Policy Number	SD12

COVID-19 DOCUMENT CHANGE FORM

NHS Mersey Care NHS Foundation Trust
Community and Mental Health Services

In light of the COVID-19 outbreak it has been necessary to make temporary changes to this Policy Document. Therefore when reading the policy document please take account of the changes highlighted in Part B and C of this form.

PART A – INFORMATION ABOUT THIS POLICY DOCUMENT

Policy Name	**Handling of Medication**				**Reference No**	**SD12**	
Executive Lead *(Trust-wide policies)*	**Executive Medical Director**						
Chief Operational Officer *(Clinical Division policies)*							
Policy Document *(Tick only one)*	Trust-wide (Board approved)	☐	Trust-wide (Executive Director approved)	☒	Secure & Specialist Learning Disabilities Division	☐	
	Community Division	☐	Local Division	☐			
Type of Policy *(Tick only one)*	Clinical Policy	☒	Non-clinical Policy	☐			
Clinical Policy Only *(Tick only one)*	Minor Change *(Not referred to the Clinical Cell)*	☐	Major Change *(Referred to Clinical Cell, then to SCG for approval)*	☒			
Approving Body *(Tick only one)*	Board of Directors	☐	COVID-19 Strategic Coordination Group	☒	Community Division Tactical Coordination Group	☐	
	Corporate Division Tactical Coordination Group	☐	Local Division Tactical Coordination Group	☐	Secure & Specialist LD Division Tactical Coordination Group	☐	

PART B – CHANGES TO THE POLICY DOCUMENT

Section / Paragraph No	Outline of the information that has been amended in this policy document
Please Note – two sets of temporary changes have been approved for this policy document. Both these changes are recorded on this COViD-19 Document Change Form	
Change 1 – addition to section 6 (Prescription / Ordering of Medication)	Temporary addition to support remote prescribing by all prescribers during the COVID-19 pandemic
Change 2 – addition to section 8 (Use of Service Users' Own Medication / Self Administration)	To support the safe handling of patients own drugs brought into hospital
Change 2 – addition to section 10 (Storage, Transportation & Disposal of Medications)	Temporary change to sub-section 10.2 (Disposal or Return of Medicines) in respect of disposal of medication for inpatient wards and community location

PART C – RATIONALE FOR CHANGES

Please explain why this document needs to be amended during the COVID-19 outbreak
Change 1 – to minimise face to face contact with patients during COVID-19, the following guidance to support all registered prescribers who are being asked to treat patients via a telephone or video or through other remote consultation when they would normally see them face to face. **Change 2** – to support the disposal of medication at ward level to reduce the risk of cross contamination when moving medication from one area to another during the COVID-19 pandemic and reduce unnecessary pressure to the supply chain for medicines. To support the safe handling of patients own drugs brought into hospital and to reduce the risk of cross contamination during the COVID-19 pandemic.

Policy Number	SD12

COVID-19 DOCUMENT CHANGE FORM

PART D – APPROVAL (for completion by officer loading policy document onto intranet / website)

Date Referred to the Clinical Cell *(Clinical Policies only)*	**Change 1** – 6 April 2020 **Change 2** – 15 April 2020
Date Referred by the Clinical Cell to the SCG *(Clinical Policies only)*	**Change 1** – 6 April 2020 **Change 2** – 15 April 2020
Date Approved by the Approving Body	**Change 1** – 7 April 2020 **Change 2** – 17 April 2020
Date Circulated to Relevant Staff	**Change 1** – 10 April 2020 **Change 2** – 20 April 2020
Date Published on the Divisional Intranet / Trust Website	**Change 1** – 10 April 2020 **Change 2** – 20 April 2020

Change 1 – SD12: Handling of Medication – Changes Approved 7 April 2020
Temporary Addition to Section 6 (Prescribing) – Prescribing via remote consultation

Supporting remote prescribing in the COVID- 19 pandemic

In response to national guidance to minimise face to face contact with patients during this COVID-19 pandemic the following guidance to support **all registered prescribers** who are being asked to treat patients via a telephone or video or through other remote consultation when they would normally see them face to face.

It is intended to provide additional principles around working remotely and applies to all prescribers working within their normal scope of prescribing practice. Independent Prescribers can prescribe based on a remote assessment if they can assure themselves that they are prescribing within their competence, have made an informed assessment and are safe.

The national advice is that during the COVID-19 pandemic care should, as far as possible, be carried out remotely and that online and telephone consultations be increased to help increase capacity. All care that can be undertaken remotely should be done so through appropriate channels and care should be prioritised for those patients at highest risk. At this time of unprecedented demand there is a need for increased use of remote prescribing. This change in practice is essential to limit the spread of the virus and protect patients and staff by reducing the footfall in clinical areas.

Guidance is already in place across the UK to move towards increased remote prescribing, and mechanisms for remote independent prescribing already exist. However, there are some services which will have little or no experience in running remote consultations in order to help services build capacity.

Supervision and clear guidance will also be required in the event of prescribers being required to prescribe outside of their usual clinical area, as a result of staff shortages.

High level principles for good practice in remote consultations and prescribing have been co-authored and agreed by a range of healthcare regulators and organisations including the

Policy Number	SD12

COVID-19 DOCUMENT CHANGE FORM

Nursing and Midwifery council (NMC) and the Royal Pharmaceutical Society (RPharmS). The General Pharmaceutical Council (GPhC) has produced a comprehensive document covering various aspects of pharmacist prescribing: In-practice – Guidance for Pharmacist Prescribers (November 2019) and the Royal College of Nursing (RCN) has released guidance on prescribing safely under COVID-19 (April 2020).

Recognising these principles, this guidance has been developed to support prescribers in prescribing safely under these conditions.

Prescribers are accountable for their prescribing decisions, including when prescribing remotely, and should only prescribe if satisfied that they have adequate knowledge of the patient's health and their medical and prescribing history. If the prescriber is satisfied that the remote assessment provides sufficient information to provide the correct prescribing decision then they are able to prescribe.

Prescribers are responsible for any prescription they sign, including repeat prescriptions for medicines initiated by colleagues.

Prescribers must identifies the potential risks associated with prescribing via remote media (telephone, email or through a third party) and takes steps to minimise them.

When undertaking a remote consultation prescribers must:

1. Ensure they are working in an environment that is adequate for private and confidential work, as they will have access to patient identifiable information. Understand how to identify vulnerable patients and take appropriate steps to protect them.
2. Provide an introduction by advising patients of their name and role, establish a dialogue and make sure the patient understands how the remote consultation is going to take place. Explain that:
    a. They can only prescribe if it is safe to do so.
    b. It is not safe if they don't have sufficient information about the patients health or if remote care is unsuitable to meet their needs.
    c. They will share relevant information with other healthcare providers involved in their care, e.g. GP practice.
    d. If they can't prescribe because it's unsafe they will signpost to other appropriate services.
    e. Obtain and document informed consent and follow relevant mental capacity law and codes of practice.
3. Undertake an appropriate clinical assessment and access medical records and history:
    a. Establish the reason for the remote consultation.
    b. The prescriber should assess whether they have sufficient information and knowledge of the person's current health and medical history to make an assessment of the condition.

c. History of presenting complaint – to include symptoms, how long they have had it, any over the counter medication, symptoms getting better/worse.

d. Confirm if the patient has any allergies or adverse reactions to medicines or other relevant substances.

e. Check compliance with any prescribed medication and check if any recent acute medicines like antibiotics and steroids have been prescribed.

f. Confirm if the patient is taking any prescription medicines obtained from another provider e.g. hospital trust or any medicines obtained over the internet (e.g. via online services)

g. Confirm if the patient is taking any non-prescribed medicines, e.g. over the counter medicines, herbal medicines or illegal drugs.

h. Verify important information by examination or testing where necessary before prescribing. Gain information by asking the patient to describe signs such as breathing and vital signs and rashes. Questions around the signs and symptoms which can include home readings (for example blood pressure or temperature) and documentation of patient's description of symptoms. Use video conferencing if available and needed. In the absence of other cues, the tone and content of speech is important.

i. Consider the risk/benefit and medication interactions for the patient and prescribe or decide not to prescribe accordingly.

4. Decide if you can you make a diagnosis and treat based on the information you have collated or if you need to see the patient (you may choose to treat with less information than you would do normally to avoid seeing a patient face to face both for their safety and yours).

5. Provide the patient with information about all the options available to them, including declining treatment, in a way they can understand.

6. Provide clear instructions on any treatment recommended including when and how to take medication if you issue a prescription. Prescriptions can be sent to the relevant pharmacy via electronic prescribing and transfer of care around medicines systems, or if this is not available then physically sent to the pharmacy reducing footfall in clinical services as far as possible.

7. Make appropriate arrangements for after care and ongoing monitoring and treatment. Advise patients when to seek further advice including if symptoms get worse, don't improve or if any red flag symptoms don't improve. Remember that a face-to-face consultation may be needed. Consider if follow up is needed, and when and how the patient will be followed up.

8. Document all notes on the relevant clinical notes system, fully explaining and justify the decisions made. Ensure the documentation reflects that this is a remote consultation and be specific over how information was obtained

9. Share relevant information with other healthcare providers involved in their care, e.g. general practice

10. Stay up to date with relevant training, support and guidance for providing healthcare in a remote context.

Policy Number	SD12

COVID-19 DOCUMENT CHANGE FORM

Some categories of medicines require extra consideration to make sure that they are clinically appropriate to be prescribed remotely. The categories include:

- Antimicrobial medication - it is important to effectively manage their use, to help slow the emergence of antimicrobial resistance and make sure that antimicrobials remain an effective treatment for infection. These should be supplied only in line with good practice guidance, with an awareness of antimicrobial stewardship.
- Medicines liable for abuse, diversion, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important.
- Medicines that require ongoing monitoring or management. For example: medicines with a narrow therapeutic index

References:

1. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf?ver=2019-02-13-163215-030
2. https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/high-level-principles-for-remote-prescribing-.pdf
3. https://www.pharmacyregulation.org/sites/default/files/document/in-practice-guidance-for-pharmacist-prescribers-february-2020.pdf
4. https://www.rcn.org.uk/clinical-topics/medicines-management/covid-19-remote-prescribing

Change 2 – SD12: Handling of Medication – Changes Approved 17 April 2020

1. **Disposal of Medication for inpatient Wards/ Community Locations**
2. **Handling Patients Own medication brought into hospital**

To Support the disposal of medication at ward/community location level and reduce unnecessary movement of medication to reduce the risk of cross contamination during the COVID- 19 pandemic and reduce unnecessary pressure to the supply chain for medicines. To Support the safe handling of patients own medication brought into hospital to reduce the risk of cross contamination during the COVID- 19 pandemic.

The principles set out in this change are to minimise the unnecessary movement of medication and reduce the risk of cross contamination during the COVID-19 Pandemic. Medication that is no longer required e.g. expired will be disposed of at ward or community location level in the appropriate clinical waste bins. A record of what has been disposed of should continue in the pharmacy 'medication returns book', the sheets should not be removed from the returns book; the book should be retained on the ward.

Controlled and Recorded drug medication returns including patients own Controlled and Recorded drugs will continue to be returned by a Pharmacist (Controlled Drugs) or a Pharmacist/Pharmacy Technician (Recorded Drugs)

In response to guidance set out by North West England 'The use of patients own medicines (PODs) brought into health and social care settings during the Covid-19 Pandemic, the Principles outlined in the change are to reduce the risks of cross contamination and to support staff health and wellbeing by having consistent approach.

Policy Number	SD12

COVID-19 DOCUMENT CHANGE FORM

The following advice is recommended;

- All patients own medication that is brought into the ward must be placed in a bag, sealed and segregated from other medicines in a locked medicines cupboard.
- Nursing staff must wear disposable gloves when handling PODs and wash hands immediately after removing gloves.
- The Medicines Management Department must be contacted as soon as possible, a pharmacist will check if any of this medication is prescribed and will need to be re-used. This will only apply to medication that would not routinely be supplied by the Medicines Management Department.
- After receiving advice from Medicines Management, PODs that are required to be re-used should remain in the bag or placed in a new bag and stored in a locked Medicines cupboard, when handling follow the guidance above (gloves and hand washing).
- All other PODs that are not required to be re-used must remain in the sealed bag and be disposed of in the appropriate clinical waste bin, wash hands after disposing in the bin.

Controlled Drug Patient Own Medicines (CD PODs)

Patient own CD PODs - when handling follow guidance above* (gloves must be worn). The controlled drug must be counted, the quantity entered in the patients own CD register and then placed in a sealed bag. The bag containing the CD must be segregated in a locked CD cupboard. The Medicines Management Department should be contacted immediately to request removal and denaturing of the CD POD by a pharmacist.

Recorded Drug Patient Own Medicines (RD PODs)

Patient own RD PODs – when handling follow guidance above* (gloves must be worn). The recorded drug must be counted, quantity entered in the patients own RD register, or at the back of the RD register, the RD POD must then placed in a sealed bag. The bag containing the RD must be segregated in a locked medicines cupboard. *If needed the RD should be ordered via the medicines management email address; mhhpharmacy@merseycare.nhs.uk*

The Medicines Management Department should be contacted immediately to request removal of the RD POD by medicines management staff

The Medicines Management Department will distribute a supply of appropriate bags to wards for PODs, please email to the address above if you require more

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

TRUST-WIDE CLINICAL POLICY DOCUMENT

HANDLING OF MEDICATION

Policy Number:	**SD12**
Scope of this Document:	**All Clinical Staff**
Recommending Committee:	**Drugs and Therapeutics Committee**
Approving Committee:	**Executive Committee**
Date Ratified:	**March 2017**
Next Review Date (by):	**April 2020**
Version Number:	**2017 – Version 3.0**
Lead Executive Director:	**Medical Director**
Lead Author(s):	**Chief Pharmacist**

TRUST-WIDE CLINICAL POLICY DOCUMENT

2017 – Version 3.0

Striving for perfect care and a just culture

TRUST-WIDE CLINICAL POLICY DOCUMENT

HANDLING OF MEDICINES

Further information about this document:

Document name	**HANDLING OF MEDICINES (SD12)**
Document summary	**Sets out policy for the safe and effective handling of medicines within the trust covering:-** **(i) Prescribing and ordering of medication** **(ii) The administration of medication** **(iii) Storage, Tranportation and Disposal of medication** **(iv) Handling of Controlled and Recorded Drugs** **(v) Role of Pharmacy Services**
Author(s) Contact(s) for further information about this document	**Lee Knowles** **Chief Pharmacist** **Telephone: 0151 250 6030** **Email: lee.knowles@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** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**SD36 The Unlicensed and Off-label use of Medications Policy** **The trust's Clinical Guidelines and Formulary**
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 2.0	Update version approved by Corporate Policy Review Group	January 2015
Version 2.1	Approved by Executive Committee	June 2016
Version 3.0	Approved by Executive Committee subject to minor amendments and Executive Lead approval	May 2017
Version 3.0	Executive Committee approved	February 2020

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, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not 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 trust carries legal liability for the safety, storage and administration of medicines. The purpose of the Medicines Policy is to ensure the safe and secure handling of medicines at all stages of the medication process within ward / inpatient and community/team settings and in doing so minimise the incidents of harm caused by medication errors.

1.2 The Department of Health requires that NHS Trusts establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner. This policy document outlines the mandatory legal and ethical aspects involved in medicines management.

1.3 This policy covers all aspects of the handling of medicines within the trust and how medicines are managed within each of the clinical divisions. Policy is set out for the following:-

(i) The prescription and ordering of medications
(ii) The administration of medications
(iii) The storage, transportation and disposal of medications
(iv) The handling of Controlled and Record Drugs
(v) The role of the trust Pharmacy Services

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 Practitioners must be fully aware of their responsibilities when handling medicines and must have sufficient knowledge, information or experience when handling medication.

2.2 This policy document aims to set out the mandatory legal and ethical aspects involved in the handling of medicines and covers the following areas:-

(i) Procurement and Supply of Medication
(ii) Prescribing of Medication
(iii) Safe and Secure Storage of Medication
(iv) Administration of Medication
(v) Appropriate Disposal of Medication

3. SCOPE

3.1 This policy applies to all clinical staff working within the clinical divisions of the trust.

3.2 Additional procedures are in operation for some aspects of work within the separate clinical divisions and are available as annex documents to this policy on the trust website.

4. DEFINITIONS

4.1 Staff definitions **-** Throughout the policy the term practitioner is used. This is a general term used to describe a qualified medical practitioner, nurse, pharmacist or authorised health care employee. Also, certain specialist titles describe health care staff who have defined responsibility with regard to the management of medications. In general only staff with contracts of

employment to work across Mersey Care NHS Trust are assessed as having any involvement with medicines. However, certain regular bank staff may be considered competent to administer medicines. Any practitioners who are either new or unsure about certain practices should **only** administer medications under the supervision of a second experienced individual.

