Medicines Management Policy

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Authors Name:			
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Policy to be followed by (target staff): All staff involved in any aspect of medicines or medicines management			
To be read in conjunction with the following documents: Other Trust policies, guidelines and procedures on medicines			
CQC Fundamental standards: Regulation 12 – Safe care and treatment Regulation 17 – Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014			

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Policy Statement

- Medicines Management encompasses the way medicines are selected, procured, delivered, prescribed, prepared, administered, reviewed and disposed of, to optimize the contribution that medicines make to producing informed and desired outcomes of patient care (Audit Commission 2001). Medicines management includes the clinical, cost effective and safe use of medicines within the health system to help patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm. It is essential that all medicines are used in a safe and effective way that minimises the risks to both patients and staff.
- Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety. The medicines optimisation approach requires multidisciplinary team working to individualise care, monitor outcomes more carefully, review medicines more frequently and support patients when needed.

- The Trust requires a policy that describes the processes for managing the risks associated with medicines. This is because the use of medicines is the commonest healthcare intervention and their use is associated with significant risks. It is also a requirement of NHS Litigation Authority (NHSLA) Standards. The purpose of this Medicines Management policy is to set out the principles to be followed and provide guidance to support safe and consistent management of medicines.

- Ensuring appropriate processes are in place for the safe, secure effective and consistent management of medicines is paramount and is a key component of clinical governance. The Medicines Management Policy brings the responsibilities of all staff groups involved in these processes into a single policy.
- This policy applies to all medicinal products, prescription only contrast media and medical gasses.
- This is currently a working document due to ongoing reviews and development of associated documents.

Executive Summary

- All members of staff who are involved with medicines in any capacity are expected to read and comply with the standards and procedures detailed in the Medicine Management Policy. Failure to do so may leave members of staff liable to action by the Trust under its performance and capability procedures.

- The medicines management policy should be read in conjunction with national guidance and/or local procedures and guidelines that relate to the use of medicines in clinical practice, specific settings or clinical areas.

- All use of medicines (ordering, storage, handling, prescribing, administration etc.) by registered healthcare practitioners must also take account of the requirements and guidance produced by their registering and/or professional bodies.

- Account must always be taken of current legislation and professional guidance. Any apparent conflict between these and this medicines management policy should be brought to the attention of the Clinical Director of Pharmacy (Chief Pharmacist). Where procedures and guidelines involving medicines are produced or amended the Clinical Director of Pharmacy (Chief Pharmacist) or the Principal Pharmacist responsible for a particular clinical area should be consulted to ensure that changes in practice do not create unanticipated risks or lead to arrangements contrary to agreed Trust policy or national good practice guidance on the management of medicines.

- In this policy, we use the terms 'you must' and 'you should' in the following ways.

  'You must' is used for an overriding duty or principle.
  'You should' is used when we are providing an explanation of how you will meet the overriding duty.
  'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance

- Completion of the medicines management training is deemed mandatory for each group of health professionals involved in the handling of medicines within the Trust. Failure to complete training in a timely manner may lead to action under Trust HR policies.

1.0 Roles and Responsibilities

Board Level

- The Chief Executive and The Trust Board have corporate responsibility for the delivery of safe services, including the management of medicines. The Chief Executive is accountable for medicines management within the Trust; the authorisation and implementation of this policy.
- The Chief Executive must appoint a 'Controlled Drugs Accountable Officer' to establish assurance mechanisms to provide evidence of safe management and use of Controlled Drugs and oversee all Controlled Drug governance issues in the Trust. The Accountable Officer must ensure that appropriate systems are in place for the sharing and disclosure of relevant information through the Controlled Drug Local Intelligence Network (LIN).
- The Trust is required to nominate a 'Medication Safety Officer' to improve medication error and incident reporting and learning to be the main expert in this area. At MKUH medication safety is coordinated through the Clinical Director of Pharmacy (Chief Pharmacist) on behalf of the Trust.

Divisional Triumvirates, Trust Operational Managers and Clinical Service Units (CSU) Clinical Directors

- Divisional Triumvirates, Trust Operational Managers and CSU Clinical Directors, must ensure their local managers recognise which sections of the Medicines Management Policy must be implemented within their areas, that they promote adherence to the policy by all staff and that they communicate any changes in policy to staff in a timely manner.
- Divisional Triumvirates, Trust Operational Managers, CSU Clinical Directors and their local managers including Charge Nurses/Ward Managers and departmental managers, are separately and together responsible for ensuring that the responsibilities and accountabilities for medicines and Controlled Stationery relating to medicines ordering, supply etc. are allocated to specific staff as defined in this policy e.g. to ward sisters / charge nurses.
- Divisional Triumvirates, Trust Operational Managers, CSU Clinical Directors and their local managers are responsible for ensuring all healthcare staff, including medical staff whether permanent, trainees or locums, have access to the medicines management policies, procedures and guidance and that these are implemented, monitored and reviewed when appropriate.
- Divisional Triumvirates, Trust Operational Managers, CSU Clinical Directors and their local managers are responsible for ensuring local arrangements are in place to comply with medicines management requirements and where a need for additional funding is recognised to fulfil the requirements of this policy, this is incorporated into an action plan and implemented in a timely manner through the appropriate Trust processes.
- Divisional Triumvirates, Trust Operational Managers, CSU Clinical Directors and their local managers are responsible for ensuring any service developments where medicines are involved are discussed with the Divisional, Principal Pharmacists or Deputy Chief Pharmacist or Clinical Director of Pharmacy (Chief Pharmacist).

- Divisional Triumvirates, Trust Operational Managers, CSU Clinical Directors and their local managers, will highlight medicines-related risks specific to their area and consider methods of risk reduction, seeking advice where necessary from the Divisional, Principal Pharmacists or Deputy Chief Pharmacist or Clinical Director of Pharmacy (Chief Pharmacist).

Chief Pharmacist – Clinical Director of Pharmacy

- The Chief Pharmacist has delegated responsibility for all aspects of the safe and secure handling of medicines, and must ensure that there is a clear vision for the use of medicines across the Trust to optimise outcomes for patients.
- The Chief Pharmacist must have an overview of the medicines-related risks throughout the Trust and is responsible for establishing, monitoring and reporting on systems for assuring the safe and secure handling of medicines.
- The Chief Pharmacist has delegated responsibility for ensuring that policies or procedures exist for activities relating to medicines management, incorporating references to relevant legislation, guidance and appropriate standards, ensuring that risks are appropriately managed and escalated to the Board if necessary.
- The Chief Pharmacist must inform the Accountable Officer about any issues, risks and their implications regarding Controlled Drugs identified through incidents or raised within the Trust.
- The Chief Pharmacist must ensure there is a process for managing the use of and introduction of new medicines and that there is engagement with commissioners to promote prescribing choices which deliver value from the investment in medicines across the local health economy.

Medicines Optimisation Leads (MOLs)

- Act as link between Pharmacy & Division for medicines related issues
- Support communication with other doctors and prescribers around medication related issues
- Provide a link to action medication shortage communications
- Attend Prescribing & Medicines Governance Committee and provide a report on the following aspects for the division:
    - Medicines related risks on risk register
    - Any significant medicines related Datix
    - Themes from medicines related Datix
- Attend MK Prescribing Advisory Group
- Have oversight for the Division on:
    - Medicines related Incidents
    - Medicines related risks
    - Medicines related finance

Ward and Departmental/Clinical Managers e.g. Matrons and ward sisters/charge nurses

- Ward and Departmental/Clinical managers are accountable for the safe custody and administration of medicines within their clinical area of responsibility. In addition they are responsible for ensuring that healthcare staff have read and understood the Medicines Management Policy and have the necessary competences to handle medicines and follow the Medicines Management policy and related procedures.
- Ward and Departmental/Clinical Managers are responsible for ensuring incidents and near misses involving medicines are reported and are investigated through the Trust Incident Reporting and Management system, and that learning is used to inform future practice and that any suspected adverse drug reactions are reported to the prescriber.
- Ward and Departmental/Clinical managers are responsible for ensuring that all healthcare staff in their clinical area understand their scope of practice and work within it and understand all necessary medicines documentation and follow the procedures and processes set down in Trust policies, procedures and guidelines to support and facilitate safe, appropriate practice.

All Healthcare professionals

- All healthcare professionals are accountable to the Trust and to their professional bodies in terms of standards of practice and codes of conduct and must adhere to their professional practice guidelines. In addition all healthcare staff should act in accordance with this medicines management policy and related medicines procedures. Where that is not clinically appropriate or possible e.g. in a major incident all healthcare staff must be prepared to justify their decisions and actions where they differ from the agreed policies and procedures.
- All healthcare staff are accountable for their practice and must work within their scope of competence and are accountable for their actions and responsible for the tasks they undertake. They must highlight to their manager when a task is beyond their knowledge, skill or experience. All healthcare staff must ensure that they have received the necessary training, maintain competences expected and required, and that they maintain and update their knowledge and skills in the relevant area of practice.
- All healthcare staff will ensure they are familiar with all applicable sections of the policy, follow all relevant procedures and guidelines on the handling of medicines within their clinical area.
- All healthcare staff must attend the Trust's mandatory medicines management training
- All healthcare staff must ensure that medicine related risks, concerns, near misses and incidents are reported.
- All healthcare professionals must work to the values of the NHS constitution in relating with patients and other members of staff, delivering care and handling medicines.

Prescribers

- All prescribers will prescribe medicines for use within their area of competence and in accordance with the British National Formulary (BNF), Trust guidance and policies.
- Decisions relating to prescribing must always focus on the needs and wishes of the individual patient. Whenever possible, discuss with the patient the condition being treated, how the prescribed medicine will affect the condition and the risks and benefits of the medicine, and clarify what outcomes the patient expects from the treatment in accordance with the *NICE Clinical Guideline (NG5), Medicines Optimisation 2015* and subsequent revisions and supplementary/replacement guidance.
- Prescribers will seek agreement from the patient when a new medicine is prescribed or existing medicines are changed or discontinued. Document all changes, rationale, and discussions in the patient's electronic medical records on eCARE.
- Prescribers will prescribe all medicines, including medical gases, clearly and safely in accordance with legislation, this medicines management policy and related procedures, in a manner that is clear, legible and unambiguous to those dispensing and administering the medicines.
- Prescribers will prescribe medicines that are clinically appropriate and cost effective in accordance with the MK Formulary, local prescribing and shared care guidelines and national guidance e.g. local prioritisation policies for NHS funding, NICE, National Reporting & Learning Service.
- Prescribers will follow Trust and local departmental guidelines regarding how and when medicines can be prescribed and in what quantities.
- The prescriber must ensure that they have sufficient knowledge about the medicine being prescribed to ensure safety. Any unfamiliar medicines must, as a minimum, be checked in the British National Formulary (BNF). Confirmation of atypical doses should not rely on the patient's medication history if this is at variance with the BNF advice. If in doubt the prescriber should always make further checks with specialist sources.
- Prescribers must use their own allocated SMART card or Temporary Access Card (TAC) when necessary when provided by the IT department. This will ensure that the name of the prescriber (or traceable information to lead to the prescriber) is clearly documented for each medication prescribed. Contact method to provide details of where they can be contacted ideally by bleep/mobile phone should also be included on eCARE under 'General Clinical Note' when an initiation of a medication is documented.
- If paper prescriptions are used, Non-medical prescribers must annotate with NMP (Non-Medical Prescriber).

Dieticians are authorised to initiate the use of agreed oral dietetic products by adding the item on a patient's inpatient electronic prescription chart from the "Oral Nutritional Supplements" PowerPlan. These items must be in line with the agreed terms between dietetics and pharmacy. When doing this they must use their own SMART card to document their name and state their profession under 'Special Instructions' for the order.

