Policy Document Control Page
Title **Title: Medicines Policy** **Version: Version 9** **Reference Number: CL15**
Supersedes **Supersedes: Version 8** **Description of amendment(s)** • **Organisational learning and development (OL&D) amended to Organisational Development Team (OD) throughout** • **Support staff amended to non-registered staff (NRS) throughout** • **NPSA amended to NRLS throughout** • **Section 2. Human Medicines Regulations 2012 added** • **Updated references where applicable** • **3.1.5 terminology amended to reflect that some medical staff are not employed by the Trust** • **3.2 Definition of transcribing added** • **3.1.12 Deleted term QAP** • **3.1.6 Addition of V300** • **3.2.3 Addition of definition for *Medicines Optimisation*** • **3.2.4 Clarification of definition of transcription** • **3.2.7 PGD sub-group approval of PGD** • **Clarification around role of GMMMG in development of SCG** • **4 Accountable Officer for Controlled Drugs added** • **4.11 and 4.12 Addition of reference to two D&T Committee sub-groups** • **6.3.5 & 7.2 text amended** • **6.7.2 Clarification of adrenaline dose for anaphylaxis** • **7 Patient's own drugs definition and SOP added** • **7.4.1 Reference to zaleplon removed** • **7.7.1 text amended to 14 days supply/ reference to POD use and Choice and Medication leaflets** • **7.7.3 ref to intranet and text amended** • **8.1 Ref to NRS administering meds and the preparation of meds in advance** • **8.4 Ref to blank administration boxes** • **8.6 Ref to preparation of oral syringes in advance/ Addition of MM077** • **8.9 Blood result for clozapine advice added** • **10 clarification of British Standard for medicine cupboards and ref to temperature monitoring** • **10.5 Ref to SOP** • **10.6 Ref to temperature monitoring** • **10.9 Ref to policy** • **11.2 Ref to SOP** • **12.1 Text amended and ref to SOP added**

- **13.1 Text amended re POD CDs and RDs**
- **14 Amended to include all inpatients**
- **20 Ref to SOP**
- **22.2 text amended**
- **30.1 text amended**

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Lesley Smith/ Robert Hallworth

ERA undertaken on: **21 December 2016**

ERA approved by EIA Work group on: 30 December 2016

Where policy deemed relevant to equality-

EIA undertaken by:

EIA undertaken on:

EIA approved by EIA work group on:

Approval and Ratification

Referred for approval by: Lesley Smith

Date of Referral: 16 December 2016

Approved by: Drugs and Therapeutics Committee

Approval Date: 16 December 2016

Date Ratified by Executive Directors: 16th January 2017

Executive Director Lead: Medical Director

Circulation

Issue Date: 17th January 2017

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES / NO

Review

Review Date: 16 December 2019

Responsibility of: Lesley Smith

Designation: Chief Pharmacist

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 17th January 2017

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1 INTRODUCTION

1.1 Rationale

The Department of Health requires that NHS Trusts establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner.

This policy document outlines the mandatory legal and ethical aspects involved in the processes surrounding medication in all care environments and will cover the following areas:

- The prescribing of medication
- The supply of medication
- The storage of medication
- The administration of medication
- The monitoring of medication and side effects

1.2 Scope

This policy applies to all employees of Pennine Care NHS Foundation Trust in both mental health and community health services and covers all aspects of medication.

The policy applies to Registered Nurse contracted to work via the Central Trust Staffing Department (Trust Bank) or via a nursing agency and to all locum staff

This policy also applies to members of staff who are not directly employed by the Trust but act in a professional capacity within the Trust through a Service Level Agreement (SLA).

This policy covers those members of staff who are identified as having the required legal authority to engage in the processes listed.

1.3 Principles

As part of the clinical governance agenda, the Trust has a responsibility to ensure the safe and effective use of medication.

1.4 Compliance and duties of staff

The responsibility for compliance with this policy rests with the Chief Executive but the operational responsibility rests with the Medical Director, the Director of Nursing and the Chief Pharmacist.

It is the responsibility of the Drug and Therapeutics Committee to monitor, advise and amend as appropriate any aspects of the policy, the ratification of any amendments being made through the Integrated Governance Group (IGG).

It is the responsibility of the Chief Pharmacist to ensure compliance with all aspects of the policy relevant to the provision of pharmaceutical services by monitoring and auditing the SLA with the pharmacy departments of the acute trusts and the contracts with external pharmacy provider.

Managers will ensure that all staff engaged in any activity covered by this policy will receive the appropriate training and supervision.

All staff engaged in any activity covered by this policy are required to adhere strictly to the policy and failure to do so may result in disciplinary action.

2 LEGISLATION

The following legislation is mandatory regarding the use of medicinal products and will be referred to where appropriate in the policy.

- Human Medicines Regulations 2012 (amended 2013 and 2016)
- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Controlled Drugs (Supervision of Management and Use) Regulations 2006
- Health Act 2006
- Poisons Act 1972
- Medicinal Products (Prescription by Nurses Act) 1992
- Medicines and Human Use (Prescribing) Miscellaneous amendment order May 2006.

3 DEFINITIONS

3.1 Staff Definitions

3.1.1 *Allied Health Professional (AHP)*
Professional working in an occupation which is registered with the Health Professionals Council and is covered by the remit of the Department of Health Chief Allied Health Professions Officer.

3.1.2 *Authorised Person*
A member of staff who has, following training, been authorised by Pennine Care NHS Foundation Trust to undertake specific duties in relation to medicines.

3.1.3 *Dentist*
A person trained and licensed to practice dentistry and registered with the British Dentistry Association (BDA).

3.1.4 *Designated Complementary Therapist*
Any practitioner of a complementary therapy who has obtained the appropriate qualification for a recognised organisation and is approved by the Trust.

3.1.5 *Doctor / General practitioner (GP)*
Medical Practitioner with registration with General Medical Council that permits prescribing of medicines working for Pennine Care NHS Foundation Trust.

3.1.6 *Non Medical Prescriber (NMP)*
A first level Registered Nurse, registered pharmacist or AHP who has successfully completed a validated Prescribing Training Programme and whose name is recorded on the appropriate professional register. There are three categories of Non-Medical Prescriber:

3.1.6.1 *Independent and Supplementary Prescribers (V300)*
A first level Registered Nurse, registered pharmacist or AHP who is qualified to order drugs, medicines and appliances as an Independent or Supplementary prescriber. Independent prescribers are responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing (within their individual area of competence). Supplementary prescribers may prescribe any medicine, within the framework of a patient-specific clinical management plan, which has been agreed with a doctor/dentist.

3.1.6.2 *Community Practitioners*
Community practitioners are nurses who have successfully completed a nurse prescribers training scheme. They are able to prescribe independently only from the Nurse Prescribers' Formulary For Community Prescribers (NPF), which comprises of a limited range of medicines, dressings and appliances suitable for use in community settings. V100 prescribers are nurses with a community specialist practitioner qualification and V150 prescribers are nurses without a specialist qualification.

3.1.7 *Pharmacist*
A pharmaceutical chemist currently registered to practise with the General Pharmaceutical Council (GPhC).

3.1.8 *Pharmacy Technician*
A qualified pharmacy technician currently registered to practise with the General Pharmaceutical Council (GPhC).

3.1.9 *Practitioner*
General term used within the Medicines Policy to describe a qualified medical practitioner, Registered Nurse, pharmacist, AHP or other authorised employee.

3.1.10 *Registered Nurse (RN)*
A nurse currently registered with the Nursing and Midwifery Council (NMC).

3.1.11 *Non-registered staff (NRS)*
A Healthcare Assistant (HCA), Assistant Practitioner (AP), Support worker (SW) or Healthcare ~~Assistant~~ Support worker (HCSW) provide direct care and support to service users under the direction of a Registered Nurse.

3.1.12 *Ward/ Service Manager*
A person appointed by Pennine Care NHS Foundation Trust to manage a ward or service. This person need not necessarily be a RN. In this instance, responsibility for medicines becomes that of the Senior RN on duty.

3.2 Process Definitions

3.2.1 *Medicine*

Any substance or combination of substances presented for treating or preventing illness. Also, 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.

In this policy, the term *medicine* has the same meaning as *medicinal products* in the Medicines Act 1968.

3.2.2 *Prescribe*

To authorise (in writing), by full signature, the supply and administration of a medicine.

3.2.3 Medicines optimisation

Approach that seeks to maximise beneficial outcomes for patients with an emphasis on safety, governance, professional collaboration and patient engagement

3.2.4 *Transcribe*

Any act by which medicinal products are written from one form of direction to administer to another. This includes discharge letters, transfer letters, copying illegible patient administration charts to new charts, whether hand written or computer generated.
(*Nursing and Midwifery Council Standards for Medicines Management*)

Inpatient charts are considered to be Patient Specific Directions (PSD) which enables a nurse to administer medication to a patient. The information from an inpatient chart can be transcribed by a pharmacist. Pharmacist transcription should be clinically checked by a second pharmacist.

3.2.5 *Dispense*

To prepare a clinically appropriate medicine for a patient for self-administration or administration by another. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the produce). These functions are performed under the supervision of a pharmacist.

3.2.6 Supply/Issue

To supply a medicine to a patient or authorised representative for administration to that patient.

3.2.7 Administer

To give a medicine to a patient either by introduction into the body, (e.g. orally or by injection) or by external application (e.g. cream, ointment or application of a patch) or to hand to the patient for immediate supervised use.

3.2.8 *Patient Group Directions (PGD)*
A specific and detailed written direction for the administration or supply of named medicines, including those classified as prescription-only (POM), by named RN, pharmacists or other healthcare professionals, in a specific clinical situation. PGD are developed within the Trust are approved by the Patient Group Direction sub-group of the Drugs and Therapeutics Committee.

3.2.9 *Shared Care Guidelines (SCG)*
SCG are documents which allow the transfer of prescribing and monitoring of a limited number of specialist medicines which are rated as Amber under the local Red/ Amber/ Green (RAG) list to a GP while the Consultant or specialist team retains overall clinical responsibility for the care of the patient. SCG are developed jointly by the Trust Drugs and Therapeutics Committee and the Greater Manchester Medicines Management Group (GMMMG).

3.2.10 *Inpatient services*
For the purpose of this policy inpatient service refers to a unit on which patients are admitted for the provision of health care and/ or rehabilitation. Such units may be based in the hospital setting or within the community setting (for example, intermediate care).

3.2.11 *Mental health services*
Trust services providing healthcare to patient's with mental illness.

3.2.12 *Community health services*
Community based services providing healthcare in a variety of settings.

4 ROLES AND RESPONSIBILITIES

4.1 *Chief Executive and Trust Board*
Authorise implementation of the Medicines Policy in to the working arrangements of the Trust and maintain an overview of significant risks via the Integrated Governance Group and by monitoring the Risk Register. The Chief Executive will designate an Accountable Officer who is responsible for all aspects of the safe and secure management of Controlled Drugs.

4.2 *The Medical Director*
The Medical Director is the executive lead for medicines optimisation.

4.3 *Chief Pharmacist*
The Chief Pharmacist is responsible for medicines optimisation across the Trust and for ensuring that medicines optimisation practice across the Trust meets the required clinical governance standards.

4.4 *Accountable Officer for Controlled Drugs*
A specific person nominated by a NHS Trust (CCG, Foundation Trust or independent hospital) to be responsible for a range of measures relating to the safe use and management of Controlled Drugs in their organisation.

4.5 *Pharmacists/ pharmacy technicians*
Will promote use of the Medicines Policy and related medicines optimisation procedures. Will ensure staff are aware of changes that influence their practice and contribute to the development of strategies to minimise indentified risks. Pharmacists and pharmacy technicians will ensure the accuracy of prescriptions, annotate prescription charts and be involved in the delivery of medicines optimisation training. Pharmacists will confirm that prescriptions are clinically appropriate.

4.6 *Prescribers (Medical and Non-Medical)*
Have undergone the accredited training to be a prescriber and will be given access to prescribing guidance (for example, British National Formularies, Trust prescribing guidelines) to help ensure the accuracy of all prescriptions. Will follow the Medicines Policy and related medicines optimisation procedures in relation to prescribing.

4.7 *Ward/ Service managers*
Will ensure that the Medicines Policy and related medicines optimisation procedures are followed by their staff. Will ensure that all staff are aware of how to access the policy if undertaking a task that may occur only rarely. Will bring the Medicines Policy to the attention of all new staff who deal with medicines as part of their role. Will identify areas of significant risk and take action to control that risk and promote and demonstrate good practice associated with the use of medicines. Will ensure that their staff have access to medicines optimisation training in accordance with the Training Needs Analysis (TNA).

4.8 *All staff*
Will ensure they are familiar with all relevant sections of the Medicines Policy and related medicines optimisation procedures when undertaking medicines related tasks. Will report any concerns relating to medication risk to their line manager or a pharmacist so that action can be taken as necessary and report medication error incidents. All staff groups identified in the TNA will attend medicines optimisation training.
Will always carry their Trust identification badge.

4.9 *Drugs and Therapeutics Committee(D&T Committee)*
Will identify the key risks associated with medicines use with input from the Managing Prescribing Risk group. The committee will identify any changes required to the Medicines Policy and related medicines optimisation procedures and allocate responsibility for the update. New or amended policy documents will be approved by the committee. The committee will review audits and recommend actions as necessary.

4.10 *Managing Prescribing Risk sub-group*
Reports to the D&T Committee. Has multidisciplinary membership to review medication error incidents and will recommend, develop and implement solutions to these and other medication related risks.

4.11 Horizon Scanning and Prescribing Guideline sub-group
Reports to the D&T Committee. Has multidisciplinary membership to develop and review medicines related procedures and guidelines, horizon scans and

makes recommendations to the D&T Committee about new medicines on to the market.

4.12 Patient Group Direction sub-group
Reports to the D&T Committee. Has multidisciplinary membership to develop, manage and review PGDs

4.13 *Organisational Development Team (OD)*
Will check and monitor the completion of mandatory medicines optimisation training. Will enter details of staff attendance on to the Trust's electronic training record and provide monthly reports to service managers. Will provide reports on staff attendance for all medicines optimisation training to the senior managers.

5 TRUST PHARMACY SERVICES

Pharmacy services can be divided into the supply function and the clinical function including the provision of medicines information.

A specialised medicines information service is available within the Trust.
Requests for information may be sent via a dedicated e-mail address penninecare.medsinfo@nhs.net or by telephone to 0161 716 3378.
Medicines information services are also provided from the pharmacy departments of Royal Oldham Hospital and Tameside General Hospital.

5.1 Mental Health Services

The supply of medicines to the Trust is provided under SLA with acute trust partners or via contracts with external pharmacy providers. The clinical pharmacy service is delivered by pharmacists employed directly by the Trust or providing services under SLA.

5.1.1 Inpatient services

Process for ensuring the accuracy of prescription charts

The responsibilities of the Trust pharmacist for ensuring the accuracy of prescriptions include a check of the following

- Patient details
- Completion of the Adverse Drug Reaction/ Allergy section
- Use of generic drug name (or trade name if appropriate)
- Duration of treatment
- Timing and frequency of dose
- Maximum dose frequency for 'As Required' PRN medicines
- Additional relevant information

The process for ensuring the accuracy of all prescription charts within inpatient services is as follows:

Pharmacists visit inpatient wards/ units on a daily or twice weekly basis (Monday – Friday) depending on the acuity of the ward, to check the accuracy and appropriateness of all prescribing on charts.

Pharmacy staff review of the medication history of all patients (medicines reconciliation)

Refer to:

- **Procedure for checking and annotating prescriptions by pharmacy staff (MM083)**
- **Procedure for medicines reconciliation on admission of patients to hospital (MM026)**

5.1.2 Community mental health services

Process for ensuring the accuracy of prescription charts

Consultants are responsible for ensuring the accuracy of prescriptions for injectable antipsychotic (depot) medication.

RNs are responsible for checking the prescriptions for injectable antipsychotic (depot) medication are legible, signed, dated and include the dose, frequency and review date, prior to administration. Where the prescription does not contain all the required information the prescription chart must be returned to the prescriber for amendment in accordance with:

- **Procedure for the prescribing of medication (MM041)**

All prescriptions for injectable antipsychotic (depot) medication must be reviewed by the prescriber at least 12 monthly.

5.2 Community health services

The supply of medicines to community health services is either provided under a service level agreement (SLA) with acute trust partners or through external pharmacy providers on FP10 prescriptions. The clinical advice service is delivered by pharmacy staff employed directly by the Trust.

5.2.1 Intermediate care/ inpatient services

The process for ensuring the accuracy of all prescriptions within community health services is via an external pharmacy provider upon receipt of an FP10 prescription. Clinical pharmacy technicians can check and advise on the accuracy of prescriptions

Refer to:

- **Procedure for checking and annotating prescriptions by pharmacy technicians (community health service) (MMCH030).**

5.2.2 The role of Trust pharmacy staff is to provide clinical and therapeutic medicines optimisation advice to healthcare professionals and patients within community health services including:-

- Professional and specialist advice on all aspects of medicines optimisation
- Risk management, medicines governance and patient safety
- National initiatives in respect of non-medical prescribing
- Medicines optimisation training
- The review and development of arrangements for providing medicines to community based clinics, community hospitals and prisons
- Co-ordination and development of processes around Patient Groups Directions (PGD)

6 PRESCRIBING RESPONSIBILITIES

6.1 No person may prescribe unless he/she is a registered medical practitioner, prescribing nurse, prescribing pharmacist or prescribing AHP and in particular:

- Doctors must be registered with the General Medical Council
- Nurses must be registered with the Nursing and Midwifery Council and have their register entry annotated as a prescriber
- Pharmacists must be registered with the General Pharmaceutical Council (GPhC) and have their entry registered as a prescriber
- AHP must be registered with the Health Professions Council (HPC) and have their entry registered as a prescriber

Medical staff and Non-Medical Prescribers are not permitted to prescribe for other than patients of the Trust. Prescribing for self, family, friends and others who are not present patients of the Trust, is prohibited.

The Trust has a responsibility to ensure that medicines are used safely and effectively. This includes safe and effective prescribing.

6.2 All prescribers are required to read and adhere to the prescribing standards and requirements described in:

- **Procedure for the prescribing of medication (MM 041)**

They must also work within the boundaries and codes of practice of their relevant professional body and the legislation described therein and also the relevant Trust policies and procedures outlined below.

All Non-Medical Prescribers must work in accordance with:

- **Non-Medical Prescribing Policy (CL43)**

Prescribers should make reference to Trust Medicines optimisation Procedures when prescribing specific medication or to specific patient groups.

Prescribers must refer to the following document when completing all types of prescriptions:

- **Guidelines for the use of Pennine Care NHS Foundation Trust prescribing stationery. (MM 034)**

6.3 PRN medication

6.3.1 Prescribing a medicine on an ‘as required’ basis provides a useful method of assessing the requirement for medicines such as anticholinergics, analgesics and hypnotics.

6.3.2 Medicines originally prescribed ‘as required’, but which are needed regularly as indicated, by the administration record, must be reviewed and rewritten in the regular prescription section.

6.3.3 Once a patient’s medical condition has improved there may be less frequent requirement for PRN medicines. The ‘as required’ prescription should provide a useful indicator to ensure that medicines that are no longer required do not continue.

6.3.4 Care must be taken not to duplicate medicines being taken regularly and thus overdose the patient. Combination analgesics frequently contain paracetamol, which may already be prescribed in the regular section of the prescription chart. No more than 4g (8 tablets of 500mg) of paracetamol to be given in 24 hours. Particular care should be taken with drugs administered in accordance with Patient Group Directions and recorded on the in-patient chart.

6.3.5 Prescribers should be aware that rapid dose escalation using combinations of PRN and regularly prescribed antipsychotic drugs is one of the most common causes of severe side effects and adverse reactions and should monitor patients accordingly.

Refer to:

- **Key principles in prescribing “when required” (PRN) medication. (MM 009**)

6.4 Prescription charts

The Trust has an inpatient prescription chart developed primarily, though not exclusively for, inpatient mental health services (PEN 8).

Prescription charts are used in inpatient mental health services, residential Learning Disability services, Bealey community hospital, prison services and in intermediate care services.

There may be also be prescription charts of other types in use within the Trust, for example, Medicine Administration Record (MAR) charts. The use of these will be subject to review

6.4.1 Ideally no more than one inpatient prescription chart should exist at any one time for any patient. In the circumstances where more than one chart is needed the prescriber must indicate on each chart, the existence of all others.

6.4.2 If a patient is readmitted, including for respite care, a new prescription chart must be used for each admission. In addition to the main prescription chart

there may be additional charts on which medication is considered or prescribed (e.g. detoxification, anticoagulant, depot). The main prescription chart must make reference to any therapy prescribed on such charts.

6.4.3 It is the prescriber's responsibility to confirm whether or not the patient has a drug allergy / intolerance before a prescription is written.

6.4.4 Pharmacists, RN or other health professionals who wish to query or comment on a patient's prescription should speak to the prescriber directly. For instance, when the query relates to a potentially serious error or risk the health professional must make a record of the conversation with the prescriber in the patient's medical notes. Sticky notes or other attachments to the inpatient prescription chart must not be used.

6.4.5 A pharmacist or clinical pharmacy technician will alert the prescriber to a prescribing error that is, sufficiently serious to cause the patient direct harm.

6.4.6 A licensed medicine is a product which holds a UK Product Licence or Marketing Authorisation and is being used in accordance with a product data sheet or Summary of Product Characteristics (SPC). Medicines may sometimes be prescribed outside the terms of the licence and the Trust will generally accept liability in the event of an untoward event providing the prescription would be considered reasonable by the body of medical opinion and command peer group support. A product which has a licence for the proposed indication should generally be used in preference to a product which has not. Prescribers should be aware of the licensed status of medicines. Patients must be informed if a medicine being used to treat them is being used outside its licensed indications by the Consultant in charge of their care.

6.4.7 Prescribers must work in accordance with:

- **Policy on the Prescribing, Supply and Use of Unlicensed Medicines (CL16)**
- **Policy on the Use of Licensed Medicines outside of their Product Licence (CL17)**.

6.5 Range of medicines to be prescribed

6.5.1 Mental health services

For the treatment of mental health, only medicines on the Trust Medicines Formulary or newly approved by the Drugs and Therapeutics Committee may be prescribed. The medicines formulary for the treatment of mental health can be accessed via the Pharmacy Services intranet site.

Limited exception will be given to patient's own medicines, medicines undergoing clinical trial and specialist therapy for individual patients that have been agreed with the Chief Pharmacist.

For the treatment of non-mental health conditions (for example, cardiovascular disease or skin conditions) prescribing must be in accordance

with that previously prescribed by the patient's GP or Specialist and / or the Greater Manchester Medicines Management Group (GMMMG) formulary.

Prescribing by NMP will be in accordance with the professional formulary of the individual practitioner.

6.5.2 Community health services

Prescribing must be in accordance with that recommended by the patient's GP or Specialist and / or the Greater Manchester Medicines Management Group (GMMMG) formulary.

Prescribing by NMP will be in accordance with the professional formulary of the individual practitioner.

6.6 Verbal Orders

6.6.1 Mental health services

Verbal orders from doctors or other designated prescribers by telephone to nursing staff are prohibited (Nursing & Midwifery Council 2010).

A pharmacist may receive a verbal order from a doctor to alter a prescription item (Medicines and Ethics guide July 2016). All alterations must be written clearly and signed by the pharmacist.
The pharmacist must read the alteration back to the doctor who must then confirm it. The alterations will be made in photocopiable ink.

If the pharmacist is on a ward or outside unit or in any situation where the medical notes are available they must make a clear entry in indelible ink in the patient's medical notes stating the circumstances leading to the alteration.

If the prescription is on an outpatient prescription form the pharmacist will annotate the prescription clearly.

Prescriptions for Schedule 2 Controlled Drugs cannot be altered or ordered in this way.

6.6.2 Community health services

Verbal orders from doctors or other designated prescribers by telephone to nursing staff are prohibited (Nursing & Midwifery Council 2010).

6.7 Initiation of Treatment

6.7.1 Only staff authorised to do so may prescribe medicines.

Practitioners must not administer to patients medicines that have not been authorised by medical staff or NMPs.

6.7.2. Authorisation to administer must be in writing, in the form of a prescription in advance of the administration of the medicine.

The recognised exceptions to this are listed as follows:

The administration of parenteral medicines for the purpose of saving life in an emergency.

The Human Medicines Regulations 2012 Schedule 19 states that no one may administer a parenteral prescription only medicine otherwise than to himself, unless he is an appropriate practitioner or is acting in accordance with the directions of an appropriate practitioner.

The following list of medicines for parenteral (injectable) administration, are exempt from this restriction when administered for the purpose of saving life in an emergency. An * indicates those held on stock on inpatient wards.

Adrenaline injection (1 in 1000)*. Up to 1mg for intramuscular use in anaphylaxis
Atropine sulphate injection
Atropine sulphate and obidoxime chloride injection
Atropine sulphate and pralidoxime chloride injection
Atropine sulphate, pralidoxime mesilate and avizafone injection
Chlorphenamine injection*
Dicobalt edetate injection
Glucagon injection*
Glucose injection 50%
Hydrocortisone injection
Naloxone hydrochloride*
Pralidoxime chloride injection
Pralidoxime mesilate injection
Promethazine hydrochloride injection
Snake venom antiserum
Sodium nitrite injection
Sodium thiosulphate injection
Sterile pralidoxime

6.7.3 Certain medicines may be administered at the practitioner's discretion against an agreed Patient Group Direction. In each instance a record of the administration must be entered on the inpatient prescription chart or as stated in the Patient Group Direction and signed by the RN.

Specialist practitioners and pharmacists involved in certain services may be authorised to modify dose regimens and, in certain instances, to initiate or stop medicine therapy in accordance with protocols approved by the Drugs and Therapeutics Committee.

Dieticians may be authorised to initiate the use of dietetic products by prescribing them on inpatient prescription charts.

6.8 Patient Group Directions (PGD)

A PGD should only be developed where there are clear benefits to patient care or organisational advantage without any reduction in patient care, and in accordance with:

- **Patient Group Direction Policy (CL12)**

6.9 Outpatients

The Consultant or hospital prescriber who recommends a change in treatment is responsible for ensuring either that the treatment is prescribed or that a prompt and appropriate communication is sent to the GP giving recommendations (using a Trust Non Urgent Prescribing Advice to GP letter (PEN11). The continued prescription of regular medicines is normally the responsibility of the GP

6.10 Shared Care Guidelines (SCG)

A limited number of specialist medicines rated as Amber under the local Red/ Amber/ Green (RAG) list are the subject of SCG. Effective shared care relies on clear processes and good communication and Trust SCG identify the areas of care for which each partner in the arrangement has responsibility

Refer to:

- **Trust Shared Care Guidelines (various)**

7 ORDERING AND RECEIPT OF MEDICINES

Each service has a different ordering procedure for medicines depending on whether the pharmacy service is provided under SLA by an acute trust, which acute trust provides the service or if the service is provided by a contract with an external pharmacy provider. The principles involved in ordering from pharmacy are essentially the same and are all based on a ward stock and / or non-stock system.

All medicines ordered for and received onto the inpatient wards and services are for the use of patient's ONLY. They must not be used or taken by staff or removed from Trust premises. To do so would constitute theft.

This section will cover the general principles of ordering and transport of medicines.

Ward stock
These are medicines commonly prescribed for the patients of the ward. Ward stocks are retained on the ward regardless of whether they are currently prescribed for any patient.

Named patient medicines
These are supplied for a particular patient. Once the patient is discharged from the ward the medicines are returned to the pharmacy. Named patient medicines may also be known as 'non-stocks'.

Medicines to take out/home (TTO/TTHs)

These are specifically supplied for an individual patient who has authorised leave from the ward or who is to be discharged.

Patients own drugs (PODs)
Medicines brought into hospital by the patient. These medicines can be assessed as fit for use on the ward by healthcare professionals following the Trust standard operating procedure:

- **Standard operating procedure for the use of patients own drugs (PODs) during admission on an inpatient ward (SOP 0028)**

The ordering and receipt of all medicines must be in accordance with the medicines policies and standard operating procedures (SOP) of the acute trusts and/ or SOP of the external pharmacy provider.

7.1 Ward Stock Medicines

7.1.1 Local procedures will be followed in each area for obtaining stock medication from the pharmacy department of the acute trust or dispensary of the external pharmacy provider.

7.1.2 A list of all stock medication will be agreed in consultation with the pharmacist and the ward manager and a copy of the agreed list will be kept on the ward. The list will be subject to review at regular intervals to reflect changing prescribing patterns.

7.1.3 Where a topping up service is in place, pharmacy staff will visit the ward on the appropriate top-up date to re-stock the ward stock cupboards.

7.1.4 In the event that stock medication runs out prior to the top-up, the pharmacy department of the acute trust or dispensary of the external pharmacy provider must be contacted and a requisition using agreed stationery should be sent to pharmacy stating clearly what is required and signed by the RN requisitioning it. An agreed list of signatories will be in place.

7.1.5 All stationery used for the requisitioning of medication should provide a permanent record of what is ordered and be stored in a locked cupboard when not in use. Where electronic systems are in place for ordering medication, a permanent record must be kept by the ward.

7.1.6 Records of all stock holding in any service will be made and include all receipts and returns.

7.2 Named patient medicines (Ward Non-Stocks)

7.2.1 Medicines not kept as stock in the ward or department, are supplied by the pharmacy department for individual patients, either as part of the clinical pharmacy service or upon requirement. Supplies of named patient (non-stock) medicines can be obtained by either method in line with the medicines policies and SOP of the acute trusts and/ or SOP of the external pharmacy provider.

7.2.2 Pharmacy departments or dispensaries will not supply new medication for individual patients without having seen a prescription (fax or photocopy) or clinically checked request.

7.2.3 If patient's own medicines are available they may be used with the patient's consent and provided they comply with the standards set out in Section 12.

7.3 Transfer of Medicines between wards

7.3.1 During pharmacy department opening hours medicines should not be transferred between wards. A supply of the medicines should be obtained from the pharmacy department.

7.3.2 If it is necessary to transfer medicines between wards outside of pharmacy opening hours then a nurse from the ward requiring the medicine must take the relevant inpatient prescription to the supplying ward. The nurse on the supplying ward must check that the requested medicine is prescribed before making a supply.

7.3.3 Any medicine supplied should be in its original container although if unavoidable intact strips of blister packed medication clearly showing it's name, dose, batch number and expiry date may be exceptionally supplied.

7.3.4 In the North Division, the Pennine Acute Hospitals NHS Trust (PAHNT) document *"The transfer of medicines between wards when the pharmacy is closed"* should be additionally followed.

7.3.5 In the Stockport Borough the lending / borrowing procedures in the Stockport NHS Foundation Trust document TMM030 (Procedure for the emergency supply of drugs and medicines information out of hours) should be additionally followed.

7.3.6 In the Tameside Borough (South Division), the *"Medicines Transfer Book"* and associated procedure should be used.

Controlled Drugs must not be supplied for administration to a patient on another ward except in an emergency and then only as a SINGLE DOSE for a named patient and in accordance with:

- **Policy for the Safe Management of Controlled Drugs (CL44)**

There must be NO transfer of stocks of controlled drugs between wards or departments.

There must be NO transfer of stocks of controlled drugs between sites.

7.4 Recorded Drugs (inpatient mental health services)

7.4.1 In the North Division of mental health services, the following ordinary solid dose medicines are designated Recorded Drugs:-

Diazepam tablets/capsules
Dihydrocodeine tablets/capsules
Lorazepam tablets
Lormetazepam
Nitrazepam tablets/capsules
Zolpidem tablets
Zopiclone tablets
Oxazepam tablets.

7.4.2 The ordering and receipt of these medicines must follow the Recorded Drugs Policy of PAHNT.

7.4.3 A copy of the Recorded Drugs Policy of PAHNT will be made available on all wards and departments of Pennine Care NHS Foundation Trust by the pharmacy department providing pharmacy services under SLA.

7.5 Controlled Drugs

Controlled drugs must be ordered and received in accordance with:

- **Policy on the Safe Management of Controlled Drugs (CL44)**
- **Standard Operating Procedure for the ordering, collection, receipt and storage of Controlled Drugs by wards and clinical areas. (SOP 0010**).

Controlled Drugs must not be dispensed from the ward. Prescriptions for Controlled Drugs must be sent to the pharmacy department for dispensing in plenty of time for the period of leave or time of discharge.

7.6 Delivery and Receipt of Medicines

7.6.1 All medicines must be delivered to wards/departments in a secure container.

7.6.2 Where appropriate, a porter or messenger may deliver medicines in a tamper evident bag, tamper evident box or locked box. The porter or messenger must sign delivery documentation as per the medicines policies and standard operating procedures (SOP) of the acute trusts and/ or SOP of the external pharmacy provider.

7.6.3 A RN must receive the package or box and sign the documentation. The RN signs for the receipt of a tamper evident pharmacy bag or locked box.

7.6.4 A designated person should be responsible for the receipt of stock medicines delivered to the ward or department.

7.6.5 The medicines delivered should be checked against the delivery note and a record of the check should be made, with a signature and date on the appropriate documentation. Any discrepancies should be reported to the pharmacy department immediately.

7.6.6 Delivery notes should be retained in the ward or department in line with the medicines policies and standard operating procedures (SOP) of the acute trusts and/ or SOP of the external pharmacy provider.

7.7 Discharge and Leave prescriptions

7.7.1 Discharge medication

Prescribers are responsible for ensuring that prescriptions for discharge medication (TTO/TTH) are written in sufficient time for them to be dispensed and returned to the ward for the patient to take with them when they leave hospital. **This should ideally be at least 24 hours prior to discharge.**

Patients will receive a minimum of 7 days supply of discharge medication..

Patients who have been assessed as being at risk of significant self-harm must not receive more than 14 days supply of discharge medication.

Where there is a need for a patient to receive more than a 7 day supply, the prescriber must make the number of days supply clear in addition to the reason for the request. Ward staff should ensure that the request and reasons are also documented in the medical notes.

PODs can be used as part of the discharge medication supply where appropriate.

Refer to:

- **Standard operating procedure for the return of patients own drugs to the patient at the point of discharge (SOP 0075)**

Discharge (and leave) prescriptions should ideally be 'clinically checked' by a pharmacist before being sent to the pharmacy department.
Where this is not possible the inpatient chart, or a copy of it, must be sent to the pharmacy department or dispensary along with the discharge prescription. **This should ideally be at least 24 hours prior to discharge.**

TTO/TTH can be ordered by:-

- Submitting a discharge prescription (or leave prescription) together with the inpatient chart.
- Using a fax machine to send copies of the above. The pharmacy department or dispensary will usually expect the original prescription to be received before the dispensed items are sent back to the ward.

The delivery of discharge/leave medication is the same as for stock medicines.

All medicines coming into a ward or department shall be received by a RN, who must:-

- Check them against the prescription chart, leave card or discharge letter to confirm that all details are correct i.e. name, medicine, dose, directions
- Lock them in the medicines cupboard immediately
- Report any discrepancies to pharmacy immediately.

It is important that the patient receives adequate information about their medicines prior to discharge. The patient should know the purpose of the medicine, how to take it and for how long it is to be taken.

Additional written information should be provided. Suitable information may be printed from the Choice and Medication site on the Trust intranet (Visa Electronic Systems). It is the responsibility of the RN who discharges the patient from the hospital to ensure that the patient has received adequate information about their medicines.

7.7.2 Leave medication

All leave medication must be dispensed by the pharmacy department or pharmacy dispensary during opening hours.

It is considered good practice for a RN to check that the medicines issued for the discharge / leave are those currently prescribed on the inpatient prescription chart.

Only in exceptional circumstances should medication be dispensed for leave by the ward staff using stock medication (i.e. when the pharmacy is closed). Under NO circumstances should Controlled Drug medication be dispensed for leave by ward staff.

Where RN dispensing occurs it should be according to a locally agreed protocol. Nurse dispensing represents an extension to professional practice. The patient has the legal right to expect that dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.

Refer to:

- **The prescribing on and use of leave prescriptions (SOP 044)**
- **RN dispensing of emergency leave or discharge prescriptions from ward stock, maximum of 48 hours supply (SOP 036)**

7.8 Supplies of medication ‘out-of-hours’

A pharmacy emergency drug room for medicines required out-of-hours is available on all hospital sites. A list of medicines held in the emergency drug room is available from the pharmacy department of the acute trust and is amended to reflect usage trends on a regular basis. Medical or nursing staff must follow the local procedure for obtaining medicines from the emergency room.

Procedures for all emergency cupboards are available under General Information on the Medicines Management pages of the intranet.

An out-of-hours pharmacy supply function including clinical advice where appropriate is provided by the pharmacy department of the acute trusts and ensures that medicines and advice are available to meet the needs of individual patients, nursing and medical staff.

In all cases where medication is prescribed 'out-of-hours' and access to the pharmacy department is not available staff must obtain a supply of medication from the emergency drug room. If the required medication is not available in the emergency drug room then staff must bleep and seek the advice of the on-call pharmacist. The pharmacist will decide on the degree of urgency, if the medication can be omitted until the pharmacy department is next open or if a supply needs to be initiated.

Controlled Drugs must not be dispensed from the ward. Prescriptions for Controlled Drugs must be sent to the pharmacy department for dispensing in plenty of time for the period of leave or time of discharge

8 ADMINISTRATION OF MEDICINES

8.1 A RN must administer medicines in accordance with the Nurse and Midwifery Council (NMC) Standards for Medicines Management 2010 Standard 8 (Standards for practice of administration of medicines)

Prior to administration the RN must ensure that they have identified the patient. The minimum information that must be asked is

- What is your name? AND
- What is your date of birth?

Consideration must be given to the use of wristbands or photographs to identify patients on wards/ units where patients are unable to answer the questions above and in accordance with:

- **Patient Identification Policy (CL01)**

RNs should also refer to:

- **Procedure for the administration of medication (MM 040)**
- **Standard Operating Procedure for the administration of medicines to inpatients (SOP0025)**
- **Policy for the administration of specified discretionary medicines for a maximum of 3 doses to inpatients aged 12 years and over (CL52).**
- **Site specific medicines management procedures for community health service locations (e.g. Cambeck Close, Butler Green etc)**

In community services medicines can be administered by non-registered staff following appropriate training and competency assessment.

All medicines must only be prepared when the patient is willing to accept them. Medicines MUST NOT be prepared in advance and left unattended.

8.2 Single Nurse Administration

A RN may carry out single nurse administration. However, within inpatient services single nurse administration does NOT apply to Controlled Drugs.

These should be administered in accordance with:

- **Policy on the Safe Management of Controlled Drugs (CL44)**

8.3 It is considered good practice for RNs to obtain a second check prior to the administration of the following:-

Insulin therapy
Where the dose requires a complex calculation (not usually applicable to depot injections)
Where the dose is weight related
Any IV therapy
Rapid Tranquillisation

The administration may be witnessed by a second RN, a pharmacist, pharmacy technician or doctor.

8.4 If a medicine is omitted the appropriate code from the front of the inpatient prescription chart must be entered in the administration box to record the reason for the omission.

Where MAR charts are in use the appropriate code from that chart/ system must be recorded.

In each instance an explanation must be recorded either in the appropriate section on the inpatient prescription chart or in the nursing notes.

Administration boxes MUST NOT be left blank. A signature or the appropriate code must always be entered.

Failure to record the administration of medicine or an omission code constitutes a medication error and must be reported via the Trust's incident reporting system. The accuracy and clarity of administration records will be subject to audit.

8.5 Injectable Medicines

8.5.1. Inpatient services

The complexities associated with the administration of many injectable medicines means that there are potentially greater risks for patients than with other routes of administration.

Intravenous (IV) fluid rate controlling devices are no longer available in the inpatient areas of the Trust. Potassium containing IV fluids must not be administered.

Refer to:

- **Guidance on the prescribing and administration of potassium containing intravenous fluids in inpatient areas (MM 003)**

When administering injectable medicines, refer to:

- **Guidelines for the administration of antipsychotic depot injections including Risperidone Long Acting Injection (MM 014)**

8.5.2 Community health services

Wherever possible two RNs should check medication to be administered intravenously, one of whom should also be the RN who then administers the intravenous (IV) medication.

In exceptional circumstances, where this is not possible, IV medication should be checked by one RN and with another competent person who knows the patient. This could be a parent, carer or the patient themselves. As a minimum any dose calculation must be independently checked.

8.6 Measuring and Administration of Oral Liquid Medicines

The National Reporting and Learning System (NRLS) advised all healthcare organisations on how the methods used to measure and administer oral liquids can improve patient safety.

All oral syringes containing oral liquid medicines must only be prepared when the patient is willing to accept them. Medicines MUST NOT be prepared in advance and left unattended.

Refer to:

- **Guidelines for the use of oral syringes (MM077)**
- **Procedure for the administration of medication (MM 040)**

8.7 Recorded Drugs (Inpatient mental health services)

In the North Division of mental health services, the administration and recording of Recorded Drugs must follow the Recorded Drugs Policy of PAHNT.

8.8 Controlled Drugs

Must be administered in accordance with:

- **Policy on the safe management of Controlled Drugs (CL44).**

8.9 Clozapine

Must only be administered to the named patient it is dispensed for and only if there is a GREEN blood test result. Staff must take the advice from medical staff or a pharmacist for patients who have an AMBER or RED result.

Refer to:

- Guidelines for dealing with clozapine treatment amber and red results (MM090)

Clozapine should NOT be lent to other wards or patients, unless it is specifically authorised by a pharmacist.

8.10 Side effect monitoring

All medicines may cause unwanted side effects. Consideration of side effect monitoring and discussion of this must be documented and appropriate clinical actions taken.

A Yellow Card https://yellowcard.mhra.gov.uk/ should be submitted to the MHRA if a serious adverse drug reaction (ADR) occurs, even if it well recognised.

Refer to:

- **Procedure for the monitoring of side effects of prescribed medication (MM051)**
- **Guidelines for reporting suspected Adverse Drug Reactions (MM038)**

8.11 Supplies of medication 'out-of-hours'
Please see Section 7.8

9 TRANSPORT OF MEDICINES

9.1 Transport within hospital/ inpatient services

Medicines may only be transported by members of the Trust or authorised staff of acute trusts providing pharmacy services under SLA or authorised staff of external pharmacy providers.

Medicines must not be left unattended at any time during transportation.

When medicines are received at their final destination they must not be left unattended or unsecured. They must be handed to a RN and locked away in medicine cupboards and/ or fridge immediately.

9.2 Transport of medicines between health service premises

Discharge/ leave medication accompanying a patient and being transferred from one unit to another may be transported with the patient in an ambulance or by authorised hospital transport, or taxi. It is important that medicines are packaged securely and labelled.

9.2.1 Transport of Medicines from the supplying pharmacy department by authorised transport

All medicines will be transported in sealed, tamper evident containers.

Containers will be kept securely or under surveillance whilst awaiting collection from or on receipt at the designated Trust areas.

On arrival, containers should be placed in a designated area. Once delivered the responsibility for the security of the medicines rests with a RN who will arrange that the contents be unpacked, checked against the delivery note and put away securely as soon as possible.

The authorised person accepting the delivery must sign the documentation on receipt and deal with it as specified in the Medicines Policies and SOP of the acute trusts providing pharmacy services under SLA or SOP of the external pharmacy provider.

9.2.2 Transportation by taxi

Where it is necessary to transport medicines by taxi, all medicines must be transported in tamper-evident sealed containers.

The need to transport medicines by taxi must be risk assessed.

Transport must be obtained from the Trust's contracted service.

Only hospital contract taxis with drivers able to produce identification bearing a photograph will be used.

Medicines must be collected from the pharmacy department or an agreed designated area and delivered directly to the addressee.

If medicines are not delivered directly to the addressee the responsibility for security rests with those receiving the container until delivery is completed.

9.3 Transport of Medicines to Individual Patients at Home

Medicines may be transported home by patients or their carers following a hospital attendance or on discharge.

Patients who have left the hospital before all their medicines have been dispensed must be instructed to return to the hospital later to collect their medicines.

The transport of medicines to a patient's home must be authorised by the RN following appropriate risk assessment.

Medicines will NOT be posted to patients.

9.4 Vaccines

Vaccines must be transported (and stored) in accordance with Trust policy and records of such storage and transport kept in accordance with the Trust document retention schedule.

Refer to:

- **Storage, handling, distribution and disposal of vaccines (CL98).**

9.5 Transport of medicines by community based practitioners

Medicines issued to, or accepted by an employee are the responsibility of the person to whom they are issued.

All staff required to carry prescribed medication must have a valid identification card issued by the Trust. This must be shown if requested by a client or any other person having reason to check the identity of the employee.

Medication carried by staff must be:-

Prescribed by a medical practitioner and be accompanied by a written prescription on an approved medicine card except as described below:

On a PGD which the practitioner is authorised to work within.

For direct administration by a nurse to an identified patient, or

For delivery to an identified patient for self-administration over a specified period.

Teams will normally receive prescribed medication from the hospital pharmacy department or an external pharmacy provider. Where a Trust employee collects and delivers medication on behalf of a patient this should be clearly documented in the patient's records / management plan.

Staff who are not RNs may deliver medication for self-administration by the patient. They may witness and subsequently report back to the clinical team that a patient has self-administered medication as prescribed. The clinical team must be satisfied that it is appropriate for the patient to self-administer, having regard to both the medication prescribed and the patient's clinical state. However, where medication is to be administered via any route, the person supervising the administration of the medication must be a RN.

When carrying medication, the following requirements must be adhered to:-

Medicines must ideally be carried in a secure container.

When transporting medication by car, the employee will ensure that the medication is contained within a secure container and is out of sight, locked in the car boot or equivalent.

Additional medicines may be carried to allow for breakages or emergencies.

Medication for self-administration must be directly handed to the client for whom they have been prescribed, or to a responsible adult nominated to receive the medicines by the client.

Whenever practicable, unused medicines should be returned to the medicine cupboard at the team base for overnight and weekend storage. Where this is not possible, they may be stored in a locked cupboard or drawer at home but not usually for longer than 72 hours without appropriate risk assessment.

10 STORAGE OF MEDICINES

The Ward Manager or RN is responsible for the safekeeping of medicines on their ward, department or service.

The design and location of all new medicine storage cupboards must be approved by pharmacy staff and regularly monitored. Drug cupboards used for internal and external medicines should comply with current British Standards. At the time of writing this is BS2881 (1989) NHS Estates Building Note Number 29 which states that a medicine cupboard must be of specific construction for storage of certain medicines.

All medicines, disinfectants and reagents must be stored in locked cupboards, trolleys or other secure cabinets that are reserved solely for medicinal products. The only exception to this requirement, are medicines for clinical emergencies, for example, those stored on a resuscitation trolley.

Medicines for internal administration must be stored separately from other medicines. Under no circumstances must medicines be transferred from one container to another, nor must they be taken out of their container and left loose.

Cupboards and trolleys must be sited where most convenient for staff, allowing adequate space and permitting surveillance to afford maximum security against unauthorised entry. Medicine cupboards should generally be sited in a clean utility room to which the general public/patients do not have access. Cupboards must not be sited where they may be subjected to higher than average humidity or temperature. Reagent cabinets must be sited in areas where testing is carried out.

Where a team utilises storage facilities contained within a Trust facility which has RN on duty for 24 hours (eg. on a ward), then formal arrangements must be made for access to the medicines cupboard by the community based team. These arrangements must be documented and agreed by both teams.

The temperature of the medicine cupboard must be monitored on a daily basis and/or in accordance with the standard operating procedure.

- **Standard operating procedure for monitoring of medicines cupboard internal temperatures (SOP 0058)**

Each service/ team base, where medicines are stored and used, should have a system of Standard Operating Procedures covering each of the activities concerned with medicines. These should ensure that this Medicines Policy is followed correctly and that the medicines are stored safely and securely.

10.1 Recorded Drugs (inpatient mental health services)

In the North Division of mental health services, Recorded Drugs must be stored according to the Recorded Drugs Policy of PAHNT.

The quantities, range and storage of medicines to be stocked will be reviewed regularly by the pharmacy staff and the RN.

10.2 Controlled Drugs

No ward or service must store Controlled Drugs unless there is a RN responsible for their storage and use and a Controlled Drug Register in which to record them.

Controlled Drugs must be stored in accordance with:

Refer to:

- **Policy on the Safe Management of Controlled Drugs (CL44)**
- **Standard Operating Procedure for the ordering, collection, receipt and storage of controlled drugs by wards and clinical areas. (SOP 0010)**
- **The administration, recording and stock reconciliation of Controlled Drugs in ward and clinical areas (SOP 0011)**
- **The storage of patients own Controlled Drugs on inpatient areas (SOP 0012).**

10.3 Sample medicines

Samples of medicines must not be left on wards or within services unless the supply of such samples has previously been agreed on behalf of the trust and their acceptance registered. This is in accordance with the policy for:

- **The conduct of and liaison with Pharmaceutical Company Employees (CO30)**

10.4 Closure of a Ward or Department

When a ward or service closes, the Controlled Drugs must be handed over by a RN to a pharmacist who will sign the appropriate section of the register and return the Controlled Drugs to the pharmacy department or dispensary.

Refer to:

- **Standard Operating Procedure for the return of CDs to pharmacy due to discontinuation or ward closure (SOP 0014)**

If a ward or department is to close for more than 4 days, all other medicines must be returned to the pharmacy. However, if a ward is to close for less than 4 days, the medicines (other than Controlled Drugs) may, with the agreement of local pharmacy department and the Ward Manager or RN, stay on the ward provided there is adequate security to prevent unauthorised access to the cupboards.

10.5 Breach of Security

Any loss, discrepancy or suspected theft of medicines constitutes a breach in security and thus any incident must be reported immediately and investigated by the RN together with a member of the pharmacy staff.

A decision to involve the Police may be taken by a Manager within the Trust.

Refer to:

- **Standard Operating Procedure for escalating concerns, dealing with security breaches or incidents involving the loss or theft of medicines (SOP 0060)**

10.6 Storage Accommodation

Clinical areas may have some or all of the following lockable medicine storage units:

10.6.1 Controlled Drug Cupboard

Reserved solely for the storage of Controlled Drugs and secured to the wall. These cupboards may be separate from others or be inside other locked medicines cupboards used to store internal medicines. The lock must not be the same as any other lock in the hospital.

10.6.2 Internal Medicine Cupboard

For the storage of tablets, liquid medicines, injections etc.

10.6.3 External Medicine Cupboards

For the storage of creams, lotions etc.

10.6.4 Medicine Refrigerator

Medicines are not to be stored together with food or pathological specimens, but in a separate locked fridge. Medicines requiring storage below room temperature will be marked “Store between 2°C and 8°C, in a refrigerator”. A maximum/minimum thermometer should be kept in the refrigerator and used to make daily recorded readings by nursing staff.

10.6.5 Reagent Cupboards

Situated in the area where urine testing is carried out. Some wards may not require a separate cupboard if urine testing is only very rarely carried out but in such circumstances there should be a ward agreement about where such testing is to take place.

10.6.6 Clean Storage Room

For intravenous fluids and sterile topical fluids if no suitable cupboard is available.

10.6.7 Medicine Trolley

For storage of medicines in current use on the medicine administration round. When not being used the medicine trolley must be locked and ideally secured to the wall. The trolley must not be left open and unattended during the medicine round nor should it be unlocked unless attended by a RN.

10.6.8 Medicines for clinical emergencies (Emergency Boxes)

Must be readily accessible and in a position to afford supervision to prevent unauthorised access. These must be held in a tamper evident box. Once opened the box must be returned to the pharmacy for replacement.

10.6.9 Named Patient Cupboards.

Medicines dispensed for individuals (together with the patient’s own medicines) can be stored in a locked medicine cabinet at the side of the patient’s bed. These cabinets must be kept locked when not in use and the keys held by a RN and, where self-medication is occurring, the individual patient.

The temperature of the medicine cupboard and medicines fridge must be monitored on a daily basis and/or in accordance with the standard operating procedures

Refer to:

- **Standard Operating Procedure for monitoring of medicines cupboard internal temperatures (SOP 0058)**
- **Standard Operating Procedure for monitoring fridge temperatures (SOP 0039)**

10.7 Flammable Liquids, Gases, Aerosols.

These may only be stored following advice from the Fire and Health and Safety Officer and appropriate risk assessment Safety Officer.

10.8 Medical Gases / Oxygen

See Section 20

10.9 Vaccines

Vaccines must be stored (and transported) in accordance with Trust policy and records of such storage and transport kept in accordance with the Trust document retention schedule.

Refer to:

- **Storage, handling, distribution and disposal of vaccines (CL98).**

11 LOSSES OR DISCREPANCIES

11.1 Controlled Drugs

In the event of a discrepancy between the stock balance and register for Controlled Drugs, a RN must immediately and thoroughly investigate the loss.
A search must be conducted to find missing medication and/or reconcile entries in the register. After an unsuccessful investigation, the discrepancy must be reported immediately to the Ward Manager or RN responsible for the ward or service and the pharmacist and/ or pharmacy department or dispensary.

Pharmacists may report or discuss Controlled Drug losses or discrepancies with the Chief Pharmacist, who as Accountable Officer, will decide whether or not the Police should be notified.

This is in accordance with:

- **Policy on the Safe Management of Controlled Drugs (CL44)**

11.2 Other Medicines

Any loss of other medicines must be reported to the Ward Manager or RN responsible for the ward or department, the pharmacist and/or pharmacy department.

Pharmacists may report or discuss losses with the Chief Pharmacist who will decide on a further course of action.

Refer to section 23

Refer to:

- **Standard Operating Procedure for escalating concerns, dealing with security breaches or incidents involving the loss or theft of medicines (SOP 0060)**

12 DISPOSAL OF MEDICINES

12.1 Inpatient services

Defective or suspected batches of defective medicines must be dealt with as in Section 25.

The disposal of small quantities of medication i.e. broken tablets, dropped tablets, part doses, expired medicines, will be disposed into the medicine waste bin in accordance with:

- **Waste Management Policy (CO45)**

Controlled Drugs must be dealt with in accordance with:

- **Policy for the Safe Management of Controlled Drugs (CL44)**
- **Standard Operating Procedure for the destruction of Controlled Drugs on wards/ clinical areas (SOP 0015)**

Recorded Drugs in the North Division must not be returned to the pharmacy without prior arrangement.

Refer to PAHNT:

- **Guidelines for the ordering, storage and administration of Recorded Drugs**

Other Medicines

All out of date medicines no longer required by the ward or department must be placed into the medicine waste bin.

Medicines brought into hospital by patients and no longer required must be dealt with as in Section 13.

12.2 Community health services

The disposal of medicines within community health services must be in accordance with

- **Procedure for the disposal of medication within community health services (MMCH 005)**

12.3 Disposal of Sharps

The Trust provides sharps disposal boxes which must be carried (discretely) and used whenever medication requiring the use of needles and syringes is being administered.

Used sharps boxes must be disposed of in accordance with:

- **Waste Management Policy (CO45).**

13 PATIENT'S OWN MEDICINES

13.1 Inpatient services

All medicines brought into inpatient services by patients remain their own property and should not therefore be destroyed or otherwise disposed of without their agreement or, if this is not possible, their relatives' agreement.

Medicines brought into hospital by patients should be reviewed by the admitting doctor who may or may not wish to prescribe them in accordance with:

- **Procedure for medicines reconciliation on admission of patients to hospital (MM 026)**

Medicines brought into inpatient services may, continue to be used after they have been deemed suitable for use.

Refer to:

- **Standard Operating Procedure for the use of patients own drugs (PODs) during admission on an inpatient ward. (SOP 0028)**

In no instance should it be necessary for a hospital mental health inpatient to receive a further supply of a medicine from the GP. These items may be supplied from the hospital pharmacy department by special arrangement.

Patient's own Controlled Drugs must be stored in the Controlled Drugs cupboard and recorded in the Controlled Drug register. Such Controlled Drugs can be used for that individual patient on the ward as with other PODs.

Refer to:

- **Controlled Drug policy CL44 (section 18)**

In the North Division of mental health services, patient's own medicines which are deemed to be Recorded Drugs must be stored according to the Recorded Drugs Policy of PAHNT. Such Recorded Drugs can be used for that individual patient on the ward as with other PODs.

Refer to PAHNT policy:

- **Guidelines for the ordering, storage and administration of Recorded Drugs**

If the patient's own medicines are in a compliance aid they should not normally be used to administer the medicines to the patient. The compliance aid is the patient's property and should be stored on the ward until such time as a decision can be made about the compliance aid and its contents.

Where medicines are stored in individual medicine cabinets for self-administration it is the responsibility of a RN to ensure that if a patient is moved to a new location all of their medicines move with them. Medication errors have occurred when a previous patient's medicines remaining in the cabinet have been supplied to the next patient.

At discharge a RN must check the patient's own medicines against the discharge prescription prior to issuing to the patient to take home. If the items are no longer appropriate advice should be given to this effect and the patient encouraged not to take the medicines home. If there has been a change of therapy or if additional medicines are required, the pharmacy service must be contacted to arrange for supplies to be dispensed.

The patient's own medicine, if not required, can be dealt with as in Section 12.

13.2 Community services

Prescribed medicines are the property of the patient and remain so even when no longer needed. Healthcare professionals require the permission of the patient to remove medication from the home or when accepting it from carers.

Where medication is removed a record of the medicines, the quantities removed and reason for removal must be made and signed by the healthcare professional and patient or carer.

Wherever possible, patients and carers should be advised to make their own arrangements to return unused medicines to a community pharmacy. This should ideally be the community pharmacy from which the medicines were supplied.

14 SELF-ADMINISTRATION OF MEDICINES

Inpatients may self-administer medicines following the agreement of the multidisciplinary team and a full risk assessment. The multidisciplinary team must decide whether the self-administration is fully independent or is to be supervised.

Refer to:

- **Procedure for the self-administration of medicines by inpatients within Pennine Care NHS Foundation Trust (MM 012)**
- **Guidelines for the self-administration of certain prescribed medicines on inpatient wards (MM 006).**

15 CUSTODY AND SAFE KEEPING OF MEDICINES KEYS

15.1 Medicine keys must be kept on the person of a RN.

The Controlled Drug cupboard key must be kept on a separate key ring that can be readily identified.

Keys must not be handed over to medical staff or any staff unauthorised to hold them.

In community service bases where a number of RNs may require access to the medicine cupboards at different times a key box may be utilised.

Refer to:

- **The Safe Storage and Reconciliation of Medicines keys within community health services and mental health services and community based mental health teams (SOP 0017).**

15.2 Keys for Medicine Cupboards, Medicine Trolley and Refrigerators

The keys for the external medicine cupboard, internal medicine cupboard, medicine trolley, medicine refrigerator and pharmacy transport box should be ideally kept together on one key ring reserved solely for these keys. The keys must be clearly identified.

15.3 Loss of medicine cupboard keys

Every effort must be made to find the keys or retrieve them, for example, from off duty staff. Should access to the medicine cupboard be required before the keys are retrieved the duty manager must be informed and a duplicate key may be obtained. A second set of keys must be kept with the appropriate manager where 24-hour access is available. The keys must be clearly identified and easily accessible to the duty manager. Where the cupboard keys are not found a new lock must be fitted to the cupboard.
If there is no duplicate key, the duty manager will arrange for the cupboard to be broken open and a new lock fitted. The pharmacy department must be notified and the incident reported in accordance with:

- **Incident reporting, management and investigation policy (CO10)**

Refer to:

- **Standard Operating Procedure, The handover of Controlled Drugs cupboard keys, responsibilities, access to CDs and authorised signatories. (SOP 0013).**

16 CHECKING OF STOCK BALANCES

16.1 The checking of Controlled Drugs, stock balances must be in accordance with:

- **Policy on the Safe Management of Controlled Drugs (CL44)**
- **Standard Operating Procedure, The checking of CD stock by Registered Nurses on wards/clinical areas (SOP 0004)**
- **Standard Operating Procedure, The administration, recording and stock reconciliation of CDs in ward and clinical areas. (SOP 0011)**

- **Section 10, Controlled Drugs, Losses or discrepancies**.

16.2 Recorded Drugs (inpatient mental health services)

In the North Division of mental health services, the checking of stock balances of Recorded Drugs must be in accordance with:

- **Standard Operating Procedure for the checking of Recorded Drug stocks by Registered Nurses on wards/clinical areas (SOP 0005).**

16.3 Other medicines

Any need for checking stock balances of other medicines must be left to the discretion of a RN. If, however, there is suspicion of misuse or misappropriation this must be reported to the department manager and local pharmacy department and Chief Pharmacist. In such cases it is advised that a stock balance must be recorded and regular checking introduced. If this shows discrepancies the medicine must be made subject to similar procedures as Controlled Drugs and register entries must be made whenever the medicine is supplied or administered.

17 ALTERNATIVE AND COMPLEMENTARY TREATMENTS

Complementary therapies are not provided within the Trust unless specifically commissioned.

If a patient wishes to self-administer an alternative medicine, they must discuss this with the doctor responsible for their care. This discussion should normally include the pharmacist and RN looking after the patient.

If the use of alternative medicine administered to themselves is agreed, this should be recorded on the inpatient prescription chart. The patient must supply the alternative medicine themselves and the chart endorsed ‘patient’s own’ (POD) by the pharmacist.

It should be made clear to the patient and recorded in the patient’s notes that the Trust cannot accept responsibility for the quality or efficacy of this group of agents and any such items brought in by the patient and not supplied through the pharmacy department of the acute trust or dispensary of the external pharmacy provider.

18 USE OF UNLICENSED MEDICINES OR USE OF LICENSED MEDICINES OUTSIDE OF THEIR PRODUCT LICENCE

Prescribing must be in accordance with:

- **Policy on the Prescribing, Supply and Use of Unlicensed Medicines (CL16).**
- **Policy on the Use of Licensed Medicines outside the conditions of their Product License (CL17).**

19 CLINICAL TRIALS INVOLVING MEDICINES

The Innovation and Research Team are responsible for co-ordinating all research undertaken within the Trust.

Clinical trials involving medicines must comply with all the necessary legislation and be in accordance with:

- **Research and Development Policy (CL83)**

Refer to:

- **Procedure for the Safe Handling of Clinical Trial Medicines (MM 044)**

Funding issues surrounding the use of a trial drug in the post trial phase must be clarified prior to commencement. Where the drug company is unwilling to maintain supplies at the end of the trial, the consent form must indicate to the patient that supplies will only be maintained for the duration of the trial.

20 MEDICAL GASES

All medical gases used in the Trust are Licensed Medicines and as such are subject to the Medicines Act and must be treated in the same way as any other medicines and in accordance with:

- **Policy for the Safe Management of Medical Gases (CL55)**
- **Standard Operating Procedure for the safe administration of oxygen (SOP 0029)**
- **Standard Operating Procedure for the maintenance of medical gas cylinders (SOP 0030)**
- **Standard Operating Procedure for the ordering, receipt, storage and authorisation for payment of medical gas cylinders by Trust Units (SOP 0009)**
- **Standard Operating Procedure for the use of oxygen concentrators in inpatient areas when a patient is admitted with one (SOP 0062)**

The majority of medical gas used in the Trust is oxygen.

Before a medical gas is administered to a patient, it must be prescribed. The prescription must include the name, and concentration of the medical gas (where appropriate), the method of administration and the rate of flow.

In an emergency situation a RN may undertake the administration of oxygen to a patient in the absence of a prescription and without referral to a medical practitioner.

20.1 Community health services

Patients or carers may administer oxygen in their own homes. Oxygen supply and training in the use of oxygen is the responsibility of the supplier.

In an emergency situation a RN may undertake the administration of oxygen to a patient in the absence of a prescription and without referral to a medical practitioner.

Refer to:

- **Carrying oxygen and other medical gas cylinders within vehicles (community dental services) (SOPCH 0001)**

21 NON-REGISTERED STAFF AND MEDICINES RELATED DUTIES

21.1 Inpatient services

21.1.1 Non-registered staff may assist RN to perform the following:-

Check the patient's identity, in accordance with:

- **Identification of service users policy (CL1)**

Check discharge medicines with a RN against a discharge prescription.

21.1.2 Non-registered staff CANNOT perform the following duties:-

Ordering of medicines
Preparation and supply of medicines
Administration of medicines (EXCEPT where under the direct supervision of a RN)
Administration or checking of Controlled Drugs
Supply of discharge medicines.

21.2 In mental health services, Assistant Practitioners (AP) may be authorised by the Trust to administer medicines under a specific protocol or Standard Operating Procedure. The protocol must specify the training and assessment of the Qualified Assistant Practitioners in relation to specific tasks to be carried out and records of this will be kept.

Protocols or SOPs already in place are:

- **The Receipt and Storage of Pharmacy Stock received by Qualified Assistant Practitioners onto Trust Units (SOP 0024)**

- **Protocol for the Administration of Depot Medication by intra-muscular injection to adults by Qualified Assistant Practitioners (SOP 0031)**

21.3 Community health services

Within community health services NRS who have undergone the safe administration of medicines training and subsequent assessments (CAF) are able to administer medicines. This does not include Controlled Drugs (CDs).

The exception to this is buccal midazolam but only if the NRS has undergone the relevant training to administer this. NRS can however **be a witness** to the administration and checking of CDs following the appropriate training.

22 DAY HOSPITAL AND RESPITE CARE (including special schools)

A variety of arrangements may be in place to prescribe and provide medicines for patients who attend day hospitals, who receive respite care or who attend special schools.

Good liaison is vital to ensure that both the GP and healthcare staff are aware of all the medicines to be received by the patient and, who is responsible for the prescription, the supply and the administration of each medicine.

22.1 The prescribing of medicines for patients who attend day care is usually the responsibility of the GP. In some situations, a hospital prescriber may wish to take responsibility for part or all of the prescribing.

In such situations, the prescriber will prescribe the medicines using a day hospital medicine card (where used) and if the medicine is to be administered at the day hospital this will also be used to provide a record of medicine administration.

Patients who attend day care will be encouraged to self-administer their own medicines prescribed by their GP. In some situations, it may be necessary for some or all of these medicines to be administered by a RN at the day hospital. In such situations, the following must occur:

- Confirmation of the patient's medicines with the patient's carers and GP (Medicines Reconciliation)
- Inspection of the medicines provided
- Completion of a prescription sheet of solely the items that are to be administered or supplied to the patient.
- Where a patient receives medicines other than those administered at day care, cross-reference must be made to those medicines as recorded in the patient's notes.

Refer to:

- **Procedure for Medicines Reconciliation on admission of patients to hospital (MM 026)**

If for any reason a difference between the medicine provided by the patient and those prescribed on the inpatient prescription occurs, the prescriber must be contacted to clarify the prescription.

At some day hospitals, it is usual for the patient or carers to provide the medicines from the patient's own supply. However, in some situations the medicines may be obtained from the pharmacy department.

22.2 For patients admitted for respite care and special schools, it is usual for the patient or carers to provide the medicines from the patient's own supply.

The RN must:

Confirm with the patient's GP prior to admission the medicines prescribed for the patient.

Confirm with the carers prior to admission that the necessary medicines to span the period of respite care will be provided.

Confirm with the hospital prescriber that the patient's own supply agrees with the account provided by the carer and the GP. Once the confirmation has taken place the medicines must be transcribed onto a Trust prescription form.

Ensure that if a patient is self medicating it is safe to do so.

Refer to:

- **Standard Operating Procedure, The use of patients own drugs (PODs) during admission on an inpatient ward (SOP 0028).**
- **Guidelines for the self-administration of certain prescribed medicines on inpatient wards (MM 006)**
  Cambeck close short breaks medicine management procedures (MMCH 021)
- **Bury supported living scheme medicine management procedures (MMCH 022)**
- **Special education needs school medicine management procedures (MMCH 028)**
- **The transcribing of medicines for children and young people attending Special Educational Needs (SEN) schools within Pennine Care NHS Foundation Trust (PCFT) (SOPCH 012)**

23 MEDICATION ERROR INCIDENTS

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

All medication error incidents must be reported in accordance with:

- **Incident Reporting, Management and Investigation Policy (CO10).**

The pharmacy team review all medication related incident reports and utilise the information to highlight recurrent or high-risk issues. These findings are discussed at the Managing Prescribing Risk sub group and reported to the Drugs and Therapeutics Committee. Action may involve system redesign or improvement and/or education and training on any aspect of medicine use.

All incidents involving medicines are reported to the National Reporting and Learning System (NRLS) via the Trust's Risk Management system Safeguard.

Medication errors may be reportable to the Health and Safety Executive under Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 95 and are subject to time restrictive reporting constraints.

Reporting of losses and discrepancies should only occur where no explanation can be given.

24 ADVERSE DRUG REACTIONS

Refer to:

- **Guidelines for the reporting of Suspected Adverse Drug Reactions (MM 038)**

25 THE DISSEMINATION OF DRUG ALERTS VIA CENTRAL ALERTS SYSTEM

The dissemination of Drug Alerts via the Central Alerts System (CAS) will be in accordance with:

- **Central Alerts System Policy (CO36)**

An SOP is also in place:

- **The dissemination of Drug Alerts within the Trust once received via the Central Alerts System (SOP0045)**

26 ILLICIT SUBSTANCES

Illicit substances must be managed in accordance with:

- **The Management of Suspected Illicit Substances on Trust Premises Policy (CL40).**

27 CONSENT TO TREATMENT

Consent to treatment must be managed in accordance with:

- **Consent to treatment or examination policy (CL2).**

28 THE COVERT ADMINISTRATION OF MEDICINES

The covert administration of medicines is only likely to be necessary or appropriate in the case of patients who actively refuse medication but are judged not to have the capacity to understand the consequence of their refusal.

This must be in accordance with:

- **Covert Administration of Medicines Policy (CL37).**

29 COMPLIANCE AIDS

Refer to:

- **Guidance for requesting a Monitored Dosage System (MDS) for inpatients (MM 015).**

Check with Medicines Information (penninecare.medsinfo@nhs.net) to confirm that medication is suitable for use in a compliance aid.

30 FORMULARIES

30.1 Mental health services

The Trust medicines formulary for the treatment of mental health is available via the Trust Pharmacy Services intranet site. The formulary is a working document incorporating national and locally agreed prescribing policies and guidelines.

Agreement has been reached within the health economy that the Drugs and Therapeutics Committee of Pennine Care NHS Foundation Trust will consider the introduction of medicines for the treatment of mental illness.

The Greater Manchester Medicines Management Group (GMMMG) produced a Joint Formulary which has been implemented across Greater Manchester and the Trust.

The personal formularies of NMP will be in accordance with the Trust formulary for the treatment of mental health and / or the GMMMG Joint Formulary.

30.2 Community health services

A variety of formularies are in use across the community health services of the Trust, for example, wound care formularies.

The personal formularies of NMP will be in accordance with the formulary of the GMMMG Joint Formulary.

31 IMPLEMENTATION AND TRAINING

The Trust will ensure that the Medicines Policy has been issued and implemented as follows:

31.1 Issue and Implementation

A variety of dissemination methods are in place to make sure that all staff are aware of, have access to and comply with, the Medicines Policy.

Lists of all new policies are published in the Trust's Corporate Brief including a brief description and its intended audience.

All policies are held on the Trust's intranet, to which all staff have access. Staff should always consult the intranet for the latest version.

Where a hard copy is kept on a ward/clinical area, it is the responsibility of the Ward/ Service manager to ensure that the current version is on file.

Following approval, the Chief Pharmacist is responsible for cascading details of the latest version of all policies to all healthcare professionals.

Ward and service managers are responsible for ensuring staff in their area of managerial control are fully aware of the content of policy on the prescribing, supply and use of unlicensed medicines and to act accordingly.

All healthcare staff are responsible for ensuring they understand the content of the Medicines Policy and to act accordingly.

31.2 Training

Training in medicines optimisation and in relation to the Medicines Policy forms part of the Trust's core and essential skills (mandatory) training for identified staff groups.

The format of the medicines optimisation training is described as per the Trust Training Needs Analysis (TNA) which is included in the Trust's Core and Essential Skills (Mandatory Training) Education Policy (CO81).

Where pharmacy staff provides additional training on medicines on an ad hoc basis or at the request of managers within the Trust, attendance records will be completed and forwarded to the OD Department for inclusion on the electronic training record.

Pharmacy staff input on an ongoing basis to the induction programme of junior medical staff.

Further training will be made available when necessary to support initiatives of the National Reporting and Learning System (NRLS) and /or NICE.

Medicines optimisation training needs in relation to the Medicines Policy should be identified through the Individual Performance and Development Review (IPDR) process and fed into the Trust TNA.

Training required for individual members of staff is identified through the Trust's IPDR process and arranged as appropriate.

32 AUDIT AND MONITORING OF COMPLIANCE

32.1 Audit

Audit in relation to the Medicines Policy will be carried out as part of the Trust's clinical audit programme, in accordance with the annual audit calendar and will be overseen by the Drugs and Therapeutics Committee.

32.2 Monitoring

Compliance with this policy will be monitored using an analysis of incidents and complaints, by the Managing Prescribing Risk group on a quarterly basis, where there has been a failure to follow procedure.

Quarterly medication error/incident reports (Safeguard) are reviewed by Managing Prescribing Risk Sub Group. Analysis allows identification of trends and themes.

Quarterly prescribing error incident data is reviewed by the Managing Prescribing Risk sub group and reported to the Medical Director.

Action plans to manage improvement in compliance will be developed by the Managing Prescribing Risk group on a quarterly basis where necessary.

Key findings of both audit and monitoring of compliance will be reported to the Drugs and Therapeutics Committee.

Checking and monitoring of non-completion of mandatory medicines management training is undertaken by the OD Department and entered on to the Trust's electronic training record. A monthly report is provided to service managers by the OD Department on the completion of mandatory and essential training. Any non-attendance is reported via e-mail from the OD Department to the individual's authorising manager for action and future attendance to be arranged

33 SUPPORTING POLICIES, PROCEDURES AND GUIDELINES

This policy should be read in conjunction with the appropriate medicines optimisation policies and procedures. Up to date versions can be found on the Medicines Management pages of the Trust intranet site.

34 REVIEW

This policy will be reviewed by the Drugs and Therapeutics Committee every three years or sooner should the need arise.