Lincolnshire Partnership
NHS Foundation Trust

Medicines Management Policy

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Contents

Equality statement

Lincolnshire Partnership NHS Foundation Trust (LPFT) will develop and implement business plans, project initiation documents, service change, service delivery and provision and policies and other corporate documents that meet the needs of the local community. They will take account of the provisions outlined in the Equality Act 2010, to eliminate discrimination, harassment and victimisation, promote equality of opportunity and build on good relations between the diverse communities.

The aim is to ensure no individual receives less favourable treatment on the grounds of age, disability (learning disabilities), sex (gender), race, gender reassignment, sexual orientation, religion and belief, marriage and civil partnership and pregnancy and maternity.

LPFT will have due regard to the different needs of those listed as the 'protected characteristics' and those not listed to ensure dignity and respect, leading to a fair and equitable service for all.

1. Introduction

1.1 This policy outlines the Trust's responsibility to ensure that the organisation handles medicines safely and securely, in accordance with legislative requirements and best practice. This includes:

- The Medicine Act 1968, as amended which regulates the manufacture, distribution, import, export and supply of medicinal products.
- The Misuse of Drugs Act 1971, which controls the availability of drugs liable for misuse.
- The Misuse of Drugs Regulations 2001 which enables specified health care professionals to possess, supply, prescribe and/or administer controlled drugs in the sphere of their practice.
- The Controlled Drugs (Supervision and Management of Use) Regulations 2013.

1.2 It is the responsibility of the Trust to recognise the risks associated with medicines management, taking action to fully resource the training and development of all clinical staff to fulfil their duty to safely administer medicines to patients. This will be achieved by:

- Raising the profile of Medicines Management and Optimisation within the Trust.
- Recognising that all clinical staff need to be appropriately trained in the administration of medicines.
- Acknowledging the need of service users to consent to treatment.
- Providing information about medicines to service users.
- Supporting multi-disciplinary collaboration and communication, forums and other networks to monitor the effectiveness of the service.
- Complying with all legal, statutory and local requirements to meet the standards of medicine management.
- Implementing a programme of clinical audit to determine compliance to relevant standards and procedures.
- Ensuring all clinical staff have access to up to date guidance and research relating to the safe and secure handling of medicines and that all procedures support evidence based best practice.

2. Purpose and Scope

2.1 This policy aims to ensure that:

- All relevant staff are aware of the requirements for the ordering, dispensing, distribution, safe storage, prescribing and administration of medicines.
- Service Users receive correct medication in a safe and timely manner.
- A system is in place to effectively monitor the standards of medicines management.

Important Note: Procedures relating to all aspects of medicines management throughout this Policy are supported by either Medicines Related Standard Operating Procedures (MRSOPs) or Controlled Drug Standard Operating Procedures (CDSOPs) and can be found under the Pharmacy Pages on Sharon.

2.2 In some situations staff may also need to refer to additional local policies. LPFT staff working in other NHS Trusts, including United Lincolnshire Hospitals NHS Trust (ULHT) should follow the Medicines policy and guidance of these other trusts which may differ from LPFT.

2.3 The core policies and procedures outlined within this document apply to all employees of the Trust. Those persons employed by other Authorities or Trusts who are contracted to work within the premises of this Trust will observe the policies and procedures. Managers who contract for services must make it explicit within the written contract that these staff must follow the policy, procedures and associated standards.

2.4 All those with delegated responsibilities under the Trust's policy for medicine management and related guidelines must in addition act in accordance with current statutory legislation, Department of Health & Social Care, and ones' own professional standards of practice.

2.5 All employees are reminded that breaches of rules, including breaches of these guidelines, will be dealt with under the provisions of the Trust's disciplinary procedure.

2.6 All employees with responsibilities relating to these guidelines must apply the provisions relating to the Health and Safety at Work Act and COSHH regulations when handling medicinal products. Particular attention is drawn to the hazards of cytotoxic/cytostatic drugs.

2.7 This policy should be read in association with other Trust Policies and other legal, statutory and professional guidance.

3. Duties

3.1 It is a requirement of the revision of the Duthie Report – "The Safe and Secure Handling of Medicines: A Team Approach "(Royal Pharmaceutical Society March 2005) that the senior management board designate a senior pharmacist to be responsible for medicines management systems.

The Chief Pharmacist has Board designated responsibility for organising, monitoring, reporting and to maintain an effective and economical system by which medicines are managed safely and securely to meet the service user's clinical needs. Those in charge of wards, departments or teams are given delegated responsibility and will ensure that this policy and associated procedures are carried out correctly and are

considerate of the needs of patients, consent to treatment, relevant legislation including the Mental Health Act (2007) and Care Quality Commission assurance standards / NHSLA standards.

3.2 Chief Executive (CE)

The CE for LPFT is responsible for ensuring that a medicines policy is in place and that all staff working in the Trust are aware of, and operate within the policy.

3.3 The Chief Pharmacist (CP)

The CP for LPFT has overall responsibility for the management and optimisation of medicines within the Trust including the safe and secure handling of medicines. In liaison with clinical teams and pharmaceutical staff, he/she will implement the controls assurance Care Quality Commission standards (medicine management) and local procedures, standards and guidance relating to the management of medicines.

The CP is responsible in partnership with service manager for instituting an effective monitoring system as required by Controls Assurance/Care Quality Commission Standards and NHSLA.

The CP is responsible for all aspects of the safe and secure management of controlled drugs within the Trust. This includes ensuring that safe systems are in place for the management and use of controlled drugs, monitoring and auditing the management systems and investigations of concerns and incidents relating to controlled drugs.

3.4 The Medical Director (MD)

The Medical Director (MD) is the Executive Director responsible for informing the Trust Board about medicine related issues.

The MD is responsible for ensuring that all medical staff are aware of and operate within the policy.

3.5 The Director of Nursing and Quality (DoN&Q)

The DoN&Q is responsible for ensuring mechanisms are put in place to ensure nursing and allied health professionals within all services are aware of and comply with the requirements of the medicine policy.

3.6 The role of the pharmacy team is to:

- Advise on, provide training on and monitor the safe, effective and economic use of medicines
- Guide the most appropriate, patient-centred prescribing regimes for service users through advice and recommendations
- Procure medicines
- Supply and/or dispense ready to administer medicines
- Review medication history of service users
- Provide medicines for discharge and leave
- Advise and counsel service users on their use of medicines
- To prescribe for service users in agreed circumstances (if qualified).

Medicines will be procured, supplied and dispensed in accordance with the relevant legislation, professional standards, NHS recommended practice and controls assurance guidance.

Pharmacists will monitor prescriptions for service users in their care and place special emphasis on complex and potentially toxic medicines that require higher levels of monitoring.

When a request for a medicine has been made the pharmacist must check the prescription and other related service user records to ensure the safe, effective and economic use of medicines. Attention must be given to each step of the medicine use process. This includes the need for the medicine, the medicine formulation and the route of administration. In addition pharmacists must monitor for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic end points.

Authorised Pharmacy Staff may annotate the prescription in green ink that can be photocopied. This annotation should ensure the approved name; dose, route and precautions are included on the prescription, to guide practitioners when they administer the medicine.

Where a pharmacist wishes to make a recommendation to change or modify a service user's therapy, the pharmacist must record the recommendation in the service user's electronic notes (EPR). It is essential to sign and date the recommendation and provide some background details. These written records must be made, in addition to any verbal communication, with the prescriber.

Service User's should be advised about their medicines by Authorised Pharmacy Staff during their admission stay or period of admission. This should be a part of an agreed programme for each ward.

3.7 **The Appointed Practitioner in Charge** should agree with the pharmacist and consultant the arrangements for advising service users about their medicines.

Alternative arrangements for advising service users about their medicine may be provided if:

- The nature of the hospital stay is less than one week.
- There is a need for a rapid discharge.
- The nature of the discussion is considered inappropriate by the consultant.
- There is insufficient availability of suitably trained pharmacists.

Such alternative arrangements must identify the person responsible for the provision of information and the nature of the information to be provided.

Routine supplies of newly prescribed medicines are made when the pharmacy team is on duty (Monday to Friday currently). Out of hours the contracted on-call pharmacist (currently, The Co-Op) will determine the clinical urgency of the items and arrange for the supply as appropriate. Please refer to "Access to Medicines & Supply Out of Hours" (MRSOP15).

