Safe and Secure Handling of Medicines Procedures (Proc431)

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8.9	*January 2023*	*Replaced reference to "Adverse incednet reporting form" with "A DATIX" throughout. Updated table of contact in 5.3. Updated section 5. Updated section 9 to account for all medical gases. Updated section 20. Added Management and control of prescription forms (cfa.nhs.uk) to references. Updated Appendix 12.*
9.0	*March 2023*	*Added link to Search Policy in section 3.1. Update to section 7.2 to clarify CD administration process. Section 9 – updated medical gas ordering process. Updated section 11 and 14.3 to include the delivery consignment notes. Updated 16.3 & 16.4 Waste flow charts updated. Foils removed. Appendix 12 – removed account information, added expected minimum stock levels. Added Appendix 22 – delivery consignment sheet Added Appendix 23 – Fridge item delivery note. Added Appendix 24 – CD item delivery note.*
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9.4	*January 2024*	*Updated section 5.6 tp allow for spoiled prescriptions to be destroyed on site. Addition of appendix 9c – spoiled FP10 destruction log. Appendix 16 – removed HCAs being able to administer NRT. Approved at DTG (25 January 2024).*
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Documents should be accessed via the Trust intranet to ensure the current version is used.

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1. INTRODUCTION

These Procedures supersede all previous policies and procedures for the management and administration of medicines.

These Procedures describe the standard operating procedures for safe and secure handling of medicines including prescribing, ordering, transport, preparation, administration, monitoring, storage and disposal.

This is the procedure document referred to throughout the Medicines Optimisation Policy (M-006).

These Procedures and all related forms are available on the Medicines Management Intranet site Medicines Management Policies and Procedures

Pharmacy contact details can be found on the intranet here: Pharmacy Contact Details

2. SCOPE

These procedures must be adhered to by all staff employed by Humber Teaching NHS Foundation Trust (the Trust), who have dealings with medicines. These include staff who are seconded into the Trust, staff who are on clinical placement, locums, student nurses, all grades of medical staff, bank staff and agency staff.

3. RELATED POLICIES, PROTOCOLS, LEGISLATION AND GUIDELINES

All staff who have dealings with medicines must be acquainted with the following:

3.1. Policies and Guidelines

- Alerts Protocol (going to be replaced by Violent Marker Procedure)
- Any other Drugs and Therapeutics Group approved policies, procedures and guidelines
- Business Integrity Policy
- Consent to Assessment, Examination and Treatment Policy and Procedure
- Delegation of Administration of Medicine via an Enteral Tube to a HCA SOP22-038
- Discharge and Transfer Policy
- Guidance Note for Ordering Out-Patient Prescription Related Stationery
- Guidelines For the Prescribing & Administration of Depot Antipsychotic Medication
- Health & Safety Policy
- Inpatient Identification Policy and Procedure
- Insulin Prescribing, Administration and Blood Glucose Monitoring Policy
- Intravenous and Subcutaneous Administration Policy
- Management of Medication Incidents
- Medicine Optimisation Policy
- Medicines Reconciliation Guidelines
- Mental Health Act Legislation Policy
- NICE Policy – Implementation and Monitoring of NICE Guidance
- Non-Medical Prescribing Policy
- Patient Group Direction Policy
- Physical Security of Premises and Other Assets Policy F-017
- Prescribing Guidelines and Prescribing frameworks
- Rapid Tranquilisation (RT) Policy
- Risk Management Strategy including Adverse Incident Reporting
- Safety Alerts Procedure
- Scope of Practice for Registered Nurse Associates SOP23-036
- Unlicensed Prescribing Guidelines
- Venous Thromboembolism Assessment, Initiation of Thromboprophylaxis and Community Venous Thromboembolism Management Procedure
- Waste Management Policy

3.2. Confidentiality and Data Protection

- Caldicott and Data Protection Policy
- Confidentiality Code of Conduct
- Electronic Communications and Internet Acceptable Use Procedure
- Information Security and Risk Policy
- Safe Haven Procedure

3.3. Legislation, National Guidelines and their latest amendments

- Control of Substances Hazardous to Health (COSHH) Regulations 1989
- Duthie Report – Guidelines for the Safe and Secure Handling of Medicines 1988
- Guidance issued by the National Institute for Clinical Excellence (NICE)
- Guidelines issued by the General Medical Council (GMC) and the British Medical Association (BMA)
- Guidelines issued by The Royal Pharmaceutical Society of Great Britain and General Pharmaceutical Council (GPhC)
- Health Act 2006 and its associated Regulations
- Mental Capacity Act 2005
- Mental Health Act 2007
- Patient Group Directions HSC2000/026
- Safer Management of Controlled Drugs (DOH – A Guide to Good Practice in Secondary Care (England) Oct 2007
- Standards issued by the Nursing & Midwifery Council (NMC)
- The Medicines Act 1968 and related legislation
- The Misuse of Drugs Act 1971 and its associated Regulations
- The Royal Marsden Hospital Manual of Clinical Nursing procedures

4. DEFINITIONS

- **'Administer'** – To give a medicine by either introduction into the body, (e.g. orally or by injection) or by external application (e.g. cream or ointment).
- **'Administering Practitioner'** refers to a member of staff who has evidance of compitancy in Medicine Optimisation.
- **'Authorised Prescriber '**see 'Prescriber'
- **'CDs'** (Controlled Drugs) – Schedule 2 and 3 medicines regulated by the Misuse of Drugs Act 1971. These are annotated in the *British National Formulary* by the symbol CD
- **'Clinical Notes'** – Electronic and paper records.
- **'Clinical Trial Material'** – Investigational products being used as part of a research study approved by the Local Research Ethics Committee and conducted within the Trust.
-
- **'Dispense'** – To prepare a clinically appropriate medicines for a patient for self-administration or administration by another. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient and assembly of the product). This must be preformed to the standard of a dispensing Pharmacist.
- **'Doctor'** – A medical practitioner fully registered with the General Medical Council (GMC).
- **HAPC** – Humber Area Prescribing Committee.
- **'Hull and East Riding Prescribing Frameworks'** – shared care framework agreed.
- **'Illicit Substance'** – A substance covered by the Misuse of Drugs Act or other legislation which is not lawfully held in accordance with the relevant legislation
- **'Licenced Medicines'** – Medicines which hold a UK Product Licence or Marketing Authorisation and are being used in accordance with their Summaries of Product Characteristics (SPC).
- **'Medicines optimisation' –** a person-centred approach to safe and effective **medicines** use, to ensure people obtain the best possible outcomes from their medicines.

- **'Medicines'** – All medicinal products as defined under the Medicines Act 1968. It also includes items such as lotions, creams, nutritional products, essential oils, interactive dressings and medical gases.
- **'MOT'** – Medicines Optimisation Technician employed by the Trust Pharmacy Department.
- **'NSMs'** – Non-stock medicines.
- **'Nurse-in-Charge'** – The nurse appointed in clinical charge of a ward, shift or department.
- **'Patients Group Direction'** (PGD) – A specific written instruction for the sale, supply and administration of named medicines in an identified clinical situation in the absence of a written prescription.
- **'Pharmacist'** – A pharmaceutical chemist holding a practicing registration with the General Pharmaceutical Council (GPhC).
- **'Practitioner'** – A member of staff who is competant in the safe and secure handling of medicines.
- **'Prescribe'** – To direct in writing the supply or administration of a medicine by a qualified prescriber.
- **'Prescribers'** – Practitioners who are qualified to prescribe medicines in the Trust.
- **'Summary of Product Characteristics'** (SPC) – The information required to accompany any application for a marketing authorisation under Council Directive 65/65/EEC.
- **'Supply'** – To give a medicine to a patient/carer for administration.
- between Primary and Secondary Care via Hull and East Riding Prescribing Committee(HERPC).
- GPs or any other visiting professional, who are not employess of the Trust, are not allowed to prescribe directly onto the Trust prescription stationery, **except** when there is explicit contractual arrangement for prescribing.

5. STATIONERY

For the most up to date information on ordering outpatient prescription related stationery please refer to the guidance note that can be found here:
Prescription Stationery Guidance Note.pdf (humber.nhs.uk)

5.1. Prescription Forms, Administration Record Charts, Medicines Stock Order Forms, Prescription Stamps, Ward Controlled Drug Record and Order Books

	HTFT Approved Stationery and stationery related items	Form/Code	Order via	Collection/Delivery
A	Medicines Stock Order Forms(formerly known as 'Ward Stock Sheets')		Contract Pharmacy Supplier will automatically send out a new form when the current form is full.(see Section 11)	Sent out in Pharmacy Box
B	CD Requistition Form (Schedules 1& 2)	FP10CDF	HumberNet	Print off from HumberNet
C	In-patient Warfarin Inpatient Prescription Form	PPW1	HumberNet	
	In-patient – Warfarin Administration Record Chart	PPW2	HumberNet	
D	Protocol for Administration of Sunscreen including administration chart	PPS	HumberNet	
E	Hepatitis A & B Vaccination Chart	HepAB	HumberNet	
F	Buprenorphine/Naloxone Prescription & Administration Record Chart	PBUPNAL	HumberNet	
G	Buprenorphine Prescription & Administration Record Chart	PBUP	HumberNet	
H	Chlordiazepoxide Prescription, Adminstration and Supply Record Chart	PCAT	HumberNet	

I	Diazepam Prescription, Administration and Supply Record Chart	PDIA	HumberNet	
J	Methadone Prescription, Administration Record Chart	PMET	HumberNet	
K	In-patient Medicines Administration Record Chart (MAR Chart) 2 week PRN	PPI(Adm)	Oracle - Code:937	Please place order at least 10 working days before the Stock has run out. Delivered directly to the Ordering Team/Unit by the contracted printer
	In-patient Medicines Administration Record Chart (MAR Chart) 4 week	PPI4	Oracle - Code:852	
	In-patient Medicines Administration Record Chart (MAR Chart) 10 week	PPI10	Oracle - Code:936	
L	Depot Injections (Community) Prescription Form	PPP	Oracle - Code:982	
Q	Prescription Form (Green)	FP10HNC	Refer to 5.2	Refer to 5.3
	Prescription Form (Green)	FP10NC & FP10SS		
	Prescription Form (Blue)	FP10MDA-		
	Prescription Form (Purple)	FP10-REC		
R	Prescription Form (Purple)	FP10PN	Refer to 5.2	Refer to 5.2
S	Prescription Validation Stamp		Refer to 5.2	Refer to 5.2
T	Ward Controlled Drugs Record Book	CDWRB	Contact HTFT Pharmacy email hnf-tr.pharmacyprocurement@nhs.net	7 years after the last entry.
	Ward Controlled Drugs Order Book	CDWORB		2 years after the last entry.

5.2. Stationery Q - S): FP10HNC, FP10HC, FP10MDA-SS, FP10-REC

5.2.1. Ordering

To order replacement prescription pads or stamps please click the link below and complete the form.
Order Prescription pad and stamps or use this link https://forms.office.com/e/bZfUTPLKDS

Should you have any questions please email hnf-tr-nmp@nhs.net.

Name	Contact Details	Locality
Caroline Playfair, Locality Administrator caroline.playfair@nhs.net	01759 448320	Driffield, Pocklington & Goole (to be collected from Goole Health Centre)
Helen Watts Medical Secretary helen.watts17@nhs.net	01482 344400	Withernsea, Hornsea & Hedon (to be collected from Rosedale, Preston Road, Hedon)
David Sandy Administrator d.sandy@nhs.net	01723 344480	Community Nursing Scarborough To be collected from 174 Prospect Road
Michelle Ritchie michelle.ritchie4@nhs.net	01723 344260	Community Nursing Ryedale (to be collected from Malton Community Hospital)
Anne Wild Anne.wild1@nhs.net		Whitby Community Nurses
Dawn Todd dawntodd@nhs.net	07977 161911	For all others not listed above and where the preferred collection point is Trust HQ.

5.2.2. Collection

- The orders will be delivered directly to the Locality Administrator, who will record the serial numbers and inform the prescriber that the pads are ready for collection from the Locality base.
- If a member of Trust staff other than the prescriber is to collect the prescriptions, this must be agreed and arranged with the Locality administrator prior to collection.
- The prescriber or a pre-arranged nominated signatory must collect the prescription pads in person. (Trust ID badge must be presented.)
- The member of staff collecting the prescription pads must check the Serial Numbers of the prescription pads and sign a Collection Record Form.
- If the prescriptions are to be distributed to other prescribers within the Team/Unit an additional Form will be supplied by the Locality Administrator.
- This form must be used to record the Serial Number(s) of the prescription/prescription pads when issued to the prescriber.
- The prescriber must check the Serial Number of the prescription/prescription pads issued and sign and date.
- This Form must be kept by the Team/Unit for two years from the date of the last entry on the form.

5.2.3. Collection:

The prescriber must collect the Prescription Validation Stamp in person. (Trust ID badge must be presented).

Any old stamps with outdated information/change of base etc. must be **brought in person**, to Dawn Todd at Trust HQ for destruction.

Under the Medicines Act 1968 both the prescription pads and stamps are classed as controlled stationery and must be locked away securely when not in use.

5.3. Storage and Handling Requirements

Stationery Q) to T) is classed as controlled stationery and has certain security restrictions as stated below.

- Must be locked away securely when not in use. Preferably a dedicated safe or locked drawer with limited access.
- Access must be restricted to authorised staff.
- Should be ordered and collected as outlined in the relevant section above.
- Preferred and safest option is for prescriptions to be collected in person or by a named representative however, if this is not feasible, prescriptions may be posted as a last resort. When posting prescriptions, the following precautions should be followed:
  - Check the address is up to date
  - Use postal method with tracking information, recorded and signed for
  - Discreet information on external envelope/packing so that the item is not easily identified
  - Return address if the item cannot be delivered
  - Reconciliation checks to ensure the prescription(s) have been received by the intended recipient
  - Escalation and reporting actions in the event the prescription(s) are not received by the intended recipient.
- Once issued to the prescribers, it is the prescriber's responsibility to store prescription/ prescription pad(s) and the Prescription Validation Stamp securely.
- It is a security risk to pre-stamp all the prescription pads prior to issue.

For more information please refer to Management and control of prescription forms (cfa.nhs.uk)

Distribution of FP10 forms should be recorded on the appropriate distribution form (appendix 8 a/b)
FP10 forms should not be left unattended or stored in printers.
When not in use, the prescription forms should be returned to the locked cabinet/drawer.

A record of the prescription forms collected and returned from the locked cabinet/draw should be made on the appropriate distribution form. The form should be retained for 2 years after the last entry.

Stationery: A) to N) must be stored safely by the Unit/Team for appropriate access and use.

5.4. Destruction of controlled stationery

5.4.1. Prescription pads and Prescription Validation Stamps

Prescription validation stamps, un-used prescriptions and prescription pads that are no longer required or with outdated information must be destroyed by a member of the pharmacy team in the presence of a witness.

Please email hnf-tr.medicinessafety@nhs.net to make arrangement for the destruction and disposal.

The form in appendix 4 will be completed, scanned and emailed to hnf-tr.medicinessafety@nhs.net

When a non-medical prescriber leaves their prescription pads should be returned to trust pharmacy for destruction and the non-medical prescribing lead should be informed (elizabeth.harrison11@nhs.net).

5.4.2. Spoiled Prescriptions

Spoiled prescriptions can be destroyed on site in the presence of a witness.
Appendix 8B is to be completed for each individual prescription. The serial number is to be recorded, a signature of the person destroying the prescription and a signature of the witness.

5.5. Other types of Pharmacy medicines related stationery

- These Forms can be downloaded from the Trust Intranet Medicines Management page, e.g. Pharmacy Waste Destruction Record, Pharmacy Stock List Amendment Request, Pharmacy Fridge Temperature Monitoring Form.

5.6. Loss or Theft of Prescriptions

Wards/Units/Clinics

If the loss/theft of a prescription/prescription pad is identified the following actions must be taken:

- Check the area to ensure that the prescription/prescription pad has not been misplaced.
- Report the loss/theft to the staff member with overall responsibility for prescriptions in your area.
- Notify the Pharmacy Department at HTFT
- Complete a Datix.
- Notify the Police by emailing SPOCFIB@humberside.police.uk
- Notify the Controlled Drugs Accountable Officer (CDAO) at NHS England by emailing England.yhcdao@nhs.net.

  The following information will be required:
  - Details of the incident
  - Prescription type (FP10, FP10PN, FP10-REC, etc.)
  - Prescription numbers unaccounted for
  - Quantity lost/stolen
  - Prescriber's details
  - Have the police been notified?
  - Has the Local Pharmaceutical Committee (LPC) been notified?

- Inform the LPC by completing an HTFT Lost/Stolen Prescription Form (Appendix 17) and emailing to humber.lpc@nhs.net.
- Notify the Local Counter Fraud Specialist: Fraud if you have any suspicions or concerns regarding prescription forms being fraudulently used.

Patient Loss/Theft

If a loss/theft of a prescription is reported by a patient the following actions must be taken:

- Check to ensure the prescription has not been misplaced.
- A risk assessment should be undertaken to ensure that the loss is genuine and not an attempt to obtain further supplies fraudulently.
- Details of the loss/theft should be fully documented within the patient's notes.
- Theft should be reported to the police – the crime number given should be documented within the patient's notes.
- Complete a Datix
- The Controlled Drugs Accountable Officer (CDAO) at NHS England must be notified using the www.cdreporting.co.uk site.
- Inform the LPC by completing an HTFT lost/stolen prescription form (Appendix 17) and emailing to humber.lpc@nhs.net.
- Notify the Local Counter Fraud Specialist: Fraud if you have any suspicions or concerns regarding prescription forms being fraudulently used.
- Notify the Police by emailing SPOCFIB@humberside.police.uk

5.7. Archiving and Filing of Used Medicines Related Stationery

Prescription records specific to individual patients are considered 'Clinical Record' and as such must be managed in accordance with the Health and Social Care Records Policy.

HTFT Approved Stationery	Form/Code	WHERE TO FILE	LENGTH OF TIME
Medicines “Stock Order Forms” (formerly known as ‘Ward Stock Sheets’)		File Safely on Unit base. Must be accesible for inspection.	2 years from date of last entry.
All MAR Charts & Prescription Form Charts Refer to Section 5.1, B) to L)	Various	Patient Clinical Record.	As per the Health and Social Care Records Policy.
Discharge Prescription Form	PPD	One copy file in Patient Clinical Record (other copy must be sent to GP)	2 years.*
Leave Prescription Form	PPD	Both copies file in Patient Clinical Record.	2 years.*
Requisition for Non-Stock MedicineS	PMR	File Safely on Unit base. Must be accesible for inspection.	2 years from date of last entry.
Trust Outpatient Prescription Forms	PPO PPO- R	One copy file in Patient Clinical Record Other copy must be sent to GP	2 years.*
Prescription Forms Refer to Section 5.1, Q) & R)	FP10’s Various Codes	Any photocopies held to support records or confirm delivery file in Patient Clinical record.	2 years.*
Ward Controlled Drugs Record Book		Securely on the Unit base. Must be accesible for inspection.	7 years from date of last entry.
Ward Controlled Drugs Order Book		Securely on the Unit base. Must be accesible for inspection.	2 years from date of last entry.
Pharmacy Delivery Notes		File Safely on Unit base. Must be accesible for inspection.	2 years from date of last entry.
AAH invoices		Invoice can be shredded once it has been checked and confirmed as correct.	
Alliance Medication invoices		Invoice can be shredded once it has been checked and confirmed as correct.	
Alliance invioces for Controlled Drugs		File Safely on Unit base. Must be accesible for inspection.	6 years from the date of the last entry
Phoenix invoices		Invoice can be shredded once it has been checked and confirmed as correct.	
Invoices for controlled drugs which are not available on the online portal		File Safely on Unit base. Must be accesible for inspection.	6 years from the date of the last entry
All other Pharmacy Medicines Management related Forms or invoices		File Safely on Unit base. Must be accesible for inspection.	2 years from date of last entry.
Waste Consignment Notes (when Waste collected by waste Contractor)		File Safely on Unit base. Must be accesible for inspection.	As per Waste Legislation requirements 3 years from date of last entry.

*Where the prescription has been produced electronically, there is not a need to retain a paper copy for 2 years.

6. PRESCRIBING OF MEDICINES

6.1. General Standards

- Medicines must be prescribed by an authorised prescriber.
- Initiation of medication, changes to medication and rationale for the change must be recorded in the patients electronic record and clinical notes.
- Prescribers are not allowed to prescribe for themselves or their family members.
- Prescribers must record any significant potential drug interactions with the current medication, in the clinical notes.
- Treatment recommendations made by other visiting professionals must be recorded and communicated either in the electronic record and clinical notes or via some other form of written correspondence.

- For in-patients, all medicines including medicines bought over the counter (e.g. vitamins) and complementary medicines, must be prescribed on the MAR chart and, if applicable, Discharge/Leave prescription once the prescriber has approved their use.
- Prescriptions must be written in ink or computer generated, on an approved prescription form. For Remote Prescribing refer to section 6.6.

Paper MAR Charts

- For in-patients, preprinted self-adhesive name & address labels should be used when available- all pages must have a label applied
- When more than one MAR Charts are used for a patient due to the number of medicines prescribed they must be filed together. The number of current MAR Charts in use should be indicated in the box provided, e.g. FORM 1 OF 1 or FORM 1 OF 2
- Multiple MAR Charts must be condensed onto one chart whenever it is possible.
- The whole MAR Chart must be re-written when it becomes messy or illegible, especially after several medications have been stopped or changed.
- When a patient is re-admitted, including for respite care, a new MAR Chart must be written.

Prescribing on SystmOne

Help guides for prescribing on SystmOne can be found here:
Mental Health wards/units: SystmOne Help Guides - Mental Health | Humber Teaching NHS Foundation Trust
Community wards/teams and UTC: Electronic Prescribing and Medication Administration | Humber Teaching NHS Foundation Trust

6.1.1. Recommended Medicines for Prescribing

- Each service area must follow their locality prescribing committee formulary.
  All prescribing guidelines and frameworks approved by the Drug and Therapeutics Group (DTG) should be followed.
- Prescribing of specialist medications should only be undertaken by prescribers within HTFT if the prescriber has specific competency in the condition for which it is prescribed for, including:
  - Assessment of the condition.
  - Risk assessment.
  - Diagnosis, including diferencial diagnosis.
  - Knowledgeable, experienced and upto date regarding the current treatment options of the current diagnosed condition.
  - To be aware of the patients other conditions which may influence the prescribers treatment decision.
  - Non-pharmacological management options
  - Pharmacological management options
  - Monitoring requirements (for the condition or medication)

Or

- Under specialist recommendation provided the specialist is making a recommendation for treatment under national guidelines or is providing sufficient information to allow safe prescribing.

