NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

COMMUNITY DIVISION CLINICAL POLICY

MEDICINES OVERARCHING POLICY

Policy Number:	**MC089**
Scope of this Document:	**Relevent Health Professionals within Mersey Care**
Recommending Committee:	**N/A**
Approving Committee:	**Divisional Policies & Procedures Group**
Date Ratified:	**June 2019**
Next Review Date (by):	**June 2021**
Version Number:	**2019 – Version 11**
Lead Executive Director:	**Joint Heads of Medicines Management**
Lead Author(s):	**Medicines Management Pharmacists & Technicians**

COMMUNITY DIVISION CLINICAL POLICY

2019 – Version 11

Striving for perfect care and a Just Culture

COMMUNITY DIVISION CLINICAL POLICY

MEDICINES OVERARCHING POLICY

Further information about this document:

Document name	**MEDICINES OVERARCHING POLICY (MC089)**
Document summary	**The overarching purpose of this policy is to to be used as a resource to explain the roles, responsibilities and processes for the handling of medicines and related products for all Mersey Care Community Division staff that have any involvement with them**
Author(s) Contact(s) for further information about this document	**Hillary Smith** **Medicines Management Pharmacist** **Telephone: 0151 295 3633** **Email: Hillary.Smith@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**038 Controlled Drugs Policy** **032 Cold Chain Policy** **SA50 Patient Group Directions Policy** **SA03 Incident Reporting Policy** **129 Joint Working with Pharmaceutical Industry & Commercial Sponsorship Policy** **027 Medicines in Special Schools Policy** **References as listed in Appendix 1**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Version 11	Rebranding of policy following LCH transition to Mersey Care NHS Foundation Trust but expanded to include Ward 35 and Transcribing	April 2019
Version		
Version		

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 adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / 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 / 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 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

Contents

1. PURPOSE AND RATIONALE

1.1 The overarching purpose of this policy is to explain the roles, responsibilities and processes for the handling of medicines and related products

1.2 The rationale for this policy is for it to be used as a resource for all Mersey Care Community Division staff that have any involvement with the handling of medicines and related products

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 The aim of this policy is to inform health professionals and other staff employed by Mersey Care of the correct procedures for the safe handling, ordering, storage, transportation, administration and disposal of medicines and related preparations

2.2 The outcome of adhering to this policy will be to minimise the risk of errors associated with medicines

3. SCOPE

3.1 This policy document applies to all staff employed by the trust (whether on a temporary or permanent contract) who need to supply, administer, advise or monitor the use of medicines

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

4. DEFINITIONS

4.1 The following table contains the key terms and their definitions used in the document:

Term	Definition
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
The Medicine Trail	The medicine trail covers all the potential activities that are associated with a medicinal 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.
Controlled Drug	Legal classification of a substance which comes under the Misuse of Drugs Act (1971) and subsequent regulations
Licensed Medicine	All medicines with a valid Marketing Authorisation for use within the UK
Unlicensed Medicine	Any medicine that has not been granted a valid Marketing Authorisation for use within the UK
Non-medicines	These substances include surface disinfectants, urine testing and other reagents, and medical gases
Prescription Only Medicines (POM)	These medicines can only be supplied or administered to a patient on the instruction of an authorised 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
Off-label use	This is the use of a licensed pharmaceutical drug for an unapproved indication or in an unapproved age group, dosage, or route of administration
Standard Operating Procedures (SOP)	These are a set of step-by-step instructions compiled by the organisation to help staff carry out

	complex routine procedures. SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply with company regulations.
Prescriber	Under UK law, only "appropriate practitioners" can prescribe medicine in the UK. A prescriber is a healthcare professional who can write a prescription. This applies to both NHS prescriptions and private prescriptions. Appropriate practitioners are “independent prescriber” (someone able to prescribe medicines under their own initiative) or “supplementary prescriber” (someone able to prescribe medicines in accordance with a pre-agreed care plan that's been drawn up between a doctor and their patient)
Non-medical prescriber	Non-medical prescribing is undertaken by a health professional who is not a doctor.
Prescription	A clinician's order for the preparation and administration of a drug or device for a patient
Patient Specific Direction	A 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 name patient
Authorisation to Administer	In the absence of a PSD, the prescriber should ensure that an authorisation to administer is completed for the healthcare practitioner who is being asked to administer
Patient Group Direction (PGD)	A PGD is a specific written instruction for the supply and/or administration of a named medicine to a group of patients in an identified clinical situation for use by registered healthcare workers who are not prescribers
DATIX	This is the incident reporting system used by Mersey Care. It is important that incidents are identified and reported on Datix using access to the system via SIRS
Adverse Drug Reaction (ADR)	An ADR is an unwanted or harmful reaction which occurs after administration of a drug or drugs
Side effect	In medicine, a side effect is an effect, whether therapeutic or adverse, that is secondary to the one intended
Procurement/ Acquisition of Medicines	This is the process through which a medicine is acquired for use in treating a patient
GP	General Practitioner (medical doctor)
FP10	The FP10 is a prescription that can be issued by a GP, nurse, pharmacist prescriber, supplementary prescriber or a hospital doctor in England.
MRSA	**M**eticillin-**r**esistant **S**taphylococcus **a**ureus

5. DUTIES

5.1 It is the responsibility of the Chief Pharmacist to ensure systems are implemented so that medicines are managed safely and securely throughout Mersey Care to meet patient's needs and safety of staff, and ensure compliance with current legislation

5.2 It is the responsibility of the Heads of Medicines of Management of the Community Division to ensure that systems are implemented so that medicines are managed safely and securely in the community division as delegated by the Chief Pharmacist and that they report appropriately and effectively to the Chief Pharmacist

5.3 It is the responsibility of each department that deals with medicines to produce standard operating procedures (SOP) for any activity undertaken throughout the medicine trail. The Practitioner in Charge is responsible for writing the SOPs for their department, using the Mersey Care approved procedural document template

5.4 The Practitioner in Charge of a department is responsible for auditing compliance with their departmental SOPs

5.5 It is the responsibility of all prescribers and non-medical prescribers to work only within their own competencies and to maintain their skills

5.6 It is the responsibility of all staff to adhere to the guidance outlined in this policy and guidelines issued by individual professional bodies and all related NHS documents

5.7 It is the duty of all staff to adhere to related Mersey Care policies and to be accountable to their own professional bodies to promote safe practice for patients and for their own Continuing Professional Development

6. PROCESS

6.1 **Ordering of Medicines**

a) The ordering or procurement of medicines also includes dressings, devices and reagents.
b) The quality of medicines is of prime importance and is supported through the Pharmacy Quality Control Service and Regional/ National procurement contracts that Mersey Care access.
c) Mersey Care must ensure legal and ethical requirements are met in this area and that procurement is in line with Mersey Care Standing Financial Instructions.
d) Emergency contingency plans must be in place to enable orders to be raised when the ordering system is inoperable.
e) 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 & Sefton Community Division and the wider Mersey Care Divisions. Any queries about this service should always be directed to ImmForm.

6.1.1 Medicines Distribution Service, Liverpool Community Division

a) The Medicines Distribution Service (MDS), based in Liverpool Innovation Park, orders, stores and supplies medicines to the Liverpool and Sefton community based clinics. It holds a Wholesale Dealer's Licence (WDL(H)). All items ordered by the MDS are procured via the JAC Pharmacy Stock Control System, on official stationary or via NHS Supply Chain.
b) 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 MDS.
c) 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.
d) The MDS staff member carrying out stock checks on supplies will report any discrepancies on stock checking to the service lead.
e) The MDS is also responsible for the top-up service for Total Wound Purchasing (TWP) across Liverpool and Sefton. TWP ensures dressings are available to Community Nurses and Assistant Health Practitioners (AHP) to enable them to provide required wound care products at the point of patient care. It also minimises the requirement for GPs to write FP10s for wound care products

6.2 **Receipt of Medicines**

a) All medicines deliveries should be in a tamper evident container. If on receipt at either the MDS unit or the clinic, the seal on the container is broken this should be reported to the supplier for investigation and a Datix completed.
b) Damaged goods should not be accepted and should be reported and returned to the supplier.
c) 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 drugs in a secure place, including taking into account refrigeration
    - Items 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 (please refer to policy on Cold Chain for further detail)
    - Ensuring deliveries are not left unattended in unsecured areas (e.g. clinic corridor, outdoor clinic room) where there is a potential for theft
    - Informing the appropriate manager/ clinician of the delivery
    - Checking off the received order against the delivery note, and contacting the supplier 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

d) Medicines should be stored appropriately (see 6.4)
e) 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 placed at the back of the storage unit.
f) All documentation must be retained for the period specified:
    - Order & delivery notes – 2 years (current financial year plus one)
    - Requisition sheets – 2 years (current financial year plus one)
    - Order, delivery notes and requisition sheets for controlled drugs – 10 years (current financial year plus nine years)

g) Community teams and departments in receipt of medicines from either MDS should immediately report any transit containers received without the unique numbered tags which ensure an audit trail between supplier and community team/ department.
h) The recipient of deliveries is responsible for ensuring that medicine delivery containers are returned. Replacement charges will be levied for any boxes not returned
i) Under **no circumstances** should samples be accepted from drug representatives for use in Mersey Care (please refer to policy on Joint

