COMMUNITY HEALTH AND EYE CARE LTD

MEDICINES MANAGEMENT POLICY

Contents

1. INTRODUCTION & PURPOSE

This policy sets out the standards which the organisation expects its all directly and indirectly employed staff to adhere to in relation to the care and control, prescribing, supply, disposal, and administration of medicines.

The policy takes account of current legislations, official guidance, local policies, recommendations, and professional codes of practice, and requirements of the NHS Litigation Authority and standards set by the Care Quality Commission. These, however, change with time and all staff have a responsibility to identify where new guidance may conflict with this policy.

This policy lays out the key principles for the care and control of medicines. Individual services can then develop local procedures within this framework in consultation with the Director of Clinical Services. Any local procedure must be approved by the Director of Clinical Services and Medical Director and must adhere to both regulations and professional body standards/requirements.

2. SCOPE & DEFINITIONS

SCOPE

This policy applies to bank, locum, permanent and fixed term contract employees who hold a contract of employment or engagement with Community Health and Eyecare (CHEC), and secondees (including students), volunteers and Directors. It also applies to external contractors, Agency workers, and other workers who are assigned to CHEC.

CHEC is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community, and our staff.

This policy covers all aspects of prescribing, supply, administration, storage, and disposal of medicines at all CHEC hospital and subsidiary community sites and is an important aspect in the treatment of all patients receiving care provided by the organisation.

DEFINITIONS

Administration of Medicines - to give to a patient a medicinal product, dressing or medical device, by introduction into the body (e.g. by injection or orally) or by external application (e.g. application of an ointment or dressing). This would normally include removal of medication from its packaging and giving it to a patient who either is not able to inform staff on what medication they need and therefore take it themselves appropriately or it is not appropriate for that patient to give the medication to him or herself.

Dispensing – to prepare a clinically appropriate medicine for a patient for self-administration or administration by another person. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product).

Medicines - all medicinal products prepared for administration to patients, and which are controlled by the Medicines Act 1968 and Misuse of Drugs Act 1971. For the purposes of this policy, this term also includes diagnostic agents, wound care products, and medical gases.

Supply – the act of handing over medication to a patient for later use by themselves. This includes handing over of TTO medicines.

Patient Specific Direction – written instruction for the supply or administration of medicines to individual patients.

TTO – medicines issued to patients to take home and medicate from. TTOs may only be prepared against a written instruction of a prescriber and must be labelled with patient's name, medication name, strength, and quantity, and instructions for use.

3. ROLES AND RESPONSIBILITES

All Healthcare Professionals

All registered clinical staff are responsible for their own professional practice. All staff involved in the prescribing, supply, dispensing, handling, storage, administration, and disposal of medicines, including controlled drugs, are accountable for:

- Working within current legislation and to within the Code of Conduct of their professional body, comply with their professional guidance including General Medical Council (GMC), Nursing & Midwifery Council (NMC), Health and Care Professions Council (HCPC), General

Optical Council (GOC) ensuring that medicines are prescribed and administered only to treat direct patients of the organization.
- Are aware of the group policy and local procedures with respect to medical, and non-medical medicine prescribing and administration.
- Undertake appropriate training to become and continue to be competent practitioners through competency self-assessment, peer review and appraisal demonstrate that these competencies are sustained.

Board of Directors

- Holds the ultimate responsibility for the organization's adherence to legal requirements with regards to all aspects of service delivery.
- Oversee patient care quality and safety, ensuring compliance with healthcare standards.
- Appoint, evaluate, and guide the Chief Executive Officer to align with strategic objectives.

Chief Executive Officer

- The Chief Executive is accountable for medicines management and the associated risks across the organisation.
- It is the responsibility of the Chief Executive to ensure there are clear lines of accountability established and maintained throughout the organisation, defining interpersonal relationships between the Board, relevant committees, and heads of services.
- The Chief Executive must ensure the Board is kept fully informed of any medicines management risks and any associated medicines management issues.

Clinical Advisory Groups

CAG will be set up for each medical speciality (e.g. ophthalmic, endoscopy) and be chaired by the Medical Director and include members from within the organization as well as filed experts from the outside.

- To act as a local focus for developing and refining professional opinion, supporting clinical effectiveness and efficiency to ensure prescribing and administration of medicines meets the best national guidance.
- To conduct Initial review and endorsement of clinical policies and procedures.
- Receiving, contributing to, and endorsing the annual medicines management policy and audit programme.
- Promoting and evidence-based approach to prescribing through the managed introduction of new medicines and the development of local prescribing guidelines.

Clinical Governance Steering Group

- Ensure that robust standards and governance are observed.

- Oversee the development and implementation of the Medicines Management Policy and all policies and procedures relating to the use of medicines.
- Identify trends relating to medicines incidents and monitor and review medicines audit ensuring that changes are implemented.
- Approval of guidelines (both new and review)
- Approval of local protocols (both new and review)
- Maintain an overview of infection prevention and control and Antimicrobial prescribing priorities within the organization.

Controlled Drugs Accountable Officer

- The Accountable Officer (AO) for Controlled Drugs is accountable for:
- Ensuring monitoring arrangements are in place for management and use of controlled drugs
- Establishing mechanisms for the very quick sharing of intelligence and joint action in cases of urgency (where patient safety is at risk or evidence may be destroyed)
- Ensuring clear routes, such as the NHS complaints system, are available for any healthcare professional, patient, or member of the public to raise matters of concern, within a framework of appropriate confidentiality. This includes routes for healthcare professionals to self-refer if they have concerns about their own performance.
- Establishing mechanisms for further investigation of causes for concern
- Determining whether a targeted inspection is required and those who should be involved
- Determining remedial action to be taken (e.g. no action required, support to healthcare professional, referral to regulatory body, CQC, police, NHS England counter-fraud)
- Any other responsibilities according to the development of the AO role nationally and is a member of the Local Intelligence Network (LIN).

Director of Care

- medicines management with board accountability
- ensuring that safe systems and practices are implemented, maintained, and monitored.
- ensuring that staff are made aware of this policy and its contents. New staff must be informed at induction.

Director of Clinical Services

- Maintaining active membership of the National Medication Safety Network.
- Improving reporting and learning of medication error incidents in the organisation.
- Managing medication incident reporting in the organisation. This may entail reviewing all medication incident reports to ensure data quality for local and national learning and where

necessary to investigate and find additional information from reporters. Also, to authorise the release of medication error reports to external bodies (e.g. ICBs)
- Receiving and responding to requests for more information about medication error incident reports from the Patient Safety Doman in NHS England and the MHRA.
- Working as a member of the medication safety committee to deliver their responsibilities.
- Supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation

Medical Director

- Medical Director is responsible on behalf of the Chief Executive Officer for ensuring compliance with standing legal and quality frameworks relating to the safe and secure handling of medicines.
- Medical Director is the Controlled Drugs Authorised Officer
- Ensuring prescribers operate within the organisation's policy.
- Ensuring the 'off license' use of medicines only occurs where products with a suitable licensed indication are unavailable or inappropriate.
- that unlicensed medicines are only used where licensed products are unavailable or
- inappropriate both within and outside of their licensed indications

Regional Operations Managers

Registered Manager

- Incorporating the Medicines Policy into local procedures and working practices.
- Delegating tasks related to the ordering, receipt, and handling of medicines.
- Making arrangements so that staff are able to implement the policy.
- Ensuring all staff handling medicines are trained and competent to do so.
- Review and act on all concerns relating to medicines use at the locations they are responsible for.
- Ensuring appropriate audit related to medicines management and practice is undertaken.
- Ensuring that following audit, action plans to improve safe medicines practice are implemented and monitored.
- Ensuring facilities and equipment being utilised are provided and maintained to the required standards.
- Ensuring that audit of routine use of medicines, review of adverse events and patient complaints relating to the handling of medicines are in place.

Prescribers (doctors and non-medical prescribers)

Each prescriber is responsible for ensuring they are.

- working within current legislation
- working within the Code of Conduct of their professional body including General Medical Council, British Dental Association, Nursing & Midwifery Council, General Pharmaceutical Council & Department of Health guidance on Prescribing practices
- Appropriately trained and continue to be competent practitioners.
- ensuring that medicines are prescribed and administered only to treat the organisation's patients.
- prescribing appropriately and accurately within the organisation's policy and defined role.
- not prescribing medicines outside of their confidence until they have sufficient working knowledge.
- Pre-registration doctors may prescribe medicines in line with the supervisory conditions of their employment.
- Creating a prescription that is unambiguous and legible for the dispensing and administration of the medicine.
- Monitoring the effects of the treatment
- Reviewing the prescription
- Informing the patient about the treatment

Non-registered healthcare staff

- Handle medicines only to an extent to which they have been trained and assessed to be competent in by the registered manager.

4. CONTROLLED STATIONERY

NHS FP10 prescription forms are valuable items, and their theft and misuse can represent risk to the public and significant financial loss for the business. FP10 prescription forms may be treated as 'blank cheques' for obtaining medicines including Controlled Drugs therefore must be held securely by any organization. Individual prescribers and Hospital Managers are responsible for the security of prescription forms once issued to them and must ensure that they are locked away securely when not in use.

The Hospital Manager is responsible for maintaining an up to date record of permitted prescribers for each Hospital site or clinic.

Any person issued with a blank prescription form/pad will be held accountable for its security and arrangements for security.

All Hospitals must maintain clear and unambiguous records of FP10 prescription pads ordered, received, and distributed. As a matter of best practice prescribers must keep a record of serial number of prescription forms issued to them.

Blank prescriptions must never be pre-signed.

The CHEC SOP for Ordering, Supply and Security of FP10 Prescription Pads must be followed at any time when handling FP10 prescriptions.

Where one or more prescriptions are believed to be lost or stolen. An incident form must be completed and reported.

5. PRESCRIBING

A patient's treatment must be initiated through a formal process, which may be the production of a prescription chart or form or electronic prescription by an authorised prescriber or by an approved procedural document for routine procedures. Some staff e.g., doctors and optometrists, may administer medicines on their own authority when acting within the scope of their practice. This does not remove the need for a clear record to be made. All prescribing will follow local guidance and the drug formulary as set out contractually by each ICB.

Patients should be helped to be active partners in discussions about their medicines. Risks and benefits of treatment must be discussed, considering differing values and beliefs to support concordance.

Specimen Signatures

Hospitals must keep an up-to-date list of specimen signatures/initial's to be able to identify who has prescribed and administered medicines.