6.1.2. Licensed and Unlicensed Medicines

- A medicine which has a valid UK licence for the proposed indication should generally be used.
- Prescribers should be aware of the licenced status of medicines and pharmacists must advise prescribers of any changes to such status.
- Medicines may sometimes be prescribed for an unlicenced indication. The Trust will only accept liability in the event of an untoward incident if the prescription is considered reasonable by the body of medical opinion (e.g. Royal College of Psychiatrist).
- The use of any other unlicenced medicines may be sought through application to the Drug and Therapeutics Group
  Unlicensed Prescribing Guidelines.pdf (humber.nhs.uk)

6.1.3. Allergies

- Before a prescription is written the prescriber, wherever posible should aquire a full medical history and confirm the patients allergy status.
- The patients allergy status should be updated on their electronic record as outlined in the relevant help guide.
- The patients allergen status must **be recorded on the patient's MAR chart (if applicable) using one of the** following:
  - 'drug allergy'
  - 'no known drug allergies'
  - 'unable to ascertain' (record as soon as the information is available)
- All confirmed allergens should have the following recorded as a minimum:
  - Allergen.
  - The signs,symptoms and severity of the reaction.
  - The date when the reaction occurred.
  - Source of information
  - Signature and date of the person completing the information
- When a person presents with a suspected drug allergy, their reaction should be documented in a structured approach following the guidance in NICE CG183.

6.1.4. Dietary Requirements

- Specific dietary requirements that have an impact on the prescribing of medications must be indicated e.g.: MAOI diet, Coeliac diet, Vegan or restricted diets. This information must be documented in the patients record and in the allergy section of the MAR.

6.1.5. Prescribing Queries

- Practitioners or other health professionals who wish to query or comment on a patient's prescription should speak to the prescriber directly.
- When the query relates to a potentially serious error or risk the health professional must alert the prescriber immediately so that the appropriate action is taken to ensure patient safety. The outcome must be documented in the patient record.

6.1.6. Monitoring Effectiveness and Side Effects of Prescribed Medication

- Prescribers are responsible for ensuring that effectiveness and side effects of medication are monitored according to HTFT, local and national guidance.
- When this responsibility is delegated the prescribers must ensure that a care plan is produced or that the delegation is in accordance with a local agreement, this must be documented in the patients record.

6.2. Prescription Forms and Administration Charts

Ordering, Collection/Delivery, Storage and Archiving see Section 5.

Where e-prescribing has not been implemented, medicines must be prescribed on the following approved prescription forms according to the needs of individual patients and Units:

In-patient

Description	Form
Discharge/Leave Prescription Form	**Form PPD**
Medicines Administration Record Chart (MAR Chart)4 week	**Form PPI4**
In-patient Warfarin Dosing Chart	

Outpatient

Description	Form
Outpatient Prescription Form – Community Pharmacy	**FP10HNC, FP10MDA-SS, FP10PN**
Outpatient Prescription Form – Out of Hours Only	**Form FP10-REC**
Depot Injections (Community) Prescription Form	**Form PPP**
Specific Direction to Administer e.g., Immunisation	

East Riding Partnership Addictions Service and Community Alcohol Team (CAT) services:

Description	Form
Buprenorphine Prescription & Administration Record Chart	**Form PBUP**
Buprenorphine/Naloxone Prescription & Administration Record Chart	**Form PBUPNAL**
Chlordiazepoxide Prescription, Administration & Supply Record Chart	**Form PCAT**
Diazepam Prescription, Administration& Supply Record Chart	**Form PDIA**
Methadone Prescription, Administration Record Chart	**Form PMET**

6.3. Outpatient prescribing

(For General Standards see Section 6.1)

- Each service area must follow their locality prescribing committee formulary.
- All prescribing guidelines and frameworks approved by the Hull and East Riding Prescribing Committee should be followed.
- The Trust's prescriber who recommends a change in treatment is responsible for sending a prompt and appropriate communication to the patient's GP.
- When issuing a prescription, a record must be kept in the clinical notes
- For medicines which have been classified by the Humber Area Prescribing Committee (**HAPC**) traffic light system as:

  'Green Drugs'
  - Only prescriptions (or changes to an existing prescription regimen) which are urgent should be prescribed by specialist prescribers of the Trust.
  - The quantity of the prescription should be sufficient to cover the immediate period until the GP is able to initiate the changes, up to a maximum of twenty eight days.
  - Non urgent prescriptions or changes should be carried out by the patient's GP with a written advice from the specialist prescribers of the Trust.

  'Amber Drugs'
  - The prescribing should be in accordance with the relevant Prescribing Framework (i.e. Shared Care Frameworks).

  'Red Drugs'
  - Prescriptions should be issued in line with the trusts current supply model.
  - Should only be prescribed and monitored by specialists in Secondary Care.

- All outpatients who are prescribed medication should be monitored for effectiveness and side effects by the prescriber in line with the drug traffic light status.

6.3.1. FP10HC & FP10HNC Prescriptions

- Green FP10HC can be dispensed by any Community Pharmacy within the UK.
- FP10HC forms will be pre-printed with the details of a unit or team, and must be used only by the unit or team specified.
- Sharing of FP10HC between teams or units is not appropriate.

6.3.2. FP10MDASS Prescriptions

- Blue FP10MDASS prescriptions are Single Sheet Drug Mis-Use Instalment Prescriptions.
- These can be dispensed by any Community pharmacy which provides a supervision service for patients to take their medicines at the point of dispensing.
- The Unit must liaise with the relevant Community pharmacy of choice with all the necessary information to ensure a smooth provision of service.

6.3.3. Clozapine Outpatient Prescription

Clozapine prescriptions are completed electronically via SystmOne electronic patient record.

6.4. Prescription Writing

(See Section 6.5 Prescription Writing of Controlled Drugs)

6.4.1. Prescriptions

Must be printed or written legibly using indelible ink with the following details:

- Patient's name and address
- Patient's NHS number and/or hospital number
- Date of birth
- Age (the age of children under 12 years and of adults over 60 years must be stated. The age of children under five years should be printed in years and months.
- Weight (when appropriate)
- The Recommended International Non-proprietary Name (rINN), unless the BNF directs brand specific prescribing is necessary.
- The form and strength of the medicine
- Dose and frequency
- Route of administration where necessary
- The duration of treatment or total amount to be supplied
- Prescriber's name
- Prescribers signature in their own hand
- Date of prescriber's signature
- The address of the team that the prescription is being issued for.

Note: F1s cannot prescribe on FP10 forms

6.4.2. Discharge/Leave Prescriptions

Unless generated through the trusts electronic prescribing systems, the prescribed must ensure the following details are present:

- Prescriber's name
- Ward, Unit or Team name
- Patient's name
- Patient's address (discharge prescription only)
- Patient's NHS number and/or hospital number
- Date of birth
- Gender
- Age (the age of children under 12 years and of adults over 60 years must be stated. The age of children under five years should be printed in years and months.
- Weight (when appropriate)
- Known allergies or sensitivities to medicines and nature of reaction if known
- The Recommended International Non-proprietary Name (rINN), unless the BNF directs brand specific prescribing is necessary

Where e-prescribing has not been implemented, the name of the medicine must be written in block capitals.

- When necessary, the form, the strength of the medicine including the release profile of the medication (e.g., 12-hourly, 7-day)
- Dose & frequency
- Where necessary, the route of administration
- The date that the form was written, the date of the prescription or the date the medication is due to start.
- Stop date (if applicable)
- Discharge or Leave date (if applicable)
- The prescriber must sign the prescription in indelible ink.

6.4.3. Dose

- The dose must be expressed in metric units, except for topical, inhaler and drop preparations. However, for these medicines the strength of the preparation must be stated if appropriate.
- For single active ingredient preparations, the quantity of the active ingredient per dose should be stated and not the number of dosage forms, e.g. 10mg tds and not 2 tablets tds.
- Decimal points must be avoided if possible e.g. 500mg and not 0.5g. Whenever a decimal point is necessary, great care must be exercised by the prescriber, the pharmacist and the practitioner administering the medicine.
- For the purposes of the Mental Health Act, when the BNF states a 'usual dose range' the upper limit will be taken as the BNF maximum.
- The terms 'micrograms', 'nanograms' and 'units' must not be abbreviated. Only the following abbreviations are allowed:

Mg	Milligram
g	Gram
kg	Kilogram
L	Litre
ml	Millilitre
mmol	Millimole

6.4.4. Dose Regimen

- The following abbreviations are standard means of indicating a dose regimen (frequency). All other dose regimens must be written in full:

AC	Before food
OD	Once a day
OM	Each morning
ON	Each night
BD	Twice daily
MDU	As directed
PC	After food
STAT	Immediately
TDS	Three times daily
QDS	Four times daily
PRN	As required (with indication and interval stated)

6.4.5. Route of Administration

- Unless a multi route formulary item is set up, only one route of administration may be specified for each prescription. If a second route is required, it must be prescribed as a separate item.
- Only the following abbreviations for the route of administration are allowed. All other routes of administration must be written in full.

IM	Intramuscular	PR	By Rectum
Inh	Inhalation	PV	By Vagina
IV	Intravenous	SC	Subcutaneous
Neb	Nebulisation	SL	Sublingual
PO	By Mouth	Top	Topical
Glu	Gluteal	Buc	Buccally
NG	Nasogastric	Del	Deltoid

P A N T S:

The following abbreviations on the MAR chart should be circled where appropriate

- P (Pre-admission prescription) – where the patient has been taking the medication at the dose specified prior to admission.
- A (Amended dose of a pre-admission prescription) – where the dose of a pre-admission medication has been changed during the admission.
- N (New prescription added during current admission) – where a medication has been started or restarted during the admission.
- T (Time Critical) – To be used for critical medicines.
- S (Supplementary Chart) – When a supplementary chart is being used to record administration.

6.4.6. Times of Administration

- For in-patient prescriptions, the times of administration must be specified by the prescriber in the appropriate place on the MAR chart.

6.4.7. Stop Date

- When the 'stop date' is specified in anticipation of the treatment cancellation date, this must be clearly stated.
- Unless a time is also specified, this date indicates that on the date specified, the prescription must be discontinued, and no further doses are to be administered.
- Where e-prescribing has not been implemented, crossing through the administration boxes is also advised as a method of indication when the medicine should not be administered and when it should be discontinued.

6.4.8. Cancellation of Treatment

Where e-prescribing has not been implemented:

- A single bold line must be drawn diagonally across the details of the medication on the **MAR chart and any remaining unused administration record of the MAR Chart.**
- The cancellation must be dated and signed by the practitioner cancelling it.
- Incorrect entries must be cancelled as indicated above, with the word 'Error' written against the line.
- **If a change in dose, frequency or route of administration is required,** a new prescription should be written with the original prescription cancelled as above

6.4.9. Once Only Doses or Stat Doses (doses to be given immediately)

In relation to units that do not have electronic prescribing:

- Medicines that are intended to be given once only or immediately must be stated clearly.
- For in-patients, this must be prescribed in the 'Once Only Medicines/PGD' section of the MAR Chart.
- An entry in the clinical notes must give reasons for administration and outcomes.

6.4.10. Supplementary charts

Where electronic prescribing is not in use:

- All medication prescribed on supplementary charts must be prescribed on the relevant chart. **In addition** the prescriber must reference this prescription on the 'Regular' section of the MAR chart.

6.4.11. 'As Required' Prescriptions (PRN)

- The 'As Required/PRN Medication' is used for those medicines to be given at the practitioner's discretion according to the needs of the patient.
- No more than one medicine should be prescribed as a PRN at a time for the same indication unless it is part of a regime approved by the MDT. Clinical Pharmacists should indicate such approval by indicating clinical verification through the electronic prescribing system or by endorsing their signature in the 'Pharmacy comments and Signature box'.
- The following must be clearly specified by the prescriber:
  - The indication for administration.
  - The total maximum combined dose (i.e. regular + prn), to be administered in any given period must also so be specified.
  - Where there is a requirement for a minimum interval between doses this should be specified by the prescriber, e.g. paracetamol every 4 to 6 hours.
  - Unless an electronic prescribing system is in place, where the period specified is a 24 hour period, this should ordinarily be defined as a calendar 24 hour period.
  - When prescribing PRN medication, care must be taken not to overdose the patient by unintentional duplication of medicines which may already be prescribed regularly e.g., combination analgesics frequently contain paracetamol, which may already be prescribed on a regular basis. Where the same medicine(s) is intentionally prescribed as both regular and PRN, this must be highlighted
  - Where paper MAR charts are used, the prescription must indicate this with an annotation in the 'Additional Instructions' box to highlight the additional prescribing. e.g.: check PO/PRN, check IM/PRN, check PO/Reg
  - Where electronic prescribing in place, the above information should be included in the administration instructions.
- The PRN prescription must be reviewed at least weekly by the prescriber or a practitioner unless it is part of an approved regime.
- For in-patients, medicines prescribed PRN, which are needed regularly as indicated by the administration record, must be reviewed by the MDT and if appropriate, rewritten in the regular section of the MAR Chart. Pharmacists should indicate such approval by indicating clinical verification through the electronic prescribing system or by endorsing their signature in the 'Pharmacy comments and Signature box'.
- Any PRN that has not been required for four weeks should be cancelled unless it is part of a regime approved by the MDT. Clinical Pharmacists should indicate such approval.
- Where the prescriber has not done so, the clinical pharmacist will do so
- Where a PRN medication is prescribed once daily, the administering practitioners may divert from the calendar 24-hour period when appropriate (e.g. a patient may receive a dose of hypnotic after midnight and also require a dose before midnight on the same calendar day).
- During any specified period, administering practitioners should be mindful of the need for appropriate dosage (e.g. paracetamol must have an interval of at least four hours).
- The administering practitioner must make an entry in the clinical notes giving the reasons for administration and outcomes.

6.4.12. Periodic Intramuscular Injections

For CPN administration to Community Patients

- Even when the prescription is generated and supplied against an FP10 by the GP, the long acting (Depot) Injections (Community) Prescription Form (Form PPP) must be authorised by a prescriber to allow for administration.
- It must be confirmed that the information on Form PPP corresponds with the current FP10 prescription.
- A new chart must be written if the prescription is amended.

6.4.13. MAR Chart Venous Thromboembolism (VTE) Prophylaxis record

- The outcome of the VTE assessment undertaken on admission must be recorded.
- Each time a MAR chart is rewritten, the patient's VTE risks should be reassessed. The outcome should be recorded on the MAR chart, signed by the practitioner undertaking the reassessment and dated with the date of the reassessment.

6.4.14. Mental Health Act status:

- For all inpatients on mental health or learning disability units, the nature of their admission should be recorded.
- For patients detained under sections of the Mental Health Act (other than temporary holding powers) the date and type of section must be recorded.
- For patients who are detained or recalled under the Mental Health Act, it is a legal responsibility of the prescriber to prescribe within the legal restrictions of S58
- For medicines which are subject to the legal authority of S58, details and date of the authority must be completed on the MAR chart.
- A copy of the authority (T2,T3,S62) should be accessible when viewing the MAR chart and administering mediciaton.
- Refer to Section 24 for the appropriate use of these forms and for guidance for treatment with medication for mental disorder of patients under the Mental Health Act 1983 detained in hospital and for Supervised Community Treatment patients upon recall to hospital.

6.4.15. High Dose Antipsychotics Therapy (HDAT)

- If a patient is on HDAT as defined by the HTFT Guidelines for HDAT, the chart must be annotated with 'HDAT'. Additionally for each antipsychotic prescribed, the % BNF MAX (as defined by the HDAT Guidelines) should be indicated as administrationl instruction.

6.5. Prescription Writing of Controlled Drugs

- CDs which are prescribed on a Discharge/Leave Prescription Form or Outpatient Prescription Form must have all the details specified in Section 6.4.1. and 6.4.2.
- For Outpatient prescribing, FP10 prescription forms must be used for prescribing CDs Schedule 2&3.
- The prescription must be hand written or computer generated so as to be indelible
- The prescription must state the total quantity of medication to be dispensed in both words and figures.
- The prescription must state the form of the preparation eg: tablets, capsules, oral liquid etc.
- CD prescriptions must contain a specific dosage/directions. For legal requirements the term PRN or MDU are not sufficient (one prn or one mdu would be considered legal)
- The prescription must be signed by the prescriber in their own hand.

6.6. Remote Prescribing

Remote prescribing must only be undertaken using electronic prescribing systems.

6.6.1. Verbal orders

In exceptional circumstances, where a change or addition to the administration details is required and a delay in administering a medicine would compromise patient care, verbal orders may be used . The exceptional circumstances would need to be documented as justification; the use of verbal orders must never become routine practice. Schedule 2 Controlled Drugs are excluded from verbal orders.

- The changes or addition to medication need to be communicated from the prescriber to two staff, one of these must be a registered professional.
- The Registered staff member is to enter the details of medication administered onto the patient's records.
- The prescriber requesting the changes amends the drug chart/medication administration record containing the new administration details as soon as possible (ideally within 24 hours).

- A Datix must be submitted as a prescribing incident, when a verbal order is necessary, with a brief description of the situation.
- The medication is to be added to the MAR chart as soon as possible then signed with time of actual administration by the staff member.

6.6.2. In Community nursing areas where paper MAR charts are in use

- The changes or addition to medication need to be communicated from the prescriber to the registered professional.
- The verbal instruction must also be supported by an appropriately secure electronic method such as an NHS email address.
- This electronic communication needs to contain the patient details, form dose, route and time and prescriber details.
- The electronic confirmation (i.e. NHS email) must be received and support information from the verbal order prior to the first dose being administered to the patient.
- The patient's records are to be updated by the Registered staff member.
- A prescriber amends the drug chart/medication administration record containing the new administration details as soon as possible (ideally within 24 hours), then signed for with the actual time administered.
- A Datix must be submitted when a verbal order is taken as a prescribing incident with a brief description of the situation.

7. SAFE ADMINISTRATION OF MEDICINES

A valid prescription needs to be in place for the registrant to administer any medications.

For information regarding delegation of administration of medications see section Appendix 15 part 3.

Registrants should evidence they have achieved and maintained their medication administration competency, including specific competency required regarding the patient's condition, route of administration, or type of medication (e.g., a controlled drug, medication to be administered to a palliative care patient, medication via a syringe driver).

Only registered staff will administer medication on wards due to the complexity of the patients' conditions, the patient's condition may change and the possible need to change treatment regimens such as medications.

The Trust does not support the use of 'runners' for medication administration.
The staff member signing for the administration of medication should be the same registered member who has carried out the identification checks of the patient.

Unregistered staff will only administer medication under delegation when there is a specific clinical need. **This must not be undertaken on inpatient wards**. **Unregistered staff will not be used as 'runners.'**

Delegation of medication administration should be avoided where possible to reduce the risk of medication related incidents.

On inpatient wards, unregistered staff if deemed competent, can support patients to take their medication safely as per the Covert Administration of Medicines Guideline G383.pdf (humber.nhs.uk). However, the registrant must firstly ensure they have correctly identification of the patient against the prescription and undertaken the relevant safety checks i.e., vital signs monitoring.

Registrant maintains full accountability. The unregistered staff are required to inform the registrant who delegated the task that the medication has been observed as taken.

If the delegation of medication is to be administered via a percutaneous endoscopic gastrostomy (PEG), training and competency must be achieved and maintained by both the unregistered staff and the registrant delegating this part of the administration. This will only occur in teams where this is a specification of the job role (Community complex care team and Granville Court). Again, the registrant must firstly correctly identify the resident ensuring relevant safety checks have been undertaken. **Unregistered staff at Granville Court will not be used as 'runners'.**

The majority of medicines can be administered by a single health care professional. Although there are no defined requirements, it is considered good practice, with certain higher risk medicines, for there to be a second checker e.g., complex calculations.

Wherever possible, the actions of prescribing, dispensing/supply and administration are performed by separate healthcare professionals. Exceptionally, where clinical circumstances make it necessary and in the interests of the patient, the same healthcare professional can be responsible for the prescribing and supply/administration of medicines. Where this occurs, an audit trail, documents and processes are in place to limit errors.

Second checkers:

The administering practitioner is responsible for recognising the limits of their competency and when a second check is required. If there is no one available in the team then other alternatives should be considered e.g., another ward, community pharmacists, and manager.

- The second checker must be competent and understand the checks required.
- The second checker is equally as responsible as the administering practitioner for ensuring the administration is safe and accurate.
- The second check should be undertaken independently and not influenced by the administering practitioner.
- When a second check has been completed this should be documented in the patients record.

7.1. General Preparation and Administration

- If anything in the administration process is unclear, the administering practitioner will seek advice before proceeding.
- Prepared medicines must not be left unsupervised.
- If a patient/carer is following the self-administration procedure they must be aware not to leave their medicines unsupervised.
- Where necessary medicines must be administered using the appropriate and intended medical device for safe administration, e.g:
    - Use an oral syringe to measure and administer fractionated doses of oral liquid medicines.
    - All regular and single insulin (bolus) doses are measured and administered using an insulin syringe or commercial insulin pen device.

Refer to Section 16. For IV administration refer to the Infusion Therapy Policy and the Protocol for Intravenous Infusion (including the Care and Management of Peripheral and Central Venous Access Devices)

- Each multi-dose vial must only be used for one specific patient.
- Medicines dispensed for an individual patient must be administered only to that patient and must not be shared.
- Students must never administer medicines without direct observation and supervision by the administering practitioner.
- The administering practitioner is responsible for the delegation of any aspects of the administration of medicines. Refer to appendix 15 – Who can administer medicines. Patients

must be observed to have taken their medicines by the administering practitioner or the delegated practitioner.

Halving of tablets:

- If it is necessary to half a tablet to administer the prescribed dose the tablet should be halved using the appropriate device such as a pill splitter
    - When a prescribed dose requires half a tablet ward-based technicians should be dispensed the tablets into a bottle already halved using a pill splitter and labelled appropriately.
    - If the medication is being supplied by a community pharmacy, where possible, the dispensing pharmacy/technician should be asked to supply the tablets in a bottle clearly labelled with the administration details; this way the remaining half can be placed within the bottle
    - Once dispensed into a bottle the expiry date of the tablets would be reduced to one month from the date of dispensing or the manufactures expiry date (which ever is soonest).
    - Remaining half tablets must not be placed in an open strip as this would leave the tablet open to the elements and could easily be missed or dropped on the floor.

Practitioners administering a medicine(s) to a resident in a non HTFT care home should make their record of administration available to care home staff if requested.

7.1.1. Patient Group Directions (PGDs)

- Administration of medicines in accordance with a PGD please refer to The Patient Group Direction Policy
- Recording of medicines administered in accordance with a PGD:
    - Medicines given in accordance with a PGD on inpatient Units should be entered on the MAR Chart.
    - In the community the PGD must be recorded within the patients record.
    - In-patient and Community Services must make an entry in the clinical notes must give reasons for administration and outcomes.

7.1.2. Checks prior to Administration of a Medicine

The administering practitioner:

Must check:

- The patient's identity, either by photographic ID or a wristband. However, there are situations where it is acknowledged that due to clinical presentation or risk this may not be possible. In such circumstances, every effort must be taken to establish a patient's identity, for example asking for their name and date of birth.
- The patients condition and undertake any monitoring required before administering the medication. The practitioner must contact the prescriber without delay where contraindications to the prescribed medicine are discovered (or emergency services if appropriate), where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable.
- Allergies or drug sentivities
- The name, strength, form of the medicine
- Expiry date of the medicine
- The dose
- The route
- The time of administration
- The validity of the prescription:-
    - Signed by an authorised prescriber.
    - Mental Health Act status: where the 'Consent to treatment' T2 orT3 is identified on the MAR, a copy of the relevant form must be included in the patient's notes to refer to. Additionally, where T2 applies, a copy of the record of capacity (Humbernet Mental Health Legislation Z02 Form) must also be attached.

