Hampshire Partnership NHS
NHS Trust

CP 41

MEDICINES CONTROL, ADMINISTRATION AND PRESCRIBING POLICY (MCAPP)

VERSION 4

Hampshire Partnership NHS Trust
POLICIES AND PROCEDURES PROFORMA

CP 41

Subject and Version of Document:	Medicines Control, Administration and Prescribing Policy (MCAPP) – Version 4
Author:	Chief Pharmacist
Persons/Committees etc consulted whilst document in draft:	Medicines Management Committee, HPT Pharmacists, PNAC, Heads of Professions, Chief Pharmacists Provider Services, Consultants, Modern Matrons
Date agreed:	Version 1: April 2005, Version 2: April 2007 Version 3: March 2008, Version 4: November 2008
By whom agreed:	Medicines Management Committee/P&PC
Date of next review/update and by whom:	November 2011 Chief Pharmacist
Copy obtainable from:	Website
Date document issued:	Version 1 – July 2005 – Update 13 Version 2 – April 2007 – Update 23 Version 3 – June 2008 – Update 37 Version 4 – November 2008 – Update 42
Responsibility for dissemination to new staff:	All department Heads
Principal Target Audience:	All staff working in clinical areas involved in medicines management.
Training Implications:	Staff to be made aware
Equality Impact Assessments:	Yes

Amendments Summary:

Amend. No.	Issued	Page	Subject
1, V2	April 2007	31	New point 7.4 re The Mental Capacity Act 2005 added. Following points renumbered.
2, V3	June 2008		Policy rewritten to take account of : • the changes in law resulting from Shipman and the associated requirements of standing operating procedures for all activities processes involving Controlled Drugs • the amalgamation of the MHP policy within the main trust policy • The update of the NMC standards for meds administration • The requirements resulting from the NPSA alerts • Learning from experience from error reports, litigation at both trust and national level • Problems associated with e prescribing system at Melbury lodge. • Reflecting and cross referencing other trust policies.
3, V4	Nov 2008	48 Appendix	Section 18 - Policy Compliance Monitoring updated. Training Needs Analysis added.

Medicines Control, Administration and Prescribing Policy

Index

INTRODUCTION

The safe and secure handling of medicines in both residential and community settings requires appropriate policies, procedures and quality assurance systems to be in place. This policy defines the policies and procedures to be followed within Hampshire Partnership Trust for the prescribing, administering, supplying, dispensing, storing and recording of medicines. For the purpose of this policy, medicines are defined as any therapeutic, diagnostic or preventative substances administered to patients/clients or self administered.

This policy has been developed to manage the roles associated with medicines management. These have been assessed as

- The Trust may be found non compliant with national guidance and legislation
- Staff may be unaware of optimum practice in relation to the prescription administration, storage, control and safe disposal of all medicines (including Controlled Drugs) resulting in adverse health outcomes for patients.

This policy provides clear guidance/instruction to staff to manage these risks by addressing

- Safe Prescribing
- Safe Administration
- Safe Storage and Control of Medicines including Controlled Drugs
- Roles and Responsibilities of members of staff with respect to medicines
- Legislation Relating to Medicines
- Disposal of Medicines.

All staff working within the Trust who are involved ***in any way*** with the use of medicines, must familiarise themselves with the appropriate sections. This is especially important for all new starters and locum staff as procedures may differ from elsewhere. Senior staff must ensure that all new and locum staff are familiar with this policy and complete the appropriate competency assessment before they are involved with medicines.

There have been significant changes in the legislation and standards involving the use of medicines in recent years. These are reflected in this policy and staff will need to update their work practice accordingly.

The policy has been drawn up in consultation with professional groups across the trust and is designed to facilitate best practice. Consideration has been given to the various challenges posed by modern working within Mental Health and Learning Disability Services. However, the rapidly changing NHS will continue to throw up new challenges. It is vital that such issues are brought to the attention of heads of professions/team leaders and the chief pharmacist to ensure appropriate and timely development of new or updated policies can be undertaken.

The faxes used within the framework of this policy must agree with the Trust's requirements for safe haven faxes.

All staff must be aware that any instances where there is a suspicion that there has been unauthorised administration or supply of medicines to anyone other than a Trust patient, eg. a member of Trust staff or other third party, this must be referred to either the Police or the Trusts Local Counter Fraud Specialists for investigation.

Where staff have any suspicion that medicines are being taken or used by either another member of staff or a third party they have a duty to report this to either their line manager or in confidence to the Trusts Local Counter Fraud Specialists. Further details of the Trust's Counter Fraud Policy, and means of reporting your suspicions, is available on the Trust's internet site.

(1) Medicines control within Social Care residential registered services (including short break services but excluding Townhill Way), and domicillary services is a separate but linked policy.

(2) Staff other than prescribers or nurses who administer medicines must have undertaken Hampshire Partnership NHS Trust approved training and been assessed as competent in their particular context. They must follow the Trust policies and procedures around medicines developed for their specific area and approved by the Medicines Management Committee.
These policies will be located within the Trust or directorate clinical policies file.

SECTION 1: STAFF GROUPS

1.1 A Health Professional is a member of one of the following staff groups, UK registered with their professional body:

Dentists	Nurses	Pharmacists
Dieticians	Clinical Psychologists	Occupational Therapists
Doctors	Speech and Language Therapists	Physiotherapists

1.2 Each registered health professional is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence in the ordering, prescribing, administering and recording of medicines; and work within the Code of Practice of their professional body.

1.3 All **health professionals** and **Mental Health Practitioners*** (who have been assessed as competent to administer medicines) involved in the medication process

1.3.1 must acquaint themselves with this policy and associated policies for the area in which they work.

1.3.2 will be aware of the action that should be taken if their practice or their patients safety is compromised.

1.3.3 will be aware of the safe dose range, frequency, route, administration technique, side effects, contra-indications and interactions of the drugs used and provide information to service users on their medicines and possible side effects.

1.3.4 will observe the patient for side effects and adverse reactions and manage them appropriately.

1.3.5 will monitor the outcomes of the treatment against identified treatment goals.

1.3.6 will be aware of their limitations and seek advice or support from appropriate health professionals when in doubt .

1.3.7 will avoid delegation to others who may not be qualified or experienced to carry out that task

1.4 All **staff** involved in the medication process:

1.4.1 must acquaint themselves with this policy and other related policies which apply specifically to their staff group and/or service

1.4.2 will be aware of the action that should be taken if their practice or their patients safety is compromised.

1.4.3 will be aware of their limitations and seek advice or support from appropriate health professionals when in doubt.

1.4.4 will avoid delegation to others who may not be qualified or experienced to carry out that task.

1.5 Local service or departmental managers, modern matrons, consultants and medical staff are responsible for ensuring all staff are conversant with this policy *and related policies* before they are involved in any drug administration, prescribing or ordering and that they are competent to undertake their role.
*Any reference to MHPs within this policy is referring only to those who have been assessed as competent to administer medicines.

SECTION 2: ACQUISITION OF MEDICINES

2.1 Ward and department stocks

2.1.1 A ward/department manager is responsible for the ordering, stock control, rotation, expiry date checking and reconciliation of any discrepancy. This may be delegated on a day to day basis to a nominated person who must be a qualified nurse or MHP or may be undertaken by a member of pharmacy staff where such a service is provided under a service level agreement.

2.1.2 Where the ward/team manager is not a registered nurse the manager is responsible for ensuring that a named member of nursing staff has this role delegated to them and that it is reflected within their job description. The ward manager is responsible for ensuring this policy is implemented. For the purposes of this policy, the named nurse or nurse in charge of the ward, will be referred to as the nurse in charge of medicines (NICM).

2.1.3 All medicines received from pharmacy must be checked against the order/prescription before storage or administration. This responsibility lies with the registered nurse/MHP/designated member of the pharmacy staff, but may be delegated appropriately. Non-registered staff (except mental health practitioners (MHPs)) must not complete requisitions. Any discrepancy should be reported to the supplying pharmacy and an incident form completed. Requisition forms must be locked away.

2.1.4 The range and quantities of all medicines, controlled drugs and sterile fluids held as stock should be agreed between the NICM, the ward or department, clinical pharmacist/technician and the pharmacy. Each list should reflect current prescribing patterns and include medicines for use in emergencies, Appendix P, and controlled drugs and be reviewed every six months.

2.2 Requisitioning of Controlled Drugs

2.2.1 The NICM is responsible for controlled drugs under current legislation. The NICM can delegate the task of preparing a requisition to another registered nurse but the legal responsibility remains with the NICM.

2.2.2 Controlled drugs for use on the ward/unit must be acquired using the Controlled Drug Order book and signed by a registered nurse, specifying his/her qualifications. Pharmacy will maintain a system to enable the checking of signatures. The NICM is responsible for authorising and providing pharmacy with a list of signatures and ensuring it is kept up to date.

2.2.3 Requisitions must contain the following:

- Name of Ward/Department/Hospital
- Drug name, form, strength, ampoule size if more than one available
- Total quantity and date
- Signature and printed name and qualifications of registered nurse
- Signature of pharmacist or, if pharmacist not available, doctor working in the Trust
- Signature of person issuing the item from pharmacy.

The pharmacist/doctor signature is the independent verification that the controlled drugs ordered are to be used in the requesting ward. If the request is for an unusual

item, they should take any necessary action to assure themselves that there is a patient prescribed that drug. The second signatory is not responsible for management and accountability of the CDs in the ward.

2.2.4 All Controlled Drugs must be delivered to wards or departments in a tamper evident package. The porter/driver will sign *either* the Controlled Drug Order Book as accepted for delivery *or* the Controlled Drug Order Book and a transport sheet *or* only the transport sheet depending upon local arrangements. If a driver hands over the tamper evident package to a porter for delivery, the porter must sign the delivery sheet and the driver retains a copy of the delivery sheet. When the driver/porter hands over the tamper evident package to a registered nurse on the ward, the transport sheet is signed in the appropriate section. The relevant section of the transport sheet is returned to pharmacy. On no account should they be left unattended. As a matter of good practice the receiving person should not be the same person who ordered the controlled drug. If there is no registered nurse present on the ward, a registered nurse must be bleeped to attend. On no account may anyone other than a registered nurse accept the controlled drugs. They must be taken back to the supplying pharmacy if a nurse is not available.

2.2.5 After the registered nurse accepts delivery of the CDs they must check the contents of the package containing Controlled Drugs against the requisition. Any discrepancy must be reported to pharmacy immediately. If correct, the registered nurse must sign the requisition in the received by section. The registered nurse must enter the new stock into the Controlled Drug register on the appropriate page witnessed by either another registered nurse, a health care support worker, MHP or authorised member of pharmacy staff. The following details should be recorded:

- Date received
- Time received (24 hour clock)
- Name of pharmacy making supply
- Quantity received
- Serial (page) number of the order
- Signature of registered nurse completing the entry
- Signature of witness
- New resulting total balance (checked against actual stock)

The witness's role is to check the

- Name and strength of drug
- Form
- Quantity
- New stock level balances tally with the quantity that is physically present.

The medicines must then be IMMEDIATELY LOCKED AWAY IN THE CONTROLLED DRUG CUPBOARD. Morphine and diamorphine ampoules of 30mg or more should be physically segregated from lower strength ampoules within the CD cupboard. This can be done by placing them on a separate shelf.

2.2.6 Boxes sealed by the manufacturer should be assumed to be correct and not opened until required for use. If when the seal is broken the contents do not match the expected amount stated on the pack, the registered nurse must contact the pharmacy department. Appropriate records must be made in the CD register and all necessary action taken to resolve the discrepancy. An incident form must be completed and the accountable officer informed.

2.2.7 Controlled drug register books (CDR)

2.2.7.1 The CDR should be bound (not loose-leaf) with sequentially numbered pages and it should have separate pages for each drug and each strength, so that a running balance can be kept easily. Entries should be made in chronological order, in ink or be otherwise indelible.

2.2.7.2 All entries should be signed by a registered nurse and must be witnessed by a second registered nurse, MHP, healthcare support worker, doctor, or authorised member of pharmacy staff.

2.2.7.3 On reaching the end of a page in the CDR, the balance should be transferred to another page. The new page number should be added to the bottom of the finished page and the index updated. As a matter of good practice this transfer may be witnessed.

2.2.7.4 If a mistake is made it must not be crossed out. It should be bracketed in such a way that the original entry is still clearly legible. This should be signed, dated and witnessed. The witness should also sign the correction.

2.3 Ordering Stock Medicines other than Controlled Drugs

2.3.1 Ordering methods

- A computer requisition, generated by the pharmacy service, is signed by a qualified nurse or MHP and sent to the pharmacy department in line with the agreed schedule. The requisition must be kept locked away when not in use.
- Topping Up Service
  Pharmacy staff undertake the ordering role.
- Urgent Items
  Items required urgently outside the schedule should be ordered on the requisition sheet and sent to pharmacy if the unit is on site. Off site units should telephone and then fax a request through using the appropriate form. (Telephone calls are not needed for orders sent to the pharmacy at St James Hospital).

2.3.2 All medicines must be delivered to wards/departments in a lockable drug box for main stock orders or tamper evident container for small quantities. These must be brought to the attention of the registered nurse or MHP on arrival on the ward/department.

2.3.3 The registered nurse or MHP must

- Lock the container in a secure place. Boxes and tamper evident containers must not be left unattended *or* accessible to patients and visitors and unauthorised staff.
- As soon as practical the registered nurse or MHP must
  (i) check the medicine against the delivery note
  (ii) sign the note and keep it for two years
  (iii) lock the medicines in the medicine cupboards immediately
  (iv) report any discrepancies to the pharmacy immediately
  (v) special consideration should be given to storing items which require cold storage in the fridge as soon as possible after receipt on the ward.

2.4 Method of Supply for individual patients

2.4.1 Wards receiving a regular clinical pharmacy supply service:

(a) Initial Supply - An authorised member of the clinical pharmacy team will initiate the supply in accordance with the prescription. If medicines are required urgently before the pharmacist's next visit, a medicine request slip should be completed by a registered nurse/MHP and the pharmacy telephoned and then the request faxed through if there is no pharmacy on site. Each request must have the appropriate patient(s) chart faxed through to enable the pharmacy staff to undertake pharmaceutical checks. If the pharmacy is on site then the prescription is taken to the pharmacy.

(b) Repeat Supplies - These should be ordered by the clinical pharmacy team. Where a patients own drug (POD) scheme is in operation the initial and repeat supplies will include instructions on the label and will be in a childproof container unless requested otherwise.

2.4.2 Wards not receiving a clinical pharmacy service that day:
For all medicines, a medicine request form must be completed by a registered nurse or MHP who is authorised to order medicines and sent to the pharmacy department with the prescription chart. For units where there is no pharmacy on site, both the request and the prescription chart must be faxed through. The registered nurse/MHP should telephone the pharmacy before faxing the prescription. *(Telephone calls are not needed for units supplied by St James Pharmacy).*

2.4.3 Melbury Lodge Site
Initial prescription for non stock item will be printed out automatically in the dispensary at Royal Hampshire County Hospital (RHCH), and checked by a pharmacist against the pharmacy profile. Request for a repeat supply should be made by the ward using a misogram.

2.4.4 Townhill Way and Milton House
Regular medicines are dispensed for individual residents every four weeks. Medicines are supplied labelled with full directions and may be used for leave. These medicines are ordered from the hospital pharmacy by sending a photocopy of the current medication chart (including prn/stat doses) together with the completed regular drug ordering request form. The form must be signed by an authorised prescriber. Short term leave and day centre medication may be ordered separately using the same process.

2.5 Ordering Discharge or Short Term Leave Medicines

2.5.1 Wherever possible, medicines for patients to take home should be requested well in advance of the patients discharge/leave to avoid delays on the day of discharge. Where this is not possible the time of the patients discharge/leave should be entered onto the To Take Out (TTO) request form to give the pharmacy department an indication of the urgency.

2.5.2 Medication supplies for patients in monitored dosage systems (MDS) should be processed as outlined in the Trust MDS procedures. Where the hospital pharmacy service does not provide this service, FP10HPs may be used to obtain MDS systems from a community pharmacy. Liaison with the community pharmacy is essential. Under the Disability Disabled Act community pharmacists are required to assess patients and provide accessible medication containers (usually a type of MDS). However it is the community pharmacist's responsibility to decide on need and they

can refuse on grounds of capacity to supply (see Section 6.2.8 and HPT Trust Policy on MDS CP 43 – Filling a Compliance Aid).

2.5.3 Medicines for patients to take home can only be dispensed when a pharmacist has seen the registered medical practitioner's prescription or when an authorised pharmacist has transcribed an order from the inpatient prescription chart (see section 5.2.8(iv)) Prepacked medicines and *Patients Own Drugs* (PODs) may also be issued against a TTO prescription (*see sections 13 and 14 and Trust POD Policy – CP64*).

2.5.4 Where there is a pharmacy department on site

(a) Where there is a clinical pharmacy supply service the prescription chart will remain on the ward and the clinical pharmacist will arrange for medicines to be supplied. The whole TTO form must be sent to the pharmacy for endorsing what was subsequently supplied. Triplicate forms are used so that one copy of the final TTO can be kept by the supplying pharmacy, another placed in the patient's notes and the third copy faxed/sent to the patient's GP. Standard triplicate forms are being introduced throughout the Trust.

(b) If there is no clinical pharmacy supply service or a delay in waiting for the next visit would be unacceptable, the prescription chart together with the TTO form must be sent to pharmacy together with any patients own drugs (PODs).

(c) Melbury Lodge site
TTO prescription will print out automatically in the dispensary at RHCH and will be checked against the pharmacy profile by a pharmacist.

2.5.5 Where there is no pharmacy department on site
(a) Where there is a regular clinical pharmacy supply service - 2.5.4 (a) applies

(b) If there is no clinical pharmacy service or waiting for the next visit would cause an unacceptable delay, the form may be sent via transport. If sending for TTOs via the normal mode of transport would result in an unacceptable delay and affect patient care, then the TTOs may be faxed through to pharmacy. The registered nurse contacts the pharmacy department and informs them that they wish to send a fax (This is not necessary for St James pharmacy). The registered nurse endorses the TTO form "faxed" and signs and dates it before sending it. The pharmacy copy of the original TTO is sent to the pharmacy. The inpatient chart must also be faxed through or, if using transport, a photocopy sent. A photocopy of the faxed prescription form from which the items were dispensed including all annotations must be sent back with the TTOs. Copies of this are then kept in the notes and sent to the GP. Note that prescriptions containing controlled drugs including temazepam cannot be released from pharmacy until the complete original TTO prescription has been received.

2.5.6 Outside Pharmacy Hours

Nurses cannot supply or authorise the supply of medicines for patients to take home. If a patient is discharged when pharmacy is closed and the discharge medicines have not been prescribed and dispensed in advance, the doctor who prescribed them is responsible for their supply. In these circumstances the doctor may dispense from ward stock. The medication must be labelled to include: Patient's name (in full), date of dispensing, address of unit, name and strength of drug, quantity and full directions, and include a manufacturers patient information leaflet. The doctor who prescribes and dispenses the medicines is responsible for ensuring that these

requirements are met and that the right medicine is supplied. (See section 13 for full details and procedure).

