

**Policy for the Ordering
Supply, Storage, Prescribing and
Administration of Medicines**

October 2005

**POLICY FOR THE ORDERING SUPPLY. STORAGE, PRESCRIBING AND ADMINISTRATION OF
MEDICINES**

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1) **INTRODUCTION**

This policy aims to outline the roles and responsibilities in relation to the ordering, supply, storage, prescribing and administration of medicinal products by Sunderland Teaching Primary Care Trust (STPCT) staff. A medicinal product is defined by the Medicines and Healthcare Products Regulatory Authority (2003) as “any substance or combination of substances presented for the treating or prevention of disease in human being or animals”. This includes active wound dressings but not other medical products such as urinary sheaths / stoma appliances which are classed as medical devices.

The policy will be of primary interest to all Trust employed Medical Staff, Pharmaceutical Staff, Registered Nurses and Health Visitors, Student Nurses and Retinal Screeners. A separate policy exists for St Benedict’s Hospice.

The key principle that this policy is seeking to uphold is that there is safe practice in relation to all aspects of medicines. Medicines are one of the most common healthcare interventions that patients are likely to receive. They also have the capacity to cause harm and are a source of risk in terms of adverse reactions or medication errors.

Many aspects of medicines use are covered by legislation as well as professional regulation and guidance. STPCT wishes to support its staff by ensuring that their work is in line with relevant legislative and professional standards.

All staff involved with medicines shall be appropriately trained with regard to their safe and secure handling and administration. The Clinical Excellence Group and individual professional leads will be responsible for considering the Continuing Professional Development needs of staff in the context of the safe and secure handling and administration of medicines.

This policy should be read in conjunction with other STPCT policies which relate to medicines. The policy has been developed within the context of the following documents:

- ◆ Medicines, Ethics and Practice. A Guide for Pharmacists 1999
- ◆ Guidelines for the safe and secure handling of medicines - ‘The Duthrie Report, DOH 1988.
- ◆ DOH (2000) Health Service Circular 2000/026 Patient Group Directions (England Only)
- ◆ www.doh.gov.uk/nurseprescribing
- ◆ HMSO (2000) Statutory Instrument 2000 No. 1917 The Prescription Only Medicines (Human Use) Amendment Order 2000
- ◆ Medicines Control Agency MLX 273 – Consultation on Prescription Only Medicines, GSL & P Medicines for nurse prescribing
- ◆ Standards for the Administration of Medicines (NMC 2002).
- ◆ Midwives Rules and Code of Practice (UKCC 1998 – now NMC).
- ◆ Code of Professional Conduct (NMC 2002).
- ◆ Scope in Practice (NMC 2001 – formerly UKCC 1997).
- ◆ Covert administration of medicines (UKCC 2001- now NMC)

ALL working practices and procedures involving controlled drugs and medicines within STPCT will conform to the contents of this policy document.

ALL persons who administer medicines are responsible for their actions and if unsure will need to refer to a recognised source of information e.g. any of the above documents, the British National Formulary (BNF), CHS Prescribing Guide, MIMs or the Pharmacy Department.

Under no circumstances will any person employed by STPCT remove any medicines from any premises for their personal use.

STPCT staff will not use samples provided by company representatives.

Clinical Trial Material. Any materials that are being used as part of a clinical trial should be kept separate from other supplies of medicines so that there is no opportunity for patients not part of the trial to receive such material.

Under no circumstances should medicines or medicinal products prescribed for an individual patient be used for any other patient. Such recycling of medicines is regarded as secondary dispensing and is illegal.

2) DEFINITIONS

For the purpose of this document the following definitions apply:

Administration refers to the process of nurses providing medicines by a range of routes for patients. It also includes those administered by patient group directions rather than a standard prescription. It is recognised that the actual process of assisting patients to take oral medication may be delegated to an untrained nurse (except paediatrics) however; it remains the trained nurse's responsibility to ensure medicines are administered according to policy.

Extended independent nurse prescriber refers to any nurse who has undergone the extended independent nurse prescriber course and is registered with the Nursing and Midwifery Council (NMC) as an extended independent nurse prescriber.

Independent prescriber is a doctor or dentist.

Medical practitioner is any provisionally registered or fully registered medical practitioner.

Medicine / medication is defined as any substance, internal or external, used for therapeutic, diagnostic or preventative purposes.

Nurse is defined as Registered Nurses and Health Visitors whose name appears on the NMC register. It also refers to those Enrolled Nurses who have undergone further training and assessment in the administration of medicines.

Patient refers to the patient in their own home, residential or nursing home or school environment, or any health care premises or an employee attending the occupational health department.

Patient group direction refers to a trust-ratified protocol that supports the supply or administration of medicines without prescription by appropriately trained healthcare professionals.

Pharmacist is defined as any person registered with the Royal Pharmaceutical Society of Great Britain.

Supplementary prescriber refers to a nurse or pharmacist who has undergone the appropriate approved Higher Education Institution (HEI) Supplementary Prescribing course and is registered with the Nursing and Midwifery Council (NMC) or Royal Pharmaceutical Society of Great Britain (RPSGB) as a supplementary prescriber.