- The administering practitioner must ascertain from the MAR chart that the prescribed dose has not already been given prior to administration.

The administering practitioner must be aware of:

- The patient's care plan/medicines management plan.
- The patient's capacity.
- The administering practitioner must know the therapeutic uses of the medicine(s) to be administered, its normal dosage, side effects, precautions and contra-indications

No medication should be administered to a patient if there is any doubt about the **appropriateness, safety or validity of the prescription**. The prescriber and the nurse in charge must be informed immediately

- If the prescription is in anyway unclear, illegible or incomplete, the administering practitioner should contact the prescriber before administration. The prescriber should rewrite the prescription. If the prescriber is not available an alternate prescriber must be contacted.
- Mental Health nurses administering medication must also refer to: Section 24.Nurses, the Administration of Medicine for Mental Disorder and the Mental Health Act 1983' – Mental Health Act Commission Guidance Note

7.1.3. Expiry Date of a Medicine

Wording on packaging	**Definition**
Best before January 2030	Discard 31/12/2029
Use by January 2030	Discard 31/12/2029
Use before end January 2030	Discard 31/01/2029
Discard after January 2030	Discard 31/01/2029
Expires January 2030	Discard 31/01/2029
Use within one month of opening	*Discard 28 days after opening*
Discard 7 days after opening	*Self-explanatory*

- If an official expiry date is absent, the product is valid 28 days from the date of dispensing on the pharmacy label.
- If there is no identifiable expiry date or dispensing date the medicine must not be administered.
- **If a medicine has a reduced expiry once opened** , it is the administering practitioner's responsibility to ensure details of the reduced expiry date are noted on the bottle.
- This information can be found on the manufacturer's label.
- Apply the 'Date Opened' label to the bottle ensuring the label does not cover any relevant product information.
- If the labels are not available please note the reduced expiry date directly onto the container's label.
- The reduced expiry date must not exceed the manufacturer's expiry date

7.1.4. Time of Administration:

- The administering practitioner is responsible for ensuring that prescribed medicines are administered within 60 minutes either side of the prescribed time. If this is not possible a record must be made within the patient record indicating the reason(s) why and the MAR chart must be annoted with an appropriately. Consideration must be given for the timing of the next dose, advice may be sort from the prescriber or trust pharmacy.
- Further guidance on the administration of depots can be found in Appendix 5.

7.1.5. Critical Medicines

- Medication doses are sometimes omitted or delayed for a variety of reasons. While these events may not seem serious, for some critical medicines or conditions, delays or omissions can cause serious complications and/or serious harm, or sometimes even death (National Patient Safety Agency (NPSA) 2010).

HTFT has approved a list of Critical Medicines, which must be administered on time.

- Anti-cancer drugs and the medication required to prevent their immediate side effects.
- Anti-coagulants
- Anti-convulsants for seizure control (including benzodiazepines for seizure termination)
-
- Anti-Parkinson medication
- Clozapine
- Insulin & other anti-diabetic medication
- Lithium
- Systemic Anti-Infectives (Oral, IV and IM formulations)
- Systemic corticosteroids e.g. prednisolone, hydrocortisone, fludrocortisone AND high dose steroid inhalers

This list is not exhaustive, as other medicines may be critical in specific circumstances, where this applies it is the prescriber's responsibility to make this clear on the prescription.
If the medication is to be omitted, discussion should take place with the prescriber. The reason for the omission and outcome of the discussion with the prescriber must be documented in the patients record. If this medication is omitted without a prescriber's decision, this should be reported via Datix.

7.1.6. Missed Doses

- If the patient is absent from the ward, or has missed a dose for some other reason, the delayed dose may be administered at a later time provided:
- A prescriber or pharmacist has confirmed that it is appropriate to do so or that it is according to an agreed protocol.
- The actual time of administration must be clearly recorded on the MAR Chart record by the administering practitioner.
- A record must also be made in the clinical note.

7.1.7. Variant Codes

- If a dose is omitted or if there is any variation from the prescribed regimen, the reason must be entered on the MAR Chart and the initials of the administrating practitioner recorded. Full details of the reasons for variations and actions taken must also be recorded in the clinical notes if appropriate.

For wards where electronic administration records are not in use:

- Use the variant code key on the MAR
- Prescribed omissions are used for intermittant dose regimes. An 'X' or ' —' must be recorded by the prescriber on the day(s) an ommision of the prescribed medication is intended.
- New codes can be added for any other reasons. An explanation must be recorded in the Variant Codes section of the MAR Chart.

7.1.8. 'Nil by Mouth'

Those patients classified 'Nil by Mouth' prior to a diagnostic procedure or receiving an anaesthetic:

- Must have all their prescribed oral medicines administered to them at the prescribed time unless specifically advised otherwise by the prescriber or anaesthetist.
- The medicines should be taken with a small amount of water to enable them to swallow these medicines.
- Only medicines that have been clearly marked for omission on the MAR Chart may be omitted.
- It is the responsibility of the prescriber to provide clear written instructions to the administering practitioner concerning the omission of prescribed doses.
- For patients under going light anaesthia, e.g ECT specific guidance should be sought from the anaesthiatist or ECT guidelines.

7.1.9. Documentation

The ‘administering practitioner’ who has administered, supervised or delegated the administration of the medicine must annotate the MAR chart at the time of administration.

- The initial of the administering practioner confirms that they are satisfied with the appropriateness, safety and validity of the prescription and that the medicine(s), as prescribed, have been administered in accordance with the SSHMP and any associated Trust protocols.
- Where there are unannoted doses on the MAR Chart prior to the time of administration the administering practitioner should asertain if the dose of medication was prescribed after the due time indicated.
- Where medications have been prescribed after the due time indicated on the MAR chart these should be anotated by the administering practitioner using the appropriate varient code.
- Where a medication was due but has not been anotated the administering practitioner should consider if administration of the dose due is appropriate and ensure that the non anotation is refered to the nurse in charge.
- It is the responsibility of the administering practitioner to ensure that anyone who has been delegated with aspects of medicines administration verbally feedsback that the task has been carried out.
- Where electronic administration charts are used, the administrating practitioner should record who the administration was delegated to in the administration comments.
- Where a paper MAR chart is in use, it is good practice for the delegate to initial the chat. The initial of the delegate confirms that they have performed the delegated tasks appropriate to their level of responsibility and proven competency.
- If more than one person shares the same initial then arrangements must be made to enable easy identification.
- A record of signatures and corresponding initials must be kept by the Unit Manager.

7.1.10. Monitoring Side Effects

The administering practitioners must monitor the effectiveness and side effects of medication prescribed according to the summary of product characteristics (SPC), agreed care plans, HTFT guidance, local and national guidance.

- All practitioners, unregistered practitioners and other healthcare professionals must observe and note any adverse side effects of medicines. The nurse in charge is responsible for informing the prescriber of any observed adverse effects.

7.1.11. Directions to Administer Charts from another Hospital Trust

On receipt of a direction to administer from another hospital trust a registered practitioner must reconcile that the direction is appropriate and legible.
This involves the practitioner reconciling the direction against the discharge information and the medication dispensed by the discharging hospital.

The direction to administer should state:

- Patient details
- Name of medication
- Strength
- Form
- Dose
- Frequency
- Route
- Allergy Status
- Prescribers Signature or name*
- Date

* When the direction to administer is a printout from a discharging hospital clinical digital solution in the form of an Electronic Prescription Medication Administration (EPMA) chart. The printed name of the prescriber is sufficient.

A new direction to administer written on a HTFT MAR chart should be sought at the earliest possible opportunity.

The direction to administer charts from another hospital trust can only be used for up to 7 days.

7.2. Administration of Controlled Drugs (CDs)

7.2.1. Community Services

In the community, in a patient's home, where a registrant is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

- In a Care/Residential Home an approrpiate staff member of that organisation should act as a second check.

7.2.2. In-Patient

- Administration should be witnessed for schedule 2 CDs and schedule 3 CDs that require recording in the CD record book.

7.2.3. In-Patient and Community Services:

- An entry must also be made in the Ward CD Record Book or Community MAR, and in residential/nursing homes in their CD record book; recording under the appropriate headings:
  - Date and time of administration.
  - Name of patient.
  - Amount given – this must be recorded as the DOSE administered including details of any part doses wasted eg.2.5mg given 2.5mg wasted
  - Signature of administering practitioner.
  - Signature of the Witness. (Only on wards and residential/nursing homes).
    The signature of the Witness confirms that the whole process of administration including documentation has been witnessed.
    - ✓ This includes that the stock balance of the administered Controlled Drug has been checked and recorded.
    - ✓ **For solid dose forms** eg: tabs,caps, amps, patches etc. This is a check confirming the remaining physical stock and the stock balance recorded in the Ward Controlled Drugs Record Book(CDWRB
    - ✓) or Community MAR chart are correct.
    - ✓ **For liquid CDs**: The overall volume of any sealed bottles is correct. (Refer to the manufacturer's product label for volume size, or the dispensing label if the dispensed bottle is sealed). Do not open bottles with intact tamper evident seals. For an open bottle, the volume check cannot be confirmed. This is a visual estimate only. However, exercise good judgement; if the stock balance of an open bottle is recorded as 70ml and the visual estimate appears to be 15ml, a confirmed Stock Check for that preparation must be undertaken.

Student nurses and student nursing associates <u>should not</u> act or sign as a witness or second check for the Controlled Drug stock check or administration procedure.

For learning purposes students are encouraged to observe the process and could take part in some scenario based learning in their placement area.

In order to witness administration of controlled drugs, the relevant training should be completed as outlined in section 25.

If the only available witness is a HCA awaiting the CD Witness training, the registered professional can assess the understanding and competency of the HCA to witness the whole process of the CD administration. If the Registered professional deems them competent to act as a witness, the professional can allow the HCA to witness the CD administration on this occasion.

SystmOne administration help guides can be found here:
Administering Medication using S1

8. CONTROLLED DRUGS (CDS)

Schedule 2 Controlled Drugs are subject to the full Controlled Drug requirements relating to prescriptions, safe custody (except for quinalbarbitone (secobarbital) and some liquid preparations), denatured on disposal and the need to keep a Controlled Drug register.

Schedule 3 controlled drugs are subject to the special prescription requirements, denaturing on disposal and safe custody. Records in registers do not need to be kept apart from in secured services (Secured Services - handling of Schedule 3CDs.pdf (england.nhs.uk))

Schedule 4 part 1 controlled drugs are subject to minimal control. Denaturing is required on disposal.
Schedule 4 part 1 are not subject to prescription requirements, safe custody or records in register requirements.
Information on controlled drugs schedules can be found in the BNF Controlled drugs and drug dependence | Medicines guidance | BNF | NICE

CDs for use on in-patient units should be ordered as stock medicines. See section 11.

8.1. For the safe management of CDs

Only one container of a CD preparation, form and strength, should be open at any one time. (This excludes expired CDs awaiting Trust pharmacy to attend for safe disposal or in the Community ask the patients relatives to return to their local pharmacy).

8.2. Ward Controlled Drug Record Book (CDWRB)

- Ordering, Collection/Delivery, Storage and Archiving see Section 5.
- When the CDWORB is delivered the form in Appendix 13 must be completed.
- CDWRB is classed as Controlled stationery and must be maintained in good condition. The binding must remain intact. To prevent damage the pages of the CDWRB should not be folded.
- The CDWRB must not leave the Unit/Team base. Please contact the Trust pharmacy if the Unit/Team is to close or transfer base.
- The index at the front of the CDWRB should be maintained and current.
- The Unit/Team may operate a second CDWRB specifically for recording CDs labelled with a patient's name. This would usually be where there is a high activity of PODs. Alternatively, a separate section of the CDWRB can be allocated for this use, either the front or back pages. This helps to prevent confusion with documentation and handling of CDs on the Unit.
- Specialist Teams may operate a CDWRB per CD, e.g., SDS services. This practice must be agreed by Trust pharmacy.
- The CDWRB must be retained on the Unit for seven years after the last entry.

Page Heading Details:

- **Name:** Recommended International Non-proprietary Name (rINN) should be used unless the BNF directs brand specific prescribing
- **Form of Preparation**: It is essential to record the exact details of the preparation i.e;
- Tablets, capsules,injection,patches, oral solution etc.
- Type of formulation, e.g.Modified Release (MR), Sustained Release (SR) etc.
- The release profile when necessary e.g. Buprenorphine 3,4 or 7 day patch.
- **Strength:** must only use approved abreviations see section 6.4.7.
- **Patient's Name:** If the product is **labelled** with a specific patient's name, thismust also be recorded at the Page Heading Section.

Transfer of Balances

- When a balance is transferred from one page in the CDWRB to another page, a full record must be made accounting for the transfer.
- The new version of the CDWRB is preprinted at the beginning and end of each page, prompting the transfer details to be recorded.
- The previous version of the CDWRB does not have this pre-printed prompt and the transfer information can be recorded as follows:-
  On the page where the balance is being transferred from, the record should state words to the effect of :- 'balance transferred to page XX'.
  On the new page the record should state words to the effect of:
  'balance transferred from page XX'.
- **Previous Version**:The balance transfer within a current and active CDWRB need only be signed by the practitioner.
- **New Version**: **The balance transfer within a current and active CDWRB does not need to be signed or witnessed.**
- **However when a balance is being transferred to a new CDWRB this must be signed by the practioner and witness**

Recording of Corrections/Amendments of the CDWRB

- It is illegal to obliterate any entry.
- It is acceptable practice for a single line to be scored through the entry alternatively the error can be bracketed.
- An explanation of the error/correction must be recorded in an appropriate available space e.g. 'written in error'.
- The correction/amendment must be SIGNED by the practitioner **and** the witness.
  - An asterix symbol can be used to identify the error and match it to a corresponding asterix where the explanaition of the error has been recorded, signed by the practitioner and witness.
- If an entry is being corrected/amended after a transaction has been recorded e.g. receipt, administration, stock check, issue of discharge/leave, a full explanation of this retrospective correction/amendment must be recorded in an appropriate available space.

8.3. Ward Controlled Drug Order Book (CDWORB)

- Ordering, Collection/Delivery, Storage and Archiving see Section 5.
- When the CDWORB is delivered the form in Appendix 14 must be completed.
- CDWORB is classed as Controlled Stationery and must be maintained in good condition. The binding must remain intact. If you do fold over the pages in the CDWORB, fold diagonally to reduce bulk thus limiting any damage.
- Only one CDWORB must be in operation on a Unit at any one time.
- The CDWORB must be retained on the Unit for two years after the last entry.

The CDWORB is used for the following transactions:

- Ordering Unit Stock CDs (See Section 11).
- Transfer of CDs between HTFT in-patient Units (see Section 13).

Recording of Corrections/Amendments in the CDWORB

Any correction/amendment to the Name of Preparation, Form, Strength or Quantity must be annotated by the nurse in charge .

8.4. Stock Balance Check

Stock balances of individual preparations must be checked after every administration. For liquid CDs check as follows:

- The overall volume of any sealed bottles is correct. (Refer to the manufacturer's product label for volume size, or the dispensing label if the dispensed bottle is sealed).

- For an open bottle, the volume check cannot be confirmed. This is a visual estimate only. However good judgement must be applied; if the Stock balance of an open bottle is recorded as 70ml and the visual estimate appears to be 15ml, a confirmed Stock Check for that preparation must be undertaken.

8.5. Stock Checks in the Ward CD Record Book

- A Stock Check of all CDs entered in the Ward CD Record Book (CDWRB) must be conducted weekly to ensure that should there be a discrepancy, it can be identified in a timely way.
- The Stock Check must be performed by the Nurse-in-Charge and a Witness.
- To ensure all balances are checked, it is important to check the balance in the CDWRB against the contents of the CD cupboard, not the reverse.
- Do not open packs with intact tamper evident seals.
- A record by those conducting the check must be made in the CDWRB and must:
    - Confirm whether the stock is correct and record the balance in the appropriate column, e.g. '*stock check correct*'.
    - Be dated and signed by both the nurse in charge and the Witness.

Stock Checks and Liquid CDs:

- Stock Checks for liquid CDs must be confirmed to be correct:
    - At the Weekly Stock check.
    - On completion of a bottle.
    - When the Stock Balance recorded in the CDWRB is NIL
    - When PODs are brought into the Ward.
- The overall volume of any sealed bottles is correct. (Refer to the manufacturer's product label for volume size, or the dispensing label if the dispensed bottle is sealed).
- Where there is an open bottle the contents must be measured.
- When recording a Stock Check entry for liquid CDs, **the record must clearly state what the stock comprises, e.g. 2x100ml sealed + 12ml**
- Any discrepancy from the recorded balance must be investigated.
- **Discrepancy of +/- 5% is permitted.** However a check of the arithmetic must be made to ensure that balances have been calculated correctly, and the discrepancy is not due to a mis-calculation
    - If the volume of the discrepancy is greater than +/- 5%, the allowance for variation must be calculated.
    - For liquid balances of **an open bottle** the allowance for variation is calculated against the volume of the open bottle from the previous recorded Stock Check.
    - When a new bottle is opened, a Stock Check must be conducted immediately following administration from this bottle.In these circumstances ,the allowance for variation is calculated against the original volume of this bottle.
- Any permitted discrepancy (+/-5%) recorded will be reviewed by Trust pharmacy at the CD Inspection Visit. Any concerns will be acted upon. The Accountable Officer and Modern Matron will be alerted.
- Any other discrepancy must be reported and investigated without delay. The following should be carefully checked:
- All CDs received and administered have been entered into the correct page of the CDWRB.
- Items have not been accidentally put into the wrong place in the cupboard.
- Arithmetic to ensure that balances have been calculated correctly.
- If the discrepancy cannot be traced the nurse in charge must complete a DATIX, and inform the Trust pharmacy.

A guide and working examples for Liquid CD stock checks can be found here:
Liquid CD stock Check information.pdf (humber.nhs.uk)

8.6. Transfer of CDs between HTFT Units

HTFT pharmacy would only advise on transferring CDs where it is essential for the clinical need of the patient and by not doing so would result in an unacceptable delay.

When transferring CDs there must be a clear, auditable train to account for all aspects of the transfer process, issue, delivery, receipt.

8.6.1. Transfer of Stock CDs

To account for this process the CD Ward Order Book (CDWORB) is used as a CD'Transfer' Order book.

Filling in the 'Transfer Order'

- ✓ Use the Ward CD Order Book to record the transfer of CDs
- ✓ Before entering the 'Transfer Order' details, ensure that the carbon paper is face down between the white page and the corresponding pink page.
- ✓ Only one CD preparation (or volume of methadone) can be documented per page

The following details must be entered under the **headings**.

- **Hospital:** HTFT.
- **Ward/Department**: state 'Transfer of Stock, Non-Stock CDs or Patient Own CDs to ……. Unit'. **If the transfer is for Non-Stock CDs or Patient's Own CDs** include the patient's name.
- **Name of Preparation:** no abbreviations accepted
- **Strength.**
- **Quantity:** recording details as a box, bottle or OP(original pack) is not acceptable. The quantity must be entered as the number of tablets, caps, amps, patches etc or the volume of oral liquid.
- **Ordered by:** state **'transferred by'**. Sign **and** print name.
- **Supplied by:** Name of **transferring** Unit.

Ensure a record of transfer has been entered in the CDWRB

- ✓ Under 'Name of Patient' enter 'transferred to …….Unit' **and**
- ✓ Record the Serial Number of the Requisition that has been used to detail the transfer. This is located on the top right hand corner of the relevant white/pink page of the CD ward order book (CDWORB)

Delivery:

On completion of all documentation place meds for delivery into an appropriate sized envelope. Seal envelope - Transferring practitioner and witness to sign across seal.

Accepted for Delivery:

Signature of the member of staff who is to deliver the CDs must be recorded in the CDWORB. The member of staff who is delivering the CDs must take the CDWORB. This is because the relevant page in the CDWORB will need to be signed by the receiving Unit.

Transportation:

Recommend that the CDs and the CDWORB are transported in an inconsipcuous bag.

<u>Receiving Unit :</u>Receipt of transferred CDs.

The delivery must be handed directly to the nurse in charge at the Unit to which the CDs are being transferred to.

On receipt of the transferred CDs the nurse in charge must check the order in the presence of the member of staff who has delivered the transferred CDs.

If the transfer is correct, annotate the top, white page in the CDWORB (in an appropriate, available space)as follows:

- 'Received, checked & correct'. **Sign,print and date.**
- The Receiving Unit must remove the top, white page. This must be:
  - Retained on the Receiving Unit for two years
  - Filed securely with the pharmacy delivery notes.
- Ensure that all recorded information has carboned through to the pink corresponding page.
- The CDWORB of the transferring Unit must be handed back to the delivery staff for safe return to that Unit.

- The received, transferred CDs must be entered into the CDWRB (refer to Section 14.

If the transfer is incorrect, annotate the top white page in the CDWORB (in an appropriate, available space) as follows:

- 'Transfer incorrect' and record exactly what has been transferred. **Sign,print and date.**
- Record if the CDs are to be immediately returned to the Unit making the transfer.
  - If the CDs are to be retained by the Receiving Unit they must be entered into the CDWRB (refer to section)
- The top white page must be counter signed by the member of staff who has delivered the transferred CDs.
- Ensure that all recorded information has carboned through to the pink corresponding page.
- The CDWORB of the transferring Unit must be handed back to the delivery staff (together with the CDs if appropriate) for safe return to that Unit.

ENTERING TRANSFERRED CDs into the CDWRB

STOCK CDs :The following details must be recorded:

In the 'Amount(s) Obtained' section under the relevant column headings, record:

- Amount Obtained
- Date received
- Serial number of requisition that has been used to detail the transfer (located on the top right hand corner of white/pink pages of CDWORB)
  - Additionally record whose CDWORB was used for the Transfer Order

In the 'Amounts Administered' section where one would normally record "Date, Time, Patient's Name, Amount Given" record:

- Where the supply has been obtained, e.g. *'received from …….. Unit'*.
- Signature of receiving practitioner (sign in the 'Given By' column).
- Signature of the Witness (sign in the 'Witnessed By' column).
- The new stock balance of the CD must be checked and recorded.

8.6.2. Transfer of NON-STOCK and Patients' Own Drugs (POD)CDs between units

The prescription should be printed from the clinical system.

Delivery, transportation and receipt as per section 8.6.1.

<u>Receiving Unit :</u>Entry into CDWRB

Use the appropriate book or section of the CDWRB where your Unit record patient labelled CDs (i.e. Non-Stock or PODs). This helps to prevent any confusion with the documentation and balance of Stock CDs.

A **separate page** must be used for **each patient**.

- **Different forms and strengths of medication (including different volumes of methadone) for that patient must be recorded on separate pages.**

Ensure the page heading has been completed, recording the 'Name, Form of Preparation and Strength' **also adding the patient's name.**

Schedule 2 CDs and those requiring record in the CDWRB: The prescription must be retained by the receiving unit for 7 years.

Schedule 3 CDs: The prescription can be destroyed once the delivery has been confirmed as correct.

8.7. Ordering and Storage of CDs for Unit Holidays

The following guidelines apply when any controlled drug (CD) is required on unit holidays:

Prior to Holiday:

- ✓ The CD should be ordered on a Discharge/Leave Prescription Form (Form PPD)
- ✓ The prescription must meet all the legal requirements for a CD

- ✓ On arrival on the unit each drug should be written into the back of the ward CD register or ward POCD register (a separate ward CD register reserved for recording patients own CDs)
- ✓ A separate page of the register must be used for each different preparation
- ✓ A small book should be obtained (if not already held), reserved solely for recording CD administration during unit holidays
- ✓ The small book should be marked with the name of the unit and “Administration of CDs to Patients during Unit Holidays

On Departure:

- ✓ The holiday supply should be written out from the back of the relevant ward CD register.
- ✓ The holiday supply should be written into the small book
- ✓ A separate page of the small book must be used for each different preparation
- ✓ While off the unit each dose given should be recorded and deducted from the balance
- ✓ The medicines administration record (MAR) chart should be signed for each dose given
- ✓ The medication should be stored out of sight in a locked box in a locked vehicle when not in use.

On Return:

- ✓ Any unused quantity should be written out of the small book and back into the appropriate page(s) of the relevant ward CD register
- ✓ Any returned quantity should be put into an envelope, sealed and marked ‘For Pharmacy to denature and destroy’
- ✓ The Pharmacy should be notified to make appropriate arrangements to visit and carry out the above.
- ✓ The small book should be kept in the CD cupboard for future use and to account for supplies held
- ✓ Once full the small book must be kept on the unit for two years from the date of the last entry

8.8. Administering CDs in a care home

When HTFT staff administer CDs in a care home, the record should be made in the administering column in the care homes CD record book and on the patients HTFT MAR chart. The care home staff are responsible for recording on the care home MAR chart that the medication is administered by a community nurse

The care home staff are responsible for completing the CD record book when CD medication is received into the home.

When signing the administering column in the care homes CD record book you are signing to say that you have administered the medication and that the amount of CD medication in the record book tallies with the amount of medication available.

If it does not tally the amount available should be written in the CD record book with the amount missing. The discrepancy should be reported to the care home manager as well as your own manager. A DATIX must be completed and documented in the patients record.

Refer to the following Sections for further instruction on handling CDs

- Section 5.8: Archiving and Filing of Used Medicines Related Stationery
- Section 6.5: Prescription Writing of CDs
- Section 6.7: Remote Prescribingof CDs
- Section 7.3: Administration of CDs
- Section 10.14: Discharge/Leave CDs (including Receipt, Issue and Proof of Issue)
- Section 11: Stock CDs (including Ordering)
- Section 12.1: Non-Stock Medicines CDs (including Ordering)
- Section 13: Transport and Transfer of CDs
- Section 14: Receipt of Stock and Non-Stock CDs
- Section 15: Storage of CDs
- Section 16: Disposal of CDs
- Section 17: Suspected Illicit Substance

9. ORDER PROCESS FOR MEDICINES AND MEDICAL GASES

9.1. Order Process for Medicines from the Pharmacy Supplier

Printable order flow charts are available for your area on the intranet:
Ordering Medicines (humber.nhs.uk)
For the written processes, please see the following:
Ordering of Discharge or Leave prescriptions: Section 10
Ordering of stock CDs: Section 11.4
Ordering of Non-stock medicines: Section 12

9.2. Ordering Process for Medical Gases

This is a National Contract with BOC

For for supply or replacement of medical gas cylinders email hnf-tr.pharmacyprocurement@nhs.net with the following information:

- Order details:
  - Medical gas required
  - Cylinder size
  - Number of cylinders required
  - Number of cylinders to be collected
- Unit/service name and address
- Contact name and number for delivery

Routine Order

- Place order Monday – Thursday before midday.
- Delivery next **working day.** The Unit can request a morning or afternoon delivery, however this is not guaranteed.

Emergency Order

- Call pharmacy procurement on 01482 301732
- The requesting Unit must consider that once placed,an Emergency Order can take **up to six hours for delivery to be made**

Out of hours

Contact the manager on call.

List of expected minimum stock levels in Appendix 11

10. DISCHARGE/LEAVE MEDICINES

All the Discharge/Leave medicines must be prescribed on the appropriate prescription forms and dispensed by pharmacy for individual named patients.
For Discharges all the medicines that a patient is currently prescribed must be written on the Prescription Form.

If a patient is to be discharged or is to go on leave with their own medicines, then this must be written on the Prescription Form and annotated with ‘patient’s own drugs’ or ‘POD’ (See Section 18 Patient’s Own Drugs).

10.1. Prescribing Discharge or Leave medication

SystmOne help guide is available here: prescribe-to-take-out-medication.pdf

10.2. The use of FP10 for Discharge/Leave medicines

- If an FP10 is required to obtain supply of a medication, the preferred method is to use the Electronic Prescription Service (EPS) which transmits the prescription to a chosen community pharmacy using the NHS spine.
- If EPS is unavailable a FP10HNC will need to be handwritten.

- A record of the prescription will need to be made under the prescription section in the clinical tree.

Note: F1s cannot prescribe on FP10 forms.

10.3. Sharps

If the Discharge/Leave comprises of any Sharps, e.g., insulin or Fragmin, that the patient is to self-administer, the unit must supply the patient with the appropriate Sharps Bin, information on how to use the sharps bin safely and how to safely dispose of the bin:-

- Hull City Council: www.hullcc.gov.uk: Waste and recycling :Clinical Waste
- East Riding Council: https://www.eastriding.gov.uk/ : Bins, recycling and rubbish (go to: 'Not listed? Browse the 'bins' section') Clinical Waste.
- North Yorkshire Council: https://www.northyorks.gov.uk/household-waste-and-recycling-collections. Refer to the appropriate borough council.

10.4. Storage

The dispensed medicines must be stored in a locked medicine cupboard until required.

10.5. Discharge/Leave Copies

The discharging practitioner must:

- Check that all medication supplied correspond with the Discharge/Leave Prescription Form.
- Confirm the identity of the patient before handing the Discharge/Leave Prescription to the patient/carer.
- Ensure the patient/carer understands the medication being supplied including: What the medication is prescribed for, how to take/apply/use the prescribed medication.
- Ensure the patient/carer is able to administer the prescribed medication.
- **Proof of Issue:-**The patient or their representative must sign the Discharge/Leave Form (PPD) in the 'Dispensed Medicines Collected By:' section.
- Where this section is not present on the Discharge/Leave Form or the prescription has been supplied against an FP10, anotate the Discharge/Leave Form or the photocopy of the FP10 with 'collected by' and request the patient or their representative to sign.

- On discharge arrangements must be made to ensure a smooth transfer of care. Patients' treatment must not be compromised by any delay in obtaining further supply of medicines after discharge.
- On discharge the immediate discharge letter must be sent to the GP and other services involved with the patients care.
- The Unit copy of the Discharge/Leave form must be filed with the Clinical Notes.

10.6. Discharge/Leave Controlled Drugs

If CDs are dispensed for Discharge/Leave and not handed out immediately, they should be entered out of the stock and entered as PODs in the appropriate section of the CDWRB.

The CDs must remain locked in the CD cabinet until they are issued to the patient or their representative.
Once issued, the appropriate entry should be made in the CD register (see section 10.9)
(See Section 18 Patient's Own Drugs and Section 6.5 Prescription Writing of CDs)

10.7. Receipt of Discharge/Leave CDs

- If dispensed CDs for Discharge/Leave are not to be handed out immediately, they must be locked away in the CD cabinet and an entry must be made into the appropriate section of the CDWRB.

10.8. For Discharge/Leave CDs received, the following details must be recorded:

- Enter CDs in the appropriate section of the CDWRB.
- A separate page must be used for each patient.
- Different forms and strengths of medication for that patient must be recorded on separate pages.
- Ensure the patient's name is recorded as part of the 'Page Heading' details see Section 8.

- **In the 'Amount(s) Obtained' section** under the relevant column headings, record:
  - Amount i.e: number of unit doses received e.g. 10 tabs, 2x100ml
  - Date received
- If the CDs have been obtained using FP10, under 'Serial No of Requisition' enter the Serial Number of the FP10.
  - **In the 'Amounts Administered' section** where one would normally record 'Date, Time, Patient's Name, Amount Given' record:
    - Where the supply has been obtained from
    - Signature of receiving practitioner (sign in the 'Given By' column).
    - Signature of the Witness (sign in the 'Witnessed By' column).
    - The stock balance following receipt of the CD must be checked and recorded.

10.9. Issue of Discharge/Leave Controlled Drugs to the patient or their representative

The following details must be recorded in the CDWRB: (please note: this process applies whether medicines have been dispensed specifically for Discharge/Leave or if the patient's own medicines (PODs) are being issued for Discharge/Leave. Refer to Section 18 Patients Own Drugs (PODs) and Section 8).

10.10. In the 'Amounts Administered' section record

- Date and time of issue of the Discharge or Leave.
- Under the column heading 'Patient's Name' enter 'meds for Discharge or Leave' (whichever is applicable).Additionally record the Serial Number of the Discharge/Leave Form, FP10 or Trust PPO prescription form against which the medicines are being supplied.
- Amount Given i.e: number of unit doses received, e.g. 10 tabs.
- Signature of administering practitioner.
- Signature of the Witness. The signature of the Witness confirms that the whole process of issue has been witnessed.
- The remaining stock balance of the CD must be checked and recorded.

11. STOCK MEDICINES

- Each unit should have a list specifying which medicines are available for ordering and for use as Stock on the unit. The list of stock medicines will vary with the nature of the clinical area.
- Where a quantity is recorded in the 'Stock Level' column, this is the minimum amount that should be available at any given time on the Unit.
- The Medicines Optimisation Technician, the nurse in charge and the relevant medical staff should review the contents of the list at least every three months.
- Before amending the stocklist, the following should be considered:
  1. Is there a clinical need to keep the medication in stock (for example, is it a critical medication)?
  2. Is the medication used regularly in this patient cohort?
  3. Is the medication readily available?
  4. Is the item expensive? (over £100 for a months supply)
- Amendments to the stocklist should be agreed with the ward pharmacist.
- Groups of medicine can be added at the pharmacist descretion i.e. Ramipril capsules (all strengths).
  If added in this way, a column will need to be available to state the stength for ordering purposes.
- Unlicensed medicines cannot be held as stock without the approval of the Drug & Therapeutics Group.
- The nurse in charge should be responsible for maintaining and ordering of ward stock.
- Unit stock orders must be placed via the ward-based technician or emailing the stock order form to hnf-tr.pharmacyprocurement@nhs.net
  - For items received from pharmacy procurement the practitioner accepting the delivery must sign a consignment note presented by the delivery driver (appendix 20)

- It the delivery contains a Fridge item, the practitioner must also sign the fridge item delivery note presented to them by the delivery driver (appendix 21)
- For CD see section 14.3

- Medicines that are not usually held as stock should not be borrowed from other units without taking the advice of a pharmacist.
- The Medicines Optimisation Technician must be notified of any medicines borrowed from or lent to another unit.
- A Patient Own Drug (POD) label should be attached to stock medicines that are indicated on the stocklist as single patient use i.e. inhalers and creams
  The labels are available via hnf-tr.pharmacyprocurement@nhs.net
  This is not a dispensing label and the medication will need labelling with full instructions before being issued for leave/discharge.

11.1. Stock order sheets

Electronic copies of the stock order sheets are held on the v:drive by the HTFT pharmacy department.
Old versions of the electronic order sheets are archived on the v:drive.
V:\Corporate\Pharmacy\Pharmacy Team\Public\Complete Stock Lists

When orders are placed using the stock order form, the form must be retained for two years after the last entry.

Once scanned onto the v:drive, hard copies can be destroyed.

11.2. Stock Medicines Controlled Drugs

The Nurse-in-Charge of the unit is responsible for ordering, receipt and storage of CDs.

- CDs for in-patient use must always be ordered as stock.
- Procedures stated in Section 16. Controlled Drug Waste Flowchart must be followed for the disposal of Stock CDs.
- Transfer of Stock CDs between Trust Units – see section 13.

11.3. Ordering of Stock CDs

Using the CD Ward order Book (CDWORB)

- Orders and records must be in indelible ink that would be readable on any copies (black or blue ink).
- The CDWORB comprises of duplicate pages (white and pink) with corresponding serial numbers. The pages must follow sequentially.
- Before entering the order details ensure that the carbon paper is face down between the white page and the corresponding pink page.
- Only one CD preparation can be ordered per page.
- For the headings listed in the CDWORB the following details must be completed to meet the relevant legal requirements for ordering and supply of Stock CDs:
  Hospital: HTFT.
  Ward/Department: Name of Unit/Team.
  Name of Preparation including:
  Form i.e: liquid,tabs,patches etc.
  - State if a specific formulation, i.e. MR/SR etc.
  - Recommended International Non-proprietary Name (rINN) should be used unless the BNF directs brand specific.
- **Strength: must only use approved abreviations see section 6.4.5.**
- **Quantity:**
  - Requesting as a box, bottle or OP(original pack) will not be accepted. The quantity must be entered as the number of tablets, caps, amps, patches etc or the volume of oral liquid.
  - Wholesalers can only supply the quantity that is issued by the manufacturer. If you do not know the manufacturer's pack size refer to the BNF or contact the dispensing pharmacy.

- **Ordered by: Sign and Print.** Ordering practitioner
- **Date:**
- Check that the order details have carbon-copied through to the corresponding page.

CDWORB must be retained on the Unit for two years after the last entry
Only those named as staff authorised to order controlled drugs (Appendix 18) can place an order for controlled drugs.

Completed forms to be saved to: V:\Pharmacy\Technical\CDs\CD Signature Lists completed

During Working Hours (Mon-Fri 09.00 to 17.30)

- Complete the order in the CDWORB as above.
- If your ward-based technician is available, liaise with them regarding ordering
- If you ward-based technician is unavailable, email the order to hnf-tr.pharmacyprocurement@nhs.net

Out of Hours (after 17.30 Mon-Fri, Weekends and Bank Holidays)

- If there is a need to order any controlled drug(s) out of hours, the item should be sourced from a community pharmacy and obtained using FP10.

Transfers of Stock CDs between Trust units refer to section 13.

12. NON-STOCK MEDICINES (NSMS)

Medicines not kept as stock on the unit must first be prescribed on the MAR Chart before a supply can be obtained.
The following items should be labelled for the patient with full instructions:

- Clozapine.
- Creams
- Eye/ear/nasal preparations
- Inhalers
- Medicines the patient will be self-administering (SAMs)
- One Stop Dispensing

NSMs not in the list above should be labelled for the patient with “Use as per Medication Administration Record” in place of the administration instructions.

12.1. Requisition for Non-Stock Medicines

Please follow the “ePMA – Request medication” help guide which can be found here:
Medication Requests using S1

13. TRANSPORT AND TRANSFER OF MEDICINES INCLUDING CDS

13.1. Collection and Transport of medicines by Trust Staff

Refer to Section 9: Pharmacy Ordering Process Part 1 & Part 2 for further information regarding collection and transport of medicines by Trust staff.

13.2. Transport by Community Teams:

- Medicines collected by community practitioners from community pharmacies must provide identification to the supplying pharmacy.
- Medicines that are being transported to community bases or patients’ homes must be under the personal control of the member of staff at all times.
- The medicines should be transported in a non-identifiable manner.
- If transportation is by car, any medicines must be kept in the locked boot of the car when they are not under personal control – medicines **must not** be stored in within the car boot overnight.

13.3. Transfer of Medicines

13.3.1. Transfer from one hospital or unit to another

If a patient is transferred to a hospital on an acute admission (i.e., an unplanned admission such as A&E) a copy of the eMAR Chart should be sent with the patient.
On arrival, critical medication should be highlighted to the receiving team.
The receiving team will assess the patient and prescribe the relevant medication.
If medication is prescribed but unavailable, a member of the receiving team should call the ward and the transfer of Non-Stock Medication for the named patient to the receiving hospital can be arranged.

If medicines are being transferred between HTFT wards, the ward should keep a log of the medication being transferred, the quantity and the name of the receiving ward. This information should be handed over to the ward-based technician at the next available opportunity.

If medicines are being transferred from a HTFT service to HQ, an email should be sent to hnf-tr.pharmacyprocurement@nhs.net listing the medication being transferred, quantity and expiry date.

If a patient is being transferred as part of a planned admission the transferring unit should liaise with the receiving team to determine whether a supply of medication needs to be transferred with the patient.

Medicines accompanying a patient and being transferred from one hospital or unit to another may be transported with the patient in an ambulance or on authorised transport. The following guidelines should be observed:

- Check the expiry date(see Section 7.2.3.).
- Any special storage requirements must also be maintained.
- It is important that medicines are packaged securely and the final destination clearly specified.
- A record of the medicines (form, strength and quantity) being transferred must be made.
- This must be checked and signed by the receiving practitioner and filed in the clinical notes.

13.3.2. Transfer of CDs between HTFT Units

- At each point where a controlled drug moves from the authorised possession of one person to another, the process must provide an auditable trail, with signatures authorising, transfer, delivery and receipt.
- HTFT pharmacy would only advise on transferring CDs where it is essential for the clinical need of the patient and by not doing so would result in an unacceptable delay.

Arrangements must be made to ensure a smooth transfer of care. The transferring and receiving Units/Teams must liaise to ensure that the patient's treatment is not compromised by any delay in obtaining further or additional supply of medicines.

14. RECEIPT OF MEDICINES

14.1. Stock Orders

- Invoices must be retained in the unit for two years.

14.2. Medicines ordered and received using FP10

- If an FP10 is required to obtain supply of a medication, the preferred method is to use the Electronic Prescription Service (EPS) which transmits the prescription to a chosen community pharmacy using the NHS spine.
- If EPS is unavailable a FP10HNC will need to be handwritten.
- A record of the prescription will need to be made under the prescription section in the clinical tree.
- Medication ordered and supplied by the community pharmacy must be checked against the record of the prescription on the patient's electronic record.

(Note – the original prescription is retained by the dispensing pharmacy).

- The practitioner receiving and checking the delivery must sign the delivery note/copy of the original order when the check is complete.

- Any discrepancies must be recorded on the delivery note/copy of original order and countersigned by a Witness. The community supplier must be alerted as soon as possible.

14.3. Receipt of Stock CDs:

- The practitioner accepting the delivery for stock CDs must sign a consignment note presented by the delivery driver (appendix 22) in addition to the Ward CD Order Book.
- A practitioner must check the contents of the delivery package containing CDs against the requisition in the Ward CD Order Book
- Any discrepancy must be reported to the nurse in charge and the supplier immediately, the discrepancy:
  - ✓ Must be noted on the requisition in the Ward CD Order Book.
  - ✓ Must be signed, dated and countersigned by a Witness.
  - ✓ Must also be recorded on the delivery note issued by the supplier.
- The new stock must be entered into the Ward CD Record Book on the appropriate page.
- **Stock CDs Received**, the following details must be recorded:
  In the 'Amount(s) Obtained' section under the relevant column headings, record:
  - ✓ Amount Obtained, i.e. actual quantity received, e.g. 10, 2 x 100ml
  - ✓ Date received
  - ✓ Serial number of requisition (located on the top right hand corner of Ward CD Order Book) and

  In the 'Amounts Administered' section where one would normally record "Date, Time, Patient's Name, Amount Given" record:
  - ✓ Where the supply has been obtained from
  - ✓ Signature of receiving practitioner (sign in the 'Given By' column)
  - ✓ Signature of the Witness (sign in the 'Witnessed By' column)
  - ✓ The remaining stock balance of the CD must be checked and recorded.

15. STORAGE OF MEDICINES

- The nurse in charge/team leader is responsible at all times for the safekeeping of all medicines on their ward, unit or team base.
- The design and location of medicine cupboards must be approved by authorised Pharmacy Staff and regularly monitored.
- All medicines, disinfectants and reagents must be stored in locked cupboards, trolleys, or other secure cabinets – reserved solely for medicinal products. The only exceptions to this requirement are medicines for clinical emergencies, intravenous fluids, sterile topical fluids and nutritional products and some bulky medicated dressings which, because of their bulk, are stored in a clean cupboard.
- Medicines for internal use must be stored separately from medicines for external use.
- Under no circumstances must medicines be transferred from one container to another, nor must they be taken out of their container and left loose.
- Cupboards and trolleys must be sited where most convenient for staff, allowing adequate space and permitting surveillance to afford maximum security against unauthorised entry. Cupboards must not be sited where they may be subjected to higher than average humidity or temperature. Reagent cabinets must be sited in areas where testing is carried out.
- Medicine cupboards and refrigerators must be locked when not in used.
- The quantities, range and storage of medicines to be stocked must be reviewed regularly by the authorised pharmacy staff and the nurse in charge/team leader.
- Expiry date check should be completed monthly and evidenced on the "Expiry Date Checklist" and evidenced on Appendix 19.
  - Copies of the completed checklist are to be retained for 2 years.
    Hard copies can be retained on the unit or scanned on to the v:drive here:
    V:\Corporate\Pharmacy\Pharmacy Team\Public\Expiry Date Checklists
    Once scanned onto the v:drive the hard copies can be destroyed.
- Some or All of the following medicine storage units may be used:

- ✓ Internal Medicine Cupboard – for the storage of tablets, liquid medicines, injections etc.
- ✓ External Medicine Cupboard – for the storage of creams, lotions etc.
- ✓ Medicine Refrigerator – for medicines requiring storage below room temperature. The temperature must be within 2–8°C. Food or pathological specimens must not be kept in this refrigerator.
- ✓ Reagent Cupboard – situated in the area where tests are carried out. Some wards or unit may not require a separate cupboard if urine testing is only very rarely carried out but, in such circumstances, there should be a ward agreement about where such testing is to take place.
- ✓ A Clean Storage Room – for intravenous fluids and sterile topical fluids, if no suitable cupboard is available.
- ✓ Medicine Trolley or designated cupboard – for storage of medicines in current use. When not being used the medicine trolleys should be secured at an anchor point (i.e. a point at which trolleys can be secured to the floor or wall). Alternatively, medicines trolleys may be stored securely in a locked clinic room when not in use if access to the room is restricted to authorised persons.
  The trolley must not be left unattended during the medicine round. If the practitioner leaves the trolley, it must be locked immediately.
- ✓ Patient own medicines storage cupboards – for storage of medicines to be used in approved self-administration schemes. Each cupboard should be of the standard applicable to all medicines cupboards and have a unique key to only allow access by the individual patient. A master key should be held by the nurse in charge.

15.1. Medicines Stored at "room temperature"

- The room temperature where medicines are stored should be kept between 15-25˚C.
- Room temperature should be monitored daily or when the service is operational and recorded on a Temperature Monitoring Form (form PTM) see Appendix 6.
- If a temperature breach is noted, for solid dose forms, the following should be applied:

Storage range in SmPC	Temperature reached	Length of time at high temperature temperature	Reduce the expiry on the pack by
25^{O}C or below	25-30 ^{O}C	24 hours	2 days
	25-30 ^{O}C	1 week	2 weeks
	30-35 ^{O}C	24 hours	4 days
	30-35 ^{O}C	1 week	4 weeks
	35-40 ^{O}C	24 hours	8 days
	35-40 ^{O}C	1 week	8 weeks
30^{O}C or below	30-35 ^{O}C	24 hours	2 days
	30-35 ^{O}C	1 week	2 weeks
	35-40 ^{O}C	24 hours	4 days
	35-40 ^{O}C	1 week	4 weeks

- If a temperature breach is noted that is not covered above or for non-solid dose forms, contact the medicines safety team: hnf-tr.medicinessafety@nhs.net

15.2. Cold Chain

- The maximum and minimum temperature of the refrigerator must be recorded daily according to the working hours of the service, e.g., in-patients = every day.
- The maximum and minimum temperature should be recorded using the fridges integral thermometer. Once the readings have been taken, the thermometer must be reset.
- A secondary temperature monitoring device (data logger), approved by HTFT pharmacy must also be used to record and monitor the fridge temperature.
- The data logger must be downloaded at least once a week or when a temperature breach has been identified using the integral thermometer.
- The temperatures and confirmation of the data logger being downloaded must be recorded on the approved form. (see Appendix 6).

- The fridge must be serviced and calibrated yearly by a trust approved contractor. The contractor (Airco at present) will ensure that at sticker stating the last date of service is visible on the fridge.
- If the service sticker is not visible, please contact HTFT pharmacy department for advice.
- If the reading falls outside the required temperature range, the nurse in charge must be informed and the Pharmacy Department must be contacted to check the stability of the medicines stored. Staff must quarantine the medicine affected by the temperature excursion. Other resources may need to be accessed.
- A DATIX must be completed if any medicines are considered damaged.
- The Facilities Department must be contacted urgently.

15.3. Medicine Cabinet Keys

- The nurse in charge is responsible for the units Medicine Cabinet Keys. Key-holding may be delegated to other practitioners, but the legal responsibility rests with the nurse in charge.
- The keys must be returned to the nurse in charge immediately after use by another practitioner.
- The unit manager is responsible for the safe and secure keeping of a spare set of medicine cabinet keys for emergency access.
    - The spare set of keys should be stored in a key safe on the unit
    - Access to the key safe should be limited to the unit manager and deputy.
- The controlled drug medicine cabinet key(s) must be detachable from the main medicine keys (i.e., using a clip to attach/un-attach from the main medicine keys).
- **Community Teams** – special arrangements must be made for the safe keeping of medicine keys. Where it is not practicably possible for an identified key holder for the medicine cabinet, then special arrangements must be made with the Trust Pharmacy on an individual basis.
- Loss of keys must be reported immediately to the senior manager on duty and immediately recorded.
- Urgent efforts must be made to retrieve the keys as speedily as possible e.g.by contacting practitioners who have gone off duty.
- If the keys cannot be found, then the following actions must be observed:
    - A DATIX must be completed.
    - A Stock Check of all CDs held on the Unit must be conducted.
    - Facilities must be informed immediately to replace the medicine cabinets with new locks.
    - The MMT should be informed as soon as possible or the next working day where appropriate.
- Broken or damaged medicine keys must be reported immediately to the senior manager on duty and make Trust Pharmacy aware as soon as possible.
- Replacement keys are to be obtained via the Pharmacy Department.
  If you have a ward-based technician they can facilitate the order otherwise you can email hnf-tr.medicinessafety@nhs.net
  When the replacement key is delivered Appendix 1 should be completed and retained by the Pharmacy Department.

15.4. Storage of Controlled Drug

- CDs that require safe storage as per BNF must be stored in a locked CD cupboard
- The cupboard and its exact location must be approved by pharmacy.
- The lock must not be the same as any other lock in the unit.
- The CD cupboard must be reserved for the sole storage of CDs
- Conical measures, CD ward order book and record book may be stored in the CD cabinet if these are used for administration/stock checking of CD's only.
- All medication stored in the CD cabinet should be recorded in the CD record book.
- Access must be limited to the assigned practitioners or Authorised Pharmacy Staff.

15.5. Storage of Oxygen Cylinders

See Appendix 12.

16. DISPOSAL OF MEDICINES

Pharmaceutical waste is not to be disposed of via the foul water system in a sink or sluice

16.1. Record for the Destruction of Pharmacy Waste Form

- This form (see Appendix 10) is used to record hazardous medicine waste and part dose controlled drugs being disposed of.
- it is to be retained for two years from date of last entry.
  - It can be retained as a hard copy on the unit or
  - Scanned into the units folder here: V:\Corporate\Pharmacy\Pharmacy Team\Public\Record for the Destruction of Pharmacy Waste Forms
    Once scanned onto the v:drive, the hard copy can be destroyed.
- Hazardous medicines listed in appendix 9 should be disposed of in a hazardous waste bin
- All other pharmaceutical waste should be disposed of in the non-hazardous waste bin.
- Outer packaging and information leaflets should not be disposed of in the pharmaceutical waste bins.

16.2. Hazardous Waste

Hazardous medical waste is a product with one or more of the hazardous properties

- Toxic
- Carcinogenic
- Toxic For Reproduction
- Mutagenic

Medicines which are identified as hazardous are listed on the 'Hazardous List' (See Appendix 9).

Hazardous Waste must be disposed of in a Hazardous Waste Bin. **This includes any empty blister foils, tubes, bottles that have contained the hazardous medicines.**

16.3. Routine Collection of Waste

- An external Waste Contractor is responsible for the collection of the Hazardous and Non-hazardous waste bins.
- Any documentation for collection of the Waste Bins is managed by the Waste Contractor.
- It is a legal requirement that any documentation provided by the Waste Contractor to the Unit must be securely stored on the Unit for three years from the date of collection. Routinely electronic collection notes will be emailed to Hotel Services by the waste contractor.
- **Urgent request**: e-mail hnf-tr.wastemanagement@nhs.net (flag as 'high importance') or contact the Infrastructure and Informatics help desk Tel 01482 477877 Option 3 (Hotel Services) requesting an up lift.

16.4. Amendment to Waste Collection Timetable

- This can be altered depending upon the needs of the particular unit/team, please e-mail hnf-tr.wastemanagement@nhs.net to agree revised collection schedule.

16.5. Ordering Hazardous and Non-Hazardous Waste Bins

- HTFT Pharmacy Hazardous Pharmacy Waste Bin hnf-tr.pharmacyprocurement@nhs.net
- NHS Supplies Non-Hazardous Pharmacy Waste Bin ordering code: FSL883 30litre
- Services using other sizes of Non-Hazardous Pharmacy Waste Bins contact HTFT Pharmacy hnf-tr.pharmacyprocurement@nhs.net
- See the Trusts Standard Operating Procedure Waste Management Policy SOP17-002 Waste Management Standard Operating Procedure.pdf (.nhs.uk)

16.6. Waste – General Medicines

The procedures stated in Flow Charts Waste Part 1 must be adhered to (see section 16.8.).

16.6.1. In-Patient and Day-Care Units:

- All staff are required to follow the Waste Management Policy of the Trust when disposing of any medicines. Most medicines and pharmaceuticals are defined as 'special waste' by the

Control of Pollution (Special Waste) Regulation 1988 and the Hazardous Waste (England and Wales) Regulations 2005.

16.6.2. Community Setting:

- Patient and carers should be advised to return all medicines, including CDs, which are no longer required or have reached their expiry date to a community pharmacy.
- Such medicines from special schools must be returned to the parent or guardian, with advice of returning the medicines to a community pharmacy.

16.6.3. Removal of Medicines from a Patient's Home

- When it is considered necessary for a practitioner to remove from a patient's home, the practitioner should, whenever possible, do so in the presence of a witness.
- This witness may be a family member, carer, or the patient themselves.
- A record of why the medicines have been removed must be made in the clinical notes.

Reasons may include:

- Medication no longer required,
- Out of date medication
- Stock piling
- A concern of immediate risk to the patient.

- Record if consent was obtained or not, if consent was not obtained, record the rational for removing without consent
- The name and quantity of the medicines removed must be recorded, and both the practitioner and the witness (if present) must sign and date the documentation.
- These medicines should then be returned to a community pharmacy. The documentation should be stamped by the community pharmacy as evidence of this return. This record should then be filed in the clinical notes.
- If it is not possible to return the medicines to a community pharmacy, the medicines should be taken to a convenient in-patient unit/ward for disposal.
  Documentation of this should be added to the clinical notes.
- **See Section 17, Suspected Illicit Substances.**

16.7. Waste - Controlled Drugs and Medicines Handled as CDs in HTFT:

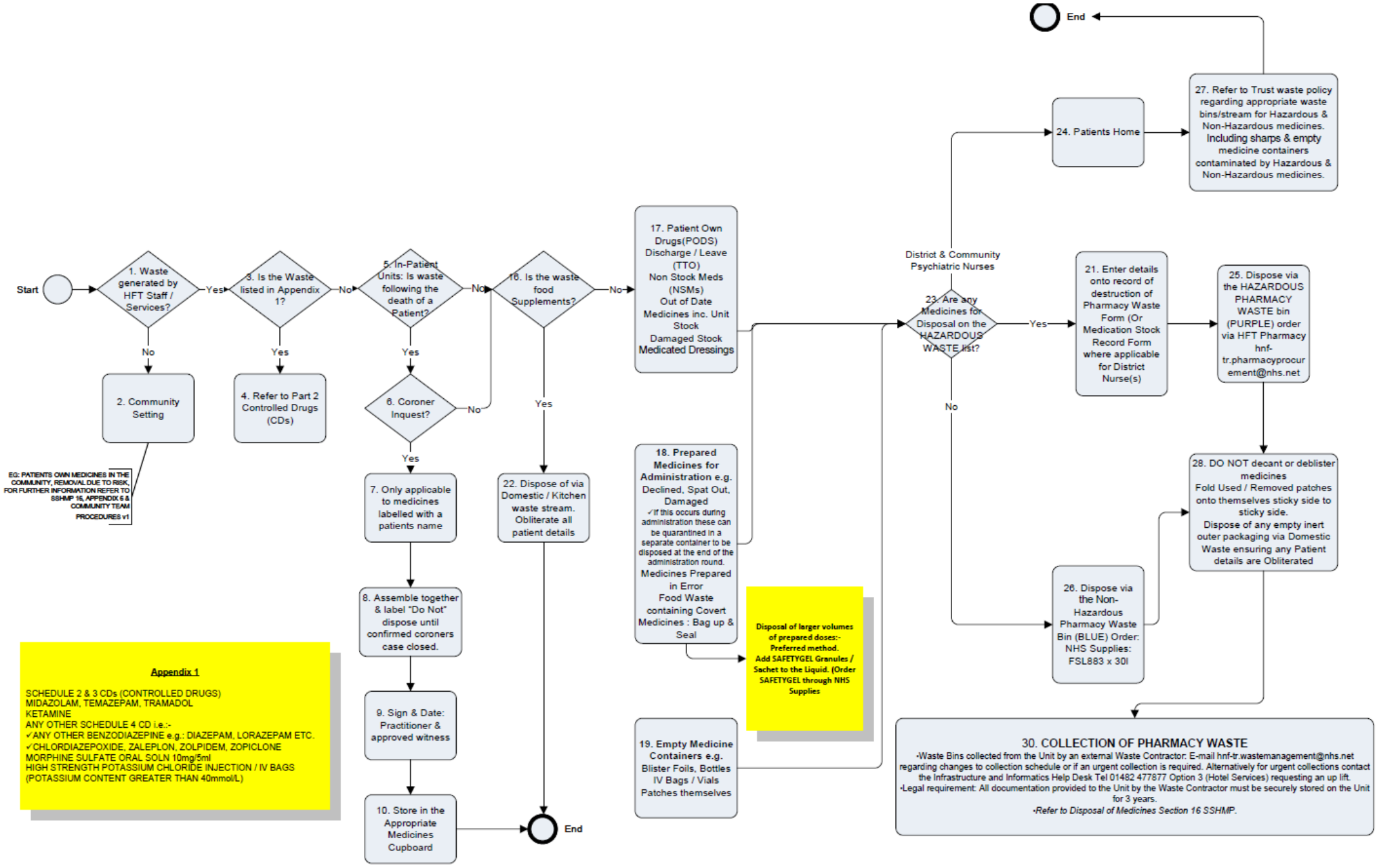
- The procedures stated in Flow Charts Waste Part 2 – Controlled Drugs must be adhered to (see Section 16.9.).
- Disposal of CDs within the Community setting (see Sections 16.6.2 and 16.6.3).
- The HTFT pharmacy must be contacted for an authorised member of the pharmacy team to be present for the process of the destruction of waste or out-of-date CDs on the Unit, according to relevant legislation, national and local guidelines.
- Waste or out of date controlled drugs must be destroyed in the presence of an authorised member of the pharmacy team and a person independent of the ward.
- Upon denaturing and destruction of the CDs, the Medicines Management Technician or an authorised pharmacist, together with the member of the Unit staff will sign the CDWRB, ensuring that the Stock Balance and all relevant documentation is correct.

16.7.1. Removing CDs from a patient's home

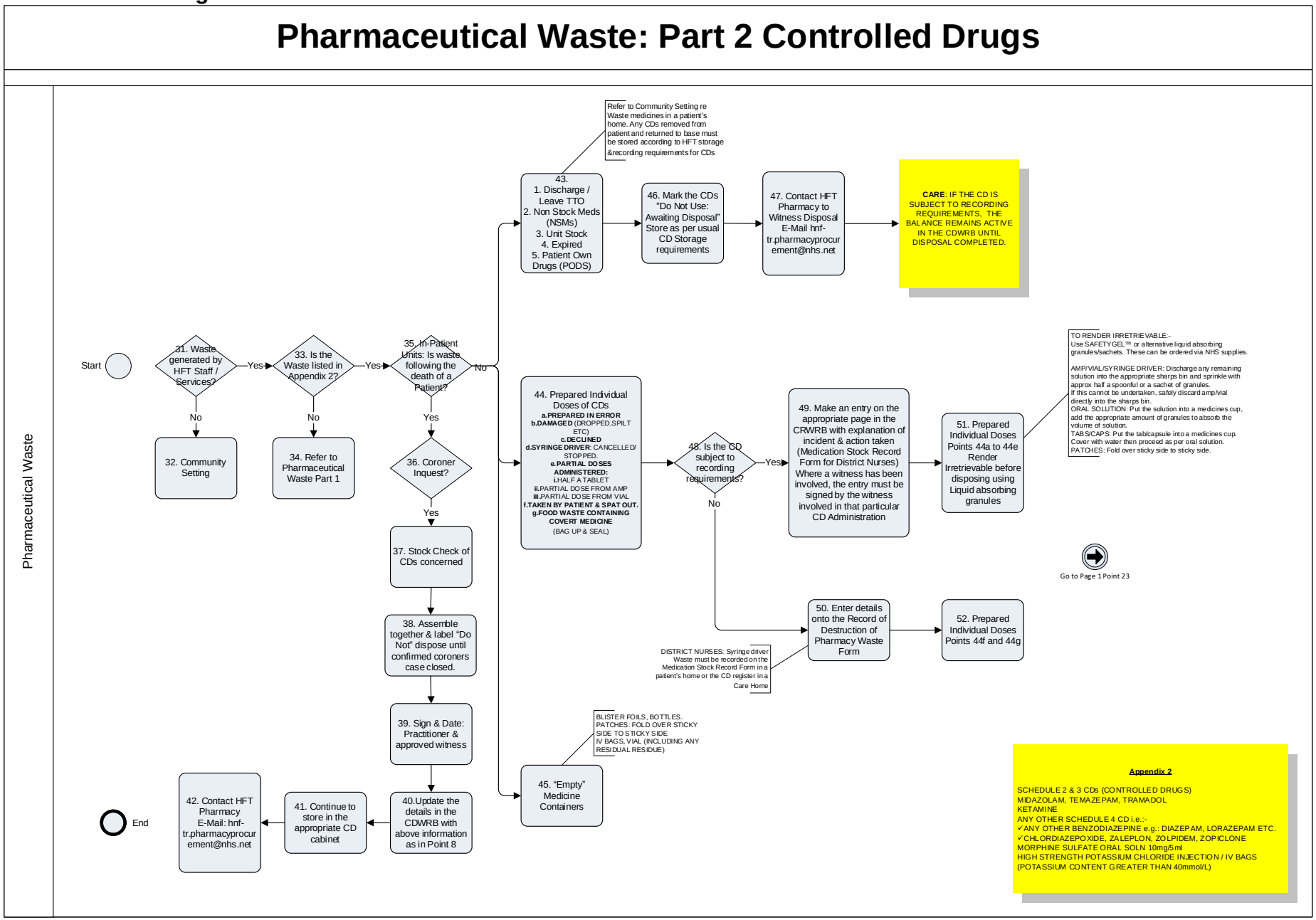
When a person has died in their home and controlled drugs need to be removed for destruction and disposal in primary care, consider:

- discussing the removal of controlled drugs with a family member or carer
- recording the action taken and details of the controlled drugs listed in the person's medical record or notes
- having a witness to the removal
- any requirements of the coroner to keep medicines in the person's home for a period of time
- taking the drugs to a health professional, such as a community pharmacist who is legally allowed to possess controlled drugs, for safe disposal at the earliest opportunity.
- If it is not possible to return the medicines to a community pharmacy, the medicines should be taken to a convenient in-patient unit/ward for disposal.
  Documentation of this should be added to the clinical notes.

16.8 General Waste Flowchart



16.9 Controlled Drug Waste Flowchart



17. SUSPECTED ILLICIT SUBSTANCES

- It is illegal for an individual to be in possession of a Controlled Drug unless it has been prescribed by a prescriber.
- Substances that cannot be identified should be treated as “illicit”.
- If a patient is admitted with a substance which is suspected or known to be illegal, it must be handed to the nurse in charge.
    - The individual should be asked to voluntarily give up the substance for the purpose of destruction.
    - It the patient refuses to hand over the suspected illicit substance for destruction the safety of the individual, other patients and members of staff must be considered. There may be no other alternative than to call the police. The incident should be discussed with the Consultant and the Matron responsible for the patients care.
- The nurse in charge must, in the presence of a Witness, store the substance immediately in a signed, dated and sealed container clearly marked ‘Unknown Substance’, and locked away in the CD Cupboard.
- A record must be made at the back of the Ward CD Record Book and in the patient’s clinical notes.
- Record the entry of an ‘unknown substance’ in the Ward CD Record Book as follows:
    - A separate page must be used for ‘unknown substance’. Several ‘unknown substances’ can be recorded on the same page.
    - Complete the page heading, as ‘unknown substances’.
    - Enter the date.
    - State ‘unknown substance removed from patient, (the patient’s identity should not be recorded).
    - Enter details of the unknown substance, description, quantity.
      Note: The substance should not be identified; a brief description should be entered.
    - Signature of receiving practitioner (sign in the ‘Given By’ column).
    - Signature of the Witness (sign in the ‘Witnessed By’ column).
    - The unknown substance should be placed in an envelope and sealed. The page number on which the substance is recorded along with the date and time of the record should be written on the envelope as a reference.
- Quantities that indicate personal use can be destroyed locally. The police will need to be notified of larger quantities, which are indicative of supply (not for personal use).
- At the earliest opportunity, the Medicine Optimisation Technician or an authorised pharmacist must be contacted to witness the denaturing and destruction of the unknown substance.(see Section 16).
- If an arrangement with the Police has been made to collect these substances, then a signed receipt should be obtained. An entry must be made in the Ward CD Record Book signed by a practitioner and nurse in charge.
- **Community staff** who are asked to dispose of illegal substances must never transport them. In such circumstances they should advise their client or their representative to hand the item in at a police station.

Drug Paraphernalia

- The nurse in charge must check with the patient what they would like them to do with any drug parahernalia brought on to the ward/unit.
  If the patient would like the drug paraphernalia stored until discharge it should be checked to ensure it does not contain any illicit substance (this should be destroyed as above), bagged, labelled and stored securly until discharge.
  If the patient agrees to the destruction of the drug parahernalia it should be checked to ensure it does not contain any illicit substance (this should be destroyed as above), and placed in the pharmaceutical waste bin.

18. PATIENT'S OWN DRUGS ("PODS") IN-PATIENTS

All patients admitted to an inpatient unit should be encouraged to bring their own medicines into hospital as the implementation of the use of PODs has been shown to be beneficial in a number of areas e.g.:

- ✓ Reduction of drug wastage.
- ✓ Avoids the duplication of discharge medication.
- ✓ Supports self-care and improves the patient's understanding of their medical condition
- ✓ Highlights problems with patients' compliance. These can be addressed to facilitate safe discharge and reduce unnecessary readmissions due to medicine related issues

PODs primarily refer to any medication that a patient brings into hospital (on admission and on return from Leave).
These may include items prescribed by the GP, secondary care specialist items, items purchased over the counter (OTC), vitamins or minerals, food supplements or herbal medicines.
PODs that have been brought into hospital must be assessed as suitable if they are to be used for administration.
'POD' will be annotated against a prescription item where appropriate.

18.1. General standards for the safe and effective use of PODs

PODs:

- × Must not be used for any patient other than for the named individual.
- × Must not be amalgamated into inpatient Unit stock.
- × Should not be used for administration or destroyed or otherwise disposed of without patient or their carer's consent. (Appendix 2 Patient Consent Form)

With consent, the PODs can:

- ✓ Continue to be used (following assessment for prescribing and suitability for use).
- ✓ Be appropriately stored for safe keeping (Section 15 SSHMP) on the unit until discharge.
- ✓ Be disposed of as per Disposal of Medicines.(Section 16 SSHMP)

If the patient does not consent to the medicines being destroyed the patient should be asked to arrange for the medication to be taken home advising return to community pharmacy for disposal. Where this is not immediately possible, the medications will require safe storage, preferably in the ward medicine cabinet specifically allocated for PODs. Any Controlled Drugs(CDs) will require handling in accordance with Safe and Secure Handling of Medicine Procedures (SSHMP).They should be segregated from items to be used and clearly labelled "unsuitable for administration/awaiting collection by family/carer". A record must be made in the patient notes.

However, if the prescriber does not consider it to be appropriate to prescribe, and if the PODs are considered to present a risk to the patient, e.g., overdose, risk of duplication of medicines at discharge, drug interaction, advice should be given to this effect and these medicines should not be returned to the patient.

PODs should only be used following Medicines Reconcilliation, the aim of which is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission.
Before use the PODs must be assessed by a practitioner as suitable for use, in accordance with 18.4 Criteria for Assessing PODs.

- ✓ All sections of the criteria in 18.4 must be satisfied.
- ✓ If suitable for use the appropriate POD documentation must be completed. If you are unsure as to what that is, please consult the Medicine Reconciliation Guidelines.
- ✓ Only PODs that have been assessed as suitable for use and have been prescribed can be used for administration or issued as supply against a Discharge/Leave Form.

PODs returned following Leave, must be reassessed to ensure they are suitable for use.
PODs that have been supplied by the Trust dispensing pharmacy whilst the patient is an inpatient do not require patient consent if they are not assessed as suitable for use and are to be disposed.

When treatment is changed or discontinued, no alterations to labels and directions should be made by unit staff or prescribers. A new supply of non-stock medication(NSM) should be ordered or supplies of unit stock used and the changed or discontinued POD destroyed.

Contact HTFT Pharmacy Team, or Intergrated Hospital (IHT) Pharmacist if the IHT Pharmacist has facilitated transfer, if the POD are identified as one of the following:

- ✓ **A clinical trial medication**
  - ⇒ Further supplies will have to be obtained via the clinical trial.
  - ⇒ Do not destroy clinical trial medication without appropriate authorisation.
  - ⇒ The patient and their GP will be able to provide information regarding specific ordering requirements and handling of waste clinical trial medication.
- ✓ **Red classified medication**.(Hull and East Riding Prescribing Committee Red Amber List)

Any queries that arise regarding the use of PODs should be directed to the HTFT Pharmacy Team or IHT Pharmacist if the IHT Pharmacist has facilitated transfer.

18.2. PODs – Discharge/Leave

PODs must never be returned to the patient on Discharge/Leave without an assessment by a practitioner. The assessment applies to appropriate NSMs (labelled with the patient's name and full instructions) which are to be issued for Discharge/Leave supply. This is to ensure that the PODs returned are correct according to the patient's MAR and Discharge/Leave Form.
The practitioner must check the PODs against the Discharge/Leave Form to ensure:

- ✓ The dosage on the label corresponds with the current Discharge/Leave Form. If it does not, a new supply for discharge/leave must be obtained.
- ✓ Sufficient quantities are supplied to cover the leave period.
- ✓ For Discharge, that sufficient quantities are supplied to cover the period before a new prescription can be obtained from their GP. The minimum quantities are as follows unless otherwise prescribed:-
  - ⇒ For Community inpatient units minimum of 14 days.
  - ⇒ For Mental Health inpatient units minimum of seven days.

The practitioner must annotate the Discharge/Leave Prescription Form with 'POD' next to the relevant prescription item to show that the patient's own drugs are being used for supply.
Where the discharge/leave can be completely supplied by PODs, the patient can be discharged or commence their Leave immediately.
The patient may be given a leaflet detailing where to obtain their next supply of medications (Appendix 2C).
Where a patient's medicines have been stored in their own allocated storage, a member of staff must check this storage is empty following discharge to ensure there is no risk of the next patient receiving incorrect medications.

18.3. PODs – CDs (any CD labelled with a patient's name).

The sutibility criteria in 18.4 also applies to Patient's Own CDs.
Patient's Own CDs must be stored in the inpatient Unit CD medicines cabinet.This will either be a specific CD medicines cabinet reserved for the storage of Patient's Own CDs; alternativeley a seperate shelf allocated for Patient's Own CDs within the CD medicines cabinet. Patient's Own CDs must be kept separated from Unit Stock CDs
The Unit may have a specific CDWRB for recording Patient Own CDs. Where use of CDs is a low activity, a single CDWRB may be in use.If so,the Unit must allocate a section of their CDWRB for recording Patient's Own CDs.The back of the CDWRB is usually recommended when this is the case.This helps to prevent any confusion with the documentation and balance of Stock CDS.
Patient's Own CDs must be entered in the Ward CD Record Book(CDWRB)on a new page specifically allocated for the patient's own medicine.
A separate page must be used for each patient. Different forms and strengths of medication for that patient must be recorded on separate pages.
Ensure the page heading has been completed, recording the 'Name, Form of Preparation and Strength' also adding the patient's name.
Record the receipt Patient's Own CDs as follows:

- In the 'Amount(s) Obtained' section under the relevant column headings, record:
  - ✓ Amount Obtained (i.e., received).
  - ✓ Date & Time received.
- Under 'Serial No of Requisition' enter PODs.

- In the ‘Amounts Administered’ section where one would normally record “Date, Time, Patient’s Name, Amount Given” record:
  - ✓ Where the supply has been obtained from, i.e., ‘brought in by patient’.
  - ✓ Signature of receiving practitioner (sign in the ‘Given By’ column).
  - ✓ Signature of the Witness (sign in the ‘Witnessed By’ column).
  - ✓ The stock balance following receipt of the Patient’s Own CD must be physically checked and recorded.

If the Patient’s Own CDs are to be used on the Unit whilst as an in-patient each administration must be recorded. (Section 7 SSHMP Administration of CDs).
If the Patient’s Own CDs are to be given out to the patient as Discharge/Leave, all details must be recorded.(Section 10 SSHMP. Discharge/Leave Medicines).
If the Patient Own CDs are stored in a compliance aid, e.g. Monitored Dose System (MDS), the compliance aid must be stored in the CD cupboard and all relevant CD recordings made.
If the Patient’s Own CDs are to be destroyed refer Section 16.SSHMP Disposal of Medicines.Controlled Drug Waste Flow Chart.

18.4. Criteria for Assessing Patients’ Own drugs (PODs)

These criteria are intended to guide staff through the assessment of PODs. For a POD to be suitable for use it must be acceptable in the criteria. If you are at all unsure about any of the PODs you are not under any obligation to sign that they are satisfactory, if you are unsure about any item obtain a new supply. There may be circumstances where a POD is used but does not completely meet the criteria below. This should be at the nurse’s discretion and in agreement with the patient and also recorded into the patient’s records.

Ensure patients are asked about the following:

- Have they brought all of their currently prescribed medication with them?
- Do they take the medication as prescribed? If not, do they take it? How do they take it? Why is it not taken as prescribed)
- Do they take any ‘prn’ when required medication?
- Other types of medication including:
  - Inhalers
  - Eye drops
  - Topical preparations
  - Once weekly medication, e.g., methotrexate
  - Injections such as depot antipsychotics or vitamins
  - Oral contraceptives
  - Hormone replacement therapy
  - Nebules
  - Home oxygen
  - Insulin
  - Over the counter medication
  - Herbal preparations
  - Other non-prescribed medication

PODs to be used on the ward **MUST** meet **ALL** the following criteria;

- Labelled with the correct patients name
- Labelled with instructions matching the HTFT inpatient MAR*
- Detail the correct drug name, form and strength
- Identifiable
- In good condition
- Within expiry date

See below for additional information and details on products with reduced expiry after opening or subject to special storage requirements.

Any POD approved by the IHT Pharmacist may be used unless the treatment has been changed and the instructions on the label no longer match the MAR.
No alterations to the instructions on PODs are allowed.

Tablets and capsules Loose tablets must have a tamper evident seal and be within printed expiry date/28 days of dispensing. Original packs must be within expiry date. Blister strips/packaging drug name, form and strength must match Pharmacy label.	**Special storage and reduced expiry items** If refrigerated item, conditions must have been adhered to e.g., insulin. If a shortened expiry date, conditions must have been adhered to e.g., eye/ear drops, GTN tablets, reconstituted antibiotic liquids. Further information on additional products with special storage or reduced expiry can be obtained from HTFT Pharmacy.
Liquids Must have an intact tamper evident seal and be within printed expiry date/28 days of dispensing.	**Eye and Ear drops** Must be unopened or opened less than 4weeks ago.
MDS Must be filled by Pharmacy within last 28 days and sealed with tamper evident seal unless approved by IHT Pharmacist. Contents must match items, doses and frequencies on dispensing sheet/label. Must only be used for a maximum of three working days.	**Other formulations** Must be within expiry date. Topical agents must be within 4 weeks of opening.

Controlled Drugs
Must meet criteria specified above.
Must be recorded in accordance with the Safe and Secure Handling of Medicines Procedure.

Checking the PODs against the MAR
Before the PODs are used, they must be checked against the MAR.

- Have each item present and check the drug name, form, strength and dose frequency against the MAR.
- If there are any discrepancies check with the prescriber and
- if necessary get a new supply of the medication(s).
- The prescriber producing the MAR should check that the medicines prescribed on admission correspond to those taken prior to admission.
- If there are any discrepancies check with the patient's discharging hospital or the patient's own GP.

*** OTC medications may not be labelled with instruction. These may be used if they fulfil all other POD criteria and are prescribed on the MAR**
*** Professional discretion can be used in the best interest of the patient, if you are unsure, consult with a Medicine Optimisation Technician or Pharmacist.**

19. MEDICINES INFORMATION FOR PATIENTS

Patients should be provided with impartial, up to date information about the risks and benefits of taking medication. The information should include alternatives treatments.

This should take place in discussion and be supported by written advice.

Where patients are not able to take part in informed discussions about the risks and benefits of treatment a carer (if available) should be involved in such discussions.

Patients who do not have a carer should have an advocate involved in such discussions.

Such discussions and the provision of written information should be recorded in the clincal notes.

Medicines Information resources can be accessed via the Humbernet:-

Humber Teaching NHS Foundation Trust Home (choiceandmedication.org)
Patient information: Symptom Checker, Health Information and Medicines Guide | Patient

Approved written leaflets from HTFT should be used.

20. MEDICATION ERRORS

A medication error is a preventable incident associated with the use of medicines which has or may put a patient at risk. Such incidents may happen at any steps of the medicine use process. This includes prescribing, dispensing and administration of the medicine and the transfer of information.

Incidents that have led to harm are referred to as “adverse incidents” while those that did not lead to harm but could have, are referred to as “near misses”.

Adverse incidents that have led to serious injury, major permanent harm or unexpected death (or the risk of death or injury) are further classed as “Serious Untoward Incidents”.
The patient’s well-being is of prime importance following a medication error and appropriate action must be taken to ensure patient safety and appropriate clinical care.

The Nurse-in-Charge/Team Leader must be informed of the medication error immediately. A prompt decision must be made by the nurse in charge to minimise harm, e.g., making arrangement for first aid, attendance at A&E etc.

The procedure stated in the Management of Medication Incidents must be followed. The objective of a reporting system is improvement in care and not the disciplining of staff.

A DATIX should be completed for all medication-related adverse incidents and near misses. The incident must also be recorded in the clinical notes.

21. REPORTING OF ADVERSE DRUG REACTIONS

Any medicines may produce unwanted or unexpected adverse reactions. Detection and recording of these is of vital importance.

Limited safety information is obtained from clinical trials on new medicines. Further understanding about the safety of medicines depends on the availability of information from routine clinical practice.

Reports can be made for suspected adverse drug reactions (ADRs) to **all medicines** including:

- ✓ blood factors and immunoglobulins
- ✓ herbal medicines

- ✓ homeopathic remedies
- ✓ over the counter medicines
- ✓ all medical devices available on the UK market
- ✓ defective medicines (those that are not of an acceptable quality)
- ✓ fake or counterfeit medicines or medical devices

Black triangle medicines (▼): Newly licensed medicines are monitored intensively by the Medicines and Healthcare products Regulatory (MHRA)/Commission on Human Medicines (CHM) and are identified by a black inverted triangle (▼) in the British National Formulary (BNF). All adverse reactions for black triangle medicines must be reported through the Yellow Card reporting scheme.

The reporting of all suspected adverse drug reactions in children is strongly encouraged for all medicines because experience in children may still be limited.

The procedure stated in the Risk Management Strategy including Adverse Incident Reporting must also be followed. A DATIX should be completed.

21.1. Yellow Card Reporting

The Yellow Card Scheme is the system for recording adverse incidents with medicines and medical devices in the UK.

- The Yellow Card scheme has expanded to include reporting from anyone concerned with side effects from medicines. This applies to healthcare professionals, patients and carers.
- Practitioners should make patient/carers aware of the Yellow Card system
- Reporting Forms, and Yellow Card Scheme – Information in other languages, can be downloaded from the following site: https://yellowcard.mhra.gov.uk/downloadable-information/.
- You can download the app from the iTunes App Store and Google Play for your IOS or Android device. Further information is available at https://www.gov.uk/government/news/digital-evolution-for-ground-breaking-yellow-card-scheme
- Reporting Forms are available from pharmacies or GP surgeries or by calling 0808 1003352
- Paper copies can be returned using the freepost address 'FREEPOST YELLOW CARD'

22. FITNESS TO DRIVE

Notification to DVLA - It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition, which may affect safe driving. On occasions however, there are circumstances in which the licence holder cannot, or will not do so.

The GMC has issued clear guidelines that should be applied where an individual cannot or will not notify the DVLA. The recommendation is that the medical practitioner should:

- Make sure that the patients understand that their condition may impair their ability to drive.
- Explain to patients that they have a legal duty to inform the DVLA about the condition.
- Inform the DVLA immediately if a patient is incapable of understanding this advice, for example because of dementia.
- Advise the patient to seek a second opinion and make arrangements for them to do so if the patient refuses to accept the diagnosis or the effect of the condition on their ability to drive.
- Advise patients not to drive until the second opinion has been obtained.
- Make every reasonable effort to persuade patients to stop, if they continue to drive when they are not fit to do so.This may include telling their next of kin, if they agree to this.
- Disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA if the patient cannot be persuaded to stop driving, or there is evidence that a patient is continuing to drive contrary to advice.

- Attempt to inform the patient of their decision to report to DVLA before they do so.
- Inform the patient in writing when a disclosure to the DVLA has been made.

The standards for fitness to drive are updated every six months and the latest advice can be found on the DVLA website: http://www.dft.gov.uk/dvla/medical/ataglance.aspx

Drugs and Driving Leaflets for patients

- It is very important to provide HTFT service users with accurate information about the law with regard to the use of certain prescription drugs while driving.
- Two leaflets produced by GovUK and DfT have been approved for use within HTFT, allowing teams to select the most appropriate leaflet for their patient group
  Drug Driving: Your eyes will give you away.
  Drug Driving Rules - Department for Transport

23. COMMUNITY TEAMS

'Community Teams' refers to all non-in-patient teams, for example Recovery and Support Teams, Recovery and Psychological Intervention Teams, Neighbourhood Care Teams, etc.

For each community team base where medicines are stored, a suitably qualified practitioner must be designated as the nurse in charge who is ultimately accountable for the stock of all medicines held. The nurse in charge should ensure that the safe and secure handling procedures are followed correctly and that the security of medicines is maintained. A deputy should be designated to cover absence and holiday.

All medicines carried by the Community Teams must be prescribed by an authorised prescriber or are to be administered/supplied using a PGD. Except for stock items held by the Community Team, the medicine must be clearly labelled with a specified dose for each individual named patient.

All medicines will be supplied by a community or hospital pharmacy and must be kept in a locked medicine cupboard to which only authorised community practitioners have access.

Each medicine carried must be recorded on a medicines administration record. The date, time and dosage administered must be recorded after each administration. Prescribed doses that are not given or refused must also be recorded.

The community practitioner must keep the medicine in a locked container when visiting a patient. This box must be kept out of sight within the locked boot of a car when travelling between visits.

Unused medicines should be returned to the medicine cupboard at the team base for overnight and weekend storage. Where this is not possible, specific guidelines should be developed between the team the Trust Pharmacy Department.

Where it is decided that a Stock Control Form is required, the form Appendix 7 is to be used.

Medicines no longer required by patients should be disposed of by returning them to a pharmacy. A record should be made and a signature should be obtained from the pharmacy to confirm disposal.

If CDs are to be stored on the Team base, the required storage, recording and handling requirements must be applied (refer to Section 8).

Shortage of medication.
If you are experiencing difficulties obtaining medication after trying alternative pharmacies consider the urgency of the administration. If it needs to be administered before it can be obtained from a community pharmacy, contact hnf-tr.pharmacyprocurement@nhs.net for advice.
If the administration of medication is going to be delayed, contact the prescriber.

23.1. Treatment Adherence with medicines for Mental Health conditions

Medicine adherence in patients with a mental health illness can pose significant challenges; particularly in patients with severe mental illness who may have little insight into their illness and as a consequence often do not believe themselves to be ill. Other reasons for poor adherence may include concurrent alcohol or drug abuse and/ or a poor relationship between the healthcare professional and the patients.

Clinicians should take any opportunity to engage with patients to establish any concerns they have that would impact on their adherence to prescribed medicines through all contacts.
Those working in the community should have discussions regularly with patients regarding their medication taking into consideration patients risk factors should prescribed medication not be taken. For this approach to have the maximum effect it is vital clinicians involve patients and where appropriate family/carer(s) in their care and develop supportive, trusting relations.

Any issues with treatment adherence, especially where adherence has been an issue previously the following steps should be taken to help the patients improve adherence and prevent relapse:

- Discuss the purpose and possible side effects of each medicine with the patients.
- Regularly remind patients of the importance and positive benefits of taking their medication using language appropriate for the individual. Say for example, "Your medicines help quiet the voices you hear," or "Your medicines help you study and keep your grades up." Link taking the medicines with things that the person enjoys.
- Emphasise the risks of stopping medications for mental health, in particular lithium and antipsychotics and outline how to access medication review if they want to reduce and/or stop taking their medication.
- Regularly ask how they are doing with their medication including physical checks such as tablets counts, GP issues etc. Frame questions appropriately for the patient in a way to maintain the therapeutic relationship.
- Ask patients if they are experiencing any side effects. Take any concerns about side effects seriously and offer a medication review.
- Ask patients if they are ok taking their tablets; if they are difficult to swallow, too big, remember to take them at the time prescribed.
- Where available, involve family/carers so they are aware of the importance of the medication, side effects and possible signs of relapse which may be due to not taking medication. Ensure they know who to contact if concerned.
- Plan for relapses with the patients and the family/carer as appropriate for example discuss how they may feel should they stop taking the medication
- Provide written information on medicines in a format suitable for the patient/carer and ensure that they understand the purpose of the manufacturers leaflets included in dispended items.
- Document the outcome of discussions about medication in the patients' electronic record.

24. REFERENCES

Documents listed in Section 3 and also

- Mental Health Act 1983 Code of Practice (Department of Health 2015)
  Mental Health Act 1983 Code of Practice
  Refer to:
  Chapter 24 & 25 Medical Treatment for Adults
  Chapter 19 Children
  - ePMA helpguides: Electronic Prescribing and Medication Administration (humber.nhs.uk)
  - Specialist Pharmacy Services: www.sps.nhs.uk (11.06.2020)

Intravenous and Subcutaneous Administration Policy

Management and Control of Prescription Forms: A Guide for Prescribers and Health Organisations

NHS fraud guidance | Preventing fraud within the NHS | NHS Counter Fraud Authority | NHSCFA

Aide Memoire for prescribers

NHS fraud guidance | Preventing fraud within the NHS | NHS Counter Fraud Authority | NHSCFA

Admin of Meds prof guidance.pdf (rpharms.com)

Ward Based Dispensing SOP

Ward Based Dispensing Procedure v 01.pdf (humber.nhs.uk)

Hazardous waste:

HTM 07-01 Final.pdf (england.nhs.uk)

Archiving and Filing (Section 5.9)

Health and Social Care Records Policy.pdf (humber.nhs.uk)
https://www.sps.nhs.uk/wp-content/uploads/2021/01/Recommendations-for-the-Retention-of-Pharmacy-Records-2020-21-Jan-2021-update-v.2.pdf

Room temperature guidance (Section 15.1)

Temperature and managing the risks to medicines – UAT - SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Section 5:

Management and control of prescription forms (cfa.nhs.uk)

Key issues in 2023 - Care Quality Commission

25. TRAINING

HTFT staff administering or handling medicines must ensure that they have evidence of medicine optimisation competency. This must be reviewed at least every 3 years.

Registered HTFT staff involved in processes with controlled drugs (CDs) should complete the CD e-learning. This is renewed every 3 years.
Unregistered HTFT staff witnessing controlled drugs procedures need to be competent and understand the process. The process for ensuring competency is the completion of the CD e-learning and CD witness training.

25.1. Medicine Optimisation Educational Pathway for Practitioners:

New clinical staff to Humber Teaching NHS Foundation Trust who will administer medicines – to complete before administering medicine unsupervised	
Element	Method / frequency
Proven successful completion of the e-learning module Medication Optimisation.	E-learning module, accessed via ESR.
Proven successful completion of the Medication Optimisation training.	Face to face training facilitated by Medicine Optimisation Nurse, bookable via ESR following completion of the above e-learning module.
Proven competence with the Trust's annual medicine administration core competencies.	Complete Trust's Annual Medicine Administration competencies. Clinical Competency - Annual Medicine Administration (humber.nhs.uk) Competency booklet should be signed off by a suitably experienced Registered Professional (excluding Nurse Associates) who are up to date with their own competencies.
Clinical staff who administer medicines	
Element	Method / frequency
Proven successful completion of the Trust's Medicine Optimisation Programme when commencing employment.	Evidence gained from ESR that all elements of the above medicine optimisation programme have been successfully completed previously.
Proven competence with the Trust's annual medicine administration core competencies.	As per role requirement, each year complete Trust's Annual Medicine Administration competencies. Clinical Competency - Annual Medicine Administration (humber.nhs.uk) Competency booklet should be signed off by a suitably experienced Registered Professional (excluding Nurse Associates) who are up to date with their own competencies.

APPENDIX 1 – RECEIPT OF MEDICINE STORAGE KEYS

Improving Health and Wellbeing

NHS Humber Teaching NHS Foundation Trust

Receipt of Medicine Storage Keys

Unit/Team Issued to:	
Key Number/Identification:	
Medicine Storage: (Make/Model)	

Issued by: Name (Print)	Designation	Signature	Date
Accepted for delivery by: Name (Print)	Designation	Signature	Date
Received by: Name (Print)	Designation	Signature	Date

Confirm key(s) issued operate the medicine storage equipment as specified above:

Confirmed by: Name (Print)	Designation	Signature	Date

Additional Information:

C:\Users\Leanne.Bloor\Documents\Receipt Of Medicine Storage Keys Form V1.1 Draft.Docx

APPENDIX 2 – PATIENT CONSENT FORM

Patient Label
Name:
NHS No:
Date of Birth:

Patient Consent Form

Dear Patient,

Within Humber Teaching NHS Foundation Trust Community Hospitals we operate procedures for using your own medicines. This allows you to continue with familiar tablets and other treatments and helps to avoid waste.

We will obtain supplies of any new medications you require from a pharmacy and when you go home we will ensure you receive a supply of all your current medications.

Your medicines may be changed while you are here and therefore we may need to dispose of your old ones.

If you are happy for us to use your medicines (for your treatment only), obtain supplies, and destroy any medication not suitable, please sign below.

SIGNED…….. DATE ……

I confirm that I have explained the use and destruction of patient's own drugs to this patient.

Print Name ……Signature ……..

Designation ……..…… Band …….

Date ……..… Time ……..

APPENDIX 3 – PATIENT DISCHARGE LEAFLET

Humber NHS
NHS Foundation Trust

……. Ward gave you at least ……days' supply of your current medications. Further supplies need to be ordered from your own doctor.

The hospital will send your doctor a list of your current medicines.

Any unwanted medications should be returned to your community pharmacist for safe disposal.

If you have any questions about your medications ask your doctor or pharmacist.

Patient Name ……

Date ……..

Doctor/Surgery ……

Ward Contact Tel: .....

APPENDIX 4 – SECURE STATIONERY DESTRUCTION FORM

NHS
Humber Teaching
NHS Foundation Trust

Pharmacy Department
Mary Seacole Building
Willerby Hill Business Park
Willerby
HU10 6ED

Prescription Pads for Destruction

Pad type (FP10 etc) ……

No……to……..

No……to……..

No……to……..

Date Destroyed …… Destroyed by (Print name):……

(Signature):……..

.

Witnessed by (Print name):……

(Signature):……..

02 August 2018
V:\Corporate\Pharmacy\FP10 Admin\Private\FP10 Admin Folder

APPENDIX 5 – ADMINISTRATION OF DEPOTS TO CLIENTS ATTENDING EARLY OR LATE

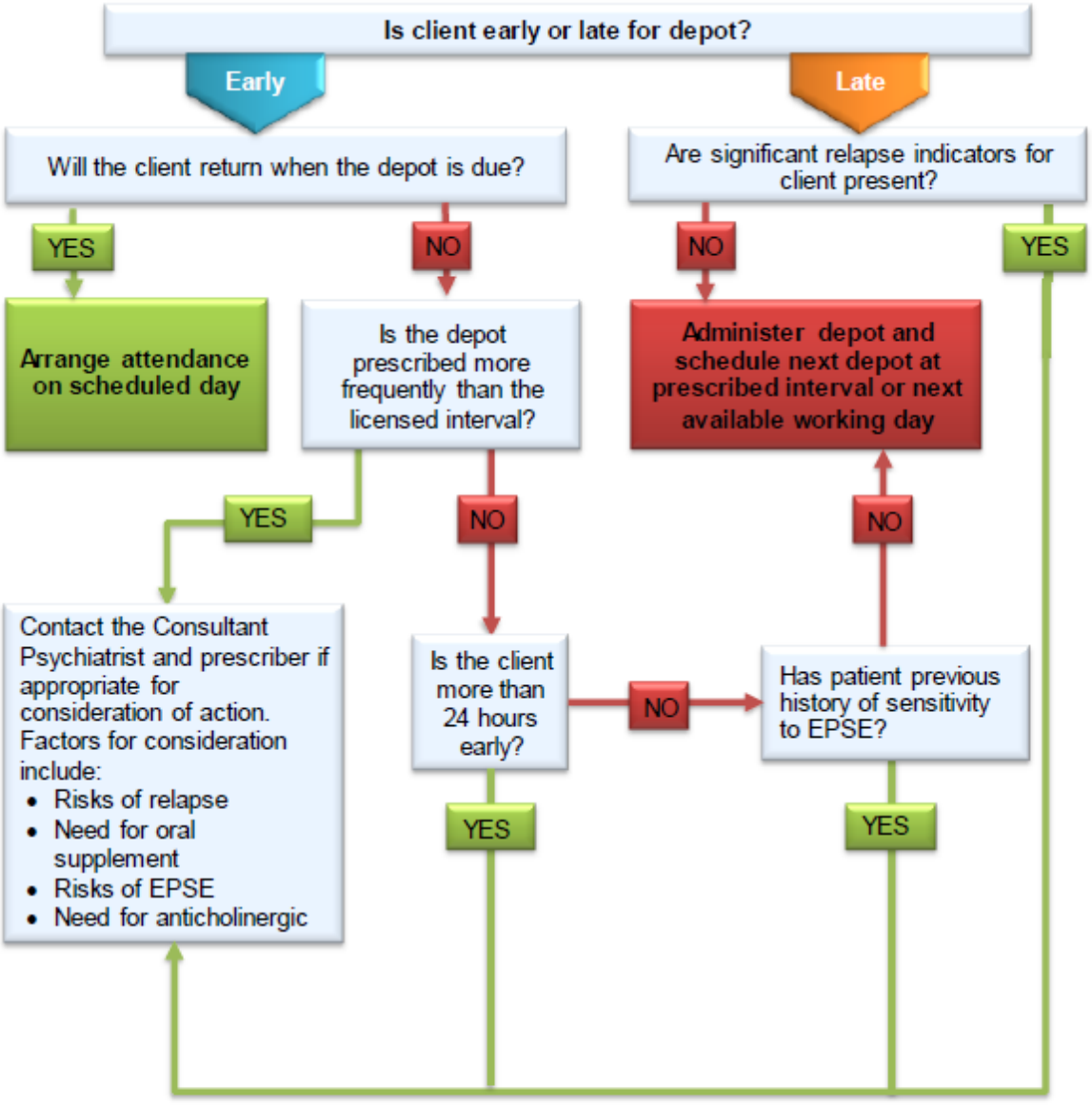
Extract from Guidelines For The Prescribing & Administration Of Depot Antipsychotic Medication
[Administration of Depot Medication (humber.nhs.uk)]

Improving Health and Wellbeing

Humber NHS Foundation Trust

Appendix 1

FLOW CHART FOR THE ADMINISTRATION OF DEPOTS TO CLIENTS ATTENDING EARLY OR LATE



APPENDIX 6 – TEMPERATURE MONITORING FORM

TEMPERATURE MONITORING FORM – FOR MEDICINE STORAGE

NHS Humber Teaching NHS Foundation Trust

Unit/Team Name:	Fridge No': (If more than one medicine fridge)	Room:	Month:	Year:

	Room (15°C-25°C)		Fridge (2°C-8°C)				Checked and Actioned by			Room (15°C-25°C)		Fridge (2°C-8°C)				Checked and Actioned by	
Date	Min	Max	Min	Max	Data logger downloaded	Temp Within Range	Sign	Print	Date	Min	Max	Min	Max	Data logger downloaded	Temp Within Range	Sign	Print
eg:	18	22	3	6	Y / N	Y / N	HC Assistant	HC Assistant	16					Y / N	Y / N		
1					Y / N	Y / N			17					Y / N	Y / N		
2					Y / N	Y / N			18					Y / N	Y / N		
3					Y / N	Y / N			19					Y / N	Y / N		
4					Y / N	Y / N			20					Y / N	Y / N		
5					Y / N	Y / N			21					Y / N	Y / N		
6					Y / N	Y / N			22					Y / N	Y / N		
7					Y / N	Y / N			23					Y / N	Y / N		
8					Y / N	Y / N			24					Y / N	Y / N		
9					Y / N	Y / N			25					Y / N	Y / N		
10					Y / N	Y / N			26					Y / N	Y / N		
11					Y / N	Y / N			27					Y / N	Y / N		
12					Y / N	Y / N			28					Y / N	Y / N		
13					Y / N	Y / N			29					Y / N	Y / N		
14					Y / N	Y / N			30					Y / N	Y / N		
15					Y / N	Y / N			31					Y / N	Y / N		

Note:

1. ALL devices for fridge and room temperature monitoring MUST be approved by HFT Pharmacy.
2. Temperature MUST be monitored daily according to the working hours of the service, e.g. In-Patient = every day.
3. Where a Data Logger/SD Card is in use, readings MUST be downloaded, reviewed and stored in the Unit's allocated folder on the V: Drive, in accordance with the appropriate user guide/instructions.
4. ALL devices MUST be reset/re-started after each temperature recording. User guide/instructions must be followed for reset/re-start.
5. Further copies of this form can be downloaded via HumberNet.
6. **Action MUST be taken if the fridge temperature falls outside the accepted range. Inform immediately the Unit/Team manager and HFT Pharmacy (Tel: 01482 301724 or e-mail hnf-tr.medicinessafety@nhs.net).**
7. Completed forms must be kept for 2 years. These are to be scanned and saved into the appropriate folder V:\Corporate\Pharmacy\Pharmacy Team\Public\Pharmacy Fridge Log\Temperature Monitoring Forms

PTM4

APPENDIX 7 – STOCK CONTROL FORM

Medication name, strength, form:	

Date	Time	Quantity Received	Quantity Administered	Staff Name	Staff signature	Stock Balance

Stock control form v1: V:\Corporate\Pharmacy\Pharmacy Team\Shared\Policy Procedure Protocol & Guideline\Procedures\SSHMP

APPENDIX 8A – FP10SS DISTRIBUTION RECORD

NHS
Humber Teaching
NHS Foundation Trust

FP10 Distribution Record

Serial Number		Date Collected	Prescriber's Name	Job Title	Signature	Collected? (please tick)	Returned? (please tick)
From	To						

Please Note:
This is your record of distributing FP10 prescription form(s) to other prescribers working in the same team following your collection from Pharmacy at Trust Headquarters.
You must retain this form for two years after the last entry.

FP10 Distribution record v1 - V:\Corporate\Pharmacy\FP10 Admin\Private\FP10 Admin Folder

APPENDIX 8B - SPOILED FP10 DESTRUCTION LOG

NHS
Humber Teaching
NHS Foundation Trust

Spoiled FP10 Destruction Log
Location:

Date	Serial number	Destroyed by	Witnessed by

V:\Corporate\Pharmacy\FP10 Admin\Private\FP10 Admin Folder

APPENDIX 9 – HAZARDOUS WASTE

The list below is taken from the Department of Health, Health Technical Memorandum 07-01: Safe management of healthcare waste. HTM_07-01_Final.pdf (england.nhs.uk) last updated August 2021.

The following list is not exhaustive.

Product approved name (Non Chemotherapy drugs)
Anastrozole
Azathioprine
Bicalutamide
Chloramphenicol – classified as a category 2A carcinogen and as such will include eye drops with a concentration of 0.1% (the legal threshold in waste legislation)
Ciclosporin
Cidofovir
Coal tar containing products
Colchicine
Danazol
Diethylstilbestrol
Dinoprostone
Dithranol containing products
Dutasteride
Estradiol
Exemestane
Finasteride
Flutamide
Ganciclovir
Gonadotrophin, chorionic
Goserelin
Interferon containing products (including peginterferon)
Leflunomide
Letrozole
Leuprorelin acetate
Medroxyprogesterone
Megestrol
Menotropins
Mifepristone
Mycophenolate mofetil
Nafarelin
Oestrogen containing products
Oxytocin (including syntocinon and syntometrine)
Podophyllyn
Progesterone containing products
Raloxifene
Ribavarin
Sirolimus
Streptozocin
Tacrolimus
Tamoxifen
Testosterone
Thalidomide
Toremifene
Trifluridine
Triptorelin
Valganciclovir
Zidovudine

Product approved name (Chemotherapy drugs)	
Aldesleukin	Gemcitabine
Alemtuzumab	Gemtuzumab
Amsacrine	Hydroxycarbamide
Arsenic trioxide	Idarubicin
Asparaginase	Ifosfamide
Bleomycin	Imatinib mesylate
Bortezomib	Irinotecan
Busulphan	Lomustine
Capecitabine	Melphalan
Carboplatin	Mercaptopurine
Carmustine	Methotrexate
Cetuximab	Mitomycin
Chlorambucil	Mitotane
Cisplatin	Mitoxantrone
Cladribine	Oxaliplatin
Cyclophosphamide	Paclitaxel
Cytarabine	Pentamidine
Dacarbazine	Pentostatin
Dactinomycin	Procarbazine
Daunorubicin	Raltitrexed
Dasatinib	Rituximab
Docetaxel	Temozolomide
Doxorubicin	Thiotepa
Epirubicin	Topotecan
Estramustine	Trastuzumab
Etoposide	Vidaradine
Fludarabine	Vinblastine
Fluorouracil	Vincristine

APPENDIX 10 – RECORD FOR DESTRUCTION OF PHARMACY WASTE

RECORD FOR DESTRUCTION OF PHARMACY WASTE

(Retain completed sheet for 2 years from date of last entry)

Refer to Disposal of Medicines Section 16, Safe and Secure Handling of Medicine Procedures (SSHMP)

NHS Humber Teaching NHS Foundation Trust

UNIT / TEAM NAME:.....

DATE	PATIENT ID OR STOCK (S)	**DRUG, FORM, AND STRENGTH:** refer to SSHMP 16.10 for disposal of CDs i.e.: - • Schedule 2&3, Gabapentin, Pregabalin, Midazolam, Temazepam, Tramadol • Medicines handled as Schedule 2&3 :- ○ Potassium chloride concentrate solutions (potassium chloride content equal to or greater than 10%, i.e. 1g in 10ml, in ampoules/vials or greater than 40mmol/L in IV bags) ○ Solutions of potassium hydrogen phosphate and potassium dihydrogen phosphate in ampoules and vials • Schedule 4 part 1: all other benzodiazepines (e.g. Diazepam, Lorazepam etc.), Chlordiazepoxide, Zaleplon, Zolpidem , Zopiclone.	Quantity	Hazardous Waste (Y / N)	Denatured (Y / N)	REASON (See Codes)	SIGNATURES (2 x SIGNATURES REQUIRED)	
							Destroyed by	Witnessed by

CODES:

A= PATIENT'S OWN DRUGS (Brought into Unit)	**G**=	SPECIFY MEANING	
B= WARD STOCK – EXPIRED	**H**=		
C= NON-STOCK MEDS (NSM) / SELF ADMINISTRATION MEDS (SAM) – EXPIRED	**I**=		
D= NSM/SAM – NOT REQUIRED	**J**=		
E= NSM/SAM – NOT TRANSFERRED WITH PATIENT	**K**=		
F= DISCHARGE / LEAVE (TTOs)	**L**=		

RecordPharmacyWasteForm PWR10
V:\Corporate\Pharmacy\Pharmacy Team\Shared\Technical\Waste\Record of Pharmacy Waste Form

APPENDIX 11 – EXPECTED STOCK LEVELS OF MEDICAL GASES

Location	101-CD	101-HX	101-F
136 Suite	2		
Avondale Unit - Miranda House	2		
Bartholomew House	1		
Becca House	1		
Coltman Street Clinic	1		
ECT Unit - Miranda House	1	8	
Estates/facilities - Mary Seacole Building		1	
Granville Court	3	3	
Hallgate Surgery	5		
Hawthorne Court	1		
Humber Centre	6	1	1
Inspire Walker Street	3	1	
Learning Centre	3	1	
Lilac Ward - Townend Court	3		
Maister Court	1		
Maister Lodge	1	2	
Humber Primary Care - Providence Place	3		
Humber Primary Care – Station Avenue	4		
Market Weighton Group Practice	2	1	
Mill view Court	1		
Mill View Lodge	1	1	
Newbridges Acute Unit	5		
Occupational Health - Victoria House	1		
PICU - Miranda House	4		
Pine View	1		
Pocklington Health Centre	1		
STaRS - Townend Court	1		
Substance Misuse - 7 Baker Street	1		
Westlands Acute Unit	2		
Whitby Community Ward	1	1	
Whitby UTC	1		2
Willow Ward - Townend Court	2		

APPENDIX 12 – STORAGE AND HANDLING OF OXYGEN CYLINDERS

Top tips on care and handling of oxygen cylinders and their regulators

MHRA
Regulating Medicines and Medical Devices

- Staff should be fully trained in the use of oxygen cylinders, the attachment of regulators if required, and aware of all the related risks such as fire and manual handling.
- Carry out full checks on oxygen cylinders and their regulators prior to each use and ensure that they contain enough oxygen for the required therapy. In patient transfers ensure there is sufficient oxygen for the whole journey, allowing for changes in oxygen requirements and delays such as faulty lifts or heavy traffic.
- Check the cylinder labels to make sure the oxygen is within its use-by date and any regulators attached are suitable for the cylinder pressure and have been serviced regularly.
- Ensure hands are clean before handling oxygen cylinders due to the risk of combustion from oils and grease. In particular, make sure that hands are adequately dried after the use of alcohol gels.
- Make sure that the oxygen cylinder outlet and oxygen regulator inlet are clean before attaching a regulator. Always open the cylinder slowly and check for leaks. Close cylinder valves when not in use and before returning the cylinder to the supplier.
- Handle oxygen cylinders with care. If the cylinder is dropped or knocked in use it must be checked before further use; cylinders with integral valves should be returned to the supplier; separate regulators should be sent to the service department for inspection.
- Have spare cylinders available, ensure they are full and have an opening key if required.
- Ensure oxygen cylinders are securely attached to beds, trolleys or walls when in use. Modern light-weight oxygen cylinders can be damaged by sharp objects such as securing screws.
- Store oxygen cylinders in a secure area that is well ventilated, clean and dry. This area must be free from any sources of ignition such as patients/staff smoking or machinery.
- If using a bull-nose regulator, double-check you are attaching it to an oxygen cylinder as they can be mistakenly fitted onto cylinders of medical air and other gases.
- Carry out magnetic testing of all oxygen cylinders, and their attachments, before taking them into an MRI environment.
- Report defective oxygen cylinders to the Defective Medicines Reporting Centre (DMRC) and defective detachable regulators to the Adverse Incident Centre (AIC), both at the MHRA (www.mhra.gov.uk).

APPENDIX 13 – RECORD OF ISSUE OF CDWRB/CDWORB

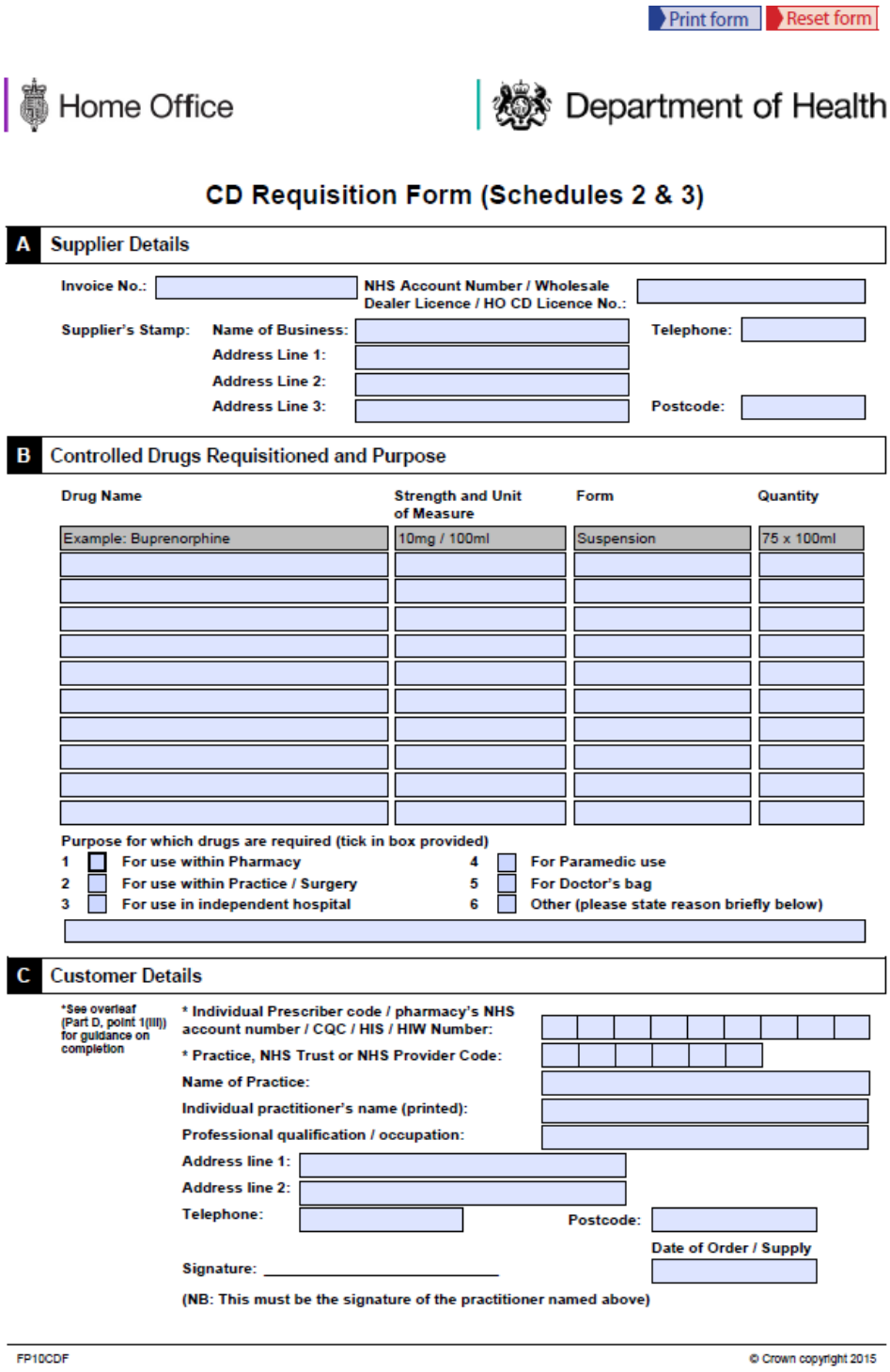
Humber Teaching NHS Foundation Trust

HFT Pharmacy Department Record of Issue of CDWRB/CDWORB

DATE	Unit/Team	Stationary issued/ordered	Ordered By: Name & Designation	Issued By: Sign & Designation	Collected/Received by: Sign, Print & designation
		CDWORB/CDWRB			
		CDWORB/CDWRB			

APPENDIX 14 – COMPLETING FP10CDF

Sections A, B and C should be completed as follows:



Print form Reset form

Home Office | Department of Health

CD Requisition Form (Schedules 2 & 3)

A Supplier Details

Invoice No.: | NHS Account Number / Wholesale Dealer Licence / HO CD Licence No.:

Supplier's Stamp: | Name of Business: | Telephone:

Address Line 1:

Address Line 2:

Address Line 3: | Postcode:

B Controlled Drugs Requisitioned and Purpose

Drug Name	Strength and Unit of Measure	Form	Quantity
Example: Buprenorphine	10mg / 100ml	Suspension	75 x 100ml

Purpose for which drugs are required (tick in box provided)

1 ☐ For use within Pharmacy
2 ☐ For use within Practice / Surgery
3 ☐ For use in independent hospital
4 ☐ For Paramedic use
5 ☐ For Doctor's bag
6 ☐ Other (please state reason briefly below)

C Customer Details

*See overleaf (Part D, point 1(iii)) for guidance on completion

* Individual Prescriber code / pharmacy's NHS account number / CQC / HIS / HIW Number:

* Practice, NHS Trust or NHS Provider Code:

Name of Practice:

Individual practitioner's name (printed):

Professional qualification / occupation:

Address line 1:

Address line 2:

Telephone: | Postcode:

Date of Order / Supply

Signature: _____

(NB: This must be the signature of the practitioner named above)

FP10CDF © Crown copyright 2015

Section B:
Full description of the product required should be entered

Purpose is option 6; For use on/in Humber Teaching NHS Foundation Trust in-patient units/GP practices

Section C:
This section should be completed in full excluding the NHS provider code. This code is not required.

The Name of practice and address is referring to the unit/GP name and address.

APPENDIX 15 – WHO CAN ADMINISTER MEDICINES.

1. Introduction

Guidance suggests that "organisational policies should define who can administer medicines, or when appropriate delegate the administration of medicines, within a particular setting. Those administering medicines are appropriately trained, assessed as competent and meet relevant professional and regulatory standards and guidance" (Professional Guidance on the Administration of Medicines in Healthcare Settings RPS/RCN2019 Admin of Meds prof guidance.pdf (rpharms.com)

2. Trust Approach

Professionals who can administer medication independently in the trust and delegate to unregistered staff:

All registered health care workers who have evidence of medication competency who in addition can evidence they have annual updates and maintain their medication administration competency, including specific competency required regarding the patient's condition, route or type of medication (e.g. a controlled drug, medication to be administered to a palliative care patient, medication of be administered via a syringe driver).

Only registered staff will administer medication on wards due to the complexity of the patients' conditions, a patient's condition may change and the possible need to change treatment regimens such as medications

3. Delegation

The Trust does not support the use of 'runners' for medication administration.
The staff member signing for the administration of medication should be the same registered member who has carried out the identification checks of the patient.

Unregistered staff will only administer medication under delegation. The registrant delegating the task must be assured of the competency of the unregistered staff member and retain ultimate accountability for the task in line with professional responsibility for delegation such as:

Unregistered staff will only administer medication under delegation when there is a specific clinical need for the patient. Only registered staff will administer medication on wards due to the complexity of the patient's conditions and acuity.

Delegation in settings other than wards may be appropriate providing the following principles are followed.

- This has been risk assessed and has been approved by the division and the Drugs and Therapeutic Group
- Delegation must always be in the best interest of the patient.
- The registrant will retain ultimate accountability for delegating any part of medication administration in line with their professional code of conduct.
- The registrant delegating the task must be assured of the competency of the unregistered staff member.
- The unregistered staff member must have been suitably trained to perform the intervention.
- Full records of training given, including dates, must be kept.
- Evidence of competence assessment must be recorded.
- There should be clear guidelines and protocols in place so that the unregistered staff member is not required to make a 'stand-alone' clinical judgement in relation to the administration of medication.
- The role should be within the unregistered staff member's job description.
- The activity has been delegated should also be documented in patient notes.

- The person who delegates the activity must ensure that an appropriate level of supervision is available and that the unregistered staff member has the opportunity for mentorship. The level of supervision and feedback provided must be appropriate to the activity being delegated.
- Ongoing development to ensure that competency is maintained annually is essential.
- The whole process must be assessed for the degree of risk prior to being undertaken.
- Following the administration of the medication, the unregistered staff member will ensure this is documented in the clinical record and immediately escalate any concerns to the registrant.

Below is who will administer medication in the trust and who can administer medication under delegation

Profession	Service area	Training/Competency	Working Under Delegation and or Supervision
Medical staff	All clinical areas	Specific competency for specialist administration	
Nurses	All clinical areas	Medicine optimisation competency programme with 3-yearly review Specific competency for specialist administration	
Nursing associates	All clinical areas	Medicine optimisation competency programme with 3-yearly review. On registration the nursing associate should be competent to administer medication via oral, topical, injections using subcutaneous and intramuscular routes, enteral, enemas and suppositories, Inhalation routes. Specific competency would have to be identified and completed for specialist administration	Refer to Scope of Practice for Registered Nurse Associates SOP23-036
Physiotherapists	GP practice	Trigger point injection competency	
Pharmacy Technician	All clinical areas	Medicine optimisation competency programme with 3-yearly review. Specific competency for specialist administration	
Pharmacist	All clinical areas	Specific competency for specialist administration	
Paramedics	All clinical areas	Medicine optimisation competency programme with 3-yearly review. Specific competency for specialist administration	

Staff only to administer under delegation	**Service area**	**Training/Competency**	**Working Under Delegation and or Supervision**
Health Care Assistant	Community Pocklington/Malton/ Scarborough/Whitby	E-Learning available on ESR 'Delegated Administration of Insulin'. Insulin Administration for Unregistered Practitioners: Role Specific Competency available on the competency intranet page Record of practical assessment. Diabetes and VTE competency training. Wound care and emollient application Bladder and Bowel Training	Community - Delegation of Care to Non-Registrants SOP21-027.pdf (humber.nhs.uk) Delegation of Insulin Administration SOP21-031.pdf (humber.nhs.uk) Community - Safe Admin of Dalteparin-Fragmin Tinzaparin Enoxaparin by Unregistered Staff SOP19-050.pdf (humber.nhs.uk) The RN assesses and reviews the wound care and prescribes, delegates care but regularly reviews. Unregistered staff would follow this care plan. The RN assesses and reviews the wound care and prescribes, delegates care but regularly reviews. Micralax Enema has been assessed as required.
Health Care Assistant	Granville Court	Medicine optimisation competency programme with 3-yearly review. PEG training.	The RN checks the prescription, prepares the medication, and takes this to the patient to ensure identity. If there is a clinical need e.g., covert medication, PEG, the HCA can continue the administration process to ensure the medication is taken/given.
Health Care Assistant	Learning Disability Complex Care in the community	Medicine optimisation competency programme with 3-yearly review. PEG feeding training	Each HCA works with a specific patient in their own home. They have a RN supervisor and an SOP in place which they must adhere to. Delegation of Administration of Medicine via an Enteral Tube to a HCA SOP22-038
Health Care Assistant	GP practices	Immunisation foundation course (same as RN) Competencies assessed in practice	Maintenance Vit B12/flu/ Pneumovax and Shingles. Nurse or Dr are on site at all times
Health Care Assistant	Wards	Controlled Drug e-learning training on ESR.	Controlled Drug administration witness

		Controlled Drug training from pharmacy technician including practical element.	in the absence of 2 registrants. Witnessing the process of checking the Controlled Drug process including taking medication to the patient **with the registrant** and observes it has been taken, then both signing the CD book and MAR chart.
Occupational Therapist, Occupational Therapist Assistant and Health Care Assistant	wards	Instruction how and when to administer and how to record following the Trust protocol.	Sun cream

APPENDIX 16 – GRANVILLE COURT

Introduction
Granville Court, Hornsea is a Humber Teaching NHS Foundation Trust (HTFT) Care Home with Nursing and Residential Care.

Granville Court has three bungalows:

Bungalow Name	Type of Service	Service delivered by	Number of Beds	Number Respite Beds
Carlyle	Nursing	HTFT Nurses	6	1
Ambassador	Nursing	HTFT Nurses	5	1
Millside	Residential	HTFT Nurses & Carers	5	0

People who reside at Granville Court are referred to as 'residents' as opposed to 'patients' as Granville Court is their long-term home.

Granville Court cares for residents, who are over 18 years of age with learning disabilities and complex needs which may include

- Dementia
- Physical Disabilities
- Sensory Disabilities

The scope of this appendix applies to all registered nurses, student nurses, carers, bank and agency staff, and anyone who deals with medicines within Granville Court.

The full *Procedures for Safe and Secure Handling of Medicines* will apply with the following exceptions:

Section 6.2 Prescription Forms

6.2.1. Prescriptions should be requested by the nurse in charge three weeks before the next medication cycle is due to start. The nurse in charge will inform the supplying pharmacy of the start date of each medication cycle for the date to be printed on the MAR Charts

6.2.2. Within Granville Court, the four-weekly Medicines Administration Record Charts (MAR Charts) are provided by the supplying pharmacies and should be used instead of HTFT MAR Charts.

6.2.3. When there are problems or issues regarding prescriptions, it is the nurse in charge's responsibility to liaise with the relevant GP to ensure the prescription is correct.

6.2.4. The nurse in charge must ensure that all records including the care plan, prescription and medication record are updated immediately when there are changes to medication (e.g., medication, quantity, directions or discontinuation of medication). Prescription changes must be communicated in writing to the supplying Pharmacy immediately to enable the maintenance of an accurate record.

Section 6.4 Prescription Writing

6.4.1 The resident's GP is responsible for writing the prescription. The prescription will be collected and checked for accuracy by a competent designated member of staff from Granville Court. If there are any errors these must be raised and rectified by the prescriber.

6.4.2 The supplying pharmacy will enter the following details on the MAR Chart:

- General Practitioner's Name
- Resident's Name
- Resident's Address
- Resident's NHS Number and/or Patient Number
- Name and Address of the Supplying Pharmacy
- Date of Birth or Age

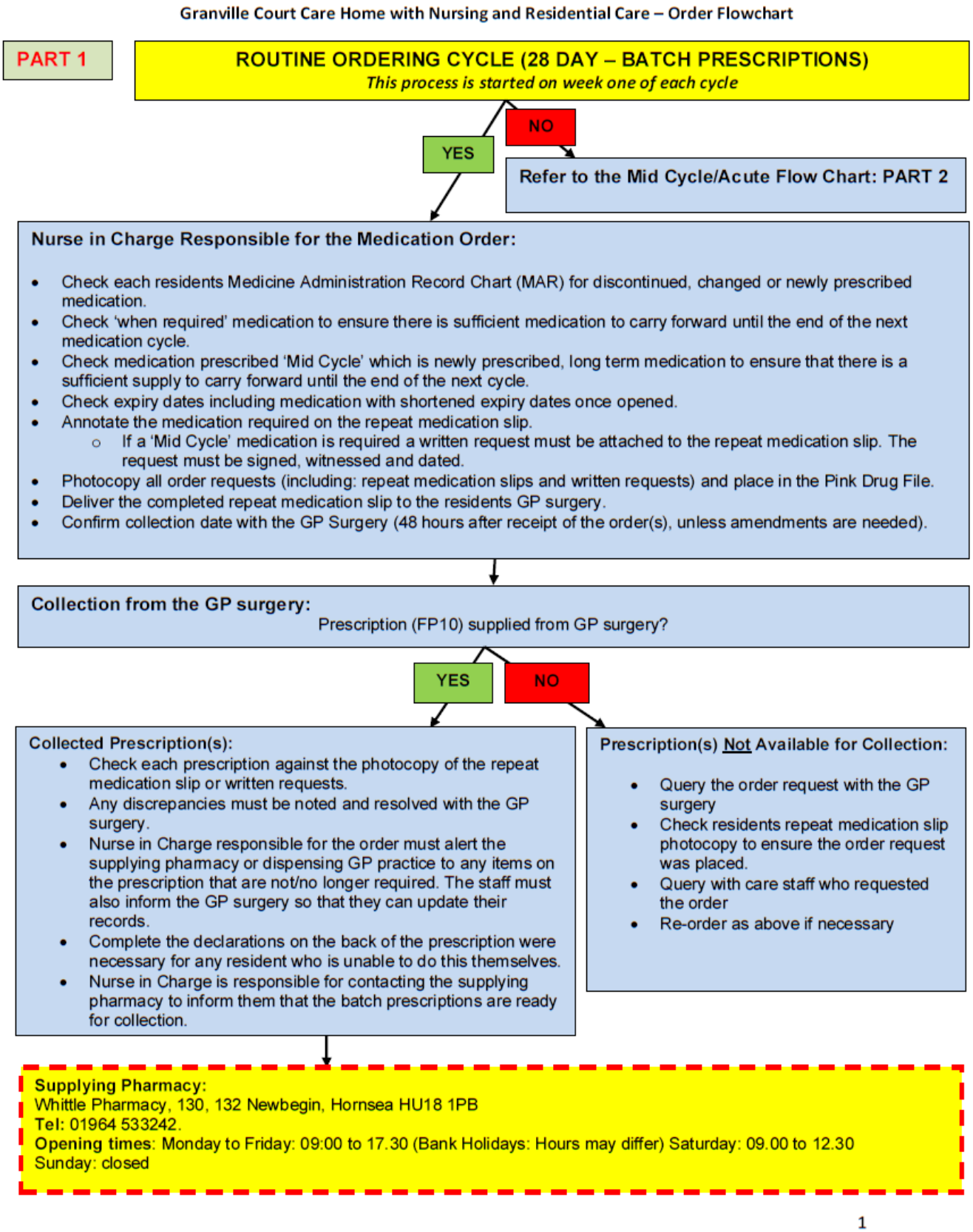
- Known Allergies or Sensitivities to Medicines
- Recommended International No-proprietary Name (rINN) should be used unless the BNF directs brand specific
- form and strength of medicine
- Dose and Frequency
- Route of Administration
- Start Date (of that particular treatment cycle)
- Stop Date (if applicable)

Section 6.6 Remote Prescribing

6.5.1 Based on NICE guidance “Managing medicines in care homes”

a. Ensure that any change to a prescription or prescription of a new medicine remotely is supported in writing (by email) before the first dose is given
b. Ask the prescriber using remote prescribing to change the prescription
c. Update the medicines administration record and the care plan as soon as the email is received following the HTFT Transcribing standards.
d. The name of medicines, dose, and indication, time of administration, and reason for accepting an amendment remotely must also be recorded in the resident’s notes.
e. Amendments to prescription of Controlled Drugs including temazepam must not be accepted remotely.

Ordering Medicines



Granville Court Care Home with Nursing and Residential Care – Order Flowchart

PART 2 — **Urgent Medication Orders**

Mid Cycle or Acute Medication Order

YES

Mid Cycle Medication:

Medication started/ordered part way through the medication cycle

Newly Prescribed Medication:

- Nurse in Charge must ensure that if a newly prescribed medication is to be taken long term the GP supplies enough to last until the end of the current cycle.
  - **Short term:** Nurse in Charge must clarify with the GP the duration of the course of treatment.
- Nurse in Charge must photocopy the prescription and place the photocopy in the Pink Drug File.
- Complete the declaration on the reverse of the prescription(s) were necessary for any resident who is unable to do this themselves.
- Deliver the prescription(s) to the nominated pharmacy.

Previously Prescribed Medication:

The care home manager must be informed;* Nurse in Charge *must investigate why an order is required outside of the normal cycle.

- Check the residents Medicine Administration Record Chart (MAR) to ensure the medication has not been discontinued or changed. The MAR will also indicate if a supply was issued for the current cycle or if any medication was carried forward from the previous cycle.
- Is the item to follow (owing) from the supplying pharmacy? – Liaise with the supplying pharmacy.
- Contact the Residents GP Surgery or the Out of Hours Service (if appropriate) to request an urgent prescription(s). Advice may need to be sought from the GP/Out of Hours Service if a resident has missed/ is due a dose. The advice received must be fully documented in the resident's notes.
- Photocopy prescription(s) and place in the Pink Drug File.
- Complete the declaration on the reverse of the prescription(s) were necessary for any resident who is unable to do this themselves.
- Deliver/Fax the prescription(s) to the nominated pharmacy.

NO → **Refer to the Routine Order Cycle Flow Chart: PART 1**

Acute Medication:

Acute medication is prescribed in response to an illness for example: Antibiotics therefore the prescription(s) must be obtained as soon as possible.

- Nurse in Charge must photocopy the prescription(s) and place the photocopy in the Pink Drug File.
- Complete the declaration on the reverse of the prescription(s) were necessary for any resident who is unable to do this themselves.
- Deliver the prescription(s) to the nominated pharmacy.

Collected Prescription(s):

- Check each prescription(s) against the photocopy of the repeat medication slip or written requests.
- Any discrepancies must be noted and resolved with the GP surgery/Out of Hours service.
- Nurse in Charge responsible for the order must alert the supplying pharmacy or dispensing GP practice to any items on the prescription(s) that are not/no longer required.
- Complete the declarations on the back of the prescription(s) were necessary for any resident who is unable to do this themselves.
- Deliver the prescription(s) to the nominated pharmacy.

Controlled Drugs: The Pharmacy must be in possession of the (FP10) prescription before controlled drug prescriptions can be supplied.

Hornsea Pharmacies:

Living Care Pharmacy, 55a Newbegin, Hornsea HU18 1AB, Tel: 01964 532967. **Opening times**: Monday to Friday: 09:00 to 18.30 (Bank Holidays: Hours may differ) Saturday: 09.00 to 13.00 Sunday: closed

Tesco Pharmacy, Southgate, Hornsea, HU18 1RE, East Yorkshire, Tel 01916939224. **Opening times:** Monday to Saturday 09:00 to 21.00, Sunday 10:00 to 16:00 (Bank Holidays: Hours may differ).

Day Lewis, 85 Newbigin, Hornsea, HU18 1PA, East Yorkshire, Tel: 01964 532006. **Opening times**: Monday to Friday: 08:45 to 18:00, Saturday: 09:00 to 12:30, Sundays: Closed (Bank Holidays: Hours may differ).

Ba Whittles Pharmacy, 130 Newbigin, Hornsea, HU18 1PB, East Yorkshire. Tel 01964 533242. **Opening times:** Monday to Friday: 09:00 to 17.30 , Saturday: 09:00to 12:30, Sunday Closed (Bank Holidays: Hours may differ).

Receipt of Medication from the supplying Pharmacy
Refer to the current Safe and Secure Handling of Medicine Procedures

On receipt of medication from the supplying pharmacy, receiving staff must check the received medication and MAR charts are the same as the original order (the photocopy of the FP10 prescription).

On receipt of the CD from the supplying pharmacy, the date, name and branch of supplying pharmacy, FP10 number, and the quantity received should be entered into the CD Register. The CD register should be signed by the receiving Nurse-in-Charge with a Witness. The correct stock balance should be verified each time.

Medication left over from the previous month must be carried forward and recorded on the new MAR chart in the carried forward box.

Storage of Medicines
Refer to the current Safe and Secure Handling of Medicines Procedures.

Stock Medicines
Stock medicines are not held within Granville Court.

Administration of Medicines
Refer to the current Safe and Secure Handling of Medicines Procedures.

Disposal of Medicines
Refer to the current Safe and Secure Handling of Medicines Procedures.

NHS
Humber Teaching
NHS Foundation Trust

Medication on Discharge – Granville Court

Patient Name	
Address	
Date	

Preparation: Name Form & Strength	Quantity	Expiry

Completed by: Name (Print)	Designation and Band	Signature
Accepted for delivery by: Name (Print)	Designation and Band	Signature
Received By: Name (Print)	Relationship to Patient	Signature

Retain for 2 years

V:\Corporate\Pharmacy\Pharmacy Team\Shared\Policy Procedure Protocol & Guideline\Procedures\SSHMP

APPENDIX 17 – LOST/STOLEN PRESCRIPTION NOTIFICATION FORM

Date of Incident	**Reporter Details:**
	Contact Number:
Lost Prescription Y/N	**Stolen Prescription Y/N**

Type of Prescription Lost/Stolen:

Prescription Type	Colour	Please indicate prescription type and Quantity
FP10NC	Green	
FP10HNC	Green	
FP10 MDA	Blue	
FP10-REC	Purple	
FP10PN	Purple	

Where did the Loss/Theft occur?

Serial number(S) of prescription form(s):

Patient details (initials and DOB only):

Medication details (include name, strength, formulation, form, quantity – number of days supplied):

Prescription start date and or date signed:

Name and contact details of the prescriber:

Crime number if reported to the police:

Community pharmacy information (where Applicable):

APPENDIX 18 – STAFF AUTHORISED TO ORDER CONTROLLED DRUGS

NHS
Humber Teaching
NHS Foundation Trust

Department Of Pharmacy

Staff Authorised To Order Controlled Drugs

Signature List

Date | Ward / Department

NAME	SIGNATURE	Grade/Designation
BLOCK CAPITALS	SIGN WITHIN BOX	

APPENDIX 19 – EXPIRY DATE CHECKLIST

Expiry Date Checklist (Monthly) – Stock Medicines

Humber Teaching NHS Foundation Trust

Unit/Team: _____

Month:	Date:	Checked By:		
		Sign	Print	Designation
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				

Note:

1. This check also applies to dressings and medical gases.
2. Check manufacturers guidelines to shelf life once opened.
3. Medicines must be disposed:-
    a. If there is no identifiable expiry date
    b. The date of opening has not been recorded on medicines that have a shortened expiry once opened.
4. Dispose of expired medication as per SSHMP, section 16
5. Reorder as per SSHMP Section 9:
    a. Medicines in current use.
    b. Medicines due to expire within 30 days where the stock holding has fallen below the minimum quantity specified on the Stock List
    c. Expired emergency medicines. Where replacements have not been received, inform Nurse in charge immediately.

Definitions:

SSHMP = Safe and Secure Handling of Medicines Procedures.

Expiry date:-

Wording on packaging	Definition
Best before January 2030	Discard 31/12/2029
Use by January 2030	Discard 31/12/2029
Use before end January 2030	Discard 31/01/2029
Discard after January 2030	Discard 31/01/2029
Expires January 2030	Discard 31/01/2029
Use within one month of opening	Discard 28 days after opening.
Discard 7 days after opening	Self-explanatory

Form EDCMSMv2

V:\Corporate\Pharmacy\Pharmacy Team\Shared\Technical\Stock Medicines Expiry Date Checklist

APPENDIX 20 – DELIVERY CONSIGNMENT SHEET

Delivery consignment sheet.

Date	Delivery Person's Name
/ /	

Humber Teaching NHS Foundation Trust

Pharmacy Department
Trust Headquarters
Willerby Hill
Beverley Road
Willerby

HU10 6ED
01482 389113

For use by delivery person only				For use by non pharmacy staff		
Deliverylocation/ Name	Number of boxes/bags	Number of CD items	Number of fridge items	Seal Intact?	Received by	Signatureof staff

Once completed, please scan this sheet to: >Shares>Corporate>Pharmacy>Pharmacy Team>Shared>Delivery Consignment Sheets>2023>month that the delivery took place.

APPENDIX 21 – FRIDGE ITEM DELIVERY NOTE

NHS
Humber Teaching
NHS Foundation Trust

Pharmacy Department
Mary Seacole Building
Willerby Hill
Beverley Road
Willerby
HU10 6ED
Tel: 01482 389113

Fridge item delivery note:

Pharmacist / Technician's name : (Block capitals)	
Signature:	
Date:	
Delivery person's name: (Block capitals)	
Signature:	
Delivery date:	
Time left pharmacy:	
Delivery address:	
Details of items to be delivered:	
Name of person receiving fridge items: (Block capitals)	
Signature:	
Date of receipt:	
Time of receipt:	

APPENDIX 22 – CD DELIVERY NOTE

NHS
Humber Teaching
NHS Foundation Trust

Pharmacy Department
Mary Seacole Building
Willerby Hill
Beverley Road
Willerby
HU10 6ED
Tel: 01482 389113

Controlled Drug (CD) delivery note:

Pharmacist / Technician's name : (Block capitals)	
Signature:	
Date:	
Entered into CD register? (must be entered before handing to driver)	☐ **Yes** ☐ **No** ☐ **N/A**
Delivery person's name: (Block capitals)	
Signature:	
Delivery date:	
Delivery address:	
Details of items to be delivered:	
Name of person receiving CD items: (Block capitals)	
Signature:	
Date of receipt:	
Time of receipt:	

Please note:

- CD's MUST be kept securely at all times
- Delivery notes should be returned to the pharmacy department on the same day

APPENDIX 23 – EQUALITY AND HEALTH INEQUALITIES IMPACT ASSESSMENT (EHIIA) TOOLKIT

Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Safe and Secure Handling of Medicines Procedure
2. EHIIA Reviewer (name, job title, base and contact details): Leanne Bloor – Chief Technician
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Procedure

Main Aims of the Document, Process or Service To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	How have you arrived at the equality impact score? • who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	This procedure is consistent in its approach regardless of age.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	This procedure is consistent in its approach regardless of disability.
Sex	Man/Male, Woman/Female.	Neutral	This procedure is consistent in its approach regardless of gender.
Marriage/Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	The procedure applies to all irrespective of relationship status.
Pregnancy/Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.	Neutral	This procedure is consistent in its approach regardless of pregnancy/maternity status.

Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	The procedure applies to all irrespective of race.
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	The procedure applies to all irrespective of religion or belief
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	The procedure applies to all irrespective of sexual orientation
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	This procedure is consistent in its approach regardless of the gender the individual wishes to be identified as.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	This procedure is consistent in its approach regardless of wealth
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	This procedure is consistent in its approach regardless of literacy skills. Information is to be provided to the patient in an accessible format based on their needs.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	This procedure is consistent in its approach regardless of language spoken. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	This procedure is consistent in its approach regardless of risk group.
	• people who experience homelessness	Neutral	
	• drug and alcohol dependence	Neutral	
	• vulnerable migrants	Neutral	
	• Gypsy, Roma and Traveller communities	Neutral	
	• sex workers	Neutral	
	• people in contact with the justice system	Neutral	
	• victims of modern slavery	Neutral	

Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	This procedure is consistent in its approach regardless of locality
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	This procedure is consistent in its approach. Carers should receive information in a format that is accessible for them.
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	This procedure is consistent in its approach. Looked after children should receive information in a format that is accessible for them.
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	This procedure is consistent in its approach. Veterans should receive information in a format that is accessible for them.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	This procedure is consistent in its approach regardless of diagnosis.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted		

Summary

Please describe the main points/actions arising from your assessment that supports your decision above See evidence above.	
EIA Review	
Date Completed: 15/01/2025	Signature: L. Bloor