Mersey Care NHS
NHS Foundation Trust

Policy Number	SSCSD010
Policy Name	Medicines Overarching Policy
Policy Type	Divisional
Accountable Director	Exec Director of Nursing
Author	Marie Buckley/Alison Butt- Joint Heads of Medicines Optimisation
Recommending Committee	South Sefton Community Services Division Transaction Workforce Work Stream
Approving Committee	Executive Committee
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This document is a valid document, however due to organisation change some references to organisations, organisational structures and roles have now been superseded. The table below provides a list of the terminology used in this document and what it has been replaced with. When reading this document please take account of the terminology changes on this front cover

Terminology used in this Document	New terminology when reading this Document
Liverpool Community Health (LCH)	Mersey Care NHS Foundation Trust

To be adopted as a South Sefton Division policy due to specific service requirements

FOR OFFICE USE ONLY (Work Stream submission check)	
This document is compliant with current best practice guidance	☒
This document is compliant with legislation required in relation to its content	☒

What change has this document undergone in the policy alignment process relating to the South Sefton Transaction?

☐ None ☐ Minor ☐ Major ☒ This is a new document

☐ This document has been reviewed and is no longer required

Does this document impact on any other policy documents?

☐ Yes , **if yes, which policies are effected?** **32T**

☐ No

Signed: **Date: 25/05/2017**

Mersey Care NHS
NHS Foundation Trust

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Liverpool Community Health NHS
NHS Trust

MEDICINES POLICY

POLICY NUMBER 89

Version Number:	6
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Name of Lead Director / Managing Director:	Medical Director
Changes / Alterations Made To Previous Version:	Updated with changes following closure of Ward 9 & 11

Contents

Medicines Policy

1. Introduction

Liverpool Community Health NHS Trust (herein referred to as LCH) is required to establish, maintain, document and audit safe and effective systems for the handling of medicines via:

- Compliance with current legislation
- Adherence to guidelines for the administration and handling of medicines issued by individual professional bodies and all related NHS documents
- Management of the risks to patients and staff arising from the use of medicines

2. Aim of the Policy

It is the responsibility of the Head of Medicines Optimisation to ensure systems are implemented so that medicines are managed safely and securely throughout LCH to meet patients' needs.

The aim of this policy is therefore to inform all health professionals and other LCH staff of the correct procedures for the safe handling, ordering, storage, transportation, administration and disposal of medicines and related preparations.

This policy only considers the processes associated with the physical handling of medicines. It is not intended to give guidance on the prescribing of medicines by doctors or other authorised prescribers. However, general advice on the prescribing of unlicensed medicines is included.

LCH staff (including self-employed and contract staff) will follow best practice when dealing with medicines and will follow all relevant NHS guidance and Medicines Act legislation.

LCH staff will adhere to the safe management of all medicines and related products, therefore minimising the risk of errors associated with medicines. This policy will act as a reference source for independent contractors, supporting compliance with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This policy is intended to be used as a resource for all LCH staff that have any involvement with the handling of medicines and related products.

3. Definitions

The Medicine Trail:
The medicine trail covers all the potential activities that are associated with a medical product, from the initiation of the patient treatment through a prescription or a patient group direction, to the administration and the disposal of any waste material.
As this is a multistage process there is a need to introduce controlled links between the relevant stages. These links must be included to ensure full consideration of all aspects of the safe use of medicines throughout the trail.

Initiation of Treatment:
A patient's treatment must be initiated through a formal process. This may be by a doctor or other authorised prescriber's prescription or may be through an approved patient group direction (see Section 11, Patient Group Directions).

Procurement /Acquisition of Medicines:
This is the process through which a medicine is acquired for use in treating a patient.

Receipt of Medicines:
Defined as the formal activities undertaken when medicines are received by an organisation from an external source or transferred from one department to another. Procedures must be in place to ensure product identity, quantity and quality.

Safe Storage of Medicines:
Medicines must be stored in a secure manner and in conditions that will not affect their potency. Procedures must be in place to ensure compliance with the manufacturer's storage recommendations and any legislation covering for example the storage of controlled drugs.

Administration or Supply of Medicines:
The activities undertaken when a medicine is administered to a patient or given to the patient for administration at a later date. Procedures must be in place to ensure the right patient is given the right medicine at the right time.

Removal/ Disposal of Surplus/Waste Medicines from Departments:
The activities associated with the removal and disposal of medicines that are no longer required or no longer suitable for their intended use.
Appropriate records should be made for a complete audit trail as outlined in each department's standard operating procedure.

Standard Operating Procedures:
Each department that deals with medicines is required to produce a standard operating procedure (SOP) for any activity undertaken throughout the medicines trail.

Patient Group Direction:
A Patient Group Direction (PGD) is a specific written instruction for the supply and administration of a named medicine to a group of patients in an identified

clinical situation. See Section 11.6 for the professional groups who can be authorised to administer or supply medicines using a PGD.

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

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

DATIX:
This is the incident reporting system used by LCH. It is important that incidents are identified and reported on Datix using access to the system via SIRS.

3.1 Classification of Medicines and Related Preparations
For the purpose of this policy, medicines are classified as follows:

Controlled Drugs:
Those which come within the Misuse of Drugs Act (1971) and subsequent regulations

Licensed Medicines:
All medicines with a valid Marketing Authorisation for use within the UK e.g. oral, external, prescription only (POM), pharmacy (P), general sales list (GSL), or controlled drugs.

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

Non-medicines, classified into the following groups:

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

The Medicines Act 1968 classifies medicines into three main categories:

Prescription Only Medicines (POM)
These are medicines, which may only be supplied or administered to a patient:

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

Pharmacy Medicines (P)
These medicines can be purchased from a registered primary care pharmacy, provided the pharmacist supervises the sale.

General Sale List Medicines (GSL)
These medicines need neither a prescription nor the supervision of a pharmacist and can be obtained from retail outlets.

3.2 Standard Operating Procedures

Each department that deals with medicines is required to produce a standard operating procedure (SOP) for any activity undertaken throughout the medicines trail. The Practitioner in Charge is responsible for writing the SOPs for their department, using the LCH approved standard template (see appendix 1)

The Practitioner in Charge is also responsible for auditing compliance with their departmental SOPs.

Further advice on the contents of SOPs can be found in the revised Duthie Report March 2005. “The Safe and Secure Handling of Medicines, A Team Approach”.

LCH SOPs may be accessed via the SIRS page.

4. Ordering of Medicines (Procurement/Acquisition of Medicines including dressings)

The LCH Medicines Distribution Service (MDS) orders, stores and supplies medicines to LCH community based clinics. All items ordered by the MDS are procured via the JAC Pharmacy Stock Control System, on official stationary or via NHS Supply chain. Emergency contingency plans must be in place to enable orders to be raised when the JAC system is inoperable. The Medicines Optimisation Service and Medicines Distribution Service work to ensure legal and ethical requirements are met in this area, and that procurement is in line with the LCH Standing Financial Instructions.

The quality of medicines is of prime importance and is supported through the Pharmacy Quality Control service and Regional / National procurement contracts, that Liverpool Community Health access.

The MDS can supply a top-up service to larger clinics across the city which involves a member of the team attending clinics to assess agreed stock levels, this includes expiry date checks and general medicines storage advice. For services or staff groups that do not receive a stock control visit, a service specific proforma has been agreed, listing the items that are normally required. These are completed by a member of the service and faxed to the Medicines Distribution Service.

Additional items (extra stocks) can be requested in writing to cover a particularly busy service period. These requests are noted and will be included in the review of stock sheets to ensure that routine stock levels are

sufficient.

If new stock items are required then the service manager must initially request this in writing.

The MDS staff member carrying out stock checks on supplies must report any discrepancies on stock checking to the service lead.

The MDS service is responsible for the top-up service for Total Wound Purchasing (TWP) across Liverpool and Sefton. TWP ensures dressings are available for Community Nurses and AHPs to enable them to provide required wound care products at the point of patient treatment. It also minimises the requirement for GPs to write FP10s for wound care products

Vaccines are ordered directly from ImmForm (www.immform.dh.gov.uk) and services need to arrange their own account with the exception of HPV vaccine which is ordered centrally for Liverpool teams. If you have queries or need advice about this service then contact ImmForm.

Individual patient items are obtained on an FP10 from the GP or Non-Medical Prescriber. These prescriptions are dispensed by a Community Pharmacist. The medicines are the property of the individual patient and cannot be used for another patient.

5. Receipt of Medicines

All medicines deliveries should be in a tamper evident container. If the seal on the container is broken this should be reported to the supplier for investigation and Datix completed.

Damaged goods should not be accepted and should be reported and returned to the supplier.

Receipt should be by an authorised person or their delegated representative.

The delivery is signed for against the Driver's log. The signatory is responsible for the following:

- Storing the delivered goods in a secure place, including taking into account refrigeration
- **I**tems for refrigeration will be clearly marked and identified by the courier and must be placed in the refrigerator **immediately** on receipt. All staff have a responsibility to ensure items requiring refrigeration are placed in a vaccine/medicine refrigerator as soon as possible and notify the relevant clinical team
- Ensuring deliveries are not left unattended in unsecured areas (e.g. clinic corridor, outside clinic room) where there is the potential for theft
- Informing the appropriate clinician of the delivery
- Checking off the received order against the delivery note, and

contacting the supplier or Medicines Distribution service promptly, if a discrepancy is found and annotating the delivery note
- Checking that expiry dates are appropriate to service use. If the expiry date is too short, contact the supplier. Expired stock must be separated for return to the supplier or discarded in the appropriate clinical waste bin and recorded as per supplier's instructions. A record of what has been returned should be retained

Medicines should be stored appropriately (see section 7). Stock rotation should take place, this ensures the stock closest to expiry is placed at the front to be used first and longer dated stock is placed at the back of the cupboard.

All documentation must be retained for the period specified below:-

Order and delivery notes	2 years (current financial year plus one)
Requisition sheets	2 years (current financial year plus one)

- The service is responsible for ensuring that Medicine Delivery Boxes are returned via the Medicines Courier Service to the Medicines Distribution Service. A replacement charge will be levied if boxes are not returned
- Under NO CIRCUMSTANCES should samples be accepted from drug representatives for use in LCH

6. Transport of Medicines

The potency and security of medicines must not be compromised during transportation. Goods will be delivered in tamper evident containers with an accompanying delivery note.

Refrigerated items are delivered via a refrigerated van.

All healthcare professionals in legal possession of a medicine have a duty of care to take all reasonable steps to maintain the security of that medicine at all times.

See separate Cold Chain Policy for Medicines (esp. vaccines) for staff involved in immunisations for details of transporting medicines that need to be maintained between 2°C and 8°C. Cool boxes and thermometers are available in each service that routinely transports vaccines to immunisation sessions.

7. Storage of Medicines and Medication Related Stationary

7.1 Safe Storage of Medicines within Departments

- The recommended temperature for storing medicines will be indicated on the container issued by the manufacturer
- Medicines that do not require storage in a refrigerator are usually stored at temperatures up to 25^{o}C. Cupboards used to store medicines must therefore not be located near radiators or hot water pipes or in areas of high humidity
- The room used to store medicines must be monitored with a room minimum/maximum thermometer that has the ability to be reset and temperatures recorded each day. When temperatures exceed 25^{o}C staff must inform their line manager immediately and complete Datix. Advice must be sought from LCH Medicines Optimisation Team 0151 295 3633, as to whether the medicines stored in the room are fit for purpose. Any advice given must be documented for audit purposes
- Medicines requiring storage in a refrigerator must be stored in a lockable fridge manufactured specifically for the storage of medicines. Medicine fridges must be monitored using a minimum/maximum thermometer that has the ability to be reset and temperatures recorded each working day to ensure temperatures are maintained between 2 and 8^{o}C. When temperatures fall outside this recommended temperature range staff must inform their line manager immediately and complete Datix as per LCH Cold Chain Policy (esp. vaccines). Advice will be provided by LCH Medicines Optimisation Team as to whether the medicines are fit for purpose. Any advice given must be documented for audit purposes. Nursing staff are reminded to follow the SOP for the Safe Storage of Vaccines
- Refrigerators and cupboards designated for the storage of medicines and pharmaceutical supplies must on no account be used for the storage of food, valuables or other items
- Cupboards designated for medicines must be lockable and the designated area ideally should not be accessible to the public. They must comply with the current British Standards BS2881 (1989) NHS
- Refrigerators and cupboards designated for the storage of medicines and pharmaceutical supplies must be kept locked and the keys kept within a designated safe place, ideally held personally by the Assigned Practitioner in Charge. The Assigned Practitioner in Charge is responsible at all times for the safekeeping of all medicines in their department
- The keys for the medicines cupboard must be kept on one key ring solely for this purpose and clearly identified
- Any breaches of security must be reported on the LCH Datix Incident Reporting form
- Staff in any supervisory position must be aware of the signs that may indicate the abuse or diversion of medicines. These include changes in an individual's behaviour, loss of stock and excessive ordering. Contact the Medicines Optimisation Team, the police and NHS Protect, as appropriate

- All medicines to be taken orally and those for external use must be stored separately in locked cupboards, reserved solely for medicinal products. It is acceptable for medicines to be taken orally and external products to be stored on separate shelves in the same cupboard
- Disinfectants and reagents must be stored separately
- No samples of medicines or dressings will be left in clinics to be used by patients
- Where premises are shared by a number of clinics, each clinic is responsible for its own stock and this stock must be stored separately
- At community bases where a number of Designated Practitioners may require access to the medicines cupboard at different times, a secure system must be agreed between the Designated Practitioners at the base. This system must be outlined in a standard operating procedure
- Stock must be rotated to ensure that the stock with the shortest expiry date is used first
- There must be no part-used pharmaceuticals, such as creams or ointments, kept in any medicines cupboards. This is because communal use of such products has resulted in outbreaks of infections such as MRSA
- It is an illegal practice to administer pharmaceuticals to any person for whom they were not prescribed

7.2 Security of Medicines Related Stationery within Departments

The security of medicines and related stationery must be audited regularly by the service lead and annually by the Medicines Optimisation Team.