2.5.7 An essential part of any discharge plan is ensuring that the registered nurse/MHP has adequate time to go through all the discharge medicines with the patient and/or carer and answer any questions which may arise. The patient should know the purpose of the medicine, how to take it, and how long for. The registered nurse/MHP is also responsible for checking the discharge medicines are complete and up to date. Special care must be taken to ensure any medicines which are not supplied by pharmacy but are already on the ward labelled for leave or discharge, eg. inhalers, PODs, are added to the bag of medicines.

2.5.8 Controlled Drugs as discharge medicines

Controlled drugs to take home must be stored in the ward/department in the Controlled Drug cupboard. These medicines should be segregated from the ward CD stock and clearly marked and remain in the bag. The Controlled Drug should be recorded in the POD section of the register or separate POD register and witnessed as outlined in 2.2.4. On discharge the Controlled Drug must then be booked out by a registered nurse and witness who both sign and date the register. The following must be checked:

Patient Name
Date
Drug name + strength + form
Quantity

The patient/carer/driver should also sign the register for the receipt of the controlled drugs.
The rest of the discharge procedure is identical to 2.5.6.

2.6 "One Stop" Dispensing or PODs

2.6.1 Where one stop dispensing or PODs has been introduced, supplies of medicines used during the inpatient stay may be used for short term leave or discharge provided:

- Staff follow and medicines comply with the Trust policy on Patients Own Drugs and related local procedures.
- Consideration must be given to amount of medication supplied and a risk assessment undertaken by medical and ward staff. The outcome of this should be documented in the notes.
- The practitioner checking the medicines for use must be deemed competent to check one stop or PODs for discharge.
- A discharge/short term leave form detailing the medicines issued must be completed and retained in the notes.

2.7 Emergency Medicines and Advice Required Outside Pharmacy Hours

2.7.1 Outside pharmacy hours emergency medicines may be obtained by the prescriber or senior registered nurse using one of the following routes:

(a) borrowing from neighbouring wards (see 2.8 below)

(b) the local on-site emergency cupboard (St James Hospital, Royal South Hants Hospital). Up to date lists of contents are held by on-call managers or advice can be obtained from the emergency duty pharmacist.

(c) The local emergency duty pharmacist service contactable via switchboards at:

(i) Royal Hampshire County Hospital for Mid Hants and Eastleigh & Test Valley South (TVS) services
(ii) Southampton General Hospital for Southampton City, Eastleigh & TVS and New Forest localities
(iii) Queen Alexandra Hospital for Fareham & Gosport and East Hants localities and Ravenswood
(iv) North Hampshire Hospital for North Hants locality

Local procedures are available. The service does not cover discharge medicines.

(d) A Community Pharmacy On Call (CPOC) service can be accessed by community teams working in the New Forest, Eastleigh & TVS, Mid Hants and Southampton City areas. The service dispenses medicines in an emergency on FP10HNCs when late opening or rota pharmacies are closed. Pharmacy On Call Coordinator number: 07789 504639. The coordinator will be on duty from 8 pm to 8 am weekdays and Saturdays and from 5 pm to 8 am on Sundays and Public Holidays.

2.7.2 The ward manager is responsible for reviewing the use of emergency supply procedures and ensuring these do not become the norm.

2.8 Borrowing Medicines from other wards/units/services

2.8.1 Medicines should not normally be borrowed from another ward or department when a supply can be obtained from pharmacy within an acceptable time for the circumstances.

2.8.2 The decanting of medicines into another container ***is forbidden***. The original container must be transferred to the borrowing ward/*service*. If only one container is available and the drug is needed on the original ward, the full container must be taken and the dose administered from it. The container is then returned to the original ward. A record must be made of the transfer. See Appendix M.

2.8.3 Controlled Drugs must never be borrowed. If a Controlled Drug is required in an emergency the emergency duty pharmacist must be contacted.

2.9 Patients Own Drugs

2.9.1 All medicines brought into the hospital by patients remain their own property and must not therefore be destroyed or otherwise disposed of without their agreement or, if this is not possible, their relatives' agreement.

2.9.2 Medicines brought into hospital by patient must be reviewed by the admitting doctor who may or may not wish to prescribe them.

2.9.3 Patients own medicines brought into the hospital may, with the patient's permission, continue to be used provided:

2.9.3.1 The admitting doctor wishes the medication to continue and has prescribed the medication on Trust drug prescription and administration chart.

2.9.3.2 The ward has a procedure to routinely use 'patients' own medicines.

2.9.3.3 The medication is examined by the Trust doctor, authorised pharmacy staff, or a designated practitioner and is considered suitable for use.

The authorised practitioner may use the patients own medicines provided they comply with the Trust policy on use of Patients Own Drugs (CP64) and the practitioner has been deemed competent.

SECTION 3: STORAGE OF MEDICINES

3.1 All medicines stored in a ward, clinic or department must be stored in a locked cupboard, medicine trolley or medicines refrigerator as specified below. No other substances or articles may be stored in these cupboards/refrigerators which must be reserved strictly for the storage of medicines. Clinic rooms where drug cupboards are placed must be kept locked.
The only exceptions to this requirement are:-

- Storage of intravenous fluids and sterile topical fluids which because of their bulk are stored in designated clean areas, as agreed between the ward manager and pharmacy department.
- Medicines for resuscitation

3.1.2 The NICM is responsible for custody of medicines stored in their clinical area and must ensure that no unauthorised person has access to them. Advice can be obtained from the Trust Chief Pharmacist. The NICM is also responsible for ensuring regular expiry date checks are undertaken.

3.1.3 A pharmacist (normally the clinical pharmacist) will formally monitor the storage arrangements on each ward or department every three months. This will include a full check of all controlled drugs and the entries within the register in line with Appendix A. All changes to storage arrangements and arrangements for new units must be discussed with and approved by the Lead Locality Pharmacist or Chief Pharmacist.

3.1.4 Medicines must not be transferred from one container to another nor must they be stored in any container other than that supplied by the pharmacy department.

3.2 Keys

3.2.1 The following keys must be kept together on one key ring and held by a registered nurse/or MHP at all times or they may be kept locked in a key safe to which only the registered nurse/MHP/or authorised pharmacy staff has access.

If an MHP is responsible for the medicines and the ward is storing controlled drugs, the MHP may hold or have access to all the keys except the controlled drug cupboard key. This key must be held by a registered nurse. If there is no registered nurse on the ward there must be a local SOP for handing them to a suitably qualified nurse on an adjacent ward or department. This procedure must be fully auditable and must be approved by a pharmacist. If the unit currently has no controlled drugs in stock, the MHP may hold the controlled drug cupboard key.

Keys: Controlled Drug Cupboard
Medicine Trolley
Lock securing medicine trolley to wall
Medicine Cupboards
Medicine Refrigerator
Pharmacy ward stock box

3.2.2 Should a key or set of keys be lost, every effort must be made to find it or retrieve it from off duty staff. A spare set of keys must be held in a keypress in the senior nurses office. The senior nurse and bleep holder each hold a key to the key press. The bleepholder also has a key to the senior nurses office. In hours the senior nurse

(or nominated deputy when on leave) must be contacted. Out of hours the bleepholder will be contacted. It is the responsibility of the ward manager to ensure that a full set of spares is available. If the missing key(s) is not recovered quickly (i.e. by the next working day) the locks must be replaced and a Trust adverse incident form completed. A full check of controlled drugs should be undertaken as per Appendix 1. All other medicines should be checked to see if there are any obvious losses discernable. The Accountable Officer and locality lead pharmacist must be informed.

If duplicate keys are issued, the date and time of issue of duplicate keys must be recorded together with the names of people handing over or receiving them.

If the original keys are found, the duplicates must be returned and a record with the same details above recorded.

Extra vigilance must be observed in the period before the lost keys are found or new locks fitted.

3.2.3 A separate set of keys other than the duplicate is held by pharmacy staff when a POD or top up service is provided.

3.2.4 Access by any other member of staff other than those described above can only be allowed under the direct supervision of the registered nurse or MHP.

3.2.5 **Community Team Keys.** Keys held by nurses, MHPs or other authorised trained and competent staff, should not be identifiable by any marking. Any loss must be reported immediately and action taken as above.

3.3 Storage Area

3.3.1 Controlled Drugs Cupboard

All medicines listed in schedule 2 and most in schedule 3 of the Misuse of Drugs Regulations must be stored in a lockable cupboard complying with the regulations. (Contact the Trust Chief Pharmacist for advice and a list of the more frequently used products). This cupboard must be reserved solely for the storage of Controlled Drugs.

3.3.2 Medicines Trolley

A medicines trolley may be used for the storage of all orally administered preparations which are in current use and which require neither special storage conditions *nor* have special procedures for preparation/administration. The trolley must not be left unattended during medicine rounds. When not in use, a medicine trolley must be locked and immobilised by locking to the wall or by some other means which prevents its unauthorised removal. The trolley must be designed to provide adequate space to facilitate the safe selection of medicines whether they be stock or patients own drugs. Advice can be obtained from the pharmacy team.

3.3.3 Patients own drug boxes

If patients own drug boxes are used, consideration must be taken to their placing and a full risk assessment undertaken.

These boxes must be kept locked and the key held by the registered nurse in charge of the ward.

3.3.4 Medicines Cupboards

Medicines cupboards are for the storage of medicines such as oral, parenteral, topical and rectal preparations. These must be made of metal and comply with the latest British Standard. They must be always locked. Internal and external preparations must be stored separately either in different cupboards or on a separate shelf to minimise the risk of incorrect selection.

3.3.5 Medicines Refrigerator

Used for the storage of preparations labelled "Store in Refrigerator" or which indicate that they should be stored between 2°C - 8°C. It must be an approved design for the storage of medicines with an integral thermometer or temperature recording device or maximum and minimum thermometer. The temperature must be checked and recorded daily. It should be kept locked and used only for pharmaceutical products.

3.3.6 Disinfectant Cupboard

Preparations that are neither administered nor applied to patients must be stored in this cupboard which must be clearly labelled and locked.

3.3.7 Sterile Fluids

It may not be practical to store these in a cupboard. In this case storage should be in clean conditions in a designated area.

3.3.8 Where self medication is in place and individual locked cupboards are needed, these must be of metal and attached to the wall.

3.3.9 Siting of Storage Accommodation

3.3.9.1 The ward manager is responsible for ensuring that suitable storage conditions are available for all preparations and that any preparations in storage are in suitable condition for use. Information and advice may be obtained from the clinical pharmacy team or the local medicines information centre.

3.3.9.2 If any medicine is found to have been improperly stored, e.g. refrigerator found to be not working or ordinary medicines being subject to extreme high temperatures, the Medicines Information Centre should be contacted for advice. Medicines should not be administered to a patient until advice is gained. If urgent the out of hours pharmacist may be contacted.

3.3.9.3 Storage accommodation should be sited in a locked room where possible, ie away from public areas. Cupboards should not be stored near sources of heat, e.g. radiators, near sunny windows, or humidity (eg. near sinks). Storage facilities should always be locked when not in use.

Staff should lock the door of the storage room when opening cupboards/trolleys to access medicines both for personal safety and that of service users and visitors.

3.4 Storage and Handling of Flammable Liquids, Gases and Aerosols.

3.4.1 Medical Gases

3.4.1.1 Oxygen cylinders should be stored in a dry, clear and well-ventilated area and secured in a safe position where they cannot fall over. Cylinders must never be used or stored where there are naked flames or high temperatures. Where necessary, the Fire Officer should be consulted on the safe **use** and storage of oxygen cylinders, 'No Smoking' signs must be displayed where oxygen is in use or being stored near areas where smoking is allowed.

3.4.1.2 Where cylinders are held they should be in specifically designed trolleys or wall racks to prevent them from falling over. Their storage position on the ward should be agreed with the Trust Fire Safety Officer.

3.4.1.3 Staff involved in the use of oxygen should receive approved and documented training regarding the safe use of equipment including checking, maintenance and storage of oxygen cylinders.

3.4.1.4 When not in use the cylinders should be closed at the cylinder head (with the appropriate spanner) as well as at the flow meter.

3.4.1.5 Flow meters seals ('O' rings) must be replaced every 2 years to prevent leakage which is a fire risk.

3.4.1.6 When changing cylinders hands must be clean as the mixture of oil or grease eg. *butter* with oxygen is combustible.

3.4.1.7 More details on the storage and use of medical gas cylinders, and the issues associated with medical gases together with Health & Safety information will be found in the guidance set out in Health Technical Manual HTM2022.

3.4.1.8 A local written procedure should be available which details the ordering, receipt, handling, storage, issue and use of medical gases.

3.5 Ward/Department Closures or Transfers

When a ward is due to close, the ward manager is responsible for making adequate security arrangements to ensure that there can be no unauthorised access to medicines. For isolated units, the medicines must be returned to the pharmacy department for storage on all occasions. For other wards/departments, medicines may stay for short term closures but if long term closure is expected, arrangements must be made with pharmacy to return the medicines for storage/or return to stock. (Greater than five days is long term) See Appendix N. When a ward moves to another location, an assessment must be made by the nurse in charge of medicines and the locality pharmacist how the CDs are to be managed. A local auditable procedure must be drawn up and approved by the accountable officer. The procedure must include

- A risk assessment
- Arrangement for transfer of CDs and registers
- Arrangement s for checking and reconciliation of stocks in particular when ward staff transfer and CDs and registers are left in place
- Specifications of the entries required in the register.

The clinical pharmacy team responsible for stock control must ensure the ward signatory lists and stock lists are updated to reflect the new ward location/name/number.

3.6 Recording balances, losses and discrepancies

3.6.1 Controlled Drugs.

The NICM is responsible for balancing stocks of controlled drugs and for ensuring that the records and stock balances are correct at all times. Checks must be carried out weekly to ensure that the balance of stocks against the records is correct (see Appendix A – Procedure for Auditing Controlled Drug Stocks and Record Books).

Where discrepancies are identified, the procedure outlined in Appendix B – Procedure for Managers when Discrepancies in Controlled Drug Stock Levels are Identified - must be followed. Where the medicines remain unaccounted for, the fraud officer must be contacted and an internal investigation commenced. Incident Form to be completed.

3.6.2 Any Other Medicines

Where there is a suspicion of medicine misappropriation or abuse

- The nurse manager and locality manager, clinical pharmacist/locality lead pharmacist and chief pharmacist must be informed. The medical director and consultant must be informed if medical staff are involved
- A stock balance must be recorded within the controlled drug register and the drug temporarily treated for recording purposes as a controlled drug.

SECTION 4: DISPOSAL OF MEDICINES

Staff must read this in conjunction with the Trust Policy for the Handling and Disposal of Healthcare Waste.

4.1 Controlled Drugs – ward stock

4.1.1 Under no circumstances may any controlled drug be returned to pharmacy in the ward box or by a messenger. Surplus stocks of controlled drugs must be notified to the clinical pharmacist or the pharmacy supplying the site. Those that can be returned for reuse and credit will be collected from the ward by a pharmacist. An entry must be in the ward Controlled Drug Record book and signed and dated by the pharmacist and registered nurse. See Appendix O.

4.1.2 Out of date controlled drugs must be rendered inaccessible on the ward by disposal via a doop bin by an HPT pharmacist and registered nurse in line with Appendix O.

4.1.3 An individual dose, or part of a dose, of a controlled drug which is prepared and not used must not be returned to stock. It must be destroyed on the ward by two registered nurses or by a registered nurse and pharmacist or registered nurse and MHP or registered nurse and HCA. The destruction must be recorded in the Controlled Drug register with both nurses signatures and the procedure in Appendix L followed.

4.2 Controlled Drugs brought into hospitals by patients

4.2.1 Controlled drugs brought into hospital by a patient must be recorded in the ward Controlled Drug Register on a separate page from stock controlled drugs, or into a separate book kept solely for the use of patients own controlled drugs. The medicines may be used by that patient during their inpatient stay providing that the following criteria are met and patients consent is obtained in line with the POD policy:

(a) the use of patients own controlled drugs will be limited to ampoules, blister packed tablets or unit dose liquids so that nursing and medical staff can positively identify the medicines and check expiry dates and batch numbers

(b) the prescriber or clinical pharmacist endorses the prescription chart "patient's own"

(c) the name of the drug and the patient's name must be recorded at the top of the page and each drug entered onto a separate page.

4.2.2 If the criteria are not met the drugs must be disposed of as in section 4.1.2.

4.3 Medicines held as ward stock

4.3.1 In most cases surplus stock medicines used routinely on the ward should be used up on the ward or wait until the regular check by pharmacy staff who will return and credit the ward. Exceptionally, by prior arrangement with pharmacy staff, excess stock may be returned to the pharmacy in the ward box.

4.3.2 Medicines no longer required by individual patients may be returned to the pharmacy for credit, in the ward box. (Units supplied by St James Pharmacy must be returned to the pharmacy in a sealed envopak – not the ward box).

4.3.3 Patients Own Drugs (PODs)

Where a POD policy is in place patients consent will be obtained for the use of their medicines in hospital (see POD policy). Where this is not possible, a risk assessment must be undertaken and clearly documented in the notes and the medicines will either be:

- Sent to pharmacy for destruction
- Stored in a designated place on the ward for return to the patient on discharge (this will require a further risk assessment closer to the discharge date)

Controlled Drugs returned to the patient must be booked out of the register and a record made and signed by the nurse and patient.

4.4 Faulty Medicines

Details of medicines that appear to be faulty should be reported to the supplying pharmacy/clinical pharmacy team and an incident form completed.

SECTION 5: PATIENT AND CARER INFORMATION

It is important that the patient (or carer if appropriate) receives adequate information about their medicines prior to discharge unless their care plan deems it inappropriate.

The patient should know as a minimum:

- The purpose of the medicine
- How to take it
- For how long it is to be taken for
- What side effects they may experience.

This is the responsibility of the prescriber who may choose to involve the clinical pharmacy team in this process and the actions taken should be documented in the patient's notes.

SECTION 6: PRESCRIBING

6.1 Prescription Charts/Forms

6.1.1 Functions of the Prescription Sheet

- To provide a permanent record of the patients treatment with medicines
- To indicate the patients sensitivity to medicines
- To facilitate the provision of correct medicine from the pharmacy
- To direct and record the administration of the medicine to the patient
- To record when treatment commenced in relation to the Mental Health Act
- To ensure accurate records of expenditure on medicines are maintained

6.1.2 All blank prescription chart / forms are controlled stationery and must be stored in such a manner as to avoid use by non appropriate persons.

6.1.3 All medicines for patients under the care of Hampshire Partnership NHS Trust must be prescribed on official Hampshire Partnership NHS Trust prescription stationery.

6.1.4 Best practice dictates that only one chart should be in use for each patient. In exceptional circumstances, where the number of prescribed items dictates, an additional chart should be used. All charts must be stapled together. All charts must indicate the existence of additional charts, eg. this is 1 of 2.

6.1.5 When a subsidiary chart e.g. warfarin chart is required then it must be cross referenced on the main treatment chart.

6.1.6 When patients are transferred from elsewhere prescriptions must be rewritten within 24 hours
onto local prescription charts,

6.2 Prescribing

6.2.1 The prescriber will be a registered doctor, dentist or registered supplementary or independent prescriber. Nurses, pharmacists *and* other authorised health professionals may supply and / or administer within a Trust approved patient group direction. Registered dieticians may give such directions for enteral feeds and food supplements. Medical students, and staff undertaking the Independent and Supplementary Prescribing Course may not prescribe.

6.2.2 The prescriber must have all the relevant information required before prescribing for a patient and complete inpatient details essential for prescribing, ie. name, date of birth, Mental Health Act (MHA) status, allergies, weight (when appropriate). Other details may be completed by ward staff. When patients are admitted prescribers must take

steps to ensure that they have accurate information on the patients current medication. This may include checking with the GP practice or checking medicines brought in by patient/carer. Certain medicines which require a higher level of monitoring, eg. anticoagulants, methotrexate and insulin, will require special care. Prescribers must ensure that appropriate monitoring is undertaken in line with local prescribing guidelines and/or the individual drug SPC.

6.2.3 Inpatient and Community Prescription Charts must be computer generated or legibly and indelibly hand written in black ink and include:

- Patient name in full, including aliases
- Date of Birth
- Name of unit or home address
- Patient's NHS number
- MHA status (plus copy of consent to treatment where applicable)
- A record of all known allergies, where there is none known this should be recorded as 'none known'
- The weight of the patient (where appropriate)
- The patient's consultant

6.2.4 Where a patient has a similar sounding name to another patient on the ward, a standard sticker warning staff must be attached to the charts. This may be done by any member of the ward team at any time.

6.2.5 The specific details of each medicine prescribed must include:

6.2.5.1 (i) The name of the medicine written in block capitals. The generic name must be used except in instances of known bioavailability differences occurring between preparations e.g. lithium, anticonvulsants (when prescribed for epilepsy). In such cases both the generic name and trade name should be used.

(ii) The form where this provides specific pharmacokinetic properties e.g. modified release, soluble.

(iii) The strength

(iv) The dose

- Where a variable dose is required e.g. in dose titration of clozapine, the dose should be written in the appropriate section of the chart
- Where a steady dose regimen includes different doses during the day these may be written next to the times, this is indicated by stating "see times" in the dose box, or as two separate prescriptions on the chart.
- Doses of 1gram or more should be written using the abbreviation g or gram and a decimal point if required.
- Quantities of less than 1 gram should be written as milligrams. The abbreviation mg should be used for milligram.
- Quantities less than 1 mg must be written as micrograms and in full.
- Where decimal points are unavoidable a zero should be written in front of the decimal point when there is no other fi
- Calculation should be double checked

0.5ml 5ml

- The word "units" must be written in full rather than as an abbreviation, eg. "u or iu".

- Where a dose is to be given once a week the prescriber must strike out the six days when a dose must not be administered on the administration side of the chart and state "weekly" on the prescription side.

X	X	X	X	X	X		X	X	X	X	X	X	

(v) The route must be specified using the following permitted abbreviations:

IV	intravenous	PR	per rectum
IM	intramuscular	PV	per vagina
Inh	inhalation	Oral or PO	by mouth
SC	subcutaneous	SL	sublingual
NG	nasogastric		
PEG	Percutaneous endoscopic gastrostomy		

If there is a choice of routes e.g. oral or IM, a separate prescription should be written with a clear indication of there being a choice of either oral or IM.

(vi) The prescriber should always indicate the appropriate time using the **24 hour clock**. Outpatient, discharge and FP10HNC/FP10MDA/FP10SS prescriptions must include the times of administration. od (daily), as directed **must not be used**, instead the most appropriate time e.g. om (morning) should be used. For medicines given every X weeks e.g. depots the prescriber may indicate a time either side of the due date when a medicine may still be given. If no such direction is given for each patient the nurse must contact the prescriber if a dose cannot be given on the due date.

(vii) Where a medicine is prescribed for use "when necessary", it must be clearly stated the purpose of the medicine. The minimum intervals between doses and the maximum number of doses must also be stated. Where there is a range of doses, the range should be narrow with a clear rationale for movement within the range.

(viii) Prescriptions must be signed in full and dated by the approved prescriber.

(ix) The completed prescription should be re-read to ensure it is correct.

6.2.5.2 For Injectable medicines, the Prescription must specify the following:

- name and formulation of the medicine
- concentration or total quantity of medicine in the final infusion container or syringe
- name and volume of diluent and/or infusion fluid
- rate *and* duration of administration
- stability information to determine the expiry date of the final product
- type of rate-control pump or device(s) to be used
- the age and weight of any patient under 16 years of age, where relevant
- date on which treatment should be reviewed
- arrangements for fluid balance or clinical monitoring should be made on an individual patient basis and according to local protocol and clinical need.

6.2.5.3 Monitoring requirements for medicines must be clearly recorded in the notes.

6.2.6 Procedure For Obtaining An Urgent Prescription For An In-Patient (Excluding Social Care) When A Prescriber Is Not On Site (excluding Melbury Lodge – see 6.2.6.1).

If a prescriber is not on site and both the prescriber and nurse consider that a medicine is required before a prescriber is next due to visit the unit, and that neither the prescriber nor the nurse consider it essential for the doctor to attend, then *in these circumstances*, a faxed prescription may be used. This procedure only applies to those patients who have already been assessed by a doctor either on admission or following admission. The following procedure must be followed:-

The nurse must:

(i Describe the patient's presenting symptoms

(ii) Fax the patient's current prescription sheet(s) for information to the prescriber

(iii) Ensure that all information sections are completed correctly, eg. allergies, weight, date of birth etc.

(iv) Fax any other relevant information, eg. path lab results, GP surgery repeat order slips, to the prescriber

(v) Inform the prescriber of any relevant information on previous response to prescribed medication, eg. "responded well to 1mg lorazepam"

(vi) Not accept faxed orders for Schedule 2 or 3 Controlled Drugs (this includes Temazepam, morphine, diamorphine, buprenorphine, pethidine). Further advice on the status of a drug can be obtained from the local pharmacy service.

The prescriber must:

(i) Ensure they have adequate information on which to base their decision to prescribe which must be, as a minimum, (1), (2), (3), (4) and (5) above.

(ii) Fax a separate prescription for each drug prescribed using the preprinted form. (Appendix J).

General

(i) The prescription must be signed within 24 hours

(ii) The medicine involved must have been previously prescribed for the named patient by a prescriber, eg. on this or a previous admission. The nurse must have clear proof of this, eg. a previous prescription chart and no recorded "adverse effect" in the patient record. Or if the medicine is the patient's regular current medicine (ie. omitted from prescription chart on admission) a GP repeat order slip or patient's own drugs brought in from home.

(iii) Faxed orders may only be arranged by a registered nurse and prescriber.

(iv) The nurse should attach the faxed prescription to the patient's chart and record all administrations in the once only section of the administration chart, noting the prescriber's name, date, time, drug, dose and route of administration.

(v) Inpatient Safe Haven fax to be used.

(vi) A record of which drugs were ordered and who was involved should be entered in the medical and nursing notes.

In exceptional circumstances, where a drug not previously prescribed was required urgently and the delay caused by a prescriber travelling to assess the patient would place the patient at risk in the opinion of the nurse and prescriber, then a faxed order would be acceptable in the best interest of the patient. All such instances must be reported on the Trust incident form.

For unqualified staff, see specific policies.

6.2.6.1 Procedure For Obtaining An Urgent Prescription For An In-Patient When A Prescriber Is Not On Site At Melbury Lodge

If a prescriber is not on site and both the prescriber and nurse consider that a medicine is required before a prescriber is next due to visit the unit and that neither the prescriber nor the nurse consider it essential for the doctor to attend, then in these circumstances the prescription can be written on HIS remotely, on a laptop computer.

This procedure only applies to those patients who have already been assessed by a doctor either on admission or following admission. The following procedure must be followed:-

The nurse must:

1. Describe the patient's presenting symptoms.

2. Inform the prescriber of any relevant information on previous response to prescribed medication, eg. "responded well to 1 mg Lorazepam".

The prescriber must:

1. Ensure they have adequate information on which to base their decision to prescribe which will be available on JAC eg. administration chart on prescribed order entry (POE), path lab results.

Prescribing on JAC via laptop

1. Connect laptop to mouse, mains and phone line.
2. Power up laptop which takes 1 – 2 minutes.
3. Press Ctrl, Alt & Delete.
4. Check correct user name appears on screen or remove previous name and type in own user name.
5. Tab and enter own password.
6. Select- log on using dial up connection.
7. Select – OK.
8. Select – connect on next panel.
9. Wipe out previous password "dots" and enter own special PIN (4 numbers) and securID number from fob key on next panel.
10. Select – dial (takes 1-2 minutes).
11. When ready, double click on HIS icon and sign onto HIS in the usual way and prescribe as required.
12. When finished using HIS, home out as usual.
13. Close HIS either by selecting the 'X' in the top right hand corner and OK or by selecting file and exit and OK.
14. Select start (bottom left of screen).
15. Shut down – OK.

General:

1. The medicine involved must have been previously prescribed for the named patient by a prescriber, eg. on this or a previous admission. The nurse and prescriber must have clear proof of this and no recorded "adverse effect" in the patient records. Or, if the medicine is on the patient's regular current medicine (ie. omitted from the HIS system on admission) a GP repeat order slip or patient's own drugs brought in from home.

2. This procedure may only be arranged by a registered nurse and prescriber.

3. A record of which drugs were ordered and who was involved should be entered in the medical and nursing notes.

4. **In exceptional circumstances**, where a drug not previously prescribed was required urgently and the delay caused by a doctor travelling to assess the patient would place the patient at risk in the opinion of the nurse and doctor, then this procedure would be acceptable in the best interest of the patient. All such incidents must be reported on the Trust incident form.

6.2.7 Cancellations and alterations to a prescription

(i) To cancel a prescription

- Draw a bold X across the drug name and dose, initial and date the cancellation
- Draw a vertical line at the end of the last day that a drug is given and a bold X across the remainder of the administration section.
- If specific doses are to be omitted they should be cancelled individually by a diagonal line in the individual administration box.

(ii) Prescriptions must not be altered. The old prescription must be cancelled as in 6.2.7(i) and a new prescription must be rewritten.

6.2.8 Discharge Medicines (TTOs)

(i) Discharge medicines must be prescribed electronically or on approved Hampshire Partnership NHS Trust forms and conform to the relevant sections of (6.2.1, 6.2.3 and 6.2.5.1).

(ii) Medicines intended for long term treatment should be prescribed for 28 days. Short term treatment should be indicated by writing "X days only then stop". Patients for whom there is a risk of self harm should be written up for whatever quantity of medicines is deemed acceptable by the prescriber and stated "X days only". If a patient has a history of self harm in the previous 3 months no more than 14 days should be supplied.

(iii) The discharge medicine form must contain all medicines being taken at the time of discharge with their dosage and frequency. Non specific directions eg od (daily), as directed, **must not be used**, instead the most appropriate time eg om (morning) must be used. If patients have sufficient of their own supply of medicines the quantity should be endorsed POD (patients own drugs), (minimum of 7 days). This form is then the formal record of their medicines at discharge.

(iv) In certain circumstances an approved pharmacist may write up the medicines required on discharge/short term leave and these be dispensed. However, the prescription must be confirmed and signed by a registered medical practitioner before the patient is discharged/leaves the unit.

6.2.9 Outpatient Prescribing (This should be read in conjunction with the Trust guidelines on Outpatient and Community Prescribing, CP 76)

(i) Outpatients requiring a non urgent prescription should be referred to their GP using the approved pro forma.

(ii) If an urgent supply is required sufficient for up to 28 days treatment may be prescribed on an approved outpatient prescription or FP10HNC pads/FP10MDA/FP10SS forms (see section 5.3). A larger supply may be given if there are specific reasons for example that the consultant is maintaining prescribing responsibility for the patient, rather than transferring it to the GP, or the medicine is not available in the community.

(iii) Outpatients and FP10HNC pads/FP10MDA/FP10SS prescriptions must include the times of administration, non specific directions e.g. od (daily), as directed – **must not be used**, instead the most appropriate time e.g. om (morning) should be used.

6.2.10 Controlled Drugs Prescribing for Outpatients and TTOs

6.2.10.1 (i) The misuse of Drugs Regulations 2001 require that outpatient and TTO prescription for Controlled Drugs in Schedule 2 and 3 must:

a) Be signed with his/her usual signature and dated by the prescriber (the date does not have to be handwritten)
b) The requirement for prescriptions for Schedule 2 and 3 CDs (except temazepam) to be written in the prescribers own handwriting (other than the signature) has been removed. If the prescription is prepared by someone other than the prescriber then the person must be a registered health professional.
c) Include the full name, address and date of birth of the patient
d) Include the form, even when only one form exists, and where appropriate the strength of the preparation
e) The dose
f) The total quantity of the preparation or the number of dose units to be supplied in both words and figures
g) Be in indelible blue or black ink
h) It is good practice to include the patients NHS number on the prescription
i) The use of preprinted sticky labels on prescriptions for CDs is not recommended. If they are used they must be tamper evident. Prescribers must also sign the sticky label.
j) Prescribing of controlled drugs falls within the Trust guidelines for outpatients, but if there are particular reasons for prescribing more than 14 days for Outpatients or 28 days for discharge without posing an unacceptable risk to patient safety, the prescriber should make a note of the reasons in the patient's notes.

N.B. It is an offence for a prescriber to issue an incomplete prescription and a pharmacist is not allowed to dispense a Controlled Drug unless all the information required by law is given on the prescription.

(ii) Where prescribing to be dispensed in instalments is
(a) permissible (schedule 2 drugs and buprenorphine)
(b) clinically desirable

this should be on form FP10MDA.

(iii) When prescribing for substance misusers the responsibility for prescribing cannot be delegated and decisions to prescribe should be based on multidisciplinary assessment. The prescribing doctor should be satisfied before prescribing that adequate assessment has occurred.

(iv) Prescribing for substance misusers should be in accordance with "Drug Misuse and Dependence Guidelines on Clinical Management" (DOH 1999) and with the substance misuse services agreement.

(v) Only doctors in possession of a Home Office licence may prescribe, for the treatment of addiction, diamorphine, dipipanone or cocaine.

(vi) A maximum of **30** days supply of any schedule 2 controlled drug and buprenorphine can be prescribed for the treatment of addiction.

6.2.10.2 NB. At Melbury Lodge both a handwritten prescription and a prescription on the JAC are required.

6.2.11 Receipt of CDs by outpatients

Patients or their representatives may be asked to provide evidence of identity when collecting CDs.

From July 2006, there has been a requirement for persons asked to supply CDs on prescription to seek to establish whether the person collecting the medicine is the patient, their representative or a healthcare professional acting in his professional capacity on behalf of the patient.

Where the person is the patient or their representative, the dispenser

- **May** request evidence of that person's identity and
- May refuse to supply the medicine if he is not satisfied as to the identity of the person.

Where it is a healthcare professional acting in his professional capacity on behalf of the patient, the dispenser

- **Must** obtain the person's name and address
- **Must**, unless he is acquainted with that person, request evidence of that person's identity (the formal indentification for health care professionals should be their professional registration number): but
- **May** supply the medicine even if he is not satisfied as to the identity of the person.

Any strengthening of controls has been balanced with ensuring that patients have access to medicines they need and have been prescribed for them. The new requirement placed on the dispenser therefore allows them:

- Discretion not to ask patients or patient representatives for proof of identity if, for example, they have concerns that to do so may compromise patient confidentiality or deter patients from having their medicines dispensed.

From 1st January 2008, it will be a requirement to record the following information in the CD register for Schedule 2 CDs supplied on prescription:

- Whether the person who collected the drug was the patient, the patient's representative or a health care professional acting on behalf of the patient.
- If the person who collected the drug was a health care professional acting on behalf of the patient, that person's name and address.
- If the person who collected the drug was the patient or their representative, whether evidence of identity was requested (as a matter of good practice a note as to why the dispenser did not ask may be included but this is not mandatory).
- And whether evidence of identity was provided by the person collecting the drug.

6.3 Prescription Form FP10HNC, FP10MDA and FP10SS

6.3.1 Supply

- The supply of FP10HNC, FP10MDA and FP10SS forms is strictly controlled. Stocks are held by local hospital pharmacy departments or the Trust's chief pharmacist's office and are issued only when a requisition has been received from an authorised signatory.

- A register of authorised signatories with specimen signatures is maintained by the chief pharmacist (Hampshire Partnership NHS Trust) office and also by the local supplying hospital pharmacy department.

- For someone to become an authorised signatory, written approval must be obtained from both the locality manager and the chief pharmacist.

6.3.2 Security

- The number of FP10HNC/FP10MDA/FP10SS forms held by a ward/unit must be kept to a working minimum.

- Immediately on receipt of FP10HNC/FP10MDA/FP10SS forms, the receipt must be signed and returned to the appropriate pharmacy manager or chief pharmacist office as appropriate

- A log must be held by the authorised signatory of all prescription forms received and issued. The following information is required:

  On Receipt:
  Date, Quantity and Reference Numbers, Signature of authorised signatory.

  On Supply:
  Date, Quantity and Reference Numbers, Signature of prescriber and authorised signatory.

  On Return:

Date, Quantity and Reference Numbers, Signature of prescriber and authorised signatory.

- It is the responsibility of the prescriber to return unused prescription forms before leaving the Trust.
- All FP10HNC/FP10MDA/FP10SS forms must be kept locked in the custody of the authorised signatory or their deputy.
- Loss of pads should be reported together with reference numbers to the chief pharmacist and locality manager. A risk event form must be completed. The prescriber should contact the local police and an incident reference number obtained and given to the locality manager.
- The chief pharmacist will inform PPSA Contracts Department, Coitbury House, telephone number 01962 876625, who will inform the local retail chemists.
- The prescriber must inform all prescribers in the team of the need to write in red on their pads for the next 3 months.
- Should the prescriptions be recovered the police and Chief Pharmacist should be informed.

6.3.3 Private Patients
FP10HNC/FP10MDA/FP10SS forms must not be used for private patients. The hospital doctor should either refer the patient back to the GP with the appropriate advice or give the patient a private prescription.

6.3.4 Self Medication
In line with GMC guidance, self medication or prescribing for the *prescriber's* own family is not allowed.

6.3.5 Cost
The cost of all FP10HNC/FP10MDA/FP10SS forms is charged against the service/community team's budget.

6.3.6 Use of FP10HPHNCs
Where possible, outpatients who need medicines should be given a prescription for dispensing at the local hospital pharmacy. Where this is not practical, they may be given *green* FP10HNC prescription forms, which they take to their local community pharmacy.

