# MEDICINES POLICY

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<th>Medicines Policy</th>
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<tr>
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Introduction

- This policy is applicable to all acute and community locations with the exception of residential homes, care homes, children’s homes and respite care facilities. A separate medicines policy will be written for these facilities.

- High risk medicines are covered in separate polices and staff should refer to these (Intrathecal chemotherapy, oral methotrexate and potassium infusions).

- Throughout the document, the Head of Department is named as the person responsible for certain elements of the system. This includes those with 24 hour responsibility for an area i.e Ward Managers, Primary Care Managers and District Nurse Managers

- Throughout the document, the senior nurse or nurse in charge is named as the responsible person for certain elements of the system This includes those responsible for a ward / department for a specified time period  i.e. senior nurse / nurse in charge, district nursing sisters, midwives, health visitors and treatment room sisters.

- Throughout the document, the terms ‘kardex’ or Medicine prescription and administration form are used to describe the documents used for in-patients and patients in primary care respectively.
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1 Introduction

1.1 Policy statements

1.1.1 The purpose of this policy is to provide guidance for all Trust healthcare staff involved in any aspect of the use of medicines (with the exception of staff in residential homes, care homes and respite care facilities). It defines the mandatory requirements of the Trust.

1.1.2 The Policy complies with and reflects the contents of the following:
- Misuse of Drugs Act 1971
- Medicines Act 1968
- Misuse of Drugs (Safe Custody) Regulations 1973
- DHSSPS Guidelines on the Use and Control of Medicines 2004
- NMC Code of Professional Conduct 2004
- NMC Medicines Management Guidelines 2007
- Controls Assurance Standard (Medicines Management) 2006
- Red/Amber List (Northern Ireland Regional Group on Specialist Medicines) 2007
- Building a safer NHS for patients: improving medication safety, 2004

1.1.3 The policy compliments the following related Trust Policies and documents:
- Management of IV Potassium Solutions
- Policy for the administration of Intrathecal Chemotherapy SET/Pt.Ct.care/Med(01) 2009
- Policy and Procedures for Waste Management
- Operational Policy for Medical Gas Systems
1.1.4 The policy applies to all employees of SET including bank staff and agency staff working in the Trust. The safe and secure handling of medicines is the responsibility of each healthcare professional who must ensure that he/she works within his/her professional guidelines. All staff are accountable for properly discharging their duties and responsibilities in relation to medicines as detailed in this policy.

1.2 Responsibilities of staff
Prescribing, ordering, dispensing, storing, monitoring and administration of medicines is the responsibility of various practitioners working within the organisation. Practitioners must be aware of the tasks for which they are responsible, as detailed in this section.

1.2.1 Medical staff, dentists and other authorised prescribers
1.2.1.1 Medical staff are responsible for the majority of prescribing of medicines for patients. They and any other authorised prescribers, must comply with legislation, Trust policy, local formularies, the Medicines Policy and professional guidance when prescribing.

1.2.1.2 Medical staff have a responsibility for prescribing in accordance with the appropriate marketing authorisation (product licence) of a medicine. Where a product does not have a UK marketing authorisation, prescribing should be in accordance with an adequate body of evidence or expert opinion, and with the support of the D&T Committee as per Trust ‘Unlicensed Medicines policy’.

1.2.1.3 Medical students are not permitted to prescribe.
1.2.1.4 Prescribers must sign all prescriptions for medicines, and it is essential that the identity of the prescriber is known. A prescriber should sign and print their name on prescriptions for this purpose (including bleep number and GMC number if applicable).

1.2.1.5 Non-Medical Prescribers must only prescribe in accordance with the Trust ‘Non-Medical Prescribing Policy’.

1.2.2 Pharmacists

1.2.2.1 Pharmacists are responsible for ensuring the safe, effective and economic use of medicines in the hospital. This process includes regular monitoring of prescribing to ensure appropriateness, accuracy, safety and clarity.

1.2.2.2 Pharmacy staff are responsible for the stock of medicines held in the Pharmacy to ensure that medicines are stored under the proper legal and environmental conditions. They are responsible for manipulation and preparation into user ready presentation and for their supply to wards and departments.

1.2.2.3 Pharmacy staff, where appropriate, have a responsibility to advise practitioners on the safe and secure storage of medicines in clinical areas.

1.2.2.4 Pharmacy is responsible for ensuring that when medicines are prescribed, supplied and administered, there is a clear audit trail i.e. a secure system for recording, monitoring and reconciling medicines whether electronic or paper based.

1.2.2.5 Pharmacy staff provide information to patients, carers, nursing/midwifery, medical and other healthcare professions with the aim of improving concordance, and the safety and effectiveness of therapy.

1.2.2.6 Pharmacy is responsible for the purchase of all pharmaceuticals within the hospital.

1.2.2.7 Clinical pharmacists provide all the general responsibilities of a pharmacist as above but are working at ward level. They assist medical and nursing/midwifery staff ensuring safe, effective and economic use of medicines and contributing to the pharmaceutical care of patients. They can assist in ensuring accuracy of
admission medicine histories as well as monitoring of therapy and discharge information.

1.2.3 **Registered Nurses/Midwives**

1.2.3.1 The nurse/midwife in charge of a ward or department is responsible for setting and monitoring the standard of administration of medicines by staff within the ward and department.

1.2.3.2 The nurse/midwife in charge of a ward or department is responsible for the safe custody of medicines on a ward/department and is responsible for ensuring that staff are deemed competent, have access to up to date medicines information and that Medicines Policy is followed correctly by ward/departmental staff.

1.2.3.3 The nurse/midwife in charge of a ward or department is responsible for the security of the stock of medicines held in the ward or department.

1.2.3.4 The nurse/midwife in charge of a ward or department is responsible for controlling access (by keys or other means) to the medicines cupboard (including Patient's Own Drugs lockers) and medicine trolley(s). The responsibility remains with the appointed nurse/midwife in charge even if he/she decides to delegate the duty to another nurse.

1.2.3.5 The nurse/midwife in charge of a ward or department must ensure that medicine cupboard keys are not given over to other healthcare staff, except to a member of pharmacy staff for medicines stock management. In this instance, the nurse/midwife must confirm identity by checking the Trust photo ID of the member of pharmacy staff. If another member of healthcare staff (non-nursing) requires medicines, it is the responsibility of the nurse/midwife in charge to access the medicines required; they must not hand over the keys to allow other healthcare staff to access medicines.

1.2.3.6 Each registered nurse/midwife is responsible for ensuring the safe and appropriate administration of medicines and is expected to adhere to the standards as defined by the Nursing and Midwifery Council, Use and Control of Medicines (DHSSPS) April 2004 and elsewhere in this Code.
1.2.3.7 Trust staff who may also be in the Trust as healthcare students or bank staff may only undertake duties appropriate for the role in which they are in the Trust at any one time, whether that be their employed role or their student/bank role.

1.2.4 Nursing/Midwifery students on pre-registration programmes
1.2.4.1 Nurses/midwives in training must be given every opportunity to become proficient in medicines related activities under appropriate supervision. The supervising registered nurse/midwife has responsibility for medicines related procedures at such times.

1.2.4.2 Prior to registration, nursing/midwifery students are not permitted to administer medicines without supervision. They may, under the direct supervision of a registered nurse/midwife, administer for the purpose of instruction and learning and sign for the administration. Where a nursing/midwifery student is involved in the administration of a medicine they are unable to provide the second check. The supervising registered nurse/midwife must countersign the medicine chart following administration of the medicine by a nursing/midwifery student. If the particular medicine needs a second check (see section 9.1.5), this must be carried out by a registered nurse.

1.3 Interfacing with the pharmaceutical industry
1.3.1 Company medical representatives
1.3.1.1 Pharmaceutical products may only be promoted on a one-to-one basis to consultants, staff grades, clinical nurse specialists or professional heads of departments. The promotion of products to other staff on a one-to-one basis is not permitted.

1.3.1.2 Visits to the Trust should only be made to keep agreed appointments or to make an appointment. Representatives are not allowed to tour Trust premises looking for staff, and are not to enter clinical areas without a prior appointment.

1.3.1.3 Representatives will only be seen by appointment. When making appointments, they must state what they wish to discuss/promote and whether they will be accompanied by another member of their company.
1.3.1.4 Representatives may sponsor non-promotional educational meetings for all grades of staff if the meeting is organised by a Consultant, staff grade, clinical nurse specialist or professional head of department. Appendix 1 of the Gifts and Hospitality Policy must be completed and returned to the Trust Board Secretary for all sponsored events.

1.3.1.5 Representatives, as a matter of courtesy, must give the pharmacy Medicines Information section copies of relevant information about the products that they are promoting within the Trust.

1.3.1.6 Representatives must wear a visible identification badge at all times when visiting Trust facilities. The badge must state their name and their company’s name.

1.3.1.7 Representatives must not ask Trust staff for information about amounts of product being used, other company’s products, supplier details, or other such data as often this information is commercially confidential due to the procurement contracts in place.

1.3.1.8 Representatives may not use the Trust telephone system to bleep staff or ask switchboard staff to do this for them.

1.3.1.9 The Trust expects that all pharmaceutical company representatives will adhere to the Code of Practice of the Association of the British Pharmaceutical Industry (ABPI) at all times irrespective of whether or not the company they represent is a member of ABPI.

1.4 **Samples of pharmaceutical products**

1.4.1 All pharmaceutical products to be used in the South Eastern HSC Trust must be purchased through the Pharmacy Service.

1.4.2 A sample is defined as a small quantity of a pharmaceutical product provided to a health professional so that he/she may acquire experience in using it. A sample may only be provided to a health professional qualified to prescribe that particular product.
1.4.3 All samples must be licensed and have a UK marketing authorisation.

1.4.4 Samples of pharmaceutical products may only be supplied in response to a written request from a Consultant, clinical nurse specialist or professional head of department. The request should contain the following information:

- The clinical area in which the sample will be used
- The reason for requesting the sample
- Where the sample should be sent to
- The person who will receive and store the sample at ward/department level
- Confirmation that feedback will be given to the pharmacy Services Manager (Downe and LVH) or the Pharmacy Procurement lead (Ulster) once the sample has been used.
- The request must be sent to the Pharmacy services manager (Downe and LVH) or the Pharmacy Procurement lead (Ulster) in writing or by e-mail

1.4.5 To ensure compliance with Product Liability Legislation, Medicines Act Regulations, DHSSPS guidelines and ABPI code, samples must not be left in clinical or administrative areas. All samples must be receipted and issued from the pharmacy department.

1.4.6 The samples must be clearly labelled with details of the Consultant, clinical nurse specialist or professional head of departments who requested them.

1.4.7 To ensure that products can be traced in the event of a product safety recall, the pharmacy department will log the batch number and expiry date of each sample before sending them to the requesting member of staff. After a period of six months, any unused samples will be disposed of.

1.4.8 The request for and use of a sample does not indicate an intention to prescribe the product on a recurring basis. The Trust guidance for the acquisition of a new drug must be followed (see section 3.1.1) and appropriate funding streams secured.

1.4.9 Failure to respect the spirit of this guidance could result in the pharmaceutical company representative being denied access to the Trust facilities.
1.5 Approval of new medicines for use in the Trust

1.5.1 Medicines that are approved for use will be found within Trust Guidelines and the Red/Amber List (to cover more specialised prescribing circumstances). The Red/Amber List document is available on the Trust intranet or via www.ipnsm.hscni.net

1.5.2 All requests from clinicians for the routine use of non-approved drugs will require a Formulary Application Request Form to be completed (available from Pharmacy and the Trust intranet - department, pharmacy, forms). These requests will be subject to review at Directorate level, by the Clinical Guidelines and Protocols/Drug and Therapeutics Committee and the Executive Management Team.

1.5.3 Non-approved medicines for one-off use which are not classified as high cost can be requested by completing the CR1 – Consultant request Form (available from pharmacy and Trust intranet – departments>pharmacy>forms). If frequent requests for the same medicine are being submitted the consultant will be asked to complete the formulary Application Request Form for consideration by the Drug and Therapeutics Committee.

1.5.4 High cost non-approved medicines for ‘one-off’ use will not be purchased or supplied by the Pharmacy unless approved by the Medical Director on a case by case basis. Clinicians should complete a CR2 – Consultant Request Form ((available from pharmacy and Trust intranet – departments>pharmacy>forms) and get it approved by the Medical Director before sending it to the pharmacy department. Consultant staff should not arrange clinic appointments until the request has been approved and sufficient time for the medicines to be purchased has been given. Requests will be regularly reviewed to detect pressures for the introduction of new non-approved drugs. If frequent requests for the same medicine are being submitted the consultant will be asked to complete a Formulary Application Request Form for consideration by the Drug and Therapeutics Committee.

1.5.5 Some medicines will be approved by the Drug and Therapeutics Committee for restricted use i.e. Consultant use only. Pharmacy will advise ward staff when these are ordered and send the CR1 form (available from pharmacy and Trust intranet – departments>pharmacy>forms) to the ward for completion before the supply is made.
2 Definition of a medicine

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

- treating disease
- preventing disease
- diagnosing disease
- ascertaining the existence, degree or extent of a physiological condition
- contraception
- inducing anaesthesia, or
- otherwise preventing or interfering with the normal operation of a physiological function

2.2 Medicines may be categorised as follows.

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

2. Controlled drugs i.e. substances controlled under the provisions of the Misuse of Drugs Act (1971) and Regulations made under the Act.

3. Alternative medicinal products e.g. herbal or homeopathic remedies, which are used for therapeutic purposes.

2.3 Disinfectants, reagents (eg blood glucose testing strips) and other preparations not used directly to treat patients do not have to be prescribed for an individual patient. Their ordering and storage however must comply with the relevant section of the Medicines Policy.
3. Procurement of medicines

3.1 Principles

3.1.1 Medicines may only be purchased or acquired by a pharmacist or member of pharmacy staff acting under the delegated authority of the Head of Pharmacy and Medicines Management. All procurement of medicines must comply with public procurement policy and strategy. This will be achieved by ensuring:

- UK licensed products are always used in preference to unlicensed products.
- All new medicines within the Trust must be approved for use by the Drug and Therapeutics Committee. Consideration must be given to the recurring financial cost of a medicine and when necessary, commissioner approval must be sought after D&T approval. Formulary submission forms are available on the Trust intranet: Department>pharmacy>forms
- All Investigational Medicinal Products must be delivered directly to, and managed by, Pharmacy (See section 15).

3.1.2 Medicines must be supplied to wards and departments by the Pharmacy department. This is essential to ensure an appropriate audit trail exists and to ensure that all medicines are assessed before use in the Trust.

3.1.3 All Trust staff must comply with the Trust Policy on Interfacing with the Pharmaceutical Industry (Section 1.3 and 1.4). This includes the management of samples which must be issued through Pharmacy.

3.1.4 Shortages of medicines can occur for various reasons e.g. manufacturing problems. Shortages will be communicated to the relevant clinical areas. An action plan will be implemented for a major shortage of medicines after consultation with the relevant parties.

3.1.5 Medicines should be prescribed from the selection of pharmaceuticals available as ward stock. Non-stock ward items can be ordered from Trust pharmacies by pharmacy requisition.

3.1.6 Medicines newly prescribed outside the formulary may only be prescribed by senior medical staff.

3.1.7 A patient may be admitted to the hospital on a medicine, on which they have been stabilised for chronic conditions such as Parkinson’s disease, epilepsy etc. If
Pharmacy do not stock this medicine the treatment should not be changed unless the time involved in obtaining supplies compromises the patient’s care. To ensure the patient continues to receive their medicine, the patient’s own medication can be used provided an assessment, by appropriately trained staff, has been made on the quality of medicine before administering. Medicines brought in by the patient should only be used when they can be positively identified, meet defined quality criteria and are appropriately labelled. If the treatment is for a condition for which the patient has been admitted, medication review is reasonable.

3.2 Purchase for safety
3.2.1 The Trust will purchase pharmaceuticals in line with ‘purchasing for safety’ recommendations (see below), to ensure the procurement of pharmaceuticals with inherent safety features.

3.2.2 All HSC Pharmacy staff have a duty of care when supplying a pharmaceutical. The use of all pharmaceuticals involves the potential risk of an adverse event. It is important to identify these potential risks and take action to reduce them.

3.2.3 Adopting a ‘purchasing for safety’ approach will ensure that the procurement process, so far as is possible, assures the availability of a pharmaceutical which is of a suitable quality, and is safe in use i.e. prescribing, dispensing, preparation, administration and disposal.

3.2.4 A strategic and joint approach to purchasing for safety is required where efforts are coordinated between national (NI Regional Pharmaceutical Contracting Executive Group and NHS PASA), regional and local purchasing, the NPSA, and the industry in response to managed clinical risk assessment evidence that is provided from local Trusts and the NHS.

3.3 Purchasing for Safety Recommendations
A number of purchasing for safety recommendations are mentioned in the six documents referenced at the end of this policy. These recommendations are summarised below.

3.3.1 Risk assessment
3.3.1.1 A risk assessment of the pharmaceutical procurement process for the Trust should be undertaken by staff with a full understanding of the purpose and end use of the product being procured.

3.3.3.2 Risks should be identified on an appropriate Trust risk register and minimised. Incident and risk reporting systems should be available and acted upon, and if a pharmaceutical is not available from normal sources (e.g. in a shortage situation) then alternatives need to be assessed in the
light of the increased risk they may present to patients. This should be carried out by a designated person in the Pharmacy.

3.3.3.3 It is essential that the risk assessment of the procurement process includes an assessment of the capabilities of the upstream supply chain to ensure products are genuine, stored correctly and are available when required.

3.3.3.4 Risk assessment should take account of the following factors.
   a. The quality of products – is it in accordance with the accepted specification?
   b. The design and use of products (e.g. ready-to-use and ready-to-administer products)
   c. The labelling and packaging of products
   d. The source of products and materials
   e. The treatment of product within supply chain
   f. Product delivery into the pharmacy
   g. Product storage within the hospital
   h. Product distribution.

3.3.3.5 If a product is assessed locally as having a high risk of causing a patient safety incident, this should be reported to the Trust Procurement Pharmacist who will pass it on to the Medicines Governance Pharmacist Team, regional Quality Control Service and Regional Procurement Pharmacy Team as appropriate. A list of high risk products will be complied by the Regional Procurement Pharmacist. This list can then form the basis of discussion with manufacturers about possible changes in presentation. This discussion will be led by the Regional Procurement Pharmacist.

3.3.3.6 In-house processes should be put in place to minimise identified risk e.g. separating stock of different drugs with similar labelling where an alternative product cannot be sourced. The use of automated dispensing systems will minimise the incidence of this type of picking error.

3.3.2 Quality, design and labelling of product
3.3.2.1 The default position should always be that a ready-to-use or ready-to-administer medicine with a product license (or a devices license) issued by the Medicines and Healthcare Regulatory Authority (MHRA) should be used in preference to an unlicensed product.

3.3.2.2 Licensed ‘concentrate’ products that have to be diluted or reconstituted into an unlicensed product in clinical areas before they can be administered to patients may not be safer in use than unlicensed ready-to-use or ready-to-administer formulations of the same medicine. The National Patient Safety Agency (NPSA) has produced a risk assessment tool for use with injectable products and practices in clinical areas¹. This should be used in accordance to NPSA guidance. The results of the NPSA risk assessment will help to identify high risk injectable products that require their associated risks to be managed in practice.
3.3.2.3 If an unlicensed formulation has to be used then it should be procured as outlined in the Trust’s Unlicensed Medicines Policy which takes into account the increased risks with these types of products.