Pharmacy staff

- Pharmacy staff will promote use of the Medicines Management Policy and associated procedures/guidelines, alert other staff to changes that influence their practice and assist with developing strategies to minimise any identified risks.
- Pharmacy staff will advise on and monitor prescribing, administration and handling of medicines to promote, support and facilitate the safe, effective and economic use of medicines.
- Pharmacy staff will provide information to patients, nursing, medical and other healthcare staff with the aim of improving adherence and the effectiveness and safety of drug and drug-related therapy.
- Pharmacy staff are responsible for the procurement of all medicines to be used in the Trust, to ensure the quality of the medicines.
- It is the responsibility of all pharmacy line managers to ensure that pharmacy staff for whom they are responsible have received the relevant training and experience before undertaking the responsibility for medicines-related procedures and that training is recorded.
- Pharmacy staff are responsible for the stock of medicines held in the pharmacy, the manipulation and preparation into ready to use presentations and for their supply to wards and departments and dispensing to patients.
- Pharmacy staff will inspect ward, departmental or midwives' stock of medicines to ensure that drugs are in date and stored under the proper, legal and environmental conditions. The inspection of Controlled Drugs by pharmacy staff should be undertaken in the presence of a Registered Nurse/Midwife/Healthcare Professional as appropriate.
- Pharmacists, working with other pharmacy staff, are responsible for supporting the safe, effective and economic use of medicines in the Trust. This process includes regular monitoring of prescriptions to ensure accuracy, safety, clarity of prescribing and appropriateness.
- The Senior Pharmacy Team is responsible for ensuring that Pharmacy staff are deployed to clinical areas and that the pharmacist review of prescriptions is prioritised to manage medication risks to patients' and to ensure frequency for monitoring is achieved as defined in Key Performance Indicators (KPIs).

Medicines Specific Groups

- The Trust works closely with Milton Keynes Prescribing Advisory Group (MKPAG) to ensure local health economy decisions in relation to medicines use are reflected within the Trust.
- The Trust Prescribing and Medicines Governance Committee (PMGC) is responsible for developing and maintaining the medicines management strategy and provides leadership and direction on matters relating to medicines management, safety and security in the Trust.
- The PMGC provides assurance and reports to the Board through the quality reporting framework on progress against identified national and local quality standards and supports an appropriate level of scrutiny on medication related policies and procedures, patient group directions and delivery of care against required standards of practice.

- The PMGC will review medication risks in light of national or local incidents, and implement plans to promote and embed learning to help reduce the likelihood of similar incidents in the future.

2.0 Implementation and dissemination of document

This document will be published on the Trust intranet following ratification. The information will be cascaded through clinical forum and ward/department meetings.

An e-mail with link to the Policy location will be circulated to all acute user groups within the Trust.

All healthcare staff will be made aware of the document on induction, either through the mandatory Medicines Management training (doctors, most registered nurses/midwives and pharmacy staff) or through their line managers if medicines use is to form any part of their work for the Trust.

3.0 Processes and Procedures

3.1 Prescribing

Prescribers may issue Patient Specific Directions to supply or administer medicines to patients ("prescriptions") for clinical treatment of individual patients by the following methods:

- Authority to Administer medicines via Orders on eCARE
- Authority to Administer medicines on printed MKUH Trust proforma Prescription and Administration Record Charts for in-patients if eCARE is not available.
- Supply to patient instructions on printed MKUH Trust proforma Prescription forms or FP10(HP) printed MKUH Trust proforma Prescription forms
- ARIA system for prescribing chemotherapy and supportive agents.

All individuals who prescribe within the Trust must be employed by the Trust or work for the Trust under a formal written agreement and must only prescribe within their Scope of Practice.

Registered medical practitioners, dental practitioners, non-medical prescribers have a legal authority to prescribe medicines.

Non-medical and medical prescribers are normally each required to meet established standards and appear on their respective professional registers prior to writing prescriptions for patients of the Trust.

Neither overseas-qualified doctors undertaking clinical attachments who do not hold full registration with the General Medical Council nor medical students are authorised to order drugs (medicines) nor write prescriptions.

Medical staff with limited registration (Foundation Year 1 Doctors) are only permitted to prescribe for patients within the speciality in which they are employed, under the supervision of a consultant.

Non-medical prescribers can prescribe in accordance with the current legal framework and must work within their scope of professional practice.

Supply or administration of specific medicines without a prescription, by registered healthcare professionals within the Trust, may be authorised through approved Patient Group Directions (PGDs), Patient Specific Directions (PSDs), Standard Operating Procedures (limited range of medicines) or where exemptions to legislation permit, e.g. Midwives, Chiropodists.

Prescribers must not prescribe for themselves or anyone with whom they have a close personal relationship. Prescribing and issuing of prescriptions within the Trust should be for patients registered with the Trust and under the care of Trust clinician. NHS prescription documents should not be used for treating private patients. The issue of prescriptions to staff members to keep them at work where required can be provided by the Trust Staff Health and Wellbeing Team when possible

The accuracy of prescribing is the responsibility of the prescriber. They are supported in this process by procedural documents, eCARE order sentences and Power Plans, checking systems, which include consultant / senior review, pharmacist surveillance and nursing intervention at administration.

Supply of medicines for individual patients in emergency situations e.g. major incidents, may be undertaken without either a full prescription or a completed electronic prescription on eCARE, provided records are kept that identify the patients (Name, DoB and GP practice name as a minimum) and the medicines involved (drug, form, strength, dose) and that documentation of administration is done retrospectively in a timely manner.

3.1.1 Prescription Stationery

All prescription stationery, including Prescription Charts, Outpatient Prescriptions, FP10s, CD record books and CD order books, must be kept securely to prevent misuse.

Prescription Charts

In clinical areas where paper prescriptions charts are still in use, prescriptions must be written on specific stationery and all variations to, or new, prescription stationery must be authorised through the Prescribing and Medicines Governance Committee.

The Prescription and Administration Record Chart ("prescription chart") provides a permanent record of the prescription, supply and administration of a patient's medication. It forms part of the required record of medicines administration in individual patient's healthcare records.

- Ideally the patient should have only one prescription chart in use at any one time, however where a second chart or supplementary charts are used these must be cross-referenced to the main chart.
- Where a second main chart is in use at the same time as the first this must be attached to the first chart (using a treasury tag, not paperclips or other similar devices) and clearly identified as relating to an individual patient, including making clear how many (e.g.1of 2, etc.) and what type of additional active supplementary chart(s) are in use by ticking the appropriate spaces on the chart.
- If medication requirements reduce or there is no more space on the chart, the prescriber should rewrite the chart, & cross through the cover page of the old one to provide one main chart as soon as is practical. The new drug chart MUST be annotated to indicate it's been rewritten by the prescriber.

FP10s and hospital outpatient prescription forms

In some areas of the hospital FP10 prescription forms and/or hospital outpatient prescription forms are used. MKUH FP10 prescriptions may be taken to any community pharmacy holding an NHS contract to dispense. They may also be dispensed by MKUH pharmacy where there is an exceptional circumstance preventing supply from community pharmacy, if the prescriber is not from MKUH this requires approval from a senior manager in Pharmacy Department.

Prescription forms (hospital outpatient or FP10s) must be ordered from the Pharmacy Department following the FP10 ordering procedure. Minimal stocks of prescription stationery should be held to limit the number of forms vulnerable to theft, and to keep stocks up-to-date.

Prescription forms (hospital outpatient or FP10s) must be stored securely in a locked cabinet or drawer whenever they are not in use. The keys to the cupboard / drawer where FP10 stationery is stored must be stored securely and access limited to Prescribers and administrative staff ordering prescription pads.

Prescription forms (hospital outpatient or FP10s) should not be left unattended at any time and patients or visitors should not be left alone with prescription forms e.g. in clinic rooms.

In all settings where prescription forms (hospital outpatient or FP10s) are used, there must be a stock control system to aid reconciliation and provide an audit trail by recording the serial numbers of all pads received, issued, used, returned and sent for disposal. Records should be checked by the responsible person in the clinical area at the end of every clinic. Pharmacy Administration staff to perform weekly checks to check that prescription forms can be accounted for and none are missing.

Blank prescriptions must not be signed in advance.

Missing FP10 prescriptions should be reported via the Trust's incident reporting system (Datix) in a timely manner and Pharmacy team to be contacted for advice.

3.1.2 Allergies and Sensitivities

Prescribing medicines: Allergies and sensitivities should be recorded on eCARE at the first opportunity by any healthcare professional. Prescribing must not be attempted until an allergy status is recorded for the patient. If there are no known allergies, this option should be selected and documented. This is essential to allow prescribing. If allergies cannot be identified on initial presentation the option of 'Unable to Obtain' can be used for initial documentation.

All known drug allergies/sensitivities must be accurately selected via the allergies section on eCARE and electronically entered and signed providing an audit trail of name of the healthcare professional and date of entry. Non-medication allergies may also be recorded. Where known, the nature of the allergy or sensitivity must also be documented electronically, eCARE provides a list of possible adverse effects, if a suitable option is not available; a 'free text' entry can be made. Sources of information should also be documented.

Where a new allergy or sensitivity arises, it must be documented on eCARE allergy section and an entry must be made in the patient's electronic record as a 'general clinical note' together with the suspected allergen and nature of the allergy. The patient's own GP must be informed in a timely fashion by documenting the allergy on the patient's discharge summary. For adverse effects that are reportable to the MHRA, this can be done via 'Yellow Card Reporting' available on eCARE or on the MHRA website.

For administration of medicines, every effort should be made to establish allergy status before administering medicines to the patient. In case of doubt or lack of documentation, the prescriber should be contacted and medication not given until allergy status is documented.

3.1.3 Prescribing (ordering) medications

On admission of a patient, the doctor must attempt to obtain a medication history from the available sources at the time and prescribe the medications that are suitable to continue.

Information sources include, patient/carers, patient's own medicines, Summary Care Records or HIE Community view on eCARE, SystmOne and specialist sources example for chemotherapy or neurology medicines). Medicines reconciliation is to assess whether all regular medication is to continue during the hospital stay and whether all necessary additional medicines have been prescribed e.g. for symptom control or to address the reason for admission, such as antibiotics or pain relief.

Electronic prescribing

Electronic Prescribing and Medicines Administration system via eCARE must be used for prescribing medicines for inpatients where available.

Prescribing via eCARE must be done by using personal SmartCards only. Sharing of personal SmartCards is not permitted under any circumstances. If a member of staff does not have access to their personal SmartCard then they must contact IT for a temporary replacement of a Temporary Access Card (TAC) suitable for the role.

Prescribing of medicines via eCARE provides full and legible details of prescriptions with doses and routes of administration as mandatory fields that must be selected for the orders to be accepted.

Prescriptions (Orders) on eCARE should be initiated wherever possible using the order sentences or Power Plans which existing within the order catalogue. These have been designed to meet accepted good practice standards and are provided to mitigate the risks of prescribing errors. The prescriber should check the schedule on eCARE after an order has been signed to ensure that it is programmed as intended

Where appropriate order sentences do not exist, the nearest available order sentence should be selected and modified to meet the needs of the patient.

Prescribers who use specific regimen on a regular basis which is not available as order sentences or Power Plans should contact the Pharmacy EPMA team to discuss with a change to the eCARE catalogue.

The weight of all in patients (adults and children) must be measured and documented on eCARE as soon as possible following each admission to ensure medicines prescribed are appropriate for the patient's weight. On eCARE this is called the Weight Measured. and is then recorded on the blue banner bar with date weight taken. For babies/children and Young People an estimated weight (as per PILS/EPLS SORT guidance) should only be used in the event of life threatening events and or cardiac arrest where it is impossible to weigh the child at that time. For adults, estimated weight should only be used in an emergency for medicines with weight critical dosing.

Prescribing on paper medication charts

In clinical areas where paper prescription charts are still in use, prescription charts MUST clearly indicate:-

- The patient's name, hospital number (MRN), date of birth (or age), and address in the case of outpatients and discharges should be stated on every page of the prescription chart. Where possible the patients NHS number should be included as the recommended, consistent identifier between healthcare sectors and organisations.
- Consultant and Ward or clinic
- Patient's weight (and date weighed), height or body surface area (this should be included wherever possible and always where this is required for calculating dosage).
- A weight is always required for children of all ages up to 18 years.
- Prescribers name (PRINTED IN CAPITALS) bleep number and signature
- Prescriptions must be written legibly in black ink
- Known allergies and the signs, symptoms and severity of the reaction, or "no known allergies"
- Medicines should be prescribed using full approved names and must not be abbreviated.
- Brand names should not be used except where recommended in the BNF or local guidelines such as multi-ingredient preparations, some modified release preparations, drugs with a narrow therapeutic index or where there are differences between formulations.
- Date the prescription was written
- The dose, frequency, route and duration of administration of medication must be clearly stated
- Date the treatment is due to start
- Any days on which treatment should not be given

When prescribing electronically or on paper, the following points must be considered (see BNF):

1. Never use unnecessary decimal points, e.g.: 3mg never 3.0mg
2. Doses of 1 gram or more should be written in grams (g) e.g. 1g *never 1,000mg*
3. Doses of less than 1 gram should be written in milligrams (mg), micrograms or nanograms as appropriate e.g. 500mg *never 0.5g.*
4. The words Micrograms and Nanograms *must not be abbreviated*.
5. If necessary and when the decimal point is unavoidable, for example in liquid volumes of less than 1ml, a zero should always be written in front of the decimal point where there is no other figure e.g. 0.5ml *never .5ml*
6. When International Units are used (e.g. insulin), 'units' must be written in full and not abbreviated e.g. 16 units *never 16u or 16 IU.*
7. Where a dose range is prescribed 'to' should be used not a dash (-) where confusion regarding the intended dose may arise e.g. 2 to 5 mg *never 2-5mg or the units follow each dose e.g. 2mg - 5mg. Do NOT use dose ranges on regular medication.(Dose ranges cannot be used on eCARE)*

For all medicines, the route of administration must be clear and unambiguous. For regular medicines, the route of administration should be specific and not variable (never more than one route against a single drug and dose e.g. *never po / sc*).

The following prescribing points should also be noted;

- For liquid formulations, the dose should be prescribed in milligrams and not by volume except where this is not practical, e.g. lactulose.
- For inhaler therapy, the dose should be specified in terms of micrograms strength, type of inhaler device and also state number of 'puffs' for metered dose inhaler devices. For multi-component inhalers, the brand name of the inhaler should be specified to avoid errors.
- For nebuliser solutions, the dose should be specified in milligrams or micrograms, also the type and volume of diluent (if required) and the driving gas (e.g. air or oxygen) should be stated where appropriate.
- For drugs where the dose may be varied over time or in response to test results e.g. warfarin, prednisolone, chlordiazepoxide or alternate day therapy etc., concise indications on the prescription chart are essential, including where appropriate stating how the variable dose will be communicated e.g. in response to INR results, or on a pre-determined schedule (This is not possible on eCARE).
- Where doses are not to be given every day the prescription chart must be marked by the prescriber to show in the administration section on which days the drug must not be given e.g. methotrexate dosed on one day per week, non-dosing days should be marked with an 'X'.
- For "as required" medicines (prn) the frequency and the reason for use must be stated, together with the maximum dose or frequency in 24hrs and minimum dose interval with an indication when the prescriber is to be contacted if symptoms do not improve.
- Where more than one prn medicine is prescribed for the same indication, the prescriber must state when each medicine is to be used. As required medicines' should be reviewed regularly – usually at least once every 48 to 72 hours.
- For intermittent or limited courses of medicines, indicate duration for time limited therapy where appropriate, e.g. antibiotic, corticosteroid courses.
- For antibiotics, the indication for use, and whether micro approval has been obtained when prescribing is not in line with the Trust Antimicrobial Policy, must be documented on the prescription.
- If the patient's treatment is to be modified (e.g. change of dose, route or frequency), this MUST be done by crossing off the former and re-writing the new prescription, e.g. IV crossed through and amended to oral is not acceptable.
- Medicines which have been discontinued must be clearly indicated by drawing a line across the prescribing and administration section of the chart then initialed and dated.

3.1.4 Discharge Medication and Information

Electronic Discharge prescriptions should be completed and submitted for Pharmacy to process with as much notification as is possible, ideally 24 hours before discharge or wherever possible before 4pm on the day of discharge. For discharges requiring Medication Dosage Systems (MDS), a notice period of 48 hours should be given to the ward pharmacist, unless there are exceptional circumstances.

All prescriptions for discharge medication should be via eCARE system. Prescribers must reconcile all medications documented as 'medication on admission' with a clear choice that must be selected to indicate if a medication is to continue, stop or changed if the dose has been altered. Reference should be made to eCARE Quick Reference Guides for detailed steps to prescribing. Where changes have been made to regular medicines prior to admission, this should be clearly documented with reasons and monitoring advice for GPs to follow if needed.

Once the discharge prescription is finalised and completed, a copy will be automatically sent to the GP surgery. Any necessary changes made following this completion must be flagged by the prescriber to the ward pharmacist and the discharging nurse. An updated copy must then be sent to the GP with a follow-up call to alert the GP surgery of the update.

Where applicable, paper discharge prescriptions should only be used when eCARE is inaccessible due to a technical fault; where handwritten the prescription writing guidance in the previous section should be followed.

When using paper discharge prescriptions, the prescriber should provide the following details to support reconciliation of medicines following discharge:

- Patient's name, date of birth, hospital number (MRN), NHS number and address, GP / Practice details.
- Other relevant contacts e.g. Consultant, Specialist Nurse, Community Pharmacy
- Allergies and sensitivities, and the signs, symptoms and severity of the reaction
- Medicines, including brand name where relevant
- Medicine changes e.g. stopped, started, dose changes and the reasons
- The intended duration of treatment
- Any monitoring and follow up requirements
- Name, signature, job title and contact details

The prescriber should update any patient held record e.g. warfarin, methotrexate, lithium, insulin passport.

A minimum of 14 days to a maximum of 28 days' supply of regular medicines will be supplied; where the medication is a limited course, the whole course should be supplied and where a medication is "as required" the smallest appropriate whole pack should be supplied. Pharmacy may adjust quantities as appropriate in order to limit waste and provide adequate supplies to cover bank holidays and other periods where obtaining further supplies may be difficult.

In some cases, for example the supply of dalteparin on discharge, prior agreements with CCGs or GP practices should be adhered to.

For all discharges, it is the responsibility of the nurses and midwives, with support from pharmacy, to assess the patients' / carers' knowledge and abilities (with consideration of mental capacity and relevant assessments if needed) to administer their own medication after discharge. It is important to identify at the time of admission potential medicines problems affecting discharge, including possible use of monitored dose systems (MDS or dosettes) so that they can be managed to avoid an extension in the patient's stay in hospital or problems thereafter.

Discharge medicines should be discussed with the patient or carer/ next of kin prior to discharge and any written or verbal information provided should be tailored to the individual's needs. Where this is written locally, pharmacy staff must be involved.

It is a legal requirement that patients are given a manufacturer's Patient Information Leaflet (PIL) with all medicines supplied; these can be found in / or attached to the medicine container supplied by the hospital pharmacy.

Special consideration should be given to patients on 'high risk' and 'critical medicines' with regard to dosage regimes and monitoring (see section 3.1.5).

The patient should be made aware of the need to obtain further supplies from their GP and be advised to visit their community pharmacist post-discharge for a review if appropriate.

Reviews in community pharmacy are an opportunity for patients to discuss their medication and compliance with a pharmacist of their choice when they are at home.

Pharmacy may refer patients to their own community pharmacy on discharge where this is considered to be helpful to support the patient and with the patient's consent.

In specific areas of the hospital, procedures are in place, supported by suitable training and monitoring, to enable supply of discharge medication using pre-packed, pre-labelled medicines for a patient to take home. For further guidance refer to the Guideline for Supply of Discharge Medicines – use of TTO pre-packs. Supply must not in any other case be made from ward stock for discharge or against a PGD.

Inpatients may leave the ward for a period of time prior to full discharge from hospital, for example day or weekend leave. All medicines supplied to the patient must be correctly labelled and meet the legal requirements for labelling. The procedure for obtaining discharge medication and assessing the patient/carer understanding and ability to administer medication as prescribed must be undertaken against the most up-to-date version of the discharge prescription whatever the period of leave. These leave periods should be planned and the medication requested at least one day in advance.

It is the responsibility of the discharging nurse to check all the medications provided to the patient on discharge against the most up to date Discharge Final Summary on eCARE. Any discrepancies should be raised with the Pharmacy team or the doctor looking after the patient.

Controlled Drugs Supplied on Discharge

Prescriptions for inpatient orders and discharge should be prescribed on electronic medication charts via eCARE when available. Electronic prescriptions for CDs would automatically generate legible and clear instructions as mandatory fields must be completed for the prescription to be signed and submitted.

Suitable order sentences available on eCARE should always be used when clinically appropriate.

Prescriptions for controlled drugs on discharge must include,

- Name & address of patient,
- The drug and formulation and
- The total quantity of CDs to be supplied in words and figures (e.g. 14 (fourteen) of fifty (50) milligrams tablets). If the strength of the medication available in MKUH Pharmacy is not known, the total quantity expressed in the units of the medication can be used (e.g. 700 (seven hundred) milligrams total supply) and
- Signed by the registered prescriber.

When the discharge prescription is electronically prescribed via eCARE, a copy of the Discharge Summary Prescription must be printed and signed by the prescriber in order to comply fully with all relevant legislation. CDs will not be issued by Pharmacy until the legal requirements are fully met.

Pharmacist Amendments to CD Prescriptions

Where a prescription for a Schedule 2 or 3 Controlled Drug contains a minor typographical error or spelling mistake, or where either the words or figures (but not both) of the total quantity has been omitted, a pharmacist can amend the prescription indelibly so that it becomes compliant with legislation.

The pharmacist needs to have exercised due diligence, be satisfied that the prescription is genuine and that the supply is in accordance with the intention of the prescriber. The prescription should also be marked to show that the amendments are attributable to the pharmacist (e.g. name, date, signature and GPhC registration number).

Pharmacists cannot correct other amendments or omissions (e.g. incorrect dose, form or strength). These should be corrected by the original prescriber or, in an emergency, another prescriber authorised to prescribe Controlled Drugs.

Where clinically appropriate, in End of Life patients, the Trust palliative care 'Just In Case' (JIC) prescription form should be referred to for choice of medications, doses and quantities to be supplied. A copy of the JIC form is available on Trust intranet.

Controlled Drugs which have been dispensed for discharge and received by the ward must be recorded in the ward Patient's Own CD record book and stored on the ward as indicated in the Trust Controlled Drug Procedures.

For further guidance refer to the Trust Controlled Drug Procedures.

3.1.5 Prescribing Medicines with Special Considerations

All medicines must be used carefully and appropriately; many medicines require specific care and consideration in their prescription, preparation, administration or monitoring.

HIGH RISK AND CRITICAL MEDICINES: Designated high-risk medicines can be managed safely when key Patient Safety approaches and learning are followed. Refer to specific medicine safety guidance for these high risk medicines.

CHEMOTHERAPY: SACT (Systemic Anti-Cancer Medicine) MUST only be prescribed by a Consultant Haemato-Oncologist or Consultant Medical Oncologist or their delegated Specialist Registrars in training (ST3 or above), who have completed the necessary training, are registered with their professional body and are authorised by the Trust to prescribe within their competence. For all chemotherapy drugs, prescribers who are not familiar with each drug must seek specialist guidance and/or refer to relevant Trust guidance on cytotoxic medicines.

ANTIBIOTICS: Appropriate antimicrobial prescribing improves patient outcomes, reduces hospital stay, is associated with fewer adverse events and helps to reduce the spread of resistant bacteria. Antibiotic prescribing should comply with the relevant adult or paediatric antimicrobial guidelines.

GENTAMICIN PRESCRIBING AND ADMINISTRATION FOR NEONATES: The NPSA Alert 'Safer use of intravenous gentamicin for neonates' actions must be followed. The Alert can be found here: https://www.sps.nhs.uk/wp-content/uploads/2018/02/2010-NRLS-1085-Safer-use-of-inonates-2010.02.03-v1.pdf
Further resources and can be found here: https://www.sps.nhs.uk/articles/npsa-alert-safer-use-of-intravenous-gentamicin-for-neonates-2010/

Main requirements include;

1. When prescribing gentamicin, the 24-hour clock format should be used and the unused time slots in the prescription administration record blocked out at the time of prescribing to prevent wrong time dosing.
2. Interruptions during the preparation and administration of gentamicin should be minimised by the wearing of a disposable coloured apron by staff to indicate that they should not be disturbed.
3. A double-checking prompt should be used during the preparation and administration of gentamicin.
4. The prescribed dose of gentamicin should be given within one hour of the prescribed time.
5. Full compliance with the NPSA alert for all patients receiving gentamicin must be achieved.
6. All staff involved in the prescribing and administration of intravenous gentamicin are provided with training relating to its use and the details of this alert. This should include education regarding the interpretation and management of gentamicin blood levels including actions to be taken in relation to dose or frequency following a blood level result.

PARENTERAL POTASSIUM: High strength intravenous potassium is only available for use in designated intensive care areas. Prescribing of this medication must follow Trust procedure.

