follow their own local procedures for the ordering, receipt, storage, dispensing, and destruction of Controlled Drugs within the pharmacy department. The Accountable Officer for the local sites will be accountable for these parts of the SOP.

Ordering CDs into pharmacy

- No licence is necessary to order CDs into the trust.
- The pharmacy computer system generates an order when the automatic re-order level is reached. In addition some sites may place written orders if the re-order level is not suitable.
- This order must be checked by the Purchasing or Buying Officer.
- The CDs must then be manually ordered by the pharmacy Purchasing or Buying Officer from the appropriate supplier for direct delivery to the requesting pharmacy site.

Receipt of CDs into pharmacy

- A pharmacist or senior technician must take receipt of CDs from the supplier's driver and sign the driver's paperwork if the delivery location, drug form, strength and quantity are correct.
- If the CDs are not correct (e.g. damaged, wrong CD or wrong quantity), the pharmacist or senior technician must refuse receipt of the CD and send them back with the driver. The supplier must be informed as soon as possible.
- The CDs must be stored in the pharmacy CD cupboard immediately.
- Details of the CDs received must be checked against the Pharmacy order by the Purchasing or Buying Officer or Stores Assistant Technical officer.
- Details of the CD must be entered onto the Pharmacy computer system by the Purchasing or Buying Officer or Stores Assistant Technical Officer.
- Details of the CD, the name of the supplier, the order number and CD quantity received must be recorded in the pharmacy CD register by a pharmacist or qualified technician. The entry must be signed and dated.

Storage of CDs in pharmacy

- All CDs must be stored in a locked, alarmed CD cupboard.
- The key must be held by a named pharmacist in the dispensary each day.

Discrepancies in the CD balance in the pharmacy

- Any discrepancies in balance must be reported to the dispensary manager or senior pharmacist on that site.
- The balance must not be adjusted without identifying the source of the error.
- An incident from must be filled in if the discrepancy cannot be rectified.

Prescribing of CDs on trust prescriptions

- CDs may be ordered on any trust prescription chart, FP10HP or FP10MDA.
- Prescriptions for CDs may be computer-generated or hand-written. The signature must be in the prescriber's own handwriting.
- The prescription must be dated. The prescription is valid for 28 days.
- The prescription must state the name and address (or hospital number) of the patient and the dose (and directions), form, strength and total quantity of the required CD. The total quantity of the CD to be supplied must be stated in words as well as figures. A total quantity need not be stated for CDs prescribed for administration to in-patients.
- A pharmacist may amend the prescription if it specifies the total quantity only in words or in figures or if it contains minor typographical errors. These changes need to be indelible and signed by the pharmacist.
- The supply quantity should not exceed 30 days. In exceptional circumstances where a supply of more than 30 days is necessary and not thought to pose a risk to the patient, the prescriber must make a note in the patient's medical records. The pharmacist must check that the prescriber intended the supply to be more than 30 days.
- The prescriber must sign any changes he/she makes to the prescription.
- At Lewisham, the pharmacy may supply UHL CD prescription forms on request to enable easier compliance with CD regulation for prescribing

Prescribing of CDs by non-medical prescribers (NMPs)

- Please refer to the NMP policy for further details.

Storage and supply of CD stationery (e.g. requisition books, registers)

- CD registers and CD order books for supply to wards/units/dept must be kept in a locked cupboard in pharmacy.
- CD registers and CD order books on wards/unit/dept must be kept in a locked cupboard.
- Only one CD order book must be in use per ward/unit/dept at any one time.
- The CD order book and CD register must be retained on the ward/unit/dept (and be available for inspection) for at least 2 years from the last entry.
- CD stationery may be ordered from pharmacy by a permanent qualified nurse using the CD order book.
- The date of issue must be recorded on the front of CD stationery supplied by pharmacy.
- CD stationery may be collected from pharmacy by a permanent qualified nurse
- The following details must be recorded in the CD stationery issue book in pharmacy: date of issue, ward/unit/dept, name of person ordering and collecting and the type and quantity of stationery issued. The entry must be signed by the pharmacy member issuing as well as the staff member collecting
- Any unused stationery must be returned to pharmacy. An entry of return must be made in the CD stationery issue book.
- Each CD register and CD order book is allocated a number by pharmacy and this number is recorded when the stationery is issued.

Loss or theft of CD stationery

- All loss or theft of CD stationery must be reported immediately to the Chief Pharmacist

- At GSTT the pharmacist in charge of the relevant pharmacy department must also be informed.

Ordering CDs from pharmacy for administration to patients on the ward/unit or in community clinics

- The nurse in charge of the ward/unit carries the overall responsibility for ordering CDs from Pharmacy. The task of ordering may be delegated to another nurse on the unit.
- CDs should be ordered as 'stock' or 'temporary stock' not for individual patients.
- CDs must be ordered in the ward CD order book supplied for the purpose. The order book must state the name of the trust and the ward/unit.
- The order must state the name, strength, form and quantity of the drug required.
- The order must be dated and signed (with a print of the name in block capitals) by an authorised nurse from the ward/unit/clinic/dept. The person signing the order must have previously supplied pharmacy with a sample signature. It is the responsibility of the ward/unit/clinic to supply pharmacy with up- to- date signatures. Orders signed by an "unknown" qualified nurse will not be supplied. The patient's prescription must also be sent to pharmacy.
- At Marina House the order may be signed by any permanent qualified nurse. Prescriptions need not be sent to pharmacy at Marina House.
- A pharmacist may amend the order on the request of the person ordering the CD. The pharmacist must sign and print their name on the order page. At Lewisham, the ward pharmacist may write the order for the ward if necessary.
- A duplicate of the order must be made in the order book, using the carbon paper provided. This duplicate must be retained (and be available for inspection) by the ward for two years.
- Any member of staff may deliver a CD order book to Pharmacy.
- At Guy's and St Thomas' hospitals a member of pharmacy staff can order a CD but the requisition must be signed by an authorised signatory from the ward/clinical area.
- Staff ordering CDs will need to be authorised signatories. Pharmacy will keep a list of authorised signatures.

Ordering CDs for patients in community teams or TTAs

- A copy of the prescription must be sent to pharmacy. The CD does not need to be ordered in the CD book in this case.
- At Marina house a database with details of patients' TTA medicines is kept by pharmacy and updated at least once a week. A dispensing form is printed once a week and signed by the prescriber. All TTAs are supplied against this dispensing form.
- At Lewisham, drugs used to treat addiction are not supplied on out-patient, TTA or leave prescriptions. Patients should continue with supervised administration on the ward. For discharge, arrangements should be made for supplies to be obtained in the community.

Dispensing of controlled drugs in pharmacy

- The CD may be dispensed by a pharmacist (or pre-registration pharmacist under supervision) or a band 5 (and above) technician. The dispensed CD must be final checked by two people (either a pharmacist or technician but not the same person who dispensed it). A pharmacist must be involved in at least one stage of the process.
- When dispensing a CD, the following details must be recorded in the CD register:
  - either the name of the ward (for stock) or the patient's name (for TTA)
  - the CD requisition number from the order book (for stock) and the name of the nurse ordering the CD or the prescribing doctor (for TTA)
  - the CD name, form and strength
  - the quantity issued
  - the entry must be signed and dated

- The stock balance must be checked and recorded in the register on each dispensing. The two people involved in the dispensing and checking must do this. Any discrepancy must be accounted for and clearly documented in the CD book.

Recording details in any CD register (ward or pharmacy)

- All entries must be made in ink or be otherwise indelible.
- All entries must be made in chronological order.
- The pages should be sequentially labelled with a separate page assigned to each drug, strength or form.
- Under no circumstances must there be use of 'Tippex' in the CD register.
- Incorrect entries must not in anyway altered or obliterated.
- Any incorrect entry may either be:

  crossed out using a single line
  or
  bracketed and numbered. An explanation of the error must be written at the bottom of the page.

  The error must be signed and witnessed by 2 nurses.

- In either case the correct details should be entered underneath the incorrect entry.
- At Lewisham, at the end of a page, the balance should be transferred and witnessed to a new page and the index adjusted accordingly.
- At Guy's and St Thomas' hospitals each CD requisition should relate to its corresponding page in the CD record book (i.e. page no 1 requisition is recorded on page 1 in the CD record book). By restricting the amount ordered to a maximum of 20 doses the balance at the end of each page should be zero. If it is necessary to transfer the balance to the next page in the CD record book, the corresponding page in the order book must be cancelled.

Collection of CDs from pharmacy

- In all other cases, the CD must be collected from pharmacy by a qualified nurse (permanent or agency). Appropriate photo identification must be supplied (e.g. trust ID badge).
- If a CD is prescribed as a TTA or for a patient in a community team (ie the CD is labelled with directions for use), it may be collected by the person for whom it is prescribed, the carer or a healthcare professional. A record must be made in the CD register of who collected the CD and whether proof of ID was requested from them and whether ID was seen.
- Before leaving pharmacy, the nurse must check the supplied CD against the CD order or prescription.
- The collecting nurse must sign in the case of stock items, the section in the ward CD order book marked "accepted for delivery" and in the case of CDs dispensed for the patient, the CD register in pharmacy.
- Carers collecting CDs on behalf of a patient must sign the CD collection book.
- The top copy of a CD order will be kept by pharmacy.
- Copies of CD orders and the CD collection book must be retained (and available for inspection) in pharmacy for at least 2 years
- In the case of a TTA, community or out-patient prescription, a photocopy of the prescription should be kept by pharmacy. Copies should be retained in pharmacy for at least 2 years.
- At Lewisham, Guy's and St Thomas' CDs for wards or departments may be collected by unqualified ward staff, but they must have appropriate photo identification. The pharmacy porter may deliver CDs to the wards.
- At Guy's and St Thomas' hospitals if TTA medication contains a CD then it should be entered in the Patient's Own Drugs CD record book when delivered/received on the

ward. The TTA must be stored in the CD cupboard and issued to the patient on discharge. The issue must be recorded in the patient's Own Drugs CD record book.

Transport of CDs between sites (wards/clinics/pharmacy)/and out of hours

- The dispensed CD must be packed in a sealed 'Jiffy bag' or sealed box.
- The CDs must be transported via an approved hospital taxi firm/courier service or porter (delivery) service.
- The transport service must:
  - provide their name, business address and emergency number.
  - undertake to notify the pharmacy of any delays to the journey.
- The Pharmacy must:
  - record the driver's details including name, ID number, vehicle registration number and make and model of car in the pharmacy transport log. The driver must sign the log of details.
  - record the details of the recipient in a log book.
  - provide the driver with the name and address and contact number of the recipient.
  - not tell the driver he/she is carrying a CD
- The driver must:
  - deliver the package only to the person named by pharmacy.
  - be contactable at all times during the journey.
- Out of hours:
  - The pharmacist must contact the recipient to ensure the delivery has been received.

Storage and security of CDs on the ward/unit

- The nurse in charge of the ward/unit has the overall responsibility for the safe and appropriate management of CDs in that area
- CDs must be stored in a locked cupboard specifically designated for this purpose. The cupboard must conform to the British Standard BS 2881 or be otherwise approved by Pharmacy.
- Two registered nurses must be present in the clinic room at all times when the CD cupboard is open.

Controlled drugs Keys

- The keys must be kept with the nurse in charge.
- The keys to the CD cupboard should be kept separate from other medicines keys. The nurse in charge at the time should be in possession of the CD keys. The nurse in charge may delegate responsibility for the key to a designated deputy.
- At Lewisham, Guy's and St Thomas' dispensed TTAs and leave medications must be stored in the CD cupboard, but kept apart from stock CDs

Missing CD keys

- Any missing CD keys in pharmacy must be reported to the pharmacist in charge on that site.
- Missing keys on the wards/unit must be reported to the person in charge on the ward/unit as well as the senior registered nurse.
- There should be provision for a spare key to be available (in pharmacy/wards/units) to ensure patient care is not compromised.
- Any CD keys whose whereabouts cannot be ascertained must be reported to the Chief Pharmacist and the Accountable Officer.

Controlled drugs stock

- Wards/units may have a list of CDs to be held as stock. The list must be reviewed every 3 months. All other CDs must be ordered when necessary from Pharmacy

Receipt of CDs on the ward

- On receipt of CDs on the ward, the nurse in charge or designated deputy must check that the drugs received correspond to the order in the CD order book and sign the section marked "Received by".
- If there is a discrepancy, the pharmacy must be informed immediately
- The CDs must be stored in the CD cupboard as soon as they are received on the ward.
- Details of the CD must immediately be entered into the ward CD register. Each CD must be entered under the name, form and strength of the drug provided.
- The requisition number must be recorded when entering the drug into the register.
- All entries into the CD register must be witnessed and countersigned by another registered nurse.
- Each strength and form of a CD preparation must be recorded on a separate page.
- **For tablets and injections:** If the balance of the CD is nil, simply enter the amount received into the balance column. However, if there is already an amount stated in the balance column, add the new amount to the outstanding balance to give a new overall total. The total should be expressed in numbers of tablets/capsules/ injections. (This does not apply at Guy's and St Thomas' as each order is entered on a new page).
  For liquids only – A new page must be started for each requisition number/receipt*****. The received volume must not be added to any existing volume in the register. The total volume must be expressed in millilitres not number of bottles. A running total should be kept in the CD register by subtracting each administered amount from the original volume. A margin of up to 2.5% (under or over) of the original volume may be allowed for liquids.
- At Lewisham, a running balance maybe kept for liquids. It is not necessary to start a new page with each supply
- *******The Marina house supervised administration unit may start a new line (not page) for each bottle. A new balance must be started with each new bottle. The existing volume from the old bottle must **not** be added to the new volume.*

Administration of CDs to patients on the ward/unit/clinic

- Registered nurses and doctors may administer CDs to a patient. Two people must be involved in the administration.
- When a dose is administered to a patient, the patient's name must be entered in the CD register, together with the amount administered.
- The administered amount must be subtracted from the running balance and the new balance recorded. A margin of up to 2.5% (under or over) of the original volume may be allowed for liquids
- Extreme care must be taken when measuring volumes of concentrated potent liquids (e.g. methadone 10mg/ml). Always read-off volumes from the bottom of the meniscus at eye-level to avoid parallax errors. It is recommended that an oral syringe with a bottle stopper (obtainable from Pharmacy or Supplies) be used to measure small volumes (less than 5ml).
- It is recommended that an accurate measure is used for liquids, either an oral syringe, or for large volumes a cylinder or conical measure that should be ordered from supplies.

CD stock checks

- The CD balance in the CD cupboard must be checked against the record in the register every 24 hours. The check must be performed by two registered nurses.

- It is not necessary to decant the liquid into a measure for the daily balance check.
- At Lewisham, Guy's and St Thomas' the liquid balance should be a visual check, but the balance in the register should be reconciled at the end of each bottle.
- At GSTT, the checks should be recorded either in the back of the CD record book or in a separate CD check log book. The balance in the CD record book should be checked against the contents of the CD cupboard (not the reverse) to ensure that all balances are checked. As a minimum, the record should state the date and time of the reconciliation and include wording such as "check of stock level". Both members of staff should sign the record. This record is controlled CD stationery and if a separate log book is used it should be kept with the CD record book.

Discrepancies in balance

- Any discrepancies in CD balances on the ward/unit/clinic/dept must be reported to the ward/unit/clinic manager and ward/clinic pharmacist at the earliest opportunity.
- Discrepancies in balance in the pharmacy must be reported to the senior pharmacist on that site.
- The balance must not be adjusted without identifying the source of the error.
- An incident form must be filled in if the discrepancy cannot be rectified.

Self administration of CDs

- CDs for self administration by patients should be labelled with directions for use.
- A record of administration must be made in a CD register.
- Patients receiving CDs for self administration should sign for receipt of a specified number of doses.
- On the ward CDs for self administration must be stored in a non-portable locked metal receptacle next to the patient's bed or the ward CD cupboard.

Return to pharmacy or destruction of CDs on the ward

- If a CD has expired or is no longer needed (e.g. patient discharged, medication changed) the pharmacy must be contacted to arrange for the CD to be returned to pharmacy.
- CDs that may be suitable for re-use must be checked by a pharmacist before they are returned to pharmacy.
- The pharmacist must sign the CD out of the ward CD register with a registered nurse acting as witness and deliver it to pharmacy. A record must be made in the CD register of the date, reason for return, name, strength, form and quantity removed.
- The balance must be adjusted accordingly in the ward CD book.
- On return to Pharmacy the CD must be entered onto the Pharmacy computer system and in the CD register. Balances must be adjusted accordingly on both.
- CDs returned from a ward to Pharmacy that are not suitable for re-use (e.g. opened bottles of liquids or expired stock) should be destroyed. Small amounts of a liquid (<2.5% of the original volume) may be destroyed by the returning pharmacist using a DOOP kit. It is good practice for this procedure to be witnessed (by another pharmacist or a technician band 5 or above) Larger volumes of liquids and any amount of other preparations (tablets, injections etc.) must be entered in to the relevant section of the CD register for drugs awaiting destruction (see below 'Destruction of CDs in pharmacy')
- CDs should not be returned to pharmacy by any ward staff or via porters.
- At Lewisham, Guy's and St Thomas' if part of a dose or vial is wasted, this should be recorded and witnessed in the register. An individual dose that is prepared but not administered should be destroyed on the ward by placing in the sharps bin and should be witnessed and recorded.
- At GSTT and Lewisham at each point where the authorised possession of a CD is transferred (e.g. between wards or ward and pharmacy) a record must be made. When

returning a CD to pharmacy as well as making a record in the CD record book on the ward the details must be recorded on the transfer note.

Destruction of CDs in pharmacy

- Expired CD stock in the pharmacy must be destroyed using a DOOP kit by a pharmacist in the presence the borough manager for that site.
- A record of the date, drug name, strength, form, quantity, name of pharmacist and borough manager must be made in the CD register.

Patients' own CDs

- If patients bring their own CDs onto the ward and consent to them being used on the ward, they must be assessed as per trust Patients' Own Drugs (PODs) procedure.
- If the CD is no longer suitable for the patient the pharmacist should be contacted to return the CD to Pharmacy for destruction.
- Patients' own CDs should be stored in the ward CD cupboard.
- The CD should be entered in the ward CD register on a page designated for patients' own drugs. A new page must be started for each POD.
- When the drug is returned or removed it must be signed out of register in the normal way.
- On discharge, if still prescribed, the CD should be returned to the patient.
- Illicit drugs and unknown substances are not covered by this policy. A separate policy for illicit drugs can be found on the trust intranet.
- At Lewisham, it should be made clear that it a Patient's own CD and not ward stock by clearly entering the patient's name at the top of the page. If it is necessary to use the patients' supply, (e.g. out of hours), a senior Nurse, Doctor or preferably a Pharmacist should check it for suitability. A ward stock supply should be obtained from the Pharmacy as soon as possible. A patient's own supply must not be used for any other patient.

Obtaining CDs out of Pharmacy opening hours

- See appendix 5 page 73 for details for Maudsley, Bethlem and Lambeth site procedures
- At Lewisham, if a CD is required outside of pharmacy opening hours, it should be ascertained if the CD is available on another ward in the unit. If so, the CD register and drug should be taken from that ward and the dose administered and recorded as if the patient were on that ward; the register and any remaining drug should then be returned. Ideally a nurse from each ward should be involved in the transfer and administration. CDs cannot be issued from one ward to another. The CD should be ordered from the pharmacy at the first opportunity. If the CD is not available elsewhere and the administration cannot wait until the pharmacy is open the on call pharmacist should be contacted.
- At Guy's and St Thomas' if CDs are required outside of normal pharmacy opening hours the resident pharmacist should be contacted. See appendix 5.

Clinical trials

- Clinical trials CDs should be stored separately from stock CDs (separate cupboard not necessary).
- A Home Office licence must be obtained for trials involving schedule 1 CDs. The licence should be held by the chief pharmacist or Accountable Officer. A copy should be kept with the trial protocol.
- The trial protocol must include instructions for dispensing, administration, return and destruction of CDs.

Audit of storage and record keeping

- The CD stock balance in the pharmacy will be checked each week. A record of the check will be made in the CD register.
- The storage and record keeping of CDs on wards will be audited every 3 months.
- Storage and record keeping of CDs in the supervised administration areas of addictions services such as Marina House will be audited every 3 months.
- Results of the audits will be presented at the trust Medicines Management Committee and CEO performance management meetings. A copy of the results will be sent to the Accountable Officer.

Off-site residential wards e.g. Heather Close

- Heather Close should follow the CD SOP for oral medication.
- For end of life treatment involving parenteral CDs, an outside agency may be involved in care. In this situation the palliative care team will usually prescribe, supply and administer the CDs according to their own policies.
- If excess CDs are left on the premises, they should be locked away in a CD cupboard and an entry made in the register as if they are a patient's own drug.
- They should be returned to the palliative care team for use or destruction and signed out of the register.

Staff training

- The Accountable Officer is responsible for ensuring that members of staff involved in prescribing, supply, administration and disposal of CDs receive appropriate training to carry out their duties.
- Staff should receive training on CD SOPs when they first become involved in the prescribing, administration, supply and disposal of CDs and regularly thereafter.

Table 1: Summary of legal requirements that apply to controlled drugs in Schedules 2,3,4 and 5 of the Misuse of Drugs Regulations

Schedule (refers to schedules of the Misuse of Drugs Regulations)	**Schedule 2** Includes – Opioids, (e.g. diamorphine, morphine, methadone), major stimulants (eg amphetamines) ,remifentanil secobarbital,	**Schedule 3** Includes minor stimulants, temazepam, diethylpropion, buprenorphine, flunitrazepam, Barbiturates except secobarbital	**Schedule 4, pt I** Includes benzo-diazepines	**Schedule 4, pt II Includes** anabolic steroids, clenbuterol, growth hormones	**Schedule 5** Includes low strength opioids
Designation	CD	CD No Reg	CD Benz	CD Anab	CD Inv
Safe custody	Yes, except quinalbarbitone	Yes, with certain exemptions (see MEP)	No	No	No
Prescription requirements (including handwriting*) – apply to OP and discharge prescriptions	Yes	Yes, except temazepam	No	No	No
Requisitions necessary?	Yes	Yes	No	No	No
Records to be kept in CD register	Yes	No	No	No	No
Pharmacist must ascertain the identity of the person collecting CD	Yes	No	No	No	No
Emergency supplies allowed	No	No, except phenobarbitone for epilepsy	Yes	Yes	Yes
Validity of prescription	28 days	28 days	28 days	28 days	6 mths (if POM)
Maximum duration that may be prescribed	30 days as good practice	30 days as good practice	30 days as good practice	30 days as good practice	

(Table adapted from the Medicines, Ethics and Practice Guide *(http://www.rpsgb.org/pdfs/MEP30s1-2b.pdf)*

* Prescriptions for schedule 2 and 3 CDs may be typed or computer generated but must be signed by the prescriber. (SI 2005 No.2864)

APPENDIX 4

NON-MEDICAL PRESCRIBING POLICY

NON-MEDICAL PRESCRIBING POLICY

1. INTRODUCTION

This policy has been formulated to support staff in understanding the process of non-medical prescribing.

The aim of the policy is to provide staff with advice as to how non-medical prescribing should be implemented. It is critical that all staff are conversant with this policy prior to undertaking and following non medical prescribing training programmes.

Non-medical prescribing is defined as: the prescribing of medicines by non-medical practitioners. This was initially introduced for nurses and pharmacists but has recently been extended to include physiotherapists, chiropodists/ podiatrists, radiographers and optometrists.

1.1 BACKGROUND

The NHS Plan: A plan for investment, a plan for reform emphasised the need to organise and deliver services around the needs of the patient (DOH 2000). To achieve this aim it was envisaged that traditional boundaries between clinical roles be broken down to allow clinical professionals to work more flexibly for the benefit of patients. One area where traditional barriers have been removed is in the area of prescribing.

It was the Cumberlege report of 1986 (DHSS 1986) that first recommended prescribing by community nurses as a way of improving patient care and access to health care resources. Since 1994 suitably trained nurses have been able to prescribe from a limited list of items (Nurse Prescribers Formulary). The right to prescribe has been extended following the Health and Social Care Act 2001. Once trained a wider range of nurses and health care professionals including pharmacists are now able to prescribe from an Extended Prescribers Formulary.

In May 2001 ministers announced that steps would be taken to allow supplementary prescribing by nurses and other health professionals. It was envisaged that this form of prescribing is likely to be particularly suitable for health professionals working with patients experiencing more complex chronic conditions such as asthma, diabetes or mental ill health.

Supplementary Prescribing rights for pharmacists and nurses were introduced in 2003. In April 2005, prescribing rights extended to Controlled Drugs and unlicensed medicines. Also in April 2005, supplementary prescribing was extended to a variety of other healthcare professionals (see above)

In addition, from May 2006, a new category of prescriber “The Independent Prescriber” was created to allow nurses and pharmacists to prescribe any licensed medicine for any medical condition within their competence.

1.2 PURPOSE/SCOPE OF THE POLICY

- To govern the practice of the non-medical prescribing in the trust.
- To provide a guide to services who wish to consider non-medical prescribing as an option for their patient group.
- This policy will focus on the practice of Supplementary and independent Prescribing only.

2. SUPPLEMENTARY PRESCRIBING (SP)

2.1 DEFINITION

A voluntary partnership between the responsible independent prescriber (IP) and a supplementary prescriber (SP), to implement an agreed patient specific clinical management plan, with the patients agreement *(Medicines Control Agency/Department of Health 2002).*

The overall aim of this new way of working is to enhance patient care by providing quicker and more efficient access to health care through an increased flexible use of non-medical professionals.

2.2 KEY PRINCIPLES OF SUPPLEMENTARY PRESCRIBING

There are a number of key principles that should underpin supplementary prescribing. These principles emphasise the importance of communication between the prescribing partners, and the need for access to shared patient records. It is also essential that the patient is treated as a partner in their care and is involved at all stages in decision making, including whether part of their care is delivered via supplementary prescribing.

The criteria that are currently set in regulations for lawful supplementary prescribing are:-

- the independent prescriber must be a doctor (or dentist).
- the supplementary prescriber must be a Registered Nurse, Registered Midwife, a Registered Pharmacist, a podiatrist/ chiropodist, a radiographer (or), a physiotherapist or an optometrist.
- the supplementary prescriber must have successfully completed a recognised training course for supplementary prescription.
- there must be a written Clinical Management Plan relating to a named patient and to that patient's specific conditions. Agreement to the plan must be recorded by both the independent and supplementary prescriber before supplementary prescribing begins. The management plan must include clear aims of treatment and circumstances for referral.
- the independent and supplementary prescriber must share access to, consult and use the same common patient record.

For supplementary prescribing there will be no legal restrictions on the clinical conditions which supplementary prescribers may treat. As supplementary prescribing requires a prescribing partnership and a Clinical Management Plan for the patient before it can begin, it is likely to be most useful in dealing with long-term conditions such as asthma, diabetes or coronary heart disease, and mental ill health. However, it will be for the independent prescriber with the supplementary prescriber to decide, in drawing up the Clinical Management Plan, when supplementary prescribing will be appropriate.

Unlike independent prescribing, there is no specific formulary or list of medicines for supplementary prescribing. Provided medicines are prescribable by a doctor or dentist (an independent prescriber) at NHS expense, and that they are referred to in the patient's Clinical Management Plan, supplementary prescribers are able to prescribe:

- All General Sales List (GSL) medicines, Pharmacy (P) medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All Prescription Only Medicines (including Controlled Drugs).
- Medicines for use outside of their licensed indications (i.e. 'off label' prescribing), 'black triangle' drugs, and drugs marked 'less suitable for prescribing' in the BNF.
- Unlicensed drugs that are part of a clinical trial which has a Clinical Trial Authorisation.
- The supplementary prescriber should not be required to enter into a prescribing partnership that entails them prescribing any medicine that they do not feel competent to prescribe.

Note: Supplementary prescribers are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name - see the Nurse Prescribers' Formulary for District Nurses and Health Visitors, the Nurse Prescribers' Extended Formulary, the BNF and the Drug Tariff.

2.3 PRESCRIBING RELATIONSHIP

- The relationship between independent prescriber and supplementary prescriber is a voluntary one, both parties agree to share responsibility for the practice and will be accountable for their own prescribing decisions.
- If the independent prescriber changes and responsibility for the patient moves to another doctor/nurse, the supplementary prescribing arrangement is discontinued unless a new partnership is agreed and recorded by a new independent prescriber.
- The trust is committed to ensuring that supplementary prescribing practice continues following the employment of a new independent prescriber. That is, newly appointed independent prescribers will be discouraged from abandoning previously successful supplementary prescribing practice.

2.4 RESPONSIBILITIES OF THE INDEPENDENT PRESCRIBER

- The independent prescriber must conduct an initial clinical assessment of patient and provide a diagnosis.
- In partnership with the supplementary prescriber and the patient a clinical management plan will be drawn up (see appendix 1A).
- The independent prescriber must clearly outline the limits of the delegated responsibility and state the parameters of the drug/s and the doses, which can be administered.
- The independent prescriber will provide advice and support to supplementary prescriber as required.
- The patient must be reviewed on a regular basis and the frequency of this is recorded on the clinical management plan.
- The independent prescriber will resume full responsibility for patient prescribing at the supplementary prescriber's request when required.
- The independent prescriber will provide access to patients' records for supplementary prescriber.

- The independent prescriber must take action to ensure that the supplementary prescribing practice continues following periods of absence and if they leave the service.

2.5 RESPONSIBILITIES OF THE SUPPLEMENTARY PRESCRIBER

- The supplementary prescriber will monitor and assess the patient's progress as stated in the clinical management plan.
- The supplementary prescriber will work in partnership with the independent prescriber and patient to draw up the agreed clinical management plan.
- The supplementary prescriber will prescribe as agreed in the clinical management plan.
- The supplementary prescriber will change the prescribed medicine as stated within the limits of the clinical management plan if monitoring of the patient's progress indicates this is clinically appropriate.
- It is essential that the supplementary prescriber works in accordance with their professional governing organisation for example the Nurse & Midwifery Council (NMC) Code of Professional Conduct consulting the independent prescriber as required.
- The supplementary prescriber will accept clinical responsibility/professional accountability for their prescribing decisions and practice.
- The supplementary prescriber will refer back to independent prescriber as required.
- The supplementary prescriber must record clinical relevant facts including prescribing and monitoring activity in the patient's file.
- The supplementary prescriber may not usually dispense or administer medicines prescribed by them. Wherever possible, prescribing and dispensing or administration should be undertaken by different personnel. Where it is necessary both to prescribe and dispense/administer a second 'check' from a nurse, pharmacist or doctor should be sought.

2.6 CLINICAL MANAGEMENT PLAN (CMP)

- This is a patient specific document, which is agreed by both prescribers and the patient before supplementary prescribing begins. The plan must be completed and signed by all parties. (See appendix 1A). The patient's date of birth must be recorded. For those under 18 years of age a parent or guardian must sign the CMP.
- The clinical management plan must specify the range of medicines and circumstances within which the supplementary prescriber can vary dosage frequency and formulation of medicines identified. In describing the limits of prescribing by the supplementary prescriber the clinical management plan may include reference to recognised and reputable guidelines or protocols for a specific condition.
- The appropriate trust Pharmacy department must receive a copy of the clinical management plan. It is the responsibility of the supplementary prescriber to ensure this is done.
- The CMP once completed, must be sent to the patient's GP.
- The clinical management plan must specify the circumstances in which the SP should refer or seek advice from the independent prescriber.
- The clinical management plan must contain relevant warnings about known sensitivities to medicines and include arrangements for notifying adverse drug reactions/allergies.

- The clinical management plan must contain the date the supplementary prescriber arrangements commenced and date for review; this should not exceed one year.
- Both independent prescriber and supplementary prescriber must have access to the patient records.
- Where possible, existing trust stationery will be used (e.g. documentation from the Patient's Journey).

3. INDEPENDENT PRESCRIBERS (IP)

Independent Prescribers are professionals (e.g. doctor, dentist, nurse, pharmacist and optometrist) who are responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing (Dept of Health, 2006).

Nurse Independent Prescribers are able to prescribe any licensed medicine for any medical condition within their competence, including certain Controlled Drugs. Any additional training needs should be addressed through continued professional development and nurses must act in accordance with Clause 6 of the NMC's "code of professional conduct: standards for conduct, performance and ethics". Independent nurse prescribers must ensure that their annual appraisal includes their ongoing prescribing practice, that includes CPD and audits of prescribing practice and prescribing data.

Pharmacist and Optometrist Independent Prescribers are able to prescribe any licensed medicine for any medical condition within their competence, with the exception of all Controlled Drugs, in accordance with "Medicines, Ethics and Practice- A Guide for Pharmacists (RPSGB)".

Non-medical Independent Prescribers can prescribe medicines outside their licensed indications where this is accepted clinical practice, but cannot prescribe unlicensed medications. They must however, accept professional, clinical and legal responsibility for that prescribing and should only prescribe "off label" medicines where it is acceptable clinical practice (DOH 2006). In such cases, the prescriber should explain the situation to the patient/ guardian, where possible, but where the patient/guardian is unable to agree to such treatment, the prescriber should act in accordance with best practice in the given situation and within trust policy.

4. LOCAL DECISION TO SUPPORT NON-MEDICAL PRESCRIBING TRAINING

Local teams must first establish the need for services to be provided in this way and be able to show clear patient or service user benefit.

The initial decision to support a non-medical prescribing student is made locally. Services need to ensure that students nominated for training:-

(i) are willing, eligible and able to undertake the training programme.

(ii) that their subsequent prescribing practice will provide maximum benefit to patients in their local services.

(iii) they will have the opportunity to prescribe after their training is complete.

(iv) are sponsored by an independent prescriber who is willing to be their supervisor

It is likely that once more is known about non-medical prescribing more practitioners may wish to embark on training programmes. Local services can further prioritise potential applicants by identifying the following principles.

(i) patient safety is paramount.

(ii) that maximum benefit to patients can be achieved in terms of quicker and more efficient access to medicines.

(iii) prescribing provides a better use of nurses and pharmacists skills

(iv) that sufficient opportunities to prescribe to maintain competence and confidence and that the maximum number of patients benefit from the prescribing expertise.

5. EDUCATION, TRAINING AND PREPARATION

To be accepted for entry onto the non-medical prescribing programme the NMP student must have agreement of his/her employing organisation and be able to demonstrate that their post is one in which they will have the need and opportunity to prescribe.

5.1 CRITERIA REQUIRED

- Non-medical prescribing nursing students will need to have at least three years post registered clinical nursing experience.
- Non-medical prescribing pharmacy students will need to have a least two years post-registration experience following their pre-registration year after graduation.
- All non-medical prescribing students must have the ability to study at level 3 (degree).
- All non-medical prescribing students must either demonstrate their practical knowledge of clinical psychopharmacology or undertake educational courses to achieve sufficient knowledge and skills.
- All non-medical prescribing students must obtain a medical practitioner (supervisor) willing to provide 12 days learning in practice during training and provide a period of supervised prescribing practice post qualification.
- Application process for training - please see section 5.

5.2 WHO CAN PRESCRIBE?

To be legally eligible to prescribe individuals:-

- must be a 1st level Registered Nurse, Registered Midwife, Registered Specialist Community Public Health Nurse or Registered Pharmacist or optometrist for IP.
- must be a Registered nurse, Registered pharmacist or other recognised health professional for SP.
- hold a valid professional registration.

- have successfully completed an extension of independent/ supplementary prescribing programme.
- have recorded their prescribing qualification on the relevant professional register.

6. APPLICATION PROCESS

The Application Process (Appendix 1B)

(i) Any potential non-medical prescriber considering non-medical prescribing training will need to ensure that this practice will be of benefit to service users. A discussion must take place with the practitioners line manager and the benefits to the service user/service identified and fully documented.

(ii) All practitioners must complete a Trust Long Course application form and the supplementary application form for non medical prescribing (Appendix xxx) and their line manager, medical mentor and the trust Prescribing Lead (Chair of the Non-Medical Prescribing Committee) must sign this.

(iii) Practitioners must also complete an application form to their Higher Education Institution to book a provisional place

(iv) All potential nurse non medical prescribers must discuss their application form the lead for nurse prescribing within the Nursing and Education Directorate

(v) Each completed Long Course should be discussed at the local Training Committee where further discussion in relation to benefits could be explored.

(vi) The completed application must then be sent to the Trust's Education and Training Committee for agreement.

(vii) On successful completion of the non-medical prescribing course the independent or supplementary prescriber must register with the trust's Non-Medical Prescribing Committee and register with their professional body.

(viii) The job description of a newly qualified non-medical prescriber needs to be amended to reflect their prescribing responsibilities and scope of practice. This is the responsibility of the post-holder and their line manager.

(ix) Additional indemnity insurance should be sought by the non-medical prescriber.

7. SUPERVISION IN PRACTICE FOR NON-MEDICAL PRESCRIBERS

A designated medical practitioner must be identified to provide the non-medical prescribing student with supervision, support and opportunities to develop competence in prescribing practice.

7.1 WHO CAN SUPERVISE?

A medical practitioner must supervise each non-medical prescribing student.

The medical practitioner must be a doctor or dentist who:-

(i) has had at least three years medical, treatment and prescribing responsibility for a group of patients/clients in the relevant field of practice.

(ii) is a general practitioner (GP), a specialist, registrar, clinical assistant or consultant within an NHS trust or other NHS employer.

(iii) has the support of the employing organisation or GP practice to act as the designated medical practitioner who will provide supervision, support and opportunities to develop competence in prescribing practice.

(iv) has some experience or training in teaching and/or supervising in practice.

7.2 SUPERVISION IN PRACTICE

At the beginning of the period of supervision the supervisor will receive details of the extended non-medical prescribing programme and the learning outcomes to be achieved from the relevant university. The supervised learning in practice will comprise of a total of 12 days. The medical supervisor should be willing and able to devote a sufficient part of his or her time during this period of supervision to provide the appropriate guidance to the NMP student.

The medical supervisor must provide dedicated time and opportunities for:-

(i) the NMP student to observe prescribing in action.

(ii) to allow in depth discussion and analysis of clinical management using real cases from practice to enable prescribing behaviour to be fully examined.

(iii) facilitate student learning by encouraging critical thinking and reflection with the use of the students professional portfolio or learning log.

(iv) provide opportunities for the non-medical prescribing student to carry out consultations and suggest clinical management and prescribing options which can then be discussed with the supervisor.

The learning in practice will be related to the medical conditions and circumstances in which the non-medical prescribing student is working. The learning process will prepare the non-medical prescribing student for prescribing within their field of speciality.

The supervising medical practitioner should be a doctor with whom the non-medical prescribing student regularly works with.

7.3 ASSESSMENT IN PRACTICE

The supervising medical practitioner will need to complete and ‘sign off’ the assessment of practice form which should be returned to the higher education institution where the non-medical prescribing student is registered. This will confirm that the nurse or midwife has completed the period of learning in practice and has met the required standards.

An audit programme will be undertaken by the pharmacy department to evaluate all non-medical prescribing practice in the trust.

8. RISK AND QUALITY ASSURANCE RELATED ISSUES

Non-medical prescribing is a new practice for the trust and it is important that both practitioner and service users are protected and supported.

8.1 LEGAL AND CLINICAL LIABILITY

Liability of employer: where a non-medical prescriber is appropriately trained and qualified and prescribes as part of their professional duties with the consent of their employer, the employer is held vicariously liable for their actions. In addition, non-medical prescribers are individually professionally accountable to their professional bodies for this aspect of their practice, as for any other, and must act at all times in accordance with their Codes of Professional Conduct.

8.2 VERIFICATION OF PRESCRIBING STATUS

It is the responsibility of every employer (via the professional head) to ensure that the prescriber is legally entitled to prescribe by means of annotation to his or her professional registration. Following successful completion of the appropriate prescribing training or when a prescriber is a new employee, the employer will check with the professional organisation.

It is the responsibility of the prescriber to ensure professional registration is maintained.

Before issuing a prescription the non-medical prescriber must have carried out an holistic assessment of the patient as agreed in the clinical management plan.

8.3 OBTAINING PRESCRIPTION PADS

There will be no restriction on the type of prescription form/ chart for use by the non-medical prescriber. Normal routes of supply will be maintained. Prescriptions will be stamped to indicate that the prescriber is a non-medical prescriber.

8.4 HANDLING AND SECURITY OF PRESCRIPTION FORMS/ PADS

Non-medical prescribers will use specially identifiable prescribing stationery.

Non-medical prescribers may use trust prescriptions and FP10 forms (from issued pads).

Prescription pads are controlled stationery (Appendix 12) and must be obtained, stored securely and issued only to the nurse prescriber. The non-medical prescriber and his or her employer should keep records of issue and destruction of prescriptions. This should include the first and last serial numbers of pads issued, date of issue as well as details of the nurse requesting the pad.

It is also good practice to record the first and last serial number of an in-use pad at the end of the working day. Such steps will identify any prescriptions that are lost or stolen.

It is the responsibility of the non-medical prescriber to ensure the security of prescription pads at all times. When on duty, the prescriptions must remain in the possession of the non-medical prescriber at all times. Individual stocks of forms by non-medical prescribers should be kept to a minimum.

Prescription pads must not be left on the desk, but placed in a lockable drawer.

Blank prescription forms must **never** be pre-signed.

When travelling between patients the prescription pad should not be visible and must be locked in the boot of the car.

The prescription pad must always be removed from the car when the car is unattended. Following resignation from a post, prescription pads must be returned to the appropriate nominated person within the trust by the last working day for recording and secure destruction e.g. by shredding and put into confidential waste.

The loss or suspected theft of prescription forms is considered to be a serious untoward incident, and a trust incident form must be completed. The police will be informed and the prescriber will write and sign all scripts in red for a period of 2 months.

8.5 ACCOUNTABILITY

All non-medical prescribers remain subject to their professional bodies' codes of professional conduct.

All nurse non-medical prescribers have a responsibility to ensure that they adhere to the NMC Nurse prescribing standards of practice

Dispensed medicines and other supplies are the property of the individual patients and must not be used for any other patient.

It is essential that all practitioners keep up-to-date with current practice. This involves continuing learning i.e. continuing professional development as recommended by the National Prescribing Centre. Continuing professional development is an essential element in improving the quality of service delivery.

It is essential that all non-medical prescribers (independent/ supplementary) conduct an annual audit of their prescribing practice and report these findings within their annual appraisal structure.

9. CONTINUING PROFESSIONAL DEVELOPMENT

All non-medical prescribers have a professional responsibility to keep themselves abreast of clinical and professional developments.

All nurse non-medical prescribers must have their prescribing requirements reviewed at each appraisal

All nurse non-medical prescribers are required to attend the non-medical prescribing group a minimum of twice as year.

All nurse non medical prescribers working in Addictions are required to be members of the National Substance Misuse Non-medical Prescribing Forum and attend at least one meeting a year.

All Nurse non medical prescribers are required to complete their Scope of Practice annually foreword to the Nursing Directorate (Appendix xxxx)

Prescribers are expected to keep up to date with current practice in the management of conditions for which they may prescribe, including medicines administered.

The employer must ensure that the non-medical prescribers have access to relevant education and training provision.

Non-medical prescribers should practise within a framework of Clinical Governance. Clinical supervision sessions provide an excellent opportunity for reflection on prescribing as well as other aspects of practice.

10. APPENDICES

Appendix 1A Clinical Management Plan.

Appendix 1B Non-Medical Prescribing Application Process.

Appendix 1C Scope of Practice

11. REFERENCES

NHS Plan: A plan for investment a plan for reform (DOH 2000).

Extending Independent Nurse Prescribing within the NHS in England: A guide for implementation (DOH 2002).

Proposals for Supplementary prescribing by Nurses and Pharmacists and proposed amendments to the prescription only medicines (Human Use) order 1997 (Medicines Control Agency 2002).

Lincolnshire partnership NHS trust in partnership with Lincolnshire Health Community Draft Nurse prescribing Policy (2004 –2005).

12. WEB SITES

Department of Health	http://www.dh.gov.uk/en/index.htm
Department of Health – Nurse Prescribing	http://www.dh.gov.uk/nurseprescribing
Health Professions Council	http://www.hpc-uk.org/
Medicines and Healthcare Regulatory Agency	http://www.mhra.gov.uk/index.htm
National Prescribing Centre	http://www.npc.co.uk/
Nursing & Midwifery Council	http://www.nmc-uk.org/
Royal Pharmaceutical Society of Great Britain	http://www.rpharms.com/home/home.asp

Appendix 4a

SOUTH LONDON AND MAUDSLEY NHS TRUST
CLINICAL MANAGEMENT PLAN

<table>
<tr><td colspan="2">Patient Name:

Address:</td><td colspan="2">Clinical Team:

RMO:

Key worker/Care Co-ordinator</td></tr>
<tr><td colspan="2">Current Medication:

Drug Sensitivities/Allergies</td><td colspan="2">Past Psychiatric History:

Past Medical History:</td></tr>
<tr><td colspan="2">Independent Prescriber(s) (IP) Consultant

Contact details (tel/e-mail/address)</td><td colspan="2">Supplementary Prescriber(s) (SP)

Contact details (tel/e-mail/address)</td></tr>
<tr><td colspan="2">Condition(s) to be treated:</td><td colspan="2">Aim of Treatment:</td></tr>
<tr><td colspan="4">Medicines that may be prescribed by SP</td></tr>
<tr><td>Preparation</td><td>Indication</td><td>Dose Schedule</td><td>Specific Indications for referral back to (IP)</td></tr>
<tr><td colspan="4">Guides or protocols supporting CMP:</td></tr>
<tr><td colspan="4">Frequency of Review and Monitoring by:</td></tr>
<tr><td colspan="2">Independent Prescriber</td><td colspan="2">Independent Prescriber and Supplementary Prescriber</td></tr>
<tr><td colspan="4">Process for reporting adverse drug reactions:</td></tr>
</table>

Discussed with Patient: (signatures) **: By Whom**				**Date**
Agreed by IP(S)	**Date**	**Agreed by (SP)**	**Date**	**Date agreed with patient/carer**

Appendix 4B

Non Medical Prescribing application supporting statement for SLaM Long Courses.

Name……

PIN Number……

Service Address
……

……

CAG/Directorate……

1. Have you completed the medication management course? Y/N
2. Are you applying to become a supplementary (S) or independent prescriber (I)……
3. What medications from the BNF do you hope to prescribe in the future?

4. How do you see your prescribing role improving the patient experience within your service?

5. Who will be your medical supervisor?

   ……

6. How will you ensure regular supervision in relation to your prescribing role when qualified?

Please contact Natalie Warman Assistant Director of Nursing, Physical and Public Health for an informal discussion regarding your application.
Natalie.warman@slam.nhs.uk

Appendix 4C

South London and Maudsley NHS
NHS Foundation Trust

Scope of Practice Agreement

Independent and Supplementary Non medical prescribers must complete a Scope of practice Agreement (NMC 2010) which specifies their area(s) of clinical practice, the evidence of competence to prescribe in these areas, recent CPD, guidelines and policies used to support their prescribing.

This agreement must be signed by their employer/ clinical manager and a copy sent to the Nursing lead for Non medical prescribing- natalie.warman@slam.nhs.uk

Each scope of practice should be reviewed in line with the personal development Plan at Appraisal annually and each annual update returned to the Nurse lead for Non medical prescribing- natalie.warman@slam.nhs.uk

Intention to Prescribe Scope of Practice Statement for Non Medical Prescribers

Please complete form electronically, enlarging where necessary, then print and sign

NON-MEDICAL PRESCRIBERS NAME …… **PIN/PROF. NO. ……..**
PRESCRIBING QUALIFICATION and / supplementary **……** **DATE OF COMPLETION OF TRAINING ……**
BASE …… **TELEPHONE NUMBER ……**
EMAIL ADDRESS ……
CLINICAL AREA

Detail the disease areas you will prescribe in	Detail the type (including the BNF paragraph) of medicines you will prescribe in	Detail your evidence to prescribe competently in this area (i.e. training undertaken or work experience completed with dates / periods of time)	Detail your CPD which supports your prescribing in this area (include dates)	State the guidelines or protocols you will work towards

Governance of your Prescribing	
Describe how you will audit your prescribing?	
How will you monitor patient experience of your prescribing?	
Do you receive clinical supervision? **If so, please give a brief description**	

Identify your CPD need relating to your prescribing		
Area of CPD identified **Helpful hint: be specific and realistic in your area**	**State how you will meet your identified need** **e.g. through training, shadowing, supervised practice, peer discussions etc**	**Date to meet this CPD need by** **Helpful hint: be realistic**

Declaration **Please state if the following statements are true or false by inserting "T" for True and "F" for False in the column provided**	
1. I will not prescribe for myself	
2. I have appropriate indemnity arrangements to cover my independent prescribing	
3. I have access to www.npsa.nhs.uk and receive alerts	
4. I have access to www.cas.dh.gov.uk and receive alerts	
5. I have discussed my Scope of Practice with my practice GP prescribing lead / clinical manager	
6. I confirm my appraisal included a review of my prescribing performance	

I declare this is my current Scope of Practice Agreement and will update this agreement at least annually or if my own competencies change. I will submit an updated Scope of Practice Agreement by 1st September each year. I agree to keep up-to-date with current guidance and evidence base.

Your signature _____ **Date** _____

GP Lead / Clinical Manager Signature _____ **Date** _____

Seen and approved by:

Nursing Lead for Non-Medical Prescribing; signature _____ **Date** _____

APPENDIX 5

PHARMACY OPENING HOURS AND OUT OF HOURS SERVICE

Pharmacy opening hours

- **Maudsley Hospital**
  Monday to Friday 9am to 5pm
  Saturday 10am to 12 noon

- **Bethlem and Lambeth Hospitals**
  Monday to Friday 9am to 5pm

- **Guy's Hospital**
  Monday to Friday 9am to 5.30pm
  Saturday 10am to 3pm

- **St Thomas' Hospital**
  Monday to Friday 9am to 5.30pm
  Saturday 9am to 5pm

- **Lewisham Hospital**
  Monday to Friday 9am to 5.00pm
  Saturday and Sunday 9:30am to 12:30pm

- The duty pharmacist can be contacted via the switchboard for the relevant hospital site.
- Procedures may vary on the Guy's and St Thomas's and Lewisham sites

South London and Maudsley NHS Trust

Pharmacy On-Call / Duty Service

(Information for Emergency Team Leaders, ward staff and other staff)

- Pharmacy departments are located at Maudsley, Bethlem and Lambeth Hospitals.
- These departments provide pharmacy services across the Trust except to SLaM wards located at Guy's, St Thomas' and Lewisham hospitals for which the service is provided by the respective pharmacy departments at those hospitals.
- Opening times for all the pharmacy departments are:

Monday to Friday	9:00am to 5:00pm – dispensary 9.00am to 5.15pm – Medicines Information
Saturday	10:00am to 12:00pm. Maudsley site only: (urgent items only)

On-call Service:

- SLaM pharmacy on-call service covers the Maudsley, Bethlem and Lambeth hospitals as well as all SLaM community units and teams.
- It does not cover SLaM wards based at Guy's, St. Thomas's or Lewisham hospitals. These wards must use the on-call pharmacy service provided by the respective hospitals.
- The service operates at all times outside normal working hours.
- The on-call/duty pharmacist must be contacted via the trust switchboard.
- There is one pharmacist on duty at any given time. They are on-call for one week at a time in addition to their normal daytime working hours.
- Ward staff must not directly contact the on-call pharmacist. All queries must go via the Emergency Team Leaders (ETL) or Duty Senior Nurses (DSN), who will use their professional judgement to rate the urgency of the query and decide whether it is appropriate to contact the on-call pharmacist or whether the call can wait until the following day.
- The pharmacist does not remain on any of the hospital sites whilst on duty. It is not a residency service. It can take up to an hour for the duty pharmacist to come in to the nearest pharmacy department. Please try to order newly prescribed drugs during pharmacy opening hours where possible. The on-call pharmacist will not come in for TTAs.
- Only urgent queries that must be sorted out immediately should be referred to the on-call pharmacist. E.g. of medicines required urgently are:
- Insulin, painkillers, antibiotics, drugs for adverse drug reactions or rapid tranquilisation etc…
- Many queries can wait until the next day. E.g. of these are:
- Running out of a drug that is not actually required to be taken till the next day on the chart.
- If a new antidepressant, clozapine or a depot antipsychotic has just been prescribed. It can take several weeks for these drugs to take effect so the 1st dose can safely wait till morning.

- The duty pharmacist is on site at the Maudsley pharmacy department on Saturdays between 10:00am and 12:00pm and can be reached on 0203 228 2334. This service is only for supplies of medication that cannot wait until Monday (or the next time the pharmacy is open). Medicines can be obtained in this way by ringing the Maudsley pharmacy department on the usual number and faxing over a copy of the prescription to 020 3228 2337. Please try, as far as is practical, to order such medicines during this

time at the weekend, as it is:

(i) quicker - no pharmacist travel time to be included.
(ii) cheaper - all medicines can be transported together to the other sites.

Obtaining medication out of hours:

If a drug is required for a patient, and it is not reasonable to delay administration until the drug can be obtained from the pharmacy department during normal working hours, then the following options should be used:

- Obtain the drug from the out of hours cupboards via the ETL or DSN.
- ETL or DSN should contact the duty/on-call pharmacist via trust switchboard.

Please note:

- Only ETLs or DSNs should have access to the out of hours cupboards and they should keep the keys with them at all times.
- The Maudsley out of hours cupboard contains a lot more stock than the cupboards at Lambeth and Bethlem sites because there is a lot more space there. The ETLs at Maudsley site may therefore be required to pack and send medication from the Maudsley cupboard to wards at the other 2 sites, via taxi.
- Under no circumstances must ward staff directly contact pharmacy departments or duty pharmacists from hospitals outside the Trust to obtain supplies of medication. ALL medicines purchased for use by this Trust must be done via the SLaM Pharmacy department.
- If it is already late at night and a medicine is found to be required for the next day, please wait until the following morning before contacting the duty pharmacist (via the ETL/DSN).
- Between the hours of 10am and 12pm on Saturdays, the duty pharmacist can be contacted at the Maudsley pharmacy department on the usual phone number, please do not contact them via switchboard on the on - call phone during this time.
- Sealed bottles of green methadone mixture 1mg in 1ml are held on each site for out of hours use. Patients need to be accompanied to the respective wards keeping the methadone stock in order to be given their methadone dose.

  The stock is held at the following locations:

Maudsley Hospital	Acute Assessment Unit, AAU (1 bottle)
Lambeth Hospital	McKenzie House (1 bottle)
Bethlem Hospital	National Psychosis Unit (Fitzmary 2 - male side) (1 bottle)

  Please see procedure for out of hours supply of methadone.

(Updated June 2011)

List of pre-packed medication kept in some SLAM Home Treatment Teams/CMHTs

All prescriptions should be presented to pharmacy for dispensing during opening hours. When the pharmacy is closed FP10HPs should be used. If neither of these options is possible and the situation is an emergency the following pre-packs may be used.

Drug	Strength	Number of tablets	Number of pre-packs	Directions on label
Antipsychotics				
Aripiprazole	10mg	7		Take one tablet daily
Haloperidol	5mg	7		Take one tablet daily
Olanzapine (orodispersible)	10mg	7		Take one tablet daily
Olanzapine (orodispersible)	10mg	14		Take one tablet twice a day
Risperidone (orodispersible)	2mg	7		Take one tablet daily
Risperidone (orodispersible)	2mg	14		Take one tablet twice a day
Mood stabilisers				
Sodium Valproate MR	500mg	7		Take one tablet daily
Sodium Valproate MR	500mg	14		Take one tablet twice a day
Others				
Clonazepam	500 mcg	8		Take two tablets daily
Clonazepam	500 mcg	16		Take two tablets twice a day
Procyclidine	5mg	7		Take one tablet daily
Promethazine	25mg	7		Take one tablet daily
Zopiclone	7.5mg	8		Take half to one tablet at night

APPENDIX 6

South London and Maudsley NHS Foundation Trust

Nursing Verification of Competence

Administration of Medicines
(to be used in conjunction with the Medicines Management Policy, NMC Code of Conduct & NMC Standards for medicines management (revised 2010))

A combination of **Direct observation (O)** and **Questioning & Demonstration of Skills (Q**) is anticipated as part of the competency assessment and the assessing nurse should note what type of activity has informed the assessment.

