Torbay and South Devon NHS
NHS Foundation Trust

Title:	**Medicines Policy for Registered Professionals in Community Services Delivery Unit**	Ref No 1927 Version 3
Directorate:	Pharmacy	
Responsible for review:	Medicines Governance Officer Clinical Governance Lead in Pharmacy	Due for Review 31/01/18
Ratified by:	Care and Clinical Policies Sub Group	
Applicability:	All Registered Nurses and Prescribers	

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1. Introduction

The Medicines Policy has been developed in consultation with health and social care professionals. It is based on the law governing the supply, storage, administration and disposal of medicines. These are the Medicines Act 1968; the Misuse of Drugs Regulations, 2001, as amended; Human Medicines Regulations 2012, the Medicines (Pharmacy and General Sale – Exemption) Amendment Order 2000, SI 2000, No 1919.

In the absence of appropriate guidelines, protocols or Standard Operating Procedures (SOPs) being available, staff should use the Royal Marsden Hospital Manual of Clinical Nursing Procedures 9th Edition (2015) or online edition (www.rmmonline.co.uk).

This document should be used in conjunction with professional codes of conduct and standards (Medicines, Ethics and Practice Edition 38 (07/2014) also including the statutory and advisory publications as listed in the references to this policy.

2. Purpose

The purpose of this policy is to provide staff with standards to ensure the safe prescribing, handling, supply, storage, administration and disposal of medicines. It will provide a framework under which specific policies, standard operating procedures (SOPs) and guidelines operate, to ensure all statutory requirements and local rules governing medicines management are adhered to.

Any concerns questions or doubts regarding practice should be brought to the attention of the immediate line manager, or a member of the Trust Medicines Optimisation Team.

3. Scope of this Policy

This policy applies to all registered staff providing care or services within the Trust concerning prescribing, ordering, handling, storage, supply, administration, recording or disposal of medicines.

4. Definitions

A medicine is defined as any substance for use by humans for the treatment, prevention or diagnosis of disease; this also includes contraception and anaesthesia.

Prescription Only Medicines (POMs)
Prescription Only Medicines (POMs) are medicinal products which may only be sold or supplied in accordance with a prescription given by an appropriate practitioner to named patients.

Pharmacy (P) Medicines
There is no definitive list of Pharmacy Medicines. It comprises all those medicines which are not prescription only medicines (POMs) or General Sales List (GSL) medicines. P medicines may only be sold or supplied from a registered pharmacy premises by a pharmacist.

General Sales List (GSL) Medicines
General Sales List medicines are those which can be sold or supplied in registered pharmacies and in other retail shops.

Controlled Drugs (CDs)
Controlled Drugs are the substances controlled under the provisions of the Medicine Act (1971) and the regulations made under the act. The Misuse of Drugs Regulations 2001 permits the use of Controlled Drugs in medicine. The drugs are classified into 5 schedules according to their level of control. All controlled drugs in schedules 2, 3, 4 and 5 are also POMs. Controlled drugs in schedule 1 are seldom used as medicines.

5. Responsibility and Accountability

The Caldicott Guardian oversees disclosure of individual personal information with particular attention being paid to extraordinary disclosures (those which are not routine) in accordance with the confidentiality NHS Code of Conduct, 2010.

The Accountable Officer for Controlled Drugs is responsible for ensuring the safe and effective use and management of Controlled Drugs within the Trust and must have regard to best practice in relation to the management of Controlled Drugs.

Partner organisations have a responsibility to support NHS staff to comply with this policy.

5.1 Role of the Author of the Medicines Policy

- Ensuring that key stakeholders, are consulted with and involved in the development of the policy including staff side considerations.
- Ensuring that there is a process for the document to be disseminated and implemented. Maintaining the policy control record and ensuring that the policy is archived.
- Describing how the policy will be monitored for compliance and effectiveness.
- Reviewing the policy at the agreed interval.

5.2 Role of the Medical Director

- The Medical Director as sponsor of this document is responsible for acting as a second point of contact to support the author of the policy
- Ensuring that a replacement main author is identified should the original author be unavailable for whatever reason

5.3 Role of the Heads of Departments, Services, Teams and Professional Groups

Service Leads are responsible for ensuring appropriate care pathways and Standard Operating Procedures are in place to support service developments. The Service Leads will assure the framework of the service is in place to satisfy the Trust policies and procedures.

5.4 Role of the Sponsoring Committee

The Care and Clinical Policies Sub Group is responsible for:

- Ratifying this Medicines Policy and Standard Operating Procedures (SOPs)
- Referring policies back to the author for amendment.
- Seeking assurance that the systems for the development and management of policy are robust and effective.
- Appoint an IT Governance Lead to ensure this policy is logged and published electronically, alert authors of due review dates and maintain an archive all current and superseded medicines policies.

5.5 Role of Line Management

Line managers are responsible for:

- Engaging as stakeholders in the development process.
- Ensuring staff are aware of the organisational Medicines policy and Standard Operating Procedures
- Raising awareness of the updated Medicines policy and associated Standard Operating Procedures through management meetings and supervision.
- Implementing the organisational Medicines policy and Standard Operating Procedure for the areas in which they apply.

5.6 Role of Registered Staff

Registered staff are responsible for:

- Participating in the development and consultation process of the Medicines Policy and Standard Operating Procedure
- Making themselves aware of the Medicines Policy and Standard Operating Procedure that relate to their role and responsibilities
- Complying with the agreed Medicines Policy and Standard Operating Procedures.
- Reporting incidents using the Incident Reporting System, where non-compliance with the Medicines Policy and Standard Operating Procedures is noted and represents an actual incident or a near miss, using the organisation's agreed Incident Reporting Policy.
- Ensuring that verbal or written consent is recorded in the patient's notes. Refer to the Trust's Consent Policy (Torbay and Southern Devon Health and Care NHS Trust – Consent Policy for Examination, Assessment, Intervention, Treatment and Care).

6. Practice

In accordance with Professional Codes of Conduct the functions of prescribing, administration and / or supply should be routinely separated. There will be exceptional circumstances where this is not possible, e.g. will compromise patient care – again refer to Professional Codes of Conduct, including non medical prescribers.

6.1 Prescribing Medicines

6.1.1 Licensed prescribers, medical and non-medical can write a prescription for the treatment of patients within their care and in accordance of their Professional Codes of Conduct and Standards.

6.1.2 The legal responsibility for prescribing lies with the prescriber who signs the prescription and/or Prescription and Medication Administration Record (PMAR).

6.1.3 Prescribers must provide information to staff involved in the care of the patient on the safe and timely administration of medicines both in and out of hours

6.1.4 To promote the safe administration of medicines by health care professionals a PMAR a must be completed prior to the administration of any medication.

6.1.5 Prescribing must comply with the Medicines Act 1968 and Misuse of Drugs Act 1971, Regulations and all subsequent amendments.

6.1.6 Medical prescribing should follow the current GMC guidance: Good Practice in Prescribing Medicines.

6.1.7 Non-medical Prescribers must prescribe according to their recordable prescribing qualification and within their level of competence and/or respective prescribing formulary.

6.1.8 Prescribing must be on approved prescription stationery e.g. Prescription and Medication and Administration Record (PMAR), FP10, organisation's approved software, medication administration record sheet (MAR).

6.1.9 Prescription forms must be treated as controlled stationery and handled and secured according to the Trust procedure for the security and handling of Trust forms.

6.1.10 The prescriber must ensure they have access to relevant information to promote safe prescribing including:

- Allergy status/sensitivities/adverse drug reactions- Medications must not be prescribed or administered if the patient's allergy status is not documented on PMAR.
- Weight when relevant to dosing schedule and in children less than 12 years.
- Relevant NICE Guidance and Patient Safety Agency alerts
- Medication history to enable medicines reconciliation.
- Any other relevant clinical details, e.g. blood test results

6.1.11 The choice of medication should be made by the prescriber according to clinical need in-line with the current **South and West Devon Formulary** **www.southwest.devonformularyguidance.nhs.uk** whenever possible. It is anticipated that the current formulary choices will comprise at least 80% - 90% of all prescribing.

6.1.12 Prescribing outside of the South and West Devon Formulary should have clear reasoning and justification. This should be clearly recorded in the patient record.

6.1.13 Medicines should be prescribed by the 'approved' (generic) name except where the current **South and West Devon Formulary** or British National Formulary (BNF) recommends proprietary (brand) prescribing, e.g. combined oral contraceptives and certain topical creams anti-epileptic medication:

- Where bio-availability problems requires the patient to receive the same brand
- For combination products where there is no approved name

6.1.14 Prescriptions must be written clearly and in black ink accordance with the guidance outlined in the BNF.

6.1.15 For prescription and medication administration records, the prescriber must ensure:

- The name of the medicine is printed indelibly in full in BLOCK LETTERS. Chemical formulae must be avoided by using the full approved name e.g. ferrous sulphate not $FeS0_4$. Generic names must be used except when prescribing the following; Compound preparation e.g. Madopar, Sinemet. Pharmacokinetic properties preparations such as theophylline, nifedipine, diltiazem and oral morphine and other modified release opiate preparations
- Strength or Quantities such as *units, micrograms* and *nanograms* must be written in full and not abbreviated exception for mg and g. The unnecessary use of a decimal point should be avoided NB: Abbreviations have led to significant medicines incidents.
- When a PMAR is complete, the prescriber is responsible for transferring all current information to a new liquid formulations if only a single strength is manufactured a dose may be prescribed in millilitres (mL). However, if more than one strength is available, the dose must be indicated in units of strength, e.g. dose in mg or micrograms.
- **Variable doses**; e.g. warfarin, prednisolone, chlormethiazole or alternate day therapy: requirements must be clearly indicated.
- For weekly/monthly doses, specific dates/days and time of medication must be specified.
- Liquid formulations - if only a single strength is manufactured a dose may be prescribed in millilitres (mL). However, if more than one strength is available, the dose much be indicated in units of strength, e.g. milligrams or micrograms.
- The start date, route of administration, strength, dose, frequency, the length of course and stop date and any additional instructions are recorded.
- The signature of the prescriber and the date is recorded.

6.1.16 When FP10 prescription forms are used to facilitate discharge from a community hospital, a copy (e.g. photocopy) must be retained in the notes prior to dispensing to enable an accurate medicines check to take place pre discharge and verify the correct medication has been supplied.

6.1.17 Non-Medical prescribers using FP10 must ensure their prescription pad or computer generated prescriptions reflect their correct prescribing details including organisation identity details, prescribing status and personal identification number.

6.1.18 Prescribers must not write prescriptions for themselves, members of their families, colleagues, friends or patients who are not directly under their care.

6.1.19 Under exceptional circumstances during out-of-hours periods, when the doctor is unable to attend, the on-duty out-of-hours doctor may prescribe a medication on a PMAR which is then faxed to the community hospital / unit or base treating the patient. This faxed PMAR must be attached to any current PMAR and the medicine administered as prescribed. The prescriber responsible for the patient's care must prescribe the medication and review the patient for ongoing treatment within 24 hours or up to 72 hours over a bank holiday.

Please refer to the standard operating procedure for verbal orders and the Trust's Fax Policy.

6.1.20 The maximum frequency for "as required" dosing regimes should be indicated. It is not sufficient to prescribe medication "when required" without providing the maximum dose in 24 hours, how often the dose can be repeated and details of how and when medication should be given (indication).

6.1.21 If a prescription is not clear, or is incomplete in any detail, the prescriber must be contacted to obtain clarification. Medicines should not be given until the Registered Healthcare Professional responsible for administering has received the clarity he/she deems necessary.

Unlicensed Medicines (An unlicensed medicine is the term used to refer to a medicine that has no marketing authorisation)

6.1.22 The Medicines Act (1968) and subsequent legislation preserves the clinical freedom of prescribing doctors and independent and supplementary prescribers, to prescribe medicines for an unlicensed use or via an unlicensed route, or using an unlicensed dose. In these circumstances the manufacturer assumes no liability and the liability for the prescribing rests with the prescriber.

6.1.23 Current General Medical Council (GMC) guidance includes: "Good Practice in Prescribing Medicines on prescribing unlicensed and off-label medicines should be followed".

6.1.24 When prescribing unlicensed medicine or off-label medicine (where medication is licensed but used outside its licensed indications) the prescriber should be satisfied that it is in the patient's best interest.

6.1.25 When prescribing unlicensed medicine or off-label the prescriber should be satisfied that there is sufficient body of evidence or experience of using the medicine to demonstrate its safety and efficacy.

6.1.26 The use of unlicensed medication should have documented the patient's informed consent when using a patient-specific direction (PSD)

Unlicensed medication cannot be administered against a patient group direction (PGD).

6.1.27 It is the prescriber's responsibility to inform the nurses who will be administering drugs if a medicine does not have a product licence.

6.1.28 Local arrangements for obtaining unlicensed medicines should be followed using agreed supply routes and documentation.

Complementary and Alternative Therapies

6.1.29 Where a patient wishes to use their own remedies e.g. herbal remedies, the details much be recorded in the patient's records and brought to the attention of the responsible prescriber.