3.3.3 Products on Regional Pharmaceutical Contracts
3.3.3.1 Before a product is included onto a CSA Regional Pharmaceutical Contract it will be assessed according to an assessment tool developed by the National NHS QA Committee and given a Medication Error Potential Assessment (MEPA score), which reflects its suitability for use. This will look at areas such as the clarity of the labelling, the suitability for use, the availability of a patient information leaflet or technical information. Eventually these assessments will be available on a Regional QC and Risk Assessment database held by the NI Regional Pharmaceutical Procurement Service. Assessed products present a known risk and should be used in preference to those not assessed (and consequently presenting an unknown risk). Regional Contracts should be adhered to, however in circumstances whereby the Trust may need to purchase “off contract” due to product shortages or clinical need, this should only be undertaken with caution, risk assessment and signed-off by the Trust’s Procurement Pharmacist (or representative).

3.3.4 High Risk Products
3.3.4.1 Where there is no alternative but to award a contract for a “high risk” product, the Trust Procurement Pharmacist must be alerted by the Regional Pharmaceutical Procurement Service and the risks managed until an alternative is available. Systems for reporting patient safety incidents and defects in pharmaceuticals and medical devices exist both within the Trust and external to it. Internally, patient safety incidents should be reported using the Trust’s Adverse Incident Form. (See appendix 1 for an explanation of external reporting schemes).

3.3.5 Source of products
3.3.5.1 It is only by using trusted and appropriate supply sources that the suitability of purchased products can be assured and the possibility of counterfeit or damaged medicines being purchased can be minimised. Suppliers and wholesalers are required to hold an appropriate license from the MHRA and the Trust should check this for authenticity.

3.3.5.2 As part of the regional tendering process, companies are required to complete a pre-qualification questionnaire including licensing and quality assurance criteria. In some cases Pharmacy Quality Assurance and procurement staff can inspect the premises of potential pharmaceutical suppliers and these reports can be used to assess new suppliers. Regional Procurement specialists can give advice about potential new suppliers. The entire upstream supply chain should be included in these assessment processes as several links may be involved in obtaining the medicine.
3.3.3.3 It is important to measure supplier performance and award contracts, where possible, to those suppliers who have a better supply record. Reducing the risk associated with supply is obviously a component for patient safety. A more proactive method of reducing this risk is to cooperate with national markets initiatives (e.g. as promoted by the Pharmaceutical Market Support Group (PMSG)).

3.3.5.4 Safe and secure methods of procurement (e.g. e-procurement) should be utilised to minimise the potential for error during the process.

3.3.6 “Ready-to-use” / “Ready-to-administer”

3.3.6.1 Although many medicines are licensed and come from a suitable supplier there may be differences in the presentation. Any risk assessment should involve looking at the complete process involved with the use of the medicine. That is the identification, reconstitution, administration and disposal in the clinical settings in which it is used. This is important for all medicines but particularly those that have been identified as representing a high risk under the NPSA risk assessment guidance. Medicines which represent the minimum risk throughout the whole of this process should be preferred. Where possible, higher risk products should be prepared for use (e.g. reconstituted), either in-house by the Pharmacy Aseptic Suite or by commissioning a (licensed and suitable) manufacturer to prepare the medicine in a suitable format to minimise the risk associated with its use.

3.3.6.2 If gaps in this risk process are identified the products involved should be reported to the procurement specialist who can compare lists of these products and engage industrial solutions where possible.

3.3.7 Delivery and storage arrangements

3.3.7.1 All the above points concentrate on the “external” supply chain. That is the parts of the supply chain outside the Trust. It is equally important though to ensure that the “internal” supply chain is robust and fit for purpose; that is that arrangements are in place to ensure products are available for use and are fit for purpose when they are required for patients. The Duthie report (published by the Royal Pharmaceutical Society of Great Britain and available on their website at [www.rpsgb.org.uk](http://www.rpsgb.org.uk)) covers the requirements of the internal supply chain and storage and distribution arrangements should comply with this document.
4. Ordering, stock control and receipt of pharmaceuticals

This section covers all pharmaceuticals with the exception of medical gases and controlled drugs. Refer to the relevant section for these products.

4.1 Principles

4.1.1 The Head of Department and the Pharmacy Dispensary team must agree a schedule for ordering and delivery of medicines.

4.1.2 The Head of Department must ensure that medicines are only ordered by registered nursing staff or other relevant professionals who are trained and competent in the processes involved in ordering medicines. This should be covered during the induction of nursing staff to wards.

4.1.3 The Head of Department must monitor medicines ordering practice to ensure that it is carried out efficiently i.e. doses are not missed or delayed unnecessarily, medicines are not wasted, and nursing, pharmacy and portering time is used efficiently.

4.1.4 Medicines should be ordered in line with the recommendations and policies of the Drug and Therapeutics and Clinical Guidelines Committee or have the required level of approval for use.

4.1.5 Medicines must be ordered from the Pharmacy by the approved ordering systems and all required information i.e. drug name, strength, form, pack size, quantity etc must be clearly provided.

4.1.6 Patients’ own medicines are only to be used in the appropriate circumstances – see section 8.

4.1.7 All routine replenishment of stock and new requests for medicines (including CDs), dressings, IV fluids, medical gas cylinders must arrive in each pharmacy department 30 minutes before closing time.

4.2 Checks made before ordering

4.2.1 Previous orders should be checked as the item may have already been ordered. Next check the ward stock list. Ward stock items will not be supplied unless the request is
clearly communicated to pharmacy by endorsing the requisition with ‘no stock on ward’.

4.2.2 Pharmacy will query requests for stock medicines, especially if they are medicines liable to diversion/abuse.

4.2.3 When ordering an unlicensed medicine include the patient’s name, hospital number and name of the prescriber.

4.2.4 When ordering a restricted antibiotic medicine include the patient’s name and hospital number. The restricted list is available in the Trust Adult Empirical Antimicrobial (Antibiotics) Treatment Guidelines for Inpatients.

4.2.5 Any paperwork that is required by Pharmacy, must to be completed prior to the supply of the medicine

4.3 Ordering Via Pharmacy Computer system

4.3.1 In the Ulster Hospital, Bangor and Ards Hospital, an instruction manual detailing the procedures for ordering medicines via the Pharmacy computer system is available on every ward/department. Training is provided by Pharmacy staff. This system is not currently available in DH or LVH.

4.3.2 A new pharmacy system will be installed before April 2012 and all wards will move to electronic ordering following training.

4.4 Pharmacy requisition book

4.4.1 The nurse/midwife in charge of a ward/department or senior professional may delegate writing of a Pharmacy order in the requisition book, to another nurse/midwife or appropriate person, but the finished order should be signed by the nurse/midwife in charge or senior professional.

4.4.2 Print legibly and complete all sections to ensure a suitable quantity of the correct medicine is dispensed.

4.4.3 All remaining lines on the requisition page should be cancelled by a single diagonal line. This prevents the addition of items to the requisition after it has been signed by
4.4.4 Only one requisition book will be issued to a ward at any one time. Each book is uniquely numbered for traceability. Pharmacy will only issue a new book when they receive the last order in the old book which should include an order for a replacement book.

4.4.5 The nurse/midwife in charge must report the loss or theft of the requisition book immediately to the Pharmacy department and complete an incident form. Wards will not be issued with a new book unless Pharmacy receives a copy of the incident form. In the event of a missing requisition book, wards/departments will still have access to medicines using a requisition book in Pharmacy.

4.4.6 Pharmacy will communicate shortages or queries on the requisition/delivery note. Nurses checking the returned order against the requisition must read any comments and take the appropriate action e.g. highlight shortage with the prescriber.

4.5 Pharmacy Top-ups

4.5.1 Wards or department managers will agree, where appropriate, a suitable list of stock medicines with the Pharmacy department to cover the majority of medicines required by that ward or facility. The stock list contains a list of names and forms of all medicines required, and the minimum stock level that must be held.

4.5.2 This list is used to order replacement stock on a weekly or twice weekly basis, depending on site. In departments without nurses, e.g. physiotherapy and podiatry, the senior professional in charge of the unit or facility must sign Pharmacy orders.

4.5.3 Pharmacy will produce a picking list of the medicines required for that top-up; a copy of the picking list acts as a delivery note for wards and nurse/midwife in charge/senior professional must check the stock received against the delivery note and sign to confirm all stock was received. The delivery note also details stock items not currently available. Any discrepancies must be reported immediately to pharmacy.
4.5.4 Delivery notes must be stored in a designated location at ward level and must be retained for at least 3 months.

4.5.5 The stock list is reviewed and updated regularly, at least once every year. Only the Head of Department may request additions to the list after discussion with the pharmacist/pharmacy technician.

4.6 **Individual patient supply (IPS) / Patient’s Own Drug scheme**

4.6.1 Medicines may be supplied that are intended for use by an individual patient only. Where a medicine has been dispensed for an individual patient, it must only be administered to that patient. The IPS requisition must include patient name, drug name, strength, form, dosage instructions, hospital number and date of birth.

4.7 **Receipt of medicines**

4.7.1 Medicines will be issued from the hospital pharmacy to wards and departments in a tamper evident package, clearly labelled with the destination and accompanied by a requisition/delivery note of what has been supplied.

4.7.2 Ward staff should only collect from pharmacy in exceptional circumstances and the majority of deliveries will be made by the portering staff. When orders are delivered to ward/clinic areas the person accepting the delivery must sign for receipt of the sealed package. When orders are collected at the pharmacy reception the member of staff collecting must be wearing a trust photographic ID badge and must sign for receipt of the order.

4.7.3 If the order cannot be checked immediately the registered nurse is responsible for ensuring that the package is stored in the conditions necessary to maintain security and quality (e.g. in a locked area, under surveillance or in a fridge if required).

4.7.4 A registered nurse in the ward, theatre or department, or in Primary Care a clerical/admin staff member trained in this process, must check that:

- the received order is sealed and has not been tampered with.
- the items listed on the note of what has been supplied match the items that were ordered.
- the items listed on the note of what has been supplied match the items that have been
received.

4.7.5 In the acute sector, a registered nurse must sign for receipt of the sealed package. In Primary Care this may be done by a clerical/admin staff member trained in this process.

4.7.6 If a discrepancy is found it must be reported to the pharmacy immediately.

4.7.7 The requisition/delivery note must be retained in the ward, theatre or department for 3 months. Copies of the patient's prescription must be filed in the medical notes.

4.7.8 Pharmacy will communicate shortages or queries on the requisition/deliver note. Nurses checking the returned order against the requisition must read any comments and take the appropriate action e.g. highlight shortage with the prescriber.

4.8 **Expiry dates of medicines**

4.8.1 Pharmacy staff will check the expiry dates of ward stock items in the wards/departments receiving a pharmacy top-up service. Other wards/departments that order their own Pharmacy top-up items are responsible for checking the expiry dates of their medicines.

4.8.2 Liquid medicines should be endorsed with the date of opening and discarded according to the manufacturers expiry. Care should be taken for products which have reduced expiry after opening.

4.8.3 It is good practice to check the expiry date of medicines when the medicine is removed from or returned to the medicine cupboard.

4.9 **Pneumatic Tube**

4.9.1 Only the Downe hospital at present has a Pharmacy Station which is available from 0830 – 1630 hours on weekdays. Outside these times carriers should only be sent following prior arrangement with Pharmacy staff.
4.9.2 The Pharmacy will only accept Pharmacy requests in yellow carriers with a green band. All other carriers will be returned unopened.

4.9.3 The Pharmacy link is primarily for the delivery of patient Kardexes and discharge prescriptions from ward areas to the Pharmacy Department and where possible the return of these with the appropriate medication to the ward area.

4.9.4 The prescription/requisition should be checked to ensure the correct ward/department is stated on it before sending to pharmacy.

4.9.5 Only urgent requests for medicines which cannot wait until the next porter collection round should be sent to Pharmacy via the tube system.

4.9.6 Any medicines returned to the ward/department will have a delivery signature sheet sent with it which must be completed and returned to Pharmacy.

4.9.7 Items must be packed securely in the container. If required, the carrier should be packed with bubble wrap or foam inserts. It is essential that the complete contents of each carrier are removed upon receipt and immediately stored in the appropriate ward cupboard. Due care and attention must be taken when opening carriers to avoid the risk of injury.

4.9.8 The pharmacy department has developed a list of medications deemed to be unsuitable for delivery via the tube system. In particular controlled drugs, COSHH substances, liquid medicines, flammable substances, products in glass containers, unlicensed medicines, flammables, pharmaceutical items requiring refrigeration and cytotoxic drugs must not be delivered via the tube system.

4.9.9 If medicines have been dispatched from any Pharmacy station but have not arrived at the requested destination the System manager should be informed immediately. An incident report from should also be completed. This incident report form should clearly state the station number that it was sent from, the time it was sent, what sort of medicines the carrier contained and where it was sent. Any incidents of missing medicines should be treated as a serious and high risk and should therefore be investigated immediately.
4.10 Pharmacy Department Hours of service

4.10.1 Normal service (Monday to Friday 8.30am to 5pm) from SET pharmacy departments (Ulster, Downe and Lagan Valley). Routine supply of all medicines, dressings, discharge prescriptions and controlled drugs.

4.10.2 Saturday morning reduced service for discharge prescriptions and urgent supplies - 8.30am to 12pm from Ulster and Lagan Valley pharmacies. The Saturday service to the Downe is provided by Lagan Valley Pharmacy.

4.10.3 Medidoses must be sent to pharmacy before 1.30pm if required that day.

4.11 Arrangements for the supply of medicines when the Pharmacy Department is closed

4.11.1 Patient’s own medicines may be used in exceptional circumstances where the medicine is unavailable and continuation of treatment is necessary (see section 8 for detailed information).

4.11.2 It may be possible in exceptional circumstances, to source a medicine required from stock being held on another ward. Controlled drugs may not be transferred between wards. Information for each site is available on the SET intranet: Department >Pharmacy>Out of Hours

4.12 Medicine for Staff Personal Use

4.12.1 Medicines supplied by the Pharmacy department are for treating patients. Under no circumstances are any medicines supplied by the hospital to be used for the personal use of staff as this is theft of Trust property.
5 Transport of medicines

5.1 Principles

5.1.1 Medicines must be transported in such a way that the quality and security of medicines is maintained during transportation and with due attention to health and safety considerations.

5.1.2 A record must be kept at each step where a medicine changes hands, and when it is administered or destroyed. This includes its delivery from the pharmacy to destinations within the hospital, or to another hospital or community facility. Therefore the person responsible for the medicine at each point of the transportation chain can be identified through the audit trail.

5.1.3 Containers and packages awaiting collection or in transit must be kept in the appropriate storage conditions to maintain the quality of their contents and should be kept securely or under surveillance whilst awaiting collection or in transit between pharmacy and the final destination.

5.1.4 All medicines must be transported in sealed tamper evident containers or packages and all containers and packages must be clearly labelled with the final destination.

5.1.5 Pharmacy staff will advise of any health and safety risks and special storage conditions associated with the transport of a medicine at the time of collection. Specific arrangements are in place for the transportation of cytotoxic medicines and medical gases (see section 16).

5.1.6 Managers of staff groups responsible for transporting medicines are responsible for ensuring staff are trained to ensure an understanding of the need for security and Trust procedures, including action to be taken in the event of physical threat.

5.2 Maintaining the cold chain

5.2.1 Sensitivity to changes in temperature varies depending on the medicine. The manufacturers literature must be consulted and other expert advice must be sought if medicines that require to be stored at temperatures outside normal ambient temperatures i.e. in a fridge or freezer, need to be transported.
5.2.2 If medicines that are sensitive to temperature changes are to be transported on a regular basis, the transport system must be validated and monitored for the duration of the transport time.

5.2.3 If medicines that are sensitive to temperature changes are to be transported on an occasional basis, the following good practice should be followed:
- The medicine must be held outside the recommended storage temperature for the minimum time possible. Maximum exposure time allowed depends on the sensitivity of the product.
- Validated cool boxes or containers must be used.
- If ice packs are used, they must be evenly distributed. Direct contact with the medicines must be avoided by using layers of card between the medicines and the ice packs. Using partially frozen ice packs further reduces the risk of the medicine freezing.

5.3 **Vaccines**

5.3.1 Vaccines are very sensitive to temperature changes. Appropriate arrangements must be in place to ensure that vaccines are not adversely affected by the conditions under which they are transported. The manufacturers recommended storage conditions must be observed during transport of vaccines.

5.3.2 Staff in areas storing and administering vaccines must be familiar with the Trust Cold Chain Policy for Vaccines which is available on the Trust Intranet.

5.4 **Cytotoxic medicines**

5.4.1 Cytotoxic chemotherapy prepared in the Pharmacy Department must be packaged to avoid escape, leak or spillage during handling and transport. Each item must be individually labelled with the patient name.

5.4.2 Packaging must be suitable for the product and robust enough to withstand normal conditions of transport and handling.

5.4.3 Specific Pharmacy procedures exist for the preparation and transport of intrathecal chemotherapy (see Trust Policy for the Administration of Intrathecal Chemotherapy
setptctcaremed02009). Packaging must be:

- robust
- tamper proof
- provide protection for the handler
- able to contain any leakage
- labelled to identify the nature of the contents
- labelled to state the name and address of the sender and recipient

5.4.4 Procedures must be available for dealing with spillage during transportation. Persons transporting cytotoxic chemotherapy must be trained in the actions to be taken in the event of a spillage.

5.4.5 Any spillage incident must be reported using the Trust incident report form.

5.4.6 Cytotoxic chemotherapy is classified as prohibited or restricted material by the Postal Service and must not be sent by routine post. Special arrangements are required and the carrier must be made aware of the hazardous contents. Storage, handling and packaging requirements must be agreed. Specific Pharmacy procedures have been developed for the transport and delivery of cytotoxic medicines.

5.5 Medical gas cylinders

See section 16

5.6 Controlled Drugs

5.6.1 When controlled drugs are delivered to a ward/clinical area they should never be left unattended and must be locked in the controlled drug cupboard immediately.

5.6.2 As soon as possible after delivery the senior registered nurse, midwife or registered operating department practitioner (ODP) in charge should check the controlled drugs against the original requisition to ensure that the correct drug and quantity have been supplied (tamper proof packs should not be opened but counted as a full pack whilst the seal is intact). This check should be carried out in the presence of another member of staff to witness the checking process and protect against any future allegations of drugs missing. Pharmacy must be contacted immediately if, on opening the box, ampoules are found to be broken or any other discrepancy occurs. Refer to ward CD
5.7 **Taxis and couriers**

5.7.1 Only hospital transport staff and contract taxis/ couriers can be used to transport medicines. Taxis and couriers must always be ordered as per Trust procedures and they must not carry non-Trust passengers while transporting medicines. The driver or courier must sign for collection of medicines to be transported. Staff receiving deliveries by taxi/courier must sign and return the delivery note to pharmacy as soon as possible.

5.8 **Posting medicines**

5.8.1 Medicines must only be posted when the patient or the patient’s representative cannot collect them and there is no suitable alternative means of delivery e.g. Trust vehicle, taxi, or courier.

