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1 POLICY STATEMENT AND KEY PRINCIPLES

1. This policy lays down standards for the supply, storage, prescribing and administration of medicines for patients within Wrightington, Wigan and Leigh NHS Foundation Trust.

2. It is based on statutory requirements, and guidance from the Department of Health (Duthie Report), the Crown Report, the UKCC Standards for Administration of Medicines and The Royal Marsden Hospital Manual of Clinical Nursing Procedures.

3. The specific requirements of specialist clinical areas may not be covered in this document. This may necessitate more detailed local procedures drawn up between the Senior Sister/charge nurse of the clinical area and the pharmacist for that area, in consultation with other appropriate staff. The Trust Medicines Management Board must approve all local procedures.

4. The definition of a medicine is that used in the Medicine Act, 1968, that is ‘any substance used for treating, preventing or diagnosing disease, for contraception, for inducing anesthesia or modifying a normal physiological function’.

5. The potential for error at all stages of the process of administration of medicines should not be under-estimated. Maintenance of high standards requires attention to detail by all professionals involved in this process. Staff are asked to use common sense when faced with new situations and be personally aware of their professional limitations. If unsure about any aspect of clinical procedure they should seek advice from senior professional staff.

6. All staff must appreciate the importance of involving the patient in his/her treatment as much as possible. This includes ensuring that the patient understands, as far as possible, any potential adverse effects resulting from medication therapy.

7. Newly appointed medical, nursing and pharmaceutical staff, and any other staff group who have dealings with medicines, should read this policy and acquaint themselves with its contents. This is the responsibility of the appropriate head of department, ward, consultant or equivalent, as well as the individual member of staff.

8. In implementing this policy managers must ensure that all staff are treated fairly and within the provisions and spirit of the Trust’s Equality, Diversity and Inclusiveness Policy.
2. RESPONSIBILITIES

2.1 Medicine Management Board

- The Medicines Management Board is responsible for the approval of the Medicine Management Policy.

2.2 Divisional General Managers

- The responsibility for ensure adherence to the Medicines Management Policy rests with the Divisional Manager (or nominated deputy).
- Divisional General Managers must ensure that action is taken in response to deficiencies reported as a result of audit, reviews or incidents in the safe handling of medicines.

2.3 Consultant/ Matron / Head of Department

- Consultants/Matrons and Heads of Department are responsible for ensuring that all staff involved in the handling, prescription or administration of medicines are familiar with the contents of this policy and the safe practice guidance contained within.

2.4 All Staff involved with the handling of medicines

- All staff involved in the handling of medicines have a responsibility to familiarise themselves with the contents of the Medicines Management Policy.
- All staff have a responsibility to ensure that medicines are stored, prescribed, prepared and administered in accordance with the Medicines Management Policy.
- All staff involved in the handling of medicines have a responsibility to report all incidents involving medicines via the Trust incident reporting system to allow learning and sharing of lessons learned.
- All staff involved in the handling of medicines have a responsibility to maintain their own competency and to decline any task, which they cannot undertake in a safe and skilled manner.

3. SUPPLY OF PRESCRIBED MEDICINES

3.1 Supply of medicines:

Medicines are supplied by pharmacy departments in several ways, as follows:

- To wards and departments as stock
- To wards and departments **dispensed** against an individual patient’s prescription as temporary stocks
- To certain wards/departments as a fully labeled patient pack (one stop dispensing)
- **Dispensed directly** to a patient as discharge medication or on an out-patient prescription form
- To wards/ departments as pre-labeled medications for out of hours supply.
Prescription charts will be endorsed by pharmacy to indicate the status of the medication as detailed in Pharmacy Endorsement Standards. The endorsements will be made by Pharmacists or Pharmacy Medicine Management Technicians (MMT). The following abbreviations will be used:

- **POD** – indicates that the patients’ own drug have been checked and approved for use.
- **S** – indicates the item is held as stock on the ward.
- **T** – indicates the item is a temporary stock and has been supplied by pharmacy (these items are not suitable for issue to patients on discharge as the label does not contain any directions for use)
- **OSD** (one stop dispensing) – indicated the item has been supplied as a labeled patient pack
- **CD** – indicates the item is a controlled drug.

### 3.2 Stock Medicines:

Stock lists for wards and departments must be agreed, and regularly reviewed, between the ward manager and the ward pharmacist or qualified technician. Stock lists should be reviewed every 6 months. Each stock list will be held on file and no item will be available for issue as ward stock without the express sanction of the ward pharmacist, unless it is on an agreed list. If there is any doubt regarding the specification of any item ordered, clarification must be sought before the supply is made. Particularly toxic or corrosive items should only be issued with full identification as to the hazard and the necessary warning labels.

Pharmacy Technicians and Assistants visit wards and departments at agreed times to check stock against a previously agreed stock list. Supplies to replenish used stock are then sent to the ward or department via the Pharmacy at RAEl, Leigh or at Wrightington. The requisition will be signed by the appropriate Pharmacy Technician /Assistant.

### 3.3 Items Requested In-Between Top-Up Days:

These items can be ordered via your ward pharmacist or by faxing a requisition to the dispensary or pharmacy stores department. Care must be taken when ordering temporary stocks to ensure that the pharmacy department has not previously supplied the items.

### 3.4 Temporary Stock items:

These can be ordered via the ward pharmacist, by faxing a requisition to the dispensary or by a pharmacy technician during a ward top-up service.

Care must be taken when transcribing orders onto requisition sheets to ensure that all details are included, i.e. patient name, drug name, strength, form and dose. The order form should indicate if a pharmacist has endorsed the prescription chart. If a pharmacist has not endorsed the prescription chart then the chart must be sent to pharmacy before the item will be released.

This is an essential safety measure to ensure the clinical appropriateness of all prescriptions; therefore the order form must accurately reflect the prescription chart. The inclusion of all details will reduce telephone calls to clarify orders.
3.5 One Stop Dispensing (OSD)

One stop dispensing allows the supply of all patients' discharge medication to be issued on (or soon after) admission. OSD medications may be ordered via the ward pharmacist or technician. A 28-day supply will be dispensed which should be secured stored in patient bedside lockers. Any medicines dispensed as OSD should follow the patient in any ward changes during admission and the remainder to be issued on discharge in accordance with a discharge prescription.

3.6 Patients' Own Medication (POD's):

Patients should be encouraged to bring all regular medication into hospital with them. Following an assessment for suitability for re-use, Patients Own Drugs should be re-used wherever possible to reduce the burden of re-issue and medicine wastage on the local healthcare economy. Patients own medication should be stored in patient bedside lockers and must only be discarded with the patients consent. All POD’s sent to pharmacy will be destroyed on the assumption that consent has been granted at ward level.

3.7 Transport and Receipt:

Supplies, with the exception of bulk fluids and feeds, are delivered to the ward in a locked or sealed container.

Where a locked box is in use, one key for the locked box is held at pharmacy; the second key is held by the qualified nurse in charge of the ward or department.

Requirements outside of the above arrangements may be collected from the pharmacy by a qualified nurse, another member of the ward/ department staff authorised to collect medicines or an ‘authorised messenger’. Identification badges must be clearly visible.

OSD (one stop dispensing) medicines issued to a patient must be transferred with the patient if they are transferred to another ward or hospital within the Trust.

3.8 Borrowing of medicines:

Except in an emergency, the transfer of medicines between wards is strongly discouraged during pharmacy department opening hours. Medications required urgently should be ordered via the Ward Pharmacist / MMT or by fax as described earlier. Outside working hours all hospitals have access to an emergency medicine cupboard and the on-call pharmacist should be contacted for advice if required medications cannot be located from the emergency drugs cupboard or other wards.

If the borrowing of medications between wards can not be avoided the following must be taken into consideration:

- Controlled drugs cannot be transferred from one ward to another, individual patient doses only is permitted, see section 6.8 for more information.
- The whole container should be transferred - medications should never be decanted from one container to another; Loose foil strips should not be transferred without the original packaging.
- The container should be returned to the lending ward immediately after administration to the patient, or arrangements made with the pharmacy to supply a replacement as soon as possible after verification of the transfer has been established;
Administering drugs labeled for one patient, to another patient, is not recommended, except under exceptional circumstances. The on-call pharmacist should be contacted for advice.

**Under no circumstances should patients' own drugs (PODs) be borrowed for administration to another.**

### 3.9 Nurse Issue of Pre-packs:

Dispensing must not be undertaken by nursing staff, except for the issue of pre-packed medications prepared by the pharmacy and available for a specific purpose. Certain wards and departments have a limited range of products ready prepared for TTA (to take away). These packs must only be issued in accordance with a prescription written by a doctor or another professional that has authority under the recommendations in the Crown Report. At the time of issue to the patient the labels should be endorsed with the patients’ name, the date of issue and any blank spaces in the directions must be clearly and legibly completed in accordance with the prescription.

All issues must be recorded by means of prescription retention. The dispensed item(s) must be double checked for accuracy by another registered practitioner before issue to the patient. Both persons must sign and date the prescription. The practitioner retains accountability for any supply made under these circumstances.

### 3.10 Discrepancies:

Apparent discrepancies (e.g. dispensing errors or missing drugs) must be reported to the relevant Ward Manager, Matron or Night Nurse Practitioner. The Ward Pharmacist or Pharmacy Dispensary Lead of the site should be informed at the earliest opportunity. The person making the report must complete a Datixweb entry within 24 hours.

### 3.11 Medicines No Longer Required / Destruction (excluding controlled drugs)

Unusable portions of an administered medicine should be immediately destroyed on the ward. The pharmacy department can advise on current guidelines regarding destruction, but, in most cases flushing down the sink will be satisfactory.

Medicines no longer required for other reason (e.g. patient discharge, change of prescription, expired stock etc) should be marked with a cross over the pharmacy label (if one is attached) and returned to pharmacy via the pharmacist/MMT or pharmacy transport box.

The pharmacy team may need to consider the removal of a medicine from the ward stock list if expiry is noted.

