TRUST POLICY FOR MEDICINES MANAGEMENT (MEDICINES CODES)

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Version / Amendment History	Version	Date	Author	Reason
	1.0	Jan 2022	James Hooley	Merging sovereign Policies (Burton Medicines Policy and Derby Medicines Code)
	2.0	Jan 2025	James Hooley	Section 4 - Update of Trust quality groups to match tier system introduced by Good Governance Institute. 5.5.3.3 Update of NRFit information as per NatPSA action plan, January 2025. 5.13.1 Mandatory and essential to role training updated to reflect tiered eLeanring introduced to passport in 2024. 5.14 Update to Policy exemptions including: vitamin K administration in newborns who are not yet registered; reflection of extended-scope physiologist roles; maternity NRFit exemption for punendal needles.

				Table 1 omission codes: note added to highlight that codes may differ as Nervecentre ePMA is introduced during the life of this Policy version. Section 6 Monitoring and Compliance updates.

Intended Recipients: All staff involved in medicine use processes (i.e. any of: procurement, storage, security, prescription, supply, preparation, administration and disposal of medicine).

This is most registered professionals but may also include some non-registered staff members that have extended scope or training to support medicines management at UHDB.

Training and Dissemination:

Trust intranet and Trust communications cascade. All Divisional Directors, DMD's and DND's will be sent a copy of this Policy to facilitate email cascade. It is then responsibility of the ward and department managers to inform their staff of the Policy and any updates received.

Staff involved in prescribing, supplying, administering, storing, handling or disposing of medication should receive appropriate training to enable them to carry out their duties. Familiarisation with the Policy and procedures should be included in local inductions. For nursing staff this is supported by the Professional Development team.

Initial induction training is included in medicines management training during newly qualified nurse / midwife / pharmacist inductions. Registered healthcare staff will complete Medicines Safety training as part of their essential-to-role requirements via My Learning Passport.

To be read in conjunction with:

Trust Policy – Medicines Management for Nursing Associates

Trust Policy - Controlled Drugs

Trust Policy - Medicines Reconciliation

Trust Policy - Unlicensed Medicines

Trust Policy - Self-Administration (Burton only at point of publication – UHDB Policy under development)

Trust Policy - Self- Prescribing of Medicines

Trust Policy - Medical Gas Pipeline Systems

Trust Policy – Clinical Pharmacy Enabling

Trust Policy – Non-medical Prescribing Trust Policy – Development of Patient Group Directions Trust Policy – Patient ID (positive patient identification) Trust Policy – Consent – including the mental capacity act Trust Policy – Antimicrobial Prescribing Trust Policy – OPAT – Continued administration of parenteral antimicrobials to Discharged Patients Trust Policy – Restricted Antimicrobials Trust Clinical Guideline – Mental Capacity Act consent process for patients without capacity Trust Clinical Guideline – Intravenous Therapy Trust Clinical Guideline – Oxygen (Adult and Paediatric UHDB guidelines available)
In consultation with and Date: Medicines Safety Group – July and November 2024 Professional and Practice Development (via MSG) – July and November 2024 Chief Pharmacist and Pharmacy BU - January 2025
EIRA stage One Completed Yes stage Two Completed No

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Contact for Review	Chief Pharmacist
Executive Lead Signature	Executive Chief Medical Officer

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TRUST POLICY FOR MEDICINES MANAGEMENT (MEDICINES CODES)

1. Introduction

This Policy complies with all relevant legislation and guidelines that are considered to be good practice which relate to the procurement, storage, security, prescription, supply, preparation, administration or disposal of medicines (the '*medicines use process'*). The law relating to the prescribing and use of medicines is complex. Following this Policy will ensure that the legislation, as well as best practice NHS guidance[a], will be complied with in relation to safe and secure handling of medication.

The Medicines Policy is overseen by the Medicines Safety Group.

2. Purpose and Outcomes

This document provides the overarching Policy for the use of medicines in the Trust and applies to all healthcare disciplines providing UHDB care to patients regardless of location (i.e. within the Trust itself, community or domiciliary settings).

This Policy applies to staff employed by UHDB as well as those contracted to work on a sessional basis and those employed by other organisations providing a UHDB healthcare service.

The aim of this Policy and procedure is to define statutory and best practice standards and procedures, and to ensure that these are consistently met, in order to safeguard patient care.

3. Definitions Used

3.1. General Definitions

Administer	To introduce a medicine to a patient. This includes oral/enteral, parenteral (injection), rectal, vaginal, transdermal and external application.
Controlled Drug (CD)	The drugs listed in schedules 1-5 of the Misuse of Drugs Regulations 2001 (as amended, which are subject to varying controls on prescribing, storage, record keeping, handling and disposal). See CD Policy.
Critical Medicine	Medicines where omission or delay of a single dose could lead to patient harm. See appendix 2 for examples and summary of key Policy actions.
Dispense	To make up or supply a medicine for administration to a patient (together with all the necessary technical, clinical and professional checks). Medicines are **dispensed under the**

[a] For example: DHSC, CQC, Nursing Midwifery Council, General Medical Council, Royal Colleges (including Royal Pharmaceutical Society)

	supervision of a pharmacist (Nursing staff do NOT dispense medicines. See 'supply' below)
ePMA	Electronic Prescribing and Medicine Administration system. The term ePMA is a generic term used for any electronic system the Trust uses to prescribe and administer medicines.
MAR chart	Medicines Administration Record (MAR) charts are a record for documenting administration of medicines for formal carers e.g. social care, intermediate care, patients in care homes. MAR charts are required for patients who have been assessed as needing support with their medicines in either their own home or in a care setting (e.g. care homes).
Medicine	Substances or combination of substances administered to human beings for the purpose of investigating, preventing or treating disease.
Medicines Management	A broad term describing activities that promote the safe, clinical and cost-effective use of medicines.
Medicines use process	The processes of procurement, storage, security, prescription, supply, preparation, administration and disposal of medicines.
Multi-compartment compliance aids (MCA)	
	MCAs, often referred to as 'blister packs', are compliance devices which are divided into days of the week with several compartments per day e.g. morning, lunch, evening and bedtime. These are often used by patients to help them manage their medication.
POM	A medicine included in the *Prescription Only Medicines* (Human Use) Order of the Medicines Act.
Patient Group Direction	Specific written direction for supply and/or administration of a specified medicine to well defined groups of patients for specific conditions. These may be utilised by some 'non-prescribing' but registered clinical staff as defined by legislation, and after they have been authorised individually within UHDB. Signed by a doctor and pharmacist and authorised by UHDB approved signatories as a legal document under Human Medicines Regulations 2012 (see PGD Policy)
Patient Specific Direction (PSD)	An instruction from a doctor, dentist or other independent prescriber for a medicine to be supplied or administered to a named patient after the prescriber has assessed that patient on an individual basis. e.g. written direction in patient's notes or inpatient chart (including ePMA).
Prescription	A written or electronic authorisation to supply or administer a medicine. In the hospital environment this term is routinely used to describe a written PSD

Prescribe	To authorise electronically or in writing the supply of a medicine or medical device. Prescription only medicines (POM) can only be prescribed by a registered medical or non-medical prescriber.
Registered	A health professional who is part of a state regulated profession and named on the designated register
Supply	To provide a medicine to a patient or carer for the purpose of administration or self-administration. This would also include the supply of pre-labelled discharge packs by registered practitioners ('TTO packs' or 'Discharge packs'). Supply roles may be fulfilled by a range of clinical practitioners (compare with dispensing above which is a regulated pharmacy activity in the UK).

3.2. Staff Definitions

CD Accountable Officer	Officer in a health care organisation who is responsible for the safe management of controlled drugs, as required by Controlled Drugs (Supervision and Management of Use) Regulations 2006. See CD Policy.
Appointed Pharmacist	The lead pharmacist for a Division or Department, or their deputy, who is responsible for the safe preparation and supply of a pharmaceutical product.
Appointed Practitioner	The senior registered practitioner in overall charge of a ward or department. e.g. Senior Sister, Theatre Manager or their deputy. They have overall responsibility for the safe and secure handling of medicines for a ward or department
Assigned Practitioner	A healthcare practitioner assigned to a particular task.
Designated Practitioner	The senior registered practitioner in charge of a ward or department at a particular time / shift.
Duty Pharmacist	The most senior (in-hours) or on-call (out of hours) pharmacist on duty at any particular time for each of the main Derby and Burton sites.
Medical Practitioner	Any doctor or dentist registered to practice in the UK as an independent medical prescriber.
Non-Medical Prescriber	A registered non-medical practitioner who has completed the necessary training and registration to prescribe medicines:

- Supplementary A member of an approved healthcare profession who can prescribe medicines for a named patient as part of a written clinical management plan, agreed with the patient and an independent medical prescriber.

- Independent An approved healthcare practitioner who has undertaken formal non-medical prescribing training and assessment and is registered as a prescriber with their professional body.

Nursing Associate	A state regulated nursing support role. Nursing Associates have a role in administering and managing medicines and

	these responsibilities and restrictions are outlined in the Nursing associate Medicines Policy
Registered practitioner	A state regulated and registered practitioner who is listed on a professional practice register[b]. This does NOT include voluntary registration. When used within this Policy, this definition of registered practitioner will only include registered Nursing Associates for activities which are fully outlined and supported in the separate Nursing Associate Medicines Policy
Responsible Pharmacist	The pharmacist responsible for certain registered activities as defined in the Medicines (Responsible Pharmacist) Regulations 2008.

Health Care Support worker (HCSW) A non-registered member of healthcare staff

4. Key Responsibilities / Duties

Executive Chief Medical Officer (ECMO)

The ECMO the Trust's Executive Lead for Medicines Management and has board responsibility for all aspects of medicines management. The ECMO is responsible for appointing the Chair of the Drugs and Therapeutics Group and overseeing the Medicines Management work programme of the Chief Pharmacist. The ECMO will receive professional advice directly from the Chief Pharmacist and Medical Chair of Drugs and Therapeutics. The ECMO chairs the Medicines Optimisation Group (Tier 3) which receives reports from Trustwide medication groups within the Quality Schedule.

Chief Pharmacist

The Chief Pharmacist has responsibility for ensuring the Trust complies with local and national guidance relating to medicines, and to ensure that the Divisions are fully informed of their role in maintaining the required standards of practice relating to medicines. The Chief Pharmacist is responsible for developing and maintaining the Trust Policy and Procedures for Medicines. The Chief Pharmacist is the nominated Trust Accountable Officer for Controlled Drugs and the Responsible Officer for Homecare Services.

Medication Safety Officer (MSO)

The Medication Safety Officer chairs the Medicines Safety Group and supports the chief pharmacist with the activities above and also in demonstrating compliance with national standards (e.g. CQC and RPS standards for medicines management). The MSO reports directly to the chief pharmacist. The MSO also reports to Medicines Optimisation Group on behalf of MSG for matters requiring assurance or escalation.

[b] Does not include Nursing Associates. Medicines Management responsibilities for Nursing Associates are outlined in Trust Policy – Medicines Management for Nursing Associates

Quality Governance Steering Group (QGSG - Tier 2)

QGSG receives reports and escalations from Tier 3 Trust Groups and professional leads. This includes update on key medicines issues via escalation from MOG / PSG, and directly from the Chief Pharmacist and Controlled Drugs Accountable Officer.

Patient Safety Group (PSG - Tier 3)

The PSG review regular updates from Trust groups that regularly consider medication themes. These include Thrombosis Group, Diabetes Safety Group, Nutrition Steering Group and Deteriorating Patient Group. PSG reports or escalates upwards to QGSG.

Medicines Optimisation Group (MOG - Tier 3)

The MOG receive regular updates from medication related groups in the Trust Quality Schedule. These include Medicines Safety Group, Drugs and Therapeutics Group, PGD Governance Group, Non-Medical Prescribing Group and Medical Gases Group. MOG reports or escalates upwards to QGSG.

Medicines Safety Group (MSG - Tier 4)

The Medicines Safety Group is responsible for development and audit of Policy and procedures for the safe use of medicines. This multi-professional group reviews national publications or alerts related to medication. Divisions can share learning from incidents, risks, complaints or Quality Improvement (QI) where MSG members will help share learning with the wider organisation and our external networks including the Derbyshire Medicines Safety network and the East or West Midland Medication Safety Officer forum. MSG reports to MOG.

Drugs and Therapeutics Group (DandT or DTG - Tier 4)

The Drugs and Therapeutics (DandT) Group is responsible for the safe and cost-effective use of medicines in the Trust. This multi-disciplinary Group promotes evidence-based prescribing, reviews requests for new medicines and manages the prescribing formularies. Their subgroups include Chemotherapy Subgroup, Finance Sub-group and Immunoglobulin Subgroup. DandT group report to MOG.

Joint Area Prescribing Committee

The JAPC is the local decision-making committee with responsibility for promoting appropriate, safe, rational and cost-effective medicines use across the county. It has delegated authority from Derby and Derbyshire ICB and membership includes all provider organisations in Derbyshire. JAPC maintains a 'traffic light' classification of drugs that all prescribers (primary and secondary care) should adhere to.
http://www.derbyshiremedicinesmanagement.nhs.uk/full_traffic_light_classification

Non-Medical Prescribing Group

Trust NMP lead chairs this group and manages the NMP Policy and processes associated with training, registration, continued professional development (CPD) and review of NMP roles in the organisation.

PGD Governance Group

A Sub-group (or function) of the Medicines Safety Group tasked with managing the Policy and processes for PGDs or other non-prescription methods of supply or administration for patients (e.g. other exemptions in law such as occupational health 'Written Instructions'; Midwives exemptions; any protocols to support governance for non-registered staff to support administration or supply of medicines.

Divisional Directors (Nursing and Medical)

It is the responsibility of the Divisional Directors to ensure that all staff within their Division are trained to carry out the tasks required of them relating to medicines management.

Ward and Departmental Managers

Responsibility for the operational implementation of the Trust Medicines Policy, including ensuring staff within their ward / department attend appropriate training.

All clinical staff (Registered)

Clinical staff will ensure they are familiar with all relevant sections of the Medicines Management Policy and appendices and will follow correct procedures when undertaking any medicine-related task. They should be aware of the Medicines Management and Medicines Safety training requirements of the Trust, hosted on My Learning Passport, and ensure that they are up to date with the relevant training. They will report any concerns relating to medication risk to their Line Manager or pharmacist so action can be taken. Staff are required to report any medication incidents or near misses using the Trust Incident Reporting Policy and processes (via Datix). All staff are personally accountable for their practice according to legislation and professional code of conduct and ethics. Staff must be able to justify their decisions to their peers, employers, regulatory body, Police, patients and the public.

Non-clinical or Non-registered support staff

All staff in the hospital require awareness of responsibilities around medicines security, even if they do not have any extended scope roles handling or administering medicines directly. For example, reporting open cupboards / doors or collecting and transporting medicines (porters, volunteers, engineers for pneumatic system, HCSW, discharge coordinators etc..). ALL staff in the hospital will have a brief essential-to-role training requirement hosted on My Learning Passport eLearning platform to maximise organisational awareness of this priority.

5. Medicines Policy

5.1. Medicines Procurement

Only medicines which have been approved through the Trust's Drugs and Therapeutic Group will be available for use within the Trust and all such medicines will comply with the necessary pharmaceutical quality standards. All medicines will be purchased through the Pharmacy Department and will be subject to all necessary statutory and professional procedures applying to Pharmacy Services.

5.2. Medicines Storage and Security in clinical departments

5.2.1. Responsibility for security

The appointed practitioner in overall charge of a ward or department must ensure staff are trained to manage medicines in their area; this will include non-registered staff being made aware of their limitations in respect of medicines use processes (this is further supported by essential to role training on My Learning Passport for non-registered staff at UHDB).

The appointed practitioner in overall charge of a ward or department, in conjunction with the pharmacy team, are responsible for ensuring stock levels and demand for medicines reflect normal clinical practice.

During each shift, responsibility for the security and safe use of medicines lies with the designated practitioner in charge of a ward or department at that time. This practitioner must satisfy themselves that medicines are secured and used appropriately during their shift.

Excessive or anomalous use of medicines must be investigated promptly; any suspicion of tampering, misuse or diversion (theft) of medicines must be reported to your Divisional Lead Pharmacist or the Chief Pharmacist / deputy immediately.

All medicines on wards and departments are for the use of the Trust's patients only. Any member of staff who requires any medication for themselves should either arrange to see their GP or urgent care centre, make an appointment to attend Occupational Health or may purchase 'over the counter medication' available from a registered Pharmacy. Use of hospital medication stock by staff members is theft.

5.2.2. Medicines Keys

Departmental medicine keys are the responsibility of the designated practitioner in charge of a ward or department for that shift. The designated practitioner in charge may assign keys to another registered practitioner to carry out necessary medicines use processes. Pharmacy OOH cupboard keys (POOH store, QHB site) should be treated in the same way with access restricted to registered staff.

Local SOP advised: Implementation of SOPs or key logs in each department to facilitate an audit trail of medicines access. UHDB Key log templates are available on the Trust intranet pages: Safe and Secure Medicines Audits (UHDB) | z UHDB Intranet

Requests for keys must always prompt confirmation of staff identity and keys should only ever be given to registered practitioners and nursing associates who need to carry out a medicines use process. The following exceptions permit non-registered staff to have access to medicines keys after confirming their identity:

- Non-registered pharmacy staff providing a stock top-up service (always confirm their identity e.g. Pharmacy Assistant or 'Assistant Technical Officer')
- Non-registered HCSW who have been trained to manage stock under direct supervision of a registered practitioner (see also exceptions register in Section 5.14 for areas with approved extended scope to perform without supervision)
- All non-registered staff may be assigned the key to the RDH pharmacy collection locker ("pigeonhole") for the purpose of collecting dispensed medicines and delivering back to a registered staff member on the ward.

Medicine keys must be kept separate from other department or personal keys. Note: Controlled Drug keys must be further segregated from all other medicine keys and only given to registered staff who are authorised and have legitimate reason to access the CD cupboard (see Controlled Drugs Policy)

Two or more sets of medicines keys may be held by ward or department teams on duty. A spare set of keys should be retained securely within the Division.

5.2.2.1. Lost or mislaid keys:

If medicine cupboard keys are lost / mislaid, every effort should be made to find these as soon as possible. In the event they cannot be found, escalate to the appointed practitioner in overall charge of the ward / department who will release the spare set of keys.

Ensure all stock is secured and access to the clinical room is restricted.

If keys cannot be found, arrange with Estates to fit replacement locks and keys as soon as possible and complete a Datix incident. If CD keys go missing additional measures are required (see Controlled Drugs Policy).

5.2.3. Storing Stock Medication:

Cupboards for the storage of medicines must comply with the current British Standard 2881. Locks for cupboards (except patients' medicine cabinets / lockers) must comply with the current British Standard BS 3621 as a minimum.

Cupboards and closed storage units in which medicines are stored and / or the rooms that accommodate these are locked when not being accessed. Access is controlled (by key or other means) to cupboards, trolleys and rooms where medicines are stored.

Electronic locking systems that secure areas used to store medicines may include electronic keys, swipe cards or fingerprint and other technology that open the lock and lock immediately on closing the door. These systems allow cards or keys to be allocated to individual authorised persons, enabling audit of access to take place. Standard keypads (digilocks) where a number is shared with multiple users are not suitable for medicine cupboards.[8] Digilocks may be used on doors to rooms housing medicines cupboards, providing the codes are changed regularly (minimum Policy requirement 12 months but taking in to account any local risks or security breaches to perform more regularly if necessary).

Medicine trolleys must be lockable and secured at an anchor point (i.e. a point at which trolleys can be secured to the floor or wall) when not in use.

Storage arrangements allow for immediate access to critical medicines used in the event of cardiac arrest or anaphylaxis. Medicines needed for clinical emergency are supplied in boxes that are tamper evident clearly marked "For Emergency Use" and/or clarifying their specific use (e.g. Adult Cardiac Arrest or Paediatric Anaphylaxis). Opened boxes must be returned immediately to pharmacy (or Emergency Cupboards Out-of-hours) for a replacement, unless there is an SOP in place for areas to fill and seal their own emergency boxes/kits.

Resuscitation trolleys should be located in an accessible position where they are supervised by nursing staff but do NOT need to be locked. Areas of the trolley holding medicines (including fluids) must have tamper evident seals which are checked regularly.

5.2.4. Storing patients' own medicines (Patients' own drugs or PODs):

All patients' own medicines must be stored securely unless an assessment or exception has been agreed as below.

Where a personal locker / cabinet is used, any key / card / fob given to the individual patient must be specific to their own cabinet ONLY. Registered practitioners in the department and pharmacy staff may hold master keys for multiple patient lockers.

Where personal cabinets are not in use, patient's own medicines must be stored in locked medication storage (trolley, cupboard / cabinet) elsewhere in the department. Patient medicines must be segregated from ward stock, ideally in separate cupboards, but as a minimum by retaining patient's own medicines within a bag or container bearing the patient's name.

The level of security to be applied in the storage of patients' own drugs, and the way in which this is achieved, may need to be balanced against the need to ensure timely access to medicines when they are required. Individual patient exceptions may be considered by the appointed practitioner in overall charge of the department after consultation with the Divisional lead pharmacist or their deputy. Risks to all patients, staff and visitors must be considered and the decision documented in the nursing records for that patient which will provide on-going authority to department staff.

Any department-wide, or medicine-specific requests for exception to secure storage of patient's own medicines can be proposed to the Medicines Safety Group (via Medicines Safety Officer), with any agreement held on the Medicines Policy Exceptions Register (section 5.14).

5.2.5. Installing new medicines storage (e.g. refurbishment)

Estates and Facilities work to Health Technical Memoranda (HTM) or Health Building Notes (HBN, primarily 14-02) to determine storage options in accordance with national guidance and regulatory requirements.

Where any doubt exists, the Chief Pharmacist or deputy should be contacted who can review any new legislation (controlled drugs) or latest governance arrangements to advise on options. HBN 14-02 was updated in 2021 and recommends that all cupboards should be made of metal in order to be able to comply with BS 2881. **However, existing installations that do not comply need not be replaced immediately, but rather when plans for upgrading are being prepared (unless patient or staff safety would otherwise be compromised).**

The trust will apply a risk management approach to determine storage systems which reduce the risk of accidental access as well as unauthorised intentional access, whilst balancing the need for urgent or immediate access in clinical emergency situations. Where a proposed solution sits outside of this Policy or national recommendation, an exception may be proposed by a Business Unit for review at the Medicines Safety Group, and if accepted should be recorded and managed on the clinical BU's risk register. See section 5.14 for approved exemptions to this Policy).

For items that require refrigeration or freezing, the equipment used must be designed for the storage of medicines and conforms to current guidance.[11],[12],[13],[14]

Controlled Drugs will be stored in accordance with the separate Controlled Drug Policy.

5.2.6. Stock Management in clinical areas

Regular stock maintenance and top-ups are conducted by pharmacy staff. In a minority of areas, pharmacy logistics managers will agree to provide paperwork and methods to facilitate departments in conducting their own top-up.

Stock medicines received from pharmacy must be signed for, and locked away, as soon as possible, by a registered practitioner* on the ward or department. The registered practitioner takes responsibility for the secure storage of medicines.

*See section 5.2.2 and Policy exemptions register (section 5.14) relating to non-registered staff supporting these roles when appropriately trained and supervised

Rotate stock to ensure the oldest stock is used first and only one strip or pack is used at a time to facilitate recycling of unused stock.

Stock lists are to be reviewed annually by the appointed practitioner in charge, supported by a senior pharmacist, to ensure stock medicines and demand reflects normal clinical practice.

Excessive, unexplained stock usage or ad-hoc stock orders must be reported to the appointed practitioner in overall charge of the ward and department, and senior pharmacy logistics manager to investigate (both pharmacy and department staff have responsibility for these escalations).

Any suspicious behaviour or unexplained loss of medicines should be immediately reported to the appointed practitioner in charge, who should complete a Datix incident and report to their Divisional Lead Pharmacist or the Chief Pharmacist/deputy.

5.2.6.1. Storing Gas Cylinders

Medical gases in cylinders must be stored safely and securely [5] to mitigate risks associated with health and safety and diversion (theft) risks.

Small size medical gas cylinders (e.g. size C, CD) are stored horizontally on shelves or otherwise in floor or wall-mounted fittings. Larger cylinders are stored in a cage or secured to a fixed structure by a safety chain, at all times. When transported in vehicles, cylinders are secured appropriately so they cannot move in transit.[6]

Refer also to latest Trust Policy or Guidance on Medical Gases and Oxygen.

5.2.6.2. Temperature Monitoring

Medicines are stored under conditions specified on the manufacturer's package/insert or in their Summary of Product Characteristics (www.medicines.org).

Any decision to continue to store or use a medicine which has been stored outside the manufacturer's recommended temperature range should be made after obtaining information from manufacturer (e.g. some medicines may define a reduced expiry date to apply) or from UHDB reference sources or the Medicines Information department (on-call pharmacist if decision is urgently required out of hours). Quarantine the medicines by segregating and labelling until this assessment is complete.

Specific guidance is available for vaccines stored outside of manufacturer's recommendations.[10]

Refrigerator and Freezer storage:

Refrigerators and freezers require air to circulate around products and must not be overloaded to a point where medicines are stored in contact with the sides or bottom of the refrigerator / freezer. They should be kept clean and frost free.

Refrigerators and freezers used for the storage of medicines must be locked when not in use and are not used to store any other items (e.g. specimens or foodstuff)

The temperature of the refrigerator or freezer must be monitored on each day the department is operational, using a calibrated maximum-minimum thermometer (some are in-built within the appliance) or other approved monitoring device. This must be recorded each operational day using a monitoring form (unless a fully automated temperature monitoring system is in place e.g. Tutela®, Sematics®, Kelsius®).

For refrigerators, there is a standard Trust template (appendix 7) to use for routine monitoring from 2 to 8 degrees Celsius.

For freezers, the reference range can vary depending on the product (this will be detailed in the Summary of Product Characteristics from the manufacturer). It will be necessary to prepare a similar daily monitoring chart with the temperature range defined.

If there is a temperature excursion outside the desired range:

- take corrective and preventative action as per monitoring form
- Ensure items are quarantined and advice sought from pharmacy where the 'Required Action' directs this
- Seek maintenance support or replacement as directed on the monitoring form.

Ambient Storage

The Royal Pharmaceutical Society does not specify that ambient temperature needs to be routinely monitored in areas storing medication.

Many areas already monitor ambient room temperature in rooms where medications are stored. If routine monitoring is not in place, it should be instigated if there are any concerns around extremes of ambient temperatures within the department.

Temperature monitoring should be recorded on the forms available via appendix 7 appendix 7.

The majority of medications (except for fridge items), should be stored below 25 degrees Celsius. If medication storage areas begin consistently recording temperatures greater than 25 degrees Celsius, the following action is required:

- Check medication prior to use for any signs of physical degradation e.g. melted, changed appearance and if it appears different to normal it should NOT BE USED and should be RETURNED to pharmacy in a bag or container detailing the concerns
- Inform pharmacy / complete a Datix
- For short term resolution: contact estates to request portable air conditioning
- For long term resolution: ward managers to contact estates to complete a review of the clinic area to determine if temperature-controlled medication storage cabinets

or installation of air conditioning are viable options. Complete risk assessment if the issue cannot be resolved promptly.

5.2.7. Safe storage of medicines within clinical areas

Medicines must be retained in their original packaging to help with positive identification; do not remove blister strips from the outer packaging.

Never mix different packs of medicines together, even if they look the same.

Different strengths of the same medicine must be separated to reduce the risk of mis-selection.

Medicines with differing routes/methods of administration, or which look-alike / sound-alike [2] should be stored separately or segregated to minimise selection errors.

- external medicines (creams, lotions etc) should be in a separate cupboard to oral medication (tablets / capsules);
- All injectable medicines will, as a minimum, be on separate labelled shelf / drawer but will ideally be in separate cupboard to oral/enteral medicines
- Epidural or intrathecal-only medication must always be kept in dedicated storage with the exception of those within controlled drug cabinets where they must be segregated and labelled.

All medicines, including intravenous fluids and frequently used small volume injections in ampoules (such as dental cartridges, sodium chloride 0.9% and water for injection) are to be stored in their original packaging and not loose or decanted. Where this is not possible then a fully labelled container should be used to segregate each stock line entirely from similarly packaged medicines.

Non-medicines and chemicals such as disinfectants, diagnostic reagents (including those for urine testing), non-medicated dressings and dietary supplements, which may be accessed by people who would not otherwise have access to medicines must be stored separately from medicines.

After checking any specific product restrictions within COSHH information and local procedures, it is appropriate to store small quantities of flammable solutions, gases and aerosols in regular medicines storage areas. However, bulk quantities (e.g. in pharmacy or for high use areas and central stores e.g. within theatre suites) requires storage in lockable metal cabinets with appropriate signage. A risk assessment should be undertaken with Health and Safety leads for the area (and advice from a fire officer if uncertain), taking in to account the COSHH data to determine whether a fire-resistant cabinet is required.

5.2.7.1. Security of prescription stationery

Outpatient prescriptions and FP10s (community-style hospital prescriptions) should be held securely on the ward as per medications (i.e. within a locked cupboard accessible only to registered members of staff).

These standard outpatient prescription types should NOT be held in a controlled drug cabinet used for schedule 2 and 3 CDs with safe custody requirements (see CD Policy for detail of CD- stationery that should be held in the CD cabinet).

Further detail of FP10 management is outlined in separate UHDB Policy for FP10 Prescriptions, or via pharmacy SOPs.

5.2.8. Reporting incidents related to medication

Clinical and security related incidents involving medication should be reported on Datix as outlined in the Trust Policy – Incident Reporting, Management and Learning

Defective, damaged or contaminated medication is reported as per section 5.7.1.

Adverse events and reactions to medicines are reported as per section 5.7.1.

5.3. Prescribing Medicines

In addition to this UHDB specific Policy, all medical prescribers are expected to follow the guidance laid out by the General Medical Council: Good practice in prescribing and managing medicines and devices

Some key points from the GMC guidance applicable to UHDB Policy are:

- All prescribers take clinical, professional and legal responsibility for all prescriptions they sign. Prescribers are also accountable for your decisions and actions when supplying or administering medicines and devices, and when authorising or instructing others to do so
- You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work
- You must recognise and work within the limits of your competence
- In providing clinical care you must:

  a. prescribe medicine or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the medicine or treatment serve the patient's needs

  b. provide effective treatments based on the best available evidence

  c. check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including where possible self-prescribed over-the-counter medications.

- You should be proportionate when obtaining a patient's consent. For most prescribing decisions, you can rely on a patient's verbal consent, as long as you are satisfied that they've had the opportunity to consider any relevant information and decided to go ahead. Sometimes a patient's signature is required on a form, for example to comply with an MHRA drug safety alert about a medicine with serious side effects
- Prescribing at the recommendation of a colleague.

If you prescribe based on the recommendation of another doctor, nurse or other healthcare professional, you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence.

If you delegate the assessment of a patient's suitability for a medicine, you must be satisfied that the person you delegate to has the qualifications, experience, knowledge and skills to

make the assessment. You must give them enough information about the patient to carry out the assessment.

- Recommending a medication for a colleague to prescribe

  If you recommend that a colleague, for example a trainee doctor or GP, prescribes a particular medicine for a patient, you must consider their competence to do so. You must be satisfied they have sufficient experience (especially in the case of trainee doctors) and knowledge of the patient and the medicine in order to prescribe

- Early, routine reporting of adverse reactions, incidents and near misses involving medicines and devices must be undertaken.

  You must use the Yellow Card Scheme[c] to inform the MHRA about:

  - serious suspected adverse reactions to a medicine
  - all reactions to products marked with a Black Triangle in the BNF and elsewhere

5.3.1. Staff permitted to prescribe

The following professionals may prescribe medicines at UHDB:

- Medical staff, licensed to practice with the General Medical Council.
  - F1 medical staff may prescribe medicines for in-patients and on discharge but are NOT permitted to prescribe for out-patients, until they have achieved full registration.
- Healthcare Professionals who have successfully completed a nationally recognised prescribing course, are registered with their professional body as a person qualified to prescribe, and are Trust approved non-medical prescribers. These staff may prescribe, in accordance with the Trust Non-Medical Prescribing Policy according to their designation of either:
  - supplementary prescriber (requiring a Clinical Management Plan)
    or
  - independent prescriber
- Dentists working in secondary care are able to prescribe any licensed drug or medical device on the formulary[d], providing this is within their professional scope of practice and expertise. UHDB Outpatient or hospital FP10 prescriptions are not restricted to the Dental Prescribing Formulary[e] as they would be for dentists working in the community
- Medical students in training: These staff are not authorised to prescribe medicines. A 'training environment' in ePMA may be used to simulate prescribing activities undertaken during undergraduate studies or placement.

[c] Yellow Card | Making medicines and medical devices safer | https://yellowcard.mhra.gov.uk/

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

[e] https://bnf.nice.org.uk/dental-practitioners-formulary/

5.3.2. Prescribing Practice

Allergies must be checked and documented within ePMA (or other prescription stationery) before prescriptions are completed. Include known allergies, adverse reactions or known intolerance to specific medicines, excipients (ingredients of medicinal products) and dietary products. Always include a brief description of the reaction. For inpatients, check patient is wearing a red wrist band if you identify a known allergy.

Height and Weight (and where appropriate Body Surface Area or Body Mass Index) information must be completed where relevant to prescribing or for monitoring therapy e.g. paediatrics, chemotherapy, weight-based drugs, drugs adjusted for renal function. An accurate weight is to be recorded on admission and updated regularly.

Only medicines approved for use by the Trust Drugs and Therapeutics Group (DandT) and Joint Area Prescribing Committee should be prescribed i.e. only formulary medicines[f]. Exceptions to this may include medicines as part of a formal clinical trial approved by the Trust Research and Development unit, or where a concessional use or IFR (individual funding request) has been granted.

Hospital prescribers should not recommend non-Formulary medicines, or medicines with a 'DNP' [Do Not Prescribe] or 'RED' traffic light status to General Practitioners[g].

The Trust accepts the principle of 'generic substitution' whereby the Trust's pharmacies routinely stock one manufacturer's product of any one drug form and will routinely substitute that product if an alternative manufacturer's brand of that same drug form is prescribed. This is a routine practice in all NHS hospitals and reflects the national procurement of medicines.