Prescription Writing Requirements

Prescriptions must be clearly and unambiguously written giving full details necessary to enable staff to select and administer the correct medicine by the appropriate route at the right time. When writing a prescription, the current guidelines for prescription writing, as documented in the British National Formulary (BNF) must be followed. All prescribers must notify the patient and their GP if medication is to be discontinued or altered prior to surgery or a procedure, this will be identified as part of the pre-assessment process.

General Prescriptions requirements:

- Written legibly in black or blue ink to be indelible.

- Must be dated.
- Must state the full name and address of the patient, an addressograph should be used where available.
- Must be signed in ink by the prescriber and have the name of the prescriber printed.
- Patients must be informed of any changes in their medication and receive appropriate information.
- If treatment is being initiated for administration or supply under a procedural document for routine treatment, then the requirements of that document must be adhered to.

Specific Prescription Writing Requirements

All prescriptions must comply with the following requirements:

- They must be written on an approved prescribing document.
- Give the name of the medicine, its dose and route, the date and time of administration and where appropriate the rate.
- Instructions must be in English. Only abbreviations used in the BNF shall be used.
- Where a medicine is prescribed for use 'when necessary' it must clearly state the minimum intervals between doses and the maximum number of doses in 24 hours.
- Prescriptions must not be altered or amended by a prescriber. Changes in dose require the drug to be re-written.
- Due regard must be taken of any known hypersensitivity.
- If there is any doubt about the legibility of the prescription, or a practitioner does not understand it, the prescriber must be asked to re-write or clarify the prescription. If the prescriber is unwilling to do so, the prescriber must administer the medicine. The nurse/staff member must not, under any circumstances administer the medicines but must inform his/her manager and complete an incident form.
- Unlicensed medicines may be prescribed, and licensed medicines may be used for a condition or a dose outside of the product licence.

Name of product/medicine

- Use the Recognised International Name (RINN)
- This should be written clearly and not abbreviated.
- The trade name (proprietary or brand name) should also be used for combination products that have not been given a 'co-'title by the BNF

Dose

- The unnecessary use of a decimal point should be avoided e.g. 3mg and not 3.0mg.
- Where decimal points are unavoidable a zero must be written in front of the decimal point where there is no other figure e.g., 0.5ml and not .5ml.
- Quantities less than 1mg should be written in micrograms e.g., 500 micrograms and not 0.5mg.
- 'Micrograms' and 'nanograms' must be written in full and not abbreviated to mcg or µg.
- 'Units' must be written in full and never abbreviated to iu or u.
- Medicine names must be written in CAPITAL letters and not abbreviated.

Medicine Charts

- Medicines Charts are implemented into the Integrated Care Pathway provided as a way of standardizing and improving the safety of care received by patients receiving treatment at any of the CHEC locations.
- Although many parts of the chart, including those related to medicines administration have been pre-populated with instructions, it is the prescriber's responsibility to check and confirm those are correct, clear, and unambiguous before authorizing the administration or supply of medicines.
- It is the responsibility of an individual practitioner to ensure they are using the latest version of the chart.
- It is the prescriber's responsibility to complete all relevant patient details on an in-patient medicines chart, including the hospital/NHS number.
- The allergies box on the chart must always be complete. Where the patient is not allergic to any medicines, the words 'nil known' must be stated rather than the box left blank. It is good practice to also state the nature of the reaction and the source where this information was obtained from e.g., GP records, patient.
- Ideally only one medicine chart (unless the total number of medicines prescribed is greater than can be accommodated on one chart) should be in use at any one time for any one patient. If more than one chart is in use, they must be labelled 1 of 2, 2 of 2, etc. and also at the end of the prescription chart. When the end of a chart is reached all current prescriptions must be cancelled, and current medication must then be re-entered on a new chart.

Self-prescribing or prescribing for people that the prescriber has a close relationship to.

It is generally considered poor practice to self-prescribe or prescribe for people for whom there is a close personal relationship.

Self-prescribing is not allowed within CHEC and prescribing for close personal relationships is only permitted if those persons are current patients of CHEC.

Prescribing Antimicrobials

Antimicrobials must be prescribed in line with local guidance and pathways as stipulated by each ICB, this is available locally to minimise the development of resistance and the risks of C. difficile and MRSA. All prescribers of antibiotics must be familiar with and adhere to the relevant local antibiotic policies and guidance relevant to their clinical area.

Prior to prescribing an antimicrobial agent to be supplied as a TTO or on an FP10, the prescriber must consult the up-to-date, local guidance on the relevant area. This can be done by consulting the local microbiology department, using the MicroGuide app, or checking the local formulary.

Prescribing controlled drugs

All controlled drugs must be ordered and administered as guided within the CHEC Controlled Drug SOP available to staff on the CHEC Intranet.

Medicines and Topical Preparations Administered at the Discretion of Registered Practitioners

Registered practitioners can be approved to administer certain medicines and topical preparations at their own discretion whilst the patient attends a CHEC Hospital site. The SOP for Topical Medicines Administered at the Discretion of Registered Practitioners list the medicines that may be given, the indication for which they may be administered, the dose and frequency of administration and the maximum duration. All medication administered at the discretion of a registered practitioner must be recorded on the patient's prescription chart.