3) ORDERING AND SUPPLY OF MEDICINES

STPCT staff receive order and receive supplies of medicines from a number of different sources, these include:

- ◆ From a Hospital Pharmacy
- ◆ Via NHS Supplies in the case of some dressings
- ◆ From a third party pharmacy pre-packaging department
- ◆ Against a patient specific prescription (e.g. General Practitioner or Nurse Prescription Form FP10) from a community pharmacy

Ordering from the above sources can be carried out by individuals authorised to do so by their Line Manager.

Where departments or bases carry a stock of certain items then the Service / Department Head in conjunction with the supplier / Pharmacist will establish a stock list, including maximum and minimum stock levels. The Service / Department Head will ensure that regular stock checks are carried out and documented. Any discrepancies will be investigated and, if not resolved, reported to their respective line manager. Incident Reporting procedures should also be followed in all cases where the medicine cannot be accounted for.

Out of hours stocks of certain medicines required by nursing staff will be made available to avoid the need to call out community pharmacists. The Urgent Care Team, 24/7 Rapid Response Team and Minor Injuries Teams are able to provide treatment and some medications for certain patients using Patient Group Directions for unplanned care. On weekends and bank holidays District Nurses should plan ahead to ensure that patients requiring on-going care have enough medications and / or dressings / appliances.

Controlled drugs

Stocks of controlled drug stationery must be kept in a locked cupboard. When in use blank prescription forms/pads should not be left unattended.

Stock Requisitions for Controlled Drugs must be made by a registered nurse / medical practitioner.

Out of Hours supply of drugs

If a patient is given a FP10 prescription marked URGENT and no community pharmacy within the city is open, the prescriber will contact the on-call pharmacist on the designated mobile number – (Appendix 1- Pharmacy out of hours on call rota)

The pharmacist will agree a time for the patient/ representative to attend the pharmacy to collect the dispensed medication.

4) **RECEIPT AND STORAGE OF MEDICINES**

When ever possible items obtained from a Community Pharmacy dispensed for an individuals (via an FP10 prescription) should be obtained by the patient or his / her nominated representative. Only in exceptional cases should a STPCT employee be responsible for obtaining and transporting items. Where this does occur the employee must ensure that the item is collected as near as possible to the time of the visit and it should be transported out of sight in the boot of the vehicle.

The responsibility for maintaining the system for the security of all medicines within the clinical area lies with the clinical area/team leader/manager, unless in patient's own home where drugs remain the property of the patient.

Designated individuals within each service / health centre will take receipt of medicines. It is crucial that the quantities and specifications (i.e. strength and form) of medicines received reconcile with the order made. Therefore staff taking receipt of medicines should carefully check the quantity delivered with the quantity ordered. Any discrepancies should be documented and resolved following dialogue with the supplier. Where resolution cannot be achieved the discrepancy should be reported immediately to the individual's line manager and Incident reports completed.

The drug keys must be carried at all times by a nurse who is competent to administer drugs and is assigned to the department, either in a temporary or permanent capacity.

Drug keys must not be given to nurses not assigned to the department, medical staff or other personnel (with the exception of the department pharmacist/pharmacy technician).

Overall responsibility for the whereabouts of the keys and the medication stored on the department lies with the nurse in charge of the shift.

Departments / Day Units will hand over the keys to the appropriate officer for safe storage according to local policy.

In the event of drug keys being reported unavailable an investigation must be undertaken immediately. If the keys are not located the incident report procedure must be instigated and arrangements made for locks to be changed.

Medications must be stored securely and safely in a locked cupboard / trolley. If medicine trolleys are used they must be locked and immobilized when not in use.

Medicines must not be decanted from one bottle to another.

All medicines stocked at within the department will be checked at least once a month for expiry dates.

There must be separate, lockable cupboards for medicines allowing the separation, as necessary, of

- ◆ Controlled drugs
- ◆ Medicines for systemic use
- ◆ Medicines for external use
- ◆ Medicines requiring refrigeration – for no articles other than medicines, and dedicated blood bottles e.g. heparin bottles

Any special storage conditions will be identified on the packaging and the person responsible for putting received medicines into storage will

- ◆ Store medicines in accordance with any special requirements
- ◆ Rotate stock such that stock that is closer to its expiry date will be used first.

Medicines must be stored in their original packaging.

It is essential that medicines requiring refrigeration are stored and transported in such a way as the cold chain is maintained at all times. Such medicines should be stored in a refrigerator which has a maximum and minimum thermometer and that this is checked daily and a record of checking and temperature recordings is maintained.

Patients in the community are given information regarding their medications and safe storage by the dispensing pharmacist. This information should be reinforced by Community Nurses visiting patients at home.

Suppliers and STPCT staff transporting medicinal products must ensure that transportation containers used for carriage comply with Health and Safety and COSHH regulations (the Control of Substances Hazardous to Health regulations).

Medicines for clinical emergencies e.g. cardiac arrest or anaphylaxis, shall be kept available in strategic and accessible sites, rather than being held in a locked cupboard, at times when they may be needed.

Items dispensed to named individuals in the community should be returned to a Community Pharmacy by the patient or his / her nominated representative where possible. In exceptional circumstances a STPCT employee may transport items. Where this does occur the employee should ensure they are returned to the Community Pharmacy as soon as possible after collection and during transportation they should remain out of sight in the boot of the vehicle.

Controlled drugs

Controlled drugs will be prescribed on the Controlled Drugs Prescription sheet by the doctor. In patients' homes, a record will be kept of controlled drugs and checked at each administration to ensure that stocks are correct. Any discrepancies must be reported and investigated.

5) **PRESCRIBING AND PRESCRIPTIONS**

General Practitioners, Dentists, and some nurses / pharmacists are permitted to prescribe for patients registered or living within Sunderland.

Before Prescribing:

1. Assess patient need for prescription.
2. Use speciality guidelines where available.
3. Choose drugs in line with Sunderland Teaching Primary Care Trust Prescribing Guidelines formulary, Nurse Prescribing Guide and Wound formulary whenever possible.
4. Complete details of the patient in BLOCK CAPITALS on the front of the FP10 / medicine record card.
5. Any drug allergies should be checked.
6. In-patients: Check and clearly record the patient's NHS number/ hospital number.

General Principles:

- ◆ Use approved names for drugs and write in BLOCK CAPITALS.
- ◆ Use the metric system. Frequently used approved abbreviations are:
 - g = gram e.g. Glucose 75g
 - mg = milligram e.g. Furosemide 40 mg
 - The term microgram should not be abbreviated e.g. Levothyroxine 25 micrograms
 - The term units should not be abbreviated e.g. Insulin 20 units
 - ml = millilitres. If small volumes are prescribed, put a zero in front of the decimal point e.g. 0.5ml (not .5ml)
- ◆ Indicate the route of administration clearly. Accepted abbreviations are:

IV = intravenous

SL = sublingual

PR = rectally

SC = subcutaneous

PV = vaginally

NG = via naso gastric tube

RE = right eye

BE = both eyes

Sub-conj = Sub-conjunctival

Right aural = right ear

Left aural = left ear

IM = intramuscular

TOP = topical

PO or O = orally

INH = inhaled

PEG = via PEG

PEJ = via PEJ

LE = left eye

Occ. = ointment

G. = guttae or drop

- ◆ Write the commencing date clearly.
- ◆ Indicate course lengths wherever appropriate e.g. for antibiotic courses.
- ◆ Review parenteral treatment every 24 hours.
- ◆ Sign the prescription with your full signature and print your name.

- ◆ When prescribing Once-Only-Drugs or premedication, state the time the drug is to be given.

When discontinuing drugs draw a straight line through the drug name, write date, time and signature in the relevant boxes and write "STOP".

Start date will be date when treatment was started - not date when prescription was rewritten.

If any change is required to dose or route of a drug e.g. IV to oral, then the prescription must be rewritten.

It is the medical practitioners/nurses responsibility to ensure that ALL prescriptions are clear and legible. If a prescription is not clear and legible nurses are instructed not to administer the medication and to ask for the prescription to be re written.

Prescribers will use FP10 prescriptions to prescribe medicines for patients. Community pharmacists¹ will dispense these. All Prescribers should order prescription pads via Modern Matron with lead for prescribing (see appendix 2) using the approved documentation.

Record of Administration

In the community a record of administration is kept in the nursing records in the patients' home. All drugs administered by nurses must be recorded on the drug administration record.

Drugs will be administered as directed on the labelled medication (prescription).

Oxygen

Both the device for administration and the percentage of oxygen will be prescribed. All other recommendations for good practice must be followed.

The Urgent Care Team, Minor Injuries Team and 24/7 Rapid Response Team are able to supply and / or administer oxygen for patients requiring short-term, acute care (ref. oxygen PGD, Oxygen Policy)

Verbal prescribing

Verbal prescribing must not be used for controlled or intravenous (IV) drugs.

There is a legal requirement that all prescriptions should either be written or electronically generated by an authorised practitioner prior to administration.

Emergency Situations

In Emergency Situations it is accepted that a doctor can verbally request a medicine to be administered. Where, in an emergency situation a doctor requests a medicine to administer to the patient, the doctor must be shown the ampoule to check that the medicine being administered is the medicine of choice. Under NO circumstances must a medicine be administered without first checking the ampoule.

All qualified nurses will attend statutory training in CPR and the management of anaphylaxis. Following training, qualified nurses working in the community will be authorised to administer adrenaline via PGD.

Prescribing over the telephone

Except in exceptional circumstances, telephone orders for the administration of medicines should not be accepted.

The preferred method for urgent communication of prescription instructions is via Fax. However, it is recognised that in some circumstances this is not practicable and in the interest of timely treatment telephone orders can be taken. When taking a telephone order the practitioner should:

- ◆ Listen to the instruction from the prescriber including medicine, dose, route and time of administration repeating back to the prescriber this information.
- ◆ The practitioner who will administer the medicine should write this within the patients records
- ◆ Wherever possible a second practitioner should ask the prescriber to repeat the instruction checking the record made
- ◆ Both practitioners should sign and date the record made
- ◆ In emergency situations verbal instructions may be taken by a single practitioner who should note the medicine, dose and route and repeat this to the prescriber. The medicines should be prescribed in writing as soon as possible after resolution of the emergency by the original prescriber.

