South London and Maudsley NHS
NHS Foundation Trust

Trust Medicines Policy 2016

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Author:	Deputy Director of Pharmacy - Clinical
Responsible Director:	Medical Director
Responsible Committee:	Drug and Therapeutics Committee
Target Audience:	Nurses, Doctors, Pharmacists and Pharmacy staff, Clinical staff, Audit staff
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Equality Impact Assessment	Assessor: Shubhra Mace	Date: 13.10.2016
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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	2012	Required full review and new NHSLA Standards	Major	D. Taylor
5	2014	Required full review	Major	S. Mace
6	Dec 2016	Full review	Minor	S. Mace
6.1	June 2017	RT policy updated Covert administration policy updated To include new recommendations	Minor	S. Mace

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes Made as a Result of Consultation
Senior Pharmacy Staff and Heads of Nursing	November 2013	Policy changes incorporated
Nursing Leads; Pharmacy staff; Rosemary Peregrine-Jones; Barry Huckstep, Mike Cummins, Mike; Cliff Bean; Middleton, Anne	December 2013	1 clarification of CDs; policy changes incorporated
As above	January 2014	Policy amended according to comments received from December consultation

As above	March 2014	Policy amended according to comments
CAG Clinical Directors; D&TC committee members; patient safety team; performance team representatives; pharmacy; nursing team; director of nursing; medical director	April 2014	Wider consultation. Final version to be circulated as shown
CAG Clinical Directors; D&TC committee members; patient safety team; performance team representatives; pharmacy; nursing team; director of nursing; medical director	May 2016	Wider consultation. Final version to be circulated as shown
Drug and Therapeutics Committee	April 2017	Both policies approved by Drug and Therapeutics Committee
Service Users/Carers consulted	**Date**	**Changes Made as a Result of Consultation**
N/A		

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
All clinical staff	Trust intranet. Email link to staff	Electronic	S. Mace
Clinical audit and performance management teams	Trust intranet. Email link to staff	Electronic	S. Mace

Key changes to policy:

- Implementing CAS alerts for medicines
- Non-medical prescribing policy
- Policy compliance with the MHA
- HTT Older Adults
- Covert administration policy consistent with NICE and recent court ruling
- RT policy Consistent with NICE and include guidance of use and monitoring of zuclopentixol acetate

Guidance on:

- Monitoring clinic room temperatures
- Transport of medicines in community
- Reporting lost and stolen prescriptions
- Naloxone in community Drug and Alcohol teams
- Home Office Guidance on licence for ordering CDs

Contents

1. Introduction

This Medicines Management Policy was 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 Policy**. **The standard operating procedures for Controlled Drugs** were approved by the Governance Executive in May 2007 and are included in this policy. The covert administration and rapid tranquillisation policies, previously separately approved, and now also incorporated in this overall Medicines Policy. This policy is required by numerous NHS directives.

This updated Medicines Policy supersedes the old Medicines Management Policy (2012)

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 patient in personal care, whether paid or unpaid, and may or may not be related to the patient.
- **Patient/service user** - A person receiving services from the trust.
- **Clinical Unit** – A trust clinical facility e.g., 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 12 for the trust Unlicensed Medicines policy.
- **Pharmacy** - Departments providing a service to patients 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 8 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 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.
- 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.
- The trust Drug and Therapeutics Committee holds the overall responsibility for overseeing this policy.

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 rapid tranquillisation 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

Performance team
Patient Safety team

Targeted patient/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 Policy and appendices into the working arrangements of the Trust. They will maintain an overview of significant risks via the Drug and Therapeutics and Quality Sub Committee (of the Board) and by monitoring the trust Assurance Log.

4.2 Accountable Officer for Controlled Drugs

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 and Pathology

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 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 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 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 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

- To ensure that medication received by 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 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 General Pharmaceutical Council Standards for Conduct, Ethics and Performance (July 2012)
- 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 patients, for self-administration by the patient. To support this role the staff involved must be familiar with the trust policy and local procedures for issuing medication to patients. 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 14 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 Optimisation Report and programme.