Section A

Core Section	Activity assessed
1. Planning for administration of medication	• Nurse is competent to undertake administration of medication • Adequate number of nursing staff allocated to complete administration of medication (consider single administration, controlled drugs, IM or IV preparation, etc) • Describe how medication is a protected activity • System available to record any side effects reported, omitted medicines and any other issues to be escalated
2. Preparation for administration of medication	• All sundry items are available in clinic room e.g. pots, water, cups, spoons, oral syringes, etc • Medication charts • MEWS charts • BNF & Maudsley Prescribing Guidelines • Gloves and any additional equipment required (blood glucose meters, dressings, etc.
3. Routine checks and scrutiny	Medication chart is correctly completed and includes: • Patient name • Date of birth • Legal status • Trust ID • Allergy/sensitivities completed • Consent to Treatment completed – T2 or T3 (identify at least 1 x patient subject to Section 58) • Section 62 – able to demonstrate knowledge and responsibilities • Prescriber has signed prescription and medication is within BNF limit • Prescription includes start date, end date, route, interval, dosage, preparation (liquid, orodispersible, etc) • Nurse is able to describe process to ***confirm identify of patient*** before administering medication
4. Knowledge of medication	Nurse is able to identify a minimum of **2** medications from each class and to describe: • psychopharmacology • typical therapeutic dose • contra-indications and cautions on administration • medication half life ▪ Anti-depressant ▪ Typical and atypical antipsychotic (to include Clozapine) ▪ Mood stabiliser ▪ Anti-cholinergic ▪ Cardiovascular medication – i.e. beta-blocker ▪ Metabolic medication – i.e. insulin Other commonly used medication in clinical area
5. Knowledge of side effects of medication	Nurse to describe observable and reported side effects of a minimum of 2 medications from each class and to include: • Toxicity – NMS – signs & symptoms, lithium toxicity, etc • Sensitivities – latex allergies, tablet casing, etc

	• **Anaphylaxis** – signs & symptoms of acute reaction - breathlessness, dizziness, chest pain, abdominal cramp, palpitations, redness in face, swelling of face and/or tongue, palpitations – medical emergency response • Action to be taken to alleviate side effects • Reporting system for side effects not previously recorded (Yellow Card Scheme - escalate to prescriber) • Reporting procedure for reported or observed side effects to ensure action taken is appropriate ▪ Antipsychotic – both typical and atypical (to include Clozapine) ▪ Depot medication ▪ Anti-depressant (to include 1st, 2nd and 3rd generation) ▪ Mood stabilisers ▪ Benzodiazepines ▪ Anxiolytics
6. Preparation & administration of IM medication	Nurse to demonstrate knowledge of medicines available as depot preparation and be able to: • Prepare depot medication as prescribed • Prepare Lorazepam IM and Midazolam IM • Describe preparation of Risperdal Consta • Describe preparation of Olanzapine • Nurse should also be able to describe the 'Z' track technique Gluteal injection sites (alternative thigh & arm awareness) • Administration of paliperidone palmitate – gluteal and deltoid injection sites • Preparation of site and appropriate choice of retractable needle syringe • Disposal of sharps and medication residue
7. Calculation of medicines	Nurse to demonstrate understanding and knowledge of medicine calculations and to: **2** examples of each: • can calculate and administer oral tablets accurately • can calculate and administer liquid preparations accurately (including use of oral syringes) • can calculate and prepare IM medication
8. Controlled Medication	Nurse must be able to demonstrate: • correct storage and recording requirements for controlled medication • Correct procedure for preparation and administration of a controlled medicine • Correct recording and stock balance checks for controlled medicines • Knowledge of legal statutory regulation relating to CD management
9. Knowledge of Statutory Regulatory bodies guidance & local Policy	nurse to demonstrate an awareness and ability to locate: • Trust Medicines Management Policy • NMC – standards for medicines management • NMC – Code of Professional Conduct • NMC – Guidelines for records and record keeping
10. Administration of medication to patients	Nurse to demonstrate an ability to: • engage with patients and provide information on medication • apply principles of medication concordance • able to ensure that patient has ingested medication • able to recognise physiological symptoms that require immediate action or omission of medication (NMS, allergic reaction, overt drowsiness, Parkinsonian side effects, etc)
11. Completion of administration of medication	nurse to be able to demonstrate: • accurate recording of medication administered • correct recording of any omitted medications • medication is secured and clinic room cleaned and tidied • outcome of medication round communicated to NIC
12. Administration of oxygen therapy	nurse has an awareness of the following related to oxygen therapy: • oxygen used as therapy (not in emergency medical situation) must be prescribed • oxygen prescription should include the flow rate (litres per minute), delivery system, duration of therapy and equipment • recording baseline $SP0_2$% and monitoring on MEWS chart to track changes and point to escalate • awareness of situations where oxygen therapy is contra-indicated • aware of additional guidance/policy for oxygen therapy

Section B

Item	all nursing staff must have awareness of these aspects of medicines management	achieved yes/no	comment/action plan
13. **Procedure in the event of omitted medication**	Nurse to be able to describe: • reason for medication to be omitted • symbols to be used for omitted medication • further action to be taken and escalation procedure for omitted medication (report to NIC, medical colleagues, pharmacist, prescription to be reviewed, patient to be further counselled, alternative treatment if required, etc) potential harm related to omitted medication including increases in agitation, side effects, acuity of psychotic symptoms and risk		
14. **Critical medicines (e.g. insulin, treatment for Parkinson's disease, anticoagulants, antibiotics/antifungals, hypertension, etc.**	Nurse must be able to demonstrate: • awareness of what are critical medicines • able to identify at least 3 critical medicines appropriate to clinical area procedure to be followed in the event a critical medicine is omitted – DATIX incident, escalation to senior nursing and medical staff, need to report to pharmacist (especially if critical medicine is not available), etc		
15. **Diabetic therapy – insulin awareness and treatment for emergency presentations in diabetic patients**	Nurse can demonstrate awareness of diabetes and prescribed treatment: • Provide examples of different insulin therapy • Describe situation where Actrapid would be required • Describe signs of hypoglycaemia and treatment • Describe signs of hyperglycaemia and treatment • Able to locate Glucagon and Actrapid • Able to describe safe injecting practices • Describe blood glucose monitoring and normal mmol/L range • able to check glucose monitor and use of solutions		
16. **Procedure in the event of medication error**	Nurse can describe the procedures to be taken in the event of a medication error: • Inform patient of medication error • Report to medical staff and complete physical observations • Inform NIC and assess any immediate risk to health • Complete DATIX incident form and grade all incidents at a minimum of C Provide any additional medication (i.e. for side effect) and correct medication if agreed by medical staff		
17. **Rapid tranquilisation and physical monitoring**	Nurse will be able to describe treatment that may be used for rapid tranquilisation and appropriate use of oral medication and IM medication: • First line medication for rapid tranquilisation • IM medication for rapid tranquilisation • Indication and preparation of Diazemuls • Use of Flumazenil and preparation • Physical health monitoring regime following rapid tranquilisation - use of MEWS for monitoring of vital signs and indicators for escalation • Risks associated with rapid tranquilisation • DATIX incident reporting Review of risk management and treatment plan with senior staff and medical staff		

South London and Maudsley NHS Foundation Trust

Nursing Verification of Competence

Administration of Medicines within a community Setting (Single Nurse Administration) To be used in conjunction with the Medicines Management Policy, NMC Code of Conduct & NMC Standards for medicines management (revised 2010))

A combination of **Direct Observation (O)** and **Questioning & Demonstration of Skills (Q**) is anticipated as part of the competency assessment and the assessing nurse should note what type of activity has informed the assessment.

Section A

Core Section	Activity assessed
1. Planning for administration of medication	• Nurse is competent to undertake administration of medication • System available to record any side effects reported, omitted medicines and any other issues to be escalated • Prearranged appointment with patient confirmed
2. Preparation for administration of medication	• All necessary items are available e.g. pots, water, cups, spoons, oral syringes, etc • Medication charts • Clozapine charts and blood results • BNF & Maudsley Prescribing Guidelines • Gloves and sharps disposal boxes
3. Routine checks and scrutiny	Medication chart is correctly completed and includes: • Patient name • Date of birth • Legal status • Trust ID • Allergy/sensitivities completed • Section 17 forms completed for HTTs • Consent to Treatment completed – T2 or T3 (identify at least 1 x patient subject to Section 58) • Prescriber has signed prescription and medication is within BNF limit or clear rationale stated if above/below. • Prescription includes start date, end date, route, interval, dosage, preparation (liquid, orodispersible, etc) • Nurse is able to describe process to ***confirm identify of patient*** before administering medication
4. Knowledge of medication	Nurse is able to identify a minimum of **2** medications from each class and to describe: • psychopharmacology • typical therapeutic dose • contra-indications and cautions on administration • understanding the concept of medication half life and the implications ▪ Typical and atypical antipsychotic (to include Clozapine) ▪ Mood stabiliser ▪ Anti-cholinergic ▪ Cardiovascular medication – i.e. beta-blocker ▪ Metabolic medication – i.e. insulin ▪ Anti depressants Other commonly used medication in clinical area
5. Knowledge of side effects of medication	Nurse to describe observable and reported side effects of a minimum of 2 medications from each class and to include: • Toxicity – NMS – signs & symptoms, lithium toxicity, etc • Sensitivities – latex allergies, tablet casing, etc

	• **Anaphylaxis** – signs & symptoms of acute reaction - breathlessness, dizziness, chest pain, abdominal cramp, palpitations, redness in face, swelling of face and/or tongue, palpitations – medical emergency response • Action to be taken to alleviate side effects • Reporting system for side effects not previously recorded (Yellow Card Scheme - escalate to prescriber) • Reporting procedure for reported or observed side effects to ensure action taken is appropriate • Discontinuation syndrome in SSRIs ▪ Antipsychotic – both typical and atypical (to include Clozapine) ▪ Depot medication ▪ Anti-depressant (to include 1st, 2nd and 3rd generation) ▪ Mood stabilisers ▪ Benzodiazepines ▪ Anxiolytics
6. Preparation & administration of IM medication	Nurse to demonstrate knowledge of medicines available as depot preparation and be able to: • Prepare depot medication as prescribed • Describe preparation of Risperdal Consta • Describe preparation of Olanzapine • Nurse should also be able to describe the 'Z' track technique Gluteal injection sites (alternative thigh & arm awareness) • Administration of paliperidone palmitate – gluteal and deltoid injection sites • Preparation of site and appropriate choice of retractable needle syringe • Disposal of sharps and medication residue
7. Calculation of medicines	Nurse to demonstrate understanding and knowledge of medicine calculations and to: **2** examples of each: • can calculate and administer oral tablets accurately • can calculate and administer liquid preparations accurately (including use of oral syringes)
8. Knowledge of Statutory Regulatory bodies guidance & local Policy	nurse to demonstrate an awareness and ability to locate: • Trust Medicines Management Policy • NMC – standards for medicines management • NMC – Code of Professional Conduct • NMC – Guidelines for records and record keeping
9. Administration of medication to patients	Nurse to demonstrate an ability to: • engage with patients and provide information on medication – written and verbal • apply principles of medication concordance • able to ensure that patient has ingested medication • able to recognise physiological symptoms that require immediate action or omission of medication (NMS, allergic reaction, overt drowsiness, Parkinsonian side effects, etc)
11. Completion of administration of medication	nurse to be able to demonstrate: • accurate recording of medication administered • correct recording of any omitted medications • medication is secured and clinic room cleaned and tidied • outcome of medication round communicated to NIC
12. Administration of oxygen therapy	nurse has an awareness of the following related to oxygen therapy: • oxygen used as therapy (not in emergency medical situation) must be prescribed • oxygen prescription should include the flow rate (litres per minute), delivery system, duration of therapy and equipment • recording baseline $SP0_2$% and monitoring on MEWS chart to track changes and point to escalate • awareness of situations where oxygen therapy is contra-indicated • aware of additional guidance/policy for oxygen therapy

Section B

Item	all nursing staff must have awareness of these aspects of medicines management
13. Procedure in the event of omitted medication	Nurse to be able to describe: • reason for medication to be omitted • symbols to be used for omitted medication • further action to be taken and escalation procedure for omitted medication (report to NIC, medical colleagues, pharmacist, prescription to be reviewed, patient to be further counselled, alternative treatment if required, etc) potential harm related to omitted medication including increases in agitation, side effects, acuity of psychotic symptoms and risk
14. Critical medicines (e.g. insulin, treatment for Parkinson's disease, anticoagulants, antibiotics/antifungals, hypertension, etc.	Nurse must be able to demonstrate: • awareness of what are critical medicines • able to identify at least 3 critical medicines appropriate to clinical area procedure to be followed in the event a critical medicine is omitted – DATIX incident, escalation to senior nursing and medical staff, need to report to pharmacist (especially if critical medicine is not available), etc
15. Diabetic therapy – insulin awareness and treatment for emergency presentations in diabetic patients	Nurse can demonstrate awareness of diabetes and prescribed treatment: • Provide examples of different insulin therapy • Describe situation where Actrapid would be required • Describe signs of hypoglycaemia and treatment • Describe signs of hyperglycaemia and treatment • Able to locate Glucagon and Actrapid • Able to describe safe injecting practices • Describe blood glucose monitoring and normal mmol/L range • able to check glucose monitor and use of solutions
16. Procedure in the event of medication error	Nurse can describe the procedures to be taken in the event of a medication error: • Inform patient of medication error • Report to medical staff and complete physical observations • Inform NIC and assess any immediate risk to health • Complete DATIX incident form and grade all incidents at a minimum of C Provide any additional medication (i.e. for side effect) and correct medication if agreed by medical staff
17. Rapid tranquilisation and physical monitoring	Nurse will be able to describe treatment that may be used for rapid tranquilisation and appropriate use of oral medication and IM medication: • First line medication for rapid tranquilisation • IM medication for rapid tranquilisation • Indication and preparation of Diazemuls • Use of Flumazenil and preparation • Physical health monitoring regime following rapid tranquilisation - use of MEWS for monitoring of vital signs and indicators for escalation • Risks associated with rapid tranquilisation • DATIX incident reporting Review of risk management and treatment plan with senior staff and medical staff

South London and Maudsley NHS Foundation Trust

Nursing Verification of Competence

Administration of Medicines
(to be used in conjunction with the Medicines Management Policy, NMC Code of Conduct & NMC Standards for medicines management (revised 2010))

A combination of **Direct observation (O)** and **Questioning & Demonstration of Skills (Q**) is anticipated as part of the competency assessment and the assessing nurse should note what type of activity has informed the assessment.

Section A

Core Section	Achieved yes/no	Comment/action plan
1. Planning for administration of medication		
2. Preparation for administration of medication		
3. Routine checks and scrutiny		
4. Knowledge of medication		
5. Knowledge of side effects of medication		
6. Preparation & administration of IM medication		
7. Calculation of medicines		
8. Controlled Medication		
9. Knowledge of Statutory Regulatory bodies guidance & local Policy		
10. Administration of medication to patients		
11. Completion of administration of medication		
12. Administration of oxygen therapy		

Section B

Item	achieved yes/no	comment/action plan
13. Procedure in the event of omitted medication		
14. Critical medicines (e.g. insulin, treatment for Parkinson's disease, anticoagulants, antibiotics/antifungals, hypertension, etc.		
15. Diabetic therapy – insulin awareness and treatment for emergency presentations in diabetic patients		
16. Procedure in the event of medication error		
17. Rapid tranquilisation and physical monitoring		

Name of Nurse:……

Name of Assessor:…… **Date:……**

South London and Maudsley NHS Foundation Trust

Psychological Medicine/Mood Anxiety & Personality Services CAGs Nursing Verification of Competence

Administration of Medicines within a community Setting (Single Nurse Administration)
To be used in conjunction with the Medicines Management Policy, NMC Code of Conduct & NMC Standards for Medicines management (revised 2010))

A combination of **Direct Observation (O)** and **Questioning & Demonstration of Skills (Q**) is anticipated as part of the competency assessment and the assessing nurse should note what type of activity has informed the assessment.

Section A

Core Section	Activity assessed
1. Planning for administration of medication	• Nurse is competent to undertake administration of medication • System available to record any side effects reported, omitted medicines and any other issues to be escalated • Prearranged appointment with patient confirmed
2. Preparation for administration of medication	• All necessary items are available e.g. pots, water, cups, spoons, oral syringes, etc • Medication charts • Clozapine charts and neutrophil results • BNF & Maudsley Prescribing Guidelines • Gloves and sharps disposal boxes
3. Routine checks and scrutiny	Medication chart is correctly completed and includes: • Patient name • Date of birth • Legal status • Trust ID • Allergy/sensitivities completed • Section 17 forms completed for HTTs • Consent to Treatment completed – T2 or T3 (identify at least 1 x patient subject to Section 58) • Prescriber has signed prescription and medication is within BNF limit or clear rationale stated if above/below. • Prescription includes start date, end date, route, interval, dosage, preparation (liquid, or dispersible, etc) • Nurse is able to describe process to ***confirm identify of patient*** before administering medication
4. Knowledge of medication	Nurse is able to identify a minimum of **2** medications from each class and to describe: • psychopharmacology • typical therapeutic dose • contra-indications and cautions on administration • understanding the concept of medication half life and the implications ▪ Typical and atypical antipsychotic (to include Clozapine) ▪ Mood stabiliser ▪ Anti-cholinergic ▪ Cardiovascular medication – i.e. beta-blocker ▪ Metabolic medication – i.e. insulin ▪ Anti depressants Other commonly used medication in clinical area
5.	Nurse to describe observable and reported side effects of a minimum of 2 medications from each

Knowledge of side effects of medication	class and to include: • Toxicity – NMS – signs & symptoms, lithium toxicity, etc • Sensitivities – latex allergies, tablet casing, etc • Anaphylaxis – signs & symptoms of acute reaction - breathlessness, dizziness, chest pain, abdominal cramp, palpitations, redness in face, swelling of face and/or tongue, palpitations – medical emergency response • Action to be taken to alleviate side effects • Reporting system for side effects not previously recorded (Yellow Card Scheme - escalate to prescriber) • Reporting procedure for reported or observed side effects to ensure action taken is appropriate • Discontinuation syndrome in SSRIs ▪ Antipsychotic – both typical and atypical (to include Clozapine) ▪ Depot medication ▪ Anti-depressant (to include 1st, 2nd and 3rd generation) ▪ Mood stabilisers ▪ Benzodiazepines ▪ Anxiolytics
6. Preparation & administration of IM medication	Nurse to demonstrate knowledge of medicines available as depot preparation and be able to: • Prepare depot medication as prescribed • Describe preparation of Risperdal Consta • Describe preparation of Olanzapine • Nurse should also be able to describe the 'Z' track technique gluteal injection sites (alternative thigh & arm awareness) • Administration of Paliperidone Palmitate – gluteal and deltoid injection sites • Preparation of site and appropriate choice of retractable needle syringe • Disposal of sharps and medication residue
7. Calculation of medicines	Nurse to demonstrate understanding and knowledge of medicine calculations and to: **2** examples of each: • can calculate and administer oral tablets accurately • can calculate and administer liquid preparations accurately (including use of oral syringes)
8. Knowledge of Statutory Regulatory bodies guidance & local Policy	nurse to demonstrate an awareness and ability to locate: • Trust Medicines Management Policy • NMC – standards for medicines management • NMC – Code of Professional Conduct • NMC – Guidelines for records and record keeping
9. Administration of medication to patients	Nurse to demonstrate an ability to: • engage with patients and provide information on medication – written and verbal • apply principles of medication concordance • able to ensure that patient has ingested medication • able to recognise physiological symptoms that require immediate action or omission of medication (NMS, allergic reaction, overt drowsiness, Parkinsonian side effects, etc)
11. Completion of administration of medication	nurse to be able to demonstrate: • accurate recording of medication administered • correct recording of any omitted medications • medication is secured and clinic room cleaned and tidied • escalation process re concerns.

Section B

Item	all nursing staff must have awareness of these aspects of medicines management	achieved yes/no	comment/action plan
12. Procedure in the event of omitted medication	Nurse to be able to describe: • reason for medication to be omitted • symbols to be used for omitted medication • further action to be taken and escalation procedure for omitted medication (report to NIC, medical colleagues, pharmacist, prescription to be reviewed, patient to be further counselled, alternative treatment if required, etc) potential harm related to omitted medication including increases in agitation, side effects, acuity of psychotic symptoms and risk		
13. Critical medicines (e.g. insulin, treatment for	Nurse must be able to demonstrate: • awareness of what are critical medicines		

Parkinson's disease, anticoagulants, antibiotics/antifungals, hypertension, etc.	• able to identify at least 3 critical medicines appropriate to clinical area • procedure to be followed in the event a critical medicine is omitted – DATIX incident, escalation to senior nursing and medical staff, need to report to pharmacist (especially if critical medicine is not available), etc
14. Diabetic therapy – insulin awareness and treatment for emergency presentations in diabetic patients	Nurse can demonstrate awareness of diabetes and prescribed treatment: • Provide examples of different insulin therapy • Describe situation where rapid acting insulin would be required • Describe signs of hypoglycaemia and treatment • Describe signs of hyperglycaemia and treatment • Able to locate Glucagon and Hypostop Gel • Able to describe safe injecting practices • Describe blood glucose monitoring and normal mmol/L range • Able to check glucose monitor and use of solutions
15. Procedure in the event of medication error	Nurse can describe the procedures to be taken in the event of a medication error: • Inform patient of medication error • Report to medical staff and complete physical observations • Escalate • Complete DATIX incident form and grade all incidents at a minimum of C Provide any additional medication (i.e. for side effect) and correct medication if agreed by medical staff

APPENDIX 7

POLICY FOR SINGLE NURSE DRUG ADMINISTRATION

a) Introduction

- Individual wards and departments may adopt a Single Nurse Drug Administration Policy whereby certain nurses can administer certain medications without the need for checking these with another nurse.
- This policy may be implemented by in-patient units. Community and residential units should refer to specific policies for their areas.
- It has been agreed that any ward or department may adopt this method if desired by adhering to the following policy and accompanying nursing practice.
- Any units wishing to employ the Single Nurse drug Administration system must have written authorisation to do so from the unit manager (Ward managers/Team leaders) and CAG head of nursing

b) Who can administer medication alone?

- Any qualified nurse permanently employed by the trust who is a member of staff of the ward/team on which they are administering drugs, after having been assessed and deemed competent in practice by the manager of that ward. They must also have undertaken an assessment demonstrating their knowledge and competence and be willing to accept responsibility for any errors.
- Any qualified bank nurse, who regularly works on a particular ward/team, after having undergone the same assessment as mentioned above.
- **Agency nurses, student nurses and unqualified staff must never administer medication to a patient alone.**

d) Assessment of competence to administer

- Assessment of competency should be based on the administration of competency and a record of the assessment can be noted on the 'competency assessment outcome record' (attached) – the original copy of this record should be retained by the ward manager and a copy be provided to the nurse and the Head of Nursing
- Once a nurse has passed the assessment the unit manager/head of nursing must give authority for that nurse to administer medication alone. The unit manager/ head of nursing must keep (and update as necessary) a record of all nurses employed on the unit who are authorised to administer medication alone. This list must be readily available for inspection.
- The unit manager/ head of nursing must sign a certificate of competence for each nurse after the successful completion of the assessment. This must be done before the nurse can administer alone. See page 88 for a copy of the certificate.
- The nurse must keep a copy of the certificate of competence, a copy is also kept on the ward, and a copy sent to the relevant manager & Nurse Advisor who will keep a record of those who are competent to administer drugs alone.
- Any nurse who does not successfully complete three drugs rounds and the verbal test cannot administer medicines alone. If this is the case the manager must arrange for a repeat assessment to be carried out at a later date.

d) Drugs which may not be administered as part of the single nurse administration policy (i.e. need a second nurse check)

- Intramuscular injections, except by community psychiatric nurses in clinics or the patient's own home.
- Subcutaneous Injections such as insulin.
- Intravenous infusion/additives even if the nurse has a certificate of competence in the administration of IV fluids.
- Any "As required "(PRN) medication, except simple analgesia, laxatives, suppositories, enemas or topical applications.
- Controlled Drugs.
- Any drug which involves the calculation of a dose or where a variable dose is prescribed.
- Anticoagulants e.g. warfarin, enoxaparin.
- Cytotoxic medications such as methotrexate

e) General points

- If a nurse is not familiar with the name, indication, dosage or side effects of a particular drug, then it may not be administered alone until the necessary information has been obtained.
- Every nurse is professionally and individually accountable for their own actions, which includes the administration of medicines. If a nurse administers a medication incorrectly, the procedure contained in the Code of Professional Conduct/Guidelines for the Administration of Medicines (NMC) must be followed.
- The nurse administering medication must never leave the drug trolley/cupboard unlocked when unattended.
- If a nurse makes an error in drug administration, they must immediately cease single nurse drug administration until ward manager completes investigation of circumstances and counsels them, and if necessary they are reassessed.
- All errors must be reported as per trust procedure.
- The administration of medicines often provides an ideal learning opportunity for nursing students. It should be borne in mind that the single nurse drug administration system may lessen the chances for this opportunity to take place, and must therefore be taken into consideration.

f) Nursing practice for Single Nurse Drug Administration

Check One

- Select the drug prescription chart.
- Read the patient's name.
- Read the name of the drug prescribed for that time.
- Check the start date.
- Check the valid period date is entered.
- Check the route of administration.
- Check that the prescription is legible and has been signed by a doctor.
- If the drug is one which can be administered by a nurse alone continue.
- Check for allergies or sensitivities.
- Check that the drug has not already been given and check the time of the last dose, especially for "as required" medication.

NB: Every measure to keep interruptions to a minimum must be taken.

Check Two

- Read the prescription chart again.

- Select the appropriate drug from the trolley/cupboard.
- Read the label on the bottle/container and check it against the prescription chart, including the name of the drug, dosage, and route.
- Check the expiry date.
- Determine the amount of drug necessary for the correct dose, then measure/dispense the medication.

Check Three

- Before returning the bottle/container to the trolley/cupboard, check the label and dosage again with the prescription chart.
- Identify the patient by asking the patient their name. If the patient is unable or not willing to identify themselves, their identity must be corroborated via another source e.g. another member of staff. Check the patient's name against the prescription chart and administer the medication.
- Sign for the administration on the prescription chart. If the patient refuses medication or if it is omitted for any reason, record this on the appropriate section of the chart, and report to the nurse in charge.

Certificate of Competence in Single Drug Administration

Name
Grade
Qualification
Ward department
The above named member of staff has been assessed and deemed competent to carry out single nurse drug administration in accordance with trust Policy
Assessor Signature: Designation:
Authorised by: Head of Nursing Name NB Please ensure the HoN has agreed for single nurse administration
Date:

APPENDIX 8

HOMELY REMEDIES/SINGLE DOSE ADMINISTRATION

- Certain medicines (homely remedies), may be administered by nurses without the prescription of a doctor following current UKCC and/or local guidelines.
- Depending on the medicine and local policy, the medicine(s) may either be administered once only or for up to 24 hours after the time that the first dose is given. Administration of these remedies must be limited to the period of time agreed and be within a specific dose schedule.
- Medicines should be administered in accordance with BNF guidance (dose, maximum dose, cautions and specific guidance for use).
- The nurse must record each on the single dose record sheet. The nurse must sign and date the sheet. The nurse must inform the ward doctor that the medication has been administered so that the need for a regular/prn prescription can be assessed.

List of homely remedies approved for use in SLAM (all sites)

Medicine	**Indication**	**Dose**	**Comments**
Paracetamol	Mild to moderate pain or pyrexia	500mg to 1g every 4 to 6 hours if needed Max: 4g in 24 hours	A minimum of 4 hours must elapse between doses. Check that no other paracetamol preparations are being given (co-codamol, co-dydramol)
Simple linctus (sugar free)	For relief of dry cough	5ml-10ml up to 4 times daily if needed	
Gavison Advance **Or Peptac**	For indigestion	5-10ml after a meal (max tds) 10–20ml after a meal (max tds)	Contains 4.6mmol of sodium in 10ml – avoid in cardiac, renal or hepatic disease. Contains 6.2 mmol of sodium in 10ml – avoid in cardiac, renal or hepatic disease
Senna tablets	Use for constipation	2 tablets at night	Avoid in intestinal obstruction. Acts in 8-12 hours.

Record of administration of a non-prescribed medication

The following medicines have been approved for administration without a prescription in SLAM (all sites)

Medicine	Indication	Dose	Comments
Paracetamol	Mild to moderate pain or pyrexia	500mg to 1g every 4 to 6 hours if needed Max: 4g in 24 hours	A minimum of 4 hours must elapse between doses. Check that no other paracetamol preparations are being given (co-codamol, co-dydramol)
Simple linctus	For relief of dry cough	5ml-10ml up to 4 times daily if needed	
Gavison Advance	For indigestion	5-10ml after a meal (max tds)	Contains 4.6mmol of sodium in 10ml – avoid in cardiac, renal or hepatic disease.
Senna tablets	Use for constipation	2 tablets at night	Avoid in intestinal obstruction. Acts in 8-12 hours.

Patient name	
Consultant	
Drug administered	
Dose administered	
Preparation/form of drug administered	
Date of administration	
Time of administration	
Name of nurse administering	
Signature of nurse administering	
Doctor informed (y/n)	

APPENDIX 9

SELF ADMINISTRATION OF MEDICINES BY IN-PATIENTS

Contents

1. Policy Summary

This policy is written to support pharmacy and healthcare staff based on in-patient units to carry our self-administration of medicines in a safe and responsible manner.

2. Background

Self-administration is said to occur when a patient takes responsibility for storing and administering his/her own medication, which has been prescribed by a doctor and dispensed by a pharmacist. The pharmacist and nurse act as educators and supervisors to this process[1]. It is recognised that self-administration of medicines in hospital promotes patient independence and enables them to be more involved in their own care. Patient involvement assists in the rehabilitation process and is believed to promote improved patient satisfaction. Self-administration has also been shown to improve patient compliance with medication and to increase knowledge and understanding of treatment[2, 3].

3. Aims

The main aims of a self-administration programme are

- To assess the ability of a patient to take prescribed medication correctly and safely.
- To increase patients' knowledge and understanding of their medication. This should help to improve concordance with treatment and lead to reduced rates of relapse and re-admission.
- To suit the timing of medication to the patient.
- To promote and maintain patient independence and autonomy.

4. Ensuring Safe Practice/Minimising Clinical Risk

4.1 Self-administration programmes are not appropriate for all wards. Self-administration is not appropriate for all patients. Participation is based on an assessment of suitability of the ward by the ward manager together with the clinical team and the patient's agreement to take on the responsibility for taking or using the prescribed medication.

4.2 Self-administration programmes are time consuming and need commitment from medical, pharmacy and nursing staff.

4.3 Each ward manager together with the clinical team must look at the feasibility of implementing this policy on their ward bearing in mind the ward environment and the safety measures in place to ensure the safe practice of this policy. For example, consideration needs to be given to the level of disturbance on the ward and availability of nursing staff to monitor the running of this programme.

4.4 Patients must have a risk assessment performed to ensure they are competent to participate safely in the self-administration programme.

4.5 Patients must agree and consent to participate in the self-administration programme.

4.6 Patients must be provided with supportive education and information material about the medication they are taking and about the self-administration programme.

4.7 A secure lockable cabinet suitable for the storage of medication must be available to each patient.

4.8 Patients who self-administer must have their own individually dispensed medication provided by pharmacy. Nurses must not hand out medication for self-administration from ward stock.

4.9 The following drugs are not suitable for self-administration:

- Controlled Drugs.
- Injections (except where they will be self-administered at home following discharge e.g. insulin).
- Once only doses (stat doses).
- Drugs which have a high risk of toxicity in overdose such as tricyclic antidepressants, MAOIs and chlorpromazine[4].

4.10 When required medication (p.r.n.)

- Medication used for rapid tranquillisation is not suitable for self-administration.
- All p.r.n. medication must be labelled with maximum daily usage.

4.11 All self-administration programmes must be subject to monitoring, supervision and review.

4.12 This policy is not a substitute for more general good practice in terms of patient information and education about medication and encouraging patients to develop an understanding of and responsibility for their treatment. This should always be encouraged even when the administration of medication remains the responsibility of hospital staff.

