

POLICY FOR THE SAFE HANDLING AND ADMINISTRATION OF MEDICINES

GENERAL POLICY NO 11

Applies to:	All clinical or administrative staff contributing to the safe handling and administration of medicines, and managerial staff who monitor the quality of medicines management standards
Committee for Approval	Quality and Governance Committee
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Review and Amendment Log

Version No	Type of Change	Date	Description of change
2	Updated		Updated to meet NHS LA Standards 2012/2013

SAFE HANDLING AND ADMINISTRATION OF MEDICINES POLICY

1. Introduction

Wirral Community NHS Trust (WCT) is committed to the principle that all medicines should be handled in a safe and secure manner in order that patients receive the right medicine in the right dose at the right time. The Trust is also committed to ensuring that medicines are used in the most cost-effective manner throughout the organisation.

The Trust has set out the standards expected across the organisation to establish, maintain, document and audit safe and effective systems for the handling of medicines in order to:

- Comply with current legislation and Care Quality Commission (2010) standards
- Adhere to best practice standards for the administration and handling of medicines issued by Professional Bodies, related NHS documents and external safety agencies
- Proactively manage potential risks to patients and staff arising from the use of medicines.

2. Statement of Intent

This policy aims to inform all health professionals and staff who are involved in the handling of medicines, of the correct procedure for safe handling, ordering, prescribing, recording, storage, transportation, administration and disposal of medicines and related preparations. The Trust will also follow best practice as recommended where relevant from:-

- Medicines and Healthcare Products Regulatory Agency (MHRA)
- National Patient Safety Agency (NPSA)
- NHS Litigation Authority
- Professional Bodies
- National Institute of Clinical Excellence (NICE) and other national bodies

3. Definitions

Definition of a Medicine

Any substance or combination of substances presented for treating or preventing disease or any substance or combination of substances which may be administered with a view to making a medical diagnosis or restoring, correcting or modifying physiological or psychological functions.

Adverse Drug Reactions

An adverse drug reaction (ADR) is an unwanted or harmful reaction experienced following the administration of a drug or combination of drugs under normal conditions of use that is suspected to be related to the drug.

Near Miss Incident

A health care near miss is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care, fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient.

Procedure

A set of actions which is the official or accepted way of doing something. Reasons for deviation from the procedure should be recorded.

Standard Operating Procedures:

Each department that deals with medicines is required to comply with a standard operating procedure (SOP) for any activity undertaken throughout the medicines trail to minimise health and safety risks. Senior management authority must be obtained for any proposed deviation.

Clinical Protocols

A set of actions which are the official or accepted way of doing something. Reasons for deviation from the procedure should be recorded.

Guidance/ Guidelines

These are documents that set out preferred methods of operation. Other methods are not prohibited, but a reason for deviation from the guidance/guidelines should be fully justifiable. The Antimicrobial Guidelines for the Management of Common Infections in Primary Care is an example of this document type.

Patient Group Direction:

A patient group direction (PGD) is a specific written instruction for the supply and administration of a named medicine to a group of patients in an identified clinical situation.

Patient Specific Direction:

A patient specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient.

Patient Medicines Administration Chart:

A Patient Medicines Administration Chart (PMAC) is not a prescription, but a direction to administer medication. It must be signed by a registered prescriber and authorises the delegation to administer medication on the prescriber's behalf.

Drug and Therapeutics Committee:

This is a Wirral wide committee with representatives from Primary Care, Secondary Care and Wirral Community NHS Trust

Medicines and Healthcare Products Regulatory Agency Drug Alerts

Medicines and Healthcare Products Regulatory Agency (MHRA) Drug Alerts are cascaded directly to Service Leads using the Trust's Alert Reporting Pathway.

If needed action plans to monitor compliance are produced and implemented by the relevant services. Reports of non compliance are highlighted to the Quality, Patient Experience and Risk Group by exception.

National Patient Safety Agency Alerts and Rapid Response Reports

The Trust responds to National Patient Safety Agency (NPSA) alerts and rapid response reports involving medication and treatments. Action plans to monitor compliance are produced by liaising with relevant services, evidence of compliance is monitored and documented by the Medicines Management Group. Completed action plans are forwarded to the Quality, Patient Experience and Risk Group

The Medicine Trail:

The medicine trail covers all the potential activities that are associated with a medical product, from the initiation of the patient treatment through a prescription or a patient group direction, to the administration and the disposal of any waste material.

As this is a multistage process there is a need to introduce controlled links between the relevant stages. These links must be included to ensure full consideration of all aspects of the safe use of medicines throughout the trail.

Classification of Medicines and Related Preparations

For the purpose of this policy, medicines are classified as follows:-

Controlled Drugs - those which come within the Misuse of Drugs Act (1971) and subsequent regulations

Licensed Medicines - all medicines, oral, external, prescription only, pharmacy medicines, general sales list medicines, or controlled drugs with a valid Marketing Authorisation for use within the UK.

Unlicensed Medicines - any medicine that has not been granted a valid Marketing Authorisation for use within the UK

Non-medicines - classified into the following groups

- Surface disinfectants
- Urine testing and other reagents
- Medical gases

Medicines Act 1968

Classifies medicines into three main categories

- **Prescription-Only Medicines (POM)**

These are medicines, which may only be supplied or administered to a patient:-

- On the instruction of an authorised prescriber such as a doctor, dentist, nurse or pharmacist prescriber in the form of a prescription.
- Or under the direction of an authorised patient specific direction or a patient group direction.

- **Pharmacy-Only Medicines (P)**

These medicines can be purchased from a registered primary care pharmacy, provided the pharmacist supervises the sale.

- **General Sale List Medicines (GSL)**

These medicines need neither a prescription nor the supervision of a pharmacist and can be obtained from retail outlets.

Definition of “Off -Label Medicines”

The Summary of Product Characteristics (SPC) lists: indications, dose ranges, methods of administration and age restrictions as granted by the Marketing Authorisation for each medicine licensed for use within the UK. Any use not in accordance with the SPC is considered “off-label”, or an unlicensed use.

4 Duties

4.1 Specific Duties within the Organisation

Chief Executive

The Chief Executive is accountable for the quality and compliance with safe and effective clinical governance systems for all aspects of safe medicines management in the organisation. This responsibility is delegated to the Quality and Governance Committee

Trust Board

The Board of Directors have overall responsibility for ensuring that the Trust delivers high quality services that are efficient and effective.

The Board is made up of the Chairman, Chief Executive, Executive Directors, Medical Director and Non-Executive Directors. The Board of Directors oversee the running of the Trust, make the decisions that shape future direction, monitor performance and ensure accountability.

Quality and Governance Committee

The primary function of the Quality and Governance Committee is to provide assurance to the Board of overall compliance with all statutory and regulatory obligations and will ensure the effective management of Incidents, Complaints, Claims and Inquests and subsequent dissemination of lessons learnt, this includes the safe management of medicines. This group formally ratifies Trust Policies. The Quality, Patient Experience and Risk Group report to this committee.