6. Consultation

This is an update of the Medicines Policy. A full consultation process has been undertaken including the trust Nursing, Medical, Pharmacy and Performance and Clinical Audit teams.

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 Who can prescribers prescribe for?

- Medicines can only be prescribed on trust prescriptions for patients with a valid NHS hospital number.
- All patients should have an ePJS record.
- Exceptions include babies on the Mother and Baby Unit.
- Contact pharmacy if in doubt

7.3 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 in the patient's notes
    - 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 patient medication in community teams, at least 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.

7.4 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**.**

7.5 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 17 for details of the FP10 Security 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.
- Investigational medicines, or medicines being used as part of a research study, may only be prescribed following approval of the clinical trial protocol by the appropriate Research Ethics Committee and have Regulatory (MHRA) and R&D approval.

7.6 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.

7.7 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.

7.8 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.

7.9 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

7.10 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 after scanning.

7.11 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 19 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.

7.12 Medicines Reconciliation

See appendix 19 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.

7.13 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.
- Clinicians must assess for individual patients the risk of non-compliance with medication. Clinicians must evaluate the risk and ensure that both the appropriate medication is prescribed and that the patient is supported to continue treatment.

Note: Compliance of the medicines Policy with the Mental Health Act, please see notes below about treatment for patients who may or may not have capacity to consent to treatment.

Physical intervention may be used in order to administer medication to an unwilling patient where there is legal authority, whether under the Mental Health Act 1983 (amended by the Mental Health Act 2007) or Mental Capacity Act 2005 or otherwise, to treat the patient without consent. Physical interventions may not be used to treat an informal patient who has the capacity to refuse treatment and who has done so.

Assessment of the patient's capacity to consent or refuse physical health care must be made. If the team assesses that the patient lacks capacity to consent to treatment for a physical health care problem then the team needs to refer to Mental Capacity Act guidance to assist them in assessing and treating patients for physical ill-health.

If the patient requires emergency treatment and it has not been possible to determine the patient's mental capacity, urgent treatment can be given in the patient's best interests under the Mental Capacity Act provided that staff have reason to doubt the patient's capacity.

7.14 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.

7.15 Discharge or transfer from the service

- 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
- 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

7.16 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.

7.17 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 1 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.

7.18 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.

7.19 Prescribing medicines for use in clinical trials

For the purpose of this document the term clinical trials includes all research involving medicinal products**.**

See appendix 21

- 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 Policy.

7.20 Prescribing Controlled Drugs (CDs)

Please refer to appendix 2.
Prescriptions for controlled drugs for supply to patients must comply with the legal requirements of the Misuse of Drugs Regulations 2001 and subsequent amendments. Injectable diamorphine may only be prescribed by prescribers who hold a relevant Home Office licence.

- 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.
- When patients are admitted to an in-patient unit, the prescriber must determine the dose and supply quantity of opiate substitutes in each individual case. Note, some patients may be on a daily supervised administration regime. Care must be exercised when prescribing medication on discharge. If in doubt, confirm with the patient's community drug and alcohol team.
- All patients of the community drug and alcohol teams who use or who have ever used opiates are at risk of relapse or overdose and should be provided with take home naloxone kits and overdose management training. All clinical staff working in Addictions should be trained and competency assessed to issue kits and provide overdose training. Since October 2015 there has been no legal requirement for a PGD or prescription for this to be done (however, this only applies to recognised drug treatment services). Naloxone can also legally be issued to carers/friends/family members of people at risk of opiate overdose, including staff of relevant agencies such as probation and hostel staff who may witness an overdose.

Staff should regularly check whether kits have been used, lost or expired. Replacement kits should be re-issued regularly.
- Prescribing of CDs by non-medical prescribers (NMPs) – see appendix 3 for further details.