5. Procedure for Patient Recruitment for Self-Administration

5.1 Any member of the clinical team may suggest a patient for inclusion in a self-administration programme. The patient should meet **all** the following criteria:

5.2 Inclusion criteria

- Stable mental state.
- Capable of understanding the purpose of the medication, remembering the directions for use of the medication and agreeing to take the medication as prescribed.
- Stabilised on medication – not likely to have changes to medication on a more than fortnightly basis (subjective clinical decision).
- Progressing well in treatment.
- Patients who will assume responsibility for taking their medication at home, or their usual place of residence, including those patients who may have some support from a carer.
- Patients likely to comply with medication.

5.3 Exclusion criteria

- Patients who are confused or have an unstable mental state.
- Any patient with continuing misuse of alcohol and/or drugs.

5.4 The nurse, pharmacist/technician or doctor carries out a risk assessment. See appendix 9a. This is presented to the multidisciplinary team at the next appropriate management round.

5.5 The multidisciplinary team (MDT) agree that self-administration may occur. The consultant confirms agreement by signing the assessment form.

5.6 The patient is given the leaflet about "self-administration of medicines". See appendix 9b. The pharmacist/technician or nurse explains the reasons for self-administration.

5.7 A written consent is obtained from the patient if the patient agrees to proceed with self-administration. See appendix 9c. This is filed in the notes. The patient may withdraw consent at any time and this should be recorded in the notes.

6. Patient Information and Supervision

6.1 The information given and period of supervision should be tailored to the patient's needs. The patient must be given the following information before starting the self-administration programme:

- The name of the drug
- Why they are taking it
- Dose and frequency
- Possible side effects
- Duration of treatment
- Any additional precautions
- Who to contact if there is a problem

6.2 The patient should be given a medication record sheet completed by the pharmacist/technician (see appendix 9d) and information leaflets as appropriate. The patient's knowledge of medication should be reinforced as necessary as part of the ongoing assessment process. Any alterations to the medication regime must be discussed with the patient, altered on the prescription chart and the patient's own medication record sheet. The patient's own medication record is kept by the patient and is taken into the community when they are discharged.

7. Self-Administration Process

7.1 There are two basic stages to self-administration. All patients must start at stage 1 and if appropriate then proceed to stage 2.

7.2 Stage 1
Medication is stored in a locked cabinet in the patient's room. The nurse holds the key. The patient requests medication at the appropriate times. If the patient forgets, an agreed length of time is allowed to lapse before the patient is reminded. Medication is handed to the patient and the nurse observes the patient selecting the drug(s) and its quantity. The nurse fills in the "monitoring of self administration" sheet (see appendix 9e). Any prompting required and any interventions made to prevent wrong drug/quantity being taken must be recorded.

7.3 The front of the prescription chart should be marked with self-administration stage 1. Medication should be ordered as "self-administration stage 1" for seven days on the TTA section of the chart. When medication is administered the nurse annotates the prescription chart in the usual way.

7.4 When the patient is competent at stage 1, this fact is presented to the MDT at the next management round. The MDT agrees that the patient may proceed to stage 2. The consultant confirms agreement by signing the assessment form.

7.5 Stage 2
Medication is stored in a locked cabinet in the patient's room. The nurse and patient hold the key. The patient is responsible for taking his/her own medication at the appropriate times (no prompting will be given) and keeping it safe in the designated place. The amount of medication given e.g. 3 days supply or 7 days supply is determined by the multidisciplinary team. A gradual increasing interval is recommended.

7.6 The importance of keeping the cabinet locked must be stressed to the patient.

7.7 The front of the prescription chart must be marked with self-administration stage 2. Medication must be ordered as "self-administration stage 2" on the TTA section of the chart. The date and time the patient is given their medication in-possession must be noted on the prescription chart in the administration section. A "self-administration progress record" sheet should be attached to the prescription chart, see appendix 6. Any omissions noted should be recorded onto the progress chart by the nurse, pharmacist/technician or doctor. A pharmacist or technician will check progress by a tablet count when they visit the ward and fill in the self-administration progress record. A nurse will carry out random checks on day 1, day 3 and day 7. Thereafter, the number of spot checks will depend on the compliance of the patient. However, a minimum of two spot checks per week is recommended. The nurse is to fill in the self-administration progress record whenever a check is carried out.

7.8 **If at any time it is felt that the patient's mental state has deteriorated or they are no longer capable of self-administration at a particular stage the patient should drop a stage or cease self-administration. The nurse can make this decision alone.**

8. Keys for Self-Administration Drug Cabinets

Each cabinet must have its own individual key. Each ward will hold a set number of master keys to allow authorised staff to open the cabinets on their ward only. If an individual key is lost then only the lock for that particular cabinet need be changed and a new key supplied. If a master key is lost then the locks to all the cabinets on the ward need to be changed. The ward manager and pharmacy must be informed of all key losses. A trust incident form must be filled in.

9. Medication on Discharge/Leave

9.1 When arrangements are being made for a patient's discharge, the doctor should complete the normal discharge summary including details of prescribed medicine to be taken at home. (Please see The Patient Journey guidelines.) This should be written at least 24 hours before a planned discharge. The medication prescribed should be checked against the medication held by the patient. A pharmacist/technician or two nurses must carry out the check. If the medication is suitable (i.e. correct drug, dose and frequency) and there is sufficient supply for at least 14 days, the patient may take this home.

9.2 The same process may apply to planned leave. If the patient's supply is in excess of their period of leave, and it is not considered appropriate to give the larger amount, a separate supply of medication for that leave can be obtained from the pharmacy as a TTA in the usual way. The patient's self-administration supply of medication is then stored in the clinics room in the medicine cabinet until their return.

9.3 Upon discharge all paperwork pertaining to self-administration must be filed in the patient's notes.

10. References

1. Salmon K. Self-administration of medicines and the reuse of patients' own drugs. *In* Shaw T and Sanders K (Eds) *Foundation of Nursing Studies Dissemination Series* 2002; 1: No.3
2. Audit Commission. A spoonful of sugar – medicines management in NHS hospitals. London: Audit commission; 2001
3. Lowe CJ, Raynor DK, Courtney EA *et al*. Effects of a self-medication programme on knowledge of drugs and compliance with treatment in elderly patients. *BMJ* 1995; 310:1229-31
4. Taylor D, Paton C, Kapur, S (eds). *The Maudsley Prescribing Guidelines 10 th edition.* London: Informa Healthcare

Appendix 9A

Patient Assessment Form for Self-Administration

This should be completed prior to self-administration and presented to the multidisciplinary team. Please also see inclusion and exclusion criteria mentioned above.

Patient assessment form for self-administration

Patient Details

Name:…… Age:……

Diagnosis:…… Ward:……..

Consultant:…… Named nurse:……

Has the patient consented to be assessed for self-medication? Yes□ No□

Mental state

- Is the patient confused? Yes□ No□
- Is the patient's mental state stable? Yes□ No□

Medication issues

- Does the patient understand the need for medication? Yes□ No□
- Is the patient willing to take medication? Yes□ No□
- Does the patient require prompting? Yes□ No□
- Does the patient have a history of overdose, accidental or intentional? Yes□ No□

Details

- Has the patient a history of non-compliance with medication leading to a relapse or risk of relapse? Yes□ No□

Details

Patient's understanding of current medication

- Can the patient name all of his/her medication and the indication for use in each case? Yes□ No□
- Is the patient able to correctly identify

his/her tablets/capsules? Yes□ No□

- Is the patient able to correctly state which tablets to take at a given time of day? Yes□ No□
- Does the patient know how many tablets to take at a given time of day? Yes□ No□
- Does the patient know how long to take the medication for? Yes□ No□
- Does the patient know which side effects to report? Yes□ No□
- Does the patient know what to do if they miss a dose? Yes□ No□
- Does the patient know when and how to take 'when required' medication? Yes□ No□
- Is the patient aware of other medicines (and alcohol/food if applicable) to avoid with current medication? Yes□ No□
- Has the patient been given a list of other medicines
- To avoid with current medication? Yes□ No□

Patient's ability to administer medication

- Can the patient open bottle tops (Clic-Loc, Non Clic-Loc)? Yes□ No□
- Can the patient remove tablets from blister strips? Yes□ No□
- Other problems with dexterity e.g. halving tablets, measuring liquid doses, sachets? Yes□ No□

Details

- Any other assistance needed to ensure medication is taken appropriately? Yes□ No

Details

Language & literacy

- Is the patient sufficiently proficient in English to understand dosing instructions? Yes□ No□
- Is the patient literate? Yes□ No□

Other social and health factors (specify effect on taking medication)

- Is there a risk of inappropriate use of prescribed medication? Yes□ No□
- Does the patient have any religious/cultural/personal beliefs that may have an impact on medication? Yes□ No□
- Does the patient have a learning disability? Yes□ No□
- Any other relevant information? Yes□ No□

Details

Patient assessment form completed by.....

Comments

Signature……..

Profession……

Date……..

Discussed at multidisciplinary meeting yes/no

Date…….

The patient is suitable for self-administration with supervision (stage1)

Consultant signature.....……..

Date……

The patient is suitable for the self-administration programme (stage 2)

Consultant signature.....……

Date……..

The patient is unsuitable for the self-administration programme…….

Consultant signature.....……..

Date…….

APPENDIX 9B

Self-administration of medicines

On this ward a system is used that will improve your knowledge about your medicines and to help you cope more easily with them once you get home.

If you are entered into this programme, you will have the chance to take your medicines on the ward under supervision. A nurse or pharmacist will give you as much information and help as you need.

The medicines will be kept in a locked cupboard in your room and the nurse will initially hold the key. As you become familiar with the medicines, you may be given the key so that you may take your medicines without help. **It is important that the medicine cupboard is kept locked.** A member of pharmacy or a nurse will also need to have access to your room to carry out a stock check at various intervals.

This system is not compulsory, so you do not have to take part. If you choose not to take part, the nurses will give your medicines to you in the usual way.

APPENDIX 9C

Consent by patient

The self-administration scheme has been explained to me and I am willing to take part. I have read the information leaflet and understand that I can withdraw my consent at any time.

Patient signature:.....

Date:.....

Witnessed by:.....

Withdrawal of consent

I do not wish to remain involved in the self-administration system due to
.....
I therefore withdraw my consent

Patient signature:.....

Date:.....

Witnessed by:.....

Appendix 9D

SOUTH LONDON AND MAUDSLEY NHS TRUST- PATIENT'S MEDICATION RECORD

NAME AND DESCRIPTION OF MEDICINE	**PURPOSE OF MEDICINE**	**WHEN TO TAKE MEDICINE** (Please indicate dose)				**OTHER INFORMATION** (e.g. possible side effects)
		Morning	**Afternoon**	**Evening**	**Night**	

Appendix 9E **Monitoring of self-administration, Stage 1**

- At medication times medicines are handed to the patient and the nurse observes the patient selecting the drug(s) and its quantity.
- The nurse fills in the time taken by the patient to select and administer their drugs and any interventions made to prevent the wrong drug/quantity being taken.

Name: DOB: Hospital No:

Date/Weekday		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Time taken							
	Intervention Signature							
Noon	Time taken							
	Intervention Signature							
Evening	Time taken							
	Intervention Signature							

Night	Time taken							
	Intervention Signature							

Appendix 9F

Self-administration progress record, Stage 2

- The patient is primarily responsible for taking his/her medication at the appropriate times and for storing the drugs in the designated place.
- The pharmacist or nurse counts the tablets at specific intervals to evaluate the correct administration of medicines.
- The actual number of tablets remaining and the number of tablets supposed to be remaining are documented, as well as any other relevant observations.

Name: DOB: Hospital No:

Drug/Dose/Frequency	Date														
	No of tabs remaining: Planned:														
	Actual:														
	Initials														
	No of tabs remaining: Expected:														
	Actual:														
	Initials														
	No of tabs remaining: Expected:														
	Actual:														
	Initials														
	No of tabs remaining: Expected:														
	Actual:														
	Initials														
	No of tabs remaining: Expected:														

	Actual:														

Self-administration progress record continued – Stage 2

Date	Time	Progress report	Status & signature

APPENDIX 10

COMPLIANCE AIDS

Background

Compliance aids in the form of multi-compartment dosage systems are a significant expense to the trust in direct cost and the additional dispensing time involved for pharmacy staff. They may offer advantages for clients who have concordance problems with complex polypharmacy regimens or those who have difficulty remembering when to take regular medication. Where third parties are involved in supporting concordance with medication, multi-compartment compliance aids can appear attractive because of the visible evidence of missed doses. Compliance aids DO NOT in themselves lead to improved concordance when there is poor motivation or a fundamental reluctance to take medication. The purpose of this policy is to ensure that best use is made of compliance aids.

Suitability

Multi-compartment compliance aids are not appropriate for every client and certain medications are not suitable for dispensing in this form of compliance aid. Alternative measures to facilitate concordance may be more appropriate (see below).

Multi-compartment compliance aids are not appropriate in the following situations:

- Deliberate non-compliance.
- Manual, dexterity problems.
- Non-compliance due to lack of understanding/information on medication.
- Inability to remember to take medication or severe confusion.
- Simple regimens (less than three drugs) if medication is available in calendar packs.
- Medications not suitable for dispensing in a compliance aid (see below).
- Dislike/unable to use compliance aid.
- To assist healthcare staff in care homes.

Medications not suitable for dispensing in multi-compartment compliance aid.

- Liquid formulations.
- Topical preparations.
- Transdermal Patches.
- Suppositories.
- Pessaries.
- Combination packs (e.g. HRT, Didronel PMO).
- Calendar packs.
- Inhalers.
- Preparations that should be stored in separate or original packaging for product stability reasons e.g. effervescent tablets, dispersible tablets, significantly hygroscopic preparations, solid dose cytotoxic preparations, buccal tablets and sublingual tablets.
- Preparations that need to be separately identifiable because of specific administration instructions e.g. buccal and sublingual tablets.
- Preparations that are taken on a variable dosing scale e.g. warfarin.
- Medications to be taken as required (PRN).
- Preparations that need to be stored in a fridge.
- Medications known to be unstable in compliance aids.
- Medication where stability in compliance aids cannot be determined.

Reference

Church, C. and Smith, J. How stable are medicines moved from original packs into compliance aids? Pharm J 2006; 276: 75-81.

Alternative measures/recommendations to improve concordance

- Review each medication to ensure it is currently indicated and appropriate for the client. Simplify regimen where possible (e.g. prescribing sustained release preparations to reduce dosing frequency; timing of doses to fit in with client lifestyle or taking all medications at the same time).
- Ensure the client has been given information on their medication and understands why they have been prescribed it, when it should be taken and the importance of compliance.
- Reduce supply quantities e.g. weekly.
- Compliance chart/medication diary – suitable for motivated clients but who are unsure or have difficulty remembering as to when to take medication or if doses have been taken.
- Alternative packaging and labelling for clients with visual, language or dexterity problems.
- Carer/appropriate professional support to prompt or supervise taking medication.

Choice of compliance aid

There are a variety of compliance aids available to suit individual needs. Pharmacy department should be contacted to discuss options.

Supply of medicines in multi-compartment compliance aid

If a multi-compartment compliance aid is considered necessary, careful attention should be given to the client's suitability and understanding of how to use the compliance aid safely and effectively. All clients will need to be regularly assessed for continued appropriateness of the aid. Any multi-compartment compliance aid should be dispensed, labelled and sealed by the pharmacy department.

In exceptional circumstances where it is not possible to get the compliance aid filled by a pharmacy then registered nurses may fill the compliance aid in accordance to this policy (see below). The registered nurse must be able to account for the use of the compliance aid and reason for dispensing. The client has a right to expect that the same standard of skill and care will be applied by nurses dispensing into a compliance aid, as would be applied if the client were receiving medication from a pharmacy. This includes the same standard of labelling and record keeping (NMC April 2002).

Pharmacy

Medication should be supplied in a compliance aid by the dispensing pharmacy, either the trust pharmacy department or a community pharmacy that is normally responsible for dispensing the client's medication. Pharmacists are legally responsible for the correct dispensing and labelling of medication and therefore accountable for any errors. Where there is any doubt about the contents of a compliance aid it should be referred back to the supplying pharmacy for clarification.

When a change to prescribed medication necessitates adjustment to the contents of a compliance aid the first option must always be to refer back to the dispensing pharmacy to make the amendments.

Note: community pharmacists are not legally obliged to supply medication in compliance aids.

Registered Nurses

NMC guidelines allow for nurse preparation of compliance aids in exceptional circumstances when access to the pharmacy service is not realistically practical. The pharmacy department will not be accountable for any errors once medication is transferred from the original dispensed container. **Nursing staff who transfer medication from original containers to a compliance aid or make adjustments to the contents of a compliance aid are responsible for ensuring it is done correctly and in accordance with this policy. They will be accountable for any errors.**

The following requirements must be met;

- Only Band 6 registered nurses and above, may prepare medication in a multi-compartment dosette box. Where a second registered nurse or a doctor is available they should be asked to check that the contents and labels are correct.
- The nurse is able to account for the use of the compliance aid and their reason for filling/adjusting it.
- The client consents to the registered nurse transferring their medication to a compliance aid/their medication being adjusted in the compliance aid.
- A valid prescription is in place. The medication in the compliance aid must be in accordance with the prescription.
- Where medication is to be added only an approved source of medication may be used (i.e. that named patient's supply from a hospital or community pharmacy).
- Where medication is to be removed the redundant medication is clearly identifiable.
- Unwanted medication must be discarded safely in accordance with the medicines policy.
- The compliance aid is clearly labelled with the patient's name, date, each medication's name, form and strength, dose instructions, and is signed by the person filling the compliance aid.
- The procedure is documented as a discreet record and includes
    - Date
    - Client's name
    - Details of item(s) supplied/amended
    - Name of staff involved
- Procedure for preparation of multi-compartment compliance aids must be followed.

Non nursing staff

Non nursing staff are not legally or professionally covered to dispense or amend the contents of a compliance aid, and therefore must not do so. If the pharmacy department is not accessible then support/assistance should be sought from registered nursing staff who may dispense in accordance to this policy. Non-nursing staff may supervise the client filling their Dosette box.

Client/carer

Clients may purchase their own compliance aids and fill them themselves or request a carer/relative to do so for them. It is a good idea to check that this is being done correctly. If the client requests that a trust employee fill the compliance aid on their behalf then it should be inline with the specifications of this policy, as listed above.

Clients and carers may be trained to fill the compliance aid themselves/on behalf of the client as part of a plan to move the client towards more independent management of their medication. This should be decided after a MDT review and follow a clear training and assessment program to ensure competency.

Criteria for issuing compliance aids from pharmacy

- The client must be determined as suitable for requiring a multi-compartment compliance aid using the assessment form.
- Medication should be suitable for dispensing into a compliance aid.
- Other alternative measures for improving concordance have been attempted/implemented.
- A compliance aid request form has been completed and submitted to the pharmacy.
- Suitable arrangements are in place for the aid to be refilled after discharge, either by a community pharmacy or the patient/carer.

Monitoring the need for a compliance aid

Once the use of a compliance aid has been initiated it is important to review whether this system remains the optimum way of continuing to supply the client's medication.

- A client's need for a compliance aid must be reviewed by the multidisciplinary team (including pharmacy) at least every 3 months. A new assessment form is required by pharmacy every 3 months.
- Clients who initially use a multi-compartment compliance aid may become confident to manage their medication in the more traditional way using patient packs, with or without the assistance of other forms of compliance aids.
- Filling of the compliance aid may transfer to the client or carer as part of more independent management of medication. Clients using other forms of compliance aids may need to transfer to a multi-compartment compliance aid.
- Compliance aids may not improve the client's concordance. Reasons for non-compliance may need to be re-assessed and alternative measures attempted.

Appendix 10A

South London and Maudsley NHS Trust

MULTI-COMPARTMENT COMPLIANCE AID ASSESSMENT FORM

- This form is an appendix to the Medicine Compliance Aid policy, which should be referred to prior to completing the form.
- Other more appropriate concordance aids may be available and should be tried before requesting a multi-compartment compliance aid.
- The assessment form should be completed by the key worker or pharmacist and discussed at the MDT review.
- The form should be filed in the client's MDT notes.
- A copy of the form, along with a multi-compartment compliance aid request form, should be sent to pharmacy when the compliance aid is to be supplied by a trust pharmacy department.
- The need for a compliance aid should be reviewed at regular intervals.

Client's name:		**DOB:**
Assessment completed by:		**Status:**
Team/Ward	**Date:**	**Date for review:**

Medication details

Drug	Formulation	Dose	Frequency (inc. regular or prn)	Suitable for compliance aid *

***Drugs NOT suitable for Multi-Compartment Compliance Aid:**
(Contact pharmacy for advice on specific drugs)

- Liquid formulations.
- Topical preparations.
- Transdermal Patches.
- Suppositories.
- Pessaries.
- Inhalers.
- Combination packs (e.g. HRT, Didronel PMO).
- Calendar packs.
- Preparations that should be stored in separate or original packaging for product stability reasons.

(e.g. Effervescent tablets, dispersible tablets, significantly hygroscopic preparations, solid dose cytotoxic preparations, buccal tablets and sublingual tablets.)

- Preparations that need to be separately identifiable because of specific administration instructions.
- (e.g. Buccal and sublingual tablets.)
- Preparations that are taken on a variable dosing scale (e.g. warfarin).
- Medications to be taken as required (PRN).
- Preparations that need to be stored in a fridge.

(YES answers indicate that a multi-compartment compliance aid MAY be appropriate. NO answers indicate that a compliance aid is NOT appropriate for that criterion and alternative methods may be necessary to improve concordance).

Medication

Has the medication regimen been simplified where possible? ▪ Is all the medication still required? ▪ Is once or twice daily dosing possible?	Y/N
Are there 3 or more drugs suitable for dispensing in a compliance aid?	Y/N

Mental State

Is the client willing to comply with their medication?	Y/N
Is the client able to remember to take their medication? (If not then other concordance aids may be more appropriate)	Y/N
Does the client get confused about how to take medication correctly or have difficulty remembering whether doses have been taken?	Y/N
Has the client tried using a compliance chart / medication diary to facilitate compliance? Do they still have problems with compliance?	Y/N
Does the client have adequate cognitive skills to use a compliance aid?	Y/N

Physical health / Manual Dexterity

Does the client have difficulty using standard packaging ? ▪ blister strips ▪ bottle tops	Y/N
Can the client physically use a compliance aid? (indicate which) ▪ Medidos / Dosette ▪ Venalink	Y/N
Does the client have difficulty reading the information on the medication labels? If large print labels were supplied would a compliance aid still be required?	Y/N

Language / Literacy

Is the client unable to read the medication labels due to English language or literacy difficulties?	Y/N
Have other attempts been made to overcome this problem? Do they still have problems with compliance?	Y/N

Personal Circumstances

Is the client unable to get regular help to prompt or supervise administration of their medication?	Y/N
Does the client have a carer or relative who would be willing, if trained, to fill a compliance aid with the client's medication?	Y/N
Is the client capable, if trained, to put their own medication into a compliance aid?	Y/N

Is a compliance aid appropriate?	Y/N
Additional information (if necessary)	

What type of compliance aid is appropriate?
(contact pharmacy for available options)

Who will fill / refill the compliance aid? (indicate and give details as necessary)	
Hospital pharmacy	
Community pharmacy	
Nurse (see policy)	
Carer (Is training required?)	
Client (Is training required?)	

What arrangements should be made regarding the supply of medications NOT suitable for dispensing in a compliance aid?

APPENDIX 11

MEDICAL REPRESENTATIVES POLICY

- All medical representatives are required to meet the relevant clinical site lead in pharmacy before visiting or attempting to make appointments with any clinical staff in the trust.
- All medical representatives from all Pharmaceutical Companies must read and understand the following policy, copies of which are available from Pharmacy.
- A copy of this policy will be given to all medical representatives on their first visit to Pharmacy.

a) General points

- Medical representatives are not permitted to promote the use of any product that has not been approved for use in the trust by the Drugs and Therapeutics Committee.
- Medical representatives are expected to comply with the current Association of British Pharmaceutical Industry (ABPI) "Code of Practice".
- Representatives must only discuss the products marketed by their company.
- Representatives may only promote their products in line with current SLAM recommendations and policies.
- Representative should not, in support of their product, cite or quote verbally-stated opinions of NHS clinicians from this or other trusts.

Note: Medical representatives are not permitted access to any clinical unit unless all the consultants and the team/ward leader in the unit approve of their presence. Each unit has the right to refuse appointments with or visits from medical representatives. Educational sessions (and lunches) may only be conducted on a unit if all the consultants and the unit manager give permission in principle for these sessions.

Appointments

Appointments with medical and nursing staff

- Consultants will see representatives by appointment only. Requests for appointments should be made to the relevant consultant's secretary.
- Visits should be limited to those necessary to discuss significant product changes. Notification of minor changes should be made by post.
- When requesting an appointment, representatives should always leave a contact telephone number in case it is necessary to cancel the appointment.
- Cancellations by either party should be made as far in advance as possible.
- Appointments with other clinical staff may only be made on the request of the consultant for that area.

Appointments with pharmacy staff

- For SLAM departments, representatives should contact the Principal Pharmacist for Clinical Services at the Maudsley Hospital.
- In other parts, representatives should contact the mental health specialist pharmacists at Guy's or Lewisham hospitals, and request an appointment. Future appointments should only be made to discuss significant product changes.
- Information that does not need discussion with the pharmacist may be left at the pharmacy reception.

b) Access to Clinical Information

- Representatives are not allowed to have access to individual patient clinical information.
- Representatives must not attend meetings, reviews, ward rounds, etc. when confidential patient information will be discussed.
- Staff must take care during representative visits and during meetings to ensure that patient confidentiality is maintained at all times.
- Representatives are not permitted access to financial data relating to drug usage.

c) Samples

- Product samples are not allowed.

d) Inducement and Gifts

- All staff must comply with the trust's Standing Financial Instructions and ABPI guidelines must be followed.
- Representatives must not offer or give gifts or benefits to health professionals or administrative staff as an inducement to prescribe, supply, administer or buy any medicine.
- Gifts in the form of promotional aids and prizes may be given to staff provided that the gift or prize is inexpensive and relevant to the practice of their profession or employment.
- In the event of a dispute it is the recipient who is required to prove that an inducement was not corrupt. Trust staff are expected to keep records of their dealings with the Pharmaceutical Industry, including any declarations of conflicting interests.

e) Hospitality and meetings

- Any meeting with clinical staff must be approved by all the consultants and the manager for that unit. It is the responsibility of the member of staff organising the meeting to ensure the meeting is approved to go ahead on the unit.
- Companies are permitted to provide appropriate hospitality to members of the health professions and appropriate administrative staff in association with scientific meetings.
- Meetings must have a clear educational content.
- The hospitality must be secondary to the purpose of the meeting and must not be out of proportion to the occasion.

f) Further Information

The Code of Practice for the Pharmaceutical Industry is published in the current edition of the ABPI Compendium of Data sheets and Summaries of Product characteristics.

APPENDIX 12

DRUG AND THERAPEUTICS COMMITTEE – TERMS OF REFERENCE

Purpose of the Committee

- To develop and implement policies and guidelines on the use of medicines in the trust.
- To evaluate new medicines and recommend approval, or otherwise, for their use in the trust.
- To monitor trends in drug expenditure and liaise with the trust executive.
- To liaise with local prescribing committees (Health Authorities and PCTs).
- To consider financial outcomes in primary and secondary care of decisions made.
- To commission, organise and approve clinical audit of medicines prescribed in the trust.
- To evaluate, promote and disseminate information on medicines for service users.
- To disseminate information on optimal medicines use to all relevant persons working in the trust.
- To oversee the work of local hospital or borough drug and therapeutics committees. (These committees are directly accountable to the trust committee.)
- To have strong links with the NICE Guidelines implementation committee and oversee implementation of medicine based TAGs.

Communication with other risk management groups/committees:

The Drugs and Therapeutics Committee is integral to the trust's governance committee structure and will report into the Clinical Effectiveness Committee.

The Clinical Governance Committee will require:

1. Escalation reports of issues causing concern, or requiring wider consideration or decision.
2. Annual terms of reference review.
3. Annual review of Committee activity.

On issues of Clinical Risk the D&T Committee will escalate issues direct to the Clinical Risk Committee Meetings

- The committee will meet quarterly.

- The meeting will be quorate **when 8 members** are present.
- Minutes will be posted on the Drug and Therapeutics Committee trust intranet webpage.
- The committee will be serviced by the trust Chief Pharmacist.
- The committee chair will be by appointment, normally for a three year duration.

Membership
Chair: Dr Vivienne Curtis (until 2010).
Secretary (trust Chief Pharmacist or deputy), Pharmacy representatives from Maudsley, Bethlem, Lambeth Hospital, Guy's and St Thomas', Lewisham and any service where the committee feels a pharmacy representative is helpful to the workings of the committee.
PCT representation (Lambeth, Southwark, Lewisham and Croydon).
Consultant D&T representatives for each Directorate but including specific representation for Addictions.
Two Senior Lecturer representatives from the Institute of Psychiatry.
Places for two SpRs (ST4-6).
The committee may co-opt up to three members with special expertise or interest, or representing specific clinical services.
The Director of Nursing or nominated deputy.
The Medical Director.

South London and Maudsley NHS Trust

Drug and Therapeutics Committee – New Drug Request Form

To be completed by an assigned principal pharmacist and the requesting consultant psychiatrist.

Approved drug name
Trade name and manufacturer
Pharmacology
Licensed indications
Licensed dosage and route
Cost of other similar drugs compared with New Drug
Should there be restrictions on who may prescribe this drug? E.g. should it be available only to certain grade orspecialty of prescriber? Give reasons.
Should the New Drug replace another approved drug? If not, give reasons
Is the New Drug likely to be prescribed in primary care?
Evidence to support New Drug application e.g. clinical experience; published research; unpublished research. (Attach full references.)

Estimated number of patients to be treated(trust/year)

Describe the opinions of colleagues with whom you have discussed New Drug request

Name of Directorate

Clinical Director

For completion by **Clinical Director**

- I (clinical director) am aware of this New Drug request and am aware of the full implications of the approval of this drug
- Clinical Director's signature:……..
- Date:……..

For completion by **requesting consultant** I …….. understand that I may be contacted for further discussion about this request and that pharmacy will undertake and submit an independent review of the requested drug. I agree to attend a meeting of the committee to present the case for this request.

Declaration of interest

I have been involved in clinical trials of this drug	☐
I have been approached by a manufacturer to make this request	☐

I have a personal or financial interest in this drug and/or its manufacturer □

Requesting clinician name:……..

Telephone:……..

Email:……..

Signature:…….

Date:……..

APPENDIX 13

UNLICENSED MEDICINES/OFF-LICENCE MEDICINES POLICY

South London and Maudsley Unlicensed Medicines policy

See link below for Royal College of Psychiatrists' guidance for prescribers on unlicensed prescribing

http://www.rcpsych.ac.uk/files/pdfversion/cr142.pdf

Introduction
In accordance with The Medicines Act 1968 all medicinal products sold in the United Kingdom (UK) must carry a UK Product Licence. Pharmaceutical manufacturers must apply to the MHRA (Medicines and Healthcare products Regulatory agency) for this licence before being able to sell their product on the UK market. The MHRA decide whether to grant a licence for a product based on available safety and efficacy data. Manufacturers operating in accordance with this legislation are likely to be found liable for harm only if the harm is directly attributable to a defect in their product.

Wherever possible, UK licensed drugs should be used first line for the treatment of patients in SLAM. The trust does however recognise that unlicensed medications or uses may be necessary and beneficial in the treatment of certain conditions.

The SLAM Drug and Therapeutics committee (DTC) is responsible for approving the use of unlicensed medicines as well as the unlicensed use of licensed medicines in the trust. Approval is based on the benefit of the use of the drug outweighing the risk. See appendix S1 for a list of approved drugs and indications in SLAM.

What is an unlicensed Medicine?

- Any medicinal product without a UK Product Licence from the MHRA. These may include drugs awaiting a license or previously licensed drugs where the license has been revoked or not renewed. These products may be imported from abroad.
- A medicinal product made by a hospital pharmacy department under a 'Specials' manufacturing licence, e.g. a different formulation of a licensed medication e.g. clozapine liquid and midazolam buccal.

What is an "off label use" of a medicine?

- Use of a UK licensed medicinal product outside its marketing authorisation (e.g. different indication, doses, routes of administration, age group). Note: The use of products in children and the elderly can in many cases be outside a drug's product licence.

Legal responsibilities

The manufacturer carries no legal liability for the use of unlicensed medicines or the "off-label" use of licensed medicines. In the event of an adverse outcome, the prescribing practitioner and the trust carry the burden of the patient's welfare. The prescriber who signs the prescription for an unlicensed/off-label medicine bears the responsibility for the use of that drug. The prescriber will be professionally accountable for his/her judgement. A pharmacist will share this responsibility as the purchaser of the product.

Process for requesting the use of an unlicensed medication in the trust

See application form attached. All completed applications for the use of unlicensed medications must be returned to the Chair and Secretary of the trust Drug and Therapeutics Committee along with any evidence for the use of the drug for the requested indication.

The DTC will either accept or reject the application based on the information provided. The consultant will be notified in writing of the Committee's decision

If accepted, the application is subject to the consultant and prescribing doctor adhering to the following conditions:

- Documentation in the notes as to whether the patient agrees to the medication.
- Regular monitoring of outcomes for the patient/patients.
- An agreement to feed back to the DTC every 6 months the outcomes of treatment. This would include amongst other things any adverse outcomes, efficacy data, patient numbers and patient.
- The treatment place in therapy should be reviewed in the light of emerging evidence from published research, audit and local policy guidelines.

Who can prescribe an unlicensed medicine in SLAM?

- Unlicensed medicines approved for use in the trust may be prescribed by SLAM prescribers who hold an honorary or NHS contract
- Unlicensed medicines newly requested but not yet approved for widespread use in the trust must be initiated (and subsequently prescribed) by the consultant who requested use of the drug.

Ordering unlicensed medications

- All unlicensed medication for use in the trust must be ordered through the pharmacy department
- The pharmacy department must adhere to its own local procedure for purchasing unlicensed products.
- Unlicensed medicines should be purchased from the safest source available. Consideration should be made to the quality of the preparation and to the availability of a patient information leaflet.

Administration of unlicensed medications

- Nurses are accountable for their own practice, regardless of advice or directions from another professional. They should be aware when they are giving an unlicensed medicine. They should be satisfied that sufficient information is available for the medication to be administered safely.

Other points to consider

- The prescriber must be aware that GPs are not obliged to continue the prescribing of unlicensed medicines.
- The pharmacist supplying the unlicensed medicine should ensure that the prescriber (and clinical team) is aware that the medicine is unlicensed.
- The MHRA in April 2009 issued the following advice for prescribers wishing to prescribe unlicensed medications.

Advice for prescribers:

Consider…

- Before prescribing an unlicensed medicine, be satisfied that an alternative, licensed medicine would not meet the patient's needs
- Before prescribing a medicine off-label, be satisfied that such use would better serve the patient's needs than an appropriately licensed alternative
- Before prescribing an unlicensed medicine or using a medicine off-label:
  - Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to show its safety and efficacy
  - Take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring and follow-up
  - Record the medicine prescribed and, where common practice is not being followed, the reasons for prescribing this medicine; you may wish to record that you have discussed the issue with the patient

Communicate: best practice is that…

- You give patients, or those authorising treatment on their behalf, sufficient information about the proposed treatment, including known serious or common adverse reactions, to enable them to make an informed decision
- Where current practice supports the use of a medicine outside the terms of its licence, it may not be necessary to draw attention to the licence when seeking consent. However, it is good practice to give as much information as patients or carers require or which they may see as relevant
- You explain the reasons for prescribing a medicine off-label or prescribing an unlicensed medicine where there is little evidence to support its use, or where the use of a medicine is innovative

Report suspected adverse reactions…

- Healthcare professionals have a responsibility to help monitor the safety of medicines in clinical use through submission of suspected adverse drug reactions to the MHRA and CHM via the Yellow Card Scheme (see www.yellowcard.gov.uk). Such reporting is equally important for unlicensed medicines or those used off-label as for those that are licensed

South London and Maudsley NHS Trust

Drug and Therapeutics Committee

Unlicensed medication request form

To be completed by a principal pharmacist and the requesting consultant psychiatrist.

Drug name, strength, preparation
Proposed indication for use
Pharmacology
Please list any licensed alternatives for this indication
Reason for request of unlicensed drug/indication
Cost of treatment (per month)
Anticipated number of patients to be treated
Have the patient/patients been informed of the use of this licensed treatment. Have the patient/patients consented to this treatment
Would prescribing be expected to be continued in primary care?
Please provide any relevant clinical data, in particular efficacy and safety/tolerability data. Attach links to full references wherever possible

Does the product have an English version of a patient information leaflet?

Name of Directorate and unit(s) in which the drug is to be used

For completion by **requesting consultant**

- I have read the SLAM unlicensed medication policy
- I am aware of the prescribing responsibilities attached with the use of this drug
- I agree to provide the Drug and Therapeutics Committee with outcome data at least every six months (and on request)

Declaration of interest

I have been involved in clinical trials of this drug ☐

I have been approached by a manufacturer to make this request ☐

I have a personal or financial interest in this drug and/or its manufacturer ☐

Requesting clinician name:……..

Telephone:……..

Email:…….

Signature:…….

Date:…….

For completion by **Clinical Director**

- I (clinical director) am aware of this request for an unlicensed medication/indication and give approval for the request to be considered
- Clinical director's name
- Clinical Director's signature:……..
- Date:……..

For completion by the pharmacist Please provide the supplier's name and the country from which the drug will be obtained Are there any anticipated problems with the initial or subsequent procurement of this product?

Name of pharmacist Signature of pharmacist Date

Approved by Drug and Therapeutics Committee Yes/No **Signature of Chair** **Signature of Secretary**

Approved unlicensed drugs/off-label indications

The Drug and Therapeutics Committee acknowledges that the use of drugs recommended in the Maudsley Prescribing Guidelines (see latest edition) is within the bounds of acceptable clinical practice assuming warnings and restrictions in the Prescribing Guidelines are adhered to. The following list highlights drugs not included in the prescribing guidelines but which are covered by this policy.

Use of psychotropics in adults and older adults	
Unlicensed/off-label Indication	**Drugs used**
Abreaction	Amylobarbitone, thiopentone
Bipolar affective disorder (all phases)	Sodium valproate and valproic acid preparations
Depression in older adults	Reboxetine
ECT (electroconvulsive therapy)	Methohexitone (as induction agent) Theophylline (to lower seizure threshold)
Insomnia	Trazodone
Tics – motor and vocal	Clonidine, pimozide, risperidone, sulpiride

Use of psychotropics in children and adolescents	
Unlicensed/off-label Indication	**Drugs used**
Antipsychotic-induced EPSEs	Orphenadrine, procyclidine
Bulimia	Fluoxetine
Insomnia	Temazepam

APPENDIX 14

HOME TREATMENT TEAMS (HTTs)

Home Treatment Teams should follow Medicines Management procedures outlined in this policy.

a) Responsibilities

The overall responsibility for establishing and maintaining a system for safe prescribing and issuing of medicines is that of the team leader, in consultation with the senior pharmacist and appropriate medical staff. If the team leader is not a nurse then the responsibility lies with the senior nurse in the team. In the absence of the team leader or senior nurse, the individual community mental health nursing staff, bear the responsibility.

b) Medication Risk Assessment

- Medication may be prescribed by the GP or by the HTT doctors.
- In either case, a decision should be made by the HTT as to the risks associated with leaving the medication in the client's home. If there are no risks, then it is preferable to leave the supply at the client's home (with advice on safe storage) and for the HTT staff to visit to promote compliance as necessary.
- If the medication is prescribed by the GP then it will usually be stored at the client's home. On occasion and with the client's consent, it may be considered to be safer for the medication to be stored at the HTT base.
- If there are risks associated with leaving medication in the home, then the amounts to be supplied at one time should be agreed by the HTT, e.g. 1 dose, 1 day, 2 days etc.

c) Medication Prescription by HTT doctors

- Refer to Medicines Management Policy.

d) Emergency Prescription

Medication may only be issued to a client with a valid prescription. Every effort should be made to ensure that a written prescription is obtained before medication is issued. This may mean that a prescription is written by a duty psychiatrist and faxed to the HTT base. This is preferable to taking a verbal order for a prescription.

- The relevant doctor must be contacted for a 'verbal order' before giving the medication to a client.
- This verbal order must then be repeated to a second clinical member of staff to confirm accuracy. If the nurse is working alone then he/she should repeat the message back to the doctor.
- The nurse must record the details on a South London and Maudsley NHS trust prescription and annotate " Verbal order from Dr ….. Taken by ….. (nurse signature), confirmed by ….. (2nd nurse)." A record should also be made in the patient's notes.
- There should be written confirmation on the chart by an HTT doctor, within 24 hours. At weekends or bank holidays this may be extended to a maximum of 72 hours.

e) *Supply of medication*

HTTs should not keep any unlabelled medication (stock) for issuing or administration to patients. All medication issued or administered to the patient must be labelled with the patient's name, drug name, strength and directions for use. The label must be dated.

During pharmacy opening hours

During pharmacy opening hours medication should be ordered from pharmacy. This ensures that there is a fully labelled supply of medication for the client. Every effort should be made to obtain medication during pharmacy opening hours.

Outside pharmacy opening hours

- When the pharmacy is closed medication may be supplied by qualified nursing staff. The medication must be issued from pre-packs kept at the HTT base. The pre-packs are supplied by pharmacy labelled with the drug name, strength and directions for use. The nurse issuing the medication is required to fill in the patient's name and date on the label. Two registered nurses, must be involved in the issuing process (one to dispense and one to check).
- Records must be kept of any medication issued, including medication and client details. Both nurses must sign and date the record.
- Alternatively, medication may be ordered from a retail pharmacy using an FP10HP.

f) *Ordering, Delivery, Storage, Custody and Disposal of Medication*

Refer to Medicines Management Policy.

g) *Administration of Medication*

Refer to Medicines Management Policy.

h) *Issuing of Medication*

Refer to Medicines Management Policy.

i) *Compliance Aids*

Refer to Medication Compliance Aid Policy and Guidelines.

j) *Risk Management and Medication Errors*

Refer to Medicines Management Policy.

List of pre-packed medication kept in some SLAM Home Treatment Teams/CMHTs

All prescriptions should be presented to pharmacy for dispensing during opening hours. When the pharmacy is closed FP10HPs should be used. If neither of these options is possible and the situation is an emergency the following pre-packs may be used.

Drug	Strength	Number of tablets	Number of pre-packs	Directions on label
Antipsychotics				
Aripiprazole	10mg	7		Take one tablet daily
Haloperidol	5mg	7		Take one tablet daily
Olanzapine (orodispersible)	10mg	7		Take one tablet daily
Olanzapine (orodispersible)	10mg	14		Take one tablet twice a day
Risperidone (orodispersible)	2mg	7		Take one tablet daily
Risperidone (orodispersible)	2mg	14		Take one tablet twice a day
Mood stabilisers				
Sodium Valproate MR	500mg	7		Take one tablet daily
Sodium Valproate MR	500mg	14		Take one tablet twice a day
Others				
Clonazepam	500 mcg	8		Take two tablets daily
Clonazepam	500 mcg	16		Take two tablets twice a day
Procyclidine	5mg	7		Take one tablet daily
Promethazine	25mg	7		Take one tablet daily
Zopiclone	7.5mg	8		Take half to one tablet at night

APPENDIX 15

MEDICINES MANAGEMENT IN (NON-NURSING) IN REGISTERED CARE HOMES AND SUPPORTED HOUSING

Introduction
This appendix outlines any procedural differences from the overall trust medicines management policy. For sections not covered in this appendix staff must refer to the trust medicines management policy.

Care homes which provide nursing care and employ registered nurses must follow the trust medicines management policy and not this appendix.

Roles and responsibilities

- The service director, of the borough which provides or commissions the service, is responsible for ensuring medicines management practices in the Home are safe for SLAM service users
- The manager of the Home is responsible for the security and safe handling of medication within the home
- The Service Manager/Team Leader is responsible for ensuring trust staff are adequately trained and assessed to administer medication to SLAM service users. The heads of nursing will be responsible for monitoring compliance with the trust medicines management policy and this appendix.
- In Homes not employing trust staff the manager of the Home is responsible for ensuring staff are adequately trained and assessed to administer medication to SLAM service users
- Non-nursing staff may facilitate self-administration of medication by clients
- Non-nursing staff may administer certain medications to clients once they have been assessed as being competent to do so

The following procedures apply to Care Homes/Supported Houses employing trust staff. Homes not employing trust staff must have their own medicines management policy, which must adhere to the principles outlined in the SLAM medicines management policy.

Ordering and supply of medicines
Medicines must be labelled individually, with the name and directions for use, for each client.
Unlabelled (Stock) medication must not be kept in the home

- Medicines will normally be prescribed for the service user by their General Practitioner (GP) on an FP10 form. These medicines will be dispensed by a local community pharmacy.
- Some service users (e.g. those on clozapine) will have their medication prescribed by hospital practitioners, in which case the medication will usually be supplied by one of the trust pharmacies.
- The manager of the Home is responsible for ensuring that there is an adequate supply of medication for each client at any time.
- Each Home must maintain a record of medication received into the home.
- Any medication received without the client's name and full directions for use must be returned to the pharmacy from which it was supplied

Note: Medication is the property of the client, not the service and must not be used for another client.

Administration of medicines

Self-administration

- Wherever possible, clients should self-administer medication
- The role of non-nursing staff in these cases is to encourage and facilitate self-administration
- The SLAM self-administration policy must be followed when assessing a client's ability and suitability to self-administer

Administration of medication by care home staff

- Non-nursing staff are permitted to administer certain medications to clients, once they have received the mandatory medicines management training and been assessed as competent to administer medication, in the home in which they are employed.
- Non-nursing staff are not permitted to administer any liquid, rectal or injectable preparations or controlled drugs unless they have been trained and assessed specifically to do so. Pharmacy and nursing directorate must be consulted in these cases.
- All clients to whom medication is administered must have a medication administration record (MAR). This can be in the form of a trust in-patient prescription or another form of record. Each home must adopt only one form of a record for each of its clients
- Each administration box (corresponding to a prescribed dose of medication) on the MAR must be signed either as given by staff or refused by the client.
- Non-nursing staff are only permitted to administer medication as indicated on the medication container (i.e. directions for use). Any deviation from the directions of use constitutes a medication error.
- For the administration procedure, refer to the overall medicines management policy.

Note: clients have the right to refuse medication

Training and competency assessment

- All Non-nursing staff who administer medication in the Home must attend the medication awareness course for non nurses.

- All Non-nursing staff will be competency assessed annually in the administration of medication. This will include:

    - basic knowledge of the drugs they administer
    - common side effects and their management
    - common drug-drug interactions
    - Knowledge of reporting systems in the event of an error

In the event of a medication error, the member of staff involved will be prevented from continuing with administration of medication until a fact finder has established the cause and action taken to reduce the risk of a reoccurrence. Staff members will be reassessed as part of that process (as per policy for Registered Nurses).

Verification of Competence

Administration of Medicines in Community Supported Housing Services (Support workers SLaM staff)
Support workers may administer medication providing they have been adequately trained and assessed as knowledgeable and competent to do so by a Registered Nurse who has been assessed as competent and able to assess staff as detailed in SLaM Medication management policy. Support workers will be assessed three times before they are able to administer medication.

1st, 2nd, 3rd Assessment

		Achieved	Not Achieved	Action
1	**Preparation of the area, planning of the administration** Ensure that the area is appropriate, clean, private. Understand the overall picture of events likely to take place, in the patients Home are you likely to be interrupted, Consider what measures can be in place to reduce interruptions	☐	☐	
2.	**Preparation of any equipment** Water, Compliance aids(dossett boxes, blister packs) Medicine charts / prescription/ MAR chart are available	☐	☐	
3.	**Routine checks made of:-** Patients Name (identity) Date of Birth Legal Status Allergies/ contra indications recorded on chart /MAR Medication details, Name, Dosage, Expiry date. Start/stop dates Recorded prescribers signature Date of prescription Is the chart clear, does it need to be re written, does it include all medications Prescribed	☐	☐	
4.	**Medication Knowledge, Purpose, effects maximum dose** Atypicals Mood Stabiliser Anti-cholinergic / Anti Muscarinic Anti-depressant Benzodiazepine Cardiovascular drugs, i.e. Beta Blockers Metabolic drugs, i.e. Insulin Any other medication commonly used	☐	☐	
5.	**Side Effect Knowledge / common contra indications** Antipsychotic medication Depot Anti-depressant Others	☐	☐	

	Achieved	Not Achieved	Action
6. Drug policy Demonstrates knowledge of action to take in the event of an incident involving medication. Inc the patient, informing others GP, Manager, Accurate and clear record keeping, Incident form, handover to staff. Aware of limitations on own practice.	☐	☐	
7. Physical Observations Temperature Pulse Respiration Blood Pressure Blood Glucose / urinalysis Knowledge of importance of taking observations before the administration of some medicines. Demonstrates taking recording and acting on abnormal observations	☐	☐	
8. Calculation of Drugs (Only after additional training and re assessment) Can demonstrate clear understanding and knowledge of oral drug calculations. Give 6 examples. Can administer liquid preparations accurately Give 6 examples Liquid preparations may only be administered after additional training and competence assessment.	☐	☐	

MAR = Medication administration record used in some homes

Name and Signature of Staff Member……
Grade:……..

Name and Signature of Registered Nurse Assessor……
Date:……..

APPENDIX 16

Covert Administration of Medicines within Food and Drink

Approved by: Drug and Therapeutics Committee Ratified by the Executive Governance Committee.

Issue date:	24th July 2008
Reviewed	May 2011
Review Date:	May 2013
Policy Leads:	Dr Mike Philpot, Consultant Psychiatrist for Older Adults Jenny Keech, Nurse Advisor, Mental Health of Older Adults Delia Bishara, Principal Pharmacist, Pharmacist for Older Adults Geoff Hufton, Claims and Litigation Manager
Policy Risk Owner:	Martin Baggaley, Medical Director, SLaM
Policy Category	Clinical
Number of Pages	8
Target Audience	All Staff
Equalities Compliant	☐ Date…….Assessed by……
Child Protection Compliant	☐ Date…….Assessed by……
HRA Compliant	☐ Date…….Assessed by……

Key words
Covert, Medicines, Conceal, Disguise

1. Policy Summary

This policy concerns the clinical circumstances and procedures to be followed when it may be considered in the patient's best interests to conceal or disguise medication in food or drink (known as covert administration). This practice should only be used in patients who lack the capacity to validly consent or refuse treatment. The present policy incorporates guidance from the Nursing and Midwifery Council, the Royal College of Psychiatrists and the Mental Capacity Act.

Covert administration of medication should be subject to the following safeguards:

- All efforts must be made to give medication openly in its normal form.
- A record of the examination of the patient's capacity must be made in the clinical notes, and evidence for incapacity documented.
- The proposed treatment plan and reasons for the plan should be discussed by the multidisciplinary team and the immediate relatives/carers or nominated representatives. Records of these discussions should be made in the clinical notes.
- A check should be made with the pharmacy to determine whether the properties of the medication are likely to be affected by crushing and/or being mixed with food or drink.
- The prescription card should be amended to describe how the medication is to be administered.
- The administration of medicines in this way should be reviewed regularly within care reviews.
- When the medication is administered in foodstuff it is the responsibility of the dispensing nurse to ensure that the medication is taken. This can be facilitated by direct observation or by nominating another member of the clinical team to observe the patient taking the medication.

Contents page

2. Introduction

2.1 Until relatively recently, nurses have been prohibited from concealing a patient's medication in food and drink. However, case descriptions[1] and surveys within nursing homes[2,3] have suggested that the practise was common, particularly in managing patients with dementia. In recognition of these problems the UKCC issued a position statement on the covert administration of medicines in 2001.[4]

2.2 A local policy has been in operation in the Mental Health of Older Adults Directorate within the South London & Maudsley NHS Trust since 2001 based on guidance from the UKCC[4] and other safeguards, outlined in Treloar *et al*[5] that had previously been implemented in Oxleas NHS Trust. The present policy is intended for use throughout SL&M and incorporates more recent guidance issued by the Nursing and Midwifery Council[6], the Royal College of Psychiatrists[7], and the Mental Capacity Act 2005[8]. It has also been informed by views given by the panel of users and carers convened by the MHOA Directorate.

2.3 Clinical guidelines for the covert administration of medication are given in the Appendix together with a checklist and record.

3. The Policy

3.1 General considerations

3.1.1 The routine practice of administering medication within food or drink must be discouraged. All efforts should be made to give the medication openly in its usual tablet or syrup form. There are times when covert administration might enable treatment to be provided that would otherwise have been impossible or, more likely, cause distress to the patient. However, disguising or concealing medication in the absence of a patient's informed consent may amount to deception.

3.1.2 A distinction needs to be made between patients who have the capacity to give a valid refusal to medication (whose refusal should be respected, unless treatment is under the auspices of the Mental Health Act), and those who lack this capacity. Among the latter a further distinction can be made between those for whom no covert use is necessary (because they are unaware that they are receiving medication) and others who would be aware if they were not deceived into thinking otherwise.[4]

3.1.3 The patient should be unable to learn that there is a need for them to take medicine, as well as a profound limitation of understanding what is occurring (e.g. in severe dementia or learning disability). The covert administration of medication in patients with schizophrenia and other severe mental illnesses where patients can learn and understand that they will be required to take medication is unacceptable.[7]

3.1.4 By disguising medication in food or drink, nursing or medical professionals are leading the patient to believe that they are not receiving medication when in fact they are. Health professionals should therefore be sure that their actions are in the best interests of the patient and be prepared to be accountable for their decisions.[4]

3.1.5 The best interests of the patient are paramount and the decision to administer medications covertly should not be influenced by the interests the professional team or the organisation caring for them.[4] There should be a clear expectation that the patient will benefit from covert administration, and that this will avoid significant

harm (both mental or physical) to the patient or others. The treatment must be necessary to save the patient's life, to prevent a deterioration or to ensure an improvement in physical or mental health.[4]

3.1.6 The determination of best interests must not be made on the basis of the person's age or appearance, or on the 'basis of a condition or aspect of behaviour which might lead others to make unjustified assumptions about what might be in…(the person's) best interests'8. The Mental Capacity Act further requires that the person determining an individual's best interests:

- consider whether it is likely that the person will at some time have capacity in relation to the proposed treatment, and if so, when that is likely to be;
- permit and encourage the person to participate, or to improve his/her ability to participate, as fully in any act done for him and any decision affecting him/her;
- where the determination relates to life-sustaining treatment he/she must not…be motivated by a desire to bring about his/her death;
- consider, so far as is reasonably ascertainable –

    a) the person's past and present wishes and feelings (in particular, any relevant written statement made by him/her when he/she had capacity,
    b) the beliefs and values that would be likely to influence his decision if he/she had capacity, and
    c) the other factors that he/she would be likely to consider if he/she were able to do so;

- take into account, if it is practicable and appropriate to consult them, the views of –

    a) anyone named by the person as someone to be consulted on the matter in question,
    b) anyone engaged in caring for the person or interested in his/her welfare,
    c) anyone of a lasting power of attorney* granted by the person,
    d) any deputy appointed for the person by the court.

NB * this is a new power defined within the Act and not to be confused with the 'enduring power of attorney'

3.1.7 The decision to administer medication covertly should not be made by a single individual but should involve discussion with the multi-disciplinary team caring for the patient and the patient's relatives or informal carers. Any decisions should be carefully documented and each instance of covert administration recorded on the prescription chart4,7 The decision should be subject to regular review.[7]

3.1.8 The Mental Health Act provides for the administration of psychiatric medication to patients who refuse it. Covert administration could be used to administer oral medication to a detained patient refusing treatment as long as they also lack capacity to give valid refusal. There is a general obligation to provide care to incapable adults in the least restrictive fashion[9]. The M.H.A. does not provide for treatment of physical conditions unless they are directly related to the mental disorder being managed (e.g. in delirium).

3.1.9 Patients may refuse treatment for physical illness, and for mental illness where they are not sectioned, and are entitled to do so, even when such a decision is considered to be contrary to their best interests. On the other hand, patients could consent to treatment while *choosing* not to be given full details of their diagnosis or treatment. Their uninformed consent is nevertheless valid, as long as they have the option of receiving more information. Finally, it may be impossible for patients to make a valid choice about their treatment because they lack sufficient mental capacity to do so.[10]

3.1.10 Treating patients without their knowledge as a last resort can be justified under the Mental Capacity Act 2005, where the patient lacks mental capacity to take a valid decision to consent to, or refuse treatment and the necessary treatment cannot otherwise be administered.

3.2. Assessment of Mental Capacity[4,7,10]

3.2.1 A patient is presumed to have the capacity to make treatment decisions unless he/she is unable to:

- understand information relevant to the treatment, its purpose and why it is being proposed (even when given in simple language),
- understand the principal benefits, risks and alternatives,
- understand the consequences of not receiving the proposed treatment,
- retain the information long enough to make a decision, and
- weigh up the information and make a free choice.

3.2.2 The assessment of capacity is primarily a matter for the doctors treating the patient.4,7,10 In assessing capacity it is important to make the assessment in relation to the particular treatment proposed. Capacity can vary over time and the assessment should be made at the time of the proposed treatment. Every effort should be made to enhance and maximise the level of capacity.

3.2.3 Patients with cognitive impairment may be able to make decisions about their health care provided that at the time the decision is made they are able to understand the issues.

3.2.4 The implication of the above is that where patients have the mental capacity to consent or refuse their treatment they must be given the opportunity to do so and their wishes should be respected. Where appropriate, the Mental Health Act should be used if patients consistently refuse medication for mental disorder.

3.3. Professional Roles and responsibilities

3.3.1 It is a team decision as to whether or not this practice is put in place, with the final legal responsibility lying with the consultant. Where the consultant is not available, for example out of hours, the responsibility should lie with their deputy in the interim, with review by the consultant at the earliest opportunity.

3.3.2 Nurses are responsible to their own ethical codes and if they are concerned that this treatment is inappropriate they must make their views known.

3.3.3 The pharmacist may be asked to provide available evidence on the effects of mixing medications with foodstuffs.

3.4. Training

All nursing staff will have a competency assessment in relation to the administration of medication. Any additional training issues should be identified with ward/home managers.

3.5. Links with other SLAM Policies, Procedures and Guidelines

- SLAM Medicines Management Policy
- SLAM Consent Policy

3.6. Review date

The policy will be reviewed by April 2009.

4. References

1 Kellett J. A nurse is suspended. *BMJ* 1996; 313: 1249-1250.

2 Treloar A, Beats B, Philpot M. A pill in the sandwich: covert medication in food and drink. *J Roy Soc Med* 2000; 93: 408-411.

3 Kirkevold O, Engedahl K. Concealment of drugs in food and beverages in nursing homes: cross sectional study. *BMJ* 2005; 330: 20-22.

4 United Kingdom Central Council for Nursing, Midwifery and Health. Position statement on the covert administration of medicines. 2001

5 Nursing and Midwifery Council guidance on www.nmc-uk.org.uk

6 Royal College of Psychiatrists. College statement of covert administration of medicines. *Psychiatric Bulletin* 2004; 28: 385.