Working with Pharmaceutical Industry and Commercial Sponsorship for further detail)

6.3 **Transport of Medicines**

a) The potency and security of medicines must not be compromised during transportation. Refrigerated items are delivered via a refrigerated van. It is also important to consider storage conditions during transport in hot weather.
b) For transport of vaccines refer to Policy on Cold Chain. Vaccine services need to use cool boxes and thermometers for routine transport to vaccine sessions which will maintain the temperature between 2° C and 8° C.
c) All healthcare professionals in legal possession of a medicine have a duty of care to take reasonable steps to maintain the security of that medicine at all times.

6.3.1 Transporting medication between Community Pharmacy and Patient's Own Home

a) NMC Standard for Medicines management 2015, Standard 7 states: Registrants may transport medication to patients, where patients, their carers or representatives are unable to collect them, provided the registrant is conveying the medication to a patient for whom the medicine has been prescribed.
b) Before collecting medication from a community pharmacy to deliver to a patient in their own home the following must be checked (see Appendix 2):
    - Will the community pharmacy deliver?
    - Are there any family members who can collect?
    - Are there any neighbours, friends or carers who can collect?
    - Is the medication needed urgently? This may inform if the chemist can deliver or if it needs be collected by another person sooner

c) If after the check list has been completed and documented and all alternatives have been explored, there is a need for Mersey Care staff to collect medication then the following process must be followed:
    - Two staff (1 RN, 1HCA) must collect the medication
    - Before leaving the community pharmacy, check the prescription against the contents of the bag of medication and that the medication has been dispensed as per prescription
    - Take medication immediately back to patient's home
    - Transport medicines directly to the patient ensuring own safety and the security of the medicines e.g. do not make it obvious in a public place that you are carrying medicines
    - Use a locked case out of sight within a locked boot of the car during the journey
    - Record in the patient notes that item(s) has been delivered to the patient (date, time and signature)

d) Unwanted medicines should be returned to the pharmacy of origin. Where possible arrange for the community pharmacy to collect or have patient, relative, friend or carer return the medicines to the pharmacy (see also 6.8). If it is necessary for Mersey Care staff to remove unwanted medicines for safety reasons this can only be done with the consent and permission of the patient or responsible carer as the medicines will remain the property of the patient.

6.4 Storage of Medicines

6.4.1 Safe Storage of Medicines

a) Cupboards designated for medicines must be lockable and the designated area ideally should not be accessible by the public. They must comply with the current British Standards BS2881 (1989) NHS
b) 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
c) The keys for the medicines cupboards must be kept on one key ring solely for this purpose and clearly identified
d) The recommended temperature for storing medicines will be indicated on the container issued by the manufacturer
e) Medicines that do not require storage in a refrigerator are usually stored at temperatures up to 25°C. Cupboards used to store medicines must therefore not be located near radiators or hot pipes or in areas of high humidity
f) 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°C staff must inform their line manager immediately and completed Datix. Advice can be sought from Medicines Distribution Service as to whether the medicines storage rooms/cupboards are fit for purpose
g) 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°C and 8°C. When the temperatures fall outside this recommended temperature range staff must inform their line manager immediately and complete Datix as per Cold Chain Policy. Advice will be provided by Medicines Distribution Service or Medicines Management as to whether the medicines are fit for purpose. Any advice given must be documented for audit purposes
h) Cupboards and refrigerators designated for the storage of medicines and pharmaceutical supplies must on no account be used for the storage of food, valuables or other items

i) All medicines to be taken orally must be stored separately to those for external use. It is acceptable for medicines to be taken orally and external products to be stored on separate shelves in the same cupboard
j) Disinfectants and reagents must be stored separately
k) Where premises are shared by a number of clinics, each clinic is responsible for its own stock and this stock must be stored separately
l) 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
m) Stock must be rotated to ensure that the stock with the shortest expiry date is sued first
n) There must be no part-used pharmaceuticals such as creams or ointments, kept in any medicine cupboards. This is because communal use of such products has resulted in outbreaks of infections such as MRSA
o) Any breaches of security must be reported on the Datix Incident Reporting form
p) Staff in any supervisory position must be aware of the signs that may indicate that abuse or diversion of medicines. These include changes in an individual's behaviour, loss of stock and excessive ordering. Contact Medicines Management, Police and NHS Protect, as appropriate