4.2 Appointed Practitioner in Charge - A senior practitioner appointed in charge of a ward or department, for example a ward manager, superintendent physiotherapist. The chief pharmacist or deputy, together with senior managers, must agree and authorise named individuals to be given these responsibilities.
In situations where the person in charge is not from a nursing background e.g. community team leader with a social work background, and it is inappropriate to take such responsibility, another member of the team must undertake the role of appointed practitioner in charge.

4.3 Assigned Practitioner in Charge - This is the senior practitioner on duty for the ward or department.

4.4 Designated Practitioner - This is any registered practitioner identified by the appointed practitioner in charge as competent and appropriate to perform a specific function. The designation as such has been communicated to and accepted by the designated practitioner. If the practitioner is based in the community the term used will be designated community practitioner.

4.5 Designated Complimentary Therapist - This is any practitioner of a complimentary therapy who has obtained the appropriate qualification from a recognised organisation and is approved by Mersey Care NHS Trust.

4.6 Non-medical prescriber **-** In accordance with legislation pharmacists and nurses who have completed accredited courses to become non-medical prescribers may prescribe medication within the procedure set out in The Non-medical Prescribing Procedure.

4.7 Authorised Pharmacy Staff **-** This is any qualified and registered pharmacist or pharmacy technician or qualified pharmacy dispensing assistant authorised by the chief pharmacist as competent and appropriate to perform a specific function.

4.8 Authorised Employee **-** A member of staff who has, following training, been authorised by the Trust to undertake specific duties in relation to medications.

4.9 Bank/Agency Staff **-** Bank or agency staff unfamiliar with Trust policies should not undertake any administration of medication. Regular bank or agency staff confident in Trust policies may administer alone with the approval of the appointed practitioner in charge. Bank and agency staff should be made aware before agreeing to work a shift that they will be expected to administer medication alone. They should not be pressurised into working in an area where they do not feel confident to do so.

4.10 Non-registered Nursing Staff - Nursing assistants, healthcare workers and support workers who assist in medicines management. Some of these staff may have obtained NVQs allowing them to undertake certain functions with respect to the administration of medication.

4.11 Medicine/Medication **-** Any substance or combination of substances presented in a form for treating or preventing disease or illness. The substance or combination of substances which may be administered with a view to making a medical diagnosis, restoring, correcting or modifying physiological or psychological functioning.

4.12 Prescribe - Authorise in writing the supply of a medicine or medication.

4.13 Dispense **-**To prepare an appropriate medicine for a service user for self-administration or by administration by a second individual. The act of dispensing includes supply and also encompasses a number of practical functions, for example checking the validity of the prescription, the appropriateness of the medication for the individual, the assembly of the product. These functions are usually performed under the supervision of a qualified pharmacist.

4.14 Supply - The act of supplying a medication to a service user or carer for administration.

4.15 Administer/Administration – To give a medication to an individual either by introduction to the body, (e.g. orally, by injection, per rectum or per vagina), or by external application, for example in the form of a cream or an ointment.

4.16 Patient Group Direction (PGD) – A Patient Group Direction is a specific written instruction for the supply and administration of a named medication in an identified clinical situation in the absence of a written prescription. Patient Group Directions must be drawn up within the Trust by a multi-disciplinary group including doctors, pharmacists, nursing staff and other professionals approved by the Drugs & Therapeutics/Medicines Management Committee. **The process for PGD development is covered by the trust medicines management procedure (MM 2 - How Patient Group Directions (PGDs) are developed and implemented in the trust)** A copy of the full portfolio of PGDs can be obtained from the pharmacy at Mossley Hill Hospital.

5. DUTIES

5.1 **Chief Executive** - The Chief Executive has the overall statutory responsibility for the safe and secure handling of medicines within the Trust with ultimate responsibility for the implementation and monitoring of policies in use in the Trust. This responsibility may be delegated to an appropriate colleague.

5.2 **Medical Director** - The Medical Director is the Executive Director responsible for Pharmacy and Medicines Management and has The Board of Directors responsibility for all aspects of Medicines Management. They are also responsible for ensuring all medical staff are trained to carry out the tasks required of them in the prescribing and management of medicines.

5.3 **Associate Medical Director (Medicines Safety)** - The Associate Medical Director with responsibility for Medicines Safety will carry out the duties trust Medicines Safety Officer (MSO) and Accountable Officer for Controlled Drugs (CDAO). The MSO will chair the trust's Medicines Safety Group and is responsible for the quarterly Controlled Drugs LIN returns.

5.4 **Medical Staff** - Medical staff are responsible for prescribing medicines for service users. It is their responsibility to comply with legislation, the Trust Medicines Policy and Clinical Guidelines and Formulary. Medical staff should also consider the advice of the trust's Drugs and Therapeutics Committee and all matters that arise relating to medicines.

5.5 **Chief Pharmacist** - The Chief Pharmacist is Chair of the Drugs and Therapeutics Committee and has responsibility for co-ordinating the activities of the Committee to ensure that good practice relating to medicines, as described in this policy. The Chair will report any medicines management issues to the Quality Assurance Committee. The Chief Pharmacist is also responsible for ensuring all pharmacy staff are trained to carry out the tasks required of them in the management of medicines. The Chief Pharmacist is also responsible for liaising with those services that are provided under a service level agreement (SLA) – for example the medicines supply for the Specialist Learning Disabilities Division which is provided via East Lancashire Teaching Hospitals NHS Trust.

5.6 **Pharmacy Staff** - Responsible for providing information and advice to Trust personnel on all aspects of medicines management within the Trust, assisting where appropriate in local procedures at ward, clinic and departmental level, ensuring compliance with the laws relating to the safe and secure handling and storage of medicines.

5.7 **Executive Director of Nursing** - The Executive Director of Nursing is responsible for ensuring that nurses act in accordance with this policy and that they are trained to carry out the tasks required of them in the management of medicines.

5.8 **Ward and Community Nursing Staff** - The Practitioner in Charge of the ward/team is responsible for all aspects of management of medicines within their ward or department at all times and are Responsible for the operational implementation of the Medicines Policy, including ensuring staff within their ward / department attends appropriate training.

5.9 **Ward/team staff** are responsible for carrying out duties related to medicines management in accordance with this and other medicines related policies.

5.10 **All trust staff** are responsible for undertaking appropriate medicines management training and following guidance set out in this Policy and any other medicines related policy, procedure or guidance.

5.11 **Trust Committees**. The Drugs and Therapeutics Committee (DTC) is responsible for developing guidance on prescribing for Trust clinicians. The DTC reports to the Quality Assurance Committee. The Medicines Safety Group is a working group of DTC that is responsible for the response to and learning from medicines related incidents and or errors.

6 PROCESS - THE PRESCRIBING AND ORDERING MEDICATION

6.1.1 Only staff suitably qualified and employed by Mersey Care, including those on an Honorary Contract may prescribe on Trust stationery.

6.1.2 All medication prescribed will follow Mersey Care and Pan-Mersey Formulary and clinical guidelines and must be in line with General Medical Council Code of Practice for doctors or other professional bodies for non-medical prescribers. Up to date formulary information is found on the trust website at http://www.merseycare.nhs.uk/What_we_do/CBUs/Specialist_Management_Services/Pharmacy/Mersey_care_Clinical_Guidelines_Formulary.aspx
Prescribers should also be aware of information relating to medicines safety alerts. A record of alerts is kept on the trust Pharmacy webpages.

6.1.3 When selecting medications to be prescribed service user's religious preferences and personal beliefs must be considered. Prescribers should be aware that products may contain pork or beef derivatives, and liquids may contain alcohol. Further advice can be sought from the trust's Medicines Information service.

6.1.4 As of 01-01-17 the trust is in the process of rolling out an Electronic Prescribing and Administration (EPMA) system. There will be a period of transition whilst the trust moves from traditional paper-based prescribing and recording of medications to the electronic system. The principals described below apply to both systems.

6.2 Prescribing and Administration of medicines on a ward or bedded unit.

6.2.1 Medical staff have the responsibility to ensure that any history of drug allergy or drug sensitivity is recorded in the appropriate section of the service user's inpatient administration chart/EPMA system.

6.2.2 Confirmation of the usual medication with the GP. It is the responsibility of the doctor and nursing staff admitting a service user to ensure a faxed copy of all medication usually prescribed by the GP is received and filed in the medical record. This is to confirm what medication the service user should continue whilst under the care of the Trust and forms the important first stage of the Medicines Reconciliation process.

6.2.3 A medical or dental practitioner or registered non-medical prescriber must write all prescriptions/treatment charts or on the EMPA system. Medical students are not allowed to prescribe. Service user's name, hospital number and date of birth, ward and the name of the consultant/RMO must be entered on the prescription sheet/EPMA system.

6.2.4 Nurses must not transcribe medication charts when they need rewriting – this is the responsibility of the prescriber.

6.2.5 A date on which treatment is to commence must be entered on the prescription sheet/EPMA system.

6.2.6 The name of the medication should be written legibly in black ink using block capitals and approved names. Proprietary names (brand names) must not be used. Exceptions to this are for multi-ingredient preparations, sodium valproate and lithium products. This includes details of oxygen therapy. For EPMA the medication must be selected from the appropriate list of medication.

6.2.7 The dose of medication must be expressed in metric units. Quantities less than 1g must be written as milligrams. The use of decimal points should be avoided, for example, 500mg not 0.5g should be written in order to avoid confusion, however, when a decimal point is necessary great care must be taken by the prescriber and the nurse administering the drug. For all medications prescribed in quantities less than 1mg the terms microgram and nanogram must be used. They must not be abbreviated but should be printed in full.

6.2.8 The formulation of the medication should be specified.

6.2.9 Liquid preparations should show the dose in milligrams/micrograms or the strength of the preparation and the dose expressed in millilitres.

6.2.10 If the service user has difficulties in swallowing medication the pharmacy should be contacted for advice on alternative formulations. Tablets must not be crushed or capsules opened without prior discussion with pharmacy.

6.2.11 Only the following abbreviations are acceptable for use on administration charts and prescriptions used in Mersey Care NHS Trust:

mg – milligram
g – gram
kg – kilogram
L – litre
ml – millilitre
mmol - millimol

6.2.12 The dose required must not be expressed in terms of dosage form for single ingredient preparations, for example lorazepam 2 tablets is not acceptable, it should be written as lorazepam 2mgs. In the case of insulin preparations the dosage must always be written in full and units must not be abbreviated. The EPMA system will support this approach.

6.2.13 Route of administration; only the following abbreviations are acceptable for use on Mersey Care NHS Trust prescriptions and administration charts:
I.M. – intramuscular
INH – inhalation
I.V. – intravenous
NEB – nebulised
P.O. – oral
P.R. – rectal
P.V. – vaginal
S.C. – subcutaneous
S.L. – sublingual
TOP – topical (the place of application should be specified)
N.G. – nasogastric
P.E.G. – percutaneous endoscopic gastrostomy
Other routes of administration must be written in full.

6.2.14 Only one route of administration may be specified for each medication, for example lorazepam P.O./I.M. is not acceptable. If a second route is required this must be prescribed as a separate item.

6.2.15 For 'when required' medications, the frequency of administration and clear, unambiguous indication for use must be written by the prescriber. A maximum dose in 24 hours must be stated and this must include any regularly prescribed doses. Abbreviations such as 4^0 should not be used, 4 hourly should be written out in full. As required medication must be regularly reviewed by the prescriber to determine the on-going clinical need for that medication. Good practice indicates that there should be not more than 4 (four) doses given without a review by the prescriber. No more than one medication from any BNF therapeutic category should be prescribed as prn at the same time. Care should be taken not to duplicate items that are prescribed regularly due to possibility of overdosage e.g. paracetamol

6.2.16 Oxygen is prescribed in all situations in accordance with BTS guidelines (but note these do not cover critical care or children under 16 years). In an emergency, oxygen should always be given immediately and documented later. In cases where Medical Gases (including oxygen) need to be prescribed routinely there should be a review by the relevant clinical director 0R a senior medical officer to determine whether it is more appropriate for care to take place within an Acute Trust. A separate procedure for Oxygen is in operation in the trust and is overseen by the Lead Nurse for Physical Healthcare.

6.2.17 The date when a medication is to discontinue must be entered on to the prescription sheet/EPMA system. For traditional charts the entry must be initialled and dated by the medical officer who discontinues the medication

6.2.18 Prescriptions are valid for a maximum of six months unless otherwise specified (e.g. for Controlled Drugs – see Chapter 5).

6.2.19 If a dose prescribed is greater than the BNF limits this should be indicated in the medical notes after discussion with MDT and clinical pharmacist. The trust

regularly audits the use of High Dose and Combination Antipsychotics and prescribers must be familiar with the trust procedure MM11 .

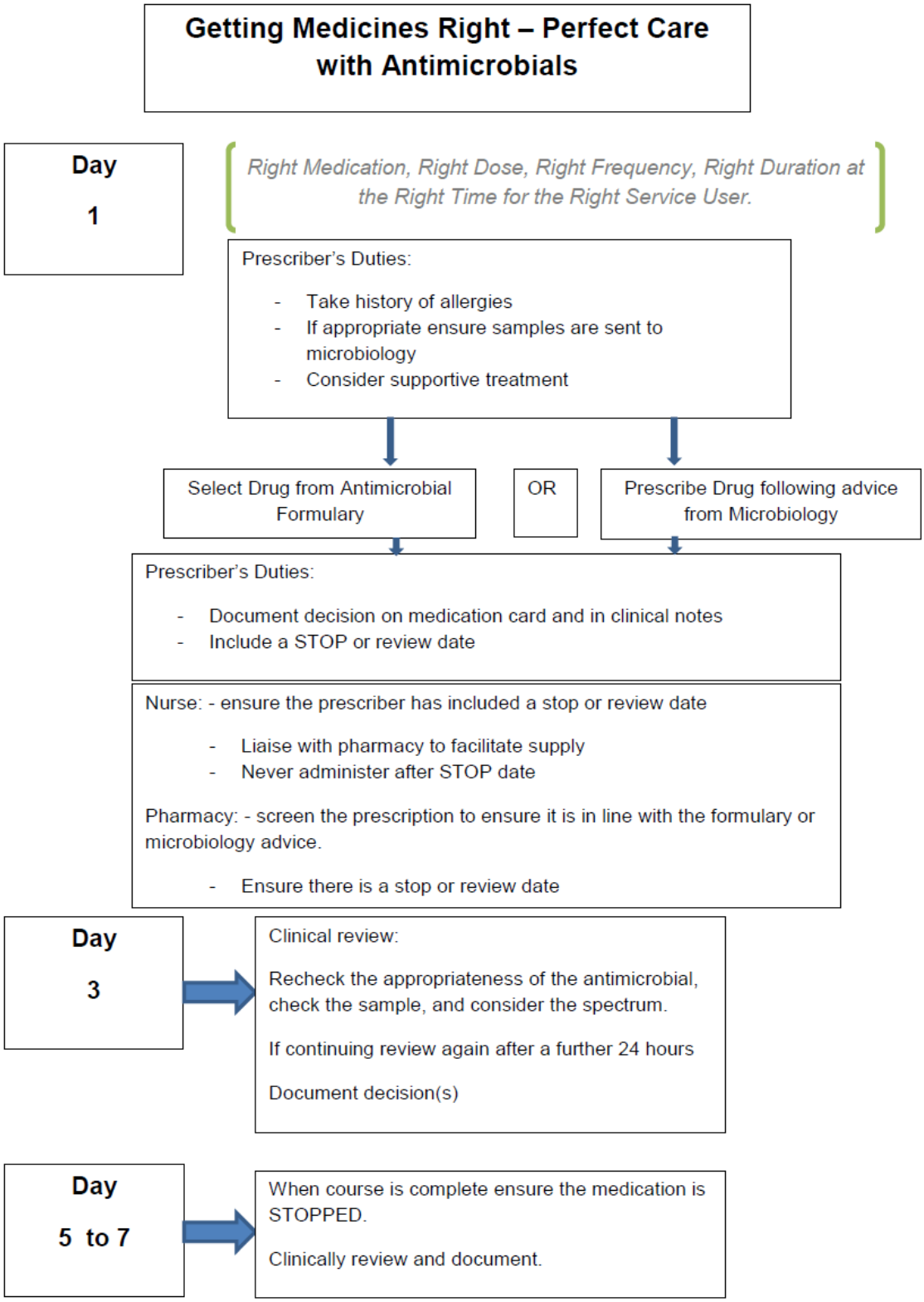
6.2.20 All service users should have access to information regarding their medication – both regular prescriptions and when required items. The trust as developed a set of Patient Information Leaflets for the most commonly used medication. Pharmacists are always available to talk to service users about any medication issues. If easy read or if information is required in different languages staff should contact Medicines Information on 0151 250 6011 and they will be able to source an appropriate leaflet for the individual service user.