6.1.30 Where the patient is an inpatient the Prescription and Medication Administration Record (PMAR) must be endorsed with "patient's own remedy... (remedy name)… taken at patient's choice".

6.1.31 Information on herbal and complementary therapies may be obtained through the local Acute Trust Medicines Information Department.

6.2 Administering Medicines

6.2.1 For staff to administer a medicine they must have access to **ONE** of the following "authority to administer", which is current:

- Patient Specific Direction (PSD)
- Prescription Medication and Administration Record (PMAR (hospital and community)
- Patient Group Direction (PGD), relevant to the condition being assessed and that the registrant has signed as competent to operate under.
- Article 7 of the Prescription Only Medicines (Human Use) Order 1997 as amended allows the following to be administered without prescription for the purpose of saving life:
  - Adrenaline Injection (1 in 1000)
  - Atropine Sulphate injection
  - Chlorphenamine injection
  - Glucagon injection
  - Glucose injection 50%
  - Hydrocortisone injection
  - Naloxone hydrochloride

The community dental practice has the following list of medicines included in their management of the common medical emergencies which may arise at their practices.

- Adrenaline injection 1 in 1000
- Aspirin dispersible 300mg tablets
- Glucagon injection
- Glucose (for administration by mouth)
- Glyceryl Trinitrate spray
- Midazolam buccal 10 mg/ml liquid
- Oxygen
- Salbutamol 100microgram.metered inhalation

Discretionary Medicines approved list **(Appendix A).**

It is not appropriate to administer or supply medicines from a package or container which is not either supported by a PMAR, individually labelled or via a PGD or discretionary medicine list.

6.2.2 When a patient is transferred to a community hospital the PMAR and all continuation sheets should be filed in the patient's clinical records, a new PMAR should be completed at the community hospital. However, if a transfer occurs out of hours, the discharging hospital PMAR can be used providing it is current and legible. A new community hospital PMAR should be completed as soon as possible, i.e. the following working day or up to 72 hours for bank holidays.

6.2.3 Registered staff in the community may delegate the administration of medicines to a skilled not registered (SNR) worker who has been assessed as competent to undertake the administration task. The accountability is retained by the registrant. (See Policy for Accountability and Delegation). This does not include intravenous administration of any medicines including controlled drugs. **NOTE:** This does not apply to staff working in a community hospital where all medicines must be administered by a Registered Professional.

6.2.4 Clear written information must be provided and signed by the SNR worker undertaking the delegated task, stating that they have full understanding of their responsibilities.

6.2.5 Administration of a medicine under a PGD cannot be delegated.

6.2.6 Staff undertaking administration of medicines must have the required knowledge of the all the medicines being administered and have current competencies for any equipment being used in the process.

6.2.7 Prior to administration of a medicine the following must be checked:

- Patient Identity (Patient full name, date of birth and hospital number)
- Allergies/hypersensitivities
- Patient is ready to receive the medicine
- Approved generic name, strength, dose, route, frequency of the medicine against the authority to administer
- Expiry date of the medicine to be administered
- Registrants must have knowledge of the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.
- The patient's condition should be checked in order to administer or withhold appropriate medication e.g. Digoxin is not usually to be given if pulse below 60 beats per minutes.

6.2.8 All medicines administration must be recorded to include details of the signature of the person administering, date, time, medicine, dose and route of administration. In addition the appropriate site of administration, and batch number should be recorded for all injectable medicines.

It is not acceptable to leave administration details on the PMAR blank.

6.2.9 If a prescription is not clear, or is incomplete in any detail, the prescriber must be contacted to obtain clarification. Medicines should not be given until the Registered Healthcare Professional responsible for administering has received the clarity he/she deems necessary.

6.2.10 Any necessary calculations should be recorded in the patient's clinical record.

6.2.11 Medicines must not be prepared in advance of the administration episode.

6.2.12 The staff member signing the administration record is accountable for ensuring that the medication is taken by the patient and for completing the administration record immediately afterwards.

6.2.13 Medicines must not be left so that they are accessible to other patients, staff or visitors.

6.2.14 Staff administering medicines must be competent in the identification and treatment of anaphylactic shock and ensure the required adrenaline (epinephrine) is available.

6.2.15 The opening of capsules and crushing of tablets (including administration via naso gastric and enteral feeding tubes) constitutes unlicensed use and should only be carried out if the individual prescriber authorises it in writing. Pharmaceutical advice should be sought as part of the risk assessment to ensure that the medicine is not compromised by these methods and there are no concerns regarding the safety or efficacy of the medicine.

6.2.16 When a medicine is authorised for administration as 'unlicensed' by the prescriber, a percentage of liability for any harm that may occur will lie with the Healthcare Professional administering the medication.

6.2.17 When an "unlicensed" medicine is authorised by a prescriber, there must be sufficient information to ensure the administration is undertaken safely.

6.2.18 Medications to be administered by the injectable route must be risk assessed and administered according to the Injectable Medicines Policy / NPSA Alert 2007/20 "Promoting Safer use of Injectable Medicines". Technical monographs to support injectable administration to support injectable medicines may be obtained at http://nww.injguide.nhs.uk. The Trust user name(s) and password(s) to access the site are found on medicine optimisation page on the Trust intranet. For those medicines not listed please contact Torbay Hospital Medicines Information or the on call pharmacist for advice.

6.2.19 Any medicine/medicinal product prescribed and dispensed for a named individual cannot be used for any other person.

6.2.20 Staff must not self-administer stock medication. Staff must not offer to supply or administer any medication to other members of staff during employed practice and may result in disciplinary action.

6.2.21 A pharmacist may amend the prescription for the purpose of clarification to assist safe administration.

Medication Loading Doses

6.2.22 In November 2010 the National Patient Safety Agency issued a Rapid Response Report (NPSA/RRR/018) to ensure reducing the risk of harm from inappropriate loading and maintenance doses of medicines.

6.2.23 A loading dose is an initial large dose of a medicine used to ensure a quick therapeutic response. It is usually given for a short period before therapy continues with a lower maintenance dose.
The use of loading doses of medicines can be complex and error prone. Incorrect use of loading doses or subsequent maintenance regimens may lead to severe harm or death.

6.2.24 There is significant evidence of harm related to:

- Incorrect loading doses.
- Omitted or delayed administration of loading doses.
- Unintentional continuation of loading doses.

6.2.25 Information relating to loading doses and subsequent maintenance doses must be communicated effectively through all stages of the patients care pathway.

Medication Loading Doses Critical List

The Trust agreed critical list of medicines with high risk is:

Warfarin
Digoxin
Amiodarone
Phenytoin
Acetylcysteine
Heparin

Reference: National Patient Safety Agency. Rapid Response Report NPSA/2010/RR018

Omitted or Delayed Medicines (Non-Administration) Against a Prescription

All non administration must be recorded appropriately.

