MEDICINES PRACTICE OPERATIONAL POLICY
For Prescribing, Supply, Administration, Storage and Disposal of Medicines

Key points
- How to prescribe medicines
- How to obtain and store medicines
- How to administer medicines
- How to destroy medicines
- Special requirements for CDs and SACT
- How to manage potassium infusions
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1.0 ASSOCIATED DOCUMENTS

Incident reporting and Investigation policy
Alcohol and substance abuse policy
Duty of Candour policy
Blood transfusion policy
Policy for the administration of epidural analgesia by clinical staff
Policy for the management of extravasation
Intrathecal policy
Non-medical prescribing policy
Patient group direction policy
Patient identification policy
Public interest disclosure policy (whistle blowing)
Medical Gases Policy
Management of patients with diabetes or at risk of developing diabetes policy
Policy the care and management of central venous devices

2.0 INTRODUCTION FROM THE MEDICAL DIRECTOR & DIRECTOR OF NURSING & QUALITY

Medicines prescribing, dispensing and administration is a major aspect of the care and treatment provided within this Trust. The importance of clear lines of responsibility and accountability together with clear policies and systems to ensure the safe and secure handling and economic use of medicines is paramount and is a key component of clinical governance.

There has been a growth in the expectations by patients that their treatments will meet the highest standards. To ensure this, it is the responsibility of all healthcare professionals involved in medication practice to ensure that they are aware of and demonstrate best practice at all times. We all need to ensure that we are maximising the effective use of medicines, minimising medicine-related morbidity for our patients and using Trust resources effectively.

It is essential that all staff involved in medicines practice adhere to the guidance set out in the document.

Dr Anthony Blower
Medical Director

Jackie Bird
Director of Nursing & Quality

2.1 Statement of intent

The Medicines Practice Operational Policy is the Trust approved document for the management of the risks associated with the prescribing, supply, administration, storage and disposal of medicines. It sets down the minimum acceptable standards for all aspects of medicines management. It is a multidisciplinary document that is intended to be comprehensive and as inclusive as possible.

The format of the Medicines Practice Operational Policy follows the process of medicines usage within the organisation and includes all activities that occur on a day-to-day basis.

The policy is available on the Trust intranet with hyperlinks to other relevant policies.

2.2 Equality Impact Analysis

As part of its development, this policy was analysed to consider its effect on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there any unintended consequences for some groups, and to consider if the policy will be fully effective for all

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protected groups. This analysis has been undertaken and recorded using the trust’s e-tool, and appropriate measures taken to remove barriers or advance equality in the delivery of this policy.

2.3 Good Corporate Citizen
As part of its development, this policy was reviewed in line with the Trust’s Corporate Citizen ideals. As a result, the document is designed to be used electronically in order to reduce any associated printing costs.

2.4 Purpose
The purpose of this policy is to set out the standards expected by the organisation in relation to the management of medicines including: prescribing, dispensing, administration, safe storage and disposal.

2.5 Scope
This policy applies to all staff involved in any aspect of the management of medicines on any of The Christie NHS Foundation Trust sites during their daily working duties.

NB: The main pharmacy dispensary service on the Withington site is provided via a third party agreement with Boots® (The Boots company PLC). The aseptic service is provided via a third party agreement with Baxter®.

3.0 DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
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<tbody>
<tr>
<td>BOC</td>
<td>Multinational industrial gas and British based company supplying medical gases</td>
</tr>
<tr>
<td>BSA</td>
<td>Body Surface Area</td>
</tr>
<tr>
<td>CCU</td>
<td>Critical Care unit</td>
</tr>
<tr>
<td>CD</td>
<td>Controlled Drug</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Means the person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust, and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust.</td>
</tr>
<tr>
<td>Clinician</td>
<td>Means a qualified medically trained doctor, nurse, allied health professional or pharmacist</td>
</tr>
<tr>
<td>Consent</td>
<td>Means agreement approval or permission as to some act or purpose, given voluntarily by a competent person, legally effective.</td>
</tr>
<tr>
<td>CrCl</td>
<td>Creatinine Clearance</td>
</tr>
<tr>
<td>CMP</td>
<td>Clinical Management Plan</td>
</tr>
<tr>
<td>CTU</td>
<td>Clinical Trials Unit</td>
</tr>
<tr>
<td>CWP</td>
<td>Clinical Web Portal</td>
</tr>
<tr>
<td>EPMA</td>
<td>Electronic Prescribing and Medicines Administration</td>
</tr>
<tr>
<td>Eudract number</td>
<td>European Union Drug Regulating Authorities Clinical Trials number – the unique identifier allocated to a clinical trial</td>
</tr>
<tr>
<td>Examination</td>
<td>Means the act of being examined or state of being examined. To look at inspect or scrutinise carefully or in detail. To investigate the patients state of health.</td>
</tr>
<tr>
<td>GFR</td>
<td>Glomerular Filtration Rate</td>
</tr>
<tr>
<td>GMMMGM</td>
<td>Greater Manchester Medicines Management Group</td>
</tr>
<tr>
<td>GSL</td>
<td>General Sales List</td>
</tr>
<tr>
<td>HTUDU</td>
<td>Haematology Treatment Unit Day Unit</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IMP</td>
<td>Investigational Medicinal Product</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>JAC</td>
<td>Informatics company supplying EPMA system</td>
</tr>
</tbody>
</table>
4.0 DUTIES

Chief Executive
The Chief Executive has overall statutory responsibility for the safe and secure handling of medicines. In practice, the Director of Pharmacy is responsible for ensuring that systems are in place to appropriately address all aspects of the safe and secure handling of medicines across the organisation.

Director of Pharmacy
The Director of Pharmacy is responsible for the supporting and overseeing the safe and effective use of medicines in the Trust. The Director of Pharmacy will attend a monthly performance meeting with members of the executive team and highlight to them any significant issues pertaining to the use of medicines in the Trust. The Director of Pharmacy will present a board report to the CCS (Cancer Centre Services) board on a monthly basis, and will be a member of the Trust’s Safe Medicines Practice Committee (SMPC), Patient Safety Committee (PSC), Clinical and Research Effectiveness Committee (CREC) and Risk and Quality Governance Committee (RQGC).

Drugs & Therapeutics Committee (DTC)
The Drugs & Therapeutics committee is responsible for:

- Approval of all new drugs and regimens
- Advising which medicines should be available to prescribe
- Authorisation of guidelines
- Horizon scanning and drug budget planning
- Developing policies where appropriate including those required by National Cancer Standards

**Drugs Management Committee (DMC)**
The Drugs management Committee is a sub-committee of the Trust’s management board. It is responsible for the oversight of the drugs budget. The committee will review the decisions of the Drugs and Therapeutics Committee and take decisions on the basis of cost effectiveness.

**Patient Safety Committee (PSC)**
The patient safety committee is responsible for:
- Providing the Risk & Quality Governance Committee with assurance that a comprehensive approach to improving patient safety is in place.
- Requesting in depth investigation of any clinical concerns
- Receiving monthly updates in the form of committee minutes from the Safe Medicines Practice Committee
- Escalating any medicines related issues to Risk & Quality Governance Committee on behalf of the committee

**Safe Medicines Practice Committee (SMPC)**
The Safe Medicines Practice committee is responsible for:
- Ensuring effective governance systems are in place and adhered to for all elements of prescribing, dispensing, storage, administration and disposal of medicines
- Review of incidents and near misses with recommendations and actions to minimise recurrence
- Co-ordinating responses to the Medicines and Healthcare products Regulatory Agency (MHRA) where appropriate
- Developing policies promoting safe medicines practice
- Co-ordinating and overseeing all medicines related audit activity, the development and completion of subsequent action plans and the dissemination of improvements required.
- Initiating and overseeing quality improvement activity to ensure changes are made which improve care
- Developing, posters, leaflets & aide memoires to ensure a consistent approach to support on-going communication with staff in practice
- Designing and overseeing implementation of any paper based prescription charts
- Overseeing the implementation and on-going management of all electronic prescribing and medicines administration systems (EPMA)

**Systemic Anti-Cancer Therapy (SACT) Delivery Group**
The Systemic Anti-Cancer Therapy committee is responsible for:
- Setting the standards and governance arrangements for SACT
- Reviewing incidents and near misses with recommendations and actions to minimise recurrence
- Monitoring information including complaints and audit results, relating to patient experience and waiting times and to advise actions to be taken in response to these
- Ensuring national and network standards in relation to SACT are met
- Implementing actions following peer review processes, NCAG/NCEPOD recommendations

**Thrombosis committee**
The Thrombosis Committee is responsible for safe anticoagulation and appropriate thromboprophylaxis across the organisation.

**Ward/Departmental Managers**
The ward/departmental managers are responsible for ensuring:
- Compliance with the medicines practice operational policy
- Individuals work within the professional scope of their registered bodies
- That all staff are trained and competent to carry out the tasks required of them in the prescribing, administration and management of medication commensurate with their level of experience
- All medicines related incidents are reported on Datix, investigated thoroughly and actions to prevent reoccurrence put in place

**Registrant in charge**
The registrant in charge of a ward/department is responsible for ensuring:
- Adherence to all policies and procedures for the appropriate management of all medicines
- Safe and appropriate management of all medicines whilst in charge of the ward/department
- Individuals work within the professional scope of their registering bodies
- That appropriate action is taken in the event of a clinical incident or near miss and where appropriate ensure a Datix form is completed

**Ward/Departmental staff**
Ward/Departmental staff have a responsibility to:-
- Adhere to all policies and procedures for the appropriate management of all medicines
- Work within the professional scope of their registering body
- Support the ward manager in ensuring the security of all medicines
- Report all clinical incidents and near misses to the nurse in charge and where appropriate ensure a Datix form is completed

**Pharmacy**
Pharmacy staff are responsible for:-
- Adhering to all policies and procedures for the appropriate management of all medicines
- Providing information and advice on the handling and storage of medicines
- Ensuring compliance with the laws relating to the safe and secure handling and storage of medicines
- Working within the professional scope of their registering body
- Assisting with the training of Trust personnel on the storage and handling of medicines
- Reporting all clinical incidents and near misses and where appropriate ensure a Datix form is completed

**Medical Staff**
Medical staff have a responsibility to:-
- Adhere to all policies and procedures for the appropriate management of all medicines
- Work within the professional scope of their registering body
- Report all clinical incidents and near misses and where appropriate ensure a Datix form is completed

**Porters**
Portering staff involved in the delivery of medicines are responsible for:
- Adhering to policies and procedures relating to safe storage, handling and delivery of medicines in transit
- Reporting all clinical incidents and near misses and where appropriate ensure a Datix form is completed
5.0 PRESCRIBING OF MEDICINES

5.1 Who may prescribe?
The prescribing of all medicines within the Trust can only be performed by either a registered doctor, dentist or a non-medical prescriber (NMP).

Medical students or NMP in training are not permitted to complete prescriptions.

Qualified prescribers are legally entitled to prescribe prescription only medicines to patients under their care. These practitioners can prescribe general sales list medications (GSL), prescription only medications (POM) and controlled drugs (CD), i.e. schedules 2 and 3 as indicated by the Misuse of Drugs Regulations 2001.

In certain circumstances within the Trust products that are legally classified as medical devices may be 'prescribed' for the purposes of supply or to direct others to administer these products to patients.

Medicines that have not been prescribed by an authorised practitioner must not be administered to a patient except when:

- A verbal instruction is given in exceptional cases of clinical emergency. See - Instruction by Telephone/Verbal Orders
- The drug is being supplied and/or administered under the terms of a Patient Group Direction (PGD) in accordance with the Supply and administration of medicines under Patient Group Direction policy
- The drug is being administered in a lifesaving situation by appropriately trained staff in accordance with the recommendations of the UK Resuscitation Council

The Human Resources department are responsible for checking the qualifications and registration of all medical staff employed by the Trust.

The NMP lead is responsible for checking the qualifications and registration of all NMPs employed by the Trust.

5.2 Non-medical prescribers
Nurses, pharmacists and allied health professionals may act as independent or supplementary prescribers following training. See - Non-Medical Prescribing Policy

5.3 Prescribing systems
All prescriptions and patient specific directions must be either handwritten on official Trust approved stationary or prescription charts or generated on a validated Trust endorsed electronic prescribing and medicines administration (EPMA) system.

There are currently a number of different prescribing systems employed within the Trust.

It is possible that a patient may have more than one prescribing system in use at any one time. It is therefore essential that cross referencing is employed within each system to inform the staff responsible for that patient’s care.

It is the responsibility of the Information Technology (IT) team to ensure that staff have undergone appropriate training before granting prescribing access rights for the JAC EPMA and e-discharge system on CWP.

It is the responsibility of the Electronic Prescribing pharmacy team to ensure that staff have undergone appropriate training before granting prescribing access rights for the Ascribe EPMA system.
It is the responsibility of the system manager for CCU to ensure that staff have undergone appropriate training before granting prescribing access rights for the Metavision system.
### 5.3.1 EPMA systems

<table>
<thead>
<tr>
<th>EPMA System</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Discharge</th>
<th>Prescribing</th>
<th>Supply via pharmacy</th>
<th>Recording administration</th>
<th>Monitoring</th>
<th>SACT?</th>
<th>CDs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascribe</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>JAC</td>
<td>Yes</td>
<td>Yes(^1)</td>
<td>No</td>
<td>Yes</td>
<td>Planned</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes(^a)</td>
</tr>
<tr>
<td>Metavision</td>
<td>CCU only</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes(^a)</td>
</tr>
<tr>
<td>CWP</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No(^c)</td>
<td>Yes(^a)</td>
</tr>
</tbody>
</table>

1. JAC may only be used for prescribing for outpatients in areas that do not use Ascribe.
2. Systemic Anti-Cancer Therapy (SACT) may be recorded on CWP discharge prescriptions for communication to the GP but will not be supplied by pharmacy against this prescription.
3. CDs may be prescribed on JAC and metastasis as a patient specific direction to direct nursing staff to administer the drug to patient. A wet ink signature is not required.
4. A wet ink signature is required on the printout of electronic discharge prescriptions where CDs are required to be supplied by pharmacy. No signature is required if supply of CDs is not required.
### 5.3.2 Paper based prescribing systems

<table>
<thead>
<tr>
<th></th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Discharge</th>
<th>Prescribing</th>
<th>Supply via pharmacy</th>
<th>Recording administration</th>
<th>Monitoring</th>
<th>SACT?</th>
<th>CDs?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General prescription charts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient prescription pad</td>
<td>No</td>
<td>Yes(^1)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient chart</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Oral SACT only(^2)</td>
<td>Yes</td>
</tr>
<tr>
<td>Day case chart</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Prescription charts for specific patients/situations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes management chart</td>
<td>Yes(^3)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient Controlled Analgesia (PCA)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Epidural</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Syringe driver</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Blood/Blood products</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Heparin</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Pre-printed SACT prescription</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blank SACT prescriptions</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Intrathecal prescriptions</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Enteral Nutrition</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Parenteral Nutrition</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

1. Outpatient prescription pads are only to be used for the prescribing and supply of medication to outpatients from areas where the Ascribe and JAC EPMA systems are not in use, for medication that is not available on the Ascribe and JAC EPMA systems and for CDs.
2. Only oral SACT may be prescribed on the inpatient prescription and administration record chart. This is for the purposes of recording administration only. Oral SACT must not be supplied through pharmacy against an inpatient chart - a prescription must also be generated on the Ascribe EPMA system for supply purposes.
3. Diabetes management chart used for all inpatients known to have diabetes or patients not known to have diabetes who require blood sugar monitoring.
4. Preprinted SACT prescriptions used for inpatient and outpatient medication or treatment protocols not currently available on the Ascribe EPMA system
5. Blank SACT prescriptions are to be used for unapproved treatment protocols or those where no preprint exists including foscarin and ganciclovir.

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5.4 Guidelines on prescription writing/generation

Legal responsibility for prescribing lies with the practitioner who signs the prescription or the practitioner whose details are recorded on the EPMA system for generating the prescription.

Prescribers must ensure that they are the user logged into the EPMA system when generating an electronic prescription.

Under no circumstances may a prescriber generate an electronic prescription using another prescriber’s log in details.

5.5 Electronic signatures

All EPMA prescribing system must record the full name. It is preferable that the EPMA system also record the designation of the prescriber, contact details of prescribers i.e. bleep/telephone number.

Electronic signatures are acceptable on all EPMA prescriptions with the exception of CDs for supply by the pharmacy department i.e. for outpatient and discharge prescriptions.

Wet ink signatures are **not** required on inpatient EPMA system for CDs as legally this is a patient specific direction and not a prescription for supply through a pharmacy.

Wet ink signatures are **not** required on electronic discharge prescriptions provided the patient has sufficient supply of their own CDs on discharge and **does not** require CDs to be dispensed by pharmacy. In this instance CDs are included on discharge prescriptions only for the purposes of communication to the GP.

5.6 Handwritten prescriptions

All handwritten prescriptions and patient specific directions must be legible and written in indelible ink.

Date and sign (using full signature) all handwritten prescriptions and patient specific directions. Prescribers should also print their name in capital letters and specify their designation and bleep/telephone number.

It is illegal to use a pre-photocopied doctor’s signature.

5.7 Prescribing standards

The following standards apply to all prescriptions, both handwritten and electronic.

The patient’s forename, surname, date of birth, hospital identification number, and allergy status must be documented.

Address is mandatory on all outpatient and discharge prescriptions. The use of addressograph labels is recommended for all handwritten prescriptions.

**NB:** Addressograph labels must be countersigned for all outpatient prescriptions for CDs.

The name, dose, frequency, route and/or form of medication must be documented.

In addition, the duration of treatment or quantity of medication to be supplied must be specified on all outpatient and discharge prescriptions.

All prescriptions should have a consultant and ward/department code.

The name of the medicine must be written in full with no abbreviations. Medicines should be prescribed in their generic or British approved name.
Brand names must only be used where clinically appropriate e.g. modified release preparations where bioavailability may vary between different branded preparations (e.g. nifedipine, lithium), multi-ingredient preparations where no approved name exists (e.g. Gaviscon Advance®) or where prescribing by brand name is recommended to reduce the risk of incorrect product selection (e.g. CDs e.g.: fentanyl, amphoteracin preparations e.g. Abelcet®, Ambisome®, certain SACT preparations eg: Myocet®, Kadcyla®).

Avoid unnecessary use of decimal points e.g. 2mg, not 2.0mg

Document quantities less than 1 gram in milligrams e.g. 500mg, not 0.5g

Document quantities less than 1mg in micrograms e.g. 100 micrograms, not 0.1mg

Document quantities less than 1 microgram in nanograms e.g. 100 nanograms not 0.1 micrograms

A zero must be inserted in front of a decimal point where there is no other figure e.g. 0.5ml, not .5ml

For all oral liquids and injections the actual dose of the drug, e.g. mg not ml must be stated unless no strength can be specified e.g.: simple linctus, mouthwashes
5.8 Recognised abbreviations

Only the following abbreviations may be used on prescriptions, both handwritten and electronic.

All other routes including ‘intrathecal’, directions for administration and strengths including ‘micrograms’, ‘nanograms’ or ‘units’ must always be documented in full.

<table>
<thead>
<tr>
<th>Strengths and quantities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gram g</td>
</tr>
<tr>
<td>Kilogram kg</td>
</tr>
<tr>
<td>Milligram mg</td>
</tr>
<tr>
<td>Litre l</td>
</tr>
<tr>
<td>Millilitre ml</td>
</tr>
<tr>
<td>Millimole mmol</td>
</tr>
<tr>
<td>One dose unit i</td>
</tr>
<tr>
<td>Two dose units ii</td>
</tr>
<tr>
<td>Three dose units iii</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous IV</td>
</tr>
<tr>
<td>Intramuscular IM</td>
</tr>
<tr>
<td>Subcutaneous SC</td>
</tr>
<tr>
<td>By mouth PO</td>
</tr>
<tr>
<td>Sublingual SL</td>
</tr>
<tr>
<td>Inhalation Inh</td>
</tr>
<tr>
<td>External use Ext</td>
</tr>
<tr>
<td>Nebulisation Neb</td>
</tr>
<tr>
<td>Per rectum PR</td>
</tr>
<tr>
<td>Topical Top</td>
</tr>
<tr>
<td>Per vaginam PV</td>
</tr>
<tr>
<td>Buccal Bucc</td>
</tr>
<tr>
<td>Mouthwash MW</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a day OD</td>
</tr>
<tr>
<td>Each morning OM</td>
</tr>
<tr>
<td>Each night ON</td>
</tr>
<tr>
<td>Twice daily BD</td>
</tr>
<tr>
<td>Three times daily TDS</td>
</tr>
<tr>
<td>Four times daily QDS</td>
</tr>
<tr>
<td>Morning Mane</td>
</tr>
<tr>
<td>At bedtime Nocte</td>
</tr>
<tr>
<td>As required PRN</td>
</tr>
<tr>
<td>Hourly Hrly</td>
</tr>
</tbody>
</table>

5.9 Drug allergies and sensitivities

All paper prescriptions and EPMA systems must have the facility to record and display the patient’s allergy status at the point of prescribing, supply and administration.

Allergy/intolerance information must also be clearly stated in the patient’s notes.

The allergy box/field must be completed for all prescriptions and patient specific directions. It is not acceptable to leave the allergy box/field blank, in this instance medicines must not be dispensed or administered.
State or indicate ‘None/NKDA’ if there is no known allergy.

It is the responsibility of the prescriber to complete the allergy box/field. However, Nurses, Operating Department Practitioner (ODPs), pharmacists and clinical pharmacy technicians are also authorised to complete the allergy box/field of a prescription, including electronic prescriptions.

All entries in the allergy/intolerance section of the paper inpatient and daycase/outpatient prescription charts must be signed and dated with designation stated. The JAC and Ascribe EPMA systems automatically record this information.

On the Ascribe, metavision, JAC EPMA systems and the inpatient/outpatient/daycase medication prescription and administration record chart the name of the drug/allergen and the nature of any allergy, sensitivity or intolerance should be recorded e.g. penicillin causing anaphylaxis, morphine causing itching.

For handwritten outpatient, electronic discharge, preprinted SACT and blank SACT prescriptions the name of the allergen is sufficient.

If you are unable to obtain information regarding allergy status e.g. an unwell patient requiring immediate treatment
- state ‘Unobtainable’ in the allergy box on all handwritten prescriptions
- select ‘Drug Allergy Status undetermined’ on the JAC EPMA system
- leave the allergy field blank (amber traffic light) on the Ascribe EPMA system
- leave the allergy field blank (unrecorded) on the Metavision EPMA system
In the case of an unobtainable history, this should be reviewed at least every 24 hours and the allergy/intolerance section completed appropriately as soon as possible.

The prescriber must use their clinical judgement as to whether they override a recorded possible reaction, depending on the suspected severity of the reaction and the patient’s clinical condition but this must be documented in the patient’s notes.

It is no longer considered best practice for patients with allergies to be given an additional red identity bracelet stating the medicines to which they are allergic. See - Standardising wristbands improves patient safety: guidance on implementing the Safer Practice Notice (SPN 24, July 2007)

All persons administering or supplying medicines must always clarify the allergy status of the patient beforehand. If in any doubt about a possible previous reaction they should refer to the prescriber or another qualified medical practitioner before administration.

If a new allergy/intolerance is discovered during a hospital admission, a specific note must be made on the discharge information in order to inform the patient’s GP. Patients should be made aware of the importance of communicating this allergy to health professionals.

5.10 Process for Prescribing for In-patients
Inpatients must have their medication prescribed on either the paper inpatient medication prescription and administration record chart or the JAC EPMA system. No inpatient should have both a paper inpatient chart and a JAC EPMA record running concurrently.

Inpatients may also have supplementary charts for specific medication that has increased requirements for prescribing and / or monitoring. Any such charts must be cross referenced on the inpatient chart or EPMA record.

Inpatients may also have SACT prescribed on the Ascribe EPMA system or paper based SACT prescriptions. This must be cross referenced on the inpatient chart or EPMA record.
5.11 Completing the Different Sections on the In-patient Prescription Chart

The sections marked * are compulsory

<table>
<thead>
<tr>
<th><strong>Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient details</strong></td>
</tr>
<tr>
<td><strong>Allergy status</strong></td>
</tr>
<tr>
<td><strong>Weight</strong></td>
</tr>
<tr>
<td><strong>Height and surface area</strong></td>
</tr>
<tr>
<td><strong>Medicines management checklist</strong></td>
</tr>
<tr>
<td><strong>Medicines prior to admission not prescribed</strong></td>
</tr>
<tr>
<td><strong>Additional information</strong></td>
</tr>
<tr>
<td><strong>Patient discharge</strong></td>
</tr>
<tr>
<td><strong>Medicine details</strong></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
</tr>
<tr>
<td><strong>Start date</strong></td>
</tr>
<tr>
<td><strong>Oxygen therapy</strong></td>
</tr>
</tbody>
</table>
be humidified or non-humidified. **NB**: Oxygen should not be withheld whilst awaiting a prescription if it is clinically indicated.

<table>
<thead>
<tr>
<th>MRSA decolonisation</th>
<th>The brand and frequency of use for each agent must be specified. Mouthwash should only be prescribed following a positive MRSA screen. <strong>NB</strong>: chlorhexidine mouthwash is not to be prescribed for head &amp; neck patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Thromboprophylaxis</td>
<td>The thromboprophylaxis box must be completed for all in-patients See – Anticoagulant Therapy management policy</td>
</tr>
<tr>
<td>Regular antimicrobial therapy</td>
<td>Only antimicrobials can be prescribed in this section. A review date must be specified for each entry by the prescriber. Once the review date is reached the medication will not be administered until the review has taken place and been documented. Prophylactic or long term antimicrobials should be documented as such in the 'review date' section.</td>
</tr>
<tr>
<td>Stopping the treatment</td>
<td>Cross both the drug, prescribing details and administration details through, sign and date.</td>
</tr>
<tr>
<td>Changing the prescription</td>
<td>If it is necessary to amend the frequency, dose, change the drug or if the original prescription is unclear then a new entry must be made on the prescription chart. Existing prescriptions must not be altered</td>
</tr>
<tr>
<td>Night sedation</td>
<td>This box may be used for patients requiring night sedation on an as required basis. Clearly indicate if to be continued on discharge</td>
</tr>
<tr>
<td>As required prescriptions</td>
<td>State the start date, dose and maximum frequency of administration. State the reason for use in the indication box, e.g. codeine phosphate for diarrhoea and not for pain control</td>
</tr>
<tr>
<td>Symptomatic relief</td>
<td>Signing this section indicates that these medications can be given at the nurses discretion. Any medication not to be given must be clearly crossed out by the prescriber. No medication may be administered from this section unless signed by a prescriber.</td>
</tr>
<tr>
<td>Infusions</td>
<td>Document the name and volume of the infusion fluid/diluent, approved name of drug, dose, strength, preparation and route of administration, concentration or total quantity of the medicine in the final infusion container or syringe, e.g. 1mg/ml or 200 nanograms/50ml, rate and/or duration of administration</td>
</tr>
<tr>
<td>Once only medicines</td>
<td>Any single use or ‘one off’ medicines should be written in the separate table. Once only medicines and pre-medication drugs must be re-written for subsequent doses. This section may also be used for variable dose medications as a dose range may be prescribed.</td>
</tr>
<tr>
<td>* Prescribers signature</td>
<td>Date and sign (using full signature) all prescriptions. Prescribers should also print their name in capital letters and specify their bleep/telephone number and designation</td>
</tr>
</tbody>
</table>

When more than one prescription chart is necessary due to the number of regular medicines prescribed, each chart must be marked clearly 1 of 2, 2 of 2, etc.

Where separate charts or prescribing systems are used e.g. epidural charts, syringe driver charts, Ascribe EPMA system they should be cross-referenced on the patient’s main medicines chart.

When a prescription chart is full, it must be entirely re-written by the doctor or alternatively, it may be re-written by a pharmacist and countersigned by the doctor.
A new prescription chart must be used if a patient is re-admitted to hospital.

Patients transferred from other Trusts must have their medicines prescribed on a Trust approved prescription chart before any medicines are administered.

5.12 Generating a JAC EPMA system prescription
In addition there are a number of user guides available on the Trust intranet.

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient details</strong></td>
</tr>
<tr>
<td>The patient’s full name, date of birth, identification number, name of consultant and ward will be automatically populated from CWP</td>
</tr>
<tr>
<td><strong>Allergy status</strong></td>
</tr>
<tr>
<td>The allergy field must be completed for all prescriptions. NB: any previous recorded allergy status will automatically populate this field but must be reconfirmed with the patient at each admission. See – Drug allergies and sensitivities</td>
</tr>
<tr>
<td><strong>Weight</strong></td>
</tr>
<tr>
<td>This can be entered manually or updated using the Ht/Wt Entry icon. An accurate and up to date weight must be documented if medication is prescribed whereby the dose is weight dependent. If an estimated or ideal body weight is used for dose calculation this should be stated in an electronic note to prescriber. NB: any previous recorded weight will automatically populate this field but must be checked at each admission</td>
</tr>
<tr>
<td><strong>Height and surface area</strong></td>
</tr>
<tr>
<td>Height and surface area need not be documented for the majority of patients but must be stated for all patients prescribed medication based on Body Surface Area. Height can be entered manually or updated using the Ht/Wt Entry icon. Once a height and weight have been entered for a patient the BSA will be automatically calculated.</td>
</tr>
<tr>
<td><strong>Medicines management activity</strong></td>
</tr>
<tr>
<td>All medicines management activity, including discharge will be recorded by pharmacy staff using electronic notes according to the SOP for clinical pharmacy ward based services using the electronic prescribing and medicines administration system</td>
</tr>
<tr>
<td><strong>Additional information</strong></td>
</tr>
<tr>
<td>Any additional information that may be relevant to the patient’s treatment may be recorded as an electronic note e.g. swallowing difficulties, liquid medicines required, renal/hepatic impairment, diabetes.</td>
</tr>
<tr>
<td><strong>Medicine details</strong></td>
</tr>
<tr>
<td>Document the approved name of drug, dose, frequency, form and route of administration. Give clear directions on the application site of treatment, if appropriate, e.g. right, left or both eyes.</td>
</tr>
<tr>
<td><strong>Start date</strong></td>
</tr>
<tr>
<td>The current date will automatically be populated. Should the medication be scheduled for a future date this must be manually entered by the prescriber.</td>
</tr>
<tr>
<td><strong>Stop date</strong></td>
</tr>
<tr>
<td>Prescriptions will all run indefinitely unless a stop date is entered by the prescriber.</td>
</tr>
<tr>
<td><strong>Oxygen therapy</strong></td>
</tr>
<tr>
<td>There is no designated prescribing field for oxygen. All patients receiving oxygen must have this prescribed, including target saturation, continuous or as required and whether to be humidified or non-humidified. NB: Oxygen should not be withheld whilst awaiting a prescription if it is clinically indicated.</td>
</tr>
<tr>
<td><strong>MRSA decolonisation</strong></td>
</tr>
<tr>
<td>There is no designated prescribing field for MRSA decolonisation. All patients requiring MRSA decolonisation treatment must have this prescribed, unless being administered under the terms of a PGD. Mouthwash should only be prescribed following a positive MRSA screen. NB: chlorhexidine mouthwash is not to be prescribed for head &amp; neck patients.</td>
</tr>
<tr>
<td><strong>Thromboprophylaxis</strong></td>
</tr>
<tr>
<td>The VTE assessment field must be completed for all in-patients. All patients requiring thromboprophylaxis must have this prescribed.</td>
</tr>
</tbody>
</table>
Antimicrobial therapy

A review date & indication must be specified for each entry by the prescriber as an electronic Antibiotic note. Once the review date is reached the medication will not be administered until the review has taken place and been documented. Prophylactic or longterm antimicrobials should be documented as such in the electronic note.

Supplementary charts

The JAC EPMA system does not have the functionality required for the prescribing and monitoring requirements of some more complex medications eg: insulin, syringe drivers. In this instance a handwritten supplementary chart will also be in use. All supplementary charts must be cross referenced on the JAC EPMA record.

Stopping the treatment

Use the ‘Discontinue Order’ icon to stop a treatment. The date, time and name of the practitioner discontinuing treatment will be automatically recorded. The practitioner will be prompted to enter a reason for treatment discontinuation.

Changing the prescription

If it is necessary to amend the frequency, dose, change the drug or if the original prescription is unclear then the ‘Modify Order’ icon may be used. The date, time and name of the practitioner changing the prescription treatment will be automatically recorded.

As required prescriptions

The dose, indication and maximum frequency of administration must be documented.

Infusions

Document the name and volume of the infusion fluid/diluent, approved name of drug, dose, strength, preparation and route of administration, concentration or total quantity of the medicine in the final infusion container or syringe, e.g. 1mg/ml or 200 nanograms/50ml, rate and/or duration of administration

Once only medicines

There is no designated prescribing field for single use or ‘one off’ medicines. These should be prescribed using the ‘Stat’ tick box or as a single dose at a specified time. Once only medicines and pre-medications drugs must be re-prescribed for subsequent doses. This method may also be used for variable dose medications as a dose range may be prescribed.

* Prescribers signature

The name of the prescriber and date and time of prescribing will be automatically recorded.

5.13 Process for Prescribing for Daycase/Out-patients

Daycase/Outpatients may have their medication prescribed for administration within the trust on:
- Ascribe EPMA system
- JAC EPMA system
- Daycase/Outpatient prescription and drug administration record chart

Daycase/Outpatients may have their medication prescribed for supply through pharmacy on:
- Ascribe EPMA system
- JAC EPMA system
- A paper outpatient prescription

If a patient has medication prescribed using multiple systems this must be cross referenced as appropriate.

5.14 Completing the Daycase/Outpatient prescription and drug administration record chart

This chart is to be used for the prescribing of medication for daycase and outpatients where the medication in question is to be administered to the patient by a member of Trust staff during the daycase or outpatient visit in areas that do not use the Ascribe or JAC EPMA systems or where the medication in question is not available on the Ascribe or JAC EPMA systems.
The sections marked * are compulsory

| Comments |
|------------------|----------------------------------|
| **Patient details** | The patient’s full name, date of birth, identification number, name of consultant and ward must be entered on each document used for prescribing. The use of addressograph labels is recommended. |
| **Allergy status** | The allergy box must be completed for all prescriptions See – Drug allergies and sensitivities |
| **Weight** | Patient’s weight must be documented if medication is prescribed whereby the dose is weight dependent (it must be clearly stated if an estimated or ideal body weight is used). |
| **Height and surface area** | Height and surface area need not be documented for the majority of patients but must be stated for all patients prescribed medication based on Body Surface Area. |
| **Medicine details** | Document the approved name of the drug, dose, route and time of administration. It may be also necessary to document the form where the dosage is dependent on the form or where a specific formulation is required eg: liquids for patients with swallowing difficulties. Give clear directions on the application site of treatment, if appropriate, e.g. right, left or both eyes. |
| **Oxygen therapy** | This section must be completed for all patients receiving oxygen, including target saturation, continuous or as required and whether to be humidified or non-humidified. NB: Oxygen should not be withheld whilst awaiting a prescription if it is clinically indicated. |
| **Thromboprophylaxis** | The thromboprophylaxis box must be completed for inpatient daycases and patients admitted overnight. See – Anticoagulant therapy management policy |
| **Start date** | This is the date on which the medicine was started in hospital not the date the chart is re-written (if the medicine is not to be administered on the date it is prescribed, this should be highlighted on the administration signature area by blocking off the days prior to the medicines start date). For all pre admission medicines state OA (on admission) in the start date box. |
| **Stopping the treatment** | Cross both the drug, prescribing details and administration details through, sign and date. |
| **Changing the prescription** | If it is necessary to amend the frequency, dose, change the drug or if the original prescription is unclear then a new entry must be made on the prescription chart. Existing prescriptions must not be altered |
| **Symptomatic relief** | Signing this section indicates that these medications can be given at the nurses discretion. Any medication not to be given must be clearly crossed out by the prescriber. No medication may be administered from this section unless signed by a prescriber. |
| **Infusions** | Document the name and volume of the infusion fluid/diluent, approved name of drug, dose, strength, preparation and route of administration, concentration or total quantity of the medicine in the final infusion container or syringe, e.g. 1mg/ml or 200 nanograms/50ml, rate and/or duration of administration |
| **Once only medicines** | Any single use or ‘one off’ medicines should be written in the separate table. Once only medicines and pre-medication drugs must be re-written for subsequent doses. This section may also be used for variable dose medications as a dose range may be prescribed. |
| **Prescribers** | Date and sign (using full signature) all prescriptions. Prescribers |
signature should also print their name in capital letters and specify their bleep/telephone number and designation

If prescribing multiple items on a single daycase/outpatient prescription chart the printed name, bleep/telephone number and designation need only be stated once. All subsequent prescriptions must be signed and dated as a minimum requirement.

### 5.15 Completing the paper out-patient prescription

The paper outpatient prescription must only be used for the prescribing and supply of medication to outpatients from areas where the Ascribe and JAC EPMA are not in use, where the medication in question is not available on the Ascribe or JAC EPMA systems or for CDs.

The sections marked * are compulsory

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<td>* Patient details</td>
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<td>Weight</td>
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<td>* Medicine details</td>
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<td>* Duration</td>
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<td>* Prescribers signature</td>
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### 5.16 Prescribing using the Ascribe EPMA system

Outpatients prescribed chemotherapy on the Ascribe system should also have all supportive therapy prescribed on this system with the exceptions of CDs to provide a complete and accurate patient medication record.

Inpatients prescribed chemotherapy on the Ascribe system should also have all supportive therapy prescribed on either the inpatient medication prescriptions and administration record or the JAC EPMA system dependant on which other inpatient prescribing system is in use for that patient.

### 5.17 Completing the Ascribe EPMA record

The sections marked * are compulsory

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<td>* Allergy status</td>
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**Weight**
Patient’s weight must be inputted if medication is prescribed whereby the dose is weight dependent (it must be clearly documented as an electronic prescribing note if an estimated or ideal body weight is used). The weight should be updated as a minimum every 3 months.

**Height and surface area**
Height and surface area must be recorded for all patients prescribed medication based on Body Surface Area. BSA will be automatically calculated once a height and weight are inputted.

**Glomerular Filtration Rate (GFR)**
GFR need not be documented for the majority of patients but must be recorded for all patients prescribed medication based on renal function. Select ‘eGFR user derived’ to record an estimated renal function based on serum creatinine eg: using the Cockcroft Gault equation, select ‘eGFR laboratory derived’ to record an estimated renal function reported by biochemistry and use ‘GFR isotopic un-normalised’ to record a measured GFR.

**Medicine details**
Document the approved name of the drug, dose, route and directions for administration. It may be also necessary to document the form where the dosage is dependent on the form or where a specific formulation is required eg: liquids for patients with swallowing difficulties. Give clear directions on the application site of treatment, if appropriate, e.g. right, left or both eyes.

**Duration**
For medicines with a specific course duration this must be stated e.g. steroids, antibiotics, chemotherapy. For all long term or ongoing medication original packs will be supplied.

**Infusions**
Document the name and volume of the infusion fluid/diluent, approved name of drug, dose, strength, preparation and route of administration, concentration or total quantity of the medicine in the final infusion container or syringe, e.g. 1mg/ml or 200 nanograms/50ml, rate and/or duration of administration.

**Prescribers signature**
The name and designation of the prescriber with the date on which the prescription was generated will automatically be recorded.

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### 5.18 Non urgent prescribing advice to the general practitioner

For any medication which is not urgent and can be prescribed by the patient’s general practitioner, a ‘non urgent prescribing advice to the general practitioner’ form should be completed.

The ‘non urgent prescribing advice to the general practitioner’ form is in triplicate copy (blue copy to be retained by pharmacy, green copy to be retained in the patient notes, white copy to be given to the patient for delivery to the GP). The prescriber must ensure all three copies are completed to a legible standard.

Pharmacists may transcribe from an outpatient prescription onto the ‘non urgent prescribing advice to the general practitioner’ in order for the patient to obtain medication from their GP if this is preferable.

The triplicate copy ‘Non urgent advice to the general practitioner’ forms may be obtained through pharmacy.

### 5.19 Process for prescribing Discharge Medication (TTOs)

All patients must have their discharge medication prescribed electronically on CWP.

Wherever possible, the immediate discharge letter and electronic discharge prescription must be completed at least 24 hours before the patients planned discharge (the pharmacy department requires a minimum of 3 hours to dispense the prescription).
An immediate discharge letter and electronic discharge medications prescription must be completed for the GP record, containing full details of all the medication the patient is currently taking, even if no additional medication is required from pharmacy.

The only exception is where a patient has been admitted for less than 24 hours or at a weekend or bank holiday providing no changes to medication were made or only acute medication was prescribed AND Medicines Reconciliation has not been undertaken by the clinical pharmacy team. In this instance there is no requirement for a complete list of all patients’ routine medication to be documented on the electronic discharge medications prescription. However the immediate discharge letter and any other relevant discharge information must be completed as normal, with the addition of a note explaining that there has been no change to the patient’s regular medication in the ‘Medication changed or stopped during this admission’ field with a statement ‘No change to regular medication’.

Any acute medication initiated during the admission eg: analgesia, antiemetics, antibiotics, laxatives must be prescribed on the Discharge Medications Prescription section of the webform, even if no medication is required from pharmacy.

In addition there is a user guide available on the Trust intranet.

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<td><strong>Patient details</strong></td>
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<td><strong>GP details</strong></td>
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<td><strong>Allergy status</strong></td>
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<tr>
<td><strong>Date of Discharge</strong></td>
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<tr>
<td><strong>Admission Details</strong></td>
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<tr>
<td><strong>Diagnosis, History and Admission outcome</strong></td>
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<td><strong>Follow up arrangements</strong></td>
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<td><strong>Discharge details and recommendation to the GP</strong></td>
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<td><strong>Weight</strong></td>
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<td><strong>Height and surface area</strong></td>
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<td><strong>Medicine details</strong></td>
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<td><strong>Duration</strong></td>
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<td><strong>Medication changed or stopped during this admission</strong></td>
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<td><strong>Prescribers signature</strong></td>
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<tr>
<td><strong>Paper copy of prescription for dispensing</strong></td>
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5.20 Prescribing for oneself or colleagues
Prescribing for oneself or a colleague is not permitted under any circumstances.

5.21 Prescribing of Unlicenced or Off-Licence/Off-label medications
An unlicenced medicinal product is one that does not have a UK medicinal product licence therefore:
- The Committee on Safety of Medicines has not assessed the safety and efficacy of the product in humans
- The quality of the product cannot be assumed and the fitness of the product for its intended use needs to be established

Off-licence use is when a licenced medicine is used outside the terms of its product licence.

When prescribing such a medicine the prescriber must:
- Be satisfied that it would better serve the patient’s needs than an appropriately licenced alternative
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy
- Take responsibility for prescribing the medicine and for overseeing the patient’s care, monitoring and any follow up treatment, or arrange for another practitioner to do so
- Make a clear, accurate and legible record of all medicines prescribed
- Where appropriate, seek approval from the Trust Drugs & Therapeutics Committee
- Patients should be informed by the prescriber if they are to be treated with an unlicenced or Off-Licence/Off-label medicine.

Pharmacy is responsible for establishing product safety and quality.

Legal liability rests with the Trust providing the prescriber follows local policy and accepted clinical practice in the course of his/her contract of employment.

All letters and documents relating to the unlicenced drug supply process should be retained for a minimum of 11 years (adults) and 25 years (children).

Independent NMPs can prescribe unlicensed and off-licence / off-label medication on the same basis as doctors provided that they are competent and take responsibility for doing so.

Supplementary NMPs can prescribe unlicensed and off-licence / off-label medication provided that the medication is included in a Clinical Management Plan (CMP).

The Unlicensed Medicinal Products committee is a sub-committee of DTC, and is responsible for approving requests for SACT in relation to the supply of unlicensed medicinal products on a named patient basis for human use in accordance with application of the MHRA Unlicensed Medicinal Products (“specials”) guidance.

5.22 Interface Prescribing
The shared care approach encourages patient care in the primary sector with secondary care support. There is joint responsibility for prescribing between hospitals and GPs.

Shared care should only be considered if:
- The drug has been approved by the Trust Drugs & Therapeutics Committee
- The treatment is safe to be administered and monitored by the GP
- The patient’s condition is stable
- The patient’s treatment is initiated in hospital by the consultant
- A written shared care protocol (SCP) has been discussed and agreed between the consultant and the GP
All new SCPs must be submitted via email to the Greater Manchester interface prescribing subgroup (rdtc.rxsupp@nuth.nhs.uk) for approval before commencing.

Approved SCPs can be found on the Greater Manchester Medicines Management Group website.

5.23 Prescribing of Controlled Drugs
Prescriptions for CDs must comply with the all Trust standards for prescribing. In addition further requirements for the prescribing of CDs are documented in the Controlled Drugs section of this policy.

5.24 Prescribing of Clinical Trial medications
It is Trust policy that all medication for supply or administration to patients as part of a clinical trial is prescribed, including both Investigational Medicinal Products (IMP) and comparator licensed medicines.

Clinical trial medication may be prescribed on the Ascribe EPMA system, JAC EPMA system or pre-printed paper prescriptions where no Ascribe prescription is available. There are limited instances where clinical trials may be prescribed on a sponsor provided paper prescription.

All clinical trial medication must be prescribed on a dedicated clinical trial prescription specific to the individual trial and comply with all Trust standards for prescribing.

The specific clinical trial prescription template must be approved by a pharmacist and the Principal Investigator (PI) before it is authorised for use in the Trust.

In addition the following information must be included on the prescription:
- Unique trial identifier ie: Eudract number
- Trust trial identifier ie: Christie assigned DOG (Disease and Orientation Group) number
- Sponsor identification patient number ie: Subject number/Patient Trial Identification number
- The name of the PI
- The protocol reference number or study acronym name
- Where there is more than one treatment arm for a study the prescription must also make reference to what arm it corresponds to, this can either be an arm specific template prescription or an endorsement will be required by the prescriber.
- Any additional endorsements required by a prescriber will either have a blank field to complete for handwritten prescriptions or must be documented electronically as ‘Prescription Notes’. A prompt as to the information required electronically will appear on the prescription template in red text in the following format **XYZ**
- For blinded studies or those studies that employ dispensation of a unique kit/vial/box or batch specific dispensing it is accepted that it is not always possible to obtain this information at point of prescribing, therefore this can either be handed in to pharmacy separately or notifications sent to the generic pharmacy email address for pack numbers iwrs@christie.nhs.uk. When sending this information to pharmacy the patient’s hospital number in addition to the subject number must be endorsed on any emails or dispensation paper sheets. Any patient identifiable information is for internal use only. Pharmacy cannot dispense any medication without proof of such documents.

It is the responsibility of any prescriber that prescribes a clinical trial to ensure that have been appropriately trained and this to be documented via assigned delegation of this duty by the PI before prescribing.

The prescriber must also ensure that they are prescribing on the correct approved version of the trial specific prescription.
5.25 Prescribing of Systemic AntiCancer Therapy (SACT)
Prescriptions for SACT must comply with all Trust standards for prescribing. In addition further requirements for the prescribing of SACT are documented in the SACT section of this policy.

5.26 Prescribing Medical Gases
All patients receiving medical gases should have them prescribed on either the JAC EPMA system, the inpatient prescription and administration record chart or the outpatient/daycase prescription and administration record chart with the exception of patients receiving Entonox under the terms of a PGD.

5.26.1 Prescribing Oxygen
All patients receiving oxygen within the Trust must have this prescribed on either the JAC EPMA system, the inpatient prescription and administration record chart or the outpatient/daycase prescription and administration record chart.

The only exception is those patients attending the hospital as an outpatient on ambulatory oxygen.

Oxygen should be prescribed in line with British Thoracic Society guidelines.

The following must be specified on the prescription:
- Flow rate
- Oxygen delivery device
- Percentage prescribed
- Target oxygen saturation level
- whether PRN or continuous administration

N.B: Oxygen should never be withheld whilst awaiting a prescription if it clinically indicated

If oxygen is required for discharge, the prescriber must complete a home oxygen consent form (HOCF) and a home oxygen order form (HOOF).

5.27 Prescribing Intravenous Infusions
Intravenous infusions may be prescribed on the:
- the ‘infusions’ section of the inpatient prescription and administration record chart or the outpatient/daycase prescription and administration record chart
- JAC EPMA system
- Ascribe EPMA system as part of a chemotherapy regime
- handwritten SACT prescription as part of a chemotherapy regime

Document the name and volume of the infusion, fluid/diluent, approved name of drug, dose, strength, preparation and route of administration, concentration or total quantity of the medicine in the final infusion container or syringe, e.g. 1mg/ml or 200 nanograms/50ml, rate and/or duration of administration.

All inpatients should have the volume of any fluids administered regularly recorded on the fluid balance chart.

5.28 Prescribing Insulin
All inpatients with diabetes and those inpatients not known to have diabetes but who require blood sugar monitoring must have a Diabetes Management Chart. This applies to all inpatients regardless of whether they have a paper inpatient prescription chart or a JAC EPMA record. The Diabetes Management Chart must be cross referenced on the paper inpatient prescription chart or a JAC EPMA record.

NB: The only exception is patients on CCU where the prescribing of insulin, all other diabetic medication and monitoring of blood sugar levels is performed on Metavision.
All insulin must be prescribed and the administration recorded on the diabetes management chart.

Patients prescribed bolus SC insulin regimes must have the insulin prescribed separately for each day so that the dose can be adjusted if required based on blood glucose readings.

The name of the insulin must be documented in full on the prescription. NB: Insulins often have similar sounding names but have very different properties. eg Humalog and Humalog mix 50 insulin.

Insulin is now available in a variety of strengths always ensure the correct strength is documented on the prescription.

The administration device for bolus SC insulin injections must be documented on the prescription.

The term ‘units’ must be documented in full on all insulin prescriptions, both handwritten and electronic. Abbreviations, such as ‘U’ or ‘IU’, are not permitted.

All patients receiving non-insulin treatment for diabetes may have their medication prescribed and administration recorded on the paper inpatient prescription and drug administration record chart or the JAC EPMA record as appropriate.

See – Management of patients with diabetes or at risk of developing diabetes policy

5.29 Prescribing Blood Products
Blood and blood components are not licensed medicines. A separate prescription/observation chart is used to provide the written instruction for the administration blood products.

All medical prescribers may provide the written instruction for the administration of blood and blood products.

Nurse Clinicians are currently the only NMPs authorised to provide the written instruction for blood component transfusion. In order to undertake this role they must have successfully completed the associated competency assessment. This process is supported and managed by the blood transfusion team.

See - Blood Transfusion Policy

5.30 Prescribing Contrast Media
5.30.1 Radiology and Radiotherapy departments
All IV and oral contrast media administered to patients within the radiology and radiotherapy departments is administered according to approved protocols or PGDs and need not be prescribed.

The only exceptions are where patients requiring contrast are excluded from administration under the terms of the PGD in which case contrast may be prescribed on an outpatient/daycase medication prescription and administration record chart in accordance with the Trust prescribing standards.

5.30.2 Inpatients
All oral contrast media administered to patients on inpatient wards must be prescribed on either the inpatient medication prescription and administration record chart or the JAC EPMA system in accordance with the Trust prescribing standards.

Guidance on the appropriate choice of contrast media and dosing is available on the radiology booking proforma on CWP or from the radiology department.
5.31 Instruction by telephone/verbal order
Prescribers must only give verbal orders for the administration of medicines in exceptional circumstances i.e. when it would be detrimental to the patients’ safety if the medicine was not given immediately and provided that they are satisfied that it is both safe and appropriate to prescribe without independently assessing the patient.

Verbal orders are only required in situations where the patient has a paper prescription and administration record chart and no EPMA system is in use. Should an EPMA system be in use (JAC or Ascribe) the prescriber must prescribe remotely for the patient.

The verbal order must always be given to two members of registered nursing staff.

The medication details must be clearly entered on to the ‘once only’ section of the paper prescription chart at the time of administration. It must be identified as a verbal instruction and the name of the prescriber giving the verbal order and their bleep number entered into the signatory box. The identity of the person making the entry must also be made apparent on the prescription chart (signature, printed name and designation). The prescriber giving the verbal order must countersign the prescription chart within 12 hours and cannot delegate this to another individual.

5.32 Medicines Reconciliation
Medicines reconciliation is:
▪ collecting information on medication history (prior to admission) using the most recent and accurate sources of information to create a full and current list of medicines
▪ checking or verifying this list against the medication currently prescribed in the hospital, ensuring any discrepancies are accounted for and actioned appropriately
▪ communicating through appropriate documentation, any changes, omissions or discrepancies.

Medicines reconciliation is a process undertaken for patients admitted to The Christie. At present medicines reconciliation is not routinely undertaken for daycase or outpatients.

5.32.1 Clerking practitioner
The practitioner (Medical or Non Medical Prescriber) clerking the patient must take a full and accurate drug history from the patient and/or carer on admission to hospital.

This drug history must be documented in the patient’s medical notes. This must include prescribed medication as well as over the counter (OTC) medication, herbal and homeopathic treatments, and illicit drug use. Any allergies must also be documented.

If unable to obtain a full and accurate drug history, this must be documented.

The practitioner clerking the patient must prescribe the patient’s medication on a Trust approved prescription or the JAC EPMA system.

Where a decision is taken to omit medication on admission this must be clearly documented in patient’s medical notes and in the designated section on the front of the inpatient prescription chart with the reason for omission.

5.32.2 Medical team responsible for the patient
The medical team responsible for the patient must review the patient’s medication regularly both on admission, throughout the admission and prior to discharge.

Any changes to the patient’s medication must be documented in the medical notes.

The medical team responsible for the patient must take note of entries made in the medical notes by pharmacy staff with respect to medicines reconciliation and act upon them accordingly.
5.32.3 Nurses
The nurse must inform the medical team responsible for the patient should they become aware of any discrepancies between the patient’s pre-admission medication and the inpatient prescription, where there is no reason documented in the medical notes.

5.32.4 Ward pharmacist
The ward pharmacist must ensure that medicines reconciliation is undertaken as soon as possible after admission. This must be undertaken for all patients within 24 hours of admission, except at weekends or out of hours when it should occur on the next working day.

5.32.5 Clinical pharmacy technician
A clinical pharmacy technician may undertake the medicines reconciliation process provided they have undertaken the appropriate training.

If the clinical pharmacy technician is undertaking medicines reconciliation they must complete the process. This includes all required documentation and communication.

If there are any unexplained discrepancies between the prescription chart and the patient’s medication, this should also be verbally communicated to the ward pharmacist.

5.32.6 Medicines Reconciliation Process
This may be undertaken by a pharmacist or clinical pharmacy technician.

Collecting information
The pharmacist or clinical pharmacy technician should take a full medication history from the patient and/or carer.

This should include prescribed medication as well as over the counter medication, herbal and homeopathic treatments, and illicit drug use. Any allergies/sensitivities should also be checked.

If the patient and/or carer does not know which medications they take or are unable to communicate, their medication history may be sought from:
- Medication brought into hospital
- A list of their current medications (such as a repeat prescription form)
- The patient’s GP
- The patient’s community pharmacy
- The patient’s medical notes
- The Trust’s electronic prescribing systems and dispensing records
- The Summary Care record on the NHS Service Spine portal

If the patient does not speak English and there is still uncertainty regarding the drug history, an interpreter can be found by the Trust to obtain the information.

If the patient has other communication difficulties, the Trust Patient Information Service can be contacted to find if there are any suitable services available.

Wherever possible the patient and/or their carer should be interviewed to determine which medicines they are taking.

Verifying information
The medication history obtained must be checked against the prescription chart or EPMA record.

The drug history documented in the patient’s medical notes should also be checked for accuracy.
Communicating information
Once medication reconciliation has been undertaken this must be recorded in the following manner.

For those patients with paper inpatient drug charts: the patient’s current drug chart will be annotated by the pharmacist or clinical ward technician on the designated Medicines Management section of the inpatient prescription chart stating:
- Date
- Signature of person undertaking medicines reconciliation

For those patients with a JAC EPMA record: Medicines Reconciliation activity will be recorded as a patient specific note by the pharmacist or clinical pharmacy technician using the designated Medicines Reconciliation note. See - The Standard Operating Procedure for Clinical Pharmacy Ward Based Services using the Electronic Prescribing and Medicines Administration System

If there are any unexplained discrepancies between the prescription chart or documented drug history in the medical notes, this must be communicated to the medical team by documentation in the medical notes.

An annotation must be made against the original drug history in the patient’s medical notes as follows:
- ‘Drug history incorrect / incomplete, please see entry on (date)’
- Signature, name, designation, contact number

A complete and accurate drug history must be recorded after the latest entry in the medical notes
- Time, Date
- Drug History
- The approved or generic name of drug, form, dose of each medicine (It may be necessary to indicate which medicines are taken regularly by the patient and which were being taken acutely at the point of admission)
- ‘The following medicines have not been prescribed’
- The approved or generic name of the drug, form, dose of each medicine
- ‘Please review and prescribe if appropriate’
- ‘Drug history obtained from (state all sources of information used)’
- Signature, name, designation, contact number

If the omission or discrepancy poses an immediate threat to the safety or health of the patient and/or others, the medical team responsible for the patient must be contacted immediately.

The nurse responsible for the patient should be verbally informed of any discrepancies.

5.33 Process for ensuring the accuracy of prescriptions
5.33.1 Inpatient prescriptions
All inpatient prescriptions charts or JAC EPMA records will be clinically screened by the designated ward pharmacist for legality, accuracy and appropriateness as soon as possible after admission. This must be undertaken for all patients within 24 hours of admission, except at weekends or out of hours when it should occur the next working day.

This includes all supplementary prescription charts for specific indications or medication e.g.: diabetes management chart, syringe driver chart

Supply of non stock medication will be withheld until the inpatient prescription has been reviewed by a pharmacist.
For handwritten inpatient medication prescription and administration record charts pharmacists must sign and date the prescription in the designated pharmacy box for each medication to indicate that this clinical check has been undertaken.

For prescriptions generated using the JAC EPMA system pharmacists must verify each medication to indicate that this clinical check has been undertaken. The name of the pharmacist and time and date of prescription verification will be automatically recorded.

‘Once only’ doses or infusions that have already been administered do not require a clinical checked.

5.33.2 Outpatient prescriptions
A pharmacist must clinically check the outpatient prescription for legality, accuracy and appropriateness prior to dispensing.

For paper outpatient prescriptions: The pharmacist must sign the prescription with their initials to indicate that this clinical check has been undertaken prior to dispensing.

For prescriptions generated using the JAC EPMA system: The pharmacist must verify each medication to indicate that this clinical check has been undertaken. The name of the pharmacist and time and date of prescription verification will be automatically recorded.

For Ascribe EPMA outpatient prescriptions: The pharmacist must mark the prescription as ‘clinically screened’. The name of the pharmacist undertaking the clinical check will be automatically recorded against the prescription.

5.33.3 Discharge prescriptions
A pharmacist must clinically check the discharge prescription for legality, accuracy and appropriateness in conjunction with the in-patient prescription chart or JAC EPMA record prior to dispensing.

The pharmacist must sign and date the printed copy of the prescription to indicate that this clinical check has been undertaken prior to dispensing.

In addition the pharmacist undertaking the clinical check must update the status of the electronic discharge prescription to 'pharmacy screened' on CWP. The dispensed column must be populated with the source of medication ie: patient’s own drug, drugs at home, from ward or dispensed. The name of the pharmacist, date and time of the clinical check will be automatically recorded.

A clinical check of discharge prescriptions will not be undertaken in the following situations
- Out of hours provided that no medication is required from pharmacy ie: patients have a full, supply of all their medication labelled with accurate and appropriate directions on the ward, at home or where medication is supplied from the Emergency Drug Cupboard or from overlabelled prepack supplies on the ward.

5.33.4 SACT
See - Ensuring the accuracy of SACT prescriptions

For further information on the clinical checking and endorsing of all prescriptions see
SOP for providing Clinical Pharmacy Ward Based Services to Inpatients
SOP for Clinical Pharmacy Ward Based Services using the Electronic Prescribing and Medicines Administration System
SOP for Clinical Pharmacy Ward Based Services using the Electronic Discharge Prescribing System
SOP for the Clinical Screening of Outpatient Prescriptions
SOP for the Clinical Screening of prescriptions for Parenteral Anti-cancer therapy
SOP for the Clinical Screening of prescriptions for Clinical Trials

5.33.4 Pharmacist Interventions
All prescriptions are clinically checked by pharmacists according for legality, accuracy and appropriateness according to the processes described above. This is one of the fundamental roles of the clinical pharmacists within the Trust.

Pharmacist intervention is the process of correcting prescriptions prior to medication being supplied and/or administered to patients. Such interventions are defined as a ‘Near Miss’.

Pharmacists will use their professional judgement as to whether a prescription may be corrected with or without contacting the original prescriber or medical team responsible for the patient.

Pharmacist interventions are categorised according to the following table. It is not practicable for all pharmacist interventions to be recorded.

Pharmacist interventions will only be recorded on the intervention reporting system from the following categories:
- potentially lethal interventions; reported as ‘high’ significance
- serious interventions; reported as ‘medium’ significance
These interventions will be reviewed on a monthly basis by SMPC.

The link to the pharmacist intervention reporting system can also be found on the pharmacy page of the intranet.

Prescribers and the patients’ consultant are informed of all high risk pharmacist interventions by email.

Pharmacist interventions that are categorised as significant or minor error will not be routinely reported electronically. However, a point prevalence audit of all pharmacy interventions regardless of severity will be undertaken periodically to capture this activity as deemed necessary by SMPC

NB: Any prescribing error where the medication has been supplied/administered to patient(s) regardless of patient harm must be reported on the incident reporting system (Datix).
See – Management of Medication Errors and Near Misses
### 5.33.4.1 Classification of Pharmacist Interventions

<table>
<thead>
<tr>
<th>POTENTIALLY LETHAL INTERVENTION</th>
<th>Serious Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>These interventions should be reported as 'HIGH' significance on the Datix intervention reporting system</td>
<td>These interventions should be reported as 'MEDIUM' significance on the Datix intervention reporting system</td>
</tr>
</tbody>
</table>

#### POTENTIALLY LETHAL INTERVENTION
- An overdose where:
  - more than 10 times the intended dose of a systemic anticancer agent is prescribed
  - more than 10 times the intended dose of a drug with a high potential to cause cardiopulmonary arrest is prescribed
  - more than 10 times the intended dose of a drug with a very low therapeutic index is prescribed
- A subtherapeutic dose where a potentially life saving drug is too low for a patient having the disease being treated
- The drug being administered has a high potential to cause a life threatening adverse reaction e.g anaphylaxis in light of the patient's medical history

#### SERIOUS INTERVENTION
- Incorrect patient name and/or hospital number on the prescription
- An overdose where:
  - more than a 20% dose increase of the intended dose of a systemic anticancer agent is prescribed
  - between 4 and 10 times the intended dose of a drug with a high potential to cause serious adverse effects
  - between 4 and 10 times the intended dose of a drug with a very low therapeutic index is prescribed
  - more than 10 times the intended dose of any drug is prescribed, excluding those listed above
- A subtherapeutic dose where
  - more than a 20% dose decrease of the intended dose of a systemic anticancer agent is prescribed with no legitimate reason for dose reduction.
  - the drug is prescribed to treat a patient with severe disease who is in acute distress
- The wrong drug(s) are prescribed with potential for serious adverse effects eg: incorrect chemotherapy regime, incorrect insulin, Oxycontin® prescribed ‘as required’ instead of Oxynorm®
- The route is inappropriate, with the potential of causing the patient to suffer a severe toxic reaction
- The duration of treatment is inappropriate with a high potential of causing the patient serious harm
- The drug prescribed is likely to exacerbate the patient’s condition by means of a drug-drug interaction or drug-disease interaction with potentially serious consequences
- Errors of omission whereby the following medicines have not been prescribed either more than 24 hours from admission, during a rewrite or on discharge and there is no legitimate reason for omission:
  - anti-infectives
  - strong opioid analgesics
  - steroids
  - insulin
- Incorrect date of chemotherapy treatment including:
  - scheduling errors where a 3 weekly regime is unintentionally prescribed at two weekly intervals
  - treatment unintentionally prescribed for a single date that should be administered on sequential days e.g: days 1,2 and 3 or days 1,8 and 15
- Incorrectly recorded or calculated height, weight, body surface area (BSA) or creatinine clearance resulting in a significant under or over dose of chemotherapy (+/- 20%) |
- Duplicate prescriptions of systemic anticancer agents on a single date either at the same dose or differing doses where the erroneous prescription has not been cancelled.
- The name of the drug is misspelt or illegible to the extent that there is a significant risk of the wrong drug being administered.
### SIGNIFICANT INTERVENTION

Do not routinely need to be reported on the Datix intervention reporting system. Should the intervention be reported electronically they are defined as having 'LOW' significance.

- An overdose of any drug excluding those situations listed above.
- A subtherapeutic dose of any drug excluding those situations listed above.
- The route of administration is incorrect for the condition being treated e.g. inappropriate conversion of IV to oral anti-infective treatment
- Errors prescribing fluids e.g. specific additives needed for complete therapy are omitted or incompatible fluids are ordered
- Errors of omission whereby patient’s regular medication is not prescribed either on admission, during a rewrite or on discharge with the exception of those listed above.
- Electronic prescribing errors whereby:
  - the prescription note has been deleted but treatment is required
  - the prescription is dated retrospectively e.g. wrong month or year
  - the orderset date is incorrect but the date of treatment is appropriate

### MINOR INTERVENTION

Do not routinely need to be reported on the Datix intervention reporting system. Should the interventions be reported electronically they are defined as having 'LOW' significance.

- Information is omitted from the prescription including:
  - drug name, dose, strength, frequency or route
  - duration where a course length is required e.g.: steroids, antibiotics, systemic anticancer therapy
  - information required to process clinical trial prescriptions e.g.: pack allocations, cohort details
- Prescription is not legal e.g.: missing signature or date, prescribing requirements for controlled drugs not met
- Prescription is illegible, uses unapproved names or non standard abbreviations
- The drug prescribed may exacerbate the patient’s condition by means of a drug-drug interaction or drug-disease interaction with only minor potential for adverse effects
- Wrong drug prescribed with low potential for adverse effects
- Incorrect route prescribed without potential for toxic reactions or therapeutic failure
- The duration of treatment is inappropriate with a low potential of causing the patient harm
- Dosing is based on an old weight, BSA or creatinine clearance without potential for toxic reactions or therapeutic failure where dose alteration is +/- 20% of the prescribed dose
- Non formulary prescribing / prescribing of a drug for an unapproved / unfunded indication
- Inappropriate dose rounding
- An errant prescription was written that was highly unlikely to be administered given the nature of the drug, dosage form, route ordered or missing information eg: bisoprolol prescribed 2 puffs four times a day
6.0 SUPPLY AND DISPENSING OF MEDICINES
6.1 Procurement
All products procured through a North West regional contract are sourced from an approved list of suppliers produced by NW Regional Quality Control. Products not on regional contract are sourced from a UK licenced manufacturer.

6.2 Obtaining medicines
Medicines may only be obtained from the Pharmacy department. It is not acceptable for staff to acquire medicines directly from companies/company representatives with the exception of IV contrast media which is supplied directly to the radiology and radiotherapy departments.

The main pharmacy dispensary service on the Withington site is provided via a third party agreement with Boots® (The Boots company PLC). There is also an NHS run clinical trials dispensary for the provision of clinical trial medication.

The aseptic service is provided jointly by the NHS run aseptic department and Baxter® via a third party agreement.

In addition medicines may be supplied for Christie patients treated at peripheral sites by other NHS Trusts under a service level agreement.

An appropriate order is necessary. The order may take the form of:
▪ An authorised prescription
▪ A pharmacy stock 'top-up' list
▪ A CD requisition
▪ An order generated by pharmacy staff during ward visits or review of prescriptions
▪ A written pharmacy requisition using the pharmacy order book
▪ A printed Omnicell order

Wards requiring stock items should contact their pharmacy ATO (Assistant Technical Officer).

All other requests should be made by contacting the ward pharmacist.

Medicines supplied for use in clinical areas must not be used for the treatment of relatives or friends of the patient or for the treatment of hospital staff.

6.3 Obtaining Medical Gases
Medical gases are jointly managed by the estates and pharmacy teams.

▪ Medical gases are requested from the wards/departments via the tele-tracking portering system and then delivered to the wards by the porters.
▪ Return of empty cylinders is undertaken by the ward putting a request on to the tele-tracking portering system and this is removed from the ward and returned to the central store by the porters.
▪ The Trust maintains two medical gas stores. One for full cylinders; one for empty cylinders.
▪ The central store is managed by the porter’s with regards to the requisition of an order to the wards and the return of the empty cylinders from the ward.
▪ The central store stock is replenished and maintained by the BOC delivery service. Once a week empty cylinders are collected and replaced with full cylinders.

See – Medical Gases policy
6.4 Supply of contrast media
6.4.1 Radiology and Radiotherapy departments
The supply of IV contrast media is organised by radiology and radiotherapy using the electronic procurement system. IV contrast media is delivered directly to the radiology and radiotherapy departments.

Oral contrast media (gastrografin, E-Z CAT) is supplied through Pharmacy.

6.4.2 Inpatient areas
Gastrografin is supplied through pharmacy. E-Z CAT must be obtained through radiology.

6.5 Stock medicines to clinical areas
Stock lists should be agreed between the ward manager and a pharmacist or clinical pharmacy technician.

Stock items are supplied via the regular pharmacy top-up system, except in areas that use very few medicines. The frequency of the pharmacy top-up is agreed between the ward/department and the senior clinical pharmacy technician dependent on usage and storage capacity.

Ad-hoc stock items may be ordered using the pharmacy requisition book.

Stock items will not be supplied at the weekend or out of hours except for clinical urgency.

6.6 Non stock medicines to clinical areas
Non stock medicines and items for medicines labelled for specific patient administration will be ordered by the ward pharmacist Monday to Friday during their daily ward visit. If non stock medicines are required prior to the next scheduled visit, contact the ward pharmacist.

The pharmacy department will issue a sufficient quantity to cover the in-patient and discharge requirements. Commercially available patient packs or hospital pre-packs will be supplied whenever possible.

Patients Own Drugs and medicines dispensed for a named inpatient must be sent with the patient if they are transferred to another clinical area. This includes CDs - see Controlled Drugs.

6.7 Discharge Medication
Wherever possible, the immediate discharge letter and electronic discharge prescription must be completed at least 24 hours before the patients planned discharge (the pharmacy department requires a minimum of 3 hours to dispense the prescription).

Once the printed signed copy of the electronic discharge medication prescription has been generated the ward pharmacist should be contacted (Monday – Friday between 09.00-17.00). The ward pharmacist will clinically check and process the discharge prescription appropriately. Any medication required from pharmacy will be delivered to the ward by the portering staff.

If discharge medication is required at any other time see - Supply of medication for discharge when pharmacy is closed.

Where medication is prescribed on discharge from inpatient or daycase care, at least 14 days medication should be supplied (unless a shorter supply is clinically appropriate, or where further supply will be available via the patient’s GP or other primary care provider within 14 day following discharge).
6.7.1 The discharge process: nursing responsibilities
The nurse responsible for the patient, on either the ward or the patient admissions and transfer suite, must oversee the patient’s discharge and ensure the following:
- The patient is correctly identified by asking the patient to state their first name, surname and date of birth; this must be checked together with the hospital number against the ID band and prescription.
- The discharge date accurately reflects the actual date the patient is to leave the hospital.
- That the place documented to which the patient is being discharged is accurate.
- The patient does not have an allergy or intolerance to any of the prescribed medication.
- The patient has a sufficient supply of all medication, labeled appropriately, by checking each medication against the prescription. The source of medication will have been annotated by the pharmacy team as follows:

<table>
<thead>
<tr>
<th>From Ward</th>
<th>Patient specific medication supplied from pharmacy in sufficient quantity is already available on the ward or other items supplied from ward supplies that are not medicines eg: nutritional products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Own</td>
<td>Patient’s Own Drug available on the ward</td>
</tr>
<tr>
<td>Drugs at Home</td>
<td>Patient’s Own Drug available at home or from the GP</td>
</tr>
<tr>
<td>Dispensed</td>
<td>Medication is not available on the ward and a supply has been made from pharmacy or Patient specific medication supplied from pharmacy or PODs are available on the ward but an additional supply is needed from pharmacy or Medication has been relabelled by pharmacy at the point of discharge</td>
</tr>
<tr>
<td>Not Required</td>
<td>Medication is not required</td>
</tr>
</tbody>
</table>

- The patient understands the reason for the medication, how and when to take it, any potential side effects and action to be taken in the event of experiencing a side effect.
- The date on the discharge letter reflects the date on which the patient is/have been discharged.
- The discharge letter must be printed using the ‘Discharge Letter’ icon.
  NB: the form should not be printed until the patient is ready to leave the ward as this will lock the form and automatically transmit to the patient’s GP electronically.

An E-Discharge Nursing Process leaflet is available on the intranet.

Under no circumstances may patients or relatives collect their own discharge medication from pharmacy.

6.8 Controlled Drugs
See - Controlled Drugs

6.9 Parenteral Nutrition
6.9.1 Standard Parenteral Nutrition bags
The dietitian will decide on the most appropriate feed which must be prescribed on the designated Request Form for Parenteral Nutrition and Prescription and Monitoring Sheet, and cross referenced on IV fluid section of the inpatient prescription and drug administration record chart or the metavision or JAC EPMA system by a qualified medical prescriber.

The actual regime must be specified with the volume and duration of infusion.

The dietitian will complete the Request Form for Parenteral Nutrition and Prescription and Monitoring Sheet.
Both the dietitian and prescriber must sign the both the request form and prescription before the order can be processed further.

The dietitian will contact the ward pharmacist to notify of prescription request. This must occur no later than 4pm for delivery to the ward on the same day.

The dietitian will supply the pharmacist with a copy of the parenteral nutrition prescription request form and place the original form in the patient’s medical notes.

The pharmacist use the copy of the prescription request to process the order and keep as a record with the relevant pharmacy order form.

The requested parenteral nutrition bag will be sent to the ward by the end of the working day.

The dietitian will complete the prescription and monitoring sheet on the reverse of the request form for each daily infusion. Both the dietitian and prescriber will sign the prescription for each daily infusion. Each daily prescription must cross referenced on IV fluid section of the inpatient prescription and drug administration record chart or the metavision or JAC EPMA system by a qualified medical prescriber.

The prescription will be processed on a daily basis until the pharmacist is notified otherwise by the dietitian/ward staff (e.g. any change to regimen; discontinuation of parenteral feeding).

A sufficient supply of parenteral nutrition for weekends and bank holidays will be made by pharmacy on the last full working day preceding the weekend or bank holiday.

6.9.2 Bespoke Parenteral Nutrition bags
The dietitian will identify the prescription required and discuss and liaise with the Baxter's pharmacist to ensure bag stability.

The dietitian will decide on the most appropriate feed which must be prescribed on the designated Request Form for Parenteral Nutrition and Prescription and Monitoring Sheet, and cross referenced on IV fluid section of the inpatient prescription and drug administration record chart or the metavision or JAC EPMA system by a qualified medical prescriber.

The actual regime must be specified with the volume and duration of infusion.

The dietitian will document the recommended prescription, daily infusion rates and total nutrient provision on CWP.

The dietitian will complete the request form for bespoke parenteral nutrition. The request form for bespoke parenteral nutrition must be signed by both the dietitian and a prescriber before the order can be processed further

The dietitian will fax the completed request form and prescription to the Baxter Aseptics Unit.

Baxter's will check the stability of the bag and fax/email back both to the Christie dietitians and pharmacy department. The dietitian will inform pharmacy procurement whether the prescription is appropriate.

The Christie ward pharmacist will check and sign the completed prescription and fax it back to Baxter. Once this authorisation has been received by Baxter the turnaround time is 48 hours (24hrs for CCU patients) for supply of the initial bag.
The Boots pharmacy procurement technician will liaise with Baxters for ongoing orders to ensure a continuous supply.

The dietitian will complete the prescription and monitoring sheet on the reverse of the request form for each daily infusion. Both the dietitian and prescriber will sign the prescription for each daily infusion. Each daily prescription must cross referenced on IV fluid section of the inpatient prescription and drug administration record chart or the metavision or JAC EPMA system by a qualified medical prescriber.

The prescription will be processed daily until the ward pharmacist is notified otherwise by the dietitian/ward staff (e.g. feed discontinued, changes required to current prescription).

6.9.3 Home TPN patients
Patients who are admitted on TPN in the community may continue to use their own supplies of TPN following the procedures described in the nutrition policy.

6.10 Supply under Patient Group Directions
See - Patient Group Direction Policy

6.11 Supply of Pre-pack medication
6.11.1 Oak Road Treatment Centre, Mobile Chemotherapy Unit, Peripheral Clinics, HTDU, YOUDU and CTU
Pre-packaged over-labelled supportive medication is stocked at the various locations to be supplied directly to outpatients receiving SACT by nursing staff.

All pre-packaged over-labelled medication will be supplied to the ward or department by pharmacy in the same way as stock medication.

The following items are currently stocked for nurses to supply to patients:

- Ondansetron 8mg tablets – Take ONE tablet TWICE a day for 2 days (4 tablets)
- Dexamethasone 2mg tablets – Take TWO tablets TWICE a day for 2 days (8 tablets)
- Cyclizine 50mg tablets – Take ONE tablet THREE times a day when required (30 tablets)
- Metoclopramide 10mg tablets – Take ONE tablet THREE times a day when required (28 tablets)
- Chlorhexidine 0.2% mouthwash – 10ml to be used as a mouthwash FOUR times a day when required (300ml)
- Benzydamine 0.15% (Difflam®) oral rinse – 10ml to be used as a mouthwash FOUR times a day when required (300ml)
- Mupirocin 2% nasal ointment (Bactroban®) – Apply to the inner surface of each nostril THREE times (3g)
- Chlorhexidine 4% hand rub (Hibiscrub®) – Use as a body wash DAILY as directed (250ml)
- *Loperamide Take TWO capsules to start, then take ONE when required after each loose stool. Do not take more than 8 in 24 hours – 30 capsules
  *For ALL patients except for those on irinotecan treatment or with a stoma. NB: Capsules are suitable for all patients EXCEPT those with a stoma. Any patients with an ileostomy or colostomy must have loperamide TABLETS dispensed by pharmacy.

Pre-packaged over-labelled medication must be stored on the ward in a locked cupboard separate from other ward stock supplies.

In order for nurse supply to take place:

- The medication must be prescribed on the Ascribe EPMA system
- The prescription must be screened by a pharmacist
- The prescription must have a 'sticky note' attached by a member of pharmacy staff directing the nurses to supply the medication
• The directions on the prescription must exactly match those on the pre-printed label

Supply of pre-packaged over-labelled medication can only be undertaken by registered nurses.

The nurse will:
• Ensure that the prescription has been screened and flagged by a pharmacist
• Take the appropriate packs of medication from the locked cupboard and add the patient’s name and the date the supply is made to each of the pre-printed labels
• Add a ‘sticky note’ to the electronic dispensing system to state what has been supplied including the name and quantity of each medicine. Any items that are prescribed but not supplied must have the reason why a supply has not been made documented on the electronic sticky note
• Obtain an independent check by a second registered nurse
• Record the names of both the nurse making the supply and the nurse performing the check on the ‘sticky note’
• Explain each medication to the patient
• Ensure that a patient information leaflet is supplied with each medicine
• Check the Ascribe Patient Medication Record for the complete record of medication required and ensure that the patient has any additional items that are dispensed from pharmacy

Any concerns of the nursing staff should be checked with a pharmacist prior to the patient leaving the hospital.

6.11.2 Surgical Oncology Unit (SOU), Surgical Day Case Unit (SDCU) and Ward 1
Pre-packaged over-labelled medication is stocked on the surgical units to be supplied directly to patients by nursing staff on discharge.

All pre-packaged over-labelled medication will be supplied to the ward or department by pharmacy in the same way as stock medication.

The following items are currently stocked for nurses to supply to patients:
• Paracetamol 500mg tablets – Take ONE or TWO tablets FOUR times a day if required for pain relief (32 tablets)
• Codeine phosphate 30mg tablets – Take ONE or TWO tablets FOUR times a day if required for pain relief (28 tablets)
• Co-amoxiclav 625mg tablets - Take ONE tablet THREE times a day for 5 days. Discard any remaining tablets (21 tablets)
• Clarithromycin 250mg tablets – Take TWO tablets TWICE a day for 5 days. Discard any remaining tablets (28 tablets)
• Flucloxacinill 250mg capsules – Take TWO capsules FOUR times a day for 5 days. Discard any remaining capsules. (56 capsules)

Pre-packaged over-labelled medication must be stored in a locked cupboard separate from other ward stock supplies.

In order for nurse supply to take place:
• The medication must be prescribed on the electronic discharge proforma on CWP using the pre-populated surgical prepack medications section of the prescription.
• The prescription must either be screened by a pharmacist OR the patient must only require surgical pre-pack medications. If additional items that are not stocked on the ward are required then the WHOLE prescription must be screened by a pharmacist.

Supply of pre-packaged over-labelled medication can only be undertaken by registered nurses

The nurse will:
- Ensure that the items are prescribed on an appropriate prescription and that the prescription has been screened by a pharmacist if necessary
- Take the appropriate packs of medication from the locked cupboard and add the patient’s name and the date the supply is made to each of the pre-printed labels
- Complete the Supply Record Sheet with the patient’s demographic details (name, unit no. & DOB or addressograph sticker), the date and the details of what has been supplied including the name, strength & quantity of each medicine. The completed Supply Record Sheets should be left in the designated wallet attached to the inside of the door of the cupboard that the pre-packs are stored in. The Supply Record Sheets will be retrieved and retained by pharmacy staff.
- Obtain an independent check by a second registered nurse
- Record the names of both the nurse making the supply and the nurse performing the check on the prescription
- Explain each medication to the patient
- Ensure that a patient information leaflet is supplied with each medicine
- Ensure that the patient has any additional items required
- Ensure that the discharge process is completed appropriately.

Any concerns by the nursing staff should be checked with a pharmacist prior to the patient leaving the hospital.

6.11.3 Brachytherapy and Molecular Radiotherapy Unit (BMRU)
Pre-packaged over-labelled medication is stocked on the BMRU to be supplied directly to patients by nursing staff on discharge.

All pre-packaged over-labelled medication will be supplied to the ward or department by pharmacy in the same way as stock medication.

The following items are currently stocked for nurses to supply to patients:
- Tamsulosin 400 microgram MR capsules – Take ONE capsule ONCE a day (30 capsules)
- Ciprofloxacin 250mg tablets – Take TWO tablets TWICE a day for one week (28 tablets)
- Ispaghula Husk sachets (orange) – Take the contents of ONE sachet TWICE a day as directed (30 sachets)
- Loperamide 2mg capsules – Take TWO immediately followed by ONE capsule after each loose stool as required for diarrhoea up to a maximum of eight capsules in a day (30 capsules)

NB: Capsules are suitable for all patients EXCEPT those with a stoma. Any patients with an ileostomy or colostomy must have loperamide TABLETS dispensed by pharmacy.