The Pharmacy Supplies Order Form must be regarded as controlled stationery and kept under lock and key and only be accessible to authorised staff.

The security of prescription forms is the responsibility of the prescriber. Under no circumstances should blank prescription forms be pre signed before use. The prescription form must only be produced when needed and never left unattended.

Prescription pads must not be left on view and must be kept in a designated lockable place i.e. locked file, drawers or cupboard. A record of prescription form serial numbers must be maintained to ensure a robust audit trail.

All prescribers should follow the relevant SOP for Safe Handling of Prescription Forms for their service.

7.2.1 Lost or Stolen Prescriptions

In the event of a lost or stolen prescription, all prescribers should follow the relevant SOP for Safe Handling of Prescription Forms for their service. Incidents involving the loss, theft or misuse of prescription forms must be

reported immediately to the Head of Medicines Optimisation on 0151 295 3633. Datix should be completed.

Outside office hours the police should be contacted directly on 0151 777 5856 or the main police switchboard on 0151 709 6010.

All details of the incident or theft should be recorded on the Missing/Lost/Stolen NHS Prescription Form(s) Notification Form (see Appendix 2) so that the theft can be reported externally to NHS Protect. Any investigation undertaken by the Local Security Management Specialist (LSMS) or Local Counter Fraud Specialist (LCFS) is in accordance with relevant legislation and will not hinder or affect any subsequent police investigation.

The Head of Medicines Optimisation will liaise with the police, the LSMS and the LCFS and report the incident to Central Operations Mersey, who will alert all pharmacies and the Prescription Pricing Division, providing as much information about serial numbers as possible.

The prescriber will be advised to write all prescriptions in a particular colour, **usually red, for a period of two months.**

7.3 Medical Gases

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

- The number of cylinders held as stock in any department should be as small as possible
- Cylinders must be firmly secured at all times to prevent them falling over
- They should be stored under cover, preferably inside and not subjected to extremes of heat
- Storage room or section should be clearly identified as a storage area for medical gases
- Naked lights must not be allowed within the immediate vicinity of a cylinder
- No oil or grease should be applied to the cylinder or tap connector, therefore ensure hands are clean before handling cylinders. In particular ensure hands are adequately dried after the use of alcohol gel
- Segregate full and empty cylinders and separate the different gases within the store
- Have warning notices posted prohibiting smoking and naked lights within the vicinity of the store
- Allow for a strict rotation of full cylinders to enable the cylinders with the oldest filling date to be used first
- The storage should be designed to prevent unauthorised access and to protect cylinders from theft
- Excessive force or any tools must not be used to open or close a cylinder valve

- Cylinders with damaged valves and defective equipment must be labelled appropriately and withdrawn from use
- Allow for Entonox cylinders to be stored at above 10^0C for 24 hours before use. Where this is not feasible it is important to consult the Entonox Medical Gas Data Sheet for further information
- Notify the emergency services of the location and contents of the medical gas cylinder store. Contact suppliers for more specialist advice where necessary

7.4 Flammable Liquids

Flammable liquids are labelled "flammable". COSHH data sheets must be available for all flammable liquids kept on the premises. The data sheets must be kept in a central point available to all staff.

To reduce the risk of combustion or explosion:

- Keep stock levels to a minimum
- Avoid spillage
- Keep bottle closed. Replace the screw cap immediately after use
- Keep well away from naked flame or electrical apparatus
- Do not store in a refrigerator
- Store all flammable liquids in a locked metal flammable cupboard that displays an appropriate hazard notice

7.4.1 Alcohol Gel

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

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

8. Prescribing and Dispensing of Medicines

8.1. Prescribing Responsibilities

Medicines will only be prescribed by suitably trained and qualified healthcare professionals e.g. medical practitioner or authorised non-medical prescriber, according to the terms of their qualification e.g. within a limited formulary, and acting within their skills, knowledge and competence.

Prescribers must also ensure there is an allocated budget prior to initiating any prescribing.

8.2 Verbal orders

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

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9. Administration of Medicines

9.1 Consent

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

For consent to be valid it must be given voluntarily by an appropriately informed person including a person having Power of Attorney for Health.

No-one can give consent on behalf of an adult lacking capacity; however such patients can be treated if the treatment would be in their best interest.

9.2 Principles of Safe Administration of Medicines

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

- Be certain of the identity of the patient to whom the medicine is to be administered
- Ascertain that the prescribed dose has not already been given
- Know the therapeutic uses of the medicine to be administered, the dosage, side effects, precautions and contra-indications
- Where it is appropriate for a care plan to be in place, know the current contents of the patient's care plan
- Check that the prescription, patient group direction or the label on a medicine dispensed by a pharmacist, is clearly written and unambiguous with clear information on:
    - The name of medication
    - The dosage
    - The name of the patient for whom the medicine is prescribed (In the case of PGDs the name of the patient will not be documented on the actual PGD)
    - Frequency of administration
    - Route of administration
    - In the case of PGDs ensure that all conditions are fully met (It is therefore essential that practitioners have a copy of the relevant PGD with them during administration or supply and they refer directly to it)
    - Have considered the dosage, method of administration, route and timing of the administration in the context of the patient and co-existing therapies
    - Check the expiry date of the medication to be administered
- Check that the patient is not allergic to the medication before administering it
- Administer or withhold in the context of the patient's condition (e.g. digoxin is not usually given to patients if their pulse is below 60)
- Contact the doctor or another authorised prescriber without delay where contra- indications to the prescribed medication are discovered, where the patient develops a reaction to the medication, or where assessment of the patient indicates that the medication is no longer suitable
- Make a clear, accurate and immediate record of all medicines administered, intentionally withheld or refused by the patient, ensuring that

any written entries including the signature are clear and legible together with the date of administration
- Where medication is not given the reason for not doing so must be recorded
- When supervising a student nurse in the administration of medicines, clearly countersign the signature of the student
- Certain medicines such as cytotoxic or warfarin, require special consideration. In the event of NHS Provider Services being requested to administer these medications, departmental SOPs must be followed
- When using syringes there is a risk of “wrong route” errors if the correct syringe is not used. When administering oral or enteral doses ensure that an appropriate purple coloured oral/ enteral syringe is used
- When administering insulin ensure that an insulin syringe or commercial insulin pen is used. This is essential, because the use of intravenous syringes to administer insulin has led to incidences of overdose
- When administering medication via the intravenous route, two appropriately trained staff members are required to check the medication to be administered (one of whom must be a registered nurse who then administers the intravenous medication)
- To reduce the risks of missed medications, a team management system should be in place, for example Community Nursing have an approved system of maintaining a team diary for safe work allocation

9.3 Incident Reporting in the Event of a Medication Administration Error
The majority of medication is prescribed, dispensed and administered safely. It is widely acknowledged that errors or near misses may occur. To build a safer NHS for patients all healthcare organisations are encouraged to develop a culture of openness. Reporting medication errors is essential if underlying problems are to be addressed.

Errors and near misses can be due to many factors, which can include:-

- Poor communication within the clinical team
- Lack of supervision
- Insufficient training
- System failures
- Poor record keeping

A failure to report an incident prevents the rest of the NHS from learning and developing.

When an error occurs the following steps must be taken:

- Make sure the patient is safe and if necessary call emergency services or the Medical Practitioner as dictated by clinical need
- Record any advice given, ensuring suggested monitoring arrangements are followed and documented
- Ensure any evidence relating to the error is retained and not tampered with. (Evidence will include any relevant documentation, the remaining

medication administered and any packaging or administration equipment)
- Inform line manager immediately who will refer to the Policy for the Management of Incidents
- Inform the General Practitioner or other Medical Practitioner with clinical responsibility.
- Complete an online Datix reporting form
- In certain circumstances, at the weekend or out of hours, the line manager may need to inform the manager on call if there are critical implications
- If a medication error has occurred within a patient's home, the healthcare professional who has discovered the error must also ensure that systems are in place to monitor the patient's condition appropriately over the following 24 hours. The GP should be informed at the earliest opportunity and an action plan drafted that defines what service will be responsible for monitoring the patient and keeping other key healthcare professionals updated.

In cases where there has been a 'near miss', it is important to report on Datix as an incident as the systems for administering medications may need to be altered. This system is a proactive way of preventing the incident from actually occurring.

10. Disposal of Pharmaceutical Waste

Pharmaceutical Waste can be divided into three broad groups:

- Pharmaceutical Hazardous (cytotoxic and cytostatic)
- Pharmaceutical Non-Hazardous (non-cytotoxic and non-cytostatic)
- Not pharmaceutically active and possessing no hazardous properties e.g. sodium chloride or glucose solutions

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

Pharmaceutical hazardous waste used or unused must be disposed of in clearly labelled purple-lidded waste containers for incineration. Bins must not be overfilled.

Pharmaceutical non-hazardous waste:
- Used sharps containers e.g. empty glass ampoules, used pre-filled syringes, needles, lancets must be disposed of in clearly labelled yellow-lidded yellow waste containers for incineration
- Unused/expired sharps containers and other forms of medication e.g. tablets, capsules, creams, ointments, syringes, must be disposed of in clearly labelled blue- lidded yellow waste containers for incineration

In both cases ensuring bins are not overfilled.

Patient's medication remains the property of the patient. Carers should be

encouraged to return any unused medication to their community pharmacy. Community pharmacies may operate a pick up as well as a delivery service for housebound patients. Medication must not be returned to clinics, bases, GP surgeries or to Doctors Bags.

Controlled drugs must be managed in accordance with the Policy for the Management of Controlled Drugs (policy number 38) and all service specific SOP.

Out of date stock for bed based services must be recorded in the out of date log and kept in a separate cupboard before return. The date of return should be recorded in the log. For clinics that operate outside of normal working hours the team leader or designated deputy should complete all appropriate documentation and the sealed container may be passed to a suitable member of clinic staff. The container must be stored in a secure place until it is collected.

Ward Stocks of obsolete expired or unwanted controlled drugs **must not** under any circumstances be returned. The Medicines Optimisation Team is to be contacted to arrange disposal for Ward 35. Liverpool Heart & Chest Hospital Pharmacy should be contacted for all other wards.

11. Patient Group Directions (PGDs)

11.1 Definition

A PGD provides a legal framework that allows specified registered healthcare professionals to supply and or administer specific medicines to a pre-defined group of patients, without them seeing a prescriber.

The majority of clinical care should be provided on an individual, patient specific basis. The supply and administration of medicines under PGD must therefore be reserved for those limited situations where they offer advantages for patient care without compromising patient safety.

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

11.2 Legal Framework for PGDs

Legislation establishing PGDs was introduced in 2000 and the Health Service Circular (HSC 2000/ 026) provided additional guidance. The current legislation for PGDs is included in The Human Medicines Regulations 2012.

Healthcare organisations need to ensure that any current or new patient group directions comply with legal requirements and the guidance set out in the above circular. Failure to comply with the legal requirements could result in a criminal prosecution under the Medicines Act.

11.3 PGD sub-group

This is a sub-group of the Medicines Optimisation Group. The role of the group is to:

- Agree the need for PGDs with service leads against set criteria
- Monitor and develop all PGDs within LCH
- Support services with the development of PGDs in line with a specific template
- Make recommendations to the authorised signatories in regard to the content of PGDs
- Monitor the auditing of PGDs by services

11.4 Developing a PGD

- Areas of practice suitable for a PGD will be identified within services as part of their review of practice and strategic service development
- Many of these initial ideas will come from the clinical networks. Service Leads within a service need to approve the proposal for a PGD
- There must be an identified budget to meet the drug costs of new PGDs
- The proposal for a PGD will be forwarded to the PGD Sub-Group
- The sub group will review the appropriateness of a PGD, identify persons to be involved in developing the PGD and follow it through with the service, providing advice on content, links to expert opinion and available documentation
- The PGD will be written within the service with the support outlined above
- The PGD Sub Group will finalise and authorise the PGD
- A new PGD should be reviewed after 1 year. Thereafter the review of a PGD can be up to 3 yearly
- Health records must be consistent with current DoH guidance and Policy

11.5 Information to be included in a Patient Group Direction

Legislation requires that each PGD must contain the following information:

- The period during which the direction is to have effect
- The description or class of medicinal product to which the direction relates
- The clinical situations which medicinal products of that description or class may be used to treat or manage in any form
- Whether there are any restrictions on the quantity of medicinal product that may be sold or supplied on any one occasion and, if so, what restrictions
- The clinical criteria under which a person is to be eligible for treatment
- Whether any class of person is excluded from treatment under the direction and, if so, what class of person
- Whether there are circumstances in which further advice should be sought from a doctor or dentist and, if so, what circumstances

- The pharmaceutical form or forms in which medicinal products of that description or class are to be administered
- The strength, or maximum strength, at which medicinal products of that description or class are to be administered
- The applicable dosage or maximum dosage
- The route of administration
- The frequency of administration
- Any minimum or maximum period of administration applicable to medicinal products of that description or class
- Whether there are any relevant warnings to note and, if so, what warnings
- Whether there is any follow up action to be taken in any circumstances and, if so, what action and in what circumstances
- Arrangements for referral for medical advice
- Details of the records to be kept of the supply, or the administration, of products under the direction

11.6 Medicines and healthcare products excluded from PGDs

Legislation requires that the following must not be included in a PGD:

- Controlled drugs
- Unlicensed medicines, including:
    - The mixing of 2 licensed medicines to form 1 new (unlicensed) product, unless 1 is a vehicle for administration, such as water for injection
    - Special manufactured medicines
- Dressings, appliances and devices
- Radiopharmaceuticals
- Abortifacients, such as mifepristone

Licensed products may exceptionally be able to be used in a PGD for indications for which they are not licensed. This is “off-license” use.

11.7 Health professionals eligible to use Patient Group Directions

Legislation requires that PGDs may only be used by the following registered health professionals:

- Chiropodists and podiatrists
- Dental hygienists
- Dental therapists
- Dietitians
- Midwives
- Nurses
- Occupational therapists
- Optometrists
- Orthoptists
- Orthotists and prosthetists
- Paramedics
- Pharmacists

- Physiotherapists
- Radiographers
- Speech and language therapists.

Individual health care professionals must be named and authorised to practice under a PGD, and must have completed the on-line CPPE training via ESR e-learning.

11.8 Authorising Signatures for a PGD

The Patient Group Directions must be signed by:

- The authorising person on behalf of the Trust or their nominated deputy
- Lead Pharmacist or nominated deputy
- A doctor or dentist as appropriate
- Lead Clinician or nominated deputy from the profession using the PGD

The individual qualified practitioners who are to follow the PGDs must be designated in the PGD and sign it to agree to comply with the PGD, a copy of this must be kept on file.

11.9 Supply and Administration issues relating to PGDs

Medicines for use on a PGD must be obtained from the Liverpool Community Health Medicines Distribution Service with the exclusion of some childhood immunisation vaccines which can be ordered directly from the Department of Health Immform website.

The medicines will be supplied ready labeled with dosage directions for use by the patient, and will include a patient information leaflet. Any patient specific sections on the medication supply must be completed before issuing to the patient.

Each service must have systems in place, which can be audited, to reconcile stock received against stock issues to patients.

Staff should counsel patients on their medication and check that there are no interactions with existing medication (as outlined in the relevant sections in the PGD).

11.10 Antibiotics

Particular caution must be exercised in any decision to draw up Patient Group Directions relating to antibiotics. A PGD should only be written for antibiotics that are included in the Joint Primary Care Antibiotic Guidelines. The PGD Working Group will review if the PGD is in line with local strategy around antibiotic prescribing for the particular condition.

Inappropriate use of broad spectrum antibiotics and repeated courses, contributes to the current infection control issues relating to Clostridium Difficile infections within local healthcare. Services using antibiotic PGDs must carry out audit of prescribing against the PGD to ensure they are being

used appropriately.

12. Unlicensed Medicines

An unlicensed medicine is the term used to refer to a medicine that does not have a Valid Marketing Authorisation for use in the UK.

If an unlicensed medicine is administered to a patient, the liability rests with the prescriber rather than the manufacturer.

Unlicensed medicinal products are only to be used when no pharmaceutically equivalent licensed product or suitable alternative licensed product is available for use at the time the patient requires it.

Complementary and alternative medicines, such as homeopathy and herbal medicines without a valid Marketing Authority for use in the UK are also classified as unlicensed medicines.

12.1 Responsibilities of Prescribers

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

Following amendments to the Medicines for Human Use Regulations 2009, independent nurse or pharmacist non-medical prescribers are now permitted to prescribe unlicensed medicines. However, non-medical prescribers should only prescribe unlicensed medicines in justifiable exceptional and approved circumstances for example, justified by current best practice (e.g. national NHS guidance).

Patients must be informed that a medicine is unlicensed prior to prescribing and an entry documenting this made in the medical notes.

12.2 Responsibility of Medicine Distribution Service

The manager of the Medicines Distribution Service (MDS) is responsible for ensuring that the manufacturer holds the appropriate licence to manufacture and that the product complies with the product specification.

12.3 LCH Staff Involved in Administering Unlicensed Medicines

It is the responsibility of each individual registered nurse to satisfy themselves that the medicine may be administered safely and wherever possible, that there is acceptable evidence for the intended use of the unlicensed medicine.

If a medicinal product is unlicensed, it should only be administered with the patient's informed consent against a patient specific direction but NOT against a patient group direction.

12.4 "Off –Label" Medicines

Medication which is licensed but outside its licensed indications i.e. "off-label", may be in exceptional circumstances administered under a patient group direction, if such use is clearly described and justified by current best practice (e.g. national NHS guidance).

The Summary of Product Characteristics (SPC) as granted by the Marketing Authorisation for each medicine licensed for use within the UK lists:

- Indications
- Dose ranges
- Methods of administration
- Age restrictions

Any use not in accordance with the SPC is considered "off-label", or an unlicensed use.

This policy also applies to products used outside their Marketing Authorisation as "off label use".

13. Training and Medicines Information

The British National Formulary is the main source of reference for medicines. It describes the preparations likely to be prescribed and summarises the relevant legislation regarding prescriptions and controlled drugs. All health professionals involved in the administration of medications are responsible for familiarising themselves with the formulary. The Nurse Prescribers Formulary (incorporated in the British National Formulary) provides information of special relevance to Nurse Prescribers.

A copy of the British National Formulary (BNF), within 12 months of date of issue will be available in each department. The most current version of the BNF is available on the internet.
https://www.medicinescomplete.com/mc/

The expert on all aspects of medicines and medicines related legislation is the pharmacist who should be consulted whenever necessary. The LCH Medicines Optimisation Team can be contacted on **0151 295 3633**.

All staff are encouraged to identify their Continuing Professional Development (CPD) needs regarding their own competency level in the safe use of medicines according to the needs of their role.

Staff and managers have joint responsibility to highlight training needs in regard to the safe storage and administration of medicines and highlight these

needs in annual appraisals and management supervision as required.

All staff must adhere to LCH policies. Health Care Professionals are also accountable to their own Professional Bodies to promote safe practice for patients and for their own Continuing Professional Development.

Staff are responsible for reading and acting within the Safe Handling and Administration of Medicines Policy and for any departmental SOPs regarding medicines.

14. LCH Intermediate Care Bed Based Ward

Ward 35 is run by LCH staff and is subject to all LCH policies, procedures and SOPs. Ward 35 is based on Aintree University Trust site.

A comprehensive pharmaceutical service is supplied by Liverpool Heart and Chest Hospital Pharmacy to ward 35. The standard level agreement comprises of:

- **Dispensary services:** Providing dispensed medication for inpatients & discharges. Out-of-hours emergency dispensing via the On-Call Pharmacist service

- **Stock supply service**: Weekly stock level assessment, supply and management service to maintain appropriate working stocks in clinical areas. Out-of-hours emergency stock supplies via the On-Call Pharmacist service

- **Clinical Pharmacy service:** Monday-Friday visits from a Pharmacist/Technician to deliver a combination of services including patient specific and general pharmaceutical information & advice. There are arrangements for the provision of weekend and out-of-hours emergency Medicines Information and urgent medication supplies via the On-Call Pharmacist service

- **Pharmaceutical Purchasing service:** Sourcing and obtaining required pharmaceutical products of appropriate quality at the best available price, taking into account prevailing NHS pharmaceutical purchasing contracts and availability

- **Formulary & Medicines Optimisation service**: Providing, in conjunction with Clinical Pharmacy and Pharmacy Purchasing staff, treatment cost/ benefit analyses and recommendations regarding medicines of choice for clinical indications, based on the best available evidence relating to the efficacy, safety and economy of medicines

- **Pharmaceutical Waste disposal mechanism**: Ward 35 have a contract with an outside disposal company

- **Invoices for drugs:** These will be issued by the service provider to LCH on a monthly basis and will be subject to the NHS Better Payment Guidelines for payment

14.1 Admissions

- **From Secondary care:** Patients admitted to the intermediate care bed based ward should arrive with a minimum of seven days of medication and a copy of the discharge prescription. If the patient is not in possession of at least 7 days' supply of medicines and a copy of the discharge prescription, then the ward that has transferred the patient must be contacted and issues rectified prior to admission
- **From a Community setting:** Patients admitted from the community to the intermediate care bed based ward should have a current list and supply of their medicines. If the list of medication is not supplied, contact the GP practice or care home and request an up to date list of the patient's medication dated within the last month. If medication is not brought in at the point of admission, request that the carer or relative bring in medication at the earliest opportunity

14.2 Medicines Reconciliation

There are risks to patients at numerous points in their journey through Health Care Services. One of these areas identified is when patients are transferred from one care setting to another. Effective medicine reconciliation reduces the risk of medication errors and the harm they can cause. Medicines reconciliation is a process designed to ensure that all medication a patient is currently taking is correctly documented on admission and at each transfer of care.

Medicines reconciliation, as defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognizing any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The term 'medicines' also includes over-the-counter or complementary medicines, and any discrepancies should be resolved.

There is a standard operating procedure for the process of Medicines Reconciliation on admission to the Bed Based Ward. This SOP applies to all staff involved in the admission of patients onto the LCH bed based ward, including those working as part of a service level agreement with LCH.
The SOP ensures:

- The responsibilities of staff involved in medicine reconciliation are clearly defined
- Standardize systems/processes are in place for collecting and documenting information about current medicines
- Pharmacists are involved in medicine reconciliation as soon as possible after admission. (within 24 hours is considered a reasonable target)

Although ideally all patients should have their medicines reconciled within 24 hours of admission, it is acknowledged that this is not possible at weekends/

bank holidays as currently the OOH pharmacy service does not include medicine reconciliation.

Please refer to the link below for service specific Standard Operating Procedure:

http://opera.liverpoolch.nhs.uk/SIRS/Policies-and-Procedures/Standard%20Operating%20Procedures/The%20process%20of%20medicine%20reconciliation%20on%20admission%20to%20a%20Bed%20based%20Ward.pdf

14.3 Patients Own Drugs (PODs)

Once a medicinal product has been prescribed and dispensed to an individual, the drug is the individuals own property. These medicinal products including controlled drugs remain the patient's property and must not be removed from the patient without their permission and must only be used for that named individual. (*NMC Standards for Medicines Optimisation April 2010).*

Patients will be advised to bring their own medicines onto the ward when they are admitted. This is to provide information regarding the patients' usual treatment regime and to enable accurate medicines reconciliation to be completed on admission. Patients must consent to use of their medicines on admission. PODs must be assessed for suitability of use prior to administration.

Please refer to the link below for service specific Standard Operating Procedure:

http://opera.liverpoolch.nhs.uk/SIRS/Policies-and-Procedures/Standard%20Operating%20Procedures/Process%20for%20the%20use%20of%20patients%20own%20medicines%20during%20admission%20to%20a%20bed%20based%20ward.pdf

14.4 Medicine Storage

- **Stock medicines: O**utlined in 7.1
- **Patient labeled medicines:** Medicines must be stored in the assigned lockable drawer within the drugs trolley or if a fridge line then in the locked medicine fridge. When not in use the medicine trolley must chained and tethered to the wall
- **Medicines for Disposal:** Medicines no longer required should be kept in an official receptacle, which is locked or in a locked cupboard

14.5 Controlled Drugs

Please refer to separate Policy for the Management of Controlled Drugs and service specific Standard Operating Procedures.

The Standard operating procedures outline the agreed process for:

- Prescribing
- Ordering
- Transportation

- Receipt
- Administration
- Storage
- Recording
- Disposal

Also outlines individual responsibilities and accountability for these processes on Intermediate care bed based wards.

14.6 Self-Administration Scheme

Liverpool Community Health (LCH) supports patients to administer their own medicines whilst an in-patient on intermediate care bed based ward. When a patient is admitted, the assumption should be made that he or she can self-administer, unless the self-administering assessment indicates otherwise. This policy applies to all patients.

Self-administration is an essential procedure to assist patients towards becoming self-sufficient in taking their medicines, prior to discharge from an inpatient area. It is also a key requirement of the Care Quality Commission regulations around medicines.

Patients' assessments will assess suitability at one of 3 different levels:

- level 1 patients are unsuitable to self-administer
- level 2 patients are able to self-administer with supervision
- level 3 patients are able to fully self-administer without supervision

Please see separate self-administration policy for Intermediate Care Bed Based wards.

http://opera.liverpoolch.nhs.uk/SIRS/Policies-and-Procedures/Clinical%20Policies/Self%20Administration%20Policy.pdf

15. Adverse Drug Reaction Reporting and Yellow Card Scheme

The Yellow Card Scheme for spontaneous reporting of suspected adverse drug reactions (ADRs) was introduced in 1964 after the thalidomide tragedy highlighted the urgent need for routine monitoring of medicines. Adverse Drug Reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) by completing a yellow card.

15.1 Who Can Report?

Reporting using the yellow card scheme is available to healthcare professionals such as doctors, nurses and pharmacists, coroners plus patients and their carers.

15.2 What Should be Reported?

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

For intensively monitored medicines (identified by ▼) report **all** suspected reactions.

For established drugs and herbal remedies report all suspected **serious** adverse reactions in adults; report **all** suspected reactions in children under 18.

Serious reactions include those that are:

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

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

Although all adverse reactions with medicines are monitored there are a number of areas of particular interest, as listed below:

- Children
- The elderly
- Delayed drug effects
- Congenital abnormalities
- Herbal remedies – it is important to monitor all herbal products to ensure their safety. It would be helpful to report the ingredients, source or supplier

15.3 Where to find a Yellow Card
A paper version of the Yellow Card is included in:

- British National Formulary
- Nurse Prescriber Formulary
- Monthly Index of Medical Specialities (MIMS)
- Electronic versions can be completed on MHRA web site https://yellowcard.mhra.gov.uk/
- Yellow Card App can be downloaded on to Smart phones/devices

15.4 Patient Details
The following patient details should be included on the yellow card:

- Patient's initials
- Age
- Sex
- Weight if known
- Local identification number

The patient's initials and a local identification number will help identify the patient in any future correspondence. Do not identify the patient by date of birth or name of patient to ensure confidentiality agreements between the health care professional and the patient are not breached.

15.5 Recording the Yellow card

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

All suspected ADRs must also be recorded on Datix.

16. Medicine Alerts

16.1 Medicines and Healthcare Products Regulation Drug Alerts

Medicines and Healthcare Products Regulatory Agency (MHRA) Drug Alerts are cascaded directly to Community Pharmacists throughout Liverpool.

Community Pharmacists are responsible for ensuring that the advised action is taken which may necessitate the removal of the affected pharmaceuticals from pharmacy stock.

All MHRA Drug Alerts can be found on the MHRA website https://www.gov.uk/government/organisations/medicines-and-healthcare- products-regulatory-agency

Any drug alerts/recalls and what action to be taken will be cascaded to LCH staff if needed in accordance with the Central Alerting System (CAS) Alert Policy.

16.2 National Patient Safety Agency Alerts and Rapid Response Reports

LCH responds to National Patient Safety Agency (NPSA) alerts and rapid response reports involving medication and treatments provided by the Trust.

Action plans to monitor compliance are produced by liaising with relevant services.

17 Incident Reporting

17.1 Medication Errors

Medication errors can include:

- Incorrect administration
- Wrong time
- Wrong medication
- Wrong patient
- Wrong dose

- Missed medication
- Duplication of medication
- Incorrect dispensing
- Incorrect prescribing

The majority of medication is prescribed, dispensed and administered safely. However, it is widely acknowledged that errors and near misses will occur. To build a safer NHS for patients all Trusts are encouraged to develop a culture of openness to enable them to become learning organisations.

Reporting drug errors and near misses is essential if underlying problems are to be addressed and removed before they do harm to patients. A failure to report an incident prevents the rest of the NHS learning from mistakes.

Errors and Near misses can be due to many factors, which can include:

- Poor communication within the clinical team
- Lack of supervision
- System failures
- Poor record keeping

Effective incident reporting allows organisations to:

- Investigate a problem
- Put it right
- Learn from what went wrong
- Reduce the risk of it happening again

Once an error has been discovered then it must be reported initially to the practitioner in charge or healthcare manager and then in accordance with the procedure outlined below.

17.2 Management of an error or near miss

- If there is any possibility of patient harm it must be ensured that the patient is safe, and if necessary emergency services contacted
- If a medication error has occurred within a patient's home, even if LCH staff have not been involved in administration, the healthcare professional who discovered the error must also ensure that systems are in place to ensure the patient's condition is appropriately monitored over the following 24 hours
- Ensure any evidence relating to the error is retained and not tampered with. Evidence will include any relevant documentation, the remaining medication and any packaging
- Inform Line Manager or Practitioner in Charge immediately and following the Incident Reporting process
- Inform the senior clinician who will arrange for the relevant people to be informed of the error (e.g. patient, medical staff etc.)
- All errors or "near misses" should be reported online via the LCH Incident

Reporting System (Datix). Any serious errors or "near misses" are also reported to the National Patient Safety Agency (NPSA), promoting nationwide patient safety through reduction of risk, by the Clinical Governance Team

- A 'near miss' is as important to report as an incident, as the systems for managing medications may need to be altered. This system is a pro-active way of preventing the incident from recurring
- If another person administered in error, the Incident must still be reported. Any additional staff involved must also provide any information relating to the incident
- When reporting it is important that only fact and not opinion is recorded. It is then up to the Incident Manager to investigate and put actions/processes in place to prevent a recurrence of the incident

WHEN AN ERROR OCCURS THE FOLLOWING STEPS MUST BE TAKEN IN LINE WITH THE TRUST's Incident Reporting Policy

http://opera.liverpoolch.nhs.uk/SIRS/Policies-and-Procedures/Corporate%20Policies/Incident%20Reporting%20Policy.pdf

17.3 Investigation of medication related incidents

The service lead/manager is responsible for the investigation. The incident should be discussed with those involved and further information obtained to understand potential causes.

Medicines Optimisation staff are available to provide advice on medication related incidents.

A plan for any immediate and future preventative actions should be implemented. Lessons learnt should be communicated to the team, disseminated through clinical governance networks and fed into the patient safety group.

How the Organisation supports learning from medication incidents is detailed below.

17.4 Organisational structure to support learning from medication related incidents

There is clear Governance reporting structure in place to report issues and identify action plans and sharing of information

17.5 Datix/ CAS Alert System

- Communicates information to service leads/designated staff relevant CAS alerts
- All Staff have a duty to input medication related incidents onto Datix
- Incidents are reviewed by the service lead
- Medication Incidents are reviewed by Medicines Optimisation Team and

advice given where appropriate
- An automated process is operational to alert staff to the fact that the incident that they have reported has been reviewed and actioned. Staff can then request details of the actions from their line manager

17.6 Committee Structures to deal with Incidents

17.6.1 Weekly Harm Free meetings

Each locality will hold their own Weekly Harm Free meeting.

From the Weekly Harm Free meeting themes are identified and plans developed to address these; for example changing processes and setting up education sessions.

17.6.2 The Patient Safety Sub-Committee (sub-committee of the Quality Committee)

Purpose

The Patient Safety Sub-Committee supports the development and implementation of a patient safety culture which will be measured by; improving the level of reporting of adverse incidents, near misses and supports the creation of a well organised safety culture within LCH. The aim is to provide assurance of delivery of safe, reliable care.

The group works to create a robust safety culture whilst building and strengthening leadership within the organisation to improve patient safety.

This sub-committee will receive reports from the membership and cascade lessons learned.

Membership

Representatives from all divisions: governance, safeguarding, Datix manager and Medicines Optimisation.

Role

- To put in place safety, measurement and monitoring approaches which facilitate a whole system understanding of patient safety within the Organisation
- Embed system, culture and processes that facilitate learning from near misses or harm that has occurred with the aim of minimising the risk of the same harm occurring in the future
- Put in place systems that facilitate real time monitoring of safety on a weekly basis
- Identify and share best practice and input into the development of a safety culture
- Put in place systems and processes to will monitor the reliability of safety interventions implemented
- Be responsible for and act as an overview and scrutiny panel for SUI investigation reports and subsequent recommendations and

action plans
- Develop strategies which support and enable patients to intervene directly to promote patient safety
- Ensure that patients are provided with education to support their own safety

17.7 The Medicines Safety Group

Role in response to medication incidents
The Group meets bi-monthly and membership includes a medical director, nurse lead, service leads, non-medical prescribing lead and Medicines Optimisation.