Prescribers are reminded that outpatient prescribing is subject to the same standards outlined in this policy for inpatients.

SECTION 7: PATIENT GROUP DIRECTION (P.G.D.)

7.1 The majority of clinical care should be provided on an individual, patient specific basis. Changes in the law enabled specific groups of health professionals; nurses, midwives; health visitors; optometrists; pharmacists; chiropodists; radiographers; orthoptists; physiotherapists, occupational therapists and ambulance paramedics to supply or administer medicines under a patient group direction.

7.2 Patient group directions are written instructions for the supply or administration of medicines. They are not prescriptions. The supply and administration of medicines under patient group directions should be reserved for those limited situations when this offers an advantage for patient care (without compromising patient safety) and where it is consistent with appropriate professional relationships and accountability.

7.3 The legislation specifies the information which must be included. To assist staff developing patient group directions a core template has been produced (Appendix I – Patient Group Direction (PGD) Proforma) which identifies each piece of information required. There is also a flow diagram which provides guidance on how to go about developing a patient group direction, who to involve and how to obtain authorisation.

7.4 It is important to ensure that the arrangements for the security, storage and labelling of all medicines used within a patient group direction are comprehensive and comply with Trust policies and the law. Wherever possible medicines should be supplied in prepacks supplied by the pharmacy department. In particular there must be a secure system for recording and monitoring medicine use from which it should be possible to reconcile incoming and outgoing stock on a patient by patient basis.

7.5 It is important that the use of any medicine is consistent with the Summary of Product Characteristics for the relevant product (save in special circumstances see below) and any relevant guidance from *National Institution for Clinical Excellence (NICE).*

7.6 Exemptions and Restrictions

Certain groups of medicines are excluded or have a restricted place under patient group directions.

Antimicrobials

Microbial resistance is a serious public health matter of major importance and great care should be taken to ensure that their inclusion in a direction is absolutely necessary. Staff wishing to develop a patient group direction which includes antimicrobials should in the first instance discuss it with the Chief Pharmacist – Tel No. 023 8087 4002.

Black Triangle Drugs and medicines used outside the terms of the Summary of Product Characteristics

Black Triangle drugs (i.e. those recently licensed and subject to special reporting arrangements for adverse reactions and identified with a black triangle within the *British National Formulary (BNF)* and medicines used outside the terms of Summary of Product Characteristics (SPC) (e.g. as used in some areas of specialist paediatric care) may be included in patient group directions provided such use is exceptional, justified by current best clinical practice (e.g. NICE guidance) and that a direction clearly describes the status of the product. Black Triangle vaccines used in immunisation programmes may be included in patient group directions, provided they are used in accordance with the schedules recommended by the Joint Committee on Vaccination and Immunisation. Where the medicine is for children, particular attention will be needed to specify any restrictions on the age, size and maturity of the child. Each patient group direction should clearly state when the product is being used outside the terms of the SPC and the documentation should include the reasons why, exceptionally, such use is necessary.

Controlled Drugs

Controlled Drugs in Schedules 2 and 3 are not currently permissible within patient group directions.

Pharmacy only (P) and General Sales List (GSL) Drugs
The legislation requires patient group directions for prescription only medicines. However, it is deemed good practice to develop them for P *and* GSL products as well.

7.7 Staff must undergo specific training and be assessed as competent before working with a PGD. The head of profession or directorate nurse lead will authorise each health professional on an individual basis to work within a PGD. Copies of the individual's PGDs should be held by each practitioner in their portfolio and, in each individuals personnel file. Copies of preceding versions of PGDs should also be retained.

SECTION 8: ADMINISTRATION OF MEDICINES

8.1 General

The administration of medicines is not solely a mechanical task; it requires thought and use of professional judgement. All clients have the right to have any proposed treatment including risks involved in that treatment and any alternatives clearly explained before they agree to consent.

Whether administering a medicine, assisting in its administration or overseeing self administration, the practitioner must be satisfied that

- The patient/carer has been given and understands the purpose and licensed status of the treatment and possible side effects.
- The patient has given their informed consent or is being treated under the M.H.A.
- The practitioner has an understanding of substances used and possible side effects.
- The practitioner is aware of any monitoring requirements and is satisfied these are being undertaken.
- The practitioner is able to justify any actions taken.
- The practitioner is prepared to be accountable for the action taken.
- The practitioner is aware of the patient's current assessment and planned programme of care.

8.2 Preparation and Administration of Medicines

Medicines must only be prepared, checked or administered to a patient by the following categories of healthcare staff:

- Nurse Practitioners.
- Medical Practitioner.
- Mental Health Practitioner (MHP).
- Trainee MHPs who have undertaken the pharmacology and drug administration training within the post graduate diploma in Mental Health at the University of Southampton and been assessed as competent (see Appendix Q).
- A practitioner in training or an employee training to administer medicines, but only under the direct supervision of a nurse or MHP. The nurse or MHP remains responsible for ensuring that the correct procedure takes place.
- Other individually authorised employees after formal competency assessed training who will be working in line with their local policy.

8.3 Administration by registered nurses

8.3.1 A registered nurse is accountable for their actions and omissions. In administering any medication, or assisting or overseeing any self administration of medication, they must exercise their professional judgement and apply their knowledge and skill in the given situation.

Medicines may only be administered by a registered nurse to a patient :

(i) in line with the directions of a registered prescriber (see section 5)
(ii) following a patient group direction (see section 6)
(iii) in line with the Trust approved list for medicines to be used at the discretion of a registered nurse (see appendix C – Medicines Administered at the Discretion of Nurses - and Appendix D – Topical Applications Administered at the Discretion of Nurses). NB. This list cannot be used in conjunction with the JAC electronic prescribing and administration system. Units using this system, eg. Melbury Lodge, must have all medicines prescribed on the prn section.
(iv) in line with the Trust procedure on obtaining an urgent prescription for an inpatient when a prescriber is not on site. (see section 5.2.6 and 5.2.6.1).

8.3.2 A registered nurse may administer medicines on their own. The administration will be in accordance with the NMC standards.

8.3.2.1 Exceptions where a second nurse or authorised person must be involved:

- All medicines given by continuous infusions, eg. IV infusion, syringe drivers.
- All bolus injections, IV additives and injections via drip tubing.
- All injections taken from multidose vials. Where a patient has proven competent to self administer the medicine, eg. insulin the checking of administration need only involve one practitioner. Staff should follow CP77 when administering insulin. Insulin syringes must be used.
- Some drug administrations may require complex calculations to ensure the correct volume or quantity of medication is administered. In these situations it may be necessary for a second nurse to check the calculation in order to minimise risk.
- Children's services - a second nurse must be involved.
- Administration of Controlled Drugs.

8.3.3 Student nurses can only administer medicines under the direction and direct supervision of a registered nurse. The registered nurse must clearly countersign the signature of the student who is being supervised. The registered nurse retains accountability at all times.

8.3.4 Mental Health Practitioners who have undertaken the Trust training and assessments may administer medicines:

(i) in line with the directions of a registered prescriber (see section 5 Medicines Control, Administration and Prescribing Policy)

(ii) in line with the Hampshire Partnership NHS Trust approved list of oral medicines to be used at the discretion of a nurse/MHP (see appendix C of Medicines Control, Administration and Prescribing Policy)

(iii) in line with the Medicines Control, Administration and Prescribing Policy.

Medicines may only be administered:

(a) by the following routes –

- oral
- topically – this includes eye, ear and nasal preparations and inhalers as well as creams/ointments
- *After further specific trust training and competency assessment MHPs may administer intramuscular injections of antipsychotic depots. This route is limited to antipsychotic depots and limited to the licensed route only. MHPs must* ***NOT*** *administer the first dose of any antipsychotic depots but may administer subsequent doses. Additional training and competency assessment is required before MHPs may administer antipsychotic depot injections - see appendix Q.*

(b) To inpatients aged 16 years and over.

A Mental Health Practitioner, approved to administer medicines, may administer medicines on their own (NB. except Controlled Drugs, Schedules 2 and 3 – see Section 9). Exceptions where a second authorised person must be involved:

Some drug administrations may require complex calculations to ensure the correct volume or quantity is administered. In these situations it may be necessary for a second authorised person to be involved to minimise risk. If the approved Mental Health Practitioner is in any doubt about undertaking a calculation, they must involve a second authorised person.

8.4 Administration Procedure

8.4.1 Before administration of a medicine the nurse/MHP must

(i) read the prescription carefully. The medicine must not be given if the practitioner has any concerns or if there is any doubt about the legibility of the prescription or other particulars, eg. dosage, route, time or frequency. The prescriber must be contacted.

(ii) check that the prescribed dose has not already been given. For "when required medicines" the size and timing of the previous dose should be checked before administering. A check *must* also be made to ensure there has been no duplication of prescribed drugs in any other section of the prescription, eg. paracetamol within more than one product.

(iii) check the patients identity. A patient's identity can be checked by use of photographs which are signed and dated with a statement saying "This is a true likeness of ...." Or by name and date of birth, or in the case of new staff or agency staff, using a regular member of staff to identify the patient, or by checking the patient's identity bracelet. (All OPMH patients are to have identity bracelets).

(iv) select the medicine required, checking the label against the prescription sheet.

(v) prepare the medicine as described below by checking:

(a) the name of the patient
(b) the name of the drug
(c) the strength of the drug
(d) the route
(e) the prescribed dose
(f) the calculation if any
(g) the time of administration
(h) the expiry date
(i) allergies
(j) any special additional instructions, eg. with respect to food, swallow whole
(k) Form 38 or 39 if appropriate
(l) The drug name and strength on the blister pack against the information on the label.

(vi) Deal with one medicine at a time and do not *prepare* the next medicine until the first has been returned to the cupboard/trolley/patient bins.

(vii) Take the measured dose and prescription sheet to the patient and administer the medicine. For liquids use oral syringes for quantities less than 5ml or calibrated glass measures.

(viii) If the patient appears to be intoxicated with alcohol or other substances, do not administer medicine until discussed with prescriber.

(ix) Administer the medicine.

(x) Registered nurses/MHPs must witness the administration.

(xi) The registered nurse/MHP must initial or sign in the appropriate column of the prescription sheet at the time of administration.

(xii) Variable Doses - Where a variable dose has been prescribed, the registered nurse/MHP will use her/his judgement to decide the dose to be administered using the following guidelines:
- Give the lowest dose as first choice.
- Be clear that they understand the rationale for the variable dose and its indication.
- Record the actual amount given.

(xiii) As required (PRN) medicines: The registered nurse must be sure of the indication for the medicines and if not must not administer the medication until the patient's condition has been discussed with the prescriber.

8.4.2 Injectable Medicines

a) Read all prescription details carefully and confirm that they relate to the patient to be treated.

b) Ensure that the area in which the medicine is to be prepared is as clean, uncluttered and free from interruption and distraction as possible. Ideally, preparation should take place in an area dedicated to this process.

c) Assemble all materials and equipment: sharps bin for waste disposal, medicine ampoule(s)/vial(s), diluent, syringe(s), needle(s), alcohol wipes, disposable protective gloves, clean re-usable plastic tray.

Check the following:

- expiry dates.
- damage to containers, vials or packaging.
- that medicines were stored as recommended, e.g. in the refrigerator.

d) Beware of the risk of confusion between similar looking medicine packs, names and strengths. Read all labels carefully.

e) Check that:

- the formulation, dose, diluent, infusion fluid and rate of administration correspond to the prescription and product information.
- the patient has no known allergy to the medicine.
- you understand the method of preparation.

f) Calculate the volume of medicine solution needed to give the prescribed dose. Write the calculation down and obtain an independent check by another qualified healthcare professional.

g) Prepare the label for the prepared medicine.

h) Cleanse your hands according to local policy.

i) Put on a pair of disposable protective gloves.

j) Use a 70% alcohol wipe or spray to disinfect the surface of the plastic tray.

k) Assemble the syringe(s) and needles(s). Peel open wrappers carefully and arrange all ampoules/vials, syringes and needles neatly in the tray.

l) Use a 'non-touch' technique, i.e. avoid touching areas where bacterial contamination may be introduce, e.g. syringe-tips, needles, vial tops. Never put down a syringe attached to an unsheathed needle.

m) Prepare the injection by following the manufacture's product information or local guidelines, and the relevant guidance in standards in 8.3.4.3.

8.4.3 Withdrawing solution from an ampoule (glass or plastic) into a syringe

a) Tap the ampoule gently to dislodge any medicine in the neck.

b) Snap open the neck of glass ampoules, using an ampoule snapper if required.

c) Attach a needle to a syringe and draw the required volume of solution into the syringe. Tilt the ampoule if necessary.

d) Invert the syringe and tap lightly to aggregate the air bubbles at the needle end. Expel air carefully.

e) Remove the needle from the syringe and fit a new needle or sterile blind hub.

f) Label the syringe.

g) Keep the ampoule and any unused medicine until administration to the patient is complete to enable further checking procedures to be undertaken.

h) If the ampoule contains a suspension rather than solution, it should be gently swirled to mix the contents immediately before they are drawn into the syringe.

i) The neck of some plastic ampoules is designed to connect directly a syringe without use of a needle, after the top of the ampoule has been twisted off.

8.4.4 Withdrawing a solution or suspension from a vial into a syringe

a) Remove the tamper-evident seal from the vial and wipe the rubber septum with an alcohol wipe. Allow to dry for at least 30 seconds.

b) With the needle sheathed, draw into the syringe a volume of air equivalent to the required volume of solution to be drawn up.

c) Remove the needle cover and insert the needle into the vial through the rubber septum.

d) Invert the vial. Keep the needle in the solution and slowly depress the plunger to push air into the vial.
e) Release the plunger so that solution flows back into the syringe.
f) If a large volume of solution is to be withdrawn, use a push-pull technique. Repeatedly inject small volumes of air and draw up an equal volume of solution until the required total is reached. This 'equilibrium method' helps to minimise the build-up of pressure in the vial.
g) Alternatively, the rubber septum may be pierced with a second needle to let air into the vial as solution is withdrawn. The tip of the vent needle must always be kept above the solution to prevent leakage.
h) With the vial still attached, invert the syringe. With the needle and vial uppermost, tap the syringe lightly to aggregate the air bubbles at the needle end. Push the air back into the vial.
i) Expel excess air from the syringe. Remove the needle and exchange it for a new needle or a sterile blind hub.
h) The vial(s) and any unused medicine should be kept until administration to the patient is complete.
j) If the vial contains a suspension rather than solution, it should be gently swirled to mix the contents, immediately before they are drawn into the syringe.

8.4.5 Reconstituting powder in a vial and drawing the resulting solution or suspension into a syringe

a) Remove the tamper-evident seal from the vial and wipe the rubber septum with an alcohol wipe. Allow to dry for at least 30 seconds.
b) Use the procedure above to withdraw the required volume of diluent (e.g. water for injections or sodium chloride 0.9%) from ampoule(s) in the syringe.
c) Inject the diluent into the vial. Keeping the tip of the needle above the level of the solution in the vial, release the plunger. The syringe will fill with air which has been displaced by the solution (if the contents of the vial were packed under a vacuum, solution will be drawn into the vial and no air will be displaced). If a large volume of diluent is to be added, use a push-pull technique (see above).
d) With the syringe and needle still in place, gently swirl the vial(s) to dissolve all the powder, unless otherwise indicated by the product information. This may take several minutes.
e) Follow the relevant steps above to withdraw the required volume of solution from the vial into the syringe.
f) Alternatively, the rubber septum may be pieced with a second needle to let air into the vial as solution is withdrawn. The tip of the vent needle must always be kept above the solution to prevent leakage.
g) If a purpose-designed reconstitution device is used, the manufacturer's instructions should be read carefully and followed closely.

8.4.6 Adding a medicine to an infusion

a) Prepare the medicine in a syringe using one of the methods described above.
b) Check the outer wrapper of the infusion container is undamaged.
c) Remove the wrapper and check the infusion container itself in good light. It should be intact and free of cracks, punctures/leaks.
d) Check the infusion solution, which should be free of haziness, particles and discolouration.
e) Where necessary, remove the tamper-evident seal on the additive port according to the manufacturer's instructions or wipe the rubber septum on the

infusion container with an alcohol wipe and allow to dry for at least 30 seconds.

f) If the volume of medicine solution to be added is more than 10% of the initial contents of the infusion container (more than 50ml to a 500ml or 100ml to a 1 litre infusion), an equivalent volume must first be removed with a syringe and needle.

g) Inject the medicine into the infusion container through the centre of the injection port, taking care to keep the tip of the needle away from the side of the infusion container. Withdraw the needle and invert the container at least five times to ensure thorough mixing before starting the infusion.

h) Do not add anything to any infusion container other than a burette when it is hanging on the infusion stand since this makes adequate mixing impossible.

i) Before adding a medicine to a hanging burette, administration must be stopped. After the addition has been made and before administration is re-started, the contents of the burette must be carefully swirled to ensure complete mixing of the contents.

k) Check the appearance of the final infusion for absence of particles, cloudiness or discolouration.

l) Label the infusion.

8.4.7 Diluting a medicine in a syringe for use in a pump or syringe-driver

a) Prepare the medicine in a syringe using one of the methods described above.

b) Draw the diluent into the syringe to be used for administration by the pump or syringe-driver. Draw in some air (slightly more than the volume of medicine needed) and remove the needle.

c) Stand the diluent syringe upright. Insert the needle of the syringe containing the medicine into the tip of the diluent (administration) syringe and add the medicine to it. Alternatively, a disposable sterile connector may be used to connect two syringes together directly.

d) Check the following:
   - The total volume of injection solution in the syringe is as specified in the prescription and that the infusion can be delivered at the prescribed rate by the administration device chosen.
   - The rate of administration is set correctly on the administration device and according to the manufacturer's instructions.

e) Fit a blind hub to the administration syringe and invert several times to mix the contents.

f) Remove the blind hub. Tap the syringe lightly to aggregate the air bubbles at the needle end. Expel the air and refit the blind hub.

g) Carefully check the syringe for cracks and leaks and then label it, especially noting the requirements specific to syringe drivers.

h) Check that the rate of administration set and starting the infusion device.

8.4.8 Labelling injection and infusion containers

a) All injections should be labelled immediately after preparation, except for syringes intended for immediate push (bolus) administration by the person who prepared them. Under no circumstances should an operator be in possession of more than one unlabelled syringe at any one time, nor must an unlabelled syringe be fitted to a syringe driver or similar device.

b) Labels used on injectable medicines prepared in clinical areas should contain the following information:
   - Name of the medicine
   - Strength

- Route of administration
- Diluent and final volume
- Patient's name
- Expiry date and time
- Name of the practitioner preparing the medicine

c) Place the final syringe or infusion and the empty ampoule(s)s/vials(s) in a clean plastic tray with the prescription for taking to the patient for administration.

8.4.9 Administration of an injectable medicine

a) Before administering any injection check all the following:
- Patient's name, hospital/NHS Number or date of birth or address
- Prescriber's signature
- The approved medicine name
- The dose and frequency of administration
- The date and route of administration
- The allergy status of the patient

b) Also check, where relevant:
- Brand name and formulation of the medicine
- Concentration or total quantity of medicine in the final infusion container or syringe
- Name and volume of diluent and/or infusion fluid
- Rate *and* duration of administration
- Type of rate-control pump or device(s) to be used
- The age and weight of any patient under 16 years of age, where relevant
- The date on which treatment should be reviewed

c) Check that the medicine is due for administration at that time and has not already been given.

d) Assemble everything you need including any flushing solution(s) needed.

e) Explain and discuss the procedure with the patient.

f) Check any infusion already in progress. It should be free of haziness, particles and discolouration.

g) Check that an appropriate access device is in place. Flush it immediately before and after administration of a medicine, and between doses of different medicines administered consecutively, according to local policy. Also check the administration site for signs of leakage, infection or inflammation.

h) For guidance on the procedure for administration of depot injections, refer to the Royal Marsden Manual of Clinical Nursing Procedures (5th Edition).

8.4.10 Administration of injections – general

a) Check infusions. They should be free of haziness, particles and discolouration.

b) Use aseptic (non-touch) technique at all times.

c) Attach administration sets to infusion containers carefully, on a flat surface and using the technique appropriate to the type of container.

d) Prime the access device according to local policy immediately before starting an infusion.

e) Before adding a medicine to a hanging burette, administration must be stopped. After the addition has been made and before re-commencement,

the contents of the burette must be carefully swirled to ensure complete mixing.

8.4.11 After Administration

a) After completion of an intermittent infusion, flush the access device according to local policy.
b) Ask the patient to report promptly any soreness at the injection site or discomfort of any sort.
c) Make a detailed record of administration. Discard the empty ampoules/vials from which the injection was prepared and any unused medicine. Ampoules or vials should *never* be used to prepare more than one injection unless specifically labelled by the manufacturer for 'multi-dose' use.
d) Re-check the administration site for signs of leakage, infection or inflammation and continue to monitor the patient, contents of the infusion container and the rate of infusion according to local policy.
e) Check that arrangements for monitoring fluid balance or clinical parameters have been made. Ensure that relevant documentation is made available for subsequent regular monitoring to take place.

8.5 Administration of Medicines by staff other than prescribers or nurses

The Trust recognises that groups of staff other than doctors/pharmacists or registered nurses undertake duties which involve them in medicines. Where this occurs, the staff concerned MUST have undertaken Hampshire Partnership NHS Trust approved training and been assessed as competent in their particular context. They must follow the Trust policies and procedures around medicines developed for their specific area and approved by the Medicines Management Committee. These members of staff are referred to by their job title, eg. Mental Health Practitioner (MHP) as authorised staff within this policy.

8.6 The Mental Health Capacity Act

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who are not able to make their own decisions. A key principle of the law is that every adult has the right to make their own decisions and is assumed to have capacity to do so unless it is proved otherwise. Further guidance is available in the Trust's Mental Capacity Act 2005 Policy.

8.7 Patient Refusing Medication

A patient lacks capacity to consent if she/he is:

- Unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question, and/or
- Unable to use and weigh up this information in the decision-making process.

Before making a judgement that a patient lacks capacity, staff must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This could involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, advocate, family, friends, carers) may often be able to help, as may specialist colleagues such as speech and language therapists.

Capacity is 'decision-specific': A patient may lack capacity to take a particular complex decision, but be quite able to take other straight-forward decisions or parts of decisions.

A patient's 'best interests' are not limited to their best medical interests. Other factors which may form part of the best interests decision include:

- The wishes and beliefs of the service user when competent
- Their current wishes
- Their general well-being
- Their spiritual and religious welfare.

Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, staff should attempt to involve people close to the patient in the decision-making process. They are likely to know the patient much better than staff and therefore likely to be able to provide valuable information about the patient's wishes and values.

Where a medicine is refused by the patient or the carer refuses to administer or allow administration of that medicine, the Nurse/MHP must make a clear and accurate record of the fact. Consider whether refusal of that medicine compromises the patient's condition or the effect of other medicines, and assess the situation and judgement made as to whether to contact the prescriber. Out of hours this should be discussed with the site bleep holder. Never force the person to take their medication.

However, a patient's views and wishes should be taken into account when administering medication. In the event of a patient declining medication an assessment of risk and discussion with the multi-disciplinary team must take place. The decision must be documented in the patient's casefile and recorded on the prescription sheet.

If refusal becomes a regular occurrence a care plan will be prepared by the multi-disciplinary team outlining an 'acceptable' level of non-compliance over a set period.

8.8 Omitted/Delayed Doses

(a) Doses omitted *must* be marked with an X in the administration box. The approved Trust coding system *must* be used to record the reason for omission. If there is no appropriate code the reason for omission must be stated on the prescription chart. In addition professional judgement should be used to decide whether it is necessary to inform the prescriber. Out of hours this should be discussed with the site bleep holder before contacting the prescriber.

(b) Melbury Lodge site: doses omitted must be entered "not given" on HIS and reason for omission entered.

(c) Doses delayed should have an arrow to the box indicating the time given. A prescriber or pharmacist should confirm that it is appropriate to give the dose at the delayed time.

8.9 Nil by Mouth

Patients classified 'Nil by Mouth' prior to a diagnostic procedure or receiving an anaesthetic and undergoing ECT must have all their prescribed oral medicines administered to them at the prescribed time unless specifically advised otherwise by

ECT staff and these omissions must be marked on the drug prescription and administration chart as 'E'. The medicines should be taken with a small amount of water to enable the patient to swallow these medicines. Only medicines that have been clearly marked on the prescription sheet may be omitted. It is the responsibility of the prescriber to provide clear written instructions to the nursing staff concerning the omission of prescribed doses.

8.10 Management of Side Effects/Adverse Effects

Nurses and MHPs must understand the expected outcome for any prescribed medication.
Any untoward effects must be recorded in the medical records and brought to the attention of the prescriber. The practitioner should consider withholding medication if serious side effects are observed. The prescriber must be contacted as soon as possible. Practitioners have a key role in explaining possible side effects, delays in onset of action etc. to patients. A Committee on the Safety of Medicines "Yellow Card" must be completed for adverse drug reactions for

- New drugs – report all suspected reactions to new drugs, even if minor (new drugs are designated by a black triangle in the BNF)
- Established drugs - report only serious events (following the above procedure) even if it is well known

Yellow cards can be found in the back of all BNFs
Yellow cards can be submitted by a doctor, pharmacist or nurse.

8.11 Privacy and Dignity

The practitioner should be aware of the need for privacy and the patient's dignity when administering medication. The nurse will need to exercise judgement in offering medication in a confidential manner.

8.12 Controlled Drugs

8.12.1 The administration of all Schedule 2 and Schedule 3 Controlled Drugs or Controlled Drugs which are subject to local rules with respect to their recording within the Controlled Drug Register, must only be undertaken by a registered nurse and must be witnessed by a second person. The second person may be a prescriber, a nurse, a student nurse, healthcare support worker or mental health practitioner. BOTH PRACTITIONERS MUST BE PRESENT DURING THE WHOLE OF THE ADMINISTRATION PROCESS. Other members of staff may be trained to take on this role BUT ONLY if approved individually by Accountable Officer and Associate Director of Nursing.

8.12.2 **In addition** to the procedure outlined in section (7.3) the following procedure must be followed.

Before administering a Controlled Drug:

(i) check the total amount of ward stock corresponds to the entry in the register. The Bridge and Southampton DIP must check levels at the end of each session and for liquids when each bottle is empty.

(ii) enter the details in the Controlled Drug Register together with the signatures of both the witness and the person who administered the drug. Details include: dose given, patient details, date and time of administration and remaining stock balance.

(iii) Check the volume if the remaining volume is less than the required dose before giving the dose and correct the register with the nurse and witness signing the register. Inform the clinical pharmacist if any discrepancies.

8.12.3 Where the second person is not a registered nurse or prescriber, the role of that person is limited to witnessing the preparation of the CDs to be administered, that the drug is administered to the appropriate patient, that the stock balance is correct, the destruction of any surplus drug (eg. part of an ampoule).

8.12.4 Controlled Drug Registers must be kept locked in the medicines cupboard.

8.12.5 Controlled Drug Registers shall be held for 2 years from the date of the last entry by the ward manager and then may be confidentially destroyed.

8.13 Medicines administered at the discretion of nurses and MHPs

Treatment with certain specified medicines (not classified as prescription only medicines) may be initiated by nurses/MHPs without the authorisation of a prescriber provided:

(a) The medicine is listed on either the Trust approved lists (internal or external for adults or separate list for under 16 year olds). (Appendices C – Medicines Administered at the Discretion of Nurses and MHPs - and D – Topical Applications Administered at the Discretion of Nurses only).
(b) The treatment is recorded on the appropriate section of the Trust prescription card or on the JAC.
(c) An appropriate note of the medicines used is made in the nursing record.

Staff working in units where JAC electronic prescribing and administration is in use (eg. Melbury) cannot utilise this list, but must have all medicines prescribed by prescribers on the 'prn' section.

8.14 Covert Administration of Medicines

This should be read in conjunction with the guidance in Appendix K.

8.14.1 In September 2001 the UKCC (now Nursing and Midwifery Council NMC) issued a position statement on the covert administration of medication. It highlighted the complexity of the issues and that it involves the fundamental principles of patient and client autonomy and consent to treatment, which are set out in common law and statute and underpinned by the Human Rights Act 1998.

8.14.2 Overview

(i) Disguising medication in the absence of informed consent may be regarded as deception.

(ii) A clear distinction should always be made between those patients or clients who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity.

(iii) Where a person lacks capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medication, and others who would be aware if they were not deceived into thinking otherwise.

8.14.3 Procedure

(i) The best interests of the patient or client are paramount. 'Best interests' are not confined to best medical interest. Case law has established that other factors which may need to be taken into account include the patient's values and preferences when competent, their psychological health, well-being, quality of life, relationships with family or other carers, spiritual and religious welfare and their own financial interests. It is good practice for the healthcare team to involve those close to the patient in order to find out about the patient's values and preferences before loss of capacity, unless the patient has previously made clear that particular individuals should not be involved.

(ii) The medication must be considered essential for the patient's or client's health and well-being, or for the safety of others.

(iii) The decision to administer a medication covertly should not be considered routine. Any decision to do so must be reached after assessing client's individual needs.

(iv) There must be a broad and open discussion by the multi-disciplinary team, including the pharmacist. Where possible, discussions should include carers and relatives.

(v) The decision and action taken, including the names of all parties concerned, must be documented in the medical and nursing notes with a review date set.

(vi) The method of administration of covert medication must be agreed with the pharmacist.

(vii) At each review, attempts should be made to encourage the patient/client to take their medication.

8.14.4 Patients detained under the Mental Health Act

Where patients/clients are detained under the Mental Health Act, the principles of consent continue to apply to any medications not related to the treatment of the mental disorder for which they have been detained.

In relation to medication for the mental disorder the Mental Health Act and Code of Practice 1983 must be adhered to regarding treatment without consent.

SECTION 9: SELF (CARER) ADMINISTRATION OF MEDICINES

9.1 Self administration of medicines by patients, or administration by carers, should be an integral part of any rehabilitation programme and an option within the delivery of routine care for all patients.

9.2 Local self (carer) administration of medicine schemes must be developed to take into account local situations and all must be approved by the Directorate Clinical Governance Committee, the Trust Professional Nurse Advisory Committee and the Trust Medicines Management Committee.

9.3 All policies must give consideration to the following issues:

- Patient selection

All patients considered for self medication must be subject to a multi-disciplinary review and documented risk assessment

- Training
The schemes should ensure that provision for patient/carer training is included in the scheme. This must include

- Knowledge of medicines and side effects
- Correct storage of medicines
- What to do if a mistake is made
- How to obtain further supplies

- Monitoring
Clear guidance on monitoring of the self administration scheme must be given

- Storage
Storage of medicines must be in line with section 3 of this policy. If individual medicine lockers are used, only the self-medicating patient and staff authorised to hold medicine keys may have access

- Records
If under supervision the registered nurse/MHP/or other authorised person is responsible for ensuring the correct drug, dose and time of administration and will still record the administration on the prescription chart. If the patient/carer is responsible suitable records must be kept to allow the registered nurse/MHP/or other authorised person to monitor and comment on progress. Patients on self medication schemes must have this clearly recorded on either the prescription chart or equivalent computer system. Doses administered by nursing staff/MHPs in addition to or instead of the self administration must be recorded in the normal way.

9.4 Self Administration of Controlled Drugs

Patients may self administer Controlled Drugs. Specific procedures must be in place and approved by the chief pharmacist and the CD entered as Patients Own Controlled Drugs in the register. Self administration of controlled drugs on the unit must always be supervised by a registered nurse.

SECTION 10: COMPLIANCE AIDS

10.1 Health professionals can employ a combination of strategies to promote patient adherence to prescribed medication. There should be a full multi-disciplinary assessment of the patients abilities and also a risk assessment of the possible outcomes of non compliance. Approaches to improve compliance should be kept as simple as possible. Rationalising medication administration to once or twice a day when a carer could supervise or provision of a reminder card may be all that is needed. **When all other approaches fail,** a medication compliance device may help. Contact your locality pharmacist for advice.

10.2 **Wherever possible a pharmacist should fill the compliance aid.** ***Check to see if the local pharmacy is able to provide this service.***

Under the Disability Discrimination Act, community pharmacists are required to assess individuals and provide a compliance aid if deemed necessary and the pharmacist has the capacity to undertake the work.

However, in the interests of patient care and where no pharmacy service is available, registered nurses, MHPs and OTs can support the patients in filling and using compliance aids as part of their role to support and instruct patients regarding their medication.

10.3 Staff must follow the Trust Guidance on Filling and Checking a Compliance Aid (Policy No. CP43).

SECTION 11: LEGAL AND HUMAN RIGHTS ISSUES

11.1 All clients have the right to have any proposed treatment, including any risks associated with that treatment and any alternatives clearly explained before they decide to agree to consent.

11.2 Mental Health Act 1983 - Section 58 Treatment Requiring Consent or a Second Opinion

If the patient is being treated under Section 58 this should be clearly indicated on the patient prescription card and a copy of the Statutory Form 38 - Consent to Treatment or Form 39 - Second Opinion, must be kept with the prescription chart when administering medication. The nurse/MHP must check that each drug being administered is included on form 38 or 39 and these forms are held with the prescription chart. Where electronic prescribing is used these forms are to be held so that they are easily accessible by the multi-disciplinary team.

Where patient/clients are detained under the Mental Health Act, the principles of consent continue to apply to any medication not related to the treatment of the mental disorder for which they have been detained.

SECTION 12: MEDICATION ERRORS

12.1 A medication error is a preventable incident associated with the use of medicines that may put a patient at risk. Such incidents may be related to one or more of the stages of the medicine use process:

a) Ordering
b) Storage
c) Prescription
d) Dispensing
e) Administration
f) Recording
g) Disposal
h) Information / Advice

This section should be read in conjunction with the Policy for Reporting, Recording and Reviewing Risk Incidents (NCP 16).

12.2 On discovering an error or a near miss, the member of staff must take immediate action to safeguard the wellbeing of the patient involved.

12.2.1 Assess current status of condition (overall presentation, level of consciousness, temperature, pulse, blood pressure, respirations).

12.2.2 In case of medical emergency, the usual procedures for obtaining immediate assistance and first aid should be followed.

12.2.3 Inform Doctor / Pharmacist / Professional Adviser / Line Manager dependent on nature of error or near miss. ***When using a phone to discuss an error, always ensure any numbers are clearly understood by using one, four, for 14, etc.***

12.2.4 Inform the patient/client.

12.2.5 Follow advice of Doctor / Pharmacist / Professional Adviser / Line Manager.

12.2.6 Inform Line manager / duty manager / bleep holder as appropriate to local arrangements.

12.2.7 Record the Incident.

12.2.8 Document the incident in the health records of all patients directly affected by the incident.

12.2.9 Complete a Trust incident form and forward it as soon as practicable to the Risk Services Manager, clearly stating

- What should have occurred - the planned intention
- What actually occurred
- What medicines were involved
- What doses
- What routes
- What actions were taken to safeguard the involved patients.

12.3 The incident must be investigated to identify the cause(s) of the incident or near miss. The scope of the investigation will be dependent on the nature of the incident / near miss and should be determined by the Service/Locality Manager. For serious incidents, a full root cause analysis may be required. For any incident involving a Controlled Drug, the Accountable Officer must be notified and must agree the terms of reference and scope of any investigation. They must also agree any subsequent action plans. The Chief Pharmacist/Risk Services Manager should be contacted for advice / support if required.

12.4 An action plan must be formulated and implemented to address any issues identified by the investigation. The Service/Locality Manager will be responsible for ensuring action plans are implemented and reviewed.

12.5 The Service/Locality Manager is responsible for ensuring that any learning points identified are disseminated across the whole Directorate and copied to the Chief Pharmacist to ensure that Cross-Directorate learning occurs where appropriate.

SECTION 13: INFECTION CONTROL AND CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)

This section must be read in conjunction with the Trust Hand Hygiene and Sharps Safety Policy.

13.1 Hand washing is the single most important means of preventing the spread of infection. Hands must be washed before and after administering medicines. For details see Hand Hygiene Policy, IPC 5.1.

13.2 When applying topical liquids, pastes, ointments and creams, or administering suppositories, enemas or pessaries and when giving injections, practitioners must follow Personal Protective Clothing Policy IPC 4.

13.3 Spills

Staff must deal with any medicine spill as outlined in COSHH Policy NCP 45 and Waste Policy.

13.4 Needlestick Injuries

In the event of a needlestick inoculation or contamination incident refer to the following Trust policies:

- Sharps Safety Policy IPC.2.
- Policy for the management of inoculation or contamination incidents IPC 3.1.

SECTION 14: COMMUNITY TEAMS (includes CRHTs and AOTs)

14.1 These medicines must be ordered, stored and administered as outlined in sections 2, 3 and 7.

14.2 Individual Patient Items

Most patients in the community will receive all their medicines from their GP and will store them in their own home. Exceptions to this practice include:

Medicines supplied through hospital pharmacy, eg. Clozapine.
For patient convenience this can be delivered to a community team base. The nurse for each patient should decide whether the patient requires counselling on the medicine. If so the nurse should arrange to personally hand over the medicines and provide the necessary advice. If the nurse does not feel this is necessary a named member of administrative staff may hand the medicines to the patient. Administrative staff should be given a list of people who may be given their medicines in this manner and a record must be kept for each time a patient collects their medicines. The role of the administrative staff member is to give the correct bag of medicine to the correct person. They must not provide advice on the drug and all such requests must be passed on immediately to the nurse. Staff who take on this role must be fully briefed and authorised by the Community Mental Health Team (CMHT) manager. A designated person(s) must ensure clozapine is collected for/by each patient and alert the appropriate team if this does not occur.