Quality, Patient Experience and Risk Group

This group provides information and assurance to the Quality and Governance Committee regarding how the Quality and Risk Strategies are being implemented and managed within the organisation.

The Group will ensure that any medicines related risks for the organisation are identified, assessed, placed on the Trust Risk Register and the action plan is monitored. The group will review and monitor any action plans which are developed as a result of NPSA alerts or from complex Root Cause Analysis investigations on medication errors and escalate them when appropriate to the Quality and Governance Committee.

The Group will review new NICE guidance and assess if it is relevant to the Community Trust and monitor any action plans. This group accepts the action plans of the Medicines Management Group for scrutiny, assurance and to monitor compliance with all relevant standards and guidance

Controlled Drugs Accountable Officer

This role is fulfilled by the Director of Quality and Governance

The Officer is responsible for the safe use and management of controlled drugs (CDs) including:

- Every aspect of the journey of CDs within the Trust
- Adequate destruction and disposal arrangements are in place
- Relevant individuals receive appropriate training
- Monitoring and auditing the management and use of CDs
- The sharing of information with other responsible bodies regarding the management and use of CDs

Medicines Management Group

The Medicines Management Group oversees the safe development and implementation of procedures and systems for the safe handling, ordering, prescribing, recording, storage, transportation, administration and disposal of medicines and related preparations across clinical services.

This group will peer review medicines related procedures and documents as required on behalf of the Trust. Formal ratification of procedures will be via the Quality, Patient Experience, and Risk Group.

Quality and Governance Service

The Quality and Governance Service manage the processes and systems for the safe handling, ordering, prescribing, recording, storage, transportation, administration and disposal of medicines and related preparations as required within the Trust.

The Quality and Governance Service also has responsibility for prescription security from the ordering, receipt, storage, transfer and access of prescription stationery, supported by the Local Security Management Specialist.

Local Security Management Specialist

The Local Security Management Specialist investigates any breaches of security and reports to the supplier, police, Accountable Officer and the Local Counter Fraud Specialist if required.

Local Counter Fraud Specialist

The Trust's Local Counter Fraud Specialist is responsible for reporting forgery or misuse of prescription forms

4.2 Specific Duties of Staff

Divisional Manager

The Divisional Manager is responsible for:-

- Monitoring that the Service Leads have appropriate systems in place to ensure all relevant staff are compliant with this policy and relevant Trust medicines related procedural documents
- Ensuring that any medicines related risks identified in the Divisional Risk Register scoring 12 or above (using the Trust's organisational risk scoring system) are escalated to the Quality, Patient Experience, and Risk Group and documented in the Trust's Risk Register.
- Ensuring any plans for service development take account of safe medicines management in relation to any new training needs, potential financial

implications and comply with legislation governing the appropriate use of medicines

Service Lead

The Service Lead is responsible for ensuring:-

- All relevant staff are conversant with the content of this policy and related procedures.
- All relevant staff comply with Patient Group Directions and procedural documents
- All relevant staff are appropriately trained and qualified to fulfil their specific duties by attending appropriate training as outlined in the Trust's and Service Training Matrix
- All staff have an annual appraisal of their learning needs
- There is a robust record of the audit trail for all medicines received into their department, administered or supplied to patients, or appropriately destroyed
- All relevant staff contribute to the maintenance of safe systems for the handling of medicines within their department
- All relevant staff report clinical incidents or near misses
- All relevant staff contribute to audits or collection of data as required for monitoring best practice
- Team meetings include a section on safe medicines management to update staff as required
- That patients have personalised care plans which reflect the patients' medication needs where clinically relevant
- Medicines related risks are identified and scored using the Trust's organisational risk scoring matrix and reported to the Divisional Manager and documented in the Divisional Risk Register and action plans are implemented to promote patient safety
- Requests for additions or deletions of medicines from the Pharmacy Supplies Order Form must be made personally by the Service Lead via email to ensure a robust audit trail
- Attendance at the Trust's Medicines Management Group or have a nominated deputy (applicable to services required to comply with this policy)

Individual Employees are responsible for:-

- Complying with this policy and related medicines management procedural documents i.e. procedures and protocols
- Attending mandatory training
- Reporting medicines related clinical incidents and near misses

4.3 Designated Roles to Clarify Clinical Responsibilities

Department

For the purpose of this document a department incorporates any community clinic, primary care centre, Walk-In Centre, GP Out of Hours, intermediate service or clinical service.

Practitioner

Practitioner in this context is a term used to describe a qualified nurse, medical practitioner, dentist, pharmacist or other authorised employee.

Assigned Practitioner in Charge

The senior practitioner on duty for the department for that shift/day.

On Call Duty Manager

The nominated senior manager on call in the out of hours period on behalf of Wirral Community NHS Trust

Designated Practitioner

Any registered practitioner whom the Trust has formally identified as competent and appropriate to perform a specific medicines related function.

Health Service Authorised Employee

A member of staff who has been trained and authorised by the Trust to undertake specific duties in relation to medicines management. Accountability for ensuring safe practice remains with the registered health professional who has delegated the task.

Community Practitioner Nurse Prescribers

A registered nurse who has completed a nationally recognised nurse prescribing course and is currently active on the Nursing and Midwifery Council, these nurses can prescribe from a limited list of preparations.

Non Medical Independent Prescribers (NMP)

Health professionals qualified to prescribe any licensed medicine and are currently active on the register of their Professional Body and on the Trust's non medical prescribing register. The NMP is authorised by the Service Manager to prescribe within the parameters of the non medical prescriber's clinical competency.

Registered Practitioners are responsible (CQC 2010 Outcome 9) for:-

- Ensuring wherever possible, information is available for people about the medicines they are taking, including the risks.

- Ensuring information is available for people about medicines advisable for them to take for their health and well being and also to prevent ill health
- Having an up to date list of medicines taken by the person, being produced when they begin to use the service

5. Processes for the Safe Handling and Administration of Medicines in the Trust

5.1 Principles

- WCT is committed to ensure that an effective system for the safe and secure handling of medicines by all staff is in place and that the necessary levels of controls and monitoring are in place
- The principles of the Royal Pharmaceutical Society (2005) A revision of the Duthie Report (1988) The Safe and Secure Handling of Medicines are incorporated into all medicines policies and procedures applicable in the Trust
- Standard Operating Procedures are required by services for any activity undertaken throughout the medicines trail. Using the Trust's approved standard template.

6. Procurement and Acquisition of Medicines

6.1 Ordering of Medicines from Wirral University Teaching Hospital NHS Foundation Trust (WUTH)

- Stock medicines and related preparations should be ordered from WUTH pharmacy department.
- A Designated Practitioner is responsible for ordering medicines from WUTH for the purpose of maintaining clinic stocks.
- A WUTH "Pharmacy Supplies Order Form" must always be completed and needs to be signed by a named Designated Senior Nurse / Designated Practitioner. By exception, clerical staff within the clinic or department can only sign for the ordering of medicines, if there are no health professionals on site or if this task has been specifically delegated to them by a named health professional.

