Reference Number: UHB 389 **Version Number:** 3	**Date of Next Review:** 27 Mar 2021 **Previous Trust/LHB Reference Number:** See Appendix 1 for all superseded documents

The Medicines Code

Introduction and Aim

The Medicines Code supports the UHB Medicines Management Policy to uphold the Health Board's commitment to avoid waste, minimise harm and avoid unwanted variation. The Health Board's Medicines Code sets out the procedures to facilitate implementation of these policy principles.

Objectives

- Ensure that people receive medication for the correct reason and receive the right medication, at the right dose and the right time.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts, involved in all or part of the medicines management process.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a positive impact.
Documents to read alongside this Procedure	Medicines Management Policy UHB 388 Infection Prevention and control All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal. Cardiff and Vale Good Prescribing Guide. Parenteral Cytotoxic Chemotherapy.Extravasation Policy Patient Property Policy
Approved by	Quality, Safety and Experience Committee and Executive Medicines Management Group

Accountable Executive or Clinical Board Director	Executive Medical Director.
Author(s)	Director Pharmacy and Medicines Management. Lead Pharmacist Quality and Safety. Nurse Advisor Medicines Management.

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1		Put on intranet only for launch in November 2017	New document that replaced 19 controlled documents (see Appendix 1)
2	Via QSE Chair's Action in March 2018	28/03/2018	EHIA produced & Cover for document
3	Via eMMG Dec 2018		• Inclusion of TTH on Short Stay and Gynaecology Areas \Procedure – Signed off at MMG March 2017 • Update of Medicines Reconciliation Procedure – Signed off at MMG August 2018 • Update of Methotrexate Procedure – Signed off at September MMG • Nurse Initiated Medicines Procedure – approved by MMG Dec 2018 • Advice for provision of TTH out of hours. • Improvement to index and page numbering • Link to UHB Approved Covert Medicines Documentation. UHB Approved Medication Error Action Form. Appendix 2

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Index:

Any questions or enquiries relating to the Medicines Code should be emailed to welshmedicines.information@wales.nhs.uk under the subject heading Medicines Code

Chapter 1 Introduction to the Medicines Code

Introduction

Cardiff and Vale University Health Board (C&V UHB) is committed to the safe and secure handling of medicines to protect its patients, staff and visitors, and its financial resources.

This Medicines Code updates and replaces previous Medicines Policies and Procedures used in Cardiff and Vale Hospitals. Cardiff and Vale's Pharmacy Directorate prepared the Medicines Code which was supported by the C&V UHB Medicines Management Group and the Nursing and Midwifery Group, and approved by the C&V UHB Quality Safety and Experience Committee.

Purpose of the Medicines Code

The purpose of this Medicines Code is to set out a clinical and corporate governance framework to promote safe and secure systems for the controlling and handling of medicinal products in the hospitals and clinics operated by the C&V UHB as part of an overall medicines management process.

Guidance on safe and appropriate prescribing has been considered and disseminated through the Medicines Code by the C&V UHB Medicines Management Group. In general, medicines need to satisfy tests of clinical and cost effectiveness and use should be justifiable on grounds of safety, given the alternative therapies available and the circumstances of the patient.

In addition to this Medicines Code, healthcare professionals must abide with the current version of their relevant professional bodies 'Policies, Standards and Codes of Practice.

If extreme circumstances arise such that this Code cannot be applied then the prime consideration will be the safe and effective treatment of any patient concerned. However, if any deviation from the Code occurs, those staff involved must document all alternative measures taken in the appropriate records and inform senior professional staff.

Scope

This Medicines Code with the underpinning principles of legal, quality and safe practice, applies to all doctors, nurses, pharmacists and other health care professionals across C&V UHB involved in the ordering, supply, storage, prescribing, administration and

disposal of medicines. The medicines include Prescription Only Medicines (POMs), Pharmacy Medicines (P), General Sales List Medicines (GSL) and Controlled Drugs (CDs). The Code also includes complementary medicines, pharmaceuticals (non-therapeutic items) which include certain medical devices traditionally supplied through hospital pharmacy departments.

Standard Operating Procedures (SOP)

Each Clinical Board may develop and implement SOPs describing safe working practice for aspects of work conducted within their Clinical Board. If an SOP involves medicines, or aspects of medicine usage, across a multi-professional area Doctors/Nurses Pharmacists, the SOP must be approved first by the Clinical Board and then by the C&V UHB Medicines Management Group.

1.1 Classification of medicines

Medicines are considered as two main sub-groups, Controlled Drugs and Medicines.

a) Controlled Drugs

Controlled Drugs are those drugs classified under the 'Misuse of Drugs Act 1971', and its associated regulations.

b) Medicines

Medicines will be taken to be all substances defined under the Medicines Act as being medicinal products. These include those restricted to supply on prescription (POM), those that can only be sold from a Pharmacy (P), and those that can be sold at any establishment, General Sales List medicines (GSL). Unlicensed medicines do not have a United Kingdom Product License.

c) Complementary medicines

The principles adopted for the use of medicines will also be followed for complementary medicines.

d) Pharmaceuticals

The term "pharmaceuticals" will be used to describe those non-therapeutic items covered by the policy (e.g. disinfecting and sterilizing agents). It will also include certain devices carrying a CE mark traditionally supplied by pharmacy.

e) Black triangle medicines are newly introduced medicines, subject to intensive monitoring for potential side effects by the European Medicines Agency (BNF) and Medicines and Healthcare Products Regulatory Agency (MHRA) (identified by ▼ in the

British National Formulary).

f) Medicines used outside product license are medicines used in a manner, indications, which are outside the as defined in the Summary of Product Characteristics (SPC). E.g. different dose, indication, administration route.

g) Specials are unlicensed medicines that do not have a product license and are usually commissioned from a licensed manufacturing unit at the request of a prescriber, or by a pharmacist acting on behalf of that prescriber.

h) Medicines which do not have a UK product license (unlicensed medicines). Usually obtained on a named patient basis.

1.2 Corporate Health Board responsibilities

a) Chief Executive

The Chief Executive has overall responsibility for medicines management in C&V UHB.

b) Medical Director

The above responsibility is delegated to the Health Board's Medical Director, supported by the C&V UHB Medicines Management Group.

c) Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management is responsible for organising, monitoring and reporting on medicines' management, its systems and procedures.

Chapter 2 Operational Responsibilities for All Professional Staff

2.1 Responsibility of the Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management is responsible for ensuring that there are sufficient systems in place for the following:

- Providing a safe, effective, efficient and secure system for medicine stocks held within pharmacy. The Health Boards Pharmacies.
- Providing a safe, effective, efficient and secure system for medicine distribution.
- Providing a system for monitoring ward medicine usage and advising on appropriate stock range and stock holding levels.
- Providing advice on medicines and controlled drug security.
- Providing advice on appropriate environmental storage conditions.
- Providing advice on safe and proper means of disposal of unused/unwanted medicines.
- Providing advice on safe and effective systems and arrangements for medicine administration. This includes commenting and advising on medicine administration errors and near misses reported via the DATIX Incident Reporting system.
- Providing advice on transport of medicines and other pharmaceuticals.
- Providing a system, when the pharmacy is closed, of access to emergency medicine stocks and the availability of a pharmacist for emergency duties.
- Where a pharmacy led stock control service is provided there is a shared responsibility between the ward/unit ward manager/clinical lead and the clinical board of pharmacist
- Providing advice on clinical pharmacy services and ensuring that there is consistency of approach such that prescriptions are monitored and appropriate action taken to ensure effective use of resources.
- Ensuring that there are adequate mechanisms in place to monitor and report on the usage on medicines throughout the Health Board and to devise strategies to promote cost effective prescribing.
- Ensuring that there are systems in place with the use of medicines throughout the Health Board.

- Ensuring medicines are held to meet the need of hospitalized patients and immediate response to civilian emergency.

Each Clinical Board will have an assigned Clinical Board Pharmacist who has a delegated responsibility for implementation of the above.

The Director of Pharmacy and Medicines Management is charged with the responsibility for medicines management throughout C&V UHB. This includes ensuring pharmacy representation on local medical devices committees to ensure safe usage of infusion systems and devices within C&V UHB

2.2 Responsibility of the Executive Nurse Director and Clinical Board Nurse Director

The Executive Nurse Director and Clinical Board Nurse Directors are responsible for ensuring that systems are in place within wards and departmental clinics to facilitate the processes within the medicines code and that information guidance within this medicines code is available to staff and adhered to.

- The ordering of medicines and pharmaceuticals.
- The appropriate storage (physical and environmental conditions of medicines and pharmaceuticals).
- The administration of medicines including patients' own medicines other than those administered by a doctor
- The recording of administration of medicines.
- The security of medicines and prescription forms.
- The supply of medicines to patients in accordance with Patient Group Directions (PGDs)/ Patient Specific Directions (PSDs).
- The reporting of medicines related incidents and errors via the DATIX Incident Reporting System.
- The safe and proper disposal of unused/unwanted medicines and pharmaceuticals.
- The retention of documents relating to the ordering, storage and administration and supply of medicines.
- The induction of new staff with respect to informing them of the Health Boards' Medicines Code
- The education and training required to enable nurses to comply with this

Medicines Code and for ensuring that a copy is readily available to staff.

2.3 Responsibility of the ward manager /clinical lead.

- The ward manager/clinical lead, will have joint responsibility with the pharmacy directorate for the ordering system where there is a pharmacy provided led stock control service.
- The ward sister/charge nurse/clinical lead is responsible for the secure storage of medicines in their area.

2.4 Responsibility of Individual health care professionals involved in the medicines management process

Each individual health care professional is responsible for:

- Reading and understanding this Medicines Code.
- Complying with this Medicines Code and their own regulatory bodies, guidance, standards policies etc.
- Ensuring they have the required qualifications, competence and/or authority to complete the tasks.
- Maintaining the security of medicines within their practice area.

2.5 Responsibility of prescribers

Medical and non medical prescribers will practice in accordance with local procedures and guidance and will comply with their respective professional Code of Practice.

Chapter 3 Medicines Audit, Suspected Fraud and Suspected Theft

3.1 Monitoring and audit

As part of the responsibility for delivery of the medicines' management process, the Director of Pharmacy and Medicines Management will ensure that the following explicit, written, quality standards are prepared and regularly audited as part of the C&V UHB audit cycle:

- The process of prescribing of medicines in C&V UHB hospitals
- The appropriateness of medicines prescribed for individual patients including license status and adherence to agreed therapeutic guidelines.
- The preparation of parenteral medicines. This will include all C&V UHB hospital clinical areas as well as the main pharmacy department.
- The clinical pharmacy review of prescriptions and dispensing of medicines.
- The administration of medicines to patients.
- The supply of medicines to take home and the counseling of patients about those medicines.
- The reporting of medication errors.
- Medicines administered for clinical research and drug trials.

3.2 Risk management and patient safety initiatives

The Director of Pharmacy and Medicines Management and/or the Medicines Safety Officer will lead on safe medicines practice within the Health Board. This will be via The Medicines Safety Executive (MSE) a multi professional sub group of the UHB's Corporate Medicines Management Group. The MSE will maintain clear and identified links with the UHB Patient Safety Team

The Director of Pharmacy and Medicines Management, MSE and Pharmacy Management Team will actively participate in patient safety initiatives e.g.

1,000 Lives Plus

The Director of Pharmacy and Medicines Management or a senior member of the Pharmacy Management Team) will hold responsibility for communication and

liaison with the Welsh Risk Pool and Patient Safety Wales on medicines safety and risk issues

The risks inherent in medicines management and the effectiveness of risk control measures must be monitored and reviewed on a continual basis.

Senior Management, both within Pharmacy and C&V UHB, must be informed of any significant risks and risk control measures.

Medication incidents should be regularly monitored and issues of significance reported to the C&V UHB Safety and Standards Committee via the Medicines Safety Executive (MSE).

3.3 Anti theft and fraud culture

C&V UHB has a zero tolerance anti fraud and theft culture and is committed to the principle that the NHS resource of medicines is always put towards the patient in need of that prescribed medicine. C&V UHB will seek to reduce medicine losses from theft and fraud to an absolute minimum by sanctions against those determined to steal or defraud the NHS. Possible sanctions may include criminal, civil or disciplinary proceedings, and C&V UHB will seek to recover the cost of stolen or defrauded medicines. Incidents involving members of staff, patients or visitors that are suspected to have stolen C&V UHB medicines or prescription forms pads, must be reported through a clinical incident entry completed by the senior nurse or senior pharmacist on duty. The local security manager must be notified – how to access this person.

The directorate lead nurse and/or directorate pharmacist may conduct initial enquiries and then, should matters proceed to an investigation, the local security manager will then take responsibility for any subsequent investigation of alleged theft. The security manager will liaise with South Wales Police and the human resources manager as appropriate.

3.4.2 Suspected fraud in respect of medicines

Some examples of NHS medicine and prescription frauds are as follows:

- Falsified medicine stock records
- Falsified orders for medicines
- Prescription fraud e.g. forged signatures and/or false representation by the patient for medicine not prescribed by an authorised NHS prescriber

- Self prescribing
- Prescribing for family members or friends
- Prescribing for those who are not entitled to be prescribed NHS medicines e.g. foreign nationals who are not entitled to NHS treatment

This list is not exhaustive and those determined to commit fraud may develop new and sophisticated methods to avoid detection.

If an alleged theft involves suspected fraud, the Medicines Safety Executive and/or the Security Manager will refer the incident to the Local Counter Fraud Specialist of C&V UHB.

Chapter 4 - Prescribing Medicines

4.1 Prescribing medicines

All prescribing must be on C&V UHB approved prescription stationery before supply or administration to patient may occur. In strictly defined situations e.g. via a Patient Group Direction, homely remedy guidance/discretionary medicine, a verbal order, in role as a midwife, or the use of specified parenteral medicines for the purpose of saving life in an emergency a prescription it is not necessary to authorise administration (see chapter 16 for list of medicines).

Each prescriber has a duty of care when issuing prescriptions to patients, to ensure that they are issued appropriately to patients under their care.

Prescription forms and pads are controlled stationery and therefore must be stored in accordance to the C&V UHB guidance.

Each prescriber is responsible for the safe storage of any blank prescription forms and pads issued to them. Should blank forms or pads be lost, they must inform their line manger must be immediately informed and an investigation be instigated

4.2 Persons authorised to prescribe medicines

Only those employed by C&V UHB or working under a service level agreement (or contractual arrangement) and legally authorized to prescribe e.g. doctor, dentist, registered non-medical prescribers (NMPs), may prescribe medicinal products.. Non-medical prescribers must have gained sign off from their appropriate line manager and in the case of a nurse or midwife NMP sign off from the appropriate Clinical Board Nurse Director. NMP's must also be registered on the C&V UHB NMP database before prescribing within their area of competence. Provisionally registered doctors (FY1s) may only prescribe in connection with their employment with C&V UHB and cannot prescribe for out-patients. Medical students cannot prescribe, but may write prescriptions to acquire and demonstrate competency. This must be under direct supervision, with the prescription being countersigned immediately by an approved prescriber.

Dentists are required by their registration to restrict their prescribing to their areas of competence.

4.2.1 Dietetic products

Whilst Dietetic products are not medicines, however dietitians can initiate formulary dietetic products by writing them on the patient's in-patient meds admin prescription chart or a C&V UHB approved nutrition chart. They should endorse any item not to be continued at discharge as 'For in-patient use only'. This avoids inadvertent long term continuation.

4.3 Prescribing guidance

4.3.1 Formulary and non-formulary medicines

All newly initiated medicines for both in and out-patients should be prescribed from the approved formulary list.

Patients admitted on most non-formulary medicines will be continued on these medicines, but in certain situations pharmacy will agree substitution with an alternative formulary item in accordance with a local procedure approved by the C&V UHB Medicines Management Group.

If a non formulary medicine is needed for treatment of an in-patient the patient's own medicine supply should be used as a first option. If/when a further supply is needed a medicines review should be undertaken and medicines swapped to formulary items where appropriate.

4.3.2 Unlicensed medicines

See Medicines Code: Chapter 12.

4.3.3 Off License / Off Label medicines

See Medicines Code: Chapter 12

4.3.4 Anti cancer medicines

The prescribing of cancer medication is limited to authorised prescribers in C&V UHB. Full Guidance can be found in the Management of Parental Cytotoxic Chemotherapy Policy.

4.3.5 Controlled Drugs

See Medicines Code Chapter 9

4.3.6 Intravenous (IV) and parenteral medication

See Medicines Code Chapter 8

4.4 Prescription writing

4.4.1 Handwritten prescriptions

Each prescription must be legal, legible, unambiguous and written or printed in indelible ink that can be photocopied. Upper or lower case may be consistently used.

A simple test for legibility is for another person who is unfamiliar with the prescriber's handwriting to read it without difficulty.

4.4.2 Computer generated prescriptions

The planning, development and implementation of any electronic prescribing system must be approved by the C&V UHB Medicines Management Group.

Different electronic prescribing systems may exist within C&V UHB. Electronic prescribing will be limited to prescribers trained in use of the particular system. Once a prescriber is enabled as a user, access will be via individual Nadex log on. Prescribers must adhere to the C&V UHB IT information technology policies.

4.5 Prescribing competence

All authorized prescribers must ensure they have appropriate knowledge and experience to prescribe competently in their area of practice. Knowledge of the "Guidance on Prescribing" sections in the current British National Formulary and the UHB Good Prescribing Guide is essential. Completion of the e –prescribing training package for the All Wales In-Patient Medication Administration Record is mandatory

4.6 Prescription documentation

Permanent changes to prescribed medicines must be noted within the patient record along with the indication for treatment or reason for stopping treatment (e.g.

ineffective / side effects).

4.6.1 In-patient medication administration record (prescription chart)

The All Wales In-Patient Medication Administration Record is to be completed in accordance with the instructions for this task. (See prescribing e-learning package on Learning@nhswales).

The following patient details must be entered:

- Name
- Address
- Unit number and NHS number when practicable
- Date of birth
- Name of consultant
- Weight (as soon as practical)
- Medicine sensitivity (allergies)

A pre-printed addressograph label should be used whenever possible and attached to the prescription chart or form before other details are added.

If more than one chart is in use “1 of 2” etc. must be written.

The clerking doctor must complete the drug/allergen section on admission, even if no allergies are known; this must be signed and dated. An allergy record in medical clerking notes is not sufficient. The medicine(s) in question must be specified and the type of allergy noted or the ‘none known’ box signed and dated. Medication must not be administered until this section is completed.

A doctor, nurse, pharmacist or a pharmacy medicines management technician can complete the allergy section at a later stage if an allergy is subsequently discovered or the detail is initially incomplete.

The weight of the patient must be entered for all paediatric patients and for patients where medicine dose adjustments by weight will be made.

If an additional specialist chart is in use e.g. warfarin, insulin or other options, as shown on the front of the All Wales In-Patient Medication Administration Record, it must be indicated on the main chart.

The following medication details must be entered:

- Route of administration
- The recommended International Non-Proprietary Name (rINN) (i.e. the approved / generic name) of the medicine should be written legibly using either upper or lower case.
- Proprietary names (i.e. brand names) may only be used for multi-ingredient preparations with no approved name, for products whose proprietary name defines a specific formulation (e.g. slow release theophylline preparations, certain creams and ointments) or for safety reasons to avoid miss selection of product (e.g. OxyNorm$^{(R)}$ and OxyContin$^{(R)}$) or bioavailability (e.g. Neoral$^{(P)}$ and Sandimmun$^{(R)}$).

Medicine names must not be abbreviated e.g. [MTX, MMT, ISMN, GTN, FeSO4 are not acceptable].

The date on which the treatment is to commence must be entered on the prescription chart. If rewritten, the *original* start date, not the rewrite date is used.

4.6.2 Variable routes

Medicines for administration by variable routes in certain circumstance can be prescribed once on the prescription chart indicating the routes e.g. PO/IV but only where the doses by each route are the same e.g. metoclopramide. When the doses by each route are different e.g. prochlorperazine, each route required must be prescribed individually.

4.6.3 Approved abbreviations for routes of administration

IM intramuscular

INH inhalation

IV intravenous

NEB nebulisation

PO /O oral

PR rectal

PV vaginal

SC sub-cutaneous

S/L sub-lingual

Top topical.

Other routes of administration should be written in full.

Intrathecal must always be written in full ref to IT policy).

4.6.4 Further guidance

Further guidance on prescribing, how doses should be expressed, permitted terminology and the use of multiple charts, refer to the C&V UHB can be found within Good Prescribing Guide and the British National Formulary section on prescribing.

4.6.5 Dose frequency

For regular medication the prescriber should preferentially use the pre-set medicine round times to indicate administration time, The 24-hour clock must be used when specific timings are needed e.g. for antibiotics to space doses evenly through 24 hours, or for frequent dosage regimen used in Parkinsonism.

4.6.6 When required medicines (*pro re nata/ p.r.n.*)

For “when/as required” medicines. Full details of the directions for administration in frequency of a for when 1 as required meds must be recorded. The time or frequency of

administration and maximum dose in 24 hours must be stated e.g. cyclizine 50mg p.r.n. is not acceptable. This should be written “cyclizine 50mg every 6 – 8 hours p.r.n., MAX 150mg in 24hours

Temazepam 10mg p.r.n. is not acceptable. Likewise “Temazepam 10mg p.r.n. at night for sleeping” is acceptable.

4.6.7 Discontinued medicines

A diagonal line must be drawn through the prescription so that cancellation is obvious, but the prescription is not obliterated. This should be signed and dated. In some cases a large ‘Z’ or a can be used as an alternative to a diagonal line and this should be signed and

dated.

4.6.8 Care pathways and the use of pre printed prescriptions and/or pre printed labels

Certain patient pathways include pre-printed prescription details and/or pre printed labels that are used where there is a need for clarity when prescribing complex regimens, or to provide a safe and complete package of care. Examples are insulin regimens where there is dosage titration dependent upon blood glucose results, and in post operative pain relief for parenteral or epidural opioid analgesia. Before use in C&V UHB, all pre-printed prescriptions or labels must be approved by the C&V UHB Medicines Management Group.

The prescriber is responsible for placing the prescription label on the patient’s chart and must sign and date the prescription in order to authorise its use. The signed chart becomes a Patient Specific Direction (PSD). Medication must not be administered until there is an authorised prescriber’s signature present.

4.7 Medicines Reconciliation

Medicines Reconciliation (Collect information, check, communicate)

Medicines should be checked and reconciled whenever a patient is transferred between care settings.

To assist in the medicines reconciliation process it is requested that all patients are admitted from primary care with sufficient information about their medication and medical history. This information is referred to as the minimum data set.

It is understood that patients presenting directly to the Emergency Unit may not bring this information with them, but it should be obtained and verified using reliable source(s) at the earliest opportunity. The patient’s Welsh GP Health Record (WGPR), an electronic summary, may be accessible via Welsh Clinical Portal (WCP) and should be considered a primary source of supporting information.

The doctor's/prescriber's responsibilities:

- Take a medication history from the patient, and/or carer to the best of their ability and using the information sources (including WGPR) available to them at that time, including the ambulance handover sheet. Document this and include with the admission documentation in the patient's medical record.

- It is recognised that the quality and accuracy of the initial medication history may be limited, particularly outside of normal working hours, owing to lack of access to key information sources e.g. Mental Health records. Every effort should be made to obtain this information at the earliest opportunity. Any inaccuracies and incomplete information must be rectified as soon as possible. Outstanding issues must be documented clearly and handed over when the patient's care changes.

- Be aware the single sources of information may not be complete. In particular, CAVUHB patients under psychiatric care may have information recorded in PARIS, which may not be readily accessible at all times. Medicines prescribed in secondary care may also not be included in WGPR.

- Annotate the medication list indicating the sources used to find the medication history, the name, signature and bleep number of the admitting doctor.

- Document intentional changes to regular medication made on admission and during the patient's hospital stay i.e. stopped (with reason), held (with reason and intended review date) or amended (with reason).

- Write an inpatient medicines administration record ("drug chart") for the patient's hospital stay.

- Prescribe medication intentionally withheld on the 'drug chart' but insert a 'X' in each drug administration box for each dose to be intentionally withheld. Regularly review to determine when appropriate to restart.

- Respond promptly (and within 24 hours) to any amendments or discrepancies highlighted by the pharmacy team on the drug chart or in the patient's record; update the patient's prescription chart as necessary.

- Further changes to medication during a patient's hospital stay must be documented in the medical record with a clear explanation of the reasons for change.

- In preparation for discharge ensure that the electronic Discharge Advice Letter (DAL) accurately lists medicines for discharge, and includes details of changes made to medicines to inform the next stage of patient care.

The pharmacy team's responsibilities:

- Check the medication history documented by the admitting doctor using at least one reliable source (preferably more). This can include sources previously accessed by the doctor.
- Be aware the single sources of information may not be complete. In particular, CAVUHB patients under psychiatric care may have information recorded in PARIS, which may not be readily accessible at all times. Medicines prescribed in secondary care may also not be included in WGPR.

- Reconcile the patient's medications by comparing the medication prescribed on the drug chart to the medication history, ensuring that any omissions or changes are intentional by referring to the medical record or the consultant team.
- If changes and omissions have been made without documented reason then an explanation and rationale will be requested from the doctor in charge of the patient's care, to be documented appropriately for the record.

- Any pre-admission medicine found to be required (i.e. indicated according to the patient's current or previous clinical status) but not documented in the medication history obtained by the doctor will be noted in the medical record. Please also refer to the All Wales Pharmacist Enabling and Therapeutic Switch Policy for further guidance. Discrepancies will be communicated to the doctors in an appropriate and timely manner for their attention and action.

- Document (on MTeD or in the medical record, which includes the drug chart) which doctor has been informed and their bleep number/method of contact.
- Pharmacists will sign and annotate entries made in the medical record and/or the inpatient drug chart with their name and contact/bleep number.

- When the medication history is accurate and complete, discrepancies and changes have been documented, and necessary urgent actions initiated then initial medicines reconciliation has been completed. **Medicines Reconciliation (MR) for the majority of patients should be carried out within 24 hours of admission.** This may be delayed e.g. at weekends but systems should be in place to facilitate identification of cases where MR has not been undertaken to enable timely follow up.

- On completion of the initial MR, the medicines reconciliation section on the front of the drug chart must be signed and dated by the pharmacist.

- Any further changes to medication during a patient's hospital stay must be documented in the medical record with a clear explanation of the reasons for change.

- If a pharmacy technician identifies discrepancies when completing a check of patients' own medicines or when importing medication history from the patient's individual healthcare record (WGPR) then these should be highlighted to the pharmacist for prompt action.

- Where appropriate, discrepancies and action to be taken should be communicated to the nurse looking after the patient.

The nurses' responsibilities:

- Ensure all medicines supplied for a patient are held securely, are accessible, and are transferred with the patient. This applies equally to medicines brought into hospital, which are the patient's personal property and should be dealt with accordingly.

- Medicines reconciliation issues may be identified in the course of routine nursing care e.g. administering medication. Any discrepancies should be documented appropriately and discussed with the doctor and/or pharmacist.

- Any medicines reconciliation issues or actions documented in the medical record but not addressed should be brought to the appropriate member of staff's attention for prompt review.

- At the time of patient's discharge home nursing staff should go through the discharge medication with the patient and/ or carer to ensure that the patient can access all current

medication as listed on the DAL, and to make sure they are aware of any changes made during admission.

- Any concerns or questions raised by the patient/carer must be responded to by reference to information documented in the medical record (including the DAL) or referred to the patient's doctor or pharmacist.

4.8 Prescribing for patients with swallowing difficulties or patients with naso-gastric or gastrostomy tubing

Some patients are unable to take medication in solid oral dosage forms. A stepwise approach is suggested to choose a suitable alternative:

- If possible, use a licensed medicine in a suitable formulation to meet the patient's needs(e.g. a dispersible tablet or licensed liquid medicine)
- If there is no suitable licensed formulation, consider using a licensed medicine in an unlicensed manner, for example by crushing tablets or opening capsules
- In order to use a licensed medicine, consider switching to a different therapeutic agent in the same class, or to a different route of administration. In most cases a suitable licensed preparation will be available to meet the patient's needs.
- In the few situations where the patient's needs cannot be met by licensed medicines, the use of special-order "unlicensed" products ('specials') may be considered.

Prescribers should be aware that many medicines are not available in a form that can be administered via naso-gastric or gastrostomy tubing. The crushing of a tablet or opening of a capsule changes its licensed status. If a tablet requires crushing or a capsule requires opening to facilitate their administration, the pharmacist should indicate this on the patient's inpatient drug admin medicine chart. In the absence of such directions a pharmacist should be consulted for advice. Alterations that change the licensed status of a medicine must be brought to the prescriber's attention and recorded in writing.

4.9 Out-Patient prescribing

Out-patient prescribing and supply should be minimal, limited to hospital only products or when an urgent clinical need exists. The internal hospital out-patient prescription form HMR 112 (W) can only be dispensed from the hospital pharmacy. Routine and non urgent amendments to medication should be made by the use of a GP prescribing referral form. An 'Outpatient Department GP Medication review' form is available to facilitate this

process.

The WP10 (HP) (or non-medical prescriber {NMP} equivalent) prescription form may only be used in exceptional pre agreed circumstances e.g. clinic held remotely to a hospital pharmacy. This form can be dispensed from community pharmacies. Prescribing quantities should be for short duration of therapy, and regular supply of medicines will be obtained from the patient's GP. The maximum quantity prescribed will usually be not more than one original pack. The WP 10 (HP) or NMP equivalent form must not be used to circumvent any hospital prescribing procedure e.g. non formulary medicine and prescribers need to be aware that data from WP 10 (HP) s or NMP equivalents is audited for compliance. The prescriber must clearly print their name and contact number when using a WP 10 (HP) or NMP equivalent, to enable contact should a query arise from the dispensing community pharmacy.

When medicines are to be prescribed for administration in out-patients they should be written within the patient notes or written on a prescription chart to allow the details of administration to be recorded and signed, include detail of COPPS etc.

4.10 Prescription amendment in order to correct individual in-patient prescriptions

Under an agreed enabling protocol pharmacists may amend in-patient medication records and transcribe GP treatments onto prescription charts for elective and emergency admissions in order to correct and/or clarify prescriber's intentions.

Any pharmacy alteration must be legible, dated, and identify the amending pharmacist by their initials and bleep number for contact. It will specify when appropriate which clinician agreed the amendment.

Where amendments would decrease readability, the prescription will be rewritten and signed by the pharmacist. The nurse is permitted to administer the medicine without a medical countersignature. Where actual or potential clinical reasons exist for omitted items, the item will not be added to chart. If the reason for omission is not documented a note will be left on the in-patient medication record or contact made with the prescriber, depending on the urgency. The pharmacist will not amend anything beyond their experience or competence. Communication with the prescriber is essential to maintain safety and ensure correct treatment.

4.11 Validity of an in-patient prescription

The prescription is valid until stopped by prescriber, administration section is full or

patient is discharged. A new medicines record must be written if patient is readmitted.

The use of a continuation sheet is not allowed when the administration section is full.

Only charts originating within the C&V UHB are valid.

4.12 Validity of out-patient prescriptions

The prescription is valid for 6 months.

Schedule 2, 3 and 4 Controlled Drug scripts are valid for 28 days.

4.13 Prescribing for discharge (To Take Home)

TTH prescriptions or MTED Discharge advice letter should ideally be written 24 hours prior to discharge to avoid delays in dispensing. They may be written by an authorised prescriber from the responsible consultant team, by other medical prescribers covering shifts or by a non medical independent prescriber.

4.14 MTeD

The Medicines Transcription and electronic Discharge (MTeD) system is a module of the Welsh Clinical Portal which has been implemented across all inpatient wards across Cardiff and Vale UHB. MTeD allows for the electronic transcription of a list of patient's medication which contributes to a final discharge advice letter (DAL). The DAL is sent electronically to a patient's GP in any area of Wales automatically when a patient is discharged and is stored on Cardiff Clinical Portal and the Welsh Clinical Portal.

A patient's medication can be transcribed from the chart onto the MTED system by a pharmacy technician, pharmacist or prescriber at any stage during the inpatient stay, inpt durg admin, depending on the agreed procedure for each ward. On many wards the transcribed medication list is kept up to date by pharmacy during the inpatient stay and must be reviewed by the doctor at discharge when the DAL is prepared. Here, MTeD provides a comprehensive list to the GP of all medication continued, started, stopped or withheld while in hospital. It is used during the inpatient stay for ordering of medication both on site and remotely, and any additional information regarding supply in the community can be recorded. On other wards all medication is transcribed at the time of discharge by the prescriber. The final DAL is printed

and signed by the prescriber ready for assembly by pharmacy in during opening hours, or ward staff out of hours according to the protocol.

4.15 Leave medication

Leave medication should be ordered as set out above in 4.13 ‘Prescribing for Discharge’. Where a local procedure exists, and it has been approved by the Clinical Board and if appropriate the C&V UHB Medicines Management Group, medication dispensed and labeled by pharmacy for leave can be supplied to cover the period of time until the patient is readmitted to hospital in accordance with the procedure. Nurses must not dispense medication from ward stock to facilitate supply of leave medication as this is a contravention of Regulations under the Medicines Act.

4.16 Discharge of patients from community hospitals

Community Hospitals will arrange prescriptions for discharge medication as for acute hospitals in

4.13 above. This will ensure a safe process for prescription writing, dispensing and supply of discharge medicines for patients to take home. Supply of discharge medication may be obtained from the local hospital pharmacy or by use of the patients own drugs (PODs) or from a local

community pharmacy if a C&V UHB approved procedure is in place.

4.17 Faxed prescriptions for discharge (TTHs)

Faxed discharge prescriptions are not permitted within acute hospitals. In community hospitals, where a POMs system of medicines management is not in operation, discharge prescription supply is usually obtained by sending the original discharge prescription to the local hospital pharmacy for dispensing. In certain circumstances, the use of faxed prescriptions to the local hospital pharmacy may be used to facilitate efficient discharge. Each faxed discharge prescription must be accompanied by a copy of the in-patient medication record. Controlled Drugs cannot be issued from faxed prescriptions, but may be dispensed and supplied only when the original prescription is received and checked against facsimile copy.

4.18 Prescribing for relatives and visitors of in-patients

Relatives and visitors of in-patients may occasionally stay overnight locally or within the hospital. They are responsible for supplying their own medication. When they have not brought their own medication to the hospital and their health may suffer as a consequence they should obtain an emergency supply from a community pharmacy, or if not local to the area, a local GP practice may be willing to prescribe as a temporary resident. The GP Out of Hours Service can issue a prescription to a temporary resident, and in certain circumstances attendance for treatment at the Accident and Emergency Department is appropriate.

If relatives cannot leave the hospital, and the consultant team treating the patient agree to take prescribing responsibility, the hospital pharmacy may agree to dispense a prescription written by the hospital team treating the inpatient.

4.19 Verbal prescriptions to nursing staff - prescribing by telephone

Telephoned prescriptions are permitted only in exceptional circumstances when in the nurses' professional judgment, patient safety or care would otherwise be compromised. It is emphasised that verbal orders are only appropriate in exceptional circumstances and are expected to be minimal in number. Exceptional circumstances will mainly be for areas where there are no doctors on site, e.g. Community Hospitals, Minor Injuries Units, and when treatment is needed to urgently relieve symptoms.

Verbal prescriptions can amend, delete or add a prescription item. They cannot be used for controlled drugs. Any refusal by a nurse to accept a verbal prescription must be documented by the nurse.

The following principles for confirmation of prescription should apply:

- The prescriber must be informed of other medicines currently prescribed for that patient
- A verbal order must be received by a nurse and confirmed ideally by a second nurse (except in circumstances detailed in paragraph below).

The prescriber must state:

- The identity of the patient
- The prescriber's identity
- The name of the medicine to be administered (spelt to avoid confusion)
- The dose to be administered
- The route and time to be administered

This information must be given to the first nurse, entered on the in-patient medication record or casualty card and then repeated back to the prescriber by the second nurse.

The nurse taking the verbal message should be familiar with the medicinal product.

When it is not possible for two nurses to be present to receive the verbal order, a second member of staff who may be qualified or non-qualified should be present. Both members of staff involved must sign and date the entry.

In exceptional circumstances, when a community health professional is working alone and is unable to receive a fax or electronically transferred instruction, the health professional may accept a verbal order from a prescriber to administer an urgent single dose of a medicine until such time as a fax or electronically transferred instruction can be made.

The prescriber must sign the form as soon as possible after giving the verbal order. Where doctors are on site, this must be signed as soon as possible and within the prescriber's shift.

In areas where doctors are not on site, the order must be signed within 72 hours**.**

Where an Out of Hours service is in operation, the prescriber giving verbal instructions can arrange for a second prescriber to countersign the verbal order

In areas where doctors are not on site doses may be administered for up to 72 hours without the doctor's signature until the verbal instructions are signed by a prescriber.

4.20 Verbal prescriptions to pharmacists – corrections by telephone

Verbal orders can be given by a prescriber to a pharmacist to amend delete or add a prescription item. This need often results from a pharmacist initiated query.

Having confirmed the identity and name of the patient with the prescriber, the pharmacist must confirm the following details:

- The patient hospital number
- Date of birth
- Address
- The medicine name, form and dose
- The name of the prescriber.

The pharmacist must also have access to sufficient information to assure themselves of the appropriateness of the medicine and dose. The pharmacist must read the alteration or addition back to the prescriber who must then affirm the original instructions.

The pharmacist will then amend the in-patient medication record or out-patient prescription recording the name of the prescriber, who has been contacted, then sign and date the amendment.

If the alteration is to formulation, frequency or timings of dose, then that part of the prescription may be crossed out and altered to ensure that the alteration is clear.

If the alteration involves any other changes e.g. new medicine, change in dose, then the whole prescription for that item must be written out as a new entry on the in-patient medication record or out patient prescription form.

4.21 Controlled Drug prescribing

See Chapter 9

4.22 Prescribing for Controlled Drug Dependency

See Chapter 9

4.27 Prescribing medicines which carry a black triangle symbol in the BNF

The black triangle symbol ▼ identifies those preparations in the BNF that are monitored intensively by the Medicines and Healthcare Products Regulatory Agency (MHRA). Prescribers are urged caution when prescribing these preparations and should report

adverse drug reactions to the MHRA

4.28 Prescribing medicines for which the Patient Safety Wales (and former NPSA) has issued safety concerns

Patient Safety Wales and formerly the National Patient Safety Agency (NPSA) may/have identified certain medicines as having particular risks associated when they are prescribed. This risk is highlighted by the production of a Patient Safety Notice/Alert (NPSA through the issue of a Rapid Response Report (RRR)). Prescribers are urged to familiarise themselves with these.

4.29 Prescribing for patients detained under 'The Mental Health Act'

Circumstances arise where a patient is detained under The Mental Health Act and will need medication prescribed either by consent or against the patient's wishes. The prescribing team must ensure that any prescribing will be in accordance with the current legislation set out under the Mental Health Act.

4.30 Patient Group Directions (PGDs)

Each Clinical Board is responsible for gaining approval of the C&V UHB Medicines Management for their Patient Group Directions. PGDs must be prepared in accordance with WHC CMO (2000) 1 using a C&V UHB template for PGDs. Advice in the preparation of PGDs can be obtained from Pharmacy. A record of approved PGDs is displayed on the C&V UHB intranet. When the review date arrives the appropriate Clinical Board will be responsible for reviewing and updating the PGD.

4.31 Prescribing for staff who are unwell at work

In order to standardise practice for staff that are unwell at work and to ensure compliance with the Welsh counter fraud initiative and the principles of clinical governance, this protocol describes the circumstances in which it is acceptable for doctors to prescribe medicines for staff

Self-prescribing is held to be generally undesirable to many authorities, including the General Medical Council, and will not be accepted. This avoids the dangers associated with the loss of objectivity, misdiagnosis and circumvention of the normal general practitioner-patient relationship. All routine medicines for doctors, their

families and other hospital staff should be obtained through the General Practitioner Services. Prescriptions are subject to routine and random audit and exceptions to this protocol will be brought to the attention of the C&V UHB Audit department. There are, however, circumstances when it is reasonable for a doctor to prescribe limited quantities of medicines for a medical colleague:

- The prescriber must be a fully registered practitioner and hold the post of Consultant, Staff Grade Doctor, Trust Specialist or Specialist Registrar.
- The prescriber's decision to prescribe is taken to support the attendance of his/her colleague in the workplace.
- A maximum of one week's treatment (or one original pack where appropriate) will be supplied, prescribed.
- Prescribers should note that data from prescription forms WP 10(HP) dispensed by community pharmacies, are returned to C&V UHB for audit purpose and are subject to regular scrutiny.

- Prescriptions outside this guidance will be treated as a private transaction, and the full cost of the medication will be charged to the patient in accordance with the private prescription and signed order charge arrangements within the local hospital. Pharmacy will not dispense any prescription for any medicines that significantly affect performance, mood altering medicines or controlled drugs under this protocol.

Chapter 5 - Ordering of Medicines

5.1 Ordering ward stocks of medicines

The process of ordering and receiving medication from pharmacy as stock medication for a ward or unit must ensure that certain controls are in place to cover the safety and security of the medicines (to include a clear documented audit trail), ensure that only controlled stationery is used, prevent overstocking of the area, ensure safety of the staff and patients, and clearly show who has the direct responsibility for each stage of the process.

5.1.1 Stock control

Each ward or unit must have an agreed stock list of medicines which are either used regularly on that ward or unit, or are required in case of an emergency. The stock level should be agreed between the pharmacy department and the clinical lead and this should be reviewed on a regular basis (usually at least twice a year). The sister/charge nurse/clinical lead has responsibility for all medicines on that ward or unit. This overall responsibility cannot be transferred to anyone else since it covers the strategic elements of medication handling on the ward or unit which ensures that day to day practice is in line with current legislation, local and national policies/guidance. The pharmacy will arrange which system of regular top-ups/stock control is be best suited for that ward or unit, and the frequency with which these will take place. Ad-hoc orders should be processed as described in the Medicines Code. Community Hospitals will order stock medicines as arranged with their local hospital pharmacy.

5.1.2 Ordering ward stock (WOREQ)

The ordering system in use on that ward or unit will determine who raises the order. Where wards or units have a pharmacy top-up/stock control, the pharmacy staff that carry out the top- up/stock control will initiate the order. Wards or units that do not have pharmacy top-up/stock control will order using an agreed medicines requisition that will be completed by a member of the ward or unit staff who has been authorized to initiate orders. Authorization of staff will be the responsibility of the ward/clinical lead and all authorized staff will have their name and signature logged with pharmacy, Ad-hoc orders maybe initiated by the ward or unit staff, but they can only be made in the manner agreed with pharmacy and by a member

of staff who has been authorized to initiate orders.

5.1.3 Documentation

All documentation used in the ordering of medicines will be classed as “controlled stationery” and as such should be stored safely except when in use. Access to medicines requisitions should only be to authorised staff and any electronic medicines ordering documents or system is limited to staff with authorisation attached to their individual user name and log on. All order documentation records whether paper or electronic will need to be kept for 2 years as a record of the transaction for audit purposes

5.1.4 Order assembly and transfer of Medicines

Order assembly and the transfer back to the ward or unit will be the responsibility of the pharmacy department. The pharmacy will highlight medicines needing special storage or temperature conditions, to ensure the security and stability of the medicines until they are delivered to the ward or unit.

5.2 Receipt of medicines on the ward or clinical unit

When medicines have been delivered to the ward or clinical unit the delivery must be signed for. The ward/clinical lead in charge should delegate a member of the ward staff to check the medicines received against the delivery note issued with the medication. If all the items are correct then the nurse shall sign and date the delivery note and then put away the medicines in their designated locked cupboards on that ward or unit. Any discrepancy identified must be notified to pharmacy as soon as possible.

Chapter 6 - Control and Storage of Medicines

6.1 Storage of medicines

Medicines dispensed by pharmacy and will be labeled in a manner to indicate to patients and nurses, the correct manner of storage and use of medicines. Medicines needing storage in a controlled drug cupboard will be labeled 'Store in a Controlled Drugs cupboard' Medicines needing cold storage will be labeled 'Store in a refrigerator'. Certain medicines can carry risk of harm to those who need to handle the medicines e.g. cytotoxic medication or hormonal medication and will carry warning labels indicating this risk.

6.1.2 Stock medicines in clinical areas

The stock held in a ward or department should be the minimum for safe and effective patient treatment and efficient service provision. The ward or clinical area will agree the items to be held as ward stock with pharmacy whose staff are authorized to inspect all medicines on any C&V UHB premises at any time. Storage of medicines no longer in use can increase risk of error and they should be returned as set out in this Code. If it is found that the storage conditions are inappropriate; the nurse with continuing responsibility must be informed. In a situation of a continuing problem the Nurse Advisor for Medicines Management will notify in writing the Senior Nurse responsible for the ward or clinical area.

6.1.3 Patient's own drugs (PODs)

When a patient is in hospital, the term 'Patient's Own Drugs' (PODs) refers to medicines that have been brought into hospital by the patient, having been dispensed for that patient outside of the hospital. It also includes over the counter (OTC) medication purchased by a patient and brought into the hospital. PODs medicines are not C&V UHB property but to ensure safe use and control for an individual patient their medicines must be stored and handled as set out in 6.1.3.1. **NB Patients own medicines are patients property, if a patient refuses to surrender their medicines for safe keeping and or use whilst in hospital, this must be recorded in the patients notes. Patients must be asked to return the medicines to their home address. Patients must be reminded of their responsibilities for keeping these medicines safe. Refer to Patient Property procedure.**

6.1.3.1 Storage of PODs

Where appropriate PODs are stored in lockable bedside medicine cupboards used exclusively for that patient. Cupboards or lockers designated for PODs storage must only be used for storage of PODs, and must not be used for patient's own property, money, food or valuables. If a ward is not utilising PODs then the PODs must be stored in a cupboard or trolley until such time that they can be returned to the patient or relative. PODs should be assessed for suitability for use by a pharmacist or pharmacy technician or registered nurse/midwife in accordance to the local pharmacy procedure. An in-patient may be self-administering certain medication that is not practical nor is expedient to be kept in a locked cupboard. Examples of this are be patient controlled analgesia, inhaler therapy, glyceryl trinitrate spray or topical preparations e.g. creams. These need not be stored in a locked cupboard when prescribed and used by those patients capable of self administration. PODs that need cold storage must be kept in a refrigerator, and the medication record should be noted with the place of storage.

6.1.4 Suspicious substances or suspected illicit materials

If a patient is found to be in possession of a suspicious substance or illicit material then the member of staff must follow the guidance for disposal in the Medicines Code Chapter 9 and chapter 10. A Datix report should be completed.

6.1.5 Medicines cupboards and trolleys

A ward or clinical area must have sufficient and proper storage cupboards, medicines trolleys, racking and shelving to safely store medication in a dedicated room or area. Each area where medicines are stored must be kept clean, be well ordered and comply with current legislation for storage of medicines (PSN030 sets out the requirements). Internal and external medicines should be stored in separate cupboards or where this is not possible, on separate shelving within a cupboard. Testing reagents shall be stored in a separate locked cupboard. Disinfectants shall be stored in a locked cupboard, separate to internal medicines. Where a traditional ward medicines trolley is used to facilitate medicines administration it is good practice to ensure that medicines held on the trolley are restricted to individually dispensed items and the minimum stock from ward stock required to meet the needs of the medicine round. When the trolley is in use it must not be left unattended unless

locked. When the trolley is not in use it must be locked and secured to the wall or floor by a chain, padlock or security system. Medicines must not be left on top of the trolley or on any exposed shelf of the trolley. CDs must not be stored in the medicines trolley. Where an automated ward or department medicine storage system is in use e.g. Omnicell, the system and its access controls must be approved by pharmacy. Infusion fluids, peritoneal solutions and large volume sterile irrigations are best stored in a locked cupboard, but where they are stored on shelving it must be in a secured area, providing clean conditions and where there is not public access.

6.1.6 Medicines refrigerators

Medicines labeled 'Store in a refrigerator' shall be stored between 2-8˚C in a dedicated locked medicines refrigerator. Guidance is set out in Patient Safety Notice PSN015. Medicines refrigerators should preferably be hard wired to the electrical supply to prevent accidental switching off. The use of refrigerators with temperature recording charts is preferred. Medicines refrigerators must have the temperature monitored and recorded daily, and this should be regularly audited by a named individual.

Non medicines e.g. milk or food must not be stored in a dedicated medicines refrigerator.

6.1.7 Storage of medicines in intensive care, high dependency and coronary care units and recovery rooms

In the above clinical areas where there is continuous high level nursing/staffing, medicines may be stored in a secure or convenient location and not in a locked cupboard. However, the storage location must allow constant oversight by nursing staff. Each registered health care professional accountable for the individual patient is responsible for the safe custody of these medicines at all times. When these medicines are no longer required by the patient they must be returned to the pharmacy or the unit's medicines cupboard.

6.1.8 Epidural levobupivacaine bags

Epidural levobupivacaine bags must be stored separately from intravenous infusion bags to minimise risk of erroneous selection of levobupivacaine and inadvertent administration by an incorrect route. Compound epidural bags containing levobupivacaine and fentanyl must be stored in a CD cupboard.