6. ORDERING AND SUPPLY OF MEDICINES

The Registered Manager and Lead Endoscopy and Lead Theatre Practitioner may order medicines using approved order forms from Head Office.

Registered managers may delegate the aspects of medication ordering to registered members of staff who are competent in the handling of medicines ordering and receipt.

The specific lists of medicines, including strengths, pack sizes and quantity will be held drafted for each CHEC location and speciality. The contents of the list will be determined locally by the registered manager in cooperation with the Clinical Advisory Group and submitted to the Clinical Governance Steering Group (CGSG) for approval.

Medicines may only be procured from approved organizations holding a valid wholesaler's dealers' licence.

CHEC operates a centralized procurement system where all orders (excluding Controlled Drugs Schedule 2 and 3) are placed by designated purchasing staff based at the Head-Office.

Medicines, medical devices, and medicinal products may only be requested be registered members of staff acting on the behalf of the registered manager who will forward the list of required items to the procurement team.

Medicines ordered by the procurement team will then be despatched to each location directly from the supplier. The procurement team will forward the list of requested items to the requesting location.

Once received, staff will check the received items against the list provided by the procurement team.

A full audit trail of items requested, ordered, despatched, and received must be maintained at each location.

CONTROLLED DRUGS (Schedules 2 and 3) may only be obtained from organizations that hold a valid Home Office Wholesale Dealer licence. Orders for Controlled Drugs will be placed using secured stationery as agreed with the supplier. Orders may only be placed by a registered member of staff and must be countersigned by a prescriber.

The specifics of Controlled Drugs ordering will be set out in the CD SOP.

All controlled drugs must be ordered and administered as guided within the CHEC Controlled Drug SOP available to staff on the CHEC Intranet.

Medicines received from the supplier for use in hospitals and clinics must be checked against any delivery note provided and the original order form by a registered practitioner before accepting for storage or administration.

Any items found to be missing or damaged must be promptly notified to the purchasing team. Any issues relating to Controlled Drugs must be immediately notified to the Controlled Drugs Accountable Officer and queried with the supplier.

7. DISPENSING OF MEDICINES

Medicines to Take Home (TTOs)

Medicines for patients to take home can only be dispensed when an appropriately trained registered practitioner has clinically checked the doctor's written or electronic prescription. TTO medicines may be supplied directly to patients as prepacked items.

The medication must be labelled to include the patient's name, date of dispensing, address of unit, name and strength of drug, quantity, and directions. The doctor who prescribes and dispenses medicines is responsible for ensuring that these requirements are met and that the correct medicine is supplied, and supervises all medication dispensing at Hospital sites. Medicines should be dispensed in their original pack or suitable medicine container. It is acceptable to prescribe and dispense in some instances where medicines are required urgently or an FP10 prescription is not possible, in these circumstances having a second checker when dispensing is best practice.

It is the responsibility of the healthcare professional discharging the patient to ensure that:

- The TTO prescription used to discharge the patient with is up to date. The TTO should be checked to ensure that it has been signed and that there have been no changes by prescribers.
- All the medicines prescribed as TTO are given to the patient on discharge with directions that match the TTO Aftercare leaflet, and they are dispensed for that patient i.e. they have that patient's name on.
- At least 14 days-worth of regular medicines are given to the patient on discharge, or the specific quantity documented on the TTO prescription.
- No other medicines are given to the patient other than those on the TTO (including medicines that have been dispensed during the current hospital admission but are not on the TTO prescription).

Medicines will be dispensed in such a way as to support the safe, effective, and appropriate supply and use of medicines and the safety of patients. As CHEC hospitals have no on-premisses pharmacy service, dispensing will occur at hospital level supervised by registered medical staff.

8. TRANSPORT OF MEDICINES

Medicines may only be transported from the supplier to the delivery site using approved services that ensure temperature control, security, and tracking in line with the Good Distribution Practice (GDP).

Arrangements for the transport of controlled drugs must comply with the current legal requirements. . Medicines may not be transported in private cars or carried by members of staff between locations.

9. RECEIPT OF MEDICINES

A delivery note shall accompany each delivery of stock medicines. The authorised member of staff receiving the order shall check the medicines against the delivery note and sign for receipt. Discrepancies shall be notified to the supplier as soon as possible and an incident form completed.

Two members of staff, one of whom must be a registered practitioner, are to receive and unpack stock medication delivered to the clinical area and the stock delivered added to the stock record. The second member of staff can be another registrant or a HCA/OA. Any variance to this must be authorised by the DCS and documented.

Other products such as controlled drugs will require confirmation of compliance with legal and/or local requirements.

10. STORAGE AND SECURITY OF MEDICINES

At any time, there will be a nominated person responsible for the safekeeping of all medicines stored in the hospital. This will usually be the registered practitioner in charge. They must ensure that no unauthorised person has access to medicines.

All medicines including sterile fluids, except for medicines for emergency use, must be stored in a robust, lockable medicine cupboard or medicines trolley not exceeding 25°C. Medicines cupboards should be securely fixed to the floor or wall. Medicine cupboards must be reserved solely for the use of medicines and must not be used for any other product and should adhere to standard BS2881.

Adequate provision must be made to enable access to named medicines in an emergency. The local storage arrangements must take account of the need for quick access versus the risks associated with misappropriation.

Medicines requiring storage between 2 and 8C or labelled 'Store in a Refrigerator' must be stored in a dedicated locked refrigerator specifically designed for storage of medicines with an integral thermometer or temperature recording device. Refrigerator temperatures must be monitored daily. They must have their current, maximum, and minimum temperature recorded every day and the recording device re-set for the following day. If an item requires refrigeration but is not a medicine and there isn't another fridge or capacity for another fridge then this should be discussed with the DCS. In these circumstances, each item will be considered individually, considering alternative storage solutions, infection control risk and any risk of inadvertent administration. Any items approved must be stored in a separate container within the fridge appropriately labelled. Documentation detailing the authorisation by the DCS will be kept with the items.

If it is discovered that the medicines refrigerator has deviated from the above range, then stock should be quarantined, and the Clinical Services Team should be contacted for advice.

Preparations used for cleaning and disinfecting must be stored in a separate cupboard which must be clearly labelled and locked.

All medicines must be stored in their original containers. They must not be transferred from one container to another.

The keys to the medicine cupboards, medicines refrigerator, medicines trolley, must be kept on one key ring and must be held by a registered practitioner, normally the practitioner in charge of the clinical area to which the keys relate. The controlled drug cupboard key must be kept on a separate key ring but must also be held by the practitioner in charge. Any loss of keys must be reported to the designated manager immediately, who must then investigate (including consideration of notifying the police) and follow the incident reporting procedure.

The Hospital Manager and practitioner in charge are responsible for ensuring that all preparations in the hospital are currently in date, and that regular checks are carried out to remove out of date items. Teams are encouraged to order conservatively to avoid unnecessary waste. It is also essential, that when putting stock away, stock is rotated appropriately. Community practitioners are responsible for checking the expiry dates on any medicinal products that they either use or carry.

Staff in any supervisory position must be aware of the signs that may indicate abuse or diversion of medicines e.g. changes in an individual's behaviour, regular unexplained absences from the work area, and loss of stock or excessive ordering and take appropriate action as defined locally.

For controlled drugs (CDs) the Misuse of Drugs (Safe Custody) Regulations apply as detailed in the Controlled Drugs Policy. These Regulations state that CDs must be stored in a CD cabinet or safe, locked with a key. It must be made of metal, with suitable hinges and fixed to a wall or the floor with rag bolts that are not accessible from outside the cabinet. Additional recommendations, e.g. NPSA advice on separating high and low strength Diamorphine injections, must also be adhered to.

11. ADMINISTRATION OF MEDICINES

No person should administer any medicine unless they are competent to do so and are acting within their sphere of professional practice.

Standard operating procedures may be used within individual sites to supplement the information in this Policy to specify in detail the preparation, administration, and monitoring of medicines in that service.

Authorised staff may administer medicines without a second check except IV medication.

A practitioner must not administer medicines without the authorisation of a doctor, a non-medical prescriber, or a patient group direction, unless they have legal exemptions during the course of their professional practice or are following a procedural document for administration of topical eyedrops for example for dilation for cataract surgery, see Standard Operating Procedure for drop administration by eye clinic staff.

The identity of each medicine must be clear at all times up to and including the point of administration.

Before administration, the following must be checked, and any concerns referred to the prescriber before proceeding:

- Patient's name and Hospital/NHS Number on all pages of the drug chart.
- Date of birth.
- Any allergies / hypersensitivities.
- Date and time the dose is due.
- The maximum dose if the medication is an as required medicine.
- Name of medicine, dose, and frequency.
- Time of previous dose if any.
- Route of administration.
- Signature of prescriber.

Where medicines are dispensed with outer packaging it is important to check both the outer packaging and the inner container or tablet/ capsule strip.

When selecting the medicine, the following must be checked, and any concerns clarified before proceeding.

- Name of the medicine
- Strength
- Form
- Expiry date
- That the dose has not already been given
- If there is any doubt regarding any element, the medicine must be referred to the supplying pharmacy.

When administering a medicine, the following process must be followed:

Staff administering medicines must satisfy themselves of the patient's identity. Where identification bands are worn, the full name of the patient must be checked prior to administration of any medicines or therapeutic substance. If there is any doubt about the patient's identity, their NHS Number on the identification bracelet must be checked against the prescription sheet. In areas where identity bands are not worn and if there is continuing doubt regarding the patient's identity, medicines must be withheld until the patient's identity can be confirmed.

All controlled drugs are ordered and administered as guided the CHEC Controlled Drugs SOP available on the intranet.

- Read the prescription chart carefully.

- Check the time of last administration.

- Select the medicines required, check the label with the chart and expiry date, noting any special instructions and any recorded sensitivities of the patient to medicines.

- Prepare the medicines, one at a time, as described below by checking: -
- Name of the patient
- Drug, strength, and route
- Dose
- Calculation if any
- Time of administration
- Additional instructions, e.g., after food etc.

- Take the measured dose and prescription to the patient and administer the medicines.

- The medicine is administered to the patient by the prescribed route. Staff must witness the administration of all medicines and satisfy themselves that it has been taken.
- The administration of the medication is recorded by initialling the appropriate section on the chart. If for any reason medication is omitted, this should be recorded by entering the appropriate code (as specified on the prescription sheet) in the administration record.

Non-registered staff (Health Care Support Workers/Optical Assistants) may: -

- Assist with the identification of the patient.
- Help the patient to take the medicine.
- The registered practitioner is responsible for the delegation of any aspects of the administration of medicinal products, and they are accountable to ensure that the patient, carer, or optical assistant/technician is competent to carry out the task.
- In delegating the administration of medicinal products to unregistered practitioners, it is the registered practitioner who must apply the principles of administration of medicinal products.

Any person administering a medicine shall be held accountable for his/her own actions. Anyone may refuse to administer a medicine after discussion with the prescriber if they consider that refusal is in the best interest of the patient. A record of any such instance shall be made in the patient's notes.

A record of each medicine administered to a patient must be made and the administering person identified.

Medicines may not in any circumstances be left out unsupervised with a patient, where they could be taken by another patient.

Administration of medication must be withheld if side effects, or contra-indications are observed. A note of the withholding must be made in the Integrated Care Pathway (ICP) or electronic patient

record (EPR). A discussion must be held with the doctor as soon as possible. All changes in dosage relating to significant side effects must be entered on the patient's record and signed by a doctor.

12. ADMINISTRATION AND OR SUPPLY OF MEDICINES UNDER A PATIENT GROUP DIRECTION (PGD).

A PGD is a specific written instruction for the supply or administration of named medicines in an identified clinical situation. A PGD allows specified healthcare professionals to supply or administer medicines to a well-defined group of patients without those medicines being prescribed. The PGD specifies exactly which patients can receive the medicine, who is excluded from receiving the medicine and which medicine they may receive and at what dose. All other criteria associated with the supply and/or administration are specifically expressed within the PGD. PGDs developed for use within the organisation must follow the standard format.

CHEC do not use PGDs however if in the future this occurs the standards for PGD development, implementation, and review will be set out in a separate policy.

13. ADMINISTRATION AND OR SUPPLY OF MEDICINES UNDER A PROCEDURAL DOCUMENT

In some circumstances, it is permissible for healthcare staff to administer medicines without against a protocol that is neither a patient specific nor a patient group direction. Such practices are subject to additional scrutiny and may only be carried it out by trained and competent staff and in line with a protocol that's been approved by the Clinical Governance Advisory Group.

See Standard Operating Procedure for drop administration by eye clinic staff.

14. PRESCRIBING AND ADMINISTRATION OF INTRAVENOUS MEDICINES

The methods of administration of intravenous medication are:

- By the addition of the drug to an intravenous fluid container.
- By injection of the drug through the injection port of an intravenous giving set.
- Intermittently through an indwelling needle or cannula.
- intermittently via central and PIC lines
- By a syringe driver, pump, or other infusion device.

The Medicines Policy above should be followed when prescribing and administering intravenous drugs, but the additional steps and safeguards that must be followed for intravenous medicines, including the training/qualifications required by staff prior to administering intravenous medicines, are included in the Policy for the Safe Management of Intravenous Medicines.

15. DISPOSAL OF MEDICINES

The disposal of pharmaceutical waste is governed by the Hazardous Waste Regulations 2005 and compliance must be ensured within each service / health service setting. Refer to the company Policy for the Safe Handling and Disposal of Healthcare Waste for further guidance.

All medicines waste must be separated into hazardous and non-hazardous waste. The majority of medicines used within the organisation will be non-hazardous. Refer to the Safe Management of healthcare waste (for an example list of cytotoxic and cytostatic medicines).

Medicines waste (both hazardous or non-hazardous) includes the primary drug packaging which comes into contact with the medicine, for example, empty blister strips and bottles containing syrup residues. An outer cardboard packet is not medicines waste and can be disposed of in a domestic waste bin provided it does not have any patient identifiable information on it. All waste containing a significant amount of drug must be stored in a locked cupboard/store while waiting for disposal. Empty blister strips and empty bottles do not have to be stored in a locked cupboard but must be stored securely, for example in a treatment room. Loose tablets and capsules must be wrapped in adhesive tape or in a paper administration cup before disposal in the designated clinical waste bins.

Hazardous medicines waste (which includes any medicine which is cytotoxic or cytostatic) must be placed in purple lidded hazardous waste boxes. When these boxes are three quarters full the box is sealed, and the label completed with date closed. The removal of the box is then arranged as per local procedure. It will then await collection by the waste contractor.

Non-hazardous medicines waste including the primary drug packaging can be disposed of in blue lidded containers which are obtained from stores. They must be sealed when no more than three quarters full and the label annotated with date closed. The removal of the box is then arranged as per local procedure. It will then await collection by the waste contractor.

Locations where Controlled Drugs of any schedule are disposed of must register the "T28 waste exemption: sort and denature controlled drugs for disposal" with the Environment Agency to comply with Misuse of Drugs Regulations 2001. A copy of the registration certificate will be held (WHERE?). The registration must be renewed before the expiry date listed on the certificate.

16. INCIDENTS INVOLVING MEDICINES

If there is any risk of harm to an individual due to an incident involving medicines, priority must be given to the clinical care of that person(s).

Any incident or near miss in which medicines are involved must be reported in accordance with the organisation's incident reporting policy. The incident must immediately be reported to and investigated by the appropriate line manager, or person delegated to act on their behalf.

Where a drug administration error occurs, the appropriate prescriber must be contacted as soon as possible and when necessary, remedial action taken to ensure the safety of the patient. An entry must also be made in the patient's health care record.