7.21 Prescription of unlicensed medicines or licensed medicines for unlicensed indications

See appendix 12 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.

7.22 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 nursing staff 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 5 for competency assessment documents).
- support staff who have been trained to administer a specified medicine to a specified patient.

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 6 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 Policy.
b) Administration of medicines on behalf of the trust may take place in trust premises, in the patient'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 patient 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.
h) Injectable medicines must be drawn directly from their original ampoule or container into syringes and then administered immediately. Injections must not be decanted into open pots. Injections must not be drawn-up and left unlabelled for administration at a later time.

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 8 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 15 for the trust Covert Administration Policy

8.13 Other administrations

- See appendix 7 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 16 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
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 4 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 4 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 medicines out-of-hours

- See appendix 4 for full details of the pharmacy out-of-hours service.
- The ETL or DSN must be contacted to obtain access to the out-of-hours drugs cupboard.
- If the medicine is not available in the out-of-hours cupboard, the ETL or DSN must contact the on-call pharmacist to obtain authorisation to "borrow" a medicine from another ward. Note: this is not permitted without authorisation from the on-call pharmacist.
- ETL or DSN should contact the duty/on-call pharmacist via trust switchboard.

9.7 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.

9.8 Planned leave or discharge

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

9.9 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.
- Controlled Drugs may not be dispensed from ward stock by the Duty Doctor. The Duty Doctor may however return to the patient any of their own Controlled Drugs (PODs), which have been stored on the ward. PODs must only be returned to the patient if the Duty Doctor is satisfied that the medication is consistent with medication currently prescribed for that patient and that returning the PODs to the patient does not present any risk to the patient or others.

9.10 Ordering Controlled drugs (CDs) from pharmacy

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

9.11 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.

9.12 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.

9.13 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 2)

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 must be collected from pharmacy. 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".
- In the IOT clinic, CDs may be received by either two nurses or a nurse and a pharmacist. Two people must be involved in the receipt of a CD.
- 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. In the community drug and alcohol teams, the “overage” may be measured and the balance in the register adjusted according to the extra liquid in the bottle.

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). Note, fridges must be locked.
- 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.
- 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.
- Medicines should be stored at temperatures below 25 degrees Celsius.

11.3 Transportation of medicines in the community, for example, between community teams and patients' homes

- Medicines and related equipment such as needles and sharps bins must be transported in the community in a trust approved bag for this purpose. The bag is called DynaMed Compact Medic Bag. Bags may be ordered by following the link below:

  http://sites.intranet.slam.nhs.uk/resus/Medical%20Devices/Medical%20Devices.aspx?PageView=Shared&DisplayMode=Design

  (List of Trust-approved medical devices 2016 - alphabetical orderV1 2)

- The bag must be cleaned after each use using general purpose detergent wipes followed by disinfectant wipe if the bag is contaminated with blood or body fluids. If the bag is too contaminated to be able to be cleaned, it must be disposed of in a clinical waste bin.
- Staff must carry a copy of waste carriers licence and standard operating procedure for "transportation of sharps waste in the community".

11.4 Monitoring clinic room temperatures

- Clinic room temperatures should be monitored daily to ensure they are at the required temperatures. The clinic room temperature should not exceed 25 degrees Celsius. It is the responsibility of the unit manager to ensure that medicines are stored at the recommended temperatures.
- If the temperature is above 25 degrees Celsius, the unit manager must contact the Estates and Facilities department to report the problem and to obtain advice on rectifying the problem.
- Pharmacy should be contacted for advice on medication storage and stability.
- The unit must record the clinic room temperature on the temperature sheet (see appendix 26)
- Records must be kept for at least one year.

11.5 Monitoring fridge temperatures

- Fridge temperatures should be monitored daily to ensure they are at the required temperatures. The fridge temperature should be maintained between 2 and 8 degrees Celsius. It is the responsibility of the unit manager to ensure that medicines are stored at the recommended temperatures.
- If the fridge 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 and stability.
- The unit must record the clinic fridge temperature on the temperature sheet (see appendix 26)
- Records must be kept for at least one year.

11.6 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.

11.7 Borrowing and lending medicines between wards/departments

- Medicines must not be routinely borrowed/lent between wards during normal pharmacy opening hours.
- If a medicine is required outside normal pharmacy opening hours the out- of-hours pharmacist should be contacted according to local policy.
- In some cases, to avoid unnecessary delay, the pharmacist may authorise ‘borrowing’ the medicine from another ward.
- Pharmacy will charge/credit the borrowing/lending ward as appropriate

11.8 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.

11.9 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

11.10 Storage of Controlled Drugs in clinical areas

See appendix 2

- 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

11.11 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 after approval by clinical trials pharmacist.

- 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 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.

12.2 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.

12.3 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.

12.4 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).

12.5 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.

12.6 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.

12.7 Patient information leaflets

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

12.8 Supply of Controlled Drugs from pharmacy (see appendix 2)

Note: procedures may differ on Lewisham sites

- The CD may be dispensed by a pharmacist (or pre-registration pharmacist under supervision) or a band 4 (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
- When patients are admitted to an in-patient unit, pharmacy must determine the dose and supply quantity of opiate substitutes in each individual case. Note, some patients may be on a daily supervised administration regime. Care must be exercised when dispensing medication on discharge. One or two week supply may not be appropriate in many cases. If in doubt, confirm with the patient's community drug and alcohol team.
- 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.

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

See appendix 16 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.

12.10 Supply of clinical trials medication from Pharmacy

See appendix 21 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 2)

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

Teams on hospital sites

- 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 may be removed from the ward by a pharmacist or pharmacy technician Band 5 or above.
- If part of a vial is wasted it may be disposed of on the ward, by placing it in the sharps bin. If part of a tablet is wasted it should be destroyed on the ward using the DOOP kit. A registered nurse may dispose of individual doses/vials on wards/clinical units. The disposal must be witnessed by another nurse. Details of CD destroyed must be recorded in the ward CD register. Both nurses should sign the CD register.
- CDs must be checked by the pharmacist or pharmacy technician on the ward before being returned to pharmacy.
- The pharmacist or pharmacy technician 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).

Teams not on hospital base sites

- Teams not on hospital base sites must be registered with the Environmental Agency and trust Estates and Facilities department for authority to destroy CDs on the unit (exemptions certificate).
- CDs from units not on hospital base sites should be destroyed on the unit, not sent to pharmacy.
- Each unit will have a nominated pharmacist to witness the destruction of CDs on that unit.
- If a CD has expired or is no longer needed (e.g. patient discharged, medication changed) the unit must contact the authorised witness (in pharmacy) to arrange a suitable time for CDs to be destroyed.
- CDs must be destroyed using the DOOP kit. Destruction must be witnessed by a trust authorised witness.

- A record of all CDs destroyed must be kept in the back of the ward CD register current at the time of the CD destruction. Registers must be kept for at least 7 years after the time of record of last CD destroyed.
- Any CDs to be destroyed must be signed out of the front of the register and recorded in the back of the register. The CD stock in the cupboard must match the balance in the register. CDs must be destroyed according to the procedure for destruction in appendix 2
- A record must be made in the ward CD register of the date, reason for destruction, name, strength, form and quantity to be destroyed.
- The balance must be adjusted accordingly in the ward CD book.

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 2 for Controlled Drugs.