Authorised Pharmacy Staff must be involved in advising on safe and secure handling of medicines and storage conditions on the ward/unit or department.

The pharmacy team will provide a medicine information service for other healthcare staff and patients.

Pharmacists may undertake responsibility for prescribing for service users if suitably trained.

3.8 Registered Nurse

The following may handle, order, have custody of, administer, prescribe (if NMP trained), and/or dispose of medication:

- Registered General Nurse (RGN)
- Registered Mental Nurse (RMN)
- Registered Nurse in Learning Disability (RNLD)

3.9 Nursing Associate

Nursing associates are employed by LPFT and can handle, order, have custody of, administer, and be involved in the safe disposal of medication in accordance with the inclusion and exclusion criteria described within the nursing associate medicines management guidelines – see **Appendix 8**).

3.10 Ward Manager/Team Co-ordinators

The Appointed Practitioner in Charge with 24 hour responsibility of that ward/team.

3.11 The Medical HR Department

Is responsible for ensuring that specimen signatures of all those prescribing or ordering medicines are provided to the pharmacy departments.

3.12 Divisional Managers (DMs)

Are responsible for ensuring that all managed staff are aware of and operate within the realms of the medicine policy.

3.13 Matrons

Matrons have the responsibility for monitoring adherence to this Medicines Policy within their service and for picking up and escalating (where necessary) any medicine related issues within the service on a day to day basis.

They have the responsibility of ensuring that any appropriate training associated with medicines use within the Trust is undertaken by nursing staff within their service.

3.14 Heads of Departments & Allied Health Professionals (AHPs)

Are responsible for ensuring that all managed staff are aware of, and operate within the Medicines Policy.

3.15 Clinical and Support Staff

Staff who handle or use medicinal products have a duty to be aware of and work within the confines of the medicine management policy.

All staff who register with a professional body must also ensure that they maintain their professional registration and any associated stipulations or conditions of registration i.e. Continual Professional Development criteria.

3.16 Drug & Therapeutics Committee (DTC)

NHS Trusts are required to convene a committee to oversee all aspects of treatment with medicines for which the Trust is responsible. For Lincolnshire Partnership NHS Foundation Trust this is the Drug & Therapeutics Committee (DTC). This committee:

- Has both strategic remit and oversees the operational issues associated with medicines.
- Reports to the Quality Committee via the Patient Safety & Experience Committee.
- Is recognised by the Trust as the body through which all policy decisions relating to the management of medicines are focussed, monitored, approved, and co-ordinated across the Trust.
- Provides a strategic framework to enable and support a safe and cost effective way of providing pharmacological treatment for people with mental health problems.
- Supports effective medicines optimisation across the Trust and wider local health economy.
- Supports clinical governance in the Trust through effective policies and guidelines which assure best practice in all areas of medicines management - prescribing, supply, administration, safe disposal and storage, and monitoring of medicines.
- Advises on prescribing contract arrangements, promotion of education and research relating to medicines use and the safe use of medicines by other health care professional staffing groups working within the Trust.
- Supports and advises on the implementation of national guidelines and regulation about medicines, e.g. NICE, MHRA, RPS.

3.17 DTC Subgroups

- Medicines Safety Group: Through its Medicines Safety subgroup (MSG), the DTC reviews the reported trends of medicine related Datix incidents and advises on action plans to reduce the risk of harm caused by medicines. It is a multidisciplinary group that ensures action plans to improve prescribing, dispensing and administration of medication through senior medical, pharmacy and nursing leads can be appropriately implemented.

- Non-Medical Prescribing (NMP) Steering Group**:** This group leads on and manages all aspects of procedural, professional and governance assurance around NMP practice within LPFT.

3.18 Statutory Medicines Related Roles & Responsibilities:

- **Medicines Safety Officer:** In March 2014, the Medicines Healthcare Regulatory Agency (MHRA) published its Patient Safety Alert (PSA) as a directive for improving medication error incident reporting and learning. Its purpose was for NHS England and MHRA to work together to simplify and increase reporting, improve data report quality, maximise learning and guide practice to minimise harm from medication errors. Here is a link to the alert: https://www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-error.pdf

  For NHS Trusts, there were a number of actions to be implemented, including the identification of a board level director (medical or nursing supported by the chief

pharmacist) to have the responsibility to oversee medication error incident reporting and learning, to identify a Medication Safety Officer (MSO) who will be a member of a new National Medication Safety Network, will act as the main contact for NHS England and MHRA, receive Central Alert System (CAS) alerts and support local medication error reporting and learning.

In LPFT, the Board level director allocated is the Medical Director, and the MSO (at time of Policy update) is the Deputy Chief Pharmacist (subject to review) supported by the Medicines Safety Lead Pharmacist. The implementation of a medicines safety group mentioned above was another action resulting from this alert.

The Pharmacy Team work together with the Quality & Safety Team as part of the MSG to help provide assurance of the Trust meeting its obligations of this medicines safety PSA.

- **Antimicrobial Stewardship:** In August 2015, Health Education England, NHS England and Public Health England jointly issued a PSA to highlight the threat and challenge of global antimicrobial resistance, largely driven by inappropriate antimicrobial use.

  Implementation of this alert required NHS Trusts to engage directors with leadership responsibility for infection prevention and control; in LPFT, the Director of Nursing holds this position, with the Chief Pharmacist supporting the antimicrobial stewardship (AMS) agenda and it being a standing agenda item at the DTC.

  Although a specific AMS group within LPFT was not initiated, AMS is delivered by implementation of the Start Smart Then Focus campaign and material across the Trust, audited on a regular basis and by LPFT IP&C and Pharmacy Team members being core members of the Lincolnshire wide AMS Network.

4. Definitions & Abbreviations

4.1 Definitions

Throughout this policy, certain specialist titles describe healthcare staff who have defined responsibilities regarding the management of medicines. Only staff with contracts (or honorary contracts) of employment to work in LPFT are recognised as having any involvement with medicines.

4.1.1 Medical Practitioner

A doctor of medicine, excluding medical students.

4.1.2 Practitioner

A health care professional who is a member of a recognised registered organisation.

4.1.3 Appointed Practitioner in Charge

The senior practitioner appointed in charge of a ward, unit or team.

In situations where the person in charge is NOT from a health care professional background appropriate to take such responsibility (e.g. a community team co-ordinator with a social work background) a nurse practitioner member of the team must undertake the role of Appointed Practitioner in Charge.

4.1.4 Assigned Practitioner in Charge

The practitioner on duty for the ward or community team who has been rostered as the health care professional in charge for that shift.

4.1.5 Designated Practitioner

Any practitioner identified by the Appointed Practitioner in Charge as competent and appropriate to perform a specific function. The designation as such has been communicated to and accepted by the Designated Practitioner. If the practitioner is based in the community they are referred to as 'Designated Community Practitioner.'

4.1.6 Pharmacist

A registered member of the General Pharmaceutical Council (GPhC).

4.1.7 Authorised Pharmacy staff

Pharmacy staff that have been authorised by the Chief Pharmacist as competent and appropriate to perform a specific function.

4.1.8 Authorised Employee

A member of staff who has following training, assessment and demonstration of competence has been authorised by LPFT to undertake specific duties in relation to medicines.

4.1.9 Medicine

Within the text the term "medicine" is used not only to include substances controlled by the Medicines Act 1968 and the Misuse of Drugs Act 1971, but also those other substances where similar control is necessary e.g. disinfectants, reagents, dressings etc.

4.1.10 Self Administration/Patients Own Drugs (SAM/POD)

A local procedure, approved by Mental Health Pharmacy Services, which enables the use of patient's own drugs brought into a ward or unit and the ability of the service users to administer their own medicines whilst in hospital.

4.2 Abbreviations

Accepted Standard Abbreviations

Routes of Administration	Abbreviation
Subcutaneous	s.c.
Intramuscular	i.m.
Intravenous	i.v.
Sublingual	s.l.

Oral	o or po
Rectal	p.r.
Vaginal	p.v.
Nasogastric	NG
All other routes should be expressed in full	

Frequency and other directions

Directions	**Abbreviations**
Once a day	o.d. (omni die)
Twice a day	b.d. (bis die)
Three times a day	t.d.s (ter die sumendus)
Four times a day	q.d.s (quarter die sumendus)
At bedtime	o.n. (omni nocte)
In the morning	o.m. (omni mane)
Alternate days	alt.die. (alter die)
Immediately	stat (statim)
Before food	a.c. (ante cibum)
After food	p.c. (post cibum)
When required	p.r.n The minimum dose interval, maximum daily dose where appropriate and the indication must be specified.