As part of the incident investigation supporting statements may be required from all staff concerned and these are essential if there is any possibility of serious injury to the patient or of litigation.

Any drug may produce unwanted or unexpected adverse reactions. Detection and reporting of these is of vital importance. All staff are urged to report suspected adverse reactions to the Commission on Human Medicines using the Yellow Card Scheme.

During the manufacture or distribution of a medicine an error or accident may occur whereby the finished product does not conform to its specification. Any suspected defect in a medicine must be reported to the supplying pharmacy. Reports on suspected defective medicinal products must include the brand or the non-proprietary name, the name of the manufacturer or supplier, the strength and dosage form of the product, the product licence number, the batch number, and the nature of the defect. If the defective medicine has been administered to a patient the prescriber must be notified and the incident reported in accordance with the organisation's incident policy.

All medication errors are reviewed by the Medical Director and common themes and shared learning are discussed at the Clinical Effectiveness Group as a standard item.

17. ALLERGIC EMERGENCIES AND ANAPHYLACTIC SHOCK

The most up-to-date organisation policy for The Management of Medical Emergencies and Resuscitation must be used and is available on the CHEC intranet.

All staff who administer medication must be familiar with the particular protocol for the clinical setting in which they work and must attend annual updates on recognising the signs and symptoms of anaphylaxis and its treatment.

All settings where medicines are administered, including in the community, must have access to Adrenaline 1:1000 Injection plus associated needles and syringes to administer the medicine intramuscularly.

In an emergency, Adrenaline can be administered intramuscularly without a prescription or PGD.

Please refer to CHEC Resuscitation Policy CLI-POL -28 Resus Policy and the CHEC transfer out SOP for further guidance on managing anaphylaxis.

18. USING MEDICINES OUTSIDE OF THEIR PRODUCT LICENCE

Whilst using medicines within their product licence should be the normal practice, the organisation accepts that this may not be possible in some circumstances. A prescriber may recommend the use of a product that does not have a UK product licence (an unlicensed medicine) or may be a medicine that has a product licence for an alternative condition or at an alternative dose to the one being recommended (off-label use).

Where appropriate the patient or their parent/carer must be informed before prescribing that an unlicensed or off-label medicine is being recommended and the patient should understand that the product might be less well understood than a licensed product. They must also be informed that as many unlicensed medicines are imported, the standard of packaging of the medicine may not be as good as the usual packaging (e.g. may be in a foreign language).

Where a doctor prescribes an unlicensed or off-label medicine the practitioner signing the prescription accepts clinical responsibility and liability for the medicine's effects. The expectation is that a prescriber acts in accordance with appropriate current practice. A prescriber may be called upon to justify their prescribing by other professionals involved in supply and administration of medicines prescribed out-of-licence.

Where a prescriber recommends or advises the use of a medicine outside its product licence to another prescriber this shall be stated together with a justification of the unlicensed use.

Where a prescriber directs administration of a medicine outside its product licence the practitioner administering must be informed. Practitioners administering licensed medicines used outside the product licence must be satisfied they have sufficient information to administer the medicine safely and that there is acceptable evidence for the use of the medicine for the intended indication by actively seeking information from the prescriber and other appropriate sources.

19. MHRA Medication Safety Alerts and Drug Recalls

Medication safety alerts may be issued from various sources, included NHS England, the MHRA, or direct from pharmaceutical companies. Medicinal product recalls may lead to products being removed from wards and departments.

The Alerts will be screened and distributed by the Director of Clinical services who will email them to the Registered Managers.

The responsibility for ensuring such alerts are actioned locally rests with the Registered manager who may delegate the task of checking stock to registered healthcare professional.

Members of staff will check all areas holding stock of the affected product to check the batch numbers. If stock is believed to be affected, staff will arrange for the removal, and replace with new stock as soon as possible. In any such case the original supplier must be contacted for advice on the return or disposal of the affected items.

20. MEDICATION FOR PERSONAL USE OF STAFF

It is not permitted for hospital staff to use or take hospital medication from stock for their own personal use or to give to another person or member of staff. This constitutes theft and can lead to disciplinary and/or legal action being taken.

21. USE OF FREE SAMPLE MEDICATIONS

The supply of medicine samples by drug companies is tightly controlled and restricted by statute in the Human Medicines Regulations 2012 (Regs 298). CHEC as an organisation will accept free sample eye drops for the purpose of acquiring experience in dealing with the product in question. This practice adheres to the Human Medicines regulations 2012 reg 298 detailed below.

Free samples for persons qualified to prescribe or supply medicinal products.

298.— (1) A person ("the supplier") may not supply a free sample of a medicinal product to another person ("the recipient") unless the following conditions are met.

(2) Condition A is that the recipient—

(a)is qualified to prescribe medicinal products; and

(b)receives the sample for the purpose of acquiring experience in dealing with the product in question.

(3) Condition B is that the sample is supplied to the recipient—

(a)on an exceptional basis; and

(b)in response to a request from, and signed and dated by, the recipient.

(4) Condition C is that, taking the year in which, the sample is supplied as a whole, only a limited number of samples of the product in question are supplied to the recipient in that year.

(5) Condition D is that the sample—

(a)is no larger than the smallest presentation of the product that is available for sale in the United Kingdom.

(b)is marked "free medical sample – not for resale" or bears a similar description; and

(c)is accompanied by a copy of the summary of the product characteristics.