6.2.22 Where a medication fails to be administered against a prescription this must be clearly documented on the PMAR and (as appropriate) the patient's clinical records with the reason for non-administration documented. This must include the reason for omission or delay.

6.2.23 Where an unplanned non-administration occurs the prescriber should be informed to assess the clinical implications of non-administration and inform any remedial action that may be required.

6.2.24 Where medicines are not available for administration the prescriber must be informed to discuss the course of action. This must be clearly documented in the patient's clinical records. Merely stating that a medicine is not available is insufficient.

6.2.25 Any omitted or delayed medication must be reported in accordance with the incident reporting policy and standard operating procedure for omitted /delayed medications.

Administering or Supplying Medications against a Patient Group Direction (PGD)

6.2.26 A PGD may be developed to support the supply and/or administration of a medicine where there is a specific and predictable requirement to use that medicine in the absence of a prescriber, e.g. minor injury unit.

6.2.27 Registered Practitioners (named in the HSC 2000/026) may only administer or supply a medicine in accordance with a PGD under which they have signed that they are competent to operate under.

6.2.28 Registered Practitioners administering/supplying medicines under a PGD must work within relevant associated policies and protocols.

6.2.29 Medicines supplied must conform to the description and labelling requirements described in the PGD.

6.2.30 Where a supply is made, the supplying registered practitioner must add the patient's name, date and any dosage instruction (if blank) to the pre-pack label. No other change should be made to the label or pack.

6.2.31 Records of supply/administration must be made in the patient's records in accordance with the PGD.

6.2.32 Registered practitioners may only work to a PGD produced by, and ratified by their employing organisation.

The Discretionary Medicines List

6.2.33 Discretionary medicines may be administered without a prescription to adults, who are under the care of the Trust, by a registrant competent to administer that medicine (see Appendix A). If a discretionary medicine is required on more than 3 (three) days during a single 7 (seven)-day period it should be prescribed by a prescriber as either a regular or "when required" medicine as appropriate.

6.2.34 Discretionary medicines may not be administered to children, pregnant or breast-feeding patients.

6.2.35 The registrant administering the discretionary medicine must be competent and accountable for that administration and for ensuring that there is no interaction or duplication with the patient's prescribed medication.

6.2.36 A record must be made of the administration of discretionary medicines on the PMAR and (as appropriate) the patient's clinical records.

Self-Administration

6.2.38 Patients should be encouraged to self administer where it is beneficial and a risk assessment has taken place.

6.2.39 In-patients may retain or assume responsibility for the administration of some or all their own medicines following risk assessment. Facilities must be available within the environment to support safe self administration in accordance with the Self-Administration Standard Operating Procedure (SOP).

6.2.40 When self administration is undertaken it must be recorded on the PMAR by the registered professional and regularly monitored.

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Disguising / Covert Medication (Please refer to the Trust Covert Administration of Medicines policy 2.0)

6.2.41 It is important to remember that every adult must be presumed to have the mental capacity to consent or refuse treatment. If there is reason to doubt the service user has capacity to make the decision staff must evidence a lack of capacity. A Mental Capacity Assessment should be carried out according to Trust Policy. Further information regarding the assessment process can be accessed via the Mental Capacity Act (MCA) 2005 Code of Practice (chapter 4) http://www.justice.gov.uk/about/opg

Medical and Nursing Students

6.2.42 As part of their learning and training (when they have completed their second year or drug competency module NUR223), students of nursing are encouraged to take part in the administration of medicines during their clinical placements. They may be given increased responsibility as they progress with their course, but must be directly supervised at all times by a competent and registered practitioner.

6.2.43 The registered nurse will need to make themselves aware of the previous experience of the student, the stage of the course and assess current competencies.

6.2.44 It is the duty of the student nurse to refuse to do anything they are not competent or confident to do.

6.2.45 The registered nurse remains fully accountable when supervising a student undertaking any aspect of medication administration.

6.2.46 The supervising registered nurse must countersign any records made and signed by a student.

6.2.47 Students must not participate in parts of the administration process that require post-registration training, for example, intravenous administration

6.2.48 Medical staff who are not fully registered may not sign prescriptions.

6.3 Ordering and Supply of Medicines

6.3.1 All medicines supplies should be ordered on approved stationery (Pharmacy stock item requisition form or Non-stock item requisition form) from an approved supplier (Torbay Hospital Pharmacy). Such stationery should be locked away when not in use.

6.3.2 Orders should be signed by a registered professional and countersigned by the nurse in charge.

6.3.3 Where stocks are held, a list of medicines stocked should be agreed with relevant staff (Medicines Optimisation Pharmacy and ward matron), and reviewed at least annually.

6.3.5 Ordering and supply of controlled drugs is covered in our Trust SOP controlled drugs in community services.

6.3.6 Out of Hours requests to supply medicines for patients who have not been assessed by Trust staff must not be accepted.

6.3.7 For community patients, FP10s are used to obtain supply via a community pharmacy. For patients in community hospitals and units (where medicines are supplied under a service level agreement) medicines are ordered from the local acute trust pharmacy.

6.3.8 For community hospitals and units medicines are supplied via Torbay hospital pharmacy according to standard operating procedures.

6.3.9 Patient's own medicines may be used for the individual patient in hospitals and clinics and routinely in a patient's home. When patient's own medicines are used they should be checked to ensure they are in date, in good condition, labelled correctly and from an approved source, e.g. hospital or community pharmacy. See SOP for guidance.

6.3.10 The ordering, receipt and storage of stock drugs in a community hospital is the responsibility of the Registered Healthcare Professional in charge, but may be delegated to another Registered Healthcare Professional.

6.4 Transport and Storage of Medicines

6.4.1 Medicines should be transported in a green Envopak that is marked with the name of the ward and hospital, secured with numbered sealed boxes/packages with a clear audit trail for supply and delivery.

6.4.2 Items in transport that require refrigeration should be clearly identifiable so as to restore and respond to any break in the cold chain as soon as they are received at their destination.

6.4.3 Medicines transferred to outreach services must be recorded on transfer and receipt in an audit log. Staff must be insured to transport medicines.

6.4.4 If collecting medicines on behalf of a patient from a dispensing pharmacy, the pharmacy will request identification and a signature as the patient's representative. Appropriate identification must be offered to the pharmacy.

6.4.5 Any medication collected must be transported directly to the place of potential use e.g. hospital, clinic or the patient's home.

6.4.6 In exceptional circumstances, when staff are required to collect medicines from a pharmacy they have responsibility for the medicines while in transit. Medicines must be stored out of sight and where appropriate in accordance with any storage requirements.

6.4.7 Medicines should be stored as directed by the manufacturer. Special precautions must be taken to ensure that some medicines are stored at the correct temperature during transportation.

Storage of Stock Medicines

6.4.8 The standards for the storage of medicines is detailed in "Safe and Secure Handling of Medicines – A Team Approach", Duthie Report 1988 revised 2005

6.4.9 The Registered Practitioner in charge is responsible for the safe custody of and access to medicines within their ward/clinic/unit or service.

6.4.10 All medicines must be stored safely and securely locked away in storage trolleys/cupboards/rooms out of public view/access. Keys to medicine cupboards/areas should be held by the Senior Practitioner in charge or locked in a designated key-cupboard following a recognised or approved secure access procedure.

6.4.11 Storage conditions for medicines should be preventing deterioration by temperature, humidity, compression and exposure to light or radiation.

6.4.12 Items requiring cold storage must be locked in a pharmaceutical grade refrigerator kept solely for medicines and equipped with a maximum/minimum thermometer. The fridge must have the temperature recorded daily; this must include actual, maximum and minimum temperature readings.

6.4.13 Stock levels of flammable materials should be minimised and stored in a locked 'inflammable' cupboard approved by the fire officer. Stock levels of medical gases should be minimised and storage approved by the fire officer and health and safety adviser.

6.4.14 All staff should adhere to Health & Safety and COSHH (Control of Substances Hazardous to Health) regulations.

6.4.15 Pharmaceuticals should not be stored on non-NHS premises for sessional clinics, unless a risk assessment has been undertaken.

6.4.16 Any apparent loss of medicines, a medicine cupboard that has been tampered with, loss of keys or suspected misuse of medicines, must be reported to the practitioner in charge immediately reported as an incident in accordance with the Trust Incident Reporting and Management Policy.

Storage and Use of Patients' Own Medicines

6.4.17 Healthcare Professionals may offer advice on the safe storage of medication within the patient's own home.

6.4.18 Within hospital and clinical settings patients own medicines should be stored in their patient's own medication lockers beside their beds or separately in the TTA cupboard from ward stock medicines.

6.4.19 Please refer to the Trust SOP **USE OF PATIENTS OWN DRUGS (PODs) FOR IN-PATIENT AND DAY CARE SETTINGS**

If any doubt exists regarding the source, identity, quality or expiry date of the medicines brought in by a patient, they must not be used.

Following the death of a patient, patient's own medicines should be regarded as the patient's property. They may be destroyed seven days following the patient's death.

6.5 Management of Medicines in Coroner's cases

6.5.1 In the case of an unexpected / sudden or suspicious death, all medicines, including controlled drugs, relating to the care of that patient must be regarded as evidence and must not be removed or destroyed without the instruction from the Coroner (See Standard Operating Procedure for the Management of Unexpected/Sudden or Suspicious Death of a patient).

6.5.2 In coroners' cases; any drugs (including controlled drugs), syringes and syringe drivers must be handed to the police. Where syringe drivers are used two trained staff (nurse or doctor) must give written confirmation of the used amounts of drug in the syringe, the amount used, the rate of administration and the timing of the last dose if intermittent. It is essential that the data is recorded and the drugs kept for analysis if it is thought to be necessary.

7. Disposal of Patient's Own Medicines

7.1 It is expected that relatives or representatives of the service user will make arrangements for the return of all unwanted medication to a community pharmacy for safe disposal. Where there is no-one able to do this, and if a nurse considers it appropriate to remove excessive drugs for the benefit or protection of the patient, with the consent of the patient or patient's representative, the nurse should complete the relevant form (Appendix 10) which should be countersigned by the patient or patient's representative before removing the drugs to the nearest community pharmacy for destruction.

7.2 In the case of a death which has been confirmed as expected, and has not been referred to a Coroner, a nurse may remove drugs from the patient's home with the consent of the patient's representative. The drugs should be taken to the nearest community pharmacy for destruction.

7.3 The relevant form (Appendix 10 - Permission to Remove Unwanted Medicines) should be completed for any medication that requires disposal. This should detail the name of the medication, quantity, date and reason for return to a pharmacy. The form should be signed and dated by the service user or their authorised representative and the person who is removing the medication. The pharmacist receiving the medication should be requested to sign and date the form and return it to the nurse for its subsequent retention in the Patient Held Record. If the pharmacist does not agree to sign the form, this should be documented on the form.

7.4 Sharps, for example unwanted needles and sharps bins, will not be accepted for disposal by the community pharmacy and arrangements should be made with the council for their safe disposal.

8. Destruction of Medicines

8.1 This will be in accordance with the TSDFT Waste Management Standard Operating Procedure (SOP) and relevant standard operating procedures including SOP Controlled Drugs in Community Services.

9. Controlled Drugs (Please refer to SOP Controlled Drugs in Community Services)

9.1 The Accountable Officer is a statutory appointment and is responsible for ensuring the safe and effective use and management of controlled drugs across the organisation

9.2 All aspects of controlled drugs must be managed in accordance with the Controlled Drug Standard Operating Procedure.

All Controlled Drug cabinets must conform to standard BS2881.

Guidance for procurement of CD cupboard / storage facilities should be in accordance with the CD Standard Operating Procedure.

Controlled drug cupboard keys must be kept on a dedicated and separate key ring held by the registered professional in charge.

A second set of keys must be kept elsewhere in the community hospital/unit, in a safe and secure location.

10. Drugs of Diversion

Drugs of Diversion are a group of medicines as defined within the Trust Drugs of Diversion SOP and require extra governance arrangements within community hospitals and community units. NB: All staff should understand the potential for drugs to be misappropriated.

11. Medication Incidents

11.1 Should an incident or near miss occur, the immediate action must be to prevent harm and reduce any immediate risk to the patient.

11.2 The practitioner in charge of the ward/unit or the line manager at the time of the incident should be informed immediately. They must undertake an initial review to determine the cause of the incident and ensure the incident is reported on the Trust incident reporting system in accordance with the Incident Policy.

11.3 The details of all medicines incidents relating to specific patient(s) must be recorded in the patient's clinical record.

11.4 The following situations illustrate typical medicines incidents. All such incidents or near misses must be reported in accordance with organisation's reporting policy. These are examples and this list is not exhaustive.

- A prescribing error is found
- A patient is given a medicine that has not been prescribed
- A patient is given a medicine that is prescribed for another patient
- A patient is given the correct medicine but at the incorrect time
- A medicine is administered by the wrong route
- Controlled drug documentation discrepancies
- There is an unplanned omission of a medicine to a patient

11.5 Medicines incidents will be reviewed and learning from incidents shared.

11.6 The Medicines Optimisation team will support line managers and individual staff where incidents have occurred including notifying the Accountable Officer where appropriate.