Pre-packaged over-labelled medication must be stored in a locked cupboard separate from other ward stock supplies.

In order for nurse supply to take place:
- The medication must be prescribed on the electronic discharge proforma on CWP using the pre-populated BMRU pre-pack medications section of the prescription.
- The prescription must either be screened by a pharmacist OR the patient must only require surgical pre-pack medications. If additional items that are not stocked on the ward are required then the WHOLE prescription must be screened by a pharmacist.

Supply of pre-packaged over-labelled medication can only be undertaken by registered nurses

The nurse will:
- Ensure that the items are prescribed on an appropriate prescription and that the prescription has been screened by a pharmacist if necessary
- Take the appropriate packs of medication from the locked cupboard and add the patient’s name and the date the supply is made to each of the pre-printed labels
Complete the Supply Record Sheet with the patient’s demographic details (name, unit no. & DOB or addressograph sticker), the date and the details of what has been supplied including the name, strength & quantity of each medicine. The completed Supply Record Sheets should be left in the designated wallet attached to the inside of the door of the cupboard that the pre-packs are stored in. The Supply Record Sheets will be retrieved and retained by pharmacy staff.

- Obtain an independent check by a second registered nurse
- Record the names of both the nurse making the supply and the nurse performing the check on the Supply Record Sheet.
- Explain each medication to the patient
- Ensure that a patient information leaflet is supplied with each medicine
- Ensure that the patient has any additional items required
- Ensure that the discharge process is completed appropriately.

Any concerns by the nursing staff should be checked with a pharmacist prior to the patient leaving the hospital.

6.11.4 Oncology Admissions Unit (OAU)
Pre-packaged over-labelle medication is stocked on the OAU to be supplied directly to patients by nursing staff on discharge.

All pre-packaged over-labelle medication will be supplied to the ward or department by pharmacy in the same way as stock medication.

The following items are currently stocked for nurses to supply to patients:
- Co-amoxiclav 625mg tablets - Take ONE tablet THREE times a day for … days (21 tablets)
- Clarithromycin 250mg tablets – Take TWO tablets TWICE a day for … days (28 tablets)
- Fluvoxacin 250mg capsules – Take TWO capsules FOUR times a day for … days (56 capsules)
- Fluconazole 50mg capsules – Take TWO capsules ONCE a day for 7 days (14 capsules)
- Levofloxacin 500mg tablets – Take ONE tablet ONCE a day for 7 days (7 tablets)
- Codeine phosphate 30mg tablets – Take ONE or TWO tablets FOUR times a day if required for pain relief (28 tablets)
- Paracetamol 500mg tablets – Take ONE or TWO tablets FOUR times a day if required (32 tablets)
- Cyclizine 50mg tablets – Take ONE tablet THREE times a day when required for nausea (30 tablets)
- Metoclopramide 10mg tablets – Take ONE tablet THREE times a day when required (28 tablets)
- Loperamide 2mg capsules – Take TWO immediately followed by ONE capsule after each loose stool as required for diarrhoea up to a maximum of eight capsules in a day (30 capsules)
- NB: Capsules are suitable for all patients EXCEPT those with a stoma. Any patients with an ileostomy or colostomy must have loperamide TABLETS dispensed by pharmacy.
- Benzydamine 0.15% (Difflam®) oral rinse – 10ml to be used as a mouthwash FOUR times a day when required (300ml)

Pre-packaged over-labelle medication must be stored in a locked cupboard separate from other ward stock supplies.

In order for nurse supply to take place:
- The medication must be prescribed on the electronic discharge proforma on CWP using the pre-populated OAU prepack medications section of the prescription.
- The prescription must either be screened by a pharmacist OR the patient may only require pre-pack medications. If additional items that are not stocked on the ward are required then the WHOLE prescription must be screened by a pharmacist.

Supply of pre-packaged over-labelle medication can only be undertaken by registered nurses
The nurse will:
- Ensure that the items are prescribed on an appropriate prescription and that the prescription has been screened by a pharmacist if necessary
- Take the appropriate packs of medication from the locked cupboard and add the patient’s name and the date the supply is made to each of the pre-printed labels
- Complete the Supply Record Sheet with the patient’s demographic details (name, unit no. & DOB or addressograph sticker), the date and the details of what has been supplied including the name, strength & quantity of each medicine. The completed Supply Record Sheets should be left in the designated wallet attached to the inside of the door of the cupboard that the pre-packs are stored in. The Supply Record Sheets will be retrieved and retained by pharmacy staff.
- Obtain an independent check by a second registered nurse
- Record the names of both the nurse making the supply and the nurse performing the check on the Supply Record Sheet.
- Explain each medication to the patient
- Ensure that a patient information leaflet is supplied with each medicine
- Ensure that the patient has any additional items required
- Ensure that the discharge process is completed appropriately.

Any concerns by the nursing staff should be checked with a pharmacist prior to the patient leaving the hospital.

6.12 Transport and Receipt of Medicines
There is a dedicated pharmacy portering service Monday to Saturday.

All medicines delivered to a ward or department must be promptly unpacked and stored appropriately.

Medicines received should be checked against the accompanying prescription/original order on receipt. Any discrepancy must be reported to pharmacy immediately.

Fridge items will be delivered in a specific plastic bag clearly labelled for refrigeration. These items must be unpacked and refrigerated immediately upon receipt.

Anyone collecting medicines from pharmacy must produce a valid Trust identity badge
Student Nurses on placement within the Trust must produce a photographic university identity badge. Failure to do so will result in pharmacy refusing to supply the medicines.

All discharge medicines coming into a ward or department must be received by a registered nurse and locked in a designated medicine cupboard separate from other ward stock medication immediately, until required.

The pneumatic tube system may not be used for the transport of:
- Cytotoxic medication
- Liquid preparations
- Controlled drugs
- Intravenous fluids

Medication transported in the pneumatic tube system must always be securely packaged and labelled with the intended destination.

Areas for special consideration include transport of medicines between hospital sites, and particularly SACT between the Baxter unit and the Trust, where the following applies:
- Dedicated containers (rigid type) must be used to contain potential spillage
- Containers must be validated to maintain the cold chain (prescribed temperature range) for refrigerated drugs
- Containers must be clearly designated or labelled with storage temperature and destination
• Containers must be signed for at the delivery destination
• Containers must be promptly unpacked and contents stored appropriately

6.13 Transport and receipt of Controlled Drugs
See - Controlled Drugs

6.14 Delivery of Medicines Outside of the Hospital
6.14.1. Taxi / courier delivery of medication to patients in their own homes
Wherever possible the use of hospital drivers, or a contracted delivery company should be used. When a taxi is required this must be arranged via switchboard. The taxi driver must show their valid company ID to the registered nurse.

Do not inform the taxi driver if the drug is a CD.

The nurse should document the name, company, registration number and signature of the driver in the nursing notes.

The driver must have clear details of the patients name and delivery address.

The driver must hand the drugs directly to the patient or their representative or return to the hospital if the patient/representative is not at the delivery address.

6.14.2 Posting of Medicines
The hospital serves a wide geographical area and therefore it is not always possible, or convenient, for patients to return to the hospital to collect on-going supplies of medicines.

When medicines are posted to a patient this must be coordinated through the Trust’s post-room.

All medicines should be sent using a registered delivery posting system. This system means that in the event of a medicine not being delivered it is possible to trace the delivery.

In the event of a non-delivery of medicine a DATIX incident must be recorded and a full investigation undertaken.

NB: Some clinical trial medication may not be posted to patients – check individual trial protocols.

6.14.3 Christie@Home Scheme
The hospital has a system in place for the administration of medicines to patients in their own home/workplace by a member of the hospital’s nursing team.

These medicines will either.
  - Be collected from the pharmacy department by the patient
  - Be delivered to a local community pharmacy for collection by the patient
  - Be delivered directly to the patient’s home by a contracted courier company

Once delivered the patient is responsible for the appropriate storage of the medication.

6.14.4 Delivery to a community pharmacy
These deliveries will be coordinated by the contracted out-sourced pharmacy company using their logistical network.

6.14.5 Delivery of medicines to a peripheral hospital site
These medicines will be delivered using a contracted medicines delivery service. The pharmacy team will maintain records of which medicines have been delivered to which sites.
6.15 Supply of Medicines to Clinical Areas When Pharmacy is Closed
An on-call pharmacist is available, via switchboard, for medicines advice out-of-hours and for emergency medicines supply.

The on-call pharmacist should only be contacted by night nurse practitioners, the medical staff involved in the care of the patient or the duty manager.

6.16 Obtaining Medicines from the Emergency Drug Cupboard (EDC)
The Emergency Drug Cupboards are located within a designated area of the treatment room on the Planned Admissions & Transfer (PAT) Suite (Department 25).

Access to the PAT Suite and the treatment room will be via a swipe card and the drug cupboards will be locked. Both the swipe card and drug cupboard keys may be obtained from and should be returned to Security. The treatment room is monitored by a CCTV system.

Only nurses, doctors, pharmacists and ODPs employed by the Trust are authorised to collect medicines from the emergency drug cupboard.

Only complete packs may be obtained. Individual doses of unidentifiable medicines should not be removed.

The supply documentation form(s) must be completed including the name, strength, formulation and quantity of the medicine, the name and hospital number of the patient, the ward, the date and the full name and signature of the person taking the medicine. Completed forms must be left in the EDC.

On no account must PAT Suite stock be taken – this includes non-drug items.

6.17 Obtaining Medicines from Out of Hours Fridge
If the medication required needs to be refrigerated it will be located in the emergency box located in the fridge on ward 12.

On removing the medication, a record sheet must be completed and left in the fridge, including the name of the medicine removed, the quantity, the name and identification number of the patient, the ward, the date and the full name and signature of the nurse taking the medicine.

6.18 Obtaining Parenteral Nutrition Out of Hours
Only TPN starter bags are available out of hours.
NB: Starter bags are not suitable for patients with nut, egg and soya allergies.

Starter bags may be unsuitable for patients previously receiving fat free TPN – in such situations, do not administer and await dietetic review
This feed may be unsuitable for patients already receiving electrolyte free TPN due to its electrolyte content.

The prescriber must complete an Out of Hours TPN request form and Request Form for Parenteral Nutrition and Prescription and Monitoring Sheet, and cross referenced on IV fluid section of the inpatient prescription and drug administration record chart or the metavision or JAC EPMA system by a qualified medical prescriber.

The request form must be photocopied. The original copy will be retained on the ward for the purposes of documenting administration and monitoring.

Starter bags are available from the out of hours parenteral nutrition fridge (located on the 1st floor opposite pathology secretaries’ office). The key will be available from security. The lead nurse on call will co-ordinate the procurement of these bags.
Only one bag is to be dispensed per one request form, e.g. if a patient requires feed for 2 days over the weekend, one form for each date must be completed.

The copy of the request form must be left in the out of hours nutrition fridge.

When pharmacy is next open, the completed prescription request sheet will be processed and the parenteral nutrition bag(s) taken out of hours will be booked out to each individual patient.

The Boots pharmacy team will monitor and restock the out of hours supply of starter PN bags on a regular basis and ensure appropriate stock rotation.

NB: If the patient has not previously been receiving TPN they must also be prescribed Pabrinex on the inpatient prescription and drug administration record chart or the metavision or JAC EPMA system as appropriate.

The prescriber/nurse will ensure the patient is referred to the dietitian for nutritional assessment at the earliest opportunity during working hours.

6.19 Obtaining Medicines from Other Clinical Areas
The borrowing of medicines from other clinical areas should not occur when the pharmacy is open.

The borrowing of medicines from other clinical areas should not occur as a matter of routine when the Pharmacy is closed. The on-call pharmacist should be contacted to authorise such borrowing and check the prescription.

Only complete packs or blister strips may be borrowed. Individual doses of unidentifiable medicines should not be transferred.

6.20 Patients Own Drugs (PODs)
Patients are encouraged to bring their own medication into hospital. It is important that these are not lost and are transferred with the patient from one clinical area to another.

Patients’ own drugs should be locked in their PODs box at all times with the exception of items that must be refrigerated and CDs.

6.21 Consent for use or destruction of Patients’ Own Drugs
Patients’ own drugs used in the Trust must be prescribed on the Trust prescription chart or JAC EPMA system.

Medicines brought into the hospital by patients remain their property and may only be used for the patient named on the medication label.

Verbal consent must be obtained before a patient’s medication can be used or destroyed.

If a patient does not consent to his/her drugs being used or destroyed, then the drugs should be:
- Sent home with a relative or
- Securely stored on the ward and returned to the patient on discharge. However, at such times, it is important to advise a patient with regard to any changes to pre-admission medication regimes so that they do not administer incorrect therapy

6.22 Assessment of Patients’ Own Drugs
A registered nurse, pharmacist or clinical pharmacy technician, may assess the suitability of a patient’s own drugs for use against a valid prescription using the following criteria:
- The medicine must be identifiable with the name and strength of the drug and expiry date
- The medicine must have been dispensed within the last six months, unless an expiry date is stated on the container
• Medicines in bottles must be identifiable as being the same as that on the label
• Loose blister strips of tablets or capsules may be used if they are identifiable and an expiry date can be found on the blister
• Ophthalmic preparations must have been in use for less than three weeks. On admission, a pharmacist, clinical pharmacy technician or registered nurse should add an expiry date of 7 days
• Containers should not hold more than one type of drug
• Care should be taken to note any specific storage requirements of the drug

Because of the difficulty in accurate identification, a nurse must not administer medicines in a compliance box or blister pack that are brought into hospital by a patient unless previously checked by a pharmacist or clinical pharmacy technician who deems it suitable.

A drug should not be used if:
• It is not identifiable, is in poor condition
• The expiry date has been exceeded
• A doctor has discontinued it
Under these circumstances, verbal consent must be sought from the patient before disposal of their drugs.

Once PODs have been assessed this will be documented as follows:
For patients with a written inpatient prescription and drug administration record chart the patient’s current drug chart will be annotated by the nurse, pharmacist or clinical pharmacy technician on the designated Medicines Management section of the inpatient prescription chart stating:
• Date
• Signature of person undertaking assessment of PODs

For patients with an electronic JAC EPMA record the pharmacist or clinical pharmacy technician this will be documented using the designated Medicines Reconciliation note stating ‘PODs checked and suitable for use’. See - The Standard Operating Procedure for Clinical Pharmacy Ward Based Services using the Electronic Prescribing and Medicines Administration System.

6.23 Supply of medication for discharge when pharmacy is closed
The on-call pharmacist is not expected to be called out for discharges prescriptions; there must be compelling reasons for a discharge prescription to be processed out of hours.

Items in the patient’s bedside locker, labelled with instructions and the patients’ name, may be issued to patients at discharge provided that the medications are in accordance with the discharge prescription.

A supply of pre-labelled packs of analgesics, antiemetics and antibiotics are available in the emergency medication cupboard for issue to patients who are discharged when the pharmacy is closed.

A list of pre-labelled discharge medicines is available on the pharmacy page of the intranet

The registered nurse must take the printed copy of patient’s discharge prescription to the emergency cupboard to check the correct medicine is dispensed.

The patient’s full name and the date the medicine is dispensed must be clearly printed on the medication label.

NB: Some take home packs contain the same medication but state different instructions and/or contain different numbers of tablets. Ensure the correct one is collected.

Complete the medication record sheet clearly stating:
- Name and quantity of the medicine
- Name and identification number of the patient
- Ward or department
- Date dispensed
- Full name and signature of the nurse taking the medicine

On return to the ward, a second registered nurse must then check the dispensed item(s) against the printed prescription and both the nurses must sign the prescription ensuring the medicine is labelled with the correct instructions, the patient's name and the date of dispensing.

Ensure that the discharge process is completed appropriately.

Where discharge medication is not available in the emergency cupboard the on call pharmacist can be contacted and will arrange an agreed time with the ward staff when the required medication will be dispensed.

Under no circumstances should a patient be discharged with unlabelled or inadequately labelled medication.
7.0 STORAGE AND SECURITY
7.1 Storage of medicines within clinical areas
Ensuring that the ward or department fulfils the requirements for safe and secure storage of medicines is the responsibility of the ward manager.

The safe and secure storage of medicines within a ward or department is the responsibility of all staff working within the ward/department, however, ultimate responsibility lies with the most senior registrant in charge.

On receipt of medicines on a ward the medication should be immediately unpacked and stored appropriately.

Medicines must be retained in the manufacturer’s original packaging or in the containers in which they are supplied by the pharmacy department. They must never be transferred to another container.

7.2 Medicines storage areas / treatment rooms
All medication, including contrast media, must only be stored within clinical areas in designated storage areas or treatment rooms, with the following exceptions:
- Patient’s Own Drugs (PODs) and medication dispensed for individual patient use which may be stored in a locked PODs locker.
- Medication that must be easily accessed in an emergency situation including resuscitation boxes, resuscitation trolleys, intubation boxes and Hypoboxes. Any such medication must be stored in boxes or trolleys with tamper evident seals.

The designated medicines storage areas or treatment rooms must have restricted swipe card access. Keypad access is not sufficient. The only exception is theatres whereby the department itself has restricted swipe card access.

Access to drug storage areas is authorised by the ward/department manager and actioned by the estates officer. As a minimum this needs to be reviewed annually.

Should an individual allow access to a drug storage area to an unauthorised member of staff eg: medical, pharmacy, housekeeping or portering staff, they are responsible for ensuring the individual has:
- A Trust identity badge
- A legitimate reason to access the drug storage area

In addition medicines must be locked up at all times within a medicines cupboard, CD cupboard or medicines fridge.

Exception areas include CCU and Theatres, where urgent access to critical drugs may be required at any time. However, all medicines must be locked up in appropriate cupboards or fridges when not attended.

If there is a breach of security, this must be reported immediately to the senior ward /department manager or the duty manager, Director of Pharmacy or on-call pharmacist and the Trust’s security team.

7.3 Ambient temperature monitoring
The ambient temperature of all medicines storage areas or treatment rooms should be recorded daily using a maximum / minimum thermometer.

The room temperatures must be recorded on the ‘Ambient temperature monitoring form’ and the thermometer reset after each recording.
If the temperature of the room exceeds 25°C inform the nurse in charge immediately. The pharmacy department and estates must be informed the next working day.

Generally if the temperature excursion is only for a short period of time – no further action is required. Where the excursion is for a longer period consideration may be given to reductions in expiry dates of medicines or disposal of the medicines.

*Areas/departments that are not continuously operational must monitor the room temperatures every working day as a minimum.

Generally if the temperature excursion is only for a short period of time – no further action is required.

Where the excursion is for a longer period consideration may be given to reductions in expiry dates of medicines or disposal of the medicines.

7.4 Medicines cupboards
Medicines cupboards must meet the requirements set out in The safe and secure handling of medicines. A team approach. March 2005.

Irrigation fluids, intravenous fluids and enteral nutrition may be stored within swipe card access controlled medicines storage areas or treatment rooms but need not be further locked within medicines cupboards.

Lockable medicines cupboards must have separate designated areas for the storage of
- products for external use
- products for internal use
- products for parenteral use
- epidural preparations
- medication that has been dispensed for discharge
- pre-packaged over-labelled medication for supply to patients on discharge or under the terms of a PGD
- parenteral SACT that must be stored at an ambient temperature

7.5 Omnicell Medicines cupboards
Electronic Omnicell medicines cupboards are used to store medicines on ward 4 and PTC.

Access is by means of fingerprint recognition.

Access to the Electronic Omnicell medicines cupboards is authorised by the ward/department manager and actioned by an Omnicell Superuser. As a minimum this needs to be reviewed annually.

7.6 Controlled Drugs (CDs)
All CDs including ward stock CDs, CDs dispensed for individual patient use, CDs dispensed for discharge and Patient's Own CDs must be kept in the CD cupboard.

Other drugs may be stored in the CD cupboard where deemed necessary, e.g. Strong Potassium Chloride Infusions.

See - Controlled Drugs

7.7 Medicines Refrigerators
All medicines marked ‘store below 15°C or store in a refrigerator’ must be stored in an appropriate locked medicines refrigerator. It is unacceptable to use a refrigerator that is not specifically designed for this purpose; it should not have a freezer compartment.
The medicines’ refrigerator must never be used to store food.

Patient’s Own Drugs that require storage below 15°C may be stored in the ward medicines' refrigerator. They should be clearly labeled with the patient’s name and segregated from ward stock.

Systemic Anticancer Therapy products for intrathecal use and CDs that require storage below 15°C must each be stored in separate designated locked refrigerators.

The temperature of the refrigerator must be maintained at 2°C to 8°C and be monitored daily* using a maximum/minimum thermometer. The fridge temperatures must be recorded on the 'Fridge temperature monitoring form' and the thermometer reset after each recording.

If the fridge temperature is outside the stated range (2°C and 8°C), inform the nurse in charge immediately. The pharmacy department and estates must be informed the next working day.

Generally if the temperature excursion is only for a short period of time – no further action is required. Where the excursion is for a longer period consideration may be given to reductions in expiry dates of medicines or disposal of the medicines.

*Areas/departments that are not continuously operational must monitor the fridge temperatures every working day as a minimum.

7.8 Patients’ Own Drugs (POD) Lockers
All medicines dispensed for individual administration to that patient and PODs must be stored in a locked patient specific medication cabinet with the exception of CDs and medication that must be stored in a refrigerator.

Any medication excess that will not fit in the POD locker must be stored within a locked medicines cupboard in the ward medicines storage are or treatment room.

The following items may be kept near the patient, outside the PODs locker if the patient is responsible for using them:

- inhalers
- spacer devices
- GTN sprays
- topical preparations
- mouthwashes

The POD locker must be either securely attached to the wall or integrated into the bedside locker.

POD lockers may be accessed by means of a keypad lock.

The only exception is CCU where PODs and drugs dispensed for specific patient administration are stored in a lockable box attached to the wall behind the patient’s bed area accessed by a key. Patients on CCU do not have access to their own medicines.

Each ward has a unique 8 digit access code to unlock all the POD lockers on the specific ward (submaster code).

Pharmacy has a unique 8 digit access code to unlock all the POD lockers within the Trust (master code).

Patients who have been assessed as competent to self-medicate must be given the opportunity to set their own unique 4 digit POD locker code access.
All procedures and user guides relating the POD lockers may be found on the Pharmacy pages of the intranet:

- Procedure for using and programming the keypad lock on patient bedside lockers
- Keypad Lock Nurses User Guide
- Keypad Lock Nurses User Guide: PTC
- Keypad Lock Pharmacy User Guide
- Keypad Lock Pharmacy User Guide: PTC
- Self Administration of Medicines Patient Information Sheet and Keypad lock Patient User Guide
- Self Administration of Medicines Patient Information Sheet and Keypad lock Patient User Guide PTC

### 7.9 Medicines keys

The safekeeping and whereabouts of drug cupboard and fridge keys is the responsibility of the most senior registered nurse on the ward, theatre or department at any given time.

The keys may be temporarily handed to nursing, medical and pharmacy staff, as necessary, for fulfilment of their duties. That particular professional is responsible for ensuring the safe return of the keys to the registered nurse in charge. However, the most senior registered nurse retains the overall responsibility for drug security for that area.

Duplicate keys to medicines cupboards and fridges are stored in the security department and accessed through the duty manager or night manager.

The nurse in charge should inform the pharmacist/switchboard/security if drug cupboards/fridges and/or the locks are replaced or if new keys are cut for drug cupboards.

The area responsible for the loss will incur the cost of all replacements.

For the management of CD keys see - Controlled Drugs

### 7.10 Storage and security of medicines and medicines keys when a ward or department is closed

When a ward, department or theatre is temporarily not involved in the active treatment of a patient or is closed (e.g. overnight or weekend), the drugs may remain within the ward or department provided that the medicines cupboards are locked and the ward/theatre or department is locked or secured to prevent unauthorised access.

It is acceptable for the medicines keys to remain within a closed ward/department provided that the keys are locked within a designated key cupboard or safe within a locked and alarmed ward/department.

Should a ward/department close that has no key cupboard to facilitate the safe storage of the CD keys whilst the ward/department is closed the CD keys must be returned to security and be managed in such a way as to prevent unauthorised access.

The advice of the pharmacy department must be sought if the duration of closure is longer than overnight or a weekend.

### 7.11 Storage and Security of Stationery

All stationery that may be used for the purposes of prescribing or recording the administration of medication to patients must be stored securely within departments so as to prevent unauthorised use.

It is acceptable for all such stationery to be readily accessed by Trust staff when the ward/department is operational. However, all stationery should be locked away if the ward/department is closed or unattended.
8.0 CHECKING AND SAFE ADMINISTRATION OF MEDICINES

8.1 Authorisation to administer and check the administration of medicines

The following staff are authorised to administer medicines:

- A registered nurse
- A registered medical practitioner or dentist
- Other professional staff groups e.g. ODA/ODP, pharmacists, physiotherapists, dieticians, radiographers

Single person administration of medicines by a registered practitioner is acceptable. Exceptions include:

- Where a practitioner is instructing a learner
- Where a Controlled Drug is involved
- Where local circumstances make the involvement of a second person desirable, in the interests of minimising the potential for error

Should a practitioner choose to have his/her practice checked it must be realised that full accountability for the correct administration of the medicine lies wholly with the administering practitioner. In addition, the person checking is individually accountable for his/her part in the process.

8.2 Bank and Agency Staff

Bank and agency staff may administer medication in keeping with their professional guidelines provided they familiarise themselves with the Trust Medicines Management Operational Policy.

8.3 Dose Calculations

Some doses require complex calculations. The administering practitioner can obtain a second check from another member of staff in the clinical area. The on-call pharmacist is always available out-of-hours to check calculations if required.

The second calculation should be made independently of the first one and then compared.

8.4 Patient Identification

Every patient admitted to the hospital must be given an identification (ID) bracelet.

The information contained on the identification bracelet should include:

- Full name, date of birth, gender and hospital identification number
- The ward or department where the patient is receiving treatment

It is no longer considered best practice for patients with allergies to be given an additional red identity bracelet stating the medicines to which they are allergic. See - Standardising wristbands improves patient safety: guidance on implementing the Safer Practice Notice (SPN 24, July 2007)

See also – Patient Identification Policy

8.5 Checking the Prescription

Medication must only be administered against patient specific directions or prescriptions handwritten on official Trust approved stationary or prescription charts or generated on a validated Trust endorsed electronic prescribing and medicines administration (EPMA) system.

All sections of the prescription chart or EPMA record should be checked before administering a medicine.

All prescriptions must include the following:

- Patient’s forename and surname, date of birth and hospital identification number
• Completed allergy box. It is not acceptable to leave the allergy box blank; in this instance medicines should not be administered. Doctors, nurses, ODPs and pharmacists are authorised to complete the allergy box of a prescription. See - Drug allergies and sensitivities
• The date the drug is to be commenced

In addition handwritten prescriptions must be legible and signed by the prescriber.

Each prescription must be checked for the following information:
• The approved name of the medicine
• The route of administration
• The dose to be administered
• The frequency and time of administration of the medicine
• The duration of treatment
• The rate of administration if required
• Any special instructions (e.g. administer with food)

If a practitioner is in any doubt or needs clarification of the dose or method of administration, this should be done with the prescriber or pharmacist before administration.

If it is necessary to represcribe the medicine due to error or ambiguity, the prescriber must do so before the medicine is given.

8.6 Administration of a Medicine
When administering a CD or where a complex reconstitution/administration is required a red apron can be worn.

Always ensure the following:
• The patient is correctly identified by asking the patient to state their first name, surname and date of birth; this must be checked together with the patient identification number against the ID band for admitted patients. A 3 point check of patient’s identification must be undertaken for outpatients who are not wearing an ID band eg: name, date of birth and address.
• The patient does not have an allergy or intolerance to the medicine
• The medicine is due and the drug is being given at the correct time and on the correct date
• The correct drug, formulation, dose and route have been selected
• Check precautions or special instructions
• Check expiry date of the medicine
• Ensure the patient receives the prescribed medication and takes it at the time of administration. Do not leave medicines unattended on lockers or in unlocked containers at any time
• Record the administration on the prescription chart or EPMA record.
• Document any suspected adverse reaction and inform medical staff immediately
• Report any contra-indication to a prescribed medicine immediately to the prescriber or appropriate member of the team covering the care of the patient

8.7 Recording administration on handwritten prescription charts
Where drug administration is recorded on handwritten prescription charts the signature or initials of the practitioner administering treatment should be recorded in the designated area of the chart.

8.8 Recording administration on EPMA systems
Where drug administration is recorded on EPMA systems the name of practitioner administering treatment will be automatically recorded.

The practitioner administering treatment must be given appropriate access rights to record medication administration on the required system(s).

It is the responsibility of the Information Technology (IT) team to ensure that staff have undergone appropriate training before granting administration access rights for the JAC EPMA system.
It is the responsibility of the Electronic Prescribing pharmacy team to ensure that staff have undergone appropriate training before granting administration access rights for the Ascribe EPMA system.

It is the responsibility of the system manager for CCU to ensure that staff have undergone appropriate training before granting prescribing access rights for the Metavision system.

It will be expected that all locum/agency staff must have completed necessary training prior to starting their first shift at the Trust. NB: the e-learning package for JAC EPMA system is may be completed on a home computer.

In certain circumstances temporary access to the JAC EPMA system may be required urgently at a time when above process cannot be enacted – this will be granted by the JAC EPMA System Manager via the security desk or Theatre Manager. This access will be reviewed the next working day and the temporary access removed. It is expected at that point that this individual would have successfully completed the E-Learning package and will be granted permanent access.

8.9 Administration of a Medical Gas
All staff involved in the administration of medical gases should have undertaken the Medical Gases e-learning package.

The administration of continuous medical gases should be recorded against the prescription at each medicines round (at a minimum of four times a day).

8.10 Administering Contrast Media
8.10.1 Radiology and Radiotherapy departments
All IV and oral contrast media administered to patients within the radiology and radiotherapy departments is administered according to approved protocols or PGDs.

The only exceptions are where patients requiring contrast are excluded from administration under the terms of the PGD in which case contrast may be administered against a patient specific direction on an outpatient/daycase medication prescription and administration record chart in accordance with the Trust administration standards.

8.10.2 Inpatients
All oral contrast media administered to patients on inpatient wards must be recorded on either the inpatient medication prescription and administration record chart or the JAC EPMA system in accordance with the Trust administration standards.

8.11 Omitted or delayed medicines
The responsibility to be aware of and investigate the reasons for omitted medicines lies with all healthcare professionals. An assessment of any omitted doses on the prescription chart or JAC EPMA record should be undertaken at all medical ward rounds, pharmacy ward rounds and drug administration rounds.

Where a reason for drug omission has been documented ensure that the reason is valid and that omission is not clinically detrimental to the patient.

It is regarded as a drug error if the dose is omitted and no reason is given.

8.11.1 Recording omitted medicines on handwritten prescription charts
For patients with a handwritten prescription chart any medicines prescribed but not administered should be coded with the numerical reason for omission in the signature box and circled. The prescriber may be informed at the discretion of the nurse.
8.11.2 Recording omitted medicines on JAC EPMA system
All administrations must be accounted for within the JAC EPMA system using the appropriate code for drug omission. If at the time the MAS needs to be run there are still outstanding medications, the reason for the non-administration must be investigated and the administration recorded for the time the medicine was given. If, however, it is unclear, uncertain or unable to ascertain whether the medicine was given; the non-administration reason 'z unable to determine' must be used.

8.11.3 Recording omitted medicines Ascribe EPMA system
Omitted medicines must be recorded as 'Drug not administered'. The reason for omission should be documented in the nursing notes on the CWP outpatient chemotherapy assessment and delivery webform.

8.11.4 Recording omitted medicines on Metavision
All administrations must be accounted for within the metavision system with a reason documented for any drug omission (freetype field).

8.11.5 Codes for drug omission

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Refused</td>
<td>1</td>
</tr>
<tr>
<td>Nil by mouth</td>
<td>2</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>3</td>
</tr>
<tr>
<td>No access (IV/NG/PEG)</td>
<td>4</td>
</tr>
<tr>
<td>Not required</td>
<td>5</td>
</tr>
<tr>
<td>Other treatment in progress</td>
<td>6</td>
</tr>
<tr>
<td>Patient not on the ward</td>
<td>7</td>
</tr>
<tr>
<td>Drug not available</td>
<td>8</td>
</tr>
<tr>
<td>Awaiting medical advice</td>
<td>9</td>
</tr>
<tr>
<td>Medication taken at home prior to admission</td>
<td>10</td>
</tr>
<tr>
<td>Self administration</td>
<td>11</td>
</tr>
<tr>
<td>Inappropriate/unclear prescription</td>
<td>12</td>
</tr>
</tbody>
</table>

8.11.6 Omission of Critical Medicines
The timely administration of the following medicines is critical as delay or omission can have a serious detrimental effect on a patient’s condition

- Medicine to be given immediately or at prescribed time
- Medicine omission must not exceed 12 hrs

- Resuscitation medicines
- Anti-arythmics
- Anti-coagulants
- Anti-infectives (except prophylactic/longterm)
- Anti-convulsants
- Anti-diabetics
- Analgesics (except PRN)
- Anti-emetics (except PRN)
- Anti-psychotics
- Insulin
- Steroids
- Desmopressin for diabetes insipidus
- Folinic acid rescue following high dose methotrexate
- First dose of steroids/anti-coagulants

When patients are acutely unwell they may lack insight or capacity regarding their treatment. If a patient refuses administration of a critical medicine the advice of the medical team must be sought as to whether omission of the dose is permissible or whether it is in the patient’s best interests for the dose to be administered. The outcome of the discussion must be documented in the medical and/or nursing notes. The advice of the psycho-oncology team may be required where there are felt to be issues around capacity to consent or refuse treatment.

Drug not available’ on ward (8) is not an acceptable reason for omission of a critical medicine; all possible action must be taken to obtain the medication required.

For parenteral SACT treatment refer to Obtaining SACT Out of Hours
8.11.7 Action to be taken when a prescribed critical medication is not available on the ward

Is patient’s own medication available

Medication meets required re-use criteria – see Medicines Practice Operational policy

Check if medication has been ordered from pharmacy – if so check treatment room, delivery boxes, POD locker and ward fridge

NB: Medication that has been supplied by pharmacy will be denoted by a circled date in green ink on handwritten charts or a suppressed Drug Specific note on the JAC EPMA system

Check if medication is available at previous ward location if patient has been transferred

Check if medication is available in EMERGENCY DRUGS CUPBOARD or EMERGENCY DRUGS FRIDGE (on ward 12)

Check if medication is available from another clinical area

Administer to patient as prescribed

Bleep on-call pharmacist to supply medication

8.12 Witnessing the Preparation and/or Administration

When witnessing medicine preparation and/or administration, the witness must:

- Verify the patient’s identity against the prescription
- Check the prescription
- Witness the reconstitution of the drug
- Check the diluent used
- Check the rate of administration if necessary
- Check all expiry dates
- Check any calculations
- Witness the safe administration or disposal of the medicine
- For handwritten prescriptions: Sign documentation
- For EPMA system prescriptions: Record drug administration
**8.13 Medication Administration with Students**

Students may be involved in medicines administration, providing that they are under the direct supervision of a registered practitioner or other authorised person. Where this is done, the registered practitioner must sign the medicine prescription. The accountability for the correct checking and administration remains the responsibility of the registered nurse.

The recommendation for student involvement with medicine administration is dependent on their level of experience as follows:

<table>
<thead>
<tr>
<th>Route / Class / Activity</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral medicines (excluding controlled drugs)</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
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<tr>
<td>IV medicines</td>
<td>Observe only</td>
<td>Observe only</td>
<td>Observe only (see below for final placement students)</td>
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<tr>
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<td>Observe and practice</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
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<td>Cannot connect or commence therapy</td>
<td>Cannot connect or commence therapy</td>
<td>Cannot connect or commence therapy (see below for final placement students)</td>
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<tr>
<td>PR medicines</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
</tr>
<tr>
<td>Inhaled therapy including Oxygen</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
</tr>
<tr>
<td>Topical medicines e.g. creams, eye drops</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
</tr>
<tr>
<td>Controlled drug administration</td>
<td>Observe only</td>
<td>Act in role of 2nd checker.</td>
<td>Act in role of 2nd checker.</td>
</tr>
<tr>
<td>Via NG or PEG tube</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
<td>Observe and practice</td>
</tr>
<tr>
<td>Blood Products</td>
<td>Observe only</td>
<td>Act in role of 2nd checker</td>
<td>Act in role of 2nd checker</td>
</tr>
<tr>
<td></td>
<td>Cannot attend blood tracking training</td>
<td>Cannot connect or commence therapy</td>
<td>Cannot connect or commence therapy</td>
</tr>
<tr>
<td>Patient Controlled Analgesia (PCA) &amp; Epidurals</td>
<td>Observe only</td>
<td>Observe only</td>
<td>Observe only</td>
</tr>
</tbody>
</table>
Direct supervision is defined as: ‘The Registered Practitioner is physically present with the student from the commencement of the procedure to its completion’.

Connection and commencement of any IV medicines, IV therapy or blood products is NOT permitted.

Final placement students may undertake the following once they have completed the trust’s intravenous study day and are in possession of an attendance certificate:

- prime giving sets
- change crystalloid fluid bags
- prepare IV antibiotics

The above activities must:
- only involve crystalloids, antibiotics and gelofusin
- be practiced under the direct supervision of a registered practitioner
- be done using aseptic non-touch techniques at all times

**8.14 Administration of medicines prepared by another practitioner**

It is unacceptable to administer medicines prepared by another practitioner if this practitioner is not present.

Exceptions to this are:
- Medicines prepared by pharmacy and radiopharmacy
- Medicines prepared by Baxters
- TPN
- Commercially available prefilled syringes

In addition, where a practitioner takes over the care of a patient receiving an infusion previously prepared and initiated by another practitioner, the following must apply:
- The container must be clearly labelled, signed and dated
- Accurate administration records exist, including the name of the person who initiated the infusion

Once these checks have taken place, the practitioner who has accepted responsibility for the patient’s care is accountable for the continuous administration of the drug.

**8.15 Covert administration of medicines**

Covert administration may only be considered provided the following apply:
- The patient actively refuses medication but lacks capacity to refuse treatment
- The medication is considered to be essential for the patient’s health and well-being, or for the safety of others
- The decision to administer medication covertly should be considered as a contingency measure in an emergency rather than as regular practice
- There should be broad and open discussion among the clinical team and the patient’s relatives, carers or advocates before the decision is taken to administer medication covertly
- The pharmacist is consulted as adding medication to food or drink can alter its chemical properties and thereby affect its performance
- The decision and action taken, including the names of all parties concerned, should be documented in the patient’s medical notes and regularly reviewed
- Regular attempts should be made to encourage the patient to take medication voluntarily

The psycho-oncology team is available to determine whether a patient lacks the capacity to consent to treatment.
8.16 Preparation and Administration of medication via feeding tubes
After insertion of a feeding tube a full review of medication must be undertaken by the medical team in consultation with pharmacy to ensure that the prescribed medicines are indicated, are available in an appropriate preparation and can be administered safely.

All patients receiving medication via a feeding tube must have this clearly documented on either the front of the In-patient prescription booklet in the ‘additional information’ section or as a Patient specific note on the JAC EPMA system.

The suitability of the medication must be checked with the ‘Handbook of Drug Administration via Enteral Feeding Tubes’ (available on all in-patient wards) before administration.

Tablets must only be crushed, or capsules opened when no alternative preparation is available following consultation with pharmacy.

Tablets may only be crushed using a tablet crusher (available on all in-patient wards). After each use the device MUST be cleaned thoroughly to avoid cross contamination.

8.17 Administration of liquid medicines
Where a liquid medicine requires administration using a syringe, a specific purple oral/enteral syringe (NOT a syringe intended for parenteral use) should be used. These have a female connecting end which prevents inadvertent intravenous administration.

8.18 Preparation and Administration of parenteral medicines
Drugs for parenteral administration may be prepared and administered by:
- A registered nurse
- A registered medical practitioner or dentist
- A registered member of allied health professionals, e.g ODP, radiographer, dietitian

Before preparing and administering any drug for parenteral administration (including first doses) the practitioner:
- Must have received appropriate training that conforms to the standards set by the Trust Clinical Skills Team
- Must have had these skills assessed by an appropriate person within The Christie NHS Foundation Trust using an appropriate assessment tool
- Must be familiar with the Trust algorithms & extravasation policies

Practitioners in training may prepare drugs for parenteral administration under the direct supervision of a registered practitioner.

Drugs should not be mixed together in infusion bags or administered together via Y-sites or 3-way taps unless compatibility of the drugs has been confirmed. Further information can be obtained the Medusa injectable medicine guide, which can be found via the pharmacy department’s intranet site or the clinical pharmacists. The University College London Hospitals (UCLH) Injectable Drug Administration Guide (UCLH 2010) has brief information on compatibilities.

Drugs for parenteral administration must be prepared immediately prior to administration. The only exception to this is when the drug has been prepared by the Trust pharmacy IV service or Baxter’s, is a commercially available prefilled syringe or infusion bag and it has been stored in accordance with the instructions provided on the label.

For the ward/dept preparation of all injections and infusions, an aseptic non-touch technique (ANTT) to maintain sterility of injection items.

For SACT it is recommended that staff wear non sterile gloves for their own protection.
The responsibility for monitoring a patient for adverse effects of IV administration remains with the practitioner administering a medicine.

Therefore NO practitioner should administer a drug unless:
- They are aware of the therapeutic use of the drug or solution to be administered, its normal dosage, side effects, precautions and contra-indications
- They can prepare the drug aseptically and safely (with the exception of drugs prepared by Baxter's, Aseptic Services, prefilled syringes and TPN), they have checked the container and drug for faults, used the correct diluent and only prepare the drug immediately prior to administration
- They are able to identify the patient and check their allergy status
- They have checked the prescription
- They have checked and can maintain the patency of the vascular access device
- They have inspected the site of the vascular access device and can report/manage the complications where appropriate
- They can control the flow rate of the infusion and or speed of injection
- They monitor the condition of the patient and report changes
- They make clear and immediate records of all drugs they administer
- Crystallloid or colloid fluids may be infused using a gravity infusion line when:
  - The patient is not considered to be at high risk of developing systemic fluid overload
  - There is not more than 20mmol/l potassium chloride in the bag
  - There is an emergency situation where a rate is required that is higher than the maximum programmed rate of the infusion device
- Medusa, British National Formulary (BNF) or The UCLH Injectable Drug Administration Guide (UCLH 2010) recommends the drug be given as a bolus
- A suitable infusion pump is temporarily unavailable and the risks to the patient of not having the medication are judged to be greater than the risks caused by not using an infusion device

It is the responsibility of the practitioner commencing an infusion to monitor the infusion and ensure that it is infused over the prescribed time period. Where an infusion is due to continue past the end of the practitioners shift or on transfer between different clinical areas then the infusion should be handed over to the practitioner undertaking continued responsibility for the patient’s care. This hand-over should be documented on the patient’s observation chart in the designated place.

8.19 Anaphylactic Reaction
Anaphylaxis is a rapidly progressing, life-threatening allergic reaction. See – Anaphylaxis algorithms located in the Emergency Documents folder on the Trust intranet

8.20 Adverse Drug Reactions (ADR)
Any drug may produce unwanted or unexpected adverse reactions. Detection and recording of these reactions is essential.

Where a patient has previously suffered from an ADR to a medicine, this must be documented in the ‘allergy’ section at the top of the inpatient prescription chart. Both the drug and the reaction should be documented e.g. morphine causing itching.

Doctors, pharmacists and nurses are urged to report adverse reactions that fulfil the appropriate criteria (see below) to the MHRA/CSM using a Yellow Card available in the back of the BNF, or electronically using the MHRA website www.mhra.gov.uk and following the link to ‘Report a suspected safety problem’:
- Suspected adverse reactions to any therapeutic agent e.g. drugs, X-ray media, blood products, vaccines, dental/surgical materials, herbal products, contact lens solutions.
- All suspected reactions to new medicines (marked with a black triangle in the BNF), including those considered not serious. An adverse reaction should be reported even if it is not certain
that the drug has caused it, or if the reaction is well recognised or if other drugs have been
given at the same time
• All suspected reactions to established medicines if the reaction is fatal, life threatening,
disabling, incapacitating, results in or prolongs hospitalisation

8.21 Extravasation
Extravasation is the infiltration of a vesicant solution or medication into surrounding tissue and is a
complication associated with the administration of intravenous drugs.

A suspected extravasation incident must be reported to the medical team responsible for the
patients care/ on call doctor in some circumstances pharmacy must be informed. In addition an
incident report form must be completed. See - Extravasation policy

8.22 Controlled Drugs
See - Controlled Drugs

8.23 SACT
See - SACT

8.24 Insulin
All staff involved in the administration of insulin must have completed the necessary e-learning
package.

Insulin is now available in a variety of strengths always ensure the correct strength is selected for
administration.

Insulin must be administered in a timely fashion as delays in administration of insulin will lead to
erratic glycaemic control.

A specific insulin syringe, or the patient’s own administration device must be used for
administration. NEVER use standard syringes for administration of insulin injections.

If a nurse is administering insulin to a patient they can use the disposable insulin pen device BUT
the BD Autoshield Duo pen needle must be used. A standard insulin pen needle can only be used if
the patient can perform the insulin injection and disposal of pen needle independently and the
patient has been assessed as able to continue to self-inject their insulin.

Insulin should be drawn directly from a vial. Insulin must never be withdrawn from a cartridge.

Insulin infusions must be administered in 50ml intravenous syringes or larger infusion bags.

If a patient has been assessed as competent to self-administer and adjust their insulin dose the
diabetes management chart MUST be completed with CBG result and insulin dose administered

Do not omit doses of long-acting insulin. Insulin dose may need to be reduced/increased based on
CBG’s, but omission of insulin may result in hyperglycaemia and should be avoided if possible.

See – Management of patients with diabetes or at risk of developing diabetes policy

8.25 Flushes
8.25.1 Sodium chloride 0.9%
It is necessary to administer sodium chloride flushes to patients to maintain the patency of
intravenous lines. Registered practitioners who are appropriately trained in the intravenous
administration of medicines may administer sodium chloride flushes on cannulation, to maintain the
patency of lines and before and after the administration of medication. In addition non registered
staff who have been appropriately trained to cannulate patients may administer sodium chloride
flushes to patients with intravenous lines. Wherever possible sodium chloride 0.9% should be administered from a prefilled syringe which is licensed as a medical device. The Trust accepts that sodium chloride flushes are administered to patients without a prescription and that such administration is not formally documented on a prescription chart or EPMA record. Inpatients receiving intravenous medication should have the flushes recorded on the fluid balance chart.

8.25.2 Heparin
It is not necessary to administer heparin 50 units/5 ml sodium chloride 0.9% to patients to maintain the patency of central lines. Non tunneled (percutaneous) Central Venous Catheters (CVCs), tunneled CVCs (Hickman™ lines), Peripherally inserted CVCs (PICC) and Totally implantable vascular access devices (TIVAD) should be flushed with sodium chloride 0.9%. See – Central Venous Devices Care and Management.

Certain devices eg: femoral catheters at increased risk of thrombosis and persistent withdrawal occlusion. They should be flushed routinely with sodium chloride 0.9% but if catheter occlusion problems are ongoing, using a lock of high dose heparin solution may be required ie: heparin 5000 international units/ml. In this instance heparin must be prescribed and administered by a registered practitioner.

8.25.3 Dextrose 5%
Occasionally is necessary to administer dextrose 5% flushes to patients before and after the administration of intravenous medication that is incompatible with sodium chloride. Registered practitioners who are appropriately trained in the intravenous administration of medicines may administer dextrose flushes. The Trust accepts that dextrose flushes are administered to patients without a prescription and that such administration is not formally documented on a prescription chart or EPMA record. Inpatients receiving intravenous medication should have the flushes recorded on the fluid balance chart.

Non registered practitioners are not permitted to administer dextrose flushes to patients.

8.26 Process for Patient Self-administration of medicines
Self-medication is where the patient is completely responsible for taking his or her own medicines.

Patients may self-medicate provided they have been assessed as fit to do so and their medication has been assessed by a registered nurse using the Self Administration of Medication Patient Assessment form.

The following medication is deemed unsuitable for self administration and must always be administered by a registered practitioner:
- controlled drugs
- intravenous medication
- intramuscular medication
- parenteral SACT

Which medication an individual patient may self administer will differ according to patient ability and preference. It is the responsibility of the nursing staff the make sure they and the patient understand which medicines have been deemed suitable for self-administration.

The majority of patients will be prescribed both medication that is suitable for self administration and medication that is not suitable for self administration. This is not a contraindication to participation in the self administration of medication scheme. However, any patient who is self administering any of their prescribed medication must have been assessed as competent to do so.

All patients will be assumed to be unable to self medicate all prescribed medication (Category B) unless the self medication assessment documentation has been completed.
Patients' must be reassessed if their ability to self medicate changes. This reassessment may be undertaken at any time at the discretion of the nursing staff. Reassessment must be documented on the Self Administration of Medication Patient Assessment form.

8.26.1 Self-Medication categories

Category A - Patients fully able to self-medicate
A fully labelled supply of all regular medication is stored in the PODs locker with the exception of CDs or items that must be stored in the fridge. The patient will be instructed how to access the PODs locker by means of a 4 digit code. The patient is fully responsible for the security and administration of his or her own medicines.

See – Self Administration of Medicines Patient Information Sheet and Keypad lock Patient User Guide

All medications must be prescribed on the Trust approved in-patient prescription chart or JAC EPMA system.

When a clinical decision has been made to discontinue a medication the patient must be informed immediately and consent gained to dispose of the medication if it is their property. If the medication is to be withheld the patient must be informed immediately not to self administer the medication.

The registered nurse caring for the patient still has ultimate responsibility to ensure that the patient has taken medication as prescribed and documented administration on the medication chart or EPMA record. The nurse must continue to monitor patients for compliance and side effects.

For patients with handwritten prescriptions: the registered nurse must write “11” on the prescription at the appropriate times once they have confirmed with the patient that the correct medicines have been taken.

For patients with a JAC EPMA record: the registered nurse must document the drug as ‘not administered’ with the reason for non-administration being “11” self administered once they have confirmed with the patient that the correct medicines have been taken.

Category B - Patient unable to self-medicate
Fully labelled supplies of all regular medicines are stored in the POD locker with the exception of CDs or items that must be stored in the fridge. A registered nurse administers the medicines to the patient at the appropriate times from the supply in the POD locker.

Provided the patient understands and agrees not to self medicate they may use a 4 digit code to access the POD locker for the purpose of storing valuables. Where it is deemed to be a risk to the patient, the patient will have no access to the PODs locker without the direct supervision of a member of nursing or pharmacy staff.

The prescription chart must be signed in the normal way by the registered nurse administering the medication.
Self-administration of medication Patient Assessment Form

Please complete all sections clearly in ink using a new form for each admission

<table>
<thead>
<tr>
<th>Name</th>
<th>Hosp no</th>
<th>DOB</th>
<th>Ward/Dept</th>
</tr>
</thead>
</table>

(Attach patient identification label)

SECTION 1

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the medication suitable for self medication?</td>
<td></td>
</tr>
<tr>
<td>Is the patient physically and mentally capable of self-medicating? <em>(i.e. reach the medicine cupboard, unlock the cupboard, open child resistant lids? Not confused, no concerns regarding drug / alcohol abuse)</em></td>
<td></td>
</tr>
<tr>
<td>Does the patient self-medicate at home?</td>
<td></td>
</tr>
<tr>
<td>Does the patient wish to self-medicate in hospital?</td>
<td></td>
</tr>
</tbody>
</table>

If yes to all the above - Category A – this patient can self medicate – document status in table below then go to section 2

If no to any of the above - Category B – this patient cannot self medicate – document status in table below

<table>
<thead>
<tr>
<th>Date of assessment</th>
<th>Category</th>
<th>Assessed by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Designation</td>
</tr>
</tbody>
</table>

SECTION 2

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| Have the patient’s own medicines been assessed as suitable for use?  
*See criteria for PODs* |
| If medicines unsuitable or new items required have these been supplied from pharmacy?  *(it is not acceptable to use ward stock or items obtained from the Emergency Drug Cupboard for self administration by patients)* |
| Has the self-medication scheme been explained to the patient? |
| Has the patient given verbal consent? |
| Have the various medicines available to the patient been explained, including indication, dose and side-effects? |
| Does the patient understand fully about all the medicines he/she is taking? |

If yes to all of the above the patient may commence self medication

*This form must be filed with nursing documentation*
9.0 SAFE DISPOSAL AND RETURN OF MEDICINES NO LONGER REQUIRED BY THE CLINICAL AREA

9.1 Safe Disposal of Medicines
Pharmaceutical waste must be disposed of by incineration in approved containers at high temperatures in order to completely destroy all potentially harmful substances. The clinical pharmacy technician team will manage the safe disposal and return of medicines no longer required by a clinical area.

Exceptions to this are:
- expired medicines
- part used medicines that would pose a health and safety risk if transported to pharmacy e.g. opened vials and ampoules, part used infusion bags or syringes, dropped tablets/capsules. These items must be immediately disposed of in a sharps bin or a clinical waste bag.

9.2 Pharmacy returns bins
Green tamper evident returns bins are available on all inpatient wards.

The returns bin should be located within the restricted swipe card access medicines storage area or treatment room.

If the returns bin is not located within a restricted swipe card access medicines storage area then the bin must be attached to the wall or otherwise immobilised to prevent unauthorised removal.

The keys are held by the clinical pharmacy technician team.

The clinical pharmacy technician team are responsible for emptying the returns bins on a regular basis.

Should the returns bins need to be accessed eg: if an item has been placed into the returns bin in error the clinical pharmacy technician team must be contacted on extension 8371 during pharmacy opening hours to access the bin. Out of hours the on call pharmacist does not have access to the returns bins.

9.3 Medicines that have been dispensed for an individual patient

9.3.1 Inpatient areas
If the patient is no longer on the ward, check on CWP whether the patient has been transferred to another ward within the Trust, if so arrange for transfer of medication. If the patient is no longer an in-patient within the Trust or the medication is no longer required place the medicines in the pharmacy returns bin.

The only exception is medication from a barrier nursed patient which must be disposed of on the ward. Solid dosage forms to be disposed of should be placed in a sharps bin or a clinical waste bag. Liquids dosage forms including injections and infusions should be emptied down the sluice.

9.3.2 Daycase/outpatient areas
If the medication is no longer required this should be returned to pharmacy as soon as possible.

9.4 Patients Own Drugs

9.4.1 Inpatient areas
Patient’s own drugs should be returned to them or their relatives to take home. However if this is not possible, patients’ own drugs which are no longer required should be placed in the pharmacy returns bin.

The only exception is medication from a barrier nursed patient which must be disposed of on the ward. Solid dosage forms to be disposed of should be placed in a sharps bin or a clinical waste bag. Liquids dosage forms including injections and infusions should be emptied down the sluice.
9.4.2 Daycase/outpatient areas
The patient should be contacted to inform them that they have left their medication and either arrange for collection or confirm that the patient is happy for this to be disposed of.

Medication awaiting collection by the patient must be stored appropriately.

Solid dosage forms to be disposed of should be placed in a sharps bin or a clinical waste bag. Liquids dosage forms including injections and infusions should be emptied down the sluice.

9.5 Fridge Items
Fridge items must never be placed in the returns bin and must be stored in the medicines fridge until such time as they can be returned to the pharmacy by hand.

9.6 Expired Medicines
All expired medicines, including contrast media, should be disposed of on the ward/department. Solid dosage forms to be disposed of should be placed in a sharps bin or a clinical waste bag. Liquids dosage forms including injections and infusions should be emptied down the sluice.

9.7 Clinical trial medicines
Retention of dispensing containers and unused doses is required by some clinical trials for accountability. This requirement will be documented in the clinical trial protocol if applicable. There is a returns bin located within the Clinical Trials dispensary in the Oak Road Treatment Centre for the return of containers and unused doses that are returned by patients.

Clinical trial medication that is not required to be retained for accountability may be disposed of as per all other medication.

9.8 Empty Containers
Empty medicine containers must not be returned to the pharmacy department. These should be placed in the appropriate glass, plastic or household waste bin. Liquid bottles must be drained before placing into the glass bin.

Ensure that patient names are obliterated from empty containers before disposal.

9.9 Controlled Drugs
See - Controlled Drugs

9.10 Cytotoxic Waste
See – SACT

9.11 Defective Medicines
Adverse incidents relating to a defective medicinal product should be reported immediately to pharmacy who will notify Quality Control North West. Products should be retained and quarantined unless there is a significant threat to patient and staff safety e.g. leaking cytotoxic infusion.

9.12 Notification of drug defect from the MHRA
When defects present a significant hazard to health, the MHRA Defective Medicines Reporting Centre will usually issue a drug alert letter. This is disseminated through the Regional Quality Control North West to the Trust pharmacy department for appropriate action (via fax and email during working hours or if out of hours the on call pharmacist will be informed through the telephone cascade system).

Local dissemination of relevant MHRA drug safety warnings and appropriate action to be taken are cascaded through the organisation via the Medical Director, The Director of Nursing and Quality and the Director of Pharmacy to the relevant individuals.
10.0 CONTROLLED DRUGS
10.1 Definition of Controlled Drugs
For the purposes of this policy the term ‘Controlled Drug’ is used to describe all schedule 2 Controlled Drugs that are subject to requirements for prescription writing, safe custody and written registers.

The following comprise the schedule 2 controlled drugs used within the Trust:
- Alfentanil
- Amfetamine
- Cocaine
- Codeine (only in injectable form)
- Diamorphine
- Dipipanone
- Fentanyl
- Hydromorphone
- Ketamine
- Methadone
- Methylphenidate
- Morphine
- Oxycodone
- Pethidine
- Secobarbital

The above list is not exhaustive. Always refer to the United Kingdom Misuse of Drugs Act 1971 and associated amendments to determine the legal status of any controlled drug.

In addition the following preparations are subject to requirements for prescription writing, safe custody and written registers within the Trust:
- Buprenorphine
- Morphine sulphate 10mg/5ml oral solution
- Phenobarbitone
- Sativex® (27 mg delta-9-tetrahydrocannabinol and 25 mg cannabidiol per milliliter)
- Temazepam
- Tramadol

Sativex® will be stored in a standard medicines fridge within the pharmacy department. The drug has an expiry of 42 days at room temperature. Once dispensed for individual patient use it may be stored at room temperature in the ward CD cupboard. An appropriate expiry date will be indicated by the pharmacy department at the point of dispensing.

Midazolam is a schedule 3 CD that are subject to requirements for prescription writing but not safe custody or written registers.

All other schedule 3, 4 and 5 CDs are exempt from the prescription, safe custody and written register requirements as per the United Kingdom Misuse of Drugs Act 1971.

Any drug may be permanently or temporarily subjected to prescription, safe custody and written register requirements within the Trust at the discretion of the director of pharmacy and director of nursing.

Strong solutions of potassium chloride (e.g. 20mmol potassium chloride in 50ml 0.9% sodium chloride) should be managed as CDs within authorised areas. This applies to the ordering, receipt, storage, administration and disposal. For further guidance regarding available preparations, dilution and administration of intravenous potassium solutions see Intravenous potassium.

10.2 Accountable Officer
NHS bodies are required to appoint an accountable officer to monitor the use of controlled drugs within their organisation and take appropriate action where necessary.
The Accountable Officer’s responsibilities are set out in the Controlled Drugs Regulations (Regulations 8-16) and require that he or she be a suitable person who does not routinely supply/administer or dispose of controlled drugs as part of his or her duties.

The regulations also require Accountable Officers to complete a periodic declaration. A self assessment of CD management will be completed, including the availability of appropriate Standard Operating Procedures.

The Accountable Officer for The Christie NHS Foundation Trust is the Director of Pharmacy.

10.3 Registered Nurse in Charge
The registered nurse in charge of a ward, department or theatre is responsible for the requisition, receipt, storage and documentation of controlled drugs for use in that area. Even if the ward/department/theatre is managed by someone other than a nurse, the most senior registered nurse present is responsible for controlled drugs.

The registered nurse in charge can delegate these tasks to another registered practitioner. However legal responsibility remains with the registered nurse in charge.

10.4 Standard Operating Procedures
It is a legal requirement to have Standard Operating Procedures (SOPs) in place for the management of Controlled Drugs (CDs) within the Trust.

These SOPs have been included as part of this Medicines Practice Operational Policy in order that all guidance relating to the management of CDs by wards and departments can be found in one location.

These SOPs have been approved by the Accountable Officer as they are accountable for all systems for the safe management of CDs within the Trust. They must also ensure that all staff are aware of these SOPs as part of a training programme.

A separate set of pharmacy SOPs is in place covering responsibilities within the pharmacy and the interface with wards/departments/patients and external agencies. These procedures include details of stock control/security, issue and supply to patients, control of CD stationery and signature verification.

Clinical guidance relating to the prescribing of controlled drugs (i.e. pain and symptom control clinical guidance, acute pain guidelines) are covered by separate guidelines available on the Trust intranet.

10.5 Prescribing Controlled Drugs
Controlled Drugs must be prescribed in accordance with the prescribing section of this policy; in addition the prescriber must adhere to the following:

10.5.1 Prescribing for out-patients and on discharge
Prescriptions for Controlled Drugs are valid for 28 days from either the date of prescribing or a "valid from" date specified by the prescriber on the prescription.

Prescriptions for out-patients should be limited to a maximum of 30 days supply. If a longer period is required the reasons for this must be recorded on the prescription.

Prescriptions for out-patients and discharges must contain all the required information in accordance with the Misuse of Drugs Regulations:

- Patients full name and address (if addressograph stickers are used they must be countersigned by the prescriber)
- Name of Drug – it is recommended that CDs are prescribed using the brand name
• Form
• Strength
• Total quantity of dose units in words and figures
• Directions – including dose and frequency

Prescriptions with minor technical errors may be amended by a pharmacist (e.g. if one of the requirements for words and figures has not been included).

Should a patient who receives an out-patient/discharge prescription containing controlled drugs be travelling abroad, they may need a Home Office export licence depending on the amount. Applications should be supported by a letter from the prescribing doctor and sent to the Home Office.

Where a printed electronic CD prescription is presented for dispensing the prescription must be signed and dated in indelible ink by the prescriber recorded on the prescription. Electronic signatures alone are not acceptable for CD prescriptions.

A list of the CDs stocked by the Trust and associated strengths and packs sizes is available on the pharmacy homepage. Examples of how to complete CD prescriptions are also available.

10.5.2 Prescribing for in-patients
CDs for inpatients can be prescribed and administered from the inpatient medication chart or EPMA system without the need for full prescription requirements expected for an outpatient/discharge prescription.

10.6 Non Medical Prescribers
10.6.1 Independent Non-Medical Prescribers
Independent nurse & pharmacist prescribers can prescribe or direct other nurses to administer any controlled drug listed in schedules 2-5 for any medical condition within their competence, except diamorphine, cocaine, and dipipanone for the treatment of addiction (Independent prescribers are able to prescribe other CDs for the treatment of addiction).

10.6.2 Supplementary Non-Medical Prescribers
Supplementary prescribers can prescribe and administer any CD for any indication as long as it is within the Clinical Management Plan specific to that patient and agreed between the independent prescriber, the supplementary prescriber and the patient.

10.7 Patient Group Directions
Only the following CDs can be included within a PGD:
  • All substances on schedule 5
  • All substances on schedule 4 (with the exclusion of anabolic steroids)
  • Midazolam (schedule 3)
  • Diamorphine or morphine (schedule 2) by nurses or pharmacists for the immediate necessary treatment of sick or injured persons

10.8 Procedure for ordering CDs for ward/department stock
Controlled Drugs must be ordered directly from pharmacy, NOT from other wards departments or external agencies.

Controlled Drugs must be ordered for ward stock using the official controlled drug order book for that ward/department.

The CD order book and CD returns book must be kept in a locked place, and if missing the nurse in charge must inform the both the divisional matron or service manager and the ward pharmacist, senior clinical pharmacy technician or on call pharmacist and complete a clinical incident form.
In an emergency, where the CD order book cannot be accessed, orders may be placed in an ‘ad hoc order book’ which is issued from pharmacy.

Use a separate page for each item and place the card divider in between subsequent orders to prevent the duplicate copy transcribing through to the next order sheet.

Orders must contain the following details:
- Trust name
- Ward/department
- Drug name, form, strength, ampoule size (if more than one available)
- Total quantity
- Signature of registered nurse/pharmacist
- Printed name of registered nurse/pharmacist
- Date of the order

The completed order book must be sent to pharmacy for dispensing.

Only authorised nursing staff and pharmacists can sign orders for controlled drugs for ward stock. Authorisation of nursing staff is given by the ward manager. The completed authorisation sheet must be retained in the front of the CD order book.

The registered nurse in charge of a ward/department is responsible for the requisitioning of CDs for use in that area. If the ward/department is managed by someone other than a nurse the most senior registered nurse present is responsible for the CDs.

The registered nurse in charge can delegate the task of ordering CDs to another authorised individual but the legal responsibility remains with the registered nurse in charge.

CD top-up schemes are run by the clinical pharmacy technician team; the registered nurse in charge should sign the orders and the pharmacy staff must transfer the book to pharmacy.

The Omnicell cupboards generate automatic orders for CDs that are printed in pharmacy. These orders are checked and transcribed into the CD order book by a clinical pharmacy technician. The order number of the Omnicell printout is documented against the corresponding requisition. The order books are signed by the registered nurse in charge from the relevant ward.

10.9 Procedure for the Delivery / Collection of Controlled Drugs

CDs for ward use and discharge prescriptions may only be delivered by pharmacy staff/porters or collected by ward staff in a CD bag with a numbered tamper evident seal.

Each CD bag has a specific CD delivery log book contained within the front pocket of the bag. The CD bags and the CD delivery log books are specific to each ward for audit purposes. Larger wards or those with frequent patient turnover may have two bags to facilitate the need for frequent deliveries. On no account are bags and books inter-changeable.

Trust employees wearing a Trust identity badge may collect CDs from pharmacy.

Student Nurses on placement within the Trust must produce a photographic university identity badge.

In all cases, a signature must be obtained in the pharmacy CD collection log book on handover of a CD bag. The person responsible for transporting the CDs must then sign the CD delivery log book. The identification number of the tamper evident seal used must be recorded in the CD delivery log book.
Once in receipt of the CD bag, the member of staff must go directly to the ward and hand the bag to the nurse in charge or other designated CD keyholder for formal receipt of the CDs. The nurse receiving the CDs must sign the CD delivery log book, confirming that the bag is sealed with the correctly numbered tamper evident seal.

Outpatient prescriptions do not need to be contained in a locked CD bag. The identity of the person collecting a CD for an individual out-patient from the Pharmacy i.e. patient representative or healthcare professional must be recorded and documented in the pharmacy CD register.

10.10 Procedure for the receipt of CDs by wards/departments
Only registered practitioners can receive controlled drugs.

The drugs must immediately be entered into the CD register and the entry and balance checked and countersigned by a second authorised member of staff (including CDs for discharge).

On receipt of CDs the integrity of seals on the packaging MUST be checked.

Original packs with a fully intact seal can be assumed to contain their stated contents.

If there is any doubt at all about the integrity of the seal then the box must be opened and the contents verified.

The stock balance of the CD being received should be checked before entry of the receipt is made in the CD register.

The entry must include:
- Date
- Requisition number
- Quantity received
- Signature of the receiver
- The new stock level
- Signature of the witness

To confirm that the drugs received match the order request form, both members of staff must then sign the lower duplicate page of the requisition.

10.11 Controlled Drug Registers
All wards and departments where controlled drugs are stored must maintain a CD Register.

Only one CD register should be in use at any one time.

Theatres: Theatres have designated CD registers specifically designed for theatre use. There should be a separate CD register for each theatre or area within a theatre eg: recovery.

Registers must be bound (not loose leaf) with sequentially numbered pages.

A separate page must be allocated to each product identifying the name, strength and formulation of the drug.

An up to date index must be maintained at the front of the register.

Each transaction should be ruled off and balanced. If more than one page is needed for one requisition, amounts should be totalled and the stock balance should be carried forward to a fresh page.

The following information should be annotated at the bottom of the completed page:
- The new page number where the balance is recorded
- The date the balance was transferred
- The signature of the staff member who transferred the stock balance
- The signature of a second authorised member of staff acting as a witness
- The balance that was carried forward

The following information should be documented on the new page:
- The name, strength and formulation of the drug.
- The page number where the balance is transferred from
- The date the balance was transferred
- The signature of the staff member who transferred the stock balance
- The signature of a second authorised member of staff acting as a witness
- The balance that was carried forward

In addition, the new page number should be documented in the index at the front of the register.

No cancellation, obliteration or alteration of any entry may be made.

Corrections must be made by way of marginal notes or footnotes which must be dated.

Errors in the register are to be bracketed and endorsed “error”, signed and as good practice countersigned by a witness.

Every entry and correction must be in black ink or be otherwise indelible.

Every member of staff must document their name, designation and signature in the designated ‘specimen signatures’ section of the CD register the first time they write in a new CD register.

10.12 Procedure for checking the balance of Controlled Drugs
The stock balance of all CDs entered into the CD register, including patient’s own, must be checked and reconciled with the amounts in the cupboard, as a minimum, on a weekly basis. This must be undertaken by a registered member of staff and witnessed by another trust employee. This must be documented in the designated ‘stock check’ section of the register, with date, time and signature of both staff.

All expiry dates must also be checked, as a minimum, weekly and any drugs with short expiry must be identified and prioritised for use.

In addition stock balance checks of individual items must be made every time there is stock movement of a CD.

Discrepancies must be reported to the registered nurse in charge, investigated immediately (see below) and other parties contacted e.g. pharmacy and divisional matron if not resolved – up to a 10% discrepancy is considered acceptable in the case of liquids.

In addition, reconciliation of register balances against CD cupboard stock, a sample of entries made against corresponding CD requisitions and completion of documentation in the CD register will be carried out every 3 months by pharmacy staff.

10.13 Procedure to be followed on discovering a stock balance discrepancy (including loss and diversion)
On identifying a discrepancy this must be immediately reported to the most senior nurse on duty at that time.

The registered nurse in charge MUST:
- Check that all requisitions received have been entered into the correct page of the register.
▪ Check that all CDs administered have been entered correctly into the CD register ie: the correct dose, item, strength and page number
▪ Check that CDs have not been accidentally put into the wrong place in the cupboard.
▪ Check the arithmetic to ensure that balances have been calculated correctly.

If the error or omission is traced, the registered nurse in charge should make an entry in the CD register, clearly stating the reason for the entry and the corrected balance. This entry must be witnessed by a second nurse, pharmacist, pharmacy technician or doctor. Both persons must sign and date the CD register.

10.13.1 If the reason for the discrepancy cannot be identified by ward staff:
Report the incident via Datix immediately

In addition, the discrepancy must be reported to the divisional matron and the senior clinical technician or the ward pharmacist within 24 hours.

Where a discrepancy is identified at a weekend or Bank Holiday the senior nurse on duty/duty manager and on call pharmacist must be informed within 24 hours.

These staff must then undertake an independent check of the transactions of the CD involved, within 48 hours of the discrepancy being identified. A review of other CDs on the ward and inpatient prescription charts may be necessary.

If the error or omission is traced the staff undertaking the independent check must make an entry in the CD register, clearly stating the reason for the entry and the corrected balance. Both persons must sign and date the CD register.

Daily CD balance checks must be conducted on the ward for a minimum of two weeks

The senior clinical technician will complete a pharmacy log following notification of the discrepancy. In addition, all missing CDs are reported to the North West Controlled Drug Forum for monitoring purposes.

10.13.2 If the reason for the discrepancy cannot be identified by the independent check:
The staff undertaking the independent check must report the incident to the Director of Pharmacy or delegated deputy within 24 hours.

The Director of Pharmacy or delegated deputy will immediately notify the Director of Nursing & Quality, the security officer and the Deputy Chief Operating Officer for the division who will jointly decide on the next course of action. This may entail some or all of the following:
▪ A complete recount of all CD
▪ A thorough examination of the CD registers, reviewing all transactions back to a point in time when levels where known to be correct.
▪ A list of nurses/registered practitioners working in that area from the date of the last correct entry
▪ Notification to the police

10.14 Procedure for the storage of Controlled Drugs and management of Controlled Drugs keys
The Misuse of Drugs Regulations set out standards for cupboards used to store CDs. Ward CD cupboards should conform to BS2881 as a minimum standard or be otherwise approved by pharmacy.

All CDs must be stored in a locked receptacle which can only be opened by a person who can lawfully be in possession of the keys e.g. registered practitioner, pharmacist or a member of staff working under their authority e.g. pharmacy technician.
The controlled drug cupboard must be kept locked when not in use.

The controlled drug cupboard must only be used for the storage of controlled drugs (ward stock, temporary ward stock, CD discharge medicines and patients own CDs) and not for any other medication or items. CD discharge medicines and patients own CDs should be segregated from ward CD stock and clearly marked as such. Discharge medicines should remain in a separate bag.

The CD key must not be common to any other key in the hospital. The CD keys must be held separately from other drug cupboard keys and must not be labelled or in any way identifiable as CD keys. The CD keys must be held on the person of an authorised CD key holder i.e. not in a drawer.

Duplicate keys to medicines cupboards are stored in the security department and accessed through the duty manager or night manager.

The nurse in charge of the ward or department is accountable for the safe management of the CD keys.

The nurse in charge of each shift must ensure the keys are handed over to the next nurse in charge at the changeover of each shift.

10.14.1 Procedure for the safe management of CD keys when wards/departments close
It is acceptable for the CD keys to remain within a closed ward/department provided that the CD keys are locked within a designated key cupboard or safe within a locked and alarmed ward/department.

Should a ward/department close that has no key cupboard to facilitate the safe storage of the CD keys whilst the ward/department is closed the CD keys must be returned to security.

10.14.2 Action to be taken if the CD Key is lost
On identifying that the CD key is missing immediately report to the most senior nurse on duty at that time.

The registered nurse in charge MUST:
  ▪ Check with all staff currently on duty if they are in possession of the key or when they last had possession of the key.
  ▪ Check the ward area.
  ▪ Check the last entry in the CD register to determine the name and time that the last member of staff to access the CD cupboard.
  ▪ Contact staff members from the previous shifts to verify if they are in possession of the key.

If the CD keys have been off site at any point the Director of Pharmacy or their deputy must be informed the next working day and a decision about whether the locks must be changed must be made.

10.14.2.1 If the CD key cannot be accounted for after contacting all staff and searching the ward area:
Report the incident via Datix immediately

In addition, the loss must be reported to the divisional matron and the senior clinical technician or the ward pharmacist immediately.

Where the loss of keys occurs out of hours the senior nurse on duty/duty manager must be informed immediately.

These staff must then
- assure themselves that all necessary steps have been taken to locate the keys.
- assure themselves that there are no controlled drug discrepancies

If the CD keys have been off site at any point the Director of Pharmacy or their deputy must be informed the next working day and a decision about whether the locks must be changed must be made.

10.14.2.2 If the CD key still cannot be accounted for after an independent investigation
The loss of keys should then be escalated to the Director of Pharmacy (or their deputy) within 24 hours.

At weekends and Bank Holidays the loss should be escalated to the on-call pharmacist and the on-call executive within 24 hours.

The Director of Pharmacy or delegated deputy will immediately notify the Director of Nursing & Quality, the security officer and the Deputy Chief Operating Officer for the division who will jointly decide on the next course of action. This may entail some or all of the following within 48 hours:

▪ A complete recount of all CDs
▪ A decision as to whether to replace all locks
▪ Notification to the police

The loss of keys MUST be reported via the Regional Accountable Officers reporting network (this will be undertaken by the pharmacy team).

Should the decision be made not to replace all locks then daily CD balance checks must be conducted on the ward for a minimum of two weeks.

10.15 Procedure for the management of Patients Own Controlled Drugs
Patients own CDs should be returned home with the patient’s consent. Responsibility for this must be given to an adult relative or carer.

Medicines that have expired or are not appropriate to use should be returned to the pharmacy for safe destruction with the patient’s consent. See Return of controlled drugs

If a patient dies, CDs belonging to that patient cannot be legitimately handed back to a relative and must be disposed of via pharmacy.

Temporary storage of patient’s own CDs on the ward may be necessary whilst they are awaiting collection and removal to the pharmacy or to the patients home. In this situation, they should be stored in the ward CD cupboard, clearly marked, kept separate from ward stock and documented in the relevant section of the ward controlled drug register.

On removal they should be signed out of the ward controlled drug register.

In exceptional circumstances where patient’s own CDs are required (e.g. pharmacy do not stock or pharmacy is closed), the drugs should be checked for suitability according to Trust policy for use of patient’s own medicines.

They should be entered in the specific section of the CD register for active use. A single page must be used for the management for each preparation for each individual patient. The patient’s name must be recorded at the top of the page along with the name, form and strength of the preparation. The drugs must be checked and booked out of the CD register using the same procedure as for ward CD stocks.

Any patient’s own CDs stored in the ward CD cupboard must be transferred with the patient should they transfer to a different ward or department following the appropriate procedure.
Any patient’s own CDs stored in the ward CD cupboard must be returned to the patient on discharge following the appropriate procedure.

10.16 Procedure for the administration of Controlled Drugs
Administration must be in accordance with the Trust Medicines Administration Procedures.

CDs must be administered from ward/departmental stock.

There must always be two registered members of staff involved in the administration of a controlled drug, i.e. a registered nurse, doctor or pharmacist.

The stock balance in the CD register must be checked against the quantity in the CD cupboard before preparation of the dose to ensure all balances are correct.

The CD must be prepared by a registered practitioner, doctor or student under the supervision of a registered practitioner and checked by a second person deemed competent (as above) before administration.

The person administering the drug must complete the entry in the CD register and sign it after the drug has been administered.

The second person must sign the CD register to confirm that the procedure (preparation, administration, appropriate disposal of any surplus or refused drug) has been correctly carried out and recorded.

All oral liquids must be measured using an oral medicine syringe and bottle bung to ensure accuracy and minimise discrepancy

Each entry must clearly state:
- The patient’s full name
- The date and time of administration
- The dose
- The quantity of drug wasted, if relevant
- The running balance
- The signature of the person administering the drug
- The signature of the person performing the second check

Should a dose/part dose be wasted an authorised member of staff must witness the destruction. The destruction of the wasted dose must be documented in the CD register and signed by the witness.

If a dose is made up of two presentations of the same drug then two entries are required in the CD register, each entry giving the patient’s total dose as well as the quantity/dose booked out for that item.

Theatres: the practice of issuing “active stock” to the anaesthetist and then returning the unused portion to stock, recording both issues and returns in the theatre CD register, should be avoided. An amount should be issued to the anaesthetist for a specific patient and any surplus drug should be destroyed and witnessed.

10.17 Procedure for the recording of patient specific multi-dose devices eg: Pecfent®
On receipt of a patient specific multi-dose device enter the device into the register on the designated page for that preparation listing the amount as the total number of doses contained within the device.
For infection control purposes each device, once in use, may only be used by a single patient and may not be transferred between patients. Therefore, once it is required the device must be labelled with the patient’s name and hospital number.

The in use device must be transferred to a separate patient specific page of the CD register. The patient's name must be recorded at the top of the page along with the name, form and strength of the preparation. The quantity must be recorded as the total number of doses contained within the device.

Each dose must be documented in the register as it is administered to the patient, following the usual procedure.

10.18 Patient self administration of CDs
In patients are not permitted to self administer CDs.

10.19 Procedure for Out of Hours supply of Controlled Drugs
Under current regulations a registered nurse in charge can only supply CDs to a patient undergoing treatment on that ward or department.

There is no circumstance under which CDs should be supplied for the treatment of a patient on a different ward or department when the pharmacy department is open. The CDs required must be obtained from pharmacy.

If a CD is required by a patient out of hours that is not available on the ward the on call pharmacist must be contacted.

The on call pharmacist may choose to attend the hospital to supply the CD to the ward/department.

Alternatively the on call pharmacist may authorise the out-of-hours supply of a dose to another ward/clinical area.

10.19.1 Transfer of stock CDs between wards/departments
Wards/departments must never supply doses for administration to patients on other ward/departments without the authorisation of the on call pharmacist.

Wherever possible a full strip or container displaying the batch number and expiry date should be transferred.

The CDs should be transferred from ward to ward in a sealed CD transfer bag.

A registered nurse should check and document the transfer of CDs in the CD register. This must be witnessed by a second member of staff and include

- The date, time and destination of transfer
- The name, strength and quantity of medication
- The running balance
- The signature of the person removing the drug
- The signature of the person performing the second check

A duplicate copy CD transfer note must be completed in the CD returns book by the two nurses. This must include:

- The date
- The name, form and quantity of each drug
- The reason for transfer
- The identity of the supplying ward and of the receiving ward
- The serial number of the CD transfer bag
• The signature of the registered nurse
• The signature of the practitioner performing the second check

The primary copy from the CD return book should be placed in a CD transfer bag with the CDs. The bag should be sealed and labelled and handed to the member of staff from the receiving ward.

The duplicate copy will be retained in the ward CD returns book.

On arrival at the receiving ward, a registered nurse should immediately check the CDs against the copy list and book them in the CD register in the appropriate section following the appropriate procedure. This must be witnessed by a second member of staff.

The primary copy list should be retained by the receiving ward, stapled into the back of the CD register.

10.20 Procedure for the administration of CDs to patients in areas that do not routinely stock CDs
In exceptional circumstances, single doses of CDs may need to be administered to an out patient in an area that does not routinely stock CDs, nor do they have a CD register.

In this instance medication should be supplied from pharmacy on receipt of an outpatient prescription.

The identity of the person collecting a CD for an individual out-patient from the Pharmacy i.e. patient representative or healthcare professional must be recorded and documented in the pharmacy CD register.

Wherever possible only the dose required should be dispensed. If surplus medication is dispensed this remains the property of the patient.

Where possible, medication should be self administered by the patient.

Where this is not possible e.g. bolus injection, medication must also be prescribed on an authorised Trust prescription chart and administered by a registered practitioner, signed, dated and filed in the patient’s medical notes.

The administration should be witnessed by a second registered practitioner who must also sign the prescription chart.

Any wastage should also be documented on the prescription chart and countersigned by both registered practitioners.

10.21 Patient-controlled analgesia
For further information on the management of patient controlled analgesia, see - PCA policy

10.22 Epidural analgesia
For further information on the management of epidural analgesia, see - Epidural policy

10.23 Archiving of Controlled Drug records
The time periods for archiving CD documentation are:

<table>
<thead>
<tr>
<th>Documentation Type</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requisitions</td>
<td>2 years</td>
</tr>
<tr>
<td>CD registers</td>
<td>2 years from last entry</td>
</tr>
<tr>
<td>Extemporaneous prep worksheets</td>
<td>13 years</td>
</tr>
<tr>
<td>External orders/delivery notes</td>
<td>2 years</td>
</tr>
<tr>
<td>Prescriptions (inpatients)</td>
<td>2 years</td>
</tr>
</tbody>
</table>
10.24 Procedure for the return of Controlled Drugs to pharmacy

Any ward or department with CDs that are expired or no longer required should be returned to pharmacy.

It is the responsibility of the ward/department staff to notify pharmacy staff that CDs need to be returned to pharmacy. Pharmacy staff must then remove the CDs within 7 days.

This includes patient’s own CDs which MUST NOT be destroyed on the ward/department.

An entry must be made on the relevant page of the ward/department CD register stating:
- The date
- The quantity
- The reason for return
- New stock balance
- The signature of the pharmacist
- The signature of the practitioner performing the second check

All wards and departments where controlled drugs are stored must have a CD returns note book. A duplicate copy CD returns note must be completed by the pharmacist and the practitioner when CDs are returned to pharmacy. This must include:
- The date
- The ward/department
- The name, form and quantity of each drug
- The reason for return
- The serial number of the CD transfer bag (if used)
- The signature of the pharmacist
- The signature of the practitioner performing the second check

It is not necessary to complete a separate note for each drug returned.

The primary copy is detached and returned to pharmacy with the CD returns in either a CD bag closed with a tamper evident seal or a sealed CD transfer bag labelled ‘pharmacy returns’. The duplicate copy must remain in the CD returns note book.

10.25 Procedure for the destruction and disposal of Controlled Drugs

CDs must not be disposed of on the ward but must be returned to pharmacy for destruction and disposal.

The only exception to this is the disposal of doses prepared within the ward/department that are part used or not used.

Individual doses that are prepared and not administered/part administered should be destroyed on the ward/department by a registered practitioner in the presence of a second member of staff. This must be documented in the appropriate section of the CD register and signed by both persons.

The remains of partly used ampoules, liquid doses, single tablets, part used syringes and infusion bags should be emptied into a sharps bin. The emptied ampoule, syringe or infusion bag should also be placed in the sharps bin.
10.26 Procedure for the transfer of ward stock Controlled Drugs when a ward moves from one location to another
CDs should be transferred in CD bag(s) closed with a tamper evident seal with the order book, returns book and ward register.

All CDs should be checked against the stock balance in the CD register and placed into the CD bag(s). This must be documented in the register and witnessed by a second member of staff.

A registered nurse who transports the CDs is responsible for delivering the sealed CD bag(s) to the new location.

At the new ward location, the registered nurse must obtain a signature of receipt from a registered nurse. The CDs should then be checked in to the CD cupboard. This must be documented in the register and witnessed by both nurses.

10.27 Procedure for the transfer of ward stock Controlled Drugs to pharmacy when a ward closes
If the ward closure is only on a temporary basis e.g. several days and there is no reduction in security arrangements, the CDs should remain on the ward.

If the ward is going to be closed for a longer period of time or security cannot be assured, then all CDs, the order book, returns book and ward register must be returned to pharmacy.

All CDs should be checked against the stock balance in the CD register and placed in CD bag(s) closed with a tamper evident seal. This must be documented in the register and witnessed by a second member of staff. Each entry must be made on the relevant page of the ward/department CD register and include:
- The date
- The quantity
- The reason for return
- New stock balance
- The signature of the pharmacist
- The signature of the practitioner performing the second check

A duplicate copy CD returns note must be completed in the CD returns book by the two nurses. This must include:
- The date
- The ward/department
- The name, form and quantity of each drug
- The reason for return
- The signature of the pharmacist
- The signature of the practitioner performing the second check

A registered nurse who transports the CDs is responsible for delivering the sealed CD bag(s) to pharmacy.

The CDs will be assessed by pharmacy technician and either stored until the ward reopens, returned to pharmacy stock for reissue or assigned for destruction.

The CD order book, ward register and returns book will be retained in pharmacy for the requisite period.

Should the ward reopen, the CD order book, ward register and returns book must be collected from pharmacy and a new supply of CDs requisitioned.
The primary copy from the CD returns book must be retained in pharmacy.

10.28 Procedure for patient transfers between wards, departments or theatre to ward
The transfer of patient CDs is most likely to arise in the following situations:

- When a patient is receiving a CD via an infusion device
- When a patient has his/her own CDs
- When a CD has been dispensed on a “named-patient” basis
- When a CD has been dispensed for discharge

10.28.1 Patients receiving CDs via infusion devices (includes PCA, epidural, syringe drivers)
The registered nurse receiving the patient must check the label on the syringe matches the prescription, the device settings and the remaining volume. This must be done in conjunction with the transferring nurse and documented on the prescription.

10.28.2 Patients own CDs/Named patient CDs/Discharge CDs
The CDs should be transferred from ward to ward with the patient in a sealed CD transfer bag.

A registered nurse should check and document the transfer of CDs in the CD register. This must be witnessed by a second member of staff and include:
- The patient’s full name
- The date, time and destination of transfer
- The name, strength and quantity of medication
- The running balance
- The signature of the person removing the drug
- The signature of the person performing the second check

A duplicate copy CD returns note must be completed in the CD returns book by the two nurses. This must include:
- The date
- The name, form and quantity of each drug
- The reason for transfer
- The identity of the supplying and the identity of the receiving ward
- The serial number of the CD transfer bag
- The signature of the registered nurse
- The signature of the practitioner performing the second check

The primary copy from the CD return book should be placed in a CD transfer bag with the CDs. The bag should be sealed and labelled with the patient’s addressograph sticker.

The duplicate copy will be retained in the ward CD returns book. On arrival at the receiving ward, a registered nurse should immediately check the CDs against the copy list and book them in the CD register in the patient’s own CD section following the appropriate procedure. This must be witnessed by a second member of staff.

The primary copy list should be retained by the receiving ward, stapled into the back of the CD register.

10.29 Procedure for dealing with suspected illicit substances and patients suspected of drug abuse
If a patient is found to be in possession of CDs which have not been prescribed for them or suspected illicit substances, they must not be destroyed but removed, placed into a sealed envelope, labelled ‘suspected illicit substance’ and locked in the CD cupboard.

The same procedure should be followed for CDs or suspected illicit substances that are found within the hospital of unknown origin.
An entry must be made in the Patient’s Own Drugs section of the ward CD register. This must include:
- The date and time
- ‘Suspected illicit substance’
- The signature of the practitioner making the entry
- The signature of the practitioner performing the second check

The patient’s name, if known, must **NOT** be recorded. The patient’s confidentiality should be maintained and the police will be called in to witness the destruction and disposal in pharmacy on the understanding that there will be no identification of the source.

The ward pharmacist, senior clinical pharmacy technician or on call pharmacist and ward manager must be informed.

At the earliest opportunity the pharmacist or senior clinical pharmacy technician will remove the substance from the ward and securely retain in pharmacy for the police.

The duplicate copy CD returns book must be completed by the practitioner and the pharmacist when the substance is transported to pharmacy. This must include:
- The date and time
- The ward/department
- ‘Suspected illicit substance’
- The signature of the pharmacist
- The signature of the practitioner performing the second check

The primary copy from the CD return book should be placed in the CD transfer bag with the suspected illicit substance. The bag should be labelled ‘suspected illicit substance’ and returned to pharmacy.

The suspected illicit substance must also be signed out of the ward CD register. The entry must include:
- The date
- The statement ‘transferred to pharmacy’
- The signature of the pharmacist
- The signature of the practitioner performing the second check

The pharmacist may lawfully take possession of the suspected illicit substance for the purpose of destruction under the direction or supervision of the police. Under no circumstances should these substances be handed to other Trust personnel (who are not legally authorised) or be transported off site (eg: to hand in at a police station).

In circumstances where extreme quantities are found, this must be escalated to the director of pharmacy, divisional matron/service manager, and chief operating officer. In these circumstances it may be acceptable practice to identify the source. Advice from the Greater Manchester CD Liaison Officer would be sought in such cases.

It is not acceptable practice to hand illicit/unknown substances back to the patient on discharge since this may result in the person doing so being guilty of an offence of unlawful supply of a Controlled Drug.

If a patient does not give authority for the removal and destruction of the drug the hospital may be required to call in the police.
10.30 Suspected abuse of drugs amongst staff
If a member of staff suspects a colleague, including prescribing staff, of abusing any drugs, then they should confide their suspicions with a more senior staff member. See – Whistle blowing policy

All actions concerning this will be dealt with in a confidential way in accordance with the Alcohol and Substance Abuse policy.

10.31 Joint working between the Accountable Officer and the Local Counter Fraud Specialist
The Accountable Officer (AO), having assessed a concern regarding the use and management of CDs in any ward or department within the Trust, may decide that an investigation should be undertaken.

This could be undertaken by:
- The AO
- Another officer within the organisation
- An officer from another Responsible Body (eg Trust, PCT, SHA, CQC, police) - this could be a Local Counter Fraud Specialist (LCFS) or a Counter Fraud Specialist (CFS)
- A number of people from any Responsible Bodies to form a joint investigation team – this could include a LCFS or CFS

If a preliminary investigation uncovers well-founded concerns, the AO may:
- refer to the Counter Fraud and Security Management Service (CFSMS) Division of the NHS Business Services Authority
- request an investigation (or joint with other Responsible Bodies) by CFSMS
- share information or request information from other Responsible Bodies

If a Responsible Body (or its AO) has commenced or completed an assessment/investigation, the AO must be informed, if not already aware, in addition to the AO for any PCT or other Responsible Body as relevant.

10.31.1 Disclosure of information
The following principles must be applied:
- The confidential information must be removed prior to disclosure where practicable
- If confidential information needs to be disclosed then where practicable the patient’s consent must be obtained
- Patient’s consent is not required if in doing so it would likely prejudice an investigation being conducted by any Responsible Body; this includes investigations being conducted by an LCFS or Local Security Management Specialists.
- Any disclosure must comply with the requirements of the Data Protection Act 1998 and codes of conduct on confidentiality. Regulation 25 (9) presumes that disclosures made in this way are permitted under S35(1) of the Data Protection Act.
- Care should be exercised when sharing information about identifiable healthcare professionals and where possible they should be made aware of concerns about them
- Information regarding patients or healthcare professionals should only be shared with an AO or the AO’s staff and not to any person acting on behalf of a Responsible Body.
- A responsible body is not required to notify any person or body or disclose any information if to do so would likely prejudice the investigation undertaken by the responsible body or by any other responsible body.

10.31.2 Local Intelligence Networks (LINs)
Local Intelligence Networks are comprised of representatives of local Responsible Bodies with local agencies enabling organisations to raise concerns and share intelligence. Central oversight of LINs rests with the Care Quality Commission (CQC).

Local Intelligence Networks should:
- establish clear and secure mechanisms and processes for information sharing and storage. LCFSs may have knowledge or experience in intelligence handling which may be of benefit to their LIN in this area.
- set up a forum of all members of the network to agree and maintain joint protocols and review trends.

10.31.3 Local Counter Fraud Specialists
LCFSs must ensure that any information relating to fraud issues relating to CDs is entered on the Fraud Information Reporting System Toolkit (FIRST) in order to support effective case management, report systems weaknesses and collate national data.
11.0 SYSTEMIC ANTICANCER TREATMENT (SACT)
11.1 Treatment Protocols
A DTC application must be completed for all new protocols.
In addition there must be a written protocol made available to the nursing staff administering the treatment and a patient information leaflet available.

The written protocol should contain:
- The patient inclusion or eligibility criteria
- Details of the full treatment regimen including standard doses and posology of administration, the cycle length and expected number of cycles
- The stopping criteria
- All standard supportive therapy required including premedication, fluids and take home medication
- The initial investigations and work up prior to commencing treatment
- On treatment assessments and schedule of investigations
- The criteria under which treatment may proceed as prescribed
- The criteria for treatment delay
- Appropriate dose modifications relating to blood biochemistry results or systemic toxicity
- Recommendations for post treatment follow up
- Any other relevant information eg: the management of hypersensitivity reactions
- The names of medical consultant(s) & pharmacist(s) responsible for reviewing the protocol
- The date of approval

The orderset(s) will be built by the Electronic Prescribing Pharmacy team and approved by a medical consultant. Appropriate dose banding limits must be agreed prior to protocol build. Once approved regimens/protocols will be available on the Ascribe EPMA system.

11.2 Unapproved regimens
In exceptional circumstances, it may be necessary to treat a patient with an unapproved protocol or an approved protocol for an alternative indication.

Where use of an ‘Off Protocol’ treatment is required, the consultant must:
- Complete the DTC Chair Approval Form
- Provide full details of the proposed treatment including references, the reason for prescribing an ‘off protocol’ regimen, the proposed number of courses, and outline the expected benefits of the proposed treatment and impact on the Trust infrastructure.

Only when Pharmacy have received an email confirmation from the Chair of the DTC (or delegated deputy) will treatment be provided.

The SACT delivery group will be informed by a pharmacy representative.

The list of unapproved treatments and protocols approved by the Chair of the DTC may be accessed on the DTC shared drive.

11.3 Shared Care
On commencing SACT written guidance must be provided to the patient’s primary care practitioners covering:
- Regime-specific or drug-specific symptoms
- Neutropenic sepsis
- Nausea and vomiting
- Extravasation
11.4 SACT Prescribing

11.4.1 Pre-ordering

All parenteral SACT for outpatient administration and all scheduled inpatient treatment must be pre-ordered at least 3 working days prior to the patient’s specified appointment or admission date.

Parenteral SACT treatment will be allowed to be prescribed outside of this time frame in the following circumstances only:

- First cycle chemotherapy treatment that requires GFR tests to be completed less than 2 days before patient’s appointment
- Urgent chemotherapy treatment for oncological emergencies, for example new leukaemia treatment and diseases with high tumour burden
- Clinical trial treatments that require specific dosing information prior to preparation, as per clinical trial protocol and GCP guidelines.
- Dose reductions
- Damaged doses (those damaged in transit or during treatment delivery)

If it is discovered that treatment has not been pre-ordered this must be explained to the patient. Agreement must be sought from the patient and the schedulers as to when the patient will be treated. In addition, the prescriber must prescribe the treatment for the revised treatment date if required.

NB: Medication can be administered on the Ascribe EPMA system up to 72 hours after the original treatment date and Baxter will keep treatment not requested up to 2 working days after the original due date if expiry allows. Therefore if the patient is re-scheduled for treatment within 48 hours of from a Friday to a Monday a new prescription need not be generated, however, a deferral email must be sent to pharmacy aseptics. Treatment cannot be administered on the Ascribe EPMA system before the due date. If a patient’s treatment date is brought forward the treatment must be re-ordered.

11.4.2 Items not routinely stocked by Baxters

In addition there are certain items that Baxter do not routinely stock due to low usage levels. These are:

- Alemtuzumab
- Amsacrine
- Carfilzomib
- Carmustine
- Cladribine
- Etopophos
- Ipilimumab
- Ofatumumab
- Pentostatin
- Temsirolimus
- Thiotepa
- Vinflunine

This list is not exhaustive and would also apply to any non-routine items.

All non-stock items must be prescribed at least 5 working days prior to the patient’s specified admission date.

11.4.2 Prescribing systems

The Ascribe EPMA system must be used to prescribe all SACT protocols (IV and oral) with the following exceptions:

- Non approved protocols
- Protocols that are not available on the Ascribe EPMA system eg: some clinical trials, complex inpatient regimes and haematology regimes
• Patients who are to be treated at affiliated hospitals who do not have access to The Christie EPMA system

Whenever an EPMA prescription for SACT is not possible prescriptions should be written on approved pre-printed SACT prescriptions where available. Blank SACT prescriptions and outpatient prescriptions may only be used to prescribe SACT when no EPMA prescriptions or pre-printed prescriptions are available.

Pre-printed SACT prescriptions and blank SACT prescriptions are available from the Aseptics department.

All SACT prescriptions must contain the following information:
• Patient’s full name
• Patient identification number
• Date of birth
• Name of consultant
• Ward / clinical area where treatment is to be administered, if known
• Height, weight, BSA where appropriate for dosing
• GFR / CrCl where appropriate for dosing
• Protocol and patient diagnosis
• Cycle / course number
• Approved drug names and doses
• Route(s) of administration
• Volumes, diluents and rates of administration were appropriate
• Date and times doses are to be administered
• Date, signature, and designation of the prescriber
• Any applied dose reductions or other protocol deviations due to associated toxicities should be documented on the prescription form

NB: It is the prescriber’s responsibility to ensure that the patient’s height, weight, Body Surface Area (BSA) and Creatinine Clearance (CrCl) are up to date and accurate. The BSA calculation is automatically populated on EPMA systems based on the inputted height and weight and these values are not second checked by pharmacy.

See also - Completing the Ascribe EPMA record

11.4.3 Who can prescribe SACT
The decision whether or not to initiate chemotherapy treatment should be undertaken by a consultant oncologist/haematologist after a comprehensive clinical review of the patient.

The actual prescribing of SACT, including first cycle, may be undertaken by:
- Consultants
- Specialist registrars, staff grades, GPs with an honorary contract (following discussion of the individual case with their consultant)
- Non Medical Prescribers provided prescribing is within own designated disease group or area of competence

The decision to treat, and which protocol to employ, has been formally discussed with treating consultant (or consultant colleague) and is clearly documented in the patient’s health record

NB: Medical staff at FY1, FY2, ST1 and ST2 grade are not authorised to prescribe SACT. This guidance also applies to inpatient prescribing of oral SACT on inpatient prescription charts, the JAC EPMA system and on discharge prescriptions.
11.5 Ensuring the accuracy of SACT prescriptions
SACT drugs will only be dispensed on receipt of a valid prescription

All SACT prescriptions will be screened by a pharmacist who has undergone training and been assessed as competent prior to preparation / dispensing.

Handwritten prescriptions:
Pharmacists must sign and date the prescription in the designated pharmacy box to indicate that the prescription has been clinically screened.

Electronic prescriptions:
The name of the pharmacist undertaking the clinical check and the date and time will be recorded electronically when it has been clinically screened.

For further information regarding the pharmacist clinical checking processes see:
SOP for the Clinical Screening of Outpatient Prescriptions
SOP for the Clinical Screening of Prescriptions for Parenteral Anti-cancer therapy

11.6 SACT Dose Banding
Dose banding is a system whereby drug doses are calculated, grouped and rounded to a set of pre-defined doses. Each series of consecutive dose(s) is called a 'band', with the dose to which they are rounded towards being the ‘banded dose’.

All doses of parenteral SACT should be aligned with the dose banding tables, where appropriate, as per previous agreement through DTC.

Authorised pharmacists undertaking the clinical verification of a SACT prescription can amend doses in accordance with the tables where appropriate. Doses may be rounded within a range of ±6% for traditional cytotoxic chemotherapy and ±10% for Monoclonal antibodies*.

*Except where clinician agreement dictates otherwise.

Tables will be maintained and managed by the pharmacy department and new drugs added when necessary.

11.7 SACT Dose Rounding
Any agent that is not dose banded should be rounded to the nearest recommended increment.

See - Dose rounding table for the recommended increments for parenteral SACT

Oral SACT must be dose rounded to the nearest measurable dose as appropriate.

Authorised pharmacists undertaking the clinical screen of a SACT prescription can amend prescribed doses in accordance with the dose rounding table, or to the nearest whole vial or dose unit as appropriate.

New drugs will be added to the dose rounding table by the Aseptic Services Team.

11.8 Patient Consent
Written informed consent must be obtained prior to commencing any SACT treatment, regardless of route of administration, using the approved Trust consent form. The practitioner providing the treatment is responsible for ensuring that the patient has given valid consent before treatment begins. The task of seeking consent may be delegated to another health professional, as long as that professional is suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed treatment, and understand the potential benefits and adverse effects, in order to be able to provide any information the patient may require.
Before giving consent, patients should have had sufficient opportunity to read and discuss:

- The Trust’s information booklet - Chemotherapy: a guide for patients and their carers
- Specific patient information relating to the relevant regimen/treatment

The practitioner must ensure that the following are explained and discussed in a way that the patient can understand:

- The potential benefits of treatment
- Anticipated or potential side effects
- The long term effects of treatment

The practitioner will sign to confirm that the patient has been provided with all relevant written information. The name and grade of practitioner should always be stated on the consent form.

Whenever there is a change in chemotherapy regimen patients should be provided with the relevant new information and written informed consent again obtained.

11.9 Fitness for Treatment

Before requesting the release of parenteral SACT the nurse treating the patient must confirm that there is a treatment chair/bed available for the patient and that either a member of the clinical team responsible for the patient has given the go ahead for treatment or that all test results are satisfactory and that the patient is fit for treatment according to the specific treatment protocol.

11.10 ‘On Hold’ Treatments

In order to reduce the wastage of expensive SACT drugs, the Trust has in place a system of placing certain drugs or regimens ‘On Hold’. In practice, this means that the identified treatments will not be prepared until the go ahead for treatment to commence has been provided by the medical team or nursing staff.

The Baxter on hold list is agreed by the lead aseptic pharmacist and is regularly reviewed and amended as necessary. Where applicable the on hold status of treatment will be recorded on the prescription form(s).

In addition the following items prepared within aseptics are on-hold:

- All clinical trial preparations that say ‘aseptic trial’ next to them on the prescription.
- Unlicensed specials and some named patient items (including DTC Chair approvals) including:
  - Depocyte
- The following non-trial treatments:
  - Arsenic Trioxide
  - Busulfan
  - Cidofovir
  - Melphalan
  - Mifamurtide
  - Myocet (liposomal doxorubicin)
- All biohazard or gene therapy agents prepared in the aseptic gene therapy unit

Treatment must be taken off hold before 4.00 pm each day for that day’s treatment. The process for taking drugs off hold will apply to all drugs/regimens on the on hold list. The process must be undertaken for each cycle of treatment (consecutive days of treatment need only to be taken off hold on the first day of each cycle). The responsibility for taking treatment off hold lies with the medical team responsible for the patient’s treatment and/or the nursing team administering treatment. Treatment must never be taken off hold until the patient has been assessed as fit for treatment.
NB: Prescriptions are filed under the date they are required in both the pharmacy and Baxter Healthcare unit. In order to identify the prescription they must know the original date that the prescription was requested for.

11.10.1 Taking treatment off hold with Baxter Healthcare
Phone extension 4128 and follow the pre-recorded voice prompts. The caller must press 9 after each response to save the message. The voice mail box will be checked by Baxter Healthcare staff every 15 minutes (between 8.00am & 4.00pm). Any queries relating to the treatment will be referred back to the caller.

The following information will be required:
- What is the original date on the prescription? *(i.e. the original date required, as documented on the prescription)*
- What date is the treatment required? *(actual date the treatment is required, if treatment is required for a future date this can be taken off hold in advance)*
- What is the patient’s name?
- What is the patient’s identification number?
- What regime is it? *(to ensure the correct drug/regimen is prepared)*
- Has there been a dose change today? *(If there has been a dose reduction please state the dose to be prepared)*
- Where the patient will be treated? *(i.e. where do you want the chemotherapy delivered to?)*
- Is it a day case patient? *(it can then be prioritised)* and/or time required *(especially if pre-medication is required).*
- Please leave a contact name and number *(i.e. the name and contact details of the person taking the treatment off hold).*

Baxter Healthcare will provide a list of all treatment taken off hold to the Pharmacy department.

11.10.2 Taking treatment off hold with the Pharmacy Aseptic Unit
Phone extension 7643 and provide details of the patient’s treatment, the time the treatment is required, the treatment location, the dose required, and contact details.

For prescriptions which involving items which need to be prepared by both Baxter and the Pharmacy both services need to be contacted.

11.11 Process for releasing SACT from Baxters at The Christie, Withington site
This process applies to all parenteral SACT supplied though Baxters, including clinical trial items that are additionally labelled in aseptics, regardless of whether the item is an ‘on hold’ item or not.

Items prepared by aseptics are not requested through the email system. When an aseptic prepared item is ready the aseptics staff will ring the treatment area to inform them that it is ready for collection.

SACT must only be requested for release once the patient has presented at the ward/department where treatment will be administered and has been assessed as **fit for treatment**.

- The nurse treating the patient must email Baxter’s using the pre-defined templates including the name of the regimes, **ALL SACT drug(s) required**, dose prescribed and date to be administered.
- Notifications for go ahead will only be accepted by the electronic route
- If a patient is deferred, but has an appointment to re-attend within 48 hours or from a Friday to a Monday:
  - A deferral email must be sent to aseptics confirming the date of rescheduled treatment
- Medication can be administered on the Ascribe EPMA system up to 72 hours from the original treatment date. Therefore a new prescription need not be generated.
  - If a patient is deferred but the new appointment is > 48 hours later
    - if electronic, the original prescription must be cancelled on the Ascribe system
    - treatment must be re-prescribed for the new date. This is the responsibility of the medical team. However, the need for a prescription may need to be communicated by the nursing team. On the Ascribe system make an entry in the prescription notes field that this is a deferred treatment. On handwritten prescriptions document that this is a deferred treatment.
  - If a patient is stopping treatment there is no requirement to send a notification email UNLESS the patient has future dated items on the prescription in which case the notification email must be sent with ‘stopped treatment’ documented to prevent these future items being made unnecessarily. Alternatively the electronic prescription should be cancelled.
  - The encrypted email will be sent to the Baxter’s hub
  - For consecutive day regimes, the notification must be sent on day one of treatment only, detailing number of days treatment required. Treatments will be delivered each day
  - Where treatment is required at a weekend or bank holiday, the nurse must ensure that all requested treatment has been delivered before 4pm on last working day (i.e. Friday)

11.12 Intrathecal chemotherapy
See - Intrathecal policy

11.13 Delivery of SACT
The Baxter Healthcare or Pharmacy Aseptic Services unit will provide SACT in a ready-to-use form. Quality Control North West audits both units on an annual basis. The MHRA audits Baxter Healthcare.

11.13.1 Delivery to The Christie, Withington site
Parenteral SACT will only be released/delivered on the Withington site on completion of the process to release SACT.

All parenteral SACT produced by Baxters for administration on the Oak Road Treatment centre will be collected directly from the Baxters hub by the nursing staff.

The majority of parenteral SACT produced by Baxters for administration on all other wards/departments will be delivered directly to the treatment location from the Baxter’s hub.

SACT produced by aseptics must be collected from the aseptics department located within the pharmacy department in the Oak Road Treatment Centre.

11.13.2 Delivery to the mobile chemotherapy unit and peripheral clinics
All parenteral SACT produced by Baxters will be delivered to the relevant treatment location in the morning on the day of administration.

There is no requirement to release the chemotherapy. The clinics lists sent to Baxters in advance act as the request for the item. Any on-hold items must be taken off-hold by 12 noon the day before the day of treatment and also included on clinic list.

11.14 Out of Hours Service
The Pharmacy department will provide an emergency out-of-hours Aseptics SACT service at the following times:
Monday to Friday evening 5.00 – 8.00pm
Saturday, Sunday and Bank Holidays 9.00am – 8.00pm

Treatment will only be provided in the following situations:
  ▪ Patients requiring initiation of induction therapy for Acute Myeloid Leukaemia (AML) or Acute Lymphoblastic Leukaemia (ALL)
AML
DA (3 + 10) (trial or non-trial)
Daunorubicin and cytarabine +/- Mylotarg (AML 18 trial)
Daunorubicin and cytarabine +/- Mylotarg (AML 19 trial)
Flag-Ida +/- Mylotarg (AML 19 trial)
AIDA chemotherapy (for treatment of APL patients, AML 19 trial)
All-trans-retinoic acid (ATRA) and Idarubicin (trial or non-trial)
ALL
Vincristine +/- Daunorubicin (trial or non-trial)
Premade bags containing 1mg or 2mg of Vincristine in 50mL Sodium Chloride 0.9% are available from aseptics. The patient’s dose should be calculated according to their body weight and rounded to a dose of 1mg or 2mg for out of hours treatment. Subsequent weight specific doses will be provided within working hours

- Rituximab for Post-Transplant Lymphoproliferative Disorder (PTLD)
  - Rituximab vials may be supplied for reconstitution/preparation on the ward
- Patients with Central Nervous System (CNS) disease requiring intrathecal doses of Methotrexate or Cytarabine (see Intrathecal policy)
- Patients with Small Cell Lung Cancer (SCLC) requiring treatment with carboplatin and etoposide
- Patients with Lymphoma with a mediastinal mass requiring treatment with R-CHOP
  - Premade bags containing 1mg or 2mg of Vincristine in 50mL Sodium Chloride 0.9% are available from aseptics. The patient’s dose should be calculated according to their body weight and rounded to a dose of 1mg or 2mg for out of hours treatment. Subsequent weight specific doses will be provided within working hours
  - Rituximab vials may be supplied for reconstitution/preparation on the ward
- Subsequent or scheduled therapy would be adversely affected by any treatment delays e.g. bone marrow transplants
  - high dose Cyclophosphamide (60mg/kg)
  - melphalan 140mg/m² or 200mg/m²
  - LEAM
  - fludarabine containing regimens (e.g. FLAG-Ida, Fludarabine / Melphalan)
- Patients with CMV infection
  - A pre-made bag containing 150mg ganciclovir in 100ml 0.9% Sodium Chloride is available from aseptics. The patient’s dose should be calculated according to their body weight and rounded to a dose of 150, 300, or 450mg for out of hours treatment. Subsequent weight specific doses will be provided within working hours
  - Foscarnet doses will be individually prepared according to the patient’s weight
- Specified Clinical Trials / Unlicensed Specials
  Where treatment schedules require medication to be prepared at weekend or on a bank holiday, this requirement must be discussed and agreed with pharmacy prior to introduction of the protocol. Specific remuneration for the pharmacy must also be agreed with the trial sponsor and the investigator where necessary.
  Savene, for the treatment of anthracycline extravasation, will be provided by the on-call pharmacist, but prepared at by the most appropriate person available on duty at the time using the CareFusion system.

All requests must be made directly by the either the on-call Consultant or Registrar or the medical team responsible for the care of the patient.

The medical practitioner must discuss with the on-call pharmacist the degree of the emergency and the clinical need for preparation outside of normal working hours.

In each situation sufficient doses will be provided until the next scheduled opening of the Baxter or Pharmacy manufacturing units.

Treatment will not be provided where:
- the drugs have been stored inappropriately
▪ the drugs have been given in the incorrect sequence (and as a consequence have expired)
▪ the drugs have not been taken off hold/requested from the Baxter hub.
▪ the drugs have not been supplied by the Baxter unit
▪ the drugs cannot be located

All treatment manufactured by Baxters is stored off site and cannot be accessed by the on call pharmacist.

11.15 Vinca Alkaloids
In accordance with national guidance, all vinca alkaloids i.e. vincristine, vinblastine, vindesine or vinorelbine, must be dispensed in a 50ml minibag (as per NPSA/2008/RRR004) to help distinguish them from drugs intended for intrathecal injection.

11.16 Parenteral SACT Administration
All SACT administration must comply with the Trust standards for medicines administration.

In addition all patients must be given a 'Patient Treatment Record' book when they commence treatment. This is used to document treatment, relevant blood results and take home medications or other supportive therapy as necessary. The patient can also document their own toxicities in it.

11.16.1 Hours of Treatment
The initiation and administration of parenteral SACT should be undertaken between 8.30am and 6pm daily where possible to ensure that support services and expert advice are immediately available if required.

11.16.2 Staff Authorised to Administer SACT
Parenteral SACT may only be administered by nurses who have satisfactorily completed the appropriate training programme for cannulation and IV drug administration.

11.16.3 Intrathecal Drugs
Only staff named on the Trust intrathecal register may administer intrathecal drugs.
See - Intrathecal policy

11.17 Extravasation
See - Extravasation policy

11.18 SACT Wastage
11.18.1 Waste from The Christie, Withington site
All unused or expired parenteral SACT must be returned to the aseptics department in the Oak Road pharmacy.

On one morning of the week one of the aseptic ATO’s will be responsible for collecting all the Baxter/aseptically prepared waste (unused or expired parenteral SACT) from all the wards that administer parenteral SACT; wards 4, 11, 12, PTC, YOUDU and HTDU. Waste will also be collected from the ORTC and the CTU on a daily basis.

11.18.2 Waste from the Mobile Chemotherapy Unit & Peripheral clinics
All unused or expired parenteral SACT must be disposed of locally.

11.19 Spillage and/or staff contamination
See - Management of cytotoxic chemotherapy spillage & contamination of personnel policy
12.0 INTRAVENOUS POTASSIUM

12.1 Prescribing intravenous potassium solutions

- Intravenous treatment of hypokalaemia must only be initiated where the oral route is unavailable or will not achieve the required elevation of serum potassium within a clinically acceptable time
- All prescribing of intravenous potassium must be expressed in terms of millimoles of potassium and must specify the rate of infusion and duration of treatment. A treatment programme considering the patient’s potassium requirements for the following 24-48 hours should be prepared, where necessary
- Only the listed ready to use potassium containing infusion fluids may be used.
- All potassium containing infusions must be administered via a suitable infusion pump to control the infusion rate and volume
- All patients receiving intravenous potassium should have at least daily measurements of serum potassium until levels are shown to be satisfactory

12.2 Availability of intravenous potassium solutions

All wards and departments must use ready-mixed infusion fluids whenever potassium-containing solutions are required. A range of ready to use infusion fluids containing potassium will be available within the Trust (See Table).

Infusions containing concentrated potassium solutions (e.g. 20mmol in 50ml 0.9% Sodium Chloride) will be restricted to the pharmacy department and only issued to authorised areas (Palatine Treatment Centre, Critical Care Unit and Theatres).

Under no circumstances will ampoules of strong potassium chloride solution (20%) be issued.

12.3 Special requirements for the management of strong intravenous potassium solutions

Large volume ready diluted potassium containing intravenous fluids can be ordered, stored, administered and disposed of in clinical areas in the same way as other intravenous fluids.

Strong solutions of potassium chloride (e.g. 20mmol potassium chloride in 50ml 0.9% sodium chloride) should be managed as CDs within authorised areas. This applies to the ordering, receipt, storage, administration and disposal. See - Controlled Drugs

Concentrated potassium containing solutions should not be transferred between clinical areas or issued for use in another clinical area. All supplies must be made directly from the pharmacy department during normal working hours.

Outside of normal working hours, the on-call pharmacist must be contacted where there is a clear clinical need for strong potassium solutions to be used. Authority may be given for the transfer of strong potassium solutions between wards or departments. Documentation of the transfer should follow the pattern for controlled drugs and record the requisition, supply, receipt, formulation and administration of strong potassium chloride solutions. See - Controlled Drugs

12.4 Administration of intravenous potassium solutions

The maximum recommended concentration for peripheral administration is 40mmol per litre. However pain and phlebitis may occur during peripheral administration of potassium solutions particularly at higher concentrations (>30mmol/l). The infusion site should be checked regularly for signs of redness or inflammation.

The rate of administration should not normally exceed 5 to 10mmol/hour and no more than 20mmol/hour in emergencies.

Administration rates above 20mmol/hour will require ECG monitoring.
12.4.1 Administration of strong intravenous potassium solutions

Strong potassium solutions eg: 20mmol in 50ml sodium chloride 0.9% must be administered via a 50 ml syringe pump.

Strong intravenous potassium solutions must NEVER be administered via a volumetric pump or gravity drip.

A lumen must be designated solely to the administration of the strong potassium infusion. Both the syringe and line must be labelled with the specific blue ‘Caution high strength Potassium’ labels. Further supplies of these labels may be obtained from Medical Illustration.

12.5 Availability of potassium containing infusions

<table>
<thead>
<tr>
<th>Potassium content</th>
<th>Volume</th>
<th>Fluid</th>
<th>Ordering/Storage</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>mmol per bag</td>
<td>mmol per litre</td>
<td></td>
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<tr>
<td>0.15%</td>
<td>10</td>
<td>20</td>
<td>500ml Glucose 5%</td>
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<tr>
<td>0.15%</td>
<td>20</td>
<td>20</td>
<td>1000ml Glucose 5%</td>
</tr>
<tr>
<td>0.15%</td>
<td>10</td>
<td>20</td>
<td>500ml Sodium chloride 0.9%</td>
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<tr>
<td>0.15%</td>
<td>20</td>
<td>20</td>
<td>1000ml Sodium chloride 0.9%</td>
</tr>
<tr>
<td>0.15%</td>
<td>10</td>
<td>20</td>
<td>500ml Sodium chloride 0.18% and glucose 4%</td>
</tr>
<tr>
<td>0.15%</td>
<td>20</td>
<td>20</td>
<td>1000ml Sodium chloride 0.18% and glucose 4%</td>
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<tr>
<td>0.15%*</td>
<td>20</td>
<td>20</td>
<td>1000ml Sodium Chloride 0.9% also containing 10mmol Magnesium Sulfate</td>
</tr>
<tr>
<td>0.15%</td>
<td>20</td>
<td>20</td>
<td>1000ml Sodium Chloride 0.45% and Glucose 2.5%</td>
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<td>0.3%</td>
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<td>40</td>
<td>500ml Glucose 5%</td>
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<td>40</td>
<td>40</td>
<td>1000ml Glucose 5%</td>
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<td>500ml Sodium chloride 0.9%</td>
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<td>1000ml Sodium chloride 0.9%</td>
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<td>500ml Sodium chloride 0.18% and glucose 4%</td>
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<td>1000ml Sodium chloride 0.18% and glucose 4%</td>
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<td>40</td>
<td>80</td>
<td>500ml Glucose 5%</td>
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<tr>
<td>0.6%*</td>
<td>40</td>
<td>80</td>
<td>500ml Sodium chloride 0.9%</td>
</tr>
<tr>
<td>3%*</td>
<td>20</td>
<td>50</td>
<td>Sodium chloride 0.9%</td>
</tr>
</tbody>
</table>

* Unlicensed products

**For central administration only**
### 12.6 Recommended clinical guidelines for intravenous potassium infusions

Guidance applies to patients with **NORMAL** renal function and **NO** fluid restriction *(where renal function and/or fluid intake are compromised, seek specialist advice)*

<table>
<thead>
<tr>
<th>Indication / (Plasma potassium level in mmol/l)</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis against hypokalaemia (normal range 3.5-5.0)</td>
<td>20mmol in 1000ml of 0.9% sodium chloride or 5% glucose administered peripherally (or centrally) over at least 8 hours</td>
</tr>
<tr>
<td>Mild hypokalaemia (3.0-3.4 or non-urgent)</td>
<td>20-40mmol in 1000ml of 0.9% sodium chloride or 5% glucose administered peripherally (or centrally) over 6-8 hours</td>
</tr>
<tr>
<td>Severe hypokalaemia (&lt;3 or very urgent)</td>
<td>40mmol in 500ml of 0.9% sodium chloride or 5% glucose administered centrally over at least 4 hours <strong>OR</strong> 20mmol in 50ml 0.9% sodium chloride infusion administered in authorised areas over at least 2 hours via a central line <strong>OR</strong> infusion rate at discretion of the prescriber (maximum rate 20mmol/hour)</td>
</tr>
</tbody>
</table>
13.0 MANAGEMENT OF MEDICATION ERRORS AND NEAR MISSES

A medication error is defined as: any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health professional, patient or consumer.

A near miss is defined as: an incident without an adverse outcome. Any event, which would have fallen into the definition of a medication error, but did not actually happen due to intervention, should be reported as a near miss.

An Adverse Drug Reaction (ADR) is defined by: the World Health Organisation (WHO) as “Any response to a drug which is noxious, unintended and occurs at doses used for prophylaxis, diagnosis or therapy”.

Examples of Prescribing Errors
▪ Patient prescribed the wrong medication / dose / route / rate
▪ Medication prescribed for the wrong patient
▪ Transcription errors
▪ Prescribing without taking into account the patient’s clinical condition
▪ Prescribing without taking into account patients clinical parameters e.g. weight
▪ Prescription not signed

Examples of Dispensing Errors
▪ Patient dispensed the wrong medication / dose / route
▪ Medication dispensed to the wrong patient
▪ Patient dispensed an out of date medicine
▪ Medication is labelled incorrectly

Examples of Preparation and Administration Errors
▪ Patient administered the wrong medication / dose / route
▪ Patient administered an out of date medicine
▪ Medication administered to the wrong patient
▪ Medication omitted without a clinical rationale
▪ Medication incorrectly prepared
▪ Incorrect infusion rate
▪ Medication administered late / early* *(it is recognised that this is a complex issue and the full context of late/early administration should be taken into account, however where it would have a significantly detrimental effect on patient care, this would constitute an error)

Examples of Monitoring Errors
▪ Patient allergic/sensitive to medication but the medication was prescribed and/or dispensed and/or administered
▪ Failure to provide the patient with correct information regarding their medication e.g. when to take, what it is for, side effects and drug interactions
▪ Failure to monitor therapeutic levels
▪ Failure to monitor patient / carer who is undertaking self medication

13.1 Actions to be taken following the discovery of a prescribing medication error

All prescribing errors must be reported on Datix in accordance with the ‘Incident reporting and investigation policy’

All such incident reports will be reviewed by SMPC.

The only exception is whereby a pharmacist intervention has taken place prior to the medication being supplied and/or administered to the patient.

See – Pharmacist Interventions
Prescribing errors must be discussed with the prescriber as soon as it is discovered, and if appropriate, the consultant in charge of that patient's management.

If the individual involved is a NMP the NMP lead must be informed.

If a pharmacist has clinically checked the patient’s prescription and not detected the prescribing error, the Principal Pharmacist for Clinical Services or their deputy must be also informed.

13.2 Actions to be taken following the discovery of a medication administration error

- Monitor the patient for adverse reactions and take any necessary corrective action.
- Inform the nurse in charge and the appropriate medical staff immediately.
- Seek advice from pharmacy/the medical team regarding the possible outcomes of medication error
- Inform the Ward/Department Manager at the earliest opportunity.
- Inform the patient or their next of kin or guardian if the patient is unable to understand or is under age respectively. The persons should be told of the error as soon after the event as appropriate. See - Duty of candour policy
- Report the incident on Datix in accordance with the Incident reporting and investigation policy’
  All such incidents reports will be reviewed by SMPC.
- Document nature of incident and corrective action in the patient's health record.
- Where required obtain statements from the staff involved
- In the event of an incident occurring out of hours the Duty Manager/night sister on call should be informed
- A systematic review of the root causes for the error must take place with the staff involved.

13.3 Actions to be taken following the discovery of a medication dispensing error

All prescriptions dispensed will be subject to an accuracy check by a pharmacist or Accredited Checking Technician (ACT) within the Boots pharmacy department and Oak Road clinical trials dispensary. There are internal reporting and monitoring procedures should dispensing errors be detected prior to supply to the wards/departments or patients.

All dispensing errors that are not detected by the accuracy checking process are subsequently supplied to patients or wards/departments must be reported on Datix in accordance with the Incident reporting and investigation policy. All such incident reports will be reviewed by SMPC.

In addition the medicine must be recovered and returned to pharmacy. Steps must be taken to ensure that a medication administration error occurred as a result of the dispensing error. The correct medication should be supplied as required.

13.4 Reporting ADRs

See – Adverse Drug Reactions

13.5 Procedure for the Management of Staff involved in Medication Errors

Consideration should be given to the circumstances surrounding the incident and the individual’s previous practice and performance.

There may be occasions where staff wish to withdraw themselves from prescribing, clinical checking, dispensing or administration. This decision should be respected and agreed with the individual’s line manager. Any formal decision will be in consultation with the Matron/NMP Lead/Professional Lead (or duty manager if out of hours).

The error matrix may be used to identify any operational/system failures or inappropriate action(s) by a member of staff that may have led to or contributed to the medication error. This will help determine any action taken.
In the event of a culpable individual making an initial error, the recommendation will be to provide guided supervision to the staff member by their line manager. This will involve:

- Discussion on how the error occurred
- Identification and rectification of any system failures
- Identification and rectification of any knowledge deficit
- Re-education of the medicines management operational policy.
- Pastoral support

If an individual makes a subsequent medication error, they will be provided with guided supervision by their line manager.

This will involve:

- Discussion on how the error occurred
- Identification and rectification of any system failures
- Identification and rectification of any knowledge deficit
- Re-education of the medicines management operational policy
- Supervised practice for 2-4 weeks or until the individual can demonstrate fitness to practice independently
- Pastoral support
- File note made for 6 months

If an individual's practice results in a further error, they must refrain from independent practice and the Trust capability policy should be instigated.

This will involve:

- Detailed investigation on how the error occurred
- Identification and rectification of any system failures
- Identification and action plan to rectify any knowledge/skills deficits
- Re-education of the medicines management operational policy.
- Supervised practice until the individual can demonstrate fitness to practice independently
- Pastoral support
- File note made for 12 months

If however any error results in a serious incident or potentially lethal near miss, a full investigation will be instigated and disciplinary action may result as appropriate.

Each profession will need to interpret this process according to their Professional Code of Practice.

If a substantive bank nurse (substantive Trust staff who works on the Trust nurse bank) makes an error then action will be referred to their line manager and they may be limited to working in their substantive ward for a period of time of training and supervision.

If a bank nurse makes a drug error they may be limited to where they can work until such time that training has been instigated and assessed.

If an agency worker makes an error, this will be referred to their manager/agency lead for training. Evidence of that training will be required by the Trust. If any subsequent errors are made, consideration will be given as to whether placement within the Trust remains appropriate.

All incidents will be managed sensitively and a comprehensive assessment of all the circumstances undertaken before a professional and managerial decision is reached on the appropriate way to proceed. When considering the error, great care will be taken to distinguish between reckless and incompetent practice, whether the incident was reported openly or concealed, other serious pressures of work and where there was immediate honest disclosure in the patient’s interest.
### 13.6 Error Matrix

<table>
<thead>
<tr>
<th>Potential for recurrence</th>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost certain</td>
<td><strong>YELLOW</strong></td>
<td><strong>YELLOW</strong></td>
<td><strong>AMBER</strong></td>
<td><strong>RED</strong></td>
<td><strong>RED</strong></td>
</tr>
<tr>
<td></td>
<td>No harm caused to the patient but almost certain potential for reoccurrence</td>
<td>Minor harm caused to the patient but almost certain potential for reoccurrence</td>
<td>Moderate harm caused to the patient and almost certain potential for reoccurrence</td>
<td>Major harm caused to the patient and almost certain potential for reoccurrence</td>
<td>Catastrophic harm caused to the patient and almost certain potential for reoccurrence</td>
</tr>
<tr>
<td>Likely</td>
<td><strong>YELLOW</strong></td>
<td><strong>YELLOW</strong></td>
<td><strong>AMBER</strong></td>
<td><strong>RED</strong></td>
<td><strong>RED</strong></td>
</tr>
<tr>
<td></td>
<td>No harm caused to the patient but same incident likely to reoccur</td>
<td>Minor harm caused to the patient and same incident likely to reoccur</td>
<td>Moderate harm caused to the patient and same incident likely to reoccur</td>
<td>Major harm caused to the patient and same incident likely to reoccur</td>
<td>Catastrophic harm caused to the patient and same incident likely to reoccur</td>
</tr>
<tr>
<td>Possible</td>
<td><strong>GREEN</strong></td>
<td><strong>YELLOW</strong></td>
<td><strong>AMBER</strong></td>
<td><strong>AMBER</strong></td>
<td><strong>RED</strong></td>
</tr>
<tr>
<td></td>
<td>No harm caused to patient and incident could possibly reoccur</td>
<td>Minor harm caused to patient and incident could possibly reoccur</td>
<td>Moderate harm caused to patient and incident could possibly reoccur</td>
<td>Major harm caused to patient and incident could possibly reoccur</td>
<td>Catastrophic harm caused to patient and incident could possibly reoccur</td>
</tr>
<tr>
<td>Unlikely</td>
<td><strong>GREEN</strong></td>
<td><strong>GREEN</strong></td>
<td><strong>GREEN</strong></td>
<td><strong>AMBER</strong></td>
<td><strong>RED</strong></td>
</tr>
<tr>
<td></td>
<td>No harm caused to patient and incident unlikely to reoccur</td>
<td>Minor harm caused to patient and incident unlikely to reoccur</td>
<td>Moderate harm caused to patient and incident unlikely to reoccur</td>
<td>Major harm caused to patient but incident unlikely to reoccur</td>
<td>Catastrophic harm caused to patient but incident unlikely to reoccur</td>
</tr>
<tr>
<td>Rare</td>
<td><strong>GREEN</strong></td>
<td><strong>GREEN</strong></td>
<td><strong>GREEN</strong></td>
<td><strong>AMBER</strong></td>
<td><strong>RED</strong></td>
</tr>
<tr>
<td></td>
<td>No harm caused to patient and potential for recurrence is rare</td>
<td>Minor harm caused to patient and potential for recurrence is rare</td>
<td>Moderate harm caused to patient and potential for recurrence is rare</td>
<td>Major harm caused to patient but potential for recurrence is rare</td>
<td>Catastrophic harm caused to patient but potential for recurrence is rare</td>
</tr>
</tbody>
</table>

### 13.7 Support for Staff

Support for staff throughout the medication error process is available from (not a definitive list):

- Line Manager
- Clinical Skills Team
- Quality & Standards Team
- Staff Side
- Matron
- Occupational Health
- Professional Bodies
- Human Resource Department

Line Managers can gain advice and support in managing staff that have made a medication error from:

- Quality & Standards Team
- Matron
- Medicines Safety Officer
- Occupational Health
- Human Resource Department
Error Identified

Incident Report Form Completed

Is this a capability issue?

Report to line manager / ward manager for investigation

Use the Incident Decision Tree for each event
Identify Risk Ratio

Is this a system failure?

Liaise with divisional lead & appropriate department leads to prevent re-occurrence

Previous error

Ascertain whether this individual has previously made an error

No previous error

Minor 1
Managed by line manager

Minor 2
Managed by line manager (reported to matron)

Moderate
Managed by line manager/Matron (reported to divisional lead nurse)

Major
Managed by Trust risk team/ divisional lead nurse/ matron/ward/dept manager

If an individual makes a subsequent medication error the management will be that of a moderate incident (unless major incident investigation applies). They must not independently administer medications during the period of supervision. They must ensure all medicines training is up-to-date and demonstrate fitness to practice independently.

Disseminate lessons learnt across the divisions to prevent future re-occurrence

NB: If the error is a result of intentional non-compliance with policy or is a result of clear negligent practice disciplinary action may result
14.0 LEGAL LIABILITY
The organisation will generally assume vicarious liability for the acts of its staff. However, it is incumbent on staff to ensure that they:
- Have undergone any suitable training and assessment of competence identified as necessary under the terms of this policy or otherwise
- Have been fully authorised by their line manager to undertake the activity
- Fully comply with the terms of any relevant organisational policies and/or procedures at all times
- Only depart from any relevant organisational guidelines providing that such departure is confined to the specific needs of individual circumstances and, in the judgement of the responsible clinician, it is fully appropriate and justifiable – such decision to be fully recorded in the patient’s health record.

15.0 PROCESS FOR MONITORING EFFECTIVE COMPLIANCE WITH THIS POLICY
As a minimum an annual audit of practice will be undertaken by the Safe Medicines Practice Committee (SMPC) with the support of Clinical Audit Department. The audit sample size will be determined by the SMPC in advance of the audit due date and dependant on the amount of support available. The results and recommendations will be reported at SMPC with the action plan monitored by the committee until all actions have been completed.

The School of Oncology Clinical Skills team are core members of SMPC and will therefore be informed of relevant findings and subsequent actions which will need to be incorporated into training and educational sessions to ensure lessons are learnt and embedded into the organisational culture.

16.0 CONSULTATION PROCESS
The following services/staff were consulted in order to develop this policy as a true and accurate record of current practice:
- Pharmacy department
- Matrons and Ward managers
- Clinical Skills Team
- Quality & Standards Department
- Medical Staff
- Diabetes Service
- SACT Delivery Group

17.0 DISSEMINATION, IMPLEMENTATION & TRAINING
17.1 Dissemination
The updated policy will be noted in the next edition of Team brief disseminated to all staff members. In addition the Matrons, Ward managers, Non-Medical Prescribers and medical staff will be notified via email.

17.2 Implementation
The contents of this policy will be implemented from the date posted on the trust intranet

17.3 Training
As a minimum all staff involved in any element of the medication practice must watch the Safe Medicines Practice DVD at local induction and three yearly thereafter, see Training Needs Analysis. The DVD is available on the intranet under the Workforce Essential Training webpage. Compliance with this will be monitored via Education & Training Committee, and escalated in accordance with the Corporate Essential Training Policy.
18.0 PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

<table>
<thead>
<tr>
<th>Standard to be monitored</th>
<th>Process for monitoring</th>
<th>Frequency</th>
<th>Person responsible for: undertaking monitoring &amp; developing action plans</th>
<th>Committee accountable for: review of results, monitoring action plan &amp; implementation</th>
<th>Frequency of monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing &amp; administration</td>
<td>Audit</td>
<td>Annually</td>
<td>Jono Bevan Medicines Security Officer</td>
<td>Safe Medicines Practice committee</td>
<td>Monthly until actions completed</td>
</tr>
<tr>
<td>Storage &amp; security of medicines</td>
<td>Audit</td>
<td>Annually</td>
<td>Jono Bevan Medicines Security Officer</td>
<td>Safe Medicines Practice committee</td>
<td>Monthly until actions completed</td>
</tr>
</tbody>
</table>

19.0 REFERENCES


Guidance for the safe use of cytotoxic chemotherapy, Scottish Executive HDL(2005) 29

Competencies: an integrated competency framework for training programmes in the safe administration of chemotherapy to children and young people, RCN March 2005

Manual of Cancer Service Standards

Updated National Guidance on the Safe Administration of Intrathecal Chemotherapy, Department of Health; HSC 2008/001

Safer management of controlled drugs (a guide to good practice in secondary care England): Department of Health 2007

Misuse of drugs Act (1971) and Misuse of Drugs Regulations 2001

Health Act (2006) and associated regulations

National Patient Safety Association. Patient Safety Alert: Intravenous administration of potassium chloride: potassium chloride concentrate solution can be fatal if given inappropriately

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
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<tr>
<td>01</td>
<td>Jan 2010</td>
<td>Julie Gray &amp; Suzanne Towse</td>
<td>Closed</td>
<td>NHSLA format, updated Patient Self Administration of Medicines Assessment From</td>
</tr>
<tr>
<td>02</td>
<td>June 2011</td>
<td>Julie Gray &amp; Suzanne Frank</td>
<td>Closed</td>
<td>Minor amendment 8.3.4 – block capitals removed following audit results and discussion at SMPC</td>
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<tr>
<td>03</td>
<td>Sept 2011</td>
<td>Julie Gray</td>
<td>Closed</td>
<td>Minor amendment 8.3.4 – block capitals removed following audit results and discussion at SMPC</td>
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<td>3.1</td>
<td>April 2012</td>
<td>Julie Gray</td>
<td>Closed</td>
<td>Minor amendments following SMPC – Removed: Page 25 Dexamethasone 8mg bd for 2 days – 16x2mg tablets Added: 8.6.2 Where the maximum dose varies depending on route separate prescriptions must be made Page 12 8.7.6 Removed ensure allergy alert on Medway</td>
</tr>
<tr>
<td>3.2</td>
<td>June 2013</td>
<td>Julie Gray</td>
<td>Closed</td>
<td>Review date extended by SMPC due to imminent implementation of electronic prescribing &amp; admiration system.</td>
</tr>
<tr>
<td>3.2</td>
<td>June 2014</td>
<td>Julie Gray</td>
<td>Closed</td>
<td>Review date extended by SMPC due to delayed implementation of electronic prescribing &amp; admiration system.</td>
</tr>
<tr>
<td>4.0</td>
<td>February 2016</td>
<td>Julie Gray &amp; Suzanne Frank</td>
<td>Closed</td>
<td>Transferred into current template. Full review completed to include current position regarding EPMA &amp; reduction in paper prescriptions</td>
</tr>
</tbody>
</table>