Transcribing prescriptions

Transcribing from one prescription sheet to another is the responsibility of the Medical Practitioner. Nurses must not undertake this role. Pharmacists are authorised to transcribe prescriptions. The individual pharmacist must endorse the prescription "Written by (Pharmacist)". Once completed it is the Medical Practitioner's responsibility to check against the original prescription sheet to ensure all drugs have been accurately transcribed before signing the prescription.

Extended independent nurse prescribing

Nurses who have undertaken the appropriate extended nurse prescribing course (NMC-validated) are able to prescribe all General Sales List (GSL), Pharmacy (P) medicines prescribable at NHS expense (excluding Controlled Drugs) and those Prescription only Medicines (PoMs) identified in the Extended Independent Nurse Prescribers Formulary (NPEF).

Please refer to Nurse prescribing policy for further information.

6) **PATIENT GROUP DIRECTIONS**

Changes to Medicines Legislation came into effect August 2000. This involved clarification of law in relation to the supply or administration of medicines under Patient Group Directions that were previously described as 'group protocols'. These legal changes ensure that nurses and other health professionals who supply or administer medicines under such directions are acting within the law and that all Patient Group Directions comply with a legal criteria. This was achieved by the Medicines (Sale and Supply by Health Care Bodies) order 2000 which Medicines Act and by further amendments to the Prescription Only Medicines (Human Use) Order 1997 (the POM order), the Medicine (Pharmacy and General Sale – Exemption) order 1980 and the Medicines (Sale and Supply) (Miscellaneous Provisions) Regulations 1980.

Definitions

- ◆ Patient Group Directions are specific written instructions for the supply and / or administration of a named licensed medicine except Controlled drugs in an identified clinical situation (DoH 2000).
- ◆ Patient Group Directions apply to those groups of patients who may not be individually identified before presenting for treatment.
- ◆ Patient Group Directions are drawn up locally by doctors, pharmacists and other health professionals, signed by a doctor or dentist, as appropriate and approved by an appropriate healthcare body, e.g. STPCT

Each clinician will have undergone appropriate training and will utilise any supporting clinical protocols and guidelines associated with the clinical condition/procedure for which the patient group direction is used.

All patient group directions will be audited on a 6-monthly basis as part of integrated audit. Audit arrangements are the responsibility of the team lead. Any issues will be actioned through the team lead.

All patient group directions will be reviewed, and where appropriate, revised on an annual or biannual basis (the frequency of review will be identified by the prescribing sub group). Revised directions will be submitted to the clinical excellence group.

Any medicines supplied or administered via a patient group direction must be recorded in the appropriate patient documentation. The entry must include the date and time, route, method of administration, frequency, duration and dosage of medication. The clinician must print and sign their name indicating their role.

Where medicines are to be supplied via a patient group direction they will be securely stored in a lockable cupboard. Supportive leaflets will be provided where appropriate to assist the patient with administration of the medicine.

A system will be used in each area for recording and monitoring medicine use. Note: Any amendment of legislative orders enabling health care professionals to expand the

range of medications they can supply or administer under a patient group direction will be considered appropriate within the context of the medicines policy.

Patient Group Directions are approved by the prescribing sub group and signed of by Bev Atkinson, Director of Nursing Greg Moorhouse, Prescribing Advisor and Geoff Stephenson, Medical Director.

All Patient Group Directions endorsed by the STPCT Trust have an agreed format that matches National DH guidance. Key headings include:

- ◆ Description of the medicine to which the Patient Group Direction is applied
- ◆ Clinical situation to which the Patient Group Direction applies
- ◆ Criteria excluding a patient from treatment
- ◆ Action to be taken for patients excluded from treatment
- ◆ Details of the medicine to be supplied / administered including dose and frequency
- ◆ Advice to be given
- ◆ Circumstances under which further advice should be sought from a doctor
- ◆ Record keeping and audit information
- ◆ Details of which professionals may work to the PGD and specialist training required
- ◆ Details of Continuing Professional Development arrangements

Authorisation form to indicate that the professional is able to work to the PGD

All approved PGDs are available to download from STPCT intranet site or as hard copies.

Supply of Medicines to Patients under PGD

Medicines should only be supplied to a patient against an approved PGD and only in circumstances where the patient is likely to experience problems obtaining the item via a FP10 prescription or if it is the best interests of the patient.

If the medicine is being supplied for the patient to take away and self-administer then it needs to be adequately labelled and contain the appropriate patient information.

A record must be kept of all items supplied to individual patients to assist with stock monitoring and within the patients own records.

If necessary, arrangements will be put in place to collect prescription charges from patients who are liable to pay them.

7) ADMINISTRATION OF MEDICINES TO PATIENTS

The administration aspect of medicines is an important aspect of the professional practice and is not intended as a solely mechanistic task to be performed in strict compliance with the written prescription of a Health Care practitioner. It requires the exercise of professional judgement to ensure safe and effective health care.

In administering any medication either against a prescription or against a Patient Group Direction, STPCT staff will need to exercise professional judgement, and apply their professional knowledge and skill in the given situation.

Except in cases of covert administration of medicines the consent of the patient is required before administration. In accordance with Department of Health guidance this may be verbal or implied consent. Childhood immunisations should only be administered with consent (either written or verbal) from individuals who have parental responsibility.

Tablets should not be crushed or capsules opened during administration without checking with a Pharmacist that this is acceptable. Where possible suspensions etc. should be used especially for administration via PEG tubes etc.

Medicines **should only be administered by staff where:**

There is a written signed prescription indicating the medicine, route of administration, dose and frequency / times

Or

There are clear instructions on the medicine label indicating the route of administration, dose and frequency

Or

The medicine is being administered via a Patient Group Direction

Or

In exceptional circumstances the medicine is administered following a verbal instruction or during an emergency as part of emergency treatment.

If the instructions are not explicit, the nurse must obtain written instructions from a medical practitioner.

Administration procedure

Prior to administering any medicine the practitioner should check that the correct medicine is being administered to the correct patient, at the correct strength, via the correct route at the correct time. The following sequence should be used to ensure patient safety:

- ◆ Check the prescription, medicine label or that the patient meets the criteria outlined in the Patient Group Direction

- ◆ Identify that the medicine is due to be administered
- ◆ Identify that the medicine has not already being administered by checking the record of drugs administered
- ◆ Check that the medicine is not contraindicated by any known allergies or conditions the patient has
- ◆ Check the drug, dose and route of administration
- ◆ Check the medicines expiry date
- ◆ Check the patients identity by asking the patient his / her name and date of birth
- ◆ Administer the drug. The patient must be observed until the medicine has been taken (if the drug is administered orally). If the medicine is a controlled drug, the second checker must witness administration
- ◆ Record that the drug was administered (including the batch number and expiry date for vaccines)
- ◆ In situation where a prescribed medication is omitted or refused by the patient the fact should be recorded in the patients care plan and a record of omission made on the drug recording sheet – stating medicine, time and reason for omission.

Controlled Drugs

Medicines controlled under the Misuse of Drugs Act (1971) are subject to certain regulations to ensure their safe storage and administration. Under the Misuse of Drugs Act (1971) once a controlled drug is dispensed to a named individual in the community (except nursing homes, residential homes and prison healthcare environments) it is no longer subject to the controls (e.g. locked storage, recording in a register of stocks etc.), which are normally applied in a hospital setting. Therefore there is no requirement to maintain a record of the number of tablets, ampoules etc. within the patient's home however this should be done as good practice as it ensures safety for the patient and nurse involved.

Two registered nurses should check and administer controlled drugs.

Two registered nurses should check the prescription details.

A check should be made on the stock level within the controlled drug cupboard against the number remaining in the controlled drug register or against stock level within the home prior to preparing the drug for administration.

A record of the drug, dose and to whom it was administered should be made in the controlled drug register (together with details of the remaining stock and any waste disposed of) or in the patient's medicine record card.

Both registered nurses should sign the register / record card.

Oral Medicines / Oral syringes

Oral medicines must never be drawn up in IM/IV syringes, oral syringes must be

available for use where necessary (available from the supplies department). Under no circumstances should normal hypodermic syringes be used for this purpose, except for administration via a nasogastric tube.

Whenever it is necessary to administer oral medications via a syringe and other solutions for either IM/IV injection at the same time, the two procedures will be carried out separately.

Intravenous drug administration

Intravenous drug administration may be undertaken by nurses in STPCT who have extended their scope of professional practice and who are competent to do so.

All drugs for intravenous administration can be administered by one nurse, however where possible it is preferable to carry out this with two nurses.

Controlled drugs for intravenous administration on continuous infusions will be checked by two people up until the infusion is connected and commenced. The infusion does not need to be monitored by two people once a connection has been made

The nurse must have the knowledge and skills to operate any electronic equipment used for intravenous administration of drugs.

Any medicines prepared for intravenous administration must be given immediately, unless these have been pre-prepared from pharmacy.

Procedure for Intravenous Drug Administration

The administration procedure outlined above should be followed:

Prior to any intravenous medication being administered, the cannula must be inspected for patency, malfunctions and signs of extravasation or infection.

The cannula cap must be removed and the port wiped with an alcohol-impregnated swab for 8 - 10 seconds. Allow to dry for 30 seconds.

The nurse administering the drug must be involved in the checking process.

Patients must be closely monitored throughout the administration of intravenous drugs for signs of discomfort or adverse reaction. In the event of a reaction administration must be stopped immediately and reported to medical staff.

The nurse who has administered the medicine will sign for the administration.

If the prescribed medicine is omitted for any reason, a record of this must be made in the patient's notes / Medicine Record Card or other appropriate documentation.

Methods of Administration of Intravenous Drugs

Bolus Injection – Intravenous administration of a small volume drug, via a syringe, directly into a cannula/port.

Continuous Infusion – Addition of a drug to a volume of fluid and infusing it over a specified time as prescribed. Care must be taken to ensure compatibility of the drug with the infusion fluid. A drug additive label must be completed, attached and be clearly visible.