(6) Condition E is that the sample does not contain—

(a)a substance which is listed in any of Schedules I, II or IV to the Narcotic Drugs Convention (where the product is not a preparation listed in Schedule III to that Convention); or

(b)a substance which is listed in any of Schedules I to IV to the Psychotropic Substances Convention (where the product is not a preparation which may be exempted from measures of control in accordance with paragraphs 2 and 3 of article 3 of that Convention).

(7) Condition F is that the supplier maintains an adequate system of control and accountability in relation to the supply of free samples.

The ordering, receipt, and issuing of free samples will be recorded in the same manner as for medicines. Free samples must be kept separately from medicines to minimize the risk of using them instead of other medicines.

The use of free samples may only be considered where a clear benefit to patient care has been identified. Purley financial benefit to either patient or CHEC cannot be considered as sufficient.

Every CHEC location must report the use of free samples to the Clinical Governance Steering Group and must obtain explicit approval before any supplies are made to patients.

Additionally, where applicable, the relevant NHS commissioning body must give an explicit permission for the use of free samples in services provided on their behalf.

22. TRAINING

Individuals who prescribe, dispense, or administer medicines must be trained to the appropriate level for their duties.

All staff involved in the handling of medicines require appropriate training. Medicines Management training is provided by the Clinical Education Team and Ashtons Pharmacy, through medicines training courses and updates, and on a one-to-one or one to a small group basis to address more individual needs.

Staff require to be explicitly authorised by their line manager to carry out specific roles in medicines management and safety of patients is paramount. This must be reflected in the job description of the individual. The evidence of this should be held locally at each Hospital site.

Competency framework for Nurses

Competency framework for Optical Assistants.

Staff who may be exposed to risk from others or from medicines, including nonprofessional's (porters, drivers etc.) shall be trained by their line manager in the need for security, what to do if spillage occurs (e.g. COSHH regulations) and transport of pressurised containers. Staff must undergo regular updating.

All supervisory staff shall be vigilant for signs that may indicate abuse or diversion of medicines and take appropriate action or discuss with their manager. Additional advice can be sought from the Director of Clinical Services in the first instance.

23. Clinical audit

Clinical audits are key to enhancing the quality of patient care by comparing current practices with established standards. Each year, a thorough audit focusing on medicines management will be conducted at every site. This audit can be performed by either in-house or external professionals, who possess a deep understanding of the service and relevant expertise. The results and suggestions from the audit will be examined and actioned by the registered manager. A report detailing the audit's outcomes and a corresponding action plan will be presented to the clinical governance steering group.

Additionally, apart from medicines management, every site will carry out yearly audits in various areas. These areas will be determined by the Director of Care and will utilize auditing tools sanctioned by the Clinical Advisory Groups.

Document owner and approval.

The DIRECTOR OF CLINICAL SERVICES is the owner of this document and is responsible for ensuring that this policy is reviewed by the due date.

A current version of this document is available to members of staff on the CHEC intranet.

Change history record.

Issue	Description of Change	Approval	Date of Issue
Issue	Description of Change	Approval	Date of Issue
1	Initial issue	Clinical Governance Lead	05/12/2011
2	Review	Clinical Governance Lead	05/12/2014
3	Review	Clinical Governance Lead	1/12/2017
4`	Review	Clinical Governance Lead	22/10/18
5	Policy amended to reflect current practice at CHEC in line with national guidance and recommendations.	Clinical Services Manager	26/10/21
6.	Review	Director of Clinical Services	07/2022
7.	Review and update to reflect current CHEC practice and national guidance	Director of Clinical Services	01/2024
8.	Review and update to reflect current CHEC practice and national guidance	Director of Clinical Services	03/2024
9.	Review and update to reflect current CHEC practice and national guidance	Chief Nurse	04/2024

EQUALITY IMPACT ASSESSMENT FORM

PART A - INITIAL SCREENING FORM

Section One	
Name of proposal, policy, service review or report *(referred throughout as proposal)*	MEDICINE MANAGEMENT POLICY
Directorate / Service carrying out the assessment	Clinical Services
Name and role of person undertaking this EIA	Alison Fitzsimons - Director of Clinical Services
Give an overview of the aims, objectives, and purpose of the proposal: To provide policy for the safe use and storage of medicines.	

Section Two		
Equality Groups:	**Could the proposal have a positive impact**	**Could the proposal have a negative impact**
People of different ages	yes	
People of different religions / beliefs.	yes	
People with disabilities (physical, mental or learning)	yes	
Women	yes	
Men	yes	

Transgendered people	yes	
People from different ethnic groups	yes	
Lesbian, Gay or Bisexual	yes	
Refugees and asylum seekers	yes	
Human Rights breaches	yes	

Section Three			
Is this proposal a major change in terms of scale or significance for CHEC? Is there a clear indication that, although the proposal is minor it is likely to have a major affect for people due to their protected characteristic?			
Yes		**No**	
High risk:		Low risk:	X

Section Four
It this proposal is low risk please give evidence or justification for how you reached this decision:
This Policy is to ensure compliance with clinical risk and therefore supports all people.

Sign off that this proposal is low risk and does not require a full Equality Impact Assessment:

EAI Reviewer Signed: 

Date: **Alison Fitzsimons – April 2024**