Manx Care Medicines Policy

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Contents

1. Introduction

It is important that all staff within Manx Care manage medicines in a consistent, safe and legal manner. This Policy document describes all aspects of medicines management.

1.1 Purpose

This document serves to inform staff of all aspects of the prescribing, administration, checking, ordering, storage, security, collection and disposal of medicines, ensuring these are managed safely and effectively.

This is in order to minimize the risks associated with medicines.

Medicines management encompasses the way medicines are selected, procured, delivered, prescribed, prepared, administered, reviewed and disposed of, to optimise the contribution that medicines make to producing informed and desired outcomes of patient care (Audit Commission 2001).

It is a requirement of Manx Care that all staff comply with a current medicines policy, which has clear lines of accountability for medicines management: this is to protect the safety of both patients and staff.

The Medicines Policy identifies the responsibilities of all staff groups involved with prescribing, dispensing, carriage and administration of medicines; brings them together into a single policy; and acknowledges that this policy will be supplemented by local policies depending on the site and activity e.g. prison, mental health, DAT.

The purpose of the policy is to provide guidance to all healthcare professionals on all aspects of the safe and effective management of medicines on the Isle of Man:

- to ensure that there is a framework of practice defined that embraces all relevant legislation and guidance with respect to the management of medicines;
- to ensure that patients, staff or visitors are not put at risk as a result of incorrect handling of medicines; and
- to minimise the risks associated with the management of medicines.

This policy endeavours to minimise these risks through compliance with all current legislation and best practice. It lays out roles and responsibilities of staff and where necessary provides details on unacceptable practices.

1.2 Scope

This policy applies to all healthcare professionals working with, for, or under instruction of Manx Care, who deal in any way with medicines.

1.3 Definitions

1.3.1 **Formulary.** A medicines formulary developed for use in both primary and secondary care.

1.3.2 **Patients Own Drugs (PODs)** is medication that patients bring into hospital with them that they use at home.

1.3.3 **Bedside medication locker** is a lockable box that is attached to the wall near the patient's bed, or a lockable compartment in a patient's bedside unit; for storage of PODs

1.3.4 **Self-administration.** Patients that are assessed as being suitable for self-administration are allowed to medicate as they would at home. The nurse keeps custody of the key and opens the bedside locker to facilitate self administration at appropriate times.

1.3.5 **Medicine Reconciliation, a**s defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated.

1.3.6 **Patient Specific Direction (PSD)** is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient. Each individual patient must be identified on the PSD. An example might be an inpatient medication chart, or a prescription record held in an ePMA system.

1.3.7 **Patient Group Direction (PGD)** is defined as a specific written instruction for the supply or administration of named medicines in an identified clinical situation. It is drawn up locally by doctors, pharmacists and other appropriate professionals. It applies to groups of patients who may not be individually identified before treatment.

1.3.8 **Unlicensed Medicine** is a medicinal product that does not have a UK medicinal product licence.

1.3.9 **Terms of the Product Licence.** A product licence for a medicine includes information regarding: what health conditions it may be used to treat, what dose must be used, and if it is to be used by a specific patient group. It gives warnings about known safety issues. If a medicine has a licence it tells you that the manufacturing process conforms to current safety legislation and it has been through a rigorous assessment process. This information is usually included in the summary of product characteristics (SPC); these can be found the following: https://www.medicines.org.uk/emc or https://products.mhra.gov.uk/

1.3.10 **Transcribing Medication** is the transfer or duplication of the details of a prescription for therapy that has already been prescribed by a registered prescriber.

1.3.11 **Life Saving Medication.** These medicines include: anti-infective, anti-coