Ordering, storage, security and distribution of FP10 and FP10MDA prescriptions

Standard Operating Procedure (SOP)	
Ref No: 1834 **Version: 2**	
Prepared by: Service Manager	
Presented to: Care and Clinical Group	**Date:** 21 December 2017
Ratified by: Care and Clinical Group	**Date:** 21 December 2017
	Review date: 02 February 2021
Relating to policies: TSDFT Policy for the clinical Management of Substance Misuse in the Community: 1912 TSDFT Pharmacological Management of Substance Misuse in Community; Prescribing Guideline 1893 TSDFT Non-Medical Prescribing Policy 0684	

Purpose of this document – To ensure that all prescriptions are ordered, secured and distributed legally, safely and efficiently within the Torbay Drug and Alcohol Service.

Scope of this SOP – Applicable to all clinical staff working within the Torbay Drug and Alcohol Service (TDAS). Also applicable particularly to administrative staff with associated prescription responsibilities.

Competencies required – Induction and orientation delivered by other staff already deemed competent in this area.

Patients covered – All service users presenting to the Torbay Drug and Alcohol Service for a prescribed treatment intervention.

Procedure

Ordering

1. Stock level checks of prescription pads will be the responsibility of the senior team administrator for the Torbay Drug and Alcohol Service.

2. When stock has reached the level whereby a further order is required, the senior team administrator will requisition a further supply from the recognised supplier, (Pharmacy Department at Torbay Hospital).

3. Prescriptions used within the service comprise of the following:-

- FP10SS (green prescriptions)

- FP10MDA (blue prescriptions for instalment dosing)

4. The order for the required amount of prescription pads should be e-mailed to the Torbay Hospital Pharmacy.

5. The senior team administrator will receive an email from Torbay Hospital Pharmacy to confirm they have received the order. If an email is not received within 3 working days, the senior team administrator will contact Torbay Hospital Pharmacy to ensure receipt and resend e-mail if necessary.

6. Purple FP10 prescriptions used by non-medical prescribers have their own processes for ordering and are governed by the TSDFT policy on non-medical prescribing (CL101.1). This SOP does not replace the processes for the ordering of these prescriptions.

7. Torbay Hospital Pharmacy will email the senior team administrator when prescriptions are available for collection. A named person is identified to collect prescriptions from the pharmacy.

8. Prescriptions are brought immediately to TDAS team base (Walnut Lodge) and stored securely in a safe.

Storage/prescription generation and distribution:

9. All blank prescription pads are kept in the safe at all times unless being used by the senior team administrator/prescribing coordinator to produce prescriptions.

10. The safe will be kept locked AT ALL TIMES when access is not required by the senior team administrator/prescribing coordinator. The access code for the safe will not be shared without prior authorisation by the service manager for TDAS.

11. Computer generated prescriptions will be produced by the prescribing coordinator at designated “script runs” in the main, using the recognised prescribing software module on HALO (the commissioned electronic case management tool for substance misuse services). This should never be undertaken in an area with public access and must always be done in a secure area.

12. Once the prescription has been printed, this is placed onto the prescription file of the designated prescriber for signing. These should be stored securely in the safe in the drugs team room until handed to the prescriber.

13. Prescriptions which are generated in error should be destroyed by shredding, witnessed by two members of staff, and a record made of this on clients HALO prescribing record.
14. Unused blank prescriptions must be placed back into the safe and not left on general display.

15. Once the prescription has been signed by the prescriber, the senior team administrator will then scan all scripts in order to keep a record of prescription number and save this to a file named “scanned prescriptions” on the shared drive.

16. The Senior team administrator is responsible for ensuring that all prescriptions are posted to the designated pharmacy in the first instance unless there is good reason not to do so. The only possible exceptions to this being:-

- Initial prescriptions for service users at their first appointment with the prescriber.
In exceptional circumstances, an agreed "holiday" prescription to collect in advance from a Torbay pharmacy or for collection at another destination (within the UK only).

- Where the prescription collection frequency needs to be altered urgently, (such as reverting to daily supervised consumption where clinical risk exists, and not to do so immediately would heighten that risk).

- Where clients are in a Low Intensity Treatment Model and collect their prescriptions from the service.

- Prescriptions held at TDAS for collection by clients will be stored securely in a folder in a safe, and signed out by staff/client when issued.

The pharmacy should be contacted in advance by the prescriber / recovery coordinator to communicate the arrangements for a hand delivered prescription being presented to them for dispensing.

17. Posted prescriptions will be recorded as "posted" on HALO.

18. Prescriptions delivered by hand by staff to the pharmacy will be recorded as "hand delivered" and recorded on HALO.

19. Prescriptions given to the service user face-to-face will be recorded on HALO as "given to service user" and dated.

20. Prescriptions to be posted to pharmacies will be coordinated at reception. The prescriptions will be kept in a locked drawer prior to posting.

21. Prior to posting, a report will be taken from HALO detailing service user names and how many prescriptions have been assigned to each community pharmacy. This list will be added into allocated pharmacy envelopes to allow community pharmacy staff to check that the envelope includes all the prescriptions listed. This will be generated by the senior team administrator.

22. All posted prescriptions will be sent first class, and weighed to ensure correct postage is added, at least 2 weeks in advance of the commencement date.

23. In exceptional circumstances where prescriptions are handwritten, the prescriber will ensure that a photocopy of the prescription is made before issuing the prescription. The photocopy will be forwarded to the prescribing coordinator to enable the necessary changes to be made on the HALO prescribing system. This will ensure continuation of repeat prescriptions.

