Shropshire Community Health NHS Trust

Medicines Policy
Part 1: General Principles for the safe and secure handling of medicines

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2	November 2014	Scheduled review: Section 8: update to Verbal and faxed orders
3	August 2016	Removal of morphine 10mg in 5ml from list of drugs with full controlled drug control
4	March 2018	Inclusion of paramedics regarding Non-Medical Prescribing. Reference to Covert Medicine Policy.
5	March 2022	Scheduled review: Inclusion of Transcribing. Inclusion of Remote consultations, Inclusion of Nursing Associates, Clarification over verbal orders not being accepted on their own

		Update and rewriting of all sections Greater detail around retention of documentation including electronic copies

Shropshire Community Health
NHS Trust

Medicines Policy

Part 1 - General Principles for the safe and secure handling of medicines

Safe and Secure Handling of Medicines Policy
Contents

1. Introduction

This document has been designed for the use of all healthcare professionals employed by Shropshire Community Healthcare NHS Trust (SCHT) when dealing with any aspect of care that involves medicines at any stage.

The introduction contains policy information that is relevant to all clinical and domestic circumstances where medicines are procured, delivered, stored, prescribed, administered or disposed of by staff employed by Shropshire Community Healthcare NHS Trust.

In addition, policy and procedural information for specific services within Shropshire Community Healthcare NHS Trust has been segregated into separate sections to facilitate ease of use.

References to other policies, protocols, guidance documents, Standard Operating Procedure templates and working forms are given in shaded boxes at appropriate points within the text.

The Medicines Policy is supported by the following legislation, policies and procedures:

- The Misuse of Drugs Act 1971 Misuse of Drugs Act 1971 (legislation.gov.uk)
- The Medicines Act 1968 Medicines Act 1968 (legislation.gov.uk)
- The Human Medicines Regulations 2012 The Human Medicines Regulations 2012 (legislation.gov.uk)
- Controlled Drugs (Supervision of Management and Use) Regulations 2013 Microsoft Word - 15 02 2013 - DH format FINAL v1.4 GW APPROVED.doc (publishing.service.gov.uk)
- Professional Guidance on the Administration of Medicines in Healthcare Settings Admin of Meds prof guidance.pdf (rpharms.com)
- "The Safe and Secure Handling of Medicines; a Team approach" RPSGB (revised Duthie Report) 2005
- High level principles for good practive in remote prescribing. high-level-principles-for-remote-prescribing-.pdf (nmc.org.uk)
- The Commission for Healthcare Improvement Gosport Report "Investigation into the Portsmouth Healthcare NHS Trust, Gosport War Memorial Hospital" July 2002
- Hazardous Waste (England and Wales) Regulations 2016 The Hazardous Waste (England and Wales) (Amendment) Regulations 2016 (legislation.gov.uk)
- Medicines and Ethics Guide (Royal Pharmaceutical Society of GB) July 2019
- Mental Capacity Act 2005 and Code of Practice Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)SCHT
- SCHT Consent ot Examination and Treatment Policy Approved Documents Policy (shropcom.nhs.uk)
- SCHT Medicines Policy Part 2: Controlled Drugs 10469.pdf (shropcom.nhs.uk)
- SCHT Medicines Policy Part 3: Cold Chain Standards Standard Operating Procedure: Community Hospitals – Ordering controlled drugs (shropcom.nhs.uk)
- SCHT Medicines Policy Part 4: Patient Group Directions 10471.pdf (shropcom.nhs.uk)
- SCHT Medicines Policy Part 5: Medicines Reconciliation 10472.pdf (shropcom.nhs.uk)

- SCHT Medicines Policy Part 6: Non Medical Precribing 10473.pdf (shropcom.nhs.uk)
- SCHT Medicines Policy Part 7: In possession medicines in prison Shropshire Community Health (shropcom.nhs.uk)
- SCHT Medicines Policy Part 8: Medication incidents 11802.pdf (shropcom.nhs.uk)
- SCHT Medicine Policy Part 9: Homely Remedies in Community Hospital (shropcom.nhs.uk)
- SCHT Medicine Policy Part 10: Self Administration of Medicines 12766.pdf (shropcom.nhs.uk)
- Homely Remedies in Prison (shropcom.nhs.uk)
- Covert Administration of Medicines 13015.pdf (shropcom.nhs.uk)

2. Aims

To set out the principles by which medicines are ordered, procured, transported, stored, prescribed, administered, and destroyed.

To ensure that products requiring special attention e.g. temperature sensitive products requiring refrigeration, Controlled Drugs, or hazardous waste are treated in the correct manner conforming to legislation.

To identify the responsibilities of Shropshire Community Health NHS Trust (SCHT) as the employer and its' employees

To promote the safe care, procurement, delivery, storage, administration and disposal of drugs by employees for their own safety and that of the person receiving services, and to comply with the current legislation and regulations pertaining to drugs and their use

To promote the use of local standard operating procedures (SOPs), protocols and guidelines which build on the principles of the policy.

To facilitate procedures to ensure that the right patient/service user receives the right, appropriately prescribed medication at the right dose and at the right time and by the right route.

To require that whatever the clinical setting, only practitioners who have been assessed as competent by their clinical manager are allowed to administer drugs to a patient independently. The assessment must form part of the annual performance review.

3. Definitions

For the purposes of this document, the following definitions apply:

Administer	To give a medicine by introduction into the body, (e.g. orally or by injection) or by external application (e.g. cream or ointment).
Appointed Nurse in Charge	The nurse who carries continuing responsibility for the ward, department or healthcare setting e.g. Ward Sister, Charge Nurse. At times when he/she is not on duty, delegated

	responsibility is given to another qualified nurse who assumes the role of Assigned Nurse in charge.
Assigned Nurse in Charge	The senior nurse on duty for the ward or department who has been identified as the nurse in charge for that shift.
BNF	British National Formulary.
Clinical Manager	Line manager with specific clinical supervision responsibility.
Controlled Drugs (CD)	Any substance or product specified in Schedules of the Misuse of Drugs Act 1971. There are strict procedures relating to the administration, prescribing, dispensing and storage of Controlled Drugs in Schedules 1, 2 and 3.
Controlled Stationery	Any stationery that could be used to obtain medicines fraudulently. It includes all Controlled Drug stationery, in-patient prescription or administration charts, FP10 prescription pads and nurse prescriber FP10s, stock lists, and request forms for individually dispensed items.
Cytotoxic	A medicine, which acts principally by interfering with cell division at various stages in the cell cycle, used for the treatment of neoplastic disease or other associated disorders. Specific rules apply to storage, handling and disposal of these medicines.
CYP&F	Children, Young People and Families
Designated Manager	The line manager with specific managerial responsibility.
Designated Practitioner	Any registered practitioner identified by the Appointed Nurse in Charge as competent and appropriate to perform a specific function. The designation as such has been communicated to and accepted by the Designated Practitioner.
Drug	This term is interchangeable with the term medicine.
Drug Chart	An administration record used in the hospital or Prison setting.
Health Care Assistants (HCA)	Healthcare assistants can work within hospital or community settings under the guidance of a qualified healthcare professional.
Health Care support Workers (HCSW)	Term which covers a variety of health and care support roles, including healthcare assistant (HCA), nursing assistant, theatre support worker, maternity support worker and more.
Homely remedies	Medicinal products (not prescription only drugs) which may be administered under an agreed protocol for specified indications, for a limited time period before referral to a doctor or independent prescriber, e.g. paracetamol for a headache.
In-patient	A person admitted to the Community Hospital for treatment.
Medication Administration Record (MAR chart)	A drug administration record used in the community setting i.e. patients' homes / care homes and in schools.
Medicine Incident or Error	Any occurrence that contravenes the policies and procedures laid down in this document.
Medicines	Medicinal products as defined in section 130 of the Medicines Act 1968. A substance supplied or administered to a patient for the purpose of: • Treating or preventing disease • Diagnosing disease

	• Ascertaining the existence, degree or extent of a physiological condition • Contraception • Inducing anaesthesia • Otherwise preventing or interfering with the normal operation of a physiological function. In addition, other products used should be considered i.e. dressings, disinfectants, diagnostic reagents.
Non-medical prescribing	Nurses, optometrists, podiatrists or chiropodists, physiotherapists, pharmacists, paramedics, radiographers and community practitioners with the appropriate qualification who are legally permitted and qualified to prescribe and take the responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as the responsibility for prescribing, and the appropriateness of any prescribing.
Non-professional Staff	For the purpose of this policy, non-professional staff refers to transport drivers, porters etc.
Nursing Associate	A registered band 4 individual that bridges the role between a registered Nurse and HealthCare Assistant. They are registered with the Nursing and Midwifery Council (NMC) and may administer a limited number of medicines via defined routes following competency assessments that are in-line with registered Nurse training.
Policy	A document that sets the rules to be followed.
Prescriber	A person who is authorised to undertake independent or supplementary prescribing according to current NHS Legislation.
Prescription	A written authorisation for the administration or supply of a Prescription Only Medicine (POM) to an individual patient e.g. In-patient medicine chart, discharge prescription (TTO), FP10.
Procedure (or Standard Operating Procedure - SOP)	A written document that outlines how a procedure is implemented in a particular clinical location.
Protocol	The plan for a course of medical treatment, or procedural guidance.
Registered Nurse	A nurse who is listed in part one of the NMC Register.
Registered Professional	Someone actively practicing in their profession i.e. Nurse Practitioner, Medical Practitioner, Dental Practitioner, Pharmacist.
SCHT	Shropshire Community Health NHS Trust
Second Checker	An authorised member of staff assuming the role of a witness for the preparation, administration and disposal of a medicine.
Secondary dispensing	Re-packaging medicines into another container or removal of medicines from the labelled container for consumption by the patient at a later time.
Self-administration	A scheme whereby patients are responsible for the storage and administration of their own medication after assessment and approval by the multidisciplinary team.
Service Level Agreement (SLA)	A formal written agreement made between two parties, the service provider and the service recipient that defines the basis

	of understanding between the parties for delivery of the service itself.
Service Manager	The Manager of a Community Hospital or Community Service
Supplementary prescribing	Supplementary prescribing is a voluntary prescribing partnership between an independent prescriber, a supplementary prescriber, and the patient to implement an agreed patient-specific clinical management plan.

4. Responsibilities

4.1. Directors

It is the overall responsibility of Directors to ensure that legal requirements for medicines are adhered to and regulatory body standards are met.

4.2. Service Managers

It is the responsibility of the Service Manager to seek assurance from their areas of responsibility that legal requirements for medicines are adhered to and regulatory body standards are met, and to provide this assurance to the Quality and Safety Groups. Service Managers are responsible for ensuring that any remedial action plans are implemented and completed in the required timescale.

It is the responsibility of the Service Manager, or other Manager who arranges contracts with medical staff, nursing staff, locum staff and other types of staff from other NHS Trusts or from private practices to work for SCHT on a sessional basis, to have it written explicitly within their contact that these staff must abide by SCHT policies and standard operating procedures.

4.3. Clinical Manager

It is the responsibility of the designated manager to ensure the safe procurement, delivery, storage and administration of drugs within a department or service, and that the staff reporting to them or working in their clinical area adhere to the policies and procedures set by SCHT.

4.4. Line Manager

It is the responsibility of the line manager to ensure all staff have the necessary competency assessments to handle and administer medicines and that evidence is documented in the individuals personal file which is reviewed as part of the annual performance review.

It is the responsibility of the line manager to ensure staff are aware of the contents of this policy at all times.

4.5. Staff

All Staff (who handle medicines as part of their job) are responsible for:

- Maintaining competency in the use of medicines
- Working within current legislation, professional standards and organisational procedures
- Recording and reporting medicines related incidents in accordance with the SCHT policy
- Maintaining an up to date knowledge of the content of this policy
- Identifying their individual learning needs and informing their line managers where training is required.

4.6. Other

Non-registered staff and HCSW involved in the handling of medicines should have access to training that explains what roles they may safely and legally undertake. The responsible nurse who has delegated a task must be individually identified and they are professionally accountable to ensure that a patient, carer or health care assistant is competent to carry out the task.

Specific requirements of individual departments will be documented in standard operating procedures (SOPs).

It is the responsibility of the designated manager in conjunction with the Medicines Management team to tailor SOPs to their clinical area and regularly update them. The SOPs may be subject to scrutiny by the Medicines Management team for SCHT for audit purposes.

5. Training requirements

All staff who come into contact with medicines will undertake regular medicines management training as stated in the SOP being adhered to or within the appraisal process. This is in addition to mandatory training requirements by SCHT.

Those healthcare professionals who administer medicines will complete the medicines administration competency booklet(13978.pdf (shropcom.nhs.uk)) as part of their induction. Medicines competencies will be reviewed at least annually using the annual checklist (13977.pdf (shropcom.nhs.uk)).

Should the healthcare professional become involved in medicine related incidents then the original competency booklet will be used to reassess competency within the specific area of administration that was involved in the incident. Ward Managers will keep a record of healthcare professionals involved medicine related incidents and lessons learned to help identify individual training needs.

Prescribers within SCHT Community Hospitals are required to complete the Prescribers Induction Pack with a member of Medicines Management Team. A copy will be sent to their line manager.

Nursing Associates will complete medicines administration competencies as described within this Policy.

Training records will be kept by individual staff and, where appropriate, service leads to ensure a cycle of continued professional development is maintained.

It is the responsibility of the designated manager to ensure that the roles and responsibilities relating to medicines are clearly defined in their staff job descriptions, and that “medicines management” is included in the Key Skills Framework for each individual.

If an appropriately qualified practitioner is required to prescribe as part of their role then this must be explicitly stated in their job description.

It is the responsibility of individuals to keep their knowledge up to date and to only work within their competence.

Individual training competences related to medicines will be reviewed at the annual performance development review and an action plan created if any competencies need updating.

6. Consent

All patients have the right to make fundamental decisions about what happens to them, agreement to examination, investigation and treatment is defined as consent. Seeking consent is more than a matter of common courtesy between healthcare professionals and patients, individuals have a fundamental legal and ethical right to valid consent whether it is for examination, investigations, treatment, providing personal care or undertaking major surgery. However, in certain situations individuals are unable to give fully informed consent and processes have to be followed in order that they can receive appropriate care and treatment balancing this against their views and wishes. (Refer to SCHT Consent to Examination and Treatment Policy)

In the event that there are any concerns regarding the patient's capacity to consent or withhold consent to any treatment offered, it is the responsibility of the healthcare professional who is involved in the administration of the medicines to undertake a capacity assessment and if necessary, make an appropriate decision in the best interests of the patient.

7. Prescribing

7.1. Prescribing for patients

7.1.1. Documentation

Prescribing within SCHT will usually follow one of following processes:

- Production of a prescription or Patient Specific Direction (PSD) by an authorised prescriber.
- Use of a Patient Group Direction (PGD) by a registered healthcare professional as listed in legislation to work under a PGD.
- Use of a National Protocol e.g. for the administration of Covid-19 vaccines

Prescribers must make themselves familiar with the prescription writing guidelines as documented in the BNF, along with the processes involved in writing a legally correct prescription.

Readily available references include:

- BNF Guidance on prescribing | Medicines guidance | BNF content published by NICE,
- Drug tariff Drug Tariff | NHSBSA,
- Summary of product characteristics www.medicines.org.uk.

Prescriptions and drug/medicine administration charts MUST:

- Be written or printed in indelible black ink
- Be written in English without abbreviations (unless stated in this policy)
- The prescription information be entered onto the patient's notes whether that be manual or electronic records (including reasons for dose changes, drug discontinuation etc.)

- Be written on the correct form (the appropriate FP10 form) according to the clinical situation, or on an approved drug administration chart
- Be written legibly (ideally printed)
- State the name and address of the patient (and NHS number on in-patient drug charts)
- State the date of birth (mandatory if patient is under 12 years)
- Where appropriate, state the height, weight and body surface area
- Renal function as eGFR
- Be clear about the prescriber's intent. i.e., state the name of the drug (must not be abbreviated), dose, form and frequency, and any special requirements e.g., in relation to food, drink or monitoring
- For liquid medication have the dose prescribed in mg and ml i.e., 10mg (2.5ml)
- For antibiotics, the indication and course length must be documented where appropriate
- Bear the full signature of the prescriber (blank prescriptions must NEVER be signed in advance)
- State the date the prescription was signed

If a medicine on an FP10, administration chart or MAR chart requires amendment, such as a dose change, the whole item must be crossed through, initialled by the prescriber and the item re-written in full.

7.1.2. Abbreviations

The use of abbreviations in the prescribing process will be limited to those stated below. Drug names must not be abbreviated under any circumstances.

The following are acceptable:

Dosage	Abbreviation	Dose	Abbreviation
gram	g	Units	Units
milligram	mg	Litres	l
microgram	Microg or microgram	millilitres	ml
nanogram	nanogram	millimoles	mmol
Dosage form			
tablet	tab	suppository	supp
capsule	cap	Eye drops	guttae, gutt
suspension	susp	Eye ointment	oc
Ointment (skin)	ung	Cream	cr
Injection	inj		
Special characteristics of dosage forms			
Enteric coated	ec	Modified release preparations	e.g. MR, XL, SR
Route of administration			
oral	po	sublingual	sl
intravenous	iv	rectal	pr
intramuscular	im	vaginal	pv
subcutaneous	sc	Percutaneous endoscopic gastronomy	PEG
nebulised	neb	topical	top
Dosage frequency			
Once a day	od	In the morning	om
Twice a day	bd	At night	on
Three times a day	tds	As directed	mdu
Four times a day	qds	As required	prn
At once	stat		

7.1.3. Variable dosing

It is the responsibility of the clinical manager to ensure that there are robust procedures in place to ensure that drugs with a variable dose (dependent on monitoring) are administered as intended by the prescriber e.g. warfarin, insulin. The prescriber must indicate dose range and dosing frequency.

7.1.4. Brand prescribing

Whenever practical, approved (generic) names of medicines should be used. Only a limited range of medicines are recommended by the BNF to be prescribed by their trade name, including ciclosporin, modified release preparations of

diltiazem and some anti-epileptics. See individual monographs in the BNF for full details.

In addition, Schedule 2 and 3 controlled drugs should also be prescribed by brand to avoid dispensing and administration errors.

Following dispensing errors with insulin, it is again recommended that they are prescribed by brand e.g. insulin aspart could be Fiasp or Novorapid – but these brands have completely different time profiles and could be catastrophic for a patient should they receive the incorrect preparation.

7.1.5. Controlled drug prescribing

There are additional requirements for prescriptions for controlled drugs (see Medicines Policy Part 2: Controlled Drugs 10469.pdf (shropcom.nhs.uk))

7.1.6. Antibiotic / specified course prescribing

It is best practice to also include the clinical indication and duration expected if a fixed term course of treatment is prescribed. For antibiotic prescriptions clinical indication and duration is expected to be recorded to evidence compliance with local formularies and guidelines

7.1.7. Community Hospitals

Patients may arrive at a community hospital with a drug chart from another organisation out of hours, this drug chart may be used to aid medicines administration until a SCHT prescriber is available. During working hours, patient's medication must be prescribed onto SCHT paperwork. Once a prescriber is available on the ward, it is not appropriate to continue with using a third party medicine chart (e.g. acute trust) any longer than absolutely necessary.

7.1.8. Services using PGD's

If treatment is being initiated for administration or supply under a Patient Group Direction (PGD), then the requirements of that PGD must be adhered to (see Medicines Policy Part 4: PGD)

7.1.9. Services using drug charts / MAR charts

Where a "prn" (as required) direction is used on a prescription, drug administration chart or MAR chart, a clinical indication, maximum dose and frequency should be included. The "prn" prescription should be reviewed regularly by the prescriber to determine its continued clinical need.

To avoid ambiguity, if a medicine is stopped, the item should be cancelled by drawing a diagonal line through that section of the administration chart, and the practitioner sign and date across the administration section, to prevent further administration. If a medicine is stopped it is recommended practice to document the reason(s) in the clinical record .

The prescriber is responsible for entering any known allergies in the appropriate section of the administration chart and transferring these to subsequent charts. Where there are no known medicines allergies, "none known" or 'NKDA' must be entered in the allergies section of the administration chart. The allergy section must not be left blank.

In addition prescribers need to adhere to Trust medicine policies and procedures when completing MAR sheets, drug charts and other Trust approved authority to administer. A prescriber induction pack is available from the Medicines Management team

7.2. Who can prescribe?

In addition to doctors and dentists, there are an array of non-medical prescribers who can prescribe medicines for patients.

Non-medical prescribers include independent, supplementary and community practitioner nurse prescribers.

Independent prescribers e.g. nurses and pharmacists, can prescribe all prescription only medicines including some controlled drugs and all pharmacy and over the counter medicines. They must only prescribe drugs that are within their area of expertise, and level of competence and should only prescribe for children if they have the expertise and competence to do so.

Some groups of Independent prescribers have restrictions on what they can prescribe e.g. physiotherapists, paramedics and podiatrists. The following link describes what each group of prescriber is able or unable to prescribe:

https://psnc.org.uk/dispensing-supply/receiving-a-prescription/who-can-prescribe-what/

Supplementary prescribers may prescribe in accordance with a clinical management plan (CMP) in a tripartite arrangement with a doctor or dentist, the patient and the supplementary prescriber. A supplementary prescriber when acting under and in accordance with the terms of a CMP may administer and/or supply or direct any person to administer controlled drugs in Schedules 2, 3, 4 and 5, and can prescribe unlicensed medicinal products. The link above gives a comprehensive guide.

Community Practitioner Nurse prescribers may only prescribe from a restricted list of medicines and appliances as stated in the Nurse Prescribing Formulary within the Drug Tariff. The link above gives a comprehensive guide.

The scope of practice document for non-medical prescribers MUST be sent to the non-medical prescribing lead in order for the non-medical prescriber to be authorised to prescribe within SCHT (Medicines Policy Part 6: Non-Medical Prescribing).

Unlicensed drugs should only be prescribed where there is no licensed alternative (see unlicensed medicines section).
It is the responsibility of all clinicians to ensure that the patients' GP is informed in a timely manner of any changes made to their patient's medication to keep all available records up to date.

7.3. Choice of medicine or appliance

The choice of any medicine, dressing or item used for the clinical care of patients or service users should be evidence based and reflect any local and national best

practice guidelines. Prescribing should be in line with the Shropshire and Telford local Health Economy net formulary Shropshire and Telford Local Health Economy Formulary (shropshireandtelfordformulary.nhs.uk) Where prescribing is outside these parameters, justification must be offered. To ask for any medicine or appliance to be considered for addition to the net formulary, then a formulary application must be presented to the Area Prescribing Committee (APC).

Antibiotics will be prescribed in accordance with the antibiotic stewardship guidance 14171.pdf (shropcom.nhs.uk).

The choice of a particular drug, formulation or treatment regimen and advice offered may be influenced by needs of the patient with respect to dietary preferences e.g. vegan, or to religious issues such as fasting during Ramadan.

Choice of drug may also be an issue in patients with a disability for whom an alternative drug choice, drug formulation or compliance aid may be appropriate. Monitored dosage systems (MDS) should not be considered as the only compliance aid available due to risks of reduced medication efficacy due to stability issues, and medicine interactions within this type of compliance. If a MDS is considered appropriate then a discussion with the patients' nominated Pharmacist should take place. (See MDS Section)

7.3.1. Unlicensed or off-label medicines

"Unlicensed medicine" is the term used for a medicine that has no UK product licence. A medication that is licensed but used outside its licensed indications is known as "off-label" or "off-licence" and may include practices such as crushing a tablet, opening a capsule prior to administration or mixing two solutions prior to injection where the summary of product characteristics does not indicate this as a licensed use.

Changing the formulation of a drug e.g. by crushing tablets, or opening capsules falls outside the product licence and is not recommended unless the product licence specifically allows this (refer to individual drug data sheet accessible from www.medicines.org.uk). When an unlicensed or "off-label" medicine is administered to a patient, the manufacturer has no liability for any harm that ensues. The prescriber who has requested this and the practitioner who administers the medicine are liable for any adverse effects resulting from administration of medication in this manner.

Healthcare staff must be aware that crushing solid medicines or opening capsules may alter the properties of the preparation, therefore changing the way it acts and may result in harm to the patient. Advice should be sought from the SCHT Medicines Management team.

Prescribers should usually prescribe licensed medication in accordance with the terms of their license (Prescribing unlicensed medicines - GMC (gmc-uk.org)). However unlicensed medicines maybe prescribed where, on the basis of the assessment of the individual patient, an unlicensed or off-label medicine meet the medical needs of a patient. Examples include:

- Medicine licensed for adult but not a child but would meet the needs of a child

- Dose specified for a licensed medicine does not meet the medical need of the patient
- The patient needs a medicine in a formulation that is not specified in an applicable license
- The medicines is required for a condition which the license does not include

In some cases there may be a temporary supply shortage of a licensed medicine, but an unlicensed equivalent exists.

When prescribing an unlicensed medicine the prescriber must:

- Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate safety and efficacy.
- Take responsibility for the prescribing of the medicine an oversee the patients' care, monitoring and any follow up treatments, or make sure there are arrangements in place for another suitable prescriber to do so.
- Make a clear, accurate, legible and timely record of all medicines prescribed and justification for prescribing an unlicensed medicine.
- Ensure patient, carer and other healthcare professionals involved in the care of the patient are aware its' unlicensed.

The healthcare professional administering the medicine must be satisfied that they have sufficient information to administer the medicine safely and, where possible, that there is acceptable evidence for the use of that product for the intended indication.

7.3.2. Homeopathic, complementary and alternative medicines

Homeopathic, complementary and alternative medicines would not normally be initiated by a SCHT prescriber.

All patients' own homeopathic, complementary or alternative medicines should be reviewed before prescribing whilst an in-patient and administration must be recorded alongside other medicinal products on administration charts. Consideration must be made to any interaction with conventional medicines being prescribed. Practitioners remain accountable when prescribing or administering homeopathic, complementary or alternative medicines which have no medicines product licence, or which are being used "off licence".

Note: formulary decisions are ratified by the Area Prescribing Committee. Primary care physicians are unable to continue a prescription for certain products deemed of limited clinical value.

7.3.3. Other considerations

The prescriber must give patients sufficient information about the proposed course of treatment including any known serious or common side effects or adverse reactions to enable them to make an informed decision.

The doses of drugs that require therapeutic drug monitoring must be reviewed at the appropriate intervals to reduce the risks of adverse drug reactions.

When prescribing against a shared care protocol (ESCA) ensure all parties have agreed to the conditions within the ESCA and are aware of their roles and responsibilities.

When prescribing, the English convention of decimal points must be adhered to. Commas to indicate sub-units must never be used.

7.4. Prescribing of non-drug items by therapists

Non-drug items may be written on the drug administration chart e.g. food or food supplements prescribed by a dietician or thickeners prescribed by speech and language therapists. The therapists must sign and date the chart and identify their profession. Follow up arrangements should be documented in the patient notes / electronic patient record (EPR).

7.5. Prescribing for self, family or friends

Medical practitioners and non-medical prescribers are prohibited from prescribing any medicine for themselves or for anyone with whom they have a close personal relationship with other than in exceptional circumstances such as: no other person with the legal right to prescribe is available and only then if that treatment is necessary to:

- Save a life
- Avoid serious deterioration in the patient's health, or
- Alleviate otherwise uncontrollable pain.

The professional must be able to justify their actions and must document the relationship and the exceptional circumstances.

7.6. Remote Prescribing / remote orders

Remote consultations provided over the phone, via video-link, online, or using any other non-face-to face medium can benefit patients, save resources and help meet the demands of the service user. However, there are safety risks, particularly when services are not linked to a patient's NHS GP or regular healthcare provider, and where there may be limited access to a patient's medical record.

Registered healthcare professionals are expected to follow ten high level key principles when providing remote consultations and prescribing remotely to patients. They are:

1. Make patient safety the first priority and raise concerns if the service or system they are working in does not have adequate patient safeguards including appropriate identity and verification checks

2. Understand how to identify vulnerable patients and take appropriate steps to protect them.

3. Tell patients their name, role and (if online) professional registration details, establish a dialogue and make sure the patient understands how the remote consultation is going to work.

4. Explain that:
    a. They can only prescribe if it is safe to do so.
    b. It's not safe if they don't have sufficient information about the patient's health or if remote care is unsuitable to meet their needs.

c. It may be unsafe if relevant information is not shared with other healthcare providers involved in their care.
d. If they can't prescribe because it's unsafe they will signpost to other appropriate services.

5. Obtain informed consent and follow relevant mental capacity law and codes of practice.

6. Undertake an adequate clinical assessment and access medical records or verify important information by examination or testing where necessary.

7. Give patients information about all the options available to them, including declining treatment, in a way they can understand. NHS Digital has published The Identity and Verification standard for Digital Health and Care Services (2018). For guidance on safe and appropriate online and remote provision of sexual health services please refer to Faculty of Reproductive Sexual Health (FRSH) and British Association for Sexual Health and HIV (BASHH) Standards for Online and Remote Providers of Sexual and Reproductive Health Services.

8. Make appropriate arrangements for after care and, unless the patient objects, share all relevant information with colleagues and other health and social care providers involved in their care to support ongoing monitoring and treatment.

9. Keep notes that fully explain and justify the decisions they make.

10. Stay up to date with relevant training, support and guidance for providing healthcare in a remote context.

Healthcare professionals who are responsible for leading a team or service that offers remote consultation and prescribing are expected to make sure that team members are clear about roles, personal and collective responsibilities for the individual patient, and the quality and safety of care provided by the team or service. They have a responsibility to contribute to setting up and maintaining effective systems to identity and manage risks, and to act quickly when patients may be at risk of harm.

It is important that healthcare professionals consider the limitations of remote prescribing. If the healthcare professional does not feel able to prescribe remotely, the consultation is deemed inappropriate, or there is sufficient information available to give safe advice and/or make a safe prescribing decision then a system should be in place to enable a switch to a face to face consultation.

7.6.1. Remote Prescribing – Community Services Teams

In addition to the 10 key principles or remote prescribing, when working within SCHT Community Services the following conditions must also be met:

- A non-medical prescriber may not prescribe remotely if they have not personally assessed the patient.
- Generally, the medication must have been previously prescribed for the patient.
- In certain circumstances a medical practitioner may need to prescribe remotely for a previous unprescribed medicine.

- A record of the emailed authority to administer and consultation must be documented clearly in the patient's notes including the date, time, and reason that the remote prescription was needed.
- NO schedule 2 or 3 controlled drugs can be initiated via this method, or any other locally mandated drugs treated as if they were a schedule 2 or 3 controlled drug.
- Where a patient is already prescribed a CD, but they require an adjustment to dosing and any delay in doing so could cause serious harm to the patient, an "authority to administer" may be securely emailed to the service. When this method is used, the Service Lead or Deputy must be contacted to highlight this and ensure that appropriate governance is in place to manage the situation. As the authority to administer paperwork is not a prescription there is no requirement to obtain the original authorisation.
- The communication must contain the following: name of patient and other identifying details (address, date of birth or NHS number); age if under 12 years, name of drug and its form, strength, dose and frequency; name of prescriber and contact details.
- For dose titration, e.g. insulin dosing, which is recommended to patient's or a patient's family and is often conducted verbally, this is not covered within the policy and services must have local procedures to cover this eventuality.

7.6.2. Remote Prescribing Out of hours – Community Hospitals

- Out of hours service providers will adhere to the following SOP "Standing Operating Procedure for Clinical Management of Patient Admissions to Community Hospital Inpatient Wards" and contract agreements for the standard of service provided.

- Out of hours clinicians should carry out a physical assessment of the patient and when a prescription or change in dose of a previously prescribed medicine is required, prescribe directly onto the inpatient drug charts at each Community Hospital.

- In instances where out of hours clinicians cannot visit a community hospital where the patient requires an adjustment to dosing and any delay in doing so could cause serious harm to the patient, the approved "Out of Hours Temporary Prescription for Community Hospitals" – Appendix 3 may be securely emailed to the service. This prescription **must** be attached to the drug chart and the dose adjustment altered on the drug chart by the next visiting prescriber.

- An authority to administer can be used for the initiation of morphine 10mg/5ml oral solution in exceptional circumstances (See SOP 1.08)

- An authority to administer cannot be used to initiate a new medicine.

7.7. Transcribing

Transcribing can be defined as the act of making an exact copy, usually in writing (Admin of Meds prof guidance.pdf (rpharms.com).

Transcribing is the copying of previously prescribed medicines details to enable their administration when it is in the patients' best interests.