6.4.2 Safe Storage of 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 of medical gases. In addition the following precautions must also be observed:

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

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

6.4.3 Safe Storage of Flammable Liquids

a) 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
b) 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 non-flammable cupboard that displays an appropriate hazard notice

6.4.4 Alcohol Gel

a) It should be noted that alcohol gel is also a highly flammable substance; the above precautions must be followed.
b) If nursing staff need to store alcohol gel in their car it must not be stored anywhere it would be subject to direct sunlight. It must be stored in nursing bags, pockets and/or in the boot of the car

6.4.5 Security of Medicine related Stationary

a) The Pharmacy Supplies Order Form must be regarded as controlled stationary and kept under lock and key and only be accessible to authorised staff.
b) 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.
c) 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.
d) All services using medicine related stationary should own relevant SOPs for handling of such stationary and prescribers in particular have a responsibility to adhere to the SOP.

6.4.6 Lost or Stolen Prescriptions or Medicines

a) 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.
b) Incidents involving the loss, theft or misuse of prescription forms must be reported immediately to the police.
c) For organisational purposes, a Datix should be completed and the service lead/ Head of Medicines Management/ Chief Pharmacist should be informed.
d) In addition, all details of the incident or theft should be recorded on the Missing/Lost/Stolen NHS Prescription Form(s) Notification Form so that it can be reported externally to NHS Protect.
e) 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.
f) Mersey Care will liaise with the police, the LSMS and the LCFS to 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.

6.5 **Prescribing of Medicines**

a) Prescribing responsibilities - medicines are only to 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 (within a limited formulary and acting within their skills, knowledge and competence)
b) **Prescribers must also ensure there is an allocated budget prior to initiating any prescribing**
c) When prescribing unlicensed products or medicines to be used “off label”, the prescriber owns 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.
d) Non-medical prescribers should only prescribe unlicensed medicines in justifiable exceptional and approved circumstances e.g. if justified by current best practice.
e) Patient must be informed that a medicine is unlicensed prior to prescribing and entry documenting this made in the medical notes.

6.6 **Dispensing or Supply of Medicines**

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

c) The prescription can either be a paper document or be transmitted electronically between the GP surgery and the dispensing pharmacy.
d) Dispensing will be in line with The Royal Pharmaceutical Society's Good Dispensing Guidelines England.

6.7 Administration of Medicines

6.7.1 Consent

a) Valid consent must be obtained and recorded before starting any treatment including the administration of medicines.
b) For consent to be valid it must be given voluntarily by either the patient or an appropriately informed person including a person having Power of Attorney for Health.
c) 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 interests

6.7.2 Verbal Orders

The use of verbal orders for administration of medication is **not** supported by Mersey Care and must not be carried out by Mersey Care employees. Orders should either be by PSD or Authority to Administer, handwritten or electronically generated.

6.7.3 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
- 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 or authorisation to administer matches the labelled medicine and that information is clearly written and unambiguous with respect to dose, frequency and route
- Check that the medicine has not expired
- Ascertain that the prescribed dose has not already been given
- Check that the patient is not allergic to the medication before administering
- 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
- Records must be contemporaneous but where direct access to GP held records is not possible, that the patient's GP is informed by letter within 24 hours
- Certain medicines such as cytotoxic or warfarin, require special consideration. In the event of NHS Provider Services being requested to administer these medicines, department SOPs must be followed
- When supervising a student practitioner in the administration of medicines, clearly countersign the signature of the student
- 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 incidents of overdose
- When administering medicines 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
- It is an illegal practice to administer pharmaceuticals to any person for whom they were not prescribed unless via a Patient Group Direction (see PGD Policy)

6.8 Disposal of Pharmaceutical Waste

a) 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

b) The disposal of pharmaceutical waste must be outlined in SOPs specific to each department.
c) Pharmaceutical hazardous waste:
    - Used or unused must be disposed of in a clearly labelled purple-lidded waste containers for incineration.

d) Pharmaceutical non-hazardous waste:
    - Used sharps containers e.g. empty glass ampoules, used pre-filled syringes, needles, lancets must be disposed of in a 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 a clearly labelled blue-lidded yellow waste containers for incineration

e) In all instances it is important to ensure that bins are not overfilled.
f) 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.
g) Controlled drugs must be managed in accordance with the Policy for the Management of Controlled Drugs and all service specific SOPs.
h) In relation to Ward 35, stocks of obsolete, expired or unwanted medicines must not be returned without notifying Liverpool Heart & Chest Hospital Pharmacy to arrange for removal or disposal on site.
i) 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.

6.9 Intermediate Care Bed Based Wards

a) The wards are run by Mersey Care staff and are subject to all Mersey Care NHS Foundation Trust policies, procedures and SOPs. The intermediate care Ward 35 is based on the Aintree University Trust site.
b) A comprehensive pharmaceutical service is supplied by Liverpool Heart and Chest Hospital Pharmacy to wards 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**: Providing a mechanism which will enable the safe and secure disposal of Pharmaceutical waste for Wards 9 and 11. Ward 35 have a contract with an outside **disposal company**
- **Invoices for drugs:** These will be issued by the service provider to Mersey Care NHS Foundation Trust on a monthly basis and will be subject to the NHS Better Payment Guidelines for payment

6.9.1 Admission

a) **From Secondary care:** Patients admitted to the intermediate care bed based wards 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
b) **From a Community setting:** Patients admitted from the community to an intermediate care bed based wards 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

6.9.2 Medicines Reconciliation

a) 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.
b) 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.

c) There is a standard operational procedure for the process of Medicines Reconciliation on admission to a Bed Based Ward. This SOP applies to all staff involved in the admission of patients onto this bed based ward, including those working as part of a service level agreement with Mersey Care.
d) 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)

e) 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.
f) The staff need to refer to service specific Standard Operating Procedures.

6.9.3 Patients Own Drugs

a) 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).*
b) 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.
c) The staff need to refer to service specific Standard Operating Procedures.

6.9.4 Medication Storage

a) 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
b) Medicines for Disposal: Medicines no longer required should be kept in an official receptacle, which is locked or in a locked cupboard

6.9.5 Controlled Drugs

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

b) The Standard operating procedures outline the agreed processes for:
   - Prescribing
   - Ordering
   - Transportation
   - Receipt
   - Administration
   - Storage
   - Recording
   - Disposal

c) The Standard operating procedures will also outline individual responsibilities and accountability for these processes on Intermediate care bed based wards.

6.9.6 Self-Administration Scheme

a) Liverpool & Sefton Community Division 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.
b) Self-administration is an essential procedure to assist patients towards becoming self-sufficient in taking their medicines, prior to discharge from an in-patient area. It is also a key requirement of the Care Quality Commission regulations around medicines.
c) 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

d) The staff need to refer to service specific Standard Operating Procedures.

6.10 **Transcribing**

a) Transcribing is defined as "making a full written or typewritten copy of information from another written piece of information or from a dictated / instruction". For the purpose of this policy transcribing relates to any act by which medicinal products are written from one form of "direction to administer" to another. This includes but is not limited to information from discharge letters, transfer letters, copying illegible patient administrations chart onto new charts (whether handwritten or computer generated), Medication Administration Records (MAR charts) and prescription charts.
b) In the NMC Standard for Medicines Management (2008) there is reference to transcribing under standard 3 of the Standards for Medicines Management. NMC states that registrants may transcribe but that it "should only be undertaken in exceptional circumstances and should not be routine practice".

An exceptional circumstance is a situation where an independent prescriber is unavailable to prescribe medication and the patient's condition is such that the risk to the patient's safety is significant if the administration of medication is delayed until a prescriber is available. However, the NMC Standard for Transcribing also acknowledges that: "As care is being increasingly provided in more 'closer to home' settings that are often nurse-led, managers and employers should undertake a risk assessment to develop a management process to enable transcribing to be undertaken where necessary" (NMC, 2010).

c) The Liverpool and Sefton Community Division of Mersey Care NHS Foundation Trust provides health care within various settings and within these settings, service users require medicines to be available in a timely manner. Details of service users' medicines and medication instructions need to be maintained on a range of charts and records to support safe supply and administration.
d) In the absence of comprehensive, national guidelines for transcribing for all NHS staff, transcribing has been incorporated into this policy to ensure all Mersey Care nursing staff who may need to transcribe follow risk assessed processes and the principles of the NMC Standards.
e) Staff who need to transcribe must receive specific transcribing training. All staff are aware of their roles, responsibilities and limitations with regards to transcribing. Wherever transcribing takes place service specific Standard Operating Procedures (SOPs) are available and only nursing staff who have read, understood and have completed the competencies are authorised to transcribe. Special school nurses who transcribe are competency assessed on an annual basis and will be covered by the 027 Medicines in Special Schools Policy.
f) Transcribed charts will be audited against the SOPs/Competency frameworks for the service.
g) The prescriber responsible for generating the original instruction carries the legal liability for the content of that instruction. If this is then transcribed accurately and without any alteration the person making the transcribed copy does not assume that liability. This would only become an issue if inaccuracies appear as a result of the transcribing.

h) **Transcribing takes place in the following settings:**

- Intermediate Care Wards
- Special Schools Nursing Services (see separate policy)

6.10.1 Transcribing onto Prescription Charts for Intermediate Care Wards

a) Prescribers are routinely available on **bed base therefore transcribing should not be routine practice and reserved for exceptional circumstances**.
b) The service manager or delegated service leads are responsible for organising training and assessing the competency of registered nurses in relation to transcribing and countersigning for transcription.
c) The authorised transcriber is responsible for each transcription undertaken and is accountable for his/ her actions or omissions (NMC, 2010).

d) A second check by an authorised member of staff should be completed and countersigned on the transcribed record.
e) Any transcription must include the patients full name, date of birth, drug, dosage, strength, timing, frequency and route of administration.
f) The transcriber is responsible for ensuring that any medication that has been transcribed is verified for accuracy and clinical appropriateness by an independent prescriber within 24 hours. Once the independent prescriber has verified the transcribed record they must then sign and date the transcribed record.
g) The transcriber should not transcribe drugs that are unfamiliar to them or if there are concerns regarding the prescription that cannot be resolved or clarified by the prescriber.
h) Staff must act within their ethical and/ or professional codes of conduct at all times (NMC, 2010, General Pharmaceutical Council, 2010).
i) Any requirements for a staff member without a prescribing qualification to transcribe medication must be reported on the Datix system as an incident.

6.10.2 Transcribing onto Medicine Administration Record charts in the patient's home

a) Although services are working towards paper-light, it is inevitable that in the patient's own home there is still a reliance on paper documentation. The same principles (see 6.10.1) will apply to any nurse without a prescribing qualification who may, in exceptional circumstances, be required to transcribe in order to deliver their service in a timely manner.
b) The service manager or delegated service leads are responsible for organising training and assessing the competency of registered nurses in relation to transcribing and countersigning for transcription.
c) A second check by an authorised member of staff should be completed and countersigned on the transcribed record.
d) Any requirements for a staff member without a prescribing qualification to transcribe medication must be reported on the Datix system as an incident.

6.11 **Medicine Alerts**

6.11.1 Medicines and Healthcare Products Regulatory Drug Alerts

a) Medicines and Healthcare Products Regulatory Agency (MHRA) Drug Alerts are cascaded directly to Hospital Pharmacies and Community Pharmacies throughout the Merseyside area
b) All Pharmacists are responsible for ensuring that the advised action is taken which may necessitate the removal of the affected pharmaceuticals from pharmacy stock.
c) All MHRA Drug Alerts can be found on the MHRA website
d) Any drug alerts/ recalls and what action to be taken will be cascaded to all Mersey Care staff if needed in accordance with the Central Alerting System (CAS) Alert Policy.

6.11.2 National Patient Safety Agency Alerts and Rapid Response Reports

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

6.10.2 Pharmaceutical Industry Alerts

The industry usually also send out their own alerts directly as well as informing the MHRA or the NPSA and may well precede the national alert systems. These alerts must be considered equally in case of any breakdown in cascade systems.

6.10.3 Locally instigated medicine related alerts

Local medicine issues may arise where action to be taken will be cascaded to all Mersey care staff in accordance with the Central Alerting System (CAS) Alert Policy.

6.11 Adverse Drug Reaction Reporting

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.

6.11.1 Who can report?

a) Anybody can report an adverse reaction using the yellow card scheme.
b) MHRA also collects Yellow Card reports from all healthcare professionals (including doctors, pharmacists, nurses and coroners).
c) It is also a legal requirement for pharmaceutical companies that make the medicine to report any suspected side effects to the MHRA that are reported to them.

6.11.2 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. The following should be reported:

- For intensely monitored medicines (identified by ▼) and vaccines report ALL suspected reactions
- For children under the age of 18 report ALL suspected reactions
- ALL incidents when using a medical device or e-liquid or e-cigarette should be reported
- Any serious reaction to an established medicine or vaccine, even if well recognised, should be reported

- Homeopathic and herbal remedies are of particular interest and serious suspected reactions should be reported

6.11.3 Where to find a Yellow Card

a) A paper version of the Yellow card is included in all versions of the printed British National Formulary.
b) Electronic versions can be completed on the MHRA website
c) Yellow Card App can be downloaded on to Smart phone/devices

6.11.4 Completing a Yellow Card

a) The following patient details should be included on the yellow card:
   - Patient's initials
   - Age
   - Sex
   - Weight if known
   - Local identification number

b) The patient's initials and a local identification number will help to identify the patient in 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.