HEPARINS: When prescribing low molecular weight heparin or unfractionated heparin, the dose should be calculated taking the patients weight and renal function into account. Refer to relevant Trust guidance on anticoagulation.

When prescribing the oral anticoagulant warfarin, the dose should be confirmed by reference to the INR or the patient's anticoagulant record book or other patient held record where appropriate.

DRUGS WITH A NARROW THERAPEUTIC WINDOW: If initiating methotrexate, lithium, digoxin, phenytoin or theophylline (this list is NOT exhaustive – if in doubt, refer to the BNF), prescribers must inform the patient of the risks and benefits, confirm the patient understands and seek consent. Baseline tests should be conducted, the monitoring and dosage schedule explained and a patient-held monitoring/information booklet issued if appropriate. Monitoring advice must be communicated to the GP on discharge and documented on the discharge summary.

PARENTERAL THERAPY: When prescribing or administering medicines by the parenteral route, this should be done in accordance with the relevant NPSA alerts for injectable medicines and safe local procedures. Specific reference should be made to the NPSA Alert 20 'Promoting Safer Use of Injectable Medicines'.

OPIOIDS: When initiating opioid medicines in patients who have not previously received them particularly via a parenteral route, the patient should be monitored for adverse effects post administration. Clinical areas that stock opioid injections must also stock an adequate quantity (Minimum 10) of naloxone ampoules. Prescribers and those administering medicines should

ensure that they are familiar with the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side effects.

CONTROLLED DRUGS: Refer to relevant Trust guidance on controlled drugs

INSULINS: Prescribing of insulins must state the dose and the type of device for administration. If a paper prescription is used, then it must include both the word 'INSULIN' in full and the brand name, dose in standard units must be written in full 'UNITS' and the dosage device (i.e. pen/cartridge/vial) should be specified

UNLICENSED MEDICINES: In certain circumstances it may be necessary to use an unlicensed medicine, that is, a medicine without a UK marketing authorisation. Special considerations are needed in this case; Refer to the Unlicensed Medicines Policy

USE OF LICENSED MEDICINES OUTSIDE THE TERMS OF PRODUCT LICENSE – "OFF LABEL USE": It may be necessary to use a licensed medicine for an unlicensed indication. Refer to the Use of licensed medicines outside license ("off label") policy

CLINICAL TRIALS: Refer to the relevant Trust guidance on clinical Trials. All staff involved with clinical trial activities must have up to date GCP certification and comply with GCP/GMP requirements.

PREGNANCY PREVENTION PROGRAMMES: Prescribing and dispensing of medicines contraindicated in pregnancy in females of childbearing age unless the conditions of the pregnancy prevention programme are met MUST follow the advice and actions stated in the specific Pregnancy Prevention Programmes. Examples include Valproate Pregnancy Prevention Programme and oral retinoids pregnancy prevention.

3.2 Administration

3.2.1 Authorisation to administer

All individuals who administer medicines to patients of the Trust must be employed by the Trust or work for the Trust under a formal written agreement (including bank and agency staff).

The following staff are authorised to administer medicines:

- A registered nurse
- A registered midwife
- A registered Nursing Associate (according to agreed criteria)
- A registered medical practitioner or dentist
- Other registered healthcare professionals from appropriate staff-groups provided they have undertaken appropriate Trust approved training e.g. ODP, pharmacists and pharmacy technicians, physiotherapists, dieticians, radiographers, podiatrists.

Only health care professionals who have undergone specialist training are permitted to administer cytotoxic medicines. Refer to relevant Trust guidance on cytotoxic medicines.

In accordance with the Milton Keynes University Hospital Adult Student Nurse Standards, student nurses and nursing associates will be given every opportunity to become proficient in the administration of medicines under the direct supervision of a registered nurse at all times (who is a qualified Mentor) in the following manner:

Stage 1	Student Nurses will work with a qualified mentor to observe and participate in the administration of medicines by a variety of routes. Student Nurses will observe and participate in the documentation of all aspects of medicines administration.
Stage 2	Student Nurses will work with a qualified mentor to prepare and administer a variety of oral, subcutaneous and intramuscular medications. This will include the preparation of intravenous medicines. Student Nurses will use prescription charts and work with a qualified mentor to maintain accurate records of administration and non-administration of medicines.
Stage 3	Student Nurses will work with a qualified mentor to prepare and administer a variety of oral, subcutaneous, intramuscular and intravenous medications. This will include the opportunity to complete at least two supervised medication rounds each week. Student Nurses will have a clear understanding of prescription charts and will maintain accurate records of administration and non-administration of medicines.

Student Nurses are NOT allowed to administer any of the following: IV Opioid Analgesics; IV Sedatives; Oral or IV Chemotherapy; any Medications in an Emergency Situation.

Health Care Assistants/Auxiliary Nurses/Nurse Support Workers/Ward Hostesses are not permitted to administer or check drugs as part of administration processes.

Registered Nurses, Midwives or Nursing Associates working as bank or agency staff can administer medicines, according to Medicines Management policy, if it is within their scope of practice.

3.2.2 General principles

When administering medical products healthcare professionals shall act within the framework of current legislation and in accordance with the NMC, The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (2015), The Professional Guidance on the Administration of Medicines in Healthcare Setting by the Royal Pharmaceutical Society (RPS) and Royal College of Nursing (2019) and the Advisory Guidance on Administration of

Medicines by Nursing Associates by Health Education England (2017) and in accordance with the relevant policies of the Trust.

Patients should be supported to self-administer their medicines when possible and appropriate, following the Trust Self Administration of Medicines Procedures.

Patients have the right to refuse medicines if assessed to have mental capacity; however, it is important to inform the patient of the reason for and the importance of taking the medicine and the possible consequences of omission. Healthcare professionals should be aware of religious and cultural issues that may affect administration of and attitudes to medicines e.g. fasting or medicines containing animal derived products

If a 'critical medicine' is refused, monitor the patient, inform the prescriber and document actions taken.

A second **independent** check by a competent healthcare professional is mandatory for:

- Controlled Drug preparation and recording
- Preparation and administration of intravenous medications
- Paediatric administration prior to competency assessment
- Intravenous cytotoxic medication.

The competent healthcare professional carrying out the second checking must ensure that the entire process of preparation of medicines, calculations and products used is independently checked.

For medicines administration that do not require a second check, single registered healthcare professional administration is acceptable where the practitioner regards themselves as confident and competent, they may request a second independent check if needed.

Where a second practitioner is asked to check a calculation they must undertake the full calculation independently by their own method, and compare results only after independent calculations have occurred.

Medicines prepared by one healthcare professional must not be administered by another healthcare professional, unless they were prepared in their presence. The only exception to this would be an established infusion or medicines prepared by central service such as a pharmacy department.

Following preparation of an injectable medicine, it must be immediately labelled. Unlabeled syringes or infusion bags must never be left unattended or in the presence of other unlabeled medication, as this increases risks of clinical error.

If multiple preparations of injectable medications are being undertaken, or if there is a delay between preparation and administration, **syringes and infusion containers must be labelled immediately**. When multiple preparations are needed, each must be prepared completely separately from other medications.

The practitioner administering a medicine dispensed by the Pharmacy Department in response to an individual prescription can expect that the medicine will be in a form appropriate to the administration for that particular patient, provided in an appropriate container giving the relevant information and advice on appropriate storage and security conditions. When a product is obtained from stock or transferred from another ward and the prescription has not been screened by a pharmacist, then extra care must be taken to ensure appropriateness and suitability of the medication.

3.2.3 Administration process

The process adopted for administering a medicine, or checking of preparation and administration, to any patient must ensure that the correct medicine is administered to the correct patient, in the correct form, by the correct route, at the correct dose, at the correct time.

- All sections of the Drug Chart or Drug Chart Summary on eCARE must be checked before administering a medicine.
- If a paper prescription charts is needed, the prescription chart should be legible and include the following
  - Patients full name, date of birth and NHS number/hospital number
  - The ward
  - Medicine and food allergies/intolerances and the signs, symptoms and severity of the reaction
  - Date the drug is to be commenced
  - The signature of the prescriber

The healthcare professional administering medications must;

- Be certain of the identity of the patient to whom the medicine is to be administered and ensure the privacy and dignity of the patient when medicines are administered. The patient's wristband **must be scanned** to confirm identity prior to administering medications.

- Check the patient is not allergic or sensitive to the medicine before administering. This check must include checking the patient's identity as above (scan the patient's barcode to bring up the correct medical records and prescription chart on eCARE and check allergies section) and looking in every case at the patient's wristband to check whether allergies have been noted through use of a red band, and/or on the prescription chart. Where possible discuss allergy status with the patient at the time of administration by telling them the name and nature of the medicine to be given.
- Check that authority to administer is accurate and clearly written, unambiguous, signed and dated and covers the date for administration.
- Check the dose, route, frequency and time of administration of medicine, as well as any special instructions (e.g. administer with food, rate of infusion, etc.).
- Scan the medication barcode to ensure the correct medication is being administered. If the item cannot be scanned, inform the ward pharmacist or Pharmacy EPMA team of the issue so that it can be resolved. Pharmacy labels must not be removed to facilitate scanning.
- Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- Check the time of previous dose.
- If a practitioner is unfamiliar with a medicine to be administered then the practitioner must as a minimum refer to the BNF for information (accessible online via https://bnf.nice.org.uk/ or for BNFC https://bnfc.nice.org.uk/, via the BNF app or most up to date books available in clinical areas). If still in doubt then staff should always check further with a pharmacist or prescriber.
- Refer to The Injectable Medicines Guide (IMG), also known as **Medusa** for detailed advice on injectable medicines. Medusa is an NHS resource that should be used for guidance on the preparation and administration of injectable medicines in adult and paediatric clinical areas. It is a web-based resource and can be accessed via the Trust intranet. Monographs comprise a number of different sections detailing how the medicine is presented, how it should be reconstituted and/or diluted if appropriate and how it should be administered. Risk assessments using the NPSA tool are also included.
- Ensure that the patient receives the medicine in a timely manner so that doses of critical medicines are not missed.
- Ensure that the manufacturers' and / or pharmacists' instructions for the preparation of medicines are followed.
- Whenever possible advise the patient about their medicines to assess and promote the patient's knowledge and understanding about their medicines to promote safety and prepare the patient for self-administration of medicine(s) at home or in hospital as part of a planned programme towards independence and involve relatives or other informal carers, where appropriate.
- Where appropriate the patient should be asked to confirm the dose and that it is due, and not already given, particularly for high-risk medicines such as warfarin, insulin, opioids and cytotoxic agents.
- Assess the effect of the medicine and identify side effects and interactions. If an adverse reaction is suspected this must be reported to a prescriber within an appropriate timescale, according to the clinical situation, and it must be recorded in the patient's notes. An MHRA

Yellow Card and an incident report via the trust incident reporting system (Datix) should be completed if appropriate.

- Contact the prescriber or another authorised prescriber without delay where any possible contra-indications to the prescribed medicines are discovered, where the patient develops a reaction to the medicines, and/or where assessment of the patient indicates that the medicines are no longer suitable.
- Ensure that the medicine is suitable for use, has been stored correctly and is within expiry date (and within the expiry time after opening).
- Ensure that medicines are prepared in an environment that protects both the medicine and the member of staff from possible contamination. Substances such as hormonal products, antimicrobials, immunotherapy and cytotoxics are hazardous and should be handled with caution. Contact with the skin and inhalation of dust must be avoided.
- Ensure that doses of oral liquid medicines that cannot be measured using a standard 5ml medicine spoon or graduated medicine pot are measured using an oral / enteral medicine syringe. Parenteral syringes must not be used to administer oral medicines.
- Ensure that all insulin doses are measured and administered using an insulin syringe or commercial insulin pen device. Standard non-insulin syringes must not be used for insulin measuring or administration, except for insulin infusions where administration should be set up to permit controlled-rate infusions in 50ml IV syringes or larger infusion bags.
- Be aware of the risks associated with the use of syringe pumps and electronic flow control devices (e.g. infusion pumps) and the need for specialised knowledge and training and competency before use.
- In clinical areas where paper medication administration charts are in use, reference to the patient's medication paper chart must be made to ensure all prescribed medicines are administered at the prescribed time.

Administration is complete when the patient has taken the medicine orally or by another appropriate administration process. Medicines must **not** be prepared then left out for patient's to take at a later time without direct supervision. The person responsible for administering the medicine must ensure that the administration process is completed and that all necessary records are completed. For patients who self-administer, reference should be made to the Self Administration policy.