7 Treloar A, Philpot M, Beats B. Concealing medication in patients' food. *Lancet* 2001; 357: 62-64.

8 Mental Capacity Act 2005. Chapter 9. Department for Constitutional Affairs. London: The Stationery Office Ltd, 2005.
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9 The Lord High Chancellor. Making decisions: the government's proposals for making decisions on behalf of incapable adults. London: HM Stationery Office, 1999.

10 British Medical Association. *Assessment of Mental Capacity. Guidance for Doctors and Lawyers, 2nd edition.* London: BMJ Books, 2004.

5. APPENDIX

COVERT ADMINISTRATION OF MEDICINES IN FOOD AND DRINK

CLINICAL GUIDELINES

This policy applies only to those patients who lack the capacity either to consent or refuse medication. Patients who have the mental capacity to make healthcare choices must not be given treatments without their consent unless they are subject to the Mental Health Act.

Treatment should be made available to severely incapacitated patients judged according to their best interests and administered in the least restrictive fashion. In exceptional circumstances, this may require the administration of medication within foodstuffs when the patient is not aware that this is being done (i.e. covert administration).

Administration of medication in this way should be subject to the following safeguards:

- All efforts must be made to give medication openly in its normal tablet or syrup form.
- A record of the examination of the patient's capacity must be made in the clinical notes, and evidence for incapacity documented. This should be signed by the patient's consultant (or deputy out-of-hours, and reviewed by the consultant at the earliest opportunity).
- The proposed treatment plan and reasons for the plan should be discussed by the multidisciplinary team (or between consultant and nurse in charge of the ward in cases of urgency) and a record of the discussion made. In residential or nursing home settings, this might be between the senior nurse or manager on duty, and the consultant or general practitioner.
- The proposed treatment plan should be discussed with the immediate relatives/carers or nominated representative and take into consideration what is known of the patient's past and present wishes (including any valid Advance Directives), and belief and values.
- A check should be made with the pharmacy to determine whether the properties of the medication are likely to be affected by crushing and/or being mixed with food or drink.

Practical aspects of policy administration

Once a decision has been made the following procedures will occur:

- The prescription card should be amended to describe how the medication is to be administered.
- The administration of medicines in this way should be reviewed regularly within care reviews.
- A checklist (see below) should be completed to ensure that all of the above points are satisfactorily covered. The original should be kept in the patient's notes. One copy should be kept with the prescription card and a further copy should be kept on file on the ward to enable monitoring of the practice within the Trust.
- When the medication is administered in foodstuff it is the responsibility of the dispensing nurse to ensure that the medication is taken. This can be facilitated by direct observation or by nominating another member of the clinical team to observe the patient taking the medication.

RECORD SHEET FOR COVERT ADMINISTRATION OF MEDICINES IN FOOD AND DRINK

PATIENT'S NAME:	Date of Birth:
Ward:	
Medicines to be administered in foodstuffs:	
Foodstuffs to be used:	
Has a check been made with Pharmacy to ensure that medication will not be affected by being mixed with the proposed food?	Yes ☐ No ☐
Has the prescription card been amended to describe how the medication will be administered?	Yes ☐ No ☐
Have all efforts been made to give the medication in its normal form?	Yes ☐ No ☐
Has a record been made in the clinical notes of the reasons for believing that the patient lacks mental capacity and has this been signed by the Consultant (or their deputy out-of-hours, with review by Consultant at earliest opportunity)?	***Yes ☐*** ***No ☐***
Has the proposed treatment been discussed by the multidisciplinary team (or between Consultant and Nurse in charge in cases of emergency) and has a record of the discussion been made?	Yes ☐ No ☐
Has the proposed treatment been discussed with the immediate relative, carer or nominated representative and has a record of the discussion been made?	Yes ☐ No ☐ N/A ☐
Has the decision to administer medication in foodstuffs been signed and dated by the Consultant (or their deputy with review by Consultant in cases of urgency out of hours) and nurse in charge of the ward?	Yes ☐ No ☐
Review Date:	
Signed: Nurse in Charge Date Signed: Consultant Date	

Original of this record sheet should be kept in the patient's notes. 1 copy should be kept with the prescription card. 1 copy should be kept on file on the ward.

APPENDIX 17

South London and Maudsley NHS
NHS Foundation Trust

Patient Group Direction (PGD) policy

Version:	1
Policy Lead:	David Taylor
Policy Category:	Clinical and Operational
Date issued:	21/7/2009
Review date:	
Ratified by:	Governance Executive
Date ratified:	
Name of responsible committee:	
Target audience:	Nurses, doctors, pharmacists, clinical and audit staff

Approved by ……..Committee	**Date:**
Ratified by the Governance Executive	**Date:**

Equalities Impact Assessment	**Assessor:** *Policy lead name*	**Date:**
Child Safeguarding Assessment	**Assessor:** Sue Lewis	**Date:**
HRA Impact Assessment	**Assessor:** Paul Bellerby	**Date:**

Contents

1. Background

In August 2000 the Department of Health issued a Health Service Circular HSC 2000/026 which outlines the legal requirements for the use of Patient Group Directions (PGDs). Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

This policy has been developed to ensure that the trust has a framwork for the use of PGDs which complies with legal requirements.

Purpose of Policy
The purpose of this policy is to define the processes and procedures for the proposal, development, approval, implementation and review of PGDs in SLAM.

Targeted audience
Nurses, Doctors, Pharmacists, Clinical staff and Audit staff.

Targeted patient/client/user group
This policy is relevant to all service users who are prescribed medicines.

Associated documents
This policy should be read in conjunction with the trust Medicines Management and Medicines Reconciliation policies.

1.0 Introduction

The HSC 2000/026 states "The majority of clinical care should be provided on an individual, patient-specific basis. The supply and administration of medicines under patient group directions should be reserved for those limited situations where this offers an advantage for patient care (without compromising patient safety), and where it is consistent with appropriate professional relationships and accountability".

A Patient Group Direction (PGD) provides the legal entitlement for named health professionals without prescribing rights to supply and/or administer medicines including 'prescription only medicines' to defined patient groups in defined situations. Using a PGD is not a form of prescribing and PGDs do not allow professionals to use prescription forms to order medicines to be supplied by others.

The following registered health professionals may supply or administer medicines, as named individuals under a patient group direction: nurses; midwives; health visitors; optometrists; pharmacists; chiropodists; radiographers; orthoptists; physiotherapists; ambulance paramedics; dietitians; occupational therapists; speech and language therapists; prosthetists and orthotists.

1.1 There are five key stages to consider before writing a PGD

Stage 1 Proposal of a PGD by a team/service
Stage 2 Development of the PGD
Stage 3 Approval of the PGD for use in the service/trust
Stage 4 Implementation of the PGD in the service/trust
Stage 5 Review of the PGD

1.2 Stage 1: Proposal of the PGD

The team/service should decide whether a PGD is appropriate for the proposed drug/patient group. See link below for guidance and special considerations
http://www.portal.nelm.nhs.uk/PGD/viewRecord.aspx?recordID=422
Note: Unlicensed medicines cannot be included in a PGD. Controlled drugs are only allowed for certain conditions.
The stage 1 (proposal) checklist below must be completed before proceeding to Stage 2

Criteria	Yes/No
The drug is appropriate for inclusion in a PGD	
The risk vs benefits for the patient and staff/service have been considered	
The financial implications have been considered	
The team/service has sufficient numbers of staff who are competent to supply/administer the drug according to the PGD protocol	
The team/service has designated a lead author for the PGD	
The team/service has a plan for monitoring compliance with the PGD	
Signature of the consultant of the service/team	
Signature of head of nursing	
Signature of the pharmacist for the team/service	

1.3 Stage 2: Development of the PGD

- When writing the PGD the lead author should consult and be advised by a multi-disciplinary group including a doctor, a pharmacist and a representative of any professional group expected to supply medicines under the PGD

- Special consideration must be given to the competencies of staff working in the service in relation to the supply/administration of the drug involved

- See appendix 1 for the trust approved blank PGD template

- Once completed, the PGD must be signed by the consultant and senior pharmacist for the team/service, both of whom should have been involved in developing the PGD

1.4 Stage 3: Approval of PGDs in the trust

- The trust Drug and Therapeutics Committee (DT&C) is responsible for approving a PGD for use in the trust. A copy of the PGD and Stage 1 proposal checklist should be emailed or posted to the Chair and Secretary of the DTC for submission for approval at the next DTC meeting
- The DTC meets once every 3 months. The PGD will be considered for approval at the next scheduled meeting. A member of the team/service proposing the PGD will be invited to attend the meeting
- The DTC will use the following checklist when considering the PGD for approval

Criteria	Yes/No
The drug has a UK marketing authorisation	
The drug is appropriate for inclusion in a PGD	
A PGD is an appropriate method of supply/administration for this drug/patient group	
The PGD has been approved for use in the team/service by the consultant, head of nursing and senior pharmacist of that service/team	
The protocol outlined in the PGD does not present an unecessary clinical risk to the patient	
The protocol outlined in the PGD does not present an unecessary clinical risk to the service/trust	
The protocol outlined in the PGD does not present an unecessary financial risk to the service/trust	
The service has sufficient numbers of competent clinicians to supply/administer the drug	
The service/team has a clear plan for monitoring compliance with the PGD	
The service/team has agreed to audit the use of the PGD and present results to the DTC	

- Once approved the PGD must be signed by the consultant, pharmacist and the Chair/Secretary of the DTC. A copy of the PGD will be made available on the trust intranet

1.5 Stage 4: Implementaion of the PGD

Once the PGD is approved by the DTC it is the responsibility of the consultant, head of nursing and pharmacist of the team/service to ensure:

- That the service has a list of named practioners (and their signatures) who have been assessed as competent to supply/administer medication in line with the protocol of the PGD

- That the service/team are aware of the PGD
- That the service/team has a signed copy of the PGD
- That the patients consent to the supply/administration of the drug according to the PGD
- That supplies of the medication are available in the service
- That there is an adequate system for the safe storage of the medication

1.6 Stage 5: Monitoring and review of the use of the PGD

- It is the responsibility of the consultant, senior pharmacist and head of nursing to ensure that each stage of the PGD is regularly audited and that records are kept for inspection

1.7 Competency framework

See appendix 1

Appendices

Appendix 1

Competencies for Patients Group Directions for the Administration of XXXX by XXX Team/Ward

Name of nurse:…….....

Team/Ward:……

Where they are based:……

1. Consultation

Clinical and pharmaceutical knowledge
Has up-to-date clinical and pharmaceutical knowledge relevant to the scope of the PGD

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Fully understands how to recognise, treat or prevent the condition described in the PGD **I**		
Understands the non-pharmacological or and pharmacological approaches that need to be taken to improve health or prevent ill health **I**		
Understands the mode of action and pharmacokinetics of the medication described within the PGD, and it able to state how these may be affected or altered. E.g. Age/ liver impairment **I**		
Can describe the potential side effects, drug interactions of the medication described within the PGD and is aware how these should be minimised or managed **I**		
Can demonstrate knowledge on recognising and reporting an adverse drug reaction? **I**		
Is aware of resources available that will enable them to maintain up to date knowledge of products contained in the PGD? **I**		
Is able to demonstrate knowledge on how medicines within the PGD may be subject to misuse **I**		

2. Establishing Options

Makes and/or reviews diagnosis and generates treatment options for the patient, including follow-up within the PGD

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Takes an appropriate medical history, where possible, and undertakes an appropriate physical examination that is relevant to the medicines described within the PGD **O**		
Views and assesses the patient's needs holistically (psychosocial, physical)**O**		
If appropriate is able to make and/or review a working or final diagnosis by considering and systematically deciding between various possibilities (differential diagnosis) before considering supplying or administering medicines within the PGD **O**		
Requests relevant diagnostic tests and is able to interpret or refer results for interpretation in how they relate to medicines within the PGD **O**		
Considers no treatment, non-drug and drug treatment options **O**		
Assesses the effect of multiple pathologies, existing medication and contraindications on treatment option **O**		
Assesses the risks and benefits to the patient of taking / not taking a medicine (or using / not using a treatment) **O**		
Selects the most appropriate drug, dose and formulation from the PGD **O**		
Checks doses and calculations to ensure accuracy and safety **O**		
Makes accurate, clear and timely records **O**		
Identifies the potential management plan and is able to identify referral options for the patient for ongoing management or risks **O**		
Reflects on own performance, learns and changes practice **I**		

3. Communication with patients

(parents, carers and advocates where appropriate). Establishes a relationship based on trust and mutual respect. Sees patients as partners in the consultation. Applies the principles of concordance.

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Listens to and understands patients' beliefs and expectations **O**		
Understands the cultural, linguistic and religious implications of supplying and administering medicines **O**		
Deals sensitively with patients' emotions and concerns **O**		
Adapts the consultation to meet the needs of different patients (e.g. for age, level of understanding) **O**		
Helps and supports the patients to make informed choices about their options **O**		
Negotiates an outcome of the consultation that both patient and health care professional are satisfied **O**		
Is able to give clear instructions to the patient about their medication described within the PGD (what it is for, how to take it, possible side effects and expected outcomes **O**		
Provides the patient with written information about the medication within the PGD **O**		

4. Supply and administration in accordance with the PGD
Is aware of own limitations. Does not compromise patient safety

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Is able to demonstrate limitations within their knowledge and skills within the use of the PGD and knows how to manage this by either seeking guidance or not supplying or administering medication from the PGD **I**		
Is able to demonstrate knowledge of the medications within the PGDs and discuss the medications intended actions, indications, contraindications, cautions, dose and side effects **I**		
Is able to demonstrate knowledge on the limitations of the medicines within the PGD with particular reference to the inclusion and exclusion criteria. **I**		
Is able to name some of the more common types of medicine related errors and how they may be avoided? **I**		
Is able to describe the procedure for administering a medicine under the PGD? **I**		
Is able to know how to order medicines for administration under the PGD? **I**		
Is able to demonstrate how often expiry dates of medicines require to be checked? **I**		
Demonstrates knowledge on medicine wastage, i.e. keep quantities of medicines to a minimum and use those with the soonest expiry date first? **I**		
Can describe the necessary storage arrangements for medicines described within the PGD? **I**		
Can describe the records that need to be kept when supplying medicines under PGD? **C I**		

5. Professional standards

Works within professional and organisational standards

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Understands personal responsibility for working within PGDs **I**		
Understands the legal framework for working within a PGD and how this applies to practice **I**		
Understands the criteria needed to be met before a patient can be supplied a medicine under the PGD? (Scope of the PGD) **I**		
Is aware of the NMC guidelines with regards to Patient Group Directions? **I**		
Understands the issue of consent in relation to administering medicines within a PGD **I**		
Understands the importance of record keeping standards when documenting administration or supply of medicines within the PGD **I**		

6. Practice development

Actively participates in the review and development of practice to improve patient care

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or Exceeds**
Is aware of the need to audit the PGD annually within teams and use those results to inform and improve practice **I**		
Is aware of the other professional groups required to inform improvements and developments of the PGD **I**		

7. PGDs in context

Knows how to access relevant information. Can critically appraise and apply information in practice

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Can name sources of information, other than the PGDs, you would use to inform your practice, e.g., BNF, green book for immunisations, pharmacy **I**		

8. The NHS in context

Understands, and works with, local and national policies and services that impact on PGD use

Behavioural indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Can name the relevant policies you need to be familiar with when supplying or administering medicines under PGD? **I**		
Understands the National Framework for PGD competencies. Is aware of the NHS PGD website **I**		

9. The team and individual in context

Works in partnership with colleagues for the benefit of patients. Is self-aware and confident in own ability to use PGDs

Indicator	**Needs to improve (and details of what needs to be done)**	**Meets or exceeds**
Ensures that continuity of care is not compromised, by keeping all relevant colleagues informed **I/O**		
Uses the multidisciplinary team to its full extent **I**		
Recognises and deals with pressures that result in inappropriate use of PGDs **I**		
Negotiates the appropriate level of support to enable the use of PGDs **I**		

Date of assessment:……

Mentor's name (please print):……...

Mentor's signature:… ……

nments

	Tick appropriate box
Met all criteria satisfactorily	
Met all critical criteria satisfactorily, so can supply medicines under PGD without supervision if other criteria are met but a further observation assessment should be carried out after two to four weeks	
Did not meet all critical criteria satisfactorily, will need a further observation assessment before they can supply medicines under PGD without supervision	

Appendix 2

PATIENT GROUP DIRECTION (PGD)

FOR THE SUPPLY/ADMINISTRATION

(delete as appropriate)

of MEDICINE NAME

by AUTHORISED NURSES

to CLIENTS/PATIENTS

in LOCATION

WITHIN THE TRUST

The supply and administration of medicines under Patient Group Directions should be reserved for those limited situations where this offers an advantage for patient care (without compromising its safety), and where it is consistent with appropriate professional relationships and accountability.

TRUST AUTHORISATION

Authorisation of this PGD has been conferred by South London and Maudsley NHS Foundation Trust, Drug and Therapeutics Committee (DTC)

NAME	SIGNATURE	DATE
Dr Martin Baggaley Medical Director, Chair Clinical Governance and Risk Management Committee		
Hilary McCallion Director of Nursing		
Prof. David Taylor Director of Pharmacy and Pathology		
Dr Vivienne Curtis Chair Trust Drug and Therapeutics Committee		

AUTHORS

AUTHOR	POSITION	SIGNATURE	DATE
Lead Author Name	Must be an authorised health professional who can practice under a PGD		
Lead Clinical Pharmacist	A senior clinical pharmacist must be involved in the development and writing of the PGD from the outset and throughout the whole process		
Lead doctor (Consultant/SpR) Name	A doctor for the speciality must be consulted during the development of the PGD from the outset and throughout the whole process. This person will give support to the use of a PGD over prescribing		
Others Name	Any other professional who has been involved in the production of the PGD		

The lead author (Name) has ensured that the following policies and procedures have been adhered to in the development of this PGD:

- **South London and Maudsley NHS Foundation Trust Medicines Management Policy**
- **South London and Maudsley NHS Foundation Trust PGD Development and Approval Protocol**

Signed:……

Date:……..

CLINICAL DIRECTORATE AUTHORISED SIGNATORIES

NAME	SIGNATURE	DATE
Name Head of Nursing for Directorate		
Name Clinical Director for Directorate		

Contents

OBJECTIVES OF PATIENT GROUP DIRECTION

The objective(s) of this PGD is/are:

The PGD should be used in conjunction with:

MEDICINES TO BE SUPPLIED UNDER THE PGD

This PGD includes the following medicine(s):

The decision to supply/administer any medication rests with the individual registered practitioner who must abide by the PGD and Trust policies.

MANAGEMENT AND MONITORING OF PATIENT GROUP DIRECTION

(Refer to the trust PGD development and approval protocol for management and monitoring responsibilities)

Each practitioner working under the PGD is responsible for:

- Medication administration and or supply in accordance with the PGD
- Security and storage of medication
- Recording of administration of medication in accordance with the PGD
- Obtain medical support when necessary
- Adverse drug reaction reporting
- Other adverse incident reporting

The lead author is responsible for:

- Leading on the annual audit of the PGD
- Reviewing the PGD every 2 years (unless review is required sooner e.g. informed by audit or following significant changes to the medicine SPC or practice)
- Consulting pharmacists and clinicians in the review process
- Submitting all PGD amendments to the DTC for approval, along with all related audit reports

The Clinical Nurse lead is responsible for:

- Keeping up to date documentation of signatures of all practitioners who are working under the PGD and have been assessed as competent
- Confirming with the Lead Author that the annual audits are to be undertaken.
- Ensuring that the practitioners authorised to work under the PGD have completed the signed agreement to act under the PGD (see appendix 4)
- Confirming by signing the agreement document that authorised practitioners have fulfilled the training requirements and achieved an acceptable standard of competency
- Ensuring that there is an up to date list of specimen signatures of all currently employed registered practitioners in the department working under the PGD. This list should be available to D&T on request
- Ensuring that only the currently approved PGD is available in the clinical areas and the trust intranet and that there is full document control. Note: the Chief Pharmacist will keep a copy of the currently approved PGD
- Ensuring that audits are undertaken of all registered practitioners working under the PGD at the specified intervals

STAFF CHARACTERISTICS

The PGD must detail specific training and competences required for staff authorised to work under the PGD and provide information as to how this will be monitored. This will need to be added as an appendix.

The [health professional title] authorised to administer/supply (delete as required) medications under the PGD must meet the following criteria:

Qualifications:

Specialist qualifications:

Specialist competencies:

- Successful completion of the SLAM Medicines Management Competencies (evidence required)
- Actively partaking in CPD and annual Individual Performance Review

An up to date list of names and signatures of registered practitioners who are authorised to practice under this PGD is kept in

……..(Insert department)

by ……..….. (Insert name)

Only listed practitioners are authorised to practice under this PGD

DRUG NAME / STRENGTH / FORM Quantity to supply	Legal category POM/P/GSL

Clinical Condition to which this PGD applies	
Inclusion criteria	
Exclusion criteria (i.e. situations not covered by the PGD)	
Action if excluded	
Cautions/Need for further advice/Action to be taken	
Action if patient declines	

Drug Details	
Name, form and strength of medicine	
Route/Method	
Dosage/Frequency	
Duration of treatment	
Maximum or minimum treatment period	
Side effects	List common side effects. This list may not represent all reported side effects of this medicine. Refer to the current SPC for more information

	Report any suspected adverse drug reactions on www.yellowcard.gov.uk
Advice to patient/carer	Manufacturer's Patient Information Leaflet
Follow up	
Records	The following must be recorded: ▪ Name of the health professional providing treatment ▪ Patient identifiers ▪ Details of the medicine provided ▪ Date the medicine is supplied or administered ▪ Patient consent or refusal ▪ Patient inclusion or exclusion from PGD ▪ Information given to the patient ▪ Batch number and expiry date must also be recorded for immunisations, vaccinations and blood derived products ▪ State any other agreed records to be kept for audit purposes
References	

Appendix 3

Agreement by Registered Practitioner

Statement by practitioner agreeing to act under the PGD NAME within South London and Maudsley NHS Foundation Trust

I have received, read and fully understand the following documents:

1. The PGD Name within South London & Maudsley NHS Foundation Trust

2. The Drug Monograph(s) included in the PGD

3. Operational policy/policies Name

4. The South London and Maudsley NHS Foundation Trust Medicines Management Policy

5. The South London and Maudsley NHS Foundation Trust Procedure for PGD Approval

I have received the training set out in the PGD which practitioners must undertake before being authorised to administer or supply any medicinal product under the PGD

I agree to act as a practitioner within the terms of the PGD and to administer and/or supply medicinal products in accordance with the PGD

In return, the Trust accepts vicarious liability for the practitioner acting under the terms of the PGD

I understand that by agreeing to act as a practitioner under the PGD, I am extending my role and job description. I understand that my acceptance of this extension of my role and job description has not been a compulsory requirement of South London and Maudsley NHS Foundation Trust

NAME OF PRACTITIONER: (*block capitals*).....

SIGNATURE OF PRACTITIONER:.....

DATE:.....

NAME OF DESIGNATED MANAGER; (*block capitals*).....

SIGNATURE OF DESIGNATED MANAGER:.....
(TO CONFIRM THAT TRAINING HAS BEEN COMPLETED AND ATTAINED TO A SATISFACTORY STANDARD)

DATE:.....

APPENDIX 18

FP10SS SECURITY POLICY

Ordering FP10SS forms

- FP10SS forms are individual blank green prescription forms intended to be used with the PJS FP10 printing system. They differ to the FP10HP pads in that they have no pre-printed information on them which identifies the prescriber or team. Therefore FP10SS forms can only be used with the FP10 prescription printing system.
- Blank FP10SS forms should be ordered from the appropriate pharmacy department (from the Maudsley hospital pharmacy 020 3228 2808).
- FP10SS forms should be ordered two weeks in advance to ensure stocks are available – the team business manager should ensure stocks are replenished as necessary.
- Requisitions for new pads must be written on trust headed paper.
- Blank FP10SSs should be collected in person by a member of team staff carrying trust ID.
- Prescription identifier numbers must be recorded by pharmacy (the first and last numbers of each pad) for those being supplied. The person collecting the forms should check the numbers are correct and sign for the forms.

Storage and use of FP10SS forms

- Blank FP10SS forms must not be taken home by prescribers.
- The team stock of blank FP10SS forms must be kept in a locked cupboard by the team leader/administrator.
- Each week a ‘batch’ of prescriptions will be printed for all prescriptions due the following week. This task will be the responsibility of a designated member of staff within the team. This batch of printed prescriptions will then be collected by a designated local pharmacy and dispensed ready for delivery back to the team the following week. The business manager should ensure a member of the team is available to issue required FP10s in their absence.
- Each time a weekly ‘batch’ of prescriptions is due; the required number of blank FP10SS forms must be signed out as above.
- Any FP10SS forms with errors should be marked and cross-through as ‘void’ destroyed in confidential waste
- In addition to the ‘weekly batch’ each prescriber in the team will be issued with ten blank FP10SS forms to ensure individual prescriptions can be produced in the absence of the administrator.
- All FP10SS forms issued to prescribers will be recorded by the administrator and the first and last identification number recorded.
- The prescriber will be asked to sign for all prescriptions issued to them, and should check the identification numbers they are signing for.
- Once issued, prescribers should keep their blank FP10s in a secure, locked cupboard or drawer, and ensure they request a new batch of prescriptions before they have used all of their blank forms.

Responsibility of the individual prescriber/designated member of staff printing the batch

- Keep blank prescriptions locked in a cupboard or drawer when not in use.
- Notify the manager if any forms go missing and follow the procedure above.
- Return all unused forms if leaving the employment of the team.
- Mark and cross-through as 'void' any incorrect/void prescriptions and destroy in confidential waste.
- Follow the above procedure for ordering and maintaining your own stock of blank prescriptions.
- Prescribers should only use their own issued prescriptions.

Prescribers should not

- Pre-sign blank FP10SS forms
- **Use the blank FP10SS forms to handwrite prescriptions** on (they will be rejected by the pharmacy as the prescriber address and identification details are not complete unless the form is run through a printer - Pre-printed FP10HP pads will still be available should a hand-written prescription be needed).
- Leave any FP10SS forms unattended in an unlocked place.
- Use FP10SS forms not authorised for them.

Lost, stolen or fraudulent prescriptions

- The unit manager and pharmacy manager must be informed immediately if FP10SS forms are known to be lost, stolen or used fraudulently.
- The incident must be reported on a trust incident form or on DATIX
- The unit managers must inform the relevant PCT (Lambeth PCT 020 3049 4444) and the police as soon as possible. Any instructions given by them should be followed appropriately. There is a national procedure in place for all community pharmacies to be informed of lost of stolen prescription pads.

South London and Maudsley NHS
NHS Trust

APPENDIX 19

Policy on NHS patients who wish to pay for Additional Private Care

August 2010

Version:	1
Policy Lead:	David Taylor
Policy Category:	Clinical Risk Management
Date issued:	17.02.2010
Review date:	17.021012
Ratified by:	Executive
Date ratified:	
Name of responsible committee:	Governance Executive
Target audience:	Nurses, Doctors, Pharmacists, and Pharmacy staff, Clinical staff, Audit staff
Approved by the Medicines Management Committee:	3.02.2010
Ratified by Executive.	

Equalities Impact Assessment	Assessor: David Taylor	Date
Child Safeguarding Assessment	Assessor:	Date:
HRA Impact Assessment	Assessor:	Date:

1. Purpose of this policy

1.1 This policy establishes that, where a patient opts to pay for private care, their entitlement to NHS services remains and may not be withdrawn.

1.2 Patients may pay for additional private healthcare while continuing to receive care from the NHS. However, in order to ensure that there is no risk of the NHS subsidising private care:

- It should always be clear whether an individual procedure or treatment is privately funded or NHS funded
- Private and NHS care should be kept as clearly separate as possible
- Private care should be carried out at a different time to the NHS care that a patient is receiving
- Private care should be carried out in a different place to NHS care, as separate from other NHS patients as possible

1.3 Departing from these principles of separation should only be considered where there are overriding concerns of patient safety, rather than on the basis of convenience. Such decisions should usually be agreed in advance with the Medical Director or equivalent. Where a decision has to be made without gaining prior approval from the Medical Director on the grounds of clinical urgency, the Medical Director should be informed as soon as possible afterwards. A record should be kept of all decisions to depart from these principles.

1.4 In relation to care which is provided free of charge by the NHS, the patient remains an NHS patient and should be treated in the same way as any other NHS patient. In relation to care which is provided on a private basis, the patient is a private patient.

1.5 Doctors, working with NHS managers, should exhaust all reasonable avenues for securing NHS funding before suggesting a patient's only option is to pay for care privately.

2. Scope of this policy

This policy covers the process for patients who opt to pay for additional private care (APC).

2.1 Aim

The aim of this policy is to ensure that where a patient wishes to pay for private care:

- They are advised appropriately
- Suitable arrangements are in place to deliver that care safely
- NHS and Private Care are separated
- The costs of private care are recouped without affecting NHS resources.

3. Roles and Responsibilities

3.1 South London and Maudsley NHS Foundation Trust (SLAM)

It is the responsibility of SLAM to ensure that:

- Patients who pay for private care in these circumstances are not put at any advantage or disadvantage in relation to the NHS care they receive. They are entitled to NHS services on exactly the same basis of clinical need as any other patient

- The patient bears the full costs of any private services. NHS resources should never be used to subsidise the use of private care

- Arrangements are put in place to ensure a clear separation of funding, legal status and liability and accountability between the NHS care and any private care the patient receives

- As is the case already, any individual doctor who does not wish to carry out any element of private practice is not compelled to do so.

3.2 Prescribers

- Must provide necessary information for patients/carers to be able to make an informed decision about their care.