6.2.21 Current guidance on the prescribing of Injectable medicines within the trust can be found on the trust website at http://www.merseycare.nhs.uk/services/clinical/pharmacy/pharmacy_services/Injectable_Medicines.asp and further information is available from Medicines Information on 0151 250 6011.

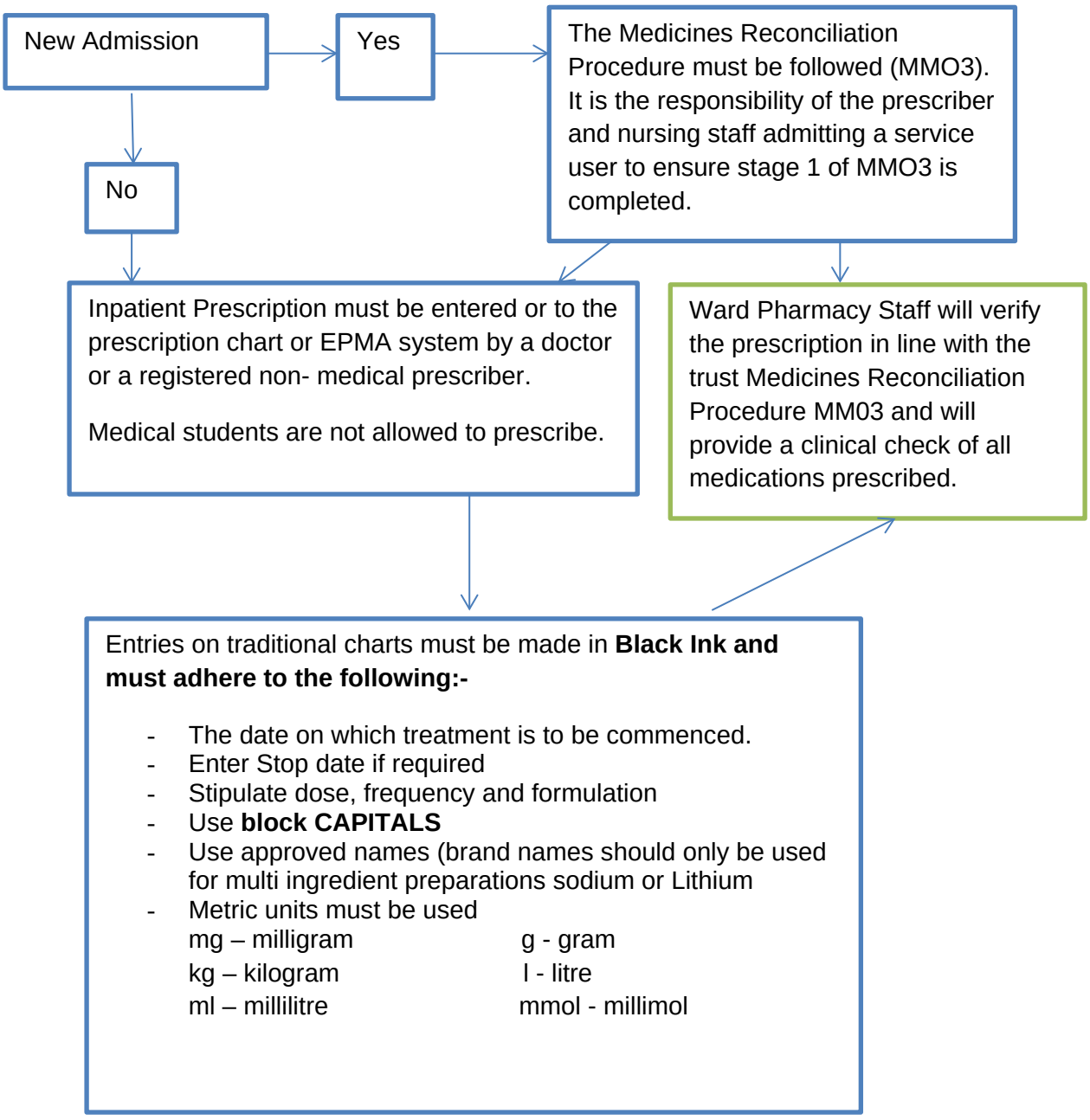
6.2.22 Antimicrobials must be prescribed in-line with the trust shared formulary, (additional copies of this can be obtained from the Pharmacy Office on 0151 250 6030) or on the advice of a specialist microbiologist. All prescriptions for antimicrobials should clearly indicate a stop date (or be annotated with the words ‘for long-term prophylaxis’ where necessary). All suspected cases of Clostridium Difficile or MRSA must be reported immediately to the trust Infection Control team.

6.2.23 Antimicrobial prescribing undergoes regular audit and surveillance with reports overseen by the Infection Prevention and Control Committee.

6.2.24 Antimicrobials should be prescribed with the ‘Start Smart then Focus’ approach, as described below:-


Getting Medicines Right – Perfect Care with Antimicrobials
Day 1
Right Medication, Right Dose, Right Frequency, Right Duration at the Right Time for the Right Service User.
Prescriber's Duties:
- Take history of allergies
- If appropriate ensure samples are sent to microbiology
- Consider supportive treatment
Select Drug from Antimicrobial Formulary
OR
Prescribe Drug following advice from Microbiology
Prescriber's Duties:
- Document decision on medication card and in clinical notes
- Include a STOP or review date
Nurse: - ensure the prescriber has included a stop or review date
- Liaise with pharmacy to facilitate supply
- Never administer after STOP date
Pharmacy: - screen the prescription to ensure it is in line with the formulary or microbiology advice.
- Ensure there is a stop or review date
Day 3
Clinical review:
Recheck the appropriateness of the antimicrobial, check the sample, and consider the spectrum.
If continuing review again after a further 24 hours
Document decision(s)
Day 5 to 7
When course is complete ensure the medication is STOPPED.
Clinically review and document.

Overview of Prescribing on an inpatient ward.



6.3 Ordering medication - The procedures below apply to all wards except for those in the **Specialist Learning Disabilities Division**; who should follow procedure **MM 15**. For this division medications are ordered and supplied via East Lancashire Teaching Hospitals NHS Trust under a SLA.

The standard operating procedure for of the Local and Secure Divisions are described below.

Ordering Ward Stock Medication from the Trust Pharmacy Departments

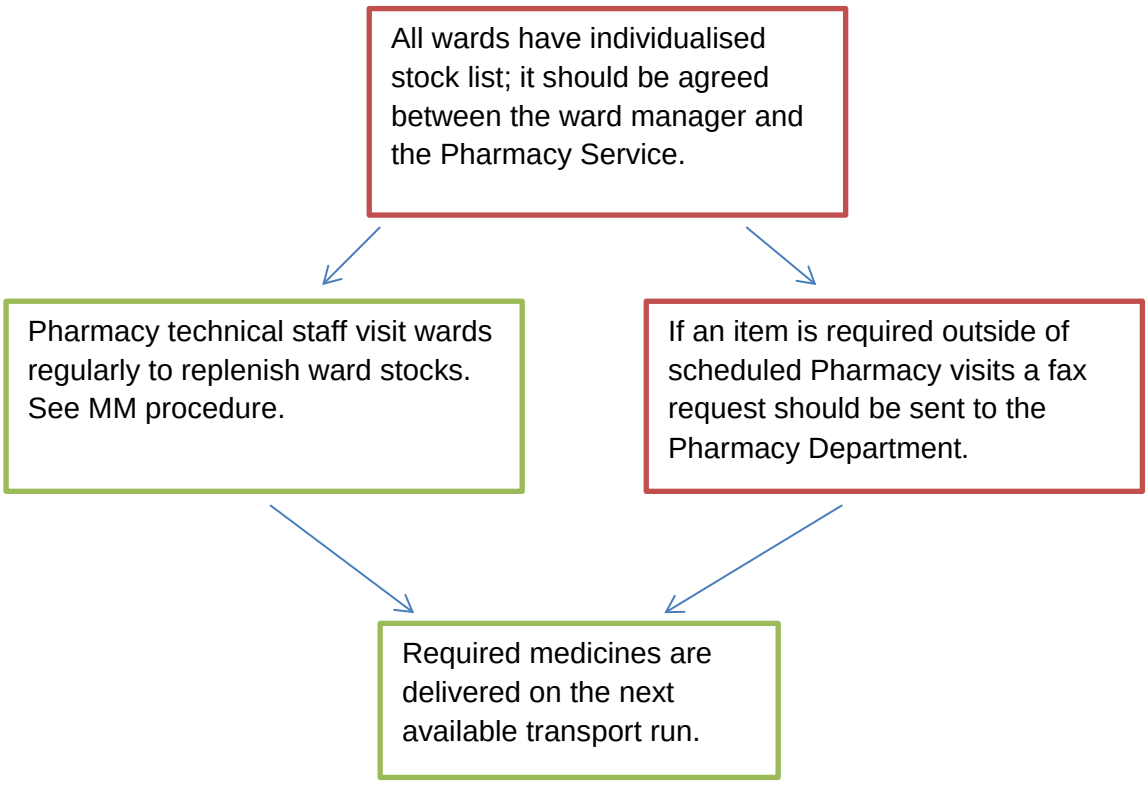
6.3.1 All wards have an individualised stock list. These are commonly used medications that are retained at a ward level.

6.3.2 The ward stock list will be agreed between the ward manager or delegated nurse and the trust pharmacy department and will change in accordance with prescribing patterns.

6.3.3 Pharmacy technical staff visit wards regularly to replenish ward stocks. A sign in the treatment area will give details of the technical staff visits

6.3.4 If an item is required before the next scheduled visit, a fax request should be sent to the pharmacy department. The medications will then be delivered on the next appropriate transport run.

Ordering Stock Overview



Ordering Individual Patient Items

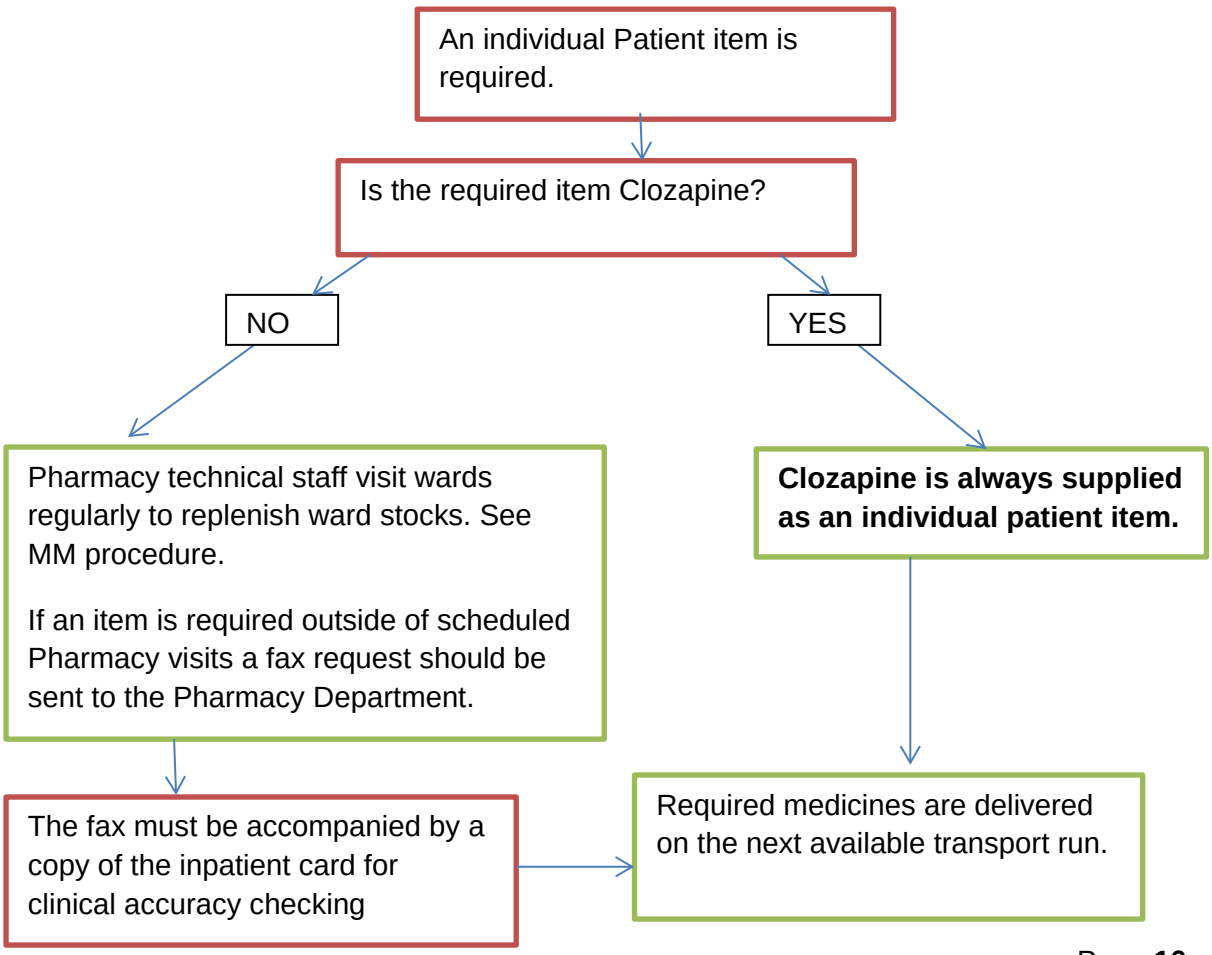
6.3.5 Pharmacy technical staff visit wards regularly to replenish individual patient items. A sign in the treatment area will give details of the technical staff visits. If an item is required before the next scheduled visit, a fax request should be sent to the pharmacy department plus a copy of the in-patient prescription card. The medications will then be delivered on the next appropriate transport run.

6.3.6 Individual patient items are supplied for the sole use of the service user whose name appears on the label. These medications are either rarely used or of high cost.

6.3.7 Clozapine is always supplied as an individual patient item. All service users that receive clozapine must be registered on a database and have regular blood tests. Clozapine must never be administered to a service user whose name does not appear on the label without consent of trust pharmacy staff.

Ordering Individual Patient Items Overview

6.3.8 These medications will be used less frequently across a ward and therefore supply is tailored to each service user need. Occasionally these medicines may also be high cost or supplied with a short expiry date.



6.4 Ordering Prescribed Leave Medication

6.4.1 Leave medications will be labelled with full instructions for the service user to follow. For example “One tablet to be taken twice a day”.

6.4.2 Leave prescriptions must be written and signed by a doctor or registered non-medical prescriber. Nursing staff must not write leave prescriptions.

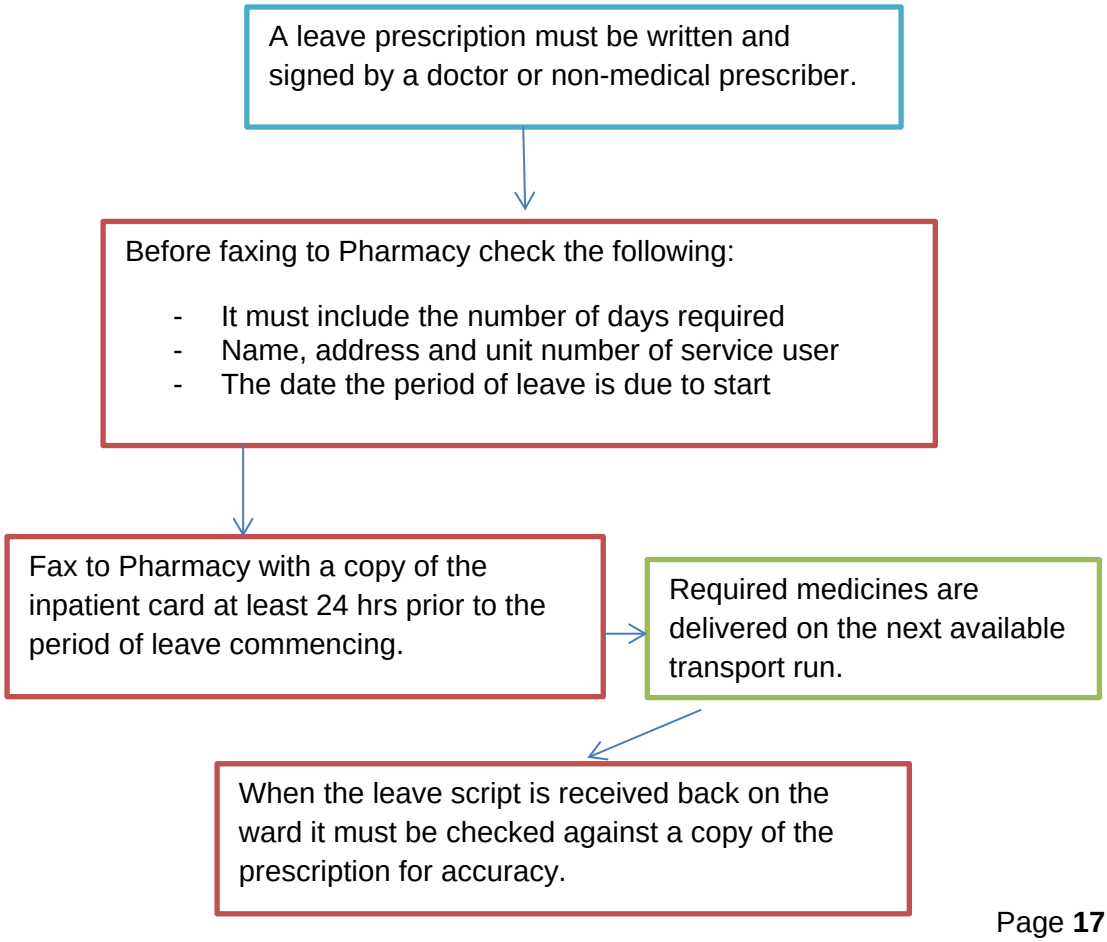
6.4.3 The number of days that the leave medication is required for must be stated clearly.

6.4.4 The name, address and unit number of the service user should be clearly indicated on the prescription.

6.4.5 Inpatient service users who receive clozapine and have their ward supplies labelled with instructions may take this supply home on leave – returning the remainder when their leave is over. If there are concerns that service users are not ready for this responsibility then the required amount of clozapine will be supplied in the usual manner.

6.4.6 Each leave prescription, plus copy of inpatient prescription card must be faxed or delivered to pharmacy at least 24 hours prior to the service users leave.

Ordering Leave Medications Overview



6.5 Ordering Prescribed Discharge Medication (TTOs)

6.5.1 Discharge medications will be labelled with full instructions for the service user to follow. For example “One tablet to be taken twice a day”.

6.5.2 Discharge medications must be written and signed by a doctor or registered non-medical prescriber. Nursing staff must not write discharge prescriptions

6.5.3 The name, address and unit number of the service user should be clearly indicated on the prescription.

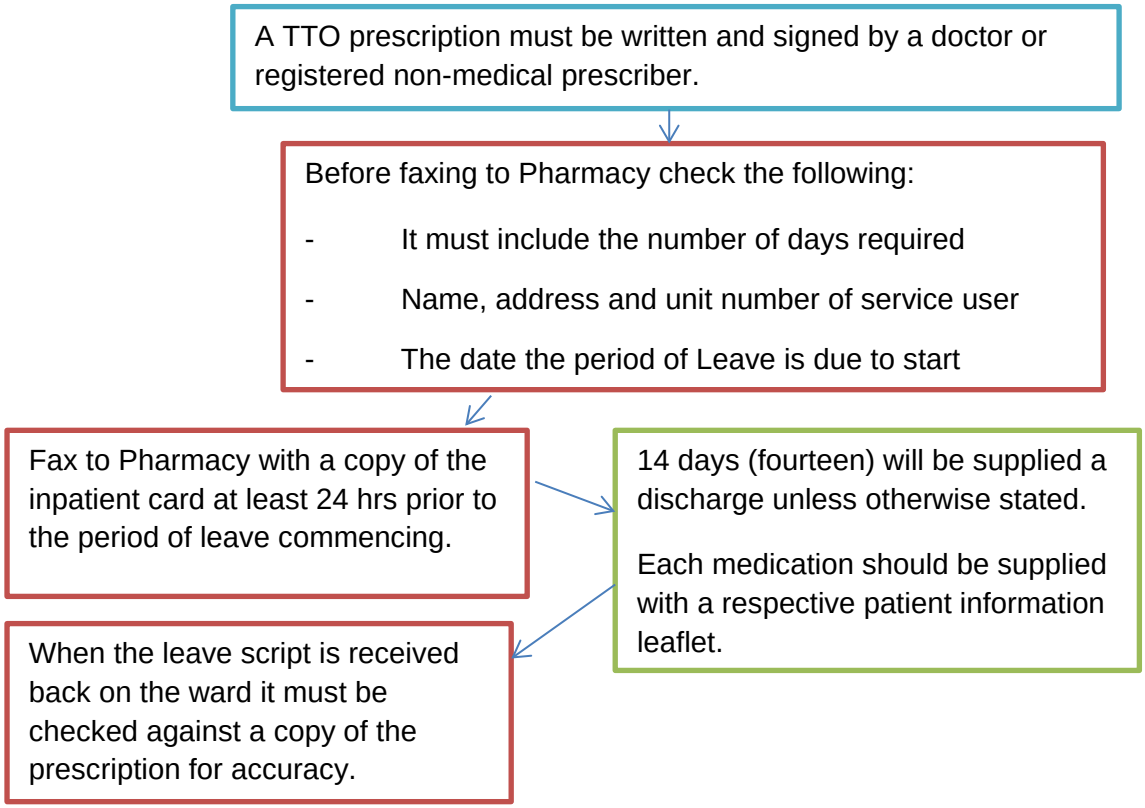
6.5.4 Fourteen (14) days of medication will be issued unless otherwise stated.

6.5.5 Each medication will be supplied with the respective patient information leaflet (PIL).

6.5.6 Inpatient service users who receive clozapine and have their ward supplies labelled with instructions may take this supply home on discharge – as long as there is a sufficient supply until the next clozapine dispensing day for that service user.

6.5.7 Each prescription for discharge, plus copy of inpatient prescription card must be faxed or delivered to pharmacy at least 24 hours prior to the service users discharge. DISCHARGE AND LEAVE MEDICATIONS WILL NOT BE DISPENSED DURING THE OUT OF HOURS PERIOD.

Ordering Discharge (TTO) Medication Overview



6.6 Outpatient Prescriptions

6.6.1 Outpatient prescriptions will be labelled with full instructions for the service user to follow. For example “One tablet to be taken twice a day”.

6.6.2 Outpatient prescriptions must be written and signed by a doctor or registered non-medical prescriber

6.6.3 Service users who receive clozapine as an outpatient will receive medication in accordance with their blood test schedule.

6.6.4 Outpatients that regularly receive medication from a trust pharmacy department will receive the relevant PILs on a quarterly basis.

6.7 Telephone Prescribing

6.7.1 Prescriptions must not be given or accepted over the telephone, except in an emergency. Telephone orders for stock or non-stock items will not be accepted in any circumstances by any of the Trust’s pharmacists.

6.7.2 In an emergency or where waiting for a doctor is considered to be detrimental to patient care, the doctor may prescribe medicines (excluding controlled or recorded drugs) over the telephone. The prescription must be dictated clearly to the senior nurse in charge of the ward or the community mental health nurse and repeated to a second registered nurse/bleep holder. The doctor is advised to record the verbal prescription contemporaneously. In the case of such verbal requests the following must apply:

a The drug, the dosage and the time must be written in the ‘once only’ section of the prescription sheet by the nurse who takes the message. Clearly indicating that this was a telephone message and recording the name of the prescriber and also signing the sheet themselves. If possible a faxed copy of details of the drug prescribed should be faxed to the ward.

b Drug dosage indication at the time of administration must be written in the nursing notes.

c The reason for an administration telephone request must be written in the nursing notes.

d The prescription must be signed by a doctor within 24 hours. If this does not occur, then the senior nurse manager or clinical service manager should be immediately informed.

6.8 Prescriptions for hospital staff and their families

6.8.1 Medical staff should not prescribe for themselves or their families in line with current General Medical Council (GMC) recommendations.

6.8.2 In an emergency staff should attend the Occupational Health Department and the current prescription charge will be payable.

6.8.3 Prescriptions for other Trust staff and their families will not be dispensed by pharmacy, unless the prescription is for emergency treatment or as the result of an injury or illness sustained at work. Routine prescriptions or continuation therapy will not be issued. However, staff attending Trust outpatient appointments will be issued with medication prescribed at that time. As a registered service user of the Trust, the current prescription charge will be payable if applicable.

6.8.4 FP10(HP)s or equivalent must not be used to prescribe for inpatients, private patients, hospital staff or their families, unless they are registered as NHS outpatients.

6.9 Medicines required in emergencies

6.9.1 All drugs borrowed from other wards should be documented and signed for by both wards involved in the process. None of the pharmacies involved in providing a service to Mersey Care NHS Trust routinely dispense discharge medication out of normal working hours.

6.9.2 A valid Trust ID badge will be required to gain access to emergency cupboards and night cupboards throughout the Trust.

6.9.3 Secure and Local Divisions - Wards who receive their pharmacy service via Mossley Hill Hospital will have access to emergency cupboards based at Mossley Hill and Broadoak sites and an automated cupboard at Clock View. If any medication is required in an emergency situation, a duty pharmacist is available via the switchboard on – 0151 250 3000. When emergency duty pharmacists are available outside normal working hours, they are available via a mobile telephone from their own home and are not based within the hospital. If a medication is required out of normal pharmacy working hours, each ward has access to a stock sheet for the emergency cupboards based at Mossley Hill, Clock View and Broadoak. These should be consulted and if the medication is available, should be requested from the ward manager from either of the wards. It should be documented which medications have been taken from the emergency cupboard and where they have been sent.

6.9.4 Ashworth Hospital and Southport Wards also have access to their own electronic out of hours cupboards

6.9.5 Specialist Learning Disabilities Division – Out of hours provision is provided via the SLA with East Lancashire Teaching Hospitals - Please follow procedure MM16.

6.10 Consent to Treatment

6.10.1 Wherever possible the medicines proposed to treat a service user should be discussed with the service user. The discussion should be carried out in such a way that the service user is able to contribute and express agreement or disagreement with the proposed treatment.

6.10.2 "Consent" is the voluntary and continuing permission of the service user to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of the treatment including the likelihood of its success and any alternative to it. Permission given under any unfair or undue pressure is not consent (Mental Health Act 1983 Code of Practice).

6.10.3 It is the duty of everyone proposing to give treatment to use reasonable care and skill, not only in giving information prior to seeking a service user's consent, but also in meeting the continuing obligation to provide the service user with adequate information about the proposed treatment and alternatives to it.

6.10.4 Discussions about the drug treatment and consent to treatment should ideally be when treatment is initiated. The nature and outcome of the discussion together with an assessment of the capacity of the service user to consent should be recorded in the medical notes. If the service user is too ill at the time of the initiation of prescribing the prescriber should seek further consent when the service user is well.

6.10.5 The Nursing and Midwifery Council (NMC) clearly states that nurses should ensure that consent is given prior to administration of treatment.
Information given by pharmacists or other practitioners about the treatment should be provided in addition to that undertaken by the prescriber rather than as an alternative.

6.10.6 Treatment of those without capacity to consent.
When a service user is incapable of consent to treatment, medicines can be prescribed for them in their best interests under the common law doctrine of necessity. The treatment must be:

- necessary to save life, or prevent a deterioration of, or ensure an improvement in, the service user's physical or mental health; and
- be in accordance with the practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question.

6.10.7 Treatment of those detained under the Mental Health Act 1983.
The Mental Health Act 1983 provides the prescriber with a 3-month period to develop a treatment programme to meet the service user's needs. Even though the Act allows treatment without consent the prescriber should observe the same

principles of seeking consent described above. The 3-month period starts on the occasion when medicines for the mental health disorder were first prescribed.

6.10.8 The 3-month rule

The MHA Administrator for each site will remind the Responsible Medical Officer (RMO) at least 4 weeks before the expiry of the 3-month period. The RMO should:

- Seek the service user's consent to continuing medication.
- Record the discussion in the medical notes including an assessment of the service user's ability to consent.
- If the service user consents to continued treatment complete a Form 38.
- If the service user refuses consent or is deemed unable to provide a reliable consent the RMO must request a second opinion appointed doctor (SOAD) visit from the Mental Health Act Commission.

If the SOAD agrees with the RMO that treatment is necessary and should be given the SOAD will complete a Form 39.

6.10.9 Practitioners must not administer medicines to service user's detained under the Mental Health Act 1983 after the 3 month period without first ensuring that a valid Form 38 or Form 39 has indicated that the treatment can be given.

7 PROCESS - THE ADMINISTRATION OF MEDICINES

7.1 **General standards -** All medications administered to service users must be written on the prescription sheet or recorded on the EPMA system. When medication is administered to service users the administration record must be annotated with the initials of the nurse giving the medication or with the relevant non-administration reasons to explain why the medication was not given. Full details of codes to be used are on the inpatient medication card.

Specialist Learning Disabilities Division should also follow procedure MM 14.

7.2 Medicines must only be administered in a line with a valid prescription that has been written by a doctor or registered non-medical prescriber, or in the case of discretionary medicines – by a nurse who has successfully completed the Trust discretionary medication training course, and any updates as they arise

7.3 In the case of prescriptions that are illegible, incomplete or unclear, the nurse, as the service user's advocate, should draw the prescriber's attention to this fact. (In a similar way, NMC standards require nurses not to administer any medicine if they have doubts about the safety or appropriateness of administration). The prescriber or on-call doctor should re-write the prescription or administer the medicine personally. If the prescriber refuses to rewrite the prescription, the nurse **must not** administer the dose but should contact his or her manager, or more senior medical assistance.

7.4 Prescriptions annotated or amended by the pharmacist after contacting the prescriber should be administered in accordance with the amended instructions.

7.5 Before administration, the nurse and the witness must check the service user's identity, the name, strength and expiry date of medicine (where available), the dose to be given, route and time of administration, drug sensitivity, and that the prescription is valid. The trust has a separate policy for the Identification of Service Users (Policy SA:36) that provides clear guidance to staff on what to do in order to ensure that service users in receipt of care and treatment provided by the Trust are correctly identified. It sets out the requirements for checking the identification of service users in the different areas of the trust with reference to what staff must do prior to administering medication. The policy can be found on the trust website.

7.6 Registered nurses must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications. If any problems arise, pharmacy or a doctor should be contacted.

7.7 The dose should then be administered, and after the nurse has satisfied himself or herself that the medicine has been taken, by ensuring the service user has drunk some water and by talking to service user, the prescription chart should be completed appropriately and clearly.

7.8 Where supervising a student nurse in the administration of medicines the supervisor should clearly countersign the signature of the student.

7.9 Prior to administering medications nursing staff should also be aware of information relating to medicines safety alerts. A record of alerts is kept on the trust Pharmacy webpages.

7.10 Medicines MUST NOT be left on service user's lockers, or in medicine pots in Treatment areas. If medication is refused by a service user it should be discarded immediately - single tablets/capsules may be disposed of in a sharps container and single liquid doses may be thrown down the sink. This is not the case for controlled drugs, cytotoxic and cytostatic agents – in which case pharmacy should be contacted for advice.

7.11 Medicines should not routinely be given to non- registered staff such as nursing assistants / health care workers or support staff to administer. In exceptional circumstances, for example if there is only one member of trained staff available on ward, such staff can administer medications so long as they have successfully completed Mersey Care NHS Trust's- The Role of the Witness in the Safe Administration & Documentation of Medicines eLearning module and assessment in practice. The qualified member of nursing staff undertaking the medicine round should ensure the following:

a. That the medicine has been received by the correct service user

b. That the medicine has been taken by the correct service user

c. That by allowing an unqualified member of staff to administer medication there will be a positive effect on compliance with medication regimes

d. That this member of staff has a good working relationship with the service user.

7.12 With the exception of subcutaneous heparin, all injections should normally be administered separately from the routine oral medicine round. Following the publication of NPSA alert 20: Promoting Safer Use of Injectable Medications the trust has produced extensive guidance on the preparation and administration of injections including monographs for injectable medications that are commonly used within the organisation. Staff can obtain monographs on injections by contacting Medicines Information on 0151 250 6011:-

7.13 If two consecutive doses of a medication are not administered for whatever reason, the prescriber should be contacted in order to review the prescription.

7.14 Where a medication is not available for administration the ordering medication section of this policy should be followed i.e.

- *MON – FRI (9am-5pm) send or fax the medication card and requisition to pharmacy or contact the ward pharmacist/technician.*
- *WHEN PHARMACY IS CLOSED use one of the emergency cupboards*
- *Borrow the medicine from another ward with the permission of the bleep holder.*
- *Use the service user's own medicines after inspection.*
- *If none of the above are possible then contact the emergency duty pharmacist via switchboard. (Mon-Fri after 5pm and at weekends)*

NB – CLOZAPINE MUST ONLY BE GIVEN TO THE NAMED SERVICE USER IT IS DISPENSED FOR. DO NOT LEND CLOZAPINE TO ANY OTHER WARD OR SERVICE USER UNLESS SPECIFICALLY AUTHORISED BY A PHARMACIST. THIS IS TO ENSURE THAT THERE IS A CURRENT BLOOD TEST.

7.15 Nurse Administration -The administration of medication should ideally be carried out by two registered nurses or by one registered nurse and one suitably trained other person. A suitably trained other person is one who has successfully completed Mersey Care NHS Trust's - The Role of the Witness in the Safe Administration & Documentation of Medicines eLearning module and assessment in practice. A pharmacist or doctor can act as a witness if necessary. For learning purposes, a nurse in training may be involved, with an authorised nurse practitioner, in the administration of medicines. The responsibility for the administration of the medicines still remains that of the nurse practitioner (this excludes checking Controlled drugs see section 5.8, or recorded drugs see section 6.3)

7.16 Only where specific pre-arranged lone working constraints apply – e.g. within community settings, should a registered nurse undertake single nurse administration of medication. This also applies within the Specialist Learning Disabilities Division, where a programme to develop suitable trained witnesses is under-development following the division becoming part of the trust. As of 01-01-17 **Specialist Division staff should follow procedure MM15**.

7.17 Single nurse administration does not apply to:

- Controlled drugs
- Where the dose requires a complex calculation e.g. one that takes into account factors such as dosage based on body weight (not usually applicable for depots)
- Any area of IV therapy including IV infusions
- Rapid Tranquillization – see Trust policy (SD11)
- Under Section 62 – i.e. Urgent Treatment

The requirements of Section 57 and Section 58 do not have to be followed in certain circumstances, where urgent treatment is required. These circumstances are where the treatment is immediately necessary:

(i) to save the service user's life

(ii) to prevent a serious deterioration in the service user's condition, so long as the treatment is not irreversible

(iii) to alleviate serious suffering so long as the treatment is neither irreversible nor hazardous

(iv) to prevent the service user from behaving violently or being a danger to self or others so long as the treatment is neither irreversible nor hazardous, and represents the minimum interference necessary.

- For telephone prescriptions

7.17 Administration of Medicines by Medical Staff

7.17.1 Should the need arise for medical staff to prescribe and administer medicines themselves:-
These must be prescribed on the prescription sheet

(i) The normal checks for dose, drug compatibility and allergies must be undertaken

(ii) Medicines must be checked with a registered nurse prior to administration

7.18 Administration of Medicines Before or Without a Prescription

The usual practice is that no medication should be administered to a service user in the absence of a valid written prescription. There are currently some exceptions:

7.18.1 A registered nurse, who has successfully completed the Mersey Care Discretionary Medication Administration Course, and any updates as required, may administer ‘homely remedies’ such as laxatives, analgesics and antacids to adults provided that the drug(s) are contained within the “Discretionary Medicines Procedure” which has been approved by Mersey Care NHS Trust, within the indications and doses listed..

7.18.2 In extreme circumstances, a drug may be given on verbal instruction from the doctor to two nurses. Provided that the name, dose, and route of the drug are recorded on the prescription sheet and nursing care plan by the nursing staff, and countersigned by the doctor within 24 hours (see section 3.7.2).

7.18.3 Two CPNs may receive a verbal instruction from a doctor as in 4.5.2 . They should ensure all documentation as above and that a prescription is written within 24 hours. This may involve the service user's GP

7.18.4 Any other form of self-medication or nurse prescribing within the Mersey Care NHS Trust must be agreed by and authorised by the Service Governance Committee. Different services may have slightly different policies.

7.19 **Medicines Related Duties Performed by Non-Registered Nurses**

7.19.1 General points relating to suitably trained other persons - Staff who have successfully completed the Mersey Care NHS Trust The Role of the Witness in the Safe Administration & Documentation of Medicines eLearning module and assessment in practice, the record of which must be available for scrutiny within an individual's personal development portfolio, may be authorised by the Trust to assist a Designated Practitioner to perform the following:

- Check the medicine label with the prescription as a second check. (This does not apply to injectable medicines which require complex calculations - see 4.2)
- Administer oral and topical medicines (including inhaler, eye and ear drops) to a service user once prepared and checked by a Designated Practitioner, and witnessed by the trained member of staff
- Check Controlled Drugs with a Designated Practitioner
- Check Recorded Drugs with a Designated Practitioner
- Assist in the administration of controlled drugs as a "second checker" of the Designated Practitioner if only one registered nurse is on duty in the ward
- Assist in the administration of recorded drugs as a "second checker" of the Designated Practitioner
- Check the service user's name and hospital number against the prescription with a Designated Practitioner.
- Check discharge medicines with a Designated Practitioner against a discharge prescription.
- Witness the self-administration of medicines either in a inpatient area or in a service user's home following patient specific assessment and training by a Designated Practitioner.

17.9.2 Recording of signature of the Witness (or Suitably Trained Other Person)
All medicines administration that has been witnessed must be recorded; this requires the signature of the witness on the Prescription Card or via the Electronic Prescribing and Medicines Administration (EPMA) system for each drug administered.

- Prescription Card: the prescription card must be signed with the initials of the nurse giving the medication and the witness (suitably trained other person) for each item administered.

- EPMA: All medicines are set-up on the JAC EPMA system so that a witness signature is requested following administration.
  When nursing staff administer medicines using EPMA the witness is required to sign within JAC to say that they have witnessed the administration. The system will prompt the nurse to ask the witness to sign each time they administer medicines.
  Instead of a handwritten signature or initials the witness must sign with a unique username and password. This is fully auditable within the system and each second checker has their own JAC EPMA account to sign with.
  If there is no second checker there is a process to bypass this however the administering nurse must then sign in to the system again to acknowledge the risks of administering without a witness.
  (NOTE: JAC is the name of the software the Trust use to facilitate EPMA)

7.19.3 Duties that cannot be performed by a suitably trained other person

- Preparation and supply of medicines
- Administration of medicines by injection, rectally or vaginally
- Use of intravenous infusion pumps
- Direct administration of Controlled Drugs
- Supply of discharge medicines

8 PROCESS - USE OF SERVICE USER'S OWN MEDICINES AND SELF ADMINISTRATION

8.1 Service users should be encouraged to bring all current medication into hospital on admission or to their first outpatient appointment. These medicines are the property of the service user, however the trust will re-use medications that are deemed as being appropriate during an inpatient stay. Please Note staff should not rely on medicines in the service user's possession being an accurate record of the medications that they currently take.

8.2 Service user's own medicines, including trial medications may be re-used in hospital but they must first be inspected and re-labelled if necessary. Patient own medication which is not labelled with the service user's name will be destroyed unless the service user has specified otherwise during their stay. Drugs must not be administered until they have been positively identified and checked, either by a pharmacist or by a doctor. It should be considered essential to remove excess medication due to there being a perceived higher

risk of suicide attempts. This should still be discussed with the service user and the multi-disciplinary team if possible. Advice must be given on the importance of getting rid of any other medication which is not currently prescribed that may be at the patient's home, preferably by taking it to a pharmacy.

8.3 The Drugs and Therapeutics Committee has approved the use of the **Self Administration Procedure (SAM) MM01** for use within the trust in applicable areas. Service users wishing to self medicate have the option to do so as long as it is agreed as part of their care plan and in line with MM01.

8.4 It is the responsibility of the ward manager or nurse in charge to ensure that service user's are made aware upon admission of the importance of not taking medications without the knowledge of hospital staff. Service users must also be aware of the importance of providing an accurate medication history.

9 PROCESS COMMUNITY TEAMS AND SERVICES

The trust has a separate procedure - **MM12: Procedure for Ordering, Receipt, Storage and Monitoring of Medicines in the Community Teams , staff working in community teams should refer to this.**

General points

9.1 For each community team base where medicines are stored, a suitably qualified practitioner must be designated as the Appointed Practitioner in Charge. This Appointed Practitioner in Charge is ultimately accountable for the stock of all medicines held, ensuring that Medicine Code procedures are followed correctly and that the security of medicines is maintained.

9.2 Designated Community Practitioners should possess a properly authenticated Mersey Care NHS Trust identification badge. The range of medicines carried will be specified by the stock list and will be agreed by the Appointed Practitioner in Charge and mental health pharmacist.

9.3 All medicines carried by the Community Practitioner must be prescribed as a specified dose for a named service user by a prescriber e.g. on a depot card. Additional medicines may be carried to allow for breakages or emergencies.

9.4 Each medicine to be carried must be accompanied by the written prescription on the relevant medicine card and the dose administered must be recorded.

9.5 All medicines will be supplied by the pharmacy and must be kept in a separate locked medicine cupboard made to BS standard BS2881 (1989) to which the Designated Community Practitioners have access. The Designated Community Practitioner must keep the medicine:

- In an inconspicuous case when visiting a service user.
- In a locked case out of sight within the locked boot of a car when travelling between visits.

9.6 Whenever practicable unused medicines should be returned to the medicine cupboard at the team base for overnight and weekend storage. Where this is not possible, they may be stored in a locked cupboard or drawer at home but not for longer than 72 hours.

Medicines no longer required by service users should be disposed of by returning them to the pharmacy of origin.

9.7 Re-Prescribing of Depot Medication- The trust standard is as follows:

Prior to continuing the prescription of depot medication, the clinician should have sight of the original depot card to confirm the current dose of medication. If this card is not available every attempt should be made to locate it, as this is the most accurate record of the dosage that the service user is currently receiving.

Prescribing medication without sight of the card and the loss of the card is an adverse incident and should be recorded as such

If the prescription is to be made without sight of the card the following should be undertaken:-

- Review case notes / ePEX for confirmation of dosage / frequency
- Confirm dosage and frequency with care co-ordinator, if available. If not immediately available and it is deemed clinically necessary for depot

medication to be delivered without delay, to confirm dosage and frequency with care co-ordinator as soon as possible.

- Confirm frequency / dosage with service user – if available
- Check appropriateness of dosage / frequency with BNF / Pharmacy, etc. – if there is any doubt
- Review the dosage / frequency at the next CPA Review and confirm acceptance by team of prescribing within the notes

9.8 Social Services Staff:

Social services staff working within Mersey Care should follow the Trusts medicines policy

9.9 Role of Non-Registered Staff

Non-registered staff may deliver dispensed medicines and aid compliance with medication by reminding and encouraging individuals to comply with treatment regimes. They must not re-dispense medication into other containers or dosset boxes.

All staff have a duty to provide information on medicines (Information sheets are available from the Medicine Information service on 0151 250 6011) and report suspected side-effects to the team.

9.10 Nurse Dispensing -The Medicines Act 1968 clearly states that nurses should only dispense in exceptional circumstances and to the same standards as a pharmacist. See NMC Guidelines for the Administration of Medicines - Community Mental Health Teams should make every effort to use community or hospital pharmacies to supply drugs.

10 PROCESS THE STORAGE, TRANSPORT AND DISPOSAL OF MEDICATION

A separate procedure MM17 is currently in operation for the transportation of medications for the Specialist Learning Disabilities Division.

10.1 All medicines must be stored in a locked cupboard, which has been approved for the purpose, or a lockable medicines trolley attached to a wall. (Compliance with DS2881: 1989). **Or within an approved ward based automated storage unit, as ward automation is introduced within the trust the procedure for Ward Based Automation.** In addition to the regular visits to all wards, every three months pharmacy staff will be required to visit wards and departments to check on storage, security and safety of medicines. In addition, recorded drugs registers, controlled drugs registers and requisition books will be inspected and stocks checked by qualified pharmacists. Technicians will also audit the storage conditions of all other medications.

10.1.1 Trolleys should only be removed from their fixings during allocated medicines rounds. The trolley should never be left open and unattended at any time.

10.1.2 The nurse in charge should hold keys for medicines cupboards and trolleys. The keys must remain on the ward and never be left unattended. Keys must never be left on desks or in drawers. Lost keys must be reported to

the ward manager or silver on call. If keys cannot be accounted for all locks must be changed. If keys have been taken home in error by ward staff this is a serious issue and every effort must be made to retrieve the keys as soon as possible.

10.1.3 Community mental health teams may find alternative methods to ensure safe storage of keys, such as cupboards with a digi-lock. **Only** authorised staff will only know the codes to the digi-lock.

10.1.4 Internal and external preparations should be segregated, either in separate cupboards or at least on different shelves.

10.1.5 Medicines refrigerator; medicines marked 'Store in Refrigerator' should be stored between 2 and 8°C. The fridge should be defrosted in accordance with the Manufacturers requirements, kept locked, and reported for repair if the temperature dial indicates a fault. No food or drink other than nutritional supplements such as Fortisips should be stored in the medicine fridge. (Subcutaneous heparin does not need to be stored in a refrigerator. If it is, then it must be allowed to warm up to ambient temperature for a few minutes before use.

10.1.6 Disinfectant cupboard should be used for preparations that are not used for service users. E.g. Virkon.

10.1.7 Reagents cupboard should be used to store urine testing and blood testing strips and litmus paper.

10.1.8 Sterile fluids for infusion and irrigation – fluids are normally stored in a designated area on wards; it is usually impractical to store them in cupboards. Stock **MUST** be rotated to ensure use within expiry dates.

Potassium containing fluids: - No wards or departments will be allowed to stock either concentrated or diluted potassium chloride. This follows an alert by the National Patient Safety Agency. Should a potassium chloride replacement be required, pharmacy will dispense ready prepared, diluted infusion bags on a named patient basis. This is in the interest of patient safety.

10.2 Disposal or Return of Medicines

All out-of-date medicines and any non-stock drugs that are no longer required should be returned to the pharmacy department who will either return the medication into stock or arrange for destruction (as appropriate) with the exception of Controlled Drugs, Cytotoxic and Cytostatic medications and residues of Liquid Medications.

10.2.1 Any member of staff returning an unwanted supply of medication should utilise the Return of Medication and Surplus record stationary and place the unwanted medication in either a designated Pharmacy Returns Bin or a lockable returns box or bag.

10.2.3 The returns record should detail the following:-

- date of return
- ward or area of the trust the medication is being returned from

- name of medication
- reason for return
- quantity of medication

The staff member should sign the returns record.

10.2.4 When received by pharmacy the medications will be assessed for appropriate re-use or destruction and the Pharmacy returns procedure must be followed.

10.2.5 Cytotoxic or cytostatic medications should not be returned in this manner a designated ‘cyto-‘ returns bin should be used – these are available via stores orders.

10.2.6 Amber bottles that contain residue or potential residue of liquid medicines should be disposed of at a ward or clinic level in a blue-lidded disposal bin in line with Infection Control Policy.

Algorithms outlining the correct returns procedures are shown on the next page. ***A separate procedure for Controlled Drugs applies please see section 11 and Annex 1 and for Specialist Learning Disabilities Division see Controlled Drugs Procedure MM19.***

Disposal of unwanted pharmaceutical products (Local Division & Scott Clinic)

Medication supplied from a community pharmacy, other NHS Trust or over the counter medication must be disposed of in pharmaceutical waste bins on the ward / department.

Recorded & Controlled Drugs – Must be removed from ward by pharmacy staff. Speak to your technician or pharmacist directly, alternatively contact the pharmacy department to arrange disposal

Sharps contaminated with pharmaceutical waste – Must be disposed of in the sharps bin (Yellow bin and Yellow lid) except cytostatic / cytotoxic medication.

For all other pharmaceutical waste which has been supplied by a Mersey Care NHS Trust pharmacy, follow the flow chart below

Medication expired or no longer required

↓

Does the pharmaceutical appear on the cytostatic / cytotoxic medication list?

→ Yes → Place in hazardous pharmaceutical waste Yellow bin and **PURPLE LID**

↓ No

↓

Is it a liquid medication in a glass or plastic bottle (this includes empty bottles which have contained liquid medication)

→ Yes → Place in a Blue bin and **BLUE LID** Pharmaceutical waste bin

↓ No

↓

Ward / department staff to complete Return of medication and surplus stock book including ward/department name, date and reason for return and the number returned. The returns book must be signed by a registered nurse.

↓

All other medication –
Place in the green pharmacy returns unit. If your ward / department does not have a returns unit, segregate pharmacy returns in a separate cupboard and return to pharmacy using a lockable pharmacy bag / box

↓

Contact pharmacy department who will arrange collection of your returns via the pharmacy driver / pharmacy staff. In pharmacy the medication will be assessed for potential re-use.

→

In Pharmacy

Medication suitable to return

Medication returned to stock on the pharmacy computer system and credited to the returning ward / department. The returns paperwork is completed and signed by pharmacy staff

Medication not suitable to return

Medication is segregated into the appropriate waste bins and stored in the pharmacy waste area until collection from the waste management company. The pharmacy waste bins are collected by the waste management company on a regular basis. If an urgent collection is required this can be arranged.

Empty glass and plastic bottles which have contained medication MUST be placed in a blue bin with a **BLUE LID** pharmaceutical waste bin for incineration. Used medicine tots should also be placed in this bin.

Disposal of unwanted pharmaceutical products (High Secure)

Medication supplied from a community pharmacy, other NHS Trust or over the counter medication must be disposed of in pharmaceutical waste bins on the ward / department. Refer to Trust Waste Management Policy for more information.

Recorded & Controlled Drugs – Must be removed from ward by pharmacy staff. Speak to your technician or pharmacist directly, alternatively contact the pharmacy department to arrange disposal

Sharps contaminated with pharmaceutical waste – Must be disposed of in the sharps bin (Yellow bin and Yellow lid) except cytostatic / cytotoxic medication.

For all other pharmaceutical waste which has been supplied by a Mersey Care NHS Trust pharmacy, follow the flow chart below

Medication expired or no longer required

↓

Does the pharmaceutical appear on the cytostatic / cytotoxic medication list?

→ Yes → Place in hazardous pharmaceutical waste Yellow bin and **PURPLE LID**

↓ No

↓

Is it an **empty** liquid medication glass or plastic bottle

→ Yes → Place in a Blue bin and **BLUE LID** Pharmaceutical waste bin

↓ No

↓

Ward / department staff to complete Return of medication and surplus stock book including ward/department name, date and reason for return and the number returned. The returns book must be signed by a registered nurse.

↓

All other medication and bottles still containing liquid must be returned to the pharmacy department for disposal

↓

When the returns have been received by the pharmacy department the medication will be assessed for potential re-use.

↓

In Pharmacy

Medication suitable to return

Medication returned to stock on the pharmacy computer system and credited to the returning ward / department. The returns paperwork is completed and signed by pharmacy staff

Medication not suitable to return

Medication is segregated into the appropriate waste bins and stored in the pharmacy waste area until collection from the waste management company. The pharmacy waste bins are collected by the waste management company on a regular basis. If an urgent collection is required this can be arranged.

10.3 Handling of Medicines following the death of a service user on an inpatient ward

10.3.4 In the event of a death of a service user whilst on a ward medication must not be returned to a carer or relative and must be kept on the ward in quarantine f in case they are requested by the coroner. The time that the medication may need to be quarantined may vary – contact pharmacy services for advice.

10.3.5 The medications must be kept in a sealable bag with the service users name on it. A full list of medications and quantities must be made in the ward diary and counter signed by two qualified nurses or a nurse and the ward pharmacist.

10.3.6 The bag should then be sealed and dated and the two signatories should sign across the seal; the bag then must be stored in a lockable drugs cupboard.

10.3.7 If any of the service users medications are Controlled Drugs, these must be booked out of the ward CD register and the following entry made "***service user deceased and their medications have been placed in quarantine.***" Again this should be witnessed by two qualified members of staff and the sealed bag must be stored in the designated CD cupboard.

10.3.8 If the Coroner asks for the medications to be released the following wording must be made in the ward diary "***handed over to the Coroner***" the entry must be dated and counter signed by the nurse in charge of the ward and the Coroner's representative.

10.3.9 If after two weeks the Coroner has not requested the medication then they should be returned to Pharmacy. This must be noted in the ward diary with the entry "***returned to pharmacy***".

10.3.10 If any of the medications are the service users own supply and the relatives or carers have insisted that the medications are returned to them then the trust Chief Pharmacist or Medicines Information Service should be contacted on 0151 250 6030 or 250 6011.

10.4 Delivery of drugs

Specialist Learning Disabilities Division should follow procedure MM17.

10.4.1 Drivers and/or porters will deliver medication to wards and departments at specified times throughout the day in sealed bags or boxes. The appointed or assigned practitioner in charge of the ward will be responsible for receiving and signing for these supplies. They must ensure that the bags and boxes are completely emptied immediately after opening, the identity of the drugs confirmed and the medications stored securely and appropriately on the ward as soon as possible. Transit bags are sealed with a uniquely numbered tag thus ensuring an audit trail between the dispensary and ward/department. Any bags received on to a ward/department without a numbered tag must be immediately reported to the Dispensary manager on 0151 250 6061.

11 PROCESS – CONTROLLED DRUGS (CDs)

Appendix 1 describes the procedures within the trust for Controlled Drugs the following issues are covered:-

1. Ordering & Receipt
2. Storage
3. Issue of Controlled Drugs
4. Handling Discrepancies
5. Return of Unwanted / Out of date CD's to Pharmacy
6. Disposal / Destruction of CD's Not Administered
7. Recording of Service Users Own CD's
8. Requisitioning of Controlled Stationery
9. Record Keeping

LOCAL AND SECURE DIVISION STAFF MUST COMPLY WITH THE PROCEDURES AS DESCRIBED IN THE APPENDIX TO THIS POLICY. SPECIALIST LEARNING DISABILITIES DIVISION STAFF MUST FOLLOW PROCEDURE MM19 WHEN HANDLING CONTROLLED DRUGS.

11.1 Prescribing of controlled drugs

16.1.1 Guidance on the use of Controlled Drugs states only doctors with full GMC registration can prescribe CDs on any outpatient/FP10 script.

16.1.2 Medical staff who are fully registered may prescribe controlled drugs within the trust, but may **NOT** prescribe diamorphine or cocaine for known opiate dependant service users unless licensed to do so.

16.1.3 Medical staff must ensure that all legal requirements are fulfilled. Students, unregistered locums or any medical staff without full registration must not prescribe Controlled Drugs.

16.1.4 In April 2012 amendments to the Misuse of Drugs Regulations permitted the independent prescribing of schedules 2-5 controlled drugs by registered nurse and pharmacist NMPs for any medical condition (but not to prescribe cocaine, diamorphine and dipipanone for the treatment of addiction). In addition to this nurse independent prescribers who work in substance misuse services can now supply articles for administering or preparing controlled drugs.

16.1.5 Mersey Care is in full support of nurses and pharmacist prescribers extending their prescribing scope to include controlled drugs however it is stressed that this must only occur within the practitioner's individual clinical competence.

16.1.6 Methadone should NOT be prescribed for discharge where a known opiate dependant service user has a regular pick-up point (usually a community pharmacy). If it is not possible to make arrangements, the minimum possible quantity should be provided and an **absolute maximum of 4 days (if service user is discharged at the weekend)** prescribed for relevant service users.

16.1.7 Controlled drugs prescriptions for out-patients or discharged service users **MUST** have the:

a) full name, address and **unit number** of the service user
b) full name of the controlled drug
c) form of the drug (e.g. tablets)
d) strength of the preparation, if several exist
e) dose
f) total quantity of the preparation, or the total number of dose units, in both words and figures

and, in addition,

g) all the above details **MUST** be in ink and in the doctor's own handwriting
h) the prescription must be signed and dated by the doctor.

11.1.8 It is illegal for the pharmacy staff to dispense an incorrectly written prescription for controlled drugs. Errors in controlled drug prescriptions on take home prescriptions can lead to delay in discharge.

11.2 Ordering Controlled Drugs for Inpatients – Please follow the procedure set out in appendix 1

11.2.1 The standard (duplicate) controlled drugs requisition book must be used at all times. It is essential to give full information regarding name of drug, form, strength, ampoule size (where more than one exists) and quantity required. Only registered nurses who have been authorised to do so should order controlled drugs. Pharmacy is greatly helped by the printing of the nurse's name underneath the signature. Only one item should be ordered on each page of the order book.

11.2.2 New books and registers can be obtained from Supplies. Completed Controlled Drugs Registers and Requisition Books should be stored on wards for at least the legal **minimum of two years**, after the date of the last entry. Requisition books should be sent to Pharmacy as early as possible on weekdays. The pharmacy should be informed by telephone when the CD order book requires collection so that the driver will come and collect it. CDs should NOT be routinely ordered at the weekend; however, CDs will be supplied in an emergency. Please note that faxed orders for CDs cannot be dispensed by Pharmacy.

11.3 Obtaining Controlled Drugs in an Emergency Out-of-Hours

11.3.1 In an emergency out-of-hours, controlled drugs (CDs) may be transferred to another ward. The CD register of the ward supplying the CDs should be signed by the designated nurse of both the supplying and receiving ward. The supplying nurse MUST observe the CD being entered into the register of the receiving ward. Only single doses can be transferred in this manner. The law prevents greater quantities being transferred. In cases of difficulty, the on-call pharmacist will help.

11.3.2 Controlled drugs should be ordered using the requisition book supplied for the ward.

11.4 Delivery of Controlled Drugs from Pharmacy – Please follow the procedure set out in appendix 1

11.4.1 The procedure for delivery of controlled drugs will depend on local circumstances but will always be within the following guidelines: -

- The person signing the 'accepted for delivery' section must ensure security in transit.
- The top copy of the requisition should not leave the pharmacy.

11.5 Receipt of Controlled Drugs on Ward – Please follow the procedure set out in appendix 1

11.5.1 Controlled drugs must be received on the ward by an authorised nurse and signed for in the presence of the messenger. The appropriate entry should be made immediately in the ward controlled drugs record book by the person who received the controlled drugs and witnessed by a second nurse. The CDs **MUST** be locked in the controlled drugs cupboard **IMMEDIATELY**.

11.6 Storage of Controlled Drugs – Please follow the procedure set out in appendix 1

11.6.1 Medicines designated as Controlled Drugs by the Misuse of Drugs Act 1971 must be stored in a locked cupboard inside another locked cupboard. Access and keys should be restricted to persons authorised under the Misuse of Drugs Act (i.e. the appointed or assigned practitioner in charge of the ward).

11.7 Stock Levels of Controlled Drugs – Please follow the procedure set out in appendix 1

11.7.1 The appointed or assigned practitioner will be responsible for a regular check of Controlled Drugs at designated intervals as agreed with the Nursing Manager as a minimum daily. Discrepancies should be reported immediately to the trust Accountable Officer and the Chief Pharmacist as well as designated deputy and the Ward Pharmacist. For liquid preparations (e.g. methadone) daily visual checks should be done, there is not a requirement to pour out and measure stocks after each administration.

11.7.2 A pharmacist, along with the ward manager, will check the balance of controlled drugs at three-monthly intervals.

11.8 Administration of Controlled Drugs – Please follow the procedure set out in appendix 1

11.8.1 Unless the drug is given by a doctor, two trained members of nursing staff must administer controlled drugs.

11.8.2 The Trust is aware that in certain circumstances, and/or in certain specified areas there may only be one member of trained staff on duty and they may administer controlled drugs with a suitably qualified other person e.g. a suitably competent nursing assistant / health care worker who has successfully completed Mersey Care NHS Trust's The Role of the Witness in the Safe Administration & Documentation of Medicines eLearning module and assessment in practice.

11.8.3 Administration should also be recorded on the prescription chart or EPMA system. In addition, student nurses, as part of their on-going education and training, may administer controlled drugs, under the constant supervision of a registered nurse. However, the student must not, under any circumstances, be considered as the "second" nurse in relation to the checking and administration of controlled drugs.

11.9 Service users' Own Controlled Drugs – Please follow the procedure set out in appendix 1

11.9.1 As with other types of medicines, these remain the service users' own property. Routinely the service user and/or their carers will be asked if they would like unwanted or unused drugs to be destroyed by the trust. If they do not wish to do so the drugs will be returned upon discharge. **This does not apply to methadone which must not be returned to service users.**

11.10 Known opiate dependant service users- Admitted as an Inpatient

11.10.1 Post admission as soon as practicable, the Addictions Service or doctor responsible for prescribing the controlled drug, must be informed immediately by the admitting nurse. This is to ensure that the prescription is cancelled at the chemist whilst the client is an inpatient and to enable confirmation of the service user's dose before a regular inpatient prescription is commenced.

11.10.2 A twice a day (bd) dosing schedule is the preferred recommendation.

11.10.2 Methadone must not be given to any service user showing obvious signs of intoxication

11.10.4 Similarly, the Addictions Service or prescriber must be informed when the client is discharged from hospital so that excessive supplies are not given on discharge and to enable contact to be made with the client's legitimate supplier in the community. This is the responsibility of the service user's named nurse and should be undertaken as soon as a discharge date is agreed. NB: Methadone should NOT be prescribed for discharge where a service user has a regular pick-up point. If it is not possible to make arrangements on discharge then the minimum possible quantity should be provided and an **absolute maximum of 4 days** prescribed for the service user **(if service user is discharged at the weekend)**

11.10.5 The Addictions Service operates an on-call service for hospital professionals to use between the hours of 5.00pm and 9.00am. Hospital staff are welcome to use this service if they require drug-related advice and/or information that cannot wait until normal working hours (Monday to Friday 9.00am to 5.00pm). To contact this service telephone 0151 250 3000 (Switchboard) who will contact the on-call worker who will in turn contact you. **Please note that this service is for staff only.** Service users or relatives can get help/advice during opening hours, or from the National Drugs Help-line on (free-phone) 0800-776600.

During normal working hours the Addictions Service can be contacted by telephoning 0151 709 0516

11.10.6 When a service user receives a regular dosage of methadone but is not known to the drugs service, staff should refer to the local standard operating procedure.

11.11 Destruction or Return of Controlled Drugs – Please follow the procedure set out in appendix 1

11.11.1 CDs may only be destroyed in accordance with trust policy and procedure.

11.11.2 The CD Accountable Officer authorises specific individuals who are suitably trained and qualified to destroy CDs in accordance with the policy and procedure.

11.11.13 If staff have any question regarding the destruction of CDs they must contact the Accountable Officer.

11.12 Recorded Drugs

11.12.1 The trust operates a Recorded Drug Procedure the latest version can be found as procedure MM RD1

12 PROCESS PHARMACY SERVICES AND MEDICINES OPTIMISTAION

12.1 Medicines Optimisation is a patient-focused approach to ensure the best use of medications by focusing on patients and their experiences; the goal of Medicines Optimisation in Mersey Care is to help service users to:-

- Improve their outcomes
- Take their medicines correctly
- Reduce wastage of medicines
- Improve the safety of medicines

12.1.1 Medicines Optimisation requires effective multidisciplinary team working in order to individualise outcomes, monitor outcomes more carefully, review medicines more frequently and support service users when needed.

12.1.2 Mersey Care has developed a Medicines Optimisation Strategy which is monitored as part of the work of the Drugs and Therapeutics Committee. Copies of the current strategy are available from the trust's Chief Pharmacist upon request.

12.1.3 There are four guiding principles for medicines optimisation; they are as follows:-

- Aim to understand the patient experience
- Evidence based choice of medicines
- Ensuring medicines use is as safe as possible
- Making medicines optimisation part of routine practice

12.1.4 There are key components within SD12 – The Handling Medicines Policy that support the trusts strategic approach to Medicines Optimisation, these include how we support:-

- Self Medication, Concordance and Adherence and monitoring of side effects

- Service users and carers with the provision of information and education around medicines and their use

- Clinicians with an evidenced based approach to medicines selection

- How the organisation reports and learns from medicines related incidents

12.2 Self Medication and Medicines Adherence/Concordance

12.2.1 An important outcome of Medicines Optimisation is that service users will feel confident to share experiences of taking medicines and how medicines impact on their daily life. It is essential that whilst inpatients at Mersey Care service

users are supported and assessed around issues of medicines adherence/concordance.

12.2.2 The trust has developed a self medication procedure (MM1 - SELF-ADMINISTRATION OF MEDICINES (SAM) PROCEDURE FOR USE WITHIN MERSEY CARE NHS TRUST) all staff should refer to this procedure with regard to the potential of service users self medicating.

12.2.3 The following principles must be followed when supporting service users with regard to adherence and concordance.

- It is the duty of the named nurse as part of the CPA process to assess service user's concordance and adherence with their medication. This can be assisted / supported by utilising the Mersey Care Trust Self Medication Procedure (handling of medicines policy SD12) if appropriate.

- Further educational support regarding the importance service users' medication adherence can be provided to the service user by the named clinical pharmacist. Regular sessions are available via the medicines optimisation pharmacists and are planned at a local level.

- For service users approaching conditional discharged from the Scott Clinic, Pharmacist led information sessions are available via the named pharmacist and there is a separate procedure (MM06). This approach is supported by the utilisation of SAM MM01 at Reed Lodge as part of the clinic's step down process.

- The responsible clinician must ensure that a record of medicines concordance/adherence issues/assessment is made on ePEX and is reflected in the CPA documentation.

- The use of self-medication and specified medication within the trust is subject to annual audit; reported to the trust Drugs and Therapeutics Committee.

- As described in NICE CG 76- Medicines Adherence, multidisciplinary teams should be aware that although medicines adherence can be improved, no specific intervention can be recommended for all service users. Any intervention needs to be tailored to individual need of each service user and the agreed approached documented and reviewed as part of the Care Planning/CPA process.

12.3 Provision of service user specific information

NICE Clinical Guideline 76 – Medicines Adherence describes how healthcare professionals should establish the most effective way of communicating with service users on an individual basis and provide accessible and understandable information.

12.3.1 In order to support service users in decisions about medication and to support medicines adherence the trust has produced more than 60 bespoke medication information leaflets for service users that describe each medication including the following key areas:-

- What is medication is used for
- How the medication should be taken
- What to do if dose(s) are missed
- Taking in combination with other medication
- The need for any additional tests
- What the side effects are?

12.3.2 The leaflets have all been produced by the trust's Medicines Information service and the update of information is overseen by the trust's Drugs and Therapeutics Committee. The leaflets are free from jargon and are written in a clear understandable manner. The format is consistent across all of the leaflets so that the benefits and disadvantages of each medication can be easily compared.

12.3.3 When a new medication is being considered or initiated, a member of the multidisciplinary team should discuss the information on each leaflet with the service user. Healthcare professionals

12.3.4 Wards and clinics have the leaflets provided via Medicines Information in hard copy format, the current version of each leaflet is kept on the trust website and they are available at the following link:-

http://www.merseycare.nhs.uk/What_we_do/CBUs/Specialist_Management_Services/Pharmacy/patient_information.aspx

Hard copies can also be requested from any of the pharmacy departments in the trust. When a service user is offered a trust information leaflet there should be an entry made on the ePEX system detailing the fact.

12.4 Side Effect Monitoring

12.4.1 It is the duty of all staff involved in direct patient care to assess service users for the presence of unwanted side effects of medication. All medicines can lead to unwanted side effects; these effects can vary in frequency and or severity. As described in Getting Medicines Right 2, it is the responsibility service user's allocated nurse to assess tolerability and side effects of medications on a daily basis.

12.4.2 Medicines that are new to the UK market or considered higher risk and requiring additional monitoring are designated black triangle drugs within the BNF. A yellow card (see the back of the current BNF) should be completed for all side effects or reactions to these.

12.4.3 In addition the Medicines Information Service should be contacted on 0151 250 6011 or during out of hours the emergency duty pharmacist via switchboard. As described in 10.2 the trust has developed a number of information leaflets that describe the side effects of medications in a clear manner.

12.4.4 The member of staff that has identified the side effect must contact the RMO at the earliest opportunity.

12.4.5 The trust has an electronic side effects rating tool that should be used for the assessment of side effects caused by anti-psychotics – this form is available via ePEX.

12.4.6 Service users should be encouraged to discuss effects of their medication at every opportunity such as the medicines round, ward rounds and during protected time with staff.

12.4.7 The trust Drugs and Therapeutics Committee should receive an annual report on the monitoring of side effects in the trust.

12.5 Medicine Allergy and adverse reactions

12.5.1 It is the responsibility of all hospital staff concerned with the administration of medicines (medical, nursing and pharmacy) to ensure that any history of drug allergy is recorded and dated:

i. On the drug chart or EPMA system

ii. On the front cover of the hospital case note folder

iii. In the nursing documentation

12.5.2 It is the responsibility of the medical staff to verify this information and amend entries if required.

12.5.3 The drug allergy box on the drug chart MUST have:

i. The name of the drug or drugs and nature of reaction.

ii. NIL – if the service user gives no history

iii. N/K (NOT KNOWN) if the service user is unable to give a history

12.5.4 Prior to a medicine being prescribed and administered, the drug sensitivity box must be re-checked by the medical and nursing staff.

12.5.5 It is the responsibility of all hospital staff concerned with the administration of medicines (medical, nursing and pharmacy) to ensure that any adverse reaction to a medicine is documented clearly in the case notes and reported to the CSM via the Yellow Card reporting scheme. Further information is available from Medicines Information on 0151 250 6011

12.6 Pharmacy Services

Pharmacy staff must operate in line with Royal Pharmaceutical Society's/General Pharmaceutical Council's Code of Ethics and Practice.

12.6.1 To ensure accuracy of the prescription on admission a member of the pharmacy team will, whenever possible, check the admitting doctor's medication reconciliation against at least two alternative sources.

12.6.2 The trust pharmacy service provides ward based clinical services in-line with Medicines Management Procedure MM04 (for local division) and MM04a (for secure division).

12.6.3 The accuracy of prescription charts will be regularly audited and reports tabled at the trust's Drugs and Therapeutics Committee. The following sets out the audits that are undertaken in the trust:-

Audit	Frequency of Audit
Medicines Reconciliation	Annual
Omitted and Delayed Medications	Annual
Anti-microbial Prescribing	Quarterly
Controlled Drugs	Quarterly
Safe and Secure Storage of Medicines	Quarterly
Recorded Drugs	Quarterly

12.6.4 For the Local division a weekly register of pharmacist ward visits is kept at Mossley Hill Pharmacy.

12.6.5 All medicines required within the trust are procured via the main trust Pharmacy Department at Mossley Hill Hospital. The Northwest framework is utilised to procure the required medication.

12.6.6 The Pharmacy Standard Operating Procedures for Stores and Dispensary Services are available form the Chief Pharmacist on request. These SOPs must be followed by all Pharmacy based staff.

13 CONSULTATION

13.1 This medicines policy has been developed with the consultation of the Drugs & Therapeutics Committee, Senior Nursing Management, Senior Leadership Team and the multi-disciplinary medicines policy review group.

13.2 It is intended to be read and complied with, by all individuals who deal with medication throughout Mersey Care NHS Foundation Trust. The policy provides guidance on all aspects of medicines management, including prescribing, ordering, storage and administration and as such constitutes an important element of Mersey Care NHS Trust risk management strategy.

14 MONITORING

14.1 The Drugs and Therapeutics Committee will oversee audit and monitor the compliance with this policy on an annual basis and report.

14.2 The handling of medicines within the trust will be subject to various audits throughout the calendar year. Pharmacy will lead on this audit and outcomes will be reported to the trust's Drugs and Therapeutics Committee.

14.3 The Drugs and Therapeutics Committee will report to the Board of Directors via the Quality Assurance Committee. A chairs report and associated minutes is reported to the Quality Assurance Committee every two months.

15 TRAINING AND SUPPORT

15.1 Training is included in medical induction, nurse training, medicines update. Clinical pharmacy staff will highlight the safe and effective use of medicines as part of their core duties.

15.2 An e-learning package for medicines management is available for staff training purposes and to support staff as part of their on going practice or provide an update.

15.3 Further information on the training packages is available from the trust's Learning and Development team.

16 REFERENCE

16.1 Trust employees can obtain additional Medicines Management procedures and documents from the trust web-pages or on request from the trust Chief Pharmacist.

16.2 This policy has developed in line with national legislation and professional guidelines and good practice.

Appendix Documents

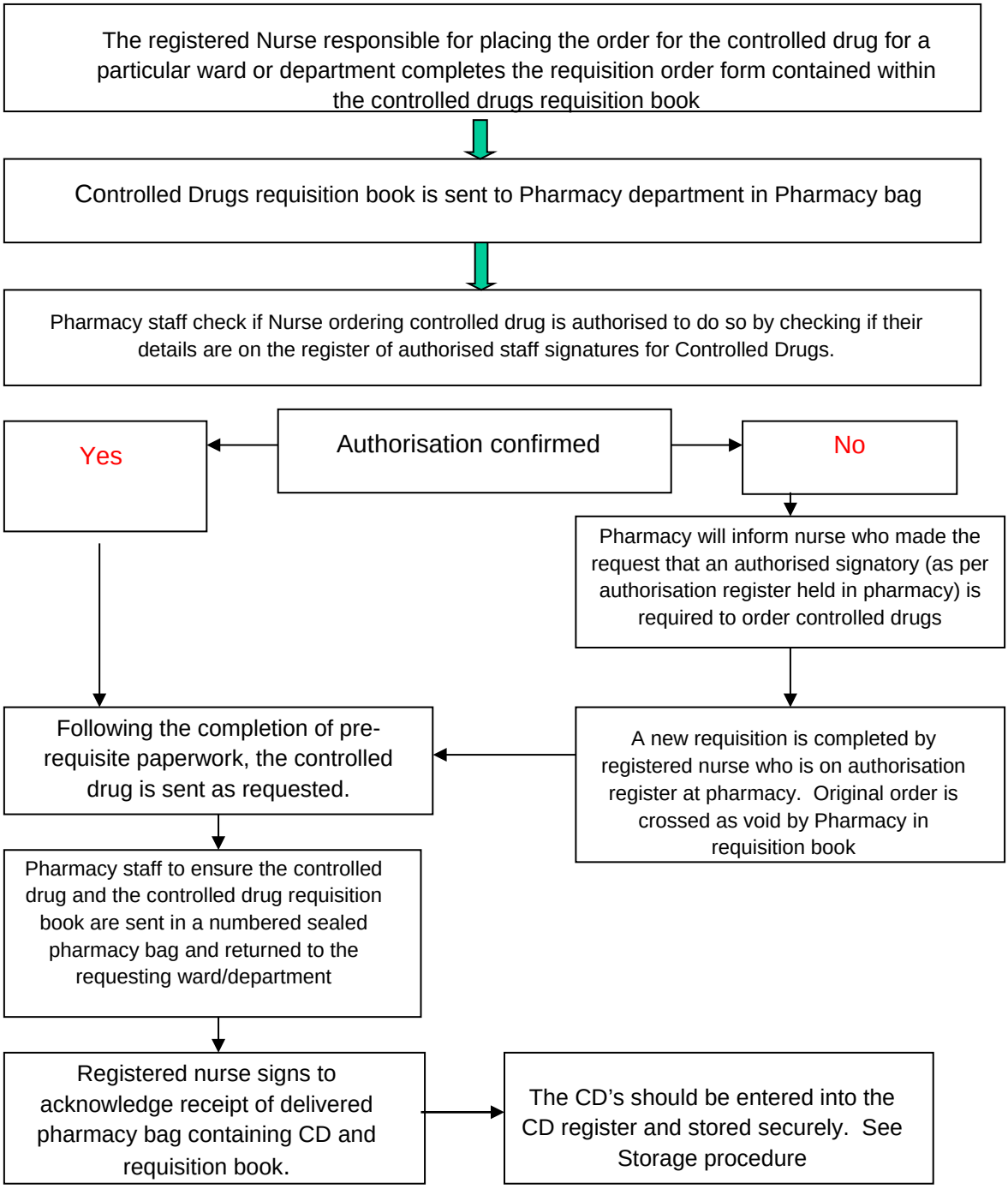
Appendix 1 Controlled Drug Policy Algorithms

The purpose of these procedures is to ensure that all staff conforms to the safe and effective use of controlled drugs throughout Mersey Care NHS Trust. Changes to governance arrangements and legislation mean there are some changes to the way tasks and responsibilities are undertaken.

As a result of these changes affecting prescribing, record keeping and destruction of controlled drugs, amendments have been made to ensure the Trusts procedures on the handling of controlled drugs is up to date and in line with current legislation and The Safe and Secure handling of Medicines: A Team Approach (the revised Duthie report) March 2005. The Accountable Officer for Controlled Drugs (CDAO) is responsible for the policy and management CDs within the organisation.

Contents

1.Ordering and Receipt.



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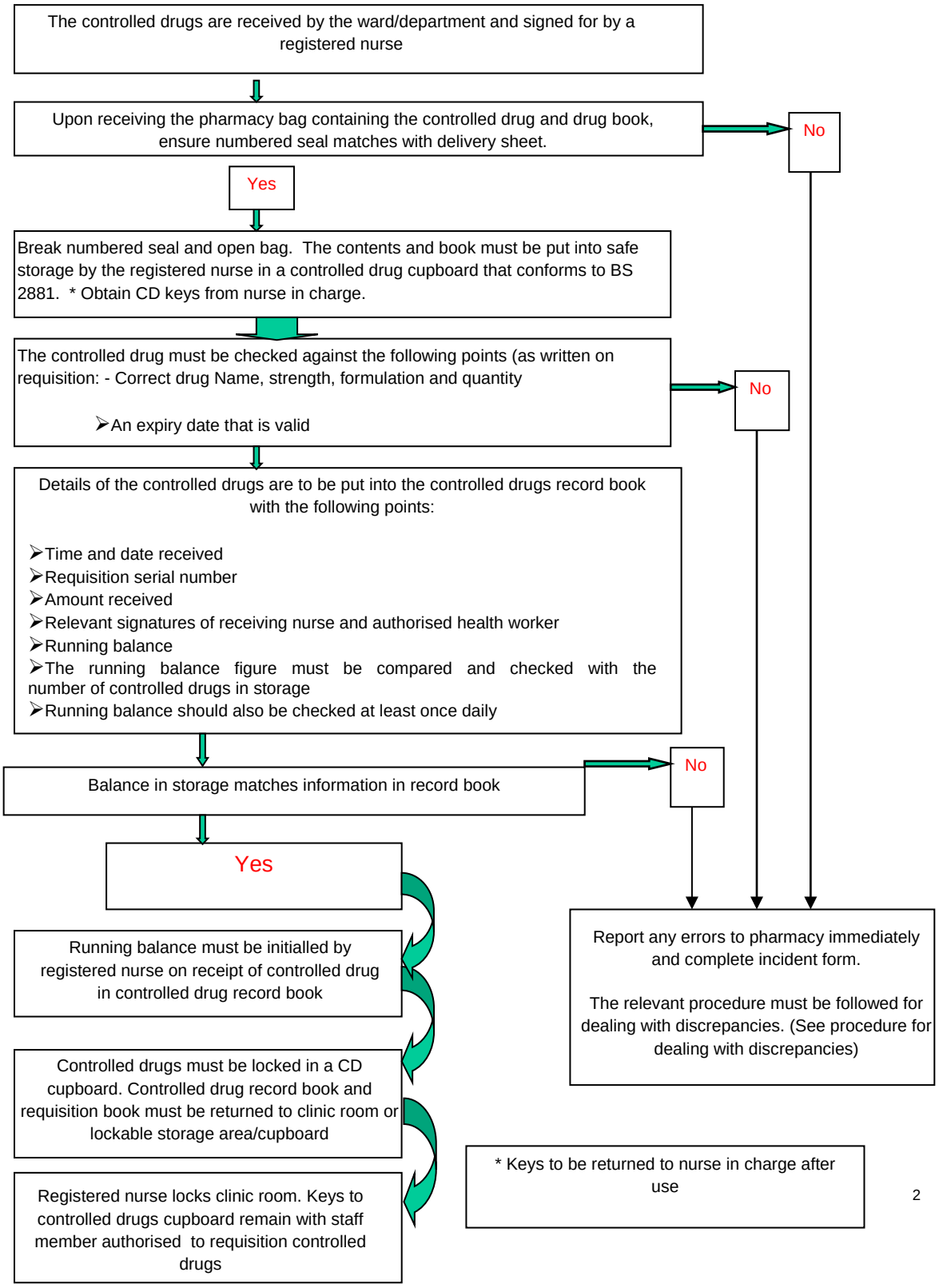
2. Storage.


The controlled drugs are received by the ward/department and signed for by a registered nurse
Upon receiving the pharmacy bag containing the controlled drug and drug book, ensure numbered seal matches with delivery sheet.
No
Yes
Break numbered seal and open bag. The contents and book must be put into safe storage by the registered nurse in a controlled drug cupboard that conforms to BS 2881. * Obtain CD keys from nurse in charge.
The controlled drug must be checked against the following points (as written on requisition: - Correct drug Name, strength, formulation and quantity
➢An expiry date that is valid
No
Details of the controlled drugs are to be put into the controlled drugs record book with the following points:
➢Time and date received
➢Requisition serial number
➢Amount received
➢Relevant signatures of receiving nurse and authorised health worker
➢Running balance
➢The running balance figure must be compared and checked with the number of controlled drugs in storage
➢Running balance should also be checked at least once daily
Balance in storage matches information in record book
No
Yes
Running balance must be initialled by registered nurse on receipt of controlled drug in controlled drug record book
Report any errors to pharmacy immediately and complete incident form.
The relevant procedure must be followed for dealing with discrepancies. (See procedure for dealing with discrepancies)
Controlled drugs must be locked in a CD cupboard. Controlled drug record book and requisition book must be returned to clinic room or lockable storage area/cupboard
* Keys to be returned to nurse in charge after use
Registered nurse locks clinic room. Keys to controlled drugs cupboard remain with staff member authorised to requisition controlled drugs

2

3. Administration of CDs.

A Controlled drug can only be administered to a patient as per prescription/treatment chart

Single nurse administration not applicable. Prescription must be processed by two registered nurses (one to check) or one nurse and one health worker.

Take the relevant controlled drug from the controlled drugs cupboard.

The following information must be checked against the prescription by two members of staff as stated above:

- Doctor has signed the prescription chart
- Name, Strength & Formulation of drug
- Quantity of drug
- Expiry date of drug

Once checked the drug must be administered according to information on prescription/treatment chart. Administration must take place in the presence of the two members of staff who have initiated the administration.

- Confirm identity of patient
- Check prescription against controlled drug once more.
- Dispense prescribed drug into container
- Return controlled drug box/bottle to storage and secure..
- Administer controlled drug if correct.

Confirm administration outcome by recording administration on patients prescription

Registered Nurse to enter following in controlled drug record book

Time and date of administration

- Name of receiving client
- Amount to be administered
- Signature of nurse administering
- Signature of nurse checking
- Running balance

Running balance figure should now be checked with controlled drug quantity in storage by registered nurse.

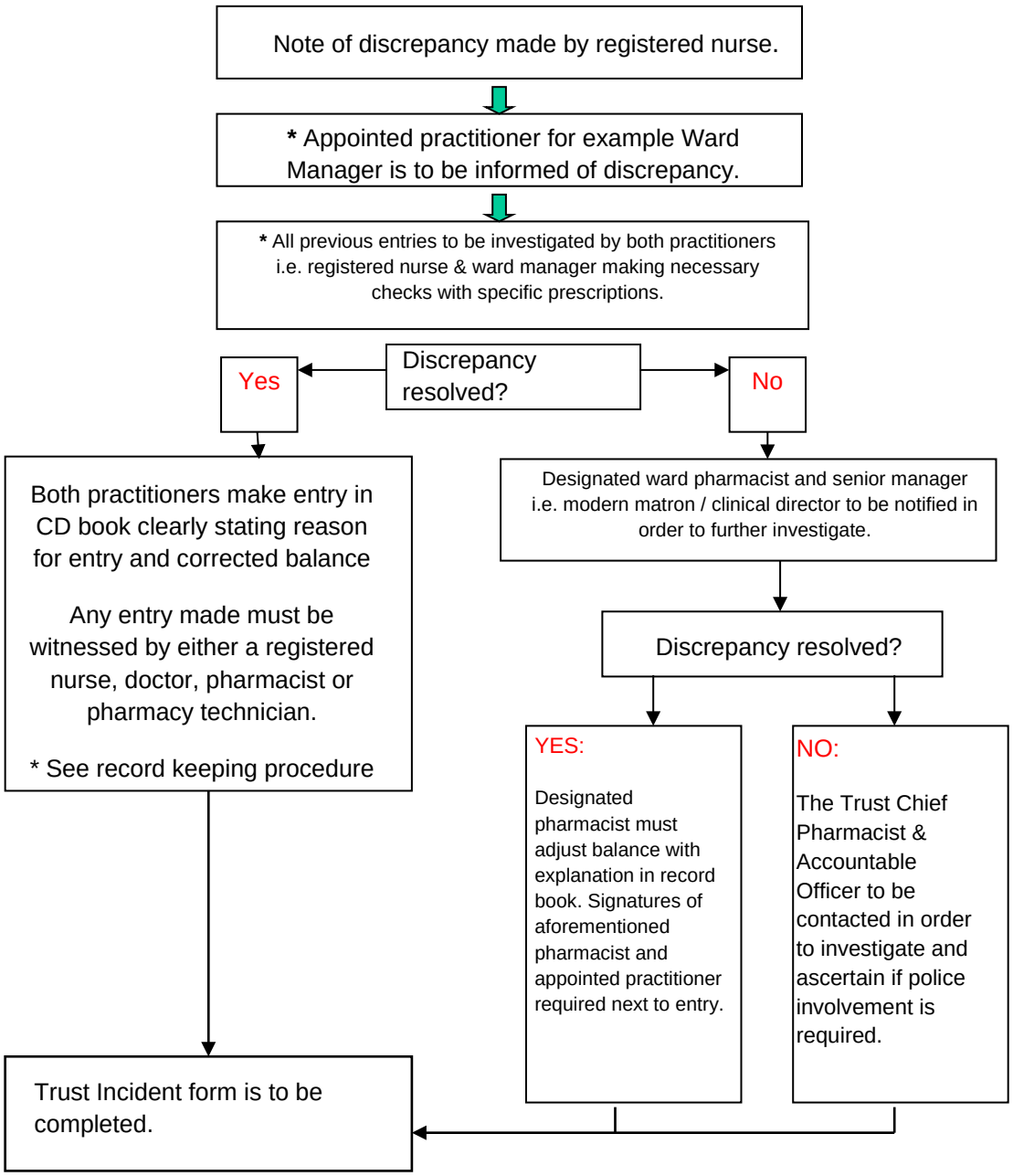
Information correct

YES: Registered nurse endorses running balance figure as correct with their initials

NO: The relevant procedure must be followed for dealing with discrepancies.

3

4. Handling discrepancies.



* See medicines policy glossary for full definitions of appointed, designated & assigned practitioners.

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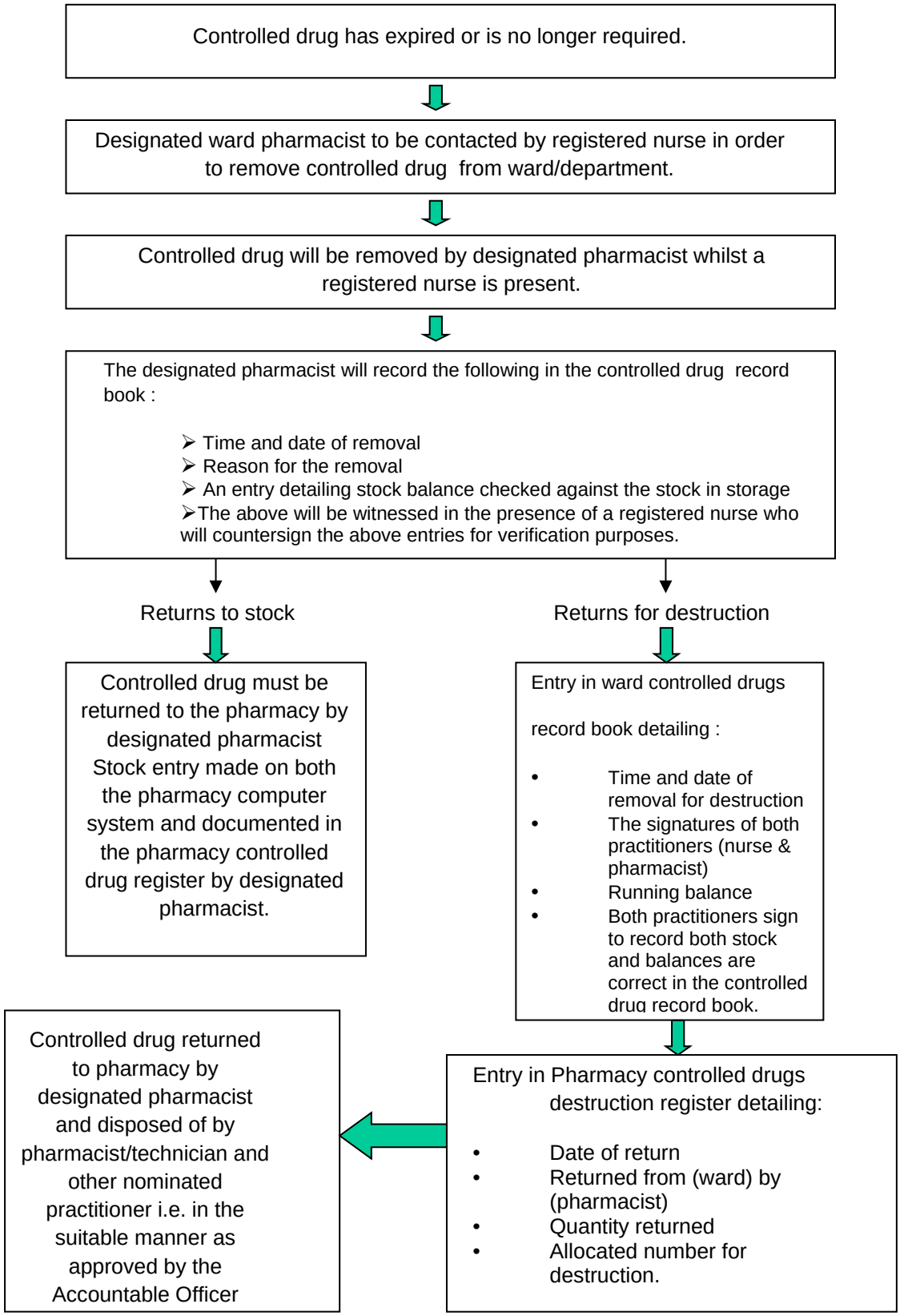
5. Return of unwanted/out of date CD stock to pharmacy



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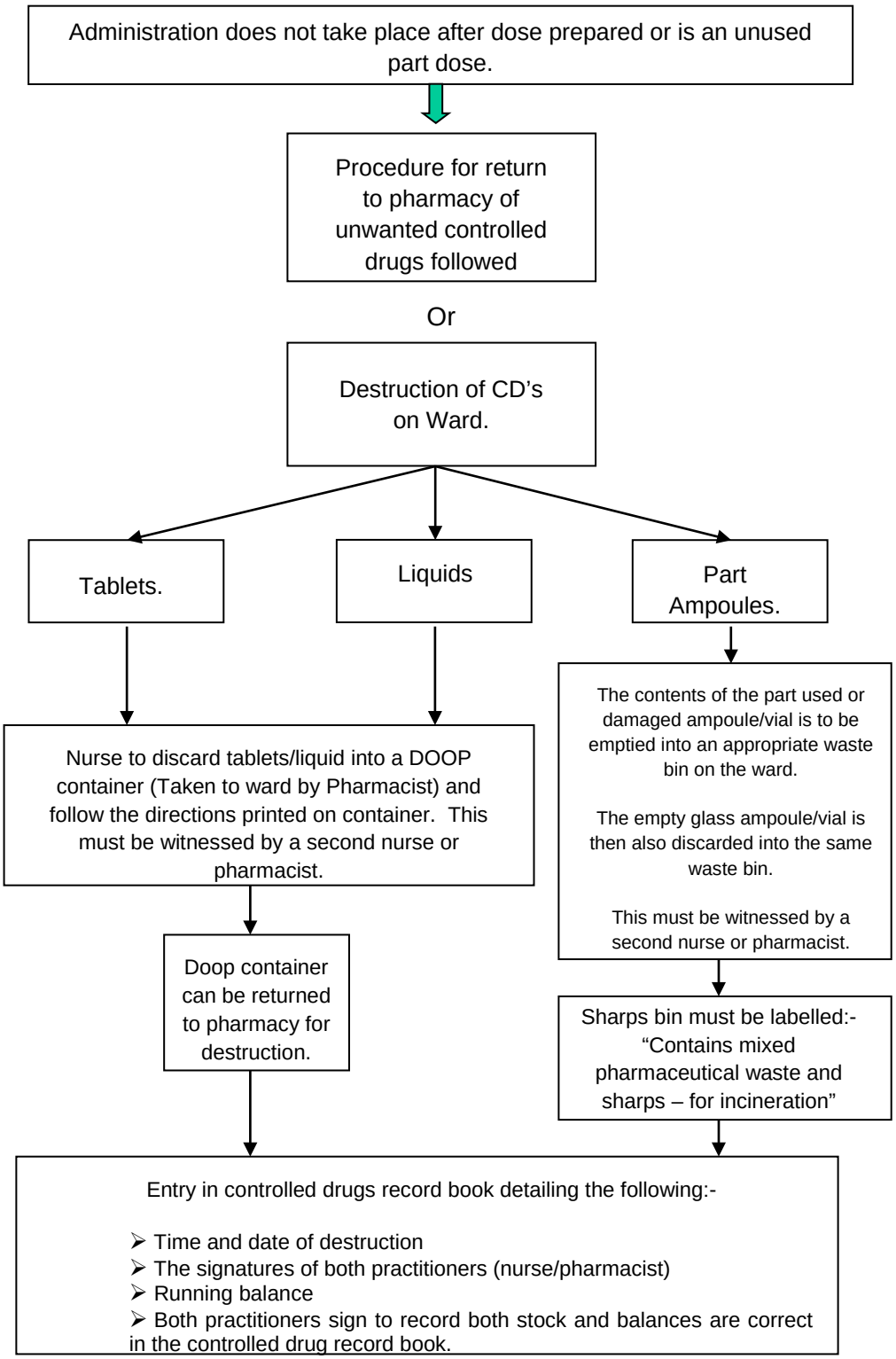
6. Disposal/Destruction of Prepared/Partly used CDs not administered.



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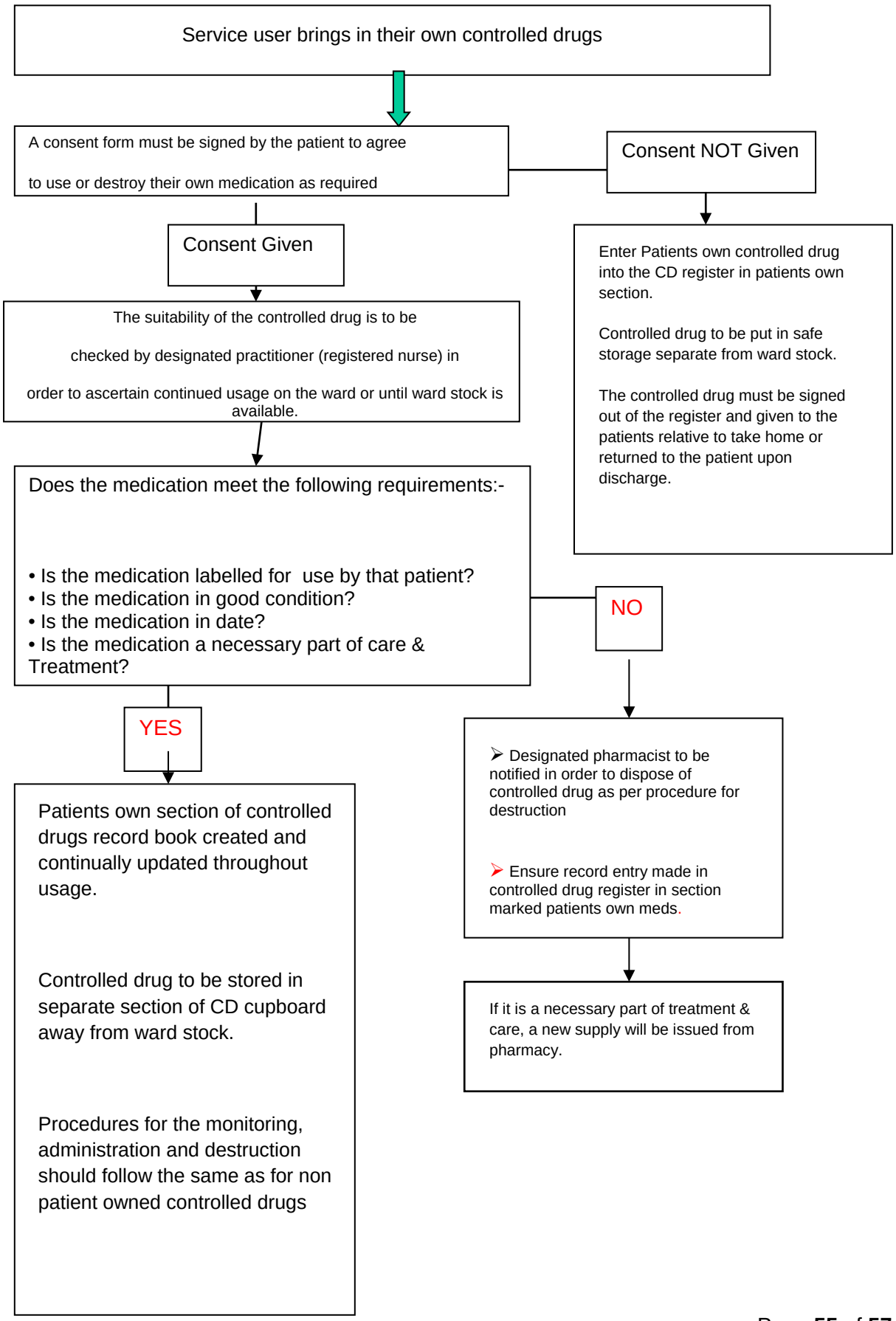
7. Handling of Service User's own CDs.



8. Requisitioning and Storage of Controlled Stationery

9. Record Keeping

Each ward or department that holds stocks of CDs should keep a record of CDs received and administered in a CD register (record book).

The Registered nurse in charge is responsible for keeping the CD register up to date and in good order.

Any transcription errors made to the CD register should NOT be crossed out. If an error occurs then:-

- Bracket the error e.g. [for example] & sign your initials
- Add a footnote e.g. [entered in error] and
- Re-write the entry on the line underneath