5.8.2 Patient’s medicines may provide confidential information about their condition and treatment, and this must be considered before posting medicines. Cytotoxic chemotherapy must **not** be posted.

5.8.3 Where medicines are posted, a record must be kept of the date, name and address of the recipient, contents of the package, and person responsible for posting. Medicines must always be posted using Special Delivery and the delivery tracked.

5.9 **Return of medicines to the Pharmacy**

See section 11

5.9 **Transfer of medicines**

5.9.1 In areas where medicines are taken from the ward/clinical area for use in the community (eg cardiac ambulance, A+E patient transfer kits, medicines required during transport of patients to other hospitals, midwifery services) the nurse/nurse in charge is responsible for ensuring that written records of issue and return are maintained. Original packs must be taken when transferring a patient or for use in the community (i.e. midwifery services) rather than taking loose ampoules / tablets etc.
5.9.2 When a patient is transferred to another clinical area within the same hospital site, or at a different hospital site, the nurse responsible for the patient’s care must make arrangements to ensure that required doses of medicines are not missed or delayed. The patient’s own medicines and other prescribed medicines not immediately available in the receiving clinical area must be transferred with the patient. A record should be made in the patient’s notes that this has been done.

5.9.3 Where patients own medicines need to accompany them, they must be placed in a green Patient’s Own Drug sealable bag (see section 8). This must be documented in the patient’s notes and the responsibility for the safety and security of these medicines is transferred to the ward receiving the patient. For patients own Controlled Drugs see the ward CD SOP.

5.9.4 Only in exceptional circumstances should medicines from ward stock be transferred from one ward to another. This should only take place when Pharmacy is closed and the medicine is urgently required. In such cases the smallest original pack should be supplied. The transfer of any medicine from one container to another, other than by Pharmacy Staff, is forbidden. See section 4.11 for information.
6 Storage and Security

6.1 Principles

6.1.1 All staff must be aware of their legal responsibility and professional accountability in relation to the storage and administration of medicines, which includes the requirement that no medicines should be left unattended and must be secured in locked cupboards/medicines trolleys.

6.1.2 The appointed nurse/midwife in charge of a ward or department is responsible at all times for maintaining the standards and the safe keeping of all medicines on the ward or department.

6.1.3 Pharmacy must approve the design and location of all new medicines storage cupboards and medicines trolleys before the order is placed. The maximum temperature in the room in which medicines are stored must not exceed 25°C at any time.

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

6.2 Standards for storage areas

6.2.1 There should be separate lockable cupboards as follows:

- Controlled Drug cupboard
- Epidural Controlled Drug cupboard
- Internal medicines cupboard(s)
- External medicines cupboards(s)
- Pharmaceutical refrigerator/freezer
- Diagnostic reagents
- Flammable fluids and gases

The following should be stored in locked, secure designated areas:

- bulk intravenous and sterile topical fluids - with separate area for bulk intravenous fluids containing potassium and other high risk infusions
- Medical gas cylinders
It is good practice that

- parenteral medicines are stored in a separate area to other internal medicines
- other internal medicines are separated into solid oral dose preparations and liquid formulations and stored in separate areas
- intravenous infusions containing medicines are stored separately from other intravenous fluids
- local anaesthetic injections and infusions are stored separately from other injections and infusions as recommended by DHSSPSNI following NPSA Patient safety Alert 21 “Safer practice with epidural injections and infusions”.

Medicines cupboards

- Medicines cupboards to be used for internal and external medicines must comply with the current British Standard (BS 2881)
- Controlled Drug cupboards must comply with the Misuse of Drugs (Safe Custody) Regulations 1973
- Medicines cupboards, including Controlled Drug cupboards, must be marked with the number and date of the British Standard (i.e. BS2881:1989) and the security level category.
- Medicines cupboards, including Controlled Drug cupboards, must not be marked to indicate their contents unless they are enclosed in a lockable room with no public access.
- Each cupboard and medicines management room must have either a unique lock and key or alternative locking system approved by Pharmacy.
- Medicines cupboards must be locked when not in use. Local exceptions may be agreed with the Head of Pharmacy e.g.
  - cupboards may be kept open in anaesthetics rooms while theatre is in use and staff are present
  - in lockable medicines management rooms with swipe or keypad access, which is available only to nursing and pharmacy staff, cupboards may be kept open while designated pharmacy or nursing staff are present.

Medicine trolleys

- must be locked and immobilised when not in use

Individual patient medication lockers
• must be locked when not in use
• must be cleared after each patient is discharged

Emergency boxes (for Clinical emergencies)
• Must be tamper evident
• Must not be held in a locked cupboard, but at strategic and accessible sites
• Must be checked daily by ward staff (stock levels and expiry dates)
• Must be returned to pharmacy when opened or expired and a replacement obtained.

Emergency trolleys
• medicines on emergency trolleys must be tamper evident
• must not be held in a locked cupboard, but at strategic and accessible sites
• must be checked daily by ward staff (stock levels and expiry dates)
• must be sealed, using the facility available on the trolley, but not locked.

Emergency kits (e.g. for emergency teams working outside the hospital)
• must be tamper evident
• if it is impractical for them to be locked up, must be stored in an area with constant staff presence
• they, or their contents, must not be obvious to the general public
• must be checked daily by ward staff (stock levels and expiry dates)

Patients’ own medicines
• Should be stored in the lockable patient bedside lockers or in a lockable cupboard on the ward.
6.3 Medicines Fridges/freezers

6.3.1 Only pharmaceutical grade fridges are suitable for the storage of medicines and vaccines. Fridges used for the storage of medicines must have:
- fan assisted air circulation
- no more than 50% of internal volume filled
- a calibrated MAX/MIN thermometer in place or alternative validated monitoring system approved by Pharmacy

6.3.2 Only medicines can be stored in the medicines fridge, with the exception of sugar drinks for use in hypoglycaemic patients.

6.3.3 Fridges must be locked when not in use and the temperature must be set between 2°C and 8°C. The maximum and minimum temperature must be recorded twice daily - charts available on Trust Intranet – Department>pharmacy>forms. Wards/departments with the web-based monitoring system (Kelsius®) need to sign off on a weekly basis using the Kelsius® website (www.kelsius.com) to show temperature has been maintained.

6.3.4 If temperatures are recorded outside the range 2°C – 8°C
- Establish the cause and rectify it if possible e.g. door left open, fridge unplugged in error, thermostat settings changed in error.
- Contact Estates helpdesk if no obvious cause can be found.
- Contact Medicines Information, Ulster Hospital (Ext 2484) to check if the fridge contents can be salvaged
- Record on an incident report form (IR1)

6.4 Control of access to medicines

6.4.1 The Head of Department is responsible for the safekeeping of, and for controlling access to, all medicines stored in his or her area of control. In order to fulfil this responsibility, the senior nurse/nurse in charge must normally hold the keys for the cupboards and the master keys for patient medication lockers.

6.4.2 In circumstances where holding the keys personally would cause delays or difficulties in making medicines available, the senior nurse/nurse in charge may delegate key holding and control of access to another registered nurse. Keys may be given to a
pharmacist or pharmacy technician when needed and must be returned to a registered nurse. No other member of staff should have access to keys.

6.4.3 The Head of Department retains responsibility for the safe custody of medicines, even if he or she decides to delegate control of access. The Head of Department must make necessary arrangements to be sure that only authorised persons are given access in appropriate circumstances, and that necessary records are maintained.

6.4.4 The Head of Department is responsible for ensuring that a duplicate set of keys for all medicine storage cupboards, trolleys, pharmacy boxes etc. are stored in an agreed designated secure area according to local arrangements – normally the directorate office. The set of duplicate keys must not be stored in the medicine cupboards, and the key for the designated area where it is stored must be kept separate from the keys for the medicine cupboards. The spare controlled drugs key must be held in pharmacy.

6.4.5 If the set of duplicate keys is stored in the clinical area, the senior nurse/nurse in charge is responsible for the safe keeping and control of access as for the medicines themselves.

6.4.6 If the key has to be replaced because it is faulty, or because a missing key cannot be located, a copy of the new key must be supplied to the designated secure area, and the replaced key withdrawn. If a new lock is required, then the new keys for the lock must be supplied and incorporated into the existing arrangements for the storage of duplicate keys.

6.4.7 If a key goes missing, the procedure is as follows:
- The senior nurse/nurse in charge will make enquiry of all staff on duty. The cupboards in question must not be left unattended.
- If the key is still missing then staff members who have left the premises must be contacted at home. If one of them has the key, he or she must return it immediately.
- If the location of the key is unknown, a thorough search of the environment must be carried out.
- If after 2 hours, the key remains missing, Security staff, the Directorate Manager or
Senior Manager on-call (if outside normal hours) on the site must be contacted. Estates department must be contacted with a view to renewing the lock.

- An incident form must be completed recording all relevant details and submitted to the relevant manager and the Risk Management Department.

6.4.8 In addition, if the missing keys are for the controlled drugs cupboard, pharmacy must be contacted (out of hours contact the emergency duty pharmacist). Nursing and pharmacy personnel must carry out a full inventory check in the clinical area, as soon as possible.

6.4.9 The Head of Department is responsible for ensuring key cards for patient medication lockers for individuals are held securely on the ward. Loss of a card must be immediately reported to Pharmacy and the missing card disabled. For detailed information refer to SET policy for the Management of Key Devices for Patient Medication Lockers.

6.4.10 The Head of Department and the Head of Pharmacy and Medicines Management are responsible for ensuring that medicine stocks in wards, theatres, clinics and departments that are to be left unmanned either routinely e.g. overnight, at weekends, or due to closure for a limited period of time, are secure. When agreeing the procedure to be followed or the course of action to be taken, a risk assessment must be undertaken and recorded, taking consideration of the following factors:

- the likelihood of immediate detection of an intruder
- the deterrents in place
- the particular medicines being stored

6.4.11 For wards with swipecard or keycard access to the medicine rooms/cupboards, the senior nurse/nurse in charge is responsible for ensuring the access to swipecards/keycodes is strictly controlled and for ensuring keypad codes are changed at 6 monthly intervals.

### 6.5 Good practice in the storage of medicines

6.5.1 The Head of Department is responsible for ensuring that good practice in the storage of medicines is followed to minimise the risk of error of selecting the wrong preparation.
6.5.2 Medicines must be stored alphabetically by approved name as far as practically possible, and in separate lockable cupboards as defined in the ‘Standards for storage areas’ (see Section 6.2).

6.5.3 Medicines must be segregated and arranged to allow them to be easily selected when required, to minimise the risk of selecting the wrong preparation, and to facilitate efficient stock control and ordering.

6.5.4 Medicines must be stored in their original packaging as received from pharmacy. Medicines which have been “packed down” or over-labelled in pharmacy are deemed to be in their original packaging. Ampoules, vials, or blister packed tablets must not be removed from the original packaging during storage or when being transferred to another hospital or clinical area with the patient.

6.5.5 Medicines must only be removed from their storage location immediately before administration as far as possible. Loose ampoules, vials and infusion bags must not be kept in the clinical area.

6.5.6 Some medicines are highly likely to cause serious harm or death to patients if they are administered inadvertently or incorrectly, for example cytotoxic medicines. Such hazardous medicines must not be stored in clinical areas where staff are not trained and experienced in their safe use.

6.5.7 Infusions for epidural administration must be stored in a separate Epidural Controlled Drug cupboard as required by NPSA Patient Safety Alert 21 “Safer practice with epidural injections and infusions”.

6.5.8 Hazardous medicines must be stored in a designated area separate from other medicines.

6.5.9 Intravenous Potassium solutions are managed as per Trust Policy Relating to the Management of IV Potassium Solutions. High strength potassium injections are stored in the Controlled Drug cupboard.
6.5.10 The Head of Department is responsible for ensuring that medicines are stored at the correct temperature to ensure that their quality is maintained and that labels remain legible.

6.5.11 The Head of Department is responsible for ensuring that there is a ward based system of checks in place for trays, trolleys and kits, which are assembled and stored ready for use, to ensure that any medicine included is correct and within its expiry date. Ward stock must be rotated according to the expiry date so that oldest stock is used first. Expired medicines must be removed for disposal (section 11).

6.5.12 Some medicines, including multidose vials and medicines requiring reconstitution, must be discarded after a limited time after opening or first use. There must be a ward based system in place to ensure that this requirement is met. Date opened labels are available from pharmacy.

6.6 Stationery used to order medicines
6.6.1 The Head of Department is responsible for the safekeeping of all controlled stationery.

6.6.2 All stationery used to order medicines is controlled stationery. This includes stationery used to order ward stock/non stock medicines, controlled drugs and prescription pads for medicines to be given to patients for discharge or at a clinic. All stationery used for ordering medicines is stored securely to prevent fraudulent use. Only authorised persons have access to stationery used for ordering medicines.

6.6.3 GPs and non medical prescribers in primary care should ensure their prescription pad is kept with them at all times during house visits and not left in a car where it may be seen by passers-by. The pads should be returned to the controlled stationery cupboard on return to the practice/out of hours office.

6.6.4 Completed order forms and delivery documentation is retained by Pharmacy for two years. A copy of the prescription forms must be filed in the patient’s medical record (original copy held by Pharmacy).
7. Prescribing and authorisation to administer or supply

7.1 Principles

7.1.1 Medicines for administration to a patient must be prescribed in writing by an authorised prescriber except:
- In an emergency
- Where administration is undertaken in accordance with an authorised patient group direction (PGD)
- Under exemption as a registered midwife

7.1.2 An authorised prescriber is
- A UK registered doctor or dentist
- A non-medical prescriber (independent or supplementary prescriber) approved by the Drugs and Therapeutics Committee and registered as a non-medical prescriber on the trust register for non-medical prescribers
- In the case of intrathecal cytotoxic chemotherapy a prescriber whose name is on the register of authorised personnel to do so.

7.1.3 Medical students are not permitted to prescribe.

7.1.4 Prescriptions must be written on Trust prescribing documents approved by the Drug and Therapeutics Committee.

7.1.5 Medicines should only be prescribed and supplied to patients registered with the Trust.

7.1.6 Medicines should not be prescribed for, or supplied to, staff or visitors unless they are registered as a patient e.g. through Accident and Emergency Department.

7.1.7 Medicines must be prescribed in line with agreed formularies and guidelines and those from Professional Regulatory Bodies. If any element of doubt exists the prescriber should seek advice from pharmacy.

7.1.8 A record of all medicines prescribed and administered or supplied must be maintained in the patients medical record.
7.2  **In-patient Prescriptions**

7.2.1  Prescriptions should be written clearly in black ink using block capitals and signed in full by the prescriber – initials are not acceptable. The patient’s weight must be clearly documented on the kardex to allow doses based on dose/kg or those requiring dose adjustments for renal impairment to be calculated and confirmed.

7.2.2  An accurate drug history should be documented on admission using a medication on admission (MOA) form. Prescribers should indicate on the kardex whether the patient was taking the drug on admission or if it is new. Any alterations to drug therapy such as dose changes should also be indicated on the kardex. A record should be kept of any drugs stopped during the admission including the reason. Full details of any medication changes in hospital must be communicated to the GP on the discharge prescription.

7.2.3  The following patient details should be present on the front of the inpatient prescription chart (kardex) and on other pages where required. An addressograph label should be used if available.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Ward or department</th>
<th>Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Unique identifier</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Weight</td>
<td>Height</td>
<td>Allergy status</td>
</tr>
</tbody>
</table>

7.2.4  Before prescribing any medicine the allergy status of the patient should be checked and documented on the kardex. For combination products ensure the patient is not allergic to either constituent.

7.2.5  The approved (generic) name of the medicine must be used, except as indicated in DHSS Policy for generic prescribing (available on the Trust Intranet – Departments>pharmacy). The drug name should be written in full, abbreviations are not acceptable. The time of administration should be stated using the 24 hour clock.

7.2.6  The dose of a medicine must be specified and written in metric units. Only the following abbreviations may be used.

\[ g = \text{gram} \quad \text{mg} = \text{milligram} \quad \text{ml} = \text{millilitre} \]
All other dose units must be written in full. Do not use abbreviations for ‘micrograms’, ‘nanograms’ or ‘units’

7.2.7 The form of the medicine must be specified e.g. ointment, inhaler, mixture

7.2.8 The use of decimal points should be avoided. For example, 0.1mg must be written as 100 micrograms. If the use of the decimal points is unavoidable, a zero must be written in front of the decimal point i.e. 0.5ml, not .5ml. Avoid trailing zeros e.g. write 4mg not 4.0mg.

7.2.9 The dosage unit should be clear and unambiguous. When prescribing insulin, the term ‘units’ **MUST** be used. Abbreviations, such as ‘U’ or ‘IU’, should never used

7.2.10 For ‘as required’ medicines, the indication, the minimum time interval between doses and the maximum daily dose or the maximum number of doses per day, must be specified.

7.2.11 The route of administration must be written in full except for the following approved abbreviations.

| IV   | Intravenous       | PR  | Per rectum                        |
| IM   | Intramuscular     | PV  | Per vagina                        |
| ID   | Intradermal       | PEG | percutaneous endoscopic gastrostomy |
| SC   | Subcutaneous      | NJ  | nasojejunal                       |
| SL   | Sublingual        | TOP | Topical                            |
| NG   | Nasogastric       | ETT | endotracheal                       |
| PO   | Oral              |     |                                    |

**N.B. Intrathecal must be written in full.**

7.2.12 Any supplementary charts in use must be referenced on the main kardex as shown:
7.2.13 For less than daily dosing, a horizontal line should be used to mark out the dates the drug is not to be given. The special directions box may be used to give further clarity to dosing instructions e.g. once a week only (Wed).

7.2.14 Prescriptions must not be altered or amended. If a change is required the medicine must be cancelled completely and a new prescription written, dated and signed.

7.2.15 When cancelling a medication prescribers should ensure that the stop date is clearly recorded on the kardex, the 'stop signature' box has been signed and that the remaining administration sections relating to that entry are crossed out. Care should be taken to ensure the previous administration records for that entry can still been seen (see below).
7.2.16 Where a regular medicine is to be temporarily withheld, a DR code (prescribed omission) should be entered in the administration section for each dose that is not given (as instructed by the prescriber). The medicine should be reviewed daily and the medication resumed or discontinued as appropriate.

7.2.17 The prescriber must verbally inform the nursing staff that a ‘stat’ dose has been prescribed to ensure administration in a timely manner, otherwise the prescription may go unnoticed for several hours before it is identified at the next regular medicines administration round.

7.2.18 Intravenous fluids should be prescribed in the appropriate section of the fluid balance chart. Where an intravenous infusion also contains a medicine it must also be referenced on the main kardex.

7.2.19 As the injectable route is more hazardous than other routes of administration, medicines should be prescribed by this particular route only if no other method of administration is suitable. The prescription should be reviewed daily and changed to a less hazardous route at the earliest opportunity.

7.2.20 Prescribe injections by bolus wherever possible and only by infusion in the following circumstances:

- constant plasma concentrations are needed, or
- medicine half-life is too short to make bolus injections feasible immediate control of plasma concentrations is needed, or
- a minimum administration time is required, or
- a more concentrated solution would be harmful, or
- the volume required for bolus, due to the dose required, is excessive, or
• administration by infusion recommended in product literature or approved administration guides eg Medusa Injectable medication Guide available via the Trust intranet and via the Pharmacy Department intranet site

7.2.21 When transdermal patches are prescribed attention should be paid to the following points:
• Prescribers should ascertain if a patch is already in situ and when it is next due for replacement.
• Care should be taken to prescribe patches accurately ensuring the kardex clearly states when patches are due to be changed and taking care to prescribe the correct strength / type of patch.
• When initiating or changing therapy the prescriber must ensure they are aware of the bioequivalent dose for that patch. Transtec and Durogesic patches should not be used to control acute pain in opioid naive patients.
• Other forms of opioid therapy should not routinely be given with opioid patches except in ICU or under the direction of an anesthetist or pain specialist. The rationale for this combination should be recorded in the medical notes and reviewed regularly.

7.2.22 The in-patient kardex should be rewritten when there is no more room to record the administration of medicines or when the information contained has become unclear due to multiple deletions and revisions.
• Each medicine should be transferred to the new kardex ensuring the original start date is carried forward
• Each page of the ‘old’ kardex should be cancelled with a diagonal line to indicate that kardex is no longer in use.
• On the front page of the kardex add the words ‘REWRITTEN ON’ the date kardex is rewritten.

7.2.23 Where possible only one inpatient kardex should exist at any one time for any patient. Where more than one kardex is necessary, for example due to a large number of medicines prescribed, the charts should be labelled e.g. 1 of 2 , 2 of 2.

7.2.24 A new in-patient kardex must be used when a patient is re-admitted, or transferred from another hospital outside the Trust. When a patient is transferred from another hospital within the Trust, or returns from pass/weekend leave, or re-attends
hospital for planned procedures at short intervals, the original in-patient kardex may be used.

7.3 Discharge Prescriptions
7.3.1 The discharge prescription must include the patients address and the GP name and address. The patient’s weight must be clearly documented on the kardex to allow doses based on dose/kg or those requiring dose adjustments for renal impairment to be calculated and confirmed.

7.3.2 Discharge prescriptions should be a complete and accurate record of the patient’s medication on discharge. ‘As before’ and ‘no change’ should not be used.

7.3.3 Particular care should be taken to avoid transcription errors and prescribers should ensure that the patients details are correct on all copies of the discharge prescription. Prescribers should prescribe according to the principles outlined in section 7.2 (above) and pay particular attention to the following:

- Ensure that in addition to the non-injectable section, all parts of the kardex are reviewed including the injectable section where drugs required on discharge such as insulin may be prescribed.
- As required medicines should be reviewed to determine if continued prescription post discharge is appropriate.

7.3.4 The frequency of drug administration should be must be stated using the following abbreviations:
Mane = every morning               Nocte = every night
Bd = twice daily                   Tid / tds = three times daily
Qid / Qds = four times a day.

7.3.4 The doctor responsible for the patient’s care must ensure that the Discharge Prescription is completed in adequate time, taking account of the patient’s planned time and date of discharge. Where possible this should be 24 hours before discharge. This is to allow adequate time for dispensing, delivery to the ward and counselling of the patient with regard to medicines.

7.3.5 In order that medication errors are minimised, the discharge prescription should advise
GPs of changes to patients drug therapy in hospital. This includes those drugs stopped or newly initiated and dose changes to existing therapy.

7.3.6 A 28 days supply of medicines will be provided by Pharmacy, unless a shorter course of treatment is appropriate or requested. The duration of shorter courses of therapy e.g. for antibiotic or steroid courses must be specified.

7.3.7 If the patient already has his or her own supply of required medicines at home or stored in the ward, an additional supply may not be required to be issued from the hospital. The patient’s own supply should be checked to ensure is of an adequate quantity, quality and is correctly labelled with the current dosage instructions. The Discharge Prescription must be endorsed ‘patient’s own supply’ or ‘POS’.

7.3.8 Where the discharge prescription has **not** been clinically verified by a clinical pharmacist the kardex should accompany the prescription to pharmacy to ensure correct transcription.

7.3.9 Where more than one prescription sheet is necessary, the prescriptions should be labelled 1 of 2, 2 of 2 etc.

7.3.10 If a supply of **controlled drugs** is required on discharge from hospital, there are specific requirements relating to writing a controlled drug prescription:

Schedule 2 drugs for patients on discharge are ordered using the Trust’s discharge prescription. It is a legal requirement for the prescription to state the following:

- Patient’s name and address
- Date
- The form e.g. capsules, tablets, suspension, patches.
- The strength
- The dose
- The total number of dosage units required, **written in words and figures (with the exception of temazepam)**. Check the available strengths of the preparation; two strengths may be required to get the right dose. If this is the case, use words and figures for the total quantity required for each strength.

When discharge prescriptions for any schedule 2 drugs are received from pharmacy they must be entered into the POD CD register in the reverse section of the register. The patient or their carer/patient’s advocate and staff nurse must sign the POD CD
register to confirm the drugs have been supplied on discharge

7.3.11 For **controlled drugs**, the Trust requires that the prescriber’s registration number is written on the prescription. Normally, a maximum of 7 days supply will be dispensed at any time. In exceptional circumstances where more than 7 days is required, the prescribing doctor must contact the pharmacy to discuss.

7.3.12 When all patients are discharged on oral anticoagulants the GP must be contacted and the referral form completed. The form is available on patient centre or as a triplicate form at ward level. Prescribers should follow the Trust ‘Guidelines for the Management of Warfarin in Inpatients’.

7.3.13 The Trust has no obligation to provide discharge medicines for patients who discharge themselves contrary to medical advice. If the patient’s own medicines are stored these should be returned to the patient but any new medicines must be obtained from the patient’s GP.

7.4 **Patient group directions**

7.4.1 A patient group direction is a written instruction for the supply or administration of named medicines in an identified clinical situation. Only registered nursing staff can supply and administer against a Patient Group Direction – this task cannot be delegated.

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

7.4.3 The patient group direction must be agreed locally by the Assistant Director, the Clinical Manager (or delegated named nurse), or professional manager for the other staff groups providing care under the direction. They must consult with all appropriate persons, including consultants whose patients may be treated under the direction, to confirm that the proposed direction is appropriate, does not compromise patient safety, and is consistent with professional relationships and accountability.

7.4.4 All consultants who have patients in the area where care is to be provided under the patient group direction must approve its use; otherwise it may not be operated. The Clinical Director is responsible for ensuring that all relevant consultants approve the
direction, and that an up-to-date record of signatures confirming approval is maintained.

7.4.5 Before it is introduced into operation, the patient group direction must be submitted to the Drug and Therapeutics Committee for approval by the chairperson of the Drug and Therapeutics Committee and the Head of Pharmacy and Medicines Management.

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

7.4.7 If any change is made to the patient group, clinical condition or situation to which the direction applies, or to the characteristics of staff authorised to practice under the direction, or to the description of treatment available under the direction, then the new version of the direction must be submitted for approval to pharmacy.

7.4.8 The patient group direction must be written using the approved Trust template available on pharmacy Intranet site and must contain the following information.

- The rationale i.e. the reason why the patient group direction offers an advantage to patient care.
- The patient group and clinical condition or situation to which the direction applies.
- A description of patients, clinical conditions or situations excluded from treatment under the direction.
- The action to be taken if a patient is excluded from or refuses treatment under the direction.
- The medicine which may be supplied or administered, and specific details of
  - the dose
  - the frequency of administration
  - the form and route of administration
  - the maximum number of doses that may be supplied or administered
  - the maximum period of time for which the medicine may be supplied or administered
  - warnings, cautions, and contra-indications to treatment with the medicine
  - the legal status of the medicine
7.4.9 Supply and administration must be in line with local guidelines, formularies and protocols.

- Instructions on the documentation required to record supply or administration, and other records to be kept for audit purposes.
- The skills, knowledge and qualifications required by staff approved to authorise supply or administration of medicines under the terms of the direction, and details of any required training programme.
- The action to be taken if an adverse drug reaction is suspected or occurs to a patient being treated under the direction.
- Details of any necessary follow-up action that will be taken after supply or administration.
- Evidence of approval by each party listed.
- The date that the direction comes into force, and the date that it expires.

7.4.10 The Head of Department, must approve and maintain an up-to-date register of persons approved to supply or administer medicines under the patient group direction in his/her area of responsibility (available on Trust intranet site – department <pharmacy<forms). The register must be signed by the approved person as confirmation that he/she has read and understood the protocol. The responsible person must also ensure that only current up-to-date patient group directions for his/her area are on the Trust intranet.

7.4.11 There must be a responsible person for document control to ensure that all staff involved in the operation of the patient group direction have access to the current version, and are aware of any changes or amendments. The system must include a record of location of all copies of the direction, a record of review of the direction, and a method of communication of changes and new versions to all copyholders and persons involved in the operation of the direction.

7.4.12 The arrangements for monitoring of care under the patient group direction must be specified.

7.4.13 Details of supply or administration of a medicine under a patient group direction must be recorded on standard Trust approved documentation used for prescribing. The
record must include
- the hospital, and ward or department
- the patient name, address, date of birth
- the medicine name, dose, route, time of dose(s), start date, number of doses and/or period of time for which the medicine is to be supplied or administered. If more than one dose requires to be administered, each dose must be administered by a person approved to administer under the patient group direction, or the person who initiated administration must ensure that a doctor prescribes the remaining required doses.
- the signature, and printed name of the approved person who supplied or administered the medicine
- Under “Signature”, the words Patient Group Direction should be written

7.5 Transfer of Medication Related Information

7.5.10 This section should be read in conjunction with the relevant Trust policy for the Transfer of Patients.

7.5.11 Evidence has shown that transcription is a source of error and this should be avoided where possible when information regarding patients medication is being transferred between settings.

7.5.12 When a patient is transferred between sites within the South Eastern Trust the kardex should accompany the patient.

7.5.13 When a patient is being transferred to another healthcare facility outside the South Eastern Trust a photocopy of the kardex must accompany the patient.

7.5.14 All relevant medical documentation must be fully completed and up-to-date e.g. clinical notes and drug kardex. If for any reason the Kardex cannot be completed, for example, a patient admitted to emergency department is transferred urgently and a full drug history cannot be obtained prior to transfer, this must be clearly indicated in the medicine Kardex and the transfer notes.

7.5.15 Where verbal medication information is given, it should be repeated back and confirmed by the two medical staff involved in the transfer of medical care.
Information on allergies must also be conveyed by medical staff.

7.5.16 The transferring ward must advise when the next medication is due and advise the receiving facility in advance of the patients current drug therapy in order that they can make arrangements to obtain a supply. If the receiving facility will encounter difficulty in obtaining medicines e.g. restricted items, red amber medicines or unlicensed medicines the transferring ward must make arrangements to provide a supply with the patient. This may be done by liasing with the hospital pharmacy prior to transfer.

7.6 Specialist medicines (Red/Amber) prescriptions

7.6.10 Prescribers should be mindful of potential difficulties which can arise in the transfer of care of patients to the community when highly specialised medicines are involved.

7.6.11 A system to manage the prescribing and supply of specialist medicines is in place regionally and such medicines are categorised using a red and amber 'traffic light' system.

7.6.12 Red List Medicines: prescribing responsibility should remain with the consultant or specialist clinician and the supply organised via the hospital pharmacy.

7.6.13 Amber List Medicines: prescribing responsibility should be transferred to primary care with the agreement of the patient’s GP and when shared care arrangements have been established. A copy of the relevant shared care guideline should be provided to the GP.

7.6.14 A complete list of red and amber medicines and copies of shared care guidelines are available via www.ipnsm.hscni.net. Any queries about red or amber medicines, or shared care should be directed to the interface pharmacist on the Ulster site ext 2212.
8 Patient's own drugs (PODs)

8.1 Principles

8.1.1 Patients’ own drugs (POD) are a valuable source for obtaining an accurate drug history on admission and patients must be encouraged to bring them into hospital.

8.1.2 Medicines brought into the Trust by patients remain the patient’s own property. They must not be disposed of without the consent of the patient, or the patient’s representative. A patient’s own drug must never be administered to another patient.

8.2 Patients own drugs on admission

8.2.1 Patients must be asked if they are taking any prescribed medication or other medicinal preparations, and if they have brought them into hospital. The patient must be asked to surrender medication for examination and identification. This will facilitate the collection of a complete medication history documented on the medication on admission (MOA) form in the patient’s medical notes.

8.2.2 The patient’s own drugs should be put into a POD bag labelled with patient’s name, address and hospital number. The patient or their representative should be asked to sign the ‘POD consent form’ (available from Pharmacy in a triplicate book format) and the drugs should be stored in the patient’s lockable bedside medicine locker. The POD consent form must be filed in the patient’s medical notes and a copy placed in the POD bag. The 3rd copy must remain in the POD consent book.

8.2.3 Fridge items and controlled drugs must be documented on the POD consent form. They must not be stored in the bedside locker.

8.2.4 Under no circumstances should a patient’s own supply of oral methotrexate be used in hospital. Only doses dispensed and labelled with the patient’s name by the hospital pharmacy must be administered. For more information on obtaining a supply refer to the Trust oral methotrexate policy.

8.2.5 In wards where there are no lockable bedside medicines lockers, the patients’ own drugs should be used to facilitate the collection of a complete medication history then placed in a POD bag and stored in an identified lockable cupboard at ward level. This should be recorded in the patient’s notes.

8.2.6 At present the Trust is introducing the use of patient’s own drugs in a planned implementation programme. In wards/departments where this is not yet
operational, PODS may be used in exceptional circumstances such as when the medicine is unavailable and continuation of treatment is necessary the medication may be used if the following apply:

- the patient gives permission to use their own medicine.
- the medicine is prescribed on the in-patient kardex.
- the medicine can be positively identified and is checked by two registered nurses before being used. The use of patients own drugs must be recorded in the nursing patient’s record and signed by the two staff responsible for checking the medicines.
- the medicine must be in good condition, dispensed within the last three months and suitable for use. It must be either in the original packaging or in labelled packaging provided by the community pharmacist, hospital pharmacy or dispensing doctor. Medicines transferred by the patient to alternative packaging or mixed with other medicines should not be used.
- check the label against the prescription on the in-patient kardex: drug name, strength, dose and frequency, patient name, date of dispensing.
- check the contents against the label: drug name, strength and expiry date. Blister packs will have the name and strength on the blister packaging.
- Medicines that cannot be positively identified with certainty by two registered nurses should not be used.
- if the medicine is a Controlled Drug see section 8.3.

8.2.7 Where a POD scheme is in operation, there are strict operating criteria and both nursing/midwifery and Pharmacy staff must be trained and deemed competent to operate the POD scheme. A local PODs protocol, approved by Pharmacy and relevant medical and nursing staff must be in place for any areas wishing to use patients own drugs on a regular basis. Wards must also follow the SET policy on ‘The use of the lockable drawer in bedside cabinet for the storage of medicines’.

8.2.8 The POD scheme involves patients bringing their own medicines into hospital where they are assessed and, if suitable, used during the hospital stay and on discharge. If newly prescribed medication and/or an additional supply of existing medication is required, then ‘one stop’ dispensing is undertaken to provide medication for use during the patients stay and at discharge.

8.2.9 The medicines should be stored in the lockable bedside medicine locker or in a designated locked cupboard after the collection of a medication history, and a record of PODs stored made in the patient’s records (preferably on the MOA form).
8.2.10 Items intended for individual patient use such as eye drops, inhalers, GTN sprays etc must be stored in the lockable bedside medicine locker.

8.2.11 Where the patient’s own drugs are contra-indicated or stopped, the medicines should not be returned to the patient but disposed of with the patients’ consent in the appropriate manner (section 8.5.2). Where the patient does not agree to the destruction of medicines they should be sent home with a responsible adult. The patient and/or their representative must be advised if the medicines are not safe for use. A declaration form confirming that they have received this advice must be signed, and placed in the patient’s record.

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

- Place medicines in a POD bag labelled for the patient, with a copy of the declining consent form is available on the Trust Intranet (Departments>pharmacy>forms). File the original declining consent form in the patient’s medical notes
- Record in the patient’s record that the medicines are stored on the ward but they are not for destruction if no longer required.
- Store in the secure area reserved for patients own drugs eg. lockable bedside medicine locker, lockable drug cupboard, drug trolley.
- Return the medication to the patient on discharge.

8.2.13 If the patient is transferred to another ward the medication should be transferred with the patient and a record made of the transfer in the patients record.

8.3 Patient’s own controlled drugs (POD CD)

8.3.1 Patients who bring controlled drugs into hospital should normally be encouraged to send them home with their representatives for safe keeping. This should be done after an accurate drug history has been taken and a supply in hospital is assured.

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

- Ensure two registered nurses count the CDs and accurately record the details in the POD CD register
- Ensure the patient/relative signs the POD consent form available on Trust Intranet (Departments>pharmacy>forms) giving consent for storage.
- Record in the patient’s notes and the POD consent form that the Controlled Drugs are stored on the ward and entered into the POD CD register
- Place the controlled drugs in an envelope, seal and store in the ward CD cabinet. Sign and date the seal.
- Transfer of patient’s own Controlled Drugs to another ward must be recorded and signed for in the POD CD register by a registered nurse from each ward. The receiving ward must enter the POD CDs into their POD CD register.
- If the seal on the envelope remains intact there is no need to check and count the contents each day until they are being returned to the patient.
- At CD check handovers the responsible ward staff should check that the POD CD register is still correct. This must be recorded with the normal CD check handover.
- If the seal is broken, the POD CD envelope contents must be checked by two registered nurses and a new seal attached, signed and dated.
- If in exceptional circumstances the POD CD is required for use by the patient during their hospital stay, a record of administration must be made in the POD CD register.
- The POD CD should only be used until a supply from Pharmacy is available.
- If the POD CD is in use, the seal may remain broken and the contents checked each day along with the other ward CDs.
- If the patient agrees to the destruction of Controlled Drugs, contact Pharmacy to arrange for the medicines to be returned to Pharmacy for disposal and signed out of the POD CD register. **Controlled drugs must not be destroyed by ward staff.** The POD CD section of the CD returns book must be completed when sending the POD CD to Pharmacy for destruction.
- On discharge the POD CD must be returned to the patient and signed out of the POD CD register.

8.4 **Patients own drugs on discharge**

8.4.1 Prior to discharge, any medicines stored on the ward for the patient should be reviewed by a nurse/midwife or pharmacist to ensure they are safe for the patient to continue to take after discharge.

8.4.2 If it is deemed inappropriate to return a patient’s medicines to them, this should be recorded in the patient’s medical notes and the medicines (other than CDs) may be destroyed as per Trust waste policy.

8.4.3 The patient’s attention should be drawn to any changes in the dose of prescribed medicines, discontinuation of medicines or the commencement of new medicines.

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

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

8.4.7 Any new discharge medication must be stored in the lockable bedside medicine locker along with the patients own drugs.

8.5 **Destruction of patient's own drugs other than controlled drugs**

8.5.1 In the acute setting, if the patient agrees to the destruction of the medicines, a completed signed POD consent form available on the Trust intranet (Departments>pharmacy>forms) giving permission “to remove and destroy patient’s own medicines if no longer suitable” should be available before destruction of any patients own medicines. Medicines should be disposed of on the ward following the Trust Policy and Procedures for Waste Management.

8.5.2 Where the patient has surrendered medicines but does not agree to their destruction and they are not sent home, arrangements must be made for their secure storage in hospital until the patient’s discharge when a decision will be made to return them to the patient or to dispose of them as appropriate. Records of the receipt of such medicines and their eventual disposal should be kept.

8.5.3 In the community, the patient should be instructed to return any medication which is no longer required to their community pharmacist for destruction. In exceptional circumstances where the patient, relative or carer cannot take these to the community pharmacist, the district nurse may return them on the patient’s behalf. This should be documented in the patient’s primary care record and signed by the pharmacist accepting the drugs for destruction.

8.5.4 Where the patient wants their medicines returned even though the taking of them would conflict with revised treatment either the patient or a representative should be made aware of this and asked to sign a declaration available on the Trust intranet (Departments>pharmacy>forms). In all cases document in the patient’s record the action taken with their medication for future reference.

8.6 **Unauthorised drugs, unidentifiable substances, illicit substances**

See section 13
9. Administration

9.1 Principles

9.1.1 Medicines are only administered when they are prescribed by a UK registered doctor, dentist, a Trust registered non medical prescriber, a midwife or on the written instruction of an approved practitioner within the terms of a patient group direction (see section 7.4). Prescriptions must normally be written. In exceptional circumstances, a medicine may be administered on the verbal instruction of a doctor (see section 9.17).

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

9.1.3 All medicines administered to Trust patients are procured by and distributed through the pharmacy, except for patients’ own medicines where their use is appropriate, or where distribution through a home delivery company is appropriate.

9.1.4 Administration involving one or more of the following elements is witnessed, except in circumstances where it is not possible e.g. administration takes place in the patient’s home, or where it is not feasible for operational reasons e.g. in theatres, baby clinics, immunisation clinics. In such circumstances, a risk assessment is undertaken and recorded.

9.1.5 Witnesses required for administration of:

- Intravenous therapy
- Intrathecal therapy
- Epidurals
- Controlled drugs
- Patients under the age of sixteen
- Medicines administered without a written prescription
- Cytotoxic medicines given by any route of administration
- Medicines administered via electronic medical devices, for example infusion pumps, syringe drivers.
- Doses requiring complex calculations

9.1.6 All staff involved in the administration of intrathecal cytotoxic chemotherapy will have undergone appropriate training, and will be named on the register of personnel authorised to do so (see Trust Policy for the Administration of Intrathecal Chemotherapy).
9.1.7 The administration of medicines is undertaken in a methodical manner, in accordance with the procedure in section 9.4, and distractions are minimised while medicines are being selected, prepared and administered.

9.1.8 Nurses and medical staff must exercise their professional judgment and knowledge each time a medicine is administered.

9.1.9 The nurse/midwife or other member of staff administering medicines is responsible for ensuring that prescribed medicines are administered as close to the prescribed time as possible. Medicines may be administered within two hours either side of the prescribed time and should be recorded in the normal way on the Kardex.

9.1.10 If two hours or more after the time the dose is due have elapsed, this delay must be discussed with medical staff and the appropriateness of the timing of the next dose reviewed, particularly if a critical medicine as outlined below.

9.1.11 Staff should seek advice if they are unfamiliar with any part of the process including, the rationale for use, the drug, prescribing procedure, dosage, reconstitution, administration, side effects and illegibility of documentation.

9.2 Practitioners authorised to administer medicines

9.2.1 Registered doctors, first level registered nurses, midwives, pre-registration house officers, operating department practitioners and second level registered nurses who are deemed competent by the Head of Department and have completed an approved educational programme, are authorised to administer medicines.

9.2.2 All Registered Nurses or Midwives whether working through the Trust Nurse Bank or an Agency, work to NMC Guidelines and Trust departmental policies and procedures. The nurse in charge of the ward/service should clarify at the start of the shift if the member of bank/agency staff deems themselves competent to administer medicines. This should be documented on the ward/department induction record and retained in line with Trust policy. If bank/agency staff deem themselves not competent to administer medicines, alternative arrangements require to be agreed immediately and the matter reported to the clinical manager and agency deploying the members of staff.

9.2.3 Student nurses and midwives may prepare and administer medications under direct supervision of authorised practitioner or registrant in accordance with guidance on delegation section 5 standard 18 NMC medicines management 2010 & appropriate NMC Essential Skills Clusters for Pre – registration nursing Programmes (NMC 2007
9.2.4 Medical students can only administer medicines under direct supervision if the medicines has been prescribed, reconstituted and drawn up by a qualified person (see FY0 log book).

9.2.5 Other suitably qualified and experienced persons may be authorised to administer medicines not prescribed by a doctor, eg. within the terms of a patient group direction, in clearly defined circumstances.

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

9.3 Transfer of patients
9.3.1 When a patient is transferred to another clinical area within the same hospital site, or at a different hospital site, the nurse responsible for the patient’s care must make arrangements to ensure that required doses of medicines are not missed or delayed. The patient’s own medicines, other medicines supplied for the individual patient’s use, and other prescribed medicines not immediately available in the receiving clinical area must be transferred with the patient and a note made in the patient’s notes (see section 5.9).

9.4 Procedure for administration
9.4.1 In the following section where two nurses are involved in the administration process in the hospital setting, only one may be involved in the community/primary care setting.

9.4.2 The following procedure must be undertaken before administering a medicine. If a witness is required (see section 9.1.5), each step of the procedure must be witnessed:
   • Ensure hand hygiene is followed before commencing any procedures to prepare and administer medicines
   • Check the patient’s allergy status has been completed on the in-patient kardex
   • Read the prescription carefully
   • Check that the medicine is correct for the patient
   • Ascertain that the prescribed dose has not already been given
   • Select the medicine required and check the details (drug name, strength, form, route) against the prescription
   • Check the expiry date
• Identify the patient by checking the name on the prescription against the name on
the patient’s name band and unique identifier/hospital number or ask the patient to
state his or her name and date of birth. If the patient’s unique identifier/hospital
number is not available/documented, two nurses must check the patient’s
demographics (ie date of birth/address) verbally with the patient and check these
correspond with their notes. Once satisfied these have been confirmed apply a
patient name band and administer the medicine.
• For “as required” medicines ensure sufficient time has elapsed since the previous
dose of the medicine, and that any maximum dose stated for that medicine has not
been exceeded. If a variable dose is permitted the dose given must be recorded. If
optional routes permitted, the route used must be recorded.

9.4.3 Complex dose calculations must be carried out independently by two registered
practitioners to check accuracy.

9.4.4 If a witness is required (see section 9.1.5), the whole administration period must be
witnessed except for slow administration that takes more than a few minutes e.g
infusions where only the set up and start of the administration must be witnessed.

9.4.5 The prescribed medicine must be administered as near as possible to the prescribed
time, and normally within an hour. If this is not possible and there is any doubt about
the implications of administering a medicine outside the prescribed time, medical
advice must be sought. Particular attention must be paid to patients requiring
Parkinson’s medication. The timing of such medication is very important and may
have to be given outside of usual drug times.

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

9.4.7 If a prescribed medicine is not given, the reason must be recorded clearly on the
administration and ‘doses omitted’ section of the prescription chart (using the standard
codes) and the responsible doctor informed in the appropriate timescale. The
standard codes for recording omitted doses are as stated and must be circled to avoid
confusion with signatures

N  nil by mouth      V  vomiting
R  patient refused  D  drug not available*
‘Prescribed omissions’ and ‘other’ reasons for omitted doses are recorded on the appropriate section of the medicine kardex.

9.4.8 Before entering a code D all efforts must be made to obtain the drug. Discussion with ward manager / nurse in charge and if necessary medical staff is mandatory before entering a code D. If a code D is utilised an explanatory note must be made in the medical notes. The name of any medical officer contacted with relation to an omitted or delayed medicine should be recorded in the medical or nursing/midwifery notes.

9.4.9 Every occasion when critical medicines have been omitted or delayed must be escalated. NPSA have identified particular medicines where timeliness of administration is crucial. These medicines include anti-infectives, anticoagulants, antiplatelets, anticonvulsants, anti-retrovirals, bronchodilators, chemotherapy, clozapine, corticosteroids, injectable proton pump inhibitors, immunosuppressants, insulin, oxygen, resuscitation medicines and medicines for Parkinson’s disease. See the ‘Give it on Time’ poster displayed in clinical areas.

9.4.10 NPSA have also identified ‘stat medicines’ as a particular problem. The prescriber must verbally inform nursing staff that a ‘stat medicine’ has been prescribed to ensure administration in a timely manner, otherwise prescription of the ‘stat medicine’ may go unnoticed for several hours before they are identified at the next regular medicines administration round.

9.4.11 Staff should follow local guidance with respect to obtaining medicines out of hours – details of how to obtain medicines when pharmacy is closed is available on the pharmacy intranet page. Staff should also follow the medicines finder pathway which is available on each ward/department.

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

9.4.13 Administration must be recorded by signing the appropriate entry on the prescription
9.4.14 Medicines should not be left at the patient’s bedside for them to take later. The nurse who signs that the drug has been administered should supervise the administration. (GTN sprays and inhalers can be left at the patient’s bedside for emergency and administration documented on the prescription chart).

9.5 Administration by injection/infusion
9.5.1 Medicines for injection/infusion that pose a health and safety risk during preparation, are supplied in a ready to use form from the pharmacy.

9.5.2 Other injections/infusions that require dilution or reconstitution before administration may be prepared in the designated preparation area within clinical area. Aseptic non-touch technique (ANTT) must be used – DVD available on Trust intranet site (Departments>Infection Control>Training and presentations).

9.5.3 Intravenous drugs must only be given via an established line with the exception of ICU, haematology, medical specialties and renal staff (see local policies). Extra caution is required when patients have multiple lines in situ. Only those clearly marked may be used for the administration of drugs.

9.5.4 Staff administering drugs via a central line must have completed additional competency training and be authorised by the departmental manager to administer via this route.

9.5.5 The administration of intravenous drugs by nurses will be carried out in partnership with medical staff and will be at the discretion of the senior nurse/nurse in charge according to staffing levels and workload. Where monitoring is required, it is the responsibility of both medical and nursing staff to ensure that appropriate monitoring has taken place before administration.

9.5.6 Intravenous medicines may only be prepared in the clinical area and administered by registered doctors, or authorised practitioners who have completed the approved intravenous therapy training course.

9.5.7 The preparation of injections/infusions must be carried out in an area that:
- has a clear, uncluttered surface for preparation
- has adequate space
- is quiet, away from distractions
- has a surface that can be cleaned
is near to information on the preparation of injections

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

9.5.9 The physical and chemical stability of an injection/infusion must be determined before the product is prepared. Information sources include:
- Manufacturer’s Summary of Product Characteristics or package inserts
- British National Formulary
- NI Medicines Administration Guide 2008
- Medusa injectable medicines guide (electronic format available on Trust intranet)
- Clinical Pharmacist
- Medicines Information

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

9.5.11 Injections/infusions prepared in the clinical area must be prepared immediately before administration. They must not be prepared and stored in the clinical area. If this is not possible for operational reasons, a risk assessment must be undertaken, and the action taken to minimise the risk must be documented.

9.5.12 Any container that has been physically opened e.g. an ampoule, rather than a dose withdrawn through the access port or rubber bung, must be discarded immediately after use. Follow the Trust procedures for preparation and administration of injections/infusions available in all wards and departments.

9.5.13 Injections/infusions prepared in the clinical area must only be administered by those individuals who are either involved in the preparation, or who are able to check that the prepared medicine is correct. Liquid oral and intravenous drugs must not be taken to the patient’s bedside at the same time.

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

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

9.5.16 All syringes and infusions containing injectable medicines must be labelled prior to
9.5.17 There are two types of infusion labels: one for medicines added to infusion bags and one for medicines in syringes for injection / infusion.

9.5.18 Labels containing the following information must be added to IV infusions:
- Patient’s name, patient identifier, and ward or clinical area (addressograph can be used)
- Date and time of preparation
- Drug name and quantity
- Name of persons who prepared and checked the injection

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

9.5.20 A time limit is required between preparation and completion of administration of infusions due to the possibility of microbial contamination and lack of stability of the prepared solution. The maximum recommended time due to the possibility of contamination is 24 hours. However, depending on the medicine, a shorter time may be required due to limited stability. Refer to the manufacturer’s product information for guidance on stability times.

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

9.5.22 In hospital and community, nurses/midwives who have completed the approved intravenous therapy training course can administer the first and all subsequent doses of intravenous drugs including antibiotics.

9.5.23 In hospital, all intravenous drugs must be cross checked by two registered nurses, one of whom must be a first level nurse. All intravenous administrations and adjustment to pump (ie flow rate changes) must be witnessed by 2 nurses who will have equal responsibility. In situations where this is not possible, local policies must be followed.
9.5.24 In community, one first level nurse can prepare, check and administer IV drugs on his/her own.

9.5.25 When infusion pumps/devices are used staff must have completed competency based training on the device being used.

9.6 **Administration from multi-dose vials**

9.6.1 Each container of an injection licensed for multi-dose use should be reserved for a *single patient* (this includes insulin). Each container should be labelled clearly with patient name and hospital number. Check product expiry date after opening and include this on the label (see package insert).

9.6.2 Multi-dose injections containing antimicrobial preservative that are not discarded immediately after use must be clearly labelled with the date and time that the first dose was withdrawn, patient details i.e name and hospital number and stored appropriately. If a container that has been used is not labelled with this information, or if there is doubt about how it has been stored, it must be discarded.

9.6.3 This guidance is based on the published evidence currently available. A risk assessment must be undertaken for any practice that deviates from the recommendations given.

9.7 **Controlled Drugs (see also section 12)**

9.7.1 Following NPSA advice, health care practitioners namely medical, pharmacy and nursing staff must be aware of their responsibilities to:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records;
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose);
- Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.

9.7.2 This guidance applies when the following opioid medicines are prescribed dispensed or administered: Buprenorphine, diamorphine, dipipanone, fentanyl, hydromorphone,
meptazinol, methadone, morphine, oxycodone, papaveretum and pethidine.
9.8 **Administration to children under the age of 16**

9.8.1 Student nurses and midwives must only administer medicines to children under 16 years old after medication has been checked by 2 authorised practitioners, one of whom should directly supervise administration. There may be circumstances when a registered nurse or midwife is working on their own, (e.g. in the community setting). In this case the student can administer medication under the direct supervision of that authorised practitioner, according to Trust policy.

9.8.2 Medical students can only administer medicines under direct supervision if the medicines has been prescribed, reconstituted and drawn up by a qualified person (see FY0 log book).

9.8.3 All medicine preparation and administration must be checked by two authorised practitioners according to local policy. It is recommended that a health care professional experienced in calculating paediatric doses is involved. Dosage calculations and final dose must be carried out separately by both practitioners involved. The Medicines Information Service should be contacted if there is any uncertainty regarding the dose or calculation.

9.8.4 A Registered Children's Nurse and midwife can administer medicines on his/her own as per NMC and local guidelines except for neonatal drugs, intravenous antibiotics, insulin and cardiac drugs when they are checked by two registered nurses. There may be circumstances when the registered nurse is working on their own. First Level Nurses working in baby clinics and immunisation clinics may administer vaccines on their own (see section 9.1.4).

9.8.5 Second level registered nurses must not carry out administration with a student nurse.

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

9.8.7 In hospital, children and infants must wear identity bracelets and particular attention must be paid to the correct identification of the child before administering medication.

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

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

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

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

9.9 Crushing tablets or opening capsules

9.9.2 Crushing tablets or opening capsules often results in the use of that medicine becoming unlicensed. Tablets should not be crushed or capsules opened unless an alternative formulation or medicines is unavailable.

9.9.3 Those involved in the prescribing and administration of unlicensed medicines are likely to carry increased responsibility for their use. In addition, crushing tablets or opening capsules might release some of the medicine into the air and present health and safety issues for staff and patients.

9.9.4 Advice should be sought from a pharmacist or from the medicines information service (Ext 2484 Ulster Hospital) for the alternative options available and the clinical consequences of crushing tablets or opening capsules.

9.10 Administration to patients with swallowing difficulties

9.10.2 Opening a capsule or crushing a tablet prior to administering will usually make its use ‘off-licence’.

9.10.3 When a medication is used outside its licence a greater liability rests with the healthcare professional, prescribing, dispensing or administering the medication and the manufacturer can refute liability for any harm that may occur to the patient or person administered the medication in an unlicensed form.

9.10.4 The Medicines Act 1968 states that only a medical or dental practitioner can authorise the use of ‘unlicensed’ or ‘off-licence’ medicines in humans. It is not strictly legal to open a capsule or crush a tablet prior to administration without prescriber authorisation which should be documented in writing in patient’s notes.
9.10.5 It is not always appropriate to crush tablets to aid administration, as this may affect the pharmacokinetics or efficacy of the drug.

9.10.6 There are certain classes and formulation of medication that should not be crushed or opened, such as sustained or modified release preparations or cytotoxic medicines. If these tablets or capsules do require to be crushed or opened prior to administration contact Pharmacy for advice.

9.10.7 Prescribers must assess the patient and decide:
- Is the situation likely to be long term or would it be safe to temporarily hold medication?
- Are all medications necessary or can any be stopped withheld for a period of time?
- Can any of the medicines be changed to a **different formulation** ie suspension, solution, buccal, soluble, topical preparation?
- Could any of the patients’ any of the patient’s medication be implicated in causing or exacerbating dysphagia ie tricyclic antidepressants?
- Is there an alternative drug/class of drug which is available in a licensed formulation?

9.11 Cytotoxic medicines

9.11.2 All cytotoxic medicines must be supplied from Pharmacy in a ready to use form, dispensed for the individual patient.

9.11.3 Cytotoxic chemotherapy must be administered preferably in a dedicated area, in an unhurried environment, and with minimum distraction. Cytotoxic chemotherapy must be administered only when there is access to specialist staff.

9.11.4 Only practitioners who have demonstrated an approved level of skill, expertise and experience may administer cytotoxic chemotherapy.

9.11.5 Detailed procedures on administration, disposal, management of spillage, and extravasation must be available in the clinical area where administration of cytotoxic chemotherapy takes place. Refer to the Trust Policy for Management of Chemotherapy Extravasation - SET/PtCtCare (12) 2009

9.11.6 Unnecessary exposure of staff to cytotoxic medicines must be minimised by the use of safe handling techniques and suitable protective clothing. Refer to the following trust policies and procedures for further information: SET Guide(04) 2007 Guidelines for the disposal of cytotoxic contaminated patient waste, materials and equipment and Nursing procedure ref no55/2006 Administration of cytotoxic agents.
9.12 Intravenous Potassium

9.12.2 Refer to the Trust Policy on the Management of Intravenous Solutions for the complete information on the procedures for the management of strong potassium solutions.

9.12.3 Ready to use infusions must be used where possible. A second practitioner must always check for correct product, dosage dilution, mixing and labelling during the preparation of and again prior to the intravenous administration of solutions prepared from strong potassium injections.

9.12.4 Potassium infusions must be administered via a volumetric infusion pump or a syringe infusion pump.

9.13 Covert administration of medicine

9.13.2 The covert administration of medicines is defined as the administration of a medicine disguised in food or drink, to a patient who has previously refused to take the medicine. The registered practitioner administering the medicine covertly must ensure they are doing this in the best interests of the patient or client and be accountable for their actions at all times.