Alterations to pre-agreed prescriptions:

24. Requests for urgent changes to the prescription should be considered carefully. For holiday prescriptions to be issued, this should usually be a planned activity, and therefore a 7-day notification will be required.

25. Any requests for urgent changes in the prescription should be made on the basis of clinical judgement and applied consistently. Verification may be requested (such as in the instance of a request made due to working commitments or holidays) in order to agree to this.

26. All change requests are to be agreed with responsible prescriber and then forwarded to the prescribing coordinator or deputy in their absence. This information needs to include:-

- Service user name
- Service users identification number
- Community pharmacy name
- Medication, including current dose and collection arrangements

No changes will be made until the above information has been given. It will be the responsibility of the prescribing coordinator (or nominated deputy in their absence) to print off the prescription once changes have been made.

27. Suspensions of prescriptions due to non-compliance with treatment can only be reinstated following a medical review. This may be done by any independent prescriber (medical doctor or NMP) within TDAS.

28. Prescriptions SHOULD NOT usually commence on Saturdays due to the difficulties arising if the prescription does not arrive at the pharmacy. The prescribing coordinator will refer this to the service manager should it occur.

29. In exceptional circumstances, a prescription may commence on a Saturday when the service user is on a weekly collection and is insistent that they do not want to change their collection day due to their commitments. Recovery coordinators to ensure this is recorded on HALO.

Lost prescriptions:

30. Prescriptions given to service users which are subsequently reported as lost will not usually be replaced unless there are exceptional and/or verifiable circumstances involved. On occasion, a balance of risk may need to be considered if not replacing the prescription may cause significant harm to the service user or another, and may fundamentally impair the recovery of that individual.

31. In the event that a prescription is lost and not replaced, (as above), then a medical review will be arranged within 7 days with an independent prescriber (medical doctor or NMP), to discuss any possible reinstatement.

32. Prescriptions posted to the nominated pharmacy which fail to arrive and are verified as such by the pharmacy concerned can be replaced. The recovery coordinator will be responsible for making this check. This includes checking on the module in HALO (with the senior team administrator and /or prescribing coordinator) that the prescription has been generated as well as liaising with the appropriate pharmacy.

33. Where it has been confirmed that the prescription has been generated and posted to the nominated community pharmacy, or given to the service user, the lost prescriptions procedure will be followed and an incident raised on the Trust's electronic incident reporting system (Datix).

34. Medication reported as lost, stolen or accidentally spilled by a service user will not be replaced unless observed by a relevant health or social care professional (eg: in cases where the service user has dropped and broken their methadone bottle in sight of the pharmacy staff).

35. Pharmacists will not accept a faxed prescription as replacement in any of the above circumstances.

36. In the event of any disagreement or difficulty, the matter should be referred for resolution to the TDAS service manager, or nominated deputy in their absence.

37. The missing, stolen and altered prescription alert procedure for reporting lost prescriptions will be initiated in all cases of reports of a lost prescription. An e-mail alert should be sent to alerts.scwcsu@nhs.net. The information required is included on a standard template and attached as appendix 1 to this SOP.

Errors:

38. Prior to dispatch, the senior team administrator, prescribing coordinator, prescriber and Recovery Coordinator (if involved) should all check that the prescription wording, figures, signing and dating are all correct in order to avoid prescriptions being produced in error in the first instance.

39. Pharmacists will under no circumstances be able to dispense medication with a verbal instruction over the telephone or dispense from a faxed prescription. Any change will require a new prescription to be produced.

40. In cases where an error has gone undetected and is reported by a pharmacist, TDAS will endeavor to provide a replacement prescription with minimal delay and raise an incident on the Trust Electronic Reporting System (Datix).

Monitoring tool

Standards

Item	%	Exceptions
Prescription correctly produced	100	Nil
Prescriptions delivered on time	100	Nil

How will monitoring be carried out?	Via Medicines Controlled Drugs Safety Group, Pharmacy Harm Reduction Panel & Quality Service Performance and internal audit.
When will monitoring be carried out?	Annually (or sooner if dictated)
Who will monitor compliance with the guideline?	DHRP & QSP, Service Manager TDAS

Appendix:

Appendix 1 - Lost, stolen or altered prescription alert template

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1		October 2015	New	Care and Clinical Group
2	Ratified	02 February 2018	Revised	Care and Clinical Group

Appendix 1

PRIVATE AND CONFIDENTIAL – NOT FOR VIEWING BY NON-NHS STAFF OR NON-AUTHORISED PERSONS

Missing, Stolen & Altered Alert NHS England

Date of Alert	
Web Availability	

Issued By	
Tel No.	

For Circulation to: (Please specify)	**Community Pharmacies**			

Prescribers Details:

Prescribers Name:	
Prescribers Address:	
Prescribers Telephone Number:	
Prescriber will write in red ink until:	
Details of when the prescription went missing:	

Prescription details:

Prescription Serial Number:	
Prescription Type:	
Medication on prescription:	
Patients Initials & road of address:	

Action to be taken:

If you are presented with a possible stolen prescription please contact the prescriber on **(please insert as necessary) or** the police on 101 or 999 as appropriate.

Any pharmacy or dispensing practice detecting and retaining a fraudulent prescription, and informing the correct channels may be eligible for a reward payment of up to £70.00.

For further information regarding the reward scheme, please contact NHS Counter Fraud Service on 0800 068 6161.

Please return completed form to the NHS England Area Team via alerts.scwcsu@nhs.net who will ensure notification of stakeholders

IF URGENT OR PATIENT OR PUBLIC SAFETY IS AT RISK TELEPHONE THE POLICE ON 101 OR 999

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐
Please provide details for each protected group where you have indicated 'Yes'.	

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)	

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our GDPR page on ICON.