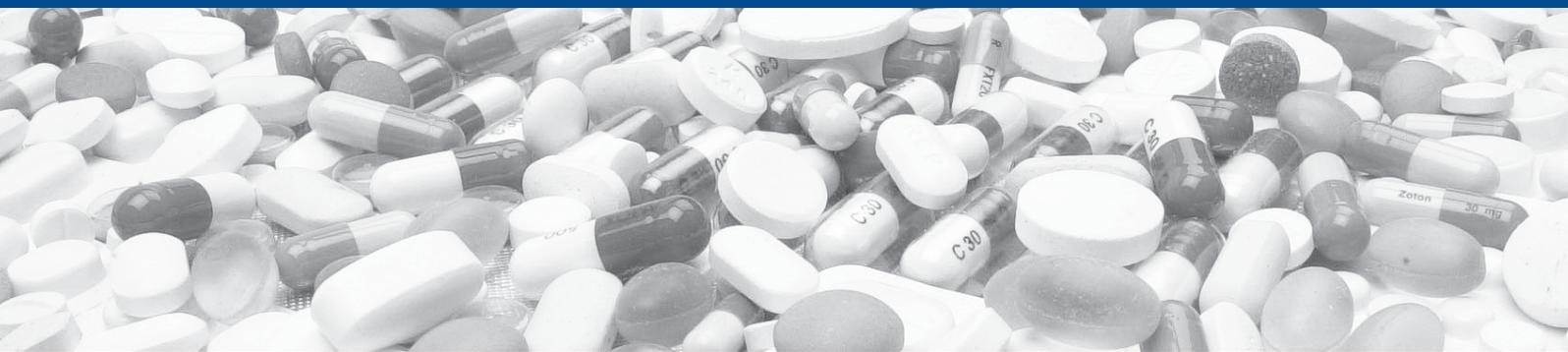


Safe and Secure Handling of Medicines in Hospital Wards, Theatres and Departments



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Before using this printed version please ensure the information contained in the section you are reading is still valid. To do this, please refer to the online policy, which will be updated on a regular basis. The online version is available on Staffnet.

If you have any suggestions that you would like taken in to account during the review of this document please e-mail your comments to: sshm@ggc.scot.nhs.uk

Contents

Introduction	1
1. Definition of a Medicine, including Controlled Drugs (CDs)	2
2. General Policy Statements	3
3. Aims of Policy	4
4. Procurement of medicines from external suppliers	5
4.1 General principles	5
4.2 Company medical representatives	5
4.3 Ordering and stock control of medicines by hospital pharmacy staff.....	6
4.4 Receipt of medicines into pharmacy	6
4.5 Approval of medicines for procurement	7
4.6 Unlicensed medicines	7
4.7 Medicines for use in research and clinical trials.....	8
5. Ordering and stock control of medicines in wards, theatres and departments	9
5.1 General principles	9
5.2 Requirements for ordering medicines for ward, theatre and department stock.....	10
5.3 Requisitioning medicines for discharge and pass prescriptions and for out-patient clinics.....	10
6. Supply of medicines from pharmacy for use within the hospital	12
6.1 General principles	12
6.2 Supply of medicines to community pharmacies or other hospital pharmacies	13
7. Arrangements for the supply of medicines when pharmacy is closed	14
7.1 General principles	14
7.2 Internal transfers of medicines between wards, theatres and departments when pharmacy is closed.....	14
8. Transport of medicines	16
8.1 General principles	16
8.2 Transport of medicines to wards, theatres and departments	16
8.3 Maintaining the cold chain	17
8.4 Taxis and couriers	17
8.5 Posting medicines	17
9. Receipt of medicines for use in wards, theatres and departments	19
9.1 General principles	19
10. Storage and security of medicines	21
10.1 General principles	21
10.2 Control of access to medicines	22
10.3 Delegating control of access to medicines and Controlled Drugs to a registered Operating Department Practitioner (ODP).....	23
10.4 Record keeping and stock check requirements for medicines by wards, theatres and departments.....	24
10.5 Storage of drugs required for emergency use	26
10.6 Action in the event of a breach of security	26
11. Patients Own Drugs (PODs)	27
11.1 General principles	27
11.2 Documentation of Patients Own Drugs.....	27
11.3 Assessment of Patients Own Drugs	28
11.4 Storage of Patients Own Drugs	28
11.5 Return of Patients Own Drugs at Point of Discharge.....	29
11.6 Destruction of Patients Own Drugs.....	29

12. Authorisation to prescribe and administer medicines	30
12.1 General principles	30
12.2 Non-medical prescribers	30
12.3 Nurse / Pharmacist / Allied Health Professions supplementary prescribers	31
12.4 Clinical Management Plans (CMPs).....	32
12.5 Nurse / Pharmacist independent prescribers	32
12.6 Registration of non-medical prescribers within NHS GG&C.....	33
12.7 Non-Medical Prescribers and Controlled Drugs.....	34
12.8 Patient Group Directions (PGDs).....	34
12.9 Symptomatic Relief Policy	35
13. Prescribing medicines	36
13.1 General principles	36
13.2 Prescriptions for in-patients.....	37
13.3 Prescriptions for discharge or pass medicine	38
13.4 Prescriptions for out-patients / Patient Packs	40
13.5 Prescriptions for clinical trial medicines	40
13.6 Prescriptions for injections and infusions	41
14. Administration of medicines	42
14.1 General principles	42
14.2 Administration of medicines to in-patients, out-patients and in clinics.....	43
14.3 Administration of medicines to patients with restricted oral intake	44
14.4 Administration of medicines by injection and infusion.....	44
14.5 Preparation of injections / infusions	45
14.6 Administration of medicines without a written prescription	46
14.7 Telephone orders to administer medicine.....	46
14.8 Self-administration of medicines	47
14.9 Administration of medicines to neonates, children and young people under the age of 16 years	47
14.10 Covert administration of medicines	47
15. Supply of medicines for patients to take away from hospital	49
15.1 General principles	49
15.2 Patient Packs.....	49
15.3 Issuing discharge medication to patients.....	49
15.4 Issue of medicines for injection by patients and carers	51
16. Return and disposal of medicines	52
16.1 General principles	52
16.2 Destruction of medicines at ward, theatre or department level	53
16.3 Destruction and disposal of Controlled Drugs belonging to the hospital pharmacy.....	54
17. Medication incidents	55
18. Defective medicines	56
Appendix 1 - Herbal / Complementary medicines	57
Appendix 2 - Sample documents – Medicines Returned to Pharmacy form / Medicines Requisition form	58
Appendix 3 - Methadone – Guidance for Patients on Methadone Programmes	59
1.1 Introduction	59
1.2 Procedure	59
1.3 Discharge planning.....	59
1.4 On discharge	59
1.5 Transitional care arrangements for new mothers	59
1.6 Arrangements for parents / relatives / carers in a Methadone Programme.....	60

Appendix 4 - Desirable drugs (drugs liable to misuse).....	61
Appendix 5 - Procedure for dealing with unauthorised drugs or other suspicious substances found in NHS hospital premises	62
1. General principles.....	62
2. Procedure when a patient is found to be in possession of unauthorised drugs or other suspicious substances ..	62
Appendix 6 - Multi-compartment medication devices	65
Appendix 7 - Medicines in Schedule 5 of the Prescription Only Medicines Order which can be supplied or administered by midwives without the directions of a doctor.	66
Glossary of terms	67
Bibliography	69

Introduction

This policy document covers all aspects of medicine procurement, storage, distribution and administration within the hospital environment. It is not intended to address the specific clinical issues that relate to therapeutic choice, medication efficacy and preventing adverse effects from medication. It has been produced in response to the revised Duthie report (2005) and other Government reviews. This document is not intended for use within primary care or hospice environments (supplementary policies will be issued specifically for these areas).

All wards, theatres and departments must have a system of procedures for the ordering, handling and use of medicines that meet legal requirements and good practice guidance to ensure safety, security and efficiency. Much of the legislation concerning medicines has been written to avoid diversion or abuse. This document is available via the NHS Greater Glasgow and Clyde (NHS GG&C) StaffNet and provides a framework for the preparation of the required detailed local procedures.

The Head of the Pharmacy and Prescribing Support Unit (PPSU), Medical Director and Director of Nursing are responsible for ensuring staff under their direction establish and maintain approved procedures to comply with current legislation and professional guidance. They must ensure the risks inherent to both staff and patients in the use of medicines are managed appropriately.

Throughout the document, the Appointed Registered Nurse / Midwife or Manager in Charge is named as the responsible person for certain elements of the system. In departments not managed by nurses / midwives the equivalent manager is the responsible person.

Certain medicines are currently classified as Controlled Drugs (CDs). These are listed in the current Misuse of Drugs Regulations and are subject to more stringent controls (see current BNF, section on Controlled Drugs and Dependence). The Accountable Officer for NHS GG&C is ultimately responsible for ensuring the policies relating to Controlled Drugs are adhered to at all times. In some instances this responsibility may be delegated to appropriate senior personnel within the organisation.

This policy will be reviewed and updated on a regular basis. Associated Standard Operating Procedures (SOPs) will be devised and regularly audited.

This document is correct at time of going to press but may change if further guidance or legislation is subsequently published. If versions of this document are printed and stored in any wards / theatres / departments, any person referring to the document after the date of printing must check on the StaffNet to ensure they are using the most up-to-date version. This document supersedes all previously published guidelines in Glasgow and Clyde.

1. Definition of a Medicine, including Controlled Drugs (CDs)

Medicines are substances that are introduced into the body, or externally applied to the body, for the purpose of

- treating disease
- preventing disease
- diagnosing disease
- ascertaining the existence, degree or extent of a physiological condition
- contraception
- inducing anaesthesia
- otherwise preventing or interfering with the normal operation of a physiological function.

Medicines may be categorised as follows:

1. Medicines and medicinal preparations that come under the provisions of the Medicines Act (1968). They include medicines used in clinical trials, unlicensed medicines and medicated dressings.
2. Controlled Drugs, (CDs), i.e. dangerous or otherwise harmful medicines controlled under the provisions of the Misuse of Drugs Act (1971) and Regulations made under the Act. Controlled Drugs are subdivided into different specifications as follows:

Schedule 1: Includes drugs such as cannabis and lysergide, which are not used medicinally. Possession and supply are prohibited except in accordance with Home Office authority. Sativex® is an unlicensed cannabis derivative product that can be imported for use in multiple sclerosis. It is the only medicinal drug in this class and can be imported from Canada. There has been some use within NHS GG&C.

Schedule 2: Includes drugs such as diamorphine (heroin), morphine, remifentanyl, pethidine, secobarbital, glutethimide, amphetamine, and cocaine and are subject to the full CDs requirements relating to prescriptions, safe custody (except secobarbital), the need to keep register, etc. (unless exempted in Schedule 5).

Schedule 3: Includes barbiturates (except secobarbital, now Schedule 2), buprenorphine, diethylpropion, mazindol, meprobamate, pentazocine, phentermine, midazolam and temazepam. They are subject to the special prescription requirements (except for temazepam) but not to the safe custody requirements (except for buprenorphine, diethylpropion, and temazepam) nor to the need to keep registers (although there are requirements for the retention of invoices for 2 years).

Schedule 4: Includes Part I benzodiazepines (except temazepam and midazolam which are in schedule 3) and zolpidem, which are subject to minimal control. Part II includes androgenic and anabolic steroids, clenbuterol, chorionic gonadotrophin (HCG), somatotrophin, somatrem, and somatrophin. Controlled Drug prescription requirements do not apply and Schedule 4 drugs are not subject to safe custody requirements.

Schedule 5: Includes those preparations which, because of their strength, are exempt from virtually all Controlled Drug requirements other than retention of invoices for two years.

3. Alternative / complementary medicinal products e.g. herbal or homeopathic remedies that are used for therapeutic purposes.

Throughout the document the term 'medicine' will only cover categories 1 and 2 of medicines identified above. Where additional controls apply e.g. for Controlled Drugs in Schedule 2 this will be clearly identified.

Products in category 3 will be covered in Appendix 1.

2. General Policy Statements

- 2.1 All medicines administered or issued to patients within NHS GG&C are procured by and distributed through pharmacies (either hospital or community), or via approved homecare suppliers, in accordance with local SOPs.
- 2.2 Patients own drugs (PODs), including CDs, may be used during the hospital stay, where they have been assessed as suitable for use, the patient consents to their use, and suitable local SOPs are in place.
- 2.3 All medicines will be stored securely in pharmacy and at ward, theatre or department level to maintain their quality and security in suitable cupboards, refrigerators and freezers as appropriate.
- 2.4 Medicines must be ordered, prescribed and administration recorded on approved stationery, which must be stored securely to prevent fraudulent use. Electronic prescription systems can be employed provided there are procedures in place to restrict access to terminals and pass codes and ensure a full audit trail is maintained.
- 2.5 Medicines are prescribed in line with agreed formularies, or have the required level of approval for use if a patient is admitted or commenced on a non-formulary medicine.
- 2.6 Unlicensed medicines, except for medicines being used for research or in clinical trials, are used only when no suitable licensed medicinal product is available.
- 2.7 Medicines are ordered, prescribed, administered or supplied to patients only by suitably competent practitioners, within a legal framework, who can exercise professional accountability and judgement in the best interests of their patients. This includes persons operating within a Patient Group Direction, (PGD), or functioning as non medical prescribers.
- 2.8 Self-administration schemes e.g. patient controlled analgesia (PCA) must incorporate a formal patient assessment which should be documented.
- 2.9 There are systems for the transport of medicines that ensure their security, quality and integrity, and maintain the health and safety of the patient, staff and the public.
- 2.10 Disposal of medicines complies with legal requirements and health and safety regulations.
- 2.11 There must be a complete audit trail available from purchase and receipt by pharmacy or approval of the use of PODs, to their administration to individual in-patients, supply at point of discharge, return to pharmacy, or their destruction at ward / theatre / department level.
- 2.12 All clinical incidents or significant near miss events involving medicines must be documented and investigated and appropriate action taken to reduce the risk of recurrence.
- 2.13 Staff are not permitted to acquire medicines purchased and supplied for patients for their own personal use or for use by their friends and family.

3. Aims of Policy

- 3.1 To ensure safety in the procurement, storage, distribution and administration of medicines to patients in NHS GG&C.
- 3.2 To ensure that medicines purchased are of the required quality from approved suppliers.
- 3.3 To achieve best price and fulfil contractual and other obligations.
- 3.4 To maintain control of the pharmacy stock inventory in line with the recommendations and policies of NHS GG&C Area Drug and Therapeutics Committee (ADTC).
- 3.5 To ensure that medicines are available at the time they are needed.
- 3.6 To ensure that stocks of an appropriate range of medicines are kept at a level to minimise wastage.
- 3.7 To ensure that medicines used for research and clinical trials and unlicensed medicines are authorised for use.
- 3.8 To ensure that the quality and security of medicines are maintained during transportation.
- 3.9 To ensure that all medicines are transported with due attention to health and safety considerations.
- 3.10 To ensure that the quality and security of medicines is maintained in all areas where medicines are stored or administered within NHS GG&C premises.
- 3.11 To ensure that all prescriptions for medicines are written according to accepted NHS GG&C standards and legal requirements.
- 3.12 To minimise the risk of errors with the prescription, administration and supply of medicines.
- 3.13 To ensure that any changes to the medicines prescribed for the patient are implemented as soon as practical.
- 3.14 To ensure that patients are provided with an appropriate quantity of the correct medicines, labelled with clear directions, or are advised how to obtain supplies in the community, where appropriate.
- 3.15 To ensure that patients are given adequate information about their medicines including any special instructions for their use.
- 3.16 To dispose of unwanted medicines according to current national legislation.
- 3.17 To prevent misappropriation of medicines by staff and / or patients.

4. Procurement of medicines from external suppliers

4.1 General principles

- 4.1.1 The Head of PPSU will delegate responsibility to specified senior staff within PPSU to negotiate contracts for medicines with suppliers on behalf of NHS GG&C. Pharmacy Managers or delegated deputies will have authority to purchase non contract medicines as required, including unlicensed medicines, in line with current policy and standing financial instructions.
- 4.1.2 Information on medicine costs is confidential within NHS GG&C and is referred to only in the most general terms by NHS GG&C personnel, except during direct negotiations of agreements and contracts.
- 4.1.3 All medicines must be obtained through pharmacy, except for patients' own drugs (see section 11, Patients Own Drugs).
- 4.1.4 Defective medicines or potentially defective medicines are withdrawn from use in an appropriate timescale to minimise risk to patients (see section 18, Defective Medicines).
- 4.1.5 Medicines used for research and clinical trials, expanded access medicines and newly licensed medicines must have the appropriate management approval and / or committee approval (see section 4.5, Approval of Medicines for Procurement and 4.7, Medicines for use in Research and Clinical trials).
- 4.1.6 Appropriate risk management arrangements are followed for the procurement of medicines that do not have a product licence in the United Kingdom (see section 4.6, Unlicensed Medicines).
- 4.1.7 The Pharmacy Manager is responsible for ensuring, as far as possible, that the medicines he or she procures and supplies are of the required quality and are used safely, effectively and appropriately, and are suitable for the patient. The Pharmacy Manager may devolve this responsibility to other senior pharmacists.
- 4.1.8 If any staff member involved in the procurement, prescribing, preparation or administration of medicines has concerns about the quality of the product or any clinical concerns regarding the use of the medicine in individual patients they should advise the relevant senior professional (e.g. Consultant / Assigned Nurse in Charge / Pharmacy Manager).

4.2 Company medical representatives

- 4.2.1 Company medical representatives must observe the current Association of British Pharmaceutical Industry (ABPI) Code of Practice and any NHS GG&C policy, i.e. Working with Suppliers of Clinical Products Policy in the course of visits to hospitals.
- 4.2.2 Only medicines approved for use by NHS GG&C Area Drug and Therapeutics Committee (ADTC) may be promoted to staff working within NHS GG&C.
- 4.2.3 Information may be requested on any product from a medical representative, irrespective of whether the medicine is on the NHS GG&C Formulary.
- 4.2.4 The presence of medical representatives must not disrupt work in clinical areas.
- 4.2.5 Junior pharmacists, medical staff and ward nursing or other staff may not be approached directly by medical representatives unless authorised to do so by a senior pharmacist, lead nurse / midwife or consultant. Any meetings with medical representatives must have a clear educational objective. Consultants, specialist registrars, nurses / midwives and pharmacy staff must see representatives by appointment only.
- 4.2.6 Sponsorship of meetings by medical representatives may be accepted only if the meeting has a clear educational objective.
- 4.2.7 Staff must not disclose information on medicine costs to representatives.
- 4.2.8 Representatives must not leave samples of medicines in wards or other clinical areas or in the pharmacy.
- 4.2.9 Representatives from companies promoting an unlicensed medicines manufacturing / distribution service should contact the Regional Quality Assurance pharmacist prior to making initial contact with individual hospital sites.

Continues overleaf

4.3 Ordering and stock control of medicines by hospital pharmacy staff

- 4.3.1 All medicines must be procured in accordance with current pharmacy computer stock control procedures for procuring drugs, which have been approved by the external auditors and finance department.
- 4.3.2 A purchase order will be raised, in accordance with current contracts, to an appropriate supplier (e.g. local wholesaler) by a suitably trained staff member and approved by a pharmacy authorised signatory for medicines, in accordance with NHS GG&C Standing Financial Instructions.
- 4.3.3 In some instances it may be necessary to procure medicines from other hospitals or community pharmacies. Such requests must be authorised by the pharmacy Operational Services Manager or delegated deputy, dependent on local policy. Out of hours, this request will be dealt with by the Emergency Duty Commitment (EDC) pharmacist. Local standard operating procedures (SOPs) will apply.
- 4.3.4 In exceptional circumstances medicines may need to be ordered from suppliers outwith normal opening hours. Local SOPs will apply.
- 4.3.5 Stock levels must be reviewed regularly to ensure medicines are available on site when they are needed and to minimise wastage.

4.4 Receipt of medicines into pharmacy

- 4.4.1 When any medicines are delivered to pharmacy the driver's identity must be confirmed. If the driver enters the pharmacy to deliver goods / obtain signatures he/she must be escorted at all times. He/she must report to the appropriate pharmacy delivery area where a pharmacy stores officer will sign for the delivery either by signing "Received unchecked" or will check the medicines against the delivery note prior to signing for receipt.
- 4.4.2 Completed delivery notes must be presented to a suitably trained staff member to mark up on the computerised stock control system. There must be clear separation of the 'procurement', 'goods received' and 'mark up' processes, with at least two suitably trained staff members involved.
- 4.4.3 A Medicines Returned to Pharmacy Form (see Appendix 2) must accompany all medicines returned from wards, theatres or departments (including prescriptions not issued to patients and patients own drugs no longer required). Returned medicines assessed as suitable for reuse must be entered into the computerised stock control system and the destruction of any medicines documented. (See section 16, Return and disposal of medicines.)

Controlled Drugs : Additional Requirements

- 4.4.4 When a CD is delivered to pharmacy the driver must report to the appropriate pharmacy delivery area and their identity must be confirmed. A pharmacist or authorised pharmacy technician will sign for the delivery and check the CDs against the delivery note.
- 4.4.5 All CDs received in pharmacy, from suppliers or returned from wards, must be stored in a designated CD storage facility which should be kept locked at all times when not in use.
- 4.4.6 All CDs received in pharmacy, either from suppliers or returned from wards, must be recorded in the appropriate section of the pharmacy Controlled Drug Register. The following particulars must be recorded:
- Date on which received
 - Name and address of supplier (wholesaler, manufacturer or ward)
 - Amount received
 - Form in which received
 - Signature of pharmacist or authorised pharmacy technician recording their receipt
- 4.4.7 All CDs received into the pharmacy department must be written into the pharmacy Controlled Drug Register within 24 hours of receipt. If any discrepancies are found the wholesaler or pharmacist returning the CDs from ward / clinical areas should be informed immediately.
- 4.4.8 Pharmacy CD balances must be checked when goods are received into stock and after each issue.
- 4.4.9 The balance in the register must be reconciled with the computer stock balance periodically, at least monthly, by pharmacy staff, with ad hoc spot checks being conducted on a regular basis. If any discrepancies are found a thorough investigation must be carried out. This must be fully documented, including any actions taken. The Pharmacy Manager must be informed. If a discrepancy cannot be resolved a report should be sent to the Accountable Officer.

4.5 Approval of medicines for procurement

- 4.5.1 Newly licensed medicines, or new indications for existing licensed medicines, will not be introduced into routine use unless they have been approved by the Scottish Medicines Consortium (SMC), NHS GG&C ADTC and, where appropriate, NHS GG&C Prescribing Management Group (PMG).
- 4.5.2 Medicines are classified as approved or non-approved within NHS GG&C.
- 4.5.3 Approved medicines include:
- Preferred list medicines - medicines that appear in the NHS GG&C Formulary in the preferred list section (covering the most common clinical conditions).
 - Total formulary medicines - medicines approved by NHS GG&C ADTC that are not included in the preferred list. These medicines are often for use within a specialist area e.g. oncology.
 - Some unlicensed medicines are also approved for use (e.g. UK licensed medicines used in Paediatrics according to accepted national guidelines, such as the BNF for Children).
 - Medicines prescribed as part of an approved clinical trial.
- 4.5.4 Non-approved medicines include:
- Some unlicensed medicines prescribed for individual patients. (See 4.6, Unlicensed medicines).
 - Medicines that have been licensed but not yet assessed by the SMC or NHS GG&C ADTC.
 - Medicines which have been assessed by the SMC and are “not recommended” for use in Scotland.
 - Medicines recommended by SMC but following consideration by NHS GG&C ADTC have not been recommended for use in NHS GG&C as suitable alternatives exist.
- 4.5.5 Certain patients will require particular non-approved medicines because of their individual clinical circumstances.
- 4.5.6 The pharmacy department will not routinely stock non-formulary or non-approved unlicensed medicines. There may be a delay in supplying non-approved medicines if they are prescribed.
- 4.5.7 Non-formulary or non-approved unlicensed medicines may be prescribed only on the authority of the patient’s consultant. In the absence of a consultant their specialist registrar may prescribe the medicine only if they have experience of treating patients receiving the medicine.
- 4.5.8 Any decision to prescribe a non-formulary or non-approved unlicensed medicine must be justified by the consultant. A Non-Formulary Medicine Request Form must be completed for all drugs on the NHS GG&C highlighted Non-Formulary List. Requests for a non-approved unlicensed medicine must be accompanied by an Unlicensed Medicines request form (with the appropriate signatures).
- 4.5.9 The appropriate Clinical Director and General Manager, in conjunction with the Directorate Pharmacist, must approve the request if the cost of an individual patient’s treatment with a non-approved medicine exceeds £3K per treatment or per annum or if significant numbers of patients are likely to require the non-approved medicine. (In Mental Health the executive group of the Mental Health Partnership Medication Resource Management Group will approve all requests).
- 4.5.10 The pharmacy department will obtain a supply of the medicine for treatment of the individual patient following confirmation by the responsible clinical pharmacist.
- 4.5.11 The Lead Clinical Pharmacist for the directorate concerned, in conjunction with the directorate Clinical Governance committee, Drug and Therapeutics or other suitable committee will review all requests for non-formulary or unlicensed medicines retrospectively, in order to identify trends and take any necessary action.
- 4.5.12 Regular requests for the same non-formulary medicine will require completion of a formulary appeal request, detailing supporting evidence of clinical efficacy. The request must be submitted to the NHS GG&C Formulary Development Pharmacist.

4.6 Unlicensed medicines

(Please continue to follow current policies and local SOPs until the new NHS GG&C Unlicensed Medicines Policy is available.)

- 4.6.1 Licensed medicines are medicines that have a Marketing Authorisation, formerly called a Product Licence, issued by the Medicines and Healthcare Products Regulatory Agency (MHRA) for the UK or by the European Medicines Agency (EMA) for all EU member states.

Continues overleaf

- 4.6.2 Unlicensed medicines are medicines that do not have a Marketing Authorisation in the UK.
- 4.6.3 A licensed medicine may be used outwith its licensed indication to treat patients. Under such circumstances it will be referred to as 'off-label use'. This includes many medicines prescribed for children. (Prescribers should refer to local policies and / or SOPs when working in areas where routine 'off-label' prescribing occurs.)
- 4.6.4 For each non-approved unlicensed medicine that a consultant wishes to prescribe an unlicensed medicines request form must be completed. In certain circumstances a 'blanket' approval form may be appropriate (if the non-approved unlicensed medicine is likely to be used frequently). This type of approval should be discussed with the Directorate Pharmacist and approval for the 'blanket' authorisation obtained from the Clinical Director and General Manager.
- 4.6.5 The Pharmacy Manager and / or the Lead Clinical Pharmacist for the directorate must review and approve all requests for non-approved unlicensed medicines. Where there is a significant cost or service delivery implications associated with the use of the unlicensed medicine, (e.g. >£3K per course of treatment), the request must also be approved by the relevant Clinical Director and General Manager.
- 4.6.6 The Regional Quality Assurance Pharmacist will provide and maintain an up to date list of approved suppliers of unlicensed medicines.

4.7 Medicines for use in research and clinical trials

- 4.7.1 Researchers wishing to undertake research must approach the local Research and Development Office for all clinical investigations involving human volunteers or patients. (Additional approval may be required, depending on the nature of the individual trial – guidance will be given by the Research and Development Department.)
- 4.7.2 A Clinical Trials Authorisation (CTA) must be submitted to the Medicines and Healthcare Products Regulatory Agency (MHRA) for all clinical trials involving an investigational medicinal product.
- 4.7.3 If the investigation involves the administration or supply of medicines the Research and Development Committee should liaise with the Pharmacy Manager prior to trial approval.
- 4.7.4 Medicine supplies for research and clinical trials must be distributed through the pharmacy.
- 4.7.5 A pharmacy file meeting current R&D requirements must be held in the pharmacy and a local dispensing procedure approved.
- 4.7.6 The clinical trial may commence only following formal management approval, MHRA and ethical approval.

Controlled Drugs : Additional Requirements

- 4.7.7 All requirements regarding storage, record keeping and destruction apply to clinical trial drugs classified as CDs in addition to any trial documentation that may be required.

5. Ordering and stock control of medicines in wards, theatres and departments

5.1 General principles

- 5.1.1 All staff ordering medicines must be trained and competent in the required procedures.
- 5.1.2 In hospital, medicines must be ordered by a registered nurse or midwife or other suitably qualified personnel (e.g. radiographers) who must be an authorised signatory for that area. Pharmacists / pharmacy technicians / pharmacy support workers can also order medicines for wards on an adhoc basis or as part of a routine ward top up service (provided they are registered in pharmacy as a signatory for that clinical area).
- 5.1.3 Where electronic ordering is in place it must be password protected and accessed only by authorised personnel.
- 5.1.4 Pharmacy departments must maintain an up to date list of authorised signatories permitted to requisition medicines and controlled drugs.
- 5.1.5 All stationery used to order medicines is controlled stationery. This includes stationery used to order ward stock, CDs, and medicines to be given to patients to take away on discharge or at a clinic. Controlled stationery must be stored and issued from pharmacy in a secure manner.
- 5.1.6 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for the safekeeping of all controlled stationery.
- 5.1.7 Controlled stationery comprises Controlled Drug Order Books, Ward Controlled Drugs Registers, Medicine Prescription Forms (Discharge Prescriptions), Emergency requisition forms, and any other stationery used locally to order medicines. All controlled stationery must be stored securely under lock and key, except Discharge Prescriptions, if doing so would compromise timeous patient discharge. They must, however, be stored safely and securely to prevent misappropriation.
- 5.1.8 The Appointed Registered Nurse / Midwife or Manager in Charge, ward / department medical staff and the designated pharmacy representative will agree a stock list that reflects the needs of the patient group in each clinical area, and is in line with agreed formularies.
- 5.1.9 The stock list must be reviewed and updated regularly, at least once every year.
- 5.1.10 The stock list contains a list of the name, form and strength of all medicines routinely required, and the minimum stock level that must be held.
- 5.1.11 All nursing staff ordering routine medicines should have the required knowledge and competence to order and safely store medicines within the clinical area.
- 5.1.12 Arrangements must be in place to ensure that medicines that are not included in the agreed stock list, or where the patient's own supply is not available or is not deemed suitable for use, are obtained timeously, so that doses are not missed or delayed if this would potentially harm the patient.
- 5.1.13 The Appointed Registered Nurse / Midwife or Manager in Charge must ensure that a system is in place to regularly check expiry dates and rotate stocks of medicines.
- 5.1.14 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring that medication ordering systems are in place that minimise dose omissions and delays, reduce medication wastage and utilise staff resource efficiently.
- 5.1.15 When a patient is transferred to another clinical area within the same hospital or to a different hospital site, the nurse / midwife responsible for the patient's care must make arrangements to ensure that required doses of medicines are not missed or delayed and that stock is not wasted by duplicate orders.
- 5.1.16 The Pharmacy Manager is responsible for ensuring that systems are in place that ensure medicines are available with minimum delay. (See section 7, Arrangements for the supply of medicines when the pharmacy is closed.)
- 5.1.17 If a patient is at risk from a missed dose and no suitable alternative medicine is available, the medicines may be transferred from another area in the hospital if pharmacy is closed, provided the correct procedures are followed. (See section 7.2, Internal transfer of medicines between wards, theatres and departments when pharmacy is closed).
- 5.1.18 Appropriate documentation must be completed at all stages of the ordering and receipt of medicines process by suitably qualified staff.

Continues overleaf

Controlled Drugs : Additional Requirements

- 5.1.19 An up to date list of authorised signatories for controlled drugs must be held in pharmacy. It is common practice to limit this list to ward managers and senior staff members.
- 5.1.20 Doctors and pharmacists are not authorised to sign Ward Controlled Drugs Order Books.
- 5.1.21 All requisitions for CDs should be made using the Ward Controlled Drugs Order Book.

5.2 Requirements for ordering medicines for ward, theatre and department stock

- 5.2.1 A schedule for ordering and delivery of medicines should be agreed with the Appointed Registered Nurse / Midwife or Manager in Charge, the Pharmacy Manager and Porter Manager.
- 5.2.2 Suitable quantities of medicines included in the stock list must be ordered so that they may be processed and delivered according to the agreed schedule. Sufficient quantities of stock should be held so that they will not require ordering outwith the agreed schedule, except in emergency situations.
- 5.2.3 The Appointed Registered Nurse / Midwife or Manager in Charge should monitor ordering practice to ensure that it is carried out efficiently i.e. doses are not missed or delayed unnecessarily, medicines are not wasted, and nursing, pharmacy and portering time is used efficiently.
- 5.2.4 Ward / department staff must arrange delivery and collection for items that are ordered outwith the agreed delivery schedule. Local SOPs will apply.

Controlled Drugs : Additional Requirements

- 5.2.5 CDs must be requisitioned in the sequentially numbered Ward Controlled Drugs Order Book, which will be signed by a registered nurse / midwife who must be an authorised signatory for CDs for the area concerned. In theatre environments, suitably qualified operating department practitioners (ODPs) can requisition CDs if they are an authorised signatory for that area.
- 5.2.6 The requisition must state the name, form and strength, where appropriate, of the CD and the total quantity required. The Ward Controlled Drugs Order Book should be sent to pharmacy for supply.
- 5.2.7 CDs for ward stock should be ordered according to a locally agreed schedule. Sufficient quantities of stock should be held so that they will not require ordering outwith the agreed schedule, except in emergency situations.

5.3 Requisitioning medicines for discharge and pass prescriptions and for out-patient clinics

(See also section 11, Patients Own Medicines and section 13, Prescribing medicines.)

- 5.3.1 A Discharge Prescription (or locally agreed Pass Prescription form, if appropriate) must be used to prescribe all medicines supplied to patients from hospital, including supply of medicines from out-patient clinics. This ensures adequate amounts of medication are provided on discharge and facilitates communication with the patient's GP. It is current good practice to include also information on medicines that have been stopped or altered and the reasons for these changes.
- 5.3.2 The information required must be accurately transcribed from the Medicine Kardex and / or the patient's medical notes, with an appropriate clinical review of the kardex to take account of the patient's current health status and desired treatment objectives.
- 5.3.3 In some departments (e.g. A&E departments) Discharge Prescriptions are not routinely required as "Patient Packs" of medicines are utilised for patients to take home and information on medication supplied is communicated to the patient's GP. (See also section 13.4, Prescriptions for out-patients / patient packs.)
- 5.3.4 Clinical trial medicines may be ordered on approved documentation as per trial protocol.
- 5.3.5 The doctor / authorised prescriber responsible for the patient's care must ensure that the prescription is completed in adequate time.
- 5.3.6 The prescription must be written legibly in black ink or otherwise so as to be indelible. The approved name for each medicine should be used, except in cases where the BNF specifies that the brand name should be used due to brand bio-availability differences, e.g. lithium, controlled release nifedipine / diltiazem / ciclosporin.

- 5.3.7 Prescriptions may be computer generated, providing they are requested by an authorised prescriber with password protected access to the computer system.
- 5.3.8 The discharge prescription must include the name of the hospital, name, address, D.O.B., CHI and hospital number of the patient, consultant name, ward or department, signature and page number of the prescriber, date of writing and the name and address of the GP, in addition to clinical information.
- 5.3.9 At least seven days supply of medicines must be provided, unless a longer or shorter course of treatment is appropriate (e.g. for completion of an antibiotic course or for day or weekend pass prescriptions). In many units original packs will be dispensed, if appropriate.
- 5.3.10 If the patient already has his or her own supply of required medicines at home or stored in the ward, an additional supply should not be issued from the hospital. The nurse / midwife / pharmacist / doctor/ pharmacy technician must annotate the prescription with "Patient's own supply" and initial each entry. In doing so they are accepting that the patient has supplied reliable and accurate information on the medicines they have at home. If there is any doubt as to the validity of the information provided by the patient a fresh supply of all required medicines should be made from pharmacy using a Discharge Prescription (or Pass Prescription form). In these circumstances, the patient should be asked to return all medicines stored at home to their local community pharmacy.
- 5.3.11 Sufficient time must be allocated for pharmacy to process and return discharge medicines, taking account of the patient's planned time and date of discharge. Where appropriate, routine discharge prescriptions should be sent to pharmacy 24 hours in advance (or given to ward based pharmacy staff 24 hours in advance if this is the normal procedure to obtain discharge prescriptions).

Controlled Drugs : Additional Requirements

- 5.3.12 Prescriptions for controlled drugs are subject to strict legal requirements. (See also 13.3, Prescriptions for discharge or pass medicine).
- 5.3.13 A separate discharge prescription is required for CDs for discharge or pass medication. More than one CD can be prescribed on the same CD discharge prescription form. A prescription for CDs should not include any non CD medicines. All discharge / pass prescriptions for CDs must be accompanied by the ward / department Controlled Drugs Order Book, which must be signed by a registered nurse / midwife who must be an authorised signatory for CDs for the area concerned. (Controlled Drugs Order Books may not be required to accompany CD prescriptions from wards on all sites if locally validated procedures ensure a complete audit trail is maintained of CDs supplied on discharge / pass prescription e.g. 3-monthly reconciliation of CD prescriptions dispensed with the Ward Controlled Drug register. Local SOPs must be followed.)
- 5.3.14 Discharge or pass prescriptions for CDs cannot be transmitted electronically as the prescriptions must be signed by the prescriber. Addressograph labels must not be used on CD prescriptions as this does not fulfil the legal requirement that the name and address are indelible.
- 5.3.15 In addition, for CD prescriptions, the name, dose, form and strength, where appropriate, of the CD must be written and the total quantity to be supplied must be written in both words and figures. The Controlled Drugs Order Book must state the name, form and strength, where appropriate, of the CD, the total quantity required and the name and CHI number of the patient concerned. Each CD required should be requested on a separate page of the ward / department Controlled Drugs Order Book.
- 5.3.16 If the CDs are to be dispensed in the hospital pharmacy, the discharge or pass prescription and the Controlled Drugs Order Book should be delivered to the pharmacy at least 24 hours before the patient is due to be discharged, to allow adequate time for the dispensing process and delivery of the completed discharge prescription to the ward. For acute, unplanned discharges at least 4 hours will be required to process the prescription in pharmacy.
- 5.3.17 Prescriptions for CDs that do not comply with legal requirements will have to be re-written correctly before the prescription can be dispensed. This may result in delays in the patient being discharged.

6. Supply of medicines from pharmacy for use within the hospital

6.1 General principles

- 6.1.1 All issues of medicines to wards, theatres and departments must follow appropriate approved pharmacy SOPs.
- 6.1.2 Pharmacy will supply medicines only against the signature of a registered nurse / midwife or other suitable qualified personnel (e.g. radiographers), who must be an authorised signatory for that area. Pharmacists, pharmacy technicians and pharmacy support workers may also order medicines, provided they are registered with pharmacy as signatories for that clinical area.
- 6.1.3 If pharmacy does not supply the exact item requested and a suitable alternative is available e.g. different strength or different quantity is supplied, this will be clearly annotated on the original order.
- 6.1.4 Pharmacy will retain the original order, where appropriate, and a copy of the picking ticket, with the signatures of pharmacy personnel involved in issuing the medicines, for 2 years.
- 6.1.5 A delivery note detailing what has been supplied will accompany all medicines supplied from pharmacy, for use within the hospital, within normal working hours.

Controlled Drugs : Additional Requirements

- 6.1.6 All CD issues will be recorded in the appropriate section of the pharmacy Controlled Drug Register, which should be maintained with a running balance total for each product. The following details must be recorded:
- Name of the patient (if CD supplied against a discharge, pass or outpatient prescription).
 - If the CD is supplied directly to the patient or their representative from pharmacy, the following additional information must also be recorded in the Pharmacy Controlled Drug Register:
 - Whether the person who collected the CD was the patient, their representative or a healthcare professional acting on behalf of the patient.
 - If the person who collected the CD was a healthcare professional, that person's name and address.
 - If the person who collected the CD was the patient or their representative, whether evidence of identity was requested. (As a matter of good practice a note as to why this was not requested may be included but this is not mandatory.)
 - Whether evidence of identity was provided by the person collecting the drug.
 - Date on which the supply was made.
 - Ward or department.
 - Name of the person requisitioning the CD who must be an authorised signatory for CDs for the area requesting it.
 - Amount supplied.
 - Form in which supplied.
 - Serial number of relevant page in the Ward Controlled Drugs Order Book.
 - Signature of the person supplying the CD.
- 6.1.7 A computerised Controlled Drug register may be used provided safeguards are incorporated into the software to ensure all of the following:
- The author of each entry is identifiable.
 - Entries cannot be altered at a later date.
 - A log of all data entered is kept and can be recalled for audit purposes.
 - Access control systems are in place to minimise the risk of unauthorised or unnecessary access to the data and adequate backups are made.

- 6.1.8 The following points are important with respect to pharmacy Controlled Drug Registers:
- All entries must be in chronological order.
 - A separate part of the register must be used for each class of CD.
 - The class of drugs must be specified at the top of each page.
 - Entries must be made on the day of the transaction or on the next following day.
 - No cancellation, obliteration or alteration may be made; correction must be by dated marginal note or footnote.
 - Entries must be ink or otherwise indelible.

6.1.9 The Ward Controlled Drugs Order Book must be signed and dated by the pharmacy personnel making the supply.

6.1.10 All CDs will be supplied in a sealed tamper evident container, e.g. an Envopak bag with a numbered security tag.

6.2 Supply of medicines to community pharmacies or other hospital pharmacies

6.2.1 Hospital and community pharmacies should procure their medicines from a local wholesaler or direct from a manufacturer.

6.2.2 In an emergency, a request may be made by other hospitals or community pharmacies to obtain a supply from hospital stock.

6.2.3 Such requests must be authorised by the pharmacy Operational Services Manager or delegated deputy, dependent on local policy.

6.2.4 Out of hours, this request will be dealt with by the EDC pharmacist. (See section 7, Arrangements for the supply of medicines when pharmacy is closed.)

6.2.5 The site receiving the request should ensure the validity of the request if they do not know the personnel involved who are making the request. This may be done by asking for contact details and confirming the number is valid by checking telephone / online directories and also phoning back to the registered phone number of the site / business requesting medicines.

6.2.6 If the request is from an unknown hospital or community pharmacist, their registration details can be verified by checking the Royal Pharmaceutical Society of Great Britain (RPSGB) web site to ensure that the person is a registered pharmacist.

6.2.7 Requests may be made by telephone but must be confirmed by a faxed or written order or requisition from the hospital / community pharmacy requesting the medicine.

6.2.8 The request will be processed through the computerised stock control system. The relevant paperwork must be sent to the Finance Department to deal with the charging process, in accordance with local SOPs.

6.2.9 Medicines may be transferred in a taxi. See section 8.4, Taxis and Couriers. The taxi driver or a member of the community pharmacy staff uplifting the medicines from pharmacy must sign for receipt. Taxi drivers must record their unique call number.

Controlled Drugs : Additional Requirements

6.2.10 CDs may be issued in an emergency on receipt of a Ward Controlled Drugs Order request from another hospital or on receipt of a request written on Company headed notepaper, signed and dated by the community pharmacist with details of their RPSGB registration number.

6.2.11 A record of the transaction will be made in the pharmacy Controlled Drug Register.

6.2.12 The CDs will be secured in a tamper evident container (e.g. an Envopak bag with a numbered security tag or other temper evident container), with a copy of the delivery note.

7. Arrangements for the supply of medicines when pharmacy is closed

7.1 General principles

- 7.1.1 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring that appropriate systems are in place so that required medicines are available to minimise unnecessary dose omissions or delays. These systems should ensure that adequate supplies of required medicines are ordered during pharmacy opening hours.
- 7.1.2 The Pharmacy Manager must ensure that an EDC pharmacist is available to provide advice on availability and safe use of medicines when the pharmacy is closed. The EDC pharmacist will provide urgently required medicines from the pharmacy, if deemed appropriate after consultation with ward medical and nursing staff.
- 7.1.3 On some sites, emergency cupboards are utilised for out-of-hours supply of medicines. These are maintained and stocked by pharmacy. Access to them is restricted to pharmacy staff and the Hospital Co-ordinator. Local SOPs must be followed.
- 7.1.4 The EDC pharmacist will not attend to supply discharge prescriptions out of hours but will respond to calls according to his / her professional judgement.
- 7.1.5 In emergency situations, the EDC pharmacist will make every effort to attend as quickly as possible.
- 7.1.6 The Hospital Co-ordinator must contact the EDC pharmacist personally, unless prescribing advice is required, when the doctor responsible for the patient's care must contact the EDC pharmacist directly, via switchboard.
- 7.1.7 If a prescribed medicine is not available in a clinical area when pharmacy is closed, the Assigned Nurse / Midwife in Charge must identify if the medicine can be obtained from another ward / department or from the emergency cupboard (if available). The Hospital Co-ordinator has access to the emergency cupboard and should be contacted by the Assigned Nurse / Midwife in Charge once it has been ascertained that the medicine is not available on another ward.
- 7.1.8 If the medicine is not available from another ward / department or the emergency cupboard, the Assigned Nurse / Midwife in Charge should consult with ward medical staff to agree whether the dose may be missed or delayed without compromising patient care, until the pharmacy reopens. If clinical care will be compromised by missing doses a decision must be made as to whether or not an alternative medicine that is available can be prescribed and administered. If not, the Hospital Co-ordinator must be advised, who will contact the EDC pharmacist via the hospital switchboard. All missed doses must be documented in the Medicine Kardex.
- 7.1.9 If the medicine is required before the pharmacy reopens, the EDC pharmacist will take action as follows:
- If patient care will be compromised due to medication omission and the medicine is not stocked in the emergency cupboard or on another ward or department but is stocked in the pharmacy, attend the hospital to supply.
 - If the medicine is not available from the emergency cupboard or on another ward and is not stocked in the pharmacy, discuss with the prescriber and agree appropriate action. In some circumstances this may involve obtaining medicine from another hospital or contacting the local wholesaler.

7.2 Internal transfers of medicines between wards, theatres and departments when pharmacy is closed

- 7.2.1 Medicines should be transferred between wards, theatres and departments only when the pharmacy is closed, (except when accompanying patients being transferred to other wards / departments / sites to ensure continuity of supply, prevent dose omissions and reduce medication wastage).
- 7.2.2 The ward that requires the medicines must check if any neighbouring wards hold the required medicine. The Assigned Nurse / Midwife in Charge of the ward holding the required medicine must agree to the transfer. The ward requiring the medicine must send a copy of the current in-patient Medicine Kardex to the ward identified as holding stock, along with their Medicine Transfer Record Book (detailing what medicine is required). This book must be signed by the Assigned Nurse / Midwife in Charge of the requesting ward.

- 7.2.3 The Medicine Transfer Record Book should record:
- Date of transfer.
 - Name, form, strength and quantity of medicine transferred.
 - Signatures of the two nurses / midwives involved.

The ward issuing the medicine should retain the 'tear-off' slip from the Medicine Transfer Record Book, which should be filed in a dedicated folder held by the Authorised Nurse in Charge. Periodically, these books will be reviewed by nursing and / or pharmacy staff and used to amend stock lists to reflect current prescribing patterns.

- 7.2.4 A complete / partially used blister strip should be borrowed rather than cutting off one or two blisters, where possible. Any medication transferred must be clearly identifiable.

Controlled Drugs : Additional Requirements

- 7.2.5 The transfer of controlled drugs must be recorded in the Medicines Transfer Record Book (as above) and also be fully documented in the CD register of both wards.
- 7.2.6 The Hospital Co-ordinator must take the patient's Medicine Kardex from the ward requiring the CD, (Ward X), to the ward holding stock of the required CD, (Ward Y).
- 7.2.7 The Assigned Nurse / Midwife in Charge of the ward holding the CD, Ward Y, must authorise the removal of the required CD from their CD cupboard.
- 7.2.8 A registered nurse / midwife on Ward Y must make an entry in the appropriate page of the Ward Controlled Drugs Register belonging to Ward Y, indicating that stock has been transferred to Ward X. The entry should state, e.g. "2 tablets transferred to Ward X for patient A". This should be signed by the nurse / midwife from Ward Y and countersigned by the Hospital Co-ordinator.
- 7.2.9 The Hospital Co-ordinator will transfer the controlled drug from Ward Y to Ward X.
- 7.2.10 A registered nurse / midwife on the ward requiring the CD, Ward X, must make an entry in the appropriate page of the Ward Controlled Drugs Register belonging to Ward X, stating e.g. "2 tablets transferred from Ward Y for patient A". This should be signed by the nurse / midwife from Ward X and countersigned by the Hospital Co-ordinator.
- 7.2.11 Ward / department Controlled Drug Registers should be checked by pharmacy staff every three months following agreed SOPs.

8. Transport of medicines

8.1 General principles

- 8.1.1 The Pharmacy Manager / Operational Services Manager, Appointed Registered Nurse / Midwife or Manager in Charge and portering lead must negotiate appropriate portering systems to facilitate efficient transport of medicines and orders across the site to meet with service requirements.
- 8.1.2 A record is kept at each step where a medicine changes hands during its delivery from the pharmacy to destinations within the hospital, or to another hospital or institution, or person outwith the site and also when medicines are returned to pharmacy. For ward top-up boxes and bulk intravenous fluid deliveries recording is impractical. Local SOPs should be followed.
- 8.1.3 In-patients are discouraged from collecting discharge prescriptions directly from pharmacy due to identification and security issues. In addition, the patient or their representative may not receive the same level of discharge counselling on the use of their medicines as is available at ward level. If patients or their representatives collect medicines directly from the hospital pharmacy (e.g. out-patients) they must sign for receipt of medicines.
- 8.1.4 The person responsible for the medicine at each point of the transportation chain must be identifiable.
- 8.1.5 Medicine containers and packages are kept securely or under surveillance whilst awaiting collection or in transit between pharmacy and the final destination.
- 8.1.6 Medicine containers and packages awaiting collection or in transit are kept in the appropriate secure storage conditions to maintain the quality of their contents. This includes maintaining the cold chain where required. (See section 8.3, Maintaining the cold chain.)
- 8.1.7 All medicines must be transported in sealed tamper evident containers or packages, e.g. securely stapled bags.
- 8.1.8 All containers and packages must be clearly labelled with the final destination.
- 8.1.9 Responsibility for security and maintenance of appropriate storage conditions remains with those collecting the sealed container until delivery is made, and documentation is signed acknowledging receipt.
- 8.1.10 Managers of staff groups responsible for transporting medicines within each hospital site are responsible for ensuring staff are trained to ensure an understanding of the need for security and NHS GG&C procedures, including action to be taken in the event of physical threat.
- 8.1.11 All incidents involving a breach of security are investigated. (See section 10.6, Action in the event of a breach in security.)
- 8.1.12 Local SOPs will apply for the transport of high-risk medicines including chemotherapy, intrathecal medicines and vaccines.

8.2 Transport of medicines to wards, theatres and departments

- 8.2.1 Medicines must be issued from pharmacy and transported in a sealed, tamper evident package. They must be clearly labelled with the destination and accompanied by a note of what has been supplied. If medicines are collected directly from pharmacy by the patient, tamper evident packaging and a note of what has been supplied are not required; however, the patient (or their representative) should always sign appropriate documentation and may be asked to verify the name and address of the patient / produce identification.
- 8.2.2 The member of staff uplifting medicines from the pharmacy department for transport to wards / theatres / departments must have their staff identification badge available. A consignment note, completed by pharmacy staff, must be signed by the staff member to take responsibility for transporting the sealed package to its final destination.
- 8.2.3 Porters delivering medicines to wards / theatres / departments are responsible for the return of the signed consignment note to pharmacy, as soon as practical, where it will be filed appropriately and stored for 3 months.
- 8.2.4 Porters delivering medicines for ward, theatre or department stock, or discharge / pass medication, must obtain a signature of receipt on the consignment note from a designated staff member, who will check that the package is sealed and has not been tampered with.
- 8.2.5 Pharmacy must be informed immediately of any suspected breaches in security. (See section 10.6, Action in the event of a breach in security.)
- 8.2.6 Intrathecal medicines and chemotherapy must be transported separately from any other medicine. (Please refer to the NHS GG&C Policy on Intrathecal Medicines).

Controlled Drugs : Additional Requirements

- 8.2.7 In-patients cannot collect discharge prescriptions for CDs direct from pharmacy. CDs for discharge or pass medication must be issued from the ward, in accordance with section 15 – Supply of medicines for patients to take away from hospital.
- 8.2.8 The consignment note for delivery of CDs to clinical areas must state the seal number on the Envopak bag (where these are used) or the relevant page number of the Ward Controlled Drugs Order Book, and the destination point.

8.3 Maintaining the cold chain

- 8.3.1 Sensitivity to changes in temperature varies depending on the medicine. Pharmacy departments will ensure that medicines sensitive to temperature change are identified and ward / department / theatre staff made aware of these items and any special storage / transport arrangements that must be followed.
- 8.3.2 If medicines that are sensitive to temperature changes are to be transported on a regular basis, pharmacy will validate the cold chain using a continuous calibrated temperature recording device for the duration of the transport time.
- 8.3.3 If medicines that are sensitive to temperature changes are to be transported on an occasional basis, the following good practice should be followed:
- The medicines sensitive to temperature change must be clearly labelled with appropriate warnings (e.g. “Store in Fridge”).
 - The medicine must be held outwith the recommended storage temperature for the minimum time possible. Maximum exposure time allowed depends on the sensitivity of the product.
 - Cold boxes or expanded polystyrene boxes must be used for medicines identified as being likely to deteriorate with even short-term temperature changes.
 - If gel packs are used, they must be evenly distributed. Direct contact with the medicines must be avoided by using bubble-wrap between the medicines and the gel packs. Using partially frozen gel packs further reduces the risk of the medicine freezing.
- 8.3.4 Medicines must not be removed from pharmacy refrigerators or freezers until the member of staff collecting or delivering the medicine to the ward / department is available.

8.4 Taxis and couriers

- 8.4.1 Only in exceptional circumstances should taxis or couriers be used for transportation of medicines.
- 8.4.2 Only hospital contract taxis and couriers able to produce identification may be used to transport medicines.
- 8.4.3 Taxis and couriers must always be ordered via the hospital switchboard or hospital transport department in accordance with local SOPs.
- 8.4.4 Taxis must not transport patients or staff whilst transporting medicines between sites (unless the medicine belongs to the patient or pharmacy staff are transporting medicines between sites, e.g. chemotherapy prepared at another site).
- 8.4.5 All packages must be sealed and tamper evident and the driver or courier must sign for collection of the medicines to be transported. Taxi drivers must record their unique call number.
- 8.4.6 Drivers must be advised of procedures to follow in the event of an accident / spillage when transporting high risk medicines. In the case of chemotherapy, it should be transported in containers that are clearly marked with information on the action to be taken in the event of a spillage (local SOPs will apply).

8.5 Posting medicines

- 8.5.1 Medicines must be posted only when the patient or the patient’s representative cannot collect them, and there is no suitable alternative means of delivery, e.g. hospital vehicle, taxi, or courier.
- 8.5.2 Patients’ medicines may provide confidential information about their condition and treatment, and this must be considered before posting medicines.

Continues overleaf

- 8.5.3 Cytotoxic chemotherapy is classified as prohibited or restricted material by the Postal Service and must therefore not be sent by routine post. Special arrangements are required and the carrier must be made aware of the hazardous contents. Storage, handling and packaging requirements must be agreed. (The Royal Mail may be contacted for further information on 08457 740 740.)
- 8.5.4 Medicines supplied by pharmacy must always be posted using Recorded Delivery or Registered Mail.
- 8.5.5 Where medicines are posted, a record must be kept of the date, name and address of the recipient, contents of the package, and person responsible for posting.

9. Receipt of medicines for use in wards, theatres and departments

9.1 General principles

- 9.1.1 A registered nurse / midwife must check that the ward box / package delivered by the messenger or porter is intended for that area, that it is sealed and has not been tampered with, before signing the consignment note. The number of the security seal should match the number on the consignment note (where these are in use).
- 9.1.2 If the order cannot be checked immediately, the registered nurse / midwife is responsible for ensuring that the package is stored in the conditions necessary to maintain security and quality (e.g. a secure lockable medicine cupboard, CD cupboard or lockable medicine refrigerator as appropriate). The medicines should then be checked as soon as practical and before changeover of shift.
- 9.1.3 The medicines should be checked by a designated staff member against the original order and the delivery note as follows:
- The package is sealed and has not been tampered with.
 - The items listed on the delivery note detailing what has been supplied match the items that have been received.
 - The items listed on the delivery note detailing what has been supplied match the items that were ordered.
- 9.1.4 The Appointed Registered Nurse / Midwife or Manager in Charge should identify any routinely used high-risk medicines (e.g. chemotherapy) and ensure SOPs are in place that facilitate prompt and safe receipt of these medicines in the ward / department, e.g. check that all of a patient's required chemotherapy has been delivered and that any items requiring refrigeration have been identified and stored appropriately.
- 9.1.5 The delivery note must be signed to confirm that it matches what has been supplied. It must be retained in the ward, theatre or department for 6 months.
- 9.1.6 Any discrepancy must be reported as soon as practicable to the pharmacy department, during working hours, and the delivery note left unsigned until the discrepancy is resolved. Outwith pharmacy working hours the EDC pharmacist should be informed by the Hospital Co-ordinator of any discrepancies involving CDs, chemotherapy or aseptically prepared products. All discrepancies will be investigated, documented, and appropriate corrective action taken to prevent a recurrence.

Controlled Drugs : Additional Requirements

- 9.1.7 The Ward Controlled Drugs Order Book should be signed by a registered nurse / midwife on the line "Received by" to confirm the CDs received on the ward are those that were ordered.
- 9.1.8 A designated staff member (e.g. registered nurse/midwife) must record receipt of all controlled drugs, including those supplied as part of a discharge prescription, in the Ward Controlled Drugs Register. Details of CDs received from Pharmacy on a discharge prescription must be entered into the Ward Controlled Drugs Register, even if the patient is to be discharged immediately. One page of the register should be headed "Controlled Drugs on Discharge Prescription In". The opposite page should be headed "Controlled Drugs on Discharge Prescription Out". All records of receipt must be recorded on the page "Controlled Drugs on Discharge Prescription In". The entry must include the signature of the person making the entry and the signature of a witness, date, time, quantity received, the strength and form of the drugs.
- 9.1.9 A separate page of the Ward Controlled Drugs Register must be dedicated to each individual product. All records of receipt and administration must be recorded on that page. The entry must include the signature of the person making the entry and the signature of a witness, date, time, quantity received the strength and form of the drug, the requisition page number of the Ward Controlled Drugs Order Book and the new balance. Patients' own CDs brought into hospital must also be entered into the Ward Controlled Drugs Register. One page of the register should be headed "Patient's Own Controlled Drugs In". The opposite page should be headed "Patient's Own Controlled Drugs Out". The patient's name and CHI number, and name, form, strength and quantity of the CDs should be recorded at receipt and on return to the patient or on destruction of the CD, if no longer clinically indicated, by the pharmacist at ward level.
- 9.1.10 When the page is full, required information must be carried over to a new page. The page that is full should indicate at the bottom "Balance transferred to page xx" and the new page should indicate at the top, "Balance transferred from page yy". The index at the front of the register must be used to indicate the current page in use for each product.

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- 9.1.11 The entry must be witnessed and signed by a second registered nurse / midwife or a suitably competent student nurse / midwife or Operating Department Practitioner (ODP). Both are responsible for checking that the correct drug has been received in the correct quantity and is within its expiry date. They must also ensure that each required detail is entered correctly and the CDs are stored securely in the ward controlled drug cupboard (or separate lockable refrigerator, if appropriate).
- 9.1.12 Replacement Ward Controlled Drugs Registers may be obtained from pharmacy. All entries must be transferred to the new register. Each entry on the old register should be annotated "Transferred to new register" and the entry short-ruled and dated. The new register should be annotated "Balance transferred from old register" and dated. Both registers (old and new) should have each entry signed by 2 designated members of staff. Pharmacy will keep a record of all CD registers issued and will check the transfer of records has been carried out correctly.
- 9.1.13 Completed Ward Controlled Drugs Order Books and Ward Controlled Drugs Registers must be retained on the ward for 2 years after the date of last entry and then destroyed in line with confidential waste procedures.

10. Storage and security of medicines

10.1 General principles

- 10.1.1 Medicines should at all times be stored at a level of security appropriate to their proposed use and at a level appropriate to the staff present at any time. There is a potential cascade of security levels, with Pharmacy departments being the most secure, followed by ward / department medicine cupboards, medication trolleys, bedside Patients Own Drugs (POD) lockers and emergency trolleys. The security level may be different in locations that are staffed continuously compared with those that are staffed only intermittently, even when the use of the medicine is the same in each location.
- 10.1.2 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring all medicines in their ward / department are stored appropriately in secure cupboards, medicine trolleys or lockable refrigerators, approved by pharmacy.
- 10.1.3 Drug cupboards, including CD cupboards, must not be marked to indicate their contents.
- 10.1.4 Medicines shall be kept locked in separate cupboards e.g. :
- Internal medicine cupboard.
 - External medicines cupboard.
 - Patient medication lockers.
 - Medicine trolleys.
 - Medicine refrigerator / freezer.
 - Flammables cupboard.
 - Controlled drugs cupboard.
 - Cupboard for non-cytotoxic intrathecal agents, if applicable. (Prior authorisation must be obtained to maintain stocks of these agents. Cytotoxic intrathecal injections cannot be stored in ward areas under any circumstances.)
 - Cupboard for intraventricular agents, if applicable. (Prior authorisation must be obtained to maintain stocks of these agents.)
 - Cupboard for epidural agents, if applicable.
- 10.1.5 Each cupboard must have a unique lock and key (although master keys are allowed for POD lockers).
- 10.1.6 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring that medicines are stored appropriately to minimise the risk of error of selecting the wrong preparation and to ensure that their quality is maintained, e.g. stored in a refrigerator if required. Medicines must be stored so that labels remain legible.
- 10.1.7 Medicine cupboards and refrigerators must be of an adequate size to allow medicines to be segregated and arranged for ease of selection, access, and stock control, and allow an adequate range and stock level to be held to meet patients' needs.
- 10.1.8 When medicines require storage in locked refrigerators or freezers, security must be in accordance with perceived risk. A temperature record must be maintained by the ward / department. It is recommended that at least daily recording of current, maximum and minimum temperature (since the last reading) is carried out. If possible, twice daily records should be kept. The records should document situation when temperatures are outwith the recommended range of 2 - 8°C for refrigerated products and any action taken to resolve the situation. In the event of equipment failure the Estates Department should be contacted and arrangements made to move medicines to a suitable storage facility. Pharmacy must also be contacted for advice regarding any medicines that may need to be destroyed and replaced due to the effects of temperature changes.
- 10.1.9 Internal medicines should be separated into solid oral dose preparations and liquid formulations as much as possible to minimise the risk of selecting the wrong preparation, and to facilitate efficient stock control and ordering. Other medicines given by non-oral routes, e.g. nebulisers / suppositories, should be kept clearly segregated from oral medicines to avoid inadvertent wrong route administration.
- 10.1.10 All products containing potassium chloride in parenteral form are subject to restricted access and special ordering and storage requirements apply. Please refer to current local policy and SOPs for further information.
- 10.1.11 Medicines intended for intrathecal, intraventricular or epidural use should be kept in separate locked cupboards from injections intended for administration by different routes. They should never be kept as ward or theatre stock unless documented and approved by pharmacy.

Continues overleaf

- 10.1.12 Medicines must be stored alphabetically by approved name as far as practically possible. They should be stored in their original packaging. Ampoules, vials, or blister packed tablets must not be removed from the original box during storage.
- 10.1.13 Ward and department cupboards used for storage must be kept locked when not in use. In theatres, cupboards can be kept unlocked whilst the theatre is in use. Between operating sessions or when the theatre is not in use the medicines should be returned to the medicine cupboards and the cupboards then locked (CDs should not be left out of cupboards unattended at any time).
- 10.1.14 Medicine trolleys must be kept locked and immobilised when not in use. They should contain medicines currently in use and commonly prescribed drugs for the clinical area. They should be kept clean and tidy and items intended for different routes of administration kept clearly segregated (e.g. nebulas / capsules / oral liquids).
- 10.1.15 Patients Own Drugs (PODs) must be stored in a separate area of the locked medicine cupboard or a POD locker that is not readily portable. PODs must be clearly distinguishable from ward stock.
- 10.1.16 Regular expiry dates checks should be carried out for all medicines. Stock must be rotated according to the expiry date so that oldest stock is used first.
- 10.1.17 Any patient responsible for self administration of medicines on the ward must keep his / her medicine in a cupboard or drawer which can not easily be removed e.g. salbutamol inhaler for use in an emergency.
- 10.1.18 All incidents involving a breach of security that cause actual or potential loss or theft of medicines are investigated and the appropriate corrective and preventative action is taken in accordance with local SOPs. (See section 10.6 Action in the event of a breach of security). This may involve contacting the police.

Controlled Drugs : Additional Requirements

- 10.1.19 All CDs for ward /department stock and discharge / pass medication and patients own CDs should be stored in areas that comply with current regulations. The provisions within The Misuse of Drugs (Safe Custody) Regulations 1973 are not applicable to the storage of CDs in NHS hospitals but are deemed good practice.
- 10.1.20 CDs should be stored in a separate locked cupboard from all other medicines, ideally inside another locked cupboard. The CD cupboard must have its own dedicated key. The key for the CD cupboard should be kept on the person of the Assigned Nurse / Midwife in Charge when not in use. This key should be kept separate from other medicine keys.
- 10.1.21 Self-administration of individual patient supplies of CDs must follow locally approved SOPs and ensure all record keeping requirements / safe custody requirements are met.
- 10.1.22 Clinical trial controlled drugs will normally be stored in the pharmacy, or in an alternative location, jointly approved by pharmacy and the clinical trial monitors. Storage requirements are as for stock CDs.
- 10.1.23 Parenteral CDs should be stored in a separate area of the CD cupboard, wherever possible.
- 10.1.24 CDs intended for intrathecal, intraventricular or epidural use should be stored in separate, clearly identified storage area, preferably in a separate CD cupboard but, if this is not practical, then in a separate area within the locked CD cupboard(s).
- 10.1.25 CDs must not be returned to pharmacy in the pharmacy box. They must be returned to pharmacy if no longer required by an appropriately authorised member of pharmacy staff accompanied by a Medicines Returned to Pharmacy form. In some sites, ward staff may be authorised to return CDs no longer required using a Medicines Returned to Pharmacy Form. On these sites, local SOPs must be followed that ensure a complete audit trail is maintained and that the CDs are handled and transported securely at all times. Some wards / departments return all CDs to pharmacy when they close (e.g. at weekends). These CDs must be returned to pharmacy in a tamper evident envopak by a designated ward / department staff member.
- 10.1.26 CDs requiring refrigeration should be stored in a separate lockable refrigerator in a secure area.

10.2 Control of access to medicines

- 10.2.1 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring a system is in place for the safekeeping of, and for controlling access to, all medicines stored in his or her area of control. In order to fulfil this responsibility, the Assigned Nurse / Midwife in Charge must normally hold the keys that allow access to any medicines (e.g. keys for drug cupboards, POD lockers, refrigerators etc). Any keys that allow access to CDs (e.g. CD cupboard keys) should be kept separate from other keys and only given to other approved staff when access to CDs is required.

- 10.2.2 In circumstances where holding the keys personally would cause delays or difficulties in making medicines available, the Assigned Nurse / Midwife in Charge may delegate keyholding and control of access to another designated staff member. In operating theatres, control of access to medicines may be delegated to a suitably qualified and competent operating department practitioner (ODP). Special arrangements apply where control of access is delegated to an ODP. (See section 10.3, Delegating control of access to medicines and CDs to an ODP.)
- 10.2.3 The Appointed Registered Nurse / Midwife or Manager in Charge retains responsibility for the safe custody of medicines and controlled stationery, even if he / she decides to delegate control of access. The Appointed Registered Nurse / Midwife or Manager in Charge must make necessary arrangements to be sure that only authorised persons are given access in appropriate circumstances.
- 10.2.4 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring that a duplicate set of keys for all medicine storage cupboards, medicine trolleys, pharmacy boxes etc. are stored securely in a designated place, approved by pharmacy, according to local arrangements.
- 10.2.5 A duplicate key will be issued for use if the original is, or appears to be faulty, or is missing. The duplicate key must be returned to the designated storage location in the nursing office or pharmacy promptly whenever the faulty key is repaired, or replaced or the missing key is located. If the lock has to be replaced the Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring a copy of the new key is supplied to the nursing office or pharmacy, and the key to the original lock is withdrawn.
- 10.2.6 Pharmacy and Heads of Nursing must ensure appropriate action is taken and the outcome documented in the event of loss or potential theft of keys for any cupboards / refrigerators / freezers containing medicines (including bedside locked cabinets used to store patients own drugs).

Controlled Drugs : Additional Requirements

- 10.2.7 A written record is made at each step where a CD changes hands, and when it is administered or destroyed.
- 10.2.8 Additional arrangements are in place to monitor stocks of controlled drugs. (See section 10.4, Record keeping and stock checks required for medicines by wards, theatres and departments).
- 10.2.9 Some devices used to administer CDs are locked to avoid tampering with the device and not to control access to the CD e.g. PCA pumps. The nurse / midwife who is caring for the patient may hold a copy of the key to the device.
- 10.2.10 If the key to a CD cupboard goes missing, the guidance given in section 10.2.6 should be followed. Additionally, the police must be informed if foul play is suspected.
- 10.2.11 The appropriate ward or department manager and the Pharmacy Manager are responsible for ensuring that CD stocks in wards, theatres and departments that are to be left unmanned either routinely, e.g. overnight, at weekends, or due to closure for a limited period of time, are secure. When agreeing the procedure to be followed or the course of action to be taken, a risk assessment must be undertaken, taking consideration of the following factors:
- The likelihood of immediate detection of an intruder.
 - The deterrents in place.
 - The particular medicines being stored.
- 10.2.12 Certain clinical areas may have special arrangements in place to allow return of a number of CDs to pharmacy for safe storage, e.g. clinics closed at weekend. Local SOPs will apply.

10.3 Delegating control of access to medicines and Controlled Drugs to a registered Operating Department Practitioner (ODP)

- 10.3.1 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for the safekeeping of, and for controlling access to, all medicines stored in his or her area of control. The keys should normally be held by the Assigned Nurse / Midwife in Charge of the ward / department.
- 10.3.2 In circumstances where holding the keys personally would cause delays or difficulties in making medicines available, the Assigned Nurse / Midwife in Charge may delegate keyholding and control of access to medicines to another registered nurse / midwife. In operating theatres, control of access to medicines may be delegated to a suitably qualified and competent registered operating department practitioner (ODP), in specific circumstances for defined periods of time
- 10.3.3 A local written protocol defining the circumstances in which the control of access to medicines will be delegated must be agreed.

- 10.3.4 The ODP must have achieved the Scottish Vocational Qualification/National Vocational Qualification in Operating Department Practice level 3, and be on the voluntary register maintained by the Association of Operating Department Practitioners. In addition, the Appointed Registered Nurse / Midwife or Manager in Charge must be satisfied that the ODP understands and will adhere to the protocol.
- 10.3.5 The protocol must include the following information:
- Situations in which authority to control access may be delegated.
 - Persons to whom the medicines may be conveyed.
 - Specific medicines and maximum quantities that may be conveyed.
 - Records that must be kept when a CD changes hands or any medicines are administered to a patient.
 - Circumstances and situations where further advice or authority must be obtained from the Appointed Registered Nurse / Midwife or Manager in Charge.
 - Monitoring arrangements for the protocol.
 - Qualifications and registration details of the ODP.
- 10.3.6 The protocol must be signed by the ODP to confirm that he / she has read and understood the protocol and by the Appointed Registered Nurse / Midwife or Manager in Charge to confirm that the ODP is authorised to practice within the protocol.
- 10.3.7 The protocol must be regularly reviewed (at least annually).

10.4 Record keeping and stock check requirements for medicines by wards, theatres and departments

- 10.4.1 A complete audit trail for all medicines must be available from the point of receipt at ward / department level to administration to patients or return to pharmacy.
- 10.4.2 A record must be made of all medicines administered to patients in wards / theatres / departments / clinics.
- 10.4.3 The Appointed Registered Nurse / Midwife or Manager in Charge should liaise with pharmacy to ensure they can account for all medicines liable to misuse. Local SOPs will apply.
- 10.4.4 It is the responsibility of the Appointed Registered Nurse / Midwife or Manager in Charge to notify pharmacy of any changes in personnel authorised to requisition medicines and CDs.

Controlled Drugs : Additional Requirements

- 10.4.5 The Appointed Registered Nurse / Midwife or Manager in Charge is responsible for ensuring that records of all CD transactions are properly maintained, and that stocks are reconciled. In their absence the responsibility can be delegated to the most senior registered nurse / midwife on duty (the Assigned Nurse / Midwife in Charge).
- 10.4.6 A record of all CD transactions must be made in the Ward Controlled Drugs Register belonging to the ward, theatre or department:
- On receipt at ward level theatre or department, including patients own CDs, brought into hospital and returned on discharge or pass.
 - On administration to patients.
 - When part of a dose is destroyed (surplus to requirements).
 - On return to pharmacy.
 - On internal transfer of CDs between wards / departments when pharmacy is closed following authorisation from the hospital co-ordinator.
 - When out of date or no longer required CDs are destroyed at ward level.
- Destruction or return of CDs to pharmacy must be arranged with the pharmacy department.
- 10.4.7 A separate page must be dedicated to each individual product, and all transactions recorded on that page in chronological order with a running balance. When the page is full, required information must be carried over to a new page. The page that is full should indicate at the bottom "Balance transferred to page xx" and the new page should indicate at the top, "Balance transferred from page yy". The index at the front of the register must be used to indicate the current page in use for each product.
- 10.4.8 In hospital, patients own controlled drugs, which are being used or stored, must be entered in the Ward Controlled Drugs Register on a dedicated page, and each transaction must be documented.

- 10.4.9 Two registered nurses / midwives, or one registered nurse / midwife and one suitably competent student nurse / midwife must record the receipt of CDs in the Ward Controlled Drugs Register and check the balance is correct. Both are responsible for checking that the correct drug has been received and that it is within its expiry date. They must ensure all required details are entered correctly in the Ward Controlled Drugs Register and that the CDs are stored securely in the ward controlled drug cupboard (or lockable refrigerator, if appropriate). In theatre environments, one member of staff may be a suitably competent registered ODP.
- 10.4.10 In a hospital ward or department two registered nurses/midwives, or one registered nurse / midwife and a registered medical practitioner or suitably competent student nurse / midwife must always participate in the administration of CDs, one witnessing the procedure and one administering the medicine. Responsibility ultimately rests with the person administering the CD (unless this is a student nurse / midwife, where responsibility lies with the nurse / midwife supervising and witnessing the administration). In theatre environments, the member of staff witnessing the administration may be a suitably competent registered ODP.
- 10.4.11 A record of all CD administrations must be made in the Ward Controlled Drugs Register. The person administering the CD should sign in the "Administered by" box and the person witnessing the administration should sign in the "Witnessed by" box. A record must also be made in the patient's Medicine Kardex. Other records should be made according to local procedures, e.g. record in nursing notes.
- 10.4.12 If part of a dose is not administered to the patient, two registered nurses / midwives, or one registered nurse / midwife and a registered medical practitioner or suitably competent student nurse / midwife, must check the amount discarded and record it in the register if only part of a dose unit is administered. In theatre environments, one member of staff may be a suitably competent registered ODP.
- 10.4.13 Two registered nurses / midwives, or one registered nurse / midwife and a registered medical practitioner or suitably competent student nurse / midwife, must reconcile the stock balance at each transaction by counting or measuring the physical stock when checking it against the register. In theatre environments, one member of staff may be a suitably competent registered ODP.
- 10.4.14 Liquid medicines should be issued from pharmacy in individual dose units, where possible. The pharmacist must check liquid medicines supplied in multi-dose bottles and amend the register to correct for small discrepancies that are accounted for by overage and loss on measurement, when necessary. The Pharmacy Manager / Designated Deputy must be contacted where there are discrepancies which cannot be accounted for by overage and loss on measurement.
- 10.4.15 The stock of every CD must be checked at each shift changeover or, as a minimum, a least once every 24 hours, by two registered nurses / midwives, as follows:
- Systematically look at each page of the register and then count or measure the corresponding physical stock. Items should not be selected first, counted and then checked with the corresponding page in the register, as this method does not ensure that all stock recorded in the register is checked.
 - Refer to the Ward Controlled Drugs Order Book. Check that each order received since the last daily check has been entered in the Ward Controlled Drugs Register.
 - Record in writing at the back of the Ward Controlled Drugs Register (or CD check book if this is in use locally) that the daily check has been carried out. Both members of staff carrying out the stock check must sign this entry.
 - Inform the Appointed Registered Nurse / Midwife or Manager in Charge of any discrepancies found and document and investigate appropriately.
- 10.4.16 CDs supplied in sealed, tamper evident boxes / packets do not need to be opened and their contents removed for counting on each occasion the CD stock balance is checked (provided the tamper evident seal remains intact). In some areas (e.g. theatres), local procedures will stipulate that all boxes / packets must be opened and the stock checked (on receipt and at each CD stock check).
- 10.4.17 If any discrepancies that cannot be resolved are found in the routine stock check of CDs by wards / departments the Assigned Nurse / Midwife in Charge must act immediately by informing the appropriate senior nurse (e.g. Clinical Co-ordinator), Pharmacy Manager / Designated Deputy. Following a thorough investigation, if criminal activity is suspected, the Police will be informed (See section 10.6, Action in the event of a breach in security).
- 10.4.18 Pharmacy staff should check the Ward Controlled Drugs Register and reconcile stock at least once every 3 months. The person undertaking the check must provide a report of the outcome of the check to the Appointed Registered Nurse / Midwife or Manager in Charge. The person undertaking the check must record any discrepancies found as a medication incident and inform the Appointed Registered Nurse / Midwife or Manager in Charge, Lead Nurse and Pharmacy Manager.

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- 10.4.19 Pharmacy will provide quarterly reports to each Directorate, detailing the CD stock checks carried out, any discrepancies found and actions needed to resolve discrepancies.
- 10.4.20 Ward Controlled Drugs Registers and Ward Controlled Drugs Order Books must be retained by the Appointed Registered Nurse / Midwife or Manager in Charge for two years after the date of the last entry.

10.5 Storage of drugs required for emergency use

- 10.5.1 Every ward must have access to medicines stored in strategic and accessible sites that can be used in emergencies such as cardiac arrest, respiratory arrest or anaphylaxis. Many wards keep the range of medicines required in their ward stock and do not require to keep a separate emergency tray / box.
- 10.5.2 Emergency kits (e.g. for emergency teams working outside the hospital and GPs out of hours service):
- Must be tamper evident.
 - If it is impractical for them to be locked up, they must be stored in an area with constant staff presence.
 - Kits, or their contents, must not be obvious to the general public.
- 10.5.3 Following a review by the resuscitation team, wards / departments which stock only a limited range of medicines will have access to an emergency medicine tray / box, which will be situated in an agreed location.
- 10.5.4 Once an emergency medicine tray / box has been opened it should be returned to the pharmacy department for replacement as soon as possible, during pharmacy opening hours, even if no medicines or equipment have been removed.
- 10.5.5 There must be a system of checks in place for emergency trays / boxes that are assembled and stored ready for use, to ensure that any medicine included is correct and within its expiry date.
- 10.5.6 On some sites, emergency cupboards are utilised for out-of-hours supply of medicines. These are maintained and stocked by pharmacy. Access to them is restricted to pharmacy staff and the hospital co-ordinator. Local SOPs must be followed

Controlled Drugs : Additional Requirements

- 10.5.7 Any areas that hold emergency trays / boxes containing CDs must check the contents of the tray / box daily to ensure the CDs have not been tampered with. The Appointed Registered Nurse / Midwife or Manager in Charge must liaise with pharmacy to ensure storage arrangements are appropriate.

10.6 Action in the event of a breach of security

- 10.6.1 A breach of security includes any deviation from the procedures that results in actual or potential loss or theft of medicines. Examples of such incidents include:
- CDs are found to be missing.
 - Controlled stationery is found to be missing.
 - A key for medicine storage areas is found to be missing.
 - Medicines belonging to ward / department stock are found to be missing.
 - Patients Own Drugs are found to be missing.
 - An unauthorised person has access to controlled stationery.
- 10.6.2 Any person who discovers a breach of security is responsible for reporting it immediately to the Assigned Nurse / Midwife in Charge, and to the Pharmacy Manager / Designated Deputy. Out of hours, the EDC pharmacist should be informed.
- 10.6.3 The Appointed Registered Nurse / Midwife or Manager in Charge of the department concerned is responsible for investigating the breach of security and for taking the necessary action according to relevant NHS GG&C policy (see Standing Financial Instructions, Section 18, Fraud, Losses and Legal Claims). This includes informing appropriate personnel within appropriate timescales, and ensuring that the relevant incident form is completed.
- 10.6.4 All incidents involving a breach of security that cause actual or potential loss or theft of medicines must be investigated and the appropriate corrective and preventative action taken in accordance with local SOPs. If medicines have been misappropriated police charges may be brought against staff members.

11. Patients Own Drugs (PODs)

11.1 General principles

- 11.1.1 Patients own drugs may be brought into the ward by the patient or patient's representatives or ambulance crews. Patients' representatives may bring medication in to hospital after the patient has been admitted.
- 11.1.2 Nursing, midwifery, pharmacy or medical staff assessing PODs must be satisfied that the medicine has been prescribed for that patient and the medicine is fit for purpose.
- 11.1.3 All medicines brought into hospital by patients remain their own property. The patient (or their representative) must give consent for PODs to be used or for their disposal (verbal consent is sufficient – this should be documented in the nursing notes / POD assessment documentation or on the front of the Medicine Kardex (dependent on local SOPs).
- 11.1.4 Careful consideration should be given to returning PODs to patients representatives during the patients stay. Controlled Drugs must not be returned to patients representatives during the patient's in-patient stay as there is the potential for misappropriation.
- 11.1.5 On no account should PODs be mixed with ward, theatre or department stock or be administered to another patient.
- 11.1.6 Where PODs need to accompany a patient who is being transferred to another ward, they must be placed in an appropriate container / bag designated for this purpose (e.g. a Patients Own Drugs 'green bag') and given to staff transferring the patient for handing over to the receiving staff. Responsibility for the safe keeping of the PODs lies with the member of staff carrying out the transfer.
- 11.1.7 Where the responsibility for a patient is transferred from one nurse / midwife or other clinician to another, or from one clinical area to another, then the nurse / midwife or other clinician receiving the patient must check that all PODs that have been transferred are correct for the patient. The responsibility for security of the PODs is also transferred to the receiving nurse / midwife or clinician. This is part of the series of checks that are required at transfer.
- 11.1.8 In certain circumstances, parents, relatives or carers of patients may be resident in hospital and require to take regular medication. Local SOPs should be followed for the storage and security of these medicines belonging to the parents, relatives or carers. Particular attention must be paid to drugs liable to misappropriation / CDs. Every possible effort should be made by the parent, relative or carer to store and take their medicine outwith the hospital, if possible.

11.2 Documentation of Patients Own Drugs

- 11.2.1 A detailed list of all PODs brought into hospital should be recorded in the patients notes or on locally agreed documentation, following approved SOPs.
- 11.2.2 If PODs have to be sent to pharmacy for destruction this must be with the patients or patients representative's permission and must be documented in the nursing notes or locally agreed documentation. All medicines returned to pharmacy must be accompanied by a Medicines Returned to Pharmacy form.
- 11.2.3 At point of discharge, the patient / patient's representative must sign the discharge prescription to indicate they have received discharge medicines, which may include return of PODs (if still clinically appropriate). A copy of the discharge/pass prescription should be filed in the patient's medical notes. If the patient cannot sign the prescription then two nurses from the ward / department should sign the prescription to indicate they have returned the medicines.

Controlled Drugs : Additional Requirements

- 11.2.4 Where it is necessary to administer a patient's own CD to them while in hospital, a separate page of the CD register should be used to allow each dose administered to be recorded in the normal manner. The CD will have been logged in on admission to the ward / department in the "Patient's Own Controlled Drugs In" page. On the opposite page, "Patient's Own Controlled Drugs Out", the entry should state "Transferred to page xx for in-patient use".

Continues overleaf

- 11.2.5 Details of patients own CDs brought into hospital must be entered into the Ward Controlled Drugs Register. One page of the register should be headed "Patient's Own Controlled Drugs In". The opposite page should be headed "Patient's Own Controlled Drugs Out". The patient's name and CHI number, and name, form, strength and quantity of the CDs should be recorded at receipt and on return to the patient or on destruction of the CD, if no longer clinically indicated, by the pharmacist at ward level.
- 11.2.6 On the page headed "Patient's Own Controlled Drugs In" the entry must state the date, time received, patient's name, drug name, form, strength and quantity received, and balance (e.g. "...Sevredol tablets 20mg, 22 tablets"). If more than one CD is brought in it should be recorded on a separate line.
- 11.2.7 When patients are transferred between wards their own medicines and CDs should accompany them. CDs should be written out of the Ward Controlled Drugs Register (on the "Patient's Own Controlled Drugs Out" page), stating where the patient is being transferred to and then written into the receiving ward's Controlled Drug Register (on the "Patient's Own Controlled Drugs In" page). The CDs should be transported in a sealed, tamper evident container.
- 11.2.8 Where it is clinically appropriate to return CDs that have not been used during the in-patient stay at point of discharge / pass, an entry must be made on the opposite page headed "Patient's Own Controlled Drugs Out", on the same line. The entry must state date, time issued, patient's name, drug name, form, strength, quantity issued (e.g. "...Sevredol 20mg tablets x 22 supplied").
- 11.2.9 The patient or their representative must sign the discharge prescription to record that they have received the CDs. The exact quantity / form / strength of any CD PODs returned to patients or their representatives must be documented on the Discharge Prescription.
- 11.2.10 Where it is inappropriate to return patients own CDs at point of discharge, e.g. no longer clinically indicated / strength inappropriate, pharmacy must be contacted to destroy the CDs at ward level.

11.3 Assessment of Patients Own Drugs

- 11.3.1 A nurse / midwife, pharmacist or pharmacy technician must take all reasonable steps to ensure that a patients own medicine is suitable before it is used in hospital, or re-issued at discharge. This will include the following checks:
- The medicine is in the original dispensing pack, or in a blister strip containing the medicine name, strength and expiry date.
 - For medicines in the original dispensing pack, the label and the contents of the pack must correspond and they must have been dispensed for the patient in question within the last 3 months.
 - There are no visible signs of deterioration.
 - The medicine has not expired if the expiry date is on the blister strips, or, if no expiry date is available it must be within 3 months of the date dispensed.
 - Medicines are not mixed in the container.
- 11.3.2 The outcomes of 11.3.1 must be formally documented in the nursing notes or approved documentation. Only medicines complying with the above criteria should be used during the in-patient stay or returned to the patient, when clinically appropriate, at point of discharge.
- 11.3.3 Multi-compartment devices, (compliance aid / dosette boxes) should not routinely be used for administration during in-patient stay. If the multi-compartment medication device is not clearly labelled, or is not a sealed device, the medicines must not be used except when the patient is at clinical risk if a medicine is omitted and an alternative supply is not available in the short term. Nursing staff administering the medicine must be able to identify the medicine contained in the multi-compartment medication device. (See Appendix 6, Multi-compartment medication devices.)

11.4 Storage of Patients Own Drugs

- 11.4.1 PODs should be stored appropriately and securely in the ward / department throughout the patient's stay (medicine cupboard / controlled drug cupboard, POD locker or refrigerator) either for use while in hospital or to be returned at point of discharge, if clinically indicated.
- 11.4.2 In certain circumstances medicines may be given to patients to be stored at their bedside, e.g. salbutamol inhalers, for emergency use. Local SOPs will apply.

Controlled Drugs : Additional Requirements

- 11.4.3 After recording the receipt of patients' own CDs in the Ward Controlled Drugs Register, CDs must be locked in the ward controlled drugs cupboard (unless the patient is self administering CDs, where a local risk assessment should be undertaken and suitable storage arrangements made for the CD that assures safety and security without compromising patient care).

11.5 Return of Patients Own Drugs at Point of Discharge

- 11.5.1 PODs may be safely returned to the patient at point of discharge providing:
- The medicine is still prescribed on discharge.
 - The medicine is appropriately labelled with the current dose.
 - The PODs are still in date.
- 11.5.2 Providing the patient has at least 7 days supply of their own medicines which are in date, are clinically indicated and are fit for use, they should be re-issued at point of discharge. Further supplies should not be ordered from pharmacy. The medicines should be prescribed in the usual manner on the Discharge Prescription and annotated as "Patient's Own Drugs".
- 11.5.3 If a patient brings in a multi-compartment device and there are no changes to their medicines during the in-patient period an appropriately trained staff member should assess if the patient's own device can be returned to the patient for use on discharge, considering:
- The number of days supply remaining.
 - The origin of the device, e.g. local pharmacy / filled by patient or family member.
 - If issuing a part used device may cause confusion / worsen compliance.
- In most cases, it is more appropriate to issue a freshly filled multi-compartment device. (See Appendix 6.)

11.6 Destruction of Patients Own Drugs

- 11.6.1 The Assigned Nurse / Midwife in Charge or pharmacy technician / pharmacist will decide if PODs have to be returned to the patient on discharge or be destroyed. This decision will be recorded in the nursing notes/ locally approved documentation.
- 11.6.2 The patient or their representative must consent prior to the destruction of the PODs. If the patient (or their representative) refuses consent for destruction of the PODs no longer clinically indicated, or otherwise unsuitable for use, this must be documented in the medical notes. If appropriate, medical staff and the patient's GP should be informed and resolution sought.
- 11.6.3 All PODs (excluding CDs) not being returned to patients must be returned to pharmacy for destruction. The PODs should be accompanied by a Medicines Returned to Pharmacy form, which must state the patient's name and hospital / CHI number and list all PODs sent for destruction. Detailed quantities of each medicine returned are not generally required to be included on this form, unless the drug is included in the Desirable Drugs Policy, where exact quantities must be documented.
- 11.6.4 The Medicines Returned to Pharmacy forms will be retained in the Pharmacy department for a period of 12 months.

Controlled Drugs : Additional Requirements

- 11.6.5 CDs must not be returned to pharmacy for destruction. They must always be destroyed at ward / department level. (See section 16, Return and disposal of medicines.)
- 11.6.6 A pharmacist and a registered nurse / midwife from the ward / department must witness the destruction of patients' own CDs at ward level. The destruction must be recorded in the Ward Controlled Drugs Register.

12. Authorisation to prescribe and administer medicines

12.1 General principles

- 12.1.1 Medicines can be prescribed only by a UK registered doctor, or dentist, or a registered supplementary / independent Prescriber.
- 12.1.2 If medicines are not prescribed, they can only be administered or supplied within the terms of a Patient Group Direction (PGD) or a Patient Specific Direction (PSD). Midwives are exempt from this requirement in relation to certain specified medicines only, allowing them to supply and administer these medicines without the directions of a doctor, by provisions in the Prescription Only Medicines (Human Use) Order 1997. The medicines to which this exemption applies are listed in Schedule 5 of the POM Order (Appendix 7).
- 12.1.3 Medicines are prescribed, or authorised for administration or supply, according to agreed local policies, formularies and stock lists.
- 12.1.4 Medicines used for research and clinical trials must have the appropriate management and ethics committee approval. (See section 4.5, Approval of new medicines for procurement and section 4.7, Medicines for use in research and clinical trials.)
- 12.1.5 Appropriate risk management arrangements must be followed for the prescribing of medicines that do not have a product licence. (See section 4.6, Unlicensed medicines.)
- 12.1.6 A record of all medicines prescribed and administered or supplied must be maintained in the patient's medical case notes. If the medicine is a CD then a record of administration will also be recorded in the Ward Controlled Drugs Register.
- 12.1.7 All medication errors or potentially serious 'near miss' events should be reported and investigated. (See section 17, Medication Incidents.)
- 12.1.8 Prescribers should not prescribe medicines for themselves or for anyone with whom they have a close personal or emotional relationship.

Controlled Drugs : Additional Requirements

- 12.1.9 If electronic prescribing is in place then any CD discharge prescription so generated will need to be signed by the prescriber.

12.2 Non-medical prescribers

- 12.2.1 The extension of prescribing roles to non-medical professions is intended to:
- Improve the quality of service to patients without compromising patient safety.
 - Make it easier for patients to get the medicines they need.
 - Increase patient choice in accessing medicines.
 - Make better use of the skills of health professionals.
 - Contribute to the introduction of more flexible teams working across the NHS.
- 12.2.2 Currently, three recognised means of non-medical prescribing exist:
- **Community practitioner nurse prescribing** – District Nurse Prescribers / Health Visitor / Public Health prescribers who can prescribe only from the "Nurse Prescribers' Formulary for Community Practitioners" (see current edition of the BNF for the current version of this formulary). (This class of prescriber is not discussed further in these Acute sector guidelines as they will only function within community settings).
 - **Supplementary prescribing** – A voluntary partnership between the patient, an independent prescriber (who must be a registered doctor or dentist), and a registered supplementary prescriber to implement an agreed patient specific Clinical Management Plan (CMP), which details medicines that can be prescribed for specific indications.
 - **Nurse / Midwife or Pharmacist independent prescribing** - Prescribing by a nurse / pharmacist responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.
- 12.2.3 Registered nurses, midwives and pharmacists, can apply for registration as independent prescribers following successful completion of an approved non-medical prescribing course.

- 12.2.4 Existing qualified pharmacist supplementary prescribers will also be able to function as independent prescribers once they have completed an appropriate conversion qualification. (See www.nes.scot.nhs.uk).
- 12.2.5 Allied Health Professionals can apply for registration as supplementary prescribers following completion of an approved course.
- 12.2.6 All training courses for non-medical prescribers can be accessed through the Non-Medical Prescribing Lead within PPSU.
- 12.2.7 Appropriate local procedures relating to registration with NHS GG&C as a qualified non-medical prescriber must be followed and job descriptions updated (if necessary).
- 12.2.8 It is essential that nurse / midwife and pharmacist prescribers are clear at all times which prescribing regime they are operating under i.e., for nurses, as a Community Practitioner nurse prescriber, supplementary prescriber or independent prescriber.

12.3 Nurse / Pharmacist / Allied Health Professions supplementary prescribers

- 12.3.1 The supplementary prescriber provides continuing care to the patient following assessment and diagnosis by the independent prescriber (who must be a doctor or dentist) and according to a CMP agreed with the independent prescriber.
- 12.3.2 The independent prescriber is responsible for:
 - The initial assessment of the patient, the formulation of the diagnosis and determining the scope of the CMP.
 - Reaching an agreement with the supplementary prescriber about the limits of the responsibility for prescribing and review – which should be set out in the CMP.
 - Providing advice and support to the supplementary prescriber as requested.
 - Carrying out a review of the patient's progress at appropriate intervals, depending on the nature and stability of the patient's condition.
 - Sharing the patient's record with the supplementary prescriber.
- 12.3.3 The supplementary prescriber is responsible for:
 - Prescribing for the patient in accordance with the CMP.
 - Altering the medicines prescribed within the limits set out in the CMP, if monitoring of the patient's progress indicates that this is clinically appropriate.
 - Monitoring and assessing the patient's progress as appropriate to the patient's condition and the medicines prescribed.
 - Working at all times within his/her clinical competence and professional code of conduct, consulting the independent prescriber as necessary.
 - Accepting professional accountability and clinical responsibility for prescribing practice.
 - Passing responsibility for prescribing back to the independent prescriber if the agreed clinical reviews are not carried out within the specified interval, or if it is felt that the patient's condition no longer falls within his / her competence.
 - Recording prescribing and monitoring activity in the shared patient record as soon as possible.
- 12.3.4 The independent prescriber assesses the patient, makes a diagnosis, and decides if the patient is suitable for supplementary prescribing. The supplementary prescriber agrees that the patient is suitable for supplementary prescribing. The Independent and supplementary prescriber agree and sign a CMP for the patient. The patient's agreement to the concept of supplementary prescribing is obtained and recorded on the CMP.
- 12.3.5 There are no legal restrictions on the clinical conditions that supplementary prescribers may treat provided they are included in the CMP and are within the prescribers competence and experience.
- 12.3.6 Supplementary prescribing is suitable in situations where treatment requires to be adjusted according to the needs of the individual patient over a reasonable period of time, following initial diagnosis by the independent prescriber. It is most useful when managing episodes of care during a hospital stay that need treatment to be tailored according to patient response (e.g. post operative pain control), and when dealing with long-term medical conditions (e.g. diabetes).

Continues overleaf

12.4 Clinical Management Plans (CMPs)

- 12.4.1 The CMP defines the treatments that may be prescribed by the supplementary prescriber. It must be agreed before supplementary prescribing can take place and must include the following:
- The name of the patient to whom the plan relates.
 - The illnesses or conditions, which may be treated by the supplementary prescriber.
 - The date on which the plan is to take effect, and when it is to be reviewed by the independent prescriber.
 - Reference to the class or description of medicines or types of appliances, which may be prescribed or administered under the plan.
 - Any restrictions or limitations as to the strength or dose of any medicine which may be prescribed or administered under the plan, and any period of administration or use of any medicine or appliance which may be prescribed or administered under the plan.
 - Relevant warnings about known sensitivities of the patient to, or known difficulties of the patient with, particular medicines or appliances.
 - The arrangements for notification of suspected or known reactions to any medicine which may be prescribed or administered under the plan, and suspected or known adverse reactions to any other medicine taken at the same time as any medicine prescribed or administered under the plan.
 - The circumstances in which the supplementary prescriber should refer to, or seek the advice of, the independent prescriber.
- 12.4.2 The CMP must be recorded on one of the approved NHS GG&C CMP templates. It can be paper-based or electronic. It may include a reference to published national or local guidelines, as long as the guidelines are easily accessible, and they identify clearly the range of the relevant medicinal products to be used in the treatment of the patient. There is no need to repeat the advice in the guideline in the body of the CMP itself.
- 12.4.3 Detailed patient information that is contained in the patient's record shared by each prescriber does not need to be repeated in the CMP, unless essential for clarity and patient safety.
- 12.4.4 Nurses, midwives and pharmacists can prescribe any medicine, including controlled drugs and unlicensed medicines that are listed in the agreed CMP. Allied health professionals cannot prescribe controlled drugs but can prescribe any other medicine, including unlicensed medicines, which are listed in the agreed CMP.
- 12.4.5 If the supplementary or independent prescriber changes, a new agreement to enter into a prescribing partnership is negotiated and recorded in the patient record.
- 12.4.6 The CMP comes to an end:
- At any time at the discretion of the independent prescriber, or
 - At the request of the supplementary prescriber or the patient, or
 - At the time specified for the review of the patient (unless it is renewed by both prescribers at that time), or
 - Where there is a sole independent prescriber and he / she is replaced for whatever reason, or
 - Where the patient is discharged from the care of the independent prescriber.

12.5 Nurse / Pharmacist independent prescribers

- 12.5.1 A nurse / midwife or pharmacist independent prescriber is responsible and accountable for the assessment of patients with diagnosed or undiagnosed conditions and for decisions made about the clinical management of the patient, which will include prescribing. This will require an initial patient assessment, interpretation of findings from that assessment (including any tests ordered), a decision on safe and appropriate therapy and a process for ongoing monitoring.
- 12.5.2 A nurse / midwife or pharmacist independent prescriber can prescribe any UK licensed medicine for any medical condition, including drugs for 'off label' use (used outwith their UK licence) and some controlled drugs. (see section 12.7).
- 12.5.3 A nurse / midwife or pharmacist independent prescriber must prescribe only for conditions within their own level of competence and expertise. They must refer patients to more appropriate professionals for ongoing clinical management in areas outside their own competency.
- 12.5.4 Nurse / midwife or pharmacist prescribers must ensure that patients are aware that their care is being managed by a non-medical professional and that they will prescribe medication only within their own area of expertise.

- 12.5.5 Nurse / midwife or pharmacist independent prescribers are required to keep accurate, unambiguous patient records, including information on medication prescribed. These must be accessible by all members of the prescribing team. No single template is recommended for use – practitioners should develop appropriate templates for use within their own clinical setting. Many practitioners will find that Clinical Management Plan templates can act as useful patient records for independent prescribers.
- 12.5.6 It is recommended that details of any prescribing practice, along with other details of patient consultation, should also be entered into the appropriate shared patient record (e.g. medical notes). It should also be entered onto nursing records if a separate record is kept in the clinical setting. For hospital in-patients, medicines prescribed must also be written on the current Medicine Kardex.
- 12.5.7 Prescriptions generated by non-medical prescribers should include:
- Patient name and date of birth.
 - CHI number.
 - The date of the prescription.
 - The name of the prescriber (and an annotation of the prescriber's status to signify that they are acting as a supplementary or independent prescriber).
 - The name of the item prescribed, the dose, frequency (and quantity to supply and duration of treatment, if applicable).
 - The prescriber's unique reference code or registration number.

12.6 Registration of non-medical prescribers within NHS GG&C

- 12.6.1 Only practitioners registered with their relevant professional body, e.g. Royal Pharmaceutical Society of Great Britain (RPSGB) as supplementary / independent prescribers will be able to apply for registration as such within NHS GG&C. Practitioners who do not renew their annual registration must inform the Lead for Non Medical Prescribing for PPSU and must cease to practice as a supplementary / independent prescriber immediately.
- 12.6.2 Hospital based nurses / midwives, who wish to apply to undertake the necessary training to become independent prescribers, must have their applications approved by their Lead Nurse. These applications must be sent to the Non-Medical Prescribing Lead for approval and processing. Pharmacists must have their applications approved by the Pharmacy Manager / Lead Clinical Pharmacist. The conditions and situations in which the non-medical prescriber intends to practice will be taken into account when considering the application. All applications must be sent to the Lead for Non-Medical Prescribing (PPSU) for final approval and processing.
- 12.6.3 On successful completion of training and following annotation on the relevant professional register, the supplementary / independent prescriber must also apply to the Lead for Non-Medical Prescribing to be added to the NHS GG&C register of supplementary / independent prescribers before they are allowed to prescribe. All supplementary / independent prescribers will be provided with a form to present a specimen signature at the pharmacy department within the hospital.
- 12.6.4 Supplementary / independent prescribers recruited from other organisations must apply to the Lead for Non-medical Prescribing to be added to the NHS GG&C register of supplementary / independent prescribers. The Head of Nursing or Senior Pharmacist for that area must take into account the conditions and situations in which the supplementary / independent prescriber intends to practice.
- 12.6.5 Job descriptions must be amended by the line manager to include the supplementary / independent prescribing role, where necessary.
- 12.6.6 If there are any changes to any of the details recorded on the NHS GG&C register of supplementary / independent prescribers, the prescriber must inform the Lead for Non-Medical Prescribing who will amend the NHS GG&C register.
- 12.6.7 The supplementary / independent prescriber can prescribe only on approved NHS GG&C prescribing documents (e.g. Medicine Kardexes, Discharge Prescriptions). The prescriber's registration code (e.g. RPSGB registration number) must be written beside the signature.
- 12.6.8 Supplementary / independent prescribers should ensure separation of prescribing, dispensing and administration activities wherever possible.

Continues overleaf

12.7 Non-Medical Prescribers and Controlled Drugs

- 12.7.1 Nurse, midwife and pharmacist supplementary prescribers can prescribe CDs (except Schedule 1 CDs, which are not intended for medical use), as long as they are specified within the CMP. Currently, allied health professionals are not permitted to prescribe controlled drugs as supplementary prescribers.
- 12.7.2 Nurse / midwife and pharmacist independent prescribers can prescribe a select range of CDs for specified conditions. Nurse / midwife and pharmacist independent prescribers must ensure that they are authorised to prescribe specific CDs by checking the current list of CDs prescribable for listed conditions (available from NMC, RPSGB or the Lead for Non-Medical Prescribing in NHS GG&C).
- 12.7.3 Non-medical prescribers must follow guidance on prescribing of Controlled Drugs (see section 13).

12.8 Patient Group Directions (PGDs)

- 12.8.1 PGDs are written instructions for the supply and / or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- 12.8.2 PGDs lend themselves to situations where medicine usage follows a predictable pattern and is less individualised (e.g. Accident / Emergency pain relief). They are useful to manage a specific treatment episode (or episodes) for which supply or administration of a medicine is necessary, but they are not generally suitable as a long-term means of managing a patient's condition.
- 12.8.3 The majority of treatment with medicines must be prescribed on an individual, patient specific basis.
- 12.8.4 Staff involved in the supply and / or administration of a prescription only medicine under a patient group direction must:
- Ensure that they have up-to-date knowledge relating to the clinical situation covered by the PGD, the medicine and its use for the indications specified.
 - Ensure that they have undertaken any training required for operation of the PGD.
 - Be satisfied that the PGD is legally valid, is within its expiry date and that it has been approved by NHS GG&C.
 - Ensure that when supplies are made the agreed protocol is followed and that the information specified in the PGD is recorded.
- 12.8.5 PGDs cannot be used to authorise the supply and administration of medicines without a UK licence , radiopharmaceuticals or most CDs. PGDs are permitted for medicines supplied and administered outwith the terms of their UK licence only if appropriate evidence supporting their use is referenced on the PGD (e.g. monograph in the BNF for Children).
- 12.8.6 PGDs must be approved locally by the lead clinician and developed by a local team which should include a doctor, pharmacist and member of the professional group who will be working under the PGD. They must consult with all appropriate persons, including all consultants whose patients may be treated under the direction, to confirm that the proposed direction is appropriate, does not compromise patient safety, and is consistent with professional relationships and accountability.
- 12.8.7 Before it is introduced into operation, the PGD must be submitted to the NHS GG&C PGD sub-group of the ADTC for approval.
- 12.8.8 Supply and administration must be in line with NHS GG&C formularies and protocols.
- 12.8.9 The PGD must be reviewed at least once every 2 years otherwise it is invalid. PGDs must not be used beyond their expiry date. The review should be undertaken by the original authors (or their replacements), in consultation with all appropriate persons. It is the responsibility of staff using the PGD to ensure it is clinically up-to-date and that it is reviewed, updated and submitted for re-approval in advance of the expiry date.
- 12.8.10 If any change is made to the patient group, clinical condition or situation to which the direction applies, or to the characteristics of staff authorised to practice under the direction, or to the description of treatment available under the direction, then the new version of the direction must be submitted for consideration and approval to the PGD committee. If no change has been made to the PGD after review then it will be re-approved by the PGD Subcommittee for a further 2 years.

- 12.8.11 The PGD must be written using the approved NHS GG&C template, and must contain the following information:
- The patient group, clinical condition or situation to which the direction applies.
 - A description of inclusion and exclusion criteria that apply to the direction.
 - Cautions / situations where further advice is required before administering / supplying medicine under the PGD.
 - Action to be taken if a patient is excluded from or refuses treatment under the direction.
 - The medicine which may be supplied or administered, and specific details of:
 - The dose.
 - The form and route of administration.
 - The frequency of administration.
 - The maximum number of doses that may be supplied or administered.
 - The maximum period of time for which the medicine may be supplied or administered.
 - Warnings, cautions and contraindications to treatment with the medicine.
 - The legal status of the medicines.
 - Details of any directions / labelling required (if the medicine is to be supplied to the patient).
 - Instructions on the documentation required to record supply or administration, and other records to be kept for audit purposes.
 - The knowledge, skills and qualifications required by staff approved to authorise supply or administration of medicines under the terms of the PGD, and details of any required training programme.
 - The action to be taken if an adverse drug reaction is suspected or occurs to a patient being treated under the direction.
 - Details of any necessary follow-up action that will be taken after supply or administration.
 - Evidence of approval (by signature) by the chair of the PGD committee, Pharmacy Clinical Governance representative and lead for the professional group working under the PGD.
 - The date that the direction comes into force, and the date that it expires.
- 12.8.12 A nominated individual (e.g. Appointed Registered Nurse / Midwife or Manager in Charge, or appropriate manager for other professions) must approve and maintain an up-to-date record of persons approved to supply or administer medicines under the PGD in their area of responsibility. The record must be signed by the approved persons as confirmation that he/she has read and understood the protocol, and by the Appointed Registered Nurse / Midwife or Manager in Charge, or appropriate manager for other professions. The record must be held and maintained locally.
- 12.8.13 The arrangements for monitoring of care under the PGD and audit of the PGD must be specified.

Controlled Drugs : Additional Requirements

- 12.8.14 There are currently only four circumstances in which CDs may be administered or supplied under a PGD:
- A registered nurse may, when acting in her capacity as such, supply or administer diamorphine under a PGD for treatment of cardiac pain to a person admitted as a patient to a coronary care unit or accident and emergency department of a hospital.
 - A registered nurse / midwife, pharmacist or any of the other named healthcare professional listed may, when acting in their capacity as such, supply or administer any Schedule 5 CD in accordance with a valid PGD.
 - A registered nurse / midwife, pharmacist or any of the other named healthcare professionals listed may, when acting in their capacity as such, supply or administer any Part 1 Schedule 4 CD in accordance with a valid PGD provided that it is not a drug in parenteral form for the treatment of addiction.
 - A registered nurse / midwife, pharmacist or any other named healthcare professional listed may, when acting in their capacity as such, supply or administer midazolam in accordance with a valid PGD.

12.9 Symptomatic Relief Policy

- 12.9.1 The Symptomatic Relief Policy allows nurses and midwives to administer medicines from an agreed list to patients. The agreed list of medicines comprises mainly general sales list or pharmacy medicines that are intended to relieve minor and common complaints (e.g. constipation, headache).
- 12.9.2 In order for the policy to be valid for individual patients the Doctors Declaration on the back of the Medicine Kardex must be signed. (In units using an alternative style kardex that does not have a section for Symptomatic Relief Policy local SOPs should be followed.)
- 12.9.3 The nurse or midwife may delegate the administration of medicines from the Symptomatic Relief Policy to health care staff under their supervision, if appropriate.

13. Prescribing medicines

13.1 General principles

- 13.1.1 Medicines are prescribed only for, and supplied to, NHS patients. They will not be prescribed for or supplied to members of staff, patients' relatives or carers unless they are registered patients, for example through the Accident and Emergency Department (except in emergency situations).
- 13.1.2 Prescriptions can be generated only by suitably qualified prescribers (registered doctors, dentists, independent nurse or pharmacist prescribers and any nurse / pharmacist / allied health professional (AHP) registered as a supplementary prescriber who is prescribing medicines authorised by the CMP). Appropriate local procedures relating to registration with NHS GG&C for nurse / pharmacist / AHP prescribers must be followed and job descriptions updated (if necessary).
- 13.1.3 Prescriptions for in-patients, out-patients, discharge or pass medication must be written legibly in black ink or otherwise so as to be indelible. Prescriptions must be written on the current appropriate approved prescribing documents, or prescribed electronically, in accordance with current local procedures. Under no circumstances should correction fluid e.g. Tippex® be used to change any prescription entry (or any other entry in medical notes etc). If any changes are made to a Medicine Kardex, Discharge or Pass prescription, they must be clearly documented and a new Discharge / Pass prescription written or new entry made on the Medicine Kardex (as appropriate).
- 13.1.4 Whenever possible no more than one main Medicine Kardex should be used for each patient. Where specific therapy is prescribed on an approved supplementary chart, it must also be documented on the Medicine Kardex (e.g. insulin, warfarin, IV infusions).
- 13.1.5 Medicine must be prescribed generically using the current British Approved Name (BAN), except where branded products of the same drug are known to have clinically significant differences in bioavailability (e.g. controlled release formulations of nifedipine, theophylline etc). For these medicines, the brand in use should be specified when prescribing.
- 13.1.6 Medicine doses must be written in metric units. Only the following abbreviations may be used:
g = gram
mg = milligram
ml = millilitre
mmol = millimoles
All other dose units must be written in full, e.g. microgram, litre and Units for Insulin International Units.
- 13.1.7 The use of decimal points must be avoided. For example, 0.1mg must be written as 100 micrograms. If the use of the decimal points is unavoidable, a zero must be written in front of the decimal point i.e. "0.5ml", not ".5ml".
- 13.1.8 The route of administration must be written in full except for the following approved abbreviations. N.B. Intrathecal must be written in full.
- | | | | |
|----|---------------|-------|-------------------------------------|
| PO | oral | PEG | percutaneous endoscopic gastrostomy |
| IV | intravenous | RIG | radiologically inserted gastrostomy |
| IM | intramuscular | PEJ | percutaneous endoscopic jejunostomy |
| ID | intra-dermal | NJ | nasojejunostomy |
| SC | subcutaneous | ETT | endotracheal |
| SL | sublingual | TOP | topical |
| NG | nasogastric | INHAL | inhaled |
| PR | per rectum | NEB | nebulised |
| PV | per vagina | | |
- 13.1.9 The times and day(s), where appropriate, of administration must be specified. Particular attention must be paid when prescribing once weekly medicine, e.g. methotrexate for rheumatoid arthritis or bisphosphonates for osteoporosis.

- 13.1.10 Oxygen, or any other medical gas prescribed for in-patients or out-patients must be prescribed on the Medicine Kardex in the regular (non-parenteral) section. The administration device used, flow rate and concentration (if applicable) must be documented.
- 13.1.11 Medicines given by continuous infusion should be signified in the Medicine Kardex by drawing an arrow through all the "Time" sections on the entry in the Medicine Kardex and writing "Continuous Infusion" on the Other Information section. If the dose is likely to vary the dose should be annotated as "Varies" on the Kardex and each dose change recorded on the additional IV Infusion Chart.
- 13.1.12 For 'as required' medicines, the symptoms to be relieved, the minimum time interval between doses, and the maximum daily dose or the maximum number of doses per day must be specified e.g.:
- 1g every four-six hours when required for pain,
Maximum 4g in 24 hours
- 13.1.13 If it is necessary to use two Medicine Kardexes or Discharge Prescriptions for the same patient this should be clearly identified by annotating the Medicine Kardexes / Discharge Prescriptions with "1 of 2" and "2 of 2".
- 13.1.14 When a patient is re-admitted, or transferred from another hospital where a shared case note record is not in place, a new Medicine Kardex must be written. When a patient returns from pass or re-attends hospital for planned procedures at short intervals, the original Medicine Kardex may be used (as guided by local procedures). A review of the patient's prescription records must take place on every admission to ensure it is appropriate and up-to-date.
- 13.1.15 Electronic prescription systems may be used if they provide at least the same level of detail and safety as the paper system and have appropriate audit trails.
- 13.1.16 Medicines are prescribed, or authorised for administration or supply, according to agreed local policies, formularies and stock lists.
- 13.1.17 Medicines used for research and clinical trials will have the appropriate management and ethics committee approval and must be prescribed on appropriate approved documentation. (See section 4.7, Medicines for use in research and clinical trials).
- 13.1.18 A record of all medicines prescribed and administered or supplied is maintained in the patient's medical case notes.
- 13.1.19 All medication errors or potentially serious 'near miss' events must be reported and investigated. (See section 17, Medication incidents).

Controlled Drugs : Additional Requirements

- 13.1.20 If electronic prescribing is in place then any CD discharge prescription so generated will need to be signed by the prescriber.

13.2 Prescriptions for in-patients

- 13.2.1 Prescriptions must be written on approved stationery, or prescribed electronically if local procedures for electronic prescribing for in-patients are in use. The following policy statements apply to wards / theatres / departments using a combined prescription and administration style Medicine Kardex. In units using other styles of kardex local SOPs should be followed (which apply the core principles outlined in this document).
- 13.2.2 For in-patient prescriptions, the following patient details are required:
- Hospital.
 - Ward or department.
 - Patient's name.
 - CHI number.
 - Hospital number.
 - Date of birth.
 - Height.
 - Weight.
 - Known drug sensitivities (allergies and known or suspected adverse drug reactions).
 - Medicine name, strength, form, dose route and times of administration.
 - Date prescribed.
 - Prescriber's signature.
 - Stop or review date for parenteral drugs (especially IV antibiotics).

Continues overleaf

- 13.2.3 The patient name must be written on each page of the Medicine Kardex.
- 13.2.4 The start date for each entry must be clearly documented.
- 13.2.5 Medicines intended to be given once only must be prescribed in the "Once Only" section of the Medicine Kardex.
- 13.2.6 'As Required' medicines must be prescribed in the "As Required" section of the Medicine Kardex. The indication for the medicine, minimum time interval between doses, dose, and the maximum dose that can be given in a 24 hour period must be stated.
- 13.2.7 When a medicine is discontinued, this must be done by drawing a line across the prescription box without obliterating what has been written, and by drawing a vertical line down the last administration time. A diagonal line should be made across the remaining days / columns. The date of discontinuation should be recorded and the signature / initials of the person responsible for discontinuing the medicine.
- 13.2.8 When a Medicine Kardex has to be rewritten:
- Any item no longer required must be discontinued and a diagonal line drawn across each blank section /page of the old chart.
 - For each medicine being continued, the original start date must be written in the new chart.
 - The word "Re-written" and the date of re-writing must be written at the top of the new chart.
- 13.2.9 Individual entries on the Medicine Kardex must not be altered or amended. If a change is required, the entry must be cancelled completely and a new prescription entry must be written. The date of cancellation should be noted.

13.3 Prescriptions for discharge or pass medicine

- 13.3.1 For discharge and pass prescriptions for medicines the following information must be included:
- Name of the hospital.
 - Name, address, D.O.B, hospital number and CHI number of the patient.
 - Consultant name.
 - Ward or department.
 - Date prescription written.
 - Prescriber's signature, and page number of the prescriber. The prescriber must print his/her name beside their signature. Initials are not acceptable.
 - Name and address of the GP.
 - If issued by a dentist, the words "For dental use only".
 - Age and weight (if the prescription is for a child under 12).
- 13.3.2 The Discharge Prescription must be used to prescribe all currently required medicines. Electronic systems may be used where these have been validated. The information required must be accurately transcribed from the inpatient prescription chart and the patient's medical notes.
- 13.3.3 The doctor or authorised prescriber responsible for the patient's care must ensure that the Discharge Prescription or Pass Medication Prescription is completed in adequate time, taking account of the patient's planned time and date of discharge.
- 13.3.4 Where deliberate changes are made from the entries on the Medicine Kardex when prescribing medicines for discharge or pass this should be noted in the patient's medical notes and Medicine Kardex (e.g. antibiotics discontinued at discharge as the course is complete). If these changes are recorded it will expedite the discharge process and facilitate accurate communication between hospital and primary care professionals.
- 13.3.5 At least seven days supply of medicines will be provided, unless a longer or shorter course of treatment is appropriate. Where Patients Own Drugs / Making the Most of Your Medicines (MmyM) systems are in use the patient may receive original packs of dispensed medicines (which may be part-used at point of discharge if they were supplied and used during the in-patient period).
- 13.3.6 If the patient already has his or her own supply of required medicines at home or stored in the ward, an additional supply should not be issued from the hospital. The nurse / midwife / pharmacist / doctor/ pharmacy technician must annotate the prescription with "Patient's own supply" and initial each entry. In doing so they are accepting that the patient has supplied reliable and accurate information on the medicines they have at home. If there is any doubt as to the validity of the information provided by the patient a fresh supply of all required medicines should be made from pharmacy using a Discharge Prescription (or Pass Prescription form). In these circumstances, the patient should be asked to return all medicines stored at home to their local community pharmacy. All medicines currently required to be taken by the patient must be written on the Discharge Prescription, regardless of whether or not the patient has their own supply.

- 13.3.7 If the medicines on the Discharge or Pass Prescription change prior to the patient going home a new prescription must be written and the original medicines and prescription returned to the pharmacy with the new prescription.
- 13.3.8 If compliance with medication is identified as an issue during the in-patient period the patient should be assessed by medical, nursing, midwifery or pharmacy staff (following local procedures). If a multi-compartment medication device is deemed helpful after assessment a suitable means of filling the multi-compartment medication device post-discharge must be organised. The discharge prescription must be annotated "Multi-compartment medication device required" before being sent to pharmacy. Patients already receiving medicines in multi-compartment medication devices before admission to hospital must also have their discharge prescription annotated "Multi-compartment medication device required". (See Appendix 6, Multi-compartment medication devices).

Controlled Drugs : Additional Requirements

- 13.3.9 A separate Discharge Prescription is required for CDs for discharge or pass medication. More than one CD can be prescribed on the same Discharge Prescription. Prescriptions containing CDs should not include any non-CD medicines. All discharge / pass prescriptions for CDs must be accompanied by the ward / department Controlled Drugs Order Book, which must be signed by a registered nurse / midwife who must be an authorised signatory for CDs for the area concerned. The Controlled Drugs Order Book must state the name, form and strength, where appropriate, of the CD, the total quantity required and the name and CHI number of the patient concerned. Each CD required should be requested on a separate page of the ward / department Controlled Drugs Order Book. (Controlled Drugs Order Books may not be required to accompany CD prescriptions from wards on all sites if locally validated procedures ensure a complete audit trail is maintained of CDs supplied on discharge / pass prescription e.g. 3-monthly reconciliation of CD prescriptions dispensed with the Ward Controlled Drug Register. Local SOPs must be followed.)
- 13.3.10 For discharge and pass prescriptions for CDs the following information must also be included for a CD prescription:
- The approved name of the CD must be used, except for combination products, or where a specific brand, e.g. sustained release products, is necessary due to variation in clinical response between brands.
 - Specify the total quantity, in both words and figures, of the preparation or the number of dosage units to be supplied (e.g. for tablets, writing "10 (ten) tablets" would be acceptable).
 - Where appropriate, identify the strength of the preparation. Where more than one strength is available, then the strength must be specified on the prescription.
 - If a prescriber orders a strength or form of controlled drug which does not exist, the discharge or pass prescription must be returned to the prescriber for amendment, e.g.

"MST Continus tablets 50mg,
One tablet twice daily x 14 (fourteen tablets)."

- Cannot be supplied as MST Continus 50mg does not exist.

- Must be returned to prescriber and rewritten as:

"MST Continus tablets 30mg,
One tablet twice daily x 14 (fourteen tablets)."

and

"MST Continus tablets 10mg,
Two tablets twice daily x 28 (twenty-eight tablets)."

• Where a CD is prescribed, the form of the preparation must be stated (e.g. capsules, injection) on the prescription even when only one form exists or where the form is implicit in the proprietary name, e.g. MST Continus tablets.
 - A dose of "To be taken as directed" or "To be taken when required" is not acceptable for CDs. The dose range must be specified and time interval between doses specified if appropriate, e.g.

"Sevredol tablets 10mg,
10-20mg every 2-4 hours,
if required for pain.
Please supply 20 (twenty) tablets."

• Prescriptions for controlled drugs to be used in a syringe driver must also specify the dose to be administered over a specified period, e.g. 40mg diamorphine SC over 24 hours and number of dose units to be dispensed (in words and figures), e.g.

"Diamorphine 40mg S/C via syringe driver over 24 hours.
Please supply 7 (seven) 30mg amps and 7 (seven) 10mg amps."

Continues overleaf

- 13.3.11 Under no circumstances can a carbon copy or faxed prescription be accepted for a Schedule 2 or a Schedule 3 controlled drug.
- 13.3.12 If the CDs are to be dispensed in the hospital pharmacy, the discharge or pass prescription must be delivered to the pharmacy at least 4 working hours before the patient is due to be discharged, to allow adequate time for dispensing and delivery to the ward.
- 13.3.13 Currently, discharge or pass prescriptions for CDs cannot be transmitted electronically as they require to be signed by the prescriber. Future developments in electronic prescribing may change this.
- 13.3.14 Where possible, the clinical pharmacist should check the discharge prescription before it is sent to pharmacy to reduce the number of queries regarding prescriptions that are unclear, inaccurate or do not comply with prescribing regulations for CDs.
- 13.3.15 A pharmacist is allowed to make minor amendments to prescriptions for Schedule 2 and 3 CDs, providing the prescriber's original intention is clear. Minor amendments include correcting typographical or spelling mistakes and adding the quantity in either words or figures (where it is written in only words OR figures).
- 13.3.16 CDs will be supplied in multi-compartment medication devices if deemed clinically appropriate (local SOPs will apply).

13.4 Prescriptions for out-patients / Patient Packs

- 13.4.1 Patients attending out-patient clinics will usually have changes in their medication / new medication initiated by their GP on receipt of a communication from the hospital practitioner. In exceptional circumstances where there is an immediate need to change medication or start new medicine, the patient should receive an initial supply from the hospital pharmacy. Medicines should be requested on a hospital Discharge Prescription form (see section 13.3, Prescriptions for discharge or pass).
- 13.4.2 If a medicine is designated 'Hospital Supply Only' the patient will be unable to obtain supplies from their community pharmacy. The prescriber should prescribe the medicine on a Discharge Prescription in the first instance and then contact the local pharmacy department to discuss ongoing supply arrangements. Prescribers may also wish to retain responsibility for prescribing certain medicines (e.g. if the medicine is being used outwith its Product Licence and the GP will not accept prescribing responsibility). In these cases the prescriber should prescribe the medicine on a Discharge Prescription in the first instance and then contact the local pharmacy department to discuss ongoing supply arrangements.
- 13.4.3 Some clinic areas utilise 'Patient Packs' of commonly used medicines. If patient-pack arrangements are in place a Discharge Prescription must be written for all patient-pack items supplied to patients by a suitably qualified prescriber. This will ensure the patient's GP receives full details of any medicines prescribed. A local record of patient-pack supplies must also be completed. (See section 15.2, Patient Packs).
- 13.4.4 Hospital doctors, dentists and other suitably qualified prescribers may also prescribe medicines on Health Board Prescriptions (HBPs), which the patient must take to their community pharmacy to be dispensed.
- 13.4.5 HBPs for medicines require only the name / identity number of the hospital, name, address, age (if under 12 years) of the patient and the signature of the prescriber, date of writing, and details of the medication to be supplied. independent nurse / pharmacist prescribers must use a designated 'stamp' which includes details of their unique Personal Identification Number (PIN) or registration number.
- 13.4.6 HBPs must be used only in out-patient clinics when there is an immediate need to start / change therapy and this need cannot be met by the local pharmacy department or GP or via the use of patient-packs.

13.5 Prescriptions for clinical trial medicines

- 13.5.1 For out-patient supply of clinical trial medicines, a trial specific approved prescription form must be used and signed by a trial investigator.
- 13.5.2 If a patient is admitted on a trial medicine the patient's own trial medicine should be used (if clinically appropriate) during the in-patient period. If further supplies are required for the patient these should be requested from the centre conducting the trial.
- 13.5.3 When medicines in clinical trials are prescribed for hospital in-patients the protocol number, patient number, the title of the trial and, if possible, the names of any potential medicines should be recorded on the Medicine Kardex (e.g. "ASA trial, Aspirin or placebo"). Supplies will be obtained by the investigator via the hospital pharmacy using approved clinical trial prescriptions / documentation
- 13.5.4 In-patients being discharged on clinical trial medicine should have supplies organised by the investigator using approved documentation. Trial medication should be included on the Discharge Prescription (annotated as "Trial medicine – supplied by investigator").

Controlled Drugs : Additional Requirements

13.5.5 Trial CDs are covered by the same regulations as non-trial Controlled Drugs.

13.6 Prescriptions for injections and infusions

13.6.1 The parenteral route is potentially more hazardous than other routes of administration of medicines.

13.6.2 Medicines should be prescribed by injection only if no other route is suitable. For example:

- The medicine is not available for administration by another route, and there is no therapeutically equivalent medicine that could be used by another route, or
- The oral, naso-gastric, rectal or other possible route is not suitable, or
- The medicine needs to be administered by injection to achieve immediate effect or the required therapeutic level.

13.6.3 If an injection needs to be prescribed the prescriber must:

- Write a specific finishing date on the prescription, if appropriate, or
- Review it every 24 hours, if appropriate, and change to a potentially less hazardous route at the earliest opportunity (local SOPs should be adhered to where regular injections are prescribed to cover defined periods (e.g. depot injections) to ensure safety and continuity of supply and administration).

14. Administration of medicines

14.1 General principles

- 14.1.1 Medicines can only be administered in accordance with one or more of the following processes:
- Against an entry made in a Medicine Kardex by a UK registered doctor, dentist, independent or supplementary prescriber.
 - Patient Group Direction (PGD).
 - Patient Specific Direction (PSD).
 - Medicines Act exemption (see Appendix 7 for Midwifery exemptions).
 - Symptomatic Relief Policy.
- 14.1.2 Prescriptions must be written legibly on approved NHS GG&C prescribing documents. In exceptional circumstances, a medicine may be administered on the verbal instruction of a registered doctor. (See section 14.6, Administration of medicines without a written prescription.)
- 14.1.3 Medicines may be administered only by an authorised practitioner, e.g. registered doctors, registered nurses and midwives. Medicines may also be supplied and / or administered to patients via approved PGDs. (See Section 12.8, Patient Group Directions.)
- 14.1.4 In exceptional circumstances, other suitably qualified and trained persons may administer medicines. This will involve local risk assessment and approval of robust procedures (to ensure NHS GG&C accepts vicarious liability for the practice).
- 14.1.5 Patients may self-administer medicines as part of a formal process which must include assessment of the patient and their medicine.
- 14.1.6 Student nurses and midwives, who have received the appropriate level of training, may participate in the administration of medicines providing they are adequately supervised.
- 14.1.7 The administration of medicines must be undertaken in a methodical manner, in accordance with section 14.2. Distractions should be minimised while medicines are being selected, prepared and administered. Staff should not be interrupted whilst undertaking medicine preparation and administration except in an emergency.
- 14.1.8 If infusion devices are necessary for the administration of the medicine, all staff involved in operating the device must be competent in using the equipment and have a record of device training documenting this.
- 14.1.9 Persons authorised to administer medicines must have sufficient knowledge of the medicine being administered, and of the patient to whom the medicine is being administered, to be able to intervene in circumstances where
- 14.1.10 administration is not appropriate.
Registered nurses or midwives employed through the NHS GG&C Bank or an agency may participate in the administration of medicines, where required.
- 14.1.11 All medication errors or 'near misses' should be reported, documented and significant errors / 'near misses' investigated as per local procedure.
- 14.1.12 Medicines may be administered by a sole practitioner providing they have been authorised to do so by the Appointed Registered Nurse / Midwife or Manager in Charge, except in the following circumstances when two practitioners are required, one as a witness and one to administer the medicine:
- Controlled Drugs.
 - Complex calculations involved (e.g. two or more separate calculations needed).
 - Intravenous medicines (including IV potassium).
 - Medicines administered to children age 12 and under.

Controlled Drugs : Additional Requirements

- 14.1.13 In hospitals, two designated members of staff must always participate in the administration of CDs, one witnessing the procedure and one administering the medicine. Responsibility ultimately rests with the person administering the CD, unless this is a student nurse / midwife, where responsibility lies with the registered nurse / midwife witnessing the administration.
- 14.1.14 A record of all CDs administered to patients must be made in the Ward Controlled Drugs Register.

- 14.1.15 In the hospital setting patients may self-administer PCA CDs only if they consent and are able to do so when formally assessed. Assessment and consent must be documented in the patient's medical record/nursing notes. Self-administration of other CDs will not normally take place, except in exceptional circumstances. Local SOPs will apply.

14.2 Administration of medicines to in-patients, out-patients and in clinics

- 14.2.1 All staff involved in the administration of medicines to patients must exercise their professional accountability in the best interests of patients.
- 14.2.2 Staff must be familiar with the therapeutic uses of the medicine to be administered, the normal dosage, side effects, precautions and contra-indications.
- 14.2.3 Formal procedures should be followed when administering medicines, which must incorporate the following steps:
- Read the prescription carefully.
 - Confirm availability of medicine.
 - Check that the prescribed medicine and route are correct for the patient.
 - Check that the prescribed dose has not already been given.
 - Select the medicine required and check the label against the prescription.
 - Check the expiry date of the medicine.
 - Identify the patient by checking the name, date of birth and CHI number on the prescription against the name, date of birth and CHI number on the patient's name band. Wherever possible, the patient should also be asked to state his or her name and date of birth. (In Mental Health departments other means of identification may be used.)
 - Check the patient is not allergic to the medicine before administering it.
 - Administer the medicine as instructed on the Medicine Kardex.
 - Record the administration on the Medicine Kardex.
 - Record any reasons for non administration as detailed on the back page of the Medicine Kardex and inform the responsible doctor in an appropriate timescale of any deviation from the prescription, if necessary. (In units using Medicine Kardexes that do not have a 'back page' section detailing non administration codes local SOPs should be followed and reasons for non administration recorded in the Kardex in use or medical notes).
- 14.2.4 Staff administering medicines should be aware of the patient's care plan.
- 14.2.5 The dosage, method of administration, route and timing of the administration must be appropriate for the patient's condition and any concurrent therapies.
- 14.2.6 Expiry dates must be checked prior to the medicine being administered. Particular attention should be paid to drugs intended to be infused over extended periods, e.g. intrathecal baclofen. The drugs used to fill the infusion pump must have an expiry date beyond the anticipated refill date of the pump.
- 14.2.7 The prescriber, or another authorised prescriber, should be contacted without delay where a contra-indication to the prescribed medicine is discovered, the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable.
- 14.2.8 In emergency situations, e.g. during resuscitation, a retrospective record of medicine administration may be made as soon as practically possible.
- 14.2.9 When supervising a student nurse or midwife in the administration of medicines, the signature of the student must be countersigned by the supervisor.
- 14.2.10 Some drug administrations require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations, it is desirable for a second practitioner to check the calculation in order to minimise the risk of error. The use of calculators to determine the volume or quantity of medication should not act as a substitute for arithmetical knowledge and skill.
- 14.2.11 It is unacceptable to prepare substances for injection in advance of their immediate use or to administer medication drawn into a syringe or container by another practitioner when not in their presence. An exception to this is an already established infusion which has been instigated by another practitioner following the principles set out above, or medication prepared under the direction of a pharmacist from a central intravenous additive service and clearly labelled for an individual patient.

Continues overleaf

Controlled Drugs : Additional Requirements

- 14.2.12 In hospital, all stages of the preparation and administration of CDs must be performed by two practitioners, i.e. registered nurse / midwife, student nurse / midwife and / or doctors or dentists. At least one of these practitioners must be a registered permanent member of staff in the ward / department. One will be the administrator and the other the witness. Those roles must be performed by the same named members of staff throughout the procedure, i.e. roles cannot be swapped mid-way. In theatre environments, the witness may be a suitably competent registered ODP.
- 14.2.13 The whole administration period for CDs must be witnessed by the two practitioners involved in the procedure, except for slow administration that takes more than a few minutes, e.g. infusions, for which the set up and start of the administration must be witnessed.
- 14.2.14 An entry must be made in the Ward Controlled Drugs Register. The person administering the CD should sign in the "Administered by box" and the person witnessing the administration should sign in the "Witnessed by" box. A record must also be made in the patient's Medicine Kardex and / or anaesthetic chart, as appropriate. The ultimate responsibility remains with the administering practitioner unless this is a student nurse / midwife, where responsibility lies with the registered nurse / midwife witnessing the administration.
- 14.2.15 If a prepared CD is not administered or is only partly administered, two registered nurses / midwives, or one registered nurse / midwife and a registered medical practitioner or suitably competent student nurse, must check the amount discarded and record it in the register. In theatre environments, one member of staff may be a suitably competent ODP. Destruction of any part vial / tablets etc must be witnessed and documented in the CD register.
- 14.2.16 Under no circumstances are CD register entries to be obliterated by pen or correction fluid (e.g. Tippex®). If changes to the CD register are required these should be annotated and initialled.
- 14.2.17 Two registered nurses / midwives, or one registered nurse / midwife and a registered medical practitioner or suitably competent student nurse / midwife must reconcile the stock balance at each transaction by counting or measuring the physical stock when checking it against the register. In theatre environments, one member of staff may be a suitably competent ODP.
- 14.2.18 If a patient refuses to take CDs from the healthcare practitioner, a parent / carer may administer oral medication but only in the presence of the practitioners involved in the preparation who will witness the administration and sign the Ward Controlled Drugs Register and Medicine Kardex. (See section 14.10, Covert administration of medicines.)

14.3 Administration of medicines to patients with restricted oral intake

- 14.3.1 For patients with restricted oral intake action must be taken depending on the category of restriction (fasting, nil by mouth, difficulty swallowing). Further advice on administering medicines / formulation is available from local Medicines Information centres.
- 14.3.2 For patients who are fasting prior to operations / procedures, the anaesthetist should indicate which medicines can be given and which should be withheld (either on an individual patient basis or by means of robust, regularly reviewed departmental guidelines).

14.4 Administration of medicines by injection and infusion

- 14.4.1 Medicines for injection and infusion that require complex calculation or manipulation to prepare, or that pose a health and safety risk during preparation, will be supplied, where possible, in a ready to use form from the pharmacy.
- 14.4.2 Other injections that require dilution or reconstitution before administration may be prepared in the near patient area. (See section 14.5, Preparation of injections / infusions.)
- 14.4.3 Hazards associated with the preparation of injections include:
- Incorrect dosage calculation.
 - Selection of wrong medicine or diluent.
 - Incorrect method of preparation.
 - Incompatibility of constituents.
 - Instability of final product.
 - Microbial contamination.
 - Particulate contamination.
 - Health and Safety risk to the operator or the environment.
 - Incorrect labelling.

- 14.4.4 Registered doctors, nurses, midwives and ODPs who have successfully completed a registered intravenous therapy training programme or equivalent may prepare and administer intravenous injections. Ongoing training needs should be identified at annual PDP review.
- 14.4.5 The physical and chemical stability of an injection (the medicine and diluent added) must be determined before the product is prepared. Information sources include:
- Summary of Product Characteristics.
 - Manufacturer's data sheet or package insert.
 - Local Intravenous monographs or Medusa monographs.
 - British National Formulary / BNF for Children.
 - Clinical pharmacist/ Medicines Information Service.
- 14.4.6 Infusions should be completed within 24 hours of preparation (or sooner if microbial contamination / chemical instability is a problem). If the infusion is required for more than 24 hours a fresh infusion must be prepared and any unused portion destroyed. In exceptional cases, e.g. epidural infusions, it may be acceptable to use infusions for longer than 24 hours without preparing a fresh infusion. A formal risk assessment must be undertaken for infusions being used for longer than 24 hours and approval for this practice granted by the lead clinician and appropriate pharmacist.
- 14.4.7 For infusions that are administered using a rate controlling infusion device, the name and strength of the medicine, dose, flow rate, preparation details, and observations during administration must be recorded on the Intravenous Infusion Chart.
- 14.4.8 Injections prepared in the near patient area must be prepared immediately before administration. They must not be prepared and stored in the near patient area. If this is not possible for operational reasons, a risk assessment must be undertaken in conjunction with pharmacy, and the action taken to minimise the risk must be documented.
- 14.4.9 Injections prepared in the near patient area must be administered only by those individuals who were involved in the preparation.

14.5 Preparation of injections / infusions

- 14.5.1 The preparation of injections must be carried out in a designated area that:
- Has a clear, uncluttered surface for preparation.
 - Has adequate space.
 - Is quiet, away from distractions.
 - Has a surface that can be cleaned.
 - Has access to hand washing facilities (medicine preparation, however, should not be carried out adjacent to sinks).
 - Is near to information on the preparation of injections.
 - Is well lit.
- 14.5.2 If available, a ready-to-use form of injection should be used in preference to one prepared at ward / pharmacy level.
- 14.5.3 Injections for one patient only should be prepared at a time, and administered before preparing any injections or infusions for another patient.
- 14.5.4 Injections must be clearly identifiable at all stages during preparation and administration.
- 14.5.5 The additive label for syringes and infusions (excluding syringes prepared for immediate use as a bolus) must be prepared before starting preparation of the injection / infusion so that it is affixed immediately after preparation is complete. The label must specify the patient name, additive, strength, diluent, route, date and time prepared, initials of staff involved in preparation and expiry date.
- 14.5.6 In wards / theatres / departments, if an injection is to be given by bolus, the name of the medicine must be affixed to the syringe (e.g. using an additive label or specific drug-name label). The finished preparation and original containers must be kept in an individual tray between preparation and administration to patient.
- 14.5.7 All prepared infusions / injections must be labelled with an appropriately sized label so as not to obliterate the name of the infusion fluid and to allow inspection of the solution and volume. For syringe drivers, the label must be attached in such a way to avoid obliterating the graduations on the syringe.

Continues overleaf

- 14.5.8 On no account should prepared injections / infusions be administered that contain particulate matter.
- 14.5.9 Infusion bags must not be routinely used as multidose containers for the preparation of injections. In some clinical areas, devices are available that facilitate the use of infusion bags as multiple use containers for a restricted time period (e.g. for drawing up small quantities to flush lines / use as a diluent). These devices should only be used after local risk assessment has been undertaken and procedures put in place that ensure patient safety at all times.

14.6 Administration of medicines without a written prescription

- 14.6.1 Medicines must only be administered without a written prescription in exceptional circumstances, e.g. an emergency arrest situation.
- 14.6.2 Where a verbal prescription is given by a doctor present at an emergency, or in theatre, the doctor must state the name, dose and route of administration of the medicine to be administered.
- 14.6.3 The individual who prepares the medicine must ensure the information is correct by repeating the name, dose and route of administration of the medicine to the doctor who ordered it.
- 14.6.4 The medicine must be administered either by the prescribing doctor or by the individual who prepared it, except in theatre, where it must be administered by the prescribing doctor. Both must be present at the time of administration.
- 14.6.5 An accurate record of all medicines administered in this situation must be kept and all medicine containers must be kept until a formal record is completed and agreed by those who were present.
- 14.6.6 All medicines that have been administered must be accurately recorded onto the appropriate documentation by the doctor who prescribed them and countersigned by the staff who administered the medicine. In theatres the second person may be a registered ODP.

14.7 Telephone orders to administer medicine

- 14.7.1 An instruction to administer medicines via telephone must be accepted only in exceptional circumstances. It must be approved by the Assigned Nurse / Midwife in Charge.
- 14.7.2 Telephone orders must be accepted only for drugs that have previously been prescribed on the Medicine Kardex (either in the "Once Only", "As required" or regular section of the Medicine Kardex).
- 14.7.3 The Assigned Nurse / Midwife in Charge must confirm the patient's identity with the prescriber and inform the prescriber of the name, doses and route of other medicine currently prescribed for the patient.
- 14.7.4 The details of the telephone prescription should be entered onto the patient's Medicine Kardex by the Assigned Nurse / Midwife in Charge at the "Once Only" section, with the following details:
- Date.
 - Time of administration.
 - Name of medicine.
 - Dose.
 - Route of administration.
- (These must be read back and verified by the Doctor.)**
- Nurse / Midwife signature.
 - Stated in capitals: "ORDERED BY TELEPHONE
BY DR (*Specify*) AT (*Specify*) ON (*Specify*)"
- The Medicine Kardex must be countersigned by the doctor within 4 hours (unless the patient is at a different site from the doctor, when the Medicine Kardex must be countersigned within 24 hours).
- 14.7.5 The patient's identity must be confirmed by a check of the full name and hospital number on the Medicine Kardex with the patient's identity wristband (or other locally agreed means of confirming identity).

Controlled Drugs : Additional Requirements

- 14.7.6 Telephone orders for CDs must not be given or accepted in any circumstances.

14.8 Self-administration of medicines

- 14.8.1 People at home usually administer their own medicines. With appropriate checks and controls it is logical for hospital in-patients to have custody of and administer their own medicines. Self-administration of medicines accords well with the use of patients own medicines scheme and promotes patient empowerment. Self administration of medicines can be carried out only after patient assessment and agreement and formal documentation of this assessment and agreement. Local procedures must be produced by medical, pharmacy and nursing staff prior to the introduction of self-administration systems. Regular review and audit must be undertaken in areas using self-administration of medicines systems.

Controlled Drugs : Additional Requirements

- 14.8.2 Not all ward areas are suitable for near-patient storage of CDs required for self-administration. The exception to this will be PCA systems in use in hospital settings.
- 14.8.3 CDs should not be stored in POD lockers unless deemed absolutely necessary to do so and a local risk assessment carried out. If CDs are stored in the POD locker they must be recorded in the usual manner in the Ward Controlled Drugs Register. In some instances the risk assessment may also indicate that a daily count of CDs in POD lockers should be undertaken by ward staff.
- 14.8.4 While a patient is self-administering PCA / syringe driver, the prescriber must inform the nurse and patient of any change to the prescription.
- 14.8.5 While a patient is self-administering his or her PCA / syringe driver, the registered nurse must make the following checks each day:
- A correctly labelled supply of the prescribed PCA CD is in the infusion device for the patient to self-administer from.
 - The patient is able to continue self-administering.
 - The administration and monitoring records show that the PCA / syringe driver is being administered correctly.
 - The infusion device is kept in a locked, tamper-free position.

The nurse / midwife must act on any concern, or change of circumstances, to inform medical staff of a change in the patient's condition as soon as possible.

14.9 Administration of medicines to neonates, children and young people age 12 and under

- 14.9.1 Preparation and administration of medicines to neonates, children and young people age 12 and under must be carried out by two designated staff members who are deemed competent by the Appointed Registered Nurse / Midwife or Manager in Charge and / or have completed an approved educational programme, and are authorised to administer medicines. (In some dedicated paediatric / specialist settings local policy may stipulate two designated staff members must be involved for all medicines prepared / administered to those age under 16).
- 14.9.2 Two designated staff members must carry out dose calculations independently. The clinical pharmacist must be contacted if there is any uncertainty regarding the dose or calculation.
- 14.9.3 If the patient refuses to take medicines from the designated staff members a parent may administer oral medication but only in the presence of one staff member involved. Both designated members of staff must sign the Medicine Kardex administration record and record that the medicine was administered by a parent.

14.10 Covert administration of medicines

- 14.10.1 The covert administration of medicines is defined as the administration of medicines in disguised form, usually by means of food or drink, to patients who have previously refused to take the medicines. All patients have the right to refuse treatment. This right may be overturned only by application of the appropriate mental health or adults with incapacity legislation. Only medicines deemed essential may be administered covertly.
- 14.10.2 The legislation governing medicine administration in those who lack capacity is covered by the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and treatment) (Scotland) Act 2003. Detailed guidance on covert medicine administration can be found in "Covert Medication – Legal and practical guidance", Mental Welfare Commission for Scotland.
- 14.10.3 The use of covert means to administer medication is occasionally necessary but it is not justified in a patient who is capable of making decisions about their medical treatment. Covert medication given in these circumstances could be considered assault. Covert medication is no substitute for explanation and education.

Continues overleaf

- 14.10.4 The 2000 Act defines incapacity as being incapable of:
- acting or
 - making decisions, or
 - communicating decisions or
 - understanding decisions or
 - retaining the memory of decisions,
- due to a mental disorder or the inability to communicate due to physical disorder. All possible assistance must be given to patients to aid their communication (e.g. interpreters) before a decision of incapacity can be made.
- 14.10.5 The covert administration of medicines must never involve restraint or force. This policy does not apply in emergency situations.
- 14.10.6 Medicines may be administered covertly only following discussion and agreement with the medical and nursing staff responsible for the patient's care and the patient's family and/or carers, and advocates. The lead practitioner must certify incapacity on an Incapacity Consent Form or other approved documentation (e.g. Section 47 certificate or other relevant documentation in relation to the Mental Health Act).
- 14.10.7 Medicines may only be administered covertly when it is in the best interests of the patient, that is, the medicine is necessary in order to save life, or to prevent deterioration in the patient's physical or mental health, or to ensure improvement in the patient's physical or mental health.
- 14.10.8 Where a young person under the age of 16 refuses a medicine, and is not deemed to be capable, consent to administer medicines covertly must be obtained from the capable adult with parental responsibility. If the person with parental responsibility consents, the medicine may be given covertly. If the person with parental responsibility does not consent, then the medicine should not be administered covertly. However, in exceptional circumstances, where the adult with the parental responsibility is absent, or is not acting in the best interests of the young person, the medicine may be given covertly if it is thought to be essential by the medical and nursing staff responsible for the young person's care.
- 14.10.9 While medicines are being administered covertly, the situation must be re-assessed regularly to take account of changes in the capability status of the patient. Regular attempts must be made to encourage the patient to take the medicine, by providing information and explanation.
- 14.10.10 Practical aspects of covert medicine administration must be considered at an early stage, including the safety of 'crushing' or 'dissolving' medication and the need to prescribe accurately and record covertly administered medicines on the usual documentation. Pharmacy should be contacted for advice where needed.

15. Supply of medicines for patients to take away from hospital

15.1 General principles

- 15.1.1 Patients will be provided with at least 7 days supply of all required medicines when they are discharged from hospital. This may be either via medicines dispensed prior to discharge and / or ongoing use of PODs brought in to hospital or by the issue of Patient Packs (see Section 13.4, Prescriptions for out-patients / Patient Packs). When a short course of treatment is required e.g. reducing course of steroids / short courses of antibiotics, the quantity of medicine required for the complete course will be provided, where appropriate, from the hospital pharmacy.
- 15.1.2 An authorised prescriber must write a prescription for current medicines on discharge from hospital, using the Discharge Prescription form, or it may be prescribed electronically. The prescription must comply with the guidelines for prescribing medicines. (See section 13, Prescribing medicines.)
- 15.1.3 Patients attending out-patient clinics will usually have changes in their medication / new medication initiated by their GP. If there is an immediate need to change medication or start new medicine or the medicine is designated 'Hospital Supply Only', the patient should receive their supply from the hospital pharmacy. Medicines should be requested on a Discharge Prescription form.
- 15.1.4 All medicines issued to patients to take away must be labelled to comply with legal requirements with:
- Name of patient.
 - Name of medicine.
 - Strength.
 - Dosage instructions.
 - Hospital name.
 - Date dispensed.
- 15.1.5 The patient must be provided with adequate verbal and written information about his or her medicines, e.g. patient information leaflet.
- 15.1.6 A copy of the Discharge Prescription must be filed in the patient's medical notes, one copy supplied to the patient's GP, and one copy retained in the pharmacy.

15.2 Patient Packs

- 15.2.1 Certain wards / departments (e.g. A&E units, short-stay surgical units) may keep a small supply of pre-labelled medicines that can be issued to patients on discharge – these supplies are termed 'Patient Packs'.
- 15.2.2 Medicines that can be supplied as Patient Packs must be agreed by the Lead Clinician and Lead Clinical Pharmacist for that area. Patient Packs will be supplied from pharmacy with agreed labels / instructions attached.
- 15.2.3 Any medicine supplied as a Patient Pack must be appropriately documented following agreed SOPs. A separate local record of stock supplied should be kept in the ward / department.
- 15.2.4 Where medicines are issued to the patient directly from a ward or department using a Patient Pack, the Assigned Nurse / Midwife or Manager in Charge must ensure that medicines are issued only by staff that he or she has authorised, and that authorised staff are trained and competent in the processes involved in issuing medicines to patients and the checking procedures required.

15.3 Issuing discharge medication to patients

- 15.3.1 On receipt of the discharge medication at ward level, nursing or pharmacy staff must check that what has been prescribed on the discharge prescription agrees with the current Medicine Kardex (as the dose of certain medicines may be altered up until the point of discharge or may be discontinued).
- 15.3.2 If any discrepancy is found whilst checking the Discharge Prescription against the Medicine Kardex the prescriber must be contacted so that necessary amendments can be made. Discrepancies may be intentional but should be confirmed and documented in the patient's notes.

Continues overleaf

- 15.3.3 If a Medicine Kardex has been changed after the patient's Discharge Prescription has been dispensed, a new Discharge Prescription must be written. The original prescription and dispensed medication must be returned to pharmacy staff (the prescription will be destroyed and medicines reused, if appropriate). The new Discharge Prescription should be given to pharmacy staff for dispensing.
- 15.3.4 Nursing or pharmacy staff must also check the accuracy of the drugs supplied by pharmacy against the Discharge Prescription before issuing to the patient or patients representative.
- 15.3.5 Check that the following details are on the prescription:
- Patient's name.
 - Patient's address.
 - CHI number (and unit number).
 - Ward or department.
 - Prescriber's signature.
- 15.3.6 Check that the name on the Discharge Prescription matches the patient's name band and, if possible, get the patient to verbally confirm their name (or use other locally agreed means of confirming identity).
- 15.3.7 Check the following information on the label for each item against the prescription:
- The medicine.
 - Name.
 - Strength.
 - Form.
 - The dose.
 - In quantity of tablets, liquid, etc.
 - Frequency.
 - Length of course, where applicable.
 - Instructions for administration, where applicable.
 - The patient's name.
 - Check expiry date (if applicable) on medicines.
- 15.3.8 If the label instructions are different from the directions on the prescription, contact pharmacy staff to arrange amendment of the medicine labels.
- 15.3.9 Ensure that at least a 7-day supply of each medicine is provided unless a longer or shorter course of treatment is appropriate, e.g. post-op pain relief.
- 15.3.10 The nurse, midwife or pharmacist issuing the medication to the patient must sign the discharge prescription along with the patient or patient's representative in the appropriate spaces.
- 15.3.11 The discharge medication will be explained to the patient, or, when appropriate, to the carer, prior to discharge.
- 15.3.12 Patients should receive a copy of their Discharge Prescription on discharge, whether or not they require discharge medication. The patient's GP must receive a copy of the discharge prescription, either directly from the patient themselves or posted from the hospital. Local arrangements may allow copies of the prescription to be posted directly to the patient's GP and / or community pharmacy.
- 15.3.13 If a patient refuses to wait for their discharge drugs and does not return to collect their medication on the day of discharge, this should be documented on the Discharge Prescription. The General Practitioner (GP) should be contacted by telephone by the ward staff if an urgent prescription is required. The top copy of the Discharge Prescription should then be posted to the patient's GP for information.
- 15.3.14 Non-issued discharge prescription medications should be returned to pharmacy.

Controlled Drugs : Additional Requirements

- 15.3.15 All CDs issued to patients on Discharge / Pass prescriptions must be recorded in the Ward Controlled Drugs Register on the page "Controlled drugs on discharge prescription – Out". The entry must include the date of issue, the name, form, strength and quantity of each CD issued, the signature of the person making the issue, the signature of a witness and the patient's name.

- 15.3.16 When issuing Schedule 2 CDs to patients or their representatives on wards the nurse / midwife or pharmacist should ascertain to whom they are issuing the medicine and obtain a signature from that person on the prescription itself. In addition a record should be made in the Ward Controlled Drugs Register of:
- Whether the person who collected the CD was the patient, their representative or a healthcare professional acting on behalf of the patient.
 - If the person who collected the CD was a healthcare professional, that person's name and address.
 - If the person who collected the CD was the patient or their representative, whether evidence of identity was requested. (As a matter of good practice a note as to why this was not requested may be included but this is not mandatory.)
 - Whether evidence of identity was provided by the person collecting the drug.
- 15.3.17 If the non-issued discharge prescription medication contains CDs, pharmacy must be contacted to arrange uplift.

15.4 Issue of medicines for injection by patients and carers

- 15.4.1 Patients and carers may need to prepare injectable medicines for self administration in clinical areas in NHS GG&C premises, e.g. as part of a training plan for Cystic Fibrosis patients. Injectable medicines may also need to be prepared by patients / carers / healthcare workers in a patient's home environment following discharge.
- 15.4.2 Injectable medicines for administration may be supplied entirely by the hospital pharmacy department via Discharge Prescription or partly by Discharge Prescription with the remainder being met by Community Pharmacy via a GP-generated prescription. In some instances, medicines may be delivered direct to patient's home by an approved home care supplier.
- 15.4.3 There are hazards associated with the preparation of medicines for injection and patients and carers must be suitably instructed and informed to ensure that these hazards are eliminated or minimised. Local SOPs will apply.
- 15.4.4 The information and instructions provided to patients and carers must be tailored to their individual needs and circumstances. Practitioners who are involved in supporting patients and carers should consider home, work and social circumstances when advising on the suitability of environments for preparation.
- 15.4.5 Patients and carers must be shown how to prepare their injections, and given adequate opportunity to practise under supervision until they are familiar and confident with the procedure and have achieved the necessary competence. Practitioners should re-assess the patient or carer's technique regularly. Records of initial instruction and re-assessment, as per local guidelines, should be kept, signed by practitioners involved, and the patient or carer.
- 15.4.6 Written information and instruction on the preparation of injections should include:
- Storage requirements for each product.
 - General good practice guidance on checking the medicines, the standard of the environment to be used, and preparation technique involved.
 - Specific step-by-step instruction on the preparation of each product.
- 15.4.7 Practitioners responsible for patient care must ensure that appropriate information and instruction are made available to patients and carers who need to prepare injections.

16. Return and disposal of medicines

16.1 General principles

- 16.1.1 All medicines brought into hospital by patients remain their own property. They must be disposed of only with the consent of the patient, or the patient's representative. This consent must be documented, e.g. in the patient's medical records, nursing notes or locally approved documentation.
- 16.1.2 It is the responsibility of the Assigned Nurse / Midwife in Charge to ensure medicines which are expired or no longer required on the ward / department are returned to the Pharmacy Department.
- 16.1.3 The Appointed Registered Nurse / Midwife or Manager in Charge must ensure that a robust system is in place to regularly check expiry dates and rotate stock within their department. Particular attention should be paid to high-cost or rarely used non-stock items. These should be returned to pharmacy for re-issue well in advance of their expiry date.
- 16.1.4 Details of the ward / department medicine being returned, the reason for their return and the signature of the Assigned Nurse / Midwife in Charge must be entered on the three part Medicines Returned to Pharmacy form and the top two copies must be sent with the medicines in a sealed bag to the Pharmacy Department, either in person or in the locked box. (Medicines Returned to Pharmacy forms are available for the Pharmacy Department.)
- 16.1.5 All PODs (excluding CDs) that are no longer required must be returned to pharmacy for destruction. The PODs should be accompanied by a Medicines Returned to Pharmacy form, stating the patient's name and unit / CHI number and list all PODs sent for destruction. Detailed quantities of each medicine are not required unless the medicine is included in the Desirable Drugs policy.
- 16.1.6 Containers or packages of returned medicines must be kept securely or under surveillance whilst in transit between the ward, theatre or department and pharmacy.
- 16.1.7 Within the hospital sector, Pharmacy Managers and the Regional Quality Assurance Pharmacist must ensure that SOPs dealing with waste management, including pharmaceutical waste, are in place. A contract must be made with an authorised carrier for the collection and disposal of pharmaceutical waste at regular intervals or on demand. All pharmaceutical waste must be segregated from pharmacy stock and promptly transferred to disposal containers. Pharmacists must ensure that consignment notes and any other requisite documentation are completed and copies kept complying with legal requirements.

Controlled Drugs : Additional Requirements

- 16.1.8 CDs that have expired or are no longer required will be disposed of in accordance with current legislation and guidance from the RPSGB. CDs must be rendered irretrievable or denatured during the destruction process.
- 16.1.9 Unused or partly used prepared individual doses of CDs can be destroyed in wards / theatres / departments (e.g. a part-used morphine PCA syringe that is no longer required, a part used morphine vial or syringe where only a portion has been administered). The part-used CD should be destroyed in the theatre / ward / department in the presence of a second person who may be a pharmacist, nurse / midwife or doctor. Appropriate records of the destruction of prepared but unused doses or partly administered doses must be recorded in the controlled drug register, recording the amount administered to the patient and the amount destroyed.
- 16.1.10 A separate section of the Ward Controlled Drugs Register should be used to record disposal of part-used infusions, syringes and epidurals prescribed, e.g. for Patient Controlled Analgesia (PCA). The volume of any unused portion of the syringe / epidural / infusion bag which is destroyed must be recorded in the CD register and witnessed by another member of staff.
- 16.1.11 Small quantities of stock CDs that are expired or are otherwise unsuitable for re-use can be disposed of in wards, theatres or departments by a pharmacist and witnessed by a registered nurse / midwife belonging to the ward or department. This must be documented in the Ward Controlled Drugs Register.
- 16.1.12 Patients own CDs that are no longer required must not be returned to pharmacy for destruction. They must always be destroyed at ward/department level.
- 16.1.13 A pharmacist and a registered nurse / midwife from the ward / department must witness the destruction of patients own CDs at ward level. The destruction must be recorded in the Ward Controlled Drugs Register.
- 16.1.14 All CDs should be rendered irretrievable before disposal. Where possible a commercial denaturing kit should be used to facilitate CD destruction. Local SOPs will apply.

16.2 Destruction of medicines at ward, theatre or department level

- 16.2.1 All medicines, including PODs, should be returned to pharmacy for destruction, with the exception of patients own CDs and small quantities of expired / part used / no longer required ward / department stock CDs.

Controlled Drugs : Additional Requirements

- 16.2.2 Patients own CDs no longer required, small quantities of stock CDs no longer required or out-of date stock CDs must be destroyed in the ward, theatre or department by a pharmacist and witnessed by a registered nurse / midwife belonging to the ward or department.
- 16.2.3 It is good practice to use commercially available CD denaturing kits. If this is not possible or practical, however, other means of denaturing CDs should be used. Local SOPs should be followed for each different formulation type (tablets / injections / patches etc).
- 16.2.4 A record of destruction of expired CDs or CDs that are otherwise unsuitable for re-use, including patients own controlled drugs must be made in the ward, theatre or department Ward Controlled Drugs Register. The register must be signed by the pharmacist destroying the CD and a registered nurse / midwife belonging to the ward, department or theatre concerned must sign the CD Register to witness this entry. The balance will be adjusted accordingly.
- 16.2.5 The pharmacy department must be contacted when a CD requires to be destroyed or returned to pharmacy e.g. unopened packs of CDs ordered specifically for a patient who no longer requires treatment. A pharmacist must attend the ward, department, theatre in person to uplift the CD. (In some sites, ward staff may be authorised to return CDs no longer required using a Medicines Returned to Pharmacy form. On these sites, local SOPs must be followed that ensure a complete audit trail is maintained and that the CDs are handled and transported securely at all times.)
- 16.2.6 CDs must not be returned to the pharmacy in the ward pharmacy box under any circumstances.
- 16.2.7 For excess ward stock of CDs, the Medicines Returned to Pharmacy Form must be completed, itemising the name, strength, form and quantity of all CDs being returned to the pharmacy. The top two copies will accompany the CDs being returned to pharmacy and the bottom (blue) copy will remain in the book on the ward, theatre or department.
- 16.2.8 The pharmacist will make an entry in the Ward Controlled Drug Register documenting the return to pharmacy or destruction of the CDs and will adjust the balance appropriately. A registered nurse / midwife in the area concerned must sign to witness this entry.
- 16.2.9 All CDs returned from wards / theatres / departments must be held securely prior to processing in pharmacy. Details of the returned CDs must be entered into the pharmacy Controlled Drug Register within 24 hours of receipt.
- 16.2.10 Once the CD return has been processed in the Pharmacy Department, the pink copy of the Medicines Returned to Pharmacy form will be sent back to the ward / department, along with a delivery note which will document the medicines returned to the pharmacy.
- 16.2.11 It is the responsibility of the Assigned Nurse / Midwife in Charge to ensure the Medicines Returned to Pharmacy form, delivery note and the entry in the ward CD register correlate. If any discrepancies are found they must be reported to the Lead Nurse / Midwife and Pharmacy Manager.
- 16.2.12 All CDs returned to the pharmacy must be checked to ensure that their quality and integrity have been maintained before they may be issued for re-use.
- 16.2.13 CDs that have been supplied via a GP prescription for use by a District Nurse or other healthcare professional in the patient's own home remain the property of the patient. The patient or their representatives should return unwanted CDs to the community pharmacy that dispensed them.
- 16.2.14 In exceptional circumstances, if a patient or patient's representative returns CDs directly to the hospital pharmacy for destruction, the CDs must not be issued for re-use by another patient. These should be documented in the Pharmacy Register for Destruction of Controlled Drugs and destroyed.
- 16.2.15 GPs and / or Community Pharmacies supplying CDs to patients must be informed by pharmacy of any CDs that are returned and destroyed in hospitals.

Continues overleaf

16.3 Destruction and disposal of Controlled Drugs belonging to the hospital pharmacy

- 16.3.1 All CDs to be destroyed must be written out of the pharmacy Controlled Drug Register and written into the Register for Destruction of Controlled Drugs, recording the CD name, form, strength, quantity being destroyed, the date of destruction and the signature of the authorised person in whose presence the CDs were destroyed.
- 16.3.2 Until they can be destroyed, obsolete, expired or unwanted CDs must be kept segregated from other stock CDs. They must be clearly identified as being for destruction to minimise the risk or errors and inadvertent supply.
- 16.3.3 Pharmacy stocks of CDs that have expired must be denatured prior to disposal, in the presence of a person authorised by the Scottish Executive Health Department.
- 16.3.4 It is good practice to use commercially available CD denaturing kits. If this is not possible or practical, however, other means of denaturing CDs should be used. Local SOPs should be followed for each different formulation type (tablets / injections / patches etc).
- 16.3.5 Once denatured, CDs must be disposed of by incineration or other safe means through a specialist contractor, according to legal requirements and current environmental standards. Local SOPs will apply. Consignment notes must be checked to ensure that the correct information has been entered prior to signing for removal of waste from the site.

17. Medication incidents

- 17.1 Medication incidents (and 'near-misses') can be clinical (e.g. administration of the wrong medicine to a patient) or non-clinical (e.g. medicine refrigerator turned off in error) in nature. When a medication incident or 'near-miss' is discovered, it should be formally reported in order to ensure that the appropriate corrective action is taken, to agree the appropriate preventative action is taken to avoid recurrence and to ensure systematic learning throughout the organisation.
- 17.2 A new single-system reporting mechanism for NHS GG&C is currently being developed. Until this reporting mechanism is in place, please continue to use existing means for reporting medication incidents and 'near-misses' (e.g. as per NHS GG&C Policy on the Management of Significant Clinical Incidents).
- 17.3 The person who discovers a medication incident or 'near-miss' must ensure the immediate remedial action is carried out, ensure the incident is reported, and inform the appropriate senior member(s) of staff in charge of the patient.
- 17.4 Any medicine may produce unwanted or unexpected adverse reactions. Any such confirmed or suspected adverse reaction to medicine (including vaccines and herbal remedies), blood products and radiographic contrast media should be reported via the UK wide 'Yellow Card' scheme (guidance on reporting can be found at www.yellowcard.gov.uk).

18. Defective medicines

- 18.1 Official notification of a defective medicine is issued as a Drug Alert from the Scottish Executive or the Medicines and Healthcare products Regulatory Agency (MHRA) or the manufacturer / supplier. Scottish Executive Drug Alerts include the required timescale for action.
- 18.2 The Pharmacy Manager must ensure that there are systems in place to check if the defective medicine has been issued for use within their site, and to facilitate withdrawal from use (in conjunction with ward / departmental staff) of any defective medicine that has been issued, within the required timescale for action.
- 18.3 If any member of staff has reason to believe that a medicine is defective, he or she must inform the Pharmacy Manager (or delegated deputy) immediately within pharmacy working hours, or contact the EDC pharmacist outwith working hours, if appropriate.
- 18.4 The person who discovers the defect must ensure that the product, container and other packaging are retained. If the defect has been discovered following reconstitution or mixing with another preparation, then the mixture, remaining unmixed constituents, and all containers and other packaging must also be retained. All retained materials must be placed in a sealed container, clearly marked "Do Not Use", and stored in the ward medicine cupboard or CD cupboard as appropriate.
- 18.5 The Pharmacy Manager must ensure that there are systems in place to investigate local reports of defective medicines, to withdraw from use other affected stock if appropriate, and to inform the Scottish Executive, via the Specialist Pharmacist in Public Health, if there are implications for the rest of the health service.
- 18.6 If a member of pharmacy staff, after receiving medicines from a supplier or returned from a ward, suspects a package has been tampered with he / she should secure the medicines in question in a sealed container, marked "Do Not Use", and inform the Pharmacy Manager (or delegated deputy) immediately. If at time of delivery a member of pharmacy staff suspects a package has been tampered with then he / she should refuse to accept it from the supplier.
- 18.7 Local SOPs for the reporting and monitoring of such defects must be followed.

Controlled Drugs : Additional Requirements

- 18.8 A pharmacist must uplift any defective CDs and return them to pharmacy as soon as possible during normal working hours and appropriate records must be made in the Ward Controlled Drugs Register.

Appendix 1

Herbal / Complementary medicines

The following principles should be applied when a patient has been using, or wishes to use, complementary medicines.

- 1.1 Complementary medicines include homeopathic, herbal, Chinese and other ethnic preparations and various 'supplements'. Aromatherapy products can also be included in this category.
- 1.2 Patients may be purchasing these preparations for use at home, whether or not they have been 'prescribed' or supplied by a 'specialist'.
- 1.3 These are not licensed medicinal products and the available preparations are not quality assured. In many cases there is little or no evidence-based information on the safety and efficacy of these products.
- 1.4 It is often difficult to know whether such preparations can safely be prescribed for, or administered to, hospital in-patients. If patients wish to continue receiving complementary medicines they usually take at home, or are found to be self-medicating with these products whilst in-patients, a risk assessment must be made considering any potential drug / disease interactions and patient-derived benefits. The local pharmacy department / Medicines Information centre should be contacted for further advice, if needed.
- 1.5 When taking a medication history, the doctor, nurse / midwife or pharmacist should prompt the patient to give information on all of the medicines being taken, whether prescribed by the GP or self-prescribed.
- 1.6 Any complementary medicines to be administered to in-patients (whether they are self-administering or not) must be prescribed on the Medicines Kardex.
- 1.7 Patients wishing to use complementary medicines in hospital should be asked to provide their own supply in its original packaging.
- 1.8 When homeopathic preparations are being used as prescribed by a qualified GP or the Homeopathic Hospital, it may be possible to obtain further supplies via pharmacy.
- 1.9 Complementary medicines should be stored in a locked cupboard, as for conventional medicines, and administered under the supervision of nursing staff in the usual manner.

Appendix 3

Methadone – Guidance for Patients on Methadone Programmes

1.1 Introduction

Patients who are receiving prescribed methadone for substance dependence in the community are generally provided with a single dose on a daily basis by their pharmacist. Consumption of the dose may be supervised by the pharmacist. Patients may be in a programme supervised by their GP or by a specialist Drug Problem Service.

If a patient on a methadone programme is admitted to hospital, it is essential that hospital / community / Drug Problem Service colleagues work together to ensure that the supply arrangements are modified appropriately during the period of the hospital stay and at discharge.

1.2 Procedure

On admission, medical, nursing or pharmacy staff should:

- Contact the usual prescriber and / or community pharmacy to confirm the dose, and to inform him / her of the admission.
- Contact the community pharmacist to cancel or suspend the supply arrangements, and to check if consumption is supervised. Check when the last dose was given.
- Remove any of the medicine that is in the patient's possession for use during the hospital stay if suitable, or destruction if not suitable.
- Methadone administration to all in-patients should be supervised.

1.3 Discharge planning

- Contact the usual prescriber in the community to inform him / her of the agreed discharge date and time, confirm the current dose and when the last dose will be administered before discharge.
- Confirm that the usual prescriber in the community will make the necessary arrangements with the community pharmacist to provide a new prescription or re-instate the suspended prescription.
- Make sure that suitable arrangements have been made to allow the patient to collect the next due dose following discharge.

1.4 On discharge

- Administer the daily dose on the ward before the patient is discharged, unless alternative arrangements have been made.
- Inform the patient of the arrangements for the next dose.
- Do not return any unused supplies that were brought in on admission, and do not provide a discharge supply unless a single dose is required until the regular arrangement in the community is put in place.

1.5 Transitional care arrangements for new mothers

Women who no longer require medical or nursing / midwifery care, and who are transferred to the transitional care area while their babies remain in hospital may have difficulties travelling to their community pharmacy to collect their methadone. The required daily dose may be dispensed from the ward under the following circumstances:

- The woman has genuine difficulty in accessing the community pharmacist.
- The arrangement lasts no longer than seven days.
- The midwife or nurse who provides the daily dose follows agreed local guidelines.

Continues overleaf

1.6 Arrangements for parents / relatives / carers in a Methadone Programme

Occasionally, parents / relatives / carers who are in a methadone programme may be resident within the hospital due to nature of the patient's condition. In most cases, their methadone supply can continue from the original supplying community pharmacy or, if the distances involved in collecting the methadone are large, from a community pharmacy close to the hospital. Only in exceptional cases should methadone belonging to parents / relatives / carers be brought in to the hospital environment for consumption / storage. Any methadone belonging to parents / relatives / carers brought in to hospital should be clearly annotated with relevant details (name, date of storage, quantity etc), recorded in the Ward Controlled Drugs Register on a page marked "Methadone – parents / relatives / carers" and locked in the controlled drug cupboard. The methadone should be issued to the parent / relative / carer on their request and in line with labelling instructions on the methadone bottle. The methadone consumption should be documented in the ward Controlled Drugs Register and the methadone consumption supervised. It is the responsibility of the parent / relative / carer to adhere to the prescribed dose – if their request for methadone exceeds the prescribed instructions on the label or their behaviour is giving cause for concern a senior member of medical staff should be contacted for advice.

Appendix 4

Desirable drugs (drugs liable to misuse)

- 1.1 A number of drugs (in addition to controlled drugs) have the potential to be misused / abused by both patients and staff. The local police authorities advise on drugs that are potentially misused within the NHS GG&C area and staff should be aware of the pattern of drug misuse within the local community. Any suspicious behaviour by staff or patients should be reported to the relevant person (e.g. patient's consultant / staff line manager). Misappropriation of any drugs by staff or patients will not be tolerated within NGS G&C.
- 1.2 Drugs potentially liable to misuse include:
- **All benzodiazepines**, including:
 - Chlordiazepoxide
 - Diazepam
 - Loprazolam
 - Lorazepam
 - Lormetazepam
 - Midazolam
 - Nitrazepam
 - Oxazepam
 - Temazepam
 - **Analgesics**
 - Codeine
 - Dihydrocodeine
 - Tramadol
 - Ketamine
 - **Hypnotics**
 - Zopiclone
 - Zolpidem
 - **Other drugs**
 - The type of drugs potentially misused by patients / staff is continually changing. Examples include corticosteroids, sildenafil and laxatives.
- 1.3 Ordering, storage and administration requirements.
Temazepam must be ordered in the Ward Controlled Drugs Order Book in all acute settings and stored in the locked CD cupboard.
Other drugs may have local restrictions on ordering and storage requirements - local SOPs must be followed, if applicable.
- 1.4 If misappropriation of any drug is suspected the guidance in section 10.6, Action in the event of a breach of security, must be followed.

Appendix 5

Procedure for dealing with unauthorised drugs or other suspicious substances found in NHS hospital premises

1. General principles

- 1.1 Many patients who misuse drugs are treated every year in hospitals, either as a direct result of drug misuse or for other reasons. In some cases, the fact that a patient misuses drugs is already known to the medical, nursing / midwifery or pharmacy staff. In others, it is not. Sometimes, a patient may be found to be in possession of suspicious powders, tablets, capsules or other substances for which he or she does not have an adequate explanation. Although the exact nature of the substance may be unclear, it could be a drug such as heroin, cocaine, LSD or amphetamines. Possession of the drug may be an offence under the Misuse of Drugs Act, 1971 and Regulations made there under.
- 1.2 When a member of staff takes possession of the substance, he or she may be placed in a vulnerable position unless it can be demonstrated that the substance was taken for the purpose of delivering it into the safe custody of a person lawfully entitled to possess it or destroy it. It is therefore important that all actions relating to the taking into safe custody or destruction of suspected substances are fully and correctly documented and witnessed and the procedures below followed. Unless large quantities of drugs are involved, the main aim is to ensure that the drugs are handled and destroyed in a safe and legal manner.
- 1.3 Where large quantities of unauthorised drugs or other substances are found on a patient's person, the police should always be informed and fully assisted in their enquiries. It is recommended that in these circumstances the local Police Station is contacted directly. They may attend the ward and initiate enquiries. In these circumstances, public interest overrides that of confidentiality.
- 1.4 Experience has shown that the discovery in the hospital setting of quantities of unauthorised drugs consistent with the patient's own personal use rarely leads to successful prosecution. Furthermore, a heavy handed response can compromise patient care and cause considerable disruption of ward routines and the waste of much time and effort. The police are well aware of this and do not wish to compromise patient care. They recognise that the delicacy of the circumstances demands a balanced and sensitive approach. Consequently, following discussions with Strathclyde Police, it is recommended that the decision to contact the police or dispose lawfully of the substance should be taken jointly by the lead nurse / midwife in conjunction with the consultant with clinical responsibility for the patient.

2. Procedure when a patient is found to be in possession of unauthorised drugs or other suspicious substances

- 2.1 The member of staff finding the substance should immediately inform the Assigned Nurse / Midwife or Manager in Charge of the ward or department.
- 2.2 The assigned nurse / midwife in charge should contact the lead nurse / midwife on the hospital site and the consultant in charge of the patient and request their attendance.
- 2.3 The person finding the suspicious substance, the lead nurse / midwife for the site and the assigned nurse / midwife or manager in charge should complete Part A of the Form for Removal and Destruction of Unauthorised Drugs or Other Suspicious Substances (sample on page 64). An entry should also be made in a separate page in the ward / department CD register, headed "Suspicious Substances".
- 2.4 Where it is agreed by the lead nurse / midwife and the patient's consultant that the quantity of the substance found is consistent with patient's own personal use, then the hospital pharmacist should be requested to remove the substance for destruction. In this case, Parts B and C of the Form for Removal and Destruction of Unauthorised Drugs or Other Suspicious Substances should be completed as indicated, by the lead nurse / midwife, consultant, pharmacist and witness. One copy of the form should be filed in the patient's medical notes and one copy retained by the Pharmacy Department. If the patient objects to this course of action, the local Police must be contacted.
- 2.5 Where either the lead nurse / midwife or the consultant in charge, or both, consider that the quantity of the substance found is greater than is consistent with the patient's own personal use the local Police must be alerted.

- 2.6 If the local Police cannot attend within 24 hours, or if circumstances require, the suspicious substance and form should be transferred to the hospital pharmacy during working hours. Part C of the Form for Removal and Destruction of Unauthorised Drugs or Other Suspicious Substances should be signed by the receiving pharmacist.
- 2.7 If the Police attend, ward staff should endeavour to cooperate fully. In some cases, the police may not need to know the identity of the patient. However, if this information is required it should be disclosed by the lead nurse / midwife or consultant. In the investigation of an alleged criminal offence, confidentiality is unlikely to be a sufficient defence in law against disclosure.
- 2.8 Each case will be treated on its own merits and it is therefore not possible to indicate the precise action the police will take. However, the patient will never be questioned or removed from the ward or department if it is considered by the consultant in charge to be inappropriate on clinical grounds.
- 2.9 Following enquiries, the Police will remove the suspicious substance either directly from the ward or from the pharmacy if it had already been transferred there. In either case, Part E of the Form for Removal and Destruction of Unauthorised Drugs or Other Suspicious Substances should be signed by the police officer and the nurse / midwife or pharmacist witnessing the transfer. One copy should be given to the police, one copy retained by the Pharmacy Department and one copy filed in the patient's medical records.

See sample form overleaf - "FORM FOR THE REMOVAL OR DESTRUCTION OF UNAUTHORISED DRUGS
OR OTHER SUSPICIOUS SUBSTANCES"

(Note: Local forms may vary in appearance but will record the same information.)

FORM FOR THE REMOVAL OR DESTRUCTION OF UNAUTHORISED DRUGS OR OTHER SUSPICIOUS SUBSTANCES

PART A Description of substance removed from patient and placed in controlled drug cupboard.

To be completed by the member of staff finding the drug and by the Ward or Departmental Manager.

Form: (eg powder, tablets, capsules) Colour: Quantity:

Removed from: Patient's initials and hospital number:

Ward/Dept: Date: Time:

Name of Finder: Signed:

Ward/Dept Manager: Title: Signed:

Witnessed by Senior Nurse Manager: Signed: Title: Time:

SAMPLE

PART B Action by Senior Nurse Manager and Consultant in charge of the patient.

We, (Senior Nurse Manager) and (Consultant in charge of the patient)

(1) are in agreement* (2) are not in agreement* that the unauthorised substances found on the person or property of the above patient are of a quantity consistent with his or her own personal use.

Action: (1) We have therefore authorised the destruction of the substances by the Pharmacy Department.*

Action: (2) We have therefore contacted the Drug Squad.*

Signed: (Nurse Manager) Date: Time:

Signed: (Consultant) Date:

*Delete both items (1) or both items (2) as appropriate.

PART C Collection and removal to Pharmacy

Sealed container received by pharmacist:

Signed: Date: Time:

PART D Confirmation of Destruction by Pharmacy

I, confirm that I have destroyed the above substances in an authorised manner.

Signed: Position: Date: Time:

Witnessed by: Signature:

PART E Collection by police (when required)

Sealed container collected by:-

Officer's name: Signed:

Witnessed by Nurse or Pharmacist Name: Signature:

Date: Time:

NB: White copy to be filled in patient's medical record Pink copy to be retained by Pharmacy Department Blue copy to be given to the Police (If appropriate)

Appendix 6

Multi-compartment medication devices

- 1.1 A multi compartment medication device is a container in which medicines can be dispensed for the day of the week and the time of day that the medicine is to be administered.
- 1.2 A multi compartment medication device may be helpful for a minority of patients with specific problems. However, they are time-consuming to fill and the risk of error is high. The following points must be considered before a patient is commenced on a multi compartment medication device:
 - There are many reasons why patients fail to comply with instructions for medicines, some intentional and some unintentional.
 - Sometimes failure to comply does not interfere appreciably with achieving the therapeutic goal.
 - Unintentional non-compliance may be due to forgetfulness, lack of knowledge or clear information, inability to read or understand the instructions or inability to use the medicine or packaging. Most of these problems can be overcome by providing support and making alternative arrangements.
- 1.3 It is essential that there is a consistent and effective method, which is clearly documented as per local policy, to assess patients to ensure that they are suitable, and would benefit from a multi-compartment medication device. Patients using multi-compartment medication devices should be reviewed regularly to check that they continue to benefit and that the multi-compartment medication device is still required.
- 1.4 At discharge, if a community pharmacist normally dispenses a patient's medicines into a multi-compartment medication device, the medicines will be dispensed into the multi-compartment medication device in the hospital pharmacy. If the patient or carer normally fills the multi-compartment medication device from packs dispensed by the community pharmacist, the medicines will be supplied in packs as for other discharge medicines.

Appendix 7

Medicines in Schedule 5 of the Prescription Only Medicines Order which can be supplied or administered by midwives without the directions of a doctor.

- 1.1 Exemption from restrictions on sale or supply (which shall be only in the course of their professional practice and in the case of ergometrine maleate only when contained in a medicinal product which is not for parenteral administration):
- Chloral hydrate
 - Ergometrine maleate
 - Pentazocine hydrochloride
 - Phytomenadione
 - Triclofos sodium
- 1.2 Exemption from restrictions on administration (which shall be only in the course of their professional practice and in the case of promazine hydrochloride, lignocaine and lignocaine hydrochloride shall be only while attending on a woman in childbirth):
- Diamorphine
 - Ergometrine maleate
 - Lignocaine
 - Lignocaine hydrochloride
 - Morphine
 - Naloxone hydrochloride
 - Oxytocins, natural and synthetic
 - Pentazocine lactate
 - Pethidine hydrochloride
 - Phytomenadione
 - Promazine hydrochloride

Glossary of terms

Accountable Officer	Officer in a health care organisation who is responsible for the safe and effective use of and management of controlled drugs. Appointment required by Controlled Drugs (Supervision and Management of Use) Regulations 2006.
Appointed Registered Nurse / Midwife or Manager in Charge	The senior nursing (or other professional) staff appointment for the ward or department (e.g. Ward Sister, Charge Nurse, Clinical Ward Manager, Lead physiotherapist etc).
Assigned Nurse / Midwife in Charge	The senior nurse or midwife on duty for the ward or department who has been identified as the Nurse or Midwife in Charge for that shift.
Audit trail	A system whereby all transactions regarding a specific medicine can be traced from the act of purchase to the point of use.
Authorised Nurse / Midwife	Any registered nurse / midwife who satisfies the criteria to enable him/her to administer medicines without supervision, i.e. First Level Registered Nurse or Second Level Nurse under the conditions outlined in Rule 18(2) of Statutory Instrument 1983 No 873. (No nurse should be expected to accept the responsibility for administering such medicines against his/her will and those who do accept the responsibility must remember the requirements of the NMC Code of Conduct.)
Authorised prescriber	A person who is authorised to undertake independent or supplementary prescribing according to current legislation. (See Department of Health website.)
Community Pharmacy	A retail pharmacy, i.e. not attached to an NHS hospital.
Controlled Drugs	Controlled Drugs (CDs) are classified in various schedules depending on their therapeutic usefulness and potential for harm. Each schedule has different requirements in relation to storage, handling, record-keeping. The classifications are set out in the current Misuse of Drugs Regulations.
Controlled Stationery	All stationery, which in the wrong hands, could be used to obtain medicines fraudulently.
Designated Nurse / Midwife	Any registered nurse / midwife who has been identified by the Appointed Nurse / Midwife in charge as competent and appropriate to perform a specific function and his/her designation as such has been communicated to and recognised by any other relevant professional.
Discrepancy	Difference between the quantity of drug that is physically present and that which is recorded as being present, e.g. quantity in the CD register or computerised stock control system differs to the actual physical amount.
EDC Pharmacist	Emergency Duty Commitment Pharmacist – a pharmacist who provides an on-call service out of regular working hours for emergencies
Immobilised (in reference to medicine trolleys)	Secured to a floor or wall, or inside a locked room.
Medicine	Medicinal products as defined in Section 130 of the Medicines Act i.e., a substance administered by mouth, applied to the body, or introduced into the body for the purpose of treating or preventing disease, diagnosing disease or ascertaining the existence, degree or extent of a physiological condition, contraception, inducing anaesthesia, or otherwise preventing or interfering with the normal operation of a physiological function.
Medicines liable to misappropriation	Those medicines whose potential for misappropriation is high. Note: This may include Family Planning products and steroids as well as the recognised drugs of abuse.

Misappropriation (of medicines)	Removal of medicines for unauthorised use, theft.
Operational Services Manager	Delegated senior member of staff with responsibility for operational issues.
Patients	Service users, clients, consumers or customers of the health services.
Patient Group Direction (PGD)	A written instruction to enable a healthcare professional to supply and/or administer a medicine to groups of patients who may not be individually identified before presentation for treatment. The majority of clinical care should be provided on an individual, patient-specific basis.
Patient Specific Direction (PSD)	A written instruction from a doctor, dentist or nurse prescriber to enable medicines to be supplied or administered to a named patient (e.g. entry in the patients notes).
Pharmacy Manager	The senior pharmacist on each hospital site with responsibility for ensuring the safe and secure handling of medicines and overall responsibility for the provision of pharmacy services.
Pharmacy Support Worker	Member of pharmacy staff who has completed SVQ level 2. They may have possession of medicine keys at ward / department level for the purposes of stock top-up. Not a pharmacy technician.
Pharmacy Technician	Member of pharmacy staff who has completed (or is in training to complete) a National Certificate in pharmaceutical Sciences and SVQ level 3. They may have possession of medicine keys at ward / department level for the purposes of stock top-up and Medicines Management duties.
Prescribe	Prescribing is the ordering of a medicine for an individual patient. In medicines legislation, certain medicines may be supplied only in accordance with a prescription by a doctor, dentist or other appropriate practitioner, and which meets the conditions specified in the Prescription Only Medicines (Human Use) Order 1997. The term has however become commonly used to describe authorising - by means of an NHS prescription - the supply of any medicine (Prescription Only Medicine, Pharmacy or General Sales List medicine) at public expense to a named patient.
Registered midwife	Any midwife who is currently registered with the NMC.
Registered nurse	Any nurse who is currently registered with the NMC.
Registered Operating Department Practitioner	Operating Department Practitioner whose name is on the register of the Health Professions Council and should be a member of the College of Operating Department Practitioners.
Registered Pharmacist	Person registered in the register of pharmacists maintained by the Royal Pharmaceutical Society of Great Britain.
Requisition (of medicines)	To make a formal, written request for a supply of a medicine for use in a ward or department. The requisition must be signed by an authorised signatory. Requisitions are usually made in stationery designed specifically for that purpose.
Ward Controlled Drugs Register	Bound book in which records are made of CDs received and administered in wards, theatres and departments.

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