Transcribing cannot include any changes to the medication, for example the timing of, or titration of a dose, as this becomes prescribing.

Medicines cannot be transcribed where details are illegible, unclear, ambiguous or incomplete and extra care is required when transcribing high risk medicines like insulin and anticoagulant. Refer to SOP's for advice on satisfactory documents which can be used for assurance.

Transcribing is only used within SCHT in those areas where patients' own medicines have been prescribed and dispensed by a pharmacy and the details transcribed onto a MAR sheet for administration by SCHT staff. Such areas include Nursing within Special Schools and Community Childrens' Nursing. Transcribing is also used by the pharmacy team within Community Hospitals to aid the ordering of prescribed inpatient medication from the contracted supplying pharmacy.

When transcribing takes place, this is usually an activity undertaken by a registered member of staff that is not a prescriber. In this case, only those practitioners who have completed the transcribing training and competency assessment and been declared competent by their clinical manager.

8. Ordering

8.1. Purchasing and ordering stock medication (excluding vaccines – see Medicines Policy Part 3: cold Chain)

Each ward or department will have a list of medicines that they may hold as stock, and the quantity held should be specified based on usage patterns and clinical urgency.

The stock list will be agreed and reviewed at least annually by the appointed nurse in charge, the medicines management team and a relevant doctor where appropriate.

Services holding stock lists will have suitable trained, nominated members of staff who complete the stock order and retain the paperwork in accordance with their stock medication order SOP's.

All medicinal products must be obtained from an approved supplier, e.g. wholesaler, or under a service level agreement with a hospital or community pharmacy holding a wholesale dealers licence or specials licence.

Staff wishing to add new items to a stock list should make a request via the medicines management team by emailing shropcom.medicines@nhs.net.

8.2. Ordering patient specific medicines

8.2.1. Community Hospital

In-patient medication written on the in-patient prescription chart will be ordered from the contracted pharmacy as appropriate by a pharmacist, pharmacy technician, or registered nurse using the authorised paperwork/ordering tools.

Telephone requests to the supplying pharmacy for individually dispensed items cannot be accepted.

Any discharge supply (TTO) supply will normally be for a minimum of 7 days unless it is a defined course of medication e.g. antibiotics.

At the community hospitals, a CD TTO form will be used to obtain controlled drugs for patient take home medication. FP10s may be used to obtain patient specific medicines for patients when the pharmacy staff are not present, and where otherwise there would be an unacceptable delay, but only after discussion with the prescriber as to the currently stocked alternatives. The prescription must be presented to a community pharmacy for dispensing.

Any FP10's written using the ward prescription pad will be recorded on the prescription pad tracker before returning the prescription pad to its' secure location. See SOP 10.01 for details. Robust communication to the pharmacy staff is required to prevent unnecessary duplication.

In the event of a medical emergency where the appropriate drugs are not kept at the community hospitals, and depending on the nature of the event, it may be appropriate to contact the out of hours service or an ambulance for transport to the acute hospital.

8.2.2. Prison

Signed prescriptions generated by the SystmOne electronic patient record system for medicines for individual patients and orders for stock medicines will be sent to the contracted pharmacy. The responsibility for the accuracy of the prescription lies with the prescriber.

8.2.3. Clinics and individual prescribers and ward prescribing

When issuing an FP10 for a patient to dispense at a local pharmacy, the FP10 pad will be stored securely, and the prescription pad tracker completed with each issue. It is the clinic or individuals responsibility to maintain safe storage of the prescription pad.

Contact the medicines management team or delegated hub to request the re-order of prescription pads or to report a prescription missing.

9. Receipts

9.1. Receipt of medicines and associated paperwork

Medicines must be transported to the services in a secure manner e.g. a sealed and tamper evident or lockable container.

It is the responsibility of the clinical manager to ensure that procedures are in place to check off the medicines received (stock items and patient specific medicines) against the delivery note and ensure that they are locked away in the appropriate drug cupboard or drug refrigerator in a timely fashion.

The delivery note must be signed, dated, filed and available for inspection by the organisation for two years. In addition, a copy of this delivery note must be sent

to the Medicines Management Administrator to allow receipt of medicines to be checked against the monthly invoices. Email shropcom.medicines@nhs.net.

Any invoices received will be kept electronically for seven years.

Any discrepancies must be reported to the supplying pharmacy.

Drugs transport boxes must not be left awaiting attention in areas accessible to the public.

Refrigerated drugs: Drugs requiring refrigeration must be transferred to the dedicated drugs fridge immediately to maintain the cold chain.

Controlled drugs (refer to Medicines Policy Part 2: Controlled Drugs policy). Controlled drugs must be checked and signed for by the authorised nurse in charge and locked in the CD cupboard immediately upon receipt. Receipts of CD's must be made in the Controlled Drugs register at this time (including those dispensed for discharge).

9.2. Patients' Own Drugs (POD's)

On receipt of discharge medications from another hospital, or medicines brought in from home, a designated nurse should check each medicine against the latest discharge documentation to ensure all items are present and correct (refer to Medicines Policy Part 5: Medicines Reconciliation).

All PODs brought into the hospital remain the property of the patient and should not be disposed of without the consent of the patient. This should also be documented in the patient notes.

If a patient is incapable of giving consent at one particular time, it may be appropriate to secure the drugs if they have been changed or discontinued with consideration to disposal of these PODs at a later time.

If a patient is in possession of illegal pharmaceutically active substances, refer to Medicines Policy Part 2: Controlled Drugs.

It is the responsibility of the clinical manager to ensure that there is a robust system for assessing the suitability for use of PODs in the community hospital. If the medicines are deemed unsuitable for use after the risk assessment, the medicine must be quarantined, so that it is not used in error. Replacement medicines must be ordered.

If the PODs are deemed suitable for use according to the criteria, they may be stored securely in a POD locker and used according to the drug chart prescription.

Patients should be made aware that an adequate supply (minimum of 7days (14 days if the patient usually has MDS)) of their medication will be available on discharge. Any medicine will be supplied as bottle and box.

10. Storage

10.1. Storage of medicines

Depending on the service location, the drugs must be stored in the locked storage cupboards within clinical areas, “POD” lockers at the bedside, drug trolley or other approved lockable storage area.

Medicines will be stored in original manufacturing containers or in a pharmacy container with patient specific instructions when dispensed by a contracted pharmacy, retail pharmacy or hospital pharmacy team. Medicines must be stored at the specified temperatures. Ambient temperature monitoring will be recorded and audited in line with SOP’s.

Access to the cupboards should be restricted to authorised health professionals only. If any health professional is concerned over a colleagues behaviour towards medicines storage that may indicate addiction or abuse then this should be reported to their line manager and appropriate protocols followed.

The location of medicines cupboards should be in a secure but practical area for each service. The room needs to be secured when unattended, preferably without direct access i.e., door or window to the exterior of the building, and where it is not obvious to non-service users that medicines are stored within the cupboards.

Patients' own controlled drugs MUST be locked in the ward patients’ own CD cupboard and recorded in an appropriate section of the patients’ own CD register. Refer to Medicines Policy Part 2: Controlled Drugs for further details and for information on gabapentin and pregabalin.

Medicine cupboards and trolleys will not be left unlocked and unattended at any time. Medicine trolleys should be rendered immobile by securing to a wall.

Medicines including injection ampoules and vials must not be transferred from an original container to another for the purposes of storage. Only appropriately trained pharmacy staff may dispense medicines from one container to another for the purposes of supply. Refer to section 13 for more details.

Appropriate consideration should be made to the cold chain for refrigerated products (refer to Medicines Policy Part 3:Cold Chain) and for the immediate storage of controlled drugs (refer to Medicines Policy Part 2: Controlled Drugs).

It is the responsibility of the clinical manager to ensure that there are procedures in place to monitor the expiry dates of stock medicines to ensure appropriate stock rotation and ensure appropriate disposal of expired medicines.

There shall be separate lockable cupboards segregating the products as follows:

- Medicines which are taken internally
- External use medicines
- Medicines requiring refrigeration (a dedicated lockable pharmaceutical ‘fridge for medicines only’). The temperature of the refrigerator (current temperature as well as maximum and minimum temperatures) must be recorded daily in the working week by a designated person; and,
- Controlled Drugs (a cabinet conforming to the Safe Custody regulations)
- Patient Own Drugs (PODs) lockers at the bedside in community hospitals

- Lockable facilities for prisoners who are allowed medicines “in-possession”.
- Separate storage must also be available for:
  - Diagnostic reagents
  - Intravenous fluids and bulk sterile topical fluids; and,
  - Flammable gases and liquids.

10.2. Storage of emergency medicines

Emergency medicines will be stored and checked in accordance with local SOP’s so that medicines can be quickly accessible in an emergency yet stored securely to prevent misuse.

10.3. Storage of medicine keys

10.3.1. Community Hospitals

The Nurse in Charge will be responsible for medication keys. There will be a signature log book to demonstrate the change in responsibility at the end/beginning of each shift.

10.3.2. Special Schools

Medication keys will be stored securely as described within the local SOP.

10.3.3. Community Nursing

Medication keys will be stored securely as described within the local SOP. A signature log book will be used to record access.

11. Transport

11.1. Transportation of medicines between clinical areas

11.1.1. Community Hospitals

Only in the event of an emergency where it would be unreasonable to wait until the next working day should drugs be transferred to another ward or clinical area.

Clinical managers are responsible for ensuring that robust procedures are in place to ensure safe custody and to preserve an audit trail for the medicines being transported. This excludes controlled drugs.

Only in extreme emergencies, where a drug is required urgently by a patient, may a Controlled Drug be transported to another hospital. There is a SOP available which must be adhered to in order to provide an audit trail.

Medicines must be transferred in the original container. It is NOT PERMITTED to supply part containers e.g. a strip of tablets or loose ampoules.

Only a registered nurse may request the supply and must ensure that it is a registered nurse who collects the medicine / drug from the other ward.

The ward supplying the drug must order a replacement pack as soon as possible to replenish their stock.

11.1.2. Community Clinics

Moving of medicinal stock between clinic sites is not usually recommended. In extreme cases where this is required medicines management should be informed and each service have SOPs in place to provide assurance of the safe storage at and between sites, along with temperature control assurances.

11.2. Collection of medicines from pharmacies by practitioners on behalf of patients

All healthcare professionals have a duty of care and must take all reasonable steps to maintain safe custody of medicines in their possession.

Wherever possible, community practitioners should be discouraged from transporting drugs.

The transport of medicines from a community pharmacy on behalf of a patient should be reserved for exceptional circumstances. All reasonable care should be taken including the keeping of medicines out of sight during transport. Services should have an SOP in place to provide temperature and safe storage assurances.

Nurses are legally allowed to collect controlled drugs (CDs) from a pharmacy for a patient provided that the CDs have been prescribed by an authorised prescriber and dispensed for that patient. However, this should be reserved for exceptional circumstances, and the nurse must expect to be asked to prove their identity and provide personal details to the pharmacist for the record of collection.

Transit times must be kept to a minimum and medicines delivered directly to the designated patient as internal car temperatures are liable to large fluctuations.

Medicines must never be stored in a car overnight.

The cold storage chain must be maintained. If drugs requiring refrigeration are being transported e.g. flu injections, a validated vaccine carrier MUST be used (refer to: Medicines Policy 3: Cold Chain Standards for Vaccines and Pharmaceuticals)

Liquids should be kept upright during transit and storage.

Healthcare professionals should promote the safe and appropriate storage of medicines at patients' homes. Where instructions for appropriate storage are unclear, advice should be sought from the community pharmacy, discharging hospital or clinic, or the SCHT medicines management team.

The patient, relative and/or their carer is responsible for the safe, appropriate storage of medicines in the patient's own home.

Stock medicines or pre-packed TTO medication must never be supplied, sold or transported to an outside agency or service.

Healthcare professionals transporting cytotoxic medicines must be trained in the actions to be taken in the event of a spillage and the reporting of such an incident. Particular care is required for cytotoxic medicines, which must be transported in

an appropriate container that is closable, provides protection for the handler, is puncture- and leak-proof and stable to prevent unnecessary movement during transport.

12. Dispensing

Dispensing medicines for individual patients at community hospitals or prison will be provided in a way that can be reasonably expected to support the safe, effective and timely supply of medicines. Medicines must not be transferred from one container to another or labelled, except in a designated dispensary area by a clinical pharmacist and pharmacy technician.

13. Secondary Dispensing

Re-packaging medicines into another container with the intention that a different care worker will give it to the patient at a later time is called 'secondary dispensing'. This also includes the removal of medicines from packaging for consumption by the patient at a later time. This is not permitted except by a pharmacist within community hospitals or prison. The reasons for the action must be clearly documented. The patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist. The healthcare professional must ensure that the legal requirements for labelling are met.

14. Medicines reconciliation on admission to Hospital

Medicines Reconciliation has been defined by the Institute of Healthcare Improvement (I.H.I.) as being the process of identifying the most accurate list of a patient's current medicines – including the name, dosage, frequency, and route – and comparing them to the current list, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated (Medicines Policy Part 5: Medicines Reconciliation 10472.pdf (shropcom.nhs.uk)).

Ideally all patients admitted to a community hospital must receive a level 2 (pharmacy consolidation) medication reconciliation

15. Administration

15.1. Administration of medicines

15.1.1. General

Administration of drugs refers to any medicine that the healthcare professional will be directly administering, which may include parenteral, oral doses, creams, eye or ear-drops and rectal doses. The legislation provides that no-one must administer a prescription-only medicine otherwise than to themselves, unless they are a healthcare professional, or acting in accordance with the directions of a practitioner. Adrenaline and glucagon and other specified injections are exempt from this restriction when administered for the purpose of saving life in an emergency.

Only healthcare professionals who have been declared as competent and confident to administer medicines will undertake this task. Any SOP's should state the level or qualification of the individual required for the task, which should include Nursing Associates and any Trainees/Students.

Medicines dispensed for an individual patient (i.e. contains a dispensed label for an individual) must not be shared with other patients.

Healthcare professionals should have they own system to accuracy check the medicine they have selected for administration is correct against the authority to administer and that it is date.

All omitted, refused or wasted medicines will be documented on the drug chart and medicines disposed of in accordance with local SOP's. The prescriber will then be informed of the omission.

15.1.2. Parenteral (Injectables)

All healthcare professionals undertaking parenteral administration must have completed up-to-date training and personally prepare parenteral medicines for immediate administration. Specifically intravenous (IV) training will be attended every three years for those professionals expected to administer IV medicines to maintain competence and follow the IV policy and associated SOP's.

Medusa can be accessed on line at https://medusa.wales.nhs.uk/. Username and password can be obtained from Medicines Management Team.

Healthcare professionals must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence. Advance preparation of insulin for patients to self -administer is permitted under strict controls (see RCN guidance). Advice is available from the specialist diabetes team.

Where IV administration takes place, it is best practice for a second check by another healthcare professional to take place. The second check will countersign the records as a witness for parenteral administration. When a second check is not available, the service must have robust SOP's in place to mitigate risks.

To prevent errors, only one patient's medicines should be prepared for administration at one time.

15.1.3. Procedure

Drugs to be administered or prompted by a practitioner or healthcare assistant MUST be recorded in the clinical records or on an approved drug chart or MAR (medication administration record) chart.

Prior to the administration of any drug, practitioners must ensure they follow their local administration SOP along with the following recommendations from RCN/RPSGB Professional Guidance on Administration of Medicines in Healthcare Settings for checking:

- The identity of the patient

- The prescription or other direction to administer meets legal requirements, is unambiguous and includes where appropriate the name, form (or route of administration), strength, and dose of the medicine to be administered
- That issues around consent have been considered
- Allergies or previous adverse drug reactions
- The directions for administration (e.g. timing and frequency of administration, route of administration and start and finish dates where appropriate)
- Any ambiguities or concerns regarding the direction for administration of the medicine are raised with the prescriber or a pharmacy professional without delay
- Any calculations needed are double checked where practicable by a second person and uncertainties raised with the prescriber or a pharmacy professional
- The identity of the medicine (or medical gas) and its expiry date (where available)
- That any specific storage requirements have been maintained
- That the dose has not already been administered by someone else (including patient or carers).

In addition the healthcare professional administering the medicines should:

- Have an overall understanding of the medicine being administered, i.e. know the therapeutic uses of the medicines to be administered, its normal dosage, side-effects, precautions and contra-indications. Advice from a prescriber or pharmacy professional will be sought if needed.
- Be familiar with SCHT '5 Rights + 3 of medicines administration'.
- Have considered the dosage, method of administration, route and administration timing in the context of the condition of the patient and co-existing therapies.
- For parenteral medicines, check and record the expiry date and batch number.
- Make a clear, accurate and immediate record of all medicines administered.
- Contact the prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a suspected reaction to the medicine or where assessment of the patient indicates that the medicine is no longer suitable.
- Document and refer if consent to treatment is withdrawn.
- Check that the correct documentation is being used.

Medicines for administration by SCHT staff will not be left unattended. If a patient subsequently refused to have the medication administered then the administration will be marked as refused and the medication safely disposed of in line with local SOP for unwanted medicines

15.1.4. Delegation

Administration of prescribed medicines is usually carried out by a registered health care professional. Where a nurse has authority to delegate tasks to another, they will retain responsibility and accountability for that delegation. A nurse may only delegate an aspect of care to a person whom they deem competent to perform the task and they should assure themselves that the person to whom they have delegated fully understands the nature of the delegated task and what is required of them.

Delegation is not permitted for patient group direction (PGD) administration.

15.1.5. Healthcare assistants / HCSW

Healthcare assistants may assist/encourage patients in taking their medicines. At the discretion of the nurse in charge on a particular shift, the registered nurse may ask a healthcare assistant to:

a. Provide the patient with a glass of water
b. Oversee the patient while they take the medication; and,
c. Give encouragement where necessary.
d. The Healthcare assistant must inform the registered nurse when the patient has taken all of their medication; or if the patient refuses or does not take their medication, it is the responsibility of the registered nurse to remove the unwanted medication and make the appropriate record.

Specifically trained health care assistants / HCSW working in patients' homes may be delegated certain medicines administration tasks e.g. administration of insulin to stable patients with diabetes. In this case the accountability remains with the delegating nurse.

15.1.6. Nursing Associates

Nursing Associates (NA's) are registered staff and therefore, are able to undertake a number of medicines related activities once they have successfully completed any local competency training requirements and signed off as competent by the service manager. These include:

- Administration of oral medicines (cytotoxic drugs such as methotrexate must be double checked by a second registered member of staff)
- Administer sub-cutaneous injections such as Tinzaparin / Enoxaparin / Eprex Injections
- Administer Insulin (no need for patient specific mentoring like for HCA level 3 but the NA needs to build their confidence and initially only work with stable patients to start with)
- Administer Intramuscular Vit B 12 injections but will need some guidance and support initially
- Manage care for patients but need to discuss with Band 5 prior to making any changes to care and care plans
- Act as a second checker with a registered nurse for the administration of controlled drugs
- Undertake CD counts as a second checker

Please note that first visits to patients for the purposes of administering medication will not be allocated to a NA.

Conversely, the following activities fall outside of the remit of an NA:

- Unable to administer Intravenous Medications
- Unable to administer Intravenous fluids
- Unable to administer Controlled Drugs
- Unable to administer medications via a Syringe Driver even if not end of life patients

15.1.7. Community Hospitals

Any omissions on a paper or electronic drug chart/MAR that has not been coded will be reported on Datix.

When two or more drug charts are in use then these must be numbered '1 of ….' to prevent missed doses.

To ensure a safe and efficient medicines administration round within the ward setting, the following should happen:

- Check at the beginning of the round that medicines have not already been administered
- Check at the end of the administration round that there have been no unintentional omissions (this should form part of the handover process)
- Phone messages should be taken for the healthcare professional who is administering medicines to minimise interruption.
- In an emergency or other urgent situation where the healthcare professional administering medicines is required to respond, all medicines will be safely secured (including any medicine trolley) before leaving the round.
- Any calculations or medication preparation may be carried out away from the patient bedside if appropriate.

15.1.8. Other

The Healthcare professional should have access to the latest reference sources for medicines, whether paper or electronic versions. Examples include BNF app and online access to Summary of Product Characteristics (SPC) via the Electronic Medicines Compendium: https://www.medicines.org.uk/emc#gref

Liquid oral doses which are not in multiples of 5ml or 2.5ml (where there is a spoon measurement available), must be administered via an approved oral syringe. Syringes intended for use with parenteral products must not be used.

Procedures must be in place to ensure that personnel authorised to administer medication are competent to ensure that the correct medicine is administered to the correct patient.

The prescription must be current and be signed by an appropriate practitioner.

If there is any doubt about the accuracy, safety, completeness or appropriateness of an individual prescription, it is the responsibility of the nurse practitioner to confirm the details with the prescriber and/or a pharmacist in a timely manner to avoid delays or unintentional omission of the dose.

If doubt remains after contacting the prescriber the nurse MUST contact their line manager or person in charge. Consideration must be made as to the risks associated with omitting a medicine. The reason for omitting a dose must be documented on the drug chart or MAR chart and in nursing notes.

Inpatients should be given medicines at the prescribed times even if these fall outside the usual drug round times in order to give optimum benefit to the patient e.g. drugs for Parkinson's disease

Medicines which have a limited shelf life once opened must be clearly marked with the date opened.

Generally, multi-dose vials should not be used in community practice. As part of the risk assessment, justification for using a multi-dose vial must be documented.

Where patients have their own supply of medicinal products, whether over the counter (from a pharmacy or supermarket / shop), complementary therapies, herbal preparations or homely remedies such as paracetamol, the healthcare professional has a responsibility to inform the prescribing clinician, document this in the patient's notes and seek advice on their suitability for use, including potential interactions.

15.2. Medication Administration Records (MAR)

15.2.1. Community nursing:

Medication Administration Record Charts (MAR charts) MUST:

- Be written or printed in indelible black ink
- The prescription information be entered onto the patient's notes whether that be manual or electronic records
- Be written on an appropriate MAR chart
- Be written legibly (ideally printed)
- State the name and address of the patient
- Be clear about the prescriber's intent. i.e. state the name of the drug (must not be abbreviated), dose and frequency, and any special requirements e.g. in relation to food, drink or monitoring
- Course length must be indicated where appropriate; and,
- Be dated.

It is good practice to obtain a prescriber's signature and the date of birth of the patient on a MAR chart, but this is not a legal requirement.

Medication will not be administered without:

- a prescription written by a doctor
- a prescription written by an independent or supplementary prescriber employed by SCHT.
- a valid patient group direction (PGD) where the healthcare professional is authorised and "signed off" by their clinical manager as competent to supply/administer under the specific PGD.
- valid homely remedy protocol and the healthcare professional has been assessed as competent to work under the protocol.

The only exceptions to this are:

- in an emergency where there are limited exceptions e.g. anaphylaxis
- there is an exemption under the Medicines Act for individual professions to be able to use specified medicines in the course of their practice. (e.g. podiatrists and ophthalmologists).

15.2.2. Educational settings

Guidance for Medicine administration records in community nursing will be followed in addition to having parental consent and a photograph of the young person on the MAR.

Local SOP's should also be in place and adhered to.

15.3. Self-administration of medicines by in-patients

When a patient is identified as suitable for self-administration, Medicine Policy Part 10: Self- administration must be followed 10472.pdf (shropcom.nhs.uk)

15.4. Administration of Controlled Drugs

(Refer to Medicines Policy Part 2: Controlled Drugs).

15.5. Covert administration of Medicines

Covert administration of medicines entails disguising medicines in food or drink in order that they can be administered.

This may only be undertaken following a "Best Interests" decision. Generally, this practice may only be employed in exceptional circumstances where the patient actively refuses medication but, lacks the mental capacity to consent or refuse treatment (Refer to Covert Medicines Policy).

15.6. Administration Of Homely Remedy

Refer to Homely Remedy Policy

15.7. Administration of PGD medicine

See PGD policy

16. Mixing of medicines

It is common practice for healthcare professionals to mix one or more medicines together before administration to a patient. This is permissible under medicines legislation where one product is a vehicle for the administration of another. However, mixing two licensed medicines where one is not a vehicle for the administration of the other, results in a new, unlicensed product being produced.

Following consultation by the Medicines and Healthcare products Regulatory Agency (MHRA), and recommendations by the Commission on Human Medicines (CHM), medicines legislation was amended to enable doctors and dentists to direct others to mix. In addition, nurse, midwife and pharmacist independent prescribers can now mix medicines themselves and direct others to mix for the purpose of administration to an individual patient. These changes also relate to supplementary prescribers provided the mixing of medicines is included in the CMP relating to the treatment of an individual patient (Parameters (publishing.service.gov.uk)).

17. Medicines supplied on leaving hospital or prison (TTO's)

The appropriate prescription will be written before TTOs can be supplied to the patient.

Discharge prescriptions will be clinically checked by a pharmacist and ordered via the services current supply system.

TTOs for controlled drugs will be via a CD TTO form or FP10 prescription and dispensed by a community pharmacy. Controlled drugs will not be released by a pharmacy before the original signed prescription is in their possession (legal requirement). Therefore, prescriptions for controlled drugs TTOs must be presented as soon as possible before the anticipated discharge.

For patients that are released from the prison and require a controlled drug, an FP10 prescription should be completed and given to the patient. It is the patient's responsibility to acquire their supply following release. Any other medication required by the patient can usually be provided by the prison pharmacy team.

Prescriptions for controlled drugs for discharge must be written according to the requirements of the Misuse of Drugs Act (see BNF "Guidance on Prescribing").

Any PODs which are not required at discharge (e.g. previously dispensed medicines) will be disposed of with the consent of the patient.

TTOs must be stored securely prior to the discharge of the patient. The patient should be fully counselled on the correct use of the medicines and any compliance aids, aide memoirs and patient information leaflets supplied as appropriate.

Monitored dosage systems are not supplied by SCHT at discharge (see Monitored Dosage System Section)

If a patient passes away whilst in hospital the patients' own medicines (either brought in by the patient or dispensed whilst in hospital for that patient) must be stored on site for seven days after their death in case required by the coroner.

18. Monitored Dosage Systems (MDS) and compliance aids

Self-administration from the original dispensing containers may not always be possible for some patients. Before considering the use of multi-compartmental compliance aids (Monitored dosage systems or MDS) other possible solutions should be explored with the patient, for example reminder charts, large print labels, non child-proof tops or a review and rationalisation of the patient's medication regimen which may support the patient to self-administer. The patients' usual community pharmacy should also be contacted to ensure continuity of the suggested compliance aid(s) (excluding MDS).

Where an aid to compliance is considered necessary, careful attention should be given to the assessment of the patient's suitability and understanding of how to use the appropriate aid safely, and the need for regular re-assessment of the appropriateness of the aid.

SCHT does not initiate MDS to patients that did not have one at home. Patients who are confused or not orientated in time or place are unlikely to use this type of device safely. Those patients who healthcare professionals feel would benefit from MDS should refer the patient to their usual community pharmacist for an assessment.

Patients' who are already receiving a MDS for their community pharmacy will only be discharged with an MDS if the one brought in by the patient remains unchanged and in date. Otherwise MDS patients will receive two week "bottle and box" supply of

medicines and the community pharmacy contacted to inform them of the discharge and discharge medicines via the NHS Discharge Medicines Scheme.

SCHT staff are not authorised to support the administration or taking of medicines from family-filled Dossett boxes.

SCHT staff are only authorised to administer medicines from a pharmacy filled monitored dosage system if the medicine is not readily available in their service, the MDS is within 8 weeks of the dispensed date, and the medicine can clearly be identified from the medication descriptors.

19. Adverse Reactions to Medicines

Suspected adverse reactions to medication should be immediately referred to the patient's GP, or to hospital A&E depending on the severity.

The details of the reaction should be documented on the patient's healthcare notes, and where appropriate on the in-patient drug chart or MAR chart.

If appropriate, a yellow card reporting form (available at the rear of the BNF, or online at www.yellowcard.gov.uk) should be completed by the prescriber.

20. Medicine (Drug) Alerts

SCHT will notify all designated clinical managers of any drug alerts or drug recalls, via the MHRA Central Alert System.

The information is loaded onto the Datix system and disseminated to the appropriate services and personnel for appropriate action as defined in the alert.

The designated manager will be responsible for ensuring that alerts or recalls are responded to in the appropriate timescale depending on the urgency stated, even where there is no weekend or bank holiday cover for the department or service.

If the drugs subject to the alert are found in stock, they must be quarantined and dealt with in the manner detailed in the alert/recall.

A record must be kept at the nurse base of any actions taken and any follow up required. Record should be kept for 5 years for audit purposes.

All safety alerts received will be dealt with as per the actions required in the alert. Action plans from each clinical area will be required to meet the standards in the alert and reported to the appropriate Medicines Management sub-group and the Medicines Governance Group.

21. Medicine Incidents and errors

(Refer to Medicines Policy 8 : Managing Medication Incidents)

A culture of reporting of incidents and errors, including near misses, must be promoted.

A medication incident is an incident or event involving prescribing, dispensing, administration, handling, storage, transportation, disposal or management of medicines and controlled stationery. A medication incident is also where a drug is unintentionally omitted or significantly delayed.

All medication incidents are potentially serious and put patients, and possibly staff, at risk. Incidents should be dealt with according to the organisation's Incident Reporting policy. Procedures must be in place to enable accurate reporting of all incidents and near misses.

If the incident involves a breach of security, the designated manager must ensure that remaining medicines are stored safely and securely.

Any and all breaches in the physical security of premises or rooms used for the storage of medicines must be reported immediately to the designated manager, for further investigation. The area must be made safe, and medicines must not be left unattended in an unsecured area at any time. A Datix incident report must be completed, and remedial action taken to prevent recurrence.

Examples include:

- Theft, loss or misplacement of medicines or controlled stationery
- The presence of unauthorised persons on the ward or department
- Discovery of evidence of tampering with medicines, controlled stationery (e.g. drug administration chart, prescription forms or medicines labels)
- Receipt of medicines from a non-approved source (includes samples)
- Delivery of medicines to a non-designated person or department.
- Breaches of security concerning controlled drugs must also be reported to the Accountable Officer, Local Security Officer (LSMS), and if appropriate, the police (refer to Medicines Policy Part 2: Controlled Drugs).

22. Security

22.1. Medicines related security

22.1.1. Controlled stationery

All stationery used for ordering or obtaining a supply of medicines e.g. FP10 prescriptions, Controlled Drug stationery order pads etc. must be stored in secure locked cupboards in an area not accessible by the public.

Blank prescription forms must be removed from printers, overnight and secured in locked storage (if produced by this method).

22.1.2. Security of medicines

All medicines storage areas must be kept locked unless in use at the time. Drug trolleys if in use must be locked and securely tethered to the wall when not in use.

The temperature of drug fridges must be monitored daily. Refrigerated drugs MUST be stored in a fridge reserved for drugs only. i.e. no biological samples, or foodstuffs.

On arrival of the medicines at the clinic, hospital or prison site, the authorised healthcare professional must accept responsibility and ensure their safe storage.

It is the responsibility of the clinical manager to ensure that procedures are in place to ensure reconciliation of controlled drugs against the Controlled Drugs register on a regular basis, according to controlled drugs policy and the service SOP. Discrepancies that cannot be accounted for must be reported immediately as per policy.

The clinical manager of the service is responsible for the implementation and maintenance of an effective system which ensures the secure management of the drug storage keys.

The nurse in charge is responsible for restricting access to the medicine storage facilities including cupboards, refrigerators and drug trolleys to authorised personnel only.

Drug cupboard and drug refrigerator keys must be kept on the person of the nurse in charge and be handed over personally (signed for) when shifts change to the nurse taking over responsibility for the ward/clinical area.

The health professional carrying out drug administration has responsibility for the security of the medicines in their custody and must ensure that the storage facilities are not left unattended and no unauthorised personnel have access to the area at any time.

Keys for the medicines cupboards, trolley or refrigerator must not be labelled or their purpose identifiable. The loss of keys must be reported immediately, investigated by the pharmacist or nurse in charge, appropriate action taken, and the incident reported via the Datix incident reporting process.

In community hospital and prison sites, the following medicines must be treated as controlled drugs if kept on the premises (some locations have exemptions, and this is clear within the policy for CDs management):

All schedule 2 and 3 Controlled Drugs including barbiturates, tramadol, midazolam and temazepam preparations, strong potassium chloride solution for injection 15%, morphine liquid, and zopiclone. (Refer to Medicines Policy Part 2: Controlled Drugs policy).

Where it has been determined that medicines are missing, the designated manager, chief pharmacist, accountable officer for controlled drugs (where appropriate), and the LSMS (security) officer must be informed immediately.

A Datix incident report must be completed.

The incident must be fully investigated, documented and remedial actions reported to the chief pharmacist and the LSMS.

Loss of controlled drugs will be reported to the controlled drugs local intelligence network by the Accountable Officer for Controlled Drugs (CDAO) and police action may be involved where necessary.

23. Temporary or Routine Ward Closures

Where a community hospital ward or prison department, or other department that stores medicines is closed for any reason, the clinical manager must ensure the safety and security of the medicines. There must be procedures in place to ensure the keys are handed over to a designated nurse in charge.

If there will be no clinical staff on site, all medicines, including controlled drugs, will need to be moved to another site. A member of the Medicines Management team must be present and on site to witness and the Chief Pharmacist informed.

24. Disposal of unwanted or expired medicines

Except in the community hospital and prison settings, patient's own drugs must not be accepted from a patient for destruction by any member of staff. The patient/carer should be referred to their local community pharmacist, or if the unwanted medicine involves sharps then their GP Practice or Local Authority. Further advice is available from the Medicines Management Team.

All out-of-date medicines, medicines no longer required by the ward/department and medicines which have failed to meet the criteria for use of patient's own drugs should be disposed of according to SCHT waste policy.

Items ordered or sent in error can be returned to the supplying pharmacy for credit if done with the prior agreement with the pharmacy. This is not permissible for stock items which have expired during storage on site.

Stock issues of multidose vials (i.e. for use on multiple patients) should be discarded ideally at the end of the day. Multidose vials (e.g. insulin) dispensed for a specific patient should be marked with the date first used and discarded within the period recommended by the manufacturer of the product.

The contents of an ampoule must not be used for more than one patient.

Individual doses or part doses of controlled drugs that have been prepared by a community practitioner but not administered must be destroyed immediately, preferably in the presence of a witness (this may be a relative or carer in the community setting) and documented in the nursing notes. This also applies to the remains of drugs in a syringe driver. (Refer to Medicines Policy Part 2: Controlled Drugs).

Wasted medication from a drug round must be disposed of immediately in a pharmaceutical waste bin.

Waste must be segregated into the legally required categories according to the nature of the waste, i.e. waste sharps or medicines must be segregated into the appropriate

bin. The label on the front of the bin must be completed. The lid and slide opening, if appropriate, must be closed properly.

All types of sharps bins in clinical areas must be securely fixed and inaccessible to patients/service users or unauthorised members of staff.

The different pharmaceutical waste categories include:

Waste Type	Colour of lid	Purpose
Pharma-sharps waste	Yellow	For sharps contaminated with trace amounts of drug but not cytotoxic/cytostatic
Pharmaceutical waste	Blue generally	Medicines (must not be removed from foil packs or strips). Liquids must remain in the original bottle.(Empty medicine bottles should not be rinsed out)
Waste Type	Colour of lid	Purpose
Hazardous waste	Purple See list of drugs this applies to in Appendix 1	Legal requirement for Environment Agency audit for cytotoxic/cytostatic medicines.
Inhalers	As per pharmaceutical waste	
Controlled drugs	Must be denatured first (Legal Requirement). Denature kit containing drugs to be deposited in pharmaceuticals bin. See reference to guidance below.	Expired CD stock MUST ONLY be disposed of and witnessed by a person specifically authorised by the Accountable Officer. Controlled drugs register must be available.
Other types of waste	Ask advice from Risk Manager	

Empty bins can be ordered from NHS Logistics or as per the contract with the waste company. Bins containing pharmaceutical or hazardous waste must not be left on site for longer than 3 months. Similarly, bins must be closed once they are two thirds full, overfilling a bin can lead to spills. When the site has filled or part-filled bins containing pharmaceutical or hazardous waste ready for collection, arrangements must be made for collection by the contracted waste disposal company.

Hazardous waste (Appendix 1) is subject to a discrete audit trail. A consignment note will be provided by the waste carrier company upon collection of hazardous waste

which, by law, must be kept for a minimum of 3 years at the place the waste was collected from.

Other than personnel with specific written approval of the Accountable Officer, staff MUST NOT dispose of or denature Controlled drugs STOCK (Legal requirement). Failure to comply may result in disciplinary action.

Within SCHT settings, patient own controlled drugs may be destroyed by two healthcare professionals, (must be nurses, pharmacists, pharmacy technicians, dentists or doctors) one of whom acts as a witness (Refer to Medicines Policy Part 2: Controlled Drugs policy). This process must be recorded on the approved paperwork and returned to the Accountable Officer for controlled drugs. Within a patient's home the controlled drugs belong to the patient and it is the patient's responsibility to make arrangements with their community pharmacy for destruction of unwanted controlled drugs.

The service must obtain the denaturing kits, or the absorbent granules to denature the drug so as to render it irretrievable and be sure to have a pharmaceuticals waste bin available.

Syringe drivers that are disconnected before all the drug has run through may be discharged into a sharps bin (yellow top) into which a sachet of, or enough granules of "Safety Gel" or similar product has been deployed.

Individual doses or part-doses of medicines which have been prepared for administration, but not given must be destroyed immediately in the correct type of waste bin. Safety gel or a similar product should be used in the sharps bin to absorb liquids. Healthcare professionals must never dispose of medicines into the mains sewerage system, i.e. sluice, sink or toilet.

25. Medical Gases

Staff handling medical gases must have completed the required training programme to ensure competency with the moving and handling issues.

Incidents related to medical gases will be discussed as part of the Medicines Governance Group and disseminated to the Medical Gases Committee.

25.1. Ward / clinic areas

a. Extra stocks of cylinders must be stored in an area which is clean, dry and not subject to extremes of heat:
b. The area must not be accessible by patients or public or unauthorised staff
c. There must be adequate room for segregation of empty and full cylinders; or where this is not possible, a robust system is in place which safely manages storage of cylinders and,
d. Ensuring cylinders are properly restrained.

Unless there is an SLA for the appropriate servicing of cylinder heads, then integral cylinder heads must be used.

If non-integral cylinder heads are used, extra care should be taken to ensure that leaks do not occur.

Where cylinders are stored in an external area, this must be a purpose built store with adequate access for delivery vehicles, in addition to the requirements above.

Piped oxygen will be subject to quality checking at regular intervals by suitably qualified staff.

25.2. Patients' homes

Where a patient uses oxygen therapy as part of their treatment programme, the day to day management of the oxygen cylinders or concentrator will be the responsibility of the patient or carer. However, it is appropriate for SCHT staff to remind patients that where oxygen is being administered, there should be no smoking because of the health and safety risk.

26. Control of Substances Hazardous to Health (COSHH)

Some substances will require a risk assessment before handling. It is the responsibility of the clinical manager to ensure that robust procedures are in place and that the correct training has been given to personnel who are required to handle substances such as cytotoxic drugs, live vaccines, cleaning materials etc.

Information can be obtained via the Health and Safety / Risk Manager adviser for SCHT.

Consideration must be made for special handling techniques, personal protective equipment, disposal arrangements and spillage kits etc.

27. Pharmaceutical Representatives

Personal gifts from pharmaceutical representatives are prohibited, and it is an offence to solicit or accept a prohibited gift or inducement.

Meetings of professionals with pharmaceutical representatives should only occur when sanctioned by senior managers e.g. the Chief Pharmacist, Service Delivery Manager or Clinical Director.

28. Retention of Records

Pharmaceutical records must be kept for the minimum periods as detailed here:

Recommendations for the Retention of Pharmacy Records - prepared by the East of England Senior Pharmacy Managers – 2012 (sps.nhs.uk)

A summary is tabulated below which reflect the importance of this information for business, audit and legal purposes can be seen over the page. These requirements are subject to change pending the publication of national legislation or guidance.

All pharmaceutical records should be stored in a secure location.

Recommended time periods for the retention of records:

TYPE OF RECORD	RETENTION PERIOD	STORAGE REQUIREMENT	DESTRUCTION REQUIREMENT**
CD ORDER BOOK	7 years (local policy)	Locked, secure cupboard	Confidential waste to be shredded or incinerated
CD REGISTERS	7 years (local policy) which must include 2 years from date of last entry (legal)	Locked, secure cupboard	Confidential waste to be shredded or incinerated
CD DELIVERY NOTES	2 years	In the Pharmacy department	Confidential waste to be shredded or incinerated
AUDITS	2 years	In the Pharmacy department or electronically on email. (Shropcom.medicines@nhs.net)	Confidential waste to be shredded or incinerated
COPY OF SIGNATURE FOR CD WARD ORDER	Duration of employment	Copy of signature of each authorised signatory should be available in the pharmacy department CD folder.	Confidential waste to be shredded or incinerated
DEPARTMENTAL & ORGANISATIONAL POLICIES, STRATEGIES, STANDARD OPERATING PROCEDURES (SOPs)	Life of organisation plus 6 years	Electronically maintained and backed up	N/A
DRUG ALERTS / RECALLS	5 years	Held at base location electronically	N/A
FRIDGE & AMBIENT TEMPERATURE RECORD CHARTS & ACTION PLANS	1 year	In a designated folder available at each relevant location	Confidential waste to be shredded or incinerated

TYPE OF RECORD	RETENTION PERIOD	STORAGE REQUIREMENT	DESTRUCTION REQUIREMENT
HAZARDOUS WASTE CONSIGNMENT NOTES	3 years	At site where the hazardous waste is collected from by the waste contractor.	Confidential waste to be shredded or incinerated
INVOICES	6 complete tax years	Held at our base location electronically	N/A
NAMED PATIENT ORDER FORMS	2 years	In the Pharmacy department	Confidential waste to be shredded or incinerated
PADS OF FP10s USAGE & ISSUE SHEETS	3 years	Within the FP10 folder	Confidential waste to be shredded or incinerated
PATIENT GROUP DIRECTION DOCUMENTATION – e.g., Clinical Record of Patient Administration	Following the expiry of the PGD – retain document for: 8 years for adults aged 18 years and over, For children up to the age of 17, retain until their 26th birthday	• Administration record to be held on RiO	Where paper records are retained, these can be scanned and held electronically where possible, paper documents once scanned may be shredded or incinerated as confidential waste
PATIENT GROUP DIRECTION DOCUMENTATION – e.g., non-Clinical essential documentation	8 years after the expiry of the PGD if the PGD relates to adults 25 years after the expiry if the PGD relates to children	• Master finalised PGD retained electronically by pharmacy • Staff authorisation signatory sheet retained electronically by the using department	Where paper records are retained, these can be scanned and held electronically where possible, paper documents once scanned may be shredded or incinerated as confidential waste

TYPE OF RECORD	RETENTION PERIOD	STORAGE REQUIREMENT	DESTRUCTION REQUIREMENT
PHARMACY DELIVERY NOTES	2 years	In the Pharmacy department	Confidential waste to be shredded or incinerated
PHOTOCOPY OF WRITTEN FP10s	6 months	In the FP10 folder	Confidential waste to be shredded or incinerated once accounted for on designated sheet
RECORD OF DISPOSAL OF MEDICINES	7 years	In the Pharmacy department	Confidential waste to be shredded or incinerated
RESUSCITATION BOX WORKSHEET	1 year after expiry of longest dated item	Resus folder	Confidential waste to be shredded or incinerated
STOCK LISTS	2 Years	Held as an electronic version within the Pharmacy department	Printed paper copy can be destroyed as ordinary paper waste
TRANSCRIPTION SHEETS	1 year	In the Pharmacy department	Confidential waste to be shredded or incinerated

** Any record which is being held electronically, may be deleted at the end of the retention period.

29. Homecare Schemes

Homecare is the term applied to the delivery of prescribed medicines to patients in their own homes by a registered homecare service. The medicines involved are typically bulky e.g. parenteral feeds or expensive e.g. HIV drugs. The Chief Pharmacist of the Trust is responsible for the governance of pharmaceutical provision. Robust contractual arrangements must be in place. Services wishing to utilise provision of drugs via Homecare must involve the Chief Pharmacist at the initial tender stages.