### 3.12 Supply of medicines outside normal pharmacy opening hours.

In the first incidence, the use of ward stock or patient’s own drugs (following assessment for suitability) should be utilised.

If a required medication is not available on the ward the administering nurse has the responsibility to ensure that the medication is obtained and administered as soon as possible. A flow chart is available on all wards and departments detailing the correct procedure for the sourcing of medications outside pharmacy opening hours. Only after this procedure has been followed should the on-call pharmacist be contacted for advice.
3.13 Patient’s Own Drug’s (POD’s)

Patients’ own drugs must be assessed as suitable following the procedure outlined below:

- The medicine must be in its original container and be in good condition, physically intact, dry, clean and uncontaminated. If the patient has a blister strip with them that is clearly identifiable as the drug prescribed, this may be used if the pharmacist/MMT deems it appropriate. The expiry date must be visible. Nursing staff administering medications from loose blister strips prior to assessment by pharmacy retain accountability for any medications administered.

- Eye, Ear or Nose Drops may be used if they are unopened (sealed). Opened creams and ointments and oral liquids may be re-used if the person checking them is satisfied with the overall acceptability.

- POD’s that must be stored in the fridge can only be used if the cold storage chain can be verified. Any unopened insulin that the patient has with them must be put in the fridge on admission but the vial/pen that they are using may be kept in the locker (for up to 28 days)

- The medication must contain a clear label showing:
  a) Correct patient’s name
  b) Correct drug name (open boxes to check contents also match)
  c) Correct drug strength
  d) Dose that matches the medicine chart
  e) Address of the pharmacy where it was originally dispensed
  f) Expiry date & dispensing date (see below)

- The expiry date on the medication must be at least 1 month later than the date of checking. Brown pharmacy bottles can be used provided that they were dispensed within the last 3 months.

- In any case, the date that the medication was dispensed must be no longer than 3 months prior to the date of checking, unless the pharmacist is satisfied there are no compliance problems and deems it appropriate.

- **DO NOT USE** any items that are in a dosette box/blister pack or are otherwise mixed together so that identification of the medication cannot be determined.

  **REMEMBER, IF IN DOUBT, DO NOT REUSE**

3.14 Emergency Drugs Cupboard (EDC)

Each site has access to an emergency drugs cupboard for use **outside pharmacy opening hours only**.

Medicines may be obtained from the Emergency Drugs Cupboard. Keys to the cupboard are held by the Night Site Co-ordinator. The emergency drugs cupboard may be accessed by medical, nursing or pharmacy staff only. Details of any medication removed from the Emergency Drugs Cupboard must be recorded in the folder provided. The security of the keys and the cupboard is paramount.

Ward stock may be borrowed from another ward as described previously.
If an urgently required drug is not available through any of the above means and the procedure for obtaining medications outside pharmacy hours has been followed, the on-call pharmacist may be contacted via switchboard by either the prescriber, the nurse in charge of the ward or the night co-ordinator.

Ward stocks and temporary stock issues must not be given to patients to take home unless authorised by Pharmacy and correctly labelled. Certain drug formulations may be dispensed for in-patients prior to discharge with full instructions, e.g. eye drops, inhalers, topical preparations. These may be given directly to the patient on discharge at the request of Pharmacy. Under no circumstances must patients be given medications from ward stock in envelopes bearing handwritten instructions, site emergency drugs cupboards contain stocks of white boxes and blank labels for this purpose.

Wards where one-stop dispensing is in place may discharge patient direct from the ward providing the discharging nurse has been trained and follows ward procedures for the safe discharge of patients out of hours.

4 STORAGE OF MEDICINES

4.1 Responsibility:

The qualified nurse-in-charge is responsible at all times for all medicine stored on the Ward/Department. The pharmacy department will advise on storage issues and may be required to implement new procedures, according to current legislation.

4.2 Custody and Safe Keeping of Keys:

Keys should be kept on the person of the qualified Nurse-in-Charge. If the qualified Nurse-in-Charge decides to delegate this responsibility, they remain accountable.

Keys must be separated into two sets: Medicines Cupboards, Medicines Trolley and Medicines Refrigerator. These are the responsibility of, and must be kept in the possession of, the qualified nurse-in-charge. In the absence of a qualified nurse-in-charge of the ward, the custody of the keys will be at the discretion of the qualified nurse-in-charge of the clinical area.

4.3 Controlled Drugs keys:

Must be kept separate from the medicine trolley/cupboard keys and must be held by the qualified nurse in charge.

4.4 Loss of keys

The loss of any keys must be reported immediately to the relevant Ward Manager, Quality & Safety Matron or Site Co-ordinator. The Ward Pharmacist or Pharmacy Dispensary Lead for the site must be informed as soon as practically possible.

Pharmacy does not hold duplicate keys for any ward storage cupboard. It is the responsibility of the reporter to ensure that a Datixweb entry is completed within 24 hours of any loss of keys.
4.5 Storage Locations

Wards and departments must have the following storage facilities:

Intravenous fluids and sterile topical fluids are stored in a cupboard or clean area acceptable to the Pharmacy Department.

All other pharmaceuticals must be stored in locked cupboards which should comply with the current British Standard for medicines storage (BS 2881).

All cupboards containing medicines, lotions and reagents should be locked when not in use. If this is not practical or feasible then they must be stored in a secure area that prevents unauthorised access.

4.6 Controlled Drug Cupboard

This is reserved solely for the storage of controlled drugs, and those medicines treated as controlled drugs, in accordance with local procedures.

This cupboard should take the form of a locked cupboard within a locked cupboard or a double locked metal cupboard. Controlled Drugs cupboards must meet with the requirements stipulated in the Misuse of Drugs (Safe Custody) Regulations. They may/ may not be fitted with a red light to identify when open.

4.7 Internal Medicines Cupboard

This may take the form of one large or several small cupboards for tablets, liquids, injections, etc. and should be in the same room or location. The Medicines Cupboard should only contain medicines as defined under the Medicines Act, 1968.

CUPBOARD FOR EXTERNAL MEDICINES, DISINFECTANTS AND ANTISEPTICS

4.8 Refrigerator

Medicines requiring storage in the refrigerator will be marked ‘Store in a refrigerator’ or state the exact temperature range suitable for storage - food and pathological specimens must never be stored in the medicine refrigerator.

Fridge temperature must be checked and recorded on a daily basis.

4.9 Medicines Trolley

For storage of medicines in current use on the medicine round. The trolley must not be left unattended during the medicine round and when not in use should be locked and immobilised (usually chained to a wall). Medicines no longer in use should be returned to the medicines cupboard or Pharmacy.

4.10 Cardiac Arrest Medicines

For clinical emergencies wards and departments should keep a limited range of medicines for life threatening emergencies on a resuscitation trolley in a tamperproof emergency box.
4.11 Patient Bedside Lockers

Most wards have patient bedside lockers. These should be used for the storage of patients' own drugs and medicines issued labeled for individual patient use only. Unlabelled stock or temporary stock items should not be stored in patient bedside lockers. It is the responsibility of the transferring nurse to ensure bedside lockers are checked when patients’ are discharged/ transferred.

4.12 Containers

All medicines must be stored in their containers. They should not be transferred from one container to another or left loose. Once a dose of any medicine has been removed from its original container it must never be returned. If the patient does not take/receive it, it must be placed in a clinical waste bin. Medicines removed from their original pack (including ampoules and vials) and subsequently unused, should not be returned to the original pack.

ACCESS TO CUPBOARDS

4.13 Cupboards Other than Controlled Drug Cupboards

In addition to the qualified nursing staff or authorised student nursing staff, only practitioners and pharmacy staff may hold keys and have access to these cupboards. They must ensure they are known to ward staff and notify their presence on each visit.

4.14 Controlled Drug Cupboards

Only in certain specified circumstances may staff other than the qualified nurse in charge have unattended access to the Controlled Drugs cupboard. Pharmacists/MMT should check stocks of controlled drugs with the qualified nurse on a regular basis.

4.15 Receipt of medicines on ward

All medicines should be securely stored on receipt on ward in the appropriate location by an authorised member of staff.

4.16 Sample Medicines, Dressings, Equipment, etc

These must not be accepted on the ward unless by prior arrangement with the relevant pharmacy, supplies or medical equipment department.

5. RESPONSIBILITIES AND PROCEDURES OF ALL STAFF FOR PRESCRIBING OF IN-PATIENT MEDICINES (SEE PRESCRIPTION CHART POLICY FOR FULL DETAILS)

5.1 General Prescription Writing Requirements

The patients' name, NHS and/or district number, date of birth, ward and the name of the consultant must be entered on the prescription chart. For paediatric patients weight should also be entered.

The date, including year, on which treatment is to commence must be entered on the prescription sheet.
The name of the medicine should be printed legibly, in indelible ink, using approved names (rINN) and avoiding abbreviations. The term M/R should be used to indicate a modified-release preparation. Proprietary names (brand names) must not be used. The only exceptions to this rule are: multi-ingredient preparations with no approved names and products whose proprietary name defines a specific formulation (e.g. slow-release diltiazem preparations and inhalers).

The dose must be expressed in S.I. units. Quantities less than 1 gram must be written as milligrams, micrograms or nanograms as appropriate.

The terms microgram and nanogram must not be abbreviated, but must be printed in full and used for quantities less than one milligram. Decimal points should be avoided, e.g. use 500mg not 0.5g. (Whenever a decimal point is necessary, both the prescriber and the Registered Nurse administering the drug must exercise great care).

Only the following abbreviations are acceptable:

- g for gram
- kg for kilogram
- L for litre
- mg for milligram
- ml for millilitre
- mmol for millimole

For single ingredient preparations, the dose required must not be expressed in terms of the dosage form e.g. ‘Paracetamol 2 tablets’ is not acceptable - it should be written as ‘Paracetamol 1g’.

5.2 Route Of Administration

Only the following abbreviations are acceptable:

- BUCC for buccal
- IV for intravenous
- IM for intramuscular
- INH for inhalation
- NEB for nebulised
- PO or O for oral
- PR for rectal
- PV for vaginal
- SC for subcutaneous
- SL for sublingual
- TOP for topical (including topical application of patches)

Other routes of administration must be written in full.

In general, only one route of administration should be specified for each medicine. Where appropriate, multiple routes may be specified for a single medicine (E.g. Metoclopramide 10mg PO/IV), provided that the dose required by each route is the same and that the Registered Nurse documents by which route the drug was administered.

5.3 Dosage Frequency – Regular

For ‘regular’ medicines, the time of administration for each dose must be indicated by a tick against the pre-printed administration times or written in the appropriate column of the prescription chart, using the 24-hour clock. The use of Latin abbreviations (especially OM and ON) is discouraged.
5.4 **Dosage Frequency – As required**
For ‘as required’ medicines the frequency of administration must be written by the prescriber in the relevant section of the prescription chart. The indication for the ‘as required medicine’ should be recorded. A maximum dose in 24 hours must also be included (the term PRN, alone, is insufficient). Occasionally this may not be possible (e.g. for nebulised Salbutamol or Glyceryl Trinitrate infusion): in these situations administration and maximum dose must be in accordance with an approved protocol.

5.5 **Dosage Frequency - ‘Stat’**
For once only and/or single immediate doses the prescription must be written in the relevant section of the prescription document. If the medicine is intended to be given immediately, then the prescriber may administer and record the administration himself or herself, alternatively the patients Registered Nurse must be informed by the prescriber.

5.6 **Recording Allergies, Hypersensitivities & Diets**
Any information relating to any allergy/hypersensitivity or special diet should be recorded on a yellow prescription chart in the spaces provided. This information should include, where possible, the name of the causative agent, type and date of reaction. It is good practice to also record this information on the Electronic Patient Record (EPR) as an alert for future reference.

5.6 **Flushes**
The prescription chart contains a section for the prescription of line flushes. This prescription should be to document each time as flush is administered.

5.7 **Pre-printed Labels**
Note that approved pre-printed labels may be used for the prescription of defined medicines. The prescription writing requirements set out in this policy must still be followed.

5.8 **Prescribers Signature**
The first item on the prescription sheet must bear the full signature of the prescriber. Subsequent entries written by the same prescriber may be initialled but ‘ditto’ marks are not acceptable. Subsequent entries by a different prescriber must bear that prescribers full signature.

For controlled drugs, a prescribers’ full signature and printed name is always necessary. The signature of a medical student is not acceptable.

5.9 **Discontinuing Medicines**
The date when a medicine is discontinued must be entered into the ‘stop date’ box (this may be entered in advance, e.g. for courses of antibiotics). The ‘stop date’ is the date where no further doses should be given.

The entry must clearly indicate the name of the Doctor (or other appropriate person) discontinuing the medicine.

A diagonal line should be drawn through the prescription so that its cancellation is obvious, but the prescription should not be obliterated. A vertical line should be drawn through the ‘Date’ column to indicate the time at which the prescription is to stop.

Medicines prescribed on separate charts must be discontinued on both documents and the other charts in use box on the front of the prescription chart updated accordingly.
5.10 Multiple Prescription Charts

Care must always be taken when multiple charts are in use. Use of more than one main chart must be avoided whenever possible. Where this is not possible the two charts should be attached to one another, and each chart clearly endorsed to indicate more than one current chart in use. Prescribers should always attempt to consolidate prescriptions onto one chart.

All current medicines must be indicated on the main prescription chart. Cross-reference must be made on the front of the prescription chart (using the spaces provided) to medicines prescribed on separate, supplementary, charts i.e.

- Anticoagulants
- IV fluids and additives
- Insulin
- Pain control
- Syringe drivers
- Chlordiazepoxide
- Antibiotics
- PCA
- Heparin
- Others as specified

5.11 Prescribing By Telephone

PRESCRIPTIONS MUST NOT BE GIVEN OR ACCEPTED OVER THE TELEPHONE. A legible faxed prescription is acceptable in urgent situations. The prescription writing requirements must still be followed.

5.12 Validity of Prescriptions

Prescriptions will be considered valid until discontinued, unless a Trust policy indicates otherwise (e.g. antibiotic courses) or the course of treatment is clearly specified. The term ‘Prolonged Treatment' may be used - where appropriate - if a definite stop-date has not been established.

5.13 Re-writing Prescriptions

Prescriptions must be re-written if the patient is re-admitted or transferred from another hospital.

Prescriptions must be re-written when the administration section is full. When re-writing prescriptions under such circumstances, the Doctor must ensure that the dates entered relate to the dates when the therapy commenced and not the date of re-writing. It should be indicated on the prescription chart that the treatment has been reviewed and the date of re-writing the prescription should be recorded on the front of the prescription sheet.

If a change in dose, frequency or route of administration is required, the whole prescription must be re-written and the original entry discontinued. If amendments are made they should be signed and dated to indicate change.
6. ADMINISTRATION OF MEDICINES

Current NMC guidelines for the administration of medicines must be followed.

6.1 Authorised Personnel

The following personnel are authorised by the Trust to administer medication (or a restricted range of medicines) against a valid written prescription or within an approved Patient Group Directive (PGD):

- Registered Nurses and Midwives
- Registered Medical Officers
- Pre-registration Medical Officers
- Radiographers
- Operating Department Practitioners
- Physiotherapists
- Podiatrists

It is the responsibility of line managers to ensure that staff participating in the administration of medicines are competent to do so. Practitioners also must bear in mind a responsibility to maintain their own competence, and ensure that they decline any tasks that they are not able to undertake in a safe and skilled manner.

6.2 Principles for administration of medicines

In exercising professional accountability in the best interests of patients, staff administering medicines must:

- Know the therapeutic uses of the medicine to be administered, its normal dosage, side-effects, precautions and contraindications
- Be certain of the identity of the patient to whom the medicine is to be administered.
- Be aware of the patients’ care plan
- Check the prescription is clearly written and unambiguous
- Have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies
- Check the expiry date of the medication
- Check the patient is not allergic to medication before administration
- Contact the prescriber immediately where contra-indications to the prescribed medication are discovered, where the patient develops a reaction to the medication, or where assessment of the patient indicates the medication is no longer suitable.
- Make a clear, accurate and immediate record of all medication administered, intentionally withheld or refused by the patient, ensuring that written entries and the signature are clear and legible.

6.3 Role of the student nurse

Pre-registration student nurses should be encouraged to undertake a role in the administration of medicines, in support of a registered nurse, as part of an educational experience. Any medicines they administer must be checked and their administration supervised by a registered nurse. All opportunities should be used to encourage learning about the therapeutic benefits and risks of medicines. Student nurses are not permitted to administer IV therapy unless a local procedure has been agreed. Please see Appendices 1 and 2.
6.7 Role of the Assistant Practitioner (AP)

Assistant practitioners may assist patients to take medications dispensed by a registered nurse. They must not dispense or prepare medications.

Competency trained assistant practitioners may act as a second check for intravenous drugs and controlled drugs. In both instances, the AP must sign the relevant documentation.

6.7 Role of the Auxiliary Nurse

Auxiliary nurses may assist the patient to take medications, but must not dispense or prepare.

The qualified nurse carrying out the medicine administration check should understand the prescription and should have knowledge of the common indications, side-effects and dosages of the medicine prescribed.

The qualified nurse administering the medication will be accountable for his/her practice in accordance with the NMC guidance.

“When administering medicines the nurse must follow a sequence of steps to ensure the safety and well being of the patient. He/she must understand the therapeutic effect and side-effects, the usual rates and method of administration and the usual dosage. The registered nurse remains accountable even if he/she delegates the action to another e.g. student nurse, health care assistant or care”.

Medicines should not be given unless appropriately prescribed. Any queries with the prescription must be clarified with the prescriber before administration.

6.6 Identification

Patient identification should be verbally confirmed prior to administration. The patient should be asked for their name and date of birth. These should be confirmed with the details on the prescription chart. If verbal confirmation is not possible, all details on the patient identity band must be confirmed including patients’ NHS/District unit number.

6.7 Preparation

Medicines should be prepared for administration using a no touch technique and be carried out directly prior to administration.

Once prepared, medications should be administered immediately to the patient. Medicines must not be left by patients’ bedside, or in tablet pots in the medicine trolley.

6.8 Documentation

For medicines not administered, only the numerical codes stated on the front of the prescription chart should be used to denote a drug not administered.

(1) Refused by patient
(2) Nil orally due to theatre
(3) Patient absent from ward
(4) Unable to take due to swallowing difficulties/vomiting
(5) No stock
(6) Incorrect prescription
(7) Patient self medicating
(8) Other reasons (Document in nursing notes)
It is vital that if a drug is not administered at the prescribed time, for any reason, that the appropriateness of the ongoing prescription be reviewed at the next medicine round. For example, if a drug was not administered at 10am because the patient was absent from ward (3), then the appropriateness of the prescription should be re-evaluated at the 2pm medication round. It may still be appropriate for the patient to receive their missed medication at 2pm. If in doubt, advice should be sought from a colleague i.e. nursing, medical or pharmacy staff.

If a drug cannot be administered because of no stock (5) then all reasonable sources must have been exhausted i.e. pharmacy, emergency drug cupboard and other wards, before this code is entered on the prescription chart. Provision should be made to ensure the medication is available for the next medication round. It is completely unacceptable for a patient to be without prescribed medication for any longer than 24 hours.

6.9 Signatures of staff administering medicines.

Every staff member administering medicines must provide a sample signature on the back of the prescription chart. If this section has already been signed, it need not be signed repeatedly.

7. PARENTERAL MEDICINES

Principles for medication administration set out in Section 6 should be adhered to at all times.

7.1 Prescription of Parenteral Medicines

All parenteral medicines must be prescribed on the parenteral therapy section of the prescription chart. All prescriptions for parenteral antibiotics must be assessed for appropriateness after 48 hours.

The pre-printed prescription for Sodium Chloride flush (0.9%) should be used each time a flush is administered.

All prescriptions must include
- Drug name – recommended International Non-proprietary Name (rINN)
- Start date and stop date (if known)
- Route, dose and frequency of drug prescribed.
- Timing of doses – signified by tick against appropriate pre-printed time, or time entered in grey box
- Signature of prescriber
- Printed name of prescriber
- Bleep number of prescriber
- It is good practice to also include the rate of administration and the diluents required.

7.2 Preparation of Doses

Nursing staff that have completed the Trusts’ IV Therapy study day (or equivalent) and obtained a certificate of competence, may prepare and administer medicines for intravenous use.

Preparation of injectable medicines in the ward/department must be prepared in such a way as to be sterile, pyrogen free and particle free.

Parenteral doses must be correctly labelled with an intravenous additives label and must contain the following information – drug, dose, volume, diluent, patient’s name, ward, date and time of preparation, expiry date and the name of the person who prepared the dose.
The preparation of all parenteral doses must be double checked by another member of
nursing staff (or doctor or pharmacist) who has witnessed the preparation and administration
of the medication. The witness must also countersign the prescription chart in the relevant
section.

If an addition has been made to an intravenous fluid (or reconstitution of the contents of an
ampoule/vial), the method, stability, and compatibility should be checked by reference to
Appendix 6 in the BNF, package insert, the summary of product characteristics (SPC data
sheet) or the UCLH injectable guide (copies of which are available on all wards).

Additives must be prepared immediately prior to administration; they must not be prepared
far in advance of their use. Unused additives should be destroyed immediately.

7.3 Administration of Parenteral Doses

Nursing staff that have successfully completed the Trust IV Therapy Study day (or
equivalent) may administer intravenous medicines.

Staff must be aware of current NMC guidelines.

The person(s) who made the preparation must only administer additives prepared on the
ward/department.

Only medicines that have been prepared by or in the presence of the administering
practitioner should be used. The only exception to this case is products prepared by the
pharmacy central intravenous additive service (CIVA), under the direct supervision of a
pharmacist.

Assurance of the chemical stability and asepsis of medications prepared outside pharmacy,
for intravenous infusion, are the responsibility of the administering practitioner.

8. CONTROLLED DRUGS (CD'S)

See Safe management of Controlled Drugs Policy for further information.

8.1 Prescription of controlled drugs

Controlled drugs should be prescribed according to the general prescription requirements as
described in Section 5. Care must be taken to ensure the correct formulation is prescribed:
the term M/R must be used to indicate modified release preparations; brand name should be
included where appropriate.

8.2 In-patient Supply of controlled drugs

CD's will usually be supplied from the pharmacy department as ‘stock’ items.

8.3 Ordering Stock from Pharmacy

The controlled drugs requisition book must be used at all times. It is essential to provide full
information regarding the name of the drug, form, strength and quantity required. Care must
be taken to ensure that the correct formulation is ordered: the term M/R must be used to
indicate modified release preparations and brand name should be included where
appropriate.

Only one item may be ordered per requisition.
The signature of the registered nurse / operating department practitioner (OPD) ordering controlled drugs must be stated along with the printed name.

Pharmacists or pharmacy technicians may write requisitions for controlled drugs, however the requisitions must be validated by a signature of the nurse in charge of the ward before sending to pharmacy.

8.4 Transport of controlled drugs

Controlled drugs for ward stock will be transported in Trust controlled drugs tins. Wards/departments must send an authorised person to Pharmacy to collect controlled drugs tins once orders are complete. The person accepting delivery must sign for receipt of the controlled drugs.

8.5 Receipt of controlled drugs on the ward

A registered nurse or ODP must immediately, formally accept the CD’s into stock. The appropriate entries should be made in the controlled drugs register; the balance checked and then the medicines locked in the controlled drugs cupboard. This action must be double checked by another registered nurse, pharmacist or doctor. Student nurses and assistant practitioners may act as a second check.

8.6 Storage of controlled drugs on the ward

Controlled drugs must be stored in a designated, locked cupboard, which meets the specifications detailed in the Medicines Act. This cupboard must be dedicated to the storage of controlled drugs.

Care must be taken to ensure that discharge prescriptions containing controlled drugs are stored in a locked cupboard prior to issue to the patient. See controlled Drugs policy for more details.

8.7 Storage of controlled drugs requisition book

The controlled drugs requisition book must be securely stored when not in use. The locked controlled drugs tin may be used for this purpose.

8.8 Controlled Drug cupboard keys

The controlled drugs cupboard keys must be kept on a separate key ring from all other keys and are the responsibility of the Registered Nurse in charge of the ward/department. Any loss of these keys must be reported to the Ward Manager, Matron, or Night Nurse Practitioner. The ward pharmacist should be informed as soon as possible. A Trust incident form must be completed within 24 hours of any loss of keys. Pharmacy department do not hold duplicate keys for CD cupboards.

8.9 Controlled drug ward register

Controlled drugs registers must be retained on the ward for a minimum of 2 years from the date of the last entry.

A separate page in the register must be used for each product. Each product must be identified by its generic name, strength and form at the top of each page, e.g. MST 10mg tablets should be documented as Morphine Sulphate 10mg Modified Release tablets.
8.10 Checking of controlled drug stock balance

Controlled drugs stock checks must be carried out every 24 hours. Stock checks must be documented using the controlled drugs check sheet.

Balance checks must be carried out by a registered nurse and a witness who may be a registered nurse pharmacist, doctor or appropriately trained assistant practitioner.

The pharmacy department must carry out a full ward controlled drugs balance check every 3 months.

Any discrepancies should be immediately reported to the Ward Manager, Matron, Senior Nurse Manager or Site Co-ordinator. The ward Pharmacist should be informed as soon as practically possible and must, at the least, carry out a full stock check with the Ward Manager. A Trust incident report must be submitted within 24 hours of any discrepancy.

8.11 Administration of controlled drugs

The administration of controlled drugs must be carried out according to the administration guidelines described in Section 6.

Additional requirements for the administration of controlled drugs must also be followed

- Controlled drugs must always be checked and administered by 2 members of staff, one of whom must be a registered nurse, ODP or doctor (who must sign the prescription chart) The other may be a registered nurse, doctor, pharmacist, ODP or assistant practitioner.

- The controlled drug register should be completed and signed by both staff described above

- After every administration the controlled drug balance must be checked and recorded.

8.12 Borrowing of Controlled drugs

Under normal circumstances there should be no need for CDs to be borrowed. However, if the situation is unavoidable then CDs may be obtained, outside Pharmacy opening hours only, for named patients following mutual agreement between the Registered Nurses-in-Charge of the respective wards/departments.

The ward supplying the CD must issue the drug to the ward borrowing the CD.

The CD registers from both wards must be completed to indicate the transaction. The process must involve a Registered Nurse from each ward, both of whom must sign both CD registers.

The ward issuing the CD must record the name of the patient for whom the controlled drug is supplied.

The issuing ward will, in addition, need to see the original prescription chart.
8.13 Out-Patient or Discharge Prescriptions for Controlled Drugs.

The current Misuse of Drugs Act governs the requirements for Controlled Drugs prescriptions. The BNF gives explicit details of the requirements, but in summary, prescriptions must:

- Be signed a Doctor (electronic signatures permitted when using EPR system)
- Include the date
- Include the name and home address of the patient.
- Specify the name, form and strength of the medicine.
- Specify the dose
- Specify the total quantity of the medicine in both words and figures
- Be for a maximum of 30 day supply.

Prescriptions for controlled drugs may be computer generated or written by an authorised person before being signed and verified by a doctor. The Misuse of Drugs Act states that pharmacists are not permitted to dispense prescriptions for controlled drugs, unless all the above information is detailed on the prescription.

8.14 Patients Own Controlled Drugs

The re-use of patients’ own controlled drugs (POCD’s) is forbidden unless there are exceptional circumstances.

Every effort must be made to send patients own controlled drugs home with the patient’s relative or representative. If this is not possible then POCD’s must be sent to pharmacy for destruction, with the patient’s consent.

Only in the rarest of circumstances should patients own POCD’s be stored on the ward. In these exceptional circumstances POCD’s must be entered into a designated section in the ward controlled drugs register (usually in the back of the register) and may be administered to the patient, assuming the process outlined above is followed (administration of CD’s)

The wards’ POCD register must be accurately completed to indicate the destiny of POCD’s.

8.15 Return/Destruction Of Controlled Drugs

The following CDs must be destroyed at ward level by a Registered Nurse and witnessed by a Pharmacist:

- Any expired stock
- Part-use containers of oral liquids (if excess to requirements) – I am still not sure if we should be destroying expired stock at ward level.

The contents of part-used vials and injections (e.g. bags and syringes) must be flushed down the sink by a Registered Nurse or ODP and witnessed by a Registered Nurse; Doctor; Pharmacist or ODP. Any destruction carried out must be documented in the controlled drugs register.

The Pharmacy department will advise on methods of destruction, according to current regulations.

Other controlled drugs which are excess to ward requirements, should be returned to pharmacy in the controlled drugs tin with a completed requisition order stating, “returned to pharmacy”.

Return or destruction of any quantity of controlled drugs must be recorded in the CD register as a separate entry in RED indelible ink and the balance checked.
9. POTASSIUM CHLORIDE

Potassium Chloride concentrate products have been the topic of a National Patient Safety Agency Safety Alert (July 2003) and, as such, are subject to stringent storage and administration requirements, see MedAlert 2 July 2002 for further information.

Potassium chloride concentrate products include strong potassium chloride ampoules and ready diluted potassium chloride bags in concentrations greater than 40mmol/litre and products containing potassium phosphate concentrate.

9.1 Inpatient supply of concentrated potassium chloride

Potassium chloride injection (20mmol in 10ml) is permitted to be held as stock on the Neonatal unit only.