Weights and Measures

Measurement	**Abbreviation**	**Comment**
Kilogram	kg	
Gram	g	
Milligram	mg	
Microgram	Microgram	No abbreviation
Nanogram	Nanogram	No abbreviation

Unit or Units	Unit or Units	Should **NEVER** be abbreviated as “u”, “iu” or “ui” due to potential harm from misinterpretation.
Litre	L	
Millilitre	ml or mL	
Millimole	mmol	
Kilocalorie	Kcal	
All weights must be expressed in units greater than one e.g. 750mg **NOT** 0.75g		
Commas must not be used to divide numbers into groups of three; instead a space must be left after every third digit e.g. 1 000 000 NOT 1,000,000		
If a value is less than one, a zero should precede the decimal sign e.g. 0.12 **NOT** .12		

Glossary of terms and List of abbreviations:

BNF	**British National Formulary**
CCG	**Clinical Commissioning Group**
CD	**Controlled Drug**
Co-Op	**The Co-Operative Pharmacy Group (Lincolnshire)**
CPA	**Care Programme Approach**
CPN	**Community Psychiatric Nurse**
CRHT	**Crisis Resolution Home Treatment**
ePMA	**Electronic Prescribing and Medicines Administration**
EDC	**Emergency Drug Cupboard**
FP10 or FP10(HP)	**A prescription that can be written by a prescriber and dispensed at a community pharmacy.**
GMC	**General Medical Council**
GPhC	**General Pharmaceutical Council**
HCSW	**Healthcare Support Worker**
LPFT	**Lincolnshire Partnership NHS Foundation Trust**
MAJAX	**Major Accident or disaster**
MMP	**Medicine Management Policy**
NICE	**National Institute for Clinical Excellence**
NHSLA	**National Health Service Litigation Authority**
NPSA	**National Patient Safety Agency**
NMC	**Nurse and Midwifery Council**
NPD	**Near Patient Dispensing**
OOH	**Out Of Hours**
PODs	**Patients Own Drugs**
PGD	**Patient Group Direction**

PMA	**Patients Medicines on Admission**
PSD	**Patient Specific Direction**
rINN	**recommended International Non-proprietary Name**
SAM/POD	**Self Administration of Medicines – Use of Patients Own Drugs**
SCR	**Summary Care Record**
SOP	**Standard Operating Procedure**
ULHT	**United Lincolnshire Hospitals NHS Trust**

5. Ordering of medicines

5.1 Controlled Drugs

The ordering, recording, administration and security of Controlled Drugs (CDs) are described in the Trust's Controlled Drugs Policy (**Appendix 3**).

5.2 Unit stock (Inpatient and Community)

Ordering of stock medication varies from site to site and ward to ward, but is achieved by one of the following methods:

- Top-up service provided by the pharmacy to an agreed stock list agreed by the Appointed Practitioner in Charge of the ward and pharmacy staff.
- A sequentially numbered requisition form signed by the Designated Practitioner of the unit (referred to as a yellow requisition). A faxed copy is acceptable and the original must remain on the unit.

5.3 Individually Dispensed Medicines

These medicines are supplied for an individual service user against a doctor's prescription. In normal circumstances a 14 - 28 day supply of medicines will be dispensed, unless clinical risk assessment dictates smaller supply in line with clinical needs and the National Suicide Prevention Strategy.

5.3.1 It is important that the service user receives adequate information about their medicines PRIOR to discharge. The service user should know the purpose of the medicine, how to take it and for how long it is to be taken.

5.3.2 This is a shared responsibility of the Medic, Designated Practitioner and Authorised Pharmacy staff. It is the responsibility of the Designated Practitioner who discharges the service user to ensure that the service user has received adequate information about their medicines.

5.3.3 Wherever possible a manufacturer's 'patient information leaflet' should be supplied with the medicines along with any other relevant literature referring to the medicines being taken.

5.4 Controlled Stationery

All stationery used for ordering medicines is potentially liable to misuse and is designated as "controlled stationery". It includes pharmacy requisition books, controlled drug order books and registers and FP10 prescription forms. All controlled stationery must be sequentially numbered and kept under secure conditions. Issued in accordance to procedure and issues recorded.

5.4.1 Prescription charts:

- ALL prescription charts are held in a centralised storage point.
- Blank prescription charts must be kept under secure conditions and only be accessed by qualified nursing, medical or pharmacy staff at the point of need.
- Prescription charts in use must be stored in a clinic room when not being used to administer or review medication.
- The completion and use of the prescription chart must be in line with the prescription writing standard guidelines.

5.4.2 FP10HPs:

- ALL FP10HPs are supplied to prescribers by the Pharmacy team.

5.5 Retention Requirements for Records (Standing Financial Instructions 2013)

Completed CD registers and CD requisition books must be stored by the ward, unit or team for at least SEVEN YEARS following the date of the last entry. In the event of a ward closure the CD records should be held by the LPFT Pharmacy department.

- All prescription charts must be retained in the patient's medical notes.
- Outpatient prescriptions must be retained in Pharmacy for 2 years.

5.6 Obtaining Medicines when the Pharmacy is closed

Refer to "Access to Medicines & Supply Out of Hours" (MRSOP15). If any medication is required out of hours then these methods of obtaining medication should be followed.

5.6.1 Emergency Medicine Cupboards

Emergency medicine cupboards are available at PHC, the Wolds (Discovery house), Langworth ward (Witham court), Rochford unit (Boston Hospital) and Manthorpe unit (Grantham hospital).

Emergency medicine cupboards are available, via the duty senior nurse and the emergency cupboard access procedure, and contain an agreed list of medicines. Access to these medicine cupboards is restricted. The cupboards are to be used when medicines are required in urgent situations. If any medicine is taken, the complete container should be removed and the record completed. For more information please refer to the above SOP.

5.6.2 On call pharmacist:

All the above emergency arrangement procedures should be exhausted before contacting the on-call pharmacist. The on-call pharmacist is available for advice and will provide medication if deemed an emergency. For more information please refer to the "accessing medication out of hours" procedure, MRSOP15.

5.6.3 Borrowing medicines from other wards:

Borrowing is strongly discouraged but in some circumstances this may be necessary to avoid detriment to the service user. If the above steps have been followed and there is still no available source of medication then borrowing from another LPFT ward/unit

may be considered. The borrowing procedure is site specific but the following guidelines must be adhered to:

- Medicines must NOT be borrowed during normal working hours unless a supply cannot be obtained from the pharmacy department and they advise an alternative supplier.
- Transfer of Controlled Drugs from one service to another is discouraged unless a delay in treatment poses a risk to the patient – this risk should be agreed by the clinicians looking after the patient at that time, and documented in the patient's notes. The necessary CD records and register entries must be made in the Controlled Drug Registers of the ward supplying and receiving the drugs and must involve at least two qualified nurses. The ward pharmacist must be informed of any transfer on the next working day so they can check and confirm the correct register entry was made.
- For other medicines, the complete container should be transferred. **Medicines should never be decanted from one container to another.**
- Only ward stock items may be borrowed NOT individually labelled medicines (patient-named medicines) unless the patient is transferring to another ward – in which case all his/her medicines need to be transferred with him/her.
- Details of any borrowing must be recorded in the ward/unit pharmacy communication book.

5.6.4 Nurse dispensing

The NMC additional standards for medication management 2007 state; the definition of dispensing is "To label from stock and supply a clinically appropriate medicine to a patient, client or carer, usually against a written prescription, for self-administration or administration by another professional, and to advise on safe and effective use". (MHRA, 2006)

Dispensing includes such activities as checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient.

If under exceptional circumstances you, as a registrant, you are engaged in dispensing, this represents an extension to your professional practice. There is no legal barrier to this practice. However, this must be in the course of a particular service and only if approved by the DTC and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure (SOP). In a dispensing doctor's practice, registrants may supply to patients under a particular doctor's care, when acting under the directions of a doctor from that practice. The patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.

Currently there are no services that practice Nurse dispensing in LPFT.