Clozapine awaiting collection must be held in a locked cupboard accessible only to authorised administrative staff.

If an error occurs the administrative staff must inform the CPN or manager immediately.

14.3 Carriage

14.3.1 It is not generally the responsibility of the CMHT to obtain patient's medication from the community pharmacist. However, registered nurses and other CMHT members may convey them to the patient's home as an 'agent' of the patient.

14.3.2 When using stock medication the medicine must be taken to the patients home in the supplying pharmacy's original container, ie. the entire box must be taken.

14.3.3 Members of the community team authorised to administer medicines must keep medicines

- In a locked case when visiting a patient
- In a locked case in a locked boot of a car where the medicines are out of sight when travelling between visits
- Where practical the medicines should be returned to the base storage cupboard for overnight or weekend storage. Where this is not possible and by exception they may be stored in a locked cupboard/drawer/cash box at home for no longer than 72 hours.
- Medicines must not be stored in cars because of the extreme temperature variations which occur. Advice can be obtained from the hospital pharmacy or Regional Medicines Information Centre.
- When removing patient's own medicines from the home, team members are reminded that this is the patient's own property and may only be removed with their consent and signatures obtained. Medicines must be returned to a community pharmacy for disposal. The pharmacist should be asked to sign and date the records for receipt of the medicines. A full record should be kept in the patient's notes. This must include the name, strength and quantity of each drug. Disposal of stock drugs must be in line with section 4.3.2. In some instances where permission is refused, leaving the medicine in the patient/client's home may endanger the patient/client. In such cases the registered nurse must take into account their duty of care and removal would be considered the most appropriate and responsible action to take. In all instances documentation and discussion with the line manager and the medical practitioner must be made.

14.4 Storage

14.4.1 When medication is prescribed for a patient/client it should be stored in the patient's own home and it is the registered nurses responsibility to teach patients and carers correct storage methods. Where risk assessment recommends that patient's medicines are held in the team base, they should be stored in line with section 3.3.

14.4.2 Keys

Only registered nurses, MHPs and authorised staff (ie. HPT staff assessed as competent to administer medications) may access the medicines stock storage areas. Those authorised staff in the community teams will require access to the medicines cupboards at different times of day. Access can be gained by each registered nurse/MHP/authorised staff having access to a key cupboard where the medicine cupboard keys are held. The team manager must keep a record of all keys held. Each key should be signed for when starting the role, and returned when leaving the role. Only registered nurses may have access to/administer/requisition schedule 2 or 3 drugs.

14.5 Administration Records

A signed Trust prescription card must be held for all medicines administered by authorised community team members. This includes medicines obtained on FP10HNC/FP10MDA/FP10SS forms.

14.6 Medication Review

The registered nurse must ensure all medication administered to patients is regularly reviewed by discussion with the patient/carer and the prescriber. Review should be in response to client needs but at least 3 monthly.

14.7 Loss or theft of medication

In the event of a loss or theft of medication whilst away from base the line manager must be informed immediately. Police must also be informed of the loss or theft. An incident form must also be completed.

SECTION 15: DISPENSING MEDICINES FROM THE WARD

The Medicines Control, Administration and Prescribing Policy allows doctors to dispense discharge medication when the pharmacy is closed and discharge medicines have not been prescribed and dispensed in advance. Wherever possible discharge medicines should be ordered well in advance from the pharmacy department or from the pharmacy ward team.

IF A PATIENT IS DISCHARGED OR WISHES TO DISCHARGE THEMSELVES OUTSIDE OF PHARMACY HOURS AND BEFORE TO TAKE OUT MEDICINES (TTOs) HAVE BEEN ARRANGED, IT IS THE RESPONSIBILITY OF THE PRESCRIBER INVOLVED TO SUPPLY THEM.

NURSES OR MHPs CANNOT SUPPLY OR AUTHORISE THE SUPPLY OF MEDICINES TO TAKE HOME.

Procedure for dispensing from ward stock:

(a) A written record of the medication supplied is required. A discharge form should be completed in the usual way

(b) Containers and labels are supplied from pharmacy to the wards and in order to fulfil all legal requirements and regulations, only these containers and labels should be used

(c) Each drug must be dispensed in a separate container

(d) Use the large dispensing labels provided (see example below). Each container must be labelled with all information (Supplies available from clinical pharmacist)

DRUG NAME AND FORM .... **STRENGTH** ..... **DIRECTIONS** .... **PATIENT'S NAME** ..... **WARD** .....**DATE**.....	**QTY** ..... **INITIALS DISPENSING DOCTOR** .... **Checked by:**	**KEEP OUT OF THE REACH OF CHILDREN**
WARD ADDRESS: **TEL.NO.**	(person in charge of ward to sign)	

(e) The relevant patient information leaflet must be supplied for each medicine for all discharge medicines.

(f) If appropriate, add any cautionary or advisory labels as indicated in Appendix 9 of British National Formulary (BNF).

The prescriber who prescribes and dispenses medicines is responsible for ensuring these requirements are met and that the right medicine is supplied. If the doctor is unable to dispense the medicines the patient will be discharged without them.

SECTION 16: DISPENSING MEDICINES FROM COMMUNITY TEAM BASES

16.1 Medicines for clients in the community should routinely be prescribed by the GP. If a prescriber believes that a medicine is required urgently and the delay in obtaining a prescription from a GP would be unacceptable, then the prescriber may issue an FP10HP. The quantity prescribed should be the minimum amount required. If it is envisaged that there will be difficulty in a patient obtaining their medicines, the prescriber may dispense from stock (or prepacks) held at the team base using the following procedure.

- A record must be made in the patient's medical notes.
- A maximum of 5 days supply can be made.
- Containers and labels (see example below) are supplied from pharmacy. In order to fulfil all legal requirements and regulations, only these containers and labels should be used. Details must include the name of the medicine, form, strength, directions in full ("as directed" is not acceptable), name of patient, date of dispensing and quantity supplied.
- The relevant patient information leaflet must be supplied for each medicine.
- Each medicine must be dispensed in a separate container.
- If appropriate, add any cautionary or advisory information as indicated in appendix 9 of the BNF.

Nurses cannot supply or authorise the supply of medicines unless as part of a patient group direction.

Example of label: (Supplies available from clinical pharmacist)

DRUG NAME AND FORM .... **STRENGTH** ..... **DIRECTIONS** .... **PATIENT'S NAME** ..... **WARD** .....**DATE**.....	**QTY** ..... **INITIALS DISPENSING DOCTOR** .... **Checked by:**	**KEEP OUT OF THE REACH OF CHILDREN**
WARD ADDRESS: **TEL.NO.**	(person in charge of ward to sign)	

SECTION 17: USE OF UNLICENSED MEDICINES

17.1 The term "unlicensed medicines" is normally applied to those medicines which do not have Marketing Authorisation (MA) formerly Product Licence (PL) issued by the Medicines & Healthcare Products Regulatory Agency (MHRA).
It is applicable also to licensed medicines when they are used for unlicensed applications.

17.2 For good clinical reasons the use of such medicines is widespread in secondary care.

17.3 Doctors may legally

- Prescribe unlicensed medicines .
- Use in a particular ("named") patient unlicensed products specially prepared, specially imported or specially supplied.
- Use unlicensed drugs in clinical trials.
- Use, or advise the use of licensed medicines for indications or in doses or by routes of administration outside the recommendations given in the licence.
- Override the warnings and precautions given in the licence.

17.4 The majority of medicines have a marketing authorisation granted by the MHRA. Should any problems arise because of defects associated with the quality of the medicine, or its use in an approved clinical situation, the Trust can transfer liability to the manufacturer.

17.5 The responsibility for prescribing any medicines falls on the prescriber. Doctors have a duty in common law to take reasonable care. If a doctor uses an unlicensed medicine it would be deemed negligent if not used in accordance with practice accepted at that time by a reasonable body of medical opinion.

17.6 In using an unlicensed drug or a drug in a way incompatible with the product specification, the doctor must act responsibly and with reasonable care and skill. When prescribing outside a license it is important that the doctor does so knowingly, recognising the responsibility that such prescribing entails and when obtaining consent to treatment should, where possible tell the patient of the drug's license status and document all the above in the health record.

17.7 The Product Liability Directive and the Consumer Protection Act 1987 makes the producer or supplier liable for damage caused by a defect in the product. Accordingly the product can be considered defective on the basis of what the reasonable patient is entitled to expect. This may be affected by the verbal and written information and warnings given to the patient.

17.8 Recognising that the use of an unlicensed medicine is sometimes necessary in order to provide the optimum treatment the Trust will accept liability on behalf of the prescriber / pharmacist provided that this procedure is followed:

(i) Wherever possible licensed products will be used.
(ii) Any exception to this must be by approval of the Medicines Management Committee.
(iii) If an unlicensed medicine is used, or one is used outside of its licensed indications, the Trust will accept liability providing such use would command the support of a reputable body of pharmacists or medical practitioners.
(iv) Patients should be informed of the license status of the medicine wherever possible.

17.9 Pharmacy staff providing unlicensed medicines will endeavour to alert, inform and advise, but it is the responsibility of each prescriber to be aware of the status of the medicines they prescribe.

17.10 Pharmacists will include information on unlicensed products use in their reports.

SECTION 18: POLICY COMPLIANCE MONITORING

The Trust has a responsibility to monitor its compliance with this policy, specifically with regards to:

- The prescribing responsibilities of staff
- The administration of medication
- Process for service user self administration
- Procedure for the safe disposal of controlled drugs
- Staff training requirements

The processes the Trust employs to monitor these standards are as follows:

- Quarterly audit of controlled drugs including prescribing, administering and storage; the contents of this audit changes to reflect the needs of the Trust
- Tri-annual Medicines management audit
- Reports on training uptake gathered from information held by Development and Training
- Compliance monitoring undertaken by clinical pharmacists and medicine management technicians as part of their regular duties
- Intervention monitoring by clinical pharmacists.

SECTION 19: REFERENCES

UKCC – Position statement on the covert administration of medicines. September 2001.

Human Rights Act 1998.

MHA Code of Practice DOH 1983

DOH 2001 Seeking Consent: Working with people with learning disabilities.

Hampshire Partnership NHS Trust Consent Policy

Medicines, Ethics & Practice July 2007

DOH Reference guide to consent for examination or treatment

British National Formulary No.54

Pharmacy Code of Ethics

NMC Guidelines for Drug Administration

Safer Management of Controlled Drugs DH May 2007

Misuse of Drugs (Safe Custody) Regulations 1973

Safer Management of Controlled Drugs (CDs): Changes to Record Keeping Requirements Feb.2008.

NPSA Alert 13. June 06. Improving compliance with oral methotrexate guidelines.

NPSA Alert 18. March 07. Actions that can make anticoagulant therapy safer.

NPSA Alert 19 Promoting safer measurement and administration of liquid medicines via oral and other enteral routes.

NPSA Alert 20. March 07. Promoting safer use of injectable medicines

Building a Safer NHS. DH.

SECTION 20: GLOSSARY OF ABBREVIATIONS

Nurse in Charge of Medicines	NICM
Mental Health Practitioner	MHP
Controlled Drugs`	CD
Controlled Drug Register	CDR
Patients's Own Drugs	POD
Discharge Medicines/Leave Medicines	TTOs
Patient Group Directions	PGD

SECTION 21	APPENDICES INDEX	Page
Appendix A	Procedure for Auditing Controlled Drug Stocks and Record Books	52
Appendix B	Procedure for Managers when Discrepancies in Controlled Drug Stock Levels are identified	54
Appendix C	Medicines Administered at the Discretion of Nurses and MHPs	55
Appendix D	Topical Applications Administered at the Discretion of Nurses	57
Appendix E	Working in Partnership with the Pharmaceutical Sector	59
Appendix F	Policy Governing Contact with Company Representatives	62
Appendix G	Clinical Management Plan Development	64
Appendix H	Patient Group Direction (PGD) Proforma	65
Appendix I	Verbal/Faxed Prescription Form	70
Appendix J	Medicines Assessment Questionnaire	71
Appendix K	Covert Administration of Medicines	76
Appendix L	Procedure for disposal of individual doses or part doses of a Controlled Drug Prepared and not used	78
Appendix M	Record of borrowed medication	79
Appendix N	Procedure For The Management Of Controlled Drugs For All Closures Of Isolated Units And Closures Of Other Units For More Than 5 Days	80
Appendix O	Procedure for disposal of Controlled Drugs (CDs)	81
Appendix P	Essential Stock Medicines for Inpatient Services (Not including cardiac resuscitation drugs)	83
Appendix Q	Mental Health Practitioner Training	84
Appendix R	Mental Health Practitioner Oral/Topical Competency Assessment	85
Appendix S	Training Needs Analysis	93

Appendix A: Procedure for Auditing Controlled Drug Stocks and Record Books

1. Purpose

1.1 To confirm the quantity, identity and integrity of controlled drug stocks for which the Nurse in Charge of Medicines/Ward Manager is responsible.

1.2 To reconcile the stock balance in the CD record with the amounts in the CD cupboard.

1.3 To ensure that stocks have not deteriorated or exceeded expiry date.

1.4 To ensure that entries in the Controlled Drugs record book are being made correctly.

1.5 To review the range and level of stocks in the light of current requirements.

2. Procedure

2.1 Stocks of the Controlled Drug must be audited weekly by the Nurse in Charge/Ward Manager or Deputy, with another nurse who may be either registered or a nurse undertaking pre-registration training. The staff undertaking this check should be rotated periodically.

2.2 Check each balance entered in the record book against the physical stock in the Controlled Drug cupboard, not the reverse to ensure all balances are checked.

2.3 Examine each ampoule and tablet and all liquids to check that they have not been substituted or tampered with. It is not necessary to open packs with intact tamper evident seals for stock checking purposes.

2.4 Stock balances of liquid medicines should be checked by visual inspection. Where there is concern volume checks should be made with the clinical pharmacist or medicines management technician. A calibrated glass measure should be used.

2.5 Check all expiry dates and labels for expired stock.

2.6 Review the range and levels of stock especially any preparation which is not in regular use, and arrange disposal with pharmacy (as section 9).

2.7 Audit the record book to ensure that:

(i) all entries have two signatures.
(ii) any errors or wastage have been witnessed by two authorised people.
(iii) all entries and signatures have been made in black ink in chronological order and are clearly legible.
(iv) No entry has been obliterated and alterations and corrections have been explained by a marginal note or footnote which has been dated and signed.
(v) All entries are complete.

2.8 Enter the date of checking on each current page of the record book with the signature of the Nurse in Charge/Ward Manager and witness.

2.9 If a discrepancy is found it should be investigated without delay.

3. Pharmacist Check

The pharmacist responsible for the ward will check all entries every three months. A record as per 2.7 will be made.

3.1 Procedure

(i) Check a sample of CD requisitions copies to ensure they have been entered correctly.

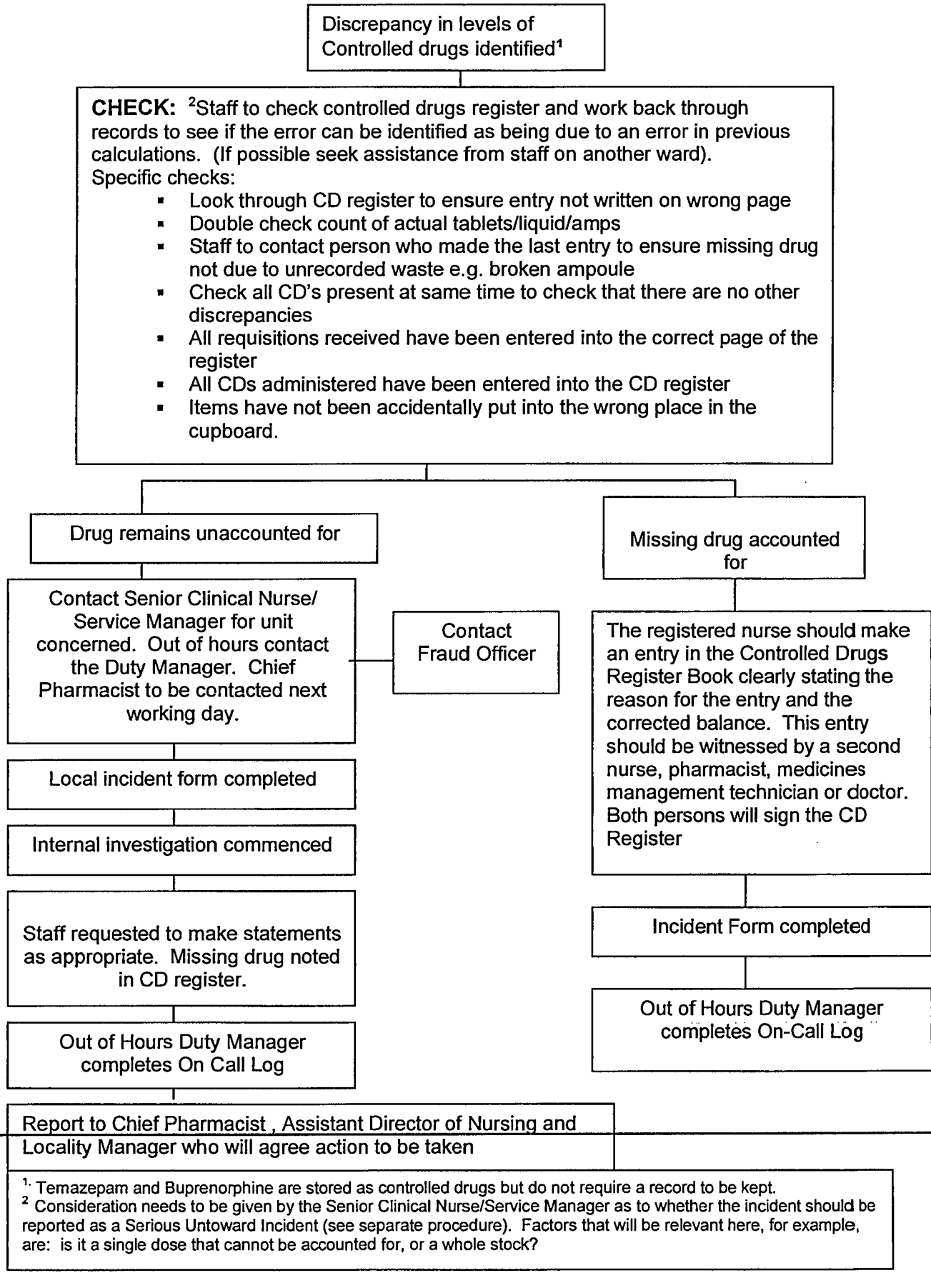
(ii) Check storage of register.

(iii) Check and update the list of authorised signatories for CD requisitions.

(iv) Check exceptional usage of CDs against orders and prescription chart to confirm medicines are prescribed and have been administered.