Within the terms of reference for this group it states:

- To monitor medicines related incidents and review lessons learned to inform changes to practice, governance, policy and training
- To provide assurance that medicines safety alerts and recommendations are communicated to staff and to receive assurance from service leads that recommendations are implemented

A key issues report is a standing item on the agenda of this group. Safety alerts, key themes emerging from incidents and actions are discussed together with communication of lessons learnt.

17.8 Medicines Optimisation Monitoring of Datix

Medicines Safety Support Manager reviews all Datix incidents relating to medicines as they come through daily. Advice is given to the manager where appropriate. Incidents are escalated to members of the Medicines Optimisation Team dependent on the incident. Members of the Medicines Optimisation Team have responsibility for advising and monitoring controlled drug, care home, intermediate care, cold chain and anticoagulant incidents.

17.9 Services through Service Leads

- Each team/service should hold its own governance meeting
- Receive CAS alerts where appropriate
- Receive MM advice regarding incidents through Datix
- Will receive the Lessons Learned bulletin from Clinical Governance. This will support the sharing of key safety and quality lessons and information
- Feedback from the weekly meeting of harm
- Feedback from the patient safety group
- Prescribing Times bulletin
- LCH Weekly staff bulletin

17.10 Individual staff

- Service governance meeting
- Staff should keep up to date with mandatory training, and highlight gaps in their knowledge and learning at their appraisal so that their PDRs can be drafted accordingly
- Staff should read any CAS alerts that are circulated
- Staff should seek feedback on any incidents they raise through their line manager
- Some services have their own bulletin
- Will receive the Lessons Learned bulletin from Clinical Governance. This will support the sharing of key safety and quality lessons and information. Feedback from the weekly meeting of harm for incidents that they have been involved in or reported
- Feedback from the patient safety group through the service lead

17.11 Clinical audit

The whole process is under-pinned by Clinical Audit. The governance team support CQC audit, collection of data and action plans.

The Medicines Optimisation team is working with service leads and the executive team to identify priority areas for audit within the organisation.

Action plans generated from the audit process must be implemented and embedded into good practice. Service leads have the responsibility for implementation.

18. Roles and Duties

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

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

Practitioner in Charge
This is the senior practitioner appointed in charge of a department. The Practitioner in Charge is responsible for ensuring the audit and maintenance of safe systems for the handling of medicines within their department.

Assigned Practitioner in Charge
This is the senior practitioner on duty for the department for that shift/ day.

Community Practitioner Nurse Prescribers
A registered nurse who has completed a nationally recognised nurse prescribing course that has been recorded with the Nursing and Midwifery Council. These nurses can prescribe from a limited list of preparations. This

list comprises of a range of medicines, dressings and appliances suitable for use in a community setting.

Non-Medical Independent Prescribers
Health professionals who are qualified to prescribe any licensed medicine (including some controlled drugs for specific medical conditions) and are registered with Provider Services and authorised by the Service Manager within the non-medical prescriber's clinical competency. The list of prescribable controlled drugs is available in the Drug Tariff (part XVIIB) and in the current edition of the BNF.

Medicines Optimisation Team
The Medicines Optimisation Team is a team of LCH employed pharmacists, prescribing support technicians and administrative support staff who:

- Work with a range of healthcare professionals to promote high quality, cost-effective prescribing to improve patient care
- Provide information and support to all LCH employed staff to ensure safe handling and administration of medicines

19. Equality Impact assessment

Equality impact assessment completed and approved 6/10/2016

20 . Monitoring Compliance with the document

Compliance with this policy will be audited via the Clinical Governance Team annual CQC Medicines Optimisation (standard 9) audit, service audits and periodic audits via the LCH Medicines Optimisation Team and review of IR1/Datix incident forms including root cause analysis of medication errors.

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- National Patient Safety Agency: Safer administration of insulin RRR013 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=74287
- National Patient Safety Agency: Reducing treatment dose errors with low molecular weight heparins RRR014 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=75208
- National Patient Safety Agency: Promoting Safer Use of Injectables NPSA/2007/20 http://www.nrls.npsa.nhs.uk/resources/?entryid45=59812
- National Patient Safety Agency: Promoting Safer Measurement and Administration of Liquid Medicines via Oral and Enteral Routes

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http://www.nrls.npsa.nhs.uk/resources/?entryid45=59808

- National Patient Safety Agency: Actions that can make Anticoagulant Therapy Safer; alert and other information http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59814
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Appendices

Appendix 1: SOP Template

Liverpool Community Health NHS Trust

Standard Operating Procedures (SOP) for:			
Replaces:			
SOP Number:		**Version Number:**	
Effective Date:		**Review Date:**	

Date Impact Assessment Undertaken	
Author:	
In Conjunction with:	

Authorisation:	
Name / Position	
Signature	
Date	

Purpose and Objective:

Background:

Responsibilities:

Procedure:

References:

Related Procedures:

Definitions:

Appendices:

Appendix 2

Reporting stolen Rx

LOST/STOLEN NHS PRESCRIPTION FORM(S) NOTIFICATION

Health body:		Date reported:	
Contact name:		Contact telephone number:	
Contact address:			

The following numbered NHS prescription forms have been identified to us as lost or stolen:	
Date of loss/theft:	
Name of person reporting:	
Telephone number:	

Full details of the loss/theft:
• Date & time of loss/theft • Date & time of reporting loss/theft • Place where loss/theft occurred • Type & quantity of prescription stationary • Serial numbers • Name of LSMS

Details of doctor/department/nurse/dentist/pharmacist etc. from whom forms have been lost/stolen:	
Name:	
Personal dispensing or ID code:	
Address:	

Serial number(s) lost or stolen:																						
From												To										

Details of NHS prescription form type lost or stolen (tick appropriate box)		
Issue	Colour	Indicate type lost/stolen

FP10NC	Green	
FP10HNC	Green	
FP10SS	Green	
FP10MDAS	Blue	
FP10HMDAS	Blue	
FP10MDASP	Blue	
FP10MDASS	Blue	
FP10PN	Lilac	
FP10CN	Lilac	
FP10SP	Lilac	
FP10P	Lilac	
FP10D	Yellow	
FP10PCDSS	Pink	
FP10PCDNC	Pink	

Has the incident been reported to the police?	Yes		No	
Name of investigating Police Officer:				
Police station:				

Has an alert and warning been issued to all local pharmacies and GP surgeries within the area?	Yes		No	
Details of the alert:				
Details of any ink changes or security measures & the effective dates of the measures:				

Name:	
Position:	
Signed:	
Dated:	