14.1 Definition

The delivery or handing over of medicine in person to a patient or carer that is for self-administration by the patient. The medication must have been dispensed by the pharmacy department, as a TTA (To Take Away) or outpatient medication, and clearly labelled with the patient's details and instructions on how the individual patient 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 patients. The issue of medication is part of the overall care of the patient and each clinician has a responsibility to ensure that prescribed medication is dispensed and issued to their patients 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 patient 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 patient, 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 patient/carer except in pre-arranged exceptional circumstances.
- The medication must always be issued to the patient 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 patient 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 9.
- The member of staff who hands out the medication to the patient 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 patient 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 patients. 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 patient 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 patients. The issue of medication to the patient should be recorded on the community prescription chart and a record made in the patient'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 patient, 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 patient is selected. Take extra care when there are patients 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 patient 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 patient 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 patient/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 patient/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 patient/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 patient e.g. hypersensitivity

reaction, serious adverse reaction, pregnancy, risk of overdose. This must be discussed with the patient's RMO or designated doctor immediately.
- The issue of medication to an individual patient must be recorded immediately on the prescription chart and/or in the patient'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.
- 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 patient has access to information about medication.
- The patient 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. At IoT clinic, one CD order book per CD may be used at any one time in such clinics.
- 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 17 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. Email "FP10" in the SLaM email address book.
- 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

- Leave FP10s unattended
- 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, pharmacy site lead and the trust Local Security Management Specialist (LSMS) 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
- For further details and the form to be completed by the unit manager, see appendix 17

16. Risk Management

16.1 Recording allergies and adverse drug reactions

See appendix 19 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 19 for Medicines Reconciliation Policy.

16.3 Medicines Safety Committee

The trust has a Medicines Safety Committee which meets once every three months. The Committee is chaired by the Medical Director and the Deputy Director of Pharmacy is the secretary. See appendix 27 for terms of reference.

Medication Safety Officer

The trust Medication Safety Officer is the Deputy Director of Pharmacy.

16.4 Error reporting

See appendix 20 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, as a "grade C" or above.

- 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 reported on DATIX will be examined every 3 months.
- A summary of the errors is presented to the Medicines Safety Committee
- The trust Patient Safety Department report all medication errors to the National Patient Safety Agency.
- Recommendations from the Medicines Safety Committee are communicated in the Medicines Bulletin and individually to CAG leads.

16.5 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**.

16.6 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.

See appendix 22 for procedure.

17. New Drugs, Clinical Trials and Unlicensed Medicines

17.1 Introduction of new drugs in the trust

See appendix 11 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 10 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 Quality Sub Committee (QSC) of the board. The committee has a chair and the secretary is the Chief Pharmacist. The terms of reference are as follows:

See appendix 11 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 12 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 Drug and Therapeutics Committees.

19. Monitoring Compliance

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 Drug and Therapeutics Committee.

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.

What will be monitored i.e. measurable policy objective	**Group(s)/committee(s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result**
The policy will be monitored as per Medicines Optimisation programme. The programme is updated annually. The trust participates in the POMH-UK audit programme The trust undertakes an audit of the storage and record keeping of Controlled Drugs every three months The trust audits the safe and secure handling of medicines once a year. In addition, as and when necessary, the trust will survey prescribing and medicines management practices	The Medicines Policy is overseen by the trust Drug and Therapeutics Committee. Medicines Incidents are reviewed by the Medicines Safety Committee. The Medicines Optimisation Report is presented to the trust board annually.

20. Associated Documentation

Medicines Annual Report and Medicines Optimisation Programme
Medicines Bulletins
Drugs and Therapeutics Committee minutes
Medicines Safety 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 'Standards for medicines management' (2007)
The NMC 'The Code - Professional standards of practice and behaviour for nurses and midwives Code of Professional Conduct' (2015)
The NMC Standards for competence for registered nurses (2014)
The Medicines Act (1968)
The 'Duthie Report' (2005)
Misuse of Drugs Act (1971)
CQC Regulations for Service Providers and Managers (2015)
Building a safer NHS for patients: improving medication safety (2004)
Healthcare Commission: Talking about Medicines (2007)
The Hackett Report. Homecare Medicines: Towards a Vision for the Future (2011)
The Carter Review (2016)

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).