(v) Check physical security arrangements for CDs, CD stationery and keyholding policy.

Appendix B: Procedure for Managers when discrepancies in Controlled Drug (CD) Stock Levels are identified



[1] Temazepam and Buprenorphine are stored as controlled drugs but do not require a record to be kept.
[2] Consideration needs to be given by the Senior Clinical Nurse/Service Manager as to whether the incident should be reported as a Serious Untoward Incident (see separate procedure). Factors that will be relevant here, for example, are: is it a single dose that cannot be accounted for, or a whole stock?

Appendix C: Medicines Administered at the Discretion of Nurses and Mental Health Practitioners (MHPs)

All medicines shall be administered on the written prescription of a registered medical or dental practitioner, or registered supplementary/independent prescriber, in accordance with the Hampshire Partnership NHS Trust Medicines Control, Administration and Prescribing Policy.

Exception:
The Medicines Management Committee approves a list of medicines whereby registered nurses, and MHPs who have been assessed as competent to administer medicines, are authorised to administer some medicines at their own discretion.

A registered nurse or MHP may administer any of the following medicines to ADULT patients.

INDICATION	DRUG	DOSE	FREQUENCY	MAXIMUM TOTAL DAILY DOSE IN 24 HRS	MAXIMUM DURATION
Constipation	Magnesium Hydroxide mixture	25 – 50 ml	Once a day	50 ml	48 hours
Constipation	Senna tablets 7.5mg	1 – 2 tablets	Once a day	2 tablets	48 hours
Pain	*Paracetamol 500 mg	1 – 2 tablets	6 hourly	4g	48 hours
Cough	Simple Linctus	5 mls	6 hourly	20 ml	48 hours
Sore throat	Thymol & Glycerin throat pastilles (Strepsils for use in North Hants Locality)	1 pastille	When required	8	48 hours
Indigestion	Magnesium Trisilicate mixture	10 ml	Three times daily	30 ml	48 hours
Indigestion	Gaviscon Advance Suspension	5-10 mls	After meals and at bedtime	40 mls	48 hours
Diarrhoea	Dioralyte	The contents of one or two sachets reconstituted as directions	After each loose bowel motion	As needed	Single dose then contact doctor for

		on sachet/			further advice

Check patient not already prescribed paracetamol *either* within any other medication, *or on its own.

Medication initiated by a registered nurse or MHP must be reported to the prescriber when he/she next visits the ward or earlier if indicated by the condition of the patient. If the patient's condition does not respond to this treatment the prescriber must be notified immediately. All such medication must be recorded on the patient's prescription sheet in the section headed "For nursing use only" and in the nursing notes.

Appendix D: Topical Applications Administered at the Discretion of Nurses

Control of infection advice has been sought in detailing this list and reference made to local wound formulary guidelines.

Topical Application	Approved Use	Comments
Acetone	Removal of nail polish	
Alcohol swabs (Sterets, Medi-swabs)	Skin cleaning	Alternatively ensure the area is cleaned with soap and water and then dried.
Alcohol hand gel (caution: flammable)	Hand disinfectant used in instances where routine hand washing with soap and water is not possible or for disinfecting hands after washing with soap and water for more invasive procedures	Used on physically clean hands
Anusol cream	Local pain relief from haemorrhoids	
Aqueous cream	Dry skin	
Calamine lotion	Skin rashes/itching skin	
Chlorhexidine (Aqueous)	Indicated under prescription for the decolonisation of MRSA	Routine hand washing should be with soap and water.
Choline salicylate paste (Teejel, Bonjela)	Minor oral ulceration/teething	
Drapolene cream	Barrier preparation for protection against urinary rashes	
E45 cream	Emollient for dry skin	
Glycerol suppositories	Constipation	
Hand cream	Hand protection/rehydration of hands when frequently cleaned	The hand cream should be compatible with the chosen hand hygiene products. Manufacturers should be consulted to ensure the products are compatible.
Lubricating Jelly (KY Jelly)	Lubrication for rectal catheters etc.	
Lignocaine Gel 1% with Chlorhexidine	Local anaesthetic prior to catherization	
Micro-enema	Constipation	
Mouthwash tablets (pharmacy to advise on product)	Oral hygiene	
Plaster remover (CFC – use sparingly)	Removal of adhesive tape marks	
Sun tan lotion (pharmacy to advise on product)	Sun barrier	

Oilatum emollient	For dry skin conditions as bath additive	
Sudocrem	Barrier preparation for protection against urinary rashes	
Sodium Bicarbonate	Oral Hygiene	
Sodium Chloride 0.9%	Mouth care	
Spermicidal Jelly	Contraception	
Zinc and castor oil	Barrier preparation for protection against urinary rashes	

WOUND CARE

Topical Applications	**Approved Use**	**Comments**
Sodium Chloride 0.9% (Normasol sachets)	Routine use to clean and irrigate wounds	
Chlorhexidine solutions	Should be used selectively where wound disinfection is indicated e.g. in the presence of MRSA. Further advice from tissue viability or control of infection staff should be sought.	
Low adherent absorbent dressings (Mepore)	An absorbent pad with a low adherent layer	
Soft silicone wound contact dressing (Mepitel)	Useful for wounds where dressing changes need to be kept to a minimum. Should be covered with an absorbent secondary dressing	
Semi-permeable adhesive film (Opsite)	Suitable for protecting unbroken skin, or open wounds with a low exudate	
Hydrocolloid paste/dressings (Granuflex, Comfeel)	Suitable for light to medium exudating wounds	Odour can be a concern to some patients
Alginates (Kalostat, Sorbsan)	Useful in wounds where there is moderate or heavy exudates.	May require a secondary dressing to support the alginate and maintain a moist environment

Appendix E: Working in Partnership with the Pharmaceutical Sector

1. Introduction

The new NHS: Modern and Dependable places an obligation on Primary Care Trusts, Health Authorities and NHS Trusts to work together and in collaboration with other agencies to improve the health of the population they serve and the health services provided for that population.

Collaborative partnerships with the pharmaceutical industry can have a number of benefits in the context of this obligation.

This policy had been developed inline with the Department of Health (DH) document "Commercial Sponsorship – Ethical Standards for the NHS" November 2000 and is designed to maximise the benefits of working with the industry in a transparent manner. Staff should also be aware of their own professional code of conducts in working with the industry. As a minimum, all staff should follow the code at Appendix F1.

2. Principles for Working with the Pharmaceutical Sector

- The Trust will use available resources to generate the greatest benefit for our local population through the promotion of high quality, effective health care.
- The Trust wishes to work in partnership with the pharmaceutical sector on issues where there is a shared common aim and is in line with the Trust's objectives.

These principles reflect a move away from the traditional relationship between the NHS and the pharmaceutical sector, which relied predominantly on 'goodwill' and product related sponsorship activity. In the future, relationships will be supportive of strategic education, training, professional and service developments.

3. Guidelines for Sponsorship / Partnership

The Pharmaceutical company will provide a written proposal outlining the initiative in detail.
The proposal should be considered by the relevant clinicians, managers, Director of Finance, Directorate General Manager and Chief Pharmacist and reference made to Appendix 3 of Standing Orders.

The following criteria must be explicitly addressed in any proposal for sponsorship / partnership.

i. How it benefits the health of the local population especially in terms of quality of healthcare delivered on evidence based clinical practice.
ii. How it links to the Trust objectives
iii. How it links with other local and national strategic priorities
iv. The operation of any partnership must be in accordance with the financial and other standing orders of the Trust.
v. How any purchasing decisions including those concerning pharmaceuticals and appliances, should always be taken on the basis of best clinical practice and value for money. Such decisions should take into account their impact on other parts of the health care system e.g. ongoing cost in primary care.
vi. Ensure sponsorship arrangements permitting access to patient information is legally and ethically sound and that a contract should be drawn up which draws attention to obligations of confidentiality, specifies security standards that should

be applied, limits use of the information to purposes specified in the contract and makes it clear that the contract will be terminated if the conditions are not met. Agreement for sponsorship / partnership deals requires the approval of the Chief Executive.

4. Hospitality and meetings

Industry representatives organising meetings are permitted to provide appropriate hospitality and/or meet any reasonable, actual costs, which may have been incurred. Further guidance is available in Appendix 2 of Standing Orders.

Hospitality must be secondary to the purpose of the meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed that level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting. Where meetings are sponsored by external sources, that fact must be disclosed in the papers relating to the meeting and in any published proceedings. Declaration of sponsorship of meetings, gifts etc. must be made by email to the Director of Finance (Letsie.Tilley@hantspt-sw.nhs.uk). The details required are:

- Name and Locality.
- Details of the gift including financial value.
- Sponsoring organisation.

5. Research and Development

5.1 Exceptionally, in the case of non-commercial research and development (R&D) originated or hosted by NHS providers, commercial sponsorship may be linked to the purchase of particular products, or to supply from particular sources. This should be in accordance with the guidance at paragraph 28 of HSG(87)32 *Responsibilities for meeting Patient care costs Associated with Research and Development in the NHS*[1]. Where there is industry collaboration in such studies, companies may alternatively make a contribution towards the study's costs, rather than supply of product.

5.2 Any funding for research purposes should be transparent. There should be no incentive to prescribe more of any particular treatment or product other than in accordance with the peer reviewed and mutually agreed protocol for the specific research intended. When considering a research proposal, whether funded in whole or part by industry, NHS bodies will wish to consider how the continuing costs of any pharmaceutical or other treatment initiated during the research will be managed once the study has ended.

5.3 Separate Guidelines exist for pharmaceutical company Sponsored Safety Assessment of Market Medicines (SAMM) which remain in force.

5.4 Where R&D is primarily for commercial purposes, NHS providers are expected to recover the full cost from the commercial company on whose behalf it is carried but. (HSG(97)32, paragraph7). An industry-sponsored trial should not commence until an indemnity agreement is in place; see the guidelines in NHS HSC(96)48. Indemnity, Arrangements for Clinical Negligence claims in the NHS. A Standard form of indemnity agreement, agreed with ABPI, can be found at Annex B of that guidance.

[1] Paragraph 28 of HSG(97)32 states: At present, industry frequently contributes to the costs of pharmaceuticals (and other products) which are the subject of non-commercial R&D in the NHS. Although, by definition, such items constitute Treatment Costs, the NHS will continue, under the Partnership Arrangements, to look to researcher and non-commercial research funders to secure such contributions before approaching the NHS for support.

5.5 The NHS should benefit from commercial exploitation of intellectual property derived from R&D that the NHS has funded, or for which it has been funded, even where the intellectual property itself is owned by people outside the NHS. NHS bodies should ensure that an agreement to this effect is included in any contracts concerning R&D. The guidelines in HSC 1998/106 *Policy framework for the Management of Intellectual Property within the NHS from R&D* should be followed.

Appendix E1: NHS Standard of Business Conduct

Staff and independent contractors working in the NHS should follow existing codes of conduct. Staff who are not covered by such a code are expected to:

- act impartially in all their work;
- refuse gifts, benefits, hospitality or sponsorship of any kind which might reasonably be seen to compromise their personal judgement or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused;
- make it a matter of policy that offers of sponsorship that could possibly breach the Code be reported to their board (NHS Trust/Primary Care Trust/Health Authorities/Primary care Groups) or to the Health Authority (independent contractors);
- not misuse their official position or information acquired in the course of their official duties, to further their private interest or those of others;
- ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services;
- beware of bias generated through sponsorship, where this might impinge on professional judgement and impartially;
- neither agree to practice under any conditions which compromise professional independence or judgement, nor impose conditions on other professionals.

Appendix F: Policy Governing Contact with Company Representatives

1. Introduction

The Trust recognises the role of drug industry representatives in promoting and providing information on their products, whilst also recognising the need for sound management of medicines. This policy seeks to ensure the relationship between industry representatives and the Trust are maintained appropriately. THIS POLICY SHOULD BE READ IN CONJUNCTION WITH THE POLICY WORKING IN PARTNERSHIP WITH THE PHARMACEUTICAL SECTOR.

2. General

There is an expectation that representatives will have adequate training and skills to present information responsibly and accurately and will follow the guidance given within this policy. If breaches occur the Chief Pharmacist should be informed so that the matter can be raised with the company and/or Association of British Pharmaceutical Industry. Company representatives must be identifiable by a badge or similar at all times on Trust property.

3. Visits

3.1 To ensure an overview can be maintained of promotional activity, representatives must inform the Chief Pharmacist's office where a register will be maintained. This should be completed by all representatives and updated when new items/indications are promoted or when new representatives are appointed. The register will record the following: Company name, name of representative(s) for all of Hampshire Partnership Trust area, detail of item/new indication, details of supportive material.

3.2 Company representatives need to be aware of the demands on Trust staff time and should avoid causing disruption. Appointments are required for meetings. Ad hoc contacts are not allowed. Paging junior staff or other staff is forbidden.

3.3 To avoid disruption or inconvenience to patients, representatives should not enter clinical areas without prior appointment, for nursing staff this should be with the agreement of the appropriate nurse manager.

Samples

3.4 Samples will not be accepted by the Trust and must not be left on wards, in ECT suites, departments or offices.

3.5 Samples of products requested for the private use of doctors should be sent to their private address or given to the doctor personally on the specific understanding that they will not be used on Trust premises.

4. Introduction of New Drugs

4.1 The Medicines Management Committee maintains the Hampshire Partnership NHS Trust Formulary which restricts the range of medicines issued by hospital pharmacies. New medicinal products are not introduced automatically into stock but are treated as non formulary until reviewed by the Medicines Management Committee. They are considered on the written request of a consultant. Doctors are asked to give the Committee published evidence that the proposed new product represents a significant

advance in safety, efficacy and cost over others in the relevant therapeutic group. *Application forms for new drugs are available from the Chief Pharmacist's office – tel: 023 8087 4023.*

4.2 Medical representatives may provide information to doctors to assist them in preparing a proposal for the introduction of a new product but all proposals are evaluated independently before presentation to the Medicines Management Committee.

4.3 Medical representatives must always make the current status i.e. formulary/non formulary of the drug clear when discussing products with health professionals.

5. Gifts, Hospitality and Declarations of Interest

The guidance given in the Trust's Standards of Business Conduct must be followed.

In particular, attention of clinicians is drawn to the following requirements:

- For the purposes of this guidance commercial sponsorship is defined as including - NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (Including trips abroad), provision of free services (speakers), buildings or premises.

- In all these cases NHS bodies, members of NHS staff and independent contractors should use local arrangements to publicly declare sponsorship or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it.

Declaration of sponsorship, gifts/interest etc., must be made via email to the Director of Finance (telephone number 023 8087 4001 (or email Letsie.Tilley@hantspt-sw.nhs.uk). Details include:

- Name and Locality
- Details of the gift including financial value
- Sponsoring organisation

The above arrangements do not apply to-

- Personal gifts of less than £25 per gift e.g. gifts or post-it pads, pens etc. However gifts should be declared if several small gifts worth a total of over £100 are received from the same or closely related source in a 12 month period.
- Income generation schemes will be logged separately at local level
- Discounts on particular pharmaceuticals
- Clinicians must declare and record financial or personal interest eg company shares, lecture fees, fees for chairing groups, advisory panel membership, research grants in any organisation with which they have to deal and be prepared to withdraw from these dealings if required thereby ensuring that their professional judgement is not influenced by such considerations. Such declarations should be sent to the Chief Executive.

6. Drug Pricing

Staff are reminded that commercial information is confidential. This must be borne in mind especially when discussing rival firms and their products and prices. Guidance is given in the Trust's Standards of Business Conduct. Representatives need to be aware that hospital costs should include V.A.T. where applicable. Care should also be taken when giving price comparisons since they may not be aware of rival companies' prices for hospital products.

Appendix G: Clinical Management Plan Development

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

The criteria set in regulations for lawful supplementary prescribing are:

- The independent prescriber (IP) must be a doctor (or dentist)
- The supplementary prescriber (SP) must be a registered nurse or registered pharmacist
- There must be a written Clinical Management Plan (CMP) relating to a named patient and to that patient's specific conditions. Agreement to the plan must be recorded by both the IP and SP before supplementary prescribing begins
- The IP and SP must share access to, consult, and use the same common patient record.

The SP may prescribe all medicines that are in the HPT guidelines (formulary) and local Trust policies unless specifically excluded and that are referred to in the patient's CMP. SPs are able to prescribe medicines for use outside of their licensed indications (ie. "off label"). "Black Triangle" drugs and drugs marked less suitable for prescribing in the BNF, NB: unlicensed drugs, may not be prescribed unless they are part of a clinical trial which has a clinical trial certificate or exemption.

The supplementary prescriber should not be required to enter into a prescribing partnership, nor to prescribe any medicine that they do not feel competent to prescribe. Clinical Management Plans must be condition specific, eg. Treatment of EPSEs and be supported by reference to reputable guidelines or agreed protocols which are readily available for consultation.

CMP Development Pathway within Hampshire Partnership Trust

Supplementary Prescriber Registered
↓
Appropriate patient condition type identified
Check whether CMP already exists
↓
SP / IP / develop CMP
↓
Approval by Associate Director of Nursing
↓
Approved by
Medicines Management Committee

Appendix H: PGD Proforma

Hampshire Partnership NHS
NHS Trust

PATIENT GROUP DIRECTION (PGD) TEMPLATE

Name of Specific Patient Group Direction: .....

Clinical Department/Service: .....

1. Clinical Condition

1.1	Define situation/condition	
1.2	Criteria for inclusion	
1.3	Criteria for exclusion	
1.4	Cautions	
1.5	Action if patient excluded	

Name of Specific Patient Group Direction:

1.6	Action if patient declines	

2. Characteristics of staff

2.1	Class of Health Professional for whom PGD is applicable	
2.2	Additional requirements considered relevant to the medicines used in the protocol	
2.3	Continued training requirements	

3. Description of Treatment

3.1	Generic Name of Medicine and Form e.g. tablets	
3.2	Legal status Prescription Only Medicine (POM)/Pharmacy Only (P)/General Sales List	
3.3	Licensed or unlicensed (state rationale for use)	
3.4	Dose(s) (Where a range is applicable include criteria for deciding on a dose)	

Name of Specific Patient Group Direction:

3.5	Route/Method of Administration	
3.6	Frequency of Administration	
3.7	Total dose and number of times treatment can be administered over what time	
3.8	Side effects of drugs (to include potential Adverse Reaction)	
3.9	Procedure for reporting Adverse Drug Reactions (ADR) to Doctor	
3.10	Information on follow up treatment if needed	
3.11	Written/verbal advice for patient/carer before/after treatment. Product information leaflet should be given to the patient	
3.12	Specify method of recording supply/administration, names of health professional, patient identifiers, sufficient to enable audit trail.	

Additional Information Required:

- Copy of training and competencies.
- Copy of Information Leaflets referred to within the PGD.

Management of Patient Group Directions

a. This patient group direction was developed by:
(Include names of everyone involved in drawing up the protocol)

Signature of Senior Doctor: .....Title:..... Date:.....