Intermittent Infusion – Addition of a drug into a small volume infusion administered at the prescribed and recommended rate, usually at specific time intervals throughout the day. Care must be taken to ensure compatibility of the drug with the infusion fluid. A drug additive label must be completed, attached and be clearly visible.

In certain circumstances, particularly palliative care, continuous sub-cutaneous route is a preferred method over intravenous infusion. Syringe drivers are used for this purpose. Please refer to the Palliative Care guidelines for further supporting information.

Concordance Aids

Medication organisers and other aids to concordance are sometimes used to improve compliance with complex medication regimens especially in older people. These aids should only be used following a comprehensive assessment of the patients needs. Concordance aids should only be filled by pharmacists and normally requires a 7-day prescription (rather than 1 month). The filling of such aids is at the discretion of the Community Pharmacist.

Where concordance aids are in use the practitioner should prompt the patient to take his / her medication rather than administering it

Administration by non-registered staff

In certain circumstances non-registered staff may be permitted to administer certain types of medicinal products such as eye drops and bowel preparations. When deciding what medicines may be administered by non-registered staff the following principles should be taken into consideration:

- ◆ That the medicine, dose and route of administration is well established (e.g. the patient has been on the drug and dose for sometime without side effects) and administration does not require the exercise of professional judgement and decision making
- ◆ The route of administration falls within the competence of the non-registered member of staff
- ◆ Where administration is delegated the registered practitioner must ensure that the non-registered member of staff has had appropriate training and understands the standard checking process associated with administration

- ◆ The registered practitioner retains responsibility and professional accountability for the delegated task.

A separate policy exists for management of medicines for home care services.

Covert administration of medicines

The disguising of medicines within food and drink in order to lead a patient that he / she is not receiving a drug when in fact they are, could be regarded as deception. However, it is accepted that there are some occasions when the covert administration of medicines is necessary “in order to save life or prevent deterioration or ensure an improvement in the patient’s or client’s physical or mental health” (NMC, 2001). In these circumstances the practitioner could be regarded as working to uphold the best interests of the patient.

Before considering the administration of medicines without informed consent (covert administration) the practitioner must satisfy him / herself that:

- ◆ administration would be in the best interests of the patient / client
- ◆ the medication is considered essential for the patient’s health and well-being or for the safety of others
- ◆ covert administration is a last resort and that the decision to proceed has been reached following individual patient assessment
- ◆ there has been broad and open discussion amongst the multi-professional clinical team and the patient / clients family / carers
- ◆ the method of administration has been approved by a registered pharmacist
- ◆ the decision taken and record of discussions held is recorded in the patients records
- ◆ the decision is regularly reviewed and attempts are made to encourage the patient / client to take their medication

8) ADVERSE EVENTS AND ERRORS

There are three broad types of adverse event that can arise in medicines use

1. An Adverse Drug Reaction. This is when a patient has been given the correct prescribed dose of a medicine but develops a reaction that is unwanted or unexpected.
2. A Defective Medicine. This is when, usually due to some problem in its manufacture, a medicine does not perform as expected.
3. A Medication Error. This is when a patient receives the wrong medicine from one or more of the following aspects
 - The wrong medicine(s) is prescribed, supplied or administered
 - The wrong dose is supplied or administered
 - The medicine is given by the wrong route
 - A medicine or dose is inadvertently omitted.

Adverse Drug Reactions

When reactions are seen then they should be documented and brought to the attention of the prescriber of the medication. When in doubt, the practitioner should contact a Doctor or Pharmacist for advice. This is important as, for some adverse reactions e.g. penicillin allergy, it is important to prevent further episodes. The Medicines Control Agency collects and analyses reports of adverse reactions and staff should be encouraged to consider initiating a report via the Yellow Card Scheme (see BNF for details.)

Defective Medicines

When a medicine is suspected of being defective, staff will bring this to the attention of their manager who will notify the pharmacist from where the medication was dispensed and the prescribing advisor.

The prescribing advisor will, if necessary in conjunction with senior colleagues (including senior pharmacy managers, medical and nursing staff,), determine the degree of patient risk associated with the suspected defective medicine and take local action to quarantine stocks as appropriate.

The prescribing advisor will contact the Defective Medicines Report Centre [Telephone: 020 7273 0574 (Out of hours – 5pm to 9am there is an answer phone giving contact names and phone numbers)], Market Towers, 1 Nine Elms Street, London SW8 5QN) and report the details of the incident.

Medication errors / incidents

The primary consideration following any medication error is to immediately safeguard patient safety by early reporting to a medical practitioner to ensure that any required emergency treatment or monitoring can be instigated. Staff should report all medication errors whether related to dispensing, administration or supply using Incident Report forms.

Reporting of drug errors is encouraged to subsequently examine procedures, inform policy, improve practice, ultimately reducing risk to patients.

Errors in drug supply, administration, dispensing or prescribing must be reported immediately by the person detecting the error to the Line Manager on duty:

All medication errors will be investigated by Line Managers / Modern Matrons using the drug matrix as a guide (appendix 2).

