Northern Health and Social Care Trust

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Medicines Administration and Management Policy for Reg Nurses, Midwives and SCPHNs

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Target audience:

Trust Nursing Staff involved in any aspect of the use of medicines

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NHSCT Mission Statement
To provide for all the quality of services we would expect for our families and ourselves

Northern Health and Social Care Trust

MEDICINES ADMINISTRATION and MANAGEMENT POLICY FOR REGISTERED NURSES, MIDWIVES and SPECIALIST COMMUNITY PUBLIC HEALTH NURSES

FEBRUARY 2010

INDEX

Northern Health and Social Care Trust

NORTHERN HEALTH AND SOCIAL CARE TRUST

MEDICINES ADMINISTRATION and MANAGEMENT POLICY FOR REGISTERED NURSES, MIDWIVES and SPECIALIST COMMUNITY PUBLIC HEALTH NURSES

1. AIMS

The aims of this policy are:

- To set standards for safe practice in the management and administration of medicines by registered nurses, midwives and specialist community public health nurses.
- To minimise the risk of error in medicines administration.
- To ensure safe and effective therapy.
- To provide accurate records of all medicines administered to patients.

2. DEFINITIONS

2.1 Medicine

Medicines are substances that are introduced into the body, or externally applied to the body, for the purpose of:

- Treating disease.
- Preventing disease.
- Diagnosing disease.
- Ascertaining the existence, degree or extent of a physiological condition.
- Contraception.
- Inducing anaesthesia.
- Or, otherwise prevention or interfering with the normal operation of a physiological function.

Medicines may be categorised as follows:

(i) Medicines and medicinal preparations which come under the provisions of the Medicines Act (1968). They include medicines used in clinical trials, unlicensed medicines, dressings and medical gases.

(ii) Controlled drugs ie. substances controlled under the provisions of the Misuse of Drugs Act (1971) and Regulations made under the Act.

(iii) Alternative medical products eg. herbal or homeopathic remedies, that are used for therapeutic purposes.

2.2 Blood and Blood Products

Blood is not classified as a medicinal product although some blood components are. Products derived from the plasma component of blood such as blood clotting factors, antibodies and albumin are licensed and classified as considered to be medicinal products. For the purpose of the administration of medicinal products nurses would be expected to apply the standards for medicines management to all medicinal products, but should consider additional guidance by the National Patient Safety Agency – guidance launched on 9 November 2006 "Right Patient, Right Blood" (available at www.npsa.nhs.uk). A key requirement of this guidance is that all staff involved in blood transfusion undergo formal competency assessment on a 3 yearly basis.

2.3 Patient

Throughout this policy where the word "patient" is used this refers to whoever the medication may be administered to eg. patient, client, user, woman (midwifery).

2.4 Nurse

Throughout this policy where the word "Nurse" is used this refers to nurses, midwives and specialist community public health nurses who are registered on the Nursing and Midwifery Council Register.

Senior Nurse / Nurse in Charge is named as the responsible person for certain elements of the system, this includes Ward Managers, Community Team Leaders, Midwifery Sisters, District Nursing Sisters, Health Visitors, Treatment Room Sisters.

2.5 Kardex

Throughout the document the term "Kardex" is used to describe the Trust Patient Medicines Prescription and Administration Record. The information given applies to all equivalent approved Trust prescribing documents, for example the 'pink card' system used in Community Settings and Treatment Rooms and the prescription sheet used in Family Planning Services.

3. SCOPE OF THIS POLICY

The framework for this policy document is drawn from the NMC Standards for Medicines Management (2008). The following standard is not reflected in the scope of this policy: **Standard 12 – Text Messaging**. The policy provides guidance for all Trust nursing staff involved in any aspect of the use of medicines.

The policy complies with and reflects the contents of the following:

- Misuse of Drugs Act (1971).
- Medicines Act (1968).
- Misuse of Drugs Regulations NI (2002).
- DHSSPS Guidelines on the Use and Control of Medicines (2008).
- The Code : Standards of Conduct, Performance and Ethics (2008).
- Controls Assurance Standard (Medicines Management) (2005).
- Safer Management of Controlled Drugs (2009).
- Health Act (2006).
- Safer Administration of Controlled Drugs in Secondary Care (2009).

3.1 Linked Policies

- Policy and Procedures for Waste Management.
- Incident Management Policy and Procedure NHSCT/09/127.
- Policy for the Administration of Medicines via Syringe Driver.
- Anaphylaxis Protocol.
- Management of Supported Practice for Nurse / Midwife following a Medicines Management Error (draft).

4. ADMINISTRATION

4.1 Policy Statements

All medicines administered or supplied to patients are prescribed by an authorised prescriber or are administered or supplied by an approved person operating within a patient group direction, and recorded on approved Trust kardexes.

Medicines are only administered or supplied to patients by suitably competent nurses who can exercise professional accountability and judgement in the best interests of their patients.

All medicines administered to inpatients are procured by and distributed through the pharmacy, except for patients' own medicines where their use is appropriate.

4.2 Principles

As a Nurse you are accountable for your actions and omissions.

Medicines are only administered when they are prescribed by:

- A UK registered Doctor or Dentist.
- A registered Independent or Supplementary Prescriber.

- Community Practitioner Nurse Prescribers who may prescribe from the Community Practitioner Nurse Prescribers Formulary (dressings, appliances and limited prescription only medicines).
- On the written instruction of an approved practitioner within the terms of a patient group direction (see section 4.5).

Prescriptions must be written on Trust approved prescribing documents.

Prescriptions must normally be written. In exceptional circumstances a medicine may be administered on the verbal instruction of a doctor (see section 12).

Administration involving one or more of the following elements is witnessed by a second Nurse, except in circumstances where it is not possible eg. administration takes place in the patient's home or where it is not feasible for operational reasons eg. in theatres, vaccination of children in schools and pre-school clinics. In such circumstances a risk assessment is undertaken and local protocols for practice developed:

- Intravenous Therapy.
- Bolus injections, IV additives and injections via drip tubing.
- All medicines dispensed from a clinical area to patients at discharge.
- Controlled Drugs.
- Patients under the age of 16.
- Medicines administered without a written prescription.
- Cytotoxic medicines given by any route of administration.
- Medicines administered via electronic medical devices, for example, infusion pumps, syringe drivers.
- Doses requiring complex calculations.
- High Alert Medicines eg. Insulin and Warfarin – see Appendix 4 for list.

Nurses carrying out the second check must do this independently from the first Nurse. Second checks must be performed completely from preparation of the dose through to administration to a patient.

The administration of medicines is undertaken in a methodical manner, in accordance with the procedure in section 4.6 and distractions are minimised while medicines are being selected, prepared and administered.

All medication errors are investigated (see section 17).

Nurses authorised to administer medicines are Trust employees and have registration on the NMC register as:

- First Level Nurses and Second Level Nurses who are deemed competent by the senior nurse / nurse in charge and have completed an approved educational programme.

- Midwives.

- Specialist Community Public Health Nurses.

- Bank and Agency Staff.

Trust Bank staff and Agency staff are Registered Nurses on the NMC Register and will administer medications as part of their role when working in the Health and Social Care Trust, governed by Trust Policy. This includes oral medicines, subcutaneous and intravenous administration following appropriate training. This will be documented on the Agency Induction Form and held at ward level as a record.

- Second Level Nurses.

Second Level Nurses who have completed an approved course of study (Pharmacology Module) and who have been deemed competent by the Senior Nurse / Nurse in Charge are viewed as having the same level of responsibility and accountability for aspects of drug administration as First Level Nurses.

Student nurses and student midwives may only administer medicines under the direct supervision of a Registered Nurse. The registered nurse must clearly countersign the signature of the student when supervising a student in the administration of medicines.

Nurses must have sufficient knowledge of the medicine being administered and of the patient to whom the medicine is being administered, to be able to intervene in circumstances where administration is not appropriate.

4.3 Methods of Supplying / Administering Medicines

(NMC Standards for Medicines Management, Standard 1) states that all prescribers (medical and non medical) have a responsibility to ensure that:

- Kardexes are completed accurately, in full, are legible and signed.

- Kardexes are reviewed and renewed as necessary to ensure clarity and safety. Consultant ward rounds and GP ward rounds in Community Hospitals should always include review of the patient's medicine kardex.

- Patient allergies are checked prior to prescribing and administering medication and are clearly recorded on kardexes.

- Medication incidents are reported in accordance with the Trust's Incident Management Policy and Procedure.

4.4 Patient Medicines Kardexes

The Patient Medicines Kardex is not a prescription but a direction to administer medication.

It must be signed by a registered prescriber and authorises the delegation to administer medication on the prescriber's behalf. However, in administering medication the Nurse is accountable for his / her actions and for raising any concerns about the direction with the prescriber eg. in respect to clarity.

4.5 Patient Group Directions

A Patient Group Direction (PGD) is a written instruction for the supply or administration of named medicines in an identified clinical situation.

Medicines may be supplied or administered under PGDs in limited situations where doing so offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability.

The PGD must be agreed locally by the Clinical Director, the Directorate Manager (or delegated named nurse), or professional manager for the other staff groups providing care under the direction, the Head of Pharmacy and Medicines Management, and in case of antibiotics, the Consultant Microbiologist.

They must consult with all appropriate persons, including Consultants whose patients may be treated under the direction, to confirm that the proposed direction is appropriate, does not compromise patient safety and is consistent with professional relationships and accountability.

Before it is introduced into operation, the PGD must be submitted to the Non Medical Prescribing Group for approval and forwarded to the Northern Prescribing Forum for endorsement.

The PGD must be reviewed at least once every 2 years otherwise it is invalid. The review must be undertaken by the Clinical Director, the Directorate Manager (or delegated named nurse) or professional manager for staff groups providing care under the direction, and the Head of Pharmacy and Medicines Management, in consultation with all appropriate persons.

If any change is made to the patient group, clinical condition or situation to which the direction applies, or to the characteristics of staff authorised to practice under the direction, or to the description of treatment available under the direction, then the new version of the direction must be submitted for approval. Minor changes may be made without further approval.

4.5.1 Development of a Patient Group Direction

The PGD must be written using the approved Trust template (Appendix 1) and must contain the following information:

- The rationale ie. the reason why the PGD offers an advantage to patient care.

- The patient group and clinical condition or situation to which the direction applies.

- A description of patients, clinical conditions or situations excluded from treatment under the direction.

- The action to be taken if a patient is excluded from or refuses treatment under the direction.

- The medicine which may be supplied or administered and specific details of:

    - The dose.
    - The frequency of administration.
    - The form and route of administration.
    - The maximum number of doses that may be supplied or administered.
    - The maximum period of time for which the medicine may be supplied or administered.
    - Warnings, cautions and contra-indications to treatment with the medicine.
    - The legal status of the medicine.

  Supply and administration under the terms of the PGD must be in line with local guidelines, formularies and protocols.

- Instructions on the documentation required to record supply or administration and other records to be kept for audit purposes.

- The skills, knowledge and qualifications required by nurses approved to authorise supply or administration of medicines under the terms of the direction and details of any required training programme.

- The action to be taken if an adverse drug reaction is suspected or occurs to a patient being treated under the direction.

- Details of any necessary follow-up action that will be taken after supply or administration.

- The date that the direction comes into force and the date that it expires.

The Senior Nurse / Nurse in Charge must approve and maintain an up-to-date register of persons approved to supply or administer medicines under the terms of the PGD in their area of responsibility. The register must be signed by the approved person as confirmation that he/she has read and understood the protocol. **The administration of drugs via a PGD may not be delegated**. Students cannot supply or administer under a PGD, but would be expected to understand the principles and be involved in the process. The Senior Nurse / Nurse in Charge must also ensure that only current up-to-date PGDs for their area are used.

The Senior Nurse / Nurse in Charge must ensure that all staff involved in the operation of the PGD have access to the current version and are aware of any changes or amendments. The system must include a record of location of all copies of the direction, a record of review of the direction and a method of communication of changes and new versions to all copy holders and persons involved in the operation of the direction. The Senior Nurse / Nurse in Charge is responsible for initiating the renewal of the PGD before the defined review date.

The arrangements for monitoring of care under the PGD must be specified.

Details of supply or administration of a medicine under a PGD must be recorded on standard Trust approved documentation used for prescribing. The record must include:

- The hospital and ward or department.

- The patient's name, address, date of birth.

- The medicine name, dose, route of dose(s), start date, number of dose(s) and/or period of time for which the medicine is to be supplied or administered. If more than one dose requires to be administered, each dose must be administered by a person approved to administer under the PGD, or the person who initiated administration must ensure that a doctor prescribes the remaining required doses.