Signature of Senior Pharmacist: .....Title:..... Date:.....

Signature of Senior Health Professional:..... Title:..... Date:.....

b. Authorised by Associate Director of Nursing or Head of Profession

Signature ..... Date
.....

The role for this member of staff is to review the PGD and training and assess the appropriateness of their profession to undertake this role.

c. Authorised by Directorate Clinical Governance Committee

Approved by
.....

Signature of Chair .....
Date.....

The purpose of this review is to ensure the directorate is approving this development.

d. Approved by PNAC:

Signature of Chair .....
Date:.....

The purpose of this is to ensure consideration of all professional issues and share practice.

e. Approved by Trust Medicines Management Committee:

Signature of Chair ....
Date:.....

This committee is reviewing the whole document in detail and makes recommendations to the Trust Clinical Governance Lead.

f. Approved by Clinical Governance Lead:

Signature ..... .
Date:.....

Approval by the Clinical Governance Lead is a requirement in law.

Review Date..... (Maximum of 2 years)

g. The direction must be read, agreed to and signed by each of the health professionals who work within it. All professions must act within their appropriate Code of Professional Conduct.

I have read the PGD and agree to work within its parameters

Name of Professional:..... Title:.....

Signature of Professional:.....

Date:.....

Name of Specific PGD:.....

Clinical Department/Service:.....

Approved by Associate Director of Nursing/Trust Lead for Profession:

I approve ..... to work under this PGD.

Signature:..... Date:.....

Entered on register: Date .....

Copies of completed forms to be held by individual health professional/service manager/ Assistant Director of Nursing/Trust Lead for Health Professional.

Hampshire Partnership NHS
NHS Trust

Appendix I: Verbal/Faxed Prescription Form (Separate form required for each drug)

Surname: ..... **Date of birth:** .....

First names: ..... **Hospital Number:** .....

Known allergies: .....

Drug name (approved name)	**Dose**	**Date**	**Route**
Prescriber's Name (PRINT)	**Prescriber's Signature**	**Frequency** (written in full)	
Times of day **0800** **1230** **1730** **2200**	**Minimum interval between doses for prn medication and clear indication for use**		

NB. Recorded Administration must be on drug chart.

Name of Nurse Contacting Doctor: .....

Signature of Nurse: .....

Hampshire Partnership NHS
NHS Trust

Appendix J:

Medicines Assessment Questionnaire

Name: ..... **Place of assessment.....**

Assessed by..... **Title.....** **Date.....**

Question	Prompts	Response	Comments
1. What do you do if you find it difficult to read the prescription card?			
2. What are the main requirements that should be written on the card?			
3. How is a discontinued prescription recorded?			
4. How is the patient to be identified on the card?			
5. In the absence of a medication being prescribed, is it acceptable for the nurse to administer the following verbal instructions from the doctors?			

Question		Response	Comments
6. What is the procedure for administering Controlled Drugs?			
7. In what circumstance is it permissible to give medication without a prescription?			
8. Where should a copy of MHA Forms 38 and 39 be kept?			
9. When are expiry dates checked?			

Question		Response	Comments
10. Why is it necessary to understand not only the purpose of the medication but also side effects and interactions			
11. Where should a refusal of a patient to accept medication be noted?			
12. Apart from fellow staff nurses, who can have access to medicine cabinets and trolleys?			
13. How is variation in prescribed dose managed and recorded?			
14. What are the requirements for PRN drugs?			

Question		Response	Comments
15. What needs to be checked when using drugs brought in by the patient?			
16. Is it acceptable for IM medication drawn up another staff member to be given?			
17. How is the administration of monitored dosage systems (e.g. dosette boxes) managed?			

Question		Response	Comments
18. What is the procedure when an error has been made in administering a drug?			
19. How is TTO medication managed?			
20. What do you do if a patient requests the return of medication he/she brought into hospital when the patient is discharged?			
21. What is the procedure when the drug keys are taken from the clinical area (e.g. when a staff member takes the keys home?)			

Appendix K: Covert Administration Of Medicines

Introduction

The following guidance **must be used whenever** covert administration of medication is considered.

It is important that the decision to administer medication covertly is underpinned by person centred principles. If the person was able to make an informed decision would they choose to take the medication rather than experience the potential outcomes of not doing so?

Example:
Mr Smith enjoys walking, being outdoors and being in quiet places. He has severe epilepsy. When he has a seizure, he is often confined to bed in a noisy hospital environment. As well as the obvious therapeutic benefits of taking the medication, there are other qualitative benefits to Mr Smith. If he stays well he is less likely to require hospital treatment and more likely to be able to retain control over his physical environment and his general wellbeing. Mr Smiths person centred assessment and plan could provide evidence that will support the decision making process around the use of covert medication for professional staff.

Considerations for preventing the need for covert administration

- Is the medication essential to maintain the person's health and wellbeing?
- What is the person's history with regard to taking medication?
- What alternative intervention strategies have been tried?
- Are alternative formulations available, would the person prefer administration of the medication to be by different method or route?
- Does the person relate better to some staff members?
- What style of communication does the person prefer?
- How do you know the person is declining to take the medication?
- Is the timing of administration an issue for the person?
- Is the environment appropriate for the person?

How?
When a decision is made to consider or review the use of covert administration:

- Arrange a discussion involving
  - -the person if possible or their advocate (where the person does not already have an advocate, it is important that an advocate should be identified and involved if appropriate as soon as possible. In emergency situations the lack of an advocate must not prevent appropriate treatment, but an advocate should be identified and involved in future review)
  - -their relatives or carers if appropriate,
  - -the prescriber,
  - -pharmacist
  - -nursing/care staff
  - -other relevant staff e.g care manager, speech and language therapist
- Review and reconsider alternatives
- The example format below must be completed following the discussion
- In addition a person centred care plan must be formulated ensuring that each medication is considered and reviewed at least every 3 months.

Person's Name: Location:	D.O.B: NHS No:
Care coordinator/keyworker	Contact number
Medication to be administered covertly, including name, dosage and times of administration:	
Method of administration (e.g. in spoonful of yogurt). Include all methods which may need to be used, taking into consideration the content of person centred assessment and plan.	
Reason for medication being administered in this way. Relevance to person centred plan:	
Family member and/or advocate, who is part of the decision making process, that the administration of medication covertly is in the best interest of the person:	
Name (printed) and 'phone no:	Signature and date:
Professionals who are part of the decision making process to administer medication covertly (minimum of three people, including the prescriber and pharmacist) who agree that this is in the best interest of the person:	
Name, role and 'phone no:	Signature and date:

Appendix L: Procedure for disposal of individual doses or part doses of a Controlled Drug Prepared and not used

L1. Individual solid dose preparations, eg. tablets/capsules/suppositories, must be disposed of using a Doop bin. The bin must then be placed in a non cytotoxic/cytostatic medicines bin.

L2. Small volumes of liquid should be mixed with soapy water and disposed of down the sluice or toilets.

L3. The CD stock balance must be checked against the register.

L4. On all occasions, the following must be recorded:

- Date
- Time
- Quantity
- Reason for disposal
- Patient name
- Signatories of a nurse and other authorised person
- Stock balance

Appendix M: Record Of Borrowed Medication

Please ensure that this form is used to record the borrowing of medication from another ward.

Borrowing Ward Name .....

Loaning Ward Name .....

Medication(s) Borrowed (include name, strength, quantity and expiry date)

.....

.....

.....

Date of Borrowing .....

Time of Borrowing .....

PART A

Signed on receipt: .....
Qualified Nurse or MHP / Loaning Ward

Signed on supply: .....
Qualified Nurse or MHP / Borrowing Ward

If stock returned to original ward complete Part B.

PART B

On return of medicines to original ward:

Signed on supply: .....
Qualified Nurse or MHP / Loaning Ward

Signed of receipt: .....
Qualified Nurse or MHP / Borrowing Ward

Action Required

- Form to be photocopied
- Original form to be retained by the loaning ward and filed in the medication ordering folder
- Photocopy of form to be kept by the borrowing ward and filed in the medication ordering folder.

Appendix N: Procedure For The Management Of Controlled Drugs For All Closures Of Isolated Units And Closures Of Other Units For More Than 5 Days

(1) The nurse in charge of medicines must contact the supplying pharmacy and agree a mutually suitable time for a named pharmacist to collect Controlled Drugs.

(2) The nurse on duty must confirm the identity of the named pharmacist on arrival at the unit.

(3) The pharmacist will sign the stock out of the CD register, witnessed and countersigned by the nurse as described below:

i. Date
ii. Time
iii. 'Returned to pharmacy temporary closure'
iv. Quantity returned
v. Zero stock balance entered
vi. Signatures of pharmacist and nurse

(4) The pharmacist will then remove the stock and return it to the pharmacy department.

(5) Depending upon the expected length of closure stock can be returned into pharmacy stock and/or disposed of in line with the pharmacy department policy, or held together with a photocopy of the appropriate pages from the Controlled Drug Register within the pharmacy.

(6) The nurse in charge of medicines must arrange storage of the register in agreement with the locality lead pharmacist.

(7) Patients Own Drugs should be transferred with the patient. The member of HPT staff who takes the medicines must sign the CD register on the closing unit and on the receiving unit. The following details must be recorded:

On departure

i. Date
ii. Time
iii. Name of patient transferred to
iv. Quantity transferred
v. Zero stock balance
vi. Signature of nurse and HPT staff member

On arrival

i. Date
ii. Time
iii. Name of patient arriving from
iv. Quantity transferred
v. New balance
vi. Signature of nurse and HPT staff member

Appendix O: Procedure for disposal of Controlled Drugs (CDs)

1.

1.1 All medicines must be disposed of in a safe and appropriate manner and in line with the Trust policy on Handling and Disposal of Healthcare Waste Policy.

1.2 All CDs awaiting disposal must be stored in the CD cupboard clearly labelled for disposal and separate from stock, eg. large paper bag.

1.3 All CDs in schedule 2, 3 and 4 (part 1) must be placed into the designated bins with other non cytotoxic/cytostatic medicines but only after the CD has been rendered irretrievable by denaturing.

1.4 With the exception of spoilt doses (see appendix L) all expired controlled drug stock and PODs which are no longer required must be destroyed by a registered nurse and a HPT pharmacist. The HPT pharmacist must not be involved in the supply of Controlled Drugs to that unit. The POD CDs must have met the disposal criteria within the POD policy.

2. Procedure

2.1.1 Registered nurse and member of clinical pharmacy team check stock levels and sign to confirm they are correct.

2.1.2 Check and record amount of CDs to be disposed of. Checks to include:

- Drug name and strength
- Form
- Expiry date
- Patient's name if applicable
- Quantity
- Where the CD is packaged in unit doses or ampoules each unit should be checked as well as the outer container.

2.1.3 Record the date and annotate as "expired stock".

2.1.4 Record the balance. Both members of staff should sign the register confirming all details are correct.

2.2 Solid dose formulations

2.2.1 Staff should wear gloves.

2.2.2 Remove tablets and capsules from outer packaging and blister packaging.

2.2.3 Grind or crush the solid dose formulation before adding to the Doop bin to prevent whole tablets or capsules being recovered.

2.2.4 The Doop bin may then be placed in the waste medicines non hazardous container for disposal.

2.2.5 All packaging which has been in contact with the destroyed medicines must also be placed in the waste medicines container.

2.3 Liquid dose formulations

2.3.1 Staff should wear gloves.

2.3.2 Add liquid to the CD denaturing kit and deal with it as above.

2.3.3 For large quantities add to cat litter which should then be placed in the non hazardous waste medicines container.

2.4 Parenteral formulations

2.4.1 Staff should wear gloves.

2.4.2 Open liquid ampoules and empty into denaturing kit. Dispose of ampoule in sharps bin.

2.4.3 Open powder ampoules and add water to dissolve the powder then pour into the CD denaturing kit.

2.4.4 Place empty ampoule in pharmaceutical sharps bin.

2.5 Fentaryl and buprenorphine patch

2.5.1 Staff must wear gloves.

2.5.2 Remove the backing and fold the patch over on itself.

2.5.3 Place in a CD denaturing kit.

Appendix P: Essential Stock Medicines for Inpatient Services (Not including cardiac resuscitation drugs)

Adrenaline	**1 in 1000**
Chlorphenamine	**4mg in 1ml**
Hydrocortisone	**HCl 100mg in 1ml**
Glucose	**50% injection**
Oral glucose solution	
Glucagon	**1mg**
Naloxone injection	

Appendix Q: Mental Health Practitioner Training

Training on psychopharmacology, safe drug administration and use of the BNF is a component of the MHP course run by Southampton University. (T)MHPs also receive in-house training and supervision on administration of medicines on their placements. Assessments are completed on wards/placements and *undertaken by an approved sign off mentor from the trust database.*

Following additional trust approved training provided by the HPT Development and Training department and competency assessment by a registered nurse, MHPs may be approved to administer depot antipsychotics. This role is an extended *role and the training does not form part of the basic course run by Southampton University. Not all approved MHPs are required to administer depots. Approved MHPs must be in a role which will allow them to practice this skill and maintain their competency before undergoing the additional training. Once authorised to administer depots, if the practitioner at any point no longer feels competent to administer depots, or a period of twelve months passes without administering a depot, the practitioner must be reassessed by a registered nurse.*

A record of the assessment and authorisation to administer depot antipsychotic drugs will be held with the MHPs personnel record.

Appendix R: **Drug Administration - Theory Assessment**
Mental Health Practitioners

R1

1. The practitioner understand the boundaries of their role in medicines administration:

   (a) Routes.
   (b) Patient status and age.
   (c) Legal Categories.

2. The practitioner knows when they can administer medicines on their own and when to involve a second person.

3. The practitioner understands their role in the administration of Controlled Drugs.

4. The practitioner understands the need to check prescription against Form 38 or 39 and what action to take if there is any discrepancy.

5. The practitioner understands and demonstrates how to administer:

   (a) eye drops.
   (b) eye ointment.
   (c) creams, ointment and lotions.
   (d) ear drops
   (e) inhalers

6. The practitioner understands what action to take if a patient refuses a medicine.

7. The practitioner understands the recording system for the omitted dose.

8. The practitioner understands what to do if a patient reports any side effects or if any side effects are observed.

9. The practitioner must understand the need for privacy and dignity when administering medicines.

10. The practitioner understands the Trust's policy and procedure on Covert Administration of Medicines.

11. Where Patient Own Drugs (POD) policies are in place, the practitioner must have been trained and assessed as competent.
    All Mental Health Practitioners understand how to handle medicines brought in by patients.

12. Ordering of Medicines: The practitioner demonstrates knowledge of the ordering system for stock items/inpatients items and discharge medicines.

13. Storage: The Mental Health Practitioner understands the storage requirements of medicines.
The Mental Health Practitioner understands what action to take if a drugs fridge is found not to be working.

14. Medication Related Errors

    (a) The practitioner demonstrates knowledge of the possible causes of drug administration errors.

    (b) The practitioner knows what to do on discovering an error:

        (i) prescribing.
        (ii) dispensing.
        (iii) administration.

15. The practitioner demonstrates what to check and discuss with patients when issuing TTOs.

16. The practitioner understands how to use the BNF.

17. The practitioner knows how to contact the on-call pharmacist.

Hampshire Partnership NHS
NHS Trust

R2

DRUG ADMINISTRATION – PRACTICAL ASSESSMENT
MENTAL HEALTH PRACTITIONERS

1. Preparation:

   (a) Hands are washed before and after preparation.

   (b) Equipment and charts for administration are prepared for use.

   (c) The patient is informed of the administration in a manner sensitive to their needs.

2. Administration and Recording:

   (a) Administration is in line with section 4 of Medicines Administration by Mental Health Practitioners Policy (HPT).

   (b) Recording of Medicines is in line with Trust Policy and the Medicines Administration by Mental Health Practitioners (HPT).

   (c) All equipment is used appropriately.

   (d) Liquids are measured accurately.

3. Pharmacology

   (a) The indication for each drug for the specific patient is known.

   (b) The side effects for each drug are known.

   (c) The specific monitoring requirements for the patient and drug are known.

4. Concluding the procedure

   (a) Medicines are returned to the trolley/cupboard.

   (b) Trolley/cupboard is locked.

   (c) Keys are held safely.

Hampshire Partnership NHS
NHS Trust

R3

Mental Health Practitioners
Medicines Assessment Questionnaire

Name: ..... Place of assessment.....

Assessed by..... Title..... Date.....

Question	Prompts	Response	Comments
1. What are the limitations placed on you when undertaking the administration of medicines with respect to: (i) Routes (ii) Patient age and status (iii) Legal categories (iv) PRN			

	Question	Prompts	Response	Comments
	2. What do you do if you find it difficult to read the prescription card?			
	3. What are the main requirements that should be written on the card?			
	4. How is a discontinued prescription recorded?			
	5. In the absence of a medication being prescribed, is it acceptable for a Mental Health Practitioner to administer following verbal instructions from the prescriber?			

Question	Prompts	Response	Comments
6. How is the patient to be identified on the card?			
7. Where should a copy of MHA Forms 38 and 39 be kept and what action should be taken if there is a discrepancy?			
8. When are expiry dates checked			
9. Why is it necessary to understand not only the purpose of the medication but also side effects and interactions?			
10. Where should a refusal of a patient to accept medication be noted?			
11. Which groups of staff members may have access to the medicine cabinets and trolleys?			

Question	Prompts	Response	Comments
12. How is variation in prescribed dose managed and recorded?			
13. Is it acceptable for medicines placed in a pot to be given by another member of staff?			
14. What needs to be checked when using drugs brought in by the patient?			
15. What is the procedure when an error has been made in administering a drug?			
16. How is TTO medication managed?			
17. What do you do if a patient requests the return of medication he/she brought into hospital when the patient is discharged?			
18. What is the procedure when			

Question	Prompts	Response	Comments
the drug keys are taken from the clinical area (eg. when a staff member takes the keys home?)			
19. How do you record if a drug has not been given?			
20. What action should be taken if a patient reports a side effect or if any side effects to a drug are observed?			
21. Under what circumstances may medicines be administered covertly?			
22. How are stock and non stock items ordered for the ward?			
23. What action must be taken if drugs fridge is found not to be working?			
24. How can the BNF be used to check a dose and indication			

Appendix S - Training Needs Analysis

Below is a training needs analysis for all staff groups to ascertain which members of staff require training on the Medicines Control, Administration and Prescribing Policy - CP 41.

This training includes:

- Responsibilities of staff
- Promotion of safe practice
- Reducing risks
- Procedures

Staff Group	Require familiarisation with policy upon appointment	Four Yearly updates	Upon Policy review
Doctors	✓		✓
Pharmacists	✓		✓
Nurses	✓	✓	✓
Mental Health Practitioners	✓	✓	✓
Admin and Clerical			
Clinical Psychology			
Occupational Therapy			
Other Allied Health Professionals			
Support to Allied Health Professionals			
Maintenance / Ancillary			
General Management			
Other Occupational Groups			