The purpose of all investigations or reviews is to ensure the identification of learning points to prevent any recurrence of the incident

Reports from investigations should be forwarded to the DEEAL group to ensure that learning can be disseminated across the organisation.

Errors will not normally lead to disciplinary action except in cases where there are repeated errors of a similar nature by the same practitioner. In these cases a period of supervised practice and retraining should be tried prior to disciplinary action being taken.

9) WASTE AND RETURNED MEDICINES AND THEIR SAFE DISPOSAL

Medicines (including used syringes, sharps etc. contaminated with medicines) are subject to the Special Waste Regulations 1996. Staff need to ensure that medicines are disposed of safely and in line with these regulations e.g. treated as special waste for incineration.

STPCT staff may come across unwanted or out of date medicines in a range of situations

9.1 Patients own medicines that are no longer required

- ◆ Patients or their carers should be encouraged to return these to a pharmacy, preferably the pharmacy from where they were dispensed, for destruction.
- ◆ Controlled Drugs in patients' homes. There is a high risk of theft, diversion and illegal use of unwanted controlled drugs in patients' homes. Where possible these drugs should be returned to the pharmacy from where they were dispensed by the patient or their carer.
- ◆ If the patient/ carer or their representative are unable to return the unused medications to pharmacy, this should be recorded as part of the risk assessment and they should be transported by the district nurse directly to pharmacy for destruction.
- ◆ Under no circumstances should controlled drugs (except those already mixed and in syringes from drivers) be placed in sharps containers or discharged into the sewerage system as this contravenes Environmental Legislation.

9.2 STPCT stocks of medicines that are date expired or no longer required

- ◆ These should be returned to the supplier for disposal.
- ◆ Details should be recorded of stock that is returned in this way and stock lists amended as necessary.

10. REFERENCES

- D.O.H. (2001), *Building a safer N.H.S. for patients*, Implementing an organisation with a memory, London, England.
- D.O.H. (2000), *An organisation with a memory*, London, England.
- P.H.W. (2000), Professional Practice Panel – Consultation paper, Sunderland
- Medicines, Ethics and Practice. A Guide for Pharmacists 1999
- Guidelines for the safe and secure handling of medicines - 'The Duthrie Report, DOH 1988.
- DOH (2000) Health Service Circular 2000/026 Patient Group Directions(England Only)
- www.doh.gov.uk/nurseprescribing
- HMSO (2000) Statutory Instrument 2000 No. 1917 The Prescription Only
- Medicines (Human Use) Amendment Order 2000
- Medicines Control Agency MLX 273 – Consultation on Prescription Only
- Medicines, GSL & P Medicines for nurse prescribing
- Standards for the Administration of Medicines (NMC 2002).
- Midwives Rules and Code of Practice (UKCC 1998 – now NMC).
- Code of Professional Conduct (NMC 2002).
- Scope in Practice (NMC 2001 – formerly UKCC 1997).
- Covert administration of medicines (UKCC 2001- now NMC)
- www.nmc.uk.org

Pharmacy out of hours on call rota

The following document describes the proposed Pharmacy out of hours on call system:

OOH Provider

The ooh provider will transfer the service mobile telephone and a container of agreed non Controlled Drug essential medicines between on call pharmacists (at premises, during opening hours)

The Trust

1. Will provide the on-call pharmacist with a resource pack, a mobile phone and a supply of agreed palliative medicine in a lockable container
2. Will pay pharmacist providers monthly at the agreed rate on receipt of an invoice
3. Will provide Sunderland Royal NHS Trust (the transport provider) the names of Pharmacists authorised to order patient transport chargeable to the PCT

The Prescriber

1. Will Issue an urgent out of hour's prescription.
2. Will contact the on call pharmacist on the designated mobile number
3. Will confirm the patient's name, address and telephone number.
(informs the pharmacist if the patient does not have a telephone)
4. Will confirm the details of the prescription with the pharmacist.
5. Will confirm the medication is urgently required.
6. Will provide the pharmacist with the name of the person collecting the medication. If the prescription is for oxygen, provides directions to the patient's address.
7. Will provide the pharmacist with the prescriber's contact number contact telephone number.
8. Will agree time for patient/representative to attend the pharmacy **see 6 under 'pharmacist'** and obtain directions if required.
9. Will inform the pharmacist if neither patient nor representative can attend the pharmacy.

The Pharmacist:

The pharmacist is required to stock and maintain the range of Controlled Drugs agreed as necessary to provide the service (see list) .

1. Will check on receipt the contents of the locked container of non-CD palliative medicines.
2. Will man the on-call telephone from receipt until dispatch in order to provide information if required on pharmacy services available from open premises.
3. Will agree with the prescriber when contacted the time of arrival of the patient or representative at the pharmacy. **see 6**
4. If neither the patient nor a representative can attend the pharmacy. Will telephone the OOH transport provider (Sunderland Royal 5656256 ask for 'Transport' provide name of authorised pharmacist) to arrange collection of the prescription from the patient, delivery to the pharmacy at a specified time and delivery of the medication to the patient.
5. If the prescription is for oxygen and the pharmacist on-call does not provide this service,

Scoring matrix for drug incidents / errors Guidelines for managers

ALL drug errors / incidents must be reported and investigated in accordance with NMC guidance. All errors/ incidents must be considered on an individual case. These guidelines have been produced to determine what action should be taken depending upon the severity of the incident. Reflection and learning outcomes for the individual and the organisation are integral to the process at all levels.

A points system has been developed whereby points are accumulated from columns 1-4 on the scoring sheet. In column 5 headed MITIGATION the points should be subtracted from the figure that you have.

- Level 1** A score of 0-12 will result in discussion / counseling with the Ward / Department Manager / Team Leader to reflect upon and learn from the incident. The Modern Matron / Medical Practitioner will be informed and a file note made.
- Level 2** A score of 13 - 20 may constitute a significant error and therefore be referred to the relevant line manager / service lead for appropriate action. A file note of these events will be made.
- Level 3** A score of >20 may equate to negligent practice and will be referred by the line manager to the relevant service lead e.g. Modern Matron / Consultant /GP Clinical Governance lead for investigation. This will be reported to the appropriate Director / Assistant Director.

***If the incident is the second incident in 6 months then Level 2 will apply.
If the error is the third incident in 6 months then Level 3 will apply***

1. ALL drugs score 1 point plus additional points using column two according to drug group.
2. Other circumstances - judgment must be used as to whether mitigation applies.
3. If more than one mitigation applies, subtract only the highest points.
4. Knowledge of error but failing to report an incident will be classed as negligent practice. Level 3 action will apply.

Matron	(for a Community/hospice nurse error)
Consultant	(for a medical hospice error)
GP Clinical Governance Lead	(for a GP error)
Line Manager	(DN Sr / Charge nurse HV / Team lead)

SCORING MATRIX FOR DRUG INCIDENTS / ERRORS

1		2		3		4		MITIGATION	
TYPE OF INCIDENT		DRUG - ALL SCORE 1 +		AWARENESS OF CONTENT OF POLICY / PROCEDURE		RECOGNITION OF ERROR			
Wrong time	4	blood	3	Trust / UKCC guidelines not followed eg.	4	Self	0	Nurse recognition of own error and Correct action carried out to ensure patient safety	- 4
Wrong route	4	insulin	3			another	2		
Wrong date	4	Controlled drug	3			Knowledge of error but failed to report	20		
Omission without justification	4	Chemotherapeutic/ antieoplastic agents	3 3						
Wrong rate	4	Potassium injection	3	Inappropriate checker	3			First error / incident	- 2
Wrong dose	4	Cardiac amines	3	Pharmacy administration guidelines not followed	3			24 hr omission - drug unavailable from pharmacy	- 4
Wrong drug	4	steroids	2						
Expired stock	4	Oral hypoglycaemics	2						
Wrong patient	4	Glucose 10% +	2	Other	3			Other circumstances (see report document)	- 2 to - 4
Drug given with documented allergy	8	Anticoagulants / thrombolytics	2						
		Electrolytes except potassium injection	2						
Wrong formulation	4	glucagon	2						
Prescribing error	4	vasodilators	2						
Repeat incident - an error that has been continued (e.g. 9am dose given at 5pm as a first dose then repeated at 5pm on subsequent days).	4	Anti-emetics	1						
Several incidents within one clinic/ drug round	4	antidepressants	1						
		anticonvulsants	1						
		diuretics	1						
		antibiotics	1						
		Antipsychotics	1						
		Codeine / dihydrocodeine	1						
		sedatives	1						
		Non medicated IV fluids eg. Dextrose saline	1						
		Childhood immunizations, travel vac, flu vac	2						

Report Proforma for Drug Error and/or Near Miss Event

To be completed by staff involved in the error

Name of patient.....DOB.....

NHS Number.....GP / Consultant

Ward/Dept/ Health Centre

Date and time medication error discovered.

Date and time medication error occurred.

Identify the medication(s) involved in the error

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.....

Name of Person Involved in error

Shift on day of error.....

Name of the person the error was reported to.....

Date and Time reported.....

Has the Patient / Relative/ Carer been informed Yes / No

If Yes Date..... Time..... By Who.....

GP / Consultant informed Yes / No

Medication error classification

- | | | | |
|---|---|-----|----|
| 1 | This medication error was of omission.
(an error of omission is a medication error in which the prescribed medication is not given) | Yes | No |
| 2 | This medication error was of commission.
(an error of commission is a medication error in which a medication that was not prescribed was given). | Yes | No |

Description of incident (include where, how, why)

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Description of action taken after medication error discovered

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Include here any associating factors which may have contributed to the cause of the medication error;

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To be completed by line manager / investigator

Investigation carried out by Date.....
Drug error score.....

Outcome of incident / investigation

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Recommendations / Action

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Signature.....Date.....

Lead for Nurse Prescribing

**Joan Down
Trust Headquarters
0191 529 7150**

Lead for Patient Group Directives

**Lynn McKale
Trust Headquarters
0191 529 7089**

Pharmaceutical Advice

**Greg Moorhouse / Phil Young
North Locality Office
516 6300**

**Peter Lowe
Trust Headquarters
0191 529 7036**