30. Audit

Adherence with this policy will be audited in conjunction with the Clinical Audit team.

The area of practice to be audited will be agreed in the Clinical Audit Programme.

Annual medicine management audits are conducted within special schools and dental services and the results discussed within CYP&F Medicines Assurance Group.

Annual medicines management audits also take place for the hospital ward and MIU settings. The results of which are discussed at the Trusts Medicines Governance Group and the Trust's Quality and Safety Committee.

Medicines safety and storage conditions are reported by all services holding medicines as stated in SOP 10.4 Reporting on Key Performance Indicators (KPI)

Monthly reviews of medicines incidents reported via Datix are undertaken by Medicines Management Team in conjunction with the Trust's Medicines Safety Officer.

Potential and significant risks identified will be the subject of discussion and any development of action plans undertaken by either the Lessons Learned Group, the Medicines Governance Group and any relevant sub-group.

Any trends or significant risks will be reported to the Quality and Safety Operational Group and service leads will be tasked with implementation of remedial action and feedback to frontline staff.

PGD audits are carried out with each reviewed PGD using the national PGD audit template for reference. See Medicines Policy Part 4: PGD.

31. Adherence to Policy

Deliberate deviation from the policies and procedures of SCHT may result in disciplinary action.

32. Outcome Measures and Process for Monitoring Compliance and Effectiveness

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/ check?	How often is the need to monitor each element? How often is the need complete a report? How often is the need to share the report?	Who or what committee will the completed report go to and how will this be monitored? How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?	How will system or practice changes be implemented the lessons learned and how will these be shared.
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Acting on recommendations and Lead(s)**	**Change in practice and lessons to be shared**
Prescription charts in the community hospital are checked for accuracy by the clinical pharmacist and medicines reconciliation undertaken within 72 hours.	clinical pharmacists	eScript record	At least a quarterly basis	eScript report	Medicines Governance Group	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate.
Medicines Administration within Special Schools compliant with Medicine Policy and SOP's	Lead Pharmacist for CYP&F	Audit document	Annual	Audit report presented to CYP&F Medicines Assurance Group	CYP&F Medicines Assurance group	Required changes to practice will be identified and actioned within a specific time frame.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
						A lead member of the team will be identified to take each change forward where appropriate.
KPI's to include FP10 accountability, temperature monitoring and safe medicine storage	Service Leads	KPI template	Monthly	Service summary presented at Medicines Management Team meeting, CYP&F medicines Assurance Group and Medicines Assurance Group	Service Leads	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate
PGD compliance	Clinical Audit team	Audit template	With each PGD	Medicines Governance Group	Clinical Audit Team	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Healthcare professionals competences for medicine administration and supply	Clinical Manager for each Service	Competency assessments	At least annually at each performance review	Service Delivery Group	Service Delivery Groups	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate
Medicines Management Audits for community hospitals and MIU's	Community Hospitals Lead Pharmacist	Audit document	Annual	Medicines Governance Group and Quality & Safety Committee	Medicines Governance Group	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate.

APPENDIX 1: Drugs defined as cytotoxic or cytostatic

List of cytotoxic/cytostatic medicines to be disposed of separately from non-hazardous pharmaceutical waste:

List of cytotoxic/cytostatic medicines – hazardous waste			
• Anastrozole • Azathioprine • Bicalutamide • Chloramphenicol – includes eye drops with a concentration of 0.1% • Ciclosporin • Cidofovir • Coal tar containing products • Colchicine • Danazol Diethylstilbestrol • Dinoprostone • Dithranol containing products	• Dutasteride • Estradiol • Exemestane Finasteride • Flutamide • Ganciclovir • Gonadotrophin, chorionic • Goserelin Interferon containing products (including peginterferon) • Leflunomide • Letrozole	• Leuprorelin acetate • Medroxyprogesterone • Megestrol • Menotropins Mifepristone • Mycophenolate mofetil • Nafarelin • Oestrogen containing products • Oxytocin (including syntocinon and syntometrine) • Podophyllyn	• Progesterone containing products • Raloxifene Ribavarin • Sirolimus • Streptozocin • Tacrolimus • Tamoxifen • Testosterone • Thalidomide • Toremifene • Trifluridine • Triptorelin • Valganciclovir • Zidovudine
List of cytotoxic/cytostatic medicines (cancer chemotherapy) – hazardous waste			
• Aldesleukin • Alemtuzumab • Amsacrine • Arsenic trioxide • Asparaginase • Bleomycin • Bortezomib • Busulphan • Capecitabine • Carboplatin • Carmustine • Cetuximab • Chlorambucil • Cisplatin • Cladribine • Cyclophosphamide • Cytarabine • Dacarbazine • Dactinomycin • Daunorubicin • Dasatinib • Docetaxel	• Doxorubicin • Epirubicin • Estramustine • Etoposide • Fludarabine • Fluorouracil • Gemcitabine • Gemtuzumab • Hydroxycarbamide • Idarubicin • Ifosfamide • Imatinib mesylate • Irinotecan • Lomustine • Melphalan • Mercaptopurine • Methotrexate • Mitomycin • Mitotane • Mitoxantrone	• Mitotane • Mitoxantrone • Pentamidine • Pentostatin • Procarbazine • Raltitrexed • Rituximab • Estramustine • Etoposide • Fludarabine • Fluorouracil • Gemcitabine • Gemtuzumab • Hydroxycarbamide • Idarubicin • Ifosfamide • Imatinib mesylate • Irinotecan • Lomustine • Melphalan • Mercaptopurine • Oxaliplatin	• Paclitaxel • Methotrexate • Pentamidine • Mitomycin • Mitotane • Mitoxantrone • Oxaliplatin • Paclitaxel • Pentostatin • Procarbazine • Raltitrexed • Rituximab • Temozolomide • Thiotepa • Topotecan • Trastuzumab • Vidaradine • Vinblastine • Vincristine

National Pharmacy Association 2017. Disposal of pharmacy stock [online]. Accessed 05.10.2021. Available at: https://www.npa.co.uk/services/essential-sops-standard-operating-procedures/

APPENDIX 2 & 3 – Authority to Administer for Community Services AND Out of Hours Temporary Prescription for Shropdoc and Community Hospitals

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Authorisation - **Community Drug Sheet**
(to be completed by General Practitioner/Nurse Prescriber)

Page

GP		Allergies:	

Prescription One:		
All directions for medication must be written in full eg UNITS for insulin.		
Doctors Signature:	Print:	
Date:	Date for review:	Date Discontinued:

Prescription Two:		
All directions for medication must be written in full eg UNITS for insulin.		
Doctors Signature:	Print:	
Date:	Date for review:	Date Discontinued:

IPF 010 - Authorisation Community Drug Sheet *V1.2* *January 2012*

MED	OUT OF HOURS TEMPORARY PRESCRIPTION FOR COMMUNITY HOSPITALS Shropdoc Page number…..of……..	NHS Shropshire Community Health NHS Trust

This form is for use when patients are admitted without a drug chart authorising nursing staff to administer, as an interim measure until the responsible GP can review medications on the next working day. Please ensure that you check the validity of the request by comparing to the discharge summary from the acute hospital and/or the summary care record from the patient's own GP. Please note any information on the allergies or intolerances.

This form is to be used for prescribing all medication – including 'when required' drugs, anticoagulants and insulin. Use the information boxes under DRUG (Approved name) for "prn" dosing and for other instructions.

This form is NOT VALID for initiation of any controlled drugs (Scheduled 2 & 3)

FIRST NAME		COMMUNITY LOCATION:	ALLERGIES/INTOLERANCE (Please state nature of reaction if known)
LAST NAME			
DATE OF BIRTH		**PLEASE ATTACH TO DRUG CHART**	
NHS NUMBER			EHR/IHR checked : yes/no/not available

Notes to prescriber: circle time or enter variable time Day and Month **(if more than 1 page required patient details must appear on each page)**				**Day and Month**							
Drug (Approved Name)		**Dose**	**Route**								
WHEN REQUIRED (PRN) PRESCRIBING INFORMATION INCLUDING MAX. NUMBER OF DOSES/24HRS.				Morning							
				Lunch							
Other instructions	Antibiotic course length		Antibiotic Indication	Evening							
	Antibiotic guideline Compliance yes/no		Microbial Advice yes/no	bedtime							
Drug (Approved Name)		**Dose**	**Route**								
WHEN REQUIRED (PRN) PRESCRIBING INFORMATION INCLUDING MAX. NUMBER OF DOSES/24HRS.				Morning							
				Lunch							
Other instructions	Antibiotic course length		Antibiotic Indication	Evening							
	Antibiotic guideline Compliance yes/no		Microbial Advice yes/no	bedtime							
Drug (Approved Name)		**Dose**	**Route**								
WHEN REQUIRED (PRN) PRESCRIBING INFORMATION INCLUDING MAX. NUMBER OF DOSES/24HRS.				Morning							
				Lunch							
Other instructions	Antibiotic course length		Antibiotic Indication	Evening							
	Antibiotic guideline Compliance yes/no		Microbial Advice yes/no	bedtime							
Drug (Approved Name)		**Dose**	**Route**								
WHEN REQUIRED (PRN) PRESCRIBING INFORMATION INCLUDING MAX. NUMBER OF DOSES/24HRS.				Morning							
				Lunch							
Other instructions	Antibiotic course length		Antibiotic Indication	Evening							
	Antibiotic guideline Compliance yes/no		Microbial Advice yes/no	bedtime							
Drug (Approved Name)		**Dose**	**Route**								
WHEN REQUIRED (PRN) PRESCRIBING INFORMATION INCLUDING MAX. NUMBER OF DOSES/24HRS.				Morning							
				Lunch							
Other instructions	Antibiotic course length		Antibiotic Indication	Evening							
	Antibiotic guideline Compliance yes/no		Microbial Advice yes/no	bedtime							

Discharge summary checked- yes/no/not available		**Print Name and PRESCRIBER number**	**Date**
SIGNATURE (form not valid without a signature)			