11.7 Incidents must be discussed with the patient and/or carer, relative.

11.8 Where it is suspected there may be a problem with equipment associated with medicines administration an incident form should be completed and guidance followed in the Medical Devices Policy and procedures. The equipment should be retained and advice sought from the appropriate authorities, e.g. medical electronics for syringe drivers.

11.9 For further information on reporting and dealing with incidents, please refer to the Trust's Policy for the Reporting & Management of Incidents including Serious Incidents that Require Investigation (SIRI).

12. Adverse Drug Reactions

12.1 In the event of the patient suffering an adverse drug reaction immediate action must be taken to reduce undue harm to the patient. This should include medical review. If occurring out of hours, the on-call manager for the Trust should be notified.

12.2 The manager in charge and the prescriber must be informed as soon as possible after the patients' needs have been addressed.

12.3 The patient's GP should be informed in addition to the prescriber if this is not the GP.

12.4 The incident must be recorded in the patient's clinical record indicating the actions taken and highlighting the medication which prompted the adverse reaction.

12.5 The incident must be reported in accordance with organisation's Policy for the Reporting & Management of Incidents including Serious Incidents that Require Investigation (SIRI).

12.6 The 'Yellow Card' will require completion and be sent to the Medicines and Healthcare Products Regulatory Agency (MHRA) – details are contained in the British National Formulary and https://yellowcard.mhra.gov.uk

13. Defective Medicines Reporting Procedure

13.1 All suspected medicine defects must be reported and the appropriate Matron informed immediately.

13.2 The incident report must also be submitted using the Incident Reporting System. Please give as much detail as you can.

13.3 If possible the defective material must be labelled clearly, isolated and retained for safekeeping. Photographs of the defective medicines are useful when the material cannot be preserved.

13.4 Drug name, strength, batch number and expiry date must be recorded.

13.5 The Chief Pharmacist will take charge of the investigation and onward reporting of the incident to the Medicines and Healthcare Regulatory Authority (MHRA) and the drug manufacturer.

13.6 If a patient is involved, use of the suspect material must be immediately discontinued. The medical practitioner in charge of the patient must be notified at once.

13.7 If further medication is required, this must be taken from a different batch. If an intravenous infusion or syringe driver has been set up both the administration set and the infusion fluid must be replaced from a different batch.

13.8 If a medicine defect is suspected outside the normal pharmacy department opening hours, the on-call pharmacist must be contacted.

13.9 The following are examples of possible medicine defects:

- particulate matter in IV fluids or other injectables
- cracks in IV fluid bottles
- growth in IV fluids or other injectables
- hairline cracks or particulate matter in ampoules / vials
- labelling on containers which does not correspond to the outer wrap
- different odour from normal
- unexpected clinical reaction
- quality of dressings lower than normal
- colour change.

14. Emergency Cascades including Medicines and Medical Devices

All medicines related alerts will be cascaded and appropriate actions taken by service managers. Please see our trust SOP on Management of the central alert system (CAS).

15. Medical Gases (see separate Medical Gases Policy)

15.1 Medical gases are licensed medicinal products and as such must be prescribed. Medical gas cylinders should be stored securely and safely. Empty and full cylinders must be separated and restrained securely from falling.

15.2 Procedures should be in place for ordering, storing and controlling movement of medical gas cylinders.

15.3 Sites with piped medical gas supplies - Hospital Technical Memorandum 2022 applies. Hospitals without a piped supply may have cylinders.

15.4 ***Oxygen therapy***: the required flow rate must be stated. For more details on how to prescribe oxygen please refer to the Joint Formulary and "Management of Medical Gasses Policy. (Incorporating the procedure for the storage and administration of oxygen).

15.5 Where medical gases are used to drive nebulisers, the specific driving gas must be specified.

16. Anticoagulants

Patients prescribed anticoagulants should receive appropriate verbal and written information at the start of therapy, at hospital discharge, on the first anticoagulant clinic appointment, and when necessary throughout the course of their treatment. Please see our Trust SOP Management of Anticoagulant patients in community services.

17. The Prescribing, Preparation and Administration of Injectable Medicines

Medicines may be prescribed, prepared and administered by trained Healthcare Professionals in accordance with the Injectable Medicines Policy and related Standard Operating Procedures.

18. Pharmaceutical Samples

18.1 The pharmaceutical industry promotes the introduction of new products through supply of pharmaceutical samples. Such samples (including dressings) must not be accepted or used.

18.2 New products will not be prescribed or used on patients until the Joint Formulary has approved them. Contact the Joint Formulary Lead Technician to find out how to include new medicines and medicinal products in the formulary. For further information see Trust **Policy on Sponsorship and Working with the Pharmaceutical Industry**

19. Development Processes

19.1 ***Prioritisation of Work***

The standards set out in the Medicines Policy and related Standard Operating Procedures are paramount to the safe and effective prescribing, ordering, handling, storage, supply, administration, recording or disposal of medicines.

19.2 ***Consultation and Communication with Stakeholders***

Identify relevant stakeholders, level of involvement, e.g. development, consultation, or receipt of final procedures.

19.3 ***Review and Revision Arrangements***

The Medicines Policy and Standard Operating Procedure will be reviewed in two years, June 2014 or earlier if required due to changes in national or local guidance, formularies, professional practice or user feedback.

19.4 ***Dissemination and Implementation***

The policy will be shared with all line managers and clinical leads that are responsible for ensuring this policy is implemented across their area of work.
Learning and Development will be informed of the ratification of the Medicines Policy and Standard Operating Procedure.

20. Ward and Departmental Closures

20.1 Background

Events arise which require planned or unplanned transfer of wards, Minor Injury Units, Outpatient departments and any other area where drugs are stored, e.g. physiotherapy.

It is essential that the transfer of drugs is managed safely and securely in such circumstances, while ensuring no interruption in patient care.

It is also important that at such a time, nursing and other staff are protected and not expected to carry out unnecessary or onerous work in achieving this, as they will have many other responsibilities around patient care at these times.

It is important for staff to be aware that they are not licensed or insured to transfer drugs, and should ensure that all drugs are transported by Trust couriers or porters.

This policy gives clear and concise instructions for the transfer of drugs during such times.

The protocol should be initiated by the matron or senior nurse responsible for overseeing the transfer.

If the process is planned in advance, please notify Pharmacy (Tel: 0180301803 655317), so that additional support can be provided if required.

20.2 Protocol

20.2.1 Check the storage facilities for drugs, specifically controlled drugs, with the ward or unit that the service or patients are being transferred to.