- The signature and printed name of the approved person who supplied or administered the medicine.

4.6 Procedure for Administration

(NMC Standards for Medicines Management Standard 2, Standard 8).

Before administering any medicine the Nurse must check that the prescription to administer:

- Is clearly written, typed or computer generated and indelible.
- Is signed and dated by the authorised prescriber. Initials are not acceptable, signatures must be written in full.
- Specifies the substance to be administered using its generic or brand name where appropriate, its stated form and the:

    - strength;
    - dosage;
    - timing;
    - frequency of administration;
    - start and finish dates;
    - route of administration.

Ensure that the prescription:

- Clearly identifies the patient's allergy status.
- Clearly identifies the patient for whom the medicine is intended.
- Clearly identifies the patient's weight where appropriate.

If the nurse has any concerns or queries in respect of any of the above he/she must seek further clarification from the authorised prescriber and document same. Prescriptions must not be altered or amended. If a change is required the medicine must be cancelled completely and a new prescription must be written, dated and signed.

Transcribing of medicines by nurses should not be undertaken. Transcribing includes the following:

- **transcribing the detail of prescribed medicines from patient kardex to discharge letters or transfer letters;**
- **the practice of copying illegible patient kardexes onto new charts (NMC Standards for Medicines Management, Standard 3). These practices must <u>not</u> be undertaken by nurses.**

Local protocols must be developed in any service area where transcription by nurses occurs and same identified by professional nurse lead as a risk within clinical governance processes.

4.7 <u>Procedure for Medicines Administration</u>

The following procedure must be undertaken before administering a medicine. If a second check is required each step of the procedure must be witnessed.

- Check the patient's allergy status has been completed on the medicines kardex.
- Read the prescription carefully and ensure the prescription on dispensed medicine is clearly written and unambiguous.
- Check that the medicine is correct for the patient.
- Ascertain that the prescribed dose has not already been given.
- Select the medicine required and check against the prescription.
- Check the expiry date.
- Identify the patient in the in-patient setting by:

(i) Checking the name on the prescription against the name on the patient's nameband and unique identifier <u>or</u>;

(ii) Asking the patient to state his or her name and date of birth. If the patient's hospital number is not available / documented, 2 nurses must check the patient's demographics verbally with the patient and check these correspond with their notes. Once satisfied these have been confirmed, apply a patient nameband and administer the medicine.

If the nurse cannot confirm patient identity, do not proceed to administer medicines. Report to Senior Nurse / Nurse in Charge.

Individual care settings (residential facilities / Intensive Care Units) must have locally agreed protocols for client identification which staff must familiarise themselves with prior to medicines administration eg. photographic ID attached to the prescription chart.

As a nurse you must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contraindications.

As a nurse you must be aware of the patient's plan of care (care plan / care pathway).

Complex dose calculations must be carried out independently by 2 Registered Nurses to check accuracy and minimise the risk of error.

If a second check is required, the whole administration period must be witnessed except for slow administration that takes more than a few minutes, for example, infusions, for which the set up and start of the administration must be witnessed.

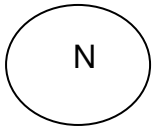
The prescribed medicine must be administered as near as possible to the prescribed time and normally within an hour. If this is not possible and there is any doubt about the implications of administering a medicine outside the prescribed time, medical advice must be sought.

The prescribed medicine should be administered or withheld in the context of the patient's condition (eg. digoxin withheld if pulse less than 60 bpm).

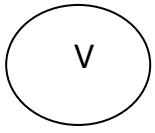
Medicines should not be administered if they are incorrectly labelled (ie. drug, strength, form, dose, frequency must be checked).

The nurse must contact the authorised prescriber / responsible doctor immediately where contraindications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine or where assessment of the patient indicates that the medicine is no longer suitable.

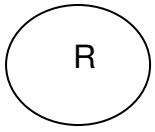
If a prescribed medicine is not given, the reason must be recorded clearly on the inpatient kardex (using the standard codes), documented in the patient's nursing notes and the responsible doctor informed in the appropriate timescale. The standards codes for recording omitting doses are:



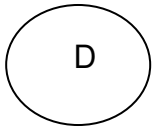
Nil by Mouth



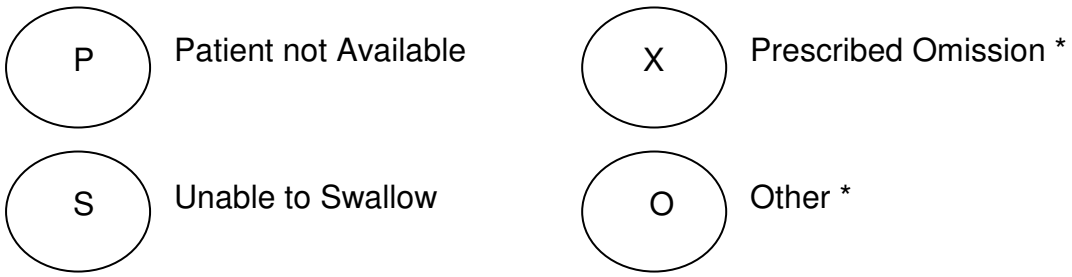
Vomiting



Patient Refused



Drug not Available



* 'Prescribed Omissions' and 'Other' reasons for omitted doses are recorded on the appropriate section of the inpatient kardex.

If the patient requests a dose that is different from the prescribed dose, the doctor must be informed so that the prescription may be reviewed before the medicine is administered.

Remember the **"No More Than 3" rule** – if you require more than 3 tablets / capsules / vials / ampoules to prepare a dose of medication, recheck the dose to make sure that any calculations have been carried out correctly as most medicines should not require more than 3 tablets / capsules / vials / ampoules in order to achieve the prescribed dosage.

For patients with restricted oral intake, action must be taken depending on the category of restriction.

Administration of medicines must be recorded immediately by signing the appropriate entry on the patient kardex, ensuring the signature is clear and legible.

Document the time administered if different from the prescription or if PRN medication.

Batch numbers should be recorded for all vaccinations.

(NMC Standards for Medicines Management, Standard 13).

Where medicines have been prescribed within a range of dosages it is acceptable for nurses to titrate dosages according to patient response and symptom control and to administer within the prescribed range.

The nurse must ensure that he/she is competent in interpretation of clinical test results which dictate the dosage to be administered within the prescribed range (eg. blood glucose levels prior to administration of insulin), follow any protocols or guidance and document dose and route if range prescribed. The Senior Nurse / Nurse in Charge must ensure that all staff within the clinical team are supervised with respect to this aspect of medicines administration and that this aspect of medicines management is covered in the induction process.

(NMC Standards for Medicines Management, Standard 14).

Nurses must not prepare medicines for injection in advance of their immediate use or administer medication drawn into a syringe by another Nurse if not in their presence.

In an emergency situation where nurses may be required to prepare substances for injection by a doctor, the nurse must ensure that the doctor administering the drug has completed the appropriate checks.

(NMC Standards for Medicines Management, Standard 15).

Nurses must not administer medication which has been purchased by an individual patient over the Internet without a valid prescription.

Nurses must not administer patient's own medication that is not labelled by a Registered Pharmacist.

4.8 Intravenous Administration

(NMC Standards for Medicines Management, Standard 14).

The administration of intravenous drugs by nurses will be carried out in partnership with medical staff and will be at the discretion of the Senior Nurse / Nurse in Charge according to staffing levels and workload.

Intravenous medicines may only be prepared and administered by nurses who have completed the approved intravenous therapy training course.

In the acute setting all intravenous drugs must be checked by 2 registered nurses.

In the community setting, where this is not possible, intravenous drugs should be checked by one Nurse with another competent person who knows the patient (ie. the patient or carer). At a minimum any dose calculation must be independently checked. In situations where this is not possible local policies must be followed.

The preparation of injections / infusions must be carried out in an area that:

- Has a clear, uncluttered surface for preparation.
- Has adequate space.
- Is quiet, away from distractions.
- Has a surface that can be cleaned.
- Is near to handwashing facilities.
- Is near to information on the preparation of injections (NHSCT Intravenous Medicines Administration Guide, 2008).

Check first that the injection / infusion required is not already available in a ready-to-use form.

The physical and chemical stability of an injection / infusion must be determined before the product is prepared. Information sources include:

- Intravenous Medicines Administration Guide.
- Manufacturer's Summary of Product Characteristics or Package Inserts.
- British National Formulary.
- Clinical Pharmacist / Medicines Information.

Only prepare injections / infusions for one patient at a time and administer them before starting preparation for another patient.

Injections / infusions prepared in the clinical area must be prepared immediately before administration. They must not be prepared and stored in the clinical area.

Injections / infusions prepared in the clinical area must only be administered by the nurses who are either involved in the preparation, or by medical staff who are able to check that the nurses preparation of the medicine was correct.

Oral and intravenous drugs must not be taken to the patient's bedside at the same time.

Injections must be clearly identifiable at all stages during preparation and administration.

Prepare the label before starting preparation of the infusion so that it may be affixed immediately after preparation is complete.

Labels containing the following information must be added to intravenous infusions:

- the patient's name and number;
- the name and amount of additives;
- the date and time prepared;
- infusion expiry date / time;
- route, diluent and final volume;
- prepared by and checked by.

If the injection is to be given by bolus and will be supervised at all times during preparation and completion of administration, write the name of the medicine on a sticker and use it to label the final container (the syringe, bag, etc). Keep the finished preparation and original containers in an individual tray between preparation and administration.

A time limit is required between preparation and completion of administration of injections due to the possibility of microbial contamination and lack of stability of the prepared solution. Refer to the manufacturer's product information for guidance on stability times.

If the injection is not to be given by bolus or is unsupervised at any time between preparation and completion of administration, label the container (the syringe, bag, etc) using the standard approved label.

For syringe drivers, affix the label to avoid obliterating the graduations on the syringe and to allow inspection of the solution. Do not use the label more than once – always use a new label when preparing a new syringe.

In hospital, nurses and midwives can administer the **first** and all subsequent doses of intravenous drugs, including antibiotics.

Community paediatric nurses should not administer the first dose of any new intravenous drug (even if the child has received previous courses of the same drug).

All intravenous administrations and adjustment to the infusion pump (ie. flow rate changes) must be witnessed by 2 nurses who will have equal responsibility. A record must be made of any adjustment to rate of infusion. In situations where this is not possible, local policies must be followed.

4.9 Administration to Children under the age of 16 years

In the acute setting, all medicine preparation and administration for children under 16 years must be checked by 2 nurses. Within the community setting this may not be possible. If only one registrant is available, that registrant should risk assess each situation individually and make a decision to proceed to administer based on the information available at the time and in line with the Standard Operating Procedure.

The child's current height and weight (in kilograms) must be recorded on the patient kardex.

Children and infants must wear identity bracelets and particular attention must be paid to the correct identification of the child before administering medication.

Oral syringes must be used for all doses of less than 5ml of a liquid oral preparation.

When administering injections of doses less than 1ml in volume, a 1ml syringe graduated to 0.05ml must be used.

Paediatric formulations must be used whenever available. When they are not available extreme vigilance must be experienced when calculating and preparing paediatric doses.

Dosage calculations and final dose must be carried out separately by both nurses involved. The Medicines Information Service / Clinical Pharmacist should be contacted if there is any uncertainty regarding the dose or calculation.

In the event of a child refusing medication from nurses, a parent may administer oral medication, but only in the presence of staff involved.

Refer to **NMC Standards for Medicines Management, Standard 10** / **page 21** for information in respect of development of standard operating procedure for self administration in children and young people.

4.10 Covert Administration of Medicines

(NMC Standards for Medicines Management, Standard 16).

The covert administration of a medicine is defined as the administration of a medicine disguised in food or drink, to a patient who has previously refused to take the medicine.

Where an adult patient is capable of giving or withholding consent to treatment no medicine may be given without the patient's agreement.

The covert administration of a medicine to an adult patient is only likely to be necessary or appropriate in the case of a patient who actively refuses a medicine, but who is deemed not to have the capacity to understand the consequences of refusal.

A medicine may only be administered covertly when it is in the best interest of the patient, that is, the medicine is necessary in order to save life, or to prevent a deterioration in the patient's physical or mental health, or to ensure improvement in the patient's physical or mental health.

A medicine may only be administered covertly following discussion and agreement with the medical and nursing staff responsible for the patient's care and the patient's family and / or carers and advocates. The discussions and agreement must be documented in the patient's notes.

Any decision to administer a medicine covertly must not be considered routine and may be reached only after assessing the care needs of the patient as an individual - it should be patient specific. In addition, the mechanics of crushing medicines may alter their therapeutic properties rendering them ineffective and the medicine would not be covered by their product licence. Medicines should not routinely be crushed unless a pharmacist advises that the medicine is not compromised by crushing and crushing has been determined to be in the patient's best interest.

A young person under the age of 16 is deemed to be capable of consenting to treatment if, in the opinion of the medical practitioner attending him or her, he or she is capable of understanding the nature and possible consequences of the treatment. It follows that where a young person under the age of 16 refuses a medicine and is deemed able to understand the nature and possible consequences of that refusal, then the medicine must not be administered covertly, even if the parents agree.

Where a young person under the age of 16 is deemed incapable of understanding the nature and possible consequences of the treatment, then the medicine may be administered covertly, provided parental consent is obtained or consent of the adult who has parental responsibility is obtained. If this consent is not forthcoming, for example, where the parent or adult with the parental responsibility is absent or is not thought to be acting in the best interests of the young person, the medicine may be given covertly if it is thought to be essential by the medical and nursing staff responsible for the young person's care and well-being.

5. DISPENSING

(NMC Standards for Medicines Management, Standard 4).

Prescriptions are dispensed from the hospital pharmacy or in certain agreed circumstances supplied by nurses directly from the ward eg. one stop dispensing wards / out-patient clinic or the Accident and Emergency Department against a written prescription (not a patient group direction).

If the medicines are to be issued to the patient direct from the ward, clinic or the Accident and Emergency Department, the Senior Nurse / Nurse in Charge ensures that medicines are only issued by staff that he or she has authorised and that authorised staff are trained and competent in the processes involved in issuing medicines to patients as follows:

NB Family Planning Nurses and Emergency Nurse Practitioners **are** authorised to dispense against a PGD – such dispensing activity is covered by a department Standard Operating Procedure).

- Prescriptions are thoroughly checked to ensure that they are dispensed correctly for the patient. Each prescription must be double checked for the following:
    - Right Patient
    - Right Medicine
    - Right Dose
    - Right Route
    - Right Time
- All medicines issued to patients to take away are labelled to comply with legal requirements.
- The patient is provided with adequate verbal and written information about his or her medicines.

Medicines issued to patients on discharge by wards should only occur in the exceptional or emergency situation ie. in the event of an unplanned discharge when pharmacy is closed.

Refer to Appendix 3 One Stop Dispensing Service – Discharge Prescriptions for additional guidance.

A 3 day supply is made at ward level with provision made for weekends or bank holidays if required (eg. 4 days on Thursday).

The Discharge Prescription must be completed by an authorised prescriber and used to prescribe all current medicines. The information required must be accurately transcribed by the authorised prescriber from the inpatient kardex and the patient's record.

A record of the quantity of medicines supplied must be made on the prescription.

The top copy of the prescription must be sent to pharmacy within 24 hours for recording and marked dispensed from ward stock. This must be signed by 2 Registered Nurses.

The patient should be instructed to take the white copy of the prescription to the General Practitioner and NOT the local pharmacy.

Before dispensing a careful check of the prescription must be undertaken to ensure it is signed, complete and accurate when checked against the inpatient kardex. Care must be taken in checking all 'when required' medicines and medicines on other prescribing sheets (eg. insulin) if required.

A check must be made to ensure the patient is not prescribed a documented allergen.

In situations where nursing staff dispense drugs eg. one stop dispensing wards, outpatient departments or Accident and Emergency departments, the nurse must write the labels and check them against the prescription before dispensing.

Items should be prepared one at a time and assembled using the containers provided by pharmacy for this purpose. Child resistant closures (CRCs) must be used on tablet bottles, with the exception for patients who are unable to use CRCs. Labels must be checked with the original stock container.

Staff should provide a patient information leaflet where possible (a legal requirement) and additional information where appropriate such as warfarin booklet, steroid card, angina booklet, instructions for inhalers.

Labels must be legible, indelible, comprehensible and in English. Refer to Trust Interpreting Policy for patients who first language is not English.

The following details must appear on the label of a dispensed medicine:

- Patient's name.
- Ward and hospital.

- Date of dispensing.
- Directions for use (do not write “as directed”).
- Keep out of Reach and Sight of Children.
- ‘FOR EXTERNAL USE ONLY’ (if appropriate).
- Quantity.
- Name of medicine (using generic name except for controlled release preparations (eg. Adizem SR and preparations such as theophylline and lithium – see BNF).
- Expiry date (liquids).
- Precautions (see BNF Appendix 9).

5.1 Aids to Support Compliance

(NMC Standards for Medicines Management, Standard 16).

Self administration from dispensed containers with CRCs may not be possible for some patients.

Any compliance aid such as a monitored dose container should be dispensed, labelled and sealed by a pharmacist. The sealed compliance aids are referred to as monitored dosage systems (mediboxes).

Compliance aids may be purchased by individual patients for their own use and are aids that are filled from containers of dispensed medicines. Nurses should not repackage dispensed medicines into compliance aids for individual patients as this practice carries a risk of error.

In addition, the properties of the prescribed medicine may change when repackaged and the medicine would not be covered by the product licence.

6. PATIENT’S OWN MEDICINES (PODs)

(NMC Standards for Medicines Management, Standard 5).

Refer to Appendix 2 One Stop Dispensing Service.

Medicines brought into the Trust by patients remain their own property. They must not be disposed of without the consent of the patient or the patient’s representative.

A system of ‘One Stop Dispensing’ is in operation in some acute hospital wards.

One stop dispensing is a system of administering and dispensing medicines. It involves using the patient’s own medicinal products during their stay in hospital, either those dispensed by a community pharmacy or by the hospital pharmacy or both, providing they contain a patient information leaflet and are labelled with full instructions for use.

Supplies are replenished should the supply run out whilst in hospital or when any new items are prescribed. Patients are discharged with a supply of medicines as agreed locally.

Nurses should check that the medication handed to the patient on discharge is as per the discharge prescription, as medicines may be altered / stopped during hospital admission. If a particular medicine has been stopped during admission and is not to be restarted on discharge, the patient must be informed and same recorded in nursing records.

A patient's own medicine must never be administered to another patient.

Patients must be asked if they are taking any prescribed medication or other medicinal preparations and if they have brought them into hospital.

The patient should be asked to surrender medication for assessment. This will facilitate the collection of a complete medication history.

In wards where one stop dispensing procedures have been introduced, any PODs which are prescribed on the kardex will be used during the patient stay, except controlled drugs.

Assessment of PODs prior to use is mandatory.

6.1 Assessment and Use of Patients Own Medicines (PODs)

Background

Patients own medicines **must** be assessed for suitability before they are used to treat the patient

Procedure

- Provide each patient with 'Making the Most of Your Medicines' leaflet.

- Obtain and document verbal agreement for the use and destruction of PODs.

- If PODs are unavailable on admission, contact a relative / carer to request that they be brought in as soon as possible. If this is not possible, or an unacceptable delay in administration would ensue, issue original packs as per procedure.

- Assess all PODs, **except Controlled Drugs,** for suitability using 'POD Algorithm' (Appendix 3). Controlled drugs must be managed by nursing staff according to this policy.

- Attach a 'date / assessed by / checked by' sticker to all suitable PODs. Endorse date in the date section and your initials in the assessed by section of the label.

- Leave PODs for second check by pharmacist or POD checker (nursing staff obtain second check by second registered nurse).

- Checker endorse initials in the checked by section of 'date / assessed by / checked by' sticker.

- Place PODs which have been assessed and checked as suitable for use, and are prescribed on the patients Kardex into the correct medicine drawer.

- Lock patient's medicine drawer.

- Leave any unsuitable PODs clearly marked for disposal by pharmacy staff.

6.2 Storage of Patient's Own Medicines

Where the patient's own medicines are not contraindicated with current treatment the medicines should be stored in the lockable bedside cabinet, in a designated locked cupboard, or sent home with a responsible adult as soon as is practicably possible after the collection of a medication history and a record made in the patient's record.

In areas where lockable bedside cabinet lockers are available, the lockable drawer is for the storage of medicines only and only medicines belonging to the patient may be stored. Controlled drugs and medicines requiring special storage conditions (ie. refrigeration) must not be stored in the bedside cabinet.

Items intended for individual patient use such as eyedrops, inhalers, GTN sprays, etc may be stored in the lockable drawer of their bedside cabinet. Discharge medications can also be stored prior to discharge (not currently available in all Trust facilities).

Where the patient's own medicines are no longer appropriate, the patient's consent to the destruction of the medicines should be sought. Where the patient does not agree to the destruction of medicines they should be sent home with a responsible adult. The patient and / or their representative must be advised if the medicines are not safe for use. The nurse must document this in the patient's notes

If a patient does not agree to the destruction of medicines, or the sending home of surrendered medicines is not possible, it is the responsibility of the nursing staff to adhere to the following arrangements for standard medicines:

- Place medicines in a resealable plastic bag.

- Record in the patient's notes that the medicines are stored on the ward.

- Store in the secure area reserved for patients own medicines eg. lockable drug cupboard, drug trolley, patients medication lockers.

Nursing staff must adhere to the following arrangements for storing patients own controlled drugs.

- Ensure 2 registered nurses sign that the patient's own controlled drugs are stored at ward level, including drug name(s), form, strength and quantity.

- Store in the Controlled Drug cupboard.

- Record in the patient's notes and in the Controlled Drug Register that the controlled drugs are stored on the ward irrespective of whether these controlled drugs will be used during the patient's stay in hospital or not.

6.3 Transfer of Patient's Own Medicines

If the patient is transferred to another ward the medication should be transferred with the patient and same documented in the patient's notes.

Transfer of patient's own controlled drug medicines to another ward must be recorded and signed for in the patient's record and the Controlled Drug Register by a registered nurse from each ward.

Medicines should be returned to the patient on discharge if no alteration has been made during their hospital stay. The lockable drawer in the bedside cabinet must be emptied and cleaned after each patient has been discharged.

If any of the medications have been altered the patient should be advised accordingly to give up these medicines for destruction.

In all cases record in the patient's record what is done with their medication for future reference.

After the patient has agreed to destruction the medicines should be disposed of on the ward following the Trust Policy and Procedure for Waste Management.

Ensure consent has been obtained and that consent is recorded in patient's notes.

7. STORAGE AND TRANSPORT OF MEDICINES

(NMC Standards for Medicines Administration, Standards 6 and 7).

7.1 Standards for Storage Areas

The Senior Nurse / Nurse in Charge is responsible for maintaining the standards for medicine storage areas, for ensuring that there is adequate storage space and for ensuring that medicines are stored at the temperature specified by the manufacturer.

Cupboards, fridges and designated areas must be of an adequate size to allow medicines to be segregated and arranged to ease selection, access and stock control and allow an adequate range and stock level to be held to meet patients' needs.

7.1.1 Drug Cupboards

Drug cupboards to be used for internal and external medicines must comply with the current British Standard (BS 2881).

Controlled drug cupboards must comply with the Misuse of Drugs (Safe Custody) Regulations 1973.

Drug cupboards, included controlled drug cupboards, must not be marked to indicate their contents.

Each cupboard must have either a unique lock and key or alternative locking system approved by Pharmacy.

7.1.2 Fridges / Freezers

Must be locked when not in use.

The temperature must be set between 2^0C and 8^0C.

A record of daily temperature monitoring and maintenance is necessary (copies of recording charts are available from Pharmacy).

Fridges used for the storage of medicines must have:

- Fan assisted air circulation.
- No more than 50% of internal volume filled.
- A calibrated MAX / MIN thermometer in place or alternative validated monitoring system approved by Pharmacy.

7.1.3 Medical Gas Cylinders

Must not be stored where the valve might be tampered with.

Must be stored using required equipment for safe storage.

7.2 Good Practice in the Storage of Medicines

The Senior Nurse / Nurse in Charge is responsible for ensuring that medicines are stored appropriately to minimise the risk of error of selecting the wrong preparation.

Medicines must be stored alphabetically by approved name as far as practically possible.

Medicines must be stored in their original packaging. Ampoules, vials or blister packed tablets must not be removed from the original box during storage.

Medicines must only be removed from their storage location immediately before administration as far as possible. Keeping loose ampoules, vials and infusion bags in the clinical area must be avoided.

Medicines must be segregated where necessary to avoid confusion that could result in serious consequences. For example, infusions for epidural administration must be stored physically separate from infusions for intravenous administration and in a separate location if possible.

The Senior Nurse / Nurse in Charge is responsible for ensuring that medicines are stored appropriately to ensure that their quality is maintained.

Medicines must be stored at the correct temperature.

Medicines must be stored so that labels remain legible.

Stock must be rotated according to the expiry date so that oldest stock is used first. Expired medicines must be removed for disposal.

There must be a system of checks in place for trays, trolleys and kits, that are assembled and stored ready for use, to ensure that any medicine included is correct and within its expiry date.

Some medicines, including multidose vials and medicines requiring reconstitution, must be discarded after a limited time after opening or first use. There must be a system in place to ensure that this requirement is met.

7.3 Transportation of Medication

(NMC Standards for Medicines Administration, Standard 7).

Nurses may transport medicines to patients, including controlled drugs, where patients or their carers / representatives are unable to collect them, provided the Nurse is conveying the medication to a patient for whom the medicine has been prescribed (eg. from a Pharmacy to the patient's home).

It is considered good practice that Nurses should not routinely transport controlled drugs in the course of their practice. This should only be undertaken in circumstances where there is no other reasonable mechanism available. All drugs should be kept out of sight during transportation.

When collecting controlled drugs from a Pharmacy the Nurse will be asked to sign for them and prove identity in the form of her professional identity badge. Midwives must be familiar with the use of Midwives Supply Orders (see NMC Circular 25/2005 www.nmc-uk.org/aFrameDisplay.aspx? DocumentID = 775.

7.4 Transfer of Medicines

In areas where medicines or medicine kits are issued to Nurses eg. Midwives, Community Midwifery Managers, Community Nurses, the Senior Nurse / Nurse in Charge is responsible for ensuring that written records of issue and return are maintained.

When a patient is transferred to another clinical area within the same hospital site, or at a different hospital site, the nurse responsible for the patient's care must make arrangements to ensure that required doses of medicines are not missed or delayed. The patient's own medicines, other medicines supplied for the individual patient's use, and other prescribed medicines not immediately available in the receiving clinical area, must be transferred. As the responsibility for the patient is transferred from one nurse to another, the responsibility for the safety and security of the medicines is also transferred.

Only in exceptional circumstances should medicines from ward stock be transferred from one ward to another. This should only take place when Pharmacy is closed. In such cases the smallest original pack should be supplied. The transfer of any medicine from one container to another, other than by Pharmacy staff, is forbidden.

The transfer of medicines must be agreed by the nurses in charge of the ward / units involved in the transaction and recorded in the patient's notes.

Pharmacy will credit the ward the drug was removed from and will charge the receiving ward.

Pharmacy will replace any stock items transferred through the normal top-up system. If replacement is urgency required, a supplementary order should be sent to Pharmacy as per normal procedures.

8. CONTROLLED DRUGS

(NMC Standards for Medicines Management, Standard 26).

The Trust has controlled drugs procedures and systems in place that comply with and reflect the requirements of:

- Misuse of Drugs Act 1971.
- Medicines Act 1968.
- Misuse of Drugs Regulations, Northern Ireland 2002.
- Use and Control of Medicines, DHSSPSNI April 2004.
- Safer Management of Controlled Drugs – A Guide to Good Practice in Secondary Care Northern Ireland. DHSSPSNI August 2009.

Controlled drugs administered or issued to Trust patients are procured by and supplied by the Pharmacy, except for patients own medicines where their use is appropriate (see Section 6.1).

Each Senior Nurse / Nurse in Charge is responsible for ensuring nursing staff comply with the Trust systems and procedures in place for the management of controlled drugs within their area or responsibility.

In the community it is the responsibility of each District Nursing Sister / Community Team Leader / Treatment Room Sister and Midwifery Sister to ensure nursing and midwifery staff comply with the Trust's systems and procedures in place for the management of controlled drugs within their area of responsibility.

8.1 Ordering Controlled Drugs

The Senior Nurse / Nurse in Charge of a ward, department, operating theatre or theatre suite is responsible for the requisitioning of controlled drugs for use in that area. The Senior Nurse / Nurse in Charge can delegate the task of preparing a requisition to another nurse, however, legal responsibility remains with the Senior Nurse / Nurse in Charge.

A copy of the signature of each authorised signatory should be available in the Pharmacy Department for validation.

Orders for controlled drugs must be made in the ward Controlled Drug Requisition Book.

Only one drug should be ordered on each of the duplicate requisition sheets. Each order must be signed, printed and dated by the Senior Nurse / Nurse in Charge.

All stationery which is used to order, return or distribute controlled drugs must be stored securely and access to it should be restricted.

Controlled drugs stationery should be kept in a locked cupboard or drawer.

Only the controlled drugs listed in the stock list may be routinely requisitioned or topped-up.

On wards where a pharmacy "top-up" system is used to manage stock levels of drugs, the Pharmacy Technician completes the controlled drug requisition and this is then signed by the Senior Nurse / Nurse in Charge.

Orders must state the hospital and ward name, drug name, drug form, drug strength, ampoule size if more than one available and quantity required (eg. number of tablets or ampoules), signature and printed name of the Nurse and date.

Stock of controlled drugs used regularly should be held at a level mutually agreed between the Senior Nurse / Nurse in Charge and the Pharmacist responsible for monitoring the ward controlled drugs.

The Controlled Drug Requisition Book with the signed order should be sent to the Pharmacy Department in the locked box for delivery by Portering staff or a designated member of ward staff.

Ordering controlled drugs outside Pharmacy opening hours. Exchange or supply of controlled drugs between wards is illegal and is strictly forbidden (Misuse of Drugs Act NI Regs 1986-89 / Misuse of Drugs Action 1971).

If a controlled drug is required in an emergency outside Pharmacy opening hours, the Senior Nurse / Nurse in Charge should contact the Emergency Duty Pharmacist through the hospital switchboard.

Ordering of controlled drugs for patients on discharge. This is done using the Trust's Discharge Prescription. The total number of capsules / tablets, etc required must be written in words and figures. Check the available strengths of the preparation, 2 strengths may be required to get the right dose. If this is the case, use words and figures for the total quantity required for each strength.

8.2 Delivery of Controlled Drugs

Controlled drugs will be delivered to the ward by a member of pharmacy staff who must be wearing a Trust photographic identification badge. The member of pharmacy staff will sign for the controlled drugs before leaving the Pharmacy Department.

A member of ward staff whom the Senior Nurse / Nurse in Charge considers to be responsible and who is wearing a Trust photographic identification badge, may collect urgently required controlled drugs from Pharmacy. This member of staff will sign for the order either in the Pharmacy Controlled Drug Delivery Book or on the white copy of the Controlled Drug Order. The member of staff will bring the controlled drugs and the Controlled Drug Order Book back to the ward in a sealed package. The Senior Nurse / Nurse in Charge will sign the pink copy of order upon receipt of drugs on the ward.

8.3 Receipt of Controlled Drugs

Controlled drugs must be handed to the Senior Nurse / Nurse in Charge who is responsible for checking the drugs received against the original order with respect to the following:

- Check the controlled drugs against the requisition including that the correct drug and quantity has been supplied (tamper proof packs should not be opened but counted as a full pack whilst the seal is intact). The Pharmacy should be contacted immediately if on opening the box ampoules are found to be broken or if the contents do not match the expected amount stated on the pack.

- The serial number on the label of the controlled drug container corresponds to that of the Controlled Drug Order Book.

- After checking the controlled drug order the Senior Nurse / Nurse in Charge must sign the Pharmacy Controlled Drug Delivery Book and the pink copy of the Controlled Drug Order.

- The controlled drugs should be locked in the controlled drug cupboard immediately.

- Enter the controlled drugs received into the ward Controlled Drug Register, update the running balance and check that the balance tallies with the quantity that is physically present.

- When recording controlled drugs received from Pharmacy, the number of units received should be recorded in words, not figures (eg. ten, not 10) to reduce the chance of entries being altered. On reaching the end of a page in the controlled drug 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 finished page number should be indicated at the top of the new follow-on page.

8.4 Storage of Controlled Drugs at Ward Level

Controlled drugs must be stored separately from all other drugs in the cupboard identified solely for this purpose. The cupboard must provide in its construction a level of security at least comparable to that laid down for controlled drug cabinets in the Misuse of Drugs (Safe Custody) Regulations 1973 and should conform to British Standard Reference BS 2881 : 1989.

The key of the controlled drug cupboard must be carried on the person of the Senior Nurse / Nurse in Charge whilst on duty in the ward environment and must be handed over personally to the nurse responsible for taking over custody of the cupboard.

There must be arrangements for keeping the keys secure. This is particularly important for areas such as Day Surgery Units which are not operational 24 hours per day.

The Senior Nurse / Nurse in Charge is responsible for the controlled drug key and should know its whereabouts at all times.

Key holding may be delegated to other nurses but the legal responsibility rests with the Senior Nurse / Nurse in Charge.

The controlled drug key should be returned to the Senior Nurse / Nurse in Charge immediately after use by another registered member of staff.

On occasions, for the purposes of stock checking, the controlled drug key may be handed to an authorised member of pharmacy staff.

If the controlled drug keys cannot be found then urgent efforts should be made to retrieve the keys as speedily as possible eg. by contacting nursing or midwifery staff who have just gone off duty.

Standard operating procedures should be in place to ensure that the Senior Nurse / Nurse in Charge or Duty Nurse Manager and the Emergency Duty Pharmacist / Deputy Head of Pharmacy are informed as soon as possible when controlled drug cupboard keys are missing. The procedure should specify the arrangements for preserving the security of controlled drug stocks and for ensuring that patient care is not impeded eg. by issuing a spare key. A Clinical Incident Report should be completed and actions taken from this untoward event.

8.5 Checking of Controlled Drugs

The stock balance of controlled drugs will be reconciled every morning and every evening at the change over of day staff and night staff.

Packs with the tamper proof seal still intact should not be opened but counted as containing the amount specified on the box label.

The check will be carried out by 2 registered nurses, one day staff and one night staff, one of whom will be the Nurse in Charge.

The exact quantity of each controlled drug must be reconciled with the number of units remaining on the corresponding Controlled Drugs Register page.

Stock balances of liquid medicines must be checked by visual inspection but the balance must be confirmed to be correct on completion of a bottle.

Each ward check of controlled drugs will be recorded by both nurses in the Controlled Drugs Register / separate record book.

This record should, as a minimum, state the date and time of the reconciliation check and be signed by both nurses performing the check.

A pharmacist will check the Controlled Drug Register and the stock of controlled drugs at 3 monthly intervals.

8.6 Transfer from Ward to Ward or Theatre to Ward

In general, the Misuse of Drugs Regulations (2002) prevent controlled drugs being supplied from ward to ward. However, local procedures should define safe, secure and auditable methods to transfer controlled drugs where a patient moves to another ward for example:

- When a patient is receiving a controlled drug via a syringe pump (PCA) or infusion or a transdermal patch.

- When a controlled drug has been dispensed on a "named patient" basis.

8.7 Midwives and Controlled Drugs

A Registered Midwife may be supplied with and be responsible for diamorphine, morphine, pethidine and pentazocine.

Supplies of diamorphine, morphine, pethidine and pentazocine may only be made to her on the authority of a Midwife's supply order signed by the Supervisor of Midwives, or other appropriate Medical Officer who is a doctor authorised in writing by the local supervising authority.

The Supervisor of Midwives or other appropriate Medical Officer should be satisfied that locally agreed procedure is being followed before signing the supply order (eg. that the amount being requested is appropriate, etc).

The order must specify the name and occupation of the midwife, the purpose for which the controlled drug is required and the total quantity to be obtained.

The Pharmacist who makes the supply should ensure that medicines are only supplied on the instruction of an authorised person. The Pharmacist must retain the Midwife's supply order for 2 years.

The Midwife should record full details of supplies of diamorphine, morphine and pethidine received and administered in his / her personal register along with supply order numbers. This register should be used solely for that purpose and be made available for inspection as required by the Supervisor of Midwives.

Once medicines are received by Midwives working in the community, they become the responsibility of the Midwife and should be stored safely and securely.

Where it is necessary for Midwives to keep controlled drugs and medicines in their homes, the medicines should be placed in a secure, locked receptacle.

Administration of controlled drugs by midwives should be in accordance with locally agreed procedures. A record of administration of the controlled drugs should also be kept in the woman's record.

8.7.1 Returns and Disposal

When a Midwife is in possession of controlled drugs that are no longer required, they should be returned to the Pharmacist from whom they were obtained or to an appropriate Medical Officer. A record of the return should be made in the Midwife's Personal Register.

When a controlled drug has been prepared / drawn up but is no longer required and / or no longer usable, it should be destroyed by the Midwife in accordance with current regulations. A record of the destruction should be made. Where possible, a member of the family should witness the destruction in the Midwife's register.

Controlled drugs obtained by a woman by prescription from her doctor, for use in her home confinement, are her own property and are not the Midwife's responsibility. However, the Midwife has a responsibility to advise the woman regarding safe storage and disposal of controlled drugs. Even when the controlled drugs are no longer required, they should not be removed by the Midwife, but the woman should be advised to return them to the Community Pharmacy for destruction.

8.8 Discrepancies in Controlled Drug Stock

If there is a discrepancy in the controlled drug stock this must be reported immediately by the Senior Nurse / Nurse in Charge to his / her Line Manager and the Pharmacist responsible for monitoring the ward's controlled drug stock. In the absence of this Pharmacist, the Pharmacy Dispensary Manager should be informed. If an incident occurs outside Pharmacy opening hours, the Emergency Duty Pharmacist and the Senior Manager on-call must be contacted through the hospital switchboard. The Line Manager / Directorate Manager must be contacted during office hours the following day. All discrepancies in controlled drugs must be reported on the Trust Clinical Incident Forms.

If the discrepancy remains unresolved following further investigations the matter will be referred to the Chief Pharmacist who will liaise with the DHSSPS Pharmacy Inspector and the Police as appropriate.

Locks may need to be replaced to prevent unauthorised access to the drugs.

8.9 Administration of Controlled Drugs

Controlled drugs must be prescribed by an authorised prescriber on the patient kardex, or the anaesthetics chart in line with local policies and procedures.

There are a number of mechanisms for the supply and administration of controlled drugs in secondary care. Controlled drugs can be:

- Prescribed by a Doctor, Dentist or Nurse Independent Prescriber.
- Supplied and administered under Patient Group Directions.
- Supplied and administered by a Midwife.

The written requirements for controlled drugs are the same for other medicines and include:

- Start date.
- Drug name, form and strength where appropriate.
- Route of administration and where appropriate, the site of application.
- Dose.
- Time of administration or frequency.
- Include a finish date where appropriate.
- Signature of the prescriber.

Details relating to the administration of controlled drugs must be entered on the Controlled Drugs Register. The Controlled Drugs Register will be signed by a First Level Registered Nurse or a Second Level Registered Nurse who has completed an appropriate programme of study and has been deemed competent by the Senior Nurse / Nurse in Charge, and a witness (student nurse, registered nurse or a medical officer) who shall be the actual person present at the administration of the drug. The following details should be recorded:

- Date on which issue was made.
- Name of patient.
- Amount issued.
- Form in which issued.
- Name / signature of nurse / authorised person making the issue.
- Name / signature of witness.
- Balance in stock.

If part of a vial is given to the patient then the nurse should record the amount given and the amount wasted eg. if the patient is prescribed a diamorphine 2.5mg and only a 5mg preparation is available, the record should show “2.5mg given and 2.5mg wasted”. The destruction should be witnessed by the second nurse, midwife or other registered health professional who should also sign the record.

Details concerning controlled drugs accidentally or deliberately wasted shall be similarly witnessed and recorded on the Controlled Drug Register.

In addition to the Controlled Drug Register, it is the responsibility of the nurse to record the administration of a controlled drug on the patient's medication sheet and in the patient's record.

It is the responsibility of the nurse to adhere to the relevant Trust nursing procedure for the administration of drugs via the prescribed route.

8.10 Disposal of Controlled Drugs at Ward Level

In the interests of safety and containment of environmental pollution, controlled drugs should as far as practicable be returned to the pharmacy for safe denaturing and disposal.

Disposal of controlled drugs at ward level must be carried out and recorded by a First Level Registered Nurse or a Second Level Registered Nurse who has completed the appropriate programme of study and has been deemed competent by the Senior Nurse / Nurse in Charge, and a witness (student nurse, registered nurse or a medical officer).

Controlled drugs that may be disposed of at ward level and their method of disposal are as follows:

- Opened, unused or partly used ampoules
  Withdraw any liquid from the ampoule and flush down the sink. Place empty ampoule in sharps box. Record volume wasted, sign, have witnessed and date on Controlled Drug Register sheet.

- Discontinued partly used patient controlled analgesia (PCA) and epidural preparations
  Record volume wasted, sign, have witnessed and date on the PCA or Epidural Observation Sheet. Flush solution down the sink in the presence of the witness.

- Used or partly used controlled drug transdermal patches (eg. Durogesic, Transtec)
  Fold patch firmly in two. Record on destruction section of the Controlled Drug Register Sheet and place patch in the Burn Bin.

- Used or partly used solutions in syringe drivers
  Record volume wasted, sign, have witnessed and signed and date in the nursing kardex. Flush solution down the sink in the presence of the witness.

All other controlled drugs including tablets / capsules refused by a patient must be returned to Pharmacy for disposal.

8.11 Return of Controlled Drugs to Pharmacy

The ward / department should keep a record of drugs returned to pharmacy. This will be in the form of a Pharmacy Returns Advice Book with duplicate pages, so that both the pharmacy and the ward have a copy of the transaction.

The following details should be recorded in the pharmacy returns when controlled drugs are returned to the pharmacy:

- Date.
- Name, form, strength and quantity of drug being returned.
- Reason for return.
- Name and signature of 2 Registered Nurses witnessing the removal of drugs from the ward.

The top copy will be taken from the book and transported with the drugs to Pharmacy.

In addition, an entry must be made on the relevant page of the ward Controlled Drug Register showing:

- Date.
- Reason for return.
- Names and signatures of both Registered Nurses.
- Quantity removed.
- Balance remaining.

The drugs must be transported in a locked box and collected from the ward by the Pharmacy Porter who is wearing a Trust identification badge.

8.12 Patient's own Controlled Drugs

Patients who bring controlled drugs into hospital should be encouraged to send them home with their representative for safe keeping within their home. If this is not possible, they can be stored at ward level and disposed of as follows:

8.12.1 Storage of Patient's own Controlled Drugs

Ensure 2 Registered Nurses record the quantity, name, form and strength of drugs stored.

Ensure the patient / relative signs the record form giving consent for storage.

Store in the Controlled Drug cupboard and enter drug name, quantity, form and strength in the Controlled Drug Register.

Record on the Patient's Medicine Kardex and in the patient's record that the controlled drugs are stored on the ward.

8.12.2 Disposal of Patient's own Controlled Drugs

After the patient has agreed to destruction, contact Pharmacy to arrange for the medication to be returned to Pharmacy for disposal.

Ensure consent for disposal is recorded in the patient's notes.

8.13 Management of Controlled Drugs by Community Nurses

8.13.1 Ordering, Delivery and Receipt of Controlled Drugs (Community)

It is the responsibility of the General Practitioner (GP) or authorised prescriber in the community to prescribe the controlled drugs. The patient or their representative collect the prescription from the GP Practice and the controlled drugs from the Community Pharmacist.

The Community Nurse may collect the prescription from the prescriber and the controlled drugs from the Community Pharmacist only in very exceptional circumstances eg. if no relative or carer is available at any time to collect the prescription and the drugs are for a patient who urgently needs them or if the Community Pharmacist will deliver the drugs but not collect the prescription from the GP. In such circumstances controlled drugs must be taken directly to the relevant patient. This should not require a journey outside the normal geographical area.

Patients on discharge from hospital should be supplied with up to 7 days supply on discharge into the community (if required).

8.13.2 Storage of Controlled Drugs (Community)

Community Nurses will advise patients and / or their representatives to keep the controlled drugs in a safe area within the home, preferably a locked cupboard.

8.13.3 Checking and Administration of Controlled Drugs (Community)

All supplies of controlled drugs are counted, documented and signed on the patient's prescription sheet by the Community Nurse.

Controlled drugs are counted and checked before and after each administration and recorded on the Stock Control Sheet in the patient's notes.

8.13.4 Disposal of Controlled Drugs (Community)

Controlled drugs are the property of the patient. Permission of the patient or their representative should be sought before disposal.

When no longer required steps should be taken to have the controlled drugs destroyed in an appropriate manner. Where possible the patient or their representative should return the controlled drugs to the Community Pharmacist. In exceptional circumstances the Community Nurse may dispose of ampoules in a sharps box. Ampoules must be broken and emptied and the sharps box sealed and returned immediately for disposal.

Details of the disposal of controlled drugs must be documented in the patient's notes. Signatures from the patient or their representatives and the nurse concerned must be included.

If unused drugs are removed by the GP, his / her signature is required on the prescription sheet within 24 hours (48 hours at weekends). The GP must make an entry in his / her Controlled Drug Register. Drugs issued for one patient should not be used for another (product liability legislation). The Community Nurse must make an entry on the Stock Control Sheet – stating the amount of each controlled drug removed by the GP.

In instances where there is Police involvement following the death of a patient eg. industrial disease and the controlled drugs cannot be disposed of at the time, the Community Nurse should advise Police / patient's representative that the controlled drugs should be disposed of (as above) as soon as possible. They should be advised that controlled drugs are dangerous if used inappropriately and may be subject to theft.

It should be noted that apart from small amounts of liquid medicines, no medicinal products should be disposed of through the sewage system. Unwanted medicines should be returned to the Community Pharmacist that supplied them.

Once the nurse concerned has taken all possible steps to ensure the safe removal of controlled drugs from the home then the responsibility no longer rests with the nurse.

9. SELF ADMINISTRATION OF MEDICINES BY PATIENTS

(NMC Standards for Medicines Management, Standard 9).

The NHSCT is committed to safe administration of medicines through the provision of a service which is effective and responsive to the needs, and wishes, of individual patients in a variety of care settings within the Trust.

The practice of self administration is an opportunity that allows for the continuation or promotion of patient independence, responsibility and autonomy during their inpatient stay. Patient involvement in care regimes not only assists in the rehabilitative aspects of care, but is also believed to promote patient satisfaction and compliance through improved knowledge and understanding of their treatment.

Self administration will not be appropriate for all patients or all care settings. Participation must therefore be based upon assessment of suitability, safe systems of practice and informed choice and consent of the patient.

Each care environment must have safety measures in place which allows safe practice of self administration to be carried out. These will include safe systems of practice such as a clear understanding of roles and responsibilities, the assessment of patient suitability, education, monitoring and supervision.

Nursing staff are responsible for the initial and continued assessment of patients who are self administering and for recognising and acting on changes in the patient's condition with regard to the safety of the patient and others.

Further guidance with respect to development of Standard Operating Procedures for patient self administration can be found in **NMC Standards for Medicines Management (2008) page 30**.

10. DELEGATION

(NMC Standards for Medicines Management, Standard 17).

Nurses are responsible for the delegation of any aspect of the administration of medicines to patients, to carers or to care assistants and are accountable to ensure that the person to whom the task is delegated is competent to carry out the task.

This will require education and training of the patient / carer / care assistant, assessment of competence and documentation of training received and outcomes in the nursing records. Periodic review through observation of medicines administration practice should be carried out to ensure continued competence. The nurse must report any concerns with respect to the competence of care assistants / carers to safely administer medicines to the Line Manager.

In the care of children with complex needs where an individual care plan has been written and signed off by a Nurse and the unregistered practitioner / carer / parent has been assessed by a Nurse as competent to undertake the specific administration of medicinal products to a specific named patient, this may be undertaken eg. children with complex health needs in community settings, palliative care.

(NMC Standards for Medicines Management, Standard 18).

Student nurses and student midwives must never administer / supply medicines without direct supervision.

In order to achieve the outcomes and standards required for registration, students must be given opportunities to participate in the administration of medication, but this must always be under direct supervision. Where this is done, both the student and Nurse must sign the patient's kardex and document in the notes.

11. VERBAL ORDERS (PRESCRIPTIONS) AND OFF-SITE COMMUNICATION

(NMC Standards for Medicines Management, Standard 11).

In exceptional circumstances, where medication (NOT including controlled drugs) has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology (such as fax or email) may be used to confirm any change to the original prescription, in addition to a verbal order.

The principles laid out for recording, validating and documenting verbal orders still apply (as below). A copy of the fax or e-mail must be stapled to the patient's kardex.

Only Registered Nurses may take a verbal order and they retain the right to refuse to take verbal orders from prescribers if they do not feel competent to do so, if there are communication problems and the intentions of the prescriber are not clear, if they feel the order is inappropriate or if they feel it is not in the patient's best interests. In this instance the Registered Nurse should document accurately the communication that has taken place.

The person receiving the verbal order will inform the prescriber of all other medicines being taken by the patient. They should request and receive information from the prescriber regarding contraindications and side effects of the verbally prescribed medications.

If the prescription is for an 'as required' medication it would usually be prescribed verbally for one dose only and written up in the 'once only' section of the patient kardex.

After the prescriber has dictated the prescription details, it must be read back by a second Registered Nurse and the prescriber asked to confirm that these details are correct.

The verbal order must be recorded in the appropriate section of the patient kardex.

A note that a verbal order has been taken must be made in the patient's notes detailing the prescriber's name, date and time and the name(s) and signature(s) of the staff receiving the verbal order.

The entry confirming the changes must be countersigned by a prescriber within 24 hours (72 hours maximum on bank holidays and weekends) in order to safeguard the patient's welfare and to minimise risk.

Any active verbal order not yet signed by a prescriber must be reported to the next shift at handover and / or recorded in the nursing notes or record of care.

There must never be more than one medication prescribed by verbal order for any patient at any one time. If further prescriptions are required the patient must be seen by a prescriber.

In exceptional circumstances, a medical practitioner may need to prescribe remotely for a previously unprescribed medicine eg. in palliative care or remote and rural areas the use of information technology (such as fax or e-mail) must confirm the prescription before it is administered. This should be followed up by a new prescription signed by the prescriber who sent the fax / e-mail confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends). The Nurse is accountable for ensuring all relevant information has been communicated to the prescriber and he / she may refuse to accept a remote prescription if it compromises care to the patient. The Nurse must document accurately the communication that has taken place.

Standard Operating Procedures to reflect this guidance must be in place in care settings where remote prescribing of medicines by a medical practitioner may happen to ensure patient and staff safety.

12. DISPOSAL OF MEDICINES

Refer to Trust Policy and Procedures on Waste Management.

Authorisation from Pharmacy is required before returning medicines. Medicines not suitable for return are disposed of at ward level as per Trust Policy and Procedure for Waste Management.

Medicines must not be returned to the Pharmacy in the ward pharmacy box unless it can be locked.

Controlled drugs, cytotoxic medicines, or items requiring refrigeration or freezer storage must not be returned in the ward box at any time.

All medicines brought into hospital by patients remain their own property. They may be returned to Pharmacy for disposal if they are no longer required.

They must only be disposed of with the consent of the patient or the patient's representative. Consent must be recorded in the patient's notes.

An itemised list containing the name, strength and form of the medicine, and the quantity being returned, must accompany all medicines returned to the Pharmacy. Pharmacy Technicians and assistants operating ward top-up services are best placed to manage the return process.

13. ADMINISTRATION OF UNLICENSED MEDICINES

(NMC Standards to Medicines Management, Standard 22).

Licensed medicines are medicines that have a Marketing Authorisation, formerly called a Product Licence, issued by the Medicines and Healthcare Products Regulatory Agency (MHRA).

Unlicensed medicines are only used when no pharmaceutically equivalent licensed product or suitable alternative licensed product is available for use at the time the patient requires it. Such uses are informed and guided by an acceptable body of professional opinion.

Prescribers of unlicensed products carry their own responsibility and are professionally accountable for their judgement in so doing.

Patients should receive the same level of information regarding unlicensed medicines as they do with licensed medicines. A patient information leaflet explaining why it is necessary to prescribe an unlicensed medicine should be provided to the patient.

More detailed guidance and information on the use of unlicensed medicines is available from the Pharmacy Department.

A Nurse may administer an unlicensed medicines with the patient's informed consent.

14. OFF-LABEL MEDICINES

Medicines which are licensed but used outside its licensed indications (commonly known as 'off-label') may be administered by nurses.

As a Nurse you should be satisfied that you have sufficient information to administer an unlicensed or 'off-label' drug safely and, wherever possible, that there is acceptable published evidence for the use of that product for the intended indication. Liability for prescribing an off-label product sits with the prescriber and the dispenser / supplier.

The BNF for Children includes advice on the use of unlicensed medicines or of the use of licensed medicines for unlicensed applications ('off-label' use) where product licenses do not adequately cover the requirements for drug therapy for children.

Prescribers of unlicensed products and 'off-label' use carry their own responsibility and are professionally accountable for their judgement in so doing.

15. COMPLEMENTARY / ALTERNATIVE THERAPIES

(NMC Standards for Medicines Management, Standard 23).

The NHSCT will **not** accept vicarious liability for nurses who administer unprescribed complementary / alternative therapies for patients. Such products may interact with other prescribed medicines and cause harm to patients.

In certain clinical areas eg. Chemotherapy Units, complementary / alternative medicines are prescribed for patients. Local policies must be developed to enable nurses who have successfully undertaken training have been assessed as being competent to practice the administration of complementary and alternative therapies.

16. MEDICATION INCIDENTS

(NMC Standards for Medicines Management, Standard 24).

A medication incident is "Any preventable medication related event that could have or did lead to patient harm, loss or damage". This could happen at the prescribing, dispensing or administration stage of the process.

Medication incidents include events that were discovered or corrected before they reached the patient and those which reached the patient and did not result in harm to the patient. These are know as "near misses". As a nurse if you make an error you must take any action to prevent any potential harm to the patient and report the incident as soon as possible to the prescriber and your line manager and document your actions. Midwives should also inform their named supervisor of midwives.

Medication incidents must be reported and investigated to ensure that appropriate corrective action is taken and to ensure the appropriate preventative action is taken to avoid recurrence.

16.1 Treat the Patient First

- In the case of an IV infusion or IV / IM / SC injection, the infusion / injection must be stopped immediately.

- Where necessary record vital signs every 15 minutes or as per medical staff instructions. Intravenous access for potential resuscitation should be secured as soon as possible.

- When a medication incident which has reached the patient has been identified, the staff member must immediately report the incident to the most senior professional immediately available (medical or nursing).

- Intervention / treatment will be initiated as per medical staff instructions.

16.2 Follow up of Medication Incidents which reach the Patient

Refer to Trust Incident Management Policy and Procedure, Appendix 1 – "Being Open – Communicating with Service Users and / or their Carers".

- Medical and nursing staff should discuss a medication incident with the patient, next of kin or main carer / advocate. If a patient's condition deteriorates or a patient becomes unconscious as a consequence of a serious medication incident, the family / relative will be informed immediately.

- All explanations to the patient / family / relatives will take place in a private area if at all possible. This will maintain confidentiality.

- The staff responsible for the incident will be counselled and given further training if needs are identified.

- Serious medication incidents will be investigated using the Trust Incident Management Policy and Procedures.

16.3 Reporting and Documenting a Medication Incident

- A medication incident which reaches the patient must be reported to the Consultant / Medical Practitioner responsible for the patient's care by the member of staff responsible for managing the incident. The nurse will document the incident in the patient's record and medical staff will fully document in the patient's notes. Clinical Pharmacists, if appropriate, will also document action taken / recommended in patient's notes.

- Serious incidents should be reported to the Risk Management Department by the fastest means available eg. telephone, fax or e-mail.

- Managers are advised to refer to Trust Policy for Management of Supported Practice for Nurse / Midwife following a medicines management error. (Medication Incident Analysis Procedure – Appendix 3).

16.4 Adverse Drug Reactions

(NMC Standards for Medicines Management, Standard 25).

Any medicine may produce unwanted or unexpected adverse reactions. Action must in the first instance be directed to patient management.

If a patient experiences an adverse drug reaction to a medicine you must immediately take action to ensure patient safety, reassure the patient and notify the Senior Nurse / Nurse in Charge and the prescriber.

A record must be made in the patient's notes and a Clinical Incident Form completed.

All suspected reactions to new medicines (indicated by a black triangle in the BNF) and any serious suspected reactions to established medicines should be reported to the Medicines and Healthcare Product Regulatory Authority (MHRA) using the Yellow Card Scheme (available in the back of the BNF or from Pharmacy). Doctors, Registered Nurses or Pharmacists can complete these cards.

REFERENCES

- DHSSPSNI (2009), Safer Management of Controlled Drugs : A Guide to Good Practice in Secondary Care (Northern Ireland).
- DHSSPSNI (2004), Use and Control of Medicines : Guidelines for the Safe Handling, Administration, Handling, Storage and Custody of Medicinal Products in the Health and Personal Social Services.
- Health Act (2006), HMSO London.
- HPSS (2005) Controls Assurance Standard Medicines Management (Safe and Secure Handling of Medicines).
- Medicines Act (1968), HMSO London.
- Misuse of Drugs Act (1971), HMSO London.
- Misuse of Drugs (Safe Custody) Regulations (1973).
- Misuse of Drugs Regulations, Northern Ireland (2002), The Stationery Office London.
- National Patient Safety Agency (NPSA) (2006) Right Patient, Right Blood : Advice for Safer Blood Transfusions. www.nrls.npsa.nhs.uk/resources
- Northern Health and Social Care Trust Patient Medicines Prescription and Administration Record.
- Nursing and Midwifery Council (2008) Standards for Medicines Management, NMC London.
- Nursing and Midwifery Council (2008) The Code : Standards of Conduct, Performance and Ethics for Nurses and Midwives, NMC London.

Equality, Human Rights and DDA

The policy is purely clinical/technical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

Alternative formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

Sources of Advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

Northern Health and Social Care Trust

APPENDIX 1

SUPPLY AND ADMINISTRATION OF MEDICINES
PATIENT GROUP DIRECTIONS (PGDs)

Directorate: _____ Ward: _____
Community: _____

Medicine Name: _____ ** Administer / Supply

Legal Status of Medicine: _____

Dose: _____ (including range IF appropriate)

Route of Administration: _____

Frequency of Administration: _____

Max. no. of Doses Permitted in Protocol: _____

Max. no. of Hours / Days covered in Protocol: _____

Record Required: _____

Patient Information to be given: _____

Side Effects: _____

Management of Side Effects: _____

Medical Referral Criteria: _____

Facilities / Supplies required: _____

***** Delete as Appropriate***

Clinical Condition to be addressed by the Patient Group Direction: _____
_____
_____

Inclusion Criteria: _____
_____
_____

Follow Up: _____
_____

Exclusion Criteria: _____
_____
_____

Action for Patients who are Excluded: _____
_____
_____

Action for Patients who Refuse or Fail to Adhere to Care Requirements under the Patient Group Direction: _____
_____
_____
_____

STAFF AUTHORISED UNDER PATIENT GROUP DIRECTION

Professional Qualification: _____ Grade: _____

Specialist Qualifications / Training / Experience: _____
_____

Recommended Updating: _____
_____

Protocol Author(s)

Consultant: _____
(Signature)

Pharmacist: _____
(Signature)

Professional Manager: _____
(Signature)

Approved by Northern Prescribing Forum: _____
(Signature – Chair of Northern Prescribing Forum)

Head of Pharmacy and Medicines Management: _____
(Signature)

Date: _____ Review Date: _____

Copies sent to Medicines Information, Antrim Hospital	

Northern Health and Social Care Trust

PATIENT GROUP DIRECTION (PGD) REGISTER

Directorate: _____ Ward: _____

Community: _____

The following staff have read *(PGD Title)* and have agreed to use it in accordance with the criteria described.

Staff Name (Print Full Name)	**Signature**	**Date**	**Signature of Professional Lead**

Copy to be retained by the Ward / Department Manager

APPENDIX 2

ONE STOP DISPENSING SERVICE

INFORMATION PACK AND PROCEDURES

FOR PHARMACY STAFF

Contents

Background Information

One stop dispensing is a process which involves providing the patient with an adequate supply of their medicines, stored at the bedside, in a quantity sufficient to meet their needs throughout the hospital stay and for discharge. Pharmacy staff provide continuing pharmaceutical care throughout the stay and assist at discharge.

New initiatives **at ward level** to facilitate this process include:-

- Full time deployment of clinical pharmacists **and** clinical pharmacy technicians.

- Assessment and use of suitable patients own medicines (PODs) following patient consent.

- Use of an integrated lockable medicine drawer within the bedside cabinet for storage of medicine(s).

- Supply of original packs to replenish medicine drawer stock.

- Supply discharge medicine(s) on the ward.

- Use of clinical pharmacist and clinical pharmacy technician time to:

    - compile an accurate and complete drug history
    - assess PODs
    - provide pharmaceutical monitoring and patient education
    - maintain adequate stocks of medicine on the ward and in patients' medicine drawers
    - conduct daily kardex reviews
    - prepare detailed discharge medication records
    - dispense discharge medicines and provide Medicine Record Sheets at discharge for patient reference.

Terms of reference

The following terms are used throughout this document and the one stop dispensing (OSD) procedures.

Patients Own Medicines (PODs)

PODs are a useful reference source in the construction of an accurate medication history. In addition, use of PODs during the patient stay reduces the risk of patient confusion and medicine incidents associated with the multiple dispensing of the same/similar medicines. PODs are the legal property of the named patient and must only be used to treat the named patient following consent. PODs may include:

- Prescription medicines
- herbal / homeopathic medicines
- clinical trial medicines
- over the counter medicines
- Controlled Drugs

When available and deemed suitable by assessment, any PODs which are prescribed on the kardex will be used during the patient stay, **except** controlled drugs. Assessment of PODs prior to use is **mandatory** and must be carried out as per Procedure (ref no) Assessment and use of Patients Own Medicines

Original Packs

Original packs usually contain a 28 day supply of medicine along with a Patient Information Leaflet. They will be issued when PODs are unavailable, are unsuitable, are expended or when a new medicine is prescribed. This quantity is usually sufficient to cover inpatient stay requirements. On discharge a minimum of 21 days supply of medicine is issued **or** as per Trust policy (appendix G). This covers the lag-time between discharge and receipt of the discharge medication record by the GP thereby ensuring continuity and safety of treatment.

Patient Medicine Drawers

Medicine for each patient will be stored in the lockable medicine drawer integrated within the bedside cabinet**. Medicines not to be stored in the patient medicine drawer are listed in Appendix B.** This drawer can be accessed by nursing and pharmacy staff only. The medicine drawer is fitted with an electronic lock which is operated using transponder technology. Keys are available as a fob which can be individually programmed to open a specific medicine drawer or a suite of medicine drawers. Fobs are subject to the same regulations as a traditional set of ward keys and are the responsibility of both nursing and pharmacy staff. Open patient medicine drawers must never be left unattended if they contain medicines (Use and Control of Medicines DHSSPSNI).

Patient Transfer

Within the One Stop Dispensing Ward

The bedside locker will be moved, with the patient, to the new location within the ward.

To Another One Stop Dispensing Ward

The contents of the medicine drawer, any items stored in the one stop dispensing cupboard and any items stored in the ward medicine fridge which belong to the patient will be placed in a bag, with the correct patient's addressograph affixed, and will be transferred to the recipient ward with the patient. Bags containing fridge items will be endorsed 'fridge item(s) enclosed'.

To A Non One Stop Dispensing Ward

PODs stored in the medicine drawer, one stop dispensing cupboard and ward medicine fridge will be placed in a bag, with the correct patient's addressograph affixed, and will be transferred to the recipient ward with the patient. Bags containing fridge items will be endorsed 'fridge item(s) enclosed'. Original packs, with labels removed, will be returned to ward stock or one stop dispensing cupboard if not on top-up. **Ward stock must NOT be transferred to non one stop dispensing wards.**

Responsibilities of Health Professionals

Nursing Staff:

- Obtain consent for use/disposal of PODs at admission.
- **Outside** normal pharmacy hours assess PODs as per 'POD Admission Algorithm' (Appendix A).
- **Outside** normal Pharmacy hours, obtain necessary original packs and place them in medicine drawer.
- Administer all medicines according to the instructions on the kardex and record as per normal Northern HSC Trust procedure.
- **Outside** normal Pharmacy hours dispense discharge prescription. Ensure patient receives all relevant discharge paperwork for the attention of the GP.
- **Outside** normal Pharmacy hours deal appropriately with medicine(s) from medicine drawer, which have not been dispensed for discharge.

Clinical Pharmacist:

- Obtain an accurate drug history within 24 hours, where possible, of admission to the ward.
- Monitor the kardex for completeness, accuracy, safety, legality, effectiveness and appropriateness (endorse Clinical check).

- Check dispensed medicines, re-labelled assessed PODs and PODs assessed by non-accredited checking technicians.
- Check all labelled medicine prior to placing in drawer.
- Prepare discharge medication record according to Approved Trust protocol (subject to satisfactory completion of approved Trust training programme).
- Dispense/check discharge prescription at ward level.
- Give the patient an MRS, GP discharge medication record and other discharge forms, if applicable, eg warfarin discharge form, product standardisation form.
- Provide appropriate patient counselling on discharge medicines.

Pharmacy Technician:

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- Assist in the procurement of an accurate drug history.
- Assess PODs and re-label where necessary.
- Supply and label original packs and place in medicine drawers.
- Dispose of unsuitable and discontinued PODs following patient consent and record details of disposal on POD disposal record.
- Monitor kardex daily to identify medicines to be supplied, identify dose changes, newly prescribed medicines etc.
- Identify interventions on kardexes.
- Provide patient counselling following training and accreditation.
- Remove discontinued original packs.
- Dispense discharge medicine.
- Deal appropriately with medicines from medicine drawer which have not been dispensed for discharge.

Roles and Responsibilities of Pharmacy Technicians

MTO1

- Assess PODS.
- Re-label PODs when necessary.
- Request Medication Histories.
- Dispense prescriptions.
- Label original packs.
- Dispose of unsuitable PODs.
- Order and obtain non ward stock items required for patients.

MTO2

- Undertake MTO1 duties in their absence.
- Check assessed PODs following training and accreditation.
- Check labelled original packs and PODs.
- Provide patient counselling following training and accreditation.
- Monitor kardex daily to identify medicines to be supplied, identify dose changes, newly prescribed medicines etc.
- Identify and refer interventions on medicine kardexes
- Check dispensed prescriptions (ACT).

Assessment and Use of Patients Own Medicines (PODs)

Background

Patients own medicines **must** be assessed for suitability before they are used to treat the patient

Procedure

1. Provide each patient with 'Making the Most of Your Medicines' leaflet.

2. Obtain and document verbal agreement for the use and destruction of PODs.

3. If PODs are unavailable on admission, contact a relative/carer to request that they be brought in as soon as possible. If this is not possible, or an unacceptable delay in administration would ensue, issue original packs as per procedure.

4. Assess all PODs, **except Controlled Drugs,** for suitability using 'POD Algorithm' (Appendix A). Controlled drugs must be managed by nursing staff according to the trust controlled drug policy.

5. Attach a 'date/assessed by/checked by' sticker to all suitable PODs. Endorse date in the date section and your initials and operator code in the assessed by section of the label.

6. Leave PODs for second check by pharmacist or POD checker (nursing staff obtain second check by second registered nurse).

7. Checker endorse initials and operator code in the checked by section of 'date/assessed by/checked by' sticker.

8. Place PODs which have been assessed and checked as suitable for use, and are prescribed on the patients Kardex into the correct medicine drawer.

9. Lock patients medicine drawer.

10. Leave any unsuitable PODs clearly marked for disposal by pharmacy staff.

Re-labelling Patients Own Medicines (PODs)

Background

PODs must be re-labelled if there are no dose directions on the POD label or if the directions on the label differ from the directions on the Kardex. PODs must only be relabelled after a Pharmacist has clinically checked the Kardex

1. Ensure clinical check is endorsed on the Kardex.

2. Label PODs with the directions on the kardex according to procedure PS/07/74/A1 Label Production for prescription items, when asked quantity enter '0'.

3. Attach the new label over the existing label leaving the name of the original dispensing pharmacy visible.

4. Attach a 'relabelled by Antrim Hospital Pharmacy' label.

5. Attach a peelable 'dispensed by/checked by' label to the pod and endorse your initials and operator code in the dispensed by section.

6. All labels **must** be checked by a Pharmacist or ACT before they are placed in the medicine locker. Checker must endorse their initials and operator code in the dispensed by section of the 'dispensed by/checked by' label.

7. Place all checked items in the correct patients medicine drawer and endorse Kardex in the pharmacy box with your initials, the date and the quantity of POD. Endorse the strength of POD if there is more than one strength available.

8. Lock medicine drawer.

Disposal of Patients Own Medicines (PODs)

1. Ensure consent has been given by the patient for PODs to be disposed.

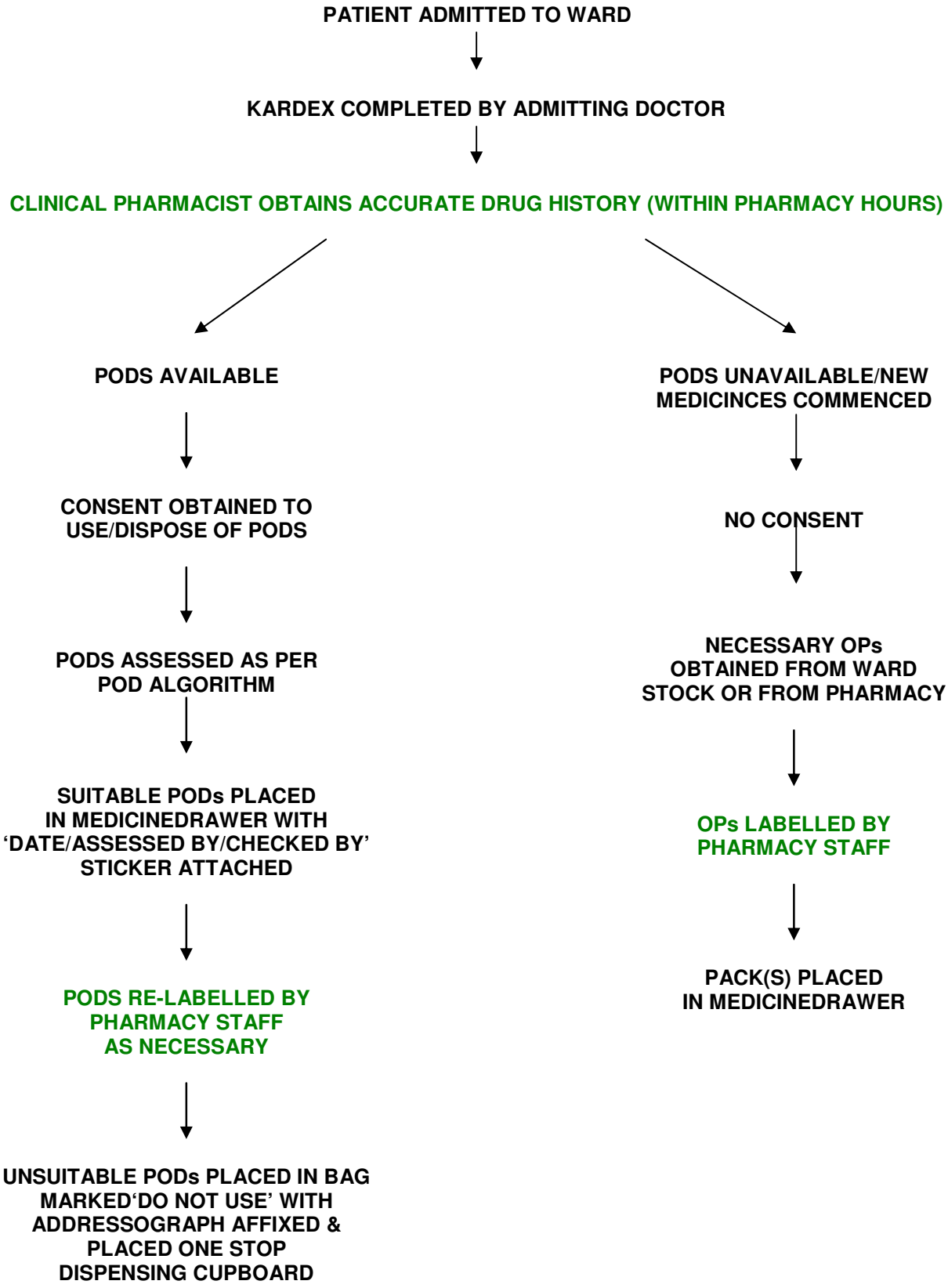
2. Record details of the POD(s) being disposed of on the 'POD Disposal Record' (appendix E).

3. Remove contents from packaging and dispose in the correct pharmaceutical waste bin as per Trust policy.

4. Dispose of any packaging or labels which contain patient name in confidential waste.

5. Keep records of disposed PODs for three months.

SUPPLY OF MEDICINES INTO PATIENTS MEDICINE LOCKERS



ALL MEDICINES MUST BE ADMINISTERED AS PER THE INSTRUCTIONS ON THE KARDEX

Supply and Labelling of Original Packs for Patient Medicine Drawers

Background

Original packs of medicine will be supplied for patients medicine drawers when PODs are unavailable, unsuitable or depleted or when a new medicine is prescribed. All original packs must be labelled before they are placed in patient medicine drawers **except** medicines which are subject to reducing doses or medicines which require stabilisation. Labels must only be generated after the medicine Kardex has been clinically checked by a pharmacist.

Within this procedure the following procedure(s) are referred to. All staff operating OSD must **read, sign and comply** with the following procedure(s):

Label Production for prescription items PS/07/74/A1

Procedure

1. Obtain original packs from ward stock or from the dispensary.

2. Ensure clinical check is endorsed on Kardex.

3. Label original packs with the directions on the kardex according to procedure PS/07/74/A1 Label Production for prescription items, when asked quantity enter '0'.

4. Do not label items which are subject to reducing doses e.g. prednisolone or require stabilisation e.g. warfarin.

5. Attach peelable 'dispensed by/checked by' label and endorse initials and operator code in dispensed by section.

6. Leave all labelled items for second check by pharmacist or ACT. Checker must endorse initials and operator code in checked by section of the 'dispensed by/checked by' label.

7. Place all checked items in the correct patients medicine drawer and endorse Kardex in the pharmacy box with your initials, the date and the quantity of item. Endorse the strength of medicine if there is more than one strength available.

8. Lock medicine drawer.

Discharge Prescriptions on One-stop Dispensing Wards

Background

Within this procedure the following procedures are referred to. All staff operating OSD must **read, sign and comply** with the following procedures:

Label Production for prescription items PS/07/74/A1
Clinical Checking of Prescriptions PS/07/72/A1
Dispensing and Labelling Items for Prescription PS/07/76/A1
Medicine Record Sheet Production PS/07/75/A1
Final Checking and Completion of Prescriptions PS/07/77/A1
Disposal of Patients Own Medicines

Procedure

1. Remove all medicines from the patient's medicine drawer.

2. Assess all PODs and original packs for suitability for use on discharge using the medicine discharge algorithm (Appendix F). Use suitable PODs and OPs to fulfil the discharge prescription.

3. Remove 'Date/Assessed by/Checked by' sticker from all PODs.

4. Remove 'dispensed by/checked by' label from all labelled original packs.

5. Dispense prescription according to procedures PS/07/74/A1 Label production for prescription items, PS/07/76/A1Dispensing and Labelling Items for Prescription, PS/07/75/A1 Medicine Record Sheet Production.

6. If a medicine is labelled with dosage instructions which are different from the discharge prescription re-label using the labels generated according to procedure PS/07/74/A1 Label production for prescription items:
    a. If existing community pharmacy labels are incorrect they must not be removed as the original dispensing source must be identifiable. Attach the correct label so that the original dispensing source is still visible.

    b. If existing hospital pharmacy department labels are incorrect, remove, place in confidential waste and attach the correct label.

7. Leave prescription for final check by a pharmacist or ACT according to procedure PS/07/77/A1 Final Checking and completion of prescriptions.

8. Ensure all necessary written information pertaining to current medicines is provided, including a sealed copy of the discharge medication record, warfarin discharge form and product standardisation form, if applicable.

9. If patient is not leaving the ward immediately, place the completed discharge script in the patient's medicine drawer and lock the medicine drawer.

10. Dispose of any unsuitable PODs according to procedure Disposal of Patients Own Medicines. If consent for destruction of PODs has been refused, return these to the patient and counsel the patient appropriately.

11. Peel off all labels from pharmacy stock items which are not required on discharge and return all items to the appropriate stock cupboard or the one stop dispensing cupboard if not on top-up.

Discharge Prescriptions on One Stop Dispensing Wards Outside normal Pharmacy hours

Background

The discharge medication record will be prepared and signed by medical staff. Once the discharge medication record is prepared two members of registered nursing staff dispense and check the prescription according to Northern HSC Trust protocol.

Procedure

1. Remove all medicines from the patient's medicine drawer.

2. Assess all PODs and original packs for suitability for use on discharge using the medicine discharge algorithm (Appendix F). Use suitable PODs and OPs to fulfil the discharge prescription .

3. Remove 'Date/Assessed by/Checked by' sticker from all PODs.

4. Remove 'dispensed by/checked by' sticker if attached to any PODs or Ops.

5. Check with patient which items they require and what quantity would be acceptable (minimum of three days supply).

6. Dispense discharge prescription using PODs, OPs and, if necessary, ward stock packs, (according to normal protocol) with suitable packaging.

7. If a medicine is labelled with dosage instructions which are different from the discharge prescription re-label using pre-printed labels with handwritten dosage instructions.

    a. If existing community pharmacy labels are incorrect they must not be removed as the original dispensing source must be identifiable. Attach the handwritten label with the correct instructions so that the original dispensing source is still visible.

b. If existing hospital pharmacy department labels are incorrect remove, place in confidential waste and attach handwritten label with the correct instructions.

8. Return all PODs not required on discharge, for which no consent for disposal has been obtained, to the patient, with appropriate counselling.

9. Ensure patient receives all relevant discharge paperwork for the attention of the GP.

10. Inform pharmacy staff on the next pharmacy working day if patient requests a Medicine Record Sheet.

11. Remove all labels from original packs which are not required on discharge and return to ward stock cupboard or to the non-stock drawer.

12. Return all PODs for disposal to the patients own medicines cupboard with the patients addressograph attached, clearly marked for disposal. Do not remove labels from PODs.

APPENDIX A

POD ALGORITHM

Northern Health and Social Care Trust

1. Is POD labelled
   - NO → Are you certain it belongs to patient?
     - YES → GO TO 3
     - NO → DO NOT USE*
   - YES ↓
2. Name on the label is the same as the patients' (confirm patient's full name/preferred name)
   - NO → DO NOT USE*
   - YES ↓
3. Is medicine a loose capsule/tablet, liquid, cream, ointment, eye/ear preparation, inhaler or nasal spray
   - NO → GO TO 5
   - YES ↓
4. Is medicine in manufacturers original container with seal intact
   - NO → DO NOT USE*
   - YES ↓
5. Does the medicine require storage in a fridge (2-8ºC)
   - YES → DO NOT USE*
   - NO ↓
6. Is Medicine name and strength clearly identifiable
   - YES ↓
7. Expiry date and batch number visible and minimum one month in date
   - YES ↓

MEDICINE IS SUITABLE FOR USE PROVIDED PATIENT HAS GIVEN CONSENT

If any areas state do not use but this would prevent the patient receiving treatment the pharmacist may make a decision after consultation to use a medicine

*PLACE "DO NOT USE" ITEMS IN A BAG WITH THE CORRECT PATIENT'S ADDRESSOGRAPH AFFIXED AND LEAVE IN PATIENTS OWN MEDICINES CUPBOARD CLEARLY MARKED 'DO NOT USE'

APPENDIX B

MEDICINES NOT TO BE STORED IN PATIENT MEDICINE DRAWERS

- **Medicines not prescribed on Kardex**

- **Controlled drugs (CDs)**

All POD CDs must be managed according to the Trust controlled drug policy

- **Temazepam**

Must be stored in the ward CD cupboard

- **Fridge medicines (except in-use insulin pens)**

- **'Stat' doses/once only prescriptions**

- **Injectables (except low molecular heparin/in-use insulin pens)**

- **Emergency / rescue medicines** e.g. Salbutamol inhaler, GTN spray
stored on top of the patient's locker

- **Loose blister strips**

APPENDIX C

MEDICINE DISCHARGE ALGORITHM

Northern Health and Social Care Trust

NB: PODs AND/OR ORIGINAL PACKS CAN BE USED TO FILL DISCHARGE PRESCRIPTION

COLLECT ALL MEDICINES FROM PATIENT'S MEDICINE DRAWER AND COMPARE TO COMPLETED DISCHARGE PRESCRIPTION

Are there items which are not on the prescription?

YES

Item discontinued on kardex?

YES

Place PODs in patients own medicines cupboard

Remove labels from original pack(s) and return to ward stock or non-stock drawer

NO

Contact Medical Officer/ Pharmacist to clarify. Is item required?

NO

NO

YES

Are directions on the discharge prescription different from the medicine labels

NO

YES

Re-label with correct dosing instructions

Are there items on the prescription which are not among the medicines from the drawer?

NO

YES

Item prescribed on kardex?

NO

Contact Medical Officer/ Pharmacist to clarify is item intended?

YES

NO

YES

SUPPLY AND LABEL ORIGINAL PACK(S)

Medical Officer/ Pharmacist to delete item from all copies of discharge medication

ALL STAFF
Ensure appropriate quantity of medicine is supplied according to Trust policy and obtain second check and signature

ENSURE PATIENT HAS ALL NECESSARY MEDICINES AND A COPY OF THE DISCHARGE MEDICATION RECORD FOR THE GP BEFORE LEAVING THE WARD

Northern Health and Social Care Trust

Appendix 3

Medication Incident Analysis – Reflection for Nurses, Midwives and Specialist Community Public Health Nurses

Name	
Ward / Department	
Date of Medication Incident	
Ward Manager / Team Leader	
Head of Service / Lead Nurse / Lead Midwife / Assistant Community General Manager	

It is important that an open culture exist in order to encourage the immediate reporting of errors or incidents in the administration of medicines. If you make an error, you must report it immediately to your line manager or employer.

As a Registrant, if you make a medication error you must take immediate action to prevent any potential harm to the patient and report as soon as possible to the prescriber and your line manager, and document your actions. Midwives should also inform their named Supervisor of Midwives.

"The NMC believes that all medication errors and incidents require a thorough and careful investigation at a local level, taking full account of the context and circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed. If a practising midwife makes or identifies a medication error or incident, she should also inform her Supervisor of Midwives as soon as possible after the event" **(NMC, 2008)**

This medication incident analysis should be completed as soon as possible after the medication error occurs and be sent to the Head of Service / Lead Nurse / Lead Midwife / Assistant Community General Manager, who will review and agree learning / action section and forward to the Deputy Director of Nursing for collation.

Sequence of Event

These are the facts in your words of what happened around the event.

1. **Identify event which occurred**. This sets the scene in context.

2. **Describe event**; what happened, who was involved, what did you do, why did you do what you did?

3. Analyse Event

It may be helpful to look factors which may have contributed to the medication error eg.

- What shift pattern were you working and how many hours had you worked in the preceding days
- Ordering of medications, storage
- Prescribing
- Documentation, labelling, information
- Patient identification
- Non-compliance
- Administration, error in measurement / calculation, drug incompatibility
- What were you thinking and feeling
- Consequences of your actions for the patient / client

4. Learn from the Event

- What else could you have done?
- What have you learnt from this experience?
- How can you improve your knowledge and skills?
- How can you use what you learned from the experience in your future practice?

5. Recommendations / Actions following Analysis

This section involves the **manager** and **staff member** identifying recommendations of actions following the analysis. It may be useful to consider:

- NHSCT Medicines Management Policy and NMC Standards for Medicines Management (2008)
- Is there a training need?
- Is other follow-up needed eg. supervision for staff members?
- Frequency and model of supervision to be employed
- What changes can be made within the team to stop a similar incident occurring?

To attend:

Date: _____

- Medicines Administration Update.
- Legal Aspects of Writing and Retaining Records and Handover Reporting.
- IV Drugs Administration.
- Syringe Driver / Infusion Pump Training.

Review

Date of Review: _____

Reviewed by: _____

After 3 months have the recommendations / actions been achieved?

Yes ☐ No ☐

If no, what further action is required?

Further review date (if required) _____

References

1. Gibbs G. (1998) Learning by Doing: A Guide to Teaching and Learning Methods. Further Education Unit, Oxford: Macmillan.
2. John's (1993b) Nuances of Reflection. Journal of Advanced Nursing. 3, pp71-75.
3. NIPEC (2006) Your Developmental Framework Part II. A Guide to Using the Development Framework Resources.
4. NMC (2008) Standards for Medicine Management.

MEDICATION ERROR

- Immediate management of situation to maintain patient safety
- **Inform patient**
- Patient assessment / observation / treatment
- ***Inform Senior Nurse / Nurse-in-Charge***
- ***Inform Medical staff / prescriber***
- ***Inform relatives / carers***
- **Document in patient's note**

Medication Incident Analysis Reflection completed

Clinical Incident Form completed and forwarded to Governance

Reflection discussed with Senior Nurse / Nurse-in-Charge and consideration given to training need / supported practice, etc

Action Plan with review dates drafted

Copy of Action Plan to Lead Nurse / Assistant Community General Manager for endorsement of training / action section – Action Plan implemented

Copy to Deputy Director of Nursing and Head of Nursing Education and Development (Education Commissioning)

Review and further actions as required

Appendix 4

HIGH ALERT MEDICATIONS

The Institute for Safe Medication Practices has compiled a list of “high-alert” drugs. These medications require extra precaution because they can cause serious patient harm when used in error.

- amiodarone, IV
- colchicine injection
- heparin, low molecular weight, injection
- heparin, unfractionated, IV
- insulin, subcutaneous and IV
- lidocaine, IV
- magnesium sulfate injection
- methotrexate, oral, non-oncologic use
- nesiritide
- nitroprusside sodium for injection
- potassium chloride for injection concentrate
- potassium phosphates injection
- sodium chloride injection, hypertonic (more than 0.9% concentration)
- warfarin