6.11.5 Recording the submission of a Yellow Card

a) 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.
b) All suspected ADRs must also be recorded on Datix.

6.12 **Incident Reporting**

a) 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 health care organisations are encouraged to develop a culture of openness. Reporting medication errors is essential if underlying problems are to be addressed.
b) 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

c) A failure to report an incident prevents the rest of the NHS from learning and developing.
d) 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
    - 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 or administration equipment
    - Inform line manager immediately who will refer to the Incident reporting Policy
    - 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

e) 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 actually occurring.
f) The service lead/manager is responsible for the investigation and a plan for immediate and future preventative actions should be implemented. They will also be responsible for alerting the committee structures to deal with incidents.

7 CONSULTATION

7.11 Medicines Management Team, Community Division

7.12 Audit Department

7.13 Learning & Development

8 TRAINING AND SUPPORT

8.11 Staff and managers have joint responsibilities 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

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

8.13 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 medicines 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, within 12 months of date of issue will be available in each department. The most current version of the BNF is available to all staff on line.

8.14 The expert on all aspects of medicines and medicines related legislation is the pharmacist who should be consulted whenever necessary

9 MONITORING

9.11 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 Mersey Care Medicines Optimisation Team

9.12 Review of IR1/ Datix incident forms including root cause analysis of medication errors to identify any trends

10 EQUALITY AND HUMAN RIGHTS ANALYSIS

Title: Overarching Medicines Policy
Area covered: Community Division

What are the intended outcomes of this work? The aim of this policy is to inform all health professionals and other staff employed by Mersey Care Community Division of the correct procedures for the safe handling, ordering, storage, transportation, administration and disposal of medicines and related preparations
Who will be affected? All staff employed by Mersey Care Community Division who will be involved with procedures to manage medicines and related preparations

Evidence
What evidence have you considered? National legislature, professional codes of conduct, Mersey Care policies, Care Quality Commission, NICE Quality Standards that considers equality and human rights
Disability (including learning disability) *No impact*
Sex *No impact*
Race *No impact*
Age *No impact*
Gender reassignment (including transgender) *No impact*
Sexual orientation *No impact*
Religion or belief *No impact*
Pregnancy and maternity *No impact*
Carers *No impact*
Other identified groups *No impact*
Cross Cutting *Not applicable*

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	*Use not engaged*
Right of freedom from inhuman and degrading treatment (Article 3)	*Not applicable*
Right to liberty (Article 5)	*Not applicable*
Right to a fair trial (Article 6)	*Not applicable*
Right to private and family life (Article 8)	*Not applicable*
Right of freedom of religion or belief (Article 9)	*Not applicable*
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	*Not applicable*
Right freedom from discrimination (Article 14)	*Not applicable*

Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.*

Summary of Analysis to meet general duties of the Equality Act 2010
Eliminate discrimination, harassment and victimisation
Advance equality of opportunity
Promote good relations between groups

What is the overall impact? No negative impact on equalities identified

Addressing the impact on equalities N/A

Action planning for improvement
Detail in the action plan below the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment* • *Plans already under way or in development to address the **challenges** and **priorities** identified.* • *Arrangements for continued engagement of stakeholders.* • *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)* • *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies* • *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results* • *Arrangements for making information accessible to staff, patients, service users and the public* • *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

For the record **Name of persons who carried out this assessment:** Hillary Smith, Medicines Management Pharmacist
Date assessment completed: 19/06/2019
Name of responsible Director: Linda Taylor
Date assessment was signed:

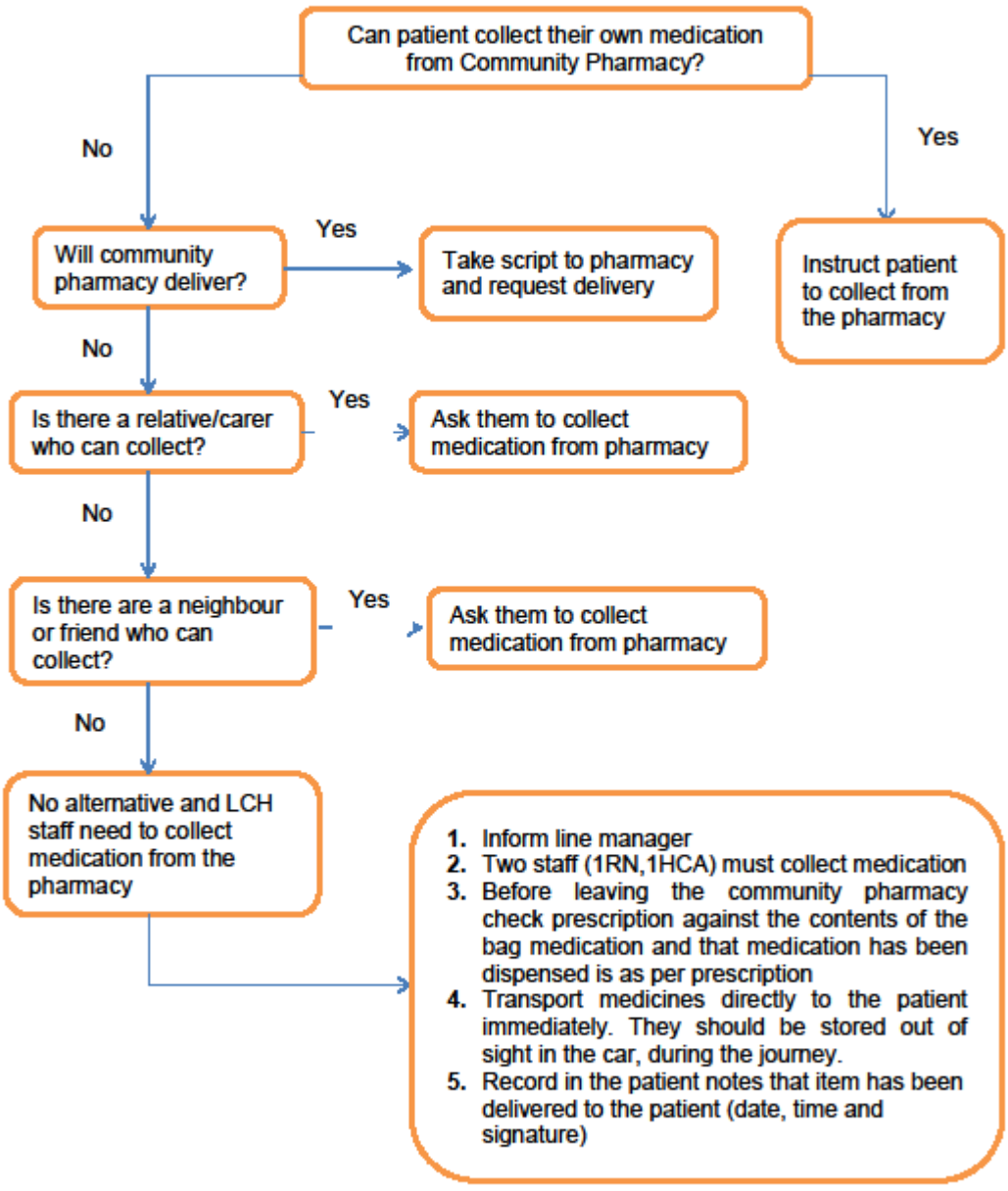
Appendices

Appendix 1 - References

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2009
- Care Quality Commission (Registration) Regulations 2009
- Department of Health (2005) Medicines Matter. March
- Department of Health (2006) Improving Patient's Access to Medicines. April
- Department of Health (2007) Safer Management of Controlled Drugs: Guidance on Standard Operating Procedures for Controlled Drugs. January
- NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)
- Health Service Circular 1998/062 Guidance for Doctors and Pharmacy Contractors
- Department of Health (2001) 12 Key Points on Consent: the Law in England
- August National Patient Safety Agency (2010) Reducing harm from omitted and delayed medicines in hospital. RRR 009
- National Patient Safety Agency (2010) Safer administration of insulin RRR013
- National Patient Safety Agency (2010) Reducing treatment dose errors with low molecular weight heparins RRR014
- National Patient Safety Agency (2007) Alert No 20 Promoting Safer Use of Injectables 28 March
- National Patient Safety Agency (2007) Alert No 19 Promoting Safer Measurement and Administration of Liquid Medicines via Oral and Enteral Routes 28 March
- National Patient Safety Agency (2007) Alert No 18 Actions that can make Anticoagulant Therapy Safer 28 March
- National Patient Safety Agency (2006) Safer Practice Notice 12 May
- National Patient Safety Agency (2006) Safer Practice Notice 1 June
- Department of Health (2006) Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste November
- RCN/ Royal Pharmaceutical Society: Professional Guidance on the Administration of Medicines in Healthcare Settings, January 2019

Appendix 2 – Transporting Medication Flow Chart

Transporting Medication from Community Pharmacy to Patient Own Home Flow Chart



1