- Should strive to avoid any actual or perceived conflict of interest between their NHS and private work.

- Must document in ePJS any discussions with patients/carers about care not routinely funded on the NHS.

- Must record on the consent form information provided to the patient/carer

- Must respect the patient's right to seek a second opinion.

- Must discuss the outcomes of cases involving the administration of unfunded treatments at Trust Drug and Therapeutics Committee

- Should contribute information to relevant national audits.

- Must ensure that the London consent agreement checklist **(Appendix A)** is completed and signed. A copy of the checklist must be scanned into ePJS.

- Must ensure that NHS staff are not used for the provision of private services without the agreement of the Trust. The consultant responsible for admitting a private patient to Trust facilities must ensure that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

4. Clinical governance

4.1 Any situations where patients receive additional private care alongside NHS care should be handled with the highest standards of professional practice and clinical governance.

4.2 Transferring between private and NHS care should be carried out in a way which avoids putting patients at any unnecessary risk. SLAM and the private provider (which may be an NHS organisation) should work collaboratively ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care at all times.

4.3 When a patient is transferred from NHS to private care it should be clear which clinician and which organisation are responsible for the assessment of the patient, the delivery of any care and the delivery of any follow up care.

4.4 Any complaints that a patient's NHS care has been 'withdrawn' as a result of choosing to have private care separately should be investigated as quickly as possible through the SLAM complaints procedure.

4.5 The London governance checklist protocol should be completed for all patients choosing to receive additional private care alongside their NHS treatment, where treatment is provided by a separate provider or by a separate clinician. **(Appendix B)**

5. Charges for private care by the Trust

5.1 Charges apply for any element of care provided by a consultant acting in a private capacity whilst using Trust facilities. The Trust should not subsidise the private element of care.

- The patient should meet any additional costs associated with the private element of care, such as additional treatment needed for the management of side effects.
- Any care which would normally have provided in the course of good NHS practice should continue to be offered free of charge by the Trust.
- Where the same diagnostic, monitoring or other procedure is needed for both the NHS element of care and the private element, the Trust will provide this free of charge as part of the patient's NHS entitlement and share the results with the private provider if necessary. Patients should not be unnecessarily subjected to two sets of tests or interventions.
- The private provider should normally deal with non-emergency complications resulting from the private element of care.
- The Trust will not refuse to treat patients simply because the cause of the complication is unclear.
- The Trust will continue to treat any patient in an emergency.

5.2 The Trust continues to be responsible for recovering all appropriate charges from private patients.

5.3 It is important that the Trust should not be seen to be profiting unreasonably from patients in these circumstances.

5.4 The Trust should ensure it complies with all relevant legislation regarding income generated from providing private healthcare.

6. Indemnity arrangements

6.1 This guidance does not change the current position in relation to indemnity arrangements for NHS professionals wishing to provide private care.

6.2 Where healthcare professionals choose to provide additional private care in a private capacity, and agree with their NHS employer that they may use NHS facilities for this purpose, they should continue to have appropriate private indemnity cover in place for themselves. If the agreement to use SLAM facilities includes the use of additional Trust staff as part of the facilities provision, those additional staff will be covered by the NHS employer's indemnity.

6.3 Where the Trust decides to provide additional private care as one of the services it offers as an organisation, healthcare professionals will be covered by their employer's indemnity as they will be providing private care in the course of their NHS employment.

6.4 Doctors having conversations about private treatment options with NHS patients in the course of their NHS duties will be covered by their employer's indemnity.

7. Wider policy on private practice in the NHS

7.1 It remains the primary purpose of NHS organisations to provide NHS care.

7.2 Any income generated should be treated in the same way as any other income generated by the Trust acting in a private capacity.

8. Operating instructions

8.1 Doctors, working with NHS managers, should exhaust all reasonable avenues for securing NHS funding before suggesting a patient's only option is to pay for care privately. In these situations, which are likely to be exceptional, the treating clinician should consider:

- Whether NICE has issued a positive technology appraisal for the treatment of the relevant indication. If so, it must be made available on the NHS.
- If not, whether the Primary Care Trust has a local policy to fund the treatment, perhaps based on collaboration with other PCTs or, in the case of cancer drugs, advice from a cancer network. If so, it should be made available on the NHS.
- If not, whether there are specific aspects of the patient's case which justify an application to the PCT for exceptional funding. If an application to this process is made and is successful the treatment will be funded on the NHS
- Only once these avenues have been explored should a doctor suggest that the patient's only option is to pay privately for a treatment.
- As some treatments may require the above processes to be completed in a very short time and to ensure the patient is not disadvantaged by any delay in initiating treatment, commissioners will need to sign up to timely processes for these cases.

8.2 Any arrangements for provision of private medicines therapy must be agreed with the Chief Pharmacist at SLAM or his/her deputy before treatment is offered to the patient.

8.3 Only medicines dispensed by the Trust pharmacy (or approved under the Patient's own Drugs Scheme) are permitted to be supplied and administered in Trust facilities.

8.4 The patient's agreement in writing to the likely costs, with either insurance details and authorisation number or for uninsured or self-funding patients full payment prior to treatment; must be obtained in advance of any private care being provided within the Trust. This agreement could include but may not necessarily be limited to the costs of drugs, diagnostics, therapies, accommodation, consumables, facilities, consultant's fees etc.

8.5 In all instances, the London Separation protocol should be completed for all patients who receive additional private care alongside their NHS treatment, where treatment is provided by the same provider and/or the same clinician. **(Appendix C)**

9. Definitions

In this policy:

"Private care" refers to privately funded care (whether provided as a private service by an NHS body or by the independent sector);

- "NHS patient" refers to any person in receipt of services funded by the NHS;
- "Private patient" refers to any person in receipt of privately funded services;
- "Patient representative" refers to any person legally able to act on the behalf of the patient in question;
- A "NHS consultant" is a consultant involved in the provision of NHS care at the time in question;
- A "NHS doctor" is a doctor involved in the provision of NHS care at the time in question; and
- A "healthcare professional" is a member of a profession concerned with the physical or mental health of individuals.

10. Dissemination

This procedure will be disseminated to all clinical staff who are authorised to initiate any additional private care treatment. These staff will be notified of subsequent updates via e-mail.

11. Monitoring implementation and effectiveness of the procedure

Non-adherences to this procedure will be monitored by the Trust Drug and Therapeutics Committee

Appendix A – London Consent Agreement for Additional Private Care

Patient Details Name: Address: Date of Birth: Hospital No: NHS Number:	Proposed Treatment: Part to be available on the NHS Part to be provided APC	NHS Provider: APC Provider

This checklist should be completed for all patients choosing to receive additional private care alongside their NHS treatment .

NHS Clinician/Patient (Initials)

The patient has received, or been informed where to find, written information about the proposed treatment in addition to a face to face consultation.		
The patient (or their representative) has been given full information about the potential benefits, risks, burdens and side effects of any treatment.		
This information has been recorded on the consent form for the patient's treatment. Informed consent has been obtained in line with GMC guidance.		
Funding options within the NHS for the proposed treatment have been exhausted.		
The outcomes of this treatment will be contributed to relevant national audits.		
The outcomes of this treatment will be discussed at multi-disciplinary clinical governance meetings.		
The outcomes of this treatment will be discussed at multi-disciplinary clinical governance meetings.		
The patient understands that the additional treatment and any associated costs (e.g. extra tests, admin costs etc.) are not being funded by the NHS		
The patient has received an outline of these costs from the private care provider		
The patient understands that if they become unable to fund their treatment (i.e. 'run out of money') the treatment will stop. The NHS will not provide treatment.		
The patient understands that if the NHS decided to fund this treatment in future, the NHS would not normally refund the cost of treatment already given privately.		
The patient understands that the NHS is not responsible for the quality of services provided by independent providers		

	Consultant Responsible for patient's NHS care	Consultant Responsible for patient's private care	Patient (or Patient's Representative)
Print Name			
Signature			
Date			

Please send copy of this form to:

- Appropriate Local Trust Clinical Governance Group/ Lead Clinician (e.g. Trust Chemotherapy Group in case of cancer medicines)
- Copy in medical notes
- Copy to Patient

Appendix B – London Governance Protocol - Additional Private Care

Patient Details **Name:** **Address:** **Date of Birth:** **Hospital No:** **NHS Number:**	**Proposed Treatment:** **Part to be available on the NHS** **Part to be provided APC**	**NHS Provider:** **APC Provider**

This governance checklist should be completed for all patients choosing to receive additional private care alongside their NHS treatment, where treatment is provided by a separate provider (including provision in patient's home) or by a separate clinician.

NHS Private Clinician/Provider (Initials)		
NHS/Private providers have agreed defined roles and responsibility for assessment of patient		
NHS/Private providers have agreed defined roles and responsibility for delivery of care elements		
NHS/Private providers have agreed defined roles and responsibility for delivery of follow up care		
NHS/Private providers agree to work to clinically tested regimen/treatment protocols, if available.		
NHS/Private providers have agreed arrangements for safe and effective transfer of care		
NHS/Private clinicians are satisfied with quality and timeliness of arrangements for sharing information on patient condition		
NHS/Private clinician satisfied with quality and timeliness of arrangements for sharing information on medicines management		
NHS/Private providers have agreed arrangements for confidential and effective transfer of medical information		
NHS/Private providers agree to provide information on treatment for any relevant national or local audit		

	Consultant Responsible for patient's NHS care	Consultant Responsible for patient's private care	Patient (or Patient's Representative)
Print Name			
Signature			
Date			

Please send copy of this form to:

- Appropriate Local Trust Clinical Governance Group/ Lead Clinician (e.g. Medicine Management Committee or Trust Chemotherapy Group in case of cancer medicines
- Copy in medical notes
- Copy to Patient

Appendix C – London Separation Protocol - Additional Private Care

Patient Details **Name:** **Address:** **Date of Birth:** **Hospital No:** **NHS Number:**	**Proposed Treatment:** **Part to be available on the NHS** **Part to be provided APC**	**NHS Provider:** **APC Provider**

This governance checklist should be completed for all patients choosing to receive additional private care alongside their NHS treatment, where treatment is provided by the same provider (including provision in patient's home) and the same clinician (in private capacity).

Private NHS Clinician/Manager (Initials)		
Clinicians and management have agreed that separate additional private care can be provided within the Trust		
Clinicians and management have agreed that there is no conflict of interest		
A reasonable charge has been agreed in accordance with para 3.4 of Code of Conduct for Private Practice 2004		
The charge takes full account of accommodation, facilities, diagnostic procedures, laboratory staff and cost of any NHS equipment used		
If medicines are included in the charge, pricing and use of these medicines is in accordance with national NHS contracts with pharmaceutical companies **Pricing policy is currently under review – clarification expected Feb 2010**		
There is a clear separation of funding, legal status, liability and accountability between NHS care and any additional private care		
Additional Private care is being carried out at a different time from a patient's NHS care		
Additional private care is being carried out in a different place to a patient's NHS care and separate from other NHS patients.		
There is agreement that the additional private care is not being subsidised by the NHS		
There is agreement that the NHS is not profiting unreasonably from the provision of additional private care to the patient		
NHS/Private providers agree to provide information on treatment for any relevant national or local audit		

	Consultant Responsible for patient's NHS care	Consultant Responsible for patient's private care	Patient (or Patient's Representative)
Print Name			
Signature			
Date			

Please send copy of this form to:

- Appropriate Local Trust Clinical Governance Group/ Lead Clinician (e.g. Medicine Management Committee or Trust Chemotherapy Group in case of cancer medicines
- Copy to Patient

Appendix D

Version Control Sheet

Version	Date	Author	Status	Comment

Appendix E

Plan for Dissemination of Procedural Documents Policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval

Title of document:			
Date finalised:		**Dissemination lead: Print name and contact details**	David Taylor
Previous document already being used?	***no***		
If yes, in what format and where?			
Proposed action to retrieve out-of-date copies of the document:	N/A		
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All Senior Managers and Core Standard Leads	A group email will be sent alerting teams to the policy and instructing them to download for local use	*Electronic*	It will be on posted on the trust intranet under clinical policies

Appendix F - Equality Impact Assessment Summary [Example]

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	▪ Race	No	
	▪ Ethnic origins (including gypsies and travellers)	No	
	▪ Nationality	no	
	▪ Gender	No	
	▪ Culture	No	
	▪ Religion or belief	no	
	▪ Sexual orientation including lesbian, gay and bisexual people	No	
	▪ Age	No	
	▪ Disability - learning disabilities, physical disability, sensory impairment and mental health problems	no	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	no	
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

Name of person completing the EIA:	S Mace
Date:	

If you have identified a potential discriminatory impact of this procedural document, please also include the full Equality Impact Assessment that was carried out at the beginning of policy development and any associated documentation.

For advice in respect of answering the above questions, please contact Kay Harwood on kay.harwood@slam.nhs.uk.

APPENDIX 20

South London and Maudsley NHS
NHS Foundation Trust

Trust Medicines Reconciliation Policy

Version:	1
Policy Lead:	Professor David Taylor
Policy Category:	Clinical
Date issued:	12th December 2008
Review date:	12th December 2009
Ratified by:	Governance Executive
Date ratified:	
Name of responsible committee:	Governance Executive
Target audience:	All medical and pharmacy staff

Approved by David Taylor (Chief Pharmacist)	Date:
Ratified by the Governance Executive.	Date:

Equalities Impact Assessment	Assessor: *policy lead name*	Date:
Child Safeguarding Assessment	Assessor: Sue Lewis	Date:
HRA Impact Assessment	Assessor: Paul Bellerby	Date:

Medicines Reconciliation Policy

Section 1: Introduction

In January 2008 NICE and the NPSA in collaboration issued guidance on medicines reconciliation for adult patients admitted to hospital. The guidance requires trusts to have in place a policy for ensuring that a patient's prescription on admission to hospital is an accurate record of what that patient was prescribed pre-admission. In addition, the guidance recommends that pharmacy staff be involved in the medicines reconciliation process. The deadline for implementation of the guidance is 12th December 2008.

Section 2: Purpose of the policy

This policy applies to all SLAM in-patients.

For the purpose of this policy medicines reconciliation is defined as the process for pharmacy to verify a patient's prescribed medication on admission to a SLAM in-patient ward. The doctor who examines the patient on admission will be expected to make a record of the patient's medication on admission.

This policy will outline the process for pharmacy staff to:

- Obtain accurate information about a patient's prescribed medication before admission
- Check and verify this information against the prescription on admission
- Communicate and document any discrepancies (intentional and unintentional) on the current prescription

Section 3:	Development of the policy

The Governance Executive commissioned Pharmacy to carry out a medicines reconciliation pilot on Southwark wards, which involved Pharmacy checking doctor's reconciliations on admission. Overall, unintentional discrepancies were identified in 32% of prescriptions checked by Pharmacy.

The Governance Executive made a strong recommendation that Pharmacy staff should carry out Medicines Reconciliation in SLAM.

Section 4: Roles and responsibilities

4.1 Service directors

It is the responsibility of the service directors to ensure that the policy is agreed (with adequate funding), for implementation in each of the trust directorates.

4.2 Chief Pharmacist

It is the responsibility of the Chief Pharmacist to ensure that once the policy is agreed, all pharmacy staff involved in medicines reconciliation, work within the framework of the policy.

Section 5: The procedure

On admission, the admitting doctor will record on ePJS a list of medication (if any) currently prescribed for the patient. All medicines that need to be continued must be prescribed on an in-patient drug chart.

5.1 General Principles

- All patients newly admitted to a SLAM in-patient ward must have medicines reconciliation
- When patients are transferred internally, medicines reconciliation is only necessary if the drug chart has been re-written on admission to the new ward.
- Medicines reconciliation must be carried out within 48 hours of admission to a SLAM ward (except at weekends)
- Medicines reconciliation must be carried out within 72 hours of admission, if the admission is between 12pm on Friday and 12pm on Saturday
- Information sources listed in this policy must be used for medicines reconciliation, whenever relevant and possible
- Pharmacy staff must attempt to interview the patient before completing medicines reconciliation
- Any information obtained from the reconciliation process must be recorded on the medicines reconciliation form (appendix E)
- Any discrepancies must be communicated to the ward doctor at the earliest opportunity

5.2 Information Sources for Medicines Reconciliation

Information must be obtained from at least two of the following sources to verify the patient's prescribed medication on admission.

- ePJS (including correspondence/ referral letters)
- Hospital pharmacy dispensing record
- Community pharmacy dispensing record
- GP practice
- Patient/Carer
- Patients' Own Drugs

5.3 How to identify new admissions

- The pharmacy staff member must:
  - check the ePJS ward list each morning for any new admissions over the last 24 hours (72 hours over the weekend)
  - identify all patients admitted to a SLAM in-patient ward
  - separate the patients into those newly admitted to SLAM and those transferred internally
  - determine whether transferred patients have had medicines reconciliation during the current admission
  - contact the ward to verify the list of new admissions

- make an appointment to interview all patients admitted who need medicines reconciliation

5.4 How to use reference sources to obtain details of prescribed medications

Any information on medications (prescribed or other) must be recorded on the medicines reconciliation form. If insufficient or no information is available from a source, a note of this must be made on the data collection form. See appendix E

Before speaking to the patient the pharmacy staff member must check the following information using ePJS, pharmacy dispensing records and by contacting the GP practice:

- patient's diagnosis and any medical conditions
- allergy status
- current prescription
- doses of substitute opioids must be confirmed with the patient's Community Drug and Alcohol team or Community Pharmacy

5.5 Guidance on interviewing the patient

- *Children under 16 must be accompanied by a ward staff member or carer*
- Before speaking to the patient the pharmacy staff member must:
  - notify the ward that they are coming to speak to the patient and check whether it is appropriate for them to see the patient unaccompanied.
  - check the drug chart for any discrepancies compared with the information from ePJS, pharmacy records and the GP

- On meeting the patient the pharmacy staff member should introduce themselves, explain the purpose of the meeting and verify the patient's name and date of birth with that on the prescription

- The pharmacy staff member should determine from the patient
  - their allergy status
  - any medications they were prescribed before admission (from their GP, psychiatrist, other specialist)
  - any non-prescribed medications they were taking before admission
  - any problems they may have been having with the prescribed medications e.g. side-effects or difficulty in understanding the directions
  - compliance with prescribed medication

5.6 Communicating discrepancies on the prescription

- The pharmacy staff member must inform the ward doctor of any discrepancies between the admission prescription and the patient's medication record pre-admission
- The pharmacy staff member must determine from the doctor whether the discrepancy was intentional or unintentional
- It remains the responsibility of pharmacy staff member to ensure that the information is communicated as soon as possible. If the matter is urgent the pharmacy staff member must contact another ward doctor

5.7 Documenting changes on the prescription chart and ePJS

- The ward doctor must document on ePJS any intentional changes to the prescription, including the reason for the change
- The ward doctor must correct any unintentional discrepancies on the prescription chart and on ePJS
- Pharmacy staff must inform the ward pharmacist of any patients for whom reconciliation has been carried out, including any issues for follow-up
- The pharmacy staff member should keep a record of prescription errors and review them monthly. All serious errors should be reported as SUIs

5.8 Annotating prescription charts/ePJS

- The pharmacy staff member must sign and date the top right hand corner of the prescription to indicate that medicines reconciliation has been completed. The new in-patient prescription charts have a section to indicate that medicines reconciliation has been completed
- The pharmacy staff member must make an entry on ePJS to indicate that medicines reconciliation has been completed

Section 6:	Training

All Pharmacy staff carrying out medicines reconciliation must be accredited through the trust competency framework. See appendix D

Section 7: Monitoring compliance with the policy

- Adult in-patients newly admitted to a SLAM ward will have medicines reconciliation carried out with 48 hours (72 hours if admitted between 12pm on Friday and 12pm on Saturday) of admission
  - *Standard 100%*
- Unintentional discrepancies will be corrected on the patient's prescription and ePJS
  - *Standard 100%*
- Pharmacy staff carrying out medicines reconciliation will receive training and accreditation as set out in local trust policy documents
  - *Standard 100%*

Appendices

Appendix A

Equality Impact Assessment Summary [Example]

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	▪ Race		
	▪ Ethnic origins (including gypsies and travellers)		
	▪ Nationality		
	▪ Gender		
	▪ Culture		
	▪ Religion or belief		
	▪ Sexual orientation including lesbian, gay and bisexual people		
	▪ Age		
	▪ Disability - learning disabilities, physical disability, sensory impairment and mental health problems		
2.	**Is there any evidence that some groups are affected differently?**		
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the policy/guidance likely to be negative?**		
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

Name of person completing the EIA:	
Date:	

If you have identified a potential discriminatory impact of this procedural document, please also include the full Equality Impact Assessment that was carried out at the beginning of policy development and any associated documentation.

For advice in respect of answering the above questions, please contact Kay Harwood on kay.harwood@slam.nhs.uk.

Appendix B

Version Control Sheet

Version	Date	Author	Status	Comment

Appendix C

Plan for Dissemination of Procedural Documents Policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**Trust medicines reconciliation policy**		
Date finalised:	2/12/2008	**Dissemination lead: Print name and contact details**	Service directors
Previous document already being used?	**No**		
If yes, in what format and where?	Once approved the policy will be available on-line on Trust intranet		
Proposed action to retrieve out-of-date copies of the document:	N/A		
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All Senior Managers and Core Standard Leads	A group email will be sent alerting teams to the policy and instructing them to download for local use	Electronic	

Appendix D

South London and Maudsley NHS Foundation Trust

MEDICINES RECONCILIATION TRAINING PROGRAMME AND COMPETENCY FRAMEWORK

Neelam Sharma, Chief Technician, Medicines Management and E&T

Sarah Ford, Senior Medicines Management Technician

Adapted from King's College 'Drug History Taking Pre-registration Pharmacists' pack

February 2007

Contents

Introduction

This training programme is compulsory for medicines management technicians who will be taking medication histories. They must have already undertaken PODs training. You will have a mentor with experience of taking drug histories for guidance.

Aim

To be able to take an accurate and comprehensive medication history for newly admitted patients.

Objectives

1. To understand the importance of drug history taking.
2. To understand the process involved in taking a complete drug history.
3. To demonstrate ability in taking a complete drug history using a range of sources and methods.
4. To undertake and complete all activities listed in the training pack.

Why take a medication history?

A drug history is a written record of a patient's current and where relevant past drug treatment. It is one of the first steps in the implementation of pharmaceutical care in hospitals. Traditionally this is taken by the doctor along with the medical history but it is a role increasingly taken over by pharmacists and technicians, who may be better placed to obtain more accurate and full histories. By obtaining an accurate medication history pharmacy has significant potential to contribute to the patient's care.

In addition to establishing current drug treatment an accurate drug history can:

- help in diagnosis; drugs can cause disease, mask disease and cause false biochemical test results and withdrawal of a drug can cause recurrence or exacerbation of disease
- prevent therapeutic failures being repeated
- highlight possible drug interactions
- document allergies, manifestations and adverse drug reactions
- identify patients who require compliance aids or who need further education with their medications

Some less obvious objectives of taking a medication history are:

- to determine compliance behaviour
- to determine the patient's attitudes and beliefs towards their treatment
- to determine response to treatment
- to gain information on difficulty in obtaining medication
- to find out about use of OTC, herbal and complementary medicines
- to determine if actual treatment matches that prescribed on the drug chart

How to take a medication history

A full medication history is made up of information about prescribed medication, OTC, herbal, homeopathic products, allergies and compliance issues.

Prescribed medication

Information regarding prescribed medicines taken immediately prior to admission should be obtained to allow maintenance drugs to be continued, reviewed or discontinued during hospitalisation. It is important to record the brand of some drugs e.g. theophylline, diltiazem, carbamazepine, lithium and insulin or type of device the patient uses where this is relevant e.g. insulins. It is also important to determine whether any medication has recently been discontinued as the action of many drugs continues beyond the cessation of administration. Furthermore, it should be established whether any drugs have been initiated recently or whether there have been any recent dose adjustments.

Patients may only volunteer information about tablets, so it is worth asking whether they use any inhalers, eye drops or creams. Also remember to enquire about medicines the patient may take PRN as well as those taken regularly.

OTC, herbal and homeopathic medication

Patients often use non-prescription medication on a regular basis but preparations bought OTC are often not routinely included in medication histories. Medicines bought by the patient including herbal and homeopathic drugs also have the potential to cause drug interactions, adverse drug reaction and drug induced disease and should be included in any medication history.

Allergies

These need to be documented in order to avoid unnecessary and potentially life threatening reactions. Food, additive, appliances and dressings (latex) allergies may also be relevant and have potential pharmaceutical implications. Record the symptoms of allergies/manifestations.

Compliance

Questioning the patient about the reasons for taking medication can help assess the patient's understanding of their treatment and their condition. Enquiring into the benefits of current regimens and any problems encountered helps determine potential for compliance, identify side effects, ineffective therapy and reasons for non-compliance. A medication review can then be conducted and adjustments to a patient's regimen suggested for enhanced compliance and efficacy. If a patient comes in with an existing compliance aid make a note of the supplier and their address. **Note, pharmacy do not initiate compliance aids. If you come across any compliance problems please refer to the pharmacist.**

The Drug History Taking Interview

Preparation before taking a drug history will help to anticipate any questions the patient might have. Ensure you have checked into known risk factors about a patient. A quick read of the GP referral letter, the medical admission notes or nurse handover sheet will give you a lead on what problems the patient is presenting with. If appropriate check POD locker for PODs.

Conduct the interview in a clinic room or interview room from which you can easily attract a nurse's attention. If there are any known risks in dealing with the patient make sure you have a nurse or other member of staff to accompany the patient during the interview.

Conducting the interview

Do not appear hurried or uninterested when conducting the interview. Communication between the patient and yourself will be facilitated if the patient feels they have adequate time to tell the whole story. On the other hand, do not let small talk get out of control so the patient thinks you're not really interested in their drug treatment. Try to establish a rapport with the patient by displaying openness, warmth and a desire to do what you can to help them.

You need to be aware of the way that people react to being ill. When people are ill in hospital they may feel frightened, confused, anxious, angry, impatient and distrustful. They may also be in pain or discomfort. It is common for a patient's feelings to be misplaced on to health care professionals. If negative responses occur during the interview, try to understand and not take it personally. You should demonstrate professional maturity by not displaying your own negative feelings. Equally however, you do not have to put up with aggressive, abusive or violent behaviour. Should this occur, terminate the interview and refer to the pharmacist for help.

Interview Techniques

Remember the patient should do most of the talking; intervene only where necessary to ask for clarification or to lead the discussion to new areas.

- Use open questions where possible. Encourage the patient to expand by using phrases such as 'tell me more about….'
- Use non-verbal communication such as nodding to show you are listening
- Remain silent when a patient has not finished their account but maintain eye contact
- Listen and be aware of indicators of further information. Acknowledge and express concern for the patient's problems to encourage further openness and spontaneity from the patient

Avoid:

- asking leading questions
- using terminology or abbreviations the patient may not understand
- asking more than one question at a time

Do not do or say anything during the interview that:

- you are not sure about
- is falsely reassuring
- is disapproving or judgmental
- is challenging
- is contradictory

Sources of information

Potential sources of accurate information are often overlooked and available information is not used to its full potential.

Sources of information for a full drug history include:

- the patient
- the patient's own drugs, which they may have brought in with them
- the patient's carer or relatives
- the GP referral letter or hospital transfer letter (if the patient has been transferred from another hospital)
- telephone enquiries to patient's GP, nursing home, community hospital or community pharmacy
- copies of medication charts from the nursing home, community hospital or residential home
- past TTAs or drug charts filed in medical notes
- Other primary care sources:
    - community/mental health drug teams
    - district nurses or other community nurses.

The most accurate drug history can usually be obtained from the patient. This is particularly true if they have brought their medication with them so that names and strengths can be confirmed by examination of the drugs. However patients may not be well enough or not know the full details of their treatment. They may also be reluctant to admit to taking certain drugs.

If the patient has not brought their medication with them a relative or carer may be able to bring these in.

Medication information cards, repeat prescription forms are also good sources of information. However it should not be assumed these are accurate and up to date. Doses may have been changed or drugs stopped. These sources are best used in conjunction with a patient interview. Use them as a basis for the interview and to prompt the patient.

Patients from nursing homes, residential homes or community hospitals are unlikely to know what medication they usually take. If you have a copy of the medication charts used in the home/hospital these are likely to be reliable but be aware of hand written records provided on information sheets. These are often incomplete or missing vital information.

If the patient's relatives or carers are present they may be able to provide additional information about the medication the patient normally takes particularly if they look after the

patient's medication when they are at home. Patient confidentiality needs to be maintained when speaking to carers or relatives.

Patients may bring a letter from the GP admitting them to hospital, which details their current medication. Unfortunately such letters are often incomplete and differ from information obtained by interviewing the patient. This may be due to a lack of awareness of what the patient is taking, often because the admitting GP is not the patient's own doctor or is part of an emergency on-call service. Details such as strengths or frequencies are often missing and sometimes individual drugs are completely missed off. GP letters alone should not be relied on and should be used in conjunction with other sources where possible.

Hospital records can be similarly inaccurate although a TTA form from a recent discharge, which has been seen by a pharmacist is likely to be reliable. Just be aware that the GP could have made changes or additions to the medication so use the TTA letter as a basis for your drug history.

When other sources have failed a telephone enquiry to the patient's GP or to the nursing home/community hospital from which they have been admitted will usually help to complete a drug history.

The key to obtaining a good drug history is to use a combination of information sources where possible and to remember the limitations and reliability of each information source consulted.

Procedure for medication history taking

Trained technicians should take and document a medication history for every patient if possible.

1. Check patient details, refer to E-PJS and any other available sources. Identify any risk factors relating to the patient or their mental stability and check these with ward staff.