6.1.9 Emergency boxes, anaphylaxis kits and hypo (hypoglycaemia) boxes

These medicines are provided to wards to provide immediate life saving treatment therefore they should not be stored in locked cupboards, but be kept in a safe location in the clinical area so as to be readily available when needed. This must be balanced against the need for medicine security, therefore wherever possible they should be stored out of direct view of the public. Some areas will have alarmed trolleys for storage of emergency boxes. Each emergency box will have a tamper evident seal and expiry date, and once the seal is broken or the box expires it should be replaced via the pharmacy as soon as possible.

6.1.10 Medicines and Health and Safety

Flammable materials must be stored away from sources of ignition and preferably locked. Medical gases are generally piped but when medical gas cylinders are used they must be secured and stored in a dedicated cradle trolley and in accordance with the supplying company's safety instructions.

6.1.11 Storage of Controlled Drugs

See Chapter 9

6.1.12 Storage of medicines by community nurses

Where community staff need to carry medicines to a patient's home or elsewhere, they must ensure that the medicine is securely stored until use or return to the originating storage cupboard at base. If the medicine requires cold storage the medicine must be carried in appropriate packaging to maintain the 'cold chain'. Medicines should be carried concealed in the boot of a vehicle and should not be left unattended,

6.2 Security of medicines

6.2.1 Custody of keys controlling access to medicines

6.2.1.1 Pharmacy

The safe custody of medicines within the pharmacy, pharmacy keys and pharmacy entry swipe cards are the responsibility of the Director of Pharmacy and Medicines Management.

6.2.1.2 Wards

In wards or clinical areas the responsibility for safe custody is that of the WRN/clinical lead of the ward or clinical area. The person with continuing responsibility can be delegated responsibility for possession of the custody of the keys to the medicine cupboards, medicine refrigerator and medicines trolleys. All ward medicines keys must be passed to the next WRN at handover. Unauthorised persons must not be permitted access to medicines within hospital premises. The ward/area should provide a copy set of medicines cupboard keys to pharmacy in order to maintain service in certain circumstances, such as the loss of keys.

A master key for PODs cupboards is held by each ward team. Lost keys must be reported in accordance with the local security procedure. A patient may hold the key to their individual bedside PODs cupboard where they have been assessed to be able to self-administer their medication according to a C&V UHB approved local procedure.

6.2.2 Custody of Controlled Drugs

See Chapter 9

6.2.3 Discrepancy or misappropriation of medicines

Each member of staff will maintain their own record of any incident and their subsequent action. The WRN lead will make initial enquiries to establish if any suspected theft or suspected fraud may have occurred. See section 3.3 and 3.4

6.2.4 Apparent loss of medicines in clinical area

The person in charge of the clinical area should assess the significance of the loss of the medicine (whether it is a CD or not) and then determine if the procedure set out for missing CDs will be followed (see Section 9.10). If theft or fraud is suspected see sections 3.3 & 3.4. All losses involving CDs must be referred as soon as possible to the senior nurse who will contact the Duty Pharmacist as necessary and the procedure set out in the Controlled Drug section of the Medicines Code must be followed.

6.2.5 Apparent loss within the pharmacy

Any apparent loss of medicines within the pharmacy must be reported immediately to the Duty Pharmacist. The senior pharmacist and the person reporting the loss should examine the records against the physical stock to confirm the apparent loss. If no satisfactory explanation is forthcoming the senior pharmacist will inform the or their deputy who will again check the stock records against physical stock. Should the apparent loss remain unexplained, the Director of Pharmacy and Medicines Management or deputy will inform the Security Manager of the loss and in consultation with him/her may report the incident to the Police and ask for an independent investigation. The relevant disciplinary and finance procedures will be applied, if appropriate.

6.2.6 Dispensing errors discovered on a ward

When an apparent dispensing error is discovered on a ward or in a department the WRN lead in charge of the ward or department will contact the pharmacy as soon as it is practical, in order to confirm the status of the medication and ensure that where necessary a new supply is made available to the patient . The ward staff should complete a Clinical Incident Report on Datix detailing the error or provide information to the local hospital pharmacy for completion. Dispensing errors are considered ‘must report incidents’ within the C&V UHB policy for clinical incident reporting.

The pharmacist receiving such a report will complete a pharmacy incident report to be submitted to the local pharmacy operations manager. The pharmacy will maintain a record

of such incidents for audit and clinical governance purpose. If a patient has wrongly received any medicine, the consultant in charge of that patient will be informed of the incident so that any clinical action needed can be taken, and that the patient and/or relatives can be informed.

6.2.7 Samples of medicines left by pharmaceutical representatives

It is imperative that C&V UHB must know what products are being used within its boundaries. Samples of medicines must not be left in clinical areas, or issued to individual healthcare staff by pharmaceutical representatives for use within C&V UHB. Representatives wishing to discuss supply of samples for use for evaluation of a medicinal product must be referred to the hospital pharmacy.

6.3 Transport of medicines

When medicines are being transported from the pharmacy to ward or unit it shall be in such a manner that ensures they reach their destination safely, undamaged and have been kept under the correct storage conditions. Each hospital pharmacy will put in place a system for recording dispatch and delivery of medicines from the originating pharmacy.

6.3 1 Storage conditions in transport

Whenever medication is to be transported from one area to another, then the recommended storage conditions e.g. Safe storage for Controlled Drugs, temperature or humidity must be considered and the method of transfer must take these storage conditions into account. When sending out items with highly sensitive temperature conditions e.g. vaccines, it is good practice to notify the receiving unit of the day/date of transportation to maintain the cold chain as described in the NPSA Rapid Response directive (RRR008 Cold Storage)

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6.3.2 Packaging for transportation

When transporting any medicine, due regard must be taken of the fragility of the item being dispatched. Those items known to be fragile e.g. items already packed in a glass container, or items which are known to have a COSHH hazard must be packed carefully (these may require extra padding around the container) in order to remain intact throughout the transport process. It is essential that when the item reaches its destination it is still intact and can be used for a patient.

Pharmacy must be notified immediately of any damaged receipts

6.3.3 Transport documentation

Medication should only be transferred from pharmacy to a ward or unit on the same site by hospital staff. In most cases this will be pharmacy/hospital porters. Other staff e.g. pharmacy, nursing or health care workers can also transport medication, but only if they can be identified by their employer identification badge. For any transfer that is going off site to another health premises, then the person carrying out the delivery must sign a pharmacy transport note on pickup within pharmacy and also ensure that the receiving staff signs for receipt of the medication to ensure a complete audit trail. The carriers in this case will be signing for the outer transport bag or box and not for the individual contents. The record of receipt will be returned to the supplying pharmacy as soon as possible. If voluntary transport arrangements are in use then a badge or similar identification system must be in place.

Chapter 7 – Administration of Medicines

The purpose of this section is to establish the principles for safe practice in the management and administration of medicines by registered nurses, midwives and other healthcare professionals. It is aligned to the Nursing and Midwifery Council Standards for Medicines Management (2010) and the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS "015).

Definition of administration: Administer is 'to give a medicine either by introduction into the body, whether by direct contact with the body or not (e.g. orally or by injection) or by external application(e.g. application of an impregnated dressing)

Definition of second checker: A staff member usually authorised to administer medication or a person on a training placement from a university course that is undergoing training for registration as a nurse or health professional. In certain defined situations the second checker may be a health care support worker who has undergone training for this task.

Remember:

In order to administer medicines safely the person administering must:

- Establish the identity of the patient in accordance with the UHB Patient Identification Policy.
- Check the prescription is clearly written, unambiguous and appropriate for the condition being treated
- Check that the patient is not allergic to medicine to be administered.
- Check the medicine against the prescription to ensure correct dosage, route and timing of the administration.
- Check the expiry date of the medicine to be administered.
- Ensure that the patient takes the medication
- Make a clear and accurate recording of initials on medicines administration chart once you are sure all medicines administered have been taken/applied. Medicines intentionally withheld or refused by patient must be annotated with the appropriate code and where necessary an entry made in the patient's notes.

Note: Medicines must never be left unattended, and must be securely stored when not in use.

7.1 Persons who are authorised to administer medicines

All health professionals set out below and deemed competent to administer medicines can administer medicines on the authorisation of a medical practitioner, dental officer, and non medical prescriber. Patient group directions only authorise those named within the PGD to administer the particular medicine. For in-patients they must be prescribed on an approved computer prescribing system or the appropriate hand-written prescription chart or stationery approved under a model of service. It is recommended that medicines to be administered orally and by injection should be prepared and given at different times.

7.1.1 Nurses and Midwives authorised to administer medicines

All nurses and midwives with a current registration with the NMC and assessed as competent within Cardiff and Vale UHB including bank nurses. Agency nurses must have received appropriate training and assessment by the agency providing the nurse and the agency must be able to demonstrate this to the UHB.

7.1.2 Non-nursing staff authorised to administer medicines

- Registered Medical Practitioners and Dentists
- Registered Operating Department Practitioners with the appropriate training and assessment of competence
- A nurse in training or student under the supervision of a registered nurse (Level 1) or registered nurse (Level 2) or midwife who remains accountable for ensuring that the correct procedure takes place
- After appropriate training and competence assessment specific medicines may be given by Pharmacy staff, Radiographers, Podiatrists, ECG Technicians, Physiotherapists and Clinical Support Workers

7.1.3 Administration requiring two registrants

It is recognized that all healthcare professionals can make human errors. For the following types of medicinal products an independent full process two person check is recommended practice to reduce the risk of adverse drug events. In C&V UHB this is required in the following processes

- All medicines administered to a child less than 16 years of age. (with the exception of Teenage Cancer Trust where oral medicines are administered with a single nurse check to patients of 14 years and upwards).
- Controlled Drugs see 9.9
- All intravenous, epidural injections and infusions.
- Where a calculation is involved

By definition the independent check must not be controlled or influenced by any other person. The independent check must include that the medicine matches the prescription, that the correct strength, dose and form has been selected, including any calculations that must be clearly documented, that the product has not expired and the patient is not allergic to the particular medicine. The process must include a check of the patients identity at the bedside and the administration or start of the administration. Accountability for the preparation and administration remains with both professionals.

The checking of medicines by a second healthcare professional does not apply in areas of anesthesia and resuscitation where the doctor or dentist can administer medicines alone. The checking of medicines by a second healthcare professional may not apply in community practice e.g. at a patient's home. However independent checking is required for any medicine, which the primary administrator is unfamiliar with, in particular**,** those medicines that are to be administered parenterally regardless of the professional group.

7.1.4 In the absence of a registered second checker

In certain clinical areas, and exceptional circumstance, if a second registrant is not available to act as a second checker, the Clinical Board can approve a process for a member of staff e.g. healthcare support worker, to undergo suitable preparation and assessment for acting as a second checker. In some instances this can include student nurses/midwives or operating department practitioners who are undergoing training in

medicines administration.

N.B. Student nurses/midwives or student operating department practitioners, cannot act as a second checker for IV preparation and administration of medicines. 1st year student nurses/midwives or student operating department practitioners cannot act as second checker for CD's.

7.1.5 Selection and administration

7.1.5.1 Selection of medicines

When a health practitioner is selecting a medicine for administration it is vital that the process results in the correct medicine to be given in the prescribed dose by the prescribed route and at the required time.

To support this process all medicines supplied from the pharmacy will be labeled by the original manufacturer or by the pharmacy in a manner that will allow identification of the medicine contents against the patient's prescription.

If the pharmacy repackages an original manufacturer pack, the pharmacy label will then identify the contents of the dispensed container. If the container is a box containing a strip of tablets it is good practice to confirm identity marked on the label with the tablet/capsule name and strength printed on the strip. This is necessary to ensure that a wrong strip has not been returned to another container box at a previous administration time. If the name and strength of a medicine is not clearly printed on a medicine strip, or a label seek advice from another health practitioner. If there is any ambiguity it is advisable to check with the local pharmacy to confirm identity of the medicine.

7.1.5.2 Safe Administration of medicines.

Remember in order to administer medicines safely the person administering must

- Establish the identity of the patient in accordance with the UHB Patient Identification Policy.
- Check the prescription is clearly written, unambiguous and appropriate for the condition being treated
- Check that the patient is not allergic to medicine to be administered.

- Check the medicine against the prescription to ensure correct dosage, route and timing of the administration.
- Check the expiry date of the medicine to be administered.
- Ensure that the patient takes the medication.
- Make a clear and accurate recording of initials on medicines administration chart, of all medicines administered, intentionally withheld or refused by patient. Where necessary an entry into the patient's notes must also be made

It is the responsibility of the Ward Sister / Ward Unite Manager/ Unit Lead to ensure that standards of medicines practice are adhered to and ensure that the person administering medicines has received the relevant training and education to enable them to safely administer medicines.

To ensure medicines are safely administered the administrator must-

- Know the therapeutic use of the medicine to be administered, its normal dose, side effects, precautions, contra-indications and monitoring requirements. In the event that the administrator is not aware of this information, they must be able to locate the information before administration. (Sources include BNF and Medusa).
- Be aware of the patients care plan, the patients condition, in particular with regards to their medication needs.
- Be alert to potential errors in prescribing or dispensing.
- Contact the prescriber without delay if :-
  - Contraindications to the medicine are identified
  - The patient develops a reaction to the medicine
  - Assessment of the patient indicates that the medicine may no longer be suitable for the patient

7.1.5.3 Non- administration of medicines.

In some circumstances it may be appropriate for the administrator not to administer the prescribed medicine, either because they are unable to administer (e.g. patient refuses) or

because the administrator feels there is an appropriate reason to withhold (e.g. with holding anti-hypertensive medication if the patient's blood pressure is too low). In the event of the non administration of medicines the administrator must annotate the medicines administration chart with the appropriate code. i.e.

X – Prescribers request.	2- Patient not on ward.
3 – Patient unable to receive/no access.	4 – Patient refused.
5 – Medicines unavailable.	6 – See notes.

It is the administrator's responsibility to inform the patient's medical team, or the ''on call' medical team, that the medicine has not been administered, the reasons why, and to discuss the need for alternative action. The patient's condition must be taken into account to determine the urgency with which this information needs to be passed onto the medical team. Discussion with the pharmacist may facilitate this.

If for any reason it is not possible to administer the medicine, then the following guidance should generally be observed, but if the administrator has any concerns they should seek further advice, from the prescriber, pharmacy or the BNF, especially where the prescription is for four hourly administrations.

Prescription is for	Guidance.
Once a day medicines	Administer the missed dose as soon as possible, up to 12 hours after the prescribed time.
Twelve hourly medicines.	Administer the missed dose as soon as possible, up to 6 hours after the prescribed time.
Eight hourly medicines	Administer the missed dose as soon as possible, up to 4 hours after the prescribed time.
Six hourly medicines	Administer the missed dose as soon as possible, up to 3 hours after the prescribed time.
Four hourly medicines	Administer the missed dose as soon as possible, up to 2 hours after the prescribed time.

7.1.5.3.4 Administration of medicines to adult with swallowing difficulties.

This section offers guidance for safe administration of medicines to patients with swallowing difficulties, it covers oral and tube administration of medicines. If a patient has difficulty swallowing tablets/capsules the prescriber must consider the need for treatment. Consider- benefit of treatment, non-formulary request, potential long term availability and cost implications. If available an assessment by Speech and language therapist (SLT) should be completed and recommendations followed. Consideration should be given to the following:-

- Is the swallowing problem likely to be short or long term?
- Is a licensed, formulary liquid formulation available?
- Is an alternative route (rectal, parenteral) available/appropriate?
- Does an alternative drug from the same class help address any of the above?

- Is enteral access available/needed?

Contact pharmacy to discuss if crushing tablet/opening capsule or use of enteral route is appropriate. Some advice is detailed below

Standard tablets

Ordinary release tablets are usually made by one of two methods, direct compression or wet granulation. A variation in the excipients used in the tablet formulation will affect the disintegration time of the tablet when it is placed in water. Several devices are available for crushing tablets. Use one per patient and care should be exercised to minimise risk of exposure to drug powder.

Soluble Tablets

A soluble tablet dissolves completely when placed in water to give a solution of the drug.

Effervescent tablets

These tablets will effervesce and disperse when placed in water and must be fully dispersed before administration to allow gases to escape. Care must be taken with sodium content.

Dispersible tablets

Although designed to be given orally, dispersible tablets disintegrate in water to give particles that may or may not suspend in water. Not all are suitable for administration via fine bore tubes. Care with sodium content.

Buccal/Sublingual tablets

These medications are designed to be absorbed through the oral mucosa and therefore bypass the first-pass metabolism effects of the liver. These formulations are a useful alternative for patients who are nil by mouth or are unable to swallow, providing the patient is able to produce normal quantities of saliva. They are not suitable for administration via enteral feeding tubes as significantly reduced drug absorption will occur.

Modified Release Tablets

As a rule these are not suitable for crushing or administration via enteral feeding tubes as the pharmacokinetic profile of the drug may change and result in excessive peak plasma concentrations and side –effects.

Hard Gelatin Capsules

Some capsules can be opened and the powder mixed with water. Some capsules contain granules rather than powder.

Soft Gelatin Capsules

These drugs are usually poorly soluble in water and are therefore contained in an oily solution within the capsule. These are not suitable for administration via an enteral feeding tube. It may be possible to pierce the capsule shell using a pin and squeeze out the contents, however, accurate dosing cannot be guaranteed. The volume contained in the capsule can vary depending on the brand used.

Enteric coated tablets

These tablets are given an enteric coating to protect the drug from degradation by the acidic conditions of the stomach or to reduce the incidence of gastric side-effects. Crushing these tablets and administering via enteral tubes in highly likely to cause tube blockage. Stomach irritation and a decrease in effectiveness may occur.

Cytotoxic tablets - Do not crush – avoid contact

Where the enteral route is appropriate – use the procedure below (section 3). Reassess the patient and their treatment as the patient's condition changes e.g. daily. Note- the implications of crushing tablets or opening capsules include:

- Modifying the product, rendering it unlicensed and therefore the UHB accepts liability for any adverse effects. N.B. Liability will rest with the person administering the medicine unless UHB procedures are followed.
- Change in stability of the product
- Change in drug absorption and therefore amount of drug that the patient receives
- Potential increased risk of adverse effects
- Health and safety risks to staff and/or patient handling the medicine
- Cross-contamination or infection risk if appropriate procedures are not followed.
- Administering Medicines in Soft Food

Crushed medicines or capsule contents may be administered with a small amount of cold soft food such as a teaspoon of yoghurt (care with dairy products and drug interactions e.g.

quinolones, tetracycline) or jam. A small amount should be used to ensure the full dose is taken. Crushed tablets or capsule contents may taste very bitter; it can be helpful to mask the taste for patients taking these medicines orally by using strong flavors' such as jam or blackcurrant cordial. Medicines should only be administered in food with the patients' knowledge and consent. Hiding medication in food is considered "covert administration" and is only permissible in certain circumstances following a defined process (see 7.2)

Procedure: administration of medicines by crushing tablets or opening capsules

N.B The use of an oral syringe or standard medicine pot is contraindicated for administering medicines to dysphagic patients (see below)

Obtain pharmacy advice on suitability and implications of crushing tablets/opening capsules for each medicine. Advice is available from ward pharmacist, medicines information (UHW Ext 42979) or if urgently required out-of-hours, the on-call pharmacist.

- Advice on preparation and administration must be documented on the drug chart (or supplementary chart if necessary- attached to the drug chart)
- Confirm dose (adjust if necessary) resulting from change in form.
- Where capsules are opened or an injection is to be given orally use a clean receptacle reserved for the specific patient.
- Where tablet is to be crushed use a tablet crusher reserved for the specific patient (and wash thoroughly between uses). Crush to a fine powder.
- Add 10-15ml sterile water to the crushed tablet, capsule powder or viscous injections to make an appropriate solution or slurry. Check the appropriate consistency that Speech and Language assessment advised e.g. normal/syrup/custard thickness.
- Consider whether administering medication from a medicine spoon or Kapi cup is most appropriate for the patient (obtain advice from speech and language therapist if necessary). N.B syringing medication orally is contraindicated in dysphagic patients as it can increase risk of aspiration. The standard medicine pots are also contraindicated in dysphagic patients due to increased risk of aspiration associated with tilted back head position.

Unless advised by pharmacy otherwise, administer each medication separately. Do not mix any medications prior to administration. Administer immediately after preparation and ensure the full dose has been taken.

Procedure: administration of medicines via enteral feeding tubes

Do not administer medicines via tubes that are being used for aspiration or are on free drainage.

- Where a multilumen tube is in use, ensure the medicine is administered via the lumen with the correct output position. Ensure any other ports are closed and airtight.
- Ensure the prescription chart indicates the appropriate route of administration (if not-contact the prescriber).
- Ensure the enteral feeding tube is patent.
- Stop/suspend any enteral feed which is running. Consult pharmacy for advice on appropriate timing intervals
- Flush the feeding tube with 30ml sterile water.
- Draw medicine into an oral/enteral syringe of suitable volume. A parenteral syringe must not be used.
- Ensure an airtight connection of syringe to the enteral tube.
- Administer each medicine in turn, flushing the tube with 10-20ml of water between medicines. The volume used should reflect the diameter of the lumen to prevent build up on the inner wall of the tube but take care with fluid-restricted patients.
- Flush the tube with 15-30ml of water on completion.
- Restart the enteral feed where appropriate

7.1.6 Administering cytotoxic medication

Cytotoxic chemotherapy can only be administered to patients by those specific health professionals authorised to administer cytotoxic chemotherapy by the C&V UHB**.**

7.2 Administration via the intravenous route

Practitioners (including doctors, dentists, nurses and other health professions) are permitted to administer intravenous medicines provided they have received UHB delivered or endorsed appropriate education, training and assessment of competence. All intravenous medicines and fluids should be prepared and administered in accordance with C&V UHB approved local procedures (See Chapter 8). Practitioners can only administer intravenous cytotoxic chemotherapy as set out in Chapter 8.

Covert administration

The covert mediation guidance and decision tool is on the intranet.

http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/SURGICAL_SUPPORT_CP/SPECIALTY/ATTACH%202%205%203%20-%20FINAL%20V%201%20COVERT%20MEDICATION.PDF

There may be times when a patient needs to be administered medication covertly – i.e. without the patient's knowledge.

It may be lawful to do this where –

- The patient is detained under the Mental Health Act 1983, the treatment is for mental disorder and the Consultant considers that it is necessary for the medication to be administered covertly, or
- The patient lacks mental capacity either to consent to, or to refuse, medical treatment, but will not accept it. In these circumstances, treatment can be given to the patient covertly if the decision to give it has been made in accordance with the Mental Capacity Act 2005 (MCA).

The impact on the patient of the covert administration of medicine must be considered carefully, as part of the best interests' decision making process. This is because the patient may regain capacity, understand what has been happening and lose trust in staff.

Given the risk of a breakdown in trust, the covert administration of medicines is likely to be appropriate only when the patient is unlikely to regain capacity to consent to or refuse the medicine. Covert administration of **any** medication (not just sedatives) can only be given in exceptional circumstances This applies to all employees of the UHB who may be involved in decisions about and/or the administration of covert medicine to patients of all ages. This includes locums and staff on honorary contracts.

A recent Court of Protection case regarding Deprivation of Liberty Safeguards (DoLS) considered at length the issue of covert administration of medication. This case has implications for all Clinical Boards within the UHB, Primary Care and the Supervisory Body

(DoLS). The ruling from the Judge with regards to the covert administration of medicines to a 92 year old woman in a care home included

- that covert medicines were being administered without any proper reviews or safeguards being in place, and
- the administration of covert meds contributed to the situation where the patient was being deprived of her liberty

He went on to say that –

- Covert medication can only be given after a best interests decision has been made, by involving relevant professionals and family members, and
- If the decision is made to give medication(s) covertly, a management plan to do this

The following sets out the issues to be considered/action taken when clinicians believe that covert medication may need to be given.

1) Covert medication can only be administered (except under Mental Health Act 1983) where
   - the patient lacks mental capacity to consent to/refuse the medication, and
   - does refuse it, and
   - it is felt to be essential for the patient's health, and
   - the circumstances are exceptional (see Nice Guidance)

2) Before the medication can be administered covertly (unless in an emergency), a best interests decision must be made involving the relevant healthcare professionals and the patient's family/friends. If the patient already has a DoLS authorisation, then the Relevant Person's Representative (RPR) must also be involved and the Supervisory Body informed in order to carry out a review.

3) If the patient (in a hospital or care home) is not already subject to a DoLS authorisation, clinicians must assess, using the DoLS Proforma whether an application for DoLS authorisation should be made, as the use of covert meds is an aspect of *continuous supervision and control*. If the patient is in their own home, Local authority legal advice must be sought.

4) If it is agreed that covert administration of medication is in the patient's best interests, then this decision, together **with details of the individual medication**(s), must be clearly and fully recorded in
   - the medical and/or care home records
   - any best interests assessment (DoLS)
   - any DOLS authorisation

5 If there is disagreement, then legal advice must be sought.

6 A management plan must be agreed and drawn up, to include timeframes and review frequency. It must specify that if medication is to be changed, a further review of the use of covert medication must be held and the Supervisory Body informed.

7 Reviews must involve the relevant healthcare professionals, the patient's family/ friends and the RPR (if in place).

8 Conditions should be included in any DoLS Standard Authorisation regarding the use of covert medication and timescales of reviews.

7.3 Self administration – Patient Orientated Medicines System (POMS)

Cardiff and Vale UHB is committed to the continued improvement of patient care. The POMS is regarded as the model for best practice in medicines management for hospitals. It provides substantial benefits for patients and hospitals. The opportunity for self- and/or supervised administration of medicines allows :-

- Improved opportunity to clarify regular medication and inform the therapeutic management plan.
- Difficulties with self-administration of medicines to be identified during the hospital stay.
- Improved opportunity to educate patients on their drug treatment
- Increased patient understanding and reduced potential for re-admission due to medication error.

POMS facilitates and supports the appropriate use of patients own medicines and self administration whilst in hospital. The aims of the POM system are :-

- To ensure that the patient, where able, understands their medication plan and is involved in their medicines administration at the appropriate level whilst an inpatient.
- To ensure that the patient is fully prepared for discharge.
- To avoid duplication of prescription dispensing and reduce waste.
- To facilitate continuity of prescribed medicines between primary and secondary care settings.
- To limit unnecessary changes to long term medicines treatment.
- To improve the quality of information to the patient and all relevant parties within the medicines management process

Most of the medicines brought into hospital by patients, where POMS is not in place, are destroyed due to a lack of storage facilities or the systems to ensure they are safely returned to the patient. Utilising patients own medicines whilst in hospital can help to reduce prescribing errors as well as avoiding duplication of supply. Costs are kept to a minimum and waste reduced. People at home usually administer their own medicines. With the appropriate assessment it is logical for patients to have access to and administer their own medicines. Nurses play a major part in education of these patients to ensure the safe and effective use of the medicines, to allow self medication in hospital to develop further. For the purposes of this procedure, the word medicine describes any medication that the patient has already used or, with appropriate support would reasonably be expected to use at home.

Using Patients own medicines.

Patients should be encouraged to bring in their own medicines. All patients should be asked if they have brought any medicines with them, any medicines remaining at home should where possible be brought in. All medicines must be locked in the patient's bedside cabinet, or temporarily in another secure location e.g. in admissions areas where cabinets are not available.

Medicines brought in from home remain the patients property and consent must be sought and given for their continued use in hospital or, where appropriate, destruction.

Patients have the right to refuse consent for continued use or destruction. Where destruction

is advised, due for example to medicines being no longer required or expired, patients should be advised of the associated risks.

Medicines will be assessed for continued use using the suitability criteria set out below. This can be done by a pharmacist or medicines management technician on their next routine visit.

A nurse may administer patient's own medicines prior to them being assessed formally by pharmacy if they are satisfied of their suitability using the criteria below.

- Medication must be clearly labelled with, the name of the patient, the name and strength of the medicine, the date dispensed (this should be less than 3 months ago)
- Where dosing instructions are given they should be current and correct.
- If the medication has not got a patient specific label, it should not be used unless it is a) in a blister pack with a clearly marked expiry date or b) is a clearly identifiable medicine in an original container, with an expiry date.
- If the medication has a short shelf life (eg. GTN tablets, eye drops) or if they require storage in a fridge, check their use with the patient and use individual judgment.
- Appearance of the container, label and medicine should be acceptable, ie. intact, clean, with no visible signs of deterioration.
- Check with patient that the medication has been stored properly. If in doubt do not use.
- If patient's medication is provided in a compliance aid, eg Dosette, the medicines may only be used if the patient is self administering at level 3 and there have been no changes to the medicines regime.
- Medicines should be discarded and returned to pharmacy with the patients consent if, the expiry date has been reached, medicines are in poor condition or mixed in one container.

Professional discretion should remain the overriding factor in assessing suitability of medicines.

Storage of medicines on POMS wards.

Supplies of oral medication for all patients are kept in a locked cabinet attached to their bedside locker. Each cabinet will have a lock operated by a single key, or key code. A master key/ master code system will be in place for nurse administration/ stock renewal etc.

It is the responsibility of the registered nurse to remove medicines no longer required from the patient's medicine cabinet.

Overall responsibility for the safety and security of patient medicines cabinets and medicine cupboard keys/codes, lies with the ward manager. The nurse in charge will hold the master key/be responsible for code system.

Each ward may have up to 4 master keys, for use by team nurses at the discretion of the ward manager nurse. These master keys must be on the nurse's person or locked away at all times. Ideally a shift by shift handover of keys should be done to account for the whereabouts of the keys. Procedures must be in place in order to ensure code systems remain secure, this includes identifying which staff have access to the codes, and when codes need to be changed, and who's responsible for change.

Patients assessed as self medicating (level 3 discussed in section 4) can be given the individual key/code to their patient medicines cabinet. They must be made aware of the need to keep the key/code out of sight and to return it to the nurse on discharge; however it remains the responsibility of the nurse to retrieve the key/code from the patient on discharge.

Patients at Level 1 and 2 must not be given access to the key/code to their medicines cabinet.

If ke the
system remains secure. If this is not achievable this must be reported via the clinical incident process

Ordering of replacement/duplicate keys/code systems must be made via the appropriate source, please discuss with the Nurse Advisor Medicines Management.

Supply of medicines from pharmacy will occur in the following ways:

Stock.

A technician will be assigned to top up the stock cupboards at least once a week, there will be two types of stock:-

- Labeled POMS pre–packs of medicines used frequently in the area. The nurse must complete the label with the patient's name and date and then place in the patient's medicine cabinet.
- Stock packs – frequently used medicines, these are for use in one off or PRN dose administration, (and issuing a pre-pack may be wasteful). The stock packs do not have patient's labels on them and must never be placed in the patient's medicine cabinet.

Patient's own medicines.

If a patient has brought medicines into hospital that are deemed suitable for continued use they will be placed in the cabinet and used to administer. When re-supply is indicated, if the medicine is not available as a POMS pre pack a supply will be dispensed from pharmacy with a label with patients name and dosing instructions. There will be at least 7 days supplied.

NB when individual supplies arrive from pharmacy it is the registrant's responsibility to place the item in the patient's medicines cabinet.

Staff Education.

It is the responsibility of the Ward Manager/Clinical Lead, to ensure that the registered staff working in their ward have been appropriately trained to work within POMS.

It is the responsibility of the registrant to identify to the Ward Sister/Charge Nurse/Clinical Lead if they require training or updates. A register of staff who have received training should be kept locally.

Medicines Administration on a POMS ward .

All patients admitted to an area where POMS is in place must be assessed using the identified assessment chart (in the UHB risk assessment document). A patient specific plan for appropriate re-assessment must also be identified. NMC Standards for Medicines Management, states that the responsibility for this assessment lies with the registrant. The assessment process ensures that the patient is placed at the right level and this minimises risks associated with self administration.

- Level 1: Registered Nurse Administration.
  Registrant administers medicines giving full explanation to patient. The patient does not have access to the key. The registrant initials the drug chart as appropriate at time of administration.

- Level 2: Patient Administration under Supervision.
  The patient administers medicines but under the supervision of the registrant. The patient does not have access to the key. The registrant initials the drug chart as appropriate at time of administration.

- Level 3: Patient Administration without Supervision.
  The patient is happy to self administer their medicines, signs consent and continues to

administer their own medicines without supervision and is given a key to their cabinet. The registrant is responsible for checking that the patient is aware of any changes to regime and is compliant and happy to continue. The registrant is required to sign the prescription chart at least once in 24 hours to demonstrate this has been done.

The registrant is responsible for acting upon a patients changing condition and move the patient to the appropriate level – NB Patients can move up or down a level.

Patient Education.

The NMC state that patient education is the professional responsibility of the nurse, in conjunction with the pharmacy and medical team. All patients must receive information regarding correct use of their medicines before commencing a self administration scheme and prior to discharge. Knowledge should be checked and reinforced throughout the process. The information can be verbal, written and where appropriate a combination of both, it should include

- The name of the medicine.
- The purpose of the medicine.
- The dose and frequency of the medicine.
- Any special instructions
- Possible side effects.
- Duration of treatment.

The Medicines Reminder Card is designed as a prompt to patients and is important when patients are self medicating and at discharge to aid compliance. It is not a prescription, and patients must be encouraged to refer to the medication label for instruction.

The Medicines Reminder Card should be completed by the registrant caring for the patient. The content of the card must be fully discussed with patients who have been assessed as Level 3 before starting self medication. The card must then be checked and, where required, updated at least once in 24hrs, and after every prescribing change. The medicines reminder card should be made available with the patients in patient medicines chart, for checking by the Pharmacist. On discharge the card should be discussed with patients as their condition allows.

At discharge wherever possible the card should be available with the TTH to be checked and signed by the Pharmacist. If the card is not present with the TTH or unavailable then a check

against the TTH and drug chart must be made by the registrant responsible for discharge and signed accordingly.

Controlled Drugs

Patients assessed as being at Level 1 or 2 follow the UHB Policy for Safe Ordering, Storage and Administration of Controlled Drugs. Patients assessed as being Level 3 can self administer oral controlled drugs if their regime is stable. CD's brought in by patients can be assessed for suitability for continued use. If a hospital supply is required for self administration a TTH must be generated and a maximum of 14 days will be supplied. Whilst the CD are the patients own medicines and they are responsible for them, appropriate assessment will minimise associated risks. A dose by dose record will not be made in the ward CD register.

Transferring Patients.

Lockers with medicines cabinets attached should not be transferred to another ward as the assigned master keys for the receiving ward may be different.

When a patient is moved to another ward please follow the following steps:-

- The registrant must remove all the medicines from the patient's medicine cabinet.
- The medicines should be placed in a pharmacy bag. These are available on POMS wards and usually used when patients are going home.
- The medicines should be taken with the patient and given to the registrant receiving the patient on the new ward.
- The medicines should then be placed in the patient's medicine cabinet if a POMS ward, or in the ward medicines trolley.

Discharge Medicines.

A TTH must be written when a patient is being discharged, this must be clinically checked by a pharmacist. Pharmacy staff will then check the patient's medicines on the ward for suitability and length of supply. This process will normally be instigated by your ward pharmacist, or by bleeping the discharge pharmacist for your area.

- You may occasionally (e.g. at weekends, or for unplanned discharges) be asked to send the discharge advice letter (DAL, or TTH) with all medicines from the patient cabinet and the in-patient drug administration record and any associated

supplementary charts to pharmacy, but you should only do this if specifically requested to by pharmacy staff.

NB – It is the responsibility of the discharging registrant to complete a final check of the discharge medicines against the TTH before the patient leaves. This check should be done with the patient wherever possible.

Non-availability of medicines

If the pharmacy department is advised by a supplier of the unavailability of a medicine it will communicate this information to medical and nursing staff as soon as possible. The pharmacy department will seek availability of any alternative that could be used. It is helpful to medicine users to know if the supply interruption is short or long term so that all avenues can be considered for temporary or long term therapeutic options.

Medication is an essential part of a patient's treatment and it is important that they receive their prescribed medication in a timely manner. This Code also covers those instances when the medication is not on the ward for administration at that appropriate time.

7.6.1 Non availability during pharmacy department opening hours

When medicines are newly prescribed for any patient, ward staff should consider if the medicines are on the ward stock list or not. If not, then they should bring this fact to the attention of the pharmacy staff providing services to the ward. If the item is urgently required, and no pharmacy staff are available, then ward staff should order the medicine from the pharmacy dept by using the appropriate medicines requisition form or local hospital pharmacy ordering system.

Newly admitted patients should have their medicines reconciled by a member of the pharmacy staff, which will include an assessment of which medicines need to be supplied.

If any medicine is unavailable from the pharmacy department, then it is the responsibility of the pharmacist to inform the ward staff of that fact, and to discuss the options e.g. wait for the original patient's medication to be brought into the hospital or arrange for a prescription change to a formulary medicine.

7.6.2 Non availability when pharmacy is closed

If a medicine to be administered to a patient is unavailable, then a decision must be made by the staff looking after that patient as to the urgency and necessity of the patient having that medication. If a decision is made that the medication is required to be given before

pharmacy reopens, then the ward staff must ensure that every effort is made to find an alternative way of obtaining it. Medications which are likely to be urgent are

- Intravenous Medicines
- Medicines to treat acute symptoms e.g. chest pain and agitation
- Antibiotics
- Steroid
- Anticonvulsants

Check the stock holding in the hospital's emergency room/cupboard on the intranet/printed list, then follow the local procedure for access to this supply. Take full packs from the emergency medicines room/cupboard and make a record what has been taken.

Ask the advice of the senior nurse on duty within the hospital to check about the possible availability of that medication on other wards or units within the hospital. Obtaining a supply of medication from one ward to another should only be carried out with the consent of the senior nurse on duty within the hospital. For Controlled Drugs Record (see Section 9.8.1).

If neither of the two options above enables supply of the urgent medicine, then contact the Emergency on call Duty pharmacist in accordance with local procedures, who may recommend an alternative, or make a supply.

For the community hospitals a WP10 (HP) can be written and dispensed locally, or in exceptional circumstances the Emergency Duty pharmacist may be contacted in accordance with local arrangements.

7.6.3 Administration error – see 6.2.6

If a medicine is administered in error, the person administering the medicine must report the incident to the medical team responsible for the patient's care so that the situation can be assessed and determine that any appropriate medical action is taken. The medical team will inform the patient of the incident. The person administering the medicine must report the incident to their line manager. A clinical incident entry on Datix must be completed

Chapter 8 - Administration of Intravenous Medicines

The National Patient Safety Agency (NPSA) issued guidelines to promote the safer use of injectable medicines resulting from reports made to NPSA of errors and incidents in the use of injectable medicines. Developments in intravenous medicines have introduced precise reconstitution and administration techniques to ensure maximum efficiency of the medicine and minimise harm to the patient. The essential theme of these guidelines is that all staff involved with intravenous medication should be trained and sufficiently knowledgeable and competent in dealing with intravenous medication. The staff should also have guidelines, information and support in respect of the medication to ensure the correct prescribing, preparation, administration and monitoring of injectable medication at all times.

Epidural injections are clearly not for intravenous use, but the principles applied to training, prescribing, preparation, labeling and administration of IV medicines apply.

8.1 Professional responsibilities and accountability

Practitioners holding registration with their professional regulatory body are accountable for their actions and omissions. When administering intravenous medication staff must exercise their professional judgment as to their knowledge and experience in dealing with each individual medication. Where an individual member of staff is unfamiliar with a particular medicine, and/or has little or limited experience in administration of the medicine the individual must refer back to the prescriber or the pharmacy department for more detailed information. This information is also available from the electronic source The Injectable Medicines Guide (Medusa). Practice set out within this policy will apply to all practitioners/ staff who are involved in the prescribing, administration and safe handling of intravenous medication within the Health Board.

Each Clinical Board must ensure that all staff that are or may be involved in intravenous medication are :

- Able to access all policies, procedures and guidelines approved by C&V UHB for the use of intravenous medication.
- Given the appropriate level of training, retraining and competence assessment which must be recorded for their involvement with intravenous medication.

- Given information as to any medicine or device alert concerning intravenous medication, device or consumable which may be used in administering intravenous or parenteral medication within C&V UHB.
- Staff that administer cytotoxic intravenous chemotherapy and cytotoxic medication by other routes, must demonstrate that they have undertaken approved training.

8.2 Training and competency for IV and other routes of parenteral administration

All staff involved in the use of intravenous and other routes of parenteral medication must be trained and competent in all roles that they may undertake concerning parenteral medication. Within C&V UHB training programmes are in place to ensure that all aspects of intravenous medication usage are covered to include:

- Prescribing
- Preparation (including calculations)
- Labeling
- Administration
- Checks involved throughout the process (who and when)
- Devices used for administration
- Monitoring requirements
- Disposal of waste material
- Risks of using intravenous medication and how to minimize them
- Standard information sources available to Health Board staff concerning intravenous medication.

C&V UHB, through its Learning and Education Department, has set up a scheme to ensure that all staff involved in any aspect of intravenous medication has undergone the training and is deemed competent. The names of those deemed competent can be recorded on a database, but as a minimum will be recorded in the staff members personal file. As part of the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal a review of competence will take place every three years and where there has been a practice gap of 12 months or more.

Competence for administration of adult chemotherapy will be set out in standard operational procedures of the C&V UHB. Administration of intravenous chemotherapy is

limited to professionals who have completed the identified training and demonstrated competence.

8.3 Prescribing intravenous medication

Medicines should only be given by the intravenous route when the practicality and appropriateness of other routes has been excluded. The use of this route should be regularly reviewed in favour of switching to oral administration (or another route) as soon as clinically appropriate. When two or more patient medication records (prescription charts) are in use, it is essential that they are cross referenced so that practitioners are aware of all prescribed medicines. To ensure safe practice prescriptions for intravenous medication must specify the following:

- The allergy status of the patient
- Patient's name
- Prescribers signature
- The medication using approved name (in certain circumstances the brand and formulation
- The dose and frequency
- Date of initiation and route of administration
- Concentration or total quantity of medication in the final infusion container or syringe
- Name and volume of diluents and/ or infusion fluid to be used
- Rate and duration of administration
- Stability information to determine expiry date of the final product
- Type of pump or device number being used
- For children the age and weight should be specified
- Date for treatment review
- What clinical monitoring should take place, how often and for how long, (See product characteristics and e- Injectable Medicines Guide)

The use of a normal saline flush(sodium chloride 0.9%) (only), is considered an essential part of cannula care and intravenous medication/fluid administration. It should therefore be considered as inclusive in the prescription of intravenous medication/fluid and a separate

prescription is not required.

8.4 Storage of intravenous medication

The storage of intravenous and other parenteral medication (except large volume infusions) stocked on a ward or department must be in the appropriate locked pharmacy cupboard or fridge. Any medication issued for individual patients that require special storage will have this highlighted on the pharmacy label.

8.5 Preparation of intravenous medication

Whenever possible ready prepared injections, infusions or Centralised Intravenous Additive Service products (CIVAS) should be used. If any extra manipulation or medication addition is required then the staff involved must ensure that they are familiar and competent to carry out the preparation of this particular intravenous medication. Preparation and administration requires two registrants , see section 7.1.3

- Read all the prescription details carefully and confirm that they relate to the patient to be treated
- Confirm that the details on the prescription are correct e.g. dosage, diluents/s. concentration rate of administration and that the patient is not allergic to the medicine or any of its components.
- Ensure that the area to be used for the preparation is clean and clear of clutter. Ideally this should be a dedicated area just for the preparation of intravenous medication
- Assemble all the equipment and infusion devices required including flushes if they are required. Process the preparation using a non-touch technique (ANTT), i.e. avoid touching areas where bacterial contamination may be introduced e.g. syringe tips, needles and vial tops.
- Prepare the label (see below)
- Beware of confusion due to similar names and/ or packaging, by reading the labels carefully.
- Check expiry date of all the materials and medication used Check for damage to containers, vials, ampoules and packaging Confirm that the materials have been stored correctly Complete any calculations. These should be written in the patient’s notes and

checked by an independent practitioner who is competent in the administration of that intravenous medication.

- Hands must be cleaned according to the control of infection guidelines
- If a giving set is required it should be attached using the technique appropriate for the type of container. The line must be primed in accordance with nursing procedures.

8.6 Labelling of intravenous medication

All injections and infusion additives must be labeled after preparation. Under no circumstances should a practitioner have in their possession or vicinity two or more unlabelled syringes at the same time. If the syringe is to be administered via a pump device then it must be labeled in a manner not to conceal the syringe calibrations or as to otherwise affect the function of the pump device.

In Line with NPSA Guidance Labels for intravenous medicines should clearly state 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 practitioners preparing the medicine.

8.7 Infusion devices for intravenous medication

All infusion devices in use within C&V UHB must be of a type that has been approved. Staff who use a particular device must be familiar with the function and limitation of each device that they need to use and ensure that the device is suitable for administration of the medication or diluent that is being used. Additionally, staff must be aware of the compatible giving set/s which can be used safely with that device. All staff using infusion devices must have received appropriate training for use of that particular device and have been shown to be competent in the use of that device.

8.8 Administration of intravenous medication

Before administering any intravenous medication a practitioner should be aware of any monitoring of the patient that is necessary after the medication is administered, and then check the following:

- Patient's name and hospital/NHS number
- Prescriber's signature
- The medication using the approved name (in certain circumstances the brand and formulation)
- The dose and frequency
- Date and route of administration
- The allergy status of the patient
- Check that the medication is free of haziness, particles and discoloration.
- Concentration or total quantity of medication in the final infusion container or syringe.
- Name and volume of diluents and/ or infusion fluid to be used
- Rate and duration of administration
- Stability information to determine expiry date of the final product
- Type of pump to be used
- For children the age and weight should be specified
- Date for review of treatment
- That the medication is due at that time and has not already been administered.

The person administering the medication must record the administration as soon as possible after the event in the appropriate patient record. Ask the patient to report any soreness at the injection site or any change in their well being. When an infusion is running, it should be regularly monitored by a competent member of staff who has undertaken the appropriate competence training. Administration of intravenous medication requires two registrants, see section 7.1.3.

8.9 Patient monitoring with intravenous medication

Prior to the administration of any intravenous medication the staff that will subsequently be looking after the patient must be made aware of any specific clinical requirements as to the monitoring of the patient, preferably this should be in the form of written details. Any of the results or findings from the monitoring must be documented within the patient's notes and the prescriber informed of any deviations from the expected findings. The patient should be involved in helping staff by being made aware that they should inform staff of any changes in their well being. The nurse who is looking after the patient will make frequent checks for :

- Signs of leakage from site or infusion bag
- Signs of infection or inflammation at the infusion site.
- Remaining contents of the infusion bag
- Rate of infusion.

Where particular risks are identified, these need to be clarified with the prescriber prior to administration of any intravenous medication.

8.10 Infection control and personal protective equipment

As parenteral medication is accessing the body directly bypassing the normal infection barriers, it is imperative that the control of infection and the maintenance of the medicines sterility are made a high priority by staff that are undertaking the preparation and administration of the product.

Guidance on Personal Protective Equipment is set out in the local Infection Prevention and Control Procedures.

8.11 Disposal of waste material

All waste must be disposed of in line with the C&V UHB policy on waste which must concur with current environmental legislation. Any material that has been in contact with the patient should be classed as hazardous clinical waste and disposed of via the standard method for clinical waste. Any item deemed as 'sharps' should be disposed of by being placed in a 'sharps' bin even if they have a small amount of medication left inside them. Empty infusion sets can be placed in the yellow/orange clinical waste bags or in 'sharps' boxes.

For guidance on disposal of Controlled Drugs see chapter 9. or Guidance on disposal of Cytotoxic Chemotherapy Agents see Management of Parentral Cytotoxic Chemotherapy Policy.

8.12 Responsibilities of the pharmacist and the pharmacy department

The Pharmacist providing clinical services to a clinical area and its patients shall

- Ensure that a risk assessment is carried out on every new intravenous medication and, whenever possible a ready to use dosage formulation of the medicine is purchased in preference to any injection that needs manipulation prior to administration.
- Provide Information and advice is provided to all health care professionals on the administration of intravenous medication.
- Assist with the training of staff.
- Ensure that staff are aware of how to access the agreed standard references for intravenous medication.
- Ensure that all guidance produced for the prescribing and administration of any intravenous medication has been approved appropriately

8.13 Identifiable risks with intravenous medication

The following list is not exhaustive but includes some common general risks:

- Incomplete and unclear prescriptions that do not contain vital information concerning the dose, preparation or administration which can lead to possible errors and increased risk to patients
- Administration of medication by the wrong parenteral route i.e. giving medication by

the epidural route when the correct route should be intravenous.

- Absence of relevant and accurate information concerning intravenous medication
- Complex calculations needed for prescribing the correct dose, infusion rate or preparation of dilution for intravenous medication. Calculations should be independently double checked by a second registrant.
- Involvement of inexperienced staff (e.g. registrant or students in training) in some parts of the process.
- Selection of wrong medication or diluent.
- Use of expired items.
- Unsafe handling of toxic medication or non aseptic technique leading to infection.
- Failure to correctly identify and confirm identification of intended patient incompatibilities between medication, diluents, other medication and infusion sets or devices.

Chapter 9 - Controlled Drugs

This chapter will ensure that the UHB has a robust framework in place for the management of controlled drugs (CDs) in secondary care.

9.1 Accountability.

C&V UHB has identified the Executive Medical Director as Accountable Officer to be responsible for all aspects of the safe and secure management of CDs.

9.2 Roles and responsibilities.

It is the responsibility of the Clinical Boards to ensure that their staff are trained and competent to carry out the tasks required of them in the management of CDs.

The registered nurse, midwife or clinical lead in charge of a ward or department is responsible for the safe and appropriate management of CDs in that area.

The practitioner in charge can delegate control of access (i.e. key-holding) to the CD cupboard to another registered nurse, however, legal responsibility remains with the practitioner in charge. Whilst the task can be delegated, the responsibility cannot.

On occasions, for the purpose of stock checking, the CD key may be handed to a pharmacist or pharmacy technician on production of a current UHB ID badge.

If CD keys go missing, urgent efforts must be made to contact staff who have just gone off duty. The senior nurse on duty must be informed immediately and the pharmacy department when they next open if the keys are not located.

A duplicate set of CD keys must be supplied to the pharmacy department who will keep them secure. In the event that a set of keys goes missing and cannot be located the practitioner in charge should contact the pharmacy department or on-call pharmacist for advice. If necessary the duplicate set can be issued by the pharmacy or site practitioner. The senior nurse on duty must sign for the duplicate set.

If the original set of keys is located, the duplicate must be signed back into the pharmacy.

If the original keys are not found, the locks must be changed as soon as practical, and a duplicate set of the new keys given to pharmacy.

An entry of the incident should be completed on Datix.

When the locks on the CD cupboard need changing for reasons other than lost keys, a duplicate set must also be provided to pharmacy.

An authorised signatory is a qualified nurse, midwife or operating department practitioner (ODP) whose signature has been provided to pharmacy.

9.3. Controlled Drug Stationery

All stationery which is used to order, return or distribute controlled drugs must be stored securely and access to it must be restricted.
CD stationery (i.e. requisition books and registers) will be issued from pharmacy against a requisition that will be written by an authorised signatory from that ward or department. Stationery will not be issued against a signature that is not on the authorised signatory list.

A record will be made of CD stationery supplied by pharmacy.
The record will include:

- Date
- Ward/department
- Name of person ordering the stationery
- Type of stationery issued
- Quantity
- The serial numbers of the stationery – to be added at the time of issue
- Signature of the member of pharmacy staff making the supply
- Signature of the member of ward staff receiving the stationery

Loss of any CD requisition books must be reported to the pharmacy and an incident form, e-Datix completed by the area responsible for the loss of the requisition book as soon as possible following recognition of the incident.

When a new CD register is started, the balance of CDs in stock must be written into the new book promptly by a registered nurse and witnessed by a second nurse or another registered health professional. It is good practice to write the start date on the front cover.

Completed ward requisition books and CD registers must be retained for a minimum of two years from the date of the last entry by the ward or department. When the CD register is complete, write on the cover a date 2 years on from the last entry. This is the date that the register can be appropriately disposed of as confidential waste.

Other requirements for the retention of CD records are listed below:

- Aseptic Worksheets (paediatric) – 26 years
- Aseptic Worksheets (Adult) – 13 years
- Clinical trials – 5 years
- Destruction of CDs – 7 years
- External Orders and delivery notes – 2 years
- Extemporaneous preparation worksheets 13 years
- Prescriptions (inpatients and outpatients) 2 years

9.4. Storage of Controlled Drugs

Ward CD cupboards must conform to the British Standard reference BS2881 or be otherwise approved by the pharmacy department. This is a minimum security standard and may not be sufficient for areas where there are large amounts of drugs in stock at a given time, and/or there is not a 24 hour staff presence, or easy control of access. In this case, a security cabinet that has been evaluated against the SOLD SECURE standard SS304 should be used (www.soldsecure.com)

Where a ward or department is to be closed for greater than 5 days, Controlled Drugs, requisition books, registers and keys must be removed from the ward and stored in pharmacy. The stock should be reconciled against the levels in the register by 2 qualified members of staff. Either 2 ward staff or a member of ward staff and a pharmacist or pharmacy technician can undertake this role. A record stating “Number returned to pharmacy XX” for each drug held in stock. The CDs will be stored in a sealed box securely in the pharmacy. When the ward or department reopens the stock will be returned and reconciled immediately against the register and an entry made in the register “Number returned to ward XX”.

The measures below must be observed for the storage of CDs:

- Cupboards must be kept locked when not in use.
- The lock must not be common to any other lock in the hospital.
- Keys must only be available to authorised members of staff and at any time the key holder must be readily available.

- The cupboard must be dedicated to the storage of CDs.

9.5. Ordering and Delivery of CDs

Controlled drugs must be requisitioned using the controlled drug order book and the requisition must be signed in full by the nurse who is an authorised signatory for that ward or department. The name of the nurse must also be printed on the requisition. A copy of the signature of each authorised signatory should be available in the pharmacy department for validation. Ward or department managers will be responsible for ensuring that new members of staff provide a specimen signature to pharmacy and inform pharmacy when members of staff leave in order that their names can be removed from the approved list. Pharmacy will co-ordinate an annual update of the records held.

Each order must be in duplicate, with the white page as the top copy and one item ordered per page.

Requisitions must contain the following:

- Name of the hospital
- Ward/department
- Drug name, form, strength, ampoule size if more than one is available
- Total quantity required e.g. 5, 10 etc – not a number of boxes (i.e. one box). When quantities ordered do not correspond to a complete box the quantity will be altered by pharmacy to the nearest appropriate number.
- Signature and printed name of the registered nurse
- Date
- Signature of the person issuing from the pharmacy

The order book must be kept in a locked cupboard or drawer when not in use. Spare CD stationery must also be kept secure.

Each ward/department should only have one order book in use at any given time. If a ward/department has more than one controlled drug cupboard then a separate book may be used for each cupboard.

Orders for stock controlled drugs from the agreed ward stock list must be sent to the pharmacy before 10:00 a.m. Controlled drugs will normally be delivered to the wards by a porter at UHW and UHL.

Controlled drugs for departments or wards may be collected by a messenger who must be a member of UHB staff and bring an official organisational ID badge for identification. The messenger need not be a qualified nurse.
The messenger or porter transporting the controlled drug to the ward/department is responsible for the safe custody of the drug until signed for by the qualified member of staff.

Controlled drugs delivered by a messenger or porter must be checked immediately on arrival at the ward/department by a qualified member of staff. The pink copy of the requisition must be signed to accept the CDs onto the ward. On receipt the CDs must be entered into the controlled drug (CD) register immediately.

The following details should be recorded on the appropriate page in the CD register:

- Date of entry
- Name and signature of nurse making the entry
- Name and signature of the witness
- Balance in stock
- The serial number of the requisition
- Quantity received

9.6. Emergency supply of Controlled Drugs

Under normal circumstances all supplies of CDs must be through the pharmacy department. If a controlled drug is required urgently for a patient when the relevant pharmacy is closed, the drug is not available on the ward and no other drug is a suitable alternative, then one dose may be obtained from another ward.
The ward requiring the dose must take their CD register to the ward providing the dose. The dose of the drug required should be signed out of the CD register on the providing ward and into the CD register of the receiving ward by 2 qualified members of nursing staff. The following must be recorded in both CD registers:

- Date and time when dose is transferred

- Name of patient
- Names & signatures of nurses who transferred the dose
- Quantity transferred
- Balance in stock in both CD registers

9.7. Return of Controlled Drugs to Pharmacy

Controlled drugs are returned to pharmacy for two purposes, safe destruction or recycling and re-use. The following must be recorded in the ward CD register when CDs are returned to the pharmacy

- Date
- Name and Signature of the nurse.
- The name and signature of the pharmacist or pharmacy technician accepting the CDs for return.
- The quantity of drug being returned.
- Reason for return e.g. out of date, excess stock
- Balance remaining.

On return to the pharmacy, the pharmacist or technician who accepted the CDs for return and re-use must enter the CDs into the appropriate page in the pharmacy CD register immediately. The stock must be booked back into the computer stock balance and a reconciliation of the balance on the shelf, the balance in the register and the balance on the computer be made. All 3 levels must tally. Any discrepancy must be investigated immediately. The following details must be recorded on the relevant page of the pharmacy CD register:

- Date
- Ward from which the return is being made.
- The amount of preparation being returned
- The name and signature of the pharmacist or technician making the return.
- Balance in stock.

If the CDs are for destruction an entry must be made in the appropriate destruction register in the pharmacy - i.e. patient’s own or returned stock registers.

Patient's own returns can be destroyed without the presence of an Authorised Person. The details required in the register are:

- Date
- The ward & the name of patient, if appropriate
- The preparation and quantity being returned
- The name & signature of the pharmacist/technician making the return
- The next reference number for destruction

If the CD is "date expired stock" for destruction it must be entered in the destruction register for this purpose and the above details recorded as appropriate

9.8. Prescribing Controlled Drugs

Inpatient Prescribing

For hospital inpatients, CDs can be prescribed on the inpatient medicines chart or the anaesthetics card in line with local policies and procedures.

The written requirements for controlled drugs on these charts are the same as for other medicines: if prescribed "when required" e.g. for breakthrough pain, a minimum interval for administration should be specified e.g. every six hours; and a total quantity to be administered in 24 hours. **Prescribing for Outpatients or discharge prescribing** Prescriptions for CDs for outpatients or discharge must comply with all the requirements of the Misuse of Drugs Act. Prescriptions must be written on a discharge form or an outpatient form. Doctors who have not achieved full registration with the GMC are permitted to prescribe CDs for patients on discharge but not for out patients. Under normal circumstances a maximum of 30 days only should be prescribed. If there are compelling circumstances for the prescription of more than this duration then the reasons must be documented in the patient's notes. A prescription for a controlled drug is valid for a period of 28 days from the date of issue. **Documentation and Prescription** The prescription must be indelible i.e. written by hand, typed or computer generated. Addressographs may be used. If an addressograph is used, it must be tamper evident. Prescribers should also sign across a corner of the addressograph. This is a further safeguard to ensure addressographs are not tampered with or another addressograph is not placed on top of the one that the prescriber signed for.

The prescription must include the following details:

- The patient's full name, address and, where appropriate age
- The patient's hospital number
- The name and form of the drug e.g. tablets, capsules even if only one form exists
- The strength of the preparation, where appropriate
- The dose to be taken
- The total quantity of the preparation (liquids) or the number of dosage units (tablets, capsules, ampoule, patches) to be supplied in both words and figures

The prescription must be signed by the prescriber with his/her usual signature, in his/her own handwriting (this must be handwritten) and dated by him/her (the date does not have to be handwritten).

A pharmacist is authorised to dispense a prescription for a Schedule 2 or 3 controlled drug if it specifies the total quantity only in words or in figures, or if it contains minor typographical errors, provided that any amendments are indelible and clearly attributable to the pharmacist dispensing.

Nurse Independent Prescribers

Nurse Independent Prescribers are now able to prescribe any licensed medicine for any medical condition within their competence, including some CDs for specific conditions.

Nurse Independent Prescribers are permitted to prescribe, administer, or direct anyone to administer as prescribed.

9.9 Administration of CD

Controlled drugs must only be administered against a prescription signed by an appropriately qualified prescriber, or in the case of midwives a relevant drug protocol. Two practitioners must be involved in the administration of CDs; one of them must be a registered nurse, midwife, ODP or doctor. The second can be one of these groups or a 2nd or 3rd year student nurse, except when checking intravenous drugs. The exception to using student nurses is in paediatrics where 2 registered nurses must administer the CD. Both practitioners must be present during the whole of the administration procedure. They should both witness:

 The preparation of the CDs to be administered

 The CD being administered to the patient (except in the administration of CDs by midwives attending a home birth where a midwife has collected the CD form the Midwifery Led Unit, and single nurse practitioners in the community) The destruction of any surplus drug e.g. part of an ampoule not required

A record must be made in the ward or department CD register when a CD is removed from the CD cupboard. The following details must be recorded on the relevant page in the CD register:

- Date and time when dose administered
- Name of patient
- Quantity administered
- Name and signature of nurse who administered the dose
- Name and signature of the witness
- Balance in stock

If part of a vial is administered to the patient, the registered nurse must record the amount given and the amount wasted e.g. if the patient is prescribed 2.5 mg diamorphine and only a 5mg preparation is available, the record should show, "*2.5mg given and 2.5mg waste*" This must be witnessed by a second registered nurse who must also sign the record. If a second registered nurse is not available, the administration can be witnessed by any of the staff listed as appropriate checkers

Individual doses of CDs which have been prepared for immediate administration but not administered must be destroyed by a registered nurse midwife or registered health professional on the ward or department in the presence of a witness who can be another registered nurse, doctor, pharmacist or pharmacy technician. The reason must be documented and signed in the CD register by the practitioner and the witness.

9.10. Disposal/Destruction of Controlled Drugs

CDs must be destroyed in such a way that the drug is denatured or rendered irretrievable so that it cannot be reconstituted or reused. Where denaturing is carried out on the wards, the methods used should be those currently recommended by the Royal Pharmaceutical Society.

Any pharmacy held stock of obsolete, expired or unwanted Schedule 2 CDs, other than those returned by patients, which require destruction, may only be destroyed in the presence of an authorised person. Authorised witnesses currently include inspectors of the Royal Pharmaceutical Society, Police constable, the Accountable Officer and the Chief Pharmaceutical Officer to Welsh Government.

The Accountable Officer for the UHB can also nominate Executives of the organisation to witness destruction.

Until they can be destroyed, obsolete, expired and unwanted stock CDs requiring safe custody, must be kept segregated from other CDs in the CD cupboard. Stock CDs awaiting destruction should be clearly marked in order to minimise the risk of errors and inadvertent re-issue or administration.

Small amounts of CDs, for example, the surplus when a dose smaller than the total quantity in an ampoule or vial is drawn up or when a dose is drawn up but not used, must be rendered irretrievable by emptying into a yellow top sharps bin. The emptied vial or ampoule must then be placed in the sharps bin. When the bin is sent for destruction it should be labelled “contains mixed pharmaceutical waste and sharps – for incineration”.

Larger quantities of CDs, for example, discontinued infusions or patient-controlled analgesia (PCA) syringes, must be denatured on the ward using denaturing kits.

All destruction must be documented in the appropriate section of the CD register. It must be witnessed by a second professional such as a registered nurse, midwife or ODP. If any of the previously listed staff are not available to witness the destruction then a doctor, pharmacist or pharmacy technician may witness it. Both persons must sign the CD register.

Individual doses of CDs which have been prepared but not administered must be destroyed by a registered nurse, midwife or registered health professional on the ward or department in the presence of a witness and the reason documented in the CD register.

Controlled drugs that are time-expired or otherwise unfit for use (e.g. opened liquids) or are excess stock must be returned to the pharmacy for safe destruction.

If it is necessary to destroy the contents of a PCA/PCEA syringe that has been transferred to the ward, the destruction must be recorded in the CD register

9.11. Controlled Drug Registers and reconciliation of balances

The CD register must be bound with sequentially numbered pages and it should have separate pages for each drug, formulation and strength of formulation, so that a running balance can be easily kept. Entries must be made in chronological order, in ink or be otherwise indelible.

- If a mistake is made it must be bracketed in such a way that the original entry is still clearly legible. No crossings out or alterations are allowed. The entry must be signed, dated and witnessed by a second registered nurse, midwife or other registered professional. The witness must also sign the correction.
- On reaching the end of a page in the CD register, the balance must be transferred to another page. The new page number must be added to the bottom of the finished page and the index updated.
- The stock balances of all controlled drugs on all wards must be reconciled a minimum of once daily and a record of the check recorded. The registered nurse in charge is responsible for ensuring that the CD stock check is carried out by staff in the ward or department
- Original packs of CDs with intact tamper evident seals, do not need to be opened for checking purposes.
- If stock reconciliations do not balance, the matter must be reported immediately to the appropriate senior nurse manager who will inform a principal pharmacist/senior member of pharmacy team e.g. PSG bleep, or deputy at the earliest convenient opportunity. An investigation to confirm the loss will be undertaken by the senior nurse in conjunction with the ward pharmacist if necessary. A formal incident form must be completed with advice to the Accountable Officer on escalation.
- The pharmacy department will carry out a full stock reconciliation on the wards and departments at a minimum of every six months. The quality of record keeping will also be assessed at that time and feedback on the quality of record keeping will be discussed with the nurse in charge. If necessary, recommendations for improvements will be agreed.
- All controlled drugs in the pharmacy must be checked every 12 months. This check may be undertaken by any competent person approved by the pharmacist with

operational responsibility for CDs or a suitable deputy approved by the chief pharmacist.

- This check is in addition to the rolling checks on the CD register.

9.12 Use of a Patient's Own Controlled Drug on the ward

Temporary storage of patients' own controlled drugs on the ward may be necessary whilst they are awaiting collection and removal to the pharmacy or to the patient's home. In this situation, they must be placed in the CD cupboard but should be marked and kept separate from ward stock. An entry detailing the patient's CD must be made on Patients Own record of the administration of a dose must be documented in the CD register.

If patients' own CDs are not required for use during the patient's admission then one of the following actions should be followed and recorded in the CD register.

- If the patient or the patient's representative agrees, medicines may be sent to the pharmacy for safe destruction. The pharmacist must take responsibility for destruction. Document the agreement to destroy the drugs in the patient's notes.
- If the patient wishes, the medicines may be returned home via an identified adult. Responsibility for security is given to that adult and this action documented in the patient's notes. If the medicines are not safe and/or appropriate for use, then the patient and/or patient's representative should be advised and they should be encouraged to send them to the pharmacy for safe destruction. This must be documented as for any other CD returned to pharmacy.

- If a patient has brought in CDs and is awaiting assessment of competence for self administration, the CDs should be held in the ward CD cupboard until the assessment is completed. A record of the CDs must be made on a page of the ward CD register headed Patients' Own CDs.
- In areas where the UHB Patients Own Medicine procedure (POMS available on Cav. Web) operates, self administration of CDs is acceptable providing the following steps are undertaken:
- The patient must be assessed as competent to level 3 for self administration in the POMS procedure
- Where patients require extra supplies, they must be dispensed as for discharge i.e. using a TTH form – discharge prescription form.
- Patients receiving CDs for self-administration should sign for receipt of the specified number of doses. A separate page of the CD register can be used for this purpose.
- The CDs for patients who self-administer their medicines must be kept locked in their bedside locker. It is not acceptable for patients self administering CDs to keep them in any other place.

9.13. Controlled Drug discharge medicines (TTHs) and receipt of CDs by outpatients

When Schedule 2 CD TTHs are collected from the pharmacy, the person collecting them will be asked to sign for receipt. They may be signed for by a healthcare professional, porter or a healthcare assistant.

The following details will be recorded in the CD collection register:

- The date, the name, form and strength of the drug and the patient's name
- The name and address of the healthcare professional collecting the CDs
- The form of identification provided by the healthcare professional e.g. identity badge or whether the messenger is known to the dispenser.
- The name of the member of pharmacy staff handing out the prescription

When an outpatient prescription is being given to the patient or their representative or relative the following details must be recorded:

- Whether the person who collected the drug was the patient, the patient's representative or a healthcare professional acting on behalf of the patient

- If the person who collected the drug was a healthcare professional acting on behalf of the patient, that person's name and address (as above)
- 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.

9.14. Transfers between clinical areas

When a patient on a PCA/PCEA containing a CD transfers between 2 clinical areas the following steps must be taken:

- The nurse/practitioner transferring the patient must make an entry on the PCA/PCEA observation sheet detailing the amount left in the syringe. He/she must sign and date the entry.
- A second practitioner must sign and date the entry as a witness.
- The nurse/practitioner accepting the patient in the new clinical area must check the contents of the syringe on receiving the patient and sign and date an entry on the PCA record which must be countersigned by the nurse/practitioner transferring the patient.

A patient transferring between 2 clinical areas on a sub-cutaneous syringe driver containing a CD must have a similar record of the amount remaining in the syringe made on the Sub Cutaneous Syringe Driver Chart.

Patients' own CDs stored in a ward CD cupboard should be transferred with the patient. The CDs must be signed out of the first CD register by two registered practitioners and into the second CD register by two registered practitioners.

9.15. Controlled Drugs for Midwives

Midwives working in the Consultant Led Unit on UHB sites must follow all the elements of this policy.

A registered midwife may possess diamorphine, morphine, pethidine and pentazocine in her own right so far as is necessary for the practice of her profession.

Midwives providing care for women during a home birth where pethidine is required will acquire the pethidine from the Midwifery Led Units (MLU) where stock for community use is stored. The procedures for administration will be followed. Midwives will carry the pethidine in a locked box on route to the woman's home. If the pethidine is not used the midwife will return it to the MLU stock and record this in the relevant CD register.

9.16. Receipt and handling of CDs by pharmacy

The is responsible for the safe and appropriate management of CDs in the pharmacy. Day-to-day management of CDs in the pharmacy will normally be delegated to a suitably-trained, competent registered pharmacy technician or pharmacist. However, legal responsibility for CDs remains with the Director of Pharmacy.

On receipt of a CD order from a wholesaler, the CDs must be brought to the member of staff in the purchasing section with responsibility for processing CD orders. He/she will take the following action:

- The delivery will be checked against the order and delivery note for accuracy.
- The delivery will be locked in the CD cupboard/room at the first opportunity.
- The quantity delivered will be checked against the delivery note and added to the balance in the register. The new total must be reconciled with the CD register and pharmacy computer system balance. All balances must be reconciled.

- When the balance is reconciled, the CD delivery must be entered into the CD register and onto the pharmacy computer system balance.
- If there is a discrepancy between the order and the delivery, the delivery should be locked in the CD room/cupboard until the discrepancy has been investigated. This should be done within 24 hours when practical but at the earliest opportunity at times such as weekends or Bank Holidays.

9.17. Transfer of CDs using messengers

A person who conveys CDs between sites is acting as a messenger and is responsible for delivering a sealed or locked container. The seals or locks used must be tamper evident.

The messenger is responsible for the delivery of a sealed intact container.

A transport log will be used to provide an audit trail for the transport of CDs and will require a signature at each point of transfer. See Appendix 3.

The procedure below will be followed:

- The CDs will be sealed in the container for transport along with the CD requisition book.
- The white copy of the CD requisition will be annotated with “Into bag/container” rather than being signed and if a numbered seal is being used the number of the seal will be recorded on the white copy.
- The sealed bag/envopak/box will be signed for on the transport log by the messenger.
- On delivery to the receiving ward the transport log will be signed by a member of staff who is qualified to handle CDs.
- This member of staff will break the seal and verify the contents of the bag and match it the order. They will enter the CDs into their CD register in the normal way.
- Any discrepancies must be reported to the duty pharmacist immediately
- The white copy of the CD requisition and the transport log will be returned to the issuing pharmacy as soon as possible by the receiving clinical area.
- All members of UHB staff signing for CDs to transport must show a valid ID badge.
- If taxis are being used to transport CDs, a record of the taxi-drivers’ car registration or taxi licence number must be obtained.
- If, at any site, the sealed bag is to be left for collection, a signature from a member of UHB staff (e.g. a porter at the porters lodge) must be obtained on the transport log. Also if the driver is required to leave the sealed bag at a porter’s lodge for onward

delivery to the ward it must be signed for. The person signing to accept the bag for onward delivery must also obtain a signature from the destination ward/department staff on the transport log when they deliver the bag.

9.18. Controlled drugs within anaesthetic rooms

- A specific controlled drug record book is available for use in Theatres/Anaesthetic rooms within the UHB.

- Controlled drug supplies may be received directly from pharmacy or from theatres suite central CD stock.

- Receipt of controlled drugs may be undertaken and witnessed by a registered nurse or registered ODP

- The quantity supplied to a doctor for a specific patient must be recorded against that specific patient name in the controlled drug record book, signed for by that doctor and signed for by an authorised witness. The quantity administered to the patient must be recorded and signed for by the doctor. The quantity destroyed must be recorded, signed for by the doctor and signed for by an authorised witness.

- The doctor is responsible for this supply whilst in their possession.

- The stock balance must be confirmed at the end of each transaction i.e. receipt, issued to doctor and recorded in the relevant column.

- The stock balance must be checked at the beginning and end of each operating list. Stock reconciliation should be recorded in the stock checks section at the back of the controlled drug record book, which the checker and witness must sign.

Chapter 10 – Return, Disposal and Destruction of Medicines

Medicines that are no longer needed retain their legal status as medicines until such time as they are assessed and destroyed when their legal status becomes controlled under Waste Regulations. It follows that the management and handling of excess or unwanted medicines requires equal diligence to the management and handling of other medicines in current use.

10.1 Return of excess or unwanted medicines

10.1.1 Acute and community hospitals

All excess or unwanted medicines must be held within the ward or clinical area until such time as safe arrangements has been made for their disposal. Wards receiving stock control by pharmacy staff must not make returns without prior agreement with the pharmacy. Pharmacy staff will return stock to pharmacy at the time of stock control. Wards who order their own stock should notify pharmacy of any excess or unwanted medicines usually by e-mail. Safe arrangements should be made for the return of these excess or unwanted medicines to pharmacy during normal pharmacy opening hours, using hospital transport or a porter with an auditable record of dispatch. It would be considered good practice for wards to have a record of items returned.

10.1.2 Community nurses

Community nurses requested to return medication of patients in the community should encourage the patient or a carer to take them to the supplying pharmacy for destruction.

10.1.3 Medicines brought into hospital by patients

These medicines remain the patient's property, and when they are bought into hospital they should be identified and those products that are appropriate to be continued, are to be retained in the patient's PODs cupboard. Medicines not required should be sent home, or with the patients permission to pharmacy for disposal.

10.2 Disposal of cytotoxic medicines

Arrangements for the disposal of cytotoxic medicines should be in accordance with the recommendations contained in the current policy on the disposal of clinical waste.

10.3 Disposal of Controlled Drugs

Excess or unwanted CDs must be returned and disposed of in accordance with the Medicines Code Chapter 9.

10.4 Disposal of part used syringes and injections

Syringes that are not fully discharged and partly used infusion bags containing prescription only medicines (POMs) should be disposed of utilising an appropriate 'sharps' container. They must not be returned to pharmacy.

10.5 Disposal of medicines by the pharmacy

All disposal and destruction of medicines within the pharmacy must be in accordance with departmental procedures and in line with current Waste Regulations and guidelines from the Professional Regulatory body for pharmacy.

Chapter 11 - Defects, Hazards, Adverse Reactions and Incidents Involving Medicines

11.1 Losses and discrepancies

Loss or suspected loss or misuse of medicines should be reported to the Sister/charge nurse/clinical lead or nurse-in-charge and the senior pharmacist who can then decide on a further course of action. A Datix entry must be submitted

11.2 Management of medication errors

In order to prevent medication errors, it is in the individual responsibility of all practitioners to adhere to their Code of Practice, Regulatory Guidance, National and Local Policy and Procedures and to the C&V UHB Hospitals' Medicines Code at all times. Adhering to this guidance will maximise patient safety and minimise risk.

A medication error can be defined as a preventable error that may cause or lead to inappropriate medication use or patient harm while medication is in control of the health care professional or patient. Such events may be related to professional practice, health care products, procedures and systems including prescribing; order communication, product labeling, packaging and nomenclature; compounding; dispensing; administration; counseling and monitoring. Health practitioners should learn from any medication error, near miss or adverse outcome in order to prevent repetition. A balanced approach is required to protect patients and staff alike. Staff must be given adequate support by their line manager as applicable to the circumstances specific to the medication error.

The over-riding concern is to protect patient care and the immediate clinical action that may be required to reverse or negate any adverse clinical consequences.

11.2.1 Action to be taken in event of medication error

Action is to be taken following a medication error (this includes administration, dispensing or prescribing errors) that has led to inappropriate medication administration to a patient: - Patient safety must be maintained. Inform a member of the patient's medical team.

The patient must be reviewed and a medical action plan produced specific to the nature of the medication error.

The ward/department manager/nurse/clinical lead in charge must be informed.

In the event of a dispensing error that has led to inappropriate medication administration, inform a senior member of the pharmacy staff.

11.2.2 Reporting a medication error

All incidents involving medicines that have led to inappropriate medication administration must be reported using a Datix entry.

This is to ensure that the Patient Safety Team is informed of all incidents in a timely manner, delivery of the incident information should not be delayed until all proposed actions have been carried out. Instead, simply specify the actions proposed.

- When completing the report, the staff member involved in, or witnessing an incident must ensure that the details recorded are concise, a true version of events and complete. An appropriate record must also be made in the clinical notes, medical / nursing. This is not duplication since all events relating to the patient need to be clearly stated, as the incident report does not form part of the medical record. It is important for the person reporting the incident to confine themselves absolutely to the facts. There is no place for an expression of opinion however well meant. No reason for events is required, even if the person reporting the incident is implicated. Merely state the facts as they are. Further information may be required at investigation, statements from staff, number of patients, dependency, staffing levels, time of day and any other circumstances which might impact on the issues.
- A Medication Incident Investigation form for fact finding use is available as appendix 2 to the Medicines Code.

A senior member of the multi disciplinary team must inform the patient / relative and this should be recorded in the clinical notes.

Where equipment is involved in the medication error, staff must ensure that the item is removed from use immediately and defects are reported to the Biomedical Engineering.

11.2.3 Serious medication errors

A serious medication error is when patient harm occurs or is anticipated. In the event of a serious error the consultant must be informed as soon as possible. If this is outside normal working hours, the Site Practitioner must be contacted via switchboard. He/she will

then contact the on call manager / consultant as appropriate.

It is important that the Executive Medical Director, the Director of Nursing and the Director of pharmacy and the patient safety team are informed of the error and the relevant circumstances at the earliest opportunity. Serious incidents may be deemed notifiable to the Welsh Government and this is required within 24 hours of the incident or the next working day.

In the event of a serious medication error, the Patient Safety Team will facilitate the preliminary investigation under the guidance of the Executive Medical Director and Medicines Safety Executive

All serious medication errors along with patient related incidents will be reported to the National Recording and Learning System (NRLS) via the Patient Safety Team.

Error analysis and recommendations will be conducted in accordance with local procedures.

11.3 Near misses

Any event that would have led to an error but did not actually happen due to last minute intervention should be reported as a ‘near miss’. In clinical risk management terms, reporting a near miss is just as important as reporting an actual error. Medication errors are rarely the ‘fault’ of individual practitioners and are commonly the result of poor processes/systems. The collation of information on near misses can provide valuable data that may indicate poor system design.

It is important that the continued reporting of errors and near misses is seen as a means of learning in order to minimise future risk.

11.4 Medicines Safety Executive a sub group of the Corporate Medicines Management Group

Will review medication errors and pharmacy intervention data and undertake trend and root cause analysis. The group will co-ordinate actions required in the event of national safety alerts and produce and issue to the clinical areas any local safety alerts deemed appropriate. The group has the authority to initiate action, which may involve system

redesign and improvement and/or education, training and competency assessment of healthcare professionals on any aspect of medicines use.

11.5 Management of staff involved in medication errors.

All medication errors should be investigated locally to determine whether the incident is due to a system failure or inappropriate action(s) by a member of staff. This procedure will only be used if it is determined that the incident is the result of inappropriate action(s) by a member of staff.

Procedures need to be in place to identify if this is the first or subsequent time (s) the individual/individuals have been involved in such an incident and the time span in which the incidents have occurred. Consideration should be given to the circumstances surroundingthe incident and the individual's previous practice and performance.

In the event of a culpable individual making an initial error the recommendation will be to provide guided supervision to the staff member by their line manager. This will involve explaining the relevant area of the UHB Medicines Code. The error will be documented in the staff members personal file where it will remain live for 2 years.

In the event of a sentinel event involving medication errors a Root Cause Analysis and its subsequent findings will be used to determine the management of staff involved.

If an individual makes a subsequent medication error within a rolling two year period then they will be provided with guided supervision and be expected to undertake training, (during this time consideration may be given to refrain the individual from prescribing, dispensing or administering drugs until a formal session of training by nurses, midwives, doctors and pharmacists dependent on the profession involved this should include a competency assessment relating to prescribing, supplying and / or administration.

If however an individual's practice results in a 3rd error within two years and where the individual has been fully supported with education and deemed competent following previous errors within the preceding two years consideration of whether implementation of the UHB's Capability and/or Disciplinary Policies is appropriate at this point must be discussed.

Following a 4th error within a two year period the UHB Capability and/or Disciplinary Policies must be implemented.

Each profession will need to interpret this guidance according to their Professional Code of Practice

If a UHB bank member of staff makes a drug error they may be limited to where they can work until such time that training has been instigated and assessed.

If an agency member of staff makes an error they will be referred to their manager for training. Evidence of that training will be required by the UHB. If any subsequent errors are made, consideration will be given as to whether placement within the UHB is appropriate.

11.6 Reporting and recording adverse drug reactions and defective medicinal products

11.6.1. Adverse drug reactions

All suspected and confirmed adverse reactions to medicines including contrast media should be reported to the Commission on Human Medicines (CHM), Medicines and Healthcare Regulatory Agency (MHRA) using the "Yellow Card system", or available on line. These can be found in the back of each copy of the British National Formulary www.yellowcard.mhra.gov.uk The nature of the adverse reactions and the medicine involved should be accurately recorded in the patients' case notes. A clearly visible statement to the effect that the patient has suffered an actual or suspected adverse reaction to a given medicine should be permanently imprinted inside the front of the case notes and/or the electronic patient record and also on the in-patient chart (patient medication record) and out-patient and discharge prescriptions, either in large lettering or using specially prepared label.

11.6.2 Defective medicinal products

The Medicines and Healthcare products Regulatory Agency (MHRA) investigates all reports of defective medicines. Where the results of investigations have implications for other patients or users, the MHRA will issue a Hazard or Medicines Alert, which advises of hazardous products or unsafe practices.

Healthcare staff must report their concerns to a duty pharmacist or emergency duty pharmacist (if out of normal working hours) if a defective or potentially defective medicine is suspected. Examples of defective medicines include defective products themselves, wrong products contained in outer packaging, poor or incorrect product labelling, poor or incorrect instructions for use. If a health professional has concerns regarding a potentially defective medicinal product they should contact the pharmacy department. The pharmacy department is responsible for informing the MHRA of defective or potentially defective

products. During normal working hours the senior pharmacist on site must be informed of the defect or potential defect. Details should be discussed with a member of pharmacy quality control prior to transmission of details to the MHRA.

Outside of normal working hours the emergency duty pharmacist should contact the Director of Pharmacy or a senior pharmacist prior to a decision to inform the MHRA. When a decision has been made to inform the MHRA, the Director of Pharmacy or other senior pharmacist should complete the Medicinal Product – Suspected Defect Report Form available online at ww.yellowcard,mhra.gov.uk.

Chapter 12 - Unlicensed Medicines and Unlicensed Indications

Note: Cardiff and Vale University Health Board's procedure for the use of unlicensed medicines and medicines outside their product licence, and the Welsh Risk Pool Services' Technical note on prescribing of unlicensed drugs or using drugs for unlicensed indications are under review. The information contained in this chapter will be updated in line with any changes in the above guidance when available.

12.1 What is a product licence?

A medicine must be granted a product license or marketing authorisation from the Medicines and Healthcare products Regulatory Agency (MHRA) or the European Medicines Agency (EMA) before it can be widely used within the UK (1). Licenses are granted only if acceptable standards of efficacy, safety and quality are met (1,2).

A licensed product must work for the purpose for which it is intended. The product license defines the medicine's terms of use and is detailed in the manufacturers Summary of Product Characteristics (SPC). Information is provided on the indication(s), recommended dose(s), contraindications, special warnings and precautions for use (3).

The licensing process therefore reduces risk in medicines usage. Occasionally there may be a clinical need for a patient to be treated with an unlicensed medicine (a medicine with no UK product license) e.g. midodrine or mexilitine; or with a licensed medicine outside the terms of the license ("off-label") e.g. vitamin K intravenous formulation administered via the oral route for the reversal of over anticoagulation in warfarinised patients (2).
The use of unlicensed medicines or medicines outside their product licence is indemnified by

the All Wales Risk Pool only if supported by an appropriate policy (4). Cardiff and Vale University Health Board requires that this Procedure for the Use of Unlicensed Medicines and Medicines Used Outside their Product Licence is followed so that they may take vicarious liability for healthcare staff involved in any aspect of unlicensed medicines procurement, prescribing, supply or administration.

12.2 Healthcare professionals' responsibilities in prescribing, supplying and administering medicines

The responsibility that falls on healthcare professionals when using an unlicensed medicine or a medicine off-label may be greater than when prescribing a licensed medicine within the terms of its license. Prescribers have a duty to ensure they are aware of the legal status of the medicines they prescribe. Prescribers should pay particular attention to the risks associated with using unlicensed medicines or using a licensed medicine off-label. These risks may include: adverse reactions; product quality; or discrepant product information or labeling (e.g. absence of information for some unlicensed medicines, information in a foreign language for unlicensed imports, and potential confusion for patients or carers when the Patient Information Leaflet is inconsistent with a medicine's off-label use) (3).

The General Medical Council's Good Practice in Prescribing Medicines (2013**)** document provides guidance on prescribing unlicensed medicines and prescribing medicines for use outside the terms of their licence (off-label). In either situation the prescriber must:

- Be satisfied that an alternative, licensed medicine would not meet the patient's needs.
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy.
- Take responsibility for prescribing the unlicensed medicine and for overseeing the patient's care, including monitoring and any follow up treatment, or arrange for another prescriber to do so.
- Make a clear, accurate and legible record of all medicines prescribed and, where common practice is not followed give reasons for prescribing the medicine.
- Give patients (or their parents or carers) sufficient information about the medicine to allow them to make an informed decision. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.
- Answer questions from patients (or their parents or carers) about medicines fully and honestly (4).

Where an unlicensed medicine or a medicine used for an unlicensed indication is prescribed the prescriber is to inform the nurse administering the medicine (where appropriate) and the patient/carer of the unlicensed use. Pharmacists supplying the medicine must consider the need to ensure the prescriber, the nurse administering the medicine (where appropriate) and the patient/carer concerned are aware of the risks of such use

The methods used for the administration of licensed medicines may in some circumstances lie outside the product license. It is important to note that for example the crushing or dispersing of a licensed solid dosage form for ease of administration may mean that the use of the medicine becomes unlicensed. In situations where the medicine is manipulated in a way that is not covered by the product license prior to administration there should be discussion and agreement between the prescriber and the person who will administer the medicine. Discussion should also take place with the pharmacist to check the administration method is appropriate and that the efficacy of the medication is not changed as a result. The patient/carer should also be involved in the decision to use the medicine in this way. Refer to chapter 7 for further information.

Medicinal products covered by this procedure include:

1. **Medicines which do not have a UK product licence (an unlicensed medicine).** These may include medicines manufactured by a licensed manufacturer but which are awaiting a UK product licence, are manufactured for export, have been withdrawn from the UK market or where the manufacturer does not intend to apply for a UK licence. These products are usually obtained on a “named patient basis”. The pharmacy will purchase such products, usually on a named patient basis, on receipt of a written request from a consultant. In an emergency this may be supplied retrospectively. Acceptance of liability by the UHB will also depend on “peer group support” as above

2. **Unlicensed medicines prepared by a manufacturer with a Specials Manufacturing Licence.** These are widely referred to as “specials”. They are not usually obtained for a named patient. The responsibility for establishing the quality of the product lies with the pharmacist. A certificate of analysis will be obtained where appropriate. Where the quality of the product is judged to be unsuitable or cannot be established the prescriber will be informed.

3. **Use of licensed products outside their product licence**. The indication may be unlicensed, the dose range or age of the patient may be outside the licence, the route or method of administration may be unlicensed. In some circumstances the product may require unlicensed reformulation before administration. The UHB will accept liability for problems associated with such use if the use would have "peer group support". Peer group support for the use of unlicensed medicines or medicines outside of product licenses will be determined by a variety of means for example by reference to literature which contains evidence, standard texts, specialist texts, and that which is currently accepted as reasonable clinical practice.

Prescribers have a duty to ensure that they are aware of the legal status of their use of medicines. Where pharmacists are aware of unlicensed use they must consider the need to ensure that the Prescriber is aware of the risks and benefits of such use.

12.3 Monitoring and Recording

Supplies of unlicensed medicines ordered at the request of a consultant will be recorded by the pharmacy. Supplies made to individual patients will be recorded manually and on the pharmacy computer system. The issue of "specials" will be recorded on the pharmacy computer system.

The pharmacy will report on the purchase and issue of unlicensed drugs annually to the Central Risk Management Committee.

12.4 Unlicensed Medicines Risk Assessment Form

Prescribers wishing to use an unlicensed medicine or a medicine outside of the terms of its product license must complete an unlicensed medicines risk assessment form giving details of the product and purpose for its use. The top section will be completed by the Pharmacist and sent to the Prescriber/Consultant who should complete the remaining sections, providing evidence from standard texts/publications or "peer support" i.e. Clinical Director's signature.

The completed form should be returned to Pharmacy and will be entered into the Unlicensed Medicines database

12.5 Non-Medical Prescribing

Nurse or pharmacist prescribers may prescribe outside the terms of the manufacturer's product license ("off-label") as either independent or supplementary prescribers. Since December 2009 Pharmacist IP's and Nurse IP's can prescribe unlicensed medicines for their

patients on the same basis as doctors and provided they are competent and take responsibility for doing so.

12.6 Packaging

On receipt of the medication, pharmacy will confirm that the pack is appropriately labeled with an English generic drug name, form, strength, expiry date and has an English version of the SPC. Where necessary the pack will be over labeled and an English SPC will be sourced to reduce the risk of dispensing errors and errors during administration.

12.7 Prescribing interface with GPs for unlicensed medicines and medicines outside of license

Hospital prescribers wishing to transfer the care of a patient for whom they prescribe an unlicensed medicine or a medicine outside of its product license must first seek agreement from the patient's GP. The GP may refuse to undertake ongoing prescribing. Information supporting the prescribing of the unlicensed medicine concerned must be provided where appropriate.

Chapter 13 - Medicines in Clinical Trials

13.1 Cardiff and Vale Research Review Service (CaRRS)

All clinical trials involving Investigational Medicinal Products (IMPs) are governance reviewed by the Cardiff and Vale Research Review Service (CaRRS), a pharmacy assessment forms part of this service.

All clinical trials involving IMPs that are sponsored by Cardiff University or Cardiff and Vale UHB, are also reviewed by the pharmacy clinical trials team as part of the sponsored assessment process (SAP).

The sponsor should provide copies of Research Ethics Committee, Medicines and Healthcare Products Regulatory Agency (MHRA) and UHB Research and Development Department approvals to the pharmacy clinical trials team, before a clinical trial involving medicines can commence.

13.2 Clinical trial storage, prescribing and supply

All medicines used in clinical trials within C&V UHB should be stored and dispensed by the Pharmacy department and managed to the same standards as other medicines used therapeutically.

- IMP must not be stored in offices, clinics or ward areas unless by prior arrangement with pharmacy and only where appropriate risk management processes and standard operating procedures (SOPs) are in place.
- IMP must only be used in patients recruited to the trial.
- All IMP deliveries will be correctly received and recorded by a member of the pharmacy clinical trials team.
- Temperature records will be maintained for all IMP storage locations as specified by the trial sponsor.

A prescription for a clinical trial medicine must be signed by an approved prescriber and member of the investigational team on a trial specific prescription form.

The IMP will be dispensed following a trial specific pharmacy dispensing procedure.

Accurate accountability records will be maintained for all IMPs, this level of support may vary between trials.

The clinical trial prescription will be retained in the pharmacy.

13.3 Unblinding a clinical trial medication

Pharmacy will ensure that a trial specific emergency unblinding procedure is written for all blinded trials before the trial commences.

Occasionally copies of the unblinding code breaks or trial randomisation codes may be kept in pharmacy. Pharmacy will ensure that the blind is maintained throughout the trial. Code break envelopes or codes will be returned to the sponsor or investigator at the end of the trial. Code break envelopes or randomisation lists will only be released to the trial sponsor (or investigator) when written evidence from the sponsor has been provided to the clinical trials pharmacist that the final locked dataset has been verified.

13.4 Disposal or return of clinical trial medicines

Any unwanted clinical trial study medication must be returned to the hospital pharmacy. Returned clinical trial study medication should be reconciled and recorded in the pharmacy site file as set out by the clinical trial sponsor. Returned clinical trial medicines or any un-issued clinical trial medication must be returned to the sponsor or disposed of in accordance with the clinical trial sponsors instructions.

This procedure is not applicable to clinical trials involving blood products or wound healing products.

Chapter 14 Strong Potassium Injections, Ordering, Storing, Prescribing and Administration

The information in this chapter reflects the requirements set out by the National patient Safety Agency in an alert aimed to minimise the risk of accidental overdose of intravenous (IV) Potassium. This information recognises the need to ensure that seriously ill patients in critical care areas who require intravenous strong Potassium as part of their treatment continue to receive it promptly

The definition of Strong Potassium injections includes:

- Solutions of Potassium Chloride of 10% or more (i.e. 1gram of potassium in 10ml)
- Solutions of Potassium Hydrogen Phosphate and Potassium Dihydrogen phosphate in ampoules and vials.

Prescribing.

IV treatment of hypokalaemia should only be instigated when the oral/enteral route is unavailable or will not achieve the required increase of serum Potassium within the clinically acceptable time.

Wherever possible prescribed ready mixed infusions. Prescriptions must be expressed as mmols of Potassium and must include rate of infusion and carrier fluid.

The rate of administration in adults should not normally exceed 10mmols/hour. ECG monitoring is recommended for higher rates.

Further guidance on dosing of Potassium is given in the UHB Good Prescribing Guide.

Pharmacy and/or your ward Pharmacist will be able to provide information on the ready mixed preparations available.

Ordering and Storage

Strong Potassium injections as defined above will be treated as a controlled drug. Ordering, supply, storage and administration must follow the procedural guidance set out in Chapter 9.

Wards required to keep a supply of strong Potassium injection are :

UHW SITE

ICU-B3, ICU-A3, ICU/HDU Cardiac, A3 HDU, CCU

CAU, PICU, Rainbow, Neonatal

B4 Haematology, B5, CAPD Unit, RTU (T5)

EU Resus.

UHL Site

ICU, ECU, MEAU

Hafan y Coed

ECT

Wards other than those named above will only be provided with a supply of strong Potassium Chloride on receipt of a prescription chart for the individual patient, it is likely that the pharmacist will wish to discuss this individual prescription with the prescriber. If authorised the ward will again need to follow the CD process.

Administration

A two registered person independent whole process check is required for the administration of strong Potassium. As per CD procedure discussed in chapter 9. Infusions prepared with strong Potassium must be thoroughly mixed with repeated inversion and agitation of the container.

NB Wards must not obtain supplies of strong Potassium from other wards. In normal working hours supplies should be obtained from pharmacy. Outside normal hours supplies must be facilitated via the H@N Co-ordinator/Site Practitioner.

CHAPTER 12 ORAL METHOTREXATE

The purpose of this chapter is to ensure the safe use of methotrexate. It reflects good practice guidance issued by the National Patient Safety Agency (August 2004 and updated June 2006). This Guidance applies to all staff who are involved with the prescribing, supplying or administration of methotrexate. It is the responsibility of every professional group to ensure that this guidance is followed

PRESCRIBING

Before initiating methotrexate,

- discuss the indication, dosing and monitoring with the patient,
- provide a patient information leaflet and confirm patient understanding and consent
- provide a patient-held monitoring booklet and explain its use to patient.
- confirm who will prescribe and monitor the methotrexate (refer to shared care guidelines) and frequency of monitoring.
- explain this to the patient, including who will communicate necessary dosage changes to the patient and who will record test results in patient-held monitoring booklet.

ALL prescriptions must state the specific dose and highlight the specific day to be taken **("as directed" is not acceptable).**

On the hospital in patient drug administration charts,

- state the day of the week when the methotrexate dose is to be given (in the "special instructions" box).
- strike through the six days of the week when the dose must not be administered.
- prescribe folic acid rescue as a single weekly dose separated from methotrexate. However a small number of patients require folic acid for six days per week to minimise nausea. Folic Acid must not usually be taken on the day methortrexate is administered.
- Ensure discharge summary information includes the form, strength, dose and directions in full and who will prescribe and monitor. This will not be the GP

unless the initiation process is complete, the patient stable and the shared care/near patient testing process has been followed, ie requested and agreed.

- Only prescribe multiples of 2.5mg methotrexate; 10mg strength tablets are deliberately not supplied from C&V pharmacy

DISPENSING/PHARMACIST SCREENING

Check that the patient has been given a patient-held monitoring booklet.

- if yes, and they have it with them, check dose against dose prescribed.
- if yes but don't have it with them, check their usual dose and day of week taken.
- if they don't have a booklet, provide one and either arrange for the patient to see appropriate specialist nurse (for outpatients) or refer to pharmacist to go through the key points with the patient (for inpatients).
- Check prescribed dose- **"as directed"** is not acceptable.
- Label the medication as follows with the number of tablets and day of week to be taken. *Take .....tablets on each .....for .....weeks*
- Communicate the dose as quantity of tablets and weekly frequency with the patient. I
  if the patient is also taking folic acid tablet, ensure the patient can easily tell the difference.
- Refer to prescriber/specialist nurse if the patient's dose has changed and the booklet needs updating.

ADMINISTRATION.