9.13.3 The covert administration of a medicine to an adult patient will only be necessary or appropriate in the case of a patient who actively refuses a medicine, but who is deemed not to have the capacity to understand the consequences of refusal. Issues regarding capacity should be considered by the consultant in charge of the patient, in the usual manner.

9.13.4 Where adult patients are capable of giving or withholding consent to treatment, no medication should be given without their agreement. The exception to this principle concerns treatment authorised under the relevant mental health legislation.

9.13.5 A medicine may only be administered covertly when it is in the best interest of the patient, that is, the medicine is necessary in order to save life, or to prevent deterioration in the patient’s physical or mental health, or to ensure improvement in the patient’s physical or mental health and where the patient has no capacity to consent or otherwise to taking medication.

9.13.6 Any decision to administer a medicine covertly must not be considered routine, and
may be reached only after assessing the care needs of the patient as an individual and recorded in the patient’s notes as time limited. It should be patient specific.

9.13.7 Where a medicine is being administered covertly, the situation must be re-assessed on an ongoing basis and recorded in the patient’s notes, at least weekly, to take account of changes in the capability of the patient to understand the nature and possible consequences of the treatment.

9.13.8 When an adult patient or client is considered incapable of providing consent and where their wishes appear to be contrary to the best interests of that person, the medical and nursing staff responsible for the patient’s care and the patient’s family and/or carers, and advocates must assess the patient and document the agreed treatment plan in the patient’s notes.

9.13.9 For patients of clients detained under the relevant mental health legislation, the principles of consent continue to apply to any medication for conditions not related to the mental disorder for which they have been obtained. However medication for the mental disorder for which the patient has been detained can be given against a patient’s wishes during the first 3 months of a detention order or afterwards if sanctioned by a second opinion approved doctor (SOAD).

9.13.10 It cannot be assumed that children are unable to give consent. Children under the age of 16 years are generally considered, but not always, to lack capacity to consent to or refuse treatment, including medication. The right to do so remains with the parents or those with parental responsibility, unless the child is considered to have significant understanding and intelligence to make up his or her own mind about it (Fraser guidelines).

9.13.11 Children of 16 or 17 years of age are presumed to be able to consent for themselves, but the refusal of a child of any age may be overridden by parents or those with parental responsibility. In exceptional circumstances, this may involve seeking an order from the court or making the child a ward of court.

9.14 Administration of Insulin

9.14.2 All regular and single insulin (bolus) doses must be measured and administered using
an INSULIN SYRINGE or commercial INSULIN PEN DEVICE. Intravenous syringes MUST NEVER be used for insulin administration.

9.14.3 Self Administration of medications should only occur where there is a locally agreed policy in place which is in line with NMC guidance.

9.14.4 Insulin ordered from pharmacy will come with a flag label. Nursing staff should attach patient’s addressograph sticker to the back of this label. Any vial or pen should be reserved for single patient use. Patients own insulin brought into hospital should be assessed for suitability of use by the nursing staff and a flag label/addressograph attached with the date of opening noted.

9.14.5 When Insulin is to be administered in glucose to treat Hyperkalaemia a HYPERKALAEMIA Kit should be used.

9.14.6 This Hyperkalaemia Kit contains the medicines necessary to treat hyperkalaemia except for Actrapid® Insulin which is stored separately in the fridge.

9.14.7 The Hyperkalaemia Kit also contains instructions on how to prepare 10 units of Actrapid® insulin in 50mL glucose 50% minijet. The insulin doses must be drawn up in the insulin syringe, provided in the kit and should be checked by the Senior Staff Nurse on duty before adding it to the glucose 50%.

9.15 Administration by Transdermal Route (Patches)

9.15.2 When administering a transdermal preparation the following must be observed:

- Refer to the patient leaflet for details regarding suitable application sites and to confirm frequency of change
- If there is an existing patch, locate and remove it prior to administering the new one
- Care must be taken to ensure that the patch prescribed is the correct strength: staff applying a patch containing an opioid must make sure that they are aware of the bioequivalent doses of the patch.
- Opioid patches can take 18-48 hours to reach steady state plasma levels. The prescriber must allow plasma levels to stabilise prior to escalating the strength(depending on the patch in use)

9.16 Administration of Sodium Heparin Flush Solutions

9.16.2 The NPSA Rapid Response Report 002 Risks with Intravenous Heparin Flush Solutions has outlined methods of improving safety in the use of sodium heparin products i.e.

- Wards and departments should normally only stock sodium heparin products of
1000 units/mL or less.

- The use of sodium heparin 10 units/mL to flush devices including central venous and arterial catheters should be minimised.
- Recent review of evidence indicates that heparin flushes should not normally be used to flush peripheral intravenous catheters.

9.16.2 To comply with the guidance, concentrated heparin sodium is only available in strength 1000 units/mL with the following exceptions:
- The Renal Unit will stock heparin sodium 5000 units/mL.
- Paediatric wards will stock 1000 units/mL.

- For most patients with peripheral intravenous catheters sodium chloride 0.9% should be used as a flush.
- For patients with peripheral midline catheters or central venous catheters, heparin sodium 10 units/mL may be used as a final flush to “lock” to catheter where recommended by manufacturer.
- Sodium Heparin will only be available on a supplementary requisition and has been removed from ward stock lists.
- Sodium heparin flush solutions should only be administered following a prescription or patient group direction. (Regional group is looking at the prescribing and recording of sodium chloride flushes and this section will be updated once agreed)

9.17 Administration of medicines without a written prescription

9.17.2 This procedure must only be carried out in exceptional circumstances, when a medicine has to be prescribed verbally in an emergency situation by a doctor who is not present. This procedure cannot be used for controlled drugs.

9.17.3 In exceptional circumstances where the prescriber is not present:

N.B. (this procedure is not suitable for controlled drugs)

- the name, dose and route of administration must be stated.
- A verbal prescription is not acceptable on its own. A fax or email prescription must be obtained and stapled to the patient’s medicine kardex/medicines administration record.
- The prescriber giving the verbal prescription must prescribe the new prescription on the patient’s medicine kardex/medicines administration record within 24 hours (72 hours max).
- An accurate record of all medicines administered in this situation must be kept.
- In the event that the prescriber fails to provide appropriate authorisation within 24 hours, further authorisation should be sought before medication is continued.
9.17.4 Verbal instructions by a non medical prescriber is not permitted.

9.17.5 In exceptional circumstances, where medication (not including Controlled Drugs) has been previously prescribed and the prescriber is unable to attend the ward/clinical area to prescribe on the Kardex, but where changes to the dose are considered necessary, or where a medicine not previously prescribed is required, the use of information technology (such as fax or email) may be used to confirm any change to the original prescription.

9.17.6 The fax or email prescription or direction to administer must be stapled to the patient’s existing Kardex. The prescriber should follow this up by ensuring the Kardex is completed within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends).

9.17.7 In any event, the changes must have been authorised (via email or fax) by a registered medical prescriber before the new dosage is administered.

9.17.8 In areas where emergency controlled drugs may be required to be administered before they are prescribed ie theatres, resus etc), there should be a local protocol agreed with pharmacy.

9.18 Verbal orders in the presence of a doctor

9.18.2 In an emergency situation such as resuscitation, a doctor may administer a medicine to a patient or direct a nurse/midwife they are working with to administer a medicine without first writing a prescription. The nurse/midwife who administers the medicine must confirm the instructions given to them with the doctor and have the doctor double check the medicine to be administered.

9.18.3 As soon as possible after the emergency, the doctor must write up the medicine as a ‘stat dose’ in the ‘once only’ section of the Kardex and the nurse/midwife who gave the medicine should record this on the administration section of the Kardex. An appropriate entry should be made in the medical and nursing/midwifery notes.
9.18.4 Controlled drugs must not be administered on the basis of a verbal order in the presence of a doctor. Theatres and ICU staff should refer to local policy which allows

9.18.5 Any instructions to prescribe a medicine, for example, given on a ward round by a consultant to a more junior member of the medical team, should be read or repeated back to the consultant to verify the accuracy of what was heard.

9.18.6 Any registered healthcare professional may administer adrenaline without direction or prescription in a life threatening situation. However, ideally, the Trust prefers that a Patient Group Direction should be in place to support staff in this situation

9.19 Administration of Pneumococcal vaccination
9.19.2 Before administering pneumococcal vaccination check carefully if the patient has had a pneumococcal polysaccharide vaccine before in primary care or in hospital. Re-vaccination at an interval of less than three years is not recommended because of an increased risk of adverse reactions. Severe reactions can occur if vaccination is repeated in adults. Revaccination is only appropriate for selected patients. For further information please refer to the pneumococcal vaccine request form on the pharmacy intranet page.(Departments>pharmacy>forms).
Supply of medicines for patients on discharge

10.1 Principles

10.1.1 All medicines supplied to patients on discharge are prescribed by an authorised prescriber on approved Trust prescription forms.

10.1.2 The Trust has no obligation to provide discharge medicines for patients who take their own discharge against medical advice. If the patient’s own medicines are stored these should be returned to the patient but any new medicines must be obtained from the patient’s GP.

10.1.3 For outpatients, the GP is normally responsible for prescribing medicines that are recommended following a hospital clinic consultation. Red list drugs are prescribed by hospital consultants and provided by the hospital pharmacy.

10.1.4 Where treatment must be initiated immediately an emergency supply (3 days), or complete treatment course where appropriate (i.e. antibiotics) is supplied to patients attending the Accident and Emergency department and outpatient departments.

10.1.5 The prescription and record for medicines provided from the Accident and Emergency department is written in a patient’s Accident and Emergency notes.

10.1.6 Prescriptions are dispensed from the hospital pharmacy, or in certain agreed circumstances, supplied directly from the ward, clinic or the Accident and Emergency department. If the medicines are to be issued to the patient direct from the ward, clinic or the Accident and Emergency department, the Head of Department ensures that medicines are only issued by staff that he or she has authorised, and that authorised staff are trained and competent in the procedures involved in issuing medicines to patients. These procedures must be approved by the clinical director and Head of Pharmacy and Medicines Management.

10.1.7 Prescriptions are adequately checked to ensure that they are correct for the patient.

10.1.8 All medicines issued to patients for discharge are labelled to comply with legal requirements.
10.1.9 The patient is provided with adequate verbal and written information about his or her medicines. Details of any new medicines, discontinued medicines or changes to medicines on admission should be clearly documented on the discharge prescription to ensure the GP can update the patient’s medication history.

10.1.10 One copy of the prescription is filed in the patient’s record, one copy is supplied to the patient’s GP, and the original copy is retained in the Pharmacy.

10.2 Medicines issued by Pharmacy when patients are discharged from hospital

10.2.1 The discharge prescription must be used to prescribe all current medicines. The information required must be accurately transcribed from the inpatient kardex.

10.2.2 The doctor or approved non medical prescriber responsible for the patient’s care must ensure that the discharge prescription is completed in adequate time, taking account of the patient’s planned time and date of discharge. Where possible this should be 24 hours before discharge. The date and expected time of discharge should be clearly marked on the prescription.

10.2.3 A 28 day supply of medicines is provided, unless a longer or shorter course of treatment is appropriate. Where one stop dispensing and use of patients own drugs is in operation patients can be discharged with a minimum of 14 days supply left. The duration of therapy for antibiotic or steroid courses must be specified.

10.2.4 If the patient already has a supply of the required medicines at home, an additional supply need not be issued from the hospital. However, the doctor or approved non medical prescriber who writes the discharge prescription, and the pharmacist, nurse or other practitioner who checks the prescription, must satisfy his or herself that if present, the patient’s own supply is of an adequate quantity, and is correctly labelled with the current dosage instructions. The discharge prescription should clearly annotate those medicines which are supplied from hospital and those that are the patient’s own (see 7.3.7)

10.2.5 If a change is made to the medicines required on discharge after they have been dispensed, a new Discharge Prescription must be written and the original medicines returned to the pharmacy. Labels may not be altered on the ward in any circumstances.
10.2.6 The registered nurse responsible for issuing the patient with their discharge medication should ensure that the dispensed discharge medicine is correct by checking the medicines against the medicine kardex and discharge prescription. Any discrepancies must be reported to the doctor/pharmacist immediately.

10.3 Medicines issued by ward to patients on discharge (when Pharmacy is closed)

10.3.1 Medicines should only be issued to patients on discharge by wards in the exceptional or emergency situation i.e. in the event of an unplanned discharge when Pharmacy is closed.

10.3.2 Schedule 2 drugs (including temazepam which is treated as a schedule 2 drug in SET) must not be issued on discharge by ward staff when the pharmacy is closed.

10.3.3 Wards using the one stop dispensing/patients own system should issue the medicines from the patient’s locker which should be labelled with the correct dosing instructions. Nursing staff must check the discharge prescription against the kardex and the medicines in the patient’s bedside locker to ensure these all concur.

10.3.4 For all other wards, a 3 day supply is made at ward level with provision made for weekends or bank holidays if required. Full courses of antibiotics or reducing doses (i.e. steroids) should be supplied.

10.3.5 The discharge prescription must be completed by an authorised prescriber and used to prescribe all current medicines. The information required must be accurately transcribed from the in-patient kardex and the patient’s medical notes, taking account of any medicines that should stop on discharge e.g. short term analgesics, antiemetics, hypnotics.

10.3.6 For hand written discharges, the top copy of the prescription must be sent to Pharmacy for recording and marked ‘dispensed from ward stock’. This must be signed by two Registered Nurses. (Ards and Bangor GP Wards original signed prescriptions are posted to Pharmacy, Ulster Hospital).

10.3.7 For Patient Centre Discharges, the original copy signed by the doctor and the 2 registered nurses dispensing the medication must be sent to pharmacy.
10.3.8 The patient should be instructed to take a copy of the prescription to the General Practitioner NOT the community pharmacy.

10.3.9 Before dispensing, a careful check of the prescription must be undertaken to ensure it is signed, complete and accurate when checked against the in-patient kardex. Care must be taken in checking all ‘when required’ medicines and medicines on other prescribing sheets (e.g. insulin) if required. A check must be made to ensure the patient is not prescribed a documented allergen.

10.3.10 The Registered Nurse must write the labels and check them against the prescription before dispensing.

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

10.3.12 The prescription and dispensed medicines must be checked and witnessed by a second Registered Nurse.

10.3.13 Staff should provide a patient information leaflet (a legal requirement) and additional information where appropriate such as Warfarin booklet, steroid card, angina booklet, instructions for inhalers. Patient information leaflets can be downloaded from www.medicines.org.uk

10.3.14 Labels must be legible, indelible, comprehensible and in English. Refer to Trust interpreting service for patients whose first language is not English.

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

- Patient's name
- Ward and Hospital
- Date of dispensing
- Name of medicine (using generic name except for items exempt from generic prescribing policy (see 7.2.5)
- Directions for use (do not write “as directed”)
- Quantity
- Keep out of Reach and Sight of Children
- Cautionary and advisory information found in Appendix 9 BNF.
- If appropriate: “FOR EXTERNAL USE ONLY” (if appropriate)
- Expiry date (liquids)
11. Return and disposal

This section must be read in conjunction with the SET Policy on Waste Management SET/Gen (29) 2010 which is currently under review.

11.1 Principles

11.1.1 Disposal of medicines complies with legal requirements and health and safety regulations. Medicines that have expired or are not reusable are disposed of in wards, theatres, departments as per SET Policy for waste management. Only re-usable medicines are returned to pharmacy.

11.1.2 Containers or packages are kept securely or under surveillance whilst awaiting collection or in transit between the ward or Pharmacy and the final destination.

11.1.3 Specific arrangements are in place for the disposal of controlled drugs to meet legal requirements (see section 12 and ward CD procedure).

11.1.4 Specific arrangements are in place for the disposal of hazardous medicines to meet health and safety requirements.

11.2 Return of medicines to the pharmacy

11.2.1 Pharmacy will not accept normal ward/department stock items to be returned. Ward staff must ensure they do not over order items which are on the ward stock list.

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

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

11.2.4 All medicines brought into hospital by patients remain their own property. They may be returned to Pharmacy for disposal if they are no longer required. They must only be disposed of with the consent of the patient, or the patient’s representative. If a patient leaves their drugs behind without signing the consent form, pharmacy will hold them for a period of seven days after which they will be destroyed if the patient does not return to collect them.
11.3 Procedure for the disposal of Medicines
Refer to the Trust Policy and Procedures on Waste Management

11.4 Re-use of medicines
11.4.1 All medicines returned to the Pharmacy are checked to ensure that their quality and integrity have been maintained before they are issued for re-use.

11.4.2 A patient’s own medicine must never be used for another patient.

11.5 Controlled drugs
See procedure available on ward.

11.5 Cytotoxic medicines
11.5.1 Unused and partially used cytotoxic medicines must be disposed of as per the detailed procedures outlined in the Trust’s Policy and Procedure on Waste Management.
12. **Controlled Drugs**

12.1 **Principles**

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

- Misuse of Drugs Act 1971
- Misuse of Drugs (NI) 2002
- Medicines Act 1968
- Misuse of Drugs (Safe Custody) Regulations 1973
- Use and Control of Medicines (DHSS&PS) April 2004
- DHSS Safer Management of controlled drugs. A guide to good practice in secondary care (Northern Ireland) 2009
- The controlled drugs (Supervision of management and use) regulations (Northern Ireland) 2009

12.1.2 Each Head of Department is responsible for ensuring staff comply with the standing operating procedure (SOP) for ordering, security, transport, receipting, prescribing, administration, disposal and return of schedule 2 controlled drugs in their area of responsibility.

12.1.3 In the community section, it is the responsibility of each District Nursing Sister/Treatment Room Sister, Midwife and Officer in Charge for ensuring staff comply with the Trust’s systems and procedures in place for the management of controlled drugs within his/her area of responsibility. A template for local adaptation can be obtained for pharmacy.

12.1.4 The Head of Pharmacy and Medicines Management is responsible for the development of the systems and procedures for the management of controlled drugs in the Trust.

12.1.5 There are five schedules of medicinal substances which are subject to various levels of control (see table). Wards and departments should follow their SOP for schedule 2 and 3 CDs. Community staff should follow the procedures below.
### Schedule 2 and 3 controlled drugs in SET

<table>
<thead>
<tr>
<th>Schedule 2 drugs</th>
<th>Schedule 3 drugs</th>
</tr>
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<tbody>
<tr>
<td>• Opiates ie</td>
<td>• Diazepam tablets and liquids</td>
</tr>
<tr>
<td>Alfentanil</td>
<td>• Midazolam</td>
</tr>
<tr>
<td>Buprenorphine including Butrans</td>
<td>• Phenobarbital</td>
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<tr>
<td>Codeine injection</td>
<td>• Ketamine</td>
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<tr>
<td>Diamorphine</td>
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<td>Fentanyl</td>
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<tr>
<td>Hydromorphone</td>
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<tr>
<td>Methadone</td>
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<td>Morphine</td>
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<td>Oxycodone</td>
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<td>Pethidine</td>
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<tr>
<td>Remifentanil</td>
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<tr>
<td>• Amphetamines</td>
<td></td>
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<tr>
<td>• Nabilone</td>
<td></td>
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<tr>
<td>• Secobarbitol</td>
<td></td>
</tr>
<tr>
<td>• Temazepam</td>
<td></td>
</tr>
<tr>
<td>• Strong Potassium Solutions (potassium chloride 15%, dipotassium hydrogen phosphate, Addiphos®)</td>
<td></td>
</tr>
</tbody>
</table>

### 12.2 Management of Controlled Drugs by District Nursing Staff

#### 12.2.1 Ordering, delivery and receipt of Controlled Drugs (Community)

- It is the responsibility of the GP or authorised prescriber in the community to prescribe the controlled drugs. The patient or their representative collects the prescription from the GP practice and the controlled drugs from the community pharmacist.
- The District Nurse may collect the prescription from the prescriber and the controlled drugs from the community pharmacist only in very exceptional circumstances e.g. (i) if no relative or carer is available at any time to collect the prescription and the drugs are for a patient who urgently needs them (ii) if the community pharmacist will deliver the drugs but not collect the prescription from the GP. In such circumstances controlled drugs must be taken directly to the relevant patient. This should not require a journey outside the normal geographical area.
- Patients on discharge from hospital should be supplied with up to 7 days supply on discharge into the community (if required).
12.2.2 Storage of Controlled Drugs (Community)

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

12.2.3 Checking and Administration of Controlled Drugs (Community)

- All supplies of controlled drugs are counted, documented and signed on the patient’s drug prescription sheet by the District Nurse.
- Controlled drugs are counted and checked before and after each administration and recorded on the Stock Control sheet in the patient’s nursing record.

12.2.4 Disposal of Controlled Drugs (Community)

- Controlled drugs are the property of the patient. Permission of the patient or their representative should be sought before disposal.
- Apart from small amounts of liquid medicines, no medicinal products should be disposed of through the sewage system, unwanted medicines should be returned to the Community Pharmacist that supplied them.
- When no longer required steps should be taken to have the controlled drugs returned to the community pharmacist by the patient or their representative for disposal.
- If the relatives/carers are unable to return the drugs to the community pharmacy, the community nurse may return them on their behalf. Details of the controlled drugs returned to the community pharmacist must be documented in the patient’s record. Signatures from the patient or their representatives and the nurse concerned must be included. The nurse should also ask the community pharmacist to sign the patient’s record acknowledging receipt of the medicines.
- In instances where there is police involvement following the death of a patient the controlled drugs should not be disposed of. They should be secured until the police arrive and take control of them for delivery to the Coroner or for evidence in any subsequent police investigation. The District Nurse should advise police that the controlled drugs should be disposed of (as above) as soon as possible. Police investigations take priority over all other considerations and there should always be proper communication between health professionals and police officers especially concerning the disposal of controlled drugs.
- Once the nurse concerned has taken all possible steps to ensure the safe removal of controlled drugs from the home then the responsibility no longer rests with them.
13 Unauthorised drug(s) or other suspicious substance(s) found in the possession of a patient

13.1 Principles

13.1.1 The Trust has procedures in place to deal with situations where unauthorised drug(s) or other suspicious substance(s) are found in the possession of a patient.

13.1.2 The Policy complies with and reflects the contents of the following:

- Drug and substance misuse in mental healthcare settings, guidelines for service providers, DoH Oct 2004
- Misuse of drugs Act 1971
- Misuse of drugs legislation (Northern Ireland) 2002
- Health and Safety legislation
- Equality and Human Rights legislation
- Data Protection Act

13.1.3 A record is kept of each step where a medicine changes hands, and when it is administered or destroyed. The form for recording unauthorised drug(s) or other suspicious substances found in the possession of a patient and their removal and/or destruction is available on the Trust Intranet. (Departments>pharmacy>forms)

13.1.4 Under the Misuse of Drugs Act 1971, those in charge of premises have a responsibility to inform the police if they believe anyone is committing an offence on their property. They may be liable to prosecution if they allow such activity to take place on their premises.

13.1.5 Senior management should be involved in a decision to disclose information to the police and the decision should be fully discussed with the clinical team.

13.1.6 Policies must comply with data protection and human rights legislation and staff must act within their code of professional conduct at all times.

13.1.7 Patient's consent should be obtained to allow the destruction of drugs and substances which are lawful e.g. alcohol, previously prescribed medication and Over the Counter (OTC) medication.

13.1.8 Where staff suspect that the patient may be a danger to themselves and others as
a result of receiving lawful substances/drugs that they have not consented to the destruction of, every attempt must be made to return the drugs/substances to a carer/relative. Clear records of all decisions must be kept.

13.1.9 Illicit/illegal drugs and non-prescribed controlled drugs should never be returned to the patient.

13.2 Procedure
13.2.1 The member of staff finding the substance must inform the manager of the unit/senior nurse on site, the doctor in charge of the patients and senior management.

13.2.2 If the patient is suspected of misusing drugs/substances, the primary concern must be the safe care and treatment of the patient. A risk assessment should be undertaken and recorded, taking account of a history of alcohol/drug use and any relationship to episodes of violence. The patient’s treatment plan may need to be reviewed.

13.2.3 The patient should then be asked to surrender the unauthorised/suspicious substance. The process must be agreed with the patient, the patient’s consultant, the pharmacist and senior management. If there is a likelihood of confrontation additional staff should be summoned to deal with the situation. It may be necessary to contact the police for assistance.

13.2.4 The multidisciplinary team should consider the seriousness and extent of the incident, including the potential evidence of possession, trafficking or related offences and make the decision on whether the police should be notified.

13.2.5 The senior managers and the patient’s consultant should clarify what information will be given to the police and nominate an appropriate spokesperson to give this information.

13.2.6 The unauthorised/suspicious substance should be placed in an appropriate container and sealed with a label that is signed by the member of staff finding the substance and the senior manager present. The description, form, colour and quantity of the substance must be included on a label attached to the container. The patient’s name, hospital number, date of birth or date of admission must not be added to the label as the container may need to be passed to the police.

13.2.7 The “Form for recording unauthorised drugs(s) or other suspicious substance(s) found in the possession of a patient and their removal and destruction” must be completed
by ward staff and pharmacy informed (available on Trust Intranet Departments>pharmacy>forms). The container should then be stored in the ward/department controlled drugs cabinet until it is removed by the pharmacist for safe storage. Each form is numbered chronologically by the pharmacist when they record the entry in the pharmacy register.

13.2.8 Detailed entries must be made in the patient’s notes. The entries must detail the processes undertaken and decisions made. The other professionals involved must sign entries in notes when involved in the process.

13.2.9 The appropriate response for the media must be agreed with the senior management team and the public relations department if required.

13.3 Documentation and destruction of unauthorised drugs or other suspicious Substances

13.3.1 The nursing staff must complete section A of the ‘Form for recording unauthorised drugs(s) or other suspicious substance(s) found in the possession of a patient and their removal and destruction’.

13.3.2 Where the quantity of drug(s)/substances(s) found in the patient's possession is consistent with personal use, the pharmacist will be requested to remove the drug(s)/substance(s) for destruction by the DHSSPS Misuse of Drugs Inspector. It is not possible to specify what represents ‘consistent with personal use’ and the decision to involve the police, or otherwise, would be made jointly by the senior professional dealing with the patient, with legal advice from the Trust's Solicitor if necessary, depending on the individual circumstances at the time.

13.3.3 Where the quantity of the drug(s)/substances(s) found in the patient’s possession is not consistent with personal use, part B and C of the form must be completed and legal advice must be sought before the police are involved.

13.3.4 The pharmacist will complete part C of the form and accept responsibility for the storage and disposal of the unauthorised or suspicious drug/substance, when it is removed from the ward CD cupboard. An entry in the pharmacy register will also be made.

13.3.5 The pharmacist will store the unauthorised drugs or suspicious substances in the pharmacy controlled drug cupboard until they are collected by the DHSSPSNI Misuse of drugs inspector or a drugs squad officer.
13.3.6 One copy of the full form (sections A to C) must be filed in the patient’s medical record and one copy must be retained by the pharmacy department.
14. Drugs taken in overdose

14.1 Principles
14.1.1 In situations where the overdose is fatal or appears suspicious the PSNI must be contacted. Patient or relative consent is not required in this situation. The medication must be kept for the PSNI and this information documented in the patient’s medical notes.

14.1.2 The medication must be handed over to the PSNI as evidence. The name, date and signature of the PSNI officer collecting the medication must be completed on the medication record in the self harm pathway.

14.2 Procedure
14.2.1 Patients overdosing on medication should be put onto the “self harm pathway”

14.2.2 A record of the name of the medication, dose and amount ingested and the time taken must be documented in the patient’s medical notes/self harm pathway.

14.2.3 Consent for the removal and destruction of all the medication listed must be obtained from the patient or their relative/carer and documented on the medication record in the self harm pathway.

14.2.4 Medication must be destroyed at ward level in line with SETrust waste guidelines in the presence of a witness who must also document and what has been destroyed on the self harm pathway.

14.2.5 If a patient refuses consent, this must be documented in the patient’s medical notes/self harm pathway. The medication may be destroyed if there is a clinical risk to the patient of not doing so.

14.2.6 If the overdose is deemed by the medical staff to be accidental then, at the discretion of the doctor, the medication may be returned to the patient on discharge and this must be documented in the patient’s medical notes/self harm pathway. It is the prescribing doctors responsibility to determine the quantity of medicines to be supplied on discharge.

14.2.7 If a young child has overdosed on an adult’s medication and there was obviously no deliberate self-harm, the medication can, if requested, be returned to the adult. The staff nurse/doctor must be satisfied that the medication will be stored out of the reach and sight of children and be enclosed in child resistant packaging.
14.2.8 As per DHSSPS Good Management: Good Records (GMGR) all documentation regarding an overdose must be retained for 3 years where there is a PSNI or Coroner’s Inquest and for 1 year for all other overdoses
15. Investigational Medicinal Products (IMPs)

15.1 Principles

15.1.1 This section should be read in conjunction with the SET policy on Management of Clinical Trials and Investigational Medicinal Products (CTMIPS).

15.1.2 An investigational medicinal product (IMP) is the pharmaceutical form of an active substance or placebo being tested or used as a reference in a clinical trial.

15.1.3 Commercial and non-commercial interventional trials of medicinal products in human subjects are regulated by the provisions of The Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended).

15.1.4 All research in the HPSS, including clinical and non-clinical research, research undertaken by HPSS staff using HPSS resources, and research undertaken within the HPSS by industry, charities, research councils and universities, must be undertaken in accordance with the requirements of the Trust Research Governance Framework.

15.1.5 Guidance on the management of clinical trials of medicines in NHS hospitals is supplementary to the overarching guidelines for the safe and secure handling of medicines in hospitals given by the Duthie Report/Use and Control of Medicines and the NHS Controls Assurance Standards on Medicines Management (Safe and Secure Handling).

15.1.6 IMPs must be manufactured in accordance with GMP in a licensed unit, labelled in accordance with annex 13 (GMP) and released for use by a Qualified Person, unless used in accordance with the terms of a marketing authorisation.

15.1.7 All medicinal products used in research must be procured, managed, stored, dispensed and distributed by the hospital Pharmacy.

15.1.8 Stocks of IMPs must not be held in offices, wards or departments (unless there are specific reasons for supplies to be held at a ward, clinic or department e.g. held on a ward because the medicine has been supplied for administration to an inpatient and this arrangement has been approved by the pharmacy department).

15.1.9 Records will be kept of receipt, dispensing, issue, administration and disposal of all IMPs. Pharmacy staff will review medicine accountability, prescription and associated forms; they will provide this documentation for use in non-commercial trials of IMPs, if not supplied by the study sponsor/coordinator.
15.1.10 Products other than the test product, placebo or comparator may be supplied to subjects participating in a trial. Such products may be used as support or escape medication for preventative, diagnostic or therapeutic reasons and/or to ensure that adequate medical care is provided for the subject or to induce a physiological response. The sponsor of a clinical trial should ensure that these Non-investigational products (NIMPs) are in accordance with the notification/request for authorisation to conduct the trial and that they are of appropriate quality for the purposes of the trial, taking into account the source of the materials, whether or not they are the subject of a marketing authorisation and whether they have been repackaged. The advice and involvement of a Qualified Person is recommended in this task.

15.1.11 Each individual involved in conducting a trial shall be qualified by education, training and experience to perform his/her tasks. These tasks will be specified on an authorised delegation log, signed by the individual and verified by the principal investigator. A current copy of the authorised delegation log must be provided to the pharmacy department prior to the start of the study. Any subsequent changes must be notified to pharmacy.

15.1.12 All staff directly involved in the treatment of a patient must be made aware of that patient’s involvement in a clinical trial, and of the nature of the trial.

15.1.13 A copy of the current version of the research protocol and the randomisation code will be held in pharmacy.

15.2 Procedure

15.2.1 The principal investigator for a clinical trial of a medicinal product must contact the Pharmacy Department well in advance of the planned start date to discuss the use of all medicinal products (both IMPs and NIMPs) in the trial setting.

15.2.2 A Protocol Impact Assessment Form (PIAF) must be completed and signed off by the Clinical Trials Pharmacist for submission to the Trust R&D Office.

15.2.3 The Clinical Trials Pharmacist will advise on regulatory compliance, source, quality, acceptability, packaging, labelling, cost and safe handling in relation to all IMPs and NIMPs.
15.2.4 The patient’s medical notes and Kardex must be annotated to indicate that the patient is a participant in a clinical trial and has been prescribed an IMP.

15.2.5 Notification of adverse events shall be in accordance with legislative requirements, Trust R&D office SOP and Trust ‘Adverse Incident Reporting Policy and Procedure including Adverse incident Investigation Procedure’.

15.2.6 No member of staff shall start or conduct a clinical trial of a medicinal product in the Trust unless all of the following have been completed:

- An ethics committee has given a favourable opinion.
- The clinical trial has been authorised by the licensing authority (The Medicines and Healthcare products Regulatory Agency).
- Trust Research Governance approval has been obtained and the medicines have been receipted and checked and are ready to dispense.
16. **Medical Gases**

16.1 **Principles**

16.1.1 Medical gases are medicinal products under the provision of the Medicines Act 1968.

16.1.2 Medical gases are managed and controlled to the same level as other medicinal products with regard to authorisation to prescribe, ordering, administration, storage and security.

16.1.3 Medical gases are only prescribed by a UK registered doctor, dentist or Trust authorised prescriber.

16.1.4 Medical gases must be prescribed on the patients Medicine Prescription Chart (Trust authorised documentation).

16.1.5 Appropriate risk management and operational arrangements are followed for the prescribing, administration, ordering, storage and quality control of medical gas supplies.

16.1.6 The Trust Medical Gas Pipeline Operational Policy details the management of the Medical Gas Pipeline System (MGPS). This section of the Medicinal Policy deals mainly with the operational arrangements for the handling of medical gas cylinders and complements the information covered in the MGPS policy.

16.1.7 The Head of Department, the Head of Pharmacy and Medicines Management, the Facilities Manager, the Estates Operational Manager and the relevant laboratory manager must ensure that all staff in their area of responsibility are adequately trained regarding medical gases, both in routine use and in emergency situations.

16.1.8 The appropriate documentation showing a clear audit trail for the ordering, delivery, receipt and return of medical gas cylinders to the medical gas compound must be completed to ensure compliance with HTM 0102.
16.2 Areas of responsibility

16.2.1 Nursing staff

- The Head of Department is responsible for the safe and secure storage, handling and use of medical gases in his/her area of control. This includes ensuring the availability and maintenance of the necessary equipment.

- The Head of Department is responsible for ensuring effective and efficient stock control. This includes ensuring that the stock levels agreed with pharmacy are adhered to and regularly reviewed. Cylinders should be checked twice daily to ensure they are stored correctly, the number and size of cylinders present on the ward is in line with agreed stockholding, and that the cylinders held contain adequate amounts of gas to meet normal clinical requirements. Recording sheets are available on the pharmacy intranet page (Departments>pharmacy>forms).

- It is essential to ensure an appropriate audit trail exists whenever cylinders arrive or leave clinical areas. Nursing staff should keep clear records to show when and where cylinders leave and return to ward areas. Forms available on the pharmacy intranet page (Departments>pharmacy>forms).

- Before a cylinder is released from the ward with a patient, nursing staff must ensure they are satisfied the cylinder contains enough gas to cover the period the patient will be absent from the ward. This calculation should take account of the patients current flow rate and also include extra supplies to allow for unexpected delays e.g. delayed procedure or transport problems. This would commonly be around an extra two hours worth of medical gas. Details can be found on the oxygen cylinder run times chart (available on the pharmacy intranet page: Departments>pharmacy).

- The senior nurse/nurse in charge is responsible for ordering replacement cylinders and signing for receipt of the new cylinders when delivered to the ward by portering staff.

16.2.2 Pharmacy

- The Head of Pharmacy and Medicines Management is responsible for the procurement and supply of medical gases and medical gas cylinders.

- The Head of Pharmacy and Medicines Management is responsible for the quality of medical gases, and for ensuring that the required quality testing is
provided under the Permit to Work System.

- Pharmacy is responsible for ensuring adequate stock levels of medical gas cylinders are procured for the Trust.
- Pharmacy is responsible for the charging of medical gas cylinders used to the appropriate user.

### 16.2.3 Portering Services

- The Patient Experience Manager is responsible for the maintenance, safety, and security of cylinder storage areas and associated transportation equipment.
- The Patient Experience Manager is responsible for the supply and issue of cylinder trolleys.
- The Patient Experience Manager is responsible for ensuring that portering staff complete the delivery sheets and return them to the Helpdesk/Pharmacy so that an audit trail is available.

### 16.2.4 Laboratories and other departments

- Laboratories and other departments that use special and industrial gases are responsible for ordering and managing their own supplies of gas cylinders. These cylinders must be segregated from medical gas cylinders.

### 16.3 Storage of medical gas cylinders (wards and departments)

#### 16.3.1 The Head of Department is responsible for the safe and secure storage of medical gas cylinders in the ward or department, and for ensuring the following:

- Cylinders must be located in a safe position and secured so they cannot fall over. Cylinders must not be stored or used freestanding.
- Cylinders must be located near to an exit so that they can be removed quickly in an emergency such as a fire. However, they must not block the exit, or present any other type of hazard.
- Cylinder storage areas must be well ventilated.
- Cylinders must be sited away from storage areas containing highly flammable liquids and other combustible materials, and from sources of heat or ignition.
- Warning notices prohibiting smoking and naked lights within the vicinity of the cylinders must be posted.
- Cylinders containing liquefiable gases must be stored and used upright with the
valve uppermost unless the attached equipment is specifically designed to withdraw liquid from the container.

16.4 Cylinder stores

16.4.1 The Facilities/Support Services Manager is responsible for the safe and secure storage of medical gas cylinders in the cylinder stores, and for ensuring the following:

16.4.2 The cylinder stores must be kept locked when not in use. Access must be restricted to authorised personnel only i.e. pharmacy, portering and technical services personnel.

16.4.3 Medical and industrial (non-medical) gases must be stored separately.

16.4.4 Cylinders of size “F” and greater must be stored secured in the vertical position to prevent toppling. Cylinders of size “E” and smaller must be stacked horizontally on racks to prevent damage to the cylinder paintwork.