3.2.4 Administration of Controlled Drugs

Selection of the correct Controlled Drug, completion of the register and identification of the patient must be witnessed by a second registered nurse/midwife/Healthcare Professional, the witness must sign on eCARE to document that an independent check has been completed.

Any Controlled Drug prepared and not used, or only partly used, must be destroyed in the presence of the second registered nurse/midwife/Healthcare Professional. An entry should be made in the Controlled Drugs register and signed by both parties or solely in the case of a community midwife. Refer to relevant Trust guidance on waste disposal.

3.2.6 Self-Administration of medicines

Self-administration of medicines by patients should be supported where this facilitates safe and appropriate patient care.

Clinical areas must follow the Self-Administration of Medicines Policy and ensure all relevant documentation is completed.

3.2.7 Delayed and Omitted Medicines

Every effort should be made to administer prescribed medicines in a timely manner as omission of certain medicines or a delay in dosing can be detrimental to patients.

A critical medication **must not** be omitted unless for justified clinical reasons documented by the prescriber or another doctor responsible for the patient. If the medication is not available on the ward then escalation to obtain supply must be followed, including contacting the on-call pharmacist during out of working hours. If a critical medication is not possible to administer then the clinical team responsible for the patient must be informed and alternative options put in place as appropriate. **Under no circumstances should a critical medication be omitted without a documentation of justification and escalation to the clinical team looking after the patient.**

Common examples of critical medications and administration times can be found in the Medicines Advice and Safety Leaflet 'Critical Medicines' (In development).

In some cases there may be a delay in treatment for non-critical medicines but the omission should be rectified promptly, for example when the patient has been off the ward. It is the responsibility of the nurse/midwife/Healthcare Professional responsible for the patient to administer medicines at the due time and to take appropriate actions to ensure the patient receives appropriate treatment in a timely manner. All omissions must be documented on eCARE and the action taken documented in the patient notes. It is regarded as a medication error if a dose is omitted and no reason documented on the prescription chart or the drug is omitted due to it being unavailable. Such medication errors should be reported via the Trusts error reporting system (RADAR). The ward manager must regularly monitor the omission of doses reports and investigate system failures to improve practice.

Individual medicines prepared and then not administered must be disposed of correctly. Refer to relevant Trust guidance on waste disposal.

3.2.8 Administration of medicines without a prescription ('verbal orders', 'standing orders' or 'homely medicines')

As eCARE can be accessed remotely, the requirement for a medicine to be administered without a prescription is in exceptional circumstances only.

In any such situation the individual authorised to administer medicines will be responsible for the following:

- Satisfying themselves through discussion with the Prescriber that the situation is urgent and treatment cannot be delayed until the Prescriber can provide a prescription.
- Satisfying themselves of the identity of the Prescriber.
- Confirming back the details with the prescriber prior to administration, the details must include the following: Name of the medicine, form, route, strength, dose (example in milligrams or grams as appropriate) and volume to be administered in the case of injections or liquids.
- Refusing to proceed if they are not satisfied that the Prescriber's instructions are sufficiently clear and taking further advice from available senior staff.
- That the order is documented immediately following administration in the patient's clinical notes on eCARE.
- That the order is prescribed and countersigned as above within 24 hours of receiving the order.

In an emergency situation, for example when a Resuscitation Team responds to the sudden collapse of a patient, an individual authorised and competent to administer medicines may act on the verbal instructions of a prescriber. Immediately after the incident the prescriber will retrospectively prescribe the medications detailing the drugs and doses given. The administration of the medicines given under verbal instructions will be retrospectively signed on eCARE by the individual who administered them.

In clinical areas where paper medication charts are still in use, administration of medicines without a prescription must be documented on the front of the drug chart in the 'once only' section stating name/position and date/time administered.

In the event of eCARE planned or unplanned downtime, the administration of medicines without a prescription should be documented on the front page of paper drug charts. Once eCARE is restored, the medications administered should then be retrospectively prescribed by the prescriber and signed as administered on eCARE by the authorised individual.

3.2.9 Complementary Medicines

If a patient wishes to administer to themselves, or requests administration of, complementary or alternative medicines they must discuss this with the prescriber responsible for their care.

- Some of these preparations can interfere with absorption, metabolism and excretion of conventional medicines and should be discussed with the ward pharmacist or by contacting pharmacy Medicines Advice.
- If agreed to be safe and appropriate to continue, the preparation must be recorded on eCARE medication chart, with product details and supply stated under Special Instructions for the medication order. If paper Inpatient Prescription Chart and Administration Record is necessary, then the prescription should be endorsed with 'patient's own' by the pharmacist.
- It should be made clear to the patient and recorded in the medical notes that the Trust cannot accept responsibility for the quality of this group of agents or any such items brought in by the patient and will not be supplied through Trust Pharmacy Services.

Safety information regarding use of complementary medicines in pregnancy and breastfeeding are very limited. In general, complementary medicines should be avoided by pregnant and breastfeeding women. This is due to the lack of scientific safety data and information on whether or not various complementary medicines pass through the placenta or into breast milk. These preparations are not necessarily safe alternatives to conventional medicines and their constituents are likely to have pharmacological activity and they might possess toxic constituents. Furthermore, Contamination cannot be ruled out and different products often vary with regard to the concentration and source(s) of their constituent herbs.

4.0 Covert administration

Medicines are administered covertly only to patients who actively refuse their medication and who are considered to lack mental capacity in accordance with an agreed management plan. Where necessary, covert administration of medicines deemed must take place within the context of existing legal and best practice frameworks including; The National Institute for Health and Care Excellence (NICE) and PrescQIPP and CQC guidance on covert administration and in accordance with the Mental Capacity Act 2005.

The following steps must be followed:

- It should be established that the patient does not have capacity to make a decision or consent to treatment in line with the Mental Capacity Act 2005.
- The treatment provided should be deemed necessary and be the least restrictive option for the patient.
- A "best interests" meeting should take place where the best course of action for the individual is decided.
- The prescribing practitioner should conduct this meeting in conjunction with a multi-disciplinary team of healthcare professionals. The person's family/representatives must be involved in and informed of the decisions made. If the patient has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.
- Following the "best interests" meeting a management plan should be agreed and documented for the patient.
- At the "best interests" meeting the timeframe or circumstances for review (for example addition or changes to medicines) should be decided. The need for covert administration must be reviewed regularly as capacity can fluctuate over time.
- Covert administration of medication will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for the decisions made lies with everyone involved in the person's care and clear documentation is essential. Documentation of when medicines are administered covertly should take place on the patient's medication administration chart. Outcomes of review meetings also need to be documented.

If the situation is clinically urgent, NICE states that it is acceptable for a less formal discussion to occur between the prescriber and family or advocate to make an urgent decision so covert administration can take place. A formal meeting should be arranged as soon as possible afterwards.

For covert administration of medicines in children, it is best to use play therapy to aid administration; however covert administration may be needed if in the patient's best interest. Advice regarding stability of medicines and covert administration should be sought from the ward pharmacist.

Altering medicinal products (for example crushing tablets) or adding to food/drink is usually an unlicensed (off-label) activity. Prescribing medicines in a manner outside of the recommendations of the marketing authorisation alters (and probably increases) the prescriber's professional responsibility and liability. This should only be conducted if the prescriber can justify, and is confident in, the use of the medicine in this manner. Additionally, Healthcare Professional s that are not independent prescribers are not presently allowed to authorise the use of medicines outside of their marketing authorisation. Therefore if medicines are to be administered in this way this must be authorised by a relevant prescriber.

There may be limited pharmaceutical information on the stability of medicines hidden in food or drink. Advice on effectiveness and stability of medicines administered covertly should be obtained from the ward pharmacist.

5.0 Ward/Department control of medicines

5.1 Procurement

Medicines may only be purchased or acquired by pharmacy staff acting under delegated authority and following pharmacy procurement standard operating procedures and complying with legal requirements to ensure that all medicines are safe and fit for purpose.

Procurement, storage, distribution and security of samples and clinical trial medication for patients should only be handled by the Pharmacy Department.

5.2 Ordering and Receipt of Medicines from Pharmacy

Each ward or department will hold a list specifying the range of medicines and quantity to be held in the ward or department as routine stock holding. Stock lists are available on the Trust intranet under Pharmacy for reference. Stock medicines will routinely be supplied by the Pharmacy Department 'top up' service but this does not replace the nurse/midwife/Healthcare Professional's responsibility for ensuring that medication is available in a timely manner for patients.

Items required for stock between top ups should be ordered using the Ward Stock Order Book provided by the Pharmacy Department.

All requests for non-stock medications required for individual inpatients must be made via eCARE supply request function. If the request is urgent, then this should be followed up with verbal contact with the ward pharmacist or pharmacy technician or dispensary helpline if necessary.

In areas or circumstances where eCARE is not available, requests for supply should be made via the ward pharmacy team or by sending the paper medication chart to the dispensary with a request (written in indelible ink) to supply the required medicine.

During out of hours, the on-call pharmacist should be contacted for urgent supplies.

A regular six monthly planned review of medicines stock lists should be undertaken by the ward pharmacist with the ward manager to ensure that the stock list reflects current clinical needs.

The ordering, receipt and storage of stock medicines and the security of all medicines on the ward is the responsibility of the nurse or midwife in charge and may be delegated to a registered nurse or registered midwife.

All medicines delivered to the ward/department must be locked away immediately in an appropriate cupboard, fridge or trolley.

5.2.1 Ordering, Collection and Receipt of Controlled drugs

Controlled Drugs (CDs) for ward and department stock should normally be ordered from Pharmacy before 12.00pm Monday to Saturday. Ordering is restricted to registered nurses, midwives and appropriate Healthcare Professionals employed by Milton Keynes University Hospital Trust whose signatures have been authorised following the Trust procedure for ordering collection and receipt of Controlled Drugs.

A midwife may order Controlled Drugs for use in community by completing a Midwives supply order form, this must be countersigned by Supervisor of Midwives and following Trust procedure.

Controlled Drugs will be delivered routinely by t either a pharmacy or general / theatre porter who will sign a delivery book for a sealed red bag containing Controlled Drugs. The sealed bag must be received on the ward / department by an appropriate registered Healthcare Professional who is employed by the Trust. The person receiving the sealed bag is accountable for ensuring safe receipt and checking of the controlled drugs. Ward staff can collect Controlled Drugs from pharmacy on behalf of their ward areas by signing receipt of collection.

Controlled Drugs that are brought into the hospital by a patient must be recorded as directed in the Trust Patient's Own Drug procedure.

5.2.2 Controlled Drug Stationery

All stationery which is used to order or record CDs must be stored securely and access restricted. Only one CD order book should be in use at any time, unless agreed with Pharmacy.

When ward CD registers are almost full, the stocks must be checked and the data transferred from the old register to the new. This should be checked by a member of the ward pharmacy team and registered nurses/midwives/Healthcare Professionals.

Completed CD registers and order books must be archived in a secure but accessible place for 2 years from the date of the last entry. Partly used controlled drug stationery that is no longer in use e.g. if a ward closes, must be archived securely as above from the date of the last entry. Empty pages must be voided using a method agreed with the Chief Pharmacist.

5.3 Storage of Medicines

The Appointed Nurse/Midwife or Healthcare Professional as appropriate, in Charge of the ward or department is responsible at all times for medicines stored in the ward or department. This responsibility may be delegated to the Nurse/Midwife/Healthcare Professional in Charge in times of absence. In certain areas, such as radiology departments or operating theatres, specific additional medicines management procedures may be produced by the responsible manager and authorised through the Chief Pharmacist and PMGC.

Storage should be sited for maximum security with access restricted to authorised staff only.

Medication must be stored in line with manufacturer recommendations to ensure the quality of the product up until administration to the patient. Medication storage facilities must therefore be maintained at appropriate temperatures to prevent degradation of the medicinal products and ensure the medication received by the patient is as intended by the manufacturer.

It is essential that the temperature of ambient storage areas is monitored and action taken if temperatures are out of range. The impact of temperatures above the specified range is dependent on the temperature the medicine has been stored at and the length of time the temperature has been out of range.

For medicines that require storage at ambient temperatures (not including chemotherapy medicines), short excursions out of range for less than two days are unlikely to impact on expiry date.

- In range: temperatures less than 25ºC
    - If all temperature points e.g. maximum and minimum are below 25ºC, then storage conditions are optimal. Reset the thermometer max and min and continue with daily monitoring.
- Temperature recording over 25ºC:
    - Individual temperature deviations are unlikely to have a detrimental effect on medications overall.
    - If the temperature reaches between 25o C and 30o C for seven consecutive days then this must be reported to the ward based Pharmacy Team.
- Temperatures recording over 30o C
    - Temperatures continuously over 30ºC may compromise the stability of medication stored in this area and immediate action must be taken.
    - If a temperature is recorded over 30ºC for 2 consecutive days the pharmacy team MUST be contacted.

The temperature of all storage locations must be monitored daily and recorded and reviewed by the Nurse/Midwife/Healthcare Professional in Charge. Deviations outside recommended temperature ranges that may impact on stability of medicines (see above) must be reported via the Trust's incident reporting scheme.

For excursions in storage temperatures related to chemotherapy medicines or medicines that require storage in a refrigerator or freezer, the Pharmacy Department must always be contacted for advice regarding stability of medicines and if safe to use. The affected medicines must be quarantined until advice from Pharmacy regarding stability is received.

Some medicines e.g. flammable, caustic or toxic products must also be stored and handled in accordance with Control of Substances Hazardous to Health (COSHH) Regulations. Advice can be obtained from Pharmacy Department.

All medicines must be stored in the containers in which they are supplied by pharmacy in a secure, locked location, such as a medicines cupboard, cart or other secure receptacle. This includes

medicines for self-medication and for discharge. It is unacceptable for loose ampoules, prefilled syringes and strips of medicines to be stored outside their original packaging or labelled packaging provided by pharmacy.

Medicines awaiting disposal should be put in the Pharmacy Returns Bins, which are emptied and contents returned to Pharmacy Department by Pharmacy porters.

Storage receptacles must be kept exclusively for medicines, other items such as valuables, money, food or specimens must not be stored in the medicine cupboards.

Parenteral fluids and sterile topical fluids because of their bulk may be stored in a secure clean area, as agreed between the Matron and the Chief Pharmacist. Care should be taken to separate parenteral infusions from non-parenteral preparations. Fluids must be kept in original boxes and boxes not disposed of until the final bag has been used. Potassium containing fluids shall be segregated from other fluids.

Medicines for internal use should be separated from those for external use.

All non-medicines including chemical reagents should be stored separately. Cleaning materials must be stored in a locked cleaning material cupboard for use by domestic staff.

Medicine carts must be tethered to the wall when not in use. Carts and Lockers must be locked when not in use. Carts and lockers must not be left unattended when unlocked.

Any issues with the storage of medicines must be reported to Pharmacy at the earliest opportunity so that a resolution can be found.

Any medication that has been diluted must be clearly labelled and stored separately from the undiluted medicine.

5.3.1 Controlled Drug Storage

The ward manager is responsible for the safe and appropriate management of Controlled Drugs on their ward, theatre and department, which can be delegated to the Nurse/Midwife/Healthcare Professional in Charge for each shift. No area can store Controlled Drugs without an authorised accountable person for the ward area, theatre or department.

The appointed nurse/midwife/Healthcare/Professional in charge for each ward is accountable for supervision and monitoring of the management of access to CDs via the CD keys, security of the CDs and CD stationery (i.e. CD order books and CD record books) in that area. They may delegate control of access to the CD cupboard and other tasks relating to CDs to another registered nurse/midwife/Healthcare Professional, however the responsibility remains with the appointed nurse/midwife/Healthcare Professional in charge.

Controlled Drugs on Trust wards must be stored in an assigned cupboard specifically for the storage of CDs, according to BS. No.2881. The lock should not be common to any other lock in the hospital. Community midwives must store controlled drugs in a locked container, within a fixed locked cupboard/room. The CD keys must be on a separate bunch and be kept on the person of a registered nurse/midwife/Healthcare Professional employed by the Trust.

Different strengths of Morphine and Diamorphine must **NOT** be stored next to one another. Separate storage locations such as cupboards, shelves, bags or boxes for low strength products used for bolus administration in acute care, and high strength products used to prepare infusions.

Higher strength opioid medicines should only be routinely kept on the ward/department when there is an established clinical need to do so.

Any area that stocks opioids must also carry an adequate stock (at least 10mg) of Naloxone at all times.

In areas where midazolam injection is held as stock, only one strength of the injection may be held and flumazenil injection must be available.

5.3.2 Refrigerator Storage

Drugs requiring storage below room temperature will be marked e.g. store between 2 to 8 degrees centigrade, or "store in a refrigerator".

A dedicated pharmaceutical grade refrigerator should be used solely for the storage of medicines requiring refrigeration and it must be kept locked.

No food or pathological specimens may be stored in the medicines refrigerator.

A calibrated maximum/minimum thermometer should be kept in the refrigerator and used to make daily recordings in line with the approved procedure and the pharmacy-agreed format when the ward or department is occupied. The acceptable temperature range is 2 to 8ºC. It must be ensured that the electricity supply to the refrigerator cannot be turned off inadvertently.

It is the responsibility of the ward manager to ensure that temperatures of refrigerators are measured and recorded as above on daily basis.

If the temperature rises above 8ºC or falls below 2ºC, where possible ascertain how long the temperature has been outside this range and seek advice regarding the stability of the medicines from the Pharmacy Department. All advice received and actions taken should be documented and an incident report completed (Datix).

Certain items e.g. insulin, eye drops require refrigerated storage before opening but may be stored at room temperature for a limited time whilst in use. Check the individual product requirements and record the date removed from the fridge on the label. Storing such items in a patient's medicines locker or the drug trolley between 8 ºC and 25 ºC makes them more comfortable for the patient when administered and does not reduce potency over the period stated for room temperature storage and reduces unnecessary interruptions to the drugs round, making patient care safer.

Some drugs require storage under frozen conditions. A calibrated maximum/minimum thermometer should be kept in the freezer and used to make daily recordings in the pharmacy-agreed format when the ward or department is occupied. The acceptable temperature range is minus 25 ºC to minus 15 ºC. It is prudent to ensure that the electricity supply to the freezer cannot be turned off inadvertently. The nurse/midwife/Healthcare Professional in charge of a ward should ensure efficiency of freezers by appropriate defrosting.

5.3.3 Resuscitation medication/ Emergency boxes

Emergency medicines in a resuscitation trolley or pack should be located where they are readily accessible in an emergency and where surveillance will prevent unauthorised access. They should not be locked away, but may be secured by breakable tamper-evident seals.

Expiry dates of emergency medicines must be checked at least weekly and the check documented.

During working hours a new emergency box may be obtained from Pharmacy returning the opened one on receipt of a new one.

Out of working hours a new resuscitation drug pack can be obtained from the Intensive Care Unit or the Pharmacy Emergency Cupboard. In this case the opened resus box should either be left with the Intensive Care Unit or returned to pharmacy on the next day during pharmacy's dispensary opening hours.

5.3.4 Medical gases

Medical gases are licensed medicinal products and must be stored and handled in accordance with the manufacturer's recommendations and by designated staff who have received appropriate training. Refer to relevant Trust guidance on Medical gases.

Oxygen usage must comply with Trust Policy on Prescription and Administration of Oxygen.

N.B. Liquid Nitrogen is not classed as a medical gas, but arrangements for safe storage and handling must be made.

Medical gases should be prescribed clearly and safely in accordance with the medical gases policy and clinical related procedures, in a manner that is understood by those administering the medical gas.

5.3.5 Stock Control

Medicines (including topical products and paracetamol) MUST NOT be taken from ward / department stock for personal use by any member of staff or individuals who are not patients. Theft of medicines is a criminal offence.

Medicines must be stored in the containers in which they are supplied by pharmacy. Medicines should not be transferred from one container to another, nor must they be taken out of their containers and left loose. Decanting medicines introduces an unnecessary risk to correct product selection.

Medicines must be used in rotation so that those with the shortest expiry are used first. Out of date stock should be removed and disposed of in accordance with waste guidelines.

The manufacturer may state a reduced shelf life after opening e.g. eye drops, some oral liquids, capsules and topical products; therefore it is important to read the label information regarding storage for each individual product and record the date opened on the label.

Controlled Drug Stock control

The stock balance of all Controlled Drugs entered in the Controlled Drug record books for stock and Patient's Own CDs must be checked and reconciled on daily basis (as a minimum) on all wards, theatres and clinical areas to ensure that discrepancies can be identified in a timely manner.

Patient's Own CDs should be returned to the patient at the earliest opportunity and CD register amended accordingly. Patient's Own CDs or CD stock that are expired or no longer required should be returned to Pharmacy for destruction, the Pharmacy team should facilitate returns in a timely manner (refer to the relevant Trust SOP of CD management)

Checks must be performed by two registered nurses/midwives/Healthcare Professional following the Trust procedure.

Full Controlled Drug reconciliation and audit trail checks are performed with a registered Pharmacist/Pharmacy Technician and a registered nurse/midwife/Healthcare Professional at a frequency defined within the Controlled Drug Procedure.

In either case, any identified discrepancies must be escalated immediately to the ward manager and a Datix completed. If the discrepancy cannot be resolved, then the incident should be escalated further to the Matron for the area, the CD Accountable Officer and a senior Pharmacy Manager.

5.4 Transfer of medicines

5.4.1 Transfer of medicines from pharmacy to wards/departments

Medicines will be transported from pharmacy to wards and departments in locked boxes or tamper evident bags in a safe and efficient manner following pharmacy department procedures.

Refrigerated items should be transported in such a way as to maintain the cold chain and ward staff will be alerted to their presence on the ward and the need to place immediately in a refrigerator.

Controlled Drugs should be transported in such a way as to maintain the security during transit and ward staff will be alerted to their presence on the ward and the need to sign for receipt and place immediately in a CD cupboard and an entry made in the CD register to document receipt.

Transport of medicines to patients and services off site must follow national and local guidance on safe handling of medicines. Contact pharmacy for advice

5.4.2 Transfer of medicines between wards/departments

In order to ensure timely administration when a patient is transferred to another ward all medications dispensed specifically for that patient should be transferred with the patient particularly the patient's own medication that they may have brought in with them. Healthcare professionals transferring a patient should ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for on-going prescribing is clear. It is the responsibility of the nurse looking after the patient to ensure patient's medicines are transferred appropriately with the patient between wards.

Stock transfer between wards is not encouraged particularly as a core stock will be common to many wards. Where medicines are required during working hours any request must be directed to the Pharmacy Department.

Where medicines are borrowed between wards or departments, medicines must not be decanted into another container. The original labelled container should be transferred. Strips of medicines must not be removed from the original container. Transfer of CDs between wards should only be made if necessary, for details please refer to the CD Standard Operating Procedures.

5.5 Keys

All cupboards, carts, lockers and refrigerators storing medicines must be kept locked at all times when not in use. Where medicines are kept in a locked room with restricted access to authorised staff only then this would be sufficient.

The medicine keys, including controlled drug keys, are the responsibility of the Appointed Nurse/Midwife/Healthcare Professional in Charge or the Delegated Nurse/Midwife/Healthcare Professional in charge of the ward at the time.

All Medicines Cupboard keys must be held on the person of a registered Healthcare Professional and the CD keys separated from the main Medicines Cupboard keys.

Individual patient lockers are accessible by a ward master key which must be held on the main ward drug keys and must be held on the person of registered staff. Each individual locker will have a specific key to enable patients' access to their own medicines for self-medication purposes. The Individual locker keys should be secured in the ward key cupboard and the transfer and security of keys is the responsibility of the Nurse/Midwife in Charge.

Keys to Controlled Drug cupboards must be held separately by the Nurse/Midwife/Healthcare Professional or authorised practitioner in charge of the area at all times and the key should not be kept on the same ring as any other key.

The keys to medicines cupboards may be held by other registered Healthcare Professionals (for example, registered radiographers). They must not be held by non-registered nursing staff.

5.5.1 Lost Keys

If the medication cupboard keys are identified as missing from the ward, the area where medicines are stored must be kept locked if possible and under observation.

All registered staff: nurses/midwives, including bank and agency staff, and any other staff who may be identified as having held the keys during the time they went missing, on the current and preceding shift must be contacted promptly about the whereabouts of the keys.

Once the location of the keys is established, the member of staff in possession is under an obligation to return the keys to the hospital as a matter of urgency. As failure to return the keys as a matter of urgency may result in delays to medication administration, it is the responsibility and the liability of the member of staff who has removed the keys from the ward to return them.