- **NEVER** administer methotrexate daily without confirming with the prescriber or pharmacist that this is intended.
- Wherever possible administer methotrexate on the day of the week the patient usually takes it.
- If you have concerns regarding infection, including wound issues, discuss with Medical/Surgical team before administering methotrexate

- Ensure administration is recorded on the inpatient medication chart correctly.
- Report any issues, concerns or non-administrations to the patients medical team and/or pharmacist in a timely manner

NB patients attending with or reporting new symptoms e.g. breathlessness, dry persistent cough, vomiting and diarrhoea, consider if these may be signs of methotrexate toxicity or intolerance.

Chapter 16 Storage of Records Relating to Medicines

Delivery notes accompanying ward/department stock deliveries

Once items delivered have been checked against the delivery note, and there are no apparent discrepancies by way of delivery error or costing error, the delivery note is to be kept on the receiving ward for 3 months and then may be destroyed

Controlled Drug order book

These are to be kept on the ward/department for 2 years after the date of the last order entry in the book. The CD order book can then be destroyed.

Controlled Drug record book

These are to be kept on the ward/department for 2 years after the date of the last entry of receipt or administration, whichever is the later. The CD record book can then be destroyed.

If the CD Controlled Drug Record Book contains a record of destruction it must be retained for 7 years.

Medicines transit records

Upon completion of signature of the receipt, the delivery driver/ porter must return the record of receipt to the dispatching pharmacy as soon as possible. The delivery record will be kept for 3 months and then may be destroyed.

Pharmacy records

The pharmacy will retain records of orders, receipt and supply as set out in WHC (2000)/71 which details document retention as follows:

3 months: Picking records/ delivery notes to wards & departments

1 year: Stock-take reports plus current year

Worksheets for resuscitation boxes (one year after expiry of longest dated item)

2 years: Orders/requisitions for medicinal products supplied by the pharmacy including all

dispensing

Top Copy of Discharge Prescription (TTH)

Controlled Drug Registers and Requisitions (2 years after last date of entry) Hazard Warnings

5 years: Unlicensed medication requests and issues

Worksheets for chemotherapy, aseptic and total parenteral nutrition

- Repackaging
- Certificates of analysis
- Recall Documentation
- Clinical trials records (5 years after end of trial)

6 years: Orders

Financial records including invoices

Disposal of waste records

7 years: Records of Controlled Drug destruction (Hospital stock or patient's own)

8 years: Medicines Information questions and answers

(25 years in case of child or obstetrics & Gynaecology)

13 years: Production records including extemporaneous Controlled Drug products and radio pharmacy

CHAPTER 17 NURSE INITIATION OF SYMPTOMATIC RELIEF

Background

Nurse initiated symptomatic relief medicines are those which are used to treat minor ailments and are available to purchase from a pharmacy (Pharmacy [P] medicine) or from any other retail outlet (General Sales List [GSL] medicine). Nurses often have to contact prescribers to write prescriptions for items which patients, if they were self-caring, could purchase "over-the-counter." There is often a delay in patients receiving the required symptomatic relief medicines.

NB permission to implement this procedure must be sought and given by the appropriate directorate quality and safety group before implementation.

Purpose

The purpose of this procedure is to enable nurses to initiate medicines to treat minor symptomatic ailments for adult inpatients. The procedure provides a clear framework to support nurse initiation of symptomatic relief medicines to provide safe, appropriate and timely patient care, and facilitate the smooth running of wards.

Scope

This procedure applies to registered nurses and midwives within adult inpatient areas who have been identified as suitable by the Sister/ Charge Nurse of the inpatient area.

In order to be identified as suitable the nurse or midwife must have :-

- A minimum of one year post registration experience.
- Have been trained and assessed as competent in using this procedure.

A registered of suitably trained and competent staff will be kept locally within the area/directorate.

Accountability

Each registered nurse, working to the Nursing and Midwifery Council (NMC) Code of Practice and NMC Guidelines, is professionally accountable for his/her practice. In a local context they are required to work to the Health Board policies, protocols, guidelines and meet expected standards.

Responsibility

Nursing/Midwifery staff identified as appropriate have a responsibility to:

- Only initiate medicines off the agreed list**.**
- Complete the training programme in order to ensure they feel competent and confident when initiating medicines from the agreed list.
- Assess the patient and plan their care.
- Record the assessment, any intervention and arrangements for review in the care plan/care pathway/medical notes.
- Record any medication administered on the medication chart.
- Record the review and reassessment in the care plan/care pathway/medical notes.
- Contact the doctor on call if they are concerned about the patient's overall condition or the medication has been ineffective.
- Report any serious adverse drug reactions via the Medicines Healthcare and products Regulatory Agency yellow card system.

Pharmacy staff have a responsibility to:

- Update and review the protocols and advise on any major changes.
- Ensure safe systems of supply for medicines named in the protocols.
- Ensure patient appropriateness

Directorates have a responsibility to:

- Identify the need for nurse/midwife initiation of symptomatic relief within the directorate and/or ward/unit area.
- Agree a plan to ensure that nurses/midwives identified as appropriate to initiate symptomatic relief are trained and competent to do so.
- Keep a register of nurses who meet the above criteria locally either at ward / unit or directorate level.

The Health Board Medicines Management Group has a responsibility to:

- Include the procedure for nurse initiation of symptomatic relief medicines in the medicines code and review in line with the code.
- Any subsequent request for additions to the nurse initiated medicines list must be approved by the UHB Medicines Management Group, prior to the medicine being added to the list. This addition to the list may be agreed as a UHB addition or a Directorate specific addition, where it is a Directorate specific addition the Directorate will be named.

The Medical Team has a responsibility to

Countersign the nurse initiated medicine as follows

- Within 24 hours if possible.
- Within a maximum of 48 hours.
- Community hospital setting max of 72 hours.

Training

The Directorate Pharmacist and/or Nurse Advisor Medicines Management and Professional Practice Development Nurse (or nominated deputies) will provide an agreed training programme. This will involve a one hour workshop. The workshop will include the following:

- Overview of legislative framework (legal classification of drugs – GSL, P, POM, CD).
- Rationale and place of patient group directives and independent prescribing.
- Principles of drug monographs/protocols.

- Questions and answers on the current drug monographs/protocols.
- The nurse/midwife will complete a competence log of medicines they initiate under supervision (minimum of 5), before they are signed off as competent. This should be achieved within a maximum of 3 months from initial training session.

Procedure

a) Identified potential need for nurse/midwife initiated medicine
b) Consider criteria for inclusion/exclusion as stated in the drug monograph
c) If appropriate to proceed, discuss with patient, provide verbal advice, prescribe on the medication chart (as indicated in monograph) and arrange administration.
d) The prescription must state ‘’nurse/midwife initiated’’ and the nurse must sign and print name (if available include bleep number).
e) Refer to the doctor responsible for the patient if medical advice is needed.
f) Document “nurse/midwife initiated medicine” in the care plan/pathway/medical notes.
g) Follow up and monitor the patient as indicated in the monograph.
h) Report any unusual/serious adverse drug reactions via the Medicines Healthcare and products Regulatory Agency yellow card system.

Audit

An audit will be undertaken at six months after implementation by an identified Pharmacist/Nurse/Midwife within the Directorate for a one week period.

Audit criteria will include:

- Patient, ward and drug initiated.
- Review of medication chart to compare documentation and criteria with the monograph and identify the number of doses administered.
- Review any related clinical incidents.
- Feedback from medical, nursing and pharmacy staff involved in the scheme.
- Review of monographs to clarify and ensure ease of use.

Permitted Drug Protocols for Nurse Initiated Medicines for Symptomatic Relief.

Protocol for the administration of

PARACETAMOL TABLETS/SOLUBLE TABLETS

Clinical Condition	
Criteria for inclusion	• Patient consents to treatment under this protocol. • Mild to moderate pain. • Pyrexia – temperature greater than 38°C (consider need for blood cultures). • Includes patients who are pregnant.
Criteria for exclusion (refer to doctor)	• Allergy or hypersensitivity to paracetamol. • Patient has received the maximum dose of paracetamol containing. product (e.g. co-codamol, codydramol) within the last 24 hours. • Patient has past or current history of moderate to severe renal/hepatic impairment. • Avoid concurrent prescription with paracetamol containing products.

Description of Treatment	
Name of medicine	Paracetamol
Legal status (POM/P/GSL)	GSL
Form	• Tablet • Soluble tablet (This effervescent preparation has a high sodium content. May be a problem if the patient needs to restrict sodium intake e.g. hypertension, heart failure).
Dosage	Dosage is dependent on body weight 35 – 39kg = 500mg 40 – 49kg = 750mg 50kg or above = 1g
Route of administration	Oral
Frequency of administration	Every four to six hours
Total daily dose	Maximum dosage is dependent on body weight, QDS
Adverse reactions	• Rare but rashes and blood disorders have been reported. • Acute pancreatitis reported after prolonged use. • Liver damage (and less frequently renal damage) following overdose.
Verbal advice for the patient	• Can request further doses at 4-6 hourly intervals if required. • Inform nursing staff if symptoms persist or worsen.
Follow up	• Review patient response to treatment • Monitor clinical observations. • Contact doctor if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **PARACETAMOL**		PHARMACIST SUPPLY
DOSE **500MG -1G**	ROUTE **PO**	FREQUENCY **4 to 6 HOURLY**	MAXIMUM DOSE IN 24 HOURS **Max 4g in 24hrs**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **PAIN or PYREXIA (STATE WHICH/BOTH)**	

Protocol for the administration of

CO-CODAMOL 8/500 TABLETS/SOLUBLE TABLETS

Clinical Condition	
Criteria for inclusion	• Patient consents to treatment under this protocol. • Mild to moderate pain.
Criteria for exclusion (refer to doctor)	• Allergy or hypersensitivity to paracetamol or codeine. • Patient has received the maximum dose of a paracetamol containing product within the last 24 hours. • Patient has past or current history of moderate to severe renal/hepatic impairment. • Avoid concurrent prescription with paracetamol containing products.

Description of Treatment	
Name of medicine	Co-codamol 8/500 (Codeine 8mg/Paracetamol 500mg)
Legal status (POM/P/GSL)	GSL
Form	• Tablet • Soluble tablet (This effervescent preparation has a high sodium content. May be a problem if the patient needs to restrict sodium intake e.g. hypertension, heart failure).
Dosage	Dependent on body weight because of paracetamol content 35 – 49kg = 1 tablet 50kg or above = 2 tablets
Route of administration	Oral
Frequency of administration	Every four to six hours
Total daily dose	Maximum dose dependent on body weight , QDS
Adverse reactions	• Rare but rashes and blood disorders have been reported. • Acute pancreatitis reported after prolonged use. • Liver damage (and less frequently renal damage) following overdose. • Nausea and vomiting. • Constipation (especially after regular dosing).
Verbal advice for the patient	• Can request further doses at 4 – 6 hourly intervals if required. • Inform nursing staff if symptoms persist/worsen or if nausea or constipation occurs.
Follow up	• Review patient response to treatment. • Monitor clinical observations. • Contact doctor if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **CO-CODAMOL 8/500**		PHARMACIST SUPPLY
DOSE **1 OR 2 TABS**	ROUTE **PO**	FREQUENCY **4 to 6 HOURLY**	MAXIMUM DOSE IN 24 HOURS **Max 8 in 24 hours**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **PAIN**	

Protocol for the administration of

ALGINATE BASED ANTACID (GAVISCON ADVANCE®)

Clinical Condition	
Criteria for inclusion	• Symptomatic relief of heartburn and acid indigestion (dyspepsia) • Patient consents to treatment under this protocol. • Includes patients who are pregnant.
Criteria for exclusion	• Vomiting with/without haematemesis, diarrhoea, rectal bleeding. • Allergy to product or excipients
Seek further advice from doctor	• History of heart failure (high sodium content – 3mmol in 5ml) • Moderate or severe renal failure

Description of Treatment	
Name of medicine	Gaviscon Advance® or generic
Legal status (POM/P/GSL)	GSL
Form	Suspension
Dosage	5-10 ml 20 minutes to 1 hour after meals and at bedtime or as required.
Route of administration	Oral
Frequency of administration	Four times a day
Adverse reactions	• None expected when used at this recommended dosage.
Further information	• Avoid administration of antacids at the same time of day as tetracyclines, ciprofloxacin, rifampicin, hydroxychloroquine, chloroquine as absorption of these medicines can be reduced. N.B. a complete list is available in the BNF.
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen. • Can request further doses, up to four times a day, if required. • Acid indigestion can be exacerbated by high fat/spicy diet, excess alcohol, smoking, obesity. (Consider reduction of risk factors as appropriate). • Antacid preparations should not be taken at the same time of day as enteric coated (e/c) tablets. The coating is removed so that stomach irritation can occur from the medication in the tablet.
Follow up	• Review patient response to treatment. • Monitor clinical observations. • Consider medical referral if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **GAVISCON**		PHARMACIST SUPPLY
DOSE **5-10 ml**	ROUTE **PO**	FREQUENCY **After meals and at bedtime**	MAXIMUM DOSE IN 24 HOURS **10ML FOUR TIMES DAILY**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **INDIGESTION**	

Protocol for the administration of

PEPPERMINT WATER

Clinical Condition	
Criteria for inclusion	• Relief of gastric and intestinal flatulence, and pain associated with these. • Relief of griping pains caused by administration of laxatives. • If regular irritable bowel syndrome sufferer. • Patient consents to treatment under this protocol.
Criteria for exclusion	• Patient already prescribed related product e.g. Colpermin® • Allergy or hypersensitivity to peppermint. • Nausea, vomiting, diarrhoea, severe abdominal pain, history of bowel obstruction, rectal bleeding, haematemesis and other possible reasons for abdominal discomfort e.g. constipation. • Patients who are pregnant are excluded.

Description of Treatment	
Name of medicine	Peppermint water
Legal status (POM/P/GSL)	P
Form	Solution
Dosage	10ml well diluted with water
Route of administration	Oral
Frequency of administration	Up to three times a day
Total daily dose	10ml three times a day
Adverse reactions	• None expected when used at this recommended dose and diluted.
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen. • Can request further doses up to three times a day if required. • Diet may have been cause of flatulence. Regular diet and avoidance of "trigger foods" may help. • Movement/exercise may assist with relief of pain associated with "trapped wind."
Follow up	• If no relief from symptoms, or symptoms worsen. • Enquire if regularly experience symptoms of this kind e.g. irritable bowel syndrome and consider medical referral if so.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **PEPPERMINT WATER**		PHARMACIST SUPPLY
DOSE **10ML**	ROUTE **PO**	FREQUENCY **THREE TIMES DAILY (DILUTED IN WATER)**	MAXIMUM DOSE IN 24 HOURS **10ML THREE TIMES DAILY**
DOCTOR'S SIGNATURE **Nurse initiated** **Nurse signature** **PRINT name**	INDICATION **e.g. GRIPING PAINS**		

Protocol for the administration of

SENNA TABLETS OR SYRUP

Clinical Condition	
Criteria for inclusion	• Chronic uncomplicated constipation. • Acute infrequent constipation (see Good Prescribing Guide) • Patient consents to treatment under this protocol.
Criteria for exclusion	• Severe abdominal pain, history of bowel obstruction, vomiting, rectal bleeding and/or haematemesis. • Patient undergoing investigations to colon/rectum and/or recent gastrointestinal surgery. • Allergy or hypersensitivity to senna. • Patients who are pregnant are excluded.
Seek further advice from doctor	• If patients are thought to misuse laxatives long term.

Description of Treatment	
Name of medicine	Senna
Legal status (POM/P/GSL)	GSL
Form	Tablets or syrup
Strength	7.5mg tablets or 7.5mg/5ml syrup
Dosage	7.5mg to 15mg (One or two 5ml spoonsful)
Route of administration	Oral
Frequency of administration	Once at night
Total daily dose	If needed 15mg (two tablets or 10ml) ON
Adverse reactions	• Abdominal cramps/griping pains. • Diarrhoea.
Further information	• Avoid syrup formulation if diabetic.
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen.
Follow up	• Review for effectiveness. • Consider need for regular prescription i.e. 15mg (two tablets or 10ml BD).

<table>
<tr><td colspan="4">AS REQUIRED MEDICINES</td></tr>
<tr><td>DATE
Today's date</td><td colspan="2">MEDICINE (Approved Name)
SENNA</td><td>PHARMACIST
SUPPLY</td></tr>
<tr><td>DOSE
ONE – TWO tablets ot 5-10ml</td><td>ROUTE
PO</td><td>FREQUENCY
AT NIGHT</td><td>MAXIMUM DOSE IN 24 HOURS
TWO (1oml) AT NIGHT</td></tr>
<tr><td colspan="2">DOCTOR'S SIGNATURE
Nurse Initiated
Nurse signature
PRINT name</td><td colspan="2">INDICATION
CONSTIPATION</td></tr>
</table>

Protocol for the administration of

LACTULOSE SOLUTION

Clinical Condition	
Criteria for inclusion	• Relief of constipation. • Patient consents to treatment.
Criteria for exclusion	• Severe abdominal pain, history of bowel obstruction, vomiting, rectal bleeding, haematemesis. • Patient undergoing investigations to colon/rectum, recent gastrointestinal surgery. • Allergy or hypersensitivity to lactulose. • Intolerance to lactose • Galactosaemia • Patients who are pregnant are excluded.
Seek further advice from doctor	• If patient is thought to misuse laxatives long term.

Description of Treatment	
Name of medicine	Lactulose
Legal status (POM/P/GSL)	P
Form	Solution
Strength	3.1-3.7g/5ml
Dosage	15ml (Three 5ml spoonsful) BD
Route of administration	Oral
Frequency of administration	BD
Total daily dose	30ml BD
Adverse reactions	• Nausea, vomiting, flatulence, cramps, abdominal discomfort
Further information	• Can take up to 48 hours to work
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen. • Eat fruit/vegetables and more fibre. • Drink plenty of water and take regular exercise. • Inform nurses if nausea develops (can be reduced by administration with water, fruit juice or meals) • Can take up to 48 hours to work.
Follow up	• Review for effectiveness.

AS REQUIRED MEDICINES		
DATE **Today's date**	MEDICINE (Approved Name) **LACTULOSE**	PHARMACIST SUPPLY
DOSE **15ML**	ROUTE **PO**	FREQUENCY **TWICE DAILY**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**	INDICATION **CONSTIPATION**	

Protocol for the administration of

MACROGOL ORAL POWDER (MOVICOL®/LAXIDO®)

Clinical Condition	
Criteria for inclusion	• Chronic constipation • Patient consents to treatment under this protocol.
Criteria for exclusion	• Intestinal perforation/obstruction, paralytic ileus, inflammatory conditions of the gastrointestinal tract e.g. Crohn's, colitis, toxic megacolon • Fluid and electrolyte disturbances • Severe abdominal pain, vomiting, rectal bleeding, haematemesis. • Patient undergoing investigations to colon/rectum, recent gastrointestinal surgery. • Allergy or hypersensitivity to macrogol • Patients who are pregnant are excluded.
Seek further advice from doctor	• If the patient is thought to misuse laxatives long term. • Patients with heart failure.

Description of Treatment	
Name of medicine	Macrogol
Legal status (POM/P/GSL)	P
Form	Powder for solution
Dosage	1 sachet daily or 1 sachet twice daily
Route of administration	Oral
Frequency of administration	OD or BD
Total daily dose	1 sachet BD
Adverse reactions	• Abdominal distension, pain, nausea, flatulence
Further information	• Dissolve the contents of 1 sachet in half a glass of water (125ml) of water. • After reconstitution the solution can be kept in the fridge and discarded if unused after 6 hours. • Patients with cardiovascular impairment should not take more than 2 sachets in any one hour.
Verbal advice to the patient	• Inform nurse if symptoms persist or worsen • Eat fruit/vegetables and more fibre. • Drink plenty of water and take regular exercise. • Inform nurses if nausea develops (can be reduced by administration with water, fruit juice or meals)
Follow up	• Review for effectiveness

DATE →		**Today's date**		MEDICINE (Approved name) **MACROGOL ORAL POWDER**	SPECIAL INSTRUCTIONS **Dissolve one sachet in half a glass of water (125ml)**	PRESCRIBER'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**	PHARMACIST
ROUTE →		**PO**					SUPPLY
SPECIFY TIME IF REQUIRED ↓		DOSE ↓	SIGN DOSE CHANGE				
MORNING	✓	Ŧ					
MIDDAY							
EVENING							
BED TIME	✓	Ŧ					

Protocol for the administration of

GLYCERIN SUPPOSITORIES

Clinical Condition	
Criteria for inclusion	• Acute infrequent constipation • Hard impacted faeces – mild • Patient consents to treatment under this protocol.
Criteria for exclusion	• Severe abdominal pain, rectal bleeding, intestinal obstruction • Vomiting with/without haematemesis • Allergy to gelatin

Description of Treatment	
Name of medicine	Glycerin
Legal status (POM/P/GSL)	GSL
Form	Suppositories
Strength	4g (adult)
Dosage	One to two suppositories
Route of administration	Rectal (moisten with water)
Frequency of administration	Stat dose (consider as required prescription)
Total daily dose	Maximum of two 4g suppositories
Adverse reactions	• May occasionally cause rectal irritation or stomach cramps.
Further information	• Glycerin suppositories also contain gelatin.
Verbal advice for the patient	• Explain procedure to patient and suggest that they lie on their left-hand side. • Explain action of glycerine suppositories is usually within 15 to 30 minutes. • Encourage adequate fluid intake.
Follow up	• Patient's response to treatment.

PRESCRIPTION FOR ONCE ONLY AND PRE-ANAESTHETIC MEDICATION										
DATE	MEDICINE (Approved Name)	DOSE	ROUTE	TIME TO BE GIVEN	DOCTOR'S SIGNATURE	PHARMACY	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
Today's date	**GLYCERIN SUPPOSITORY**	**4g**	**PR**	**14:00**	**Nurse Initiated** **Nurse signature** **PRINT name**					

Protocol for the administration of

MICRO-ENEMA

Clinical Condition	
Criteria for inclusion	• Acute and infrequent constipation (see Good Prescribing Guide) • Consider if other treatments have been tried. • Includes patients who are pregnant. • Patient consents to treatment under this protocol.
Criteria for exclusion	• Severe abdominal pain, history of bowel obstruction, rectal bleeding, haematemesis. • Inflammatory bowel disease (ulcerative colitis, Crohn's disease)

Description of Treatment	
Name of medicine	Micralax®/Micolette®/Relaxit®
Legal status (POM/P/GSL)	P
Form	As sodium citrate micro-enema
Dosage	Contents of one 5ml enema
Route of administration	Rectal
Frequency of administration	Stat dose, followed by a second enema if there is no result after 20 minutes
Total daily dose	Maximum of two enemas.
Adverse reactions	• Side-effects are unusual but occasionally there may be abdominal cramps.
Verbal advice for the patient	• Explain procedure to the patient. • Explain the action of the enema can be within 5 – 15 minutes but that it is preferable to resist the urge to empty bowels immediately and "hold on" for 10 to 15 minutes for maximum effect. • Encourage patient to lie on their left-hand side. • Encourage adequate fluid intake.
Follow up	• If no relief from symptoms or symptoms worsen. • Consider need for regular laxative (see Good Prescribing Guide).

PRESCRIPTION FOR ONCE ONLY AND PRE-ANAESTHETIC MEDICATION										
DATE	MEDICINE (Approved Name)	DOSE	ROUTE	TIME TO BE GIVEN	DOCTOR'S SIGNATURE	PHARMACY	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
Today's date	**MICRO-ENEMA**	**ONE**	**PR**	**14:00**	**Nurse Initiated Nurse signature PRINT name**					

Protocol for the administration of

SIMPLE LINCTUS

Clinical Condition	
Criteria for inclusion	• Dry cough • Includes patients who are pregnant • Patient consents to treatment under this protocol
Criteria for exclusion	• Diabetes (request sugar free formulation) • Allergy or hypersensitivity to any of the ingredients (refer to bottle – may contain alcohol) • Symptoms such as wheezing or shortness of breath

Description of Treatment	
Name of medicine	Simple Linctus BP (citric acid monohydrate 2.5% in a vehicle with an anise flavour)
Legal status (POM/P/GSL)	GSL
Form	Solution
Dosage	One or two 5ml spoonfulS
Route of administration	Oral
Frequency of administration	Up to four times a day
Total daily dose	10ml four times a day
Adverse reactions	• Side-effects not expected at this dosage
Verbal advice for the patient	• Can request further doses, up to four times a day, if required. • Inform nurse if symptoms persist or worsen.
Follow up	• Review patient response to treatment • Monitor clinical observations • Contact doctor if symptoms persist or worsen.