6.2 Additions or Deletions of Medicines from the Pharmacy Supplies Order Form

- Requests for additions or deletions of medicines from the Pharmacy Supplies Order Form must be made personally by the Service Lead via email to the Trust Pharmacist, ensuring a robust audit trail
- The appropriateness of requests will be considered by the Trust Pharmacist and if agreed, a Stock Amendment Request form will be processed

- An updated amended Pharmacy Supplies Order Form will be sent to the Service Lead who will be responsible for removing the expired pharmacy supplies order form from circulation.

7. Transport, Receipt and Storage of Medicines

7.1 Receipt of Medicines

- On receipt of medicines from WUTH it is the Designated Practitioner's responsibility to check the order is correct, received in good condition and with a reasonable shelf life.
- The Designated Practitioner must notify WUTH if there are any discrepancies in the order.
- The Designated Practitioner must also report any discrepancies to the Service Lead
- A written, signed and dated record must be maintained of stock received into the department.
- Order forms and delivery records must be kept for a period of two years as a record that the supply was complete.
- Vaccines and any other medication requiring refrigeration must be placed immediately in a refrigerator specifically designated for the storage of medicines. The cold chain must be maintained.
- Medications not requiring refrigeration must be stored in a locked cupboard.
- Written records, signed and dated, of medication appropriately destroyed must also be kept for a period of two years to maintain an audit trail.
- Samples of medicines from pharmaceutical company representatives must not be accepted for administration to patients and therefore must not be stored on Trust premises.

7.2 Transport of Medicines

- Trust employed staff should not collect dispensed medicines from community pharmacies, except in justifiable exceptional circumstances. In such cases a risk assessment should be undertaken and any risks managed accordingly.
- Patients/carers should collect dispensed medicines themselves. Where this is not possible, the majority of local pharmacies operate a delivery service.
- There will be specific situations where Trust employed staff are required to transport medicines to clinic, these activities will be described in standard operating procedures (SOPs) specific to individual departments.
- Samples of medicines from pharmaceutical company representatives must not be carried by Trust employed staff in the course of their work.

7.3 Safe Storage of Medicines within Departments

- Cupboards and refrigerators designated for the storage of medicines and pharmaceutical supplies must be kept locked and the keys kept within a designated safe place, ideally held personally by the Assigned Practitioner in Charge. The Assigned Practitioner in Charge is responsible at all times for the safe keeping of all medicines in their department.
- The keys for the medicines cupboard must be kept on one key ring solely for this purpose and clearly identified.
- Cupboards designated for medicines must be lockable and the designated area ideally should not be accessible to the public.
- The Service Lead must immediately report any breaches of security using the Trust's incident reporting system and inform the Local Security Management Specialist
- The recommended temperature for storing medicines will be indicated on the container issued by the manufacturer.
- Medicines that do not require storage in a refrigerator are usually stored at temperatures up to 25°C. Cupboards used to store medicines must therefore not be located near radiators or hot water pipes or in areas of high humidity.
- The room used to store medicines must be monitored with a room thermometer
- Medicines requiring storage in a refrigerator must be stored in a lockable fridge manufactured specifically for the storage of medicines. Medicine fridges must be monitored and temperatures recorded each working day with maximum minimum thermometers to ensure temperatures are maintained between 2 and 8°C. When temperatures fall outside this recommended temperature range advice must be requested from the Trust Pharmacist as to whether the medicines are fit for purpose. Any advice given must be documented for audit purposes. Staff are reminded to follow the SOP for the Safe Storage of Vaccines.
- Refrigerators and cupboards designated for the storage of medicines and pharmaceutical supplies must on no account be used for the storage of food, valuables or other items.
- All medicines to be taken orally and those for external use, must be stored separately in locked cupboards, reserved solely for medicinal products. It is acceptable for medicines to be taken orally and external products to be stored on separate shelves in the same cupboard.
- Disinfectants and reagents must be stored separately
- Intravenous infusions must stored in a locked cupboard and accessed only by designated practitioners
- No samples of medicines or dressings will be left in clinics to be used by patients.
- Where premises are shared by a number of clinics, each clinic is responsible for its own stock and this stock must be stored separately.
- At community bases where a number of Designated Practitioners may require access to the medicines cupboard at different times, a secure system must be agreed between the Designated Practitioners at the base. This system must be outlined in a standard operating procedure.

- Stock must be rotated to ensure that the stock with the shortest expiry date is used first.
- There must be no part-used pharmaceuticals, such as creams or ointments, kept in any medicines cupboards. This is because communal use of such products has resulted in outbreaks of infections such as MRSA and it is also an illegal practice to administer pharmaceuticals to any person for whom they were not prescribed.

7.4 Flammable Liquids

- Flammable liquids are issued from WUTH pharmacy and labelled “flammable”.
- Control of Substances Hazardous to Health (COSHH) data sheets must be available for all flammable liquids kept on the premises. The data sheets must be kept in a central point available to all staff.
- To reduce the risk of combustion or explosion:-
 - Keep stock levels to a minimum.
 - Avoid spillage.
 - Keep bottle closed. Replace the screw cap immediately after use.
 - Keep well away from naked flame or electrical apparatus.
 - Do not store in a refrigerator.
 - Store all flammable liquids in a locked metal cupboard that displays an appropriate hazard notice

7.5 Alcohol Gel

It should be noted that alcohol gel is also a highly flammable substance; the above precautions must be followed.

If clinical staff need to store alcohol gel in their car, it must not be stored anywhere where it would be subject to direct sunlight. Alcohol gel must therefore be stored in designated clinical bags, pockets and/or in the boot of the car.

7.6 Medical Gases

Practitioners that use medical gases in the course of their duties must be fully trained and aware of related risks such as fire and manual handling. They must ensure that they follow the relevant SOPs for the handling of medical gases. In addition the following precautions must also be observed:-

- The number of cylinders held as stock in any department should be as small as possible.
- Cylinders must be firmly secured at all times to prevent them falling over.
- They should be stored under cover, preferably inside and not subjected to extremes of heat.
- Naked lights must not be allowed within the immediate vicinity of a cylinder.

- No oil or grease should be applied to the cylinder or tap connector, therefore ensure hands are clean before handling cylinders. In particular ensure hands are adequately dried after the use of alcohol gel.
- Segregate full and empty cylinders and separate the different gases within the store
- Have warning notices posted prohibiting smoking and naked lights within the vicinity of the store.
- Allow for a strict rotation of full cylinders to enable the cylinders with the oldest filling date to be used first.
- The storage should be designed to prevent unauthorised access and to protect cylinders from theft.
- Excessive force or any tools must not be used to open or close a cylinder valve.
- Cylinders with damaged valves and defective equipment must be labelled appropriately, withdrawn from use and reported using the Trust's incident reporting system. The faulty equipment must be quarantined and saved as this may need to be shared with the Medical Healthcare Regulatory Authority as evidence.
- Contact suppliers for more specialist advice where necessary.