UHDB Medicines Reconciliation Policy should be followed when clerking patients and prescribing their regular medications. This must be completed for each admission and medication reviewed and prescribed for that specific episode of care (clinical 'encounter''). This includes patients transferred from external organisations and when transferring between UHDB locations with alternative prescribing formats (e.g. from Meditech to Lorenzo areas, or from paper to ePMA areas within UHDB).

When required ('PRN') prescriptions require an indication and a maximum frequency (or minimum interval). Threshold parameters for initiating administration may be required (e.g. naloxone when required *'if respiratory rate less than ____'*).

Reviewing prescriptions: During inpatient ward round or patient review, administration views (MAR charts or similar) must be used in ePMA systems to ensure that prescribers are sighted on omitted / delayed medicines and to assess the use and effectiveness of any when required ('PRN') medication.

Additional considerations for Parenteral medications:

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[f] http://www.uhdbformulary.nhs.uk/

[g] Full Traffic Light Classification (derbyshiremedicinesmanagement.nhs.uk)

South Staffordshire Joint Formulary Formulary ttps://www.southstaffordshirejointformulary.nhs.uk/

- Details of drug, dose, route and infusion fluid should always be included. Where appropriate the rate of infusion and type of line (e.g. peripheral, central line) should also be included
- Only one drug should be added to an intravenous infusion fluid, unless a current UHDB published clinical guideline, monograph or protocol has been approved following consultation with the pharmacy department.
  [Medicines must NEVER be added to blood transfusions, blood products, insulin infusions or parenteral nutrition]
- Up to three medicines may be prescribed together in a continuous subcutaneous infusion (CSCI) used in palliative care, after confirming these are compatible drugs / concentrations (refer to a pharmacist if uncertain).

Additional consideration for inpatients on oral chemotherapy

With the increasing use of oral chemotherapy, it is common that patients will be admitted on a course of oral chemotherapy, and this will be identified by the clerking team during medicines reconciliation. As soon as possible, advice from the oncology / haematology team looking after the patient needs to be sought about the appropriateness of continuing the oral chemotherapy agent; it may be more appropriate to withhold oral chemotherapy in some cases and / or for the specialists to consider if the current admission could be related to the systemic anti-cancer therapy (SACT) in-use.

5.3.2.1. Electronic Prescribing

Electronic prescribing (ePMA) is in operation in the Trust and will ordinarily be used for all in-patients in our hospitals. This ensures that legal and Policy requirements for prescribing practice (as per 5.3.2.2 below) are prompted / mandated and completed in full.

Supplementary paper charts: If a medication requires complex or variable dosing and therapeutic drug monitoring, it may be necessary to use a supplemental paper prescription chart in addition to ePMA (examples which may be site specific include: heparin infusion, GTN or isosorbide dinitrate infusion, variable rate insulin infusion).

These charts must be cross-referenced using the appropriate prescription reference in the ePMA system (sometimes referred to as the placeholder‘prescription or order string e.g. ‘Heparin Intravenous Infusion – See variable rate infusion chart’). This ePMA cross-reference is essential to ensure:

- accurate audit trail of the start / stop date in the electronic record
- medical colleagues are aware (e.g. to prevent therapeutic duplication and to proactively seek paper chart for dosing / titration / monitoring)
- nursing staff are prompted to seek the paper chart when undertaking medication rounds
- pharmacy staff are aware for monitoring, supply and review of therapy.

These supplementary charts must always be approved by the Medicines Safety Group or Drugs and Therapeutics group. These approved formats will be made available on the Policy and guideline section of the intranet (Koha) or via stationery supply stores when these have been approved for professional print by the Documentation Group.

5.3.2.2. Prescribing on paper (to facilitate administration or supply by another practitioner)

The following must be adhered to when prescribing in any area not using electronic prescribing:

- All prescriptions must be clearly written in black ball point pen by the prescriber and each prescription must bear the prescriber's signature
- Medicines must be prescribed on Trust-approved prescription stationery. The following details must appear on each sheet / chart (printed labels may be used for this purpose; ensure they are also placed on any duplicate copies):
-

  (a) The patient's name in full
  (b) Age, date of birth, height / weight (essential for children and weight/renal based adult dosing; desirable for all adults)
  (c) Ward or department
  (d) Patient's hospital number / NHS number

- The following information must be written on the prescription sheet by the prescriber:

  (a) Approved [generic] name of the medicine. Addition of a proprietary name [brand] may be required in exceptional circumstances, e.g. combined preparation or products where brand continuity is essential (e.g. Category 1 anti-epileptic medication where brand switching should always be avoided)
  Note: Abbreviations and chemical formulae, e.g. FeSO4 must not be used.
  (b) Dose in metric system wherever possible. If the medicine is one for which the potency is expressed in terms of units then the word UNITS must be written in full. Quantities less than one gram should be written in milligrams and quantities less than one milligram should be written in micrograms. Micrograms, nanograms and units should be written in full. Avoid the use of a decimal point wherever possible
  (c) Times of administration or frequency should normally be written in full. Abbreviations must not be used unless approved (see Appendix 1). When required (PRN) prescriptions also require an indication or threshold trigger for administration, and a maximum frequency (or minimum interval)
  (d) Full date of prescription (DD/MM/YY)
  (e) Route of administration should normally be written in full. Abbreviations should not be used unless approved (see Appendix 1)
  (f) Each prescriber must print their surname and contact number at least once on each sheet/chart (to enable easy identification and communication)
  (g) Where appropriate, the site of application should also be specified, e.g. left eye
  (h) Each entry on the prescription sheet, either for the commencement or discontinuation of the medicine, must be signed and dated by the prescriber. When the medicine is discontinued, a line must be drawn through the entry and signed to indicate cancellation
  (i) There are additional prescription requirements and handwriting requirements for outpatient or discharge prescriptions for Controlled Drugs in schedules 2 and 3 (for more details see Trust Controlled Drugs Policy).

Prescribing 'As per Protocol'

As per protocol is only to be used when a current published UHDB protocol/guideline is in place, which staff administering medicines can follow. These protocols will include parameters such as dose, titration, frequency and any monitoring or checks that will be made prior to further dosing. Such protocols are rarely used in the trust. The prescriber always takes responsibility for ensuring the protocol, and its parameters, are fit for the individual patient when they prescribe in this way.

5.3.2.3. Non-prescribers authorised to request / order prescription medicines in specific circumstances

See also approved Policy exemptions in section 5.14

- Pharmacists are authorised (once internal training has been completed) to determine doses of intravenous vancomycin in line with guidance on the Vancomycin prescription chart (the original prescriber creates a patient specific direction and then the pharmacist works under approved protocol / guideline; Derby sites only at point of Policy publication)

- Pharmacists are authorised to make changes to prescriptions in line with the 'Clinical Pharmacy enabling Policy'. The alterations permitted are based on correction of minor prescribing omissions / errors and approved substitutions to support the hospital formulary and JAPC traffic light classification

- Dieticians are authorised to *order* dietetic therapy on Trust prescriptions

- Registered practitioners may administer and / or supply in accordance with the following Human Medicines regulations 2012 exemptions:

    - Midwives Exemptions – documentation must meet the standards described in this Policy for prescribing practice

    - Patient group directions – training, authorisation and documentation must meet the Policy standards in the UHDB Development of PGD Policy.

5.3.2.4. Requirements for medication related correspondence (transfer of information) to primary care and external organisations

In addition to patient records standards around patient identifiers and demographics, the following medicines related fields must be included in all correspondence around medicines prescribed or advised by UHDB clinical staff, whether this is by clinical systems (e.g. inpatients discharges or ePMA outpatients) or within a clinic letter or handwritten format:

- Allergies – include known allergies, adverse reactions or known intolerance to specific medicines, excipients or dietary products, together with a brief description of the reaction

- Medication changes – including ALL medication started, stopped or where a dose has changed

- Contact details – The name and job title of the person making the medication changes

- Authorisation – the prescriber's job title, date and signature (if paper based). If advice is being offered by a clinical member of staff who is NOT a prescriber, then this should be clear in the letter (e.g. recommendation for review from non-prescribing specialist nurse, pharmacist, dietician etc…).

  The following Information should also be included where relevant:

    - Other relevant contacts defined by the patient e.g. Consultant name; usual community pharmacist; Specialist nurse

- Medication recommendations – including suggestions about duration and/or review, on-going monitoring requirements, advice on starting, discontinuing, or changing medicines. Requirements for adherence support, for example, MAR sheets, compliance aids or prompts, and any additional information about specific medicines, e.g. formulation issues

- Patient Information – information given to the patient and / or their authorised representative, e.g. if patient referred to their community pharmacist for a medicines use review (MUR / TCAM), or where further medicines information or support has been provided.

5.3.2.5. Prescriber administration and documentation of medicines

In addition to this prescribing section of the medicines Policy, prescribers who also administer medicines must follow sections 5.5 (*Preparation*), 5.6 (*Checking*), and 5.7 (*Administration*) of this Policy.

5.3.2.5.1. Inpatient settings

The prescriber who is administering the medication must always document administration using the system in place on that inpatient ward. In most inpatient ward areas this will be using the electronic prescribing system (ePMA). An entry in the notes is NOT acceptable in this scenario as dual prescribing/documentation can easily lead to therapeutic duplication or failure to recognise adverse effects which may result from the treatment.

5.3.2.5.2. Documentation in clinic, ambulatory settings and interventional areas (theatre, radiology, catheter labs, endoscopy). ***Note: anaesthetists using anaesthetic charts to see next section 5.3.2.5.3***

Prescribers (other than anaesthetists) who administer medication themselves within their practice are responsible for complete documentation of the medicine, and this should be consistent with the prescribing standards outlined in the paper prescription section above (5.3.2.2).

This documentation should commence before, or as soon as possible following, the administration event.

Good Practice note: Commencing documentation prior to the administration / procedure provides a useful mechanism for self-checking medications or to request a second check from another colleague

Primary method of documentation: Electronic Prescribing systems (ePMA) should be used wherever possible when these are implemented in the clinical area. ePMA is configured to capture all information about the product, dosage regimen and administration and provides a fully auditable record.

Second option: Where ePMA is not available, individual clinics or day case areas are encouraged to incorporate templates into their documentation pathways. These records must capture all fields outlined in the paper prescription section above (5.3.2.2).

Structured documentation such as this may also be required to facilitate second independent checks (whether good practice, e.g. high-risk IM / SC medicines, or Policy requisite, e.g. intravenous medicines outside of anaesthetic practice).

The minimum requirements for such documentation are outlined below, and clinical business units are requested to consult the Medicines Safety Group or Drugs and

Therapeutics Group / Committee when designing new pathway documents. MSG will ensure consistency in documentation standards relating to medicines:

Ensure the document includes patient identifiers/demographics and allergies as per 5.3.2.2 or add fields for this here							
Date	Time	Drug	Form	Strength/ concentration	Route / Site	Dose/ Volume	Administered by *(signature)
Ensure the document includes prescriber name, signature, date							

*an extra column for witness is required where independent second checks are required.

Third option: When working in the absence of ePMA, and outside of routine pathway practice, a prescriber may still need to administer and document a medication themselves.

In this case a free-form / free-text entry in the paper or digital healthcare record may be made by the prescriber. This must still include all of the information included in paper prescriptions (5.3.2.2) to create a complete record and robust documentation of the medication intervention provided.

Example entry in medical notes:

27/7/221 15:51 Dr A, Dermatology Cons

NKDA confirmed

Lidocaine 1% injection 5ml intralesional, right forearm

Signature Dr A Pager #1234

5.3.2.5.3. Anaesthetic Department

An anaesthetic chart is used for the recording of medicines administered during routine anaesthetic practice.

When performing anaesthesia outside of theatres, it may be necessary to document these medications directly into ePMA, patient pathways or medical records. In these cases, prescribers must follow the principles outlined for inpatients and ambulatory patients in the previous parts of this section of the Policy (5.3.2.3).

5.3.3. Verbal orders

Registered practitioners must not administer medicines on the verbal order of prescribers, apart from in the specific circumstances outlined below. A written prescription (Patient Specific Direction) is usually required to authorise medication to be administered by another suitably trained healthcare practitioner.

The registered prescriber has a duty of care and is professionally and legally accountable for the care he / she provides, including tasks delegated to others. The prescriber must be satisfied that the person to whom practice is delegated has the qualifications, experience, knowledge and skills to provide the care or treatment involved.

Remote ePMA prescriptions, whilst generally discouraged, are preferred over verbal orders wherever this is practicable.

5.3.3.1. Verbal orders **for life threatening emergencies**

In an emergency situation, where a patient's life is at risk, and it is in the patient's best interest, a medicine may be administered following a verbal order which includes details of the **drug, dose, concentration/volume (where applicable) and route.**

- **Verbal order for life-threatening emergency with prescriber in attendance**
  In cases where the prescriber is providing the verbal order within the same room, the person administering the medication must repeat back the order and confirm prior to preparation. Immediately prior to administration, the order should be repeated to the prescriber again to confirm.

The two sequences involving prescriber (P) and registered practitioner administering (A) are therefore:

VERBAL ORDER(P) – REPEAT BACK(A) – CONFIRM (P)

PREPARE(A) – REPEAT BACK(A) – CONFIRM(P) - ADMINISTER(A)

- **Remotely placed verbal order for a life-threatening emergency**

  Very exceptionally, an order may need to be given remotely because a prescriber cannot attend in person and cannot access the ePMA system. In this case the verbal order must be received and written down by a registered practitioner trained to administer medicines. This record must be retained in (or transcribed in to) the patient's permanent medical record and should be used for the required checking procedures.

RECEIVE VERBAL ORDER – WRITE DOWN - REPEAT BACK – PRESCRIBER CONFIRM
[File / transcribe into medical record]

As soon as possible afterwards, a prescriber should record the prescription in the ePMA system, taking care to confirm and document that the dose was administered to avoid duplication or overdose.

5.3.3.2. Verbal orders for theatre

Theatre practitioners may administer medicines on a verbal order in exceptional cases, where the anaesthetist/surgeon is unable to administer this themselves. Theatre staff must have been trained in, and follow, local business unit procedure/guidelines for this practice.

Registered practitioners must only prepare and administer medicines under direct supervision of the medical practitioner who takes full responsibility for the administration of any medicine in these circumstances.

5.3.4. Urgent and Critical Medicines and Prescribing Practice

All once-only medicines, urgent doses (including first doses of antimicrobials for sepsis) and pre-medications should be prescribed as once-only ('stat') doses on the prescription and communicated directly to nursing staff to ensure timely administration.

For non-standard treatments, the prescriber should liaise with a pharmacist to ensure the medicine is appropriate, available and can be supplied in a timely manner.

See appendix 2 for further procedures and links around Critical Medicines.

5.3.5. Private Prescriptions

5.3.5.1. Prescribing for Private Patients

Private prescriptions must be presented on headed notepaper and will be dispensed at the professional discretion of the responsible pharmacist in the dispensary, and only if this does not compromise NHS workload. The exception to this is for private inpatients / discharges or low value day case medications; in these cases, the fee / insurance tariff covers the routine cost of medication. If in doubt discuss with the Private Health team.

Charges for private prescriptions will be applied in line with the Private Prescription Procedure (Pharmacy SOP) in place at that time.
Medicines will not be supplied for export abroad or to treat a patient overseas.

The following drugs and classes of drugs may NOT be prescribed or supplied on private prescription at UHDB (EXCEPT for patients registered with a UHDB private service* e.g. Derby Private Health):

- Controlled drugs (all schedules including Benzodiazepines)
- Cytotoxic agents
- Drugs known to have significant abuse potential (including appetite suppressants)
- Antiviral drugs during a pandemic (or other medicines in short supply or being nationally or regionally prioritised according to patient criteria).

*The restrictions above are intended to prevent prescribing of these agents for self, family or colleagues, as well as to reduce risk when dispensing private prescriptions from other legal entities. This Policy supports UHDB affiliated Private Health services to provide these medicines when prescribed by the appropriate specialties (e.g. CDs by pain consultants, Cytotoxics by oncologists etc).

5.3.5.2. Prescribing for self, family, colleagues or friends

Refer to the Trust Policy for Self prescribing (Koha) and GMC guidance for prescribing of medicines for family members and colleagues.

5.4. Ordering / Obtaining Medicines

The Pharmacy department must ensure that the Trust intranet is kept up to date with details of how to obtain different types of medication, in different scenarios and with options for the level of urgency. This information will be hosted on the Pharmacy Pages of the intranet. Stock locator tools (document, database or spreadsheets) are available from these pages which will detail departments and emergency cupboards that hold specific medicines. Contact details for urgent advice will also be hosted on the pharmacy pages. The Levels of urgency include:

- EMERGENCY: Contacting a pharmacist to attend a cardiac arrest or medical emergency (RDH site only; 9am to 9pm only)

- EMERGENCY: Ordering urgent medicines for medical emergency

- URGENT: Ordering (or obtaining access via other wards or emergency cupboards) of critical medicines to avoid delays which may lead to harm (see also Appendix 2 on critical medicines)

- PRIORITY: newly commenced medicines unavailable to the ward
- PRIORITY: stock or named patient medicines required prior to next working day / pharmacy visit to the department
- PRIORITY: Hospital transfers or discharges for patients who no longer fit criteria to 'reside in hospital' and are otherwise medically fit to be discharged to their usual residence
- NON-URGENT: Routine stock top-up
- NON-URGENT: request for named patient stock in preparation for discharge (but where stock and/or Patient's Own Drugs are available in the mean-time)
- NON-URGENT: Request for discharge medication for a planned discharge in the future

5.4.1. Emergency cupboards - Pharmacy Out of Hours POOH-Cupboard at QHB; Pharmacy Emergency Cupboard PEC at RDH)

Only registered staff may be given keys or access to pharmacy emergency cupboards (PEC) or pharmacy out of hour's cupboards (POOH) as per 5.2.2.

A record must be made of all items taken from pharmacy emergency cupboards (PEC) or pharmacy out of hour's cupboards (POOH) and signed by the person doing so.

5.5. Safe preparation of medicines

5.5.1. General notes about assessing medicinal products prior to preparation

Check the product label / packaging / product:

- Clearly states the name and strength/concentration of the medicine, and that this is what is required
- Is within expiry date (liquid medicines which are open should have the date of opening or a reduced expiry date annotated to reflect shelf life after opening – note that this may be product specific, the manufacturer's labelling will include the details)
- Show no signs of damage, soiling or decomposition (e.g. colour change or precipitate in liquid, injections and infusions)

Check that flexible plastic containers (e.g. infusions and plastic ampoules) are not leaking by squeezing them. If leaking, they must NOT be used and must be reported and returned to pharmacy.

Check that vials have dust caps in place[h] or other coverings that would be expected to protect the critical points for Aseptic Non-Touch Technique (ANTT).

For all single use products, check packaging and seals have not been damaged and show no sign of tampering. If in doubt, do NOT use and return to pharmacy immediately.

[h] unless approved multi-dose vials are labelled in a single patient name

5.5.2. Choice of oral/enteral delivery device (consumables)

A 5ml spoon should be used to measure and administer oral liquid medication in doses (or multiples) of 5ml.

For measurement and administration of medicines where a high degree of accuracy is **no**t clinically necessary, a graduated medicines pot may be used e.g. antacids, lactulose, soluble tablets dispersed in water (where the whole tablet is needed).

A purple oral or enteral syringe[i] should be used in all of the following circumstances:

- Liquid doses of medication less than 5ml (with the exception of 2.5ml doses if 2.5ml spoons are available). Bottle adaptors or ENFit straws should always be used when drawing up with a low dose ENfit syringe
- When administration from spoon or graduated medicine pot is unsuitable or unsafe e.g. small children/infants
- All liquid medicines or feeds which are being given via a feeding tube - a purple ENfit[j] compatible <u>enteral</u> syringe must be used.

If preparation and administration is carried out in one uninterrupted process, then an unlabelled oral / enteral syringe may be used providing it does not leave the hands of the person who has prepared it.

Where this is not possible (e.g. the registered practitioner needs to seek a second check or will not continuously hold the prepared syringe), then the oral / enteral syringe must be labelled using the purple edged oral medicine label (or other dedicated oral / enteral medicines label) and include the following details:

- The name and concentration of the medicine (the dose can be calculated from the volume drawn up if a second check is required)
- Patient's name
- Date and time of preparation by the person who has prepared the oral / enteral syringe.

Once an oral/enteral syringe has been used to administer medication directly to a patient or via an enteral feeding tube, it must NOT be used to withdraw further doses of that or any other medication from a **<u>stock</u>** container, to reduce risk of cross-contamination. Dispose of these immediately.

<u>NEVER</u> use a clear or transparent syringe intended for IV/SC/IM use to measure or administer oral or enteral medicines.

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[i] Oral syringes provided by the manufacturer may be deemed suitable for supply to patients for home use, but are not to be used during inpatient stay. Use purple oral or enteral (ENFit)

[j] ENFit and NRFit are not brand names. The brand may vary (e..g Braun, BD, Terumo Pajunk etc). ENFit and NRFit are terms used for the international standard design (ISO) for consumables that are only compatible with other entero-nutritional products (ENFit) or other neuraxial-regional products (NRFit) and ensures these cannot be attached to other parenteral lines / cannulae.

NOTE: Bottle adaptors, bungs, quills and straws are available via NHS supply chain for liquid medicine bottles to allow easy removal of the dose using ENfit and oral syringes. It is recommended that these are held in your area if oral / enteral syringes are likely to be needed for medicines administration.

5.5.3. Injectable Medicines

Injectable medicines must be prepared using Aseptic Non-Touch Technique (ANTT) in accordance with Trust Policy and Procedures.

An appropriate ANTT area should be identified where injectable medicines are to be prepared; where possible this area should be separated from direct patient areas and enclosed (all doors and windows should be closed). These precautions reduce the risk of microbial contamination and interruptions, which can lead to medication errors.

If the registered practitioner is unclear as to clinical use of the medicine, or to the correct diluent or precise method for preparation, they MUST obtain this information from one of the following appropriate reference sources:

- MEDUSA Injectable Medicines Guide (Link on pharmacy pages of Net-i or from ePMA systems)
- UHDB drug monographs / protocols, clinical guidelines (Koha or linked in ePMA) – Note: if a local monograph / protocol exists it will help align your final product with UHDB Smart Pump configurations
- Manufacturer package insert (the 'Summary of Product Characteristics' or SPC is available for all licensed drugs via www.medicines.org.uk)
- BNF/BNFc.

Medicines which are unlicensed or used via unlicensed routes/doses may require specialist advice if not covered by a local guideline.
If in any doubt after consulting these reference sources, contact a pharmacist for advice.

Pre-printed additive syringe labels (e.g. those used in theatres) or hand-annotated additive/infusion labels must be completed and applied during preparation to differentiate products and to confirm dose and concentration.

The only exceptions to this are:

- Where a bolus injectable which does not require a second independent check, is drawn up and immediately administered to a patient by the same member of staff, without the product leaving the practitioner's hands
- Closed-system infusion devices (e.g. Ecoflac) where the whole dose vial and the diluent are connected (and remain connected throughout the infusion period as a definitive reference as to the dose / diluent / concentration prepared and administered).

5.5.3.1. Intravenous Medicines

For non-medical staff: Only registered practitioners who have been trained and assessed against UHDB intravenous competencies should administer intravenous products.

For medical practitioners: ANTT training compliance is essential as a minimum UHDB standard, and the practitioner must have received previous training for intravenous practice (e.g. via undergraduate training, local induction or Royal College competencies).

Central Venous Access Devices (CVAD: central lines, Hickman lines; PICC lines etc) should only be managed by those with extended scope training and competency in this area.

IV competency Policy requirements are outlined below but should be read in conjunction with UHDB guidelines for infusion therapy (intravenous and subcutaneous) on Koha.

5.5.3.1.1. General flushing requirements for IV medication:

The intravenous access device should be flushed both pre and post-dose.

Intermittent flushes are accepted as part of the patient specific direction ('prescription') for any intravenous medication at UHDB; the prescription provides implied direction to administer in accordance with the intravenous guidelines and this Policy.

Therefore, intermittent flushing does not need to be prescribed as a standalone prescription in routine circumstances (Note: intravenous infusions used to maintain patency of a line must be prescribed).

Local SOP advised: The IV competency training, clinical guideline and this Policy outline UHDB position that pre-and post-flush is routine mandatory process. Individual areas are advised to consider the most efficient ways to evidence completion for each dose/drug round by registered practitioners administering medication. This will depend on the clinical area and the systems/checklists in use. As this is not a prescribed medication, it is acceptable for areas to consider achieving this using checklists, contemporaneous notes or via notes or functionality within the ePMA system.

For ADULT patients, an intravenous access device should be flushed using at least 5ml Sodium Chloride 0.9% from a 10ml syringe[k] (or glucose 5% for saline incompatible drugs). **Caution: paediatrics follow local procedures.**

Additional flushing requirements are required for infusion therapy as below.

5.5.3.1.2. Intravenous Infusion pumps:

If an infusion is to be administered via pump (see UHDB guidelines for infusion therapy (intravenous and subcutaneous) which outlines pumps and availability), registered practitioners must check whether the pump configuration requires a fixed concentration to be prepared / ordered. Note: local guidelines and monographs on Koha or within ePMA protocols will assist compliance with this requirement.

All device settings must be independently second checked at the patient bed-side or patient's location

- Any setting changes, at any time, must be independently second checked. E.g. change of Volume To Be Infused (VTBI) or rate titration.

5.5.3.1.3. Intravenous Infusion checklists:

[k] In practice this may often be a medical device such as Posiflush.

- The Trust approved Intravenous Infusion Checklist (Appendix C of guidelines for infusion therapy – add link?) should be completed by two registered practitioners in the following circumstances:

    - When an infusion is commenced
    - When the infusion rate is altered (see notes on pump check / second check above)
    - At shift handover (one from the departing shift and one from the receiving shift) – 'infusion handover'
    - When a patient is transferred between clinical areas (one handing over and one receiving).

- At least one IV competent registered practitioner completes a Trust approved Intravenous Infusion Checklist at each medication round as a **minimum four times per day** (see local SOP advisory below as clinical condition and medication type may justify additional requirements).

Local SOP advised: Clinical areas may develop clear procedures to inform practice with regard to the frequency of checking for specific levels of care, patient condition or medication types. The Trust-approved Intravenous Infusion Checklist does not necessarily replace those local standards but sets a minimum Policy standard that must be achieved.

5.5.3.1.4. Flushing of <u>non-continuous</u> 'once only' or intermittent total-dose infusions:

It is essential to ensure a patient receives the full prescribed dose of IV medication, and an intravenous giving set may hold up to 20ml in the line itself (luminal volume). The actual volume depends on the length of the line, and whether it is used for gravity, volumetric or syringe pump administration.

A line flush should be run, using the same diluent, at the same rate as the drug infusion. If the original infusion was given via volumetric pump, the pump must be used to administer the flush – this ensures that the drug in the infusion line is delivered at the same rate as the initial infusion. For some drugs, the infusion rate is critical for safe administration. The total volume used for the flush must be sufficient for the volume of the line in use **Caution: in paediatrics, confirm local procedures which may be drug specific as per protocol or monograph e.g. preparing total-dose infusions with an overage for priming the line before infusion**.

Once the flush infusion is complete, the line must be discarded.

Definition from IV Guidelines:

Broken line: Defined as any infusion that is disconnected periodically from the patient (between doses, for example) or the circuit broken for a reason other than to renew the infusion solution. Broken lines must be discarded after use.

5.5.3.1.5. Infusion Line Labelling for continuous infusions and unbroken lines

Continuous (unbroken) lines are to be labelled with the following as a minimum standard (and supported by procurement of Trust standard medication line labels):

- Patient name AND hospital number

- Date and time the line was first used
- Date and time of line expiry

Dispose of continuous (unbroken) infusion lines after 72 hours. If the line is disconnected and becomes 'broken' at any time, the line label should be removed immediately to avoid confusion as to the line expiry. The line should then be discarded as per waste management guidelines.

Definition from IV Guidelines:

Unbroken line: Defined as a continuous infusion that is not disconnected from the patient at any time. The only time that the circuit is broken is to renew the infusion solution. Unbroken lines may be used for up to 72 hours.

5.5.3.2. Vial Sharing and Multi-dose vials

Where possible and where practice allows, vials, syringes or ampoules intended to be used as a single dose must be used in preference to multi-dose vials or vial-sharing.

Vial-sharing (ampoule-sharing) within clinical areas: the practice of using a single vial or ampoule to draw up multiple doses, or for multiple patients is not routinely supported at UHDB under this Policy (but see assessment process for exemptions below).

Multi-dose vials: In some cases, manufacturers produce vials / devices intended for multiple administrations (e.g. insulin vials). The default UHDB position is that multi-use vials are for use by a single patient only. Use for multiple patients may present a risk of non-bacterial blood-borne infection. Furthermore, multi-dose products are generally licensed for use in a single patient only.

Each vial must be labelled with the patient's name and expiry date and time, using the in-use storage timeframe found on the label or product information. In most cases the in-use expiry will be shorter than the manufacturer's original product expiry. Pharmacy must be contacted if there are any doubts on the in-use expiry to apply to a product.

A new sterile syringe and needle must be used for each withdrawal from a vial.

Authorising exemptions from Policy: Occasionally clinical BU / Divisions may have a compelling case to apply for an exemption to this Policy section (e.g. extreme cost pressure, national supply failures, international directives e.g. Covid vaccine). In such cases the business unit must seek approval from their Divisional governance group which includes formal risk assessment, medication specific SOPs and a training / competency strategy. If supported within the Division the proposal and supporting papers should be submitted for approval with the Medicines Safety Group (MSG) and Infection Control Team by contacting the Medication Safety Officer for the Trust. MSG will retain minutes of any exemptions approved and these can then be included in section 5.14 of future updates to this Policy.

5.5.3.3. Intrathecal, epidural and regional devices (NRFit)

All neuraxial and regional medication must be administered using NRFit™ compatible devices (syringes, infusion lines etc) in accordance with NatPSA/2024/002/NHSPS.

Explanation of terminology:

- Neuraxial comprises intrathecal and epidural procedures
- Intrathecal procedures include spinal anaesthesia, monitoring or removing cerebrospinal fluid (e.g. lumbar puncture) and other intrathecal drug delivery
- Regional block and wound infiltrations. Regional block is an abridged term for peripheral nerve anaesthesia block.

Any consideration for exception to this Policy position must be discussed with the Medical Devices Safety Officer for the Trust, formally risk assessed by the specialty, and approved with Medical Devices Group prior to consideration for inclusion in section 5.14 of this Policy.

5.5.3.4. Insulin syringes

Insulin syringes are graduated in a way that doses can be prepared and viewed in terms of international units, the dosing unit used for insulin.
The Insulin syringes procured at UHDB are designed for use with 100unit/ml strength insulin only. This is the standard strength of insulin, but higher strengths are also available

5.5.3.4.1. Subcutaneous doses

Insulin syringes or insulin 'pen' devices **MUST always** be used to measure insulin doses.

NEVER use an insulin syringe to withdraw from a disposable insulin pen or from an insulin cartridge intended for use in a pen-device. Doing so is considered a *Never Event*. It can lead to drawing up the incorrect dose in pens that hold insulins strength greater than 100unit/ml. It may also cause the cartridge to shatter.

5.5.3.4.2. Intravenous infusions

Intravenous insulin infusions are used for variable and fixed rate insulin infusions (VRII / FRII) and for treatment of hyperkalaemia (and occasionally other cases of drug toxicity).

Whenever available, use pre-filled "ready-to-administer" insulin syringes supplied by the hospital pharmacy.

In areas that continue to prepare intravenous insulin infusions in ward/department:

- An insulin syringe must be used to measure the insulin prior to adding to an intravenous syringe, where further dilution will be required

- Always follow a UHDB clinical guideline (Koha), UHDB monograph (Koha), UHDB specific banners on Medusa, or a UHDB protocol (within ePMA system) to guide preparation and dilution of intravenous insulin infusions
    - This will ensure the product is appropriately mapped to any local pump settings and guidelines. This cannot currently be assured when following national resources such as the BNF or the manufacturer's Summary of Product Characteristics (SmPC).

5.6. Checking Medicines

Checking is essential at all stages of the medicines use process. This involves scrutiny and reconciliation of available information, to verify that the intended medicine is prescribed, prepared and administered correctly.

Self-checking should be carried out by all registered practitioners undertaking *any* medicine activity, and the individual who initiates the preparation, administration or supply is professionally responsible for their own actions throughout the processes.

Good Practice: Where an independent second check is NOT required from another registered practitioner within this Policy, consideration should be given to including the

patient/carer in a *basic identification check:* confirming the medicine, dose and directions against those prescribed, and confirming patient identity.
This is an excellent way of keeping patients up to date with the medicines and doses they are taking, the reasons why they take them and any key counselling points such as side effects.

Checking should be undertaken in an unhurried manner, and wherever possible without interruptions or distractions.

Checking involves careful triangulation of information from the prescriptions, the product to be administered, with positive patient identification (see UHDB Patient ID Policy), and should be carried out at the patient bedside wherever possible.

Checking processes (both self-checking and when independently second checking another practitioner) should incorporate the 5 rights of medicines administration:

- Right patient
- Right time
- Right drug
- Right dose
- Right route [I]

Where a checker has concerns about the prescription, product or patient identification they must STOP the medicine activity until clarification can be sought and the practitioner is satisfied that the "5 rights" have been met. '; where necessary this should be escalated to a more senior member of staff or with a prescriber or pharmacist to resolve any query in a timely manner.

5.6.1. Second independent checks required by UHDB Policy

Second independent checks by another registered practitioner, who is also professionally responsible for their actions, will include checks throughout the whole process.

This includes the prescription, the preparation (ingredients, diluents, and methods where relevant) and the patient identification and administration itself (including connections and pump setting/initiation).

These second checks are a Policy requirement for:

- Controlled drugs requiring safe custody (See CD Policy)
- All paediatric medicines that are not included as exempt from second checks according to the Paediatric Business unit procedures
- Intravenous medicines
- Cytotoxic chemotherapy
- All discharge medication (except PGD supplies) including Patient's own drugs, medicines previously dispensed by hospital pharmacy and discharge ('TTO') packs.

[I] http://www.ihi.org/resources/Pages/ImprovementStories/FiveRightsofMedicationAdministration.aspx (Institute for Healthcare Improvement – checked June 2017)

The ‘5 rights’ process should also be adopted by independent second checkers, in order to avoid use or reliance on cues or prompts. A statement such as “please check this drug for this prescription” facilitates a true independent check whereas ‘please check this morphine for Mr X’ does not facilitate an independent check of prescription, product and patient identification.

In community settings it is recognised that a second registered practitioner is unlikely to be present to witness preparation, administration, supply or disposal of medicines. Where appropriate this can be checked with a carer or another responsible adult (see section 5.14 for Policy exemptions in community and domiciliary settings).

Good Practice - *‘clinical’ second check procedures**:* This is an enhanced option when a second independent check is not required under UHDB Policy. It may be adopted as procedure in some areas or for less experienced practitioners. A registered practitioner provides a clinical second check to confirm that the medicine, dose, time and route are clinically appropriate for the individual patient.
It is particularly useful for high risk medicines with a wide dose range e.g. insulin, anticoagulants, opioid analgesics OR for medicines with complex calculations for preparation OR considered for all medicines administered by intramuscular/subcutaneous routes.

5.7. Administration of medicines

5.7.1. General Procedures for administration of prescribed medicines

All registered healthcare professionals are authorised to administer medicines providing they have undertaken training approved at UHDB and are working within their scope of practice (see training section 5.13). The Policy requirements are listed below, and an additional procedural template is included in appendix 4 to support areas in a consistent approach to medication administration.

Non-registered staff and HCSW are only authorised to administer within the listed exemptions defined within section 5.14 or where specific medication protocols have been overseen by the Medicines Safety Group or PGD Governance group and are published on Koha. Areas exploring administration by non-registered staff should prepare a proposal to the Medicines Safety Group, after risk assessing and seeking the support from their BU or Division.

A practitioner in training, may prepare, check and administer only when under the direct supervision of a Registered Practitioner who remains responsible for ensuring that the correct procedure takes place. In Paediatrics the second check may be carried out by a Children's Student Nurse (Child Branch) who has completed the necessary competencies.

Staff should not be interrupted during the preparation and administration of medicines unless there is an emergency.

Medicines are only ever administered in accordance with a prescription, Patient Specific Direction, Patient Group Direction or other relevant exemption specified in the Human Medicines Regulations 2012 (Schedules 17 and 19, as amended, including Midwives exemptions).

Only medicines that have been supplied by the Trust Pharmacy service or Patients’ own medicines that have been reviewed as appropriate for use (see 5.7.3 below) should be administered to patients.

Medicines dispensed and labelled for an individual patient must only be administered to that patient and must not be shared with other patients.

Before administration of a medicine, the registered practitioner MUST read the prescription carefully to confirm:

- That they have an overall understanding of the medicine being administered or have sought to satisfy themselves with this knowledge. This may be achieved by accessing one of the reference sources below:
    - UHDB drug monographs/protocols, clinical guidelines (Koha or linked in ePMA)
    - Manufacturer packages insert (the 'Summary of Product Characteristics' or SPC also available for all licensed drugs via www.medicines.org.uk)
    - BNF
    - Seeks advice if necessary, from a prescriber or a pharmacy professional.
- That the patient does not have a documented allergy or significant adverse reaction with that medication or medication-type.
- The prescription or other direction to administer is unambiguous and includes where appropriate the name, form, route of administration, strength, and dose of the medicine to be administered.
- Ensure that the prescribed dose has not already been given and is due at that time.
    - For 'when required' medication this should include a check of the maximum frequency (or minimum interval) specified between doses, and of the total cumulative daily dose.
    - Check for 'stat'/once-only, completed, or recently discontinued medicines (this may require a change in filter / view on ePMA systems).
- The medicine and the label match fully with the prescription.

Some medicine administrations require complex calculations to ensure that the correct volume or dose is administered. The healthcare practitioner responsible for the administration of the medicine must ensure the calculation is correct. A second practitioner must check the calculation is correct in order to minimise the risk of error.
The second check calculation should be made independently of the first one and compared. It can be obtained from:

- A registered nurse
- A registered midwife
- Another registered healthcare professional who is trained and competent to administer medicines by the same route
- A doctor
- A pharmacist
- A Registered Pharmacy Technician trained in the administration of medications.

If there is still doubt that the correct calculation has been made, check again with a senior practitioner. Medicines must not be given if there is any doubt over the accuracy of the calculation.

Check that allergy / adverse reaction information has been completed before administration. Ensure that the patient has a red wrist band if a known allergy has been recorded. Check that the intended medication is not associated with known allergies or adverse reactions.

Any ambiguities or concerns regarding the direction for administration of the medicine must be raised with the prescriber or a pharmacy professional without delay.

Check the identity of the patient carefully in accordance with the minimum standards defined in the Trust Policy for Patient ID.

Administer the medicine by the prescribed route, and document the administration on the appropriate prescription record or chart. Such records must be completed at the time of the administration/refusal or as soon as possible thereafter.

Adverse reactions to medications should be reported to the medical team, a Datix incident completed and where required, a Yellow Card submitted to the national online database following the criteria outlined by the MHRA and in the BNF. Note that yellow cards can be completed by any person who identified the adverse reaction or event.

Defective, damaged or contaminated medications or medication devices e.g. pre-filled pens or syringes such as enoxaparin or insulin should be quarantined in the clinical area and reported to pharmacy as soon as possible. Pharmacy staff will follow defective medicines procedures (Pharmacy SOP) and where necessary, report these issues to the manufacturer and/or to the MHRA. Clinical area staff may be also asked to complete a Yellow Card report.

5.7.2. Oral medications supplied by Pharmacy

Where possible the pharmacy will supply solid and liquid oral doses in the original packaging.

Medicines that are not supplied in the original packaging (e,g, when short course lengths are required) may be 'packed down' by Pharmacy and can still be used for administration.

The hospital pharmacy will always ensure the original batch and expiry date appear on the outer carton / bottle for oral products which are not supplied in their original packaging. Partial foil blister strips may also be dispensed in this way where small quantities are required. A Patient Information Leaflet will be provided to aid identification.

If a patient has swallowing difficulties, contact pharmacy for advice regarding crushing tablets or provision of oral liquids or advice on alternative routes for prescribers to consider. Modified release tablets should not be crushed.

5.7.3. Administration using Patient's Own Medicines/Drugs (PODs)

Wherever possible, patients own medicines should be used during their stay in hospital, to facilitate continuity of care, self-administration (as per separate Policy) and to reduce waste.

Patient's medicines that have been prescribed should be stored securely as per 5.2.4 along with other named patient medicines supplied from pharmacy during the inpatient stay.

Always ensure patient's medicines are transferred with the patient and the bedside medicine cabinet is empty, before moving a new patient into a bed / bay (include this prompt on any local transfer or discharge SOPs or checklists to embed this Policy requirement).

Before patient's own medicines can be used in the hospital, they should be checked to ensure that they are clearly labelled and of sufficient quality to be safely administered. Overall appearance of bottle, label and medicine must be assessed: the container must be intact and clean, and the medicine must NOT show any visible sign of deterioration and be of uniform appearance. Confirm that the product is within its expiry date.

Consider any special storage requirements and if identified, confirm with patient or carer that medicines have been stored correctly before use.

5.7.3.1. Administration using patient's own labelled medicines

Where labelled, medicines should include the following information:

- The name of the patient
- Name and strength of the medicine
- Method and frequency of administration
- Date dispensed
- Name and address of supplier.

The directions on the label must match those on the prescription ('as directed' is acceptable). If necessary, discuss with pharmacy options to re-label or resupply.

5.7.3.2. Administration using patient's own unlabelled medicines

Patient's own over-the-counter medicines (P = pharmacy only sales; GSL = general sales list purchases) will not have a label, and do not require one unless supplied from UHDB. They should be appraised for appearance as with all other PODs.

If a patient's own prescription-only medicine (POM) has no label, it must not be used unless it is clearly identifiable and is within its expiry date (in practice usually within a 'blister strip'); such medicines are to be highlighted to pharmacy to advise on options to re-label or resupply.

5.7.3.3. Administration using medicines in a compliance aid

Sealed compliance aids (blister packs) may be used if they are clearly labelled (or accompanied by a completed medicines administration record (MAR) sheet which aids identification of the contents). Before use, staff should satisfy themselves that:

- All the medicines listed as being in the compliance aid are prescribed. Where medicines have been stopped or changed the sealed compliance aid must NOT be used, and the medicines will need to be re-dispensed by pharmacy
- The compliance aid includes the patient's name, date of birth (or alternative ID), details of the medicine and strength, and name and address of the pharmacy supplier
- The medicines within the compliance aid appear to be in good condition, with no signs of degradation.

Compliance aids that are not sealed (i.e. have a removable lid covering medicine compartments) and that can be filled by relatives and carers must not be used unless the contents have been verified and authorised by the pharmacy team. In most cases these medicines should be reordered from the hospital pharmacy for inpatient use.

5.7.4. Administration of cytotoxic medicines (outside of cancer/haematology services)

Detailed guidelines and Policies on the administration of cytotoxic chemotherapy and the related care and management of oncology and haematology patients are found on Koha. via the Derby-Burton Cancer Network.

This includes the Systemic Anti-Cancer Therapy (SACT) Policy used across the East Midlands.

Local network protocols can be accessed via the Cancer Network pages on the Trust extranet (documents are restricted to haematology/oncology/pharmacy users). Derby-Burton Local Cancer Network | University Hospitals of Derby and Burton NHS| https://www.uhdb.nhs.uk/derby-burton-local-cancer-network/

The following Policy requirements relate to non-cancer/haematology areas who may be required to administer cytotoxic medications at times.

5.7.4.1. Intravenous Chemotherapy

Administration of cytotoxic chemotherapy by practitioners via any intravenous line may only be undertaken by those who possess suitable qualifications. These staff usually work within the cancer or haematology service, or if not working within that service have received the same/comparable training and follow current SOP and guidelines to the same standard (e.g. areas administering cyclophosphamide such as renal services). The treatment can take place in care areas outside of cancer or haematology areas providing all SOP requirements are upheld including PPE, waste/spillage disposal and access to the prescriptions and administration records (which are always generated on Chemocare for intravenous SACT – Systemic Anti-Cancer Therapies).

5.7.4.2. Intravesical cytotoxics

Intravesical (into the bladder) chemotherapy must only be administered by Urology nurses who have undertaken additional training and have documented evidence of competence in the administration of intravesical chemotherapy.

5.7.4.3. Intramuscular and subcutaneous cytotoxics

Staff administering parenteral cytotoxics must avoid direct contact with the active agent by wearing an apron and gloves when handling the product. A cytotoxic spillage kit must be available.

Methotrexate for ectopic pregnancy –

The medical treatment of tubal (ectopic) pregnancies involves the administration of intramuscular doses of methotrexate.
Only registered practitioners that have undergone Trust approved training in the administration of intramuscular methotrexate may administer it.

Methotrexate in Rheumatology, Dermatology or Gastroenterology indications –

This may involve the administration of subcutaneous methotrexate to patients.
If the patient self-administers at home, ensure they have the materials required, and consider completion of assessment for self-administration where appropriate.
If the patient is unable to self-administer, contact the specialist nurses or consultant in rheumatology for advice. Only registered practitioners that have undergone Trust approved training in the administration of parenteral methotrexate may administer it.

5.7.4.4. Oral cytotoxics

Staff administering oral cytotoxic medicines must avoid direct contact with cytotoxic medication and should wear apron and gloves when handling these products.

Women who are (or think they may be) pregnant should avoid handling cytotoxic medicines and should discuss this as part of a pregnancy risk assessment with their line manager.

5.7.5. Covert administration of medicines

Covert administration is when medicines are administered in a disguised format such as medicines hidden in food, drink or given through a feeding tube without the knowledge or consent of the person receiving them.

When a person has mental capacity to make the decision about whether to take a medicine, covert administration is not appropriate. They have the right to refuse that medicine. They have this right, even if that refusal appears ill-judged to staff or family members who are caring for them.

Covert administration must be the least restrictive option after trying all other options. Carry out a functional assessment to try to understand why the person is refusing to take their medicines and consider alternative methods of administration.

Covert administration should only be considered at UHDB where:

- A person actively refuses their medicine **and**
- The medicine is deemed essential to the person's health and wellbeing (Consider how covert medicines, such as sedatives, may be a factor in depriving a person of their liberty) **and**
- That person is assessed not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005 and a best interest process* may be followed and recorded in a formal management plan. See also Trust Policy for Consent and the Mental Capacity Act and the forms available in the UHDB guidelines for consent without capacity.

***Best interest decision-making**

The decision should be undertaken by a multi-disciplinary team following the Policy / guidelines cited above. That team should include:

- Care staff (nursing / midwifery or other staff who are supporting care including medication administration)
- Medical staff or other independent prescriber involved in the pharmaceutical care plan for the patient
- A family member or patient advocate (wherever possible)
- A pharmacist, where discussions around alternative formulations / routes and/or off-license preparation are likely to be required to achieve covert administration.

Regular review

You must identify the need for covert administration for each medicine prescribed. Each time new medicines are added or the dose changes of an existing medicine, you must:

- Identify the need again
- Make and record further 'best interest' decisions.

Where no changes to the regimen take place, you must still schedule regular reviews, taking into account likelihood of fluctuating capacity where relevant.

A change in clinical location will require review and re-engagement with nursing, midwifery or other care staff managing medicines in the new area.

5.7.6. Timeliness of administration (delays)

All scheduled[m] medicine administration should be within 2 hours, either side, of the prescribed administration time. Medication administration delay at UHDB is therefore defined as failure to administer a scheduled medicine within 2 hours[n] of the specified time.

If administration is delayed by more than 2 hours, the reason for omission or delay must be documented within the ePMA administration record (or nursing notes if ePMA not in use).

Unintentional or unjustified delay of any critical medicines should be reported as a medication error using Datix. See appendix 2 for critical medicines list and procedures.

Nursing staff MUST communicate any medication delays / omissions during patient handover / transfers of care. If a dose is being held / delayed due to an unclear prescription, the prescriber (or another prescriber if original staff member is unavailable) is to be contacted to clarify instructions for administration.

5.7.7. Omission of medicines

If a medicine cannot be administered to the patient as prescribed (including when a patient refuses or another prescriber or practitioner requests the medicine to be withheld), the registered practitioner responsible for administration must record the reason why it was not administered during the medication round.

When using an omission code to record omission, the registered practitioner is responsible for taking and evidencing corrective action and recording this. Guidance on omission codes / descriptions and advisory corrective actions are included in table 1.

- ePMA: The staff member ID and date / time will be recorded when the most appropriate omission descriptor (table 1, below) is selected from the options / drop-down list provided. Additional free text may be added to the administration record in ePMA and / or nursing or medical notes to supplement decisions and actions
- Paper or free-text administration records: an appropriate omission code should be selected from table 1 below and the registered practitioner must add their initials and time on the administration record and use the nursing and / or medical notes to document decisions and actions.

Registered practitioners must communicate any medication delays / omissions during patient handover / transfers of care.

5.7.7.1. Escalation to prescribers and the medical team

[m] Urgent ‘Once-only’ prescriptions should always be given as soon as possible. This might include items such as anti-arrhythmic, anti-epileptics in status epilepticus, anti-coagulation or it’s reversal.

[n] First dose antibiotics for severe sepsis/septic shock must be administered within 60 minutes of decision to treat as per Trust urgent care standards.

If a dose of any medicine cannot be given due to an erroneous or unclear prescription, the prescriber (or another prescriber if original staff member is unavailable) is to be contacted to clarify instructions for administration.

When any prescribed medicine has not been given for two or more doses OR when any SINGLE dose of a ***critical medicine***[o] has been omitted or significantly delayed, this should always be recorded in the patient's individual health record.

A record of action(s) undertaken for dose omissions must be documented in the patient's clinical notes (wherever possible, this should be the notes used/viewed by the medical team).

If necessary (and always in the case of critical medicines), a relevant prescriber for the patient or clinical area must also be contacted and asked for further instructions. This will include cases where only partial administration of a critical medication has been possible (e.g. lost IV access part way through a critical IV infusion such as an antibiotic).

[o] Medicines where omission or delay of a single dose could lead to patient harm. See appendix 2 for examples and summary of key Policy actions.

Table 1 – Omission codes at UHDB (note that paper/free-text codes may not align with clinical system code numbers. **NerveCentre is due to roll-out from 2026 and new descriptors may be in clinical use following this change**)

Omission code (paper / free-text system only)	**Meditech ePMA descriptors**	**Lorenzo ePMA descriptors**	**Definition and action to be taken**
OM1 Clinical omission	*Clinical or Patient Clinically Unstable* Or *Not required by patient*	*Not given / deferred (clinical reason)* Or *Not given (medicine free interval)*	Use this code when a medicine is omitted for clinical reasons e.g. contra-indicated, adverse drug reaction, prescriber authorised, resolution of symptoms, BP/HR outside of parameters in the prescription or guidelines etc…. Reason for omission must always be documented and, where appropriate, the prescriber informed so alternatives can be prescribed. *NAs should also update a registered practitioner of all clinical omissions made.*
OM2 Medicine not available	*Out of Stock*	*Not given / Deferred (Medicines Unavailable)*	For long term medicines or those continued on admission, always ask if the patient has their own supply or if a relative/carer can bring in their supply from home. If not, order medication from pharmacy if it is not stock on your ward. Ensure defer process is used if system allows or otherwise consider if/how the dose will be administered later when it has been obtained/supplied.
OM3 Patient refused	*Patient Refused (use document)* Or *Not required by patient*	*Not given (patient refused with capacity)* Or *Not given (patient refused without capacity)*	Speak to patient and ensure they understand what the medicine is for and any implications of not taking the dose. (Contact medical/pharmacy staff for advice if further information needed). Where the patient is fully informed and has capacity to understand their actions, this should be respected and medicine should not be administered (update medical/prescribing team). Medication must not be disguised in food or drink[16] as this may constitute 'deception' of the patient and is reserved for formal covert administration agreements. Document the reason for refusal in the notes and inform prescriber if a patient refuses a dose of a critical medicine or refuses multiple doses.

[16] Covert Administration is only possible following application of the principles outlined in section 5.7.5 and its related Policies.

Omission code (paper / free-text system only)	Meditech ePMA descriptors	Lorenzo ePMA descriptors	Definition and action to be taken
OM4 Patient unable to take	*No generic equivalent – search through the Meditech options for closest match to the clinical scenario*	*Not given (patient unable to take)*	Patients who are fasting prior to a diagnostic procedure or surgery should receive all of their usual medicines as prescribed with a small amount of water unless specifically informed to withhold by prescriber/anaesthetist. Use this omission code when the patient is unable to take the dose for other reasons e.g. if patient is too drowsy or is vomiting or has severe nausea. Refer to specific Trust guidelines for 'nil by mouth' patients. If patient has difficulty swallowing, contact pharmacy for advice on alternative formulations. Medicines should not be crushed for ease of administration unless approved within national or UHDB guidelines or by Pharmacy.
OM5 Patient off ward	*Home Leave* Or *Patient refused (document)*	*Not given / deferred (patient unavailable)*	Give dose when patient returns to ward unless next dose is due. If unsure, ask pharmacist or prescriber for advice on timing of medication. Infusion therapy should normally be continued when patients are off the ward e.g. receiving a diagnostic test. Infusion therapy should only be temporarily discontinued on written instructions of a prescriber.
OM6 Route not available	*Nil by (Mouth/NG/PEG)* or *No access (Enteral / IV)*	*Not given (nil by mouth)* or *Not given (route not available)* Or *Not given (patient unable to take)*	Examples for when this code should be used are cannula not in situ/not patent; NG tube is pulled out. IV route – contact an appropriate practitioner to request cannula insertion. Contact the prescriber/pharmacist to consider alternative routes if necessary.
OM7 Prescription error	*Prescriber Error*	*Not given (Prescription incorrect)*	Contact a prescriber to review and amend the prescription. If there are delays in having a prescriber review and you are concerned about patient safety, then consider contacting a pharmacist to amend or annotate the prescription for clarity until prescriber is available.

NB/ Meditech has additional descriptors than those in table 1 above, which may be selected to best represent the scenario encountered.

5.8. Supply of medicines

Supply in this section refers to preparing a medicine, within clinical areas, to be handed over to a patient to take home (in outpatient, daycase or discharge 'TTO' settings). Therefore, it relates to medicines which must be labelled within the clinical area for an individual patient in order to make a supply to the patient.

[Note: *the term 'dispensing' is often used, and this is a similar process, but dispensing only relates to supply processes undertaken within a pharmacy. Dispensing practice is therefore included in separate Pharmacy Department SOPs for pharmacy staff use only*]

[Note: This section does NOT relate to medicines given to a patient to administer under supervision on routine drug rounds or during a hospital visit. See section 5.7 Administration of medicines for these scenarios].

General Policy Requirements relevant to all supplies from clinical areas:

Any registered practitioner preparing to supply medication to a patient must ensure that the minimum prescribing standards for the prescription have been completed fully by the prescriber as per section 5.3.2.

The prescription must be signed and dated (or in electronic systems be otherwise confirmed as a live / current inpatient prescription or a final discharge medication).

At least 14 days' supply of newly initiated or amended dose / formulation medicines should be supplied, unless a shorter course is indicated (e.g. antibiotics, steroids, post-operative analgesia).

Only fully labelled pre-pack ('TTO' pack) medication may be supplied to patients.
Do NOT supply stock or other unlabelled medicines. All pre-pack ('TTO' pack) medication must be supplied from the hospital pharmacy with TTO pack labels already attached. These labels include the hospital details and met the legal requirements for labelling templates.

Patient name and date of supply must be written on the label before issuing. Pre-printed instructions must never be altered or crossed out, although some packs will be formatted to include blank spaces to allow clarification of variable dose and / or frequency (e.g. 'ONE' or 'TWO' capsules. 'THREE' or 'FOUR' times daily).

Pre-pack ('TTO' pack) medicines supplied from the clinical area must be second checked by another registered practitioner against the prescription (except in the case of PGD – Patient Group Direction – supplies).

Counsel all patients and/or carers on new medications including:

- What they are used for
- Why they are important
- Dosage and how often to take/use them
- Specific administration instructions on how to take/use them
- How long for
- What to do when they run out.

- Common side effects / significant side effects which should be reported to a healthcare professional if they occur
- Recommendation to read the patient information leaflet supplied (this may already be in the box with the medication, or may be available within the clinical area / on Net-i e.g. emollients leaflet.

5.8.1. Additional requirements for Medication for discharge

Full SOPs outlining processes for discharge medication checks are available on Net-I intranet (see Appendix 6)

Check that any medicines reconciliation discrepancies have been actioned by a prescriber. If it is unclear why a medicine has been changed or discontinued, then this query must be referred to a prescriber who must clarify on the prescription / discharge letter before a supply is made and before the patient is discharged.

At least 14 days' supply of newly initiated or amended dose / formulation medicines should be supplied, unless a shorter course is indicated (e.g. antibiotics, steroids, post-operative analgesia).

Always check the following areas prior to discharge / transfer and ensure medicines are either transferred with the patient or disposed of if no longer required:

- Bedside medicines locker (POD locker)
- Department fridge
- Controlled drugs cabinet.

Discontinued medicines i.e. medications which are no longer prescribed for the patient, may be removed with the patient's permission (see section 5.9 Medication returns, disposal and waste and / or Controlled Drug Policy for procedures).

Only resupply patient's existing, unchanged long-term medicines if you are NOT able to confirm that they have access to at least 14 days'[17] supply after discharge.
Any medicines which are not available can be supplied from pre-packs held in the clinical area or by ordering via the pharmacy.

5.8.1.1. End of Life / palliative discharges

If these patients are requiring community nursing support for administration, then a MAR chart should always be provided. A full supply of all medicines (regular and anticipatory) must be requested from pharmacy. Further information is available on the Derbyshire EOL alliance website https://derbyshireeolcare.uk/

[17] Access to medicines would include confirmation that patient has the medicine at the same strength/dose/frequency at home or awaiting collection from a community pharmacy. i.e. routine supply of existing medication rarely necessary except where those UNCHANGED medicines have been depleted during the inpatient stay.

5.8.1.2. Patient's requiring Monitored dosage systems (MCA 'blister packs')

Notify ward pharmacy team at the earliest opportunity of any patient admitted on MCA or of any patient who is identified that may need to be assessed for a new initiation[18]. Note that new initiation is dependent on third-party agreements, primarily with community pharmacy providers who may only open on limited hours and days of the week.
Prior to ordering medication for discharge within an MCA, the medication regime must be stable and finalised by prescriber (TTO written), and 24 hours'[19] notice provided for pharmacy prior to discharge.

5.8.2. Medication Management during Transfers of Care Provider

5.8.2.1. National Principles adopted within UHDB Policies and SOPs

The transfer of medicines and prescribing information is prone to error, and often leads to unintentional omission of medicines, inaccuracy and wastage. National multi-professional standards[20] have been published to improve communication, accuracy and completeness of medicines information when patients transfer across care settings.

Any local UHDB procedures (SOPs) or guidance to support this Policy around discharge / transfer prescribing or medication supplies, must be aligned with the four governing principles outlined in RPS[21] guidance:

- All necessary information about the patient's medicine is accurately recorded and transferred with the patient, and responsibility for ongoing prescribing is clear
- When taking over the care of a patient, check that information about the patient's medicines has been accurately received, recorded and acted upon
- Patients (or their carers or advocates) should be encouraged to be active partners in managing their medicines when they move, and understand why, when and what medicines they are taking
- Information about patients' medicines should be communicated in a way which is timely, clear, unambiguous and legible, and ideally generated and / or transferred electronically.

5.8.2.2. Transferring medication to other care areas or providers

SOP available on Net-I intranet – see appendix 6

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[18] Initiation of MCA by acute trusts should be exceptional and necessary on grounds of patient safety. In most cases, the ward pharmacy team will follow procedures to ensure community assessment and follow up using recognised interface methods including TCAM and Discharge Medication Services (enhanced community NHS service)

[19] The turnaround may be delayed at weekends and bank-holiday's if the safe supply is dependant on liaison with GP surgery or community pharmacy to facilitate safe, continuous provision.

[20] https://digital.nhs.uk/services/interoperability-toolkit/developer-resources/transfer-of-care-specification-versions

[21] RPS. Keeping patients safe when they transfer between care providers – getting the medicines right. 2012 via https://www.rpharms.com/

Always check if the destination organisation / department require an administration chart (MAR chart or print-out / downtime report of the current inpatient chart). In most cases this **is** required (except when transfer is between two UHDB departments / hospitals who are using the same ePMA system).

Ensure that all fully labelled medicines are transferred with a patient when moved to other internal or external care providers, unless they have been intentionally discontinued. This includes medicines stored in the patient's bedside cabinet ('POD locker'), the ward drug fridge, drugs trolley, and controlled drugs cupboard (follow CD Policy SOP for transfer).

Medicines should be transferred in a green medicines bag, apart from controlled drugs, which should be transferred as per UHDB Controlled Drug Policy.

If any current medicines are unavailable (or less than 14 days' supply) contact the destination organisation / department / ward:

- Confirm whether the destination have this available as stock
- Confirm the minimum days' supply required until available from the destination organisation's pharmacy services.

If medicines are unavailable at the destination, then these must be ordered from UHDB pharmacy and supplied prior to transfer.

5.8.2.3. Transfer to Care Homes (Residential and Nursing)

When patients are being discharged back to a care home, confirm with the care home manager which medicines are required for discharge. If the care home has supplies of the patient's UNCHANGED regular medication, then it is acceptable to only send new or changed medication. If pharmacy have entered a medicines reconciliation note into the patient's records, this will usually state whether all medicines or only new / changed medications need to be supplied on discharge.

The patient should be discharged with at least 14 days' supply of newly prescribed or changed medication.

A MAR chart should also be supplied (see SOPs on Net-I via Appendix 6). If only supplying newly prescribed or changed medication, a MAR chart which includes at least these items must be also provided.

Patients NEW to a care home (including interim care)

Discuss with the care home in case of any enhanced requirements they may have to facilitate medication administration. In general, residential and nursing homes will be able to administer from fully labelled original packs of medicines, providing a MAR sheet is supplied.

A MAR chart should always be supplied which includes all of the patient's current medication regime (see SOPs on Net-I via Appendix 6).

If the patient was self-medicating using a compliance device prior to admission to hospital this might be appropriate for discharge to a care home, if no changes have been made to previous medication. The pharmacy team should be contacted to undertake an assessment.

5.9. Medications returns, disposal and waste

5.9.1. Return / recycling of medications

Excessive medicines stock or in-date medicines that are no longer required should be returned to pharmacy who will assess further for recycling or safe disposal.

Unwanted room-temperature storage medicines should be returned in their original packaging. Simply place them in the locked pharmacy returns box within the locked clinical room. If you do not have a lockable returns box, place them in the empty pharmacy ward box and secure with a padlock.

Contact the pharmacy logistics ('ward services' stock) team if you wish to return large quantities or bulky or fragile items.

Refrigerated items for return or recycling should be left within the locked medicine fridge but segregated and labelled for return. Contact pharmacy to review and return these items.

Consult the Controlled Drug Policy for details of CDs (requiring safe custody) for destruction or return.

5.9.2. Disposal of medication waste (including patient's own medicines no longer needed)

Always refer to UHDB Policy on waste management. Additional summary charts and posters are available on the Trust intranet to support staff with decision making around medicines waste. Note that at the time of publication, there are separate requirements for Covid and non-Covid areas. Waste | z UHDB Intranet https://neti.uhdb.nhs.uk/az-nc-efm-waste find the information within the site-specific tabs.

Patient's own medicines that are no longer required should be disposed of with the patient's permission (and see Controlled Drug Policy for relevant medicines).

UHDB updates the Policies and tools to support these processes regularly. The Trust recognises that waste management is an integral part of its responsibilities under the Environmental Protection Act 1990, Hazardous Waste Regulations 2005 (as amended in 2016), Waste Management Licensing Regulations 1994 (as amended) and HTM 07-01, Safe Management of Healthcare Waste and Requirements.

5.9.3. Return / destruction of Clinical Trial Investigational Medicinal products (IMPs)

Ensure that IMPS are not destroyed until a Clinical Trial pharmacy team member has been informed as communication with the company may need to take place.
Where the company or organisation co-ordinating or organising the trial provides for the waste removal, the hospital or pharmacy (as the legally responsible party) should ensure that the Trust waste Disposal requirements are met before handing over the waste.

It should be noted that accounting for unused investigational medicinal products (IMP) remains the responsibility of the sponsor under the EU Clinical trials Directive. Unused IMPs must not be destroyed or disposed of as medicinal waste without the express permission of the trial sponsor.

5.10. Ward and Department Closures

The safe and secure storage of medicines must be maintained even when wards or departments are closed and remain the responsibility of the appointed practitioner in charge.

Where wards or departments are routinely closed for short periods (e.g. weekends), medicines stock (including controlled drugs) may be retained in secure, locked medicines cupboards in the clinical area. The keys for all medicine cupboards MUST be stored securely in a designated area, accessible only to relevant registered staff, during periods of routine closure.

All non-routine closures should be discussed with a Divisional pharmacist or the pharmacy management team at the earliest opportunity. The appointed practitioner in charge and Divisional pharmacist (or deputy) should meet to consider options for managing medicines during the closure.

The decision to secure or remove stock during a non-routine closure should be based on the risks to security which may include, but are not exclusive to:

- Whether the treatment room (or other medicines storage areas) can/will be accessed during the closure
- Any requirement for building works and whether these are by UHDB staff or contractors
- Level of supervision for any building works
- Presence of CCTV / swipe access and other monitoring / deterrents
- Duration of closure.

The appointed practitioner and Divisional Pharmacist should inform the Divisional Nurse Director and the Chief Pharmacist (or their nominated deputies) in any case where there is a proposal for medicines stock to be left in the clinical area during a non-routine closure.

Where wards or departments are closed for periods >1 week, arrangements must be made with pharmacy to return all medicines stock (including Controlled Drugs) to the pharmacy. For CDs, The Trust CD Policy includes detail and procedures to facilitate this

In exceptional circumstances, consideration may be given to retaining medicines in locked storage on the ward or clinical areas for >1 week, but these exceptions must be authorised by the Divisional Nurse Director and the Chief Pharmacist (or their nominated deputies).

5.11. Clinical Trials

Clinical trials often have detailed procedures in relation to medicines use processes over and above the general principles of this UHDB Policy. The following principles should be adhered to, and the clinical trials team pharmacy team should be contacted to enquire about any medication specific questions:

- Trust staff involved in clinical trials must comply with the statutory requirements for the conduct of Clinical Trials. These regulations include the Medicines for Human Use Clinical Trials Regulations 2004 and Amendment 2006 and all other relevant UK and International guidelines and Policies as appropriate

- All Chief or Principal Investigators wishing to undertake clinical trials involving investigational medicinal products must obtain Trust approval

- All Chief or Principal Investigators must contact the clinical trials team (Research and Development service) for advice on Trust pharmaceutical requirements for clinical trials, including pharmacovigilance

- When patients included in a clinical trial are admitted to the Trust, the principal investigator and clinical trials pharmacy staff must be notified as soon as practical by the medical team looking after the patient or the ward pharmacy service.

5.12. High Strength Potassium Concentrate Policy

In the majority of clinical cases, potassium replacement and fluid maintenance can be achieved with lower strength potassium infusions (e.g. 40mmol potassium in 1000ml) which may safely be given via peripheral venous access. A range of commercially prepared, ready-to-use potassium containing infusions is available across the Trust for use by all wards / areas. Their clinical use, including appropriate concentrations, rates and monitoring is described in the UHDB Clinical Guideline for Hypokalaemia on the intranet / Net-i.

However, some specialist areas and patient groups will require access to concentrated potassium products and infusions which must follow this Policy section.

In accordance with the NPSA Patient Safety Alert 2002 *(Use and storage of concentrated potassium solutions)* the following applies:

a. Concentrated potassium solutions include the following products on the UHDB formulary:

- Potassium Chloride 15% Injection (1.5g in 10ml) - 2mmol potassium per ml
- Potassium Chloride 3% infusion bag (40mmol in 100ml)
- Potassium (di)hydrogen phosphate 13.6% Injection (potassium acid phosphate) – 1mmol potassium per ml.

The principles below also apply to any other concentrated vial or ampoules of potassium that may be procured as alternatives to the above (e.g. Addiphos®). They also apply to any commercial pre-filled syringes that contain high concentration potassium or any infusion bags containing **more than** 0.6% (80mmol/litre potassium or equivalent).

b. These concentrated products are only to be held as stock items in the clinical areas listed below.
    i. ADULT clinical areas must never request / supply potassium concentrates from/to another ADULT clinical area. Requests for supply must all be via pharmacy. **Discuss with the ward/on-call pharmacist.**
    ii. Paediatric areas who are NOT listed as stock-holding areas may occasionally need to prepare dilute potassium-containing fluid bags from potassium concentrates. In such cases the plan must ALWAYS be discussed with the paediatric or on-call pharmacist (available 24 hours per day via switchboard). Most bags for routine conditions are commercially available or can be prepared from base bags already containing potassium by adding glucose and/or sodium chloride. The pharmacist will review these options with the clinical area. Occasionally, where potassium concentrates are still needed to add to an infusion, the pharmacist will authorise this and will make a supply **or** will authorise the ward to obtain from the nearest paediatric / neonatal stock-holder from the list of authorised areas.

c. The areas listed below (and paediatric wards) must maintain clear clinical guidance and procedures for prescribing, preparation and administration. These areas should ensure this is covered in induction or training for any staff involved. The **minimum** standard for training is to record that the staff member has read this Policy section and any local SOP or guideline that must be read and understood prior to practice.

d. Potassium Concentrates must be stored in a Controlled Drugs (CD) cupboard. This is consistent with other UK hospitals.

e. CD ordering and recording processes, including administration records, should be followed for concentrated potassium solutions (see CD Policy for requirements). **All** supplies **must** come from pharmacy and these products must **not** be shared between clinical areas except the specific exception listed above for paediatrics (section bii).

The measures above reduce the risk of mis-selection of potassium when other similar looking drug-ampoules or infusion-bags are required. This Policy section also ensures that patients requiring more urgent correction of low potassium levels can receive treatment promptly in the appropriate clinical area with suitable monitoring.

Areas approved to hold Potassium Concentrates at UHDB

If there is no suitable ready-made infusion available, and a more concentrated solution is indicated for use via central line, the listed areas may use potassium concentrates to prepare an infusion for a patient ONLY when the patient is being managed **in that specialist area.**

Authorised areas at Queens Hospital - Burton (always check current CD stocklist to confirm which specific potassium concentrates are permitted in each area)

- QHB Intensive Care Unit (ICU) POD A
- QHB Intensive Care Unit (ICU) POD B
- QHB Neo-Natal Unit (NNU)
- QHB Coronary Care Unit (CCU)

Authorised areas at Royal Derby Hospital (always check current CD stocklist to confirm which specific potassium concentrates are permitted in each area)

- RDH Intensive Care Unit (ICU)
- RDH Ward 208
- RDH Paediatric Critical Care Unit RDH Neonatal Intensive Care Unit (NICU)
- RDH Coronary Care unit (CCU)
- RDH Renal High Dependency Unit (407/HDU)

5.13. Training: Medicines Management and Medicines Safety

Training and education in medicines management and the safe use of medicines is provided in a variety of formats across multiple departments. This section outlines some of the high-level essential requirements only. Additional packages can be identified by My Learning Passport.

If in doubt about the training or competencies in place in your area, contact clinical educators working in your area or contact the Professional and Practice Development Unit or the Medicines Safety Group (via the Medicines Safety Officer).

5.13.1. Mandatory / Essential to role training

Working in an acute Trust, at least some awareness of medication management is relevant to all staff. Every member of our organisation is included in at least one of the four essential-to-role tiers on the Training Passport.

Training in Medicines Management (ALL non-registered staff and volunteers working in the Trust)

- Tier 1 Medicines Safety Training: This is a brief training requirement consisting of a checklist and declaration. It highlights responsibilities for all staff around medicines security. Non-registered staff (including volunteers and porters and HCSW) play a regular role in transporting medicines around the trust. Admin staff regularly transfer prescriptions or collect items. For these reasons, this declaration is essential to role for ALL non-registered employees.

Training in Medicines Management and Safety (ALL registered healthcare staff)

- Tier 2 - Registered Healthcare Professionals (no routine role with medication or a very limited role such as use of a restricted formulary or protocol)

This handbook is the minimum level of Medicines Safety Awareness at UHDB for registered healthcare professionals that do not regularly handle or advise on medication. Some non-registered staff or HCSW may be asked to step up to this tier if they have extended scope (or Policy exemptions in 5.14 of this Policy) to have a role with medications.

- Tier 3 - Nursing, Midwifery and Allied Health Professionals (Awareness video presentations + Quiz - approx. 50 minutes total)

- Tier 4 - All Prescribers and clinical pharmacy staff (Awareness video presentation - approx. 25 minutes)

For any queries around access or recording training on your passport, contact uhdb.mandatorytraining@nhs.net

For any queries on allocation of staff groups, or feedback in relation to content, please contact the Medication Safety Officer.

Newly Qualified Nurse/Midwives/Nursing-Associates and Overseas Nurses

Regular medicines management training days are provided by the Professional and Practice development unit which includes a medicines safety presentation.

New to role/trust Nurses, Midwives, ODPs and Nursing Associates

The staff must complete the Drug assessment / competency package provided by the Professional and Practice Development team.

Electronic Prescribing and Adminsitration (EP/ePMA)

Provided by EPR / IT trainers for all staff with prescribing and / or administration responsibilities. This may be a combination of online, face to face and video format tutorials. ePMA passwords are not released to staff until they have completed training. However, access to particular functionality or medicines should never be viewed as authorisation to undertake a task for which you do not have the training or experience [see Policy requirements for administration and prescribing – ePMA systems can sometimes help to control/limit access but do NOT govern professional decision making].

5.13.2. Additional training and enhanced roles

Intravenous Medicines and Infusion training

Training with competency and assessment package is coordinated by the Professional andPractice Development team to administer infusion therapy.

Infusion Devices ("pump" training)

Training and resources are provided by the medical devices team pump trainers.

Patient Group Directions

All staff working under patient group directions must complete the core eLearning provided before working under any PGDs authorised from January 2022 onwards.

Miscellaneous

Information on other general training packages can be accessed from My Learning Passport e.g. Training for administration via enteral tubes

Specialist or enhanced roles

Some competency packages have been created by clinical business units in consultation with the Medicines Safety Group and Professional and Practice Development Unit. Examples include enhanced roles or extended scope roles e.g. joint injections in therapies; intravenous opiates in recovery.

5.14. Approved exemptions to the medicines Policy

This section includes clinical areas or practices which hold approved exemptions to previous sections of this Policy.

The medicines Policy is intended to create consistency in legal and/or best practice across UHDB. It should be upheld across all services in the absence of formal exemption. However, given the size and complexity of UHDB services, and a need for transformation to maintain quality services and make best use of staff expertise, it is recognised some specialist services will occasionally propose alternative procedures.

These agreements will be guided by the Medicines Safety Group, who will advise on any mitigation, monitoring and risk assessment that the business unit or Division should undertake before an exemption is formally added as an extension to this Policy.

The main approved exceptions at the point of publication are listed below. However, there is also a dynamic Policy exemption register. This is necessary to capture new proposals which have been approved (by Medicines Safety Group) and implemented (by Divisions) within the lifespan of this Policy. Publication rights to the register are restricted to the medicine's safety team for this purpose. The register can be accessed via the links below:

Medicines Policy and procedure | z UHDB Intranet

https://neti.uhdb.nhs.uk/az-c-pharmacy-medicines-Policy

5.14.1. Policy exceptions within Community and Domiciliary setting

It is accepted that the preparation and administration of medicines will routinely be performed by a single healthcare worker i.e. second checks are not possible, except in circumstance where two registered practitioners are working together.

The Key Principles outlined in section 5.7 for Administration of medicines do apply except that:

- Whilst the safe storage of medicines in the patient ‘s home does not involve ‘locked bedside lockers’, safe storage of medicines in the domiciliary setting is still an important consideration
- Staff are responsible for providing advice on the safe storage of medicines and should escalate any concerns they have. Inappropriate use of medicines can be a part of safeguarding concerns, so prompt escalation is required
- The principles outlined in section 5.7.3 on assessing patients own drugs before use still apply.

Non-registered support workers can undertake administration of oral or topical medicines where this approach has been agreed by the Medicines Safety group (e.g. the community Family Support Workers in paediatrics). Only staff who have undertaken a formal training package and passed the competency assessment are allowed to administer medicines and assist patients in this way.

The medicines used are generally the patient’s own, but administration of medicines obtained directly from GP practices is allowed (e.g. flu vaccine), subject to appropriate prescribing or legal authorisation to administer (e.g. PGD).

5.14.1.1. Paediatric community team (KITE) nurses

Authorised to administer paediatric and intravenous medications without a 2nd independent check within the community (however, if a second registered practitioner is also in attendance, then the second check process should be followed). However, this exemption does NOT extend to allow single nurse checks on cytotoxic or controlled drug (schedule 2 or 3).

5.14.2. Policy variation for neonatal vitamin K (phytomenadione/menadiol products)

Identification of the newborn in hospital requires two baby identification labels placed around the ankles at birth in accordance with Identification and labelling of the Newborn SOP (an appendix of the Trust Patient ID Policy).

It is a requirement that the mother’s identification number be included on the identity bands.

In circumstances when the newborn has not been registered, it is acceptable for Vitamin K to be administered against the mother's identification number.

Local SOP advised: The Division of Women and Children should maintain training and procedural documents outlining the process for this Policy variation.

5.14.3. NRFit Exemption for punendal block

As part of the final Action plan for NatPSA 2024/002 'Transition to NRFit', the patient safety team will approve continued use of non-NRFit needles for punendal block. This will be approved subject to Maternity holding a risk on the Trust risk register. There is currently no alternative for pudendal needles in the UK supply chain and this will require regular review as part of the risk management strategy in maternity.

5.14.4. Policy exemptions for Clinical Physiologists

Physiologists do not meet this Policy definition for 'Registered Practitioners' but many are involved in medication pathways and have developed roles, both leading or supporting safe medication practice. Physiologists are not legally permitted to operate using Patient Group Directions.

The exemptions below show routine physiologist medicines management roles at the time of Policy Publication. Any future development of role requires support from their clinical business unit, Division, and the Trust Medicines Safety Group before being added to the dynamic Policy exemption register on the intranet.

5.14.4.1. Medication use following protocol (Patient Specific Direction)

Some medications are required to support physiological tests performed in the clinical measurement department. Where the medicine use is implicit within a pathway, a 'protocol' has been developed and published on Koha that supports safe and consistent medication use within that pathway. A prescriber will provide patient specific direction to use these medicines in that pathway, wither by way of a prescription, or more commonly for it to be conferred within the wording of the referral letter / form.

Examples of medication protocols at the time of this Policy publication include: Salbutamol inhaler, GTN spray, Aspirin tablets, mannitol inhaler, rubefacient agents (e.g. deep heat) and lidocaine spray.

5.14.4.2. Advanced Cardiac Physiologist - Medication administration during Echocardiography

Following a patient specific direction from a prescriber, appropriately trained physiologists may prepare, check or administer intravenous contrast (e.g. Sonovue) or sodium chloride for 'bubble' echocardiogram.

Staff performing these roles must complete the Trust training and competency (or equivalent training agreed with Medicines Safety Group / Professional Development):

- They have undertaken Trust Intravenous infusion training
- Completed scope / competency assessment for intravenous therapy
- Completed pump training (if using IV infusion pumps)

- Completed their annual Medicines Safety training (minimum Tier 2 training for Registered Professionals)
- Any additional training defined in the Trust protocols for these agents on Koha.

5.14.4.3. Highly Specialist Cardiac Physiologists - Medication checks

Highly Specialist Cardiac Clinical Physiologists may perform clinical second (independent) checks, including intravenous medicines, within their specific area of practice, providing the following requirements have been met:

- They have undertaken the scope package for 2nd-Checking
- Completed pump training (if checking IV infusions)
- Completed their annual Medicines Safety training (minimum Tier 2 training for Registered Professionals).

5.14.5. Exemptions to secure storage of Patient's Own Medication (POD)

The Policy for Self-administration of Medication (SAM) defines scenarios where a patient's own medication may be stored outside of lockable storage.

6. Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trusts Monitoring Report Template:

Monitoring Requirement :	Security / safety of medicines mapped to Royal Pharmaceutical Society (RPS) Hospital standards.
Monitoring Method:	Multiple sources to inform the composite report: • Annual and interim Safe and Secure Medicines Audits mapped to RPS standards (minimum twice per year per area) • Thematic Incident analysis reviewed at Medicines Safety Group with themes shared, if appropriate, with other Medicines related Tier 4 groups (Diabetes Safety groups, Chemotherapy subgroup, Thrombosis Group, Medical Gases Group) • Escalation of audits and incidents to Tier 3 Medicines optimisation Group via quarterly reporting schedule from Medicines Safety Group • Quarterly Medication Safety Quality Schedule reports to the ICB • Prescribing compliance and performance collated from Pharmacist interventions logs and/or clinical contribution audits (Clinical Pharmacy Team)

	• Ad hoc audits or medicines use reviews for prescribing and /or administration where a risk or potential risk has been identified from adverse incidents, safety alerts, medication safety reports and issues raised regionally and nationally. Audits will be reported in the first instance to Medicines Safety Group • Primary/secondary care interface Prescribing Concerns Portal: includes formulary and Discharge concerns. Managed by Chief Pharmacy Technician – Interface.
Report prepared by:	Medicines Safety Officer
Monitoring Report presented to:	Medicines Optimisation Group (Tier 3 Quality Schedule)
Frequency of Report	3- Monthly

7. Bibliography

[1] Home Office. (2016). Security guidance for all existing or prospective Home Office Controlled Drug Licensees and/or Precursor Chemical Licensees or Registrants.

[2] Medicines and Healthcare products Regulatory Agency. Drug-name confusion: reminder to be vigilant for potential errors. (Accessed 24.01.2025)

[3] NHS Improvement. Patient Safety Alerts. (Accessed 24.01.2025)

[4] Specialist Pharmacy Service. (2018). Archived Patient (Medication) Safety Alerts from the NPSA and SPS resources to support their implementation.

[5] Department of Health. (2006). NHS estates guidance for medical gas pipeline systems (HTM 02-01).

[6] British Thoracic Society Emergency Oxygen Guideline Development Group. (2017). Thorax. BTS Guideline for Oxygen Use in Adults in Healthcare and Emergency Settings.

[7] British Compressed Gases Association. (2016). Code of Practice 44. The Storage of Gas Cylinders.

[8] NHS Wales. (2016). Patient Safety Notice PSN 030. The safe storage of medicines: Cupboards.

[9] Resuscitation Council (UK). (2016 - Reviewed 2021). Statement on Keeping Resuscitation Drugs Locked Away. Statement on keeping resuscitation drugs locked away | Resuscitation Council UK

[10] NHS. (2016). The use of vaccines that have been temporarily stored outside the recommended temperature range.

[11] NHS Pharmaceutical Quality Assurance Committee. (2015). Risk Management of Medicines in Clinical Areas: Temperature Control.

[12] Department of Health. (2013). Immunisation Against Infection Disease – 'The Green Book'. Immunisation against infectious disease - GOV.UK (Accessed 24.01.2025)

[13] Medicines and Healthcare products Regulatory Agency. (2022). Rules and Guidance for Pharmaceutical Distributors.

[14] Welsh Government and NHS Wales. (2015). Patient Safety Notice PSN 015: Storage of Medicines: Refrigerators. - (Checked this is latest version available 24.1.2025)

[15] RPS/RCN. Professional Guidance on the Administration of Medicines in Healthcare Settings. 2019 https://www.rpharms.com/ - (Checked this is latest version available 24.1.2025)

[16] RPS. Keeping patients safe when they transfer between care providers – getting the medicines right. June 2012 https://www.rpharms.com/ - (Checked this is latest version available 24.1.2025)

[17] RPS. (2024). Professional guidance to support prescribing and dispensing / supply / administration by the same healthcare professional.

[18] RCN/RPS. (2024). Prescribing and dispensing / supply / administration by the same healthcare professional Position Statement.

APPENDIX 1 – Approved Prescribing Abbreviations

Dose / Strength:

- g gram
- mg milligram (1000mg = 1g)
- microgram microgram (to be written in full) (1000micrograms = 1mg)
- ml millilitre
- unit unit (to be written in full)
- litre litre (to be written in full)

Route:

While the route is often implicit within the form of the prescribed item e.g. tablets, eye drops etc, the following standard abbreviations may be used to indicate routes of administration when handwriting prescriptions:

Ext	External	O or PO	Oral / by mouth
IM	Intramuscular	PEG	via PEG tube
Inh	Inhalation	PV	Vaginal
IV	Intravenous	SC	Subcutaneous
Jej	Via jejunostomy	Top	Topical
NG	Via nasogastric tube	PR	Rectal
Neb	Nebulisation		

All other routes of administration MUST be written out in full e.g. epidural, intrathecal, buccal, sublingual, transdermal, intraosseous etc.

Standard abbreviations:

OD	Once a day
OM	Each morning
ON	Each night
BD	Twice daily
TDS	Three times daily
QDS	Four times daily
Mane	Morning
Nocte	At bedtime
PRN	When required
Protocol	As per protocol – to be used only when a definitive published protocol/guideline is in place that staff administering medicines can work to. These will include parameters for dose, titration, frequency and any monitoring or checks that will be made prior to further dosing. Such protocols are rarely used in the trust and the prescriber takes responsibility for ensuring the protocol is fit for the individual patient

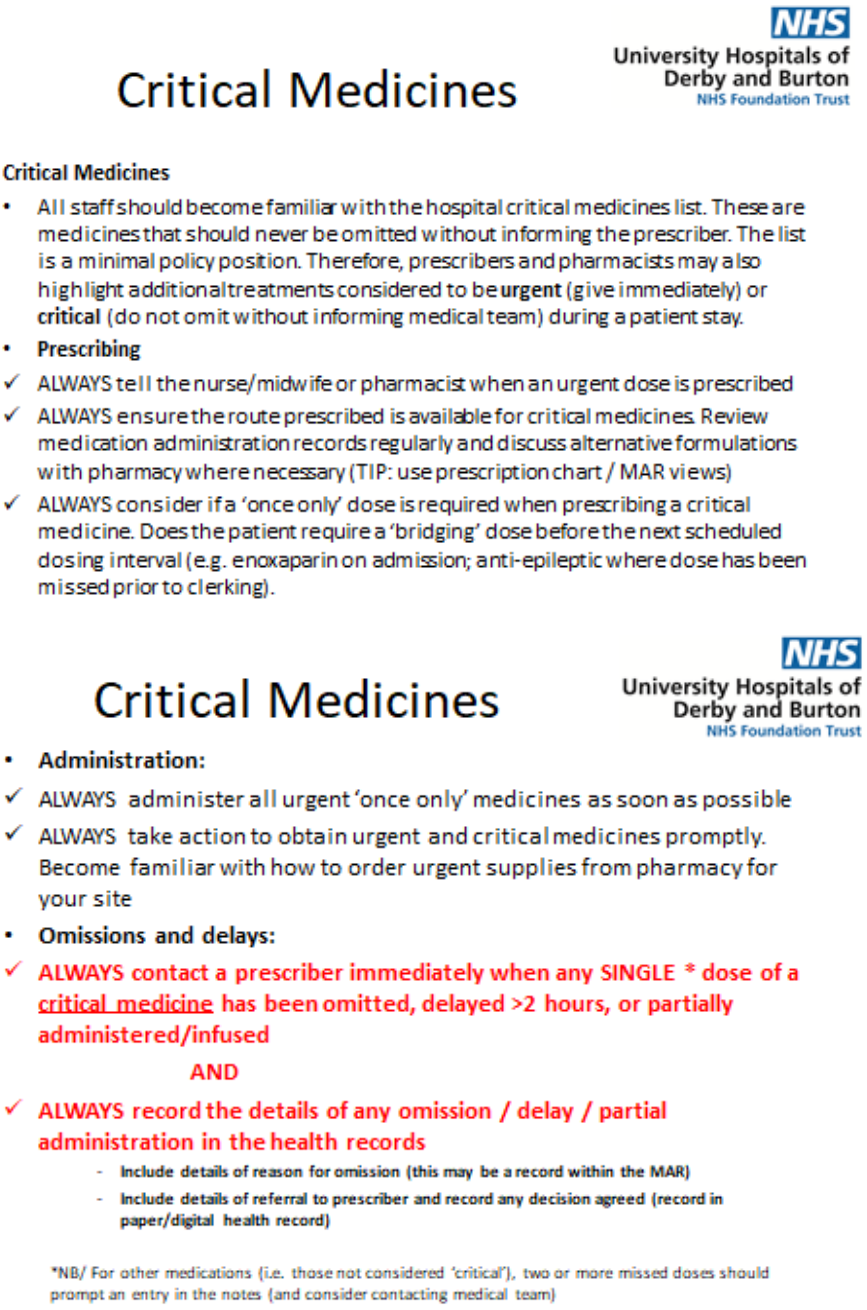
- All other dosage regimens MUST be written out in full
- Other directions should also be written in full e.g. ‘before food’, 4-hourly.

APPENDIX 2 - Critical Medicines

The list of medicines and a summary of Policy actions and procedures is held on the Medicines Safety pages of the intranet. This document also summarises the ePMA support for managing critical medicines and will be updated as processes and systems evolve. Medicines Policy and procedure | z UHDB Intranet

https://neti.uhdb.nhs.uk/az-c-pharmacy-medicines-Policy

The key process requirements at the time of publication are as follows:



Critical Medicines

NHS University Hospitals of Derby and Burton NHS Foundation Trust

Critical Medicines

- All staff should become familiar with the hospital critical medicines list. These are medicines that should never be omitted without informing the prescriber. The list is a minimal policy position. Therefore, prescribers and pharmacists may also highlight additional treatments considered to be **urgent** (give immediately) or **critical** (do not omit without informing medical team) during a patient stay.
- **Prescribing**

✓ ALWAYS tell the nurse/midwife or pharmacist when an urgent dose is prescribed

✓ ALWAYS ensure the route prescribed is available for critical medicines. Review medication administration records regularly and discuss alternative formulations with pharmacy where necessary (TIP: use prescription chart / MAR views)

✓ ALWAYS consider if a 'once only' dose is required when prescribing a critical medicine. Does the patient require a 'bridging' dose before the next scheduled dosing interval (e.g. enoxaparin on admission; anti-epileptic where dose has been missed prior to clerking).

Critical Medicines

NHS University Hospitals of Derby and Burton NHS Foundation Trust

- **Administration:**

✓ ALWAYS administer all urgent 'once only' medicines as soon as possible

✓ ALWAYS take action to obtain urgent and critical medicines promptly. Become familiar with how to order urgent supplies from pharmacy for your site

- **Omissions and delays:**

✓ **ALWAYS contact a prescriber immediately when any SINGLE * dose of a critical medicine has been omitted, delayed >2 hours, or partially administered/infused**

AND

✓ **ALWAYS record the details of any omission / delay / partial administration in the health records**

- **Include details of reason for omission (this may be a record within the MAR)**
- **Include details of referral to prescriber and record any decision agreed (record in paper/digital health record)**

*NB/ For other medications (i.e. those not considered 'critical'), two or more missed doses should prompt an entry in the notes (and consider contacting medical team)

Medical, nursing and pharmacy staff should routinely review the administration section of the prescription chart as part of their daily activities and query any omitted doses so these can be followed up and appropriate action taken.

APPENDIX 3 - RDH Operating Theatre Code of Practice (CoP)

Medicines preparation, administration and documentation

- Practices involving the prescribing and administration of medicines in the operating theatre differ substantially from those on a hospital ward.

- The contents of other sections of the Medicines Policy still apply in the operating theatre, subject to special provisions laid out below:

    - The term 'doctor' is applied to any medically or dentally trained professional who administers drugs in theatre. In practice, this is usually an anaesthetist, but the term also includes surgeons and other doctors using the operating theatre

    - Theatre Practitioners are: NMC Registered theatre nurses and HCPC Registered Operating Department Practitioners (ODP)

    - Most drugs are prepared, administered and documented by the doctor responsible in the operating theatre/ anaesthetic room. However in an emergency/ clinical urgency/ other, this is not always possible

    - On occasion, the doctor's hands are otherwise occupied and it might be unsafe to administer the drug themselves

    - Patient safety/ need must come first; therefore a registered theatre practitioner may act on a clear verbal instruction from doctor in theatre

    - This can only be carried out with the agreement of the individual theatre practitioner and must always occur under direct supervision and sight of the doctor

    - Any Theatre Practitioner has the right to refuse to administer a drug under the direct visual and verbal authority of the doctor if such an instruction is outside of the professional competencies, code of conduct or where they disagree that such an instruction is in the patient's best and safest interest

    - Any theatre practitioner administering a drug is responsible for ensuring what they are giving is correct

    - ANTT must be observed at all times

    - As good practice, both the doctor and theatre practitioner must:

        - show, check and confirm the selection of the verbally requested drug
        - show, check and confirm the preparation of the drug
        - show, check and confirm the strength, concentration and volume of the drug
        - show, check and confirm any diluents or infusion fluids
        - show, check and confirm the route of administration
        - only the volume in millilitres (ml) will be discussed, never a dose as milligrams (mg). This relies on accurate understanding of strength/concentration as above.
        - It is best practice to label the syringe before showing it to the doctor; however, time may not permit this.

    - Any theatre practitioner who administers a drug that he/she has not prepared, must make every effort to assure themselves that what they are giving is correct

- A drug must not be used where the identity of who has drawn it up cannot be established
- Before administering any injectable drug, ensure the patient has previously been positively identified and the allergy status is known
- The doctor remains responsible and accountable for the direct supervision, preparation, administration and subsequent prescription/ documentation of the drug
- All anaesthetic drugs administered by the anaesthetist, or on behalf of the anaesthetist, must be documented by the anaesthetist on the anaesthetic record
- The doctor should sign all relevant documentation
- Theatre practitioners must take part in appropriate training and assessment.

APPENDIX 4 - SOP: UHDB Administration (General Medicines*)

[*see appendix 5 for infusion therapies]

Checking processes (both self-checking and when independently second checking another practitioner) should incorporate the 5 rights of medicines administration:

- Right patient
- Right time
- Right drug
- Right dose
- Right route [22]

Preparing to administer:

Staff should not be interrupted during the preparation and administration of medicines unless there is an emergency. Inform other staff and take any locally agreed steps (e.g. disposable 'Do not Disturb' tabards)

Ensure you have an understanding of the medicine being administered or have sought this information via one of the reference sources below:

- UHDB drug monographs/protocols, clinical guidelines (Koha or linked in ePMA)
- Manufacturer package insert (the 'Summary of Product Characteristics' or SPC also available for all licensed drugs via www.medicines.org.uk)
- BNF
- advice if necessary from a prescriber or a pharmacy professional.

Check the prescription or other direction to administer meets legal requirements, is unambiguous and includes where appropriate the name, form (or route of administration), strength, and dose of the medicine to be administered

Any ambiguities or concerns regarding the direction for administration of the medicine are to be raised with the prescriber or a pharmacy professional without delay

Check directions for administration (e.g. timing and frequency of administration, route of administration and start and finish dates where appropriate)

Any calculations needed are double checked where practicable by a second person and uncertainties raised with the prescriber or a pharmacy professional

Locate the medicine and confirm its integrity, appearance and its expiry date. Liquid medicines which are open should have the date of opening or a reduced expiry date annotated to reflect shelf life after opening – product specific.

Ensure any specific storage requirements have been maintained

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22 http://www.ihi.org/resources/Pages/ImprovementStories/FiveRightsofMedicationAdministration.aspx (Institute for Healthcare Improvement – checked June 2017)

Unless it is ward/department stock, ensure the medication is labelled for the patient (or that it is a patient's own medicine assessed as suitable for use)

Prepare the medicine for administration, via the correct route, for the patient.

- Any additive solution must be checked (and second checked where required in Policy e.g. intravenous products).

Prepared medication must never be left unattended and syringes (for administration via any route) should always be labelled if leaving the hands of the practitioner who has prepared them.

Remember: Enteral/oral syringes must be purple ENFit; insulin syringes must be used if a pen/cartridge device is not appropriate; yellow NRFit syringes are for neuraxial use only.

Administration:

The prescription (electronic or downtime sheet) should be taken to the patient's location for the administration of all medications.

Complete positive patient identification as per UHDB ID Policy

Consider any issues around consent - The process of administering medicines should be explained to the patient, where appropriate.

Ascertain patient allergies/ intolerances by checking prescription, I.D. band and, where possible, asking the patient.

Confirm that the dose has not already been administered by someone else (including patient or carers)

Administer the medicine by the prescribed route, and document the administration on the appropriate prescription record or chart. Such records must be completed at the time of the administration/refusal or as soon as possible thereafter.

Ensure plans are in place for any monitoring required and include this on handover plans as necessary

Adverse reactions to medications should be reported to the medical team, a Datix incident completed and where required, a YellowCard submitted to the national online database following the criteria outlined by the MHRA and in the BNF. Note that yellow cards can be completed by any person who identified the adverse reaction or event.

APPENDIX 5 – SOP - UHDB Procedure for Administration of Infusions

Extract from UHDB Clinical Guideline – Infusion Therapy

Procedure for Administration of Intravenous/Subcutaneous Infusion

This should be read in conjunction with SOP for Second Independent Checking of Medicines (UHDB Medicines policy)

Before Preparation

- Consider if the infusion will require an independent second check as per UHDB Medicines Policy (e.g. IV medicines, chemotherapy) or department/specialty practice (e.g. Paediatrics).
- If so, the same two registered practitioners should be involved throughout the whole process.
- The independent check should be free from influence or authority of the practitioner preparing and administering the medicine.
- Perform calculations separately and avoid leading statements or questions.

Check the Drug, Dose & Route are appropriate for this patient at this time

- Be able to read and understand the prescription without any doubts.
- Read the patient's notes, prescription and relevant protocols/guidelines to identify any special instructions, investigations [including abnormal blood test results] baseline parameters such as weight, or issues for which you need to seek advice.
- Be aware of the drug's side effects, contra-indications, method of preparation and any special precautions necessary by referring to approved reference sources such as Medusa Injectable Guide (including UHDB specific sections), UHDB monographs/guidelines or the manufacturer's summary of product characteristics.
- **Do not assume that any sterile fluid or any amount of diluent can be used. If still in doubt, contact pharmacy.**
- Be certain that the dosage and method of administration are correct, appropriate for the intended treatment against the patient's current health status and concurrent medication.

Instructions for Preparation

- Wash hands before preparation and wear appropriate PPE.
- Check the expiry dates of all drugs, diluents and fluids.

- Check for faults and contamination in vials, ampoules, syringes, needles, infusion containers, and any other administration equipment.

- Prepare the drug with the utmost attention to **aseptic non touch technique (ANTT)**

- Label the drug as per Medicines Policy.

- Ensure that the infusion line, if required, is appropriate for the drug to be given. Check the line is labelled, within expiry and that it is patent.

- Inspect the site of injection for signs of infection, leakage, thrombophlebitis, swelling, irritation and extravasation.

Administration of Intravenous Medicine

- **Right Patient** - Positive Patient Identification (follow policy as per Koha)
    - Confirm Correct Patient by asking them/carer to state their full name and DOB and checking this against their wrist band.
    - The patient's ID should then be confirmed against the prescription
    - Check any label on the product matches your identified patient

- Confirm allergy status, by asking patient and checking against ID Band and prescription (paper or electronic)

- **Right Drug, Dose, Route, Time**: Follow the prescription and any other relevant instructions with utmost accuracy.

- Do not give drugs with visible particulate matter in them.

- Explain procedure to patient/parent/carer within own limitations answering questions that arise.

- Administer drugs at the **correct rate** using appropriate delivery systems and aseptic non touch technique (ANTT)
    - If using an infusion device, all device settings must be independently second checked at the patient's bedside (or patient's location)
    - Any setting changes, at any time, must be independently second checked. E.g. change of Volume To Be Infused (VTBI) or rate titration

- Commence/Administer the medication via the prescribed route, witnessed by both practitioners if requires second check

- Document on the appropriate prescription (with second signature if required), once the medication has been administered (or commenced for infusions)

- Where controlled drip rate or mechanical delivery systems are being used, it is important to monitor that the medicine continues to be delivered at the correct rate.

- Where continuous infusions are in progress, it is necessary to document this regular assessment.

- Check patency of IV lines during and after administration.

After Administration

- If used flush the giving set to ensure that full dose is administered.

- If insitu flush the needle free access device **with 5ml Sodium Chloride 0.9% in a 10ml syringe (or glucose 5% for saline incompatible drugs)** or a 5/10ml prefilled syringe. The needle free access device must be 'locked' i.e. the in-line clamp applied under positive pressure.

- Dispose of any materials used according to the hospital waste disposal policy.

- Observe, report and record any abnormality at the injection site or in the patient's condition

- Where appropriate, document the effect of the medication in the patient's records/case-notes.

For more detailed information on the specific process for administration of Bolus, Intermittent or Continuous infusions please refer to the Royal Marsden Manual on Clinical Procedures accessible via the Trust Intranet

APPENDIX 6 – Pharmacy Discharge information and SOPs

The overarching SOP – Safe Supply of Discharge Medications - can be obtained on Net-i

https://neti.uhdb.nhs.uk/az-c-pharmacy-discharge-information

This contains and is linked to additional key documents:

SOP – Hospital Transfers

SOP – Supply of MARs and MCA (+ documents with suitability criteria and assessment processed).

SOP – TTOs on Discharge.

APPENDIX 7 – Refrigerated and ambient temperature monitoring for Medicines

These forms, including corrective and preventative actions to take, can be obtained via the Safe and Secure Medicines Audit pages (Pharmacy section of Net-i).

Safe and Secure Medicines Audits (UHDB) | z UHDB Intranet

https://neti.uhdb.nhs.uk/safe-and-secure-medicines-audits-uhdb