<table>
<tr><td colspan="4">AS REQUIRED MEDICINES</td></tr>
<tr><td>DATE
Today's date</td><td colspan="2">MEDICINE (Approved Name)
SIMPLE LINCTUS</td><td>PHARMACIST
SUPPLY</td></tr>
<tr><td>DOSE
5 – 10ML</td><td>ROUTE
PO</td><td>FREQUENCY
FOUR TIMES DAILY</td><td>MAXIMUM DOSE IN 24 HOURS
10ML FOUR TIMES DAILY</td></tr>
<tr><td colspan="2">DOCTOR'S SIGNATURE
Nurse Initiated
Nurse signature
PRINT name</td><td colspan="2">INDICATION
DRY COUGH</td></tr>
</table>

Protocol for the administration of

WHITE SOFT PARAFFIN

Clinical Condition	
Criteria for inclusion	• Dry, sore chapped or cracked lips • Dry, sore nose secondary to cold/flu-like symptoms or nasal cannulae use
Criteria for exclusion	• Evidence of infection, history of cold sores with symptoms suggestive of a new cold sore e.g. tingling sensation, blistering – seek medical advice for alternative treatment.

Description of Treatment	
Name of medicine	White soft paraffin
Legal status (POM/P/GSL)	GSL
Form	Ointment
Dosage	Apply a small amount to the affected area using clean fingertip or cotton bud.
Route of administration	Topical Caution: Paraffin is flammable
Frequency of administration	Four times a day
Total daily dose	Four single applications to a localised area
Adverse reactions	• Not expected when used at this recommended frequency • Sensitivity reactions and acne have been reported rarely following topical use.
Verbal advice for the patient	• Can reapply up to four times daily to help soothe dry areas. • Avoid contact with eyes. • Keep away from naked flames. • Inform nurse if symptoms persist or worsen.
Follow up	• Review the patient's response to treatment.

<table>
<tr><td colspan="4">AS REQUIRED MEDICINES</td></tr>
<tr><td>DATE
Today's date</td><td colspan="2">MEDICINE (Approved Name)
WHITE SOFT PARAFFIN</td><td>PHARMACIST
SUPPLY</td></tr>
<tr><td>DOSE
SMEAR</td><td>ROUTE
TO LIPS OR AFFECTED AREA</td><td>FREQUENCY
FOUR TIMES DAILY</td><td>MAXIMUM DOSE IN 24 HOURS
FOUR TIMES DAILY</td></tr>
<tr><td colspan="2">DOCTOR'S SIGNATURE
Nurse Initiated
Nurse signature
PRINT name</td><td colspan="2">INDICATION
e.g. SORE LIPS</td></tr>
</table>

Protocol for the administration of

CHOLINE SALICYLATE ORAL GEL (BONJELA®)

Clinical Condition	
Criteria for inclusion	• Mouth ulcers • Sore mouth secondary to denture irritation • Patient consents to treatment under this protocol
Criteria for exclusion	• Aspirin hypersensitivity, or allergy to preservative (cetalkonium chloride) • Unexplained mouth ulcer of >3 weeks duration (refer to doctor) • Bleeding from gums or known oral cancer. • Recent or current immunosuppressant drug therapy (refer to BNF), recent chemotherapy or radiotherapy
Seek further advice	• Recurrent mouth ulcers or if sore throat also present

Description of Treatment	
Name of medicine	Choline salicylate 8.7% in an oral gel formulation (Bonjela®)
Legal status (POM/P/GSL)	GSL
Form	Gel
Dosage	Apply one clean fingertip or cotton bud of gel to the affected area
Route of administration	Oral Apply to tender areas of mouth and buccal mucosa
Frequency of administration	Up to every three hours
Total daily dose	Maximum 8 applications in 24 hours
Adverse reactions	• Excessive application or confinement under a denture irritates the mucosa and can itself cause ulceration
Verbal advice for the patient	• Can reapply up to every 3 hours (avoid application just before food or drink) • Do not apply to dentures. • Leave at least 30 minutes before reinsertion of dentures.
Further information	• Onset of pain relief is usually within 5 minutes and usually lasts approximately 3 hours. • Ulceration of the oral mucosa may be recurrent or caused by trauma (physical or chemical), infection, carcinoma, dermatology disorders, nutritional deficiencies, gastrointestinal disease, drug therapy or blood dyscrasias. • It is important to establish diagnosis and any specific management in addition to local treatment. • Refer to doctor if problem persists.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **BONJELA**		PHARMACIST SUPPLY
DOSE **ONE APPLICATION**	ROUTE **TOPICAL/ BUCCAL**	FREQUENCY **3 HOURLY AS NEEDED**	MAXIMUM DOSE IN 24 HOURS **UP TO 3 HOURLY**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **MOUTH ULCERS**	

Protocol for the administration of

CLOTRIMAZOLE 1% CREAM

Clinical Condition	
Criteria for inclusion	• Fungal skin infections e.g. nappy rash, ringworm, candida intertrigo, athlete's foot
Criteria for exclusion	• Allergy to clotrimazole

Description of Treatment	
Name of medicine	Clotimazole
Legal status (POM/P/GSL)	GSL
Form	Cream
Strength	1%
Dosage	Apply to the affected area(s) two to three times daily
Route of administration	Topical
Frequency of administration	Two to three times daily
Total daily dose	Three times daily
Adverse reactions	• Local irritation including mild burning sensation, erythema and itching. Treatment should be discontinued if these are severe.
Verbal advice for the patient	• Apply thinly and evenly to the affected area(s) • Continue treatment for at least 2 to 4 weeks. • Inform nurse if symptoms persist, worsen or signs of local irritation develop
Follow up	• Contact the doctor if symptoms persist, worsen or signs of local irritation develop. • If candida vulvitis, ask doctor to prescribe treatment for vaginal infection.

DATE →		**Today's date**		MEDICINE (Approved name) **CLOTRIMAZOLE 1% CREAM**	SPECIAL INSTRUCTIONS	PRESCRIBER'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**	PHARMACIST
ROUTE →		**TOP**				BLEEP	SUPPLY
SPECIFY TIME IF REQUIRED ↓		DOSE ↓	SIGN DOSE CHANGE				
MORNING	✓	Ŧ					
MIDDAY	✓	Ŧ					
EVENING							
BED TIME	✓	Ŧ					

Protocol for the administration of

DIPROBASE CREAM®

Clinical Condition	
Criteria for inclusion	• Dry skin
Criteria for exclusion	• Hypersensitivity to Diprobase® or any of the excipients (see tube for list of ingredients)

Description of Treatment	
Name of medicine	Diprobase® (Cetomacrogol, cetostearyl alcohol, liquid paraffin, white soft paraffin)
Legal status (POM/P/GSL)	GSL
Form	Cream
Dosage	Apply to the affected area(s) when required
Route of administration	Topical
Frequency of administration	As needed
Total daily dose	N/A
Adverse reactions	• Local irritation and sensitisation. Discontinue if irritation occurs.
Verbal advice for the patient	• Apply as often as necessary. • Rub well into the skin. • Apply cream in the direction of hair growth. • Avoid contact with eyes. • Keep away from naked flames. • Inform nurse if symptoms persist or worsen
Follow up	• Contact doctor if symptoms persist or worsen.

<table>
<tr><td colspan="4">AS REQUIRED MEDICINES</td></tr>
<tr><td>DATE
Today's date</td><td colspan="2">MEDICINE (Approved Name)
DIPROBASE</td><td>PHARMACIST
SUPPLY</td></tr>
<tr><td>DOSE
ONE APPLICATION</td><td>ROUTE
TOPICAL</td><td>FREQUENCY
AS NEEDED</td><td>MAXIMUM DOSE IN 24 HOURS
AS NEEDED</td></tr>
<tr><td colspan="2">DOCTOR'S SIGNATURE
Nurse Initiated
Nurse signature
PRINT name</td><td colspan="2">INDICATION
DRY SKIN</td></tr>
</table>

Nurse Administration of Symptomatic Relief Medicines.

Assess the patient's condition and if appropriate select the required medicine from the agreed symptomatic relief medicines listed.

Using chosen drug monograph assess the suitability using the inclusion/exclusion criteria.

Patient meets inclusion criteria. Proceed as instructed in drug monograph.

Patient does not meet inclusion criteria **EXCLUDE.** Nurse initiated medicines not suitable **refer to prescriber / medic.**

Document administration on medicines chart as instructed by drug monograph. Include all details in patient's notes.

Label product with patient name if applicable

Monitor patient as detailed in drug monograph to ensure symptomatic relief has been achieved.

NB Prompt Escalation to Medical Team if Patient does not respond to Symptomatic Relief is essential.

Responsible medic must countersign within 24 hours where possible (maximum 48 hours). In community hospitals this may be up to 72 hours.

Chapter 18 Medicines for Discharge Adult Short Stay Areas

Adult patients undergoing short-stay procedures may require new medications post-operatively (e.g. analgesia, antibiotics) for a successful outcome. These medications are often pre-determined and therefore ready labelled packs can be provided from Pharmacy to facilitate their issue by nursing staff.

The purpose of this procedure is to enable medications from an agreed list (identified by pharmacy) to be prepared and issued to patients “To Take Home” (TTH) in a safe manner on adult surgical & gynaecology short stay units dealing with minor procedures and where the stay is ≤ 48 hours

It is a legal requirement that all medicines are labelled with:

- Name and strength of the medicine
- Quantity in the container
- Directions of how and when to take the medicine and any additional instructions
- Patient’s name
- Date of supply/issue of the medicine
- Name and address of the pharmacy/hospital from which the medicine was issued
- The words “Keep out of the sight and reach of children”

In addition:

- All TTHs must be prescribed by a doctor or non-medical independent prescriber.
- All of the medications on the agreed list are available as a pre-labelled patient pack.
- Individual areas to decide the range of patient packs available from this list, in consultation with their Directorate pharmacist.

- If the medication is not on the agreed list or the prescriber requires a dose or frequency which does not match the pre-labelled directions this must **only** be dispensed by the pharmacy department (see below).

PROCEDURE

1) Obtain a discharge prescription for the patient. Prescriptions must include as a minimum the name, address, date of birth, Patient's weight (if under 12 years old) and hospital number (e.g. an addressograph).
2) Ensure that the prescription is signed and dated by a doctor/non-medical independent prescriber.
3) Check with the patient that they have not been prescribed any medication they are allergic to; if they have, contact the prescriber.
4) One qualified nurse/midwife should obtain the pack of medication (usually one pack per prescription) and clearly fill in the patient's details on the pack (patient's name and the date).
5) **Paracetamol tablets, Fybogel sachets, Chlorhexidine Mouthwash 0.2%, Gaviscon Advance and magnesium hydroxide suspension**: These are now issued as manufacturer's packs with no added pre-printed label. A hospital address sticker should be attached to each pack and the patient's name and date written on. The directions are as on the pack.
6) **Paracetamol, Paracetamol 500mg soluble , Co-codamol 8/500 & Co-codamol 30/500:** The **maximum** dose for these preparations in patients weighing less than **50kg** is **ONE** tablet up to **FOUR** times a day
7) **Eye drops/eye ointments**: The patients name and the date should be written on to the pre-printed label on the bottle/tube including the frequency and intended eye requiring treatment. A 28 day expiry should be added unless the eye drop/ointment contains an anti-infective when a 14 day expiry should be given. If both eyes are infected, a separate bottle/tube should be provided for each eye.
8) For all items, the following checks should be made:
    i) That the drug name and strength on the box are the same as those on the prescription.

ii) That the directions on the label are the same as those on the prescription.

(NB the packs are pre-labelled with standard doses and dose frequencies; if the prescription does not match these, please contact the prescriber. If the prescriber requires a different dose this must be dispensed by pharmacy.

iii) For antibiotic courses, ensure that the quantity issued will cover the whole course.

9) Endorse the prescription with the quantity of medication supplied. Sign and date the issue.

10) A second qualified nurse should then repeat the above checks and counter-sign the prescription.

11) The patient should be given an explanation of their medication and an appropriate patient information leaflet.

12) The top copy of the prescription should be returned to the pharmacy department, a copy given to the patient for their GP, and a copy filed in the patient's notes.

PRESCRIPTIONS DISPENSED BY THE PHARMACY DEPARTMENT

- If the medication is not on the agreed list or the prescriber requires a dose or frequency which does not match the pre-labelled directions this must be dispensed by the pharmacy department.
- If a patient is admitted for a period of over 48 hours the prescription must be dispensed by the pharmacy department.
- There is a separate procedure on the clinical portal: **Procedure for the Provision of Discharge Prescriptions when the Pharmacy is closed.**
- It is essential that a copy of the prescription is filed in the patient's notes on the unit/ward as this contains important dispensing information. The top copy of the prescription should be returned to pharmacy.

Directorate Pharmacists will ensure implementation in their appropriate areas working with the relevant lead/senior nursing staff to ensure nursing staff are appropriately trained.

CHAPTER 19 MEDICINES FOR DISCHARGE OUT OF HOURS

Under normal circumstances, discharge prescriptions should be written and dispensed during pharmacy opening hours. This should be completed as part of the UHB discharge planning process.

In **exceptional circumstances** e.g. discharge at short notice due to clinical need or bed shortage, the discharge prescription may not have been written and/or dispensed. The senior registered nurse on the ward caring for the patient (hereafter referred to as "the responsible nurse") must be satisfied that there is a need for an out of hours supply of medication at discharge.

The following options should then be considered:

a) For recently admitted patients, is a suitable supply of medication available at home? (N.B. need to ensure patient understands any changes to usual medication e.g. dose changes and has a supply of any new medication),

b) If no medication is due before the pharmacy re-opens, and the patient is then able to return to the hospital, they should be asked to do so. The prescription should be written and sent to pharmacy when re-open. The prescription will then be completed and returned to the requesting ward. The patient should be advised to return to the discharging ward to collect the medication.

c) If neither of the above solutions are appropriate/possible is not possible, the patient may be issued with a labelled medication pack(s)- as detailed below.

Then either :-

MTED

- An e-discharge will need to be written before the patient is discharged from the ward clinical workstation.
- There may not need to be medication added to the e-discharge in all circumstances.

- Medication can be added to the e-discharge by the doctor using the in-hours procedure.
- If an out of hours supply of medication at discharge is needed, then the doctor writing the e-discharge needs to print and sign it.
- The step requiring a pharmacy clinical check is not necessary and will not prevent the e-discharge from being transmitted to the GP.

Hard Copy TTH (where appropriate)

- The prescriber must write the UHB Discharge Advice Letter (TTH) .
- The responsible nurse and the doctor/prescriber requesting discharge must initial the prescription and indicate what was issued i.e. number of tablets (and strength if not as prescribed)..
- The completed Out of Hours TTHs form and the top copy of the prescription and the inpatient Medication Administration Record (inpatients only) and patient notes must be left in the designated area of the ward for a pharmacist to review retrospectively. The second (GP) copy should be given to the patient in a sealed envelope.
- The top yellow/white copy is the legal prescription document and should be kept in the pharmacy for 2 years from dispensing.

Checking Medicines for Take Home

- The doctor/prescriber requesting the discharge and the responsible nurse must check each item on the discharge prescription against the inpatient drug administration record for accuracy of transcription. If the therapy is intended for a discrete course and there is excess in the pack this must be made clear to the patient.

- Medication packs may be either those brought in to hospital by the patient (if fit for purpose), or pre-labelled casualty/patient/ Patient-orientated medicines POMS packs that must be annotated with patient's name and date of supply.

- Before any medicines are supplied to the patient each item prescribed must be checked as follows:
    - That the medication pack is labelled.
    - That the name on the prescription corresponds with the patient name shown on the medication pack label (where applicable).
    - That the drug name and details on the pack label corresponds with the drug, route/form and strength required by the prescription.
    - The contents should be checked to ensure they match label.

- That the route specified on the prescription is compatible with the medication available and the instructions on the label.
- That the dose volume, and dosing frequency, specified on the prescription match the instructions on the label. For some medicines the dose may need to be completed on the label. Where dose instructions are not specific (e.g. take as directed) ensure that the patient has a completed Medicines Information Card. Ward stock packs with no patient label must NOT be used.
- That the quantity is sufficient to cover the whole period of supply (normally one week). If not, arrangements must be made to complete the supply e.g. patient to return.
- That the medication has not passed its expiry date.

- Where patients own medicines are used, follow this procedure in conjunction with POMS criteria (see chapter 7 point 7.3) for use of patient's own medicines.

- Controlled drugs cannot be issued under this procedure **EXCEPT** the return of the patient's own supplies. In this case, the return must be appropriately documented in the ward controlled drug record book.

- Any drug substitution due to lack of stock must be resolved with the prescriber e.g. choice of analgesia. Any changes must be indicated on the discharge prescription.

- Ensure that the patient and/or the patients' carer understands the following about their medication(s):
    - What it is for
    - How and when to take it
    - What to do if side effects are noticed
    - When to stop taking / get medication reviewed by a doctor

- If any concerns arise during the process, **the on-call pharmacist may be contacted for advice.** Though they will not normally provide a TTH service out of hours.

- Most ward areas in UHW and Llandough have over labelled packs – "POMS packs". Addition of the necessary information at ward level allows them to be used as part of the TTH. For information on availability of POMs packs etc see WOREQ or seek advice from site practitioner. Supplies are only restocked on receipt of the prescription.

- **Ward Pharmacist's responsibility**
- The next normal working day the ward pharmacist must review the prescription utilising the patient's Inpatient Medication Administration Record and notes.
- If there are problems with the prescription, the pharmacist must contact a member of the Consultant team that was responsible for the care of the patient. The pharmacist will document any problems in the notes.
- It is the Consultant team's responsibility for resolving the problem, including (if necessary) contacting the patient.

The war**d pharmacist will provide information** for ward staff on this procedure on request by the ward manager

Resources

Summary of Product Characteristics (SPC) for each medicine is produced by the manufacture

eIV guide is a database accessible via HOWIS Local

Hospital Medicines Guide

Good Prescribing Guide

British National Formulary (BNF)

Nursing Midwifery Council Standards on Medicines Management

General Medical Council

Royal Pharmaceutical Society of Great Britain

General Pharmaceutical Council

The Pharmaceutical Journal (Vol 285) 24/31 'How to keep proper pharmacy records'

NHS Choices. Medicines Information – Licensing www.nhs.uk/Conditions/Medicinesinfo/Pages/Safetyissues.aspx accessed 20/3/2017

Medicines and Healthcare products Regulation Agency. Medicines and medical devices regulation: what you need to know Revised 2008 Available at:

www.mhra.gov.uk/home/groups/comms-ic/documents/websiteresources/con2031677.pdf Accessed 20/3/20173)

Medicines and Healthcare products Regulation Agency. Off-label or unlicensed use of medicines: prescribers' responsibilities. Published 1/4/2009. Available at https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers-responsibilities. Accessed 20/3/2017

NHS Wales Shared Services Partnership Welsh Risk Pool Services Technical note 14: Prescribing of unlicensed drugs or using drugs for unlicensed indicators. Reviewed 8/11/2004

General Medical Council. Good practice in prescribing and managing medicines and devices. Available at: www.gmc-uk.org/static/documents/content/Prescribing_guidance.pdf Accessed on 21/3/2017

Specialist information on medicines can be found from the Medicines Information Centre UHW – number 02920742251

Appendix 1.

The Medicines Code provides concise evidence based medicines practice guidance.

The following list is representative of the policies and procedures that The Medicines Code replaces.

- Ref 219 - Policy for Safe and Secure Handling of Medicines.
- UHB 046 - The Ordering, Storage, Disposal, Safe Prescribing and Administration of Controlled Drugs in Secondary Care Policy.
- UHB 125 - Prescribing for Staff Policy and Procedure.
- UHB 261 - Medicines Reconciliation Policy.
- Ref 298 - Covert Administration of Medicines Policy and Procedure.
- UHB 176 - Access to Medicines When Pharmacy is Closed Procedure.
- Ref 280 - Disposal of Medicines Procedure.
- Ref 205 - Management of Staff involved in Medication Errors Procedure.
- UHB 112 - Patient Orientated Medicines Procedure.
- UHB 187 - Prescribing, Ordering, Storage and Administration of Strong Potassium Injections Procedure.
- Procedure for the Safe Administration of Medicines to Adult Patients with Swallowing Difficulties.
- UHB 151 - Provision of Discharge Prescriptions When the Pharmacy is Closed Procedure.
- UHB 195 - Safe Administration of Medicines in Secondary Care Procedure.
- UHB 152 In-patient Prescription Monitoring Endorsement and Supply Procedure expired.
- UHB 204 Complimentary Medicines Guidelines.
- UHB 225 Take Home Medication (TTH) on Adult Short Stay Surgical and Gynaecology Areas Procedure expired Jun 2015
- UHB 226 Use of Unlicensed Medicines and Medicines used Outside their Product License Procedure expired Dec 2015
- UHB 266 Non Medical and Dental Prescribing Policy due to expire Apr 2018
- 270 Use of bed side medicine cabinets for wards without a POM service medicines management Procedure.

Appendix 2

MEDICATION INCIDENT INVESTIGATION FORM

Purpose.

This document is designed to assist in the fact finding identification of system failures that may have led to or contributed to medication errors. The information gained can then be used to agree and implement action plans, to minimise future risk. Lessons learnt from the investigation will be disseminated through the UHB as appropriate, in non-identifiable format.

Notes.

1. This form does not replace the Datix Form; staff must continue report as per UHB policy.
2. This form is designed for fact finding use at Ward/ Department / Directorate level

1.

Where was the incident detected?	Ward/Dept	Date & time of incident	Directorate

2.

Patient details (attach addressograph)		**Reporting member of staff details**	
Surname		Name	
Forename		Designation	
Address		Ward/Dept	

Date of Birth		Employed By	
NHS number			

3. Tick √ the appropriate choice (one only)

Medication process – at what stage did the incident occur?			
Prescribing/prescription process		Dispensing/supply/preparation from hospital pharmacy	
Administration/supply of medicine from a clinical area		Dispensing/supply/preparation from community pharmacy	
Advice/information		Patient's reaction to medication	
Monitoring/follow-up of medicine use		Other	

4. Tick √ the appropriate choice (one only)

Type of Incident – please select appropriate description(s)			
Patient has known allergy to treatment		Mismatching between patient and medicine	
Omitted medicine/ingredient		Contraindication to medicine in relation to drugs or condition	
Wrong drug/medicine		Wrong/unclear dose or strength	
Wrong frequency		Wrong formulation	
Wrong quantity		Wrong route	
Wrong method of preparation/supply		Wrong storage	
Wrong/passed/omitted expiry date		Wrong/omitted patient information leaflet	
Wrong/transposed/omitted		Wrong/omitted verbal patient	

medicine label		directions	
Calculation error		Wrong/ambiguous/incomplete advice	
Delay in treatment		Documentation ambiguous/unclear/incomplete	
Other (Please specify)		Adverse reaction when drug used as intended	

5. Tick √ appropriate boxes

Actual degree of harm to the patient (severity)		
Was the patient actually harmed?	**No** (No harm incident/near miss)	
	Yes (indicate degree of harm to patient below)	
Low (minimal harm – patient(s) required extra observation or minor treatment)		
Moderate (short term harm – patient(s) required further treatment or procedure)		
Severe (permanent or long term harm)		
Death (caused by the incident)		

6.

Summary of Incident
Medicines involved State name(s), strength(s), and formulation(s) of medicines involved.

Please attach copy of the medication chart/prescription form to this form
Summary of events State briefly what happened. Facts only, not opinion

7.

Immediate action taken State briefly what action was taken at time of the incident

Have the following been informed of incident.		By whom, time and date.
Patient.		
Next of Kin (if appropriate)		
Consultant		

8. Tick √ appropriate choice(s)

Were there any other important contributing factors?

Ambiguous prescription		Product storage	
Checking problems		Similar names (patient)	
Communication failures		Similar looking medicine names	
Computer problems		Similar sounding medicine names	
Documentation problems		Skill mix	
Interruptions		Space problems	
Packaging of product (Look-a-likes)		Staffing levels	
Procedure not available/unclear		Urgency of situation	
Other (please specify)			

9. Tick √ appropriate choice

Class of error			
Lack of knowledge – product (mistake)		Knew what to do but did something else (slip)	
Lack of knowledge – procedure (mistake)		Knew what to do but forgot or omitted to do it (lapse)	

Risk evaluation of incident

Risk Ratio

Potential for recurrence. ↓		minor Minor	Moderate	Major	Sentinel.

Almost certain.	YELLOW	YELLOW	AMBER	RED	RED
Likely	YELLOW	YELLOW	AMBER	RED	RED
Possible	GREEN	YELLOW	AMBER	RED	RED
Unlikely	GREEN	GREEN	GREEN	AMBER	RED
Rare	GREEN	GREEN	GREEN	AMBER	RED

RISK GRADE = _____ (green/yellow/amber/red)

Refer to Pathway for management of staff involved in medication errors.

10.

Investigation Findings/Action to be taken
Feedback to / comments from. • Individuals • Department • Directorate • Trust

Person undertaking investigation signature/date

Individuals signature/Date

Line Manager signature/Date

Directorate signature/date……

11.

Pharmacy comments/action taken **Sign and Date……** **Lessons Learnt Information disseminated to,**