Heart of England NHS
NHS Foundation Trust

MEDICINESMANAGEMENT PROCEDURE

Prescribing and Administering Medicines Procedure v1.0

CATEGORY:	Medicines Management
CLASSIFICATION:	Procedure
PURPOSE:	To set out the Trust approach to prescribing and administering medicines
Version Number:	1.0
Sponsor:	Tania Carruthers, Clinical Director - Pharmacy
Approved By:	Medicines Management Group (MMG)
On:	08/03/2017
Review Date:	08/03/2020
Distribution: • **Essential Reading for:** • **Information for:**	All staff involved in the prescribing and administering of medicines and their managers

Paper Copies of this Document

- If you are reading a printed copy of this document you should check the Trust's Policy website (http://sharepoint/policies) to ensure that you are using the most current version.

Key changes:

Procedure Version History

Version	Author and changes	Date ratified
1.0	Tania Carruthers, Clinical Director for Pharmacy	08/03/2017

Table of Contents

1 Introduction

This document should be read in conjunction with the Medicines Policy which sets the framework for all aspects of Medicines Management within the Trust.
The purpose of this document is to provide a Trust Procedure for all members of staff groups involved in the use of medicines within the Trust. It indicates how medicines will be prescribed, supplied and administered to patients. It also defines the processes that will be used to assure safe procurement, supply, custody and disposal of medicines. The ultimate aim of the document is to ensure effective systems are in place to safeguard the welfare of patients, visitors and staff in regard to the use of medicines.

It is essential that all staff involved in the prescribing, supply and administration of medicines are made aware of this procedure on joining the Trust and practice at all times in accordance with it. This procedure should be read in conjunction with the Trust Controlled Drugs Procedure and the Staff Handbook – Standards for Safe Medicines Practice.

2 Prescribing

General Guidance

Prescribing should conform with the advice which appears in the current British National Formulary (BNF) under "Guidance on Prescribing" and applies to the use of all prescribing documents used within the Trust.

The following points should be particularly noted:-

a) When prescribing for inpatients, outpatients, day case patients, Emergency department patients or on discharge prescriptions forms[1] (TTO), only Trust approved forms must be used.

b) The patient's full name, demographics, name of current consultant and ward must be entered on the drug prescribing and recording sheet.

c) The names of all medicines must be PRINTED in **BLOCK CAPITALS.**

d) The approved name of a medicine should be used at all times. (**Except** where the current BNF cautions against this e.g. slow release theophylline preparations, for multiple component medicines and other medicines where specific risks have been identified.)

e) It is essential that the metric system is used for all prescribing. The writing of the dosage should be in accordance with the recommendations in the BNF. In particular, if the medicine is one for which strength is expressed in units, then the word "**UNITS**" must be written **in full.** Similarly doses expressed as micrograms or nanograms must always have "**micrograms**" or "**nanograms**" written out in full.

f) Although directions should be in English, without abbreviation, it is recognised that some Latin abbreviations are appropriate. (For details of acceptable abbreviations see the inside back cover of the current BNF and Appendix 1 of this Procedure). No other abbreviations are acceptable.

g) The route(s) of administration must be clearly stated.

h) Prescriptions must be signed in full, in indelible, black ink and dated by the prescriber. Print name to ensure legible.

i) Medical gases, including entonox and oxygen, must be prescribed. Oxygen therapy should be prescribed in accordance with the Oxygen Prescription guidelines.

j) (j) For children:

- Prescribe paediatric preparations whenever possible to avoid the risk of giving adult dosages
- Always include the patient's age and weight on the prescription sheet
- Prescriptions should also detail calculations, i.e. mg/kg/dose or mg/kg/day but the prescription must state the actual calculated dose for the patient.
- Prescribers should utilise dose calculators or other tools where available

(k) Prescribers are strongly encouraged to ask a colleague to check any calculations that may be required when prescribing or administering medicines.

(l) Information on medicines can be accessed easily whilst working in HEFT for more information or visit the Medicines Management website

[1] A discharge prescription is sometimes referred to as a TTO, TTA or TTH (To Take Out/Away/Home)

2.1 Prescribing for Inpatients

In addition to the general prescribing guidance in section 2 above, the following should be noted:-

2.1.1 The Medicine Prescribing and Recording Sheet

a) The medicine prescribing and recording sheet should be available to the prescriber[2] whenever the patient's treatment is being reviewed, to the nurse/midwife whenever medicines have to be given and to the clinical pharmacist or medicines management technician when reviewing the inpatient treatment and discharge prescriptions.

b) Not more than one medicine prescribing and recording sheet should be in use at any one time for any one patient. When 2 sheets are in use but the current treatment could be easily accommodated on 1 sheet, the prescriber should be asked to re-write the medicine prescribing and recording sheet to reduce the risk of medication errors and missed doses.

c) Where it is unavoidable for a patient to have more than one current medicine prescribing and recording sheet at any one time, each sheet must be clearly marked as sheet 1 of 2, or sheet 2 of 2.

d) A new sheet should not be started merely because the first is not immediately available, e.g. If it is misplaced or in use elsewhere.

2.1.2 Prescribing

For medicines which are to be given by intravenous infusion refer to the IV medication procedure.

- The times of administration must be clearly indicated and should reflect appropriate practice on that ward.
- The frequency of administration of "as required"/ PRN medicines should be indicated by clear and definitely stated intervals, where possible. The maximum number of doses in any 24 hour period must be clearly stated where appropriate. The circumstances for administration must be defined.
- Any instructions as to the application of treatment e.g. left eye, or the duration or timing of treatment must be written in the "special instructions" box.
- The prescriber's full signature, written in black, indelible ink, is necessary with each prescription and the date on which administration of the medication is to be commenced must be clearly stated.

(a) **The date of prescription** – for new medication.

i. Medicines that have been started pre-admission to hospital and which need to be continued should have the word "Pre-admission" ("P/A") written in the 'start date' box or tick the 'admitted on' box on the EP system

ii. When rewriting the prescription sheet any start date / "pre-admission" appearing on the old sheet should be transferred to the new sheet. A date

[2] In relation to dental treatment, a prescription can also be written by a registered dental practitioner.

reflecting the day/time at which the prescription is rewritten should not be used.

2.1.3 **Allergy Status**

Any known medicine, food or substance allergies (including nut, arachis oil and latex) that the patient suffers and the nature or symptoms of the reaction **MUST** be recorded, signed and dated in the appropriate space provided on the medicine prescribing and recording sheet, outpatient prescription or careplans.

This information must be recorded by the person undertaking an initial assessment of the patient. This will usually be a prescriber, but other registered healthcare professionals competent to undertake assessments of medication history recording can record allergy status information in the patients' notes and on their prescription (e.g. Nurse, Midwife or Pharmacist).

It is good practice to record the source of the information in the patient's notes or on the prescription.

Patients who state that they have a known medication, food or substance allergy must wear a red allergy wrist band.

It is not uncommon for other healthcare professionals to become aware of a previously unrecorded allergy. Such new information **MUST** be recorded and signed in the appropriate places in the patient's notes and prescriptions by a registered healthcare professional (e.g. Nurse, Midwife or Pharmacist). A member of the patient's medical team must be informed if considered appropriate.

If it is established that the patient has not suffered from any previous medication allergies the prescriber or other competent staff, **MUST** state on the prescription **No known allergies (or NKA), None Known or None Declared.**

Where it has not been possible to determine the allergy status of a patient, the term **Undetermined** can be used on a temporary basis to allow essential or life saving treatment to progress until the true allergy status of the patient can be established at the earliest opportunity.