2. Introduce yourself to the patient and explain the purpose of the visit.

3. Confirm you are speaking to the correct patient by checking their name and date of birth.

4. Check with the patient that they are comfortable and they feel up to talking to you.

5. Establish what medications the patient was taking before admission by:

   - **Asking the patient** - this should be used where possible to confirm any medication history in conjunction with other sources. For each medication confirm the dose, strength, form and frequency. Where a specific brand of medication is required endorse the chart with the required brand
   - **Patient's carer or relative** – this should be used if the patient cannot answer your questions by themselves
   - **Patient's own drugs** – are they available or can they be brought in?
   - **GP referral letter** – this should be confirmed with the patient where possible.
   - **Latest prescription** – repeat FP10/dischargeletter/TTA/medication card. Check the prescription date to ensure validity
   - **Compliance aid** – a self-written list or a list in the compliance aid may not be accurate or up to date. Always confirm the history with another source e.g. community pharmacist who fills the box
   - **Phoning the GP or local pharmacy** (if the patient takes the prescription to the same pharmacy) – inform the patient if you wish to contact their GP. In patients who are critically unwell you can contact the GP if you feel it is necessary to do so without consulting the patient first

6. Ensure that the following are recorded:

   - name of medicine (brand if appropriate)
   - form of medicine
   - frequency
   - duration of therapy (if known)
   - general therapeutic response (if relevant)
   - compliance aids (name of chemist)

7. Seek information on any drug allergies the patient may have even if already noted by another professional. Document any allergies and the associated reaction in the allergy box on the patient's drug chart, if not completed. If the allergy has not already been documented in the notes the patient's nurse should be informed.

8. Establish whether there have been any additions, deletions or alterations to drug therapy where possible.

9. Ascertain their adherence to the prescribed medication regime.

10. Ask about any medicines brought from a chemist or health food shop.

11. Assess whether there are any compliance or discharge related issues that need to be addressed including the need for counselling or a medicine information card.

12. The medication history should be checked against the prescription if all is correct then write 'drug history as charted' on the back of the drug chart (see appendix 1).

13. Note any discrepancies between the medication history and that recorded by medical staff.

14. Determine if these discrepancies are intentional (from the patient, nursing staff, medical staff or medical notes).

15. Non-intentional discrepancies should be clarified with medical staff if possible or otherwise communicated to the pharmacist for follow-up.

16. Significant problems may be documented in medical notes if appropriate and trained.

Use your discretion to establish if the following are important:

17. Ask female patients if they are pregnant or are breast-feeding.

18. If a patient smokes, how long they have been smoking, have they tried to give up, what methods have they used before and would they like to give up now.

19. If a patient uses recreational drugs or are on a methadone programme. **Refer to pharmacist if unsure.**

20. Vaccination history. This can be important in some respiratory and splenectomy patients i.e. flu vaccine, boosters, tetanus etc.

If you have any questions or you are unsure about any matter you must refer them to the ward pharmacists.

Accreditation of pharmacy staff

Pharmacy staff will be required to accurately carry out 15 medicines reconciliations before they are accredited.
The reconciliations will be checked by the Chief technician or Clinical Site Leads

South London and Maudsley NHS
NHS Foundation Trust

MEDICINES RECONCILIATION FORM

Name of Patient:	**Diagnosis:**
Date of Birth:	**Staff members:**
Ward:	**Type of admission:** **New** ☐ **Inpatient transfer** ☐
Allergy documented (Y/N) **Allergy status:**	**Date of admission:** **Date of Drug Reconciliation:**

GP name…… GP Phone No…….. Date of last prescription……

MEDICATION PRESCRIBED BY GP	
Drug	**Dose & Directions**
Medication prescribed by GP not available due to:	

MEDICATION PRESCRIBED ON ADMISSION

Drug	Dose and directions	Please tick			Comments (reasons for stopping or holding drug)
		Cont	Hold	Stop	

ePJS RECORD	
Drug and Dose	**Date prescribed**

PHARMACY DISPENSING RECORD	
Drug & Dose	**Date prescribed**

DISCREPANCIES BETWEEN HOSPITAL PRESCRIPTION AND PREVIOUS PRESCRIPTION

MEDICATION BROUGHT INTO HOSPITAL				
Drug (Name/form/strength)	**Quantity**	**Suitable for re-use(Y/N)**	**Reason for unsuitability**	**Cost of meds if re-used (for office use only)**
****PLEASE PHOTOCOPY THE WHOLE FORM IF ANY PODS ASSESSED & GIVE TO PODS CO-ORDINATOR****				

OTHER CLINICAL ISSUES IDENTIFIED BY PHARMACY

PATIfENT INTERVIEW

Was the patient interviewed? **Yes☐** **No☐**

If no, why not?

Does the patient have any allergies? **Yes ☐** **No☐**

If so, please describe drug & reaction:

What (if any) issues did the patient raise?:

Any over the counter medicines? (e.g. creams, herbal remedies, sprays)

Any side effects which they are suffering from?

APPENDIX 21

REPORTING OF MEDICATION AND PRESCRIPTION ERRORS – GUIDANCE FROM THE TRUST INCIDENT POLICY
The full policy is available on the link below

http://sites.intranet.slam.nhs.uk/Policies/ClinicalPatient%20Safety/Incident%20Policy%20September%202011%20-%20v2.1.pdf

All medication errors relating to the administration, prescribing and supply and disposal of medicines should be reported on via Datixweb. Any serious error (i.e. health or life threatening) or potentially serious error (near miss) related to any aspect of medicine use must be brought to the attention of the immediate supervisor, the relevant practitioner and the ward team manager at the earliest opportunity.

An incident report must be made for all medication errors. The drug name, dose, strength and route of administration must be included in the report. The medical practitioner will decide upon the appropriate course of medical action (if any) and the immediate supervisor/service manager will decide upon the appropriate course of action in relation to the staff concerned. Minor errors must be reported to the immediate supervisor who will decide on the relevant action.

Prescribing errors noticed by other staff members should be brought to the attention of the prescriber and ward/unit manager.

All prescribing errors (resulting in administration to the patient or not) must be reported on a trust incident form. It is the responsibility of the prescriber to report the error.

A trust incident form should be completed on Datixweb for all errors leaving the pharmacy. Errors in the supply of medicines must be reported to the pharmacy as soon as possible, but certainly within two working days, (within three working days at weekends and bank holidays). Out of hours – contact the on call pharmacist if necessary.

Medication and Prescription Errors Incident Reporting

All staff are required to report all medication errors (and near misses) which occur in their services to the Trust Patient Safety Team in accordance with the Incident Policy. The Medicines Management Committee review reported errors quarterly and make recommendations for the safer use of medicines in the Trust.

For all medication incidents and prescription errors the **following information must be included** in the Incident report:

- Name of medication (both actual medication involved and, where appropriate, the intended/correct medication)
- Route of medication
- Action taken to prevent the error reoccurring
- Whether this was an actual or near-miss incident
- Effect on the patient
- Medication error type/stage NPSA descriptions to be used – see Datixweb for list

Grading guidance

- Medication incidents should be graded C (or above) ***where they reach, or nearly reach, the patient*** (e.g. wrong drug administered, dose omitted, prescribing error).
- Medication incidents related to procedural failings (e.g. CD procedures, missing keys etc) should be graded on a case-by-case basis depending on the actual or potential severity – advice should be obtained from local pharmacy contacts and/or Nurse Advisors
- Incidents relating to clinical care issues (e.g. self-medication, medication refused, unauthorised medication found on patient) will normally be graded D or E unless the patient was severely affected.
- Other incidents where medication is involved but there has been no specific medication error affecting patients (e.g. tablet found on floor, insufficient stock of medication) would normally be graded E

Medication incident investigation and follow-up

All Medication incidents which ***reach, or nearly reach, the patient*** and are graded C (or above) and a Fact Finding report will be required. The Fact Finding report should be completed within 48 hours and forwarded to the local Nurse Advisor or Nurse Lead and copied to the **SI Office** email address.

Medication errors will be monitored by pharmacy every 3 months. A report will be submitted to the trust board and educational initiatives implemented.

The trust Patient Safety team will report all medication errors to the National Patient Safety Agency.

Information on medication errors is shared with the Medicines Management Committee and partners across the interface.

Medication incidents are also reviewed at a quarterly meeting of the Nurse Advisors, Assistant Director Patient Safety and the Deputy Director of Pharmacy.

A Quarterly Bulletin is produced by the Deputy Director of Pharmacy. The alert contains information for clinicians on errors reported in the last quarter that were deemed significant either because of the numbers of similar reports or the potential to cause serious harm.

APPENDIX 22

MINIMUM STANDARDS FOR CLINICAL PHARMACY SERVICES

Outlined below are the minimum standards for provision of a clinical pharmacy service to ensure safe medicines management in the trust.

All units

- All units and wards have access to Medicines Information at the Maudsley Hospital (0203 228 2317)
- All units are included in actions required by national bodies such as NICE, NPSA, Royal Colleges or other regulatory body. Pharmacy staff will ensure compliance on all units.
- All units are included in the trust CEO PMR framework and medicines Management programme

In-patient wards on-site

- All wards will be assigned a pharmacist. The ward pharmacist will visit the ward at least once a week to clinically screen all prescriptions on the ward. A clinical screen involves reviewing the safety, effectiveness and appropriateness of medication prescribed for the patient.
- The ward pharmacist will attend ward rounds at least fortnightly on acute and PICU wards. The need for the pharmacist to attend ward rounds on other wards will be assessed individually for each ward. An alternative forum for discussion of patients' medication may be appropriate for some cases. The purpose of attendance at these meetings is to pro-actively advise on patients' medication.
- A member of the Pharmacy team will undertake a medication history from all patients newly admitted to the trust. This will happen within 24 hours of the patient being admitted
- In the absence of the regular ward pharmacist, cover will be arranged for a weekly clinical screen for safety.
- The ward pharmacist will be available for clinical advice to all ward staff.
- Ward staff will be informed of any relevant decisions made by the trust Drugs and Therapeutics or Medicines Management Committees.
- Ward staff will be informed of any local and national clinical directives/targets.
- The ward pharmacist will be available with prior arrangement to talk to individual patients or a group of patients about their medication.
- The ward pharmacist will record prescribing interventions on the ward for one week every 3 months.
- CD storage and record keeping on the ward will be audited every 6 months by Pharmacy.
- Prescribing and medicines management on the wards will be audited as part of any trust-wide audit programme or on a particular ward if a specific issue arises. Results will be presented to the relevant staff.
- Medication errors will be brought to the attention of the prescriber or nursing staff, who will also be asked to report the error on a trust incident form.
- Training will be provided on medicines management and the use of psychotropics as necessary.
- Review of ward stock lists will take place as necessary.

Out of hours

- The on-call pharmacist may be contacted via the switchboard.
- A senior clinical pharmacist is always available as back-up.

In-patient units off-site

- All wards will be assigned a pharmacist. The ward pharmacist will visit the ward once every 2 weeks to clinically screen all prescriptions on the ward. A clinical screen involves reviewing the safety, effectiveness and appropriateness of medication prescribed for the patient. In the absence of the regular ward pharmacist, cover will be arranged.
- The ward pharmacist will be available for clinical advice to all ward staff.
- Ward staff will be informed of any relevant decisions made by the trust Drugs and Therapeutics or Medicines Management Committees.
- Ward staff will be informed of any local and national clinical directives/targets.
- The ward pharmacist will record prescribing interventions on the ward for one week every 3 months.
- If CDs are supplied by the trust pharmacy, the storage and record keeping of the CDs will be audited every 6 months by Pharmacy.
- Prescribing and medicines management on the wards will be audited as part of any trust-wide audit programme or on a particular ward if a specific issue arises. Results will be presented to the relevant staff.
- Medication errors will be brought to the attention of the prescriber or nursing staff, who will also be asked to report the error on a trust incident form.
- Training will be provided on medicines management and the use of psychotropics as necessary.
- Review of ward stock lists will take place as necessary.

Out of hours

- The on-call pharmacist may be contacted via the switchboard.
- A senior clinical pharmacist is always available as back-up.

Community teams

- Prescriptions will be clinically screened by a pharmacist before medication is supplied. This may be done by a pharmacist visiting the team base or by a pharmacist in the dispensary. A clinical screen involves reviewing the safety, effectiveness and appropriateness of medication prescribed for the patient. In cases where this is not possible, the minimum screen must be for safety.
- A pharmacist will be available for clinical advice to staff. This may be via the pharmacist visiting the team, the dispensary or Medicines Information.
- A pharmacist will highlight to the team any patient whose prescribing appears suitable for transfer to the GP.
- Team staff will be informed of any relevant decisions made by the trust Drugs and Therapeutics or Medicines Management Committees.
- Team staff will be informed of any local and national clinical directives/targets.
- A pharmacist will record prescribing interventions one week every 3 months. This may be done when the prescriptions are sent to pharmacy or at the team base.
- Prescribing and medicines management in the teams will be audited as part of any trust-wide audit programme or on in a particular team if a specific issue arises. Results will be presented to the relevant staff.
- Medication errors will be brought to the attention of the prescriber or nursing staff, who will also be asked to report the error on a trust incident form.
- Training will be provided on medicines management and the use of psychotropics as necessary.

Out of hours

- The on-call pharmacist may be contacted via the switchboard.
- A senior clinical pharmacist will always be available as back-up.

Home treatment teams

- A pharmacist will visit the team base to screen prescriptions every week. A clinical screen involves reviewing the safety, effectiveness and appropriateness of medication prescribed for the patient. In cases where this is not possible, the minimum screen must be for safety.
- A pharmacist will be available for clinical advice to staff. This may be via the pharmacist visiting the team, the dispensary or Medicines Information.
- Staff will be informed of any relevant decisions made by the trust Drugs and Therapeutics or Medicines Management Committees.
- Staff will be informed of any local and national clinical directives/targets.
- A pharmacist will record prescribing interventions one week every 3 months. This may be done when the prescriptions are sent to pharmacy or at the team base.
- Prescribing and medicines management in the teams will be audited as part of any trust-wide audit programme or on a particular ward if a specific issue arises. Results will be presented to the relevant staff.
- Medication errors will be brought to the attention of the prescriber or nursing staff, who will also be asked to report the error on a trust incident form.
- Training will be provided on medicines management and the use of psychotropics as necessary.

Out of hours

- The on-call pharmacist may be contacted via the switchboard.
- A senior clinical pharmacist will always be available as back-up.

Out-patients

- A pharmacist will screen prescriptions for safety in the dispensary before medication is supplied. Information on the patient's other medication (prescribed or otherwise) must be obtained wherever possible.
- A pharmacist will be available for clinical advice to prescribers in out-patients. This may be via the dispensary or Medicines Information.
- A pharmacist will record any prescribing interventions one week every 3 months. This will be done when the prescriptions are sent to pharmacy.
- Prescribing will be audited as part of any trust-wide audit programme. Results will be presented to the relevant staff.
- All prescribing errors will be brought to the attention of the prescriber, who will be asked to report the error on a trust incident form.

Supported Housing

- Prescriptions will be screened in Pharmacy or at the community team base that the patient is seen at.
- A pharmacist will be available for clinical advice to prescribers and hostel staff. This may be via the dispensary or Medicines Information.
- Medication errors will be brought to the attention of the prescriber or hostel staff, who will also be asked to report the error on a trust incident form.

Out of hours

- The on-call pharmacist may be contacted via the switchboard.
- A senior clinical pharmacist will always be available as back-up.

The following tables show the current provision of clinical pharmacy services to SLAM wards/units/community teams. In many cases where no pharmacy service is provided, the pharmacy department has been unaware until now that the service exists.

APPENDIX 23

POLICY FOR PHARMACY SUPPORT FOR CLINICAL TRIALS

A BACKGROUND AND PURPOSE:

Statutory Instrument 2004/1031 – the Medicines for Human Use (Clinical Trials) Regulations 2004 transposed the European Union Directive 2001/20/EC for Clinical Trials into UK law effective from the 1st May 2004. The original UK regulations were amended in August 2006 to incorporate the EU Good Clinical Practice Directive (2005/28/EC) as Statutory Instrument 2006/1928.

The Regulations state that Clinical Trials involving medicinal products MUST be authorised by the MHRA and conducted according to the Principles of GCP as defined in the Amended Regulations and any subsequent amendments.

MHRA GCP Inspectors assess compliance with the requirements of GCP by conducting inspections at the sites of pharmaceutical sponsor companies, contract research organisations, academic research organisations, investigational trial sites, clinical laboratories, GCP archives and other facilities involved in clinical trial research. Mandatory GCP inspections will be conducted in both commercial and non-commercial organisations within the UK.

The purpose of this SOP is to define the processes required for the supply of IMPs for use in clinical trials in accordance with Regulation 13 of the SI 2004/1031.

DEFINITIONS

The Regulations - Medicines for Human Use (Clinical Trial) Regulations 2004 transposed the EU Clinical Trials Directive into UK legislation, as Statutory Instrument 2004 no 1031. This became effective on the 1st May 2004. An amendment to implement Directive 2005/28/EC was made to the Regulations as Statutory Instrument 2006 no 1928.

The Medicines & Healthcare products Regulatory Agency (MHRA) - UK Competent Authority responsible for regulation of clinical trials.

Clinical Trial - Any investigation in human subjects, other than a non-interventional trial intended to discover or verify the clinical, pharmacological or other pharmacodynamic effects of one or more medicinal product or to identify any adverse reactions to one or more such products and to trial absorption, distribution metabolism and excretion in one of more such

products with the object of ascertaining the safety or efficacy of those products. CTIMP is a clinical trial of an Investigational Medicinal Product.

Partner Organisations – South London & Maudsley NHS Trust, King's College London, Guy's & St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.

Standard Operating Procedure (SOP) - "detailed, written instructions to achieve uniformity of the performance of a specific function," SOPs are the base on which Quality Systems and Processes are conducted and monitored against.

Good Clinical Practice (GCP) - As defined in UK legislation Statutory Instrument 2006/1928.

International Conference on Harmonisation Tripartite Guideline Good Clinical Practice – (**ICH-GCP)** A standard definition of GCP is given in ICH GCP, (a set of internationally agreed guidelines) which ensures that trials are run to rigorous standards with regard to producing credible and ethical data. Within the UK this has been superseded by the Regulations however, ICH-GCP is commonly referred to by US Pharmaceutical Companies and CROs.

Good Manufacturing Practice - (GMP) Good Manufacturing Practice (GMP) is that part of quality assurance which ensures that medicinal products are consistently produced and controlled to the quality standards appropriate to their intended use and as required by the marketing authorisation (MA) or
product specification. GMP is concerned with both production and quality control.

Sponsor Organisation - Organisation that takes responsibility for the initiation, management and/ or financing of a trial. Sponsor responsibilities are defined in the Regulations.

Investigational Medicinal Product – (IMP) Clinical Trial Investigational Medicinal Product – (CTIMP) A pharmaceutical form of an active ingredient or placebo being tested or used as a reference in a clinical trial. This includes products unlicensed products and products with a marketing authorisation used within and outside of their licensed use.

Research Ethics Committee – (REC) Research Ethics Committee. Responsible for giving ethical approval for all clinical research.

Local Research Ethics Committee – (LREC) Local Research Ethics Committee. Responsible for giving local ethical approval for all clinical research.

Clinical Trial Authorisation - (CTA) Regulatory approval to conduct a clinical trial as authorised by an EU Competent Authority. All clinical trials conducted within the UK must have a CTA issued by the MHRA before a trial can be initiated.

Clinical Research Associate – (CRA) Individual employed by Sponsor Organisations or their representatives to monitor a trial.

Contract Research Organisation – (CRO) An Organisation who conducts trial activities on behalf of the Sponsor under a trial specific contract.

The Joint Clinical Trials Office (JCTO) - Established in 2006 by Kings College London, Guy's & St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust to provide a streamlined approach for all aspects of trial administration.

SAE – Serious adverse event.

SmPC – Summary of product characteristics.

PIL – Patient Information Leaflet.

B SCOPE:

All CTIMPs conducted at South London & Maudsley NHS Trust.

For new trials Chief Investigators should contact Pharmacy, R+D and JCTO as appropriate.

Sourcing of all IMPs must be delegated to Pharmacy and not directly by Clinical Trial Investigators. Pharmacy is responsible for providing a full audit trail of IMP.

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C RESPONSIBILITIES:

The Pharmacy site lead for clinical trials will have specific responsibility for liaising with the Trust R&D Department, JCTO, the local Investigator and where appropriate, the trial Sponsor, CRO or trial representative.

Prior to the dispensing of an IMP, the Pharmacy site lead will be responsible for ensuring local R&D approval, REC and site specific assessment and regulatory approval is in place.

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The Pharmacy site lead for clinical trials is to act as the responsible person for the trial and undertake the set-up, and daily running of all current trials. This responsibility may be delegated if appropriate to a Clinical Trials Technician or Specialist Pharmacist.

Designated pharmacy staff providing clinical trial services must be adequately qualified, trained and experienced to assume clinical research responsibilities and should be able to provide up to date GCP training records and curriculum vitae. Pharmacy staff job descriptions must provide clarity with regard to responsibility and accountability for clinical trials.

D PROCEDURE FOR THE SET- UP AND DISPENSING OF CLINICAL TRIALS.

This applies to the Pharmacy site lead for clinical trials or appropriate delegated Pharmacist/ technician

All activities are covered by Pharmacy Clinical trial SOPs

APPENDIX 24: EQUALITY IMPACT ASSESSMENT

EQUALITY IMPACT ASSESSMENT

PART 1 – INITIAL SCREENING

SLaM wants to ensure that we provide accessible and equitable services that meet the needs of our diverse community and to meet the first principle of the NHS constitution – to provide comprehensive services available to all, paying particular attention to marginalised groups who are not keeping pace with the rest of society.

Under the Equality Act 2010 we are all protected from less favourable treatment or discrimination based on
age; disability; pregnancy and maternity; gender reassignment; race; religion / belief; sex; sexual orientation; marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]. As an organisation we are legally obliged to consciously think about equality as part of the decision making process in the design, delivery and evaluation of our services and policy development/review. This is why we ask you to begin / conduct the EIA at the planning stage and in a group, using the screening tool as a prompt to the necessary conversations about the impact of your work on equality. (See guidance for further information)

1. Name of the policy / function / service development being assessed?
Medicines Management

2. Name of **Lead** person responsible for carrying out the assessment? (where there is a service change, this should be the individual with responsibility for implementing the change) *[The EIA should, wherever possible, be completed and considered in a group]*

Lead: Shubhra Mace

Others involved:
e.g. staff, service users / service user consultants / carers / carers consultants:
CAG heads of nursing, medicines management committee members

3. Describe the main aim, objective and intended outcomes of the policy / function / service change/ development?

Aim: to ensure safe, appropriate and cost effective use of medicines in SLAM

Objectives: to ensure that:
- patients receive the right medicines, at the right time
- patients are satisfied with the medicines they are prescribed
- staff are clear about the specific procedures for prescribing, administering, supplying and destroying medicines
- to ensure that the use of medicines is evidenced based and cost effective

Outcomes: to ensure safe, appropriate and cost effective use of medicines in SLAM
To ensure that patients are satisfied with the medicines they are prescribed

4 (a). What evidence do you have and how has this been collected? *[Please list the main sources of data, research and other sources of evidence reviewed to determine the impact on the equality groups, sometimes referred to as protected characteristics. Your data can include demographic data, access data, national research, surveys, reports; focus groups; information from your service?]*

None N/A

The policy provides guidance for staff in-line with national guidance and clinical evidence

Some

Substantial

4 (b). Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

YES / **NO**

Which equality groups may be disadvantaged / experience negative impact? *[please base your answers on available evidence which can include for example key themes from the general feedback you receive via patient experience data (such as patient surveys; PEDIC); carer experience; complaints; PALS; comments; audits; specialist information - your personal knowledge and experience]*

Age YES / **NO**

Disability YES / **NO**

Gender reassignment YES / **NO**

Pregnancy and maternity YES / **NO**

Race YES / **NO**

Religion / Belief YES / **NO**

Sex YES / **NO**

Sexual orientation YES / **NO**

Marriage and civil partnership YES / **NO**

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)
Group:…… YES / **NO**

5. Have you explained your policy / function / service development to people who might be affected by it? *(Please let us know who you have spoken to and the results of these conversations and what actions/ developments/ changes have come out of them)*

Yes / No

If 'yes' please give details of who you involved and what happened as a result.

Date	**Process**	**Outcome**
October 2011	Meeting with GSTT and King's medicines management leads. Aim to produce a single MMP across KHP	Joint policy not yet possible within the timeframe of this review

November-December 2011	Policy circulated to clinical leads for initial feedback and updates	Extensive feedback received. Policy amended
January 2012	First draft (version 1) of the updated MMP circulated for comments	Policy amended according to feedback
8th March 2012	Second draft (version 2) of policy circulated to all CAG leads, nurse leads, medical education lead and MMC members for comments.	Policy amended. Policy formatted by the performance team
24th April 2012	Policy was due to be presented to MMC but meeting cancelled because of poor attendance	Decision taken to present policy for ratification because of the extensive consultation process (involving professional and CAG leads and Medicines management committee members
30th April 2012	Final version (version 4) of policy emailed to heads of nursing for any final comments	No further comments received

6. If the policy / function / service development positively promotes equality please explain how?

7. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive:	High (highly likely to promote equality of opportunity and good relations)	Medium (moderately likely to promote equality of opportunity and good relations)	Low (unlikely to promote equality of opportunity and good relations)
Negative:	High (highly likely to have a negative impact)	Medium (moderately likely to have a negative impact)	Low (probably will not have a negative impact)

Neutral: High (highly likely)

Reason for your decision:

Date completed: ……..

Signed …12th July 2012…….. Print name ……Shubhra Mace……

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

1. Name of the policy / function / service development?

2. From the initial screening process, which groups may experience negative impact?

Age	YES	/	NO
Disability	YES	/	NO
Gender reassignment	YES	/	NO
Pregnancy and maternity	YES	/	NO
Race	YES	/	NO
Religion / Belief	YES	/	NO
Sex	YES	/	NO
Sexual orientation	YES	/	NO
Marriage and Civil partnership	YES	/	NO

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)

Group:…… YES / NO

3. What evidence do you have? Please give details:

(a) Strong evidence

(b) Some evidence/considerable gaps

(c) Anecdotal evidence

4. Please outline steps taken during the EIA process to raise awareness and consult/involve interested parties and those who may be affected by the policy / function / service development

5. What does available evidence / results of consultation show?

6. If you have not been able to conduct consultation how do you intend to test out your findings and recommended actions?

7. What changes or practical measures would reduce the negative impact on particular groups? (Think what a successful outcome would look like and what can be done to bring about this outcome)

If changes are required please complete the action plan template overleaf

8. What are the main conclusions of the assessment?

9. Has a monitoring process been established to measure/review the effects of the policy, function or service development? (This may include statistical analysis of monitoring data, satisfaction surveys or use of networks) Yes (if yes, please include details in the action plan overleaf) No (if no, please state why)

Date completed: ……..

Signed …… Print name ……..

Please send an electronic copy of the completed assessment, action plan (if required), any relevant monitoring reports used and a summary of replies received from people you have consulted, to:

1. Kay.harwood@slam.nhs.uk
2. Your CAG Equality Lead

ACTION PLANNING

The following action plan should summarise the proposed actions, setting out the timescale, lead individual and include details of any monitoring needed in the future to check that desired outcomes are reached.

Issue / Adverse impact identified	Proposed actions	Responsible/ lead person	Timescale	Progress

Please send an electronic copy of your completed assessment to:

1. Kay.harwood@slam.nhs.uk
2. Your Service Equality Lead

Appendix 25 – Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Paul Bellerby, Legal Services [paul.bellerby@slam.nhs.co.uk]

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]	N	
• Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management]	N	
• Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]	N	
• Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]	N	
• Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]	N	
• Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]	N	
• Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]	N	
• Article 11 - Freedom of assembly and association	N	
• Article 14 - Freedom from all discrimination	N	

Name of person completing the Initial HRA Assessment:	D. Taylor
Date:	10.07.12
Person in Legal Services completing the further HRA Assessment (if required):	
Date:	

Appendix 26 – Checklist for the Review and Approval of a Policy

This checklist must be used for self-assessment at the policy writing stage by policy leads and be completed prior to submission to an appropriate Executive Committee/Group for ratification.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Style and Format**		
	Does the document follow The South London and Maudsley NHS Foundation Trust Style Guidelines? i.e.: • The Trust logo is in the top left corner of the front page only and in a standard size and position as described on the Intranet • Front page footer contains the statement about Trust copyright in Arial 10pt • Document is written in Arial font, size 11pt (or 12pt) • Headings are all numbered • Headings for policy sections are in bold and not underlined • Pages are numbered in the format Page X of Y		
2.	**Title**		
	Is the title clear and unambiguous?		
3.	**Document History**		
	Is the document history completed?		
4.	**Definitions**		
	Are all terms which could be unclear defined?		
5.	**Policy specific content**		
	Does the policy address, as a minimum, the NHSLA Risk management Standards at Level 1 where appropriate		
6.	**Consultation and Approval**		
	Has the document been consulted upon?		
	Where required has the joint Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination**		
	Does the document include a plan for dissemination of the policy?		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
8.	**Process for Monitoring Compliance**		
	Is it explicit how compliance with the policy will be monitored?		
9.	**Review Date**		
	Is the review date identified on the cover of the document?		
10.	**References**		
	Are supporting references cited?		
11.	**Associated documents**		
	Are associated SLaM documents cited?		
12.	**Impact Assessments**		
	Is an Equality Impact Assessment included as the appendix of the document?		
	Is a HRA Assessment included as an appendix of the document?		