Potassium chloride pre-mixed bags 80mmol/litre and 40mmol/100ml may only be held as stock in the following areas

- Theatres
- ICU
- HDU
- CCU

The pharmacy department must approve the use of potassium chloride concentrate products in areas other than those specified. In such cases products will be supplied on a named patient basis provided the following criteria are met

- The patient is fluid restricted
- In severe hypokalaemia (potassium of less than 2.5mmol/litre)
- If the patient exhibits signs and symptoms of hypokalaemia

9.2 Ordering of stock of Potassium Chloride concentrate products

Potassium Chloride Concentrate should be ordered as a controlled drug, using the controlled requisition book.

9.3 Transport of Potassium Chloride

Potassium Chloride concentrate for ward stock will be transported in Trust controlled drugs tins or red transport bags designated for the transport of potassium chloride concentrate products. Wards/departments must send an authorised person to pharmacy to collect the order once complete. The person accepting delivery must sign for receipt.

9.4 Receipt of Potassium Chloride on the ward

A registered nurse or ODP must immediately formally accept the potassium chloride into stock. The appropriate entries should be made in the controlled drugs register; the balance checked and the potassium chloride locked in the controlled drugs cupboard. This action must be double checked by another registered nurse, pharmacist, doctor, or assistant practitioners
9.5 Storage of Potassium Chloride on the ward

Potassium chloride must be stored in a designated, locked cupboard or in the controlled drugs cupboard. No other infusion products or fluid bags should be stored in the same cupboard as potassium chloride bags.

9.6 Borrowing of Potassium Chloride

Potassium Chloride concentrate products should not routinely be transferred between clinical areas. Where this is absolutely necessary, pharmacy should be contacted (usually on-call) for advice. The on-call pharmacist will authorise the release of the concentrate from ward stock and will inform the ward manager. Transfer of concentrate should follow the policy for transfer of controlled drugs between clinical areas.

9.7 Administration of Potassium Chloride

The preparation and administration of solutions containing potassium chloride should be checked by two members of staff as described in Section 8.11 controlled drugs.

Potassium chloride should usually be administered at a maximum rate of 20 mmol/hour (expressed in millimoles of potassium ions).

Potassium chloride solution must always be administered via a central line using an infusion pump or driver with ECG monitoring where:

Either the concentration is greater than 40 mmol/litre
Or the administration rate is greater than 20 mmol/hour.

10. DISCHARGE/LEAVE MEDICATIONS

10.1 General Information

All discharge/leave prescriptions should be written or printed off (if EPR is being used) following the principles in Section 5 of this policy.

The discharge prescription should be written well in advance of it being required preferably no later than 5.30pm (weekdays) or 12pm (Saturdays) and 3.45pm (Sundays) at RAEI.

Ward stock supplies and medicines issued as temporary stocks should NEVER be given to patients' to take home. All medicines supplied for patients to take home must be dispensed by pharmacy.

10.2 Period of supply

The period of supply on discharge prescriptions is 28 days. If a longer or shorter supply is required, this should be clearly indicated on the prescription. On wards where OSD system is in operation, patients will be discharged with a minimum of 14 days supply.

10.3 Discharge Prescriptions

The Electronic Patient Record (EPR) system should be used to prepare discharge prescriptions wherever possible. Prescription charts should be sent to pharmacy once a prescription has been prepared by the prescriber. Ward staff must use the EPR system to check the status of discharge prescriptions prior to phoning pharmacy to enquire. Unnecessary calls into the dispensary disrupt the flow of work and potentially lengthen the time taken to prepared discharge medications. Telephone calls into the dispensary regarding prescriptions must only be made in URGENT cases.
A member of ward staff must attend pharmacy to collect discharge prescriptions. Patients, patients’ relatives or carers are not permitted to collect discharge medication from pharmacy unless there is a prior arrangement agreed between the ward and pharmacy.

The Registered Nurse must check the medicines supplied by pharmacy with against the discharge prescription prior to handing the medicines to the patient, relative or carer (where appropriate). The Registered Nurse should provide discharge counseling to the patient, relative or carer regarding the discharge medication.

10.4 Supply of Discharge Prescriptions Outside Pharmacy Hours

To avoid patients being discharged without appropriate discharge medication, medical staff have the responsibility to ensure that whenever practically possible discharge prescriptions are written during normal pharmacy opening hours.

Similarly ward staff have a responsibility to ensure that the Discharge Prescription is sent to Pharmacy during normal opening hours.

In the EXCEPTIONAL circumstances where the discharge prescription is written outside normal pharmacy opening hours the on-call pharmacist should be contacted for advice.

If patients’ are discharged outside normal pharmacy opening hours every effort should be made to ensure the patient receives their discharge medication as soon as possible post discharge. Every effort should be made to ensure that patients’ do not miss any doses of medications. However it should be noted that ward stock supplies should NEVER be given to patients to take home. All medicines supplied for patients to take home must be clearly labelled with instructions and patient details.

Wards that operate a one-stop dispensing system should consult local policy documents regarding the discharge of patients’ outside normal pharmacy opening hours.

10.5 Dispensing of pre-packed medicinal products by nurses when the pharmacy department is closed or the use of pre-packed medications during pharmacy opening hours has been agreed.

When the pharmacy is open all prescriptions must be sent to pharmacy for dispensing by qualified pharmacy staff.

Some wards have access to a supply of pre-packed medicines that may be utilised when the pharmacy department is closed, or when an agreement has been made with the pharmacy department. A registered nurse can supply these items providing the following guidelines are followed:

- A valid prescription (discharge/outpatient/ward-attendee) has been produced including
  - Patient’s name, full address and unit number
  - Drug form, strength, dose, period of supply
  - Signature of a doctor in ink
  - Date prescription was signed

Two registered nurses are involved in the process, one of whom will dispense the product and the other will check the dispensed product.

Where only one registered nurse is available on the ward/department they become the dispensing nurse. The checking nurse may be from another ward/department and must check both the prescription and the dispensed product.
Full guidance on this procedure should be displayed on all take home medicine cupboards and should be consulted prior to issuing any medications to the patient.

10.6 Role of the supplying nurse

- Check the prescription is valid (see above)
- Select the product from the TTA (to take away) cupboard.
- Read the label and check the details comply with the prescription:
  - Product name, including strength and formulation
    - E.g. co-codamol 8/500 effervescent tablets
  - Quantity - Only 1 original pack should be issued.
  - Directions – (where directions on the pre-printed label differ from those on the prescription the on-call pharmacist should be contacted for advice).
  - Check the expiry date is sufficient for the duration of treatment.
- Write (in block capitals) the patient’s name and date of dispensing on the label
- Write (in block capitals) the directions for use, if this is not already printed on the label
- Where appropriate add the expiry date e.g. eye-drops.
- Sign and date the prescription in the pharmacy box

10.7 Role of the checking nurse

- Examine the prescription and the dispensed product and double-check all of the above points.
- If all criteria are met, the checking nurse also signs and dates the prescription in the pharmacy box. If there is a problem, please refer to the on-call pharmacist e.g. the product prescribed is not stocked in TTA cupboard or the product’s labelled directions are not in accordance with the prescription.

10.8 Bed Crisis

The current bed management policy requires that the emergency on-call pharmacist will be called to assist inpatient discharge during bed crises. In this incidence the on-call pharmacist can only be requested by the bed manager / manager on-call.

11. OUTPATIENT PRESCRIPTIONS

11.1 General information

Outpatient prescriptions should be written on Trust outpatient prescriptions in accordance with requirements stipulated in Section 3.

The usual period of supply for outpatients is 28 days. If a shorter/ longer supply is required please state course length on prescription. All prescriptions should contain accurate directions for the patient to facilitate medication counseling when the medicines are issued to the patient at pharmacy.

Accident and Emergency patients will receive a 7-day supply.

Full supply of the following medications will be made

- Hospital only medications
- Unlicensed medications
- Named patient medications
- Clinical trial medications.
12. SELF-ADMINISTRATION OF MEDICATIONS

Taylor ward has procedures to facilitate the self-administration of medicines by patients, see Appendix 4.

The self-administration scheme is designed to help patients understand why they are taking their medication and to help them cope more easily and safely with their medication upon discharge. In order for patients to self medicate on the ward, they must have undergone assessment by either nursing or pharmacy staff. If self-administration is deemed appropriate then this will continue until discharge, or until there is a change in patient circumstances.

Regular medication counts by nursing staff are necessary to ensure compliance by the patient. The responsibility for ensuring safe storage of medicines on the ward still remains with the nursing staff at all times.

13. PROCEDURE FOR REPORTING INCIDENTS INVOLVING MEDICATIONS

13.1 Suspected Prescribing, Dispensing or Administration Error

- Do not administer further doses of the medicine.
- Seek Medical or Pharmaceutical advice if necessary.
- Retain the medicine and packaging. Complete a Trust Incident Form (within 24 hours) and report the incident to the Ward Pharmacist and Registered Nurse in charge at the first available opportunity.

13.2 Defects in Medicinal Products

- Do not administer further doses of the medicine.
- Seek Medical or Pharmaceutical advice if necessary.
- Contact medicines information (ext 2466) during working hours or, out-of-hours contact the emergency on-call Pharmacist.
- Where applicable, the following information should be provided:
  - Name of preparation; formulation; strength; manufacturer or supplier; route of administration; container; batch number; expiry date; manufacture date; nature of defect; details of the number of containers involved; date of incident; Physician/Surgeon responsible for patient; details of any clinical symptoms exhibited by patient.
- The Pharmacy department will then initiate the Regional Drug Defect Reporting cascade, according to the Regional protocol.
- A Trust Incident Form must be completed (within 24 hours).

13.3 Malfunction in Medical Devices

- Stop using the device.
- Seek Medical or Pharmaceutical advice if necessary.
- Contact Equipment Library
- Where applicable, the following information should be provided:
  - Name of device; model number; manufacturer or supplier; container; batch number; expiry date; manufacture date; nature of defect; details of the number of containers involved; date of incident; Physician/Surgeon responsible for patient; details of any clinical symptoms exhibited by patient.
- A Trust Incident Form must be completed (within 24 hours) if appropriate
14. **ADVERSE DRUG REACTIONS**

14.1 All doctors, nurses and pharmacists must report suspected adverse drug reactions to recently introduced medicines to the MHRA via the yellow card scheme. Recently introduced medicines are denoted by a black triangle in the BNF.

For all other medicines, serious or unusual reactions, which may be due to drug treatment, must be reported on a yellow card to the MHRA. If advice regarding an adverse drug reaction is required, medicines information should be contacted on ext. 2466.

Yellow cards are available in the BNF and from Medicine Information in pharmacy or via www.bnf.org

Pharmacists are involved in the monitoring and reporting of adverse effects of medicines. They must be informed of any suspected reactions to medicines.

The nature of the reaction, the medicine involved and the fact it has been reported to the MHRA, should be clearly recorded in the patients’ notes.

The adverse reaction should be clearly documented on the front of the patients’ case notes, prescription chart and on a red wristband.

15. **CLINICAL TRIAL MEDICATION**

Clinical trial medications are those used to treat patients’ entered into a clinical trial. Clinical trial medicines do not normally hold a UK Marketing Authorisation and their use should be covered by a clinical trials certificate (CTC), a clinical trials exemption (CTX) or a doctors and dentists exemption (DDX) from the Medicines Control Agency.

The role of the pharmacy service in relation clinical trials is to safeguard the patients, prescribers and the Trust by ensuring that products are appropriate for use and are used safely.

Official guidance concerning the purchasing, distribution and storage of clinical trial medication is encompassed in the Duthie Report. The Report recommends that stocks of clinical trial medicines should not be maintained on wards, clinics or in private offices.

All organisations supplying medicines and related products for use in clinical trials must supply these products through the Trust Pharmacy Department.

16. **MEDICINES MANAGEMENT EDUCATION AND TRAINING**

The following compulsory training is available to ensure the safe handling of medicines:

1. Induction training in medicines safety for new starters as per the Trust’s training needs analysis (TNA).

2. E-compulsory training on medicines safety for staff as per the Trust’s training needs analysis (TNA).

The TNA can be found on the Trust intranet under the training and development department.

The following non-compulsory training is available dependent on a training needs analysis being undertaken for an individual or group of staff and includes:
1. Medicines safety programme. This is for newly registered nursing staff who will be carrying out unsupervised administration of medicines to patients.

2. IV Therapy training, infection control, numeracy and calculations, legal and professional issues.

3. Training is offered for assistant practitioners in second checking of controlled drugs, injectable medicines and discharge medication.

4. Mentor training for more experienced registered nurses.

17. HUMAN RIGHTS ACT

The implications of the Human Rights Act have been considered and there are no identified implications for the Human Rights Act that affect this policy.

18. EQUALITY AND DIVERSITY

The policy has been assessed against the Equality Impact Assessment Form from the Trust’s Equality Impact Assessment Guidance and as far as we are aware, there is no impact on any Equality Target Group.

19. MONITORING AND REVIEW

Compliance with the policy will be undertaken by conducting medicine safety Quality Monitoring Programme (QMP) audits and monthly ward to board reporting. There are two QMP’s available for medicines safety, one for pharmacy and one for nursing. The QMP’s can be found on the Trust intranet under the nursing advisory home page.

Action for non-compliance is dependent upon the result of the audit. Action plans will be developed and monitored at divisional level where necessary. The Medicines Management Policy will be reviewed every two years and approved by the Medicines Management Board.

20. ACCESSIBILITY STATEMENT

This document can be made available in a range on alternative formats, e.g. large print, Braille and audiostreamcast.

For more details please contact the HR Department on 01942 77(3766) or Email equalityanddiversity@wwl.nhs.uk
Student Nurses, Medicine Administration and Blood Competencies

<table>
<thead>
<tr>
<th>Route/ Class / Activity</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Nurse medication administration</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Oral medications excluding Controlled Drugs (CD’s)</td>
<td>Can administer medications under the direct supervision of the registered nurse 2.</td>
<td>Can administer medications under the direct supervision of the registered nurse 2.</td>
<td>Can administer medications under the direct supervision of the registered nurse 2.</td>
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<tr>
<td>Intravenous (IV) medication administration and flushing of cannulae 4</td>
<td>Can observe only</td>
<td>Can observe only</td>
<td>Can observe only</td>
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<tr>
<td>Subcutaneous / Intramuscular medication administration (SC / IM) Excluding controlled drugs</td>
<td>Can observe and practice under the direct supervision of the registered nurse 2.</td>
<td>Can observe and practice under the direct supervision of the registered nurse 2.</td>
<td>Can observe and practice under the direct supervision of the registered nurse 2.</td>
</tr>
<tr>
<td>Intravenous Therapy 3</td>
<td>Can observe only</td>
<td>Can observe only</td>
<td>Can observe only</td>
</tr>
<tr>
<td>Per Rectum (PR)</td>
<td>Can administer suppositories and enemas under the direct supervision of the registered nurse 2.</td>
<td>Can administer suppositories and enemas under the direct supervision of the registered nurse 2.</td>
<td>Can administer suppositories and enemas under the direct supervision of the registered nurse 2.</td>
</tr>
<tr>
<td>Inhaled Therapy</td>
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<td>Can administer under the direct supervision of the registered nurse 2.</td>
<td>Can administer under the direct supervision of the registered nurse 2.</td>
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<tr>
<td>Topical</td>
<td>Can apply topical creams and solutions under the direct supervision of the registered nurse 2.</td>
<td>Can apply topical creams and solutions under the direct supervision of the registered nurse 2.</td>
<td>Can apply topical creams and solutions under the direct supervision of the registered nurse 2.</td>
</tr>
<tr>
<td>Controlled Drug Administration (CD’s)</td>
<td>Can observe only</td>
<td>Can administer medications under the direct supervision of the registered nurse and can act as 2nd signatory.</td>
<td>Can administer medications under the direct supervision of the registered nurse and can act as 2nd signatory.</td>
</tr>
<tr>
<td>Via Nasogastric tube or Percutaneous Endoscopic Gastrostomy</td>
<td>Can administer medications under the direct supervision of the registered nurse 2.</td>
<td>Can administer medications under the direct supervision of the registered nurse 2.</td>
<td>Can administer medications under the direct supervision of the registered nurse 2.</td>
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<tr>
<td>Blood Products (Red cells/platelets/fresh frozen plasma)</td>
<td>Can observe only</td>
<td>Students can collect blood products if they have had supportive training session and documented competency assessment 5.</td>
<td>Students can collect and second check blood products if they have had supportive training session and competency assessment 5.</td>
</tr>
<tr>
<td>Administration of medicines under a Patient Group Direction (PGD)</td>
<td>Can observe only</td>
<td>Can observe only</td>
<td>Can observe only</td>
</tr>
</tbody>
</table>

1. Direct Supervision is defined as “the registered nurse is physically present with the student on commencement and discontinuation of the procedure or if a significant change occurs to the treatment.”
2. Within child health students can only practice under the direct supervision of the registered nurse after the drug has been second checked with another registered nurse. The student will only observe the administration of Controlled Drugs and will not act as a second signatory for the administration of Controlled Drugs.
3. Intravenous therapy relates to saline, glucose, gelofusine, hartman’s solution and saline and glucose without potassium already added. Connection of other solutions to patients is NOT permitted by student nurses.
4. Mixing of intravenous drugs and antibiotics by student nurses is NOT permitted.
5. Edge Hill and UCLan student nurses Adult Branch Only are permitted to be involved in the collection or checking of blood products – Red cells, FFP, Platelets only. Child Branch students may only observe.

Acknowledgements: Table adapted from the Royal Liverpool and Broad Green University Hospital’s model of medicine administration and student nurses, received via Edge Hill University. Date of review May 2011. Date of next review October 2012.
Appendix 2

Procedure for Medication History Taking and Initial Assessment and Supply of Medication for In-patients

Purpose

- To ensure that an accurate medication history is established from a reliable source.
- To ensure that the medication history is recorded accurately and in the appropriate place
- To ensure that the patient receives the correct medication
- To ensure that patient confidentiality is maintained
- To ensure that the patients allergy/s are recorded accurately and in the appropriate places
- To minimise medication errors
- To establish patient compliance

Scope

This procedure details how pharmacy staff should obtain a patient medication history from the appropriate source, recording of the history in the correct manner, recording of the patient's allergy/s.

Procedure

1. Introduce yourself to the patient; explain who you are and what you are doing. Confirm the patients ID, by checking the patient's wrist band.
2. Locate the patient's drug board.
3. Ask the patient, if they are able to answer, if they have any allergies. Check that the appropriate drug board is used, yellow for known allergies and white for no known allergies, add any details as necessary regarding the allergy. If the patient cannot answer or is unavailable to answer a yellow board should be completed until you can confirm the allergy status.
4. Ask the patient if they take any regular medication either from their GP or that they buy (a structured questionnaire is available for less experienced staff). If they do not take any regular medication this should be documented on the drug board, see minimum endorsement standards. If the patient does take regular medication, ask the patient if they know what they take or if they have brought a list of their own medication with them.
   - If the patient knows their regular medication along with the doses and directions and you feel confident that this information is accurate, the patient can be used as the source of the medication history. You should record all details of the patient's regular medication for entry into the patient's notes.
   - If the patient has a list of their regular medication, check all the details you require are documented. Establish where the list has come from and whether you think the list will be accurate e.g. repeat prescription form from GP surgery, MAR Sheet, EPR Prescriptions. Ideally you should confirm the list with the patient, checking that they take the medication as detailed on the information source, that ALL the listed medications are still current and if any new medications have been started which are not on the list. You should record all details of the patient's regular medication for entry into the patient's notes.
   - If the patient has their medication with them firstly ensure they have ALL their medication with them, confirm that all the medicines are labelled with the patient's name and belong to the patient! Check with the patient that the directions are correct and confirm that they have not brought any discontinued medication with them. You should record all details of the patient’s regular medication for entry into the patient's notes. NB. Please ensure all details are completed on the front of the medicine chart, confirming if the patient’s own medication is with the patient, on the ward or if sent home.
5. If the patient is unavailable, unable to provide details of their regular medication or you are unsure of the accuracy of the information provided by the patient or their list, then an alternative source should be used to establish the medication history. The most appropriate source should be decided e.g. GP surgery, Nursing Home, Community pharmacist, EPR Discharge letter, Pharmacy Discharge letter from Ascribe, Community Drug Team. You may need to confirm details with the patient.

   - Ensure you have the patient’s details to hand before ringing the appropriate person, including their DOB and address.
   - On phoning the information source, tell the person answering the phone who you are and where you are calling from. Explain that you want a medication history for one of their patients.
   - Confirm with the person providing the information, the patient’s name and the DOB or the address of the patient, in case of duplication of the same name.
   - Record full details of the patient’s regular medication including directions, strengths and any specific brands etc.
   - Confirm that all items are current and or have been prescribed recently and also ask about acute items.
   - Have the fax number of the ward to hand, some information sources will only fax the information; provide your name, so they can fax for your attention only.
   - Some information sources will ask for the telephone number to ring back, to confirm who they are talking to.
   - Some sources may also ask for a headed note paper fax, detailing all information required.
   - Thank them for their help.

7. Once you have obtained an accurate medication history, you must wherever possible enter the information into the patient’s notes. If a medication history has already been entered you should check this for accuracy.
   - If any alterations are needed make them (in black ink)
   - Document that you have confirmed the medication history
   - Where you have obtained the history from
   - The date obtained, sign and that you are from pharmacy.

If there is no history in the notes, you should enter it yourself in the most appropriate place and add the above information bullets.

NB. When adding history to the patients notes, please ensure the dose and strength are added, i.e. Digoxin 500microgram OD, instead of 250microgram, two tablets OD.
   - Please ensure that the section on the front of the medicine chart regarding where the history was confirmed, and by whom, is completed.
   - On completion of a clinical check, the pharmacist should then sign the pharmacist section.

8. Once the medication history has been entered read through the patient’s notes to ascertain the reason for admission, the treatment they have received, any investigations that have been done, check blood results, any documented changes to the patients medication. It may also be possible to check the patient’s allergy status, if they have notes from previous admissions.

9. If appropriately trained you should now review the medication which has been prescribed for the patient in view of the medication history and notes. Some of the points you may wish to investigate are listed below.
- Are you looking at the correct patient’s drug board?
- Have all the patient’s regular medication been prescribed?
- If not is there a reason for this?
- If any medication dosage is calculated by body weight, check the weight of the patient and check the dose
- Has any new medication or adjustments to current medication written in the patient’s notes been implemented?
- Is any new medication in-line with the hospital formulary?
- Have abnormal blood results been acted upon?
- If appropriate, has reason for admission been acted upon, e.g. infections treated, digoxin toxicity etc.
- Has the patient got any previous illnesses which require further treatment?
- Has all prescribed medication been signed by the prescriber.
- Are all current medications appropriately prescribed, e.g. Cox 2's, bone protection required with long term steroids
- Has any medication to which the patient say’s they are allergic been prescribed?
- Could any of the patient’s medication be contributing to the patient’s admission and if so has this been reviewed.
- Always check anything that you are unsure of with the patient or doctor.

10. If any interventions need to be made, ideally approach the prescriber directly. If the prescriber is unavailable then leave a pharmacy green intervention note attached to the drug board (pharmacists and approved technicians only). It may also be appropriate to inform the nurse looking after the patient of your interventions. Further guidance on communication with medical staff is available for less experienced staff.

11. Endorse the drug board following the minimum endorsement standards.

12. Order any medication required by the ward see SOP 12b for detailed procedure.

Responsibility of staff

It is the sole responsibility of the Pharmacist, pre-registration pharmacist and medicine management technicians working for the Trust to carry out this procedure. Staff that have not been appropriately trained must not use this procedure. Staff trained in only certain areas of this procedure must only carry out the points in which they have received full training.

Known risks
- Poor handwriting
- GP receptionists
- Lack of experience
- No reliable source of information to establish the medication history
- New/unfamiliar drugs
- Critically ill patients
- Similar names
- Any medication not taken on each day of the week
• Drugs capable of causing most harm if given inappropriately e.g. methotrexate, anticoagulants, hypoglycaemics
Self-medication for patients on TAYLOR REHABILITATION UNIT

INTRODUCTION

A holistic humanitarian approach to nursing care necessitates considering people as individuals, and giving care in partnership with them. It could be said that a person’s self-esteem depends on a feeling of being involved in, and having some control over, their health care, and in being able to achieve the maximum degree of self-care. Routine administration of medications to all clients in a drug round timed to suit staff convenience rather than client needs represents a ‘batch-processing’ approach that is in direct contrast to the philosophy of individual client care.

PATIENT COMPLIANCE

Repeated studies of the elderly population have shown high levels of “non-compliance” resulting in inadequate control of symptoms, hoarding of medicines, over and under-dosage and taking drugs at the wrong time. Although clients on Taylor Unit are not always elderly, they do suffer from similar problems due to their condition. The implication of discharging a client home without sufficient knowledge is that there will be a failure to cope. In general, clients appear to benefit from the stepwise approach of counselling, demonstration and reinforcement. Apart from their own homes, the ward environment offers the most stable and reassuring setting in which to instruct clients on medication, and assess their level of compliance.

The term ‘compliance’ itself has authoritarian connotations which are at odds with a humanistic approach to care. A better term might be ‘collaboration’ because the aim must surely be for clients to take informed decisions about when to take or omit medications and when and how to seek further medical advice.

SELF-MEDICATION PROGRAMMES

A number of trials of self-medication have been undertaken to improve adherence to prescribed regimes, and there is great consistency in their findings. Reports show that anticipated problems of clients forgetting to take their medications, taking too many tablets, or gaining access to other clients’ drugs, seldom or never occurs in practice. Several reports mention the legal implications of self-medication and it was therefore decided to contact the Nursing & Midwifery Council (NMC) for their comments. In a personal communication, the NMC stated that whilst they could not comment on what was essentially a matter of District nursing policy, they were in total favour of the concept of self-medication.

POSSIBLE ADVANTAGES OF SELF-MEDICATION

1. Increased self-esteem could lead to a better quality of life for clients. The client would feel involved and have some control over health care.

2. Reduced client anxiety and stress would allow more nursing time to be devoted to other needs.

3. Self-medication schemes should encourage the objective assessment of drug regimes and could provide a stimulus to reassess treatments, allowing rationalisations to be made where appropriate.

4. “When required” drugs could be taken at the point of need. Under a nurse-administration system, medication might not be requested simply because the client would not wish to inconvenience ward staff. A client in pain, for example, might well suffer in silence rather than ask for an analgesic.
5. The client would become more independent and learn to cope alone at home. Pressure on relatives would be relieved and there would be a decreased demand on community nursing time.

6. Clients who would be unable to cope with their medications at home would be clearly identified prior to discharge and the necessary community nursing support could be arranged.

7. Better adherence to the prescriber’s instructions could lead to a reduction in readmission rates for drug-related problems.

8. By more effectively utilising hospital and community nursing time and reducing the likelihood of client readmission, self-medication programmes could lead to a more efficient use of NHS resources.

9. Increased liaison between doctor, nurse and pharmacist would further promote the team approach to client care.

10. As Taylor Rehabilitation Unit is a community-based venture, clients admitted from the community often bring in their own medication, which remains unchanged on admission. To reduce waste, a policy of using this medication can be incorporated into the scheme, thus reducing wastage of high quality medicines, saving time and costs.

11. Ready-labelled medication is available on the unit for use during weekend leave.

POSSIBLE DISADVANTAGES OF SELF-MEDICATION

1. There would be the theoretical potential for administration errors to occur which could compromise client safety and have legal repercussions.

2. A change in nursing procedures would be required, particularly in relation to drug administration, storage and security.

3. Client assessment, education, monitoring and the supply of medications in a suitable form would make increased demands on nursing and pharmacy time.

AIMS AND OBJECTIVES

(i) to educate clients about their medication;

(ii) to identify and solve any medication-related problems prior to discharge;

(iii) to select suitable clients for self-medication in preparation for discharge;

(iv) to liaise with community health care professionals once clients have been discharged:

(vi) to encourage the client’s contribution to their own care and increase independence.

TAYLOR WARD

Taylor Rehabilitation Unit provides nursing care to a range of clients with neurological deficits, including young stroke victims, head injury cases and those suffering with multiple sclerosis. Clients are admitted to the Unit via other hospitals within the Trust and directly from the Community.
In the past, some clients have been reluctant to hand over their medication to nurses, preferring to retain a little independence by taking their own medicines. Due to existing nursing policies on administration of medicines, this was not possible but could be for selected clients using the proposed scheme. Rehabilitation clients would benefit from education about their medicines. Problems which may arise when clients take their own medicines would be identified and could be solved prior to discharge.

Team nursing is practised on Taylor Rehabilitation Unit. There are two teams of nurses. Each client has a named nurse, within a specified team, who is responsible for their care. The nursing staff on the unit therefore come to know their clients very well, creating an ideal environment for a self-administration scheme.

**Clients who will be considered**

1. Clients due to be discharged home, where they will have some responsibility for their own medicines. Some clients may have more responsibility than others when at home.

2. Clients who wish to be more independent and maintain responsibility for taking their own medication whilst in hospital.

3. Those already responsible for their own medication at home who will find education about their medication beneficial to their continued rehabilitation.

4. Those taking weekend leave.

**Clients not to be included**

1. Clients who do not wish to participate in the scheme.

2. Clients who are physically or mentally incapable of managing their own medicines.

**Assessment of Clients**

Assessment of suitable clients for self-medication should be undertaken by the named nurse after the client has been orientated to the ward situation. The client is given a client information leaflet on the self-administration of medicines to read (see Appendix I) and encouraged to ask questions. When the nurse is satisfied that the client understands the reasons and requirements of the programme, the client is asked to sign the consent form (see Appendix 2).
Client interview and assessment of ability

The object of the assessment is:-

1. To obtain information from the client regarding existing drug therapy. To identify areas for education and counselling.

2. To identify any physical disabilities relating to dexterity, hearing and sight. Once identified, such problems may be overcome by use of compliance aids, large print labels or large print information sheets.

When a client has been accepted for the self-administration programme, the doctor must be informed and will write an entry in the client's case notes to this effect.

STAGES OF SELF-ADMINISTRATION

Stage 1

1. The client is given a lockable medicine box which is attached to the bedside locker. The key is kept by the nursing staff and stored in an agreed, secure location, e.g. the medicine trolley.

2. The procedure for Stage 1 is explained to the client. The medicines are placed in the client's medicine box.

3. The nurse approaches the client at predetermined times. This may be at meal times or a time preferred by the client. The nurse provides the key to the medicine box and observes the client's selection and administration technique. The nurse signs the drug administration sheet.

4. If medication is selected incorrectly, the nurse administers the correct drug. All interventions are recorded on the progress form (see Appendix 4).

5. The named nurse determines when the client is sufficiently competent to move on to Stage 2. Attempts can be made to resolve any problems encountered at this stage, e.g. by further counselling or use of compliance aids.

Stage 2

All clients must first be processed through Stage 1 before entering Stage 2 of the self-administration programme.

1. The same procedures as Stage 1 are followed except that the client is asked to seek a nurse each time medication is due, or is needed as in the case of 'as required' drugs. Medication is still given if the client forgets and a note is made on the progress form of the time allowed to elapse.

2. The nurse signs the drug administration sheet.

3. The named nurse determines when the client is sufficiently competent to move onto Stage 3.
Stage 3
All clients must first be processed through Stages 1 and 2 before entering Stage 3 of the self-administration programme.

1. The client is given the medicine box key to keep and advised to keep it safely, e.g. in a pocket or handbag. The client is told to keep the medicine box locked.
2. The client is requested to administer his own medicines. The nurse no longer supervises the client taking medication and does not sign the drug administration sheet.

All clients must enter the programme at Stage 1. A record must be made in the client’s case notes and nursing documentation each time the client moves to a different stage.

Initiation of Supply
On admission of a client to the self-administration programme one packet of each one stop medication will be locked in patient’s medication locker. The medicine board will be endorsed ‘self-medication’ and a reference made in the case notes and nursing documentation

The pharmacy will continue to supply one-stop medication to the ward with full instructions. Patients will be given stock by nursing staff as required.

On receipt of medicines for self-medicating clients, the pharmacist or supervising nurse must check the contents and label against the client’s prescription before placing inside the client’s medicine box.

Change of Medication
Will be discussed with the patient and supply changed as necessary by pharmacy and named nurse.

Controlled Drugs
Controlled drugs (CD’s) cannot be included in the self-administration programme and usual ward administration procedures must still apply. Clients who are prescribed CD’s may, however, self-administer any other non-controlled medication.

Injections
Injections will be stored in the usual drug cupboards and administered by nursing or medical staff. Insulin may be self-administered by clients willing to do so.

Clients’ Own Medication
Some clients are admitted with a supply of fully labelled medication. This medication may be used for the self-medication scheme. In such cases, it should be stored in the client’s secure box (they do not hold the key) until it is checked as suitable for use by the ward pharmacist. When the client enters the scheme, the medication can then be used.

Once the client’s own supply is exhausted, further supplies will be obtained from Pharmacy via the usual system of a discharge prescription endorsed “for self-medication”.

Security of Self-Medicating Clients’ Drugs
All drugs supplied for self-medicating clients must be stored in a numbered medicine box which will be secured to the top of the client’s bedside locker. Each box will be provided with two keys. An additional master key will be held on the ward by the nurse in charge. Self-medicating clients will be given their own keys, once on Stage 3, and the client will be responsible for security of the medicine box and its contents. It will therefore be necessary for the client to be present each time a nurse or pharmacist requires access to the box. In all other instances, keys will be held in an agreed, secure location, e.g. inside the medicine trolley.
Self administration of medicines

Information for patients

A medicines self-administration scheme is used on this ward to allow patients, where possible, to take their medicines as they would do at home.

A member of staff on the ward will assess whether self-administration is suited to your needs.

There are three stages of self-administration on the ward, with different degrees of responsibility for the patient. Every patient will start at stage 1 and progress will be reassessed weekly by the nurse. At all stages you will be provided with a prompt sheet which will list all your medicines and all the

STAGE 1- your medicines will be stored in a locked cabinet at your bedside. The nurse will approach you with the cabinet key at the times which your medicines should be taken and you will be responsible for selecting and administering the correct medicine.

STAGE 2 – at this stage you will be responsible for prompting the nurse to give you the cabinet key to take your medicines at the correct times.

STAGE 3 – you will be given the medicine cabinet key and will be solely responsible for administering the correct medicines at the correct times.

During all stages, the nurses will monitor your progress, and will always be available for help and advice. If you forget to take your medicines, the nurse will prompt you after a time.

Sometimes you may be asked to use your own supply of medicines from home if they are not kept by the hospital pharmacy. All other medicines will be provided by pharmacy.

The self-administration scheme is not compulsory and you may withdraw from the scheme at any time once started.
Patient consent for self-administration of medicines

I have understood the information which I have been given on self-administration of medicines and agree to take part in the scheme.

I understand that I may withdraw my consent at any time by informing my named nurse.

Signed………………………………………………………………………………

Witnessed……………………………………………………………………………

Date…………………………………………………………………………………
Assessment of patients for the self administration of medicines

Patients name........................................................................................................

Unit Number...........................................................................................................

Date Assessed........................................................................................................

Assessed by (name and position)...........................................................................

Cleared to self-medicate (sign)..............................................................................

Special recommendations and any other comments (e.g. Dossett, annotation of boxes, screw tops etc)
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</table>
1. Does the patient self-administer medications in the community?

2. Can the patient open the medicine containers and administer the medicines they must use?
   Please list problems/suggestions

3. Can the patient open the bedside medicine cabinet?

4. Does the patient understand what all the medicines are for?

5. Does the patient know when and how to take all the medicines and any special instructions related to the medicines?

6. Does the patient understand the concept of ‘when required’ medication (if applicable)?

7. Is the patient likely to abuse any of the medications prescribed?
## Self-administration non compliance form

Patients name…………………………………………………………………………………

Unit Number…………………………………………………………………………………

Completed by (name and position) ……………………………………………………...

Signature ……………………………………………………………………………………...

Date ……………………………

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### EQUALITY IMPACT ASSESSMENT FORM

#### STAGE 1 – INITIAL ASSESSMENT (PART 1)

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<td>Person(s) completing this form:</td>
<td>Ray Green</td>
<td>Tel No:</td>
<td>2489</td>
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<td>Others involved:</td>
<td>Connie Sharrock</td>
<td>Start date of this assessment:</td>
<td>March 2010</td>
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<tr>
<td>Title of policy being assessed:</td>
<td>Medicines Management Policy</td>
<td>Policy implementation date:</td>
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#### What is the main purpose (aims / objectives) of this policy?

To ensure the safe handling, storage, administration and destruction of all medicines

#### Is the policy existing & being reviewed or a new policy? (tick the relevant box)

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<tr>
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#### Will patients, carers, the public or staff be affected by this policy?

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#### Have patients, carers, the public or staff been involved in the development of this policy?

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<td>Staff</td>
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#### If yes, who have you involved and how have they been involved:

Patient Representative sits on the Wrightington, Wigan and Leigh Medicines Management Board which is the approving Board for this Policy.

#### What consultation method(s) did you use?

For example: focus groups, face-to-face meetings, questionnaires etc.

Medicines Management Board

#### How are any changes / amendments to the policy communicated?

For example: Meetings / Focus / Email etc.

Intranet and Policy Library
# EQUALITY IMPACT ASSESSMENT TABLE (POLICIES/SOP's)

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<th>Positive Impact</th>
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<tr>
<td>Other Group (please specify)</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applies to ALL Groups</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**High**: There is significant evidence of a negative impact or potential for a negative impact.

**Low**: Likely to have a minimal impact / There is little evidence to suggest a negative impact.

**None**: A Policy with neither a positive nor a negative impact on any group or groups of people, compared to others.
INITIAL ASSESSMENT (PART 3)

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

Not applicable

(b) How are you going to gather this information?


(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following Equality Target Groups?

Please delete as appropriate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Younger People (17-25) and Children / Older People (60+))</td>
<td>NO</td>
</tr>
<tr>
<td>Gender (Men / Women)</td>
<td>NO</td>
</tr>
<tr>
<td>Race</td>
<td>NO</td>
</tr>
<tr>
<td>Disability (Learning Difficulties / Hearing Impairment / Visual Impairment / Physical Disability / Mental Illness)</td>
<td>NO</td>
</tr>
<tr>
<td>Religion / Belief</td>
<td>NO</td>
</tr>
<tr>
<td>Sexual Orientation (Gay / Lesbian / Bisexual / Transgender)</td>
<td>NO</td>
</tr>
<tr>
<td>Carer</td>
<td>NO</td>
</tr>
<tr>
<td>Other</td>
<td>NO</td>
</tr>
</tbody>
</table>

Any Other Comments

Assessment Completed By R Green
Date Completed: March 2010

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

If required, the Full Equality Impact Assessment Form Template can be downloaded from either the Policy Library Intranet Page or the Equality & Diversity Intranet Page.

PLEASE RETURN COMPLETED FORMS VIA E-MAIL TO:

DEBBIE JONES, EQUALITY AND DIVERSITY PROJECT LEAD (for Service related Policies) debbie.jones@wwl.nhs.uk
EMMA WOOD, EQUALITY AND DIVERSITY PROJECT LEAD (for HR / Staffing related policies) emma.wood@wwl.nhs.uk