NOTE: Whatever the patient's allergy status:

- **Prescribers must always ensure that there is an entry in the allergy section and check against it before writing the prescription**
- **If the allergy box is left blank:**
  - **Nursing staff must not administer medication**
  - **Pharmacy must not dispense any medicine treatment for the patient**

2.1.4 **Cancelling, Rewriting and Amending Prescriptions**

a. Cancellations of any prescriptions no longer current must be signed and dated. A heavy line must be drawn through both the prescribing and recording sections of the medicine prescribing and recording sheet.

b. When a new medicine prescribing and recording sheet is required, medicines still in use must be transferred from the old to the new sheet by the prescriber, the old medicine prescribing and recording sheet being cancelled by a heavy line, signed, dated (showing day, month and year), and retained in the patient's records.

c. In most circumstances the medicine prescribing and recording sheet should not be altered. If a change is required, the old prescription should be cancelled and a new one written. It is only permissible to amend the dose or frequency of a prescription if this can be done clearly, with detail of the change documented within the “special instructions” box. The amending prescriber's signature and date must be written underneath the change details, and if appropriate, the time of the change. It is not permissible to alter a previously altered prescription; in such circumstances the prescription must be re-written.

See also "Amendment to a medicine prescribing and recording sheet by pharmacist" in Section 2.11.

2.2 Legibility and Detail of Prescriptions

If the nurse is in any doubt whatsoever concerning a prescription, the medication must not be given until the prescription is verified and the doubt resolved. In the case of any difficulties, the Nurse-in-Charge must be informed so that appropriate action can be taken.

2.3 Prescribing by Medical Students

Medical students are NOT allowed to prescribe medications under any circumstances. They may prepare a prescription but it must be signed only by a registered doctor / non-medical prescriber in order to authorise the prescription.

2.4 Prescribing of systemic anti-cancer therapy by FY1 doctors

FY1 doctors are NOT allowed to prescribe any systemic anti-cancer therapy under any circumstances. These should only be prescribed by an authorised prescriber.

2.5 Electronic prescribing and Medicines Administration (EPMA)

Electronic Prescribing and Medicines Administration (EPMA) is used extensively across the Trust. In areas where EPMA is in use all patients under admitting consultants recognised by the system must have their main medicine prescription and administration record on the EPMA system. For prescriptions which the EPMA system does not yet handle (e.g. continuous medication infusions, intravenous fluids, patient controlled analgesia devices, ` and warfarin), the Trust’s appropriate specialist prescribing sheet must be used (e.g. a warfarin prescription sheet). In each case a corresponding electronic prescription should be written to refer staff to the paper

prescription (e.g. Warfarin – variable dose, see Anticoagulation sheet). **Under no other circumstances** should patients have both electronic and paper prescriptions.

The username and password provided by the EPMA team to each member of staff forms the basis of their electronic signature and their accountability for actions recorded on the electronic prescribing system. Staff will protect their password in accordance with Trust procedure and should not share it or allow it to become known by anyone else. If this should occur staff must change it immediately. If they are unable to do this they must contact the EPMA Team directly.

If a patient transfers from an EPMA ward to a non-EPMA ward, a printed copy of the EPMA prescription chart **must** be transferred with the patient and utilised in place of the conventional medicine prescribing and recording sheet on the new ward.

2.6 Patient Group Directions

Arrangements exist within the Trust for *administration* and *supply* of medicines by specified healthcare professionals without the necessity of a prescription written by a prescriber for an individual patient. These arrangements are approved by the Trust's Medicines Management Group on behalf of the Trust Board.

Such arrangements are strictly limited to the detail in the patient group direction. No variation from the detail in a patient group direction is allowed. Users of PGDs are authorised to write/record on the prescription sheet or on EP system where this is specified and required in the PGD.

Further information is available in the Patient Group Direction Procedure and on the Medicines Management website http://medman/pgd

.

2.7 Anaphylaxis

See Trust Resuscitation Policy.

2.8 Verbal Orders

Verbal orders are not permitted by telephone.

Non-emergency or non life-threatening situations:
Medicines must always be prescribed electronically via EPMA or in writing on a paper chart prior to administration – also see section 2.11 for prescription amendments by a pharmacist.

In an emergency or life-threatening situations

- Cardiac arrest, the medicines administered should be administered and then recorded on the cardiac arrest record form.
- In other emergencies, the medicine(s) given must be documented in the patient's notes.

In these circumstances it is permitted for the prescriber to request the nurse in their presence to administer a medicine via a verbal order and then to document details in the patient's notes.

Medicines cannot be prescribed retrospectively on EPMA, although it is possible to do this where paper charts are being used. It is possible to prescribe 'emergency drug – see patient's notes' at the time of the emergency on EPMA and this will be valid for 24 hours.

2.9 **The Pharmacist's Role**

(a) It is the pharmacist's responsibility to promote safe, effective and economic medicines therapy. They provide information and advice on medicines to those involved in the prescribing and administration of medicines. This also covers aspects of security and storage requirements. It is also the duty of the pharmacist to encourage the reporting of adverse reactions to medicines. To support and promote Trust medicine safety projects which improve patient care, safety and experience.

(b) The clinical pharmacist examines prescriptions as outlined in the standard operating procedure for ward visits to ensure that patients prescription charts or EPMA are complete and valid (as per section 3.1 and 3.2).

(c) The pharmacist will annotate the prescription, in green or black ink, or in the EPMA notes section with any clarifications needed and/or advice on the preparation, administration method, dose calculations or monitoring of the medicines treatment.

(a) Pharmacists may transcribe inpatient treatment from an existing inpatient prescribing and recording chart onto a new one in preparation for a prescriber to sign to authorise continuation of the treatment.

(b) Pharmacists may also transcribe inpatient treatment onto a discharge prescription form which can then be dispensed prior to the prescriber signing the form/ discharge letter.

2.10 **The Role of the Medicines Management Technician (MMT)**

The Medicines Management Technician, where such posts are available, will assist the ward and the pharmacist in ensuring that patients have their current medication therapy appropriately prescribed and that treatment is available for administration in a timely manner. The principal roles of a Medicines Management technician are to:

- Review the patient's own medication which they bring into hospital and ascertain their fitness for use.
- Where necessary, assist the pharmacist to complete medicines reconciliation with the patient, carer or GP practice as per the Trust policy
- Annotate prescription sheets with additional information where appropriate.
- Discuss information with the patient on their medication treatment.
- Assist the ward-based staff with provision of medicines information where appropriate or refer to the pharmacist.
- Expedite the provision of new medicines treatment and TTOs
- Promote best practice with all aspects of security and storage of medicines e.g. via audits and to support and promote Trust medicine safety projects which improve patient care, safety and experience

2.11 Amendment to a Medicine Prescribing & Recording Sheet and EPMA Discharge Letter by a Pharmacist

In accordance with Directorate or Trust-wide signed orders

Directorates may agree to specified pharmacists being mandated to make defined amendments to prescriptions for patients of the Directorate e.g. to ensure compliance with directorate–specific guidelines. Similarly the Medicines Management Group may agree Trust-wide signed orders e.g. to substitute one medicine for another, or to limit duration of therapy. Such agreements, including directorate–specific ones, must be clearly stipulated in writing and be formally approved by the Medicines Management Group.

Inpatient or TTO amendments for any systemic anti-cancer therapy or immunosuppressant therapy

When the medicine concerned is a systemic anti-cancer or immunosuppressant therapy the prescription must be referred back to the prescriber for amendments. Pharmacists must not amend or prescribe these unless they are a Trust authorised non-medical prescriber operating within their own scope of practice.