20.2.2 If there is not adequate storage at the new site for controlled drugs, contact Torbay Pharmacy to request storage.

20.2.3 Contact Torbay Hospital Pharmacy Department to request a supply of green Envopak (CD) drug bags.

20.2.4 Contact Torbay Hospital Pharmacy Department to obtain a supply of plastic bags for the transfer of Patients' Own Drugs.

20.3 Wards:

20.3.1 Patient's own drugs (PODs) or drugs stored in the patients' bedside drugs lockers should be transferred into a separate plastic bag, the bag sealed with tape and labelled with the patient's name and details

20.3.2 These bags should be transferred into a green pharmacy bag, labelled Patients' own drugs.

20.3.3 A ward handover sheet or list of patients should be used and retained to ensure that drugs for all patients have been transferred, and a record kept of the number of green bags involved.

20.3.4 All stock **Drugs of Diversion** should be placed in a green padded Envopak CD bag with a numbered tamper-proof seal, along with the Drugs of Diversion register, witnessed by two registered nurses on the attached form (Appendix 1) and the bag should be sealed.

20.3.5 **Controlled drugs should** be placed in a green padded Envopak CD bag with a numbered tamper-proof seal, along with the Controlled Drugs register, witnessed by two registered nurses on attached form (Appendix 1) and the bag should be sealed.

20.3.6 Any **refrigerator drugs** must be put in a green bag which must be clearly marked "FRIDGE ITEMS". Wherever possible (depending on urgency of move), these should be transported in cool-boxes, or any other storage which maintains the cold chain. The time and date of removal from the fridge must be noted on the attached form (Appendix 1), and the time and date of replacing back into a fridge at the earliest opportunity must also be noted.

20.3.7 If the hospital is being totally vacated and no security service is going to be present, all drug stocks should be transferred into green pharmacy bags, or cardboard boxes, labelled to indicate that stock drugs are enclosed if there are not enough green bags.

20.3.8 If the hospital is being vacated for a short term, i.e. for up to a week, and there is security on site, non-controlled drug stocks can be left in a locked drug cupboard in a locked room, and security tasked to check the room on a daily basis.

20.3.9 A list of the number of green bags, Controlled drugs and Drugs of Diversion bags should be kept by the senior nurse or matron involved in the transfer.

20.3.10 All bags should be given to the couriers or porters to transfer to the new site. **(See Appendix B)**

20.3.11 The senior nurse at the receiving site should check the number of bags received and ensure that the drugs are appropriately and securely stored.

21. Minor Injury Units, Outpatients and other services, e.g. Physiotherapy, Theatres

As above, with the exception of Patients' own drugs and patient bedside locker drugs.

22. Monitoring Compliance and Effectiveness

Monitoring will be undertaken by the Care Quality & Safety Group with the assistance of the Medicines Governance Group and by shared learning through appropriate audits and incidents. This part should provide information on the processes and methodology for monitoring or auditing compliance with and effectiveness of the procedural document, an outline of responsibilities and the process of reviewing results and ensuring how improvements in practice. A set of key performance indicators should also be included.

As a minimum include the review/monitoring of all the minimum requirements within the NHSLA Risk Management Standards.

- monitoring arrangements for compliance, i.e. audit, review of prescription and medication administration records, ordering.
- reporting of incidents as outlined in the Incident Reporting Policy and associated shared learning of these incidents and best practice
- responsibilities for conducting the monitoring/audit;
- methodology to be used for monitoring/audit;
- frequency of monitoring/audit, i.e. quarterly, on a rolling basis, etc.;

- process for reviewing results and ensuring improvements in performance occur.

23. Training

22.1 Training is provided in line with the Training Needs Analysis and Mandatory Training Policy.

22.2 All appropriate staff should be made aware of this policy at both induction (new staff) and through team meetings and specific medicines management training

22.3 Contact with specialist wards/units within acute hospitals/specialists units should be made where an unusual procedure is prescribed, or a Registered Healthcare Professional lacks the necessary confidence or experience.

22.4 Supervision of administration, by a competent practitioner, should be arranged to safeguard individual standards of practice and maintain professional competence.

22.5 All Registered Healthcare Professionals must work within their Scope of Professional Practice and in line with their professional standards and Code of Practice.

22.6 All registered healthcare professionals prescribing, preparing or administering medicines must successfully undertake an approved Trust calculations competency test upon appointment on an annual basis. It is the responsibility of the service leads / unit manager to ensure compliance with this requirement.

24. References

- Medicines Act 1968 and associated regulations
- Misuse of Drugs Act 1971 and associated regulations and amendments
- Great Britain (1999) Control of Substances Hazardous to Health (COSHH) Regulations 1999. The Stationery Office, London
- Nursing Midwifery Council (NMC) Standards for Medicines Management (2010,2015) NHS Code of Conduct 2010
- Health Service Circular HSC 2000/026, Patient Group Directions
- Patient Group Directions - A practical guide and framework of competencies for all professionals using patient group directions. National Prescribing Centre (NPC) March 2004
- Health and Social Care Standards and Planning Framework
- Royal Pharmaceutical Society Great Britain (March 2005) *The Safe and Secure handling of medicines: a team approach*. A revision of the Duthie Report (1988 Consent – A Guide for Children and Young People DH December 2001 04074679
- A Guide to good practice in the management of controlled drugs in primary care (England) NPC Review Edition May 2004
- 'Saving time, helping patients' - A good practice guide to quality repeat prescribing NPC January 2004
- Safety Alert Bulletins/Medical Device Alerts/Public Health Alerts
- Immunisation Against Infectious Disease 1996 - "The Green Book", Department of Health
- Building a safer NHS for Patients (improving medication safety) Department of Health Jan 2004
- NHS Estates (1994) HTM 2022 Medical gas pipeline systems. The Stationery Office, London
- Medicines Matters; A guide to current mechanisms for the prescribing, supply and administration of medicines, Department of Health: March 2005, 2006
- A guide to good practice in the management of controlled drugs in primary care (England). Second edition: February 2007.
- NICE Guidance: CG 76 Medicines Adherence January 2009.