If the keys/locks have to be replaced, authorisation from a senior member of the Pharmacy Department team is required, and any costs incurred will be borne by the ward. In all cases an incident report must be completed following the Trust policy and the issue investigated. If Controlled Drug keys cannot be found, the CD Accountable Officer must be informed via the Chief Pharmacist and a Datix report made.

5.6 Closure of a Ward or Department

If a ward or department is due to close, the Controlled Drugs must be transferred back to Pharmacy Department by the Nurse/Midwife/Healthcare Professional in Charge for safe keeping.

For all other medicines the most appropriate arrangements dependent on the period of closure should be discussed with the ward pharmacist or ward pharmacy technician. These arrangements must safeguard medicine supplies and prevent potential unauthorised access.

5.7 Disposal of Medicines

Individual doses of medicines should be disposed of following the relevant Trust guidance on waste disposal. Larger quantities should be returned to Pharmacy Department by placing in the Pharmacy Returns Bins. Pharmacy porters access the Return Bins on regular basis to return contents to the Pharmacy Department.

Disposal of partially used ampoules or ampoules drawn up unnecessarily of Controlled Drugs should be witnessed and an appropriate entry made in the register. In all other circumstances arrangements should be made for returning Controlled Drugs to the Pharmacy Department for disposal.

5.8 Outside Normal Pharmacy Hours

A stock of emergency medicines for use out of working hours is available from the Pharmacy Emergency Cupboard (PEC). If a drug is required, out of pharmacy hours, which is not available on the ward the nurse/midwife/Healthcare Professional in charge will refer to the Clinical Site Manager.

Stock lists for all clinical areas and for PEC can be found on the Trust intranet in the Pharmacy section.

The on-call pharmacy service is available outside of normal pharmacy working hours and may be contacted by the appropriate senior Healthcare Professional or by individual member of medical staff via the hospital switchboard. The on-call pharmacist can provide advice on where essential drugs can be obtained from or if necessary will dispense any urgent medication.

The on-call pharmacy service should not be used to request supply routine ward stock medicines, to provide repeat dispensing or for the dispensing of discharge medicines except in exceptional circumstances.

6.0 Medication Related Events

6.1 Adverse drug reactions

Any medicine including complementary and alternative medicines may produce unwanted or unexpected adverse reactions. The detection and reporting of these adverse effects is of vital importance particularly for new products identified by a black triangle symbol (▼) in the BNF and for children. Refer to the MHRA Yellow Card website and the BNF for further information. A Yellow Card should be submitted for significant adverse effects, this can be done via the Yellow Card Scheme website or via eCARE. A Datix should also be completed.

6.2 Medication Incidents

If a medication incident or near miss incident is observed or discovered immediate action should be taken to ensure the safety of the patient. All staff must follow the Incident Reporting Policy and Procedure.

Audit trails of medication use including prescribing and administration can be found on eCARE, this information should be used as part of incident investigations to enable identification of contributory factors and to make relevant and effective recommendations. Examples of reportable medication incidents may include; omitted critical medicines, prescribing and administration errors or safe and secure handling breaches.

6.2.1 Learning from medication incidents

Trend analysis relating to medication incidents is incorporated into the Trust's incident reports. Themes of errors and Serious Incidents relating to medicines must be reported to Prescribing and Medicines Governance Committee and shared at Nursing and Midwifery Board, Clinical Board and

Patient Safety Board. Incidents reported of a Moderate grade or above must be reported to the Serious Incident Review Group and a '72 Hour Report' submitted for discussion

Learning from medication incidents is the responsibility of all healthcare staff. The Trust Medication Safety Officer will provide expert advice to clinical and operational managers and through Trust governance structures on the most appropriate means to embed learning in medicines-use systems and processes and individual clinical practice.

6.3 Hazard Alerts, Patient Safety Alerts and Drug Alerts

Alerts relating to medicines are received from a variety of sources e.g. Medical Devices Agency Hazard and Safety warning notices, Medicines and Healthcare Products Regulatory Agency (MHRA), National Reporting and Learning System (NRLS), Chief Medical Officer (CMO) and Central Alerting System (CAS) Drug Alerts.

Medication related Safety Alerts are reviewed by senior members of the Pharmacy Department, actioned and communicated to relevant clinical teams. It is the responsibility of senior clinicians, lead Healthcare Professionals and/or clinical managers to ensure that healthcare staff in their area

of responsibility are notified of relevant alerts and comply with safety notices for changes in use of medicines or recall of medicines as supervised through the Pharmacy Department. Further details can be found in the Trust's Safety Alerts policy.

6.4 Missing Medicines

Every effort should be made to keep medicines safe and secure. In the event of a theft or diversion of medicines this should be reported immediately to the clinical manager and a Datix report completed.

Issues involving drug security must be notified to the Chief Pharmacist. After consultation the issue may be referred to the police.

7.0 Training

Medicines should only be prescribed and handled by staff that have the necessary knowledge and skills and are confident and competent to carry out this practice.

The requirements for safe management of medicines may change due to changes in legislation or best practice guidance and it is therefore essential that all healthcare staff keep up to date with current practice.

The Trust training needs analysis identifies those staff groups requiring training in medicines management and completion of bi-annual Medicines Management Training (face to face, workbooks/on line) is mandatory for defined groups and will be monitored.

Staff who fail to complete this mandatory training requirement, or where competence is brought into question, may have their right to handle medicines withdrawn by their Division after consultation with the Chief Pharmacist and in line with Trust HR procedures. This may affect ability to remain at work and pay.

All healthcare staff who handle medicines must read the Medicines Management policy on induction and seek further advice from their clinical manager or from the Pharmacy Department if there are any aspects of the policy and related procedures that they do not fully understand.

Service managers must identify any role specific training and competencies required by their staff. Any gaps in competencies must be addressed through training.

Healthcare professionals must reflect on their medicines-related learning needs when discussing their Personal Development Plans with their manager during appraisal. Specific competencies are needed to prescribe and administer high-risk drugs or work in particular fields e.g. paediatrics.

Where additional training needs are identified the Pharmacy Education & Training team should be contacted. They will discuss the training needs identified with the lead pharmacy staff for the relevant area and agree a plan to provide training to bridge the gaps identified.

8.0 Other Miscellaneous Information

8.1 Controlled Drugs and Home Births

Controlled Drugs may be dispensed directly to the mother on prescription ready for an anticipated home birth. The medications which remain unused should be returned to the dispensing pharmacy by the mother for disposal.

8.2 Midwives Exemption

In law, Registered Midwives may supply and administer a range of medicines in the course of their professional midwifery practice, without a patient specific written direction or prescription from a medical practitioner. This includes:

- Medicines specified in the Midwives Exemptions, as regulated under the Human Medicines Regulations 2012;
- All medicines that are not Prescription Only Medicines (POM), i.e. all Pharmacy (P) and General Sales List (GSL) medicines;
- Supply or administration of a licensed named medicine to specific groups of patients who may not be individually identified before presenting for treatment, according to the relevant Patient Group Direction (PGD).

Midwife Exemptions are distinct from prescribing and dispensing which require involvement of a pharmacist in the sale or supply of the medicinal product.

Schedule 17 of the Human medicines Regulations lists the exemptions in part 1 (4) for supply and part 3 (2) for administration.

8.2 Suspected Illicit Substances

Illicit substances are illegal substances which include Schedule 1 Controlled Drugs. The Trust does not condone the use of illicit substances. In accordance with its duties under the Misuse of Drugs Act 1971 the Trust does not knowingly allow any activities in connection with illicit substances on its premises.

When it is suspected that an illicit substance has been brought into the Trust by a visitor or patient, Trust staff may attempt to remove the illicit substance from the visitor or patient if it is safe to do so or otherwise wait until there is additional support from Trust Security Team and/or the police.

Once Trust staff are in possession of the illicit substance, the Trust Security Team and the police should be informed if that has not already occurred. Both the Nurse/Midwife/Healthcare Professional in Charge and the ward pharmacist should be informed of the incident if they are not aware. The ward pharmacist should inform the Duty Manager in Pharmacy Department and the Chief Pharmacist.

Under no circumstances may a suspected illicit substance be returned to any person as "property" as this may constitute a criminal offence.

The illicit substance must be treated as a Controlled Drug and stored in the CD cupboard. The illicit substance must be entered into the Patients Own Drug Controlled Drug Book. This can be done by

a staff nurse/midwife or pharmacist. The entry should be clear and concise. A Datix incident should be submitted with the details of the illicit substance.

The illicit substance must be notified to the police for their actions, and entered out of the Patients Own Drug CD book by a staff nurse/midwife or pharmacist when given to the police. This entry should be countersigned by the police and when the illicit substance is handed over to them.

In the event that this incident occurs out of pharmacy working hours, the Pharmacy Department should be informed the following working day.

8.3 Patient Group Directions

Patient Group Directions (PGDs) and are approved by the Trust Prescribing and Medicines Governance Committee (PMGC) on behalf of the Trust Board. Such arrangements are strictly limited to the detail in the Patient Group Direction and to specified healthcare professionals, as detailed on the PGD. No variation from the detail in a patient group direction is allowed.

See Trust Policy for Patient Group Directions for further details.

8.4 Generic substitution

The Trust accepts the principle of 'generic substitution' whereby the Trust's pharmacies procure the optimal cost-effective medicines and will routinely substitute that product should an alternative manufacturer's brand of that same product is prescribed. This is a routine practice in all NHS hospitals.

8.5 Trust Prescribing Formulary

Prescribers should comply with the joint health economy formulary for their routine prescribing needs. The Formulary has been jointly agreed by Milton Keynes Prescribing Advisory Group (MKPAG), which comprises of representatives from the hospital, local Primary Care Trusts and Clinical Commissioning Groups; CNWL and is therefore used by local GPs. The Formulary can be accessed on the Trust intranet page or at https://www.formularymk.nhs.uk/default.asp where further information can be found.

8.6 Medicines for Staff

Medicines must not be taken from the ward or department stock for personal use by staff. Normally a member of staff will see his/her GP for their medication needs or purchase medications 'over the counter'. In an emergency, staff should attend A&E or Urgent Care Centre or be referred to Occupational Health. Theft of medicines is a criminal offence.

9.0 Other Associated Documents

Related Trust documents which guide medicines management practice

- Antimicrobial Prescribing Guidelines
- Cytotoxic Drugs Policy
- eCARE Quick Reference Guides
- Guidelines for Supply of Discharge Medicines Out of hours
- Incident Reporting Policy and Procedure
- Medical Gas Policy
- Medication Reconciliation Adults Procedure
- NICE Implementation policy
- Off-label Medicines Use Procedure
- Procedure for Dealing with homecare prescriptions
- Procedure for the use of Patients' Own Drugs
- Procedure for Anticipatory Prescribing for patients with a Terminal Illness (Just in Case)
- Procedure for the Supply of Medicines under private prescription
- Procedure for the Use of Medicines in Clinical Trials
- Policy for the Safe Storage and Handling of Potassium Chloride Concentrated and Potassium-containing Intravenous Fluids
- Policy on the safe administration of intrathecal chemotherapy
- Self and Carer Administration of Medicines Procedure – Paediatrics
- Unlicensed Medicines Use Procedure

- Waste Disposal Policy
- Policy for Self-Administration of Medicines by Adult In-patients
- Guidelines for the Assessment and Provision of Compliance Aids
- Management of shortages of medicines supply
- CSU guidelines on the treatment of specific conditions where medicines are used