16.4.5 Different sizes and types of medical gas cylinders must be stored in separate racks or defined areas.

16.4.6 Full cylinders must be arranged so that oldest stock is used first. On receipt, cylinders must be positioned in the store such that good stock rotation is maintained.

16.4.7 Cylinders must not be subject to extremes of temperature.

16.4.8 Full and empty cylinders must be segregated in clearly defined areas.

16.4.9 Cylinders marked as faulty must be segregated in a clearly defined area.

16.4.10 Cylinders must not be defaced by marking with chalk, paint, crayon or other material.

16.4.11 Cylinders containing oxygen and oxidants must be stored segregated (if possible by a physical barrier) from flammable gases. Flammable gases must not be stored routinely, and if required, quantities must be kept to a minimum.

16.4.12 The cylinder stores must be kept clean and dry and free from inflammable material.
Rubbish must not be allowed to accumulate.

16.4.13 The area surrounding the stores must be kept free of vegetation or other combustible materials. If weed killers are required, chemicals which are a potential fire hazard (e.g. sodium chlorate) must not be used.

16.5 Safe handling and use of medical gas cylinders

16.5.1 Medical gas cylinders, though robust, should be handled with care and only by personnel who have received training in this process and understand the hazards involved. The details given below are intended to serve as a reminder to staff who regularly handle and transport cylinders and who have received formal training in this process. The guidelines are therefore intended to supplement, and not replace, formal training in this process:

- Do not smoke or use naked lights in the immediate vicinity of a cylinder or in confined areas where cylinders are kept or stored.
- Do not subject cylinders to temperatures above 45 degrees centigrade.
- Use the appropriate protective clothing (gloves, overalls, safety boots). Heavy protective gloves (preferably textile or leather) and protective safety footwear must be worn when loading or unloading cylinders. Gloves, protective boots and overalls must be clean and free from oil or grease.
- Ensure cylinders are kept free from dirt, grease and oil.
- Ensure all equipment used to transport cylinders (e.g. trolleys) is clean and free from dirt, grease and oil.
- Handle cylinders with care. Do not allow them to knock against each other or against other pieces of equipment. Ensure cylinders are secured to prevent them falling or rolling against each other during transport.
- Do not use cylinders as rollers. Do not roll or drag cylinders along the floor.
- Avoid lifting cylinders by their caps or valves where possible.
- Move cylinders only with the appropriate size and type of trolley. Do not use stretchers or wheelchairs.
- Use medical gas cylinders for medical treatment only (normally associated with respiratory function) and not for other purposes such as welding, laboratory experiments, etc.
- When transporting cylinders attached to medical equipment, ensure that the gas supply is switched off and the cylinder valve is closed, unless the
equipment is attached to a patient. When cylinders are moved with apparatus attached always close the cylinder valve first and vent any residual gas to the atmosphere.

16.5.2 Equipment for use with medical gases

- All administration equipment must comply with the relevant British Standard and must only be used with the gas for which it is designed.

16.5.3 Precautions for oxygen therapy

There is a serious risk of fire when patients smoke or are in close proximity to other forms of ignition when receiving oxygen therapy. Oxygen, although not flammable, will increase the burning rate of any combustion. The following precautions must be taken:

- Fire and safety warning signs must be conspicuously displayed in all wards and departments where oxygen is to be administered (available from the Fire Officer).
- Smoking must not be permitted in the room or area where oxygen is being administered or stored. Other sources of ignition e.g. lighters, matches, open fires, cookers must be removed.
- Special consideration needs to be given for oxygen tents and canopies. Only toys approved by the Fire Officer should be given to a child receiving oxygen therapy.
- Patients receiving Oxygen therapy must not have petroleum jelly applied around their nasal cannulae as it is flammable.

16.5.4 Safe transport of medical gases

- The Facilities/Support Services Manager must ensure that the risks arising from the transport of gas cylinders around the hospital site are assessed, and appropriate precautions established and applied.
- Gas cylinders must only be transported using containers and or vehicles which are appropriate for the size and number of the cylinders, and which allow all cylinders to be firmly secured either horizontally or vertically.
- Lifts should be used whenever practicable when gas cylinders are taken from one floor to another. Cylinders of sizes G or larger should never be manually handled up or down stairs.
- When transporting a patient receiving oxygen therapy, it is the responsibility of
the transferring nurse to ensure adequate oxygen is available in the cylinder for the duration of the transfer, it is correctly attached to the patient and the oxygen cylinder is firmly secured

- During transit the patient must be accompanied by a member of staff trained in the use of oxygen cylinders.
- If a patient receiving oxygen therapy needs to be transported home for either a home assessment or home discharge the patient should be transported by ambulance.
- Book an ambulance in the usual way via Ambulance Control and request a two-man ambulance with oxygen.
- Portable oxygen will be required once inside the patient's home. - If the patient is on a home visit it is important to ensure enough oxygen is available for the patient should the return of the ambulance be delayed.
- If the patient is to be discharged the doctor arranging the discharge has the responsibility for arranging home oxygen in liaison with the patient's GP. - However, it is important to ensure a suitable quantity of oxygen is available in the home prior to discharge.
- If an oxygen concentrator is ordered the patient may initially require the use of oxygen cylinders or require oxygen cylinders for use in emergencies, again arranged through the patient's GP.
- The managers of departments which require the transportation of gas cylinders in motor vehicles, must ensure that all such vehicles are equipped so that cylinders can be firmly secured and that drivers are trained in the legal and safety requirements.
- Cylinders must only be carried in motor vehicles if they can be securely fastened in the boot of a car or rear of a van.
- Drivers must carry the appropriate handling information for the gas and be familiar with its contents.
- Any incident that causes a significant impact to a gas cylinder must be reported immediately to the relevant manager and to the pharmacy. The cylinder must be removed from the clinical area and quarantined in the medical gas store for testing by the supplier.
16.6  Provision of medical gases for home births

16.6.1 Ulster Hospital
The community midwife in charge is responsible for arranging the provision of Entonox and oxygen for home births. The following actions must be taken:

- Arrange the supply of two Entonox size F, one oxygen size PD and one oxygen size E to the home by the 37th week of pregnancy. Cylinders are ordered via the Facilities Management help desk, associated equipment from Maternity Ward and transport is arranged with the Trust Facilities Management help desk.
- Inform and advise the woman on the safe storage and use of medical gas cylinders.
- Arrange return of used and unused cylinders and associated equipment to the proper storage site at the Ulster Hospital.
- Entonox and oxygen for home births are ordered via pharmacy store. The community midwife will arrange for transport to collect and deliver to the woman’s house along with the home birth equipment. Following delivery the community midwife arranges for transport to return the cylinders to the pharmacy store and informs pharmacy that have been returned.

16.6.2 Lagan Valley Hospital
The midwifery team leader is responsible for arranging the provision of Entonox and oxygen for home births. The following actions must be taken:

- Arrange the supply of two Entonox size F, one oxygen size PD to the home by the 37th week of pregnancy. Cylinders are ordered via facilities management/support services who complete medical gas ordering form and return to pharmacy department. Associated equipment from the Midwifery Lead Unit and transport is arranged with the facilities management/support services.
- Inform and advise the woman on the safe storage and use of medical gas cylinders.
- Arrange return of used and unused cylinders and associated equipment to the Midwifery Lead Unit at LVH, then arrange via facilities management help desk to have cylinders returned to appropriate storage area.

16.6.3 Downe Hospital
The midwifery team leader is responsible for arranging the provision of Entonox and oxygen for home births. The following actions must be taken:

- Arrange the supply of two Entonox size F, to the home by the 37th week of pregnancy. Cylinders which are taken from storage area within Midwifery Lead Unit. Associated equipment from the Midwifery Lead Unit and transport is arranged with facilities management/support services. (Oxygen is prescribed by GP and obtained by patient from their local pharmacy, otherwise it can be supplied by the Midwifery Lead Unit)
- Inform and advise the woman on the safe storage and use of medical gas cylinders.
- Arrange return of used and unused Entonox cylinders and associated equipment to the Midwifery Lead Unit, then arrange via facilities management/support services to have Entonox cylinders replenished if empty and returned to appropriate storage area within the Midwifery Lead Unit.

16.7 Ordering of medical gas cylinders by wards and departments

16.7.1 Routine orders for cylinders must be telephoned to the Facilities Management help desk or to the designated portering teams.

16.7.2 Each ward/department has an agreed range and stock holding of medical gas cylinders. Cylinders will normally only be replaced on a full for empty basis. Cylinders will only be delivered if the requesting ward or department has appropriate storage facilities and equipment.

16.7.3 Cylinders may be supplied on a temporary basis when usage in a particular ward or department is high or for gases that are not normally stocked. This must be arranged through Pharmacy. When ordering such cylinders the purpose and the expected duration of need must be stated in writing.

16.7.4 The Helpdesk/porter will complete a medical gas delivery sheet for each type and size of medical gas cylinder requested. This will be signed by the nurse receiving the delivery and the number of cylinders being returned will be noted. The porter will return the form to the Help desk for collection by pharmacy.
16.7.5 The empty/used cylinder must be returned to the cylinder store.

16.7.6 All returned cylinders will be considered “empty” and returned to the supplier at the earliest opportunity.

16.8 Faulty cylinders

16.8.1 The following are typical complaints that can be classified as a fault:

- **Contents**: empty or part-full (where the cylinder is not required for immediate use).
- **Cylinder**: faulty valve operation
  - damaged valve outlet
  - minor leaks from valve

16.8.2 The senior nurse/nurse in charge is responsible for the reporting of faulty cylinders or cylinders involved in an incident in their ward or department. The following action should be taken:

- The faulty or incident cylinder must be labelled with the ward details and ‘FAULTY – DO NOT USE’
- A Trust incident form must be completed if the fault caused harm or had the potential to cause harm to a patient.
- Pharmacy must be informed (within working hours and as soon as possible the following working day if the fault is noticed at the weekend or out of hours).
- The porters should be contacted to uplift the faulty cylinder; they must be informed that it is faulty so it can be quarantined appropriately.

16.8.3 The Patient Experience Manager is responsible for ensuring that portering staff notify pharmacy (within working hours), regarding faulty cylinders found in the medical gas stores. Faulty cylinders must be labelled as such and segregated into the designated area in the empty cylinder store.

16.8.4 Pharmacy is responsible for the notification of faulty cylinders to the supplier and making the faulty cylinder available for investigation.

16.9 Action in the event of fire

In the event of a fire, it is stressed that the safety of all personnel must be the first
As soon as a fire is discovered, immediately operate the Hospital Fire Procedure and notify the Fire Services, warning them of the presence of pipeline gas or compressed gas cylinders.

Cylinders involved in the fire that cannot be removed safely may burst due to excessive heat and therefore the immediate area must be evacuated.

Cylinders in other areas which might become involved in the fire should be moved to a safe location, provided it is safe to do so.

Unless you are trained in the use of either fire extinguishers or hose reels, do not attempt to fight a fire in which cylinders are directly involved.

If you have appropriate training, endeavour to keep the cylinders cool by using either a fire extinguisher or hose reel from a protected area. - Do not take any undue risks.

If a cylinder is connected to, but is some distance away from, an apparatus involved in a fire, and it is safe to do so, close the valve and if possible remove the cylinder from the area.

Cylinders, which have been involved in a fire, must be identified and segregated from other cylinders. Under no circumstances should their contents be used. The supplier must be informed and the affected.
17 Action in the event of a breach of security

17.1 Principles

17.1.1 A breach of security includes any deviation from the procedures that causes actual or potential loss or theft of medicines. Examples of such incidents include:

- medicines are left unattended at an insecure location
- signatures are not received when a medicine changes hands
- medicines have been handled by an unauthorised person
- medicines are found to be missing
- controlled stationery is found to be missing
- a key for medicine storage areas is found to be missing
- an unauthorised person has used controlled stationery

17.1.2 Any person who discovers a breach of security is responsible for reporting it immediately to the manager of the department concerned, and to the pharmacy.

17.1.3 The manager of the department concerned is responsible for investigating the Breach of security, and for taking the necessary action according to relevant Trust procedures. This includes informing appropriate personnel within appropriate timescales and ensuring that a Trust incident form is completed.

17.2 Action required

17.2.1 The Head of Department is responsible for investigating the breach of security, and for taking the necessary action according to relevant Trust procedures. This includes informing appropriate personnel within appropriate timescales, and ensuring that the relevant incident form and investigation is completed.
18. **Defective medicines**

18.1 **Principles**

18.1.1 Official notification of a defective medicine is issued to Pharmacy from the DHSSPS as a Drug Alert, or from the manufacturer or supplier.

18.1.2 The Head of Pharmacy and Medicines management is responsible for ensuring systems are in place to cascade Drug Alerts as appropriate within the Trust with a required timescale for action.

18.1.3 Ward/Department Sister or Charge Nurses are responsible for actioning Drug Alerts within the required timescale for action.

18.2 **Reporting a defective medicine**

18.2.1 If any member of staff has reason to believe that a medicine is defective, he or she must inform Pharmacy immediately.

18.2.2 The person who discovers the defect must ensure that the product, container and other packaging are retained. If the defect has been discovered following reconstitution or mixing with another preparation, then the mixture, remaining unmixed constituents, and all containers and other packaging must also be retained.

18.2.3 All retained materials must be placed in a sealed container, clearly marked ‘Do not use’, and returned to the pharmacy as soon as possible.

18.2.4 The member of staff returning the product to pharmacy must provide name, ward and contact details to enable follow up of the report.

18.2.5 The member of Pharmacy staff receiving the defective product must complete a Suspected Defect Form and submit it to MHRA Defective Medicines Report Centre (DMRC)
19 Medication incidents

19.1 Principles

19.1.1 The Trust Adverse Incident Reporting Policy is in development. Please also refer to legacy UCHT policies:
- Policy and Procedures for the Reporting and Management of Incidents
- Policy for Completing Form IR1 - Near Miss & Incident Record Form
- Policy and Procedures for the Completion of Near Miss and Incident Investigation Proforma IR2
- Policy And Procedure For The Reporting Of Serious Adverse Incidents
- Policy And Procedure For The Investigation And Root Cause Analysis Of Incidents, Claims And Complaints

19.1.2 A medication incident is “Any preventable medication related event that could have or did lead to patient harm, loss or damage”. This includes “near misses” i.e. where the incident was prevented from reaching the patient but had the potential to cause harm.

19.1.3 A medication incident could happen at any stage of the process: prescribing, dispensing, administration, monitoring or provision of medicines related information.

19.1.4 Medication incidents and Near Misses should be reported and investigated as appropriate to ensure that appropriate corrective action is taken, and to ensure the appropriate preventative action is taken to avoid recurrence (see 19.2 and 19.3.3).

19.1.5 When an incident occurs the priority is looking after the patient and ensuring they are managed appropriately.

19.2 Reporting and Documenting a medication incident:

19.2.1 Refer to UCHT Policy and Procedures for the Reporting and Management of Incidents 8.2.2

19.2.2 Medication incidents must be reported using the Trust Incident Reporting Form (IR1 Form).

19.2.3 Pharmacy staff and other specifically designated staff groups, e.g. Dieticians, may use Med-i-forms to report incidents with insignificant actual impact only i.e. “no harm” incidents.

19.2.4 Only record known facts, not opinions, assumptions or judgements.

19.2.5 Completed incident forms (IR1 forms and Med-i-forms) must be forwarded to the
Medicines Governance Pharmacist.

19.2.6 Medication incidents must be reported to the Line Manager of any staff member involved in the incident.

19.2.7 The Trust promotes an open, just, honest and participative incident reporting culture. Completion of an incident form will not lead to disciplinary action except where acts or omissions are malicious, criminal or constitute gross or repeated professional misconduct (see UCHT Policy and procedures for the reporting and management of incidents 17).

19.3 Follow up of medication incidents which reach the patient

19.3.1 Refer to Policy and Procedure For The Reporting and Management of Incidents and Policy and Procedures for the Completion of Near Miss and Incident Investigation Proforma IR2.

19.3.2 Medical, nursing and midwifery staff should discuss a medication incident with the patient, next of kin or main carer/advocate where appropriate and record the discussion in the patient’s notes.

19.3.3 The Head of Department will ensure that incidents reports are investigated where appropriate and that necessary action is taken.

19.4 Monitoring and review of medication incidents

19.4.1 The Medicines Governance Pharmacist produces a quarterly report of medication incidents which is presented to the Lessons Learnt Committee and Drugs and Therapeutics Committee. These committees will ensure appropriate action is taken to raise awareness on specific areas of risk identified in the use of medications.

19.4.2 Data from the medication incident quarterly report is shared with the Medicines Governance Pharmacists network and a regional quarterly report provided to HSC Board.

19.4.3 Directorates/departments have a responsibility to routinely review medication incidents and near misses in their area of responsibility. The Medicines Governance Pharmacist will provide reports on request to assist in this process.
20. **Adverse drug reactions (ADR)**

20.1 **Definition**

20.1.1 Any drug may produce unwanted or unexpected adverse reactions. DHSSPS defines an adverse reaction as a harmful or non-beneficial symptom or syndrome occurring as a result of the *correct clinical use* of a product which is not defective.

20.1.2 Detection and recording of adverse drug reactions is of vital importance in order that unrecognised hazards of drug therapy are recognised promptly and appropriate action is taken to ensure medicines are used safely.

20.2 **Reporting an ADR**

20.2.1 The Medicines and Healthcare products Regulatory Agency (MHRA) database facilitates the monitoring of adverse drug reactions. All healthcare professionals should report adverse drug reactions directly to the MHRA through the voluntary yellow card scheme. This can be done electronically at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk). Alternatively hard copies of yellow cards are also available bound into the British National Formulary (BNF) and can be posted to FREEPOST YELLOW CARD.

20.2.2 Suspected adverse drug reactions to any therapeutic agent should be reported. This includes drugs (self-medication as well as those prescribed) blood products, vaccines, radiographic contrast media, complementary and herbal product.

20.2.3 The black triangle symbol ( ) identifies *newly licensed medicines*. These are monitored intensively by the MHRA who ask that all suspected reactions (*including those considered not to be serious*) are reported through the Yellow Card scheme.

20.2.4 For established medicines and vaccines:

- all *serious* suspected reactions should be reported (includes reactions that are fatal, life-threatening, disabling, incapacitating, or which result in prolonged hospitalisation).
- there is no need to report well-known relatively minor side-effects e.g. constipation with opioids

Further information and advice on drug safety issues can be obtained from the MHRA website [www.mhra.gov.uk](http://www.mhra.gov.uk)
EQUALITY STATEMENT

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote Equality of Opportunity.

In line with the duty of equality this policy has been screened against particular criteria and as a result no major issues requiring further impact assessment have been identified.

This policy has also been considered and prepared with regard to the Trust’s obligation under the Human Rights Act 1998. The Trust is satisfied that the policy complies with its obligations under the Act.

If at any stage of the life of the policy there are any issues within the policy which are perceived by any party as conflicting with his/her rights, that party should bring these to the attention of the Director of Human Resources or raise a complaint through the published complaints procedure.

Dr C Martyn
Medical Director

Mrs Charlotte McArdle
Director of Nursing, Primary Care & Quality

Dr Janet Harding
Chair, SET Drug and Therapeutics Committee

Jill MacIntyre
Head of Pharmacy and Medicines Management

Date

23/9/11

Date

26/9/11

Date

28/9/11

Date

28/9/11