6. Dispensing

6.1 Methods of Dispensing

Service Users may be in possession of medication by one of the following methods:

- Their own personal medication identified and accepted as suitable for continued use. (refer to the appropriate procedure for assessing patients' own medication) These can either be PODs from external sources and Individual Patient (IP) named supplies from contracted supplier.

The supply must be recorded on the prescription form and be signed by the authorised Practitioner and an authorised and competent witness.

- Dispensed by Pharmacy upon receipt of a prescription according to their Dispensing Policies and Procedures.

6.2 Dispensing Without a Prescription

Supplying pharmacies will not dispense medicines for individual service users without a prescription except in a critical emergency. An example of a critical emergency situation would be:

- A MAJAX (A Major Accident or disaster).
- A prescriber cannot leave a patient.
- No other prescriber is available to write a prescription and the clinical condition requires this.
- Wherever possible, full use should be made of facsimile machines, emails and other hard copy means of communication methods to communicate prescribers' intentions (except for controlled drugs). Verbal orders are discouraged and are not accepted as good practice (NMC standards for medicines management 2007 section 3).

Inconvenience to a prescriber would **never** constitute a critical emergency. Prescribing of the drug must be confirmed in writing as soon as possible (immediately after the emergency), with a clear indication that it is a retrospective order.

6.3 Outpatient prescribing and use of FP10HP prescriptions

Prescribers of LPFT may need from time to time to prescribe medicines for a person who is not resident on a hospital ward and treated in community where hospital pharmacy supply is not appropriate. For such situations prescribers will be issued with FP10 prescription pads to facilitate direct provision of medicines from a community pharmacy.

Please refer to FP10 Policy & Procedures (**Appendix 1**).

6.3.1 When LPFT prescribers should use their FP10 prescription pads

Secondary care prescribers should initiate prescribing using their prescription pads:

- Where the need for the mental health medicine is urgent.

- Where there are complicated psychiatric or social problems that would either benefit from close control of prescribed medicines by the psychiatrist or concordance is likely to be jeopardised or access to a GP is problematic.
- The level of medical risk indicates that prescribing responsibility should be initiated and retained by the consultant.
- Where management is under shared care guidelines that have been agreed (using appropriate consultation) for that particular medicine.

6.3.2 When LPFT prescribers should not use their FP10 prescription pads

Secondary care prescribers should refer back to the service user's GP for prescribing:

- Following most routine consultations.
- Where there is no immediate urgency for medication to be initiated.
- For prescription of commonly used medicines and where no unusual circumstances exist.
- Following initiation by consultant after the service user is considered to have either adequately stabilised or the medical social or psychiatric problems requiring the initial prescription have been overcome or there is no particular convenience to the service user.

6.3.3 The length of time a LPFT prescriber should continue to prescribe for a patient using an FP10

- For urgent use the prescription should be only for 1 to 4 weeks to allow arrangements to be made with the service user's GP.
- For longer term use the prescriber should only issue a prescription for one month's supply at a time.
- For the minority of service users who require secondary care prescribing, it would be very rare to continue to prescribe for longer than six months.
- For most medicines with shared care agreements the expectation is for the secondary care prescriber to refer the service user back to his or her GP after 3 months.

6.3.4 Standards of communication

It is proposed that the following standards should apply:

- In all cases the letter to the GP should be sent out to the GP in sufficient time to ensure continuation of supply.
- Where the patient's GP is asked to prescribe, the non-urgent nature of routine prescriptions should be explained to the service user.
- The letter should specifically state if new medicine is to replace a current medicine or be added on to current treatment.
- GP letters will be audited to ensure compliance with the standard.

6.3.5 Choice of Medicine

- Prescribers should prescribe using FP10s in line with appropriate LPFT guidance or the Lincolnshire formulary (add link). This is to be monitored and the Trust to take action where this standard is not met.
- Any fraudulent use of prescriptions e.g. for self-prescribing or anyone who is not a registered patient of the Trust will be subject to the Trust disciplinary policy.

6.3.6 Shared Care

For some medicines there is the expectation that the secondary care prescriber will initiate and stabilise treatment prior to transfer of prescribing responsibility back to the GP. The secondary care prescriber and the GP will agree to share the responsibility for treatment and Shared Care Guidelines will be drawn up after consultation across primary and secondary care. Please refer to shared care section on Sharon.

6.3.7 Security

It is the responsibility of the consultant/prescriber to ensure that the FP10HP pad allocated to them is kept in a locked and secure environment at all times when not in use.

In the event of an FP10HP prescription or pad going missing or being stolen, follow the relevant guidance in the FP10HP Policy & Procedures (**Appendix 1**).

In the first instance, complete a Datix report and contact the Trusts Chief Pharmacist and the relevant line manager to inform them of the incident, include all the missing or stolen pads 11 digit unique identifier number, consultant, service speciality, and last known whereabouts of the pad.

6.3.8 Guidelines for Medication Administration for Out of Area Patients

Occasionally LPFT patients who have moved out of area may need medication both supplying and administering. There may also be patients who are not known to LPFT services that require medication whilst they are residing within Lincolnshire.

The pathways for dealing with both of these circumstances can be found in **Appendix 7**.

7. Distribution

7.1 Security in Transit

All medicines will be transported in sealed containers using a variety of systems which are site specific. All such consignments from provider pharmacies should contain a delivery note describing the contents. Medicines must be checked against this note upon receipt and any discrepancy reported to the relevant pharmacy at once. Once checked, the medicines should be locked in the medicine cupboards without delay.

Managers of staff approved to transport medicines must train their staff to ensure understanding of the need for security, and the arrangements made must be approved by the Chief Pharmacist. A clear audit trail must exist between pharmacies and their users. In particular, the following must apply:

- The responsibility for the maintenance of security during transportation rests with the individual carrying out the task.
- Transit containers must be locked or sealed and supervised at all times unless being temporarily stored in a secure area away from public access. At no time should they be left unattended in corridors or departments.
- Containers must be collected from and delivered to authorised points or personnel only.

- Any suspicion of damage or discrepancy must be reported immediately to the relevant pharmacy.

7.2 Extra restrictions applied to Controlled Drugs.

7.2.1 Delivery will be carried out by:

- Service provider transport service.
- Pharmacy Staff with granted authorisation to transport CDs.
- Authorised taxi firms used by LPFT for medicines transport.

7.2.2 Receipt of Controlled Drugs

Controlled drugs must be given personally by the person transporting the medicine to a member of staff authorised to hold the appropriate Controlled Drug key. On receipt, they should be checked and signed for on the official requisition. If a box/bottle is sealed, either by the manufacturer or the pharmacy the contents need not be checked until the time comes to use that container. An entry must be made in the Controlled Drugs Register and checked by a second person at the time of receipt to account for the stock received. Delivery notes and copy of home office order form (if for stock) MUST be signed by two appropriate and authorised staff.

7.3 Security between Unit/team base and Pharmacy

The same arrangements as in 7.1 apply in reverse.

8. Storage and Security of Medicines

8.1 Responsibility

The Appointed Practitioner in Charge is responsible at all times for all medicines stored in the ward. Accountability remains with the Assigned Practitioner in Charge even if they decide to delegate the responsibility.

8.2 Containers

All medicines must be stored in their original containers. They should not be transferred from one container to another. Loose blister strips of tablets do NOT represent an original container.

8.3 Storage Locations

Storage should be sited in a locked room or in a position to allow surveillance and maximum security against unauthorised entry. All medicines, with the exception of medicines for emergency use, large volume sterile fluids and wound care products, must be stored in wards and departments within lockable cupboards which comply with the current British Standards for medicines storage (BS2881), at a temperature not exceeding 25°C. For Controlled drugs, The Misuse of Drugs (Safe Custody) Regulations 2007 apply. The table below details the storage facilities required by each ward or unit.