10.0 Statement of evidence/references

- Care Quality Commission, 2020. Covert administration of Medicines. Available at https://www.cqc.org.uk/guidance-providers/adult-social-care/covert-administration-medicines (Accessed on 22 July).
- Care Quality Commission, essential standards of quality and safety Outcome 9 Management of Medicines
- Control of Substances Hazardous to Health (COSHH) Regulations 2002
- Department of Health Guidelines for Safer Management of Controlled Drugs in Secondary Care 2007 and updates.
- DH guidance - Building a Safer NHS: medication safety. Jan 2004.
- Guidelines issued by the General Medical Council (GMC) and The British Medical Association (BMA).
- Health Act 2006
- Human Medicines Regulations 2012
- Medicinal Products: Prescription by Nurses Act
- Medicines Act 1968 and subsequent amendments
- Medicines for Human Use (Clinical Trials) Regulations 2004 and updates
- Medicines for Human Use (Miscellaneous Amendments) Order 2010 – midwives exemptions list (Department of Health - Gateway reference number: 14314)
- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 1997 and 2001 and subsequent amendments
- National Patient Safety Agency (NPSA) alerts.
- National Patient Safety Agency (NPSA), Patient Safety Alert 2007. Promoting Safer Use of Injectable Medicines.
- NHS Litigation Authority Risk Management Standards -
  - Standard 4 Criterion 10 Discharge
  - Standard 5 Criterion 10 Medicines Management
- Professional Guidance on the Safe and Secure Handling of Medicines. The Royal Pharmaceutical Society of Great Britain, December 2018.
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- Standards for Medicines Management. NMC, January 2019
- The Code - Standards of conduct, performance and ethics for nurses and midwives. Nursing and Midwifery Council (NMC), October 2018
- The Medicines, Ethics and Practice Guide. The Royal Pharmaceutical Society of Great Britain (RPSGB). Pharmaceutical Press 2019.
- UK Medicines Information, 2017. What legal and pharmaceutical issues should be considered when administering medicines covertly?
- UK Medicines Information, 2019. Is it safe to take herbal medicicines during pregnancy? Available at https://www.sps.nhs.uk/articles/is-it-safe-to-take-herbal-medicines-during-pregnancy/ (Accessed on 14/9 2020)
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- PILS Regulations - December 2019 V1.3.pdf (resus.org.uk)

11.0 Governance

11.1 Record of changes to document

Version	Date	Name	Reason
1	December 2005	(Chief Pharmacist) (Deputy Chief Pharmacist) (Director of Nursing)	New Policy
2	August 2006	(Deputy Chief Pharmacist) (Pharmacy E&T Manager)	Review to ensure compliance with NHSLA Pilot Standards for Management of Medicines and replacement of content of Appendix I, by updated IV potassium Trust policy.
3	Feb 07	(Chief Pharmacist) (Clinical Pharmacy Mgr/Deputy Chief Pharmacist) (Deputy Clinical Pharmacy Mgr	Adverse Drug Reactions added as Appendix M Revision of Appendix B – Paediatrics. Revision of Section 6 – Controlled Drugs
4	October 2009	(Clinical Pharmacy Mgr/Deputy Chief Pharmacist) (Directorate Pharmacist) (Antimicrobials pharmacist) CRMC	Electronic prescribing and recording of administration Electronic Discharge Summary (EDS) Addition of Medicines Reconciliation policy, SAM, (appendix N, O & P) Minor Changes Approved
5	February 2010	(Clinical Pharmacy Mgr/Deputy Chief Pharmacist)	Updated in response to NPSA safety alert "Prevention Of Over Infusion Of Intravenous Fluid* And Medicines In Neonates"
	July 2011		Reviewed – no change required.
5.1	August 2011		Minor amendment to replace SfBH with CQC Regulations and to include EIA.
5.2	October 2011		Minor amendments to reflect NHSLA requirements.
5.3	November 2012		Addition of paragraph in section 5.4 relating to keys taken home on the wards. And change to 6.10 relating to checking of controlled drugs. Changes agreed in Trust Documentation Committee 5.11.12
6	November 2013 and July 2014	Pharmacist Consultant Deputy to Clinical Director of Pharmacy	Complete revision of the policy, in line with current guidance Updated to take account of guidance on the role of the Medication Safety Officer
7	July 2015	Deputy Chief Pharmacist	Revision of the policy, update to take account of PMGC, translate into new trust format

Version number: 7		**Date:** July 2015		
Section Number	**Amendment**	**Deletion**	**Addition**	**Reason**
Whole document,	Revision of the policy, update to take account of PMGC, translate into new trust format	None	None	Revision of the policy

11.2 Consultation History

Stakeholders Name	Area of Expertise	Date Sent	Date Received	Comments	Changes Made
Pharmacy CIG	Specialists in the use and management of medicines within MKHFT	August 2015	August 2015	Review of Policy – no change	Yes
Clinical Board	Lead for Clinical Governance on prescribing. Senior Doctors - responsibility for governance of prescribing in their area	Sept 2015	Sept 2015	Review of Policy – no change	Yes
Trust Matrons and Senior Nurses Meeting	Storage and administration of medicines within MKHFT. Active users of medicines whose management of medicines need to follow this policy	Sept 2015	Sept 2015	Review of Policy – no change	Yes
Practice Development team MKHFT	Nursing practice competence	Sept 2015	Sept 2015	Review of Policy – no change	Yes
	MKHFT Lead practitioner for Non-Medical Prescribing	Sept 2015	Sept 2015	Review of Policy – no change	Yes
Junior Doctors Forum	Active prescribers of medicines whose management of medicines need to follow this policy	Sept 2015	Sept 2015	Review of Policy – no change	Yes
Clinical Governance leads	Responsible for enabling audit of policies and procedures within the hospital	Sept 2015	Sept 2015	Review of Policy – no change	Yes
Prescribing and Medicines Governance Committee		Nov 2015	Nov 2015	Review of Policy – no change	Yes
	Pharmacist Manager-Medicines Safety and Governance	May 2020	June 2020	Review of policy – various changes	

Stakeholders Name	Area of Expertise	Date Sent	Date Received	Comments	Changes Made
Pharmacy Senior Management Team	Medicines Management	May 2020	July 2020	Various	Yes
	Head of Risk and Clinical Governance	July 2020	July 2020	Review of Policy - Various	Yes
	Consultant Paediatrician and Medicines Optimisation Lead for Women and Children	July 2020	July 2020	Review of Policy - One typographical error	Yes
	Consultant Anaesthetist and Medicines Optimisation Lead for surgery	July 2020	July 2020	Review of Policy – no change	N/A
	Consultant in BBV Medicine Medicines Optimisation Lead Medicine	August 2020	August 2020	Review of policy – no change	N/A
	Head of Midwifery and Paediatric Nursing	August 2020	August 2020	Various comments	
	Chief Nurse and Director of Patient Care	August 2020	August 2020	Various comments	
	Deputy Chief Nurse	August 2020	September 2020	Various comments	
Prescribing and Medicines Governance Committee		September 2020	October 2020		
Pharmacy CIG	Medicines Management		November 2022	Approved	Amendments: • Body weight measurement • Verbal instruction • eCare unavailability

Stakeholders Name	Area of Expertise	Date Sent	Date Received	Comments	Changes Made
Prescribing and Medicines Governance Committee	Medicines Governance		November 2022	Approved	None
Trust Executive Committee	Governance		15 December 2022	Approved	None

11.3 Audit and Monitoring Criteria

Audit Criteria	Tool	Audit Lead	Freq. of Audit	Responsible committee	How changes will be implemented	Responsibility for Actions
Prescription standards (accuracy)	Audit of prescriptions	Deputy Chief Pharmacist Clinical & Operational Pharmacy Services		PMGC	CSU action plans	CSU clinical leads
Controlled drugs – safe and secure handling	Audit	Pharmacist Manager-Medication Safety and Governance		PMGC		
Safe and secure handling of medicines	Audit	Pharmacist Manager-Medication Safety and Governance	Six monthly	PMGC	CSU action plans	CSU clinical leads
Omitted doses	Audit	Pharmacist Manager-Medication Safety and Governance	Monthly	PMGC		
Medicines Incident report analysis	Audit	Pharmacist Manager-Medication Safety and Governance	Six monthly	PMGC		

11.4 Equality Impact Assessment

As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact Assessment			
Division	**Core Clinical**	**Department**	**Pharmacy**
Person completing the EqIA		**Contact No.**	
Others involved:		**Date of assessment:**	**October 2020**
Existing policy/service		**New policy/service**	

Will patients, carers, the public or staff be affected by the policy/service?	Staff
If staff, how many/which groups will be effected?	All staff

Protected characteristic	**Any impact?**	**Comments**
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	*For example: focus groups, face-to-face meetings, PRG, etc*
How are the changes/amendments to the policies/services communicated?	*For example: email, meetings, intranet post, etc*

What future actions need to be taken to overcome any barriers or discrimination?

Who will lead this?	Who will lead this?	Who will lead this?	Who will lead this?
Review date of EqIA	**October 2020**		

Glossary

Accountable Officer	Officer in a health care organisation who is responsible for the safe and effective use of and management of controlled drugs. Appointment required by Controlled Drugs (Supervision and Management of Use) Regulations 2006.
Administer	To apply or give a medicine to a patient by any route
Appointed Nurse/Midwife/Healthcare Professional-in-Charge	The senior nursing, midwifery or Healthcare Professional appointment for the ward, healthcare clinic or department e.g. Sister, Charge Nurse, Clinical Ward Manager etc
Audit trail	A system whereby all transactions regarding medicines can be traced from the act of purchase to the point of use
Carer / informal carer	Relative, partner, friend or neighbour. (This does not include employed care staff)
Clinical pharmacy	Promotes the correct, safe and appropriate use of medicines
Competent	An individual who demonstrates their "capability" in certain skill areas to a required standard at a point in time
Competencies	Component skills which contribute to being competent and achieving standards of proficiency. Competencies might include skills arising from learning outcomes or other requirements.
Controlled Drug (CD)	Controlled drugs are prescription only medicines that must be handled in accordance with the Medicines Act 1968 and the Misuse of Drugs Act 1971 and associated Regulations. Stricter legal controls apply to controlled medicines to prevent them from being misused, being obtained illegally or causing harm. These legal controls govern how controlled medicines may be stored, produced, supplied and prescribed. Controlled medicines are classified (by law) based on their benefit when used in medical treatment and their harm if misused.
Controlled stationery	All stationery, which in the wrong hands, could be used to obtain medicines fraudulently e.g. prescription charts, order forms, requisitions, FP10 prescription forms, Controlled Drug order books and record books etc
Critical medicine	Any medicine that has been prescribed for a patient where a delay in administering the medicine is unacceptable dependent on the patient's clinical condition The majority of critical medicines are listed in the prescription chart (page 3) either as a BNF class or individually.
Dispense	To label and supply a clinically appropriate medicine to a patient, usually against a written prescription, for self-administration or administration by another
Diversion (of medicines)	The prevention of part or all of a medicine from reaching its intended destination (i.e. patient, storage place, or point of disposal)
External medicines	Those medicines applied to body surfaces (e.g. lotions, creams etc)
FP10 Prescription forms	NHS prescriptions issued by GPs, nurse and pharmacist prescribers, hospital doctors, dentists and supplementary prescribers.
Healthcare professional	Healthcare staff that are registered with a professional body e.g. doctor, dentist, pharmacist, nurse, health visitor, podiatrist, physiotherapist, pharmacy technician etc
Healthcare staff	All staff, employed by, or working in the Trust who have clinical contact with patients
Independent prescriber	A prescriber who is legally permitted and qualified to prescribe and takes the responsibility for the clinical assessment of the patient / client, establishing a diagnosis and the clinical management required, as well

	as the responsibility for prescribing, and the appropriateness of any prescribing
Internal Medicines	Those medicines given by mouth or injection to include eye drops, eardrops, suppositories, pessaries and inhalers
Licensed medicines	The Medicines and Healthcare products Regulatory Agency (MHRA) operates a system of licensing before medicines are marketed
Medicines Healthcare Products Regulatory Agency (MHRA)	A government agency responsible for ensuring that medicines and medical devices work and are acceptably safe.
Medicines Reconciliation	Medicines reconciliation is a process designed to ensure that all medicines a patient is currently taking is accurately checked and documented at each transfer of care.
Parenteral administration	Administration of a medicine by injection or infusion
Patient	Term used throughout the policy to refer to patients, service users and clients.
Patient Group Direction (PGD)	A specific written instruction that provides legal authorisation for specified and authorised healthcare professionals to supply and/or administer named medicines in identified clinical situations to specific groups of patients who may not have been individually identified before presenting for treatment.
Patient held record	A document held by the patient used to provide information and record indication, dose, monitoring, etc of high risk medicines e.g. warfarin, methotrexate, lithium
Patient Information Leaflet (PIL)	Information leaflets found in all dispensed medicinal products which should be brought to the patient's attention on administering or supplying a medicinal product
Patients own medicines	Patients' own medicines are medicines that a patient has at home which may be brought into hospital. They are the patient's property and must only be used by that patient.
Prescribe	To authorise in writing the supply or administration of a medicine for a named patient
Prescriber	A person who is authorised to undertake independent or supplementary prescribing according to current legislation
Risk Assessment	An assessment of events (hazards) which may lead to harm in the future in order to minimise their likelihood and consequence.