- Mental Capacity Act
- Trust Incident Reporting and management Policy
- Medicines Ethics and Practice Guide. Number 3 (July 2010).
- Department of Health HSC 1999/012 : Caldicott Guardians
- Policy for the Reporting & Management of Incidents including Serious Incidents that Require Investigation (SIRI).
- Royal Pharmaceutical Society of Great Britain (July 2014) *Medicines, Ethics and Practice: A Guide for pharmacists*
- The British National Formulary online www.bnf.org.uk
- South and West Devon Formulary www.southwest.devonformularyguidance.nhs.uk

25. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	1927		
Document title:	Medicines Policy for Registered Professionals		
Purpose of document:	Safe Professional Practice		
Date of issue:	20 October 2017	**Next review date:**	31 January 2018
Version:	3	**Last review date:**	
Author:	m Head of Medicines Optimisation Medicines Optimisation Technician		
Directorate:	Medical		
Equality Impact:	The guidance contained in this document is inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care & Clinical Policies Sub Group		
Date approved:	December 2015		
Links or overlaps with other policies:	All Strategies, policies and procedure documents		

	Please select	
	Yes	*No*
Have you considered using Equality Impact Assessment?	☒	☐
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☒
Does this document have training implications? *If yes please state:*	☐	☒
Does this document have financial implications? *If yes please state:*	☐	☒
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☒

Document Amendment History

Issue	Status	Date	Reason for Change	Authorised
v 0.1	Draft	26.10.11	Amalgamation of Trust Policies	
V 0.2	Draft	15.11.11		
V 0.7	Draft	13.4.12	Amended following consultation	
V 1.0	Ratified	25.4.12		Paul Humphriss
v 1.1	Draft	12.10.12	Updated Training Section to become NHSLA compliant	Paul Humphriss
V 2.0	Ratified	24.10.12		
V 2.0	Extended	19.11.14	Extended to March 2015	Lynda Price
V 2.1	Draft	April 2015	Review	Lynda Price
V 3.0	Ratified	01.06.15		Lynda Price / Rajitha Ramakrishnan
V 3.1	Ratified	October 2015	Amended with arrangements for removing medicines from patient homes.	Lynda Price
3	Ratified	30 June 2017	Review date extended	Care and Clinical Policies Group
3	Ratified	20 October 2017	Review date extended	Care and Clinical Policies Group

26. 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.

27. Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☒
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process? **no**	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity? **no**	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*			

APPENDIX A: APPROVED LIST OF DISCRETIONARY MEDICINES

If a discretionary medicine is required on more than 3 (three) days during a single 7 (seven)-day period it should be prescribed by a prescriber as either a regular or "when required" medication as appropriate.

Discretionary medicines may be administered without a prescription to adults, who are under the care of the Trust, by a registered practitioner competent to administer that medicine.

This list does not apply to paediatric, pregnant or breastfeeding patients or those outside of the care of the Trust.

Medicine	Adult Dose	Comments
Analgesics: Paracetamol tablets, soluble tablets or syrup	1g 4-6 hourly up to a maximum total dose of 4g in 24 hours	Check if other paracetamol containing medicines are prescribed "regularly" or "prn" to avoid exceeding the maximum total dose in 24 hours.
Antacids: **Alginates** Peptac suspension	20ml four times a day after meals and before bed	Peptac suspension is sugar free but contains sodium about 3mmol/5ml (the full daily dose stated contains about 48mmol compared to an average daily requirement of 100mmol).
Simple Antacids Magnesium trisilicate mixture	10ml 3 times a day in water	Caution in renal impairment and hypertension Contains sodium 6mmol in 10ml (the full daily dose stated contains about 18mmol compared to an average daily requirement of 100mmol).
Laxatives: Bisacodyl Suppository 10mgs	Single dose	
Senna	2-4 tablets at night.	Senna - do not use in suspected intestinal obstruction or following colo-rectal surgery
Microenema	5ml single dose	
Glycerin suppositories 4g	Single dose	Glycerin Suppository - moistened with water
Phosphate enema	128ml single dose	
Cough and Throat Preparations: Simple Linctus	5ml 3-4 times a day	Simple Linctus - N.B. High sugar content not suitable for patients with diabetes
Throat Lozenges	Use as directed on	

Saline nebuliser	packet 5ml as required	

Topical Preparations

CATHETER CARE:	Catheter maintenance solutions as per current joint formularies and related policies. Local anaesthetic gel. Lubricating gel.
TOPICAL IRRIGATION:	Sodium Chloride 0.9% Irrigation Chlorhexidene (Hibiscrub) ®
MOUTH CARE:	Mouth Ulcer Gel Preparations
SKIN CARE:	Aqueous cream Emollient creams Yellow soft paraffin Barrier Cream

A record must be made of the administration of these medicines on the appropriate clinical records, e.g. Prescription Medication and Administration Record.

Appendix B: Transport / Courier Monitoring Form for Medicine Transfer

LIST OF BAGS HANDED TO COURIER / PORTER			
GREEN Envopak PADDED BAGS CONTAINING CONTROLLED DRUGS	**NUMBER OF BAGS**	**SIGNATURES OF 2 NURSE WITNESSES**	**COURIER SIGNATURE**
GREEN Envopak PADDED BAGS CONTAINING DRUGS OF DIVERSION	**NUMBER OF BAGS**	**SIGNATURES OF 2 NURSE WITNESSES**	**COURIER SIGNATURE**
GREEN BAGS CONTAINING PATIENT SPECIFIC DRUGS	**NUMBER OF BAGS**		**COURIER SIGNATURE**

GREEN BAGS CONTAINING STOCK ITEMS	NUMBER OF BAGS		COURIER SIGNATURE

FRIDGE ITEMS	NUMBER OF BAGS	TIME AND DATE OF REMOVAL FROM FRIDGE	TIME AND DATE OF REPLACEMENT INTO FRIDGE	COURIER SIGNATURE

NURSE IN CHARGE OF TRANSFER: (SIGNATURE, TIME AND DATE):

COURIER IN CHARGE OF TRANSFER: (SIGNATURE, TIME AND DATE):

RECORD OF CONTROLLED DRUGS REMOVED FROM PATIENT'S HOME TO COMMUNITY PHARMACY FOR DESTRUCTION

To support the care of service users, nurses employed by Torbay and Southern Devon Health and Care Trust may, in exceptional circumstances and with the permission of the service user or representative, remove drugs including Controlled Drugs, from the patient's home and convey them to the nearest community pharmacy for safe and secure destruction.

(This does not apply to Care Homes, who should have an approved system for destruction of unwanted drugs.)

The form must be completed to provide a clear and accurate account of the controlled drugs being removed, to provide evidence that permission has been obtained from the service user or representative, and to provide a record of the acceptance of drugs from the pharmacy.

Date:	
Nurse Name:	Signature:

Service User Name:	DOB or NHS Number	Signature:
Address:		
Representative Name (print):	Relationship to Service User:	
Signature:		

Name and address of pharmacy accepting drugs:
Name and signature of pharmacist accepting drugs:

Patient Name and DOB or NHS number……

DRUG NAME	STRENGTH	FORM (TABLETS / LIQUID /AMPS)	QUANTITY	Signature of service user/ representative to witness drugs removed	Signature of Pharmacist receiving drugs	Date and time: