DOCUMENT TYPE: Policy		**UNIQUE IDENTIFIER:** TP-140	
DOCUMENT TITLE: The Medicines Management (General) Policy		**VERSION NUMBER:** 3.1	
		STATUS: Ratified	
SCOPE: This policy appertains to all aspects of medicines use within the Trust.		**CLASSIFICATION:** Organisational	
AUTHOR: David Jones	**JOB TITLE:** Assistant Director of Pharmacy	**DIVISION:** Clinical Support Services	**DEPARTMENT:** Pharmacy
REPLACES: The Medicines Management (General) Policy v3		**HEAD OF DEPARTMENT:** Gareth Price, Chief Pharmacist	
VALIDATED BY: Medicines Governance Committee		**DATE:** 20 March 2019	
RATIFIED BY: Procedural Documents Ratification Group		**DATE:** 18 June 2019	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** 30 June 2022	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
3.1	November 2019	17	Updated escalation process where issue with a prescription is identified and there is risk of immediate harm	

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: No
Evidence reviewed by Library Services Click here to enter a date.

CONTENTS

1 SUMMARY

A policy to support members of staff responsible for the prescribing, administration and associated activities regarding the handling of medicines within Lancashire Teaching Hospitals NHS Foundation Trust.

2 PURPOSE

2.1 All staff who handle medicines are required to adhere to the Medicines Management (General) Policy. It has been compiled by the Medicines Governance Committee and will be used by all individuals who deal with medicines within the Trust.

2.2 Directorates must ensure that the policy is made available to staff.

2.3 The policy provides a procedural guide for the prescribing, storage, supply; disposal and administration of medicines and to ensure legal requirements and Department of Health guidelines are fulfilled.

2.4 It is designed to support principle 3 of medicines optimisation: to ensure medicines use is as safe as possible. The correct administration of prescribed medicines involves medical, nursing and pharmaceutical disciplines and requires vigilance and caution.

2.5 The term “medicine” also includes items such as intravenous infusions and interactive dressings.

2.6 If difficulties are encountered in implementing this policy, advice must be sought from your line manager.

2.7 This policy will be reviewed 3 years from the date of issue. Comments are welcomed for this review and should be sent to the author.

2.8 Health care professionals should also refer to their own Code of Conduct /Code of Ethics.

3 SCOPE

3.1 All Trust staff who handle medicines are required to adhere to the Medicines Management (General) Policy. It has been compiled by the Medicines Governance Committee and will be used by all individuals who deal with medicines within the Trust.

3.2 This policy appertains to all aspects of medicines use within the Trust.

4. RESPONSIBILITIES

4.1 ***Chief Pharmacist***

Oversees the systems and processes relating to medicines on behalf of the Trust Board of Directors, this includes procuring the medicinal products which are required by the Trust and ensuring that they are of a suitable quality for issue against an appropriate order. Medicines will be procured in line with national best practice guidance. It is the responsibility of the Chief Pharmacist to ensure that all pharmacy staff are aware of this policy and include it in the local induction programme.

4.2 ***The Accountable Officer for Controlled Drugs***

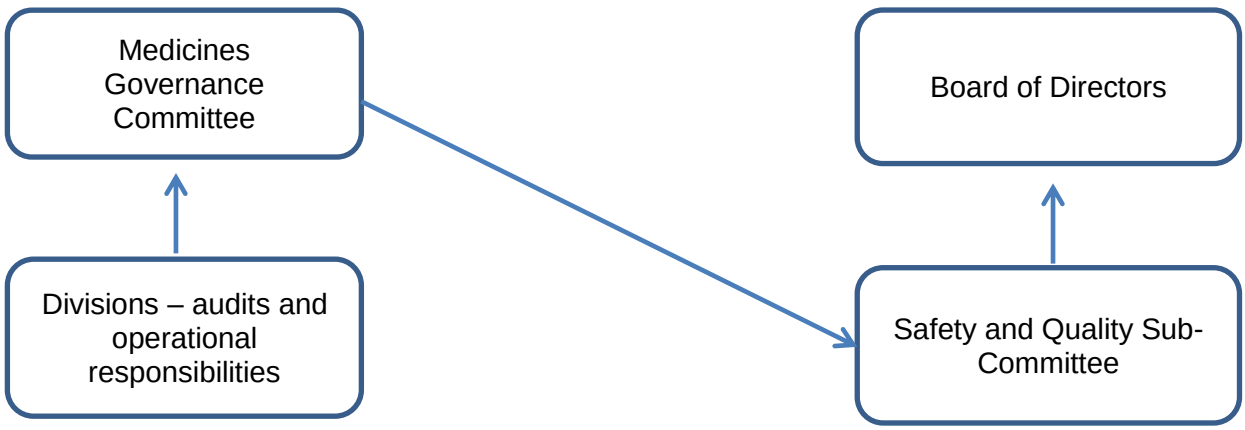
The Chief Pharmacist undertakes this role in the Trust.

4.3 ***The Medicines Governance Committee***

A Trust wide committee that oversees all aspects of medicines management including:-

- Managed introduction of new medicines.
- Reporting to external authorities e.g. Medicines and Healthcare Products Regulatory Agency and National Patient Safety Agency.
- Policy, guideline and formulary development.
- Provides an annual report to the Safety and Quality Subcommittee, which reports to the Trust Board.
- The committee identifies risks associated with medicines in the Trust, and determines actions required to reduce those risks. Information from the Trust incident reporting system is used to inform this work.
- Sub-groups that report to the committee that focus on particular aspects of medication include:
- Antimicrobial management group.
- Venous Thrombo embolism group.
- Patient Group Direction Group.
- Immunoglobulin review group.
- Policy and procedures document ratification group (where medicines form a major part of the guideline).

The relationship structure is shown below;



4.4 ***Ward / Department Managers***

It is the responsibility of ward / department managers to ensure that their staff who handle medicines are made aware of this policy. It should be included in local induction programmes. The ward /department manager is also accountable for security of medicines in their area and must ensure that the system for requisitioning and returning medicines is followed.

4.5 ***Prescribers***

It is the responsibility of medical staff and other Trust approved prescribers to follow this policy when prescribing medicines and includes the use of appropriate documentation in accordance with the prescribing procedure.

4.6 ***Pharmacy Staff***

It is the responsibility of Pharmacy staff to follow this policy when they are involved in managing medicines. The pharmacist who cares for a patient must ensure that the medicines they receive are safe, appropriate and cost effective.

4.7 ***Staff Administering Medicines***

It is the responsibility of any staff administering medicines to follow the Medicines Management (General) Policy, Controlled drugs and Self-Medication Policies and also to ensure safe storage and security of medicines at ward / department level.

4.8 ***Health Care Assistants***

Health Care Assistant's role in the management of medicines is permissible where clearly defined responsibilities are approved by the medicines governance committee and staff have completed a specified training and competency is assessed.

5. POLICY & GENERAL INFORMATION

5.1 ***Medication Incident / Error Reporting***

Medication errors, i.e. unintended prescribing, clinical checking, dispensing and administration incidents, that reach the patient, must be reported together with all medication security incidents through the Trust incident reporting system.

A routine part of a pharmacist's role is to ensure that patient's receive their medication as intended. Intrinsic to this activity is prescription review to ensure that medicines prescribed are accurate and appropriate. The amendment or optimisation of a patient's prescription by a pharmacist is known as a pharmacy intervention. This work is undertaken as part of the Pharmacy clinical team activities and although some of these interventions will be reported as an incident, the volume of such interventions prohibits the completion of an incident form on each occasion. Periodic intervention point prevalence audits are undertaken to monitor the total volume and type of pharmacy interventions to support learning. Pharmacy staff must use their professional judgement to determine when to escalate an intervention and record it as an incident, taking into account actual or potential harm of the incident.

The assistant director of pharmacy (Clinical Services) receives notification of all incidents involving a medicine. With the support of the trust Medication Safety Officer (MSO), these are reviewed, and relevant pharmacy staff involved in facilitating investigation. All incidents involving controlled drugs must be reported to the Trust Accountable Officer for Controlled Drugs. A trend analysis of medication incidents is produced, and used by the Medicines Governance Committee to identify focus areas for identifying and monitoring improvement measures. All level 3 incidents involving a medicine trigger a "root cause analysis" (RCA). All RCA involving a medicine must include a pharmacist in the investigating panel, and the outcomes are taken to the Medicines Governance Committee to facilitate trust wide learning.

5.2 ***Reporting of Adverse Reactions***

All healthcare professionals are encouraged to report adverse drug reactions via the Yellow card scheme http://yellowcard.mhra.gov.uk or paper copies available in the BNF. It may be necessary to update the patient's records/prescription chart with the details of the adverse drug reaction.

5.3 ***Process for Monitoring Compliance***

A monthly clinical area medicines safe storage and security audit is undertaken by the pharmacy team, and results reported back to the ward / area manager with appropriate recommendations for improvements. These audit results are recorded in AMAT.

It is the ward / area manager responsibility to record appropriate actions in AMAT, and monitor for completion and desired improvements. Where appropriate, the ward manager and pharmacy team can agree to increase the frequency of audit to support greater scrutiny until consistent achievement of standards is seen.
See appendix 1 - Auditing programme - The Medicines Management (General) Policy.

5.4 ***References***

See *Supporting References / Evidence based documents* in section 12.

6. PRESCRIBING

6.1 ***Authorisation of Prescriptions***

Medical and dental practitioners may prescribe medicines. Medical and dental students are **not** permitted to write prescriptions. Nurses, pharmacists and other healthcare professionals who are Trust approved non-medical prescribers may prescribe according to their designation of supplementary or independent prescriber (see Non-Medical Prescribing Policy). The standards of prescribing described in this policy will apply to all practitioners irrespective of their professional status.

Registered midwives may supply and administer, on their own initiative, any of the substances that are specified in medicines legislation under midwives exemptions, provided it is in the course of their professional midwifery practice.

6.2 ***The Prescription Form:***

a. Provides a permanent legal record of the patient's medication.

b. Facilitates the provision of the correct medicine from Pharmacy.

c. Directs the administration of medicine to the patient.

6.3 ***Trust Approved Prescription Forms***

Only Trust approved prescription forms may be used (approved by the Medicines Governance Committee):

In-patient prescription booklet (adult – standard)
In-patient prescription booklet (adult – rehab)
In-patient prescription booklet (adult – critical care)
In-patient prescription booklet (paediatrics and neonates)
Out-patient prescription
FP10 NC form
A+E prescription
Anaesthetic chart
Discharge prescription (IHDI)
Discharge prescription (orthopaedic bluespier)
Discharge prescription (yellow)
Paediatric take home analgesia prescription (yellow)
Chemotherapy prescription (electronic)
Intrathecal prescription
Ophthalmology cytotoxic prescription
Electronic prescription medication administration record EPMA (Quadramed)

6.4 ***Management and control of prescription forms***

<u>*Prescriptions as blank cheques*</u> – although we are not used to thinking about prescriptions in this way, a prescription form should be considered an asset that has a financial value. It is in effect a blank cheque open to potential misuse. Theft of prescription forms and their resulting fraudulent misuse, potentially involving third parties is a serious concern.

<u>*Precautions to prevent misuse include:*</u>

Not leaving prescription pads unsupervised in public/patient areas.
Not leaving prescription pads in patient's notes.
Ensuring prescription pads are secure when not in use.
For prescriptions used by staff off site ensure they are not left in view in a vehicle.
Prescriptions for items with potential for misuse, consider the quantity to be supplied is reasonable for the intended use and that directions have not been changed. Occasionally we have had reports where inpatient charts have been amended to enable patients to receive increased doses. Writing the frequency in the additional instructions box e.g. 'twice daily' as well as circling the time of administration can help prevent this.

Any incidents involving fraud, theft or loss of prescription forms should be reported via the trust incident reporting system. Where necessary the report

should also be made available to the NHS counter fraud authority (NHSCFA) via their reporting line or online.

6.5 ***General principles of prescribing***

Always write in ***BLOCK CAPITALS*** using black indelible ink.

- Complete Patient's name, NHS number and Ward **at the top of every page used.**
- Complete **ALL patient information** (Name, DOB, NHS No., gender, admission date, date chart started, weight, height, ward & consultant).
- **Complete and check** ALLERGY / SENSITIVITY box **prior to prescribing medicines** stating nature of allergy**.** Tick 'No' if NKDA. **Sign and date.**

If a patient develops an allergy whilst in hospital, the allergy section must be updated. When an allergy is recorded, the entry on the prescription chart must be signed and dated by the person making the entry. The information should also be updated on Quadramed alert section.

Complete 'additional charts' section and 'chart – of –'.

Tick any factors affecting drug choice e.g. renal impairment, pregnancy

- **All prescribers must** complete the signature box on the front of the in-patient adult prescription chart with name, designation, registration number, bleep and signature every time you write your first entry. This information must also be completed on the out-patient prescription (see later section). This is a ***MANDATORY*** requirement to demonstrate an audit trail of prescribing.
- Complete the **VTE** prophylaxis section. ALL patients must be risk-assessed on Quadramed.
- Use only the ***APPROVED*** name for drugs, e.g. prescribe **ENOXAPARIN** *(not Clexane),* **CO-AMOXICLAV** *not Augmentin* (unless it is a preparation that must be prescribed by brand name according to the "British National Formulary – known as the BNF" e.g. immunosuppression, slow-release brands of diltiazem, anti-epileptic medicines).
- Choose the ***correct section*** of the prescription (Rx) chart appropriate for that medicine. Once only medicines and loading doses should be prescribed on the front page. (see loading dose policy for responsibilities of different grades of staff)
- Specify the ***dose*** clearly, using only approved abbreviations for units (See Definitions / Glossary of terms section 6.6) – circle times to be administered. The dose should be specified numerically as the number of dose units e.g. 250mg or where this is not possible e.g. 2 tabs (*using roman numerals: II tabs is not acceptable*).
    - minimise the use of decimal points and trailing zeros where possible e.g. for 500mg write as 500mg *NOT* 0.5g, for 250nanograms write as 250nanograms *NOT* 0.25micrograms. For 5mg write as 5mg and *NOT* as 5.0mg.

- Consideration should be made of the presentation of the medicine and how it is labelled by the manufacturer to help avoid administration errors. E.g. Alfacalcidol 0.25 micrograms not 250 nanograms. For approved abbreviations see below e.g. mg but *NOT* mcg. "micrograms" and "nanograms" must be written in full, as should "units."
- Circle times of administration, avoiding changing these except in specific circumstances e.g. anti-Parkinson medication. (NB for the paediatric in-patient prescription chart write the times of administration in).
- State 'when required' medication frequency in number of hours between doses (e.g. '6 hourly' *NOT* 'QDS').

- Start date ***and*** time (to account for missed doses if a medication is started during the day).
- State a ***finish date*** for courses of medicines (or a review date where course length has not been established).
- For ***antibiotics*** specify a review date by circling the row above the date/time row on the appropriate date.
- For antibiotics, also complete SIRS score, formulary choice Y/N and indication and state the intended finish date.
- Specify ***route*** of administration. Where this is intravenous IV specify the line to be administered if applicable. See below for approved abbreviations for routes.
- ***SIGN & DATE*** *every* prescription.
- Indicate whether the medication is 'U' (unchanged regular prescription), 'A' (amended dose of primary care prescription) or 'N' (new prescription) and whether it is indicated for 'D' (discharge) by circling the relevant letter(s) on the LHS of each medication box.

1. ***NEVER*** *alter a prescription* – cross out, date, sign and re-write.
2. ***Do not*** abbreviate infusion fluid e.g. write SODIUM CHLORIDE 0.9% NOT NaCl 0.9% or Normal Saline or N/S. Similarly, write glucose 5% NOT D5%.
3. ***Do not*** abbreviate drug/electrolyte e.g. write POTASSIUM CHLORIDE NOT KCl.
4. Where the prescriber requires medication to be omitted for clinical reasons i.e. prior to surgery, this must be clearly indicated on the prescription chart, dated and signed.
5. Where administration is required less frequently than once daily, e.g. once a week, then the days when administration is not required are to be crossed through i.e. **XXXXX and frequency denoted in words in the drug section of the prescription.**

6. For "prn" medications: always write a maximum frequency (e.g. 4 hourly) and an indication. Using 4° or Q4-H is not appropriate, 'hourly" must be written out in full.

7. ***All Methotrexate*** prescriptions must be signed by a consultant before supply and administration.

6.6 *Approved Abbreviations*

DEFINITIONS / GLOSSARY OF TERMS			
Abbreviation	**Term Definition**	**Abbreviation**	**Term Definition**
PO	By mouth	PV	Per Vagina
IM	Intramuscular	SL	Sublingual
IV	Intravenous	Neb	By Nebuliser
SC	Subcutaneous	IP	Intra-peritoneally
PR	Per Rectum	g	gram
kg	kilogram	IV-PCA	Intravenous Patient Controlled Analgesia
l	litre	ml	millilitre
inhal	inhalation	CVC	Central Venous Catheter
tab	tablet	micrograms	no abbreviation
cap	capsule	Insulin unit	no abbreviation
Nanogram	no abbreviation		

6.7 *Inpatient Prescriptions*

Prescribing must only take place on the appropriate official Lancashire Teaching Hospitals NHS Foundation Trust (LTHFT) medication prescription chart including the EPMA chart where available. .
Complete and check ALLERGY / SENSITIVITY box ***prior to prescribing medicines***. If a patient develops an allergy whilst in hospital, the allergy section must be updated.

When an allergy is recorded, the entry on the prescription chart must be signed and dated by the person making the entry. The information should also be updated on Quadramed alert section.

6.8 *Discharge Prescriptions*

[TTO's (To Take Out) or IHDI (Immediate Hospital Discharge Information)]
For patients admitted > 48hrs the IHDI should include a record of all their regular medication in addition to any new medicines. Patients admitted <48hrs may be prescribed only new medicines on their discharge as long as a clinical assessment has been made that there is no impact on their regular medicines and that a clear indication 'no change to regular medicines' is documented. Where the patient has been reviewed in assessment area e.g. Emergency decisions unit, HOT clinic an out- patient prescription may be used to support patient flow. However this must be balanced against any relevant clinical information that needs relaying to the patients GP to ensure safe transfer of care.

The IHDI should be prepared in advance of the patient's discharge to allow time for the preparation of discharge medicines. A typed IHDI will be prepared on Quadramed. Two copies of the medication section will be printed from the system after it has been saved. One copy is the legal prescription to be retained by pharmacy and the second is a record for the nursing staff to let them know what is supplied. When the patient is discharged the IHDI is completed by the staff discharging the patient. A copy of the IHDI is either transferred via LPRES (Lancashire Person Record Exchange Service) or printed and posted to the GP if in the locality and a copy is printed, via the Print copy service icon on the desktop, for the patient and the GP if out of area.

Patients will be supplied a minimum of fourteen days' supply (or seven days if in a monitored dosing system) and a maximum of six weeks supply of medication or the appropriate quantity to complete a course. Where a patient continues on regular medicines they were taking prior to admission and it can be reliably confirmed they have sufficient supply; no further supply will be made at discharge. For patients with a history of self-harm, or there is concern the patient will abuse the medication being supplied, the quantity to be supplied will be confirmed with the doctor and clearly stated.

Reasons why medication has been stopped, started or changed must be included in discharge letters in order to ensure adequate communication with GPs regarding the patient's new medication regimen.

6.9 ***Outpatient Prescriptions***

Use the appropriate Lancashire Teaching Hospitals NHS Foundation Trust outpatient prescription form. ***Complete and check*** ALLERGY / SENSITIVITY box ***prior to prescribing medicines***. A twenty-eight day supply (or full pack) will be dispensed unless a specific course length is stated, such as a 7 day course of antibiotics. Accident and Emergency patients will be supplied with an appropriate course, usually five to seven days. Adjuvant medicines that are required long term in conjunction with a medicine that continues to be prescribed by secondary care may be transferred to the care of the GP. Out – patient prescriptions should not be utilised for the routine supply of medicines normally prescribed by the GP that the patient may be running out of.

6.10 ***Intrathecal Chemotherapy***

LTHTR is a non-intrathecal chemotherapy trust. This means that intrathecal chemotherapy must not be prescribed, manufactured or administered at LTHTR without the direct authorisation of the medical director and the chief executive. Consult the "Intrathecal Chemotherapy Policy" for further information.

Also see: 8.12 *Cytotoxic Medicines*

6.11 ***Unlicensed Medicines***

Under the Medicines Act, all medicinal products approved for use in the UK must either have a Product Licence or European Marketing Authorisation, which has been granted by the Medicines and Healthcare Products Regulatory Agency. Any medicine, which does not have either a Licence or a Marketing Authorisation, is referred to as an unlicensed medicine.

The use of all licensed medicines or off label use of a licensed medicine should be considered in preference to an unlicensed medicine due to the potential risk.

A clinician wishing to prescribe an unlicensed medicine should ensure they are aware of, and compliant with, the policy for the prescribing, supply and use of unlicensed medicines (see unlicensed medicines policy). The clinician is responsible for all the clinical aspects of the medication and ensuring that information is made available for its safe administration. The clinician must also ensure the patient consents to the use of an unlicensed medicine.
A patient admitted on an unlicensed medicine may continue this treatment where necessary, however a review and if appropriate form completed at the earliest opportunity.

6.12 ***Licensed Medicines for Unlicensed Indications***

A consultant must initiate the request to prescribe a licensed medicine for an unlicensed indication by filling in the unlicensed request form available from Pharmacy or on the Intranet.

The use of a licensed medicine for an unlicensed indication will be approved and monitored by the Medicines Governance Committee.
A patient admitted on a licensed medicine for an unlicensed indication may continue this treatment where necessary, however a review and if appropriate unlicensed form completed at the earliest opportunity.

6.13 ***Prescribing Medicines Not Approved for Use in the Trust***

The introduction of new medicines for use in LTHFT is subject to both clinical and financial scrutiny. Proposals must be submitted to the relevant Clinical Director in the first instance. The Medicines Governance Committee will only consider requests which have the signed approval of the Clinical Director and Directorate Manager. By signing the request the Clinical Director and Directorate Manager confirm the cost of the new medicine will be met within existing resources, or that additional financial resource has been secured for this purpose. The request is then forwarded to the Medicines Governance Committee. Items requiring rapid approval should be communicated to the Directorate Manager/Clinical Director and the Chairman of the Medicines Governance Committee. The Chair of the Medicines Governance Committee (or nominated deputy) is able to approve use of a new drug in a single patient prior to the full submission to the Committee.

Forms to request new medicines are available on the Intranet or from the Medicines Governance pharmacist.

6.14 ***Prescribing Complementary Therapies***
Complementary Therapies, including herbal remedies, homeopathic products and aromatherapy are not prescribed by trust staff.

Also see 8.8 *Non-prescription homeopathic/herbal remedies*

6.15 ***Verbal Prescriptions***
Verbal prescriptions are not accepted practice at the Trust.

Verbal instructions to prepare or administer medicines in life threatening situations: must be followed up by a written prescription as soon as the immediate emergency has been dealt with. The person who received the verbal instruction must document this in the patient medical record. Where possible, a second practitioner should also listen to the verbal instruction and countersign the documentation in the medical record.

6.16 ***Emergency administration of medicines***
Where there is immediate risk to life the following medicines may be administered without a prescription by staff who are trained and competent to do so: Oxygen, Sodium Chloride 0.9%, Adrenaline and Amiodiarone. A record of this administration must be made in the patient's medical record as soon as is practical.

6.17 ***Radiopharmaceuticals***
Radiopharmaceuticals are available as both licensed and unlicensed medicines. Use of radioactive substances in medical applications is governed by the Ionising Radiation (Medical Exposure) Regulations 2017 (IR (ME) R). Which requires both employers and practitioners to hold a licence for the administration of radioactive substances for a specified purpose at any given medical radiological installation. Each licence lists the procedures which the holder is authorised to undertake as well as the purpose of the administration (diagnosis, research or therapy). . Licences are issued for a period of 5 years but may be revoked at any time by the Licensing Authority. The Secretary of State for England is the licensing authority for both employers and practitioners.

In practice, this means that radiopharmaceuticals can only be administered if the following three criteria are met:

- The trust holds a licence for each administration at each medical radiological installation for the purpose of the administration of radioactive substances to patients.
- The practitioner holds a licence in order to justify the administration of radioactive substances to patients.
- Where an unlicensed medicine is to be used, prescribing is carried out in accordance with the Unlicensed Medicine Policy.

- (Available on the trust intranet, also see section 8.14 *Intrathecal Chemotherapy.*
- The current list of licenses held by the trust and relevant practitioners is maintained by the Lead Radiographer in Nuclear Medicine.

6.18 ***Medicines Reconciliation***

The patient's medicines taken prior to admission (medication history) must be identified as part of the clerking process undertaken by the admitting healthcare professional. Currently, in most instances, this individual is a doctor but increasingly as roles expand in the Trust, the clerking may be undertaken by other members of the healthcare team. Admission unit areas may utilise access to the summary care record to support this process.

In all in-patient areas of the Trust the medicines history must be documented, and a record held in the patient's medical notes, in-patient prescription chart or EPMA record. The completion of the medicines reconciliation process in all in-patient areas is indicated by a signature and date in the designated box on the in-patient prescription chart /EPMA record. In most areas this is done by a member of the pharmacy team.

Medicines reconciliation is the process of ensuring that the medicines prescribed on admission correspond to those the patient was taking prior to admission and documenting any changes, deletions or omissions ensuring any discrepancies identified are resolved. The process must be started by the healthcare professional clerking the patient. Every effort should be made by the clerking healthcare professional to obtain an accurate medicine history at the time of admission, however if information cannot be obtained at the time of admission, further consolidation of the medicines history can be undertaken by the admitting doctor, a nurse or member of pharmacy staff (pharmacy technician or pharmacist).

Pharmacy staff are able to contribute to different aspects of the medicines Reconciliation process as per chart below:

Activity	**Pharmacist**	**Pharmacy technician**	**Pre-reg pharmacist**
Documentation of an accurate drug history.	Y	Y	Y
Identification of discrepancies with the in-patient prescription.	Y	Y	Y
Completion of medicines reconciliation where no discrepancy exists or there is clear documentation in the medical notes as to the rational for discrepancy	Y	Y	Y
Completion of medicines	Y	N	N

reconciliation through resolution of discrepancies.			
Clinical check of the prescription	Y	N	N

Pharmacy staff must complete reconciliation at the earliest opportunity, and sign and date the record to indicate this is complete. The exception to this is the Maternity Ward, where midwives may check for a medicines history on clerking a patient. If the patient takes no regular medicines the midwife can sign the record to indicate medicines reconciliation is complete. If the patient takes regular medicines the completion of the medicines reconciliation will be deferred to the pharmacist once the medical staff have prescribed those medicines.

6.19 ***Pharmacy Clinical Service***

Each in-patient ward will receive a regular service by the designated Pharmacy ward based clinical team.

The pharmacist will review the prescription chart in the clinical area, assessing prescribing for dose, accuracy, legibility, interactions, appropriateness of therapy (including patient characteristics, disease state, laboratory results) formulary compliance and legal requirements. By exception a professional check of the dose and formulary compliance may be undertaken in the dispensary when access to the clinical area is not possible. Each prescribed item will be endorsed on the prescription chart with the pharmacist's initials and date to signify that the clinical check of the medicine has been completed. If a prescribed medicine is inaccurate or inappropriate the pharmacist must advise the prescriber of the change required. Where there is risk of immediate harm to a patient (including all issues regarding critical medicines) this must be communicated verbally and immediately to a member of the medical team responsible for the patient's care. Where a junior member of staff is unable to resolve the issue agreement must be made on escalating the issue through the medical leadership hierarchy until the issue is resolved. If the doctor is not able to change the prescription immediately the pharmacist may make the amendment if it is within the scope of the pharmacist amendment policy. All other required changes must be documented clearly with a reason in the medical notes. The prescription chart must be clearly annotated to draw attention to the change needed. Any clarification of a prescription made by a pharmacist will be carried out in indelible ink. Any change to a prescription that alters the prescriber's intent must be done through consultation with the prescriber.

The aim is to ensure:

1. All newly prescribed items receive a pharmacist clinical check in a timely manner.
2. All inpatients receive medicines reconciliation.

The pharmacist is supported on the ward by a medicines management technician who will undertake the collation of medication histories, medicines

reconciliation as defined above and supply medicines either for inpatient use or discharge once the pharmacist clinical check is complete.

The full pharmacy clinical service is delivered Monday to Friday (9am to 5pm), with a more limited clinical service available on the Royal Preston site until 7pm. A limited clinical service is also available on both sites on Saturday and Sunday (9am to 2pm). Outside these hours the pharmacy on call service is available to deal with clinical and supply issues. The pharmacy clinical service is targeted to address the KPIs of the Medicines Management Policy (i.e. medicines reconciliation, and check of every in-patient prescription) at all times. Due to the more limited pharmacy service at weekends it is anticipated the required performance in these KPIs will not be achieved at weekends, but it is expected this will be addressed on Monday each week.

6.20 ***Amendment of Prescriptions***

A registered pharmacist may use professional judgement and amend a prescription in order to give greater clarity provided the change does not alter the prescriber's intention. For example a branded name of a medicine may be added to the prescription to add clarity where this is needed (e.g. theophylline).

Other amendments that have been discussed with the prescriber are permissible if within the scope of the pharmacist amendments policy.

6.21 **Staff Prescriptions**

Medical staff or other prescribing staff must not under any circumstances prescribe medication for other members of staff unless they are required as part of a treatment package received as a bona fide NHS patient.

Staff must not prescribe for themselves or for members of their family.

Private prescriptions are *NOT* dispensed by LTHTR pharmacy department. Self-medication with medicines that are the property of Lancashire Teaching Hospitals NHS Foundation Trust by nursing, medical and all other staff is strictly prohibited. Any staff found doing so may be subject to disciplinary action as per the Trust policy.

Emergency treatment required to keep the member of staff at work, or as a result of an accident at work, should be limited to a recognised course, for example antibiotics, or to **two days'** supply of any other medication. The prescription should come from the Emergency Department and MUST be endorsed "**Emergency Supply**" or similar wording used, this will then be supplied free of charge.

Staff requiring medication in other circumstances are referred to Occupational Health.

In the event that staff require medication "out of hours", they must attend Accident and Emergency for assessment and any prescription requirements.

7 SUPPLY OF MEDICINES

7.1 *Pharmaceutical quality assurance*

The trust pharmacy department has a responsibility to procure medicines that meet regulatory requirements. Supporting mechanisms include the contracts awarded by the commercial medicines unit (CMU) that consider both the safety and value for money in the choice of medicines provided by NHS organisations.

The EU Falsified Medicines Directive (FMD) legislation has been introduced to create a system that ensures medicines supplied in the UK are safe. It ensures the trade in medicines is controlled to reduce the risk of fake medicines entering the medicines supply chain and reaching patients. Deregulated Regulation to the FMD came into force on 9th February 2019. This includes the introduction of security features on individual packs and a new electronic scanning authentication process to be undertaken at the point of dispensing.

Pharmacy staff may only dispense medicines against prescriptions that comply with all legal requirements and which are completed in accordance with the procedures outlined in this policy.

7.2 *Pharmacy Ward Based Service*

The pharmacist or technician will assess any medicines brought by the patient into hospital and identify those patient own medicines (POMs) which are suitable for use by that patient during their admission. The pharmacist / technician will arrange the supply of any other medicine required by the patient – either through the use of ward stock medicines or through an individual patient supply.

7.3 *Medicine Supplies*

Medicines supplied from the Trust Pharmacy department must not be used for the treatment of anyone other than Trust patients currently undergoing an episode of care. They are not to be used for anything or anyone else including the treatment of relatives or friends of the patient or for the treatment of hospital staff. Use in breach of this is fraudulent and against professional codes of conduct and employees will be subject to disciplinary action.

Medicines supplies will be made in a number of different ways:

i) Patient's Own Medicines (POMs) - Patients should be actively encouraged to bring their own medicines into hospital. These must be transferred with the patient from one clinical area to another.
POMs used in the Trust must be prescribed on the relevant inpatient prescription chart.

A pharmacist or ward based technician will assess POMs for suitability for use. Out-of-hours, a registered nurse or midwife may assess the suitability of POMs for administration against a valid prescription. Pharmacy must assess the medicine at the next available opportunity.

It can be assumed that by bringing medicines into the hospital the patient has implied consent for their continued use.

ii) Stock Medicines - Each clinical area will be visited at a designated interval by a pharmacy assistant who will assess stock levels and arrange for replenishment supplies to be sent to the ward. The stock levels will be agreed after discussion with the relevant pharmacist, senior technician and appropriate medical and nursing staff. These levels will be reviewed at regular intervals by the staff concerned. The pharmacy ward team must be notified by nursing staff if unusual amounts of any item are being utilised.

iii) Individual patient supply - All medication individually dispensed will be labelled with the approved "generic" name of the preparation except where a proprietary name defines a specific formulation or combination. These medicines should only be used for the patient named on the label.

iv) Controlled Drugs – see CD Policy.

7.4 ***Delivery of Medicines to Wards / Departments***

All medicines will be delivered to the ward/department in a dedicated secure container. The nursing staff are responsible for the security of this container on the clinical area and for transferring the contents of the container into the appropriate cupboards as soon as possible. Items requiring special storage conditions (e.g. refrigeration) will be clearly labelled and must be stored appropriately as soon as they arrive on the wards.
Staff collecting medicines from the pharmacy department must have an ID badge and be trained in the handling of medicines.

7.5 ***'Borrowing' Medicines***

Medicines must not be borrowed from another clinical area when Pharmacy is open. All supplies of medicines must be ordered from the Pharmacy department.

See section 7.12 *Inter Hospital transfer* for options outside of pharmacy opening hours

7.6 ***Urgent Supplies***

Requests for urgent dispensing of prescriptions are emailed to pharmacy utilising the InfoPath form available via the Trust intranet. Telephone messages will not be accepted.

7.7 ***Sample / Free of charge medicines/ Trial Medicine Packs/ Placebos***

Samples/ Free of charge medicines/ Trial medication must not be accepted directly from pharmaceutical companies. All supplies must come via the Pharmacy. This includes placebo devices for training purposes.

7.8 ***Clinical Trial Medication***

The contents of this policy apply equally to trial medication. Clinical Trials involving medicines; will not be accepted unless any associated medicines are supplied by Pharmacy and are also approved by the Trust Research and Innovation Committee.

Where patients are admitted to the Trust on a trial medicine, medical staff must assess the risk/benefit of continuing/stopping trial medication and contact the pharmacy team to alert them to the admission. Pharmacy will then contact the Research Nurse or Principal Investigator (PI) for the Trial. In the absence of pharmacy, contact the Research Nurse and/or the PI (whose name should be on the clinical trial medicine label). N.B. patients may be on trials being hosted by other Trusts. If appropriate the patient may continue with the course of trial medicine. The trial medicines should be treated as any other patients own medicines. If the medicine has not been brought in then a relative/carer should be asked to bring in the supply as soon as possible. The prescription chart should be clearly endorsed with the Name of the Trial, Name/Number of the Trial Medicine (or placebo), the dose and frequency, the PI's name & name of the trial and subject trial number. Only the trial medication must be administered against the prescription. Substitution of commercial medicines in the absence of the trial medicine is not permitted. Pharmacy will be responsible for arranging on-going supplies.

7.9 ***Supply of Unlicensed Medicines***

The Pharmacy department is responsible for the procurement and quality of the medication. It has a duty to ensure that the clinician is fully aware of his or her liabilities.

Unlicensed medicines are not freely available and the procurement can be difficult, with continued supply not guaranteed. GPs are often reluctant to prescribe such medicines. Therefore, an unlicensed medicine should only be used when there is no suitable UK licensed alternative available.

A consultant must initiate the request for an unlicensed medicine by filling in the unlicensed request form available from Pharmacy or on the Intranet.

The use of an unlicensed medicine will be approved and monitored by the Medicines Governance Committee. Please see the Unlicensed Medicines Policy for further details.

7.10 **Supply of *Radiopharmaceuticals***

Radiopharmaceuticals are supplied to the relevant radiology departments via a number of different routes. Licensed, ready-to-administer preparations are provided directly to their destination departments under special arrangements with the pharmacy department and chief pharmacist. Where radiopharmaceuticals are provided in a form requiring manipulation prior to use and administration is to be carried out via a parenteral route, supply is carried out via the trust Radiopharmacy department. All relevant processing will be carried out within the Radiopharmacy, such that a ready-to-administer

preparation (or Multi-Dose Vial) is provided to the end user. All radiopharmaceuticals supplied from the Radiopharmacy are unlicensed medicines, and as such are subject to the controls laid out in the trust's Unlicensed Medicines Policy (except where explicitly stated).

7.11 ***Supply of Discharge Medicines***

The IHDI / TTO's and discharge medicines should be prepared in advance of the discharge when Pharmacy is open. The IHDI should be clinically checked by a pharmacist. Individual patient supplies of medicines made during the patient stay are labelled ready for discharge – these must be assessed by pharmacy staff prior to being given to the patient for discharge. Additional supplies may be required for discharge, and these will be supplied by Pharmacy.

All licensed medicines are supplied with manufacturer's product information leaflet. Patients should be encouraged to read the information during their stay, in particular when new medicines are started. The provision of information regarding medicines will be supported by the multi-disciplinary team on the ward.

It is the nurse's responsibility to ensure that the patient has their medication prior to discharge and has explained the purpose of the medicines and side effects, and provided clear written information about the medications – and sign the discharge checklist to indicate this has been done. The discharging nurse/midwife must check that the medication supplied corresponds with the IHDI. Any discrepancy must be reported to Pharmacy immediately.

All discharge medication must be stored in a locked medicine cupboard until required. Controlled drugs dispensed for discharge, requiring storage before giving to the patient, must be entered into the back of the Controlled Drugs Register, or separate "Patients Own" Controlled drugs Register, and locked in the appropriate cupboard.

No medicine, with the exception of oral dietetic products, is to be supplied to a patient unless they are in accordance with a Trust approved prescription and circumstances above. Where patients still require oral dietetic products after discharge a supply will be provided from ward stocks.

Where access to pharmacy services is limited pre-pack medicine (ready labelled pack with pre-determined directions that requires the patient's name to be added) may be dispensed to the patient. Pre-pack medicines may be added to stock lists with agreement of the lead pharmacist responsible for the clinical area having considered the patient need and any potential medication risk. This procedure must not replace the routine management of the discharge process, ensuring that discharge medicines are available in advance from Pharmacy.

7.12 ***Inter- Hospital Transfer***

A transfer letter must be provided to accompany the patient detailing all their current medication and all individually dispensed or patient's own medicines

sent with the patient in a green medication transit bag. This includes patients transferring to Longridge Community Hospital.

7.13 ***Outpatient clinics 'out of hours'***

For outpatient clinics 'out of hours' arranged at short notice - prescriptions will need to be collated by clinic staff and sent to out-patient pharmacy on the next working day. Patients should be encouraged to return to collect their prescription. However where this is not possible items may be delivered (this does not include fridge or controlled medicines).

7.14 ***Emergency supply of medicines via the SAFE centre***

The Lancashire SAFE (Sexual Assault Forensic Examination) Centre provides forensic examinations, advice and comprehensive support services for women, men and children of all ages who make a complaint of rape or sexual assault. A limited stock of pre-pack medicines specific to this speciality is available. These medicines are prescribed and dispensed by the medical staff working in the SAFE centre.

7.15 ***Emergency Supply of In-patient Medicines 'Out of Hours'***

Each hospital site has an emergency cupboard from which medicines may be obtained when the pharmacy is closed. The stock lists for the emergency cupboards are available on the intranet.

When removing items from the emergency cupboard, the designated member of staff must record in the book/paper provided the name of the items, the quantity and the clinical area to which these medicines have been supplied. Only complete packs may be removed. A list of medicines stored in the Emergency Cupboard is available on the intranet.

Stock medicines may be borrowed from another ward/unit in exceptional circumstances out of hours. A record must be made of any items borrowed and pharmacy staff informed at the earliest opportunity during normal working hours. Controlled drugs ***may not*** be borrowed from another ward – please refer to the Controlled Drugs Policy.

Medicines labelled for a specific patient may not be borrowed without the express consent of the on-call pharmacist.

Out of hours replacement boxes for clinical emergencies are available in the pharmacy emergency cupboard.

The on-call pharmacy service is available to provide pharmaceutical advice / supply of medicines if the routes described above do not provide a solution.

7.16 ***Discharges 'Out of Hours'***

A registered nurse or medic may perform the checks normally undertaken by the pharmacist if competent to undertake this role. **A pharmacist must have clinically checked the in-patient prescription chart.** The nurse must check that the discharge prescription matches the medications on the in-patient prescription chart, noting strength, correct dose and appropriateness to

medical condition. The nurse must then check that the POMs and 'individual patient dispensed' medicines match the discharge prescription, with legible label details including patient's details and directions, and then sign the discharge letter. The nurse may telephone the on-call pharmacist for advice as necessary. When the nurse is confident that the check is completed and all criteria have been met, she may hand over the medicines to the patient on discharge.

Alternatively, the patient or relative may, if in agreement, collect them later following a clinical check by a pharmacist. This may only occur where it is deemed to be clinically safe and will not result in the omission of any critical medicines. Ward stock medicines must not be given out to patients unless the medicines container is pre-labelled for discharge with directions for use and the patients name and date can be added. Patients or carers should be advised to collect medication during pharmacy opening hours in case any queries arise.

7.17 ***Damaged medicines***

If the label on any container is damaged, altered or obliterated, the container must be returned to the Pharmacy for replacement. Staff must not make any alterations to labels except to indicate the addition of a prescribed medication to a container of intravenous fluid or to mark the date of first use on a container. If the appearance of the product differs from normal, the advice of a pharmacist should be sought.

7.18 ***Inter-Ward Transfer of Patient***

When a patient is transferred from one clinical area to another within Lancashire Teaching Hospitals NHS Foundation Trust:

Current medicines supplied specifically for that patient must be transferred at the same time.

Any patient transferred for special treatment, e.g. radiotherapy, or investigation must have the prescription sheet sent with them along with specifically required medicines.

7.19 ***Procedures for the supply of medicines***

Local procedures for the supply of medicines are held within pharmacy.

8 ADMINISTRATION OF MEDICINES

8.1 ***The General Principles of administration of medicines***

Registered nurses or midwives and operating department practitioners (ODPs) are accountable for their actions and omissions and so must have the knowledge and competence to administer medicines in accordance with their professional code. Staff must be aware of their training needs and discuss with their ward/unit manager a suitable plan to gain the knowledge and skills required.

Any doubts in relation to the safety, accuracy or clarity of a prescription must always be checked with the prescriber or a pharmacist before administration.

8.2 ***Persons Authorised to Administer Medicines***

Medicines can be administered on the authorisation of a medical practitioner, dentist, and authorised prescriber or patient group direction. For in-patients, they must be prescribed on the appropriate hand-written prescription chart or EPMA record. It is recommended that drugs to be administered orally and by injection should be prepared and given at different times.

The following staff are authorised to administer medicines providing they have undertaken the necessary training and work within their sphere of competence:

- ✓ A registered nurse.
- ✓ A registered midwife.
- ✓ A registered pharmacy technician.
- ✓ A registered nursing associate.
- ✓ A registered medical practitioner or dentist.
- ✓ A registered operating department practitioner.

- *A student nurse, midwife or nursing associate in training*- under the supervision of a registered nurse or midwife who remains responsible for ensuring that the correct procedure takes place.
- *Other healthcare professional staff groups in specific clinical areas*, provided they have undertaken appropriate training and are competency assessed, e.g. radiographers, chiropodists and physiotherapists (practice approved by Medicines Governance Committee).
- *Medicines may be administered to a patient under a Patient Group Direction (*PGD). See section below for further details.
- *Student nurses and student midwives* are <u>*not*</u> permitted to supply / or administer medicines under a PGD even if under direct supervision of a registered nurse or midwife.
- In the majority of circumstances, single person medicines administration is acceptable. Exceptions to single nurse administration are detailed below where witnessed administration is required:
    - Paediatric patients.
    - Intravenous or complex injectable medicine. This does not include IV hydration fluids requiring no calculations or manipulations.

- Insulin.
- Controlled drug.

- '*Approved witness'* refers to:
  - a second registered nurse/midwife or nursing associate.
  - advanced clinical practitioner.
  - doctor,
  - pharmacist,
  - qualified operating department practitioner,
  - a 2nd or 3rd year student nurse who has received formal classroom instruction on the administration of medicines,
  - In the case of insulin, where possible the patient (or carer) should be involved in the administration (either administration of the insulin themselves witnessed by a nurse, or administered by a nurse and witnessed by the patient). If the patient is assessed as unfit to self-administer, the administration must be carried out by a nurse with an approved witness from the list above.

Where a second check occurs, this is a complete check of both clinical and technical aspects inclusive of: right patient, drug, dose, route, time and the assessment that the medicine is clinically appropriate for the patient.

Staff that administer medication are encouraged to wear a red tabard. This indicates these staff should not be interrupted during this process.

Medicines should be prepared immediately before use.

8.3 ***Drug Administration with a Student Nurse / Midwife***
Student nurses / midwives may be involved in medicines administration (exceptions apply e.g. PGDs), providing that they are under the direct supervision of a registered practitioner or other authorised person. The accountability for the correct checking and administration remains the responsibility of the authorised registered practitioner.

8.4 ***Administration of Medicines by Occupational Health Nurses***
The occupational health nurse will administer all medicinal products in accordance with the written instructions of a prescriber or via the use of an approved PGD.

8.5 ***Unregistered Workforce***

Where the administration of a medication forms an integral part of a procedure to be undertaken by registered staff other than nursing, midwifery or medical, they must:

- Have the practice approved by the Medicines Governance Committee.
- Have undertaken an approved training package.
- Comply with all locally agreed criteria/guidelines.
- Undertake an annual assessment for competency carried out by the Charge Nurse/Sister, or Head of Department.
- The Neonatal Nursery Assistants, who are members of the NNU team who have completed level 3 NVQ and have had their role verified through the Trust Board will, within this role, be allowed to give oral medication, except controlled drugs, having checked it with a registered nurse/midwife.

8.6 ***Administration in Theatres***

A doctor must perform the administration of medication in theatre except in an emergency situation. However the doctor remains responsible for what is given. Nurses and ODPs may prepare and draw up the medication at their request. The medication must be checked prior to being given.

8.7 ***Self-Administration of Medication by Patients/Carers***

See separate Trust Policy: Self administration of medicines (SAMS) procedure.

8.8 ***Non-prescription homeopathic/herbal remedies***

These products are not available via the NHS and will not be procured by the trust pharmacy. We do recognise that patients in pursuit of improving their health and well-being may turn to alternative products. Due to the difficulty in ascertaining the quality of such products and the potential impact they may have on prescribed medication the usual recommendation will be for such products to be omitted during a hospital admission. They will not be prescribed or administered by trust staff.

Where this is deemed to have a significant impact on the patient's well-being and continuity of care such products may be self-medicated or administered by carers where specific agreement is reached with the consultant overseeing the patient's episode of care. This agreement must be documented in the medical notes. These recommendations include cannabinoid oil containing products.

8.9 ***Patient Group Directions (PGDs)***

A PGD is: "A written instruction for the sale, supply and/ or administration of named medicines in an identified clinical situation. It applies to groups of

patients who may not be individually identified before presenting for treatment"

For information regarding the use of PGDs within LTHTR, see the PGD policy.

8.10 ***Covert Administration of Medicines: Disguising Medicine in Food and Drink***

Disguising medication in the absence of informed consent may be regarded as deception.

A clear distinction should be made between those patients who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity. Please see the Trust's Mental Capacity Policy and procedure for further guidance.

The covert administration of medicines is only likely to be necessary or appropriate in the case of patients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal. In such circumstances the following considerations must apply:

- The best interests of the patient must be considered at all times.
- The medication must be considered essential for the patient's health and well-being, or for the safety of others.
- The decision to administer a medication covertly should not be considered routine, and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient or client individually. It should be patient and drug specific, in order to avoid the ritualised administration of medication in this way.
- There should be broad and open discussion among the multi-professional clinical team and the supporters/carers of the patient, and agreement that this approach is required in the circumstances. Family or advocate involvement in the care process should be positively encouraged.
- The method of administration of the medicines should be agreed with the pharmacist.
- The decision and action taken, including the names of all parties concerned, should be documented in the care plan and reviewed at appropriate intervals.
- Regular attempts should be made to encourage the patient to take their medication. This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual.

8.11 ***Administration of Controlled Medicines***
See the Controlled drugs policy.

8.12 ***Cytotoxic Medicines***
Refer to the policy for administration of cytotoxic chemotherapy for further information. The fundamental principles of intravenous therapy apply to the administration of parenteral cytotoxic medicines. However, only staff who have completed training on the additional precautions required when handling cytotoxics and are deemed competent should administer cytotoxic medicines.

Cytotoxic medicines present a potentially serious risk to health. All cytotoxic medicines must be handled with care due to their potential mutagenic, teratogenic or carcinogenic effects. Correct handling procedures must be adopted when handling cytotoxics. Pregnant Staff must not handle cytotoxic medicines.

Nursing staff ***will not*** be involved in the preparation and reconstitution of cytotoxic medicines - this is the responsibility of the Pharmacy Department, and all cytotoxic medicines will be supplied from Pharmacy in a presentation suitable for administration without manipulation*. In the event of an urgent requirement, the consultant requesting the medicines will contact the on-call pharmacist for advice.

*****An exception to this is the preparation of Mitomycin which may be prepared using a closed system device by staff specifically trained in the use of this product.*

For oral preparations, a non-touch technique must be used. Tablets must not be crushed. A suspension can be requested from Pharmacy.

8.13 ***Biological therapy***
For the purpose of preparation and reconstitution, these medicines will be treated as per cytotoxic medicines unless a specific risk assessment and agreement from pharmacy has been made to deviate from this.

8.14 ***Intrathecal Medicine***
Lancashire Teaching Hospitals is a non-intrathecal chemotherapy trust. This means that intrathecal chemotherapy must not be prescribed, manufactured or administered at LTH without the direct authorisation of the medical director and the chief executive. Consult the “Intrathecal Chemotherapy Policy” for further information.

Not all intrathecal medicines will be cytotoxic chemotherapy. Some other medicines are administered via the intrathecal route. Intrathecal medicines must only be administered by staff suitably trained and competent to do so.

8.15 ***Radiopharmaceuticals***
Radiopharmaceutical administration is strictly limited both in terms of where it can be carried out and by whom it can be carried out. The facility in which

radiopharmaceutical administration will be performed should satisfy all of the relevant requirements set out in the Ionising Radiation (Medical Exposure) Regulations 2017 (IR (ME) R) – with special consideration given to the written procedures that must be in place as per Schedule 2 of the aforementioned legislation.

Any operator carrying out administration of radiopharmaceuticals must be adequately trained to do so, and a comprehensive, contemporaneous record of this training maintained. Operator training must satisfy the requirements of Section 17 (and Schedule 3) of the IR (ME) R legislation and all trust requirements for medicines administration – including ANTT where injectable medicines are to be administered. The only exemption from this requirement is in a situation whereby an operator is undergoing training, in which case supervision must be provided by an adequately trained operator.

Special consideration should be given around the administration of injectable radiopharmaceuticals, especially where Multi-Dose Vials (MDVs) are to be utilised. Written procedures detailing correct methodologies for withdrawing from and manipulating these materials should be written, approved and acknowledged by relevant staff, and strictly adhered to in practice. No manipulation of injectable radiopharmaceuticals outside of those processes described in written procedures is to be undertaken.

8.16 ***Administration of Supplementary Enteral Feeds***

A dietician may request the administration of an enteral feeding product through recording the request on the approved prescription chart. This will only be supplied following the completion of the assessment form for the clinical review of the patient's suitability.

Nursing or auxiliary staff will comply with this direction in the same manner as they would a doctor's prescription (i.e. administer the requested product at the stated time).

8.17 ***Administration of Complementary Therapies***

The application/administration of all complementary therapies must only take place if it is prescribed by a doctor or if part of an agreed trust policy.

8.18 ***External Medicated Applications***

In view of the possible hazards inherent in the use of such preparations (which may be legally classified as Pharmacy or Prescription Only Medicines), the nurse/midwife must not administer external medicated applications unless they have been either prescribed or specified in a written patient group direction, e.g. Ametop Gel.

8.19 ***Medication at Nurse Discretion***

The in-patient prescription chart contains a section for the administration of commonly used medicines that may be administered at the discretion of the nurse. They may be administered to patients by nursing staff for a limited time

once the section has been signed by a prescriber. Longer term administration of these medicines should be undertaken under the directions of a standard prescription.

8.20 ***Omitted or Significantly Delayed Doses***

Patients have a right to receive their medicines at the time they are intended. Delays and omissions can lead to serious adverse incidents for patients. Critical medicines are those where the omission or delay is likely to cause harm.

If a critical medicine is not available, the ward pharmacist, ward based pharmacy technician or the on-call pharmacist should be contacted without delay to ensure supply is made (see pharmacy ward folders for information on contacting pharmacy when the pharmacy is closed).

If a critical medicine is not administered, it should be documented in the patient's medical record with the reason for omission and the medical team should be contacted for advice, a clinical incident (Datix) should be completed.

8.21 ***The Application of Topical Patches***

When a topical patch is administered the previous patch must be removed and the site of the newly administered patch documented. Used patches must be disposed of as pharmaceutical waste, those containing controlled drugs placed in a container that would be difficult for the patch to be retrieved from e.g. sharps bin.

8.22 ***Injectable medicines via other routes (non IV/SC)***

In specific circumstances or specialities other invasive routes of injectable medicines administration are used: e.g. epidural, intra-articular, intra-ocular and intra-osseous. Individual practitioners administering medicines via these routes will require specific training in the preparation and administration of the injectable medicine via the route and have proven competence.

9. STORAGE

9.1 ***Storage Facilities***

Each ward/department requires storage accommodation that meets British Standard BS2881 (including the locking mechanism), unless specified, as follows:

- ***Controlled Drugs Cupboard***
  Contains only those medicines controlled by the Misuse of Drugs Act (1971) and subsequent amendments. Nothing else may be stored in this cupboard.

- ***Internal Medicines Cupboard***
  Contains preparations for internal administration other than CDs.

- ***External Medicines Cupboard***

Contains preparations for external use.

- ***IV Fluids Storage***
  IV bags should be stored in their original outer boxes on the designated IV storage racking. Where necessary, individual bags can be stored in a clearly labelled area of the IV racking.

- ***Cupboard For Disinfectants/Antiseptics***
  To contain only these substances. These substances can be stored in the ward COSHH cupboard.

- ***Temperature Monitored Refrigerator Specifically Designated For Medicines And Parenteral Fluids***
  To contain those medicinal preparations requiring storage between 2^{o}C and 8^{o}C.
  Only medicines are to be stored in this refrigerator.

- ***Reagent Cupboard***
  Contains substances for clinical tests, for example urine testing. This cupboard does not need to meet the standards specified for general medicines storage.

- ***Medicine Trolley***
  Contains those medicines in current use. Must be immobilised when not in use.

- ***Individual Patient Locked Cupboards***
  For the storage of medicines dispensed to individually named patients. These must be kept locked.

- ***Flammable Substances Cupboard***
  For the storage of flammable substances.

- ***IV Flushes***
  Please note ampoules of water for injection and sodium chloride 0.9% must be stored in the standard locked medicines cupboards. The Posiflush (which contains sodium chloride 0.9%) devices used to flush IV lines are classed as medical devices, and as such storage does not need to meet the requirements for medicines storage.
  These storage areas and storage cupboards must be kept locked at all times, unless in use. They must be regularly cleaned.

9.2 ***Custody of Keys***
Keys for controlled drugs cupboards, IV-PCA, and epidural pumps, must be kept separately from other ward keys. The keys for the other medication cupboards (as listed above) must be kept separately from the keys to cupboards containing other substances. The overall responsibility for these keys lies with the nurse/midwife designated in charge of the ward/department

who must be identified on the duty rota. To ensure CDs are readily available, the ward manager/Midwife or designated person in charge of the ward/department may devolve responsibility to a registered nurse/midwife or qualified operating department practitioner. The nurse in charge must check the CD stock daily at handover.

9.3 ***Departments Unmanned at Night / Weekends***

In these areas the keys must be stored within a ward/department supported by 24 hour staffing. A registered nurse/midwife, qualified operating department practitioner/assistant can collect the keys from the area prior to use.

Loss of keys must be reported to the designated nurse/midwife bleep holder who will inform the on-call duty manager and pharmacist, and a Datix incident form completed. Every effort should be made to find or retrieve the keys and if unsuccessful, a new lock will be required.

9.4 ***Discrepancy of Stock Balance***

In the event of a suspected discrepancy in the stock balance at ward/department level, the designated nurse/midwife must be informed immediately. She will inform the pharmacist during normal opening hours. A Datix incident form must be completed for every incidence of stock discrepancy if a CD is involved. If there is a suspicion of "medicines abuse", this should be reported to the ward manager, matron and a senior pharmacist. An incident form must be completed. Out of hours, the pharmacist can be contacted via switchboard.

9.5 ***Accidental Loss***

Any medication spilled or tablet dropped must be destroyed in accordance with the Lancashire Teaching Hospitals NHS Foundation Trust Waste Management Policy. Disposal of dropped/spilled/broken vials of CDs must comply with the Controlled drugs policy.

9.6 ***Storage of Resus Medicines***

All wards/departments will have a stock of medicinal products used for resuscitation. These boxes will be tamper-evident and must **not** be held in a locked cupboard but at strategic and accessible sites. Once the box has been opened, seal broken or is expired, a replacement must be obtained from Pharmacy. Nursing/Midwifery/Operating Department Practitioner staff will check these boxes are intact and in date daily.

9.7 ***Storage of Controlled Medication Stationery***

Controlled stationery is any stationery which, in the wrong hands could be used to obtain medicines fraudulently. The following stationery is considered "controlled by the Trust" and as such must be stored in a secure manner:

- Controlled medication order books
- Controlled medication registers

- FP10 NC forms

9.8 ***Safe Keeping Of Controlled and Other Medicines by Midwives Working in the Community***

- All drugs should be stored safely in a locked case and clearly labelled with the name of the drug, batch number and expiry date.

- Outpatient prescription forms

Supplies of drugs should be obtained from the hospital pharmacy.

Drugs authorised to be carried by Midwives working in the Community are as follows:

Adrenaline 1:1,000	2 ampoules
Ergometrine 500 micrograms	2 ampoules
Syntometrine 1ml	2 ampoules
Lidocaine 1% 5ml	2 ampoules
Paracetamol	32 tablets
Senna tablets	20 tablets
Combur 7 test sticks	1 bottle (100)
Glycerin suppositories (adult) 4 g	1 box (12)
Sodium Citrate (Microlax) enema	2
Sodium Chloride 0.9% sachets 25ml	1 pack (25)
Lubricating Jelly	1 Tube (42g)
Phytomenadione 2mg in 0.2ml	2 ampoules
Misoprostol 200 microgram tablets	

9.9 ***Pethidine***

If, during a home birth Pethidine is required for pain relief the attending Midwife will request the 2nd on call midwife to obtain 100mg of Pethidine from Delivery Suite stock (Preston or Chorley). The Pethidine will be countersigned by a Midwife working on Delivery Suite and transported to the woman's home in a double locked box. The two midwives check the Pethidine again in the home. The date, time and dose are documented in the woman's case notes.

If the Pethidine is not required it may be returned to stock and documented in the register from which it was taken.

9.10 ***Safe Disposal of Medicines***

All medication waste generated by the administration process should be disposed in accordance with the Trust waste disposal policy.

9.11 ***Safe Disposal of Medicines - if a Patient Dies***

If a patient dies whilst an in-patient at Lancashire Teaching Hospitals nursing and pharmacy staff must consider if an inquiry in to the cause of death is likely to take place before the patient's medicines are removed from the bedside locker:

I. If an inquiry is unlikely, the medicines can be removed from the bedside locker and returned to pharmacy for destruction in the usual manner.

II. If it is thought an inquiry in to the cause of death is possible the medicines may need to be assessed as part of the inquiry. The medicines should be put in to a clearly labelled green medicines (patient's own) bag and stored securely until such time they have been assessed.

III. Please call ext. 4740 RPH or 01257 246207 CDH to check with the coroners officers if the medications are needed.

10. AUDIT AND MONITORING

10.1 Refer to Appendix 1- *The Auditing programme for this policy.*

11. TRAINING

11.1 All staff must be supported with appropriate training that is relevant to the tasks they are to undertake relating to the handling of medicines. Training should be provided before staff are expected to undertake the relevant tasks.

11.2 Additional training for staff may be identified as a result of a medication incident or RCA. This training should be tailored to suit the needs of the individual or group of staff.

12. DOCUMENT INFORMATION

APPENDICIES	
Appendix Number	Title
Appendix 1	Auditing programme for - The Medicines Management (General) Policy.
Appendix 2	Equality, Diversity & Inclusion Impact Assessment Form.

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
TP-46	Non-medical prescribing (NMP) Policy
TP-143	Controlled drugs policy and procedure
RMP-C-06	Self-administration of medicines (SAMS) procedure
TP-139	Mental capacity act and deprivation of liberty safeguards policy
HRP-13	Disciplinary policy and procedure
RMP C 132	Amendment of prescriptions by pharmacists policy.
TP-187	Patient group direction policy

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** Checked by library ET 18/06/2019	
Number	References
1	Royal Pharmaceutical Society. Medicines, Ethics and Practice. The professional guide for pharmacists. Edition 42, July 2018. The pharmaceutical press.
2	National Institute for Health and Care Excellence (NICE). Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NG5 March 2015.
3	Royal Pharmaceutical Society. The Safe and Secure Handling of Medicines December 2018 (revision of The Duthie Report 1988)
4	Standards for medicines management. Nursing and midwifery council 2015.
5	The current British National Formulary must be available wherever medicines are administered and the current BNF for children in those areas where children are cared for. BNF https://bnf.nice.org.uk/ BNFc https://bnfc.nice.org.uk/
6	Professional guidance on the administration of medicines in healthcare settings, Royal Pharmaceutical Society, January 2019.
7	NHS Counter fraud authority. Management and control of prescription forms, Version 1, March 2018.
Bibliography	

CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
Members of MG Committee		April 2019
Members of Pharmacy Governance Committee		April 2019

DISTRIBUTION PLAN	
Dissemination lead:	David Jones
Previous document already being used?	Yes
If yes, in what format and where?	Electronic, heritage library system, hard copy
Proposed action to retrieve out-of-date copies of the document:	Knowledge and library to replace with updated version. Any paper copies to be removed and placed in confidential waste.
To be disseminated to:	Trust wide
Document Library	
Proposed actions to communicate the	Include in the LTHTR weekly Procedural

document contents to staff:	documents communication– New documents uploaded to the Document Library

Appendix 1 ***This table shows the audit programme for "the Medicines Management (General) Policy"***

Describe Key Performance Indicators (KPIs)	Target %	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Medicines for adults will be reconciled by a pharmacist	100% (if adult inpatient stay > 24 hours)	Trust wide point prevalence study	Medicines Governance Committee	Quarterly	Pharmacy Clinical Team
Regular medicines for children and patients on the Maternity Unit will be reconciled by a pharmacist	100% (if inpatient stay > 24 hours)	Trust wide point prevalence study	Medicines Governance Committee	Quarterly	Pharmacy Clinical Team
New inpatient medicines will be clinically checked by a pharmacist and signed off if accurate	100%(if medicine prescribed > 24hours)	Trust wide point prevalence study	Medicines Governance Committee	Quarterly	Pharmacy Clinical Team
Hospital out-patient prescriptions will be clinically checked by a pharmacist prior to the dispensed medicine being handed to patient	100%	Trust wide point prevalence study	Medicines Governance Committee	Annual	Pharmacy Governance Team
Medication errors (i.e. unintended prescribing, clinical checking, dispensing and administration incidents that reach the patient) and medication security incidents are reported via the Trust incident reporting system	Med errors in top 5 incident categories reported on Datix	Medicines Safety Officer Monthly report	Medicines Governance Committee	Monthly	Medicines Safety Officer
All medication incidents that require a Root Cause Analysis to be undertaken must include a pharmacist in that investigation	100%	Medicines Safety Officer Monthly report	Medicines Governance Committee	Monthly	Medicines Safety Officer
Level 3 incidents involving medicines undergo a RCA, and these are reported at the Case Review Group	100%	Trust RCA Register	Case Review Group	Weekly	Trust Governance Team Medicines Safety Officer
Pharmacy interventions are reviewed via a periodic point prevalence audit	At least 100 interventions reported in each one day snapshot audit	Pharmacy Intervention Report	Medicines Governance Committee	Annual	Pharmacy Governance Team
An accurate record of medicine administration / omission is made in line with Trust Policy	100%	Trust wide point prevalence audit	Medicines Governance Committee	Quarterly	Pharmacy Clinical Team

Appendix 2

Lancashire Teaching Hospitals
NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Pharmacy			
Lead Assessor	David Jones			
What is being assessed?	Medicines management policy			
Date of assessment	20.5.19			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☒	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details: Medicines governance committee			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil Partnership	Neutral		
Pregnancy and maternity	Neutral		
Other (e.g. caring, human rights, social)	Neutral		

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	N/A

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	☐	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	☐
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	☐	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	☐
4. The patient will be at the heart of everything the NHS does.	☐	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	☐
5. The NHS works across organisational boundaries.	☐	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	☐
6. The NHS is committed to providing best value for taxpayers' money.	☐	6. To have a process for staff to raise an internal grievance.	☐
7. The NHS is accountable to the public, communities and patients that it serves.	☐	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	☐

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	☐
3. To drive innovation through world-class education, teaching and research.	☐	3. Deliver value for money.	☐
		4. Fit for the future.	☐