TYPE OF STORAGE	PURPOSE	COMMENTS
Controlled Drugs Cupboard	Schedule 2 and 3 Controlled Drugs and other specified medicines	Specification complies with the Misuse of Drugs (Safe Custody) Regulations 2007
Medicine Cupboard for Internal Medicines	All other medicines except those with specific storage requirements	Specification complies with British Standard BS2881
Medicine Trolley	Medicines in current use	When not in use it must be locked and secured to a fixed anchor point
Cupboard for External Medicines	Creams, ointments, lotions and related products, blood glucose monitoring reagents	Lockable cupboard
Medicines Refrigerator	For all medicines requiring storage at temperature range of 2°-8°C	Lockable. Temperature monitored and recorded daily and fridge defrosted monthly. Not to be used for storage of food or pathological specimens. In event of failure seek Pharmacy advice before using any products.
Bedside Lockable Medicine Cabinets	POD's and individual dispensed internal and external medicines in current use including Controlled Drugs	See local SAM/POD procedures. Insulin may be stored and used for up to one month in the cabinets. Remember to put 'Do not use after date', from when first put into bedside locker.
Large volume Sterile Fluids	Large volume intravenous and topical fluids	Need not be stored in a locked area, depending on local circumstances
Cupboard for Flammable Products	Significant quantities of flammable products	Purpose built metal fire retardant cupboard
Resuscitation Trolley	Agreed range of drugs for clinical emergencies consistent with local guidelines	Sealed with a tamper evident seal and labelled with an expiry date of the product with the earliest expiry.

8.4 Custody and Safe Keeping of Medicine Keys (Inpatient areas)

Refer to MRSOP14.

The Ward Manager or CMHT Lead (Registered Nurse) is responsible for the security, audit, and implementation of this SOP.

Keys should be kept on the person of the Assigned Practitioner in Charge of the ward, or Designated Practitioner nominated by them. Nurses accepting accountability for the

medicine keys must sign the appropriate key log/record acknowledging their responsibility.

8.4.1 Custody and safe keeping of medicine keys in community teams

Medicine keys should be kept locked in a separate key box which is attached to a permanent fixture in a safe location within the team base. Access to the key box is to be restricted to registered nurses only. The key box can be locked with either a key/lock system or a combination locking device as long as the combination lock is an integral part of the key cupboard and the combination is changed on a regular basis and a record kept of the person changing the number for maintaining confidentiality and audit trail.

The key box should contain a tracer card to show when and who has taken the medicine keys out for use, and a list of nurse signatories showing who has been allocated a key to access the medicine keys.

The person responsible for the security of the medicine keys should check periodically that the security of the keys is not compromised in any way.

8.4.2 Duplicate sets of medicine keys

A spare set of ALL medicine cupboard keys will be kept in a secure key cabinet accessed only by the senior nurse on duty at the following sites in case of duplicate being required by a ward/unit/community team.

A key tracer card/record log must be completed as to which sets of keys have been borrowed, when and by whom, and the date returned, and signed by the borrowing nurse and senior duty nurse.

Duplicate sets of keys MUST be authorized only by the Chief Pharmacist LPFT and a record of all duplicate sets of keys kept by appropriate unit manager or team leader.

Each area may implement their own variation of the above SOP to enable safe and secure management of keys and medication, if required with approval of the DTC.

8.5 Procedure if Drug Keys are Lost

See MRSOP14.

Every effort must be made to find the keys or retrieve them from off duty staff as a matter of urgency. If unsuccessful, the appropriate Manager during normal office hours or Senior Manager 'on-call' at all other times and the Pharmacy Manager (as defined in section 3.3) must be informed. It will be the responsibility of the ward manager or team co-ordinator to apply the provisions of the Trust's policy for reporting Untoward Incidents, Accidents and Near Misses.

8.6 Stock Balances

8.6.1 Controlled Drugs (see CD policy for more details – Appendix 3)

The stock balance of all controlled drugs entered in the register must be checked and recorded at least once a day by two authorised members of staff, one of whom must be a qualified nurse authorised to hold the drug keys. The check must validate the stock balance held. Pharmacy will audit monthly with the ward/team manager.

8.6.2 All Other Drugs

For wards and services on a “top-up” system, stocks will be checked on a regular basis by a member of the pharmacy department. For all other areas stocks will be reviewed as part of a 3-monthly review cycle carried out by LPFT pharmacy staff.

8.6.3 Losses and Discrepancies

Where there is evidence of discrepancies, the Appointed Practitioner in Charge must carry out an immediate investigation. It is the ward manager or team co-ordinators responsibility to inform the ward pharmacy team and initiate a further investigation. If there is no resolution, the Team leader during normal office hours or the Senior Manager ‘on call’ during all other times and the chief pharmacist must be informed of any loss or unexplained discrepancy.

The provisions of the Trust’s policy relating to untoward incidents, accidents and near misses apply. During the investigation it may necessitate the police being informed during or towards the end of any investigation.

8.7 Return of Medicines No Longer Required

Any medication no longer required, expired, change in regime, over supply, Patient’s Own, etc. must be disposed of as per MRSOP13.

8.7.1 Controlled Drugs:

Refer to the Controlled Drugs Policy for details on how to dispose of a Controlled Drug. Substances that are believed to be Illicit should be handed over to the police (see CD policy for more details).

8.7.2 Other Medicines:

Unwanted stock will be removed from the ward or team by Pharmacy staff.

Returns/disposal of medication will be documented using the trust approved paperwork (if appropriate).

8.7.3 Patient’s Own Medication:

Refer to the Patient’s Own Drugs SOP (MRSOP07) for the disposal of Patient’s Own Drugs (POD’s).

Disposal of unwanted Patient’s Own Drugs (POD’s) may be done if permission is obtained from the individual who is prescribed the medication.

The appropriate confirmation documentation (PAT/RET) forms need completing ensuring a full list of medication and destination of that medication (use, returned to service user, destroyed) is noted and the service users signature.

If permission is NOT given the drugs must be stored separately and removed from the site to the service user’s residence at the earliest opportunity.

8.8 Ward and Service Closures

8.8.1 Temporary Closure (7 days or less i.e. bank holidays and weekends)

Medicines including CDs may be left in the locked CD cupboard but only if security is to the satisfaction of the nurse-in-charge and the locality Pharmacist.

8.8.2 Long-term Inpatient or Community Closure (over 7 days)

The ward pharmacist or pharmacy technician should be contacted to arrange secure transit of medicines to either another ward for storage or back to the dispensing Pharmacy. An appropriate decision will be jointly made with authorisation by the Chief Pharmacist.

9. Prescribing

9.1 Authority to Prescribe

Normally, only a registered medical practitioner has the authority to complete a written prescription and to prescribe medication for Service Users except where the Trust has agreed to allow non-medical prescribing (independent or extended prescribing) and/or supplementary prescribing by non-medical healthcare professionals e.g. nurse or pharmacist. Such agreement will be subject to the Drug & Therapeutics Committee (DTC) satisfying them that the appropriate training and supportive guidance is in place for staff involved in such activities.

Only medicines that are licensed in the UK may be prescribed, and only at doses listed in the British National Formulary (BNF) Occasionally a consultant may wish to use a medicine at a dose not listed in the BNF, or for an indication not covered by the terms of its UK licence, or use a medicine with no UK licence. In such cases the consultant MUST first complete an unlicensed medicine request form (**Appendix 9**) by completing this form the consultant accepts responsibility for all outcomes resulting from this use of the medicine.

Pharmacy will NOT supply an unlicensed medicine, or a medicine being used outside the terms of its UK licence, or a medicine outside of BNF dosing recommendations unless the unlicensed medicines request form has first been completed.

Where prescribing occurs outside of a UK licence of BNF dose limits, this will be highlighted to the relevant consultant (**Appendix 9**).

There must be a system in place whereby the supplying Pharmacy has access to specimen signatures of all prescribers to be able to verify the authenticity of prescriptions.

A doctor holding limited or provisional registration must not prescribe for any persons, except for those service users they are responsible for in the course of employment in relation to which limited registration is granted. They may prescribe drugs on forms FP10 (HP) and FP10 (FP[ad]) only when specifically required to do so by their employing authority in the course of the employment in relation to which limited registration is granted. (GMC Limited Registration of Sponsored Doctors for Pre-arranged Employment Para 18). Medical students are not permitted to prescribe.

The use of Non-medical prescribers within the Trust has been authorised subject to stipulated criteria as laid out in the Non-Medical Prescribers Policy (**Appendix 5**).

Prescribing practice

- Independent prescribing means that the prescriber takes responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as responsibility for prescribing where necessary and the appropriateness of the prescription.
- All prescribers must only ever prescribe within their own level of experience and competence.
- All prescribers remain accountable for their own practice and subject to their individual professional code of conduct, standards and ethics.
- Before issuing a prescription the prescriber must carry out a holistic assessment of the patient including whether it is appropriate to issue a prescription or refer the patient to another health professional.
- Prescribing should be informed by evidenced based practice, local and national guidelines and formularies. Prescribing decisions should be made in reference to local policy; PACEF guidance and the Lincolnshire joint formulary.
- Remote prescribing is not encouraged. Prescribing decisions should be informed by access to the patient's medical records, a clear understanding and prior knowledge of the patient's medical condition, history and current medication.

Repeat prescribing

- Prescriber's may issue repeat prescriptions however they should recognise that as signatory they are responsible and accountable for their practice.
- Before undertaking to sign a repeat prescription the prescriber has a responsibility to ensure that it is safe and appropriate to do so.

Unlicensed Medicines / off label prescribing – see Appendix 9 for guidelines

- Unlicensed medicines refer to a product that does not hold a UK marketing authorisation (product licence).
- Off label prescribing is where medicines are prescribed outside of their licensed indications.
- Consideration should be given to any obvious licensed medicines available to meet the patient's need, there should be sufficient evidence base to support the prescribing and the Prescriber takes responsibility for any prescription that is unlicensed or off license use. Documenting the rationale clearly for the medicinal product choice.

9.2 Prescribing Procedure - Initial Prescription(s)

Refer to MRSOP11. The prescriber **MUST** make sure that he/she is aware of the service users full clinical and medication history. This would normally require access to:

- All of the service user's prescription charts.
- Service users own medicines.
- Information supplied from other sources about the service users medication history.

9.3 Drug sensitivities/ allergies box.

These must include any known drug/food/chemical/dressing hypersensitivity, and any information which may affect medicine selection or dosage e.g. previous gastro-

intestinal bleed with non-steroidal anti-inflammatory drugs. This must clearly be recorded on the service user RiO notes/EPR.

The prescriber MUST sign and date the drug sensitivities/allergies box. Any authorised health care professional may add to this if an allergy or sensitivity is subsequently encountered. Each entry must be signed and dated.

The dispensing pharmacy may refuse to dispense any medication unless this section is completed or a 'none known' indication is made.

9.4 Prescribing Controlled Drugs

Refer to CD policy in **Appendix 3** and relevant SOP - CDSOP01.

Monitoring Prescribing and effectiveness

- Each Prescriber is responsible for their individual practice and is required to provide evidence of this within their annual appraisal review.
- The Prescriber must carry out regular reviews of their prescribing practice to ensure efficacy of ongoing prescribing.
- ePACT data (prescribing data available on line from the NHSBSA) can be requested via the LPFT pharmacy department who accesses and monitors all FP10HP prescribing for the trust.

Documentation and record keeping

- All Prescriber's are required to keep contemporaneous records, which meet the trust standards on record keeping.
- A log of all FP10 scripts used must be maintained and returned to the LPFT pharmacy office when log is complete (See **Appendix 1**).

Adverse reaction reporting

- If a patient becomes aware of a severe or unexpected reaction to a prescribed medication the Prescriber should complete the Adverse Drug Reaction (ADR) reporting form or 'yellow card scheme'.
- The ADR must also be documented on the patient's electronic notes, any prescription charts, and the GP informed.

Informing patients

- Professionals must ensure that patients are aware they are being treated by a Prescriber and the scope and limitations of their prescribing.
- If the patient is being cared for under a clinical management plan then the patient should be involved in the review of the plan.

9.5 Verbal Orders – Emergency Use ONLY.

In areas where EPMA has been implemented this process will no longer be applicable.

Instruction by telephone to administer a previously un-prescribed medicine will not be accepted. In exceptional circumstances however, where the medication has been previously prescribed and the prescriber is unable to issue a new prescription, but

where changes to the dose are considered necessary a verbal order may be accepted by the nurse in-charge of the ward. He/she must be satisfied that the doctor's presence is unnecessary or their absence is unavoidable and the verbal message is essential**.** If possible the use of information technology (such as fax or e-mail) is the preferred method to make amendments to the prescription chart. The following procedure must always be carried out when accepting a verbal order:

- If the doctor can document the instruction in RiO remotely, he or she must do this. If this isn't possible the nurse taking the verbal order must make a clear documentation in RiO.
- Write the prescription in capital letters in the "once only" section of the prescription chart.
- The verbal order details must contain the name of the service user, the name and form of the medicine, the dose, the route of administration, the date and time of the order and the name of the prescriber and the reason for the dose change (the medicine must have been previously prescribed).
- Repeat the verbal order to the prescriber to confirm that it is correct, if in any doubt spell the name of the medicine and ask the prescriber to confirm.
- Where possible have the instruction repeated by the doctor to a second Practitioner.
- Sign the verbal order (nurse) and annotate "**verbal order**".
- Require the prescriber to sign the verbal prescription as soon as possible, preferably within twenty-four hours.
- Verbal orders **CANNOT** be given for any scheduled CD.

'Nurses have the right to refuse to act on a verbal order made by a medical officer'
(Ref: NMC standards for medicines management 2007).

10. Administration

Refer to MRSOP09 for how to administer medicines procedures.

10.1 Responsibility

The Appointed Practitioner in Charge in accordance with these guidelines will set the standards for medicine administration in their service.

10.2 Authority to Administer

Medicines may only be administered by:

- A medical practitioner.
- Designated practitioner.
- Authorised pharmacy staff.
- A practitioner in training but only under the direct supervision of a designated practitioner. The designated practitioner remains responsible for ensuring that the correct procedure takes place.
- An HCSW can give the dispensed medicines under delegation by a registered nurse.
- Other authorised employees.

Registered Nurses can delegate these clinical activities to HCSWs on the following basis:

- You must establish that anyone you delegate to is able to carry out your instructions.
- You must confirm that the outcome of any delegated task meets required standards.
- You must make sure that everyone you are responsible for is supervised and supported.

Appropriate delegation means:

- The task is necessary and delegation is in the patient's best interest.
- The HCSW understands the task and how it is to be performed.
- The HCSW has the skills and abilities to perform the task competently.
- The HCSW accepts the responsibility to perform the task competently.
- The Registered Nurse accepts the responsibility for the delegation.

No member of staff must dispense a medicine, check or witness the administration of a medicine, take part in the process of administering a medicine, unless they have a documented and demonstrable level of competence for the task. Assessments of competence will be regularly reviewed by the Appointed Practitioner in charge.

All clinical areas will be able to access the eBNF. Please ask LPFT pharmacy for more information.

10.2.1 Children

A medical practitioner or registered nurse must always accept responsibility for the administration of medicines to children. All aspects of administration must be checked by two practitioners, though it is not necessary to witness the application of topical medicines.

10.2.2 Adults

In most situations administration may be undertaken by one qualified practitioner. Some medicine administrations can require complex calculations to ensure the correct volume or quantity of medication is given. To minimise the risk of error, the following situations require a qualified practitioner and an authorised competent witness to check all aspects of administration:

- Calculation and administration of a weight related dose, where the dose is actually prescribed as e.g. mg/kg body weight or mg/m^2 body surface area.
- Where administration involves an unusual dose needing written calculation e.g. giving 6.7 ml of a 30mg/5ml mixture for a 40mg dose. The calculation method must be recorded near the prescription on the prescription chart and be signed by the two persons involved. Anyone administering subsequent doses should also check the calculation as a matter of course although the administration may be carried out by one person.
- All Controlled Drugs.

Medicines dispensed as ward stock or for individual patients MUST NOT be used to treat staff.

10.3 Self Medication

Self-medication is available to patients subject to approval by the Multidisciplinary Team following a risk assessment, and following approved Trust guidelines and procedures (refer to self-administration of medicines MRSOP08. The service user must be assessed for suitability for self-administration - this assessment will be ongoing for the duration of the service users stay.

10.4 Use of Patient's own drugs (POD's)

Patient's Own Drugs (POD's) may be used once they have been assessed for use by a suitably qualified person (i.e. pharmacist, pharmacy technician, authorised senior nurse who has undergone additional training) and assuming that the medical practitioner authorises and prescribes the continued use of them. Please refer MRSOP07.

All service users who are admitted should be encouraged to bring their medicines into the ward/unit. If a service user fails to or is unable to bring in their own medication either relatives or a carer should be asked to bring them in at the earliest opportunity.

The advantages of having access to POD's are:

- The exact nature of the prescription can be clarified.
- Compliance can be assessed.
- If the medicines are changed during admission obsolete medicines do not remain in the service user's home.
- The medicines can be used whilst the service user is on the ward.

All medicines brought in to the ward/unit by the service user, relative or carer remains the property of the service user. Therefore they should NOT be used or destroyed without the consent of the service user.

10.5 Administration by Parents and Carers

In certain circumstances parents or carers may be allowed to administer medicines (subject to service user consent) as part of the agreed treatment and care plan and following appropriate education and training provided by nursing staff. This will be at the discretion of the Assigned Practitioner in Charge. The nurse is still responsible for exercising adequate supervision to ensure that medicines are administered and stored as described in these guidelines. On units where this is applicable specific SOPs will be required and approved by the DTC.

10.5.1 Administration by health care support workers

A healthcare support worker is able to administer medicines as part of an agreed treatment and care plan and following appropriate education and training provided by nursing staff. This practice is at the discretion of the registered nurse who delegates the function to the HCSW. The responsibility for the delegation remains with the registered nurse and the HCSW is responsible for their acceptance of the competence to complete the task. On units/teams where this is applicable specific SOPs will be required and approved by the DTC.

10.6 Administration by Nursing Associates

Refer to guidelines in **Appendix 8**.

10.7 Compliance Aids

Non-compliance with medicines is a major cause of relapse and admission to hospital. There are many factors which can lead to non-compliance with medicines. These include:

- A poor understanding of the need for the medicines.
- A poor understanding of how to take the medicines.
- Forgetfulness.
- Inability to open the containers provided.
- Poor eye sight.
- A complicated regime of medicines.

For some people a compliance aid may assist a person to continue self-administering and remain out of hospital. However providing medicines in a compliance aid may not resolve the non-compliance problems.

Compliance aids may be used in a ward setting to assist the self-administration of medicines as part of a formal assessment of ability or establishment of a correct medicine taking routine prior to discharge.

Refer to compliance aid MRSOP06.

Compliance aids may be used in a community setting to assist service users to administer their own medicines and/or facilitate compliance monitoring.

10.7.1 BEFORE there is any agreement to provide medicines in a compliance aid, a full assessment of the reason for non-compliance should take place. It may be that the provision of a compliance aid may not be of benefit and some medicines are not suitable for compliance aids due to their stability.

10.7.2 Compliance aids vary but most require to be replenished on a weekly basis. Before compliance aids are issued and the service user trained to use them arrangements must be made for their regular replenishment whilst under Trust care and on discharge through community pharmacies.

11. Community Psychiatric Nurses (CPNs)

Each Community Psychiatric Nurse must carry an official Trust identity card and authorisation to carry medications. They must also be aware of the security and safety issues surrounding the transportation and administration of medicines as staff on inpatient wards. Please refer to MRSOP10.

12. Administration by Patient Group Directions (PGDs)

Refer to PGD Policy Appendix 6.

12.1 The Crown Report (HSC 1998/051) and (HSC 2000/026) allow for the supply and administration of medicines to groups of service users who may not be individually identified before presentation for treatment.

A Patient Group Direction is a specific written instruction for the supply or administration of named medicines in an identified clinical situation where this offers an advantage for individual care, without compromising safety. It will be drawn up locally by doctors, pharmacists and other appropriate professionals, and approved by the Trust. We retain the term 'Patient Group Direction' for such instructions for the supply of medication to service users.

Patient Group Directions allow medicines to be supplied or administered in the absence of a prescription written by a doctor for a specific service user.

The majority of clinical care however, will continue to be provided on an individual service user specific basis.

13. Untoward incidents, accidents, near misses involving medicines and drug alerts

13.1 Incident Reporting

Refer to the 'Reporting and Management of Risk Policy'.

It is the responsibility of the Trust Board to determine the mechanisms and procedures for reporting incidents relating to medicines. Any incident in relation to the prescribing, dispensing and administration of medicines must be reported via the policy relating to Untoward Incidents, Accident and Near Misses.

13.2 Handling of Medication Incidents

Refer to MRSOP05.

14. Medical Gases

All medical gases used in the Trust are licensed medicines and as such are subject to the Medicines Act and must be treated in the same way as any other medicine.

14.1.1 BEFORE a medical gas is administered to a service user, written authority from a prescriber MUST be obtained. This authority must include the name and concentration of the medical gas (where appropriate) the method of administration and the rate of flow. This can be achieved by:

- An inpatient prescription for an individual service user, normally written on the inpatient prescription chart.
- A Patient Group Direction (PGD) authorising the administration of a medical gas in an emergency.
- In cases of emergency the use of a verbal order as per section 9.8 of this policy could be used to initiate use of a medical gas.

14.2 A designated practitioner administering any medical gas to a service user MUST make a written record that treatment with the particular medical gas prescribed has been initiated on the relevant inpatient prescription chart.

14.3 Procurement, storage, supply of medical gases and other associated issues with medical gases is to be undertaken according to current Health & Safety legislation and locally agreed protocols.

15. Alternative & complimentary medications

Complimentary Therapies are therapies that may be used in conjunction with orthodox medical, nursing, and paramedical treatments to enhance the well-being, quality of life or symptomatic relief of the service user.

15.1 <u>BEFORE</u> any new alternative or complimentary medication therapy can be recognised by the Trust it must be approved by the Drug & Therapeutics Committee (DTC). Once agreed the therapy must be used within the guidance of this policy.

15.2 If a service user wishes to administer to themselves, or requests administration of, complimentary or alternative medicines they must discuss this with the doctor responsible for their care. This discussion should normally include a pharmacist and nurse looking after the service user. It will be necessary to check any drug interactions with existing medication.

This discussion should also include the mental capacity of the individual to understand any implications of using an alternative therapy opposed to conventional treatments.

15.3 If the use of alternative or complimentary medication is agreed, this should be recorded on the prescription chart.

15.4 The service user must be informed that any alternative or complimentary medication brought in by them and not supplied through the hospital pharmacy must be brought to the attention of the doctor responsible for their care.

15.5 The service user must be made aware that the Trust cannot accept responsibility for the quality or efficacy of these medications unless approved using the set process (see section 15.1 above) and this must be recorded in the medical notes.

15.6 Qualifications

A designated complimentary therapist MUST have obtained an appropriate qualification. Having obtained the qualification they must then ensure that the practice of the alternative or complimentary medicine is in line with the scope of the professional practice and code of conduct of the accreditation body for that therapy.

15.7 Competence

The interests and welfare of the service user are paramount and the designated complimentary therapist has a duty of care to ensure that their skills and knowledge are updated and that they remain competent to practice the therapy.

15.8 Consent

The service user MUST give informed consent for the practice of a specific alternative or complimentary medication therapy. The therapist must consult the multidisciplinary team involved in the service user's care before any treatment is undertaken.

15.9 Documentation

The designated complimentary therapist must document within the service user's care plan the alternative or complimentary medication therapy practiced, maintain the care plan notes of treatments given, dates and evaluations of the outcomes of treatment.

All documentation should be in line with the standards of the Trust on record keeping and the relevant accreditation body of the complimentary therapist.

16. Consultation, Approval and Ratification Process

Consultation and communication with stakeholders will be in accordance with policy 'Corporate Documents and Policies Procedure'.

The feedback from consultation will be maintained and any amendments made to the policy before it is submitted for approval.

The policy will be approved and ratified in accordance with 'Corporate Documents and Policies Procedure'.

17. Review and Revision Arrangements including Version Control

17.1 Review of these guidelines will be carried out by the Drug & Therapeutics Committee on a bi-annual basis or on an "as-and-when" basis should there be significant changes to the legal and statutory requirements.

17.2 Amendments

Any proposed amendments should be proposed to the Chief Pharmacist who will review any change requests through the Drug & Therapeutics Committee.

Changes approved by the Drug & Therapeutics Committee will be sent for ratification by the Quality Committee.

Once approved amendments will be issued in accordance with the Trust's Policy.

Corporate & Legal Services will maintain a version control log in accordance with 'Corporate Documents and Policies Procedure'.

18. Dissemination and Implementation of a Policy

18.1 This policy will be disseminated in accordance with 'Corporate Documents and Policies Procedure'.

18.2 The policy will be implemented through medical induction training and local area / ward induction training.

18.3 Training

The prescribing, supply and administration of medicines to service users is an important aspect of professional practice for clinicians. Professional bodies provide their own guidance/standards expected of all clinicians registered with them and the Trust expects these relevant codes of professional practice relating to the administration of medicines to be implemented in accordance with the advice provided.

All clinical staff will recognise their personal professional accountability for their actions. Dependent on their particular form of registration (i.e. doctor, nurse, pharmacist, pharmacy technician, dentist etc.) and their area of practice they have an individual responsibility to take steps to continuously develop their professional knowledge and competence.

All clinical staff have a duty to understand and be aware of this policy, relevant guidance, standards and competency requirements that need to be met to undertake any specified task. It will be the responsibility of the Trust to ensure all newly recruited clinical staff are introduced to this policy at their formal induction. In addition all clinical staff will need to sign to the effect that they have read and understood the policy before the practical administration of part or all of the medicine management arrangements relating to the treatment and care of patients.

In keeping with good practice all clinical staff will as part of their professional supervision, raise any matter in relation to this policy, matters affecting their duty to safely supply and administer medicines to service users as part of their on-going professional development. In addition matters of personal development will need to be addressed with their line manager and incorporated within their personal development plan. It will be the responsibility of the clinical line manager to ensure that where a staff member is deemed not required to undertake the competency assessments, due to meeting the desired requirements through experience, that there is evidence of that decision as part of the annual appraisal for the individual, or a plan to attain the given competence is prepared.

In the event that amendments occur to this policy and the associated guidance the Trust via Drug & Therapeutics Committee will circulate as required up to date information about the management of medicines for implementation by all clinical teams.

All staff involved in the handling of medicines should be appropriately trained and demonstrate competence with regard to safety and security of medicines and with regard to safeguarding themselves and those under their supervision from any risks posed by drug products. To ensure that staff are appropriately supported to meet this, a series of competence assessments have been drawn up that cover the main areas of medicines management responsibility.

LPFT Pharmacy Team, in conjunction with the L&D Team, offers training to support the policy (face to face and via e-learning). This includes educating relevant staff involved with handling medicines on the need for risk management in relation to drug products and procedures as well as defining lines of responsibility and secure methods of handling both medicines and controlled stationery. This basic training is available on the intranet and relevant staff will need to refresh their knowledge on this aspect of medicines management every three years.

Medicine management training is essential training. The organization will provide sufficient and appropriate training for each of the main staff groups as outlined within the Trust Mandatory Training Matrix.

19. Policy Control including Archiving Arrangements

Corporate and Legal Services will maintain a copy of this policy for a minimum of 10 years in line with the recommendations contained within ‘Records management NHS Code of practice’ (2006).This ensures that where compliance with the Policy is claimed over a period of time during which different editions of the policy were in operation the processes can be checked against the relevant standards at the time.

20. Monitoring Compliance with and Effectiveness of Policies and Procedures

This policy and the associated guidance form part of the Trusts risk management and quality controls strategy. The Drug & Therapeutics Committee will develop an annual programme of clinical audit to determine compliance to the relevant medicine management standards.

In addition a quarterly report of adverse incidents involving the management of medicines to the Drug & Therapeutics Committee. Any learning points will be identified and appropriate guidance circulated throughout the Trust to improve services.

All incidents or near misses, as defined within the Trust's Serious Untoward Incident Policy, and which relate to this policy must be reported using the Trust's incident reporting system. In the event that there has been a suspected breach of conduct such matters will require investigation and may lead to the implementation of the Disciplinary Procedure.

Systems	Monitoring and/or Audit				
Criteria	Measurables	Lead Officer/Group	Frequency	Reporting to	Action Plan/Monitoring
Systems in place to monitor the prescribing of all staff	No. of pharmacist interventions No of reported prescribing incidents	Clinical pharmacists Matrons	Six monthly reports Quarterly reports	Drug & Therapeutics Committee	Drug & Therapeutics Committee (for monitoring)
Systems in place to monitor the arrangements for administration of medication	Safe & Secure Handling of Medicines audit No. of reported administration incidents	Matrons	Annual report	Drug & Therapeutics Committee	Drug & Therapeutics Committee (for action plans)
Systems in place for the monitoring of self-administration scheme	No. of service users offered & using the self-administration programme	Matrons/ Pharmacy Technicians	Six monthly reports	Drug & Therapeutics Committee	Matrons (for monitoring)
Systems in place for monitoring the safe disposal of controlled drugs	Safe & Secure Handling of Medicines audit No. of reported incidents.	Pharmacy Technicians/ Matrons	Six monthly reports	Drug & Therapeutics Committee	Trust Accountable Officer (for monitoring)
Systems in place to monitor the uptake of medicines management training	Staff groups (inpatient, community) No. of staff taking training packages.	Matrons Training Department	Annual report Quarterly training reports	Drug & Therapeutics Committee	Matrons (for action plan) Drug & Therapeutics Committee (for monitoring)

21. References

1. Misuse of Drugs Act (1971)
2. Misuse of Drugs Regulations 1973 (IS 1973 No.797)
3. Misuse of Drugs (Amendment) Regulations 1974 (IS 1974 No. 402)
4. Misuse of Drugs (Safe Custody) Regulations 2007
5. N.B. Summary of Guidance of the above in (HC (77)16
6. The Misuse of Drugs Act 1971 (Modification) Order 1985(IS 1985) No. 1995
7. The Misuse of Drugs Regulations 1985 (IS 1985 No. 2066)
8. The Misuse of Drugs (Safe Custody) (Amendment) Regulations 1985 (IS 1985 No. 2067)
9. Security of Drugs Liable to Misuse HM (71)21
10. Dangerous Drugs. (1973)
11. Misuse of Drugs (Safe Custody) Regulations 1973
12. Metrification: Introduction into the Health Service of the International System of Units (HSC (IS) 198)
13. Addition of Drugs to Intravenous Infusion Fluids HC (76)9
14. Medicines (Prescription Only) Order 1980
15. Medicines and Poisons Guide 3rd Edition. The Pharmaceutical Press
16. Reporting Accidents with and Serious Defects in Medicinal Products, Building and Plant, Equipment and other Supplies whether Medical or Non-Medical HN (83)21
17. Prescription Only Medicines Order (1985)
18. Misuse of Drugs Regulations
19. The Safe and Secure Handling of Medicines: a Team Approach (revised Duthrie Report) March 2005
20. Cupboards for the Storage of Medicines in Health Care Premises BS2881
21. Guide to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations (DOH) December 1989
22. Standards for Pharmaceutical Services in Health Authorities, Units and Trusts in England RphO's Special Interest Group December 1991
23. Standards for the Administration of Medicines UKCC 1992
24. Guidelines for the Administration of Medicines UKCC 2000
25. Guidance to the NHS on the Licensing Requirements of the Medicine Act 1968. Medicines Control Agency September 1992
26. Guidance on Reporting Accidents with, and Defects in Medicinal Products HSG (93)13. Medicines Control Agency
27. Clothier Report 'The Allitt Enquiry'. HMSO February 1994
28. Misuse of Drugs (Amendment) (No. 2) Regulations 1995/SI 1995 No. 3244 (Temazepam)
29. Report on the Supply and Administration of Medicines under Group Protocols HSC 1998/051.
30. Security of Prescription Forms HSC 1998/062
31. Mental Health Act 2007
32. Nurse Prescribing HSC 1998/232
33. Review of Prescribing, Supply and Administration of Medicines Final Report – Dr J Crown
34. Patient Group Directions HSC 2000/026
35. Controlled Drugs (Supervision of Management and Use) Regulations 2013
36. NMC Standards for medicines management 2007
37. Standing Financial Instructions 2013

22. Hyperlinks to Appendices – other policies and guidelines

Appendix 1	FP10 Policy & Procedures
Appendix 2	Medicines Reconciliation Policy
Appendix 3	Controlled Drug Management Policy
Appendix 4	Rapid Tranquilisation Policy
Appendix 5	Non-Medical Prescribing Policy
Appendix 6	Patient Group Direction Policy
Appendix 7	Out of Area Procedure
Appendix 8	Nursing Associate Medicines Management Guidelines
Appendix 9	Unlicensed Medicines Guidelines
Appendix 10	Covert Administration Guidelines