There is a service level agreement with EBME for the service and repair of medical devices, this includes flow meters and oxygen regulators, each department must ensure these medical devices are serviced on a regular basis and should a problem arise between services to contact Electro Biomedical Engineering (EBME) Tel No: 678 5111 ext 2194 and report the incident using the Trust's incident reporting system.

7.7 Security of Medicines within Departments

- The Pharmacy Supplies Order Form must be regarded as controlled stationery and kept under lock and key and only accessible to authorised staff.
- It should be possible to audit the process and account for all movements of stock and to identify any inappropriate losses.
- Staff in any supervisory position must be aware of signs that may indicate abuse or diversion of medicines, the incident must be reported using the Trust's incident reporting system and their line manager informed.
- Staff should not prescribe for themselves or their families or to ask for medication on behalf of themselves or their family. Staff should attend their own GP or access other healthcare services e.g. Walk -In Centres.

8. Incident Reporting Process

8.1 How Medication Errors are Reported

Wirral Community NHS Trust incidents are reported using the Datix incident reporting system.

When an error occurs at any stage in the handling, ordering, prescribing, recording, storage, transportation, labelling, administration and disposal of medicines and related preparations across clinical services the following steps must be taken:

- Make sure the patient is safe and if necessary call emergency services or the Medical Practitioner as dictated by clinical need
- Record any treatment or advice given, ensuring suggested monitoring arrangements are followed and documented
- Ensure any evidence relating to the error is retained and not tampered with (evidence will include any relevant documentation, the remaining medication administered and any packaging or administration equipment.)
- Inform line manager immediately who will refer to the Trust's "Being Open" Policy to support communication with patients and or carers.
- Inform the General Practitioner or other Medical Practitioner with clinical responsibility.
- Complete an electronic Datix incident form on the same shift of duty. The Datix system will automatically email the designated Datix Reviewer who would usually be the Assigned Practitioner in Charge/ Service Lead for the service. The reviewer is responsible for recording on the Datix system any immediate actions taken
- All incidents coded as involving medicines will also automatically generate an email to the Trust Pharmacist and the Quality Manager
- At the weekend or out of hours, the Manager should inform the On Call Duty Manager.
- For any incident involving controlled drugs the Trust's Accountable Officer for Controlled Drugs, Director of Quality and Governance must also be informed by the Service Lead within the span of duty, out of hours the incident must be reported to the On Call Duty Manager.
- If a medication error has occurred within a patient's home, the healthcare professional who discovered the error must also ensure that systems are in place to monitor the patient's condition appropriately over the following 24 hours. The GP should be informed at the earliest opportunity and an action plan drafted that defines what service will be responsible for monitoring the patient and keeping other key healthcare professionals updated. An electronic Datix incident form should also be completed

8.2 How the Trust Learns from Medication Errors

- Each reported incident will generate discussion between the reporter and reviewer together with the rest of the clinical team to identify future prevention systems
- If an incident involving Trust staff has caused patient harm, then an investigation will occur in accordance with GP8 Incident Reporting Policy. The Trust pharmacist will provide expert medicines information to inform the investigation process as required.

- If harm was not caused, the Service Lead will investigate the circumstances of the incident and will report findings to the Head of Nursing, Quality and Governance.
- In addition all incidents coded as involving medicines are automatically reported to the Trust Pharmacist and the Quality and Development Manager who will review the incident and request further investigations as appropriate
- The Medicines Management Group will review all reported incidents involving medicines including any incidents involving controlled drugs on a monthly basis. The group will consider if all appropriate actions are completed prior to escalation to the Quality, Patient Experience and Risk Group.
- A summary of all incidents are reported to the Quality, Patient Experience and Risk Group in the Monthly Quality Reports. This report includes a separate section on controlled drugs. The Group scrutinise the report to ensure that the contents, including any required action or learning is shared and implemented in each service, providing assurance to the Quality and Governance Committee through the group's minutes that this has been done.
- The Quality and Governance Service produce a Medicines Management Bulletin which is circulated to all clinical staff. This bulletin includes recommendations to reduce the likelihood of recurrences of recent clinical incidents

8.3 Near Misses

In cases where there has been a 'near miss', it is important to report as an incident as trends will be analysed and the systems for the safe handling and administration of medications may need to be altered. This system is a proactive way of preventing the incident from actually occurring.

9. Process for Prescribing Medicines in All Care Environments

9.1 How Medicines are Prescribed

Medicines are prescribed to patients of Wirral Community NHS Trust via different routes depending on the particular Trust service.

- The Community Nursing Service administer patient's own medication that has been prescribed by the patient's own General Practitioner (GP) or discharging hospital. A limited amount of medication including sodium chloride 0.9% flushes and diluents are stocked by the service supplied by WUTH.
- Authorisation for Community Nurses to administer medication is given via patient medicines administration charts (PMACs). The PMAC is not a prescription, but a direction to administer medication. It must be signed by a registered prescriber (the patient's GP or other authorised prescriber)
- Primary Care Assessment Unit (PCAU) employ authorised prescribers, all medication administered to patients within the unit are prescribed on either the

Patient Centralised Information System (PCIS) an electronic prescribing system, or for specific medications, paper based specialised charts

- PCAU prescribers issue FP10 prescriptions for non stock medication or medication required on discharge.
- All other services who employ authorised prescribers issue FP10 prescriptions.

9.2 Prescribing Responsibilities

- Medicines will only be prescribed by suitably trained and qualified healthcare professionals (e.g. medical practitioner or authorised non-medical prescriber) according to the terms of their qualification and acting within their skills, knowledge and competence.
- All prescribers should adhere to local formularies and where available recognised national guidance from NHS affiliated organisations. The British National Formulary (BNF) is the main reference source for prescribers and staff administering medicines. Authorised prescribers are also supported by the Wirral Medicines Guide and the Wirral Antimicrobial Guidelines for the Management of Common Infections in Primary Care.
- Prescribers must ensure there is an allocated budget with the Head of Service prior to initiating any new prescribing.
- Each Non Medical prescriber is required to complete an Approval to Practice Form that outlines the therapeutic areas that the prescriber will prescribe. This must be signed and agreed with the relevant line manager at annual appraisals. Refer also to the Procedure for Non Medical Prescribing and Safe Handling of Prescriptions, available on the Trust website MMSOP14

9.3 Responsibilities of Prescriber of Unlicensed Medicines

Medical Prescribers of unlicensed products carry their own responsibility and are professionally accountable for their judgement in so doing. Prescribers are responsible for the patient's welfare and in the case of adverse events they maybe called upon to justify their actions.

Following amendments to the Medicines for Human Use Regulations 2009, independent nurse or pharmacist non-medical prescribers are now permitted to prescribe unlicensed medicines. Where this is the case this must be recorded on the Approval to Practice Form, which every non medical prescriber in the Trust must complete.

Non-medical prescribers should only prescribe unlicensed medicines in justifiable exceptional and approved circumstances for example, justified by current best practice (e.g. national NHS guidance)

9.4 Responsibilities of Trust Pharmacist for Unlicensed Medicines

When an unlicensed medicine is to be prescribed or administered for the first time, there needs to be critical, evidence based evaluation for its use. The Trust pharmacist is responsible for assessing the evidence and challenging its use.

9.5 Patient Group Directions (PGDs)

Refer to the Trust's Clinical Protocol for the Development and Implementation of Patient Group Directions CP12

It is essential that practitioners have a copy of the PGD to refer to when supplying or administering medication, this will ensure the practitioner will be able to check that all the conditions of the PGD are fully met for that individual.

The Trust needs to ensure that any current or new patient group directions complies with legal requirements and the guidance set out in Health Service Circular 2000/026. Failure to comply with the legal requirements could result in a criminal prosecution under the Medicines Act.

9.6 Dispensing of Prescriptions

The Trust does not operate a dispensing service, so any medicines will normally be dispensed by an external supplier. Prescriptions must be dispensed by an external qualified pharmacist from a suitably registered community pharmacy.

The only exception will be for certain departments such as Contraception and Sexual Health Clinics, Wirral Walk-In Centres, or GP Out of Hours Service, where appropriately labelled medicines may be supplied directly to patients. The medicines or prepacks must be ordered via WUTH pharmacy department from a licensed supplier and must be labelled with directions and all legally required information.

Prepacks will be given to patients to fulfil a prescription or under the conditions of a patient group direction or patient specific direction.

If a member of Trust staff has a query relating to a specific medication, e.g. product/dose, labelling instructions, quantity supplied, they should contact the dispensing pharmacist or prescriber for clarification.

9.7 Verbal Orders

The use of verbal orders for administration of medication is not supported by the Trust and must not be carried out by Trust employees.

9.8 Safe Handling of Prescription forms

For services who employ doctors or dentists who are authorised to prescribe, refer to the SOP for Safe Handling of Prescription Forms for Doctors or Dentist, available on the Trust intranet site MMSOP26

Non Medical Prescribers within the Trust should refer to the Procedure for Non Medical Prescribing and Safe Handling of Prescriptions. This document is also available on the Trust intranet site MMSOP14

These documents outline the following:

- The processes for ordering prescription forms
- Security of prescription forms including details of records of serial numbers required
- What to do in the event of lost or stolen prescription forms
- The process for safe destruction of prescription forms

10. Process for Ensuring Accuracy of All Prescription Charts

10.1 How the Trust Makes Sure that All Prescription Charts are Accurate

- Prior to prescribing or administering medication, practitioners are required to obtain a drug history and a past medical history to determine contraindications or dose adjustments to potential treatments
- A standing operating procedure (SOP) has been produced in partnership with the PCT to guide Primary Care GPs on safe practice when completing PMACs for community nurses to administer medication
- A SOP is in place MMSOP08 for the Administration of Medicines by Community Nurses who are authorised to administer medicines via Patient Medicines Administration Charts (PMACs) completed by the prescriber. This SOP outlines the following:
 1. How entries must be clearly discontinued
 2. How discontinued PMACs must be removed from patient's homes and stored in base notes
 3. That new PMACs must be written following every discharge from a healthcare provider and at set intervals
 4. When a care plan is in place, prior to administration of medicines, practitioners must know the contents of the current care plan, and to contact the authorised prescriber where assessment of the patient indicates that the medication is no longer suitable
 5. To check that all details on the PMAC correspond to the medicine's pharmacy label

- Trust employed General Practices, Leasowe Primary Care Centre and All Day Health Centre, utilise the Egton Medical Information Systems Ltd (EMIS), to maintain up to date patient records
- All employees must follow the Trust's Health Records Policy to maintain up to date health records
- The Trust undertakes annual clinical audits including audits to review PMACs and prescription charts to determine if procedures are followed and to enable corrective actions to be taken if necessary

10.2 How a Patient's Medicines are Managed on Handover Between Care Settings

- An agreement is in place for WUTH prescribers to complete PMACs for patients who are discharged from WUTH who require medication to be administered by community nurses. A WUTH pharmacist checks the PMAC for accuracy and clinical appropriateness.
- Where there is no agreement in place, to avoid patient harm, nurses can follow a patient specific direction (PSD) from a discharging healthcare provider. The authorisation to administer medication on the PSD must include the same essential information as required on the PMAC
- When using a PSD a PMAC needs to be written up within two working days (not including weekends and bank holidays.)
- PMACs are rewritten following every discharge from a healthcare provider.
- All authorised prescribers (medical and non medical) from all services are required to ensure that details of medication prescribed are shared with the patient's GP to reduce any potential risks of duplication and update the patients' health care record for safe continuity of care.

11. How Medicines are Administered in all Care Environments

11.1 Consent

Refer to Trust Consent Policy

Valid consent must be obtained before starting any treatment including the administration of medicines.

For consent to be valid it must be given voluntarily by an appropriately informed person with mental capacity and who understands the risk and benefits of the proposed treatment.

No-one can give consent on behalf of an incompetent adult; however such patients can be treated if the treatment would be in their best interest. The assessment for this must always be documented.

11.2 Principles of Safe Administration of Medicines

In exercising professional accountability, in the best interests of the patients, staff who are authorised to administer medicines must:-

- Be certain of the identity of the patient to whom the medicine is to be administered. (For further details please follow the Trust's Clinical Protocol for the Identification of Service Users CP54)
- Ascertain that the prescribed dose has not already been given.
- Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.
- Where it is appropriate for a care plan to be in place, know the current contents of the patient's care plan.
- Check that the prescription, patient group direction or the label on a medicine dispensed by a pharmacist, is clearly written and unambiguous with clear information on:-
 - The name of medication.
 - The dosage.
 - The name of the patient for whom the medicine is prescribed (In the case of patient group directions the name of the patient will not be documented on the actual PGD).
 - Frequency of administration.
 - Route of administration.
 - In the case of PGDs ensure that all conditions are fully met (It is therefore essential that practitioners have a copy of the relevant PGD with them during administration or supply and they refer directly to it).
 - Have considered the dosage, method of administration, route and timing of the administration in the context of the patient and co-existing therapies.
- Check the expiry date of the medication to be administered.
- Check that the patient is not allergic to the medication before administering it.
- Administer or withhold in the context of the patient's condition (e.g. digoxin is not usually given to patients if their pulse is below 60)
- Contact the doctor or another authorised prescriber without delay 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 that the medication is no longer suitable.
- Make a clear, accurate and immediate record of all medicines administered, intentionally withheld or refused by the patient, ensuring that any written entries including the signature are clear and legible together with the date of administration.
- Where medication is not given the reason for not doing so must be recorded.
- When supervising a student nurse in the administration of medicines, clearly countersign the signature of the student.
- Certain medicines such as cytotoxics or warfarin require special consideration, in the event of Practitioner being requested to administer these medications, departmental procedures must be followed.

- When using syringes there is a risk of 'wrong route' errors if the correct syringe is not used. When administering oral or enteral doses ensure that an appropriate purple coloured oral/ enteral syringe is used.
- When administering insulin ensure that an insulin syringe or commercial insulin pen is used. This is essential, because the use of intravenous syringes to administer insulin can lead to incidences of overdose.
- When administering medication via the intravenous route, two appropriately trained staff members are required to check the medication to be administered (one of whom must be a registered nurse who then administers the intravenous medication)

11.3 Administration of Controlled Drugs

- Dosages and frequencies for all controlled drugs should be written in full by the prescriber, to aid correct administration. Particular care must be taken to ensure clarity of dosage instructions where syringe drivers are being used.
- Two appropriately trained staff members (one of whom must be a registered nurse) are required to be present when setting up and re-priming a syringe driver, refer to the Trust Syringe Driver Procedure for the Administration of Palliative Medicines for full details MMSOP04.
- Patients who have not previously received parental opiates must be observed by the designated practitioner for any signs of adverse effects for a minimum of 15 minutes after administration.
- The patient or carers must be advised to contact the team, if there is deterioration in the patient's condition. Out of hours and weekend cover contact details must be left with the patient and/or carers.

11.4 Administering Unlicensed Medicines

- In exceptional circumstances Trust staff may be requested to administer unlicensed medicines outside their normal scope of practice. Unlicensed medicinal products are only to be used when no pharmaceutically equivalent licensed product or suitable alternative licensed product is available for use at the time the patient requires it. The incident must be reported using the Trust's incident reporting system and situation discussed with line manager to risk assess the clinical situation.
- Staff must contact their Service Lead (or On Call Duty Manager) who must establish the medicine is clinically appropriate. All evaluation, advice and risk assessments must be appropriately documented. Out of hours medicines advice may also be obtained from the referring prescriber or the General Practitioner 'Out of Hours' Service.
- In addition it is also the responsibility of each individual registered nurse to satisfy themselves that the medicine may be administered safely and wherever possible,

that there is acceptable evidence for the intended use of the unlicensed medicine.

- If a medicine is unlicensed, it should only be administered to a patient against a patient-specific prescription and not against a patient group direction.
- Medication which is licensed but outside its licensed indications may be in exceptional circumstances administered under a patient group direction, if such use is clearly described and justified by current best practice (e.g. national NHS guidance).
- Prior to administration of unlicensed medicines staff involved in administration should ensure they have appropriate informed consent.
- Complementary and alternative medicines, such as homeopathy and herbal medicines without a valid Marketing Authority for use in the UK are also classified as unlicensed medicines.

11.5 Complementary and Alternative Medicines

In the case of complementary and alternative medicines, such as homeopathy and herbal remedies, practitioners who administer such medicines to patients must have successfully undertaken training and have the role of administering these medicines outlined in their job description as agreed by their Divisional Manager and be competent to practice the administration of the particular medicine.

Many members of the public seek treatment from a homeopath or buy 'over the counter' treatments, varying from basic vitamin supplements to plant remedies for eczema. Some members of the public take homeopathic and herbal medicines in conjunction with their traditional prescribed treatments.

Any person in the care of a health practitioner, who wishes to continue with their homeopathic or alternative therapies, must have this decision respected. If administering the alternative treatments, the nurse or midwife must ensure they are competent to do safely and effectively. They must ensure that any homeopathic treatments and herbal remedies are not contra-indicated with any prescribed medications the person is taking and advise them accordingly. As with the NMC guidelines on medicines management, the same expertise is expected of a nurse or midwife as that of a pharmacist.

The multi-disciplinary team should be involved with any discussion on what is acceptable and the alternative therapy should be prescribed accordingly. Any possible contraindications should be explained to the person in the care of a nurse or midwife for the benefit of informed choice. If there is conflict of interest and the person insists on continuing, the conflict should be documented in the care record.

If the treatment/remedy is not available on the NHS formulary, alternatives for supply should be agreed locally for the availability of the alternative medication. Best practice would indicate that the alternative treatment is prescribed on the appropriate chart so that all professionals involved with the patient/client care and administration of medicines are aware of the addition.

It is the nurse or midwives responsibility to judge whether the qualification awarded in a complementary therapy has brought them to a level of competence to use that skill for the people in their care.

It should be part of professional teamwork to discuss the use of complementary therapies with the doctor, pharmacist, and any other colleagues in the health care team.

11.6 Adverse Drug Reaction Reporting and Yellow Card Scheme

Adverse Drug Reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) by completing a Yellow Card, the incident must also be reported using the Trust's incident reporting system.

Who Can Report?

Healthcare professionals can report such as doctors, pharmacists, and nurses. In October 2005 the Yellow Card Scheme was extended to patients and their carers.

What Should be Reported?

For intensively monitored medicines (identified by ▼) report all suspected reactions. For established drugs and herbal remedies report all serious adverse reactions in adults; report all serious and minor reactions in children (under 18). Serious reactions include those that are:

- Fatal
- Life threatening
- Disabling
- Incapacitating
- Result in or prolonged hospitalisation
- And / or are medically significant
- Congenital abnormalities

If in doubt about the seriousness of a reaction please report it.

Where to find a Yellow Card

A paper version of the Yellow Card is included in:

- British National Formulary
- Nurse Prescriber Formulary
- Monthly Index of Medical Specialities (MIMS)

Alternatively download a copy from the MHRA web site <http://medicines.mhra.gov.uk>

Patient Details

The following patient details should be included on the Yellow Card: the patient's initials, age, sex, weight if known, and a local identification number. The patient's initials and a local identification number will help identify the patient in any future correspondence. Do not identify the patient by date of birth or name of patient to ensure confidentiality agreements between the health care professional and the patient are not breached.

Copy of Yellow Card in Patient's Notes

It is vital that a copy of the Yellow Card Report is included in the patient's notes. It is highly recommended that a copy be sent to the GP for future reference.

12. Process for Patient Self Administration

The Trust has no inpatient beds.

The Trust upholds patients' rights to self administer their own medication in their own home. Community nursing services deliver care to certain patient groups who are unable to administer medicines by injection or infusion pump, for example patients who have visual impairment or have conditions which impact on manual dexterity. For patients with impairments who want to self administer their medication, a risk assessment would be undertaken to the minimise risks and to promote the best interests of the patient's welling being and self caring.

Refer to the Trust's Clinical Protocol, Self-Administration of Medicines and Administration of Medicines Supported by Family/Informal Carers of Patients in Community Nursing, for further guidance CP07.

13. Procedure for the Safe Disposal of Medicines

13.1 Disposal of Controlled Drugs (CDs)

Those healthcare professionals and service providers required by law to maintain a CD register are not allowed to destroy CDs from their stock without the destruction being witnessed by an authorised person.

People authorised to witness the destruction of CDs include; Police Constables, Primary Care Trust Chief Pharmacists or senior members of staff that are not involved with the day to day management of CDs, who have been given written authorisation to carry out this role by the Accountable Officer. The Accountable Officer will not undertake destruction, as one of the criteria for Accountable Officer is their independence from day to day management of controlled drugs.

13.2 Disposal of Expired Stock CDs from Departments

The disposal of stock CDs within the Trust must be witnessed by members of the Quality and Governance Service who have been authorised to witness the destruction of CDs by the Trust's Accountable Officer.

When stock controlled drugs become expired they should be clearly marked as, "date expired" and segregated from other stock to prevent them from being used in error.

The manager of the department must then ring the Quality and Governance Service to arrange an appropriate time for the authorised staff member to witness the destruction. The department requesting the destruction is responsible for providing appropriate controlled drug destruction kits, "Dooop Kits". The destruction must be documented in the CD register. The record must be signed by the authorised witness.

13.3 Disposal of Patient-Returned CDs from a Patient's Home (Not Care Home)

Refer to the Trust SOP Destruction of Patient's Controlled Drugs in the Community MM17

13.4 Disposal of CDs from Care Homes

- Care homes are inspected by the Care Quality Commission and as such have to abide by national minimum standards. Each care home should have a controlled drug register and store controlled drugs in a controlled drug cabinet.
- When community nurses are involved in administering controlled drugs in a care home setting, the controlled drug register belonging to the care home together with the medication administration record chart must be signed by the community nurses.
- Medication that is no longer required must not be removed by community nursing staff.
- Community nurses must document in their records that the medication is to be retained by the care home.
- An appropriately trained care home employee will take full responsibility for ensuring the appropriate destruction of the controlled drugs.
- If the patient has died, all the patient's medication must be kept in the care home for a minimum period of 7 days.

13.5. Disposal of Pharmaceutical Waste

Pharmaceutical Waste can be divided into three broad groups:

Pharmaceutical Hazardous (cytotoxic and cytostatic)

Pharmaceutical Non-Hazardous (non-cytotoxic and non-cytostatic)

Or not pharmaceutically active and possessing no hazardous properties e.g. sodium chloride or glucose solutions

- The disposal of pharmaceutical waste must be outlined in SOPs specific to each department.

- Pharmaceutical hazardous waste must be disposed of in clearly labelled purple lidded waste containers for incineration, ensuring bins are not overfilled.
- Pharmaceutical non-hazardous waste must be disposed of in clearly labelled yellow-lidded waste containers for incineration, ensuring bins are not overfilled.
- For information on the classification and labelling of pharmaceutical waste, refer to the Management of Healthcare Waste Policy IC5 or alternatively seek the advice of the Trust pharmacist.
- Written records, signed and dated of medication disposed of, must be kept for a period of two years to maintain an audit trail.
- Patients' medication remains the property of the patient. Carers should be encouraged to return any unused medication to their community pharmacy. Community pharmacies may operate a pick up as well as a delivery service for housebound patients.
- Trust employees must not remove medicines from the patient's home.
- For disposal of Controlled Drugs see relevant section of this policy

14. How the Trust Trains Staff in Line with the Training Needs Analysis

- Relevant staff must attend mandatory medicines management training and completion of competencies as identified in the Service Core Training Matrix, available within the service. The Learning and Development Policy GP46 details the processes for management and monitoring of attendance.

15. Safe Management of Controlled Drugs (CDs)

15.1 Ordering of CDs from WUTH

- Certain departments such as GP Out of Hours, Minor Injuries VCH and certain Primary Care Centres are able to order stock CDs from WUTH Pharmacy.
- The responsibility for ordering, receipt and storage of CDs is with the Assigned Practitioner in charge of the department who must also be a registered doctor.
- CDs can only be ordered from WUTH by submitting a requisition from the official Controlled Drugs Requisition Book. Ordering is restricted to an Assigned Practitioner in charge. All Assigned Practitioners who may order CDs must provide WUTH with specimen signatures.

15.2 Receipt of CDs from WUTH

- All CDs must be delivered to departments in a secure container or picked up directly from WUTH Pharmacy by a Designated Practitioner with an identification badge.
- Where appropriate a porter may deliver CDs in a secure container. The porter must sign a Drugs Delivery Record Sheet. A Designated Practitioner must receive the package and sign the Drugs Delivery Record Sheet. The Designated

Practitioner is signing for receipt of a secure pharmacy container. The designated practitioner must be a registered nurse or a doctor.

- A Designated Practitioner must check the amount delivered against the requisition. Any discrepancy must be reported immediately to WUTH. If correct the Designated Practitioner must sign the Requisition. The Designated Practitioner must enter the new stock into the CD Register on the appropriate page, witnessed by another Designated Practitioner or Authorised Employee who must verify the stock level and sign the CD Register. The medicines must then be immediately locked away.
- For controlled drugs received into stock the following details must be recorded in the CD register:
 1. The date on which the CD was received
 2. The name of the pharmacy who supplied the CD
 3. The quantity received
 4. The name, form and strength of the CD
- Where sealed packs of Controlled Drugs are supplied with tamper evident seals there is no requirement to open these packs for stock checking purposes.
- Registers and requisition books for Controlled Drugs are controlled stationery and obtainable only from WUTH Pharmacy. Requisition books should be locked away.
- Orders and records must be in permanent ink and must be retained for a minimum of two years from the last entry in the book.

15.3 Storage of CDs in Departments

- CDs must be stored in a locked, controlled drug cabinet that complies with The Misuse of Drugs (Safe Custody) Regulations 1973. Access must be limited to Designated Practitioners who must also be registered nurses or doctors.
- Stocks of CDs should be kept to a minimum.
- High strength opiates must not be stored alongside lower strength products due to known risks from selection errors.
- CDs must be kept in the container issued by the supplying pharmacy.

15.4 Storage of CDs in Doctor's Bags Out of Hours

- Where doctors are visiting patients in their own homes, there are occasions when CDs may need to be transported in a "doctor's bag". A "doctor's bag" is a locked bag or case which should be kept locked at all times, except when in immediate use.
- If CDs are stored in a "doctor's bag" the details on storage, security and documentation must be outlined in an approved standard operating procedure.

15.5 Storage of CDs in Patients' Homes

- There is no legislation covering how patients should store CDs in their own homes. Community nursing staff however should encourage self medicating

patients to store their medicines in a secure location, away from sources of direct heat or high humidity.

- Consideration must also be given to ensuring vulnerable persons such as children do not have access to the medicines.
- CDs are medicines of potential abuse, storage should therefore be out of sight of visitors to the patient's home, whilst maintaining access to visiting nursing staff.
- As there may be several different nursing staff visiting a particular patient, it is advisable for all the patient's medicines to be stored in one area known by all visiting nurses.
- Controlled drugs administered only by community nursing services should be stored in Envo packs, sealed with a numbered tag, to aid stock control and provide evidence of potential tampering.
- All advice given to patients or carers on the storage of CDs must be recorded in the patient's record.

15.6 CD Stock Reconciliation

Any department stocking CDs must perform a stock reconciliation. The accountability for maintaining the correct balance of CD stock lies with the Service Lead who may delegate this task to an Assigned Practitioner in Charge. Controlled drug stock reconciliation should be performed at each shift change, or at least every working day.

Although community nurses are not involved in the ordering of controlled drugs which are prescribed for patients and administered in the patient's own home, community nurses are required to keep a running balance of the amount of these prescribed controlled drugs stored within the patient's home.

15.7 Procedure for Missing CDs in Departments

- In the event of any discrepancy in the amount of CDs stocked within a department the Assigned Practitioner in Charge must immediately investigate the discrepancy.
- Double check the count, ensuring all medication has been checked in the manufacturer's packaging.
- Contact the Service Lead to report the discrepancy.
- Report the incident using the Trust's incident reporting system
- Inform the Accountable Officer for Controlled Drugs ideally via email or if email is not available by telephone on the day of the incident. Out of Hours the incident must be reported to the On Call Duty Manager
- Refer to Trust incident reporting policy for further details
- If the loss cannot be resolved satisfactorily the Local Security Management Specialist must be informed.

15.8 Procedure for Missing CDs in Community Nursing

- In the event of any discrepancy in CDs the Designated Practitioner must immediately investigate the loss.
- Double check the count, ensuring all medication has been checked in the manufacturer's packaging.
- Check with the patient / carer to determine if any further information is available.
- The nurse must record the incident in the patient's records and on the medication chart, including the date, time and signature.
- Contact the surgery to check the GP has not administered or removed controlled drugs from the patient's home. This action must also be recorded in the patient's notes.
- Contact the nurses who had previously visited to ensure there was no drug discrepancy at the last visit.
- Contact the line manager to report discrepancy.
- All of the above must be reported via the Trust's incident reporting system on the same span of duty and the Accountable Officer for Controlled Drugs must be informed
- The Accountable Officer for Controlled Drugs must be informed ideally via email or if email is unavailable via telephone on the day of the incident. Out of Hours the incident must be reported to the On Call Duty Manager
- If the loss cannot be resolved satisfactorily the Local Security Management Specialist must be informed.

16. How the Trust Monitors Compliance with the Standards

See also Appendix One Monitoring Tool

- The Annual Clinical Audit Plan will include medicines audits as per Monitoring Tool
- The Medicines Management Group will monitor overall compliance with take up of medicines training for specified groups of staff as per Trust Training Matrix
- Service Leads are responsible for monitoring compliance with this policy within their own departments
- Incident reporting and near misses will provide learning opportunities for the Trust to continuously monitor safe standards of medicines management to promote patient safety and make improvements where necessary

17. Equality Impact Assessment

During the development of this policy the Trust has considered the needs of each protected characteristic as outlined in the Equality Act (2010) with the aim of minimising and if possible remove any disproportionate impact on employees for each of the protected characteristics, age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.

If staff become aware of any clinical exclusions that impact on the delivery of care this must be reported on the Trust's incident reporting system and an appropriate action plan put in place

18. Associated Documents

- The British National Formulary is the main source of reference for medicines. It describes the preparations likely to be prescribed and summarises the relevant legislation regarding prescriptions and controlled drugs. All health professionals involved in the administration of medications are responsible for familiarising themselves with the formulary.
- The Nurse Prescribers Formulary for Community Practitioners (incorporated in the British National Formulary) provides information of special relevance to Nurse Prescribers. The most current version of the BNF is available on the internet. www.bnf.org
- The Non Medical Prescribing Procedure
- Clinical Protocol Self-Administration of Medicines and Administration of Medicines Supported by Family/Informal Carers of Patients in Community Nursing
- Health Records Policy
- Consent Policy
- Incident Reporting Policy
- Standard Operating Procedure for the Safe Storage of Vaccines
- Standard Operating Procedure for the Safe Handling of Prescription Forms by Non Medical Prescribers in Wirral
- Standard Operating Procedure for the Transport of Prescribed Controlled Drugs and Other Urgently Required Medication by Wirral Admissions Prevention Service

This list is not exhaustive, all Trust Policies, Procedures and Protocols are on the Trust's web site

19. References

- Care Quality Commission (2010) Essential Standards of Quality and Safety
- Care Quality Commission (2010) Essential Standards of Quality and Safety Outcome 9. Page 107.
- Misuse of Drugs Act 1971
- Medicines Act 1968
- Royal Pharmaceutical Society (2005) *A revision of the Duthie Report (1988) The Safe and Secure Handling of Medicines.* (March)
- Nursing and Midwifery Council (2010) *Standards for Medicines Management*
- Health Service Circular 2000/026 *Patient Group Directions* (England only)
- Medicines and Healthcare Products Regulatory Agency
<http://medicines.mhra.gov.uk>.
- National Health Service (2011) Security Management Service: Security of prescription forms guidance. March

- Medicines for Human Use (Miscellaneous Amendments) Regulations 2009

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- Department of Health (2006) *Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste* November
- National Prescribing Centre (2009) A guide to good practice in the management of controlled drugs in primary care (England.) December
- Department of Health (2007) *Safer Management of Controlled Drugs: Guidance on Standard Operating Procedures for Controlled Drugs*. January
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2009
- National Prescribing Centre (2001) *Maintaining Competency in Prescribing* – An outline framework to help nurse prescribers. November

Appendix One

MONITORING TOOL

Minimum requirement to be monitored	Process for monitoring	Responsibility for completion	Frequency of Monitoring	Responsibility for Development of Action Plans	Responsibility for Review of Results / Outcomes
a. How medicines are prescribed	Clinical Audit of Prescribing Standards, including PGDs	Pharmacist/ supported by Service Leads	Annual	Divisional Manager	Medicines Management Group and summary report shared with Quality Patient Experience and Risk Group (QPER)
b. How the organisation makes sure that all prescription charts are accurate	Clinical Audit	Pharmacist/ supported by Service Leads	Annual	Divisional Manager	Medicines Management Group and summary report shared with QPER Group
c. How medication errors are reported	Review of incidents reported via Datix in the Monthly Quality Report	Reporter of incident and allocated reviewer	Monthly	Divisional Manager	Quality and Governance Committee
d. How the organisation learns from medication errors	Learning points are incorporated in to Medicines Management Bulletins and Action Plans resulting from investigations.	Pharmacist// supported by Quality and Governance Service	Monthly	Divisional Manager	Medicines Management Group and action plans resulting from investigations by the QPER Group
e. How a patient's medicines are managed on handover between care settings	Clinical Audit	Pharmacist	Annual	Divisional Manager	Medicines Management Group and summary report shared with the QPER Group
f. How the organisation trains staff in line with the Trust's training needs analysis	Review of mandatory medicines related training as required by Service Core Mandatory Training Matrix	Divisional Manager	At least twice a year	Divisional Manager	Divisional Governance Group and by exception the Learning and Development Group
g. How the organisation monitors all of the above	Medicines Management Annual Report	Lead Pharmacist	Annual	Divisional Manager	Quality and Governance Committee

SOP = Standard Operating Procedure PGD = Patient Group Directions