Inpatient or TTO amendments to Controlled Drugs

When the medicine concerned is a CD, Schedule 2 or 3 the prescription **must** be referred back to the prescriber for amendments. Pharmacists must not amend these.

Pharmacists **may** amend CD prescriptions for Schedule 4 and 5 as long as the intention of the prescriber is clear. These should be processed as below.

Minor Amendments

Pharmacists, at their own professional discretion and in the interests of providing best patient care, may modify the prescribed treatment of a patient in a number of ways without the need to necessarily refer to the prescriber. The circumstances when this can be undertaken are:

- When there is no doubt as to the prescriber's intentions
- When some missing detail of an already prescribed maintenance treatment, which the patient was taking immediately prior to admission, comes to light through the taking of a medicines reconciliation or confirmation of one.
- When the prescribed times for administration differ from that recommended in the BNF or Summary of Product Characteristics (SPC) e.g. statins, diuretics, diabetic medications, relationship to food intake etc. to ensure best therapeutic response
- When relevant standard prescribing information has been omitted by the prescriber e.g. strength, form, injection diluent/ diluting infusion fluid, rates of administration, frequency and treatment duration
- Duplications of treatments
- Discontinued medications e.g. PCAs
- Change of product selection on EPMA to ensure that dose matches strength especially at discharge to support accurate transfer of care

Moderate Amendments

Pharmacists may in the interests of providing best patient care, using their professional discretion, add or amend items.

Examples of when this might be appropriate include:

- Medication missed unintentionally or unintentional dose changes from medicines reconciliation that is essential e.g. Anti-epileptics
- Medication omitted from TTO letter e.g. Preadmission medication
- Stop date for antibiotics

It is at the pharmacist discretion, taking into consideration area of work and personal experience, to determine the need for additional documentation of their actions. Pharmacists are reminded that the EPMA system maintains accurate records of these moderate amendments.
If an intervention note is required the relevant documentation for that area should be utilised e.g. EPMA intervention note, paper intervention note, Doctor Handover Book or Patients Medical Notes. These notes must include the following information:

- Actions taken, why and specific details of any Prescriber contacted
- Name and bleep number of Pharmacist

Significant Amendments

Suspend or Cancel
After discussion with the prescriber the Pharmacist if necessary, in the interests of providing best patient care, can cancel or suspend a prescription *if the prescription is deemed to be potentially dangerous and the prescriber is unable to review the prescription immediately.*
These may include:

- Potentially toxic dose of medication
- Incorrect medication, dose or frequency of medication
- Contra-indication to prescribed medication

The Pharmacist must make an intervention note to the patient's record, make an entry in the patient's medical notes or complete a Trust incident form as appropriate.

The prescriber must review the prescription as soon as possible and the Pharmacist must ensure the prescription has been followed up within 24hours.

Prescribe and Suspend
The pharmacist can prescribe an omitted or requested drug and immediately suspend it. The prescriber must review the patient in a timely manner to resume the prescription, ensuring that no doses are missed due to the drug being suspended. This may be of benefit in specialist areas e.g. Admissions units.

The EPMA system maintains accurate and auditable records of this activity that could be called upon at a later date if required. In non-EPMA area accurate records of this intervention must be made using paper intervention notes or patients records.

The pharmacist must make an intervention note if there will be any delay in the prescriber resuming the order and ensure the prescription has been followed up within 24hours.

2.12 Amendment to an Outpatient Prescription or a Paper Discharge Prescription by a Pharmacist.

After discussion with the prescriber

A pharmacist, or a pharmacy technician / pre-registration pharmacist on behalf of a pharmacist, may contact the prescriber concerning a prescribed item on an outpatient prescription or a discharge prescription. If this should result in a change to the prescribed treatment, the prescription may be amended and the prescription annotated with the term "prescriber contacted" or "PC" and be signed, dated and timed by the pharmacy staff member. However, the prescriber or the pharmacist may insist on the prescription being returned to the prescriber for a signed, dated and timed amendment before the prescription is dispensed.

When the medicine concerned is a CD, Schedule 2 or 3 the prescription **must** be referred back to the prescriber for amendments.

Without reference to a prescriber

Pharmacists, at their own professional discretion and in the interests of providing best patient care, may modify the prescribed treatment of a patient in a number of ways without the need to necessarily refer to the prescriber. The circumstances when this can be undertaken are:

- When there is no doubt as to the prescriber's intentions
- When the prescribed times for administration differ from that recommended in the BNF or Summary of Product Characteristics (SPC) e.g. statins, diuretics, relationship to food intake etc. to ensure best therapeutic response
- When relevant standard prescribing information has been omitted by the prescriber e.g. strength, form, frequency and treatment duration.

Pharmacists **may** amend CD prescriptions for Schedule 4 and 5 as long as the intention of the prescriber is clear.

2.13 Generic Substitution

The Trust accepts the principle of 'generic substitution' whereby the Trust's pharmacies stock only one manufacturer's product of any one medicinal form and will routinely substitute that product if an alternative manufacturer's brand of that same medicinal form is prescribed. This is a routine practice in all NHS hospitals.

2.14 Discharge Medicines (TTOs)

Discharge medication can be prescribed using one of the three currently approved systems, at least 24 hours in advance of discharge, these are –

- EPMA -TTO – the Trust's EPMA system
    - This should be used when the patient is located within a clinical area utilising EPMA, further details on the EPMA system can be found in section 2.5
- e -TTO – a web based system
    - This is the preferred method for both prescribing discharge medication and producing a GP letter in all non-EPMA areas, a guide to using the e-TTO system can be found here.
- Paper based system (traditional discharge letter)
    - These are prescribed on the appropriate official document
    - When patient addressograph labels are used, a label must to be affixed to every copy of the discharge drugs form.
    - It is essential that the information on the discharge medications is absolutely clear and complete and drug names must be written, generically where appropriate, in **BLOCK CAPITALS in black ink.**

- Unless the pharmacist had been able to clinically check a TTO whilst on the ward, the patient's prescription chart **must** be sent to the Pharmacy with the TTO form to enable the prescribed discharge treatment to be checked against the inpatient treatment.

The discharge letter is a communication to the general practitioner (GP) and so must show a full record of the patient's discharge treatment including any items which may not need dispensing because the patient has sufficient supplies of their own. Such items should be endorsed "patient's own medication" whichever prescribing system is utilised. The prescriber should make it clear on the discharge medicine form which medicines it is anticipated will need to be continued by the patient's GP. To ensure safe transfer of medication across the interface the letter should explicitly state which medicines have been discontinued, changed or started compared to pre-admission together with an explanation included in the letter and also state explicitly where there have been no changes.

In the event that Pharmacy is closed, see section 2.15.2.

Special care is needed in the prescribing of **Controlled Drugs** for discharge. Reference should be made to the Controlled Drugs Procedure or the BNF where there are 'exemplar prescriptions' to demonstrate the legal requirements.

N.B. If Controlled Drugs are not prescribed in the legal manner the prescription cannot legally be dispensed.

A maximum of 28 days supply of discharge medications will normally be dispensed unless other arrangements are made with the Pharmacy. If 'original pack dispensing' is operating on the ward, patients may be supplied with up to 41 days of treatment (with a minimum of 14 days) for on-going maintenance therapy.

Exception:
For patients who are an in hospital for less than 24 hours (e.g. short stay surgery, assessment units), it may be more appropriate to prescribe only the additional medication needed **if the patient's pre-admission medication is to remain totally unchanged on discharge.** If only additional treatment has been recorded on the discharge medication form, this must be made absolutely clear on the form and the prescriber must ensure that the new medication is compatible with the patient's pre-existing medication.

If there are any changes whatsoever to the pre-existing medication, the discharge medication form **must** show the full record of discharge medication.

2.15 Outpatient Prescribing

Doctors, dentists and other specifically authorised healthcare professionals may write prescriptions for outpatients only on the appropriate official document.

Drug treatment referral letters are available in outpatient clinics and may be used to advise a recommended treatment to a patient's GP but **not** if the treatment is:

- needed urgently
- a specialised course of treatment
- a product only available in hospitals

In the above circumstances a hospital prescription, or FP10(HNC) prescription where these are used, must be provided.

Outpatient prescribing should not be used to supplement a patient's routine supply from the G.P.

Any treatment recommendations made must be in line with the HEFT Formulary for Adults (see section 3.17) as GPs may decline to prescribe non- formulary and unlicensed medicines.

Both outpatient prescriptions and FP10(HNC)s will attract prescription charges for each item dispensed unless the patient is exempt. Classes for exemption or pre-payment are printed on the reverse of the prescription form.

Application forms for exemption or prepayment can be obtained from hospital or community pharmacies or from the Post Office.

Within community services, prescribers may prescribe on-going treatment on FP10(HNC)s that are within their services remit. Local arrangement must be in place for recharging for this service.

2.15.1 Hospital Outpatient Prescription Forms

Hospital prescriptions are only valid for dispensing at pharmacies within the sites of the Trust and at the Trust's on-site dispensing pharmacy partner. The prescriptions cannot be taken for dispensing at a normal community/ high street pharmacy (not even to another branch of the Trust's partner).

Up to 28 days treatment will be issued unless it is a hospital only product or other arrangements have been made with the Pharmacy.

Non - formulary items are not stocked by the Pharmacy and therefore will be unavailable for dispensing (see Formulary section 2.17 for further guidance).

In order to reduce the potential for forgery when using outpatient prescriptions:

- ***Never*** leave prescriptions unattended in clinic room
- Draw a line(s) underneath the prescribed medicine/product so it is difficult for other items to be added
- Write as close to the top of the prescribing section as possible
- Indicate on the prescription the number of items prescribed in words

2.15.2 FP10(HNC) Forms

The use of these prescription forms is limited. However, if it is necessary to issue one, the following procedure should be observed.

Medicines prescribed on FP10(HNC) Forms can be obtained by the patient from any community pharmacy. They cannot be dispensed by the hospital pharmacy. These prescriptions should only be used for urgent commencement of treatment when the hospital pharmacy is closed or if the patient requires a blister pack at SH. Again the 28 day rule should apply.

These forms should not be used for patient's routine medication supplies (they should be obtained from the GP) nor for non-formulary items.

Patients should be advised to take the prescription to the community pharmacy of their choice. Staff are not allowed to direct patients to specific community pharmacies. Please note that the full cost of all drugs prescribed on FP10(HNC) forms plus a dispensing fee are borne by the directorate issuing the prescription.

Security of the Blank FP10(HNC) Forms is the responsibility of the Medical Officer concerned, including safe (locked) storage but may be delegated to the trained nurse in charge of the department. Prescriptions must not be left unattended at any time. (Refer to prevention of forgery guidance in 2.15.1).

2.15.3 Authorised Prescription and Administration Documents

The format of all prescribing and administration documents used within the Trust must be authorised by the Medicines Management Group. The only exceptions are formal clinical study prescription documents whose format is determined as part of the study. Any proposals for new prescription documents or amendments of existing documents should be forwarded in the first instance to the Principal Pharmacist – Clinical Effectiveness and Medicine Safety or the Clinical Director of Pharmacy.

2.15.4 Pre-printed Prescription Labels

Pre-printed prescription labels for specific, but often complex dose regimens can be used to improve the safety of prescribing in certain situations. Such pre-printed labels must be authorised by the Medicines Management Group and in the first instance, should be forwarded to the Principal Pharmacist – Clinical Effectiveness and Medicine Safety or the Clinical Director of Pharmacy.

2.15.5 Faxing of Prescription Charts

It is not normal practice to fax prescriptions or medicine prescribing and recording sheets. In the event that this practice is required, an approved local procedure must be available. This procedure must have been ratified by the Trust Medicines Management Group.

2.16 Antimicrobial Prescribing

Antibiotics should only be prescribed if there is a culture proven or clinically suspected, treatable infection.

Good collaboration between the clinicians, the microbiology laboratory, the Trust Antibiotics Group, the Infection Prevention Group and pharmacy is necessary in order to ensure rational prescribing of antimicrobials.

Antimicrobial prescribing must be in keeping with the current adult and paediatric guidelines for the Trust. The Trust Antibiotic Group must monitor and report antibiotic consumption. The guidelines must be regularly updated based on recent evidence/ research, local epidemiology surveillance and local resistance patterns. The choice of antibiotics has important public health implications. It is sometimes necessary to restrict the use of certain antimicrobials for reasons related to selection or transmission of resistance. The indication, choice, duration and route of administration must be regularly audited.

Before starting antibiotic therapy, an indication must be documented in the clinical notes/prescription chart and appropriate specimens should be taken, as indicated in the guidelines.

- Antibiotics for severe sepsis must be administered within one hour
- A stop/review date needs to be indicated for all antibiotic prescriptions in the clinical notes/prescription chart at the point of prescribing
- Antibiotic prescriptions must be reviewed at 48 hours and if continuing need to be clinically reviewed daily thereafter
- IV antibiotics should be switched to oral where appropriate according to Trust guidelines.
- Patients on prolonged IV antibiotics may need referral to the home IV service.
- Prophylaxis when indicated must be restricted to a single dose for surgical patients.
- Microbiology laboratory results must be used to guide and modify/de-escalate therapy.
- Consultation with the Consultant Microbiologists or the Antibiotic Pharmacist is encouraged for advice and guidance.

Within Solihull Community Services, prescribers should consult the latest local guidelines for the management of infections in primary care which is specifically aimed at treatment of infections in a non-acute setting.

2.17 **HEFT Formulary**

The HEFT Formulary has been developed in conjunction with the Area Prescribing Committee. It continues to represent evidence based, cost effective medicine and is regularly updated. The HEFT Formulary mirrors the formal Area Prescribing Committee Formulary but contains extra information which is pertinent to specific specialities at HEFT.

It is expected that all routine prescribing at HEFT should comply with the HEFT Formulary. Prescribing practice and formulary concordance is monitored by the Formulary Team and the CCGs.

The HEFT Formulary can be accessed on the Medicines Management website http://medman/formulary where further explanatory information and contact details can be found.

2.18 **Licensed/ Unlicensed Use of Drugs**

Medicines are granted a Marketing Authorisation (MA) (previously known as a Product Licence) if they meet standards of safety, quality and efficacy. The MA defines the indication, dosage ranges and routes and methods of administration.

A doctor prescribing an unlicensed medicine or a licensed medicine in an unlicensed way does so entirely on their own responsibility, carrying the total burden for the patient's welfare and may be called upon to justify their actions in the event of an adverse reaction. Prescribing medicines in an unlicensed way may therefore have medico-legal implications. The prescriber is responsible for ensuring that informed consent is obtained as necessary. The Trust's 'Procedure on the Use of Unlicensed and

'Off-label' Medicinal Products for Adults and Children' requires a doctor to sign a "Declaration of Medico-legal Responsibility for Prescribing Unlicensed or Off-label Medicines' form on the first occasion of use. There are some exceptions to these requirements, for example some medications in Paediatrics which or routinely used off-label, further information can be found in the Trust Procedure.

A pharmacist who manufactures, prepares or purchases an unlicensed medicine in response to a prescription is professionally accountable for any harm caused by a defect in the medicine, which is attributable to the pharmacist's own actions or omissions.

The Pharmacy Department is required to record the names of patients who are prescribed unlicensed medicines and this is achieved in part by requiring the ward nursing staff to record the names of the patients to whom the unlicensed medicine is administered on the pro-forma provided.

The practitioner administering an unlicensed medicine, or administering a medicine in an unlicensed way, in accordance with a prescription written by a registered medical practitioner, should be satisfied that they have sufficient information to administer the drug safely, as detailed in Section 3 of this Procedure. Liability for use of the medicine lies with the prescriber and liability for any defect in the product supplied lies with the supplying pharmacy.

2.19 Clinical Trial Drugs/ Investigational Medicinal Products (IMPs)

In the UK, clinical trials of investigational medicinal products (CTIMPs) are regulated by the Medicine for Human Use (Clinical Trials) Regulation 2004. Research ethics approval, Clinical Trial Authorisation by the MHRA and Trust R&D Department approval must be complete before initiation of a trial within the Trust. Some clinical trials involve the use of existing marketed products used within their licensed indications and others use new medicines, formulations or methods of administration.

The Investigator (consultant in charge of trial) takes overall responsibility for the trial within the Trust and delegates trial tasks to relevant staff within the Trust ensuring that adequate training for procedures in the trial has taken place. Trial specific prescriptions are designed to include the trial code and patient identification number.

Labelling of IMPs is regulated and will include the trial code and the wording "For Clinical Trial Use Only". If the trial is blinded, the name of the trial drug may be deliberately unclear, so that neither hospital staff nor patients will know which active ingredient is in the medication, or if it is placebo.

The Pharmacy must be provided with copies of protocols for all trials involving IMPs. All organisations supplying IMPs must do so through the Trust Pharmacy Department. IMPs should be stored and dispensed by the Trust Pharmacy in accordance with standard operating procedures (SOPs) and the trial sponsor's requirements. Pharmacy will determine the appropriateness of any storage requirements on wards, clinics or units.

Storage temperatures of trial medicine will be monitored and trial records maintained in accordance with sponsor requirements for the trial.

Inpatient Prescribing or via EPMA

Properly labelled clinical trial medicines brought in by a patient on admission as part of current medication can be checked by an authorised prescriber in the ward setting, noted, prescribed and administered as directed.

When prescribing for inpatients the standard approved inpatient prescribing form should be used. The prescription should include the trial drug approved name or code number, the protocol number, patient number and clearly indicate "**CLINICAL TRIAL**". For blinded trials, the medicine name may be deliberately unclear.

Emergency Breaking of Randomisation Codes
In an emergency it may be important to find out what medication a patient has received during a trial, e.g. whether it is active or placebo, and the dose. These details can be obtained from the randomisation code. Randomisation codes should be easily accessible from the investigator, pharmacy department or via a trial-specific telephone access number set up by the sponsoring company.

2.20 Non-medical Prescribing

Nurses, pharmacists, physiotherapists, radiographers, chiropodists and podiatrists who have successfully completed a validated supplementary/ independent prescribing course, are registered with their respective registration body and have attended the NMP trust induction and have been issued with a HEFT 'authorisation to practice' certificate are able to prescribe for patients of the Trust subject to limitations detailed in the Trust's "Non- Medical Prescribing Procedure".

2.21 Use of the Prescription Sheet by Other Specific Clinical Practitioners

Dieticians may write enteral feeds and dietary supplements on the prescription.

Tissue viability nurses or other nominated nurses specialising in wound care may write dressings on the medicine chart (except those containing Prescription Only Medicines).

2.22 Self Prescribing and prescribing for relatives, friends or colleagues

All Trust employees are expected to be registered with a local general practitioner. It follows that all prescribers are expected to obtain their primary needs through this mechanism. However, the Trust appreciates that at times this may cause serious operational difficulties. Guidance is provided that allows fully registered medical and dental consultants only to write a prescription for an acute medical condition needing immediate treatment. Further information and guidance is available **here.**

3 Administration Of Medicines

More detailed information about intravenous administration of fluids and medicines is available in the IV administration procedure, but must be read in conjunction with this section and the relevant clinical procedures in the Nursing Policies & Procedures file.

3.1 Introduction and General Principles of Medicine Administration

a) Whilst most medicine administration is undertaken by nursing/midwifery staff, section 3 equally applies to doctors and other registered healthcare professionals who have undertaken appropriate training and can demonstrate competency in medicines administration.

b) The prescriber has responsibility for telling the assigned nurse-in-charge about any new prescriptions that have been written and that he/she has not administered themselves.

c) It is that nurse's responsibility to ensure that, if necessary, a medicine is ordered from pharmacy and that a nurse has been allocated to carry out administration at the prescribed times.

d) The appointed nurse in charge has responsibility for putting systems in place on the ward for ensuring the availability of medicines and for the allocation of trained nurses to the administration of medicines at the prescribed times. STAT doses of antibiotics must be given within 1hour. Missed doses should be avoided.

e) All newly qualified and newly appointed nurses to the Trust on either permanent or temporary contracts (but excluding bank and agency nurses) must undertake assessment of competence for medicines administration before administering medicines alone.

f) The appointed nurse must ensure that nurses have been assessed as competent in all aspects of the administration of medicines, including performing calculations.

g) No nurse should be expected to accept the responsibility for administering any medicines against his/her will and those who do accept the responsibility must remember the requirements of the *Code of Professional Conduct; standards for performance, conduct and ethics*. Nursing and Midwifery Council (November 2004) and *Standards for Medicines Management* Nursing and Midwifery Council (October 2007).

h) Registered midwives may supply and administer on their own initiative, any of the substances that are specified in medicines legislation under midwives exemptions, provided it is in the course of their professional practice. Student midwives may administer medicines on the midwives exemptions list, except controlled drugs, under the supervision of a midwife.

i) It is the responsibility of the nurse administering the medicine to ensure that he/she is aware of the following:

   i. Medication being given and its purpose
   ii. Major contra-indications
   iii. Main side effects
   iv. Normal dose
   v. Correct method of administration
   vi. Appropriate nursing interventions which need to be undertaken e.g.: pre and/or post administration observations

For "Sources of Information about Medicines for Professional Staff", see Appendix C of the Medicines Policy.

j) It is the responsibility of the nurse/midwife to ensure that medicines are administered at, or around, the prescribed time. When a medicine is not administered as prescribed, the nurse/midwife must have a good, justifiable reason for not so doing, and the appropriate code must be recorded on the medication prescribing and recording sheet. It may be appropriate for the nurse /midwife to contact the prescriber to inform him/her and ask for advice.

k) Medicines must not be prepared in advance of administration except when reconstituted by pharmacy staff or when authorised by the Trust's Medicines Management Group.

l) Crushing tablets or opening capsules are unlicensed uses of a medicine and should only be carried out after consultation with the pharmacy.

m) If there are any risks associated with handling or administration of a medicine, a pharmacist must advise the staff in order that risks may be minimised or suitable equipment provided.

n) The nurse should use the administration round as an opportunity to inform patients about potential side-effects especially when new medicines have been started.

3.2 **Controlled Drugs**

Refer to the Trust CD procedure

3.3 **Cytotoxic Drugs**

Cytotoxic drugs may only be given in accordance with the approved Trust Procedure for the Safe Prescribing, Handling and Administration of Anti Cancer Agents.
These drugs must be administered by appropriately trained staff and the chemotherapy nurses must be contacted for all patients receiving intravenous cytotoxic therapy outside the Oncology and Haematology units.

Handling of cytotoxic drugs and some other non-cytotoxic drugs is hazardous. These drugs are transported to wards and departments in special boxes highlighting the nature of the contents. Staff handling these drugs must be aware of the procedure to follow in the light of any spillage on route or in clinical areas. Any member of staff involved in preparation or administration of these drugs by routes other than oral should have undergone specific education and training recognised by the Trust.

3.4 **Other Medicines**

(For medicines which are to be given by intravenous infusion refer to the IV medication procedure.)

Nurses with the necessary knowledge and competence may administer medicines alone.

Restricted lists of medicines are approved for single nurse administration for paediatric (those under 16) and neonatal patients. The medicines must be prescribed as a standard dose of medicine from the Trust approved single nurse administration list and the nurse must have completed the directorate final assessment for first checkers.

The EXCEPTIONS BEING:

a) Medicines are being administered to children under the age of 16.

b) It is essential that the administration be undertaken by two nurses one of whom should preferably be a Registered Nurse (Children's Branch) or by a nurse and a doctor.

c) When the medicine is not listed on the Trust approved single nurse administration list (paediatrics or neonatal) or the nurse has not completed the directorate final assessment for first checker.

d) When instruction is being given to a nurse in training.

e) Where ward or unit procedure is for two nurses to be involved in the preparation, checking and administration of medicines.

f) When the patient's condition is such that two nurses are required.

g) When complicated dose calculations are required e.g. weight related doses. (nurses and doctors are strongly encouraged to routinely ask a colleague to check any calculations that may be required when administering medicines).

h) In any other circumstances where the nurse deems it is necessary to have a second nurse present.

i) In all the above exceptions, where a check by a second person is essential, **the identity of the checker must also be recorded.**

3.5 Administration of Homoeopathic or Herbal Substances

Where a patient wishes to use a herbal or homoeopathic preparation, its use should be discussed with the patient's consultant prior to the patient using it.

3.6 Administration of Complementary and Alternative Therapies

Some nurses, midwives and health visitors, having first successfully undertaken training in complementary or alternative therapy may provide the service. It is essential that practice in these respects, as in all others, is based upon sound principles, available knowledge and skill. The importance of consent to the use of such treatment must be recognised. So, too, must the practitioner's personal accountability for their professional practice.

Complementary and alternative therapies involving the use of substances such as essential oils may only be carried out where there are approved policies and procedures in place.

3.7 Procedure for Administration

It is essential that all medicines be administered in accordance with the patient's current medicine prescribing and recording sheet (see sections 3.1 and 3.2).

The steps in the procedure are:

a) Read the medicine prescribing and recording sheet carefully, taking note of any special instructions or patient sensitivities/ allergies recorded.
N.B. If the "allergy" box has not been completed (with either details of allergies or a statement that the patient has no known allergies), then medicine administration for that patient must be put on hold pending urgent resolution of the situation by a prescriber.

(b) Read each prescription, taking note of any special instructions and ensuring that the prescribed dose has not already been administered and the prescription is still valid.

(c) If the prescription is unclear in any respect whatsoever, the medicine must not be given until the prescription is verified and the doubt resolved. In the case of any difficulties, the nurse in charge must be informed so that appropriate action can be taken.

(d) Select the medicine required, check the dispensing label or the manufacturer's pack labelling with the prescription and check that the medicine is within its expiry date. Do not use any medicine if the dispensing label is unclear in any way. Where possible, confirm correct selection of solid dose medicines by checking the information printed on the foil pack.

(e) Prepare the medicine and check with the medicine prescribing and recording sheet:

i. The medicine including form and strength.
ii. The calculation, if any.
iii. The measured dose.
iv. The route of administration.

(f) Take the measured dose and the medicine prescribing and recording sheet to the patient.

i. Address the patient by name.
ii. Where it is the hospital procedure to use an identity band, read aloud the patient's full name and registration number and check against the medicine prescribing and recording sheet.
iii. Where the nurse is unable to identify the patient in the normal way, alternative means of identification must be used. i.e. checking the patient's address and date of birth or photo ID of the patient.
iv. Where there are two patients with the same or similar name on the ward, extra care must be taken in the identification of the patient.

(g) It is the nurse's responsibility to ensure that the medicines are taken/ given. After the medicine has been administered, the nurse responsible for administration must initial the medicine prescribing and recording sheet in the appropriate place. Medication must not be left on the patient's bedside locker/ table if unable to be taken at that time. If a dose of a medicine is removed from its container/ packaging and then not used it must be destroyed.

(h) Where a prescription is for a variable dose, e.g. 1 or 2 tablets, the dose given must be recorded along with the initials.

(i) Where a specific dose is prescribed, the nurse administering the medication does not have the authority to titrate or vary the prescribed dose. If the nurse has any concerns about the appropriateness of the prescribed dose it must not be given until the matter has been verified with a prescriber.

(j) **If the medication is wasted** or cannot be given to the patient and is destroyed a note to this effect must be made on the medication sheet and recorded in the nursing/midwifery documentation.

(k) **If a medicine is omitted**, the reason must be stated on the prescription sheet and identified by the appropriate code. Using EP, the correct code should be selected and the reason (if not due to 'omitted – drug unavailable) recorded in the notes section.

(l) **In the case of Controlled Drugs**, the details must be entered in the ward Controlled Drugs register. The record must be signed in full by both the nurse giving the medication and the witness, one of whom must be a registered nurse on that ward/department.

(m) For pre-operative patients, the medical/surgical team will determine which, if any, medication is to be withheld prior to surgery. This should be suspended on the in-patient prescription, as should any items to be temporarily stopped in the post-operative period. All other prescribed medications should be administered on the day of surgery.

(n) Administration of oral liquid medicines.
Oral dose syringes (labelled "oral" and/or "enteral" and coloured purple) should be used for measuring oral liquid medicine doses in the following circumstances:

- For oral doses of less than 5mL
- For oral doses of more than 5mL that are NOT multiples of 5mL e.g.7.5mL, 12.5mL etc.
- For all oral doses of Controlled Drug liquids
- For all liquid medicine doses being administered into enteral feeding lines.

They must be discarded after administration of the dose - for single use only

Under NO CIRCUMSTANCES should intravenous syringes be used to measure oral liquid medicine doses or doses to be given into enteral feeding lines. Ref. *NPSA Patient Safety Alert number 19*

3.8 Administration of Medicines via Enteral Feeding Tubes

Liquids or soluble tablets are the preferred formulations to be administered via a feeding tube. Crushing tablets or opening capsules should be considered as a last resort as this generally falls outside a drug's product licence and in these circumstances the prescriber and practitioner accept liability for any adverse effects resulting from this administration. For more information about the administration of specific medication contact your ward pharmacist or medicines information

3.9 Multiple Doses from One Vial.

Only one single dose, for one single patient, on one occasion, should be taken from a drug vial unless the vial label/ package information indicates that it is for multiple dose use, or shows the presence of a preservative on the vial label, or is prepared in the

Pharmacy Aseptic Dispensing Unit. Most vials and all intravenous fluid bags are for single use only. A notable exception is insulin in vials where multiple doses can be taken from one vial.

All ampoules are single use only.
Ref. NPSA Patient Safety Alert No. 20

3.10 Non-Registered Staff

In certain specified circumstances, non-registered staff working in professional specialties, (e.g. healthcare assistants, nursery nurses, physician assistants or other) if appropriately trained and able to demonstrate competence, may undertake the administration of medicines against agreed written protocols signed by the Clinical Director of the specialty and approved by the Trust's Medicines Management Group. These must follow the guidance within the Trust procedure for non-registered practitioners and medicines administration.

3.11 Assistance with Medicine Administration by Parents and Carers.

It is accepted that, in certain circumstances, the assistance of parents/ carers in helping patients to take medicines, after the nurse has selected and prepared the medicine for administration, can be beneficial in ensuring treatment is taken. The nurse who selects and prepares the medicine must be assured that the parent/ carer is fully capable of safely administering the medicine by explaining why the drug is being given, how it should be given, observing administration and documenting actions taken.

The nurse retains full responsibility for the administration and recording of the medicine.

3.12 Covert Administration of Medicines

The covert administration of medicines refers to the disguising of medication in food or drink.

Disguising medication in the absence of informed consent may be regarded as deception. However, a clear distinction should always be made between those patients/clients who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity to understand the consequences of their refusal.

Among those who lack this capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medication and others who would be aware if they were not deceived into thinking otherwise. By disguising medication in food or drink, the patient is being led to believe that they are not receiving medication, when in fact they are.

A patient/client who has capacity and who has refused medication must never be given medication covertly. However, a patient/client who is refusing to take their medication and who has been assessed as lacking capacity to understand the consequences of this refusal may be given the medication covertly, if the medication is in his or her best interests (Following the principles contained within the Mental Capacity Act 2005, and the Trust's policy on Consent to Treatment. The assessment of capacity is primarily a matter for the treating clinicians, but other practitioners involved in the patient's care retain a responsibility to participate in discussions about this assessment. For further

information please see the Trust's policy on assessing capacity "Consent to Examination or Treatment Policy and Procedure".

Once the patient/client has been assessed as lacking capacity the treating clinicians should consider whether it is in the best interests of the patient/client to covertly administer the medication. When reviewing this question clinicians must consider the following:

- The Trust's best interest checklist can be found in 'Consent to Examination or Treatment Policy'

- The medication must be considered essential for the patient's or client's health and well being, or (in extreme cases) for the safety of others.
  Such examples would include:
  Pain relief including end of life care
  Treatment to maintain dignity
  Treatment of life-threatening conditions
  Treatment of conditions which cause them to lack capacity

Administering medicine covertly is not for the convenience of the professionals.

- It should not be assumed that all medicines would be considered appropriate for covert administration.

- The decision to administer a medication covertly should not be considered routine, and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient or client individually. It should be patient- or client-specific, in order to avoid the ritualised administration of medication in this way.

- There should be broad and open discussion among the multi-professional clinical team and the supporters of the patient or client, and agreement that this approach is required in the circumstances. Those involved should include carers, relatives, advocates, and the multi-disciplinary team (especially the pharmacist). Family involvement in the care process should be positively encouraged unless the service user has requested that this does not happen (although the appropriateness of this request should also be assessed in relation to capacity).

- The method of administration of the medicines should be agreed with the pharmacist. Consideration must be given to the fact that if medication is crushed, dissolved or otherwise tampered with, the product will be rendered unlicensed. This may also result in the need to increase or decrease the dose.

- Regular attempts should be made to encourage the patient or client to take their medication. This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual.

The discussion and subsequent decision, including the names of all parties involved in these discussions, must be documented in the care records and the method of covert administration must be recorded clearly on the medicine administration card.

The decision to covertly administer medication must be reviewed on a regular basis i.e. at least weekly. However, it will be appropriate to review this decision more regularly than this if capacity appears capable of returning in the short to medium term.

Even with completed risk assessments and guidelines, and following the involvement of all relevant parties, good record keeping is imperative.

3.13 Self-Administration

A self administration scheme for patients on a ward can only be established and undertaken as part of an organised arrangement agreed with the medical team, senior nurse and ward pharmacist and fully supported by relevant procedures. Refer to Trust procedure.

3.14 Medicine usage within Endoscopy units

HEFT endoscopy units must follow the principles of the medicines policy and work within the policies, procedures and care plans approved by their directorate and the Trust. Within the specialised area of endoscopy the Trust acknowledges that administration of medicines via scope is an accepted method of medicines delivery.

4 Medication Errors

No matter how careful clinical practitioners are in their provision of healthcare, medication errors will occasionally happen. It is important that errors are fully investigated to determine whether changes in practice, procedures or policies might minimise the chance of similar errors occurring in the future.

Whenever it is discovered that a patient has been administered incorrect medicine treatment through a prescribing, dispensing or medicine administration error, the person noting the error must:

a. Immediately inform the nurse in charge of the ward/ unit
b. Urgently contact the appropriate medical officer in charge of the patient so that, if necessary, remedial action can be taken (e.g. discussion with the Poisons Unit) to ensure the safety of the patient. The notified medical officer has a duty to inform the appropriate consultant during normal working hours unless he/she has been called to take remedial action.
c. Urgently report the incident to the matron for the area.
d. Ensure that the incident is documented in the patient's notes along with details of any remedial action taken and the individuals informed.
e. Complete an incident report form (IR1 form) on line

It is the responsibility of the nurse-in-charge to ensure that the patient (and/or relatives, depending on circumstances) is/are advised at an early stage. How this occurs, and by whom, will need to take account of the nature of the error and any adverse consequences suffered by the patient. Any discussions should be documented in the patient's notes.

It is imperative that an incident report form is completed for any prescribing, dispensing or administration error where a patient receives incorrect treatment **and also for a 'near miss'.** The Trust's Incident Reporting Policy must be followed and details of the

error/'near miss' must be reported to the pharmacist and the nurse-in-charge (if not already aware).

Where harm occurs and medicines are suspected the medicines should not be disposed of until suitably investigated.

5 Reporting of Suspected Adverse Drug Reactions

If a healthcare professional is suspicious that an adverse reaction may be related to a medicine or combination of medicines, a Yellow Card (which can be found in the back of the BNF) should be completed. Reports can be made online at www.yellowcard.gov.uk. Or sent FREEPOST YELLOW CARD (no address details required). All adverse reactions must be reported for black triangle medications and only serious adverse reactions for established medicines. An admission to hospital that may be directly due to a medicine is also considered serious and must be reported. Do not be put off reporting because some details are not known.

Clinicians and nurses are encouraged to liaise with pharmacy staff before submitting as further information may be helpful.

6 Responsibilities

6.1 Overall Responsibility

The Chief Executive of the Trust has overall responsibility for medicines management within the Trust. The Clinical Director of Pharmacy has delegated responsibility as the Trust's Lead of Medicines Management which includes the safe and secure handling of medicines throughout the Trust. The Clinical Director of Pharmacy reports directly to the Chief Executive for this purpose across the whole of the organisation. The Clinical Director of Pharmacy is also the Trust's Accountable Officer for the safe and secure handling of Controlled Drugs within the Trust.

6.2 Medicines Policy Accountability

The Trust's Medicines Management Group is responsible, with the Clinical Director of Pharmacy, for producing and distributing this Medicines Policy.

The Medicines Policy is a Trust Policy approved by the Medicines Management Group and this procedure is appended from it.

The Trust's Medicines Management Group reports to the Trust's Clinical Quality Monitoring Group. The Medicines Policy describes the Trust's control measures for reducing medicine-related risks.

The Medicines Policy supports clinical governance within the Trust.

6.3 Medicines Policy Application and Personal Responsibility

The Medicines Policy covers the policy and procedures associated with prescribing, administration, requisitioning and storage of medicinal products. **It is mandatory for all staff employed by and/or working for Heart of England NHS Foundation Trust.** This includes all midwifery and nursing personnel working in the home or visiting general practitioners' premises but excludes those staff seconded to other organisations.

Healthcare staff involved with medicines should undertake continuing

professional development, keeping up to date with changes in medicines and medicines management, and regularly updating themselves on the changes in content of this policy.

6.4 Consultants' and Department Managers' Responsibilities

Consultants' are responsible for ensuring that all prescribers in their team are trained to be competent in all aspects of prescribing medicines, as specified in the Medicines Policy.

Senior Sisters and Managers of all departments using medicines must ensure that:

- A copy of the Medicines Policy is available to their staff
- Staff are fully aware of the Procedure and associated procedures applicable to their ward or department
- Staff are competent to carry out any of their duties encompassed by this Procedure and associated procedures.

7 Assessment of Compliance

Part of the daily activity of pharmacy staff is to ensure that medicines management throughout the Trust is undertaken in accordance with the Medicines Policy. Variation from procedure will initially be taken up with the clinical practitioner concerned unless of a serious nature or repeated transgressions, when the matter will be appropriately escalated to consultants and/or managers.

8 Monitoring

Monitoring of this procedure will be undertaken by the Medicines Management Group with regular reports from the responsible leads. The reports for safe and secure handling of medicines (including CDs) and the medication incidents are also reported to Clinical Quality Monitoring Group and Safe Medication Practice Group.

Criteria	Monitoring Mechanism	Responsible	Group	Frequency
Prescription standards (accuracy)	Prescription audit	Clinical Services Lead & Pharmacists	Medicines Management Group	Annually
Safe & secure handling of medicines	Audit	Pharmacy Governance team	Medicines Management Group	Annually
Prescribing practice	Pharmacist clinical intervention audit	Pharmacy Clinical Services lead	Medicines Management Group	Minimum of annually
Medication Incidents	Review of IR1s	Pharmacy Governance team	Medicines Management Group	Quarterly
Provision of Medicines Information	Patient survey	Patient Quality & Information Team	Medicines Management Group	Annually

Appendix 1 Accepted Abbreviations

The use of abbreviations on prescriptions **MUST** be confined to those noted below. **No other abbreviations are acceptable.** Directions for which there are no accepted abbreviations **MUST** be written in full.

Strengths and quantities

G or g	- gram
mg	- milligram (1000 mg = 1G)
mcg	- microgram (1000 micrograms = 1mg)
ng	- nanogram (1000 nanograms = 1 microgram)
ml or mL	- millilitre
unit	- unit, to be written in full

Routes of Administration

O	-	oral
P.R.	-	rectal
P.V.	-	vaginal
I.V.	-	intravenous injection
I.M.	-	intramuscular injection
S.C.	-	subcutaneous injection
I.P.	-	intraperitoneal
INH	-	inhalation by inhaler through mouth
Neb	-	inhalation by nebuliser (via mask)
Top	-	topical
NG	-	via a nasogastric tube
PEG	-	via a PEG tube

N.B. There are no approved abbreviations for (i) unit of blood (ii) epidural**. These must be written in full**

<u>Dose Frequency</u> (to be used on outpatient prescriptions only)

OD	-	once a day
BD	-	twice a day
TDS	-	three times a day
QDS	-	four times a day
MANE	-	in the morning
NOCTE	-	at night
PRN	-	when necessary
STAT	-	immediately

<u>Other Abbreviations</u>

a.c.	-	before food
p.c.	-	after food

Appendix 2 Groups Of Staff

Throughout this procedure the term "his" or "her" refers to all staff for whom the procedure is intended.

In the application of this Procedure the following groups of staff are referred to: -

Nurse:	This encompasses all practising nurses and midwives, registered with the Nursing and Midwifery Council, working for and on behalf of the Trust.
Nurse-in-Charge:	The most senior nurse or midwife on duty for the ward or department who has been identified as the nurse/midwife in charge for that shift.
Designated Nurse:	Any nurse or midwife who has been identified by the Ward/Department Manager as competent and appropriate to perform a specific task or function. This competence should be communicated to and recognised by any other relevant professionals.
Senior sister:	The senior nursing appointment for the ward or department (e.g. senior sister, charge nurse, clinical nurse manager, team leader, senior midwife).
Duty Senior Nurse:	The most senior nurse or midwife on hospital site cover.
Non-medical prescriber:	A nurse, midwife, physiotherapist, radiographer, podiatrist, chiropodist or pharmacist who has successfully completed a validated supplementary / independent prescribing course and who has been designated to carry out a role as a supplementary prescriber or as an independent prescriber.
Pre-registration Nursing Students:	Can administer medicines only under the direct supervision of a registered nurse. The registered nurse is accountable and responsible for both the conduct of the learner and the safety of the procedure. Pre-registration students nurses may administer an intramuscular and subcutaneous injections under direct observation of the registered nurse. The Pre-registration student nurse can participate in the preparation intravenous medications only under the direct supervision of the Registered competent nurse who can administer intravenous medication. **Under no circumstances can the student nurse administer intravenous medication.** Student nurses can observe the process of controlled drug administration only as the third person but the preparation and administration process must be undertaken by two registered nurses. Pre-registration students taking part in these procedures must ensure they are familiar with the particular policies and procedures of the hospital. Students who are already registered on another part of the register and are undertaking further training (e.g. conversion course students) are not considered to be registered in their training allocations for the purposes of this Policy. Student midwives may administer medicines on the midwives exemptions list, except controlled drugs, under the direct supervision of a midwife.
Operating Department Assistants/ Operating Department Practitioners:	**Operating Department Assistants/Practitioners (ODAs/ODPs) having completed a recognised training**

	course, assist in theatre procedures. ODPs are registered with the Health and Care Professionals Council. ODAs/ODPs who have attended an approved training course and who have been deemed competent by the Theatre Manager may be involved in the administration of a limited range of medicines. ODAs are <u>not</u> legally authorised to requisition Controlled Drugs. The nature of the involvement of an ODA/ODP is set out in local policies agreed by the Clinical Director (Anaesthetics) and the Theatre Manager. These policies are reviewed annually.
Doctors & Dentists:	All medical and dental staff are registered with the relevant professional body. Medical staff may have full, limited or provisional registration. For the purposes of this document the three types of registration will be treated as synonymous. The term "registered dental practitioner" refers to a dentist or orthodontist or any dental practitioner qualified and registered to prescribe or administer medication. Throughout the document, in respect to prescribing rights, the term “doctor” applies to other professional staff authorised to prescribe such as dentists and non-medical prescribers working within their remit of authorisation.
Prescribers:	The term is used to include doctors, dentists and non-medical prescribers working within their remit of authorisation.
Pharmacists:	Pharmacists are registered with the General Pharmaceutical Council. The terms "clinical pharmacist” and “ward pharmacist” are used synonymously.
Pharmacist-in-Charge:	The term "pharmacist-in-charge" refers to the most senior pharmacist on duty at that site, at the time (usually the Clinical Director of Pharmacy or a Principal Pharmacist). Outside normal working hours, this will be the on-call pharmacist. The Responsible Pharmacist is the pharmacist in charge at that time for the registerable activities of the pharmacy.
On-call Pharmacist:	A pharmacist providing an emergency out-of-hours pharmacy service when the Pharmacy Department is closed.
Pharmacy Technicians:	Pharmacy technicians have completed a recognised Pharmaceutical Sciences course and are registered with the General Pharmaceutical Council
Dietician	Dieticians are registered with the Health and Care Professionals Council
Registered Health Professionals:	In addition to the staff groups listed above other registered health professionals working within HEFT may include: Physiotherapists, Radiographers and Biomedical Scientists. These staff groups are registered with and regulated by the Health and Care Professions Council
Non-registered staff: may include Healthcare Assistants, Nursery Nurses and Physicians Assistants	Are excluded from participating in the administration of medicines except in the circumstances described in section 6.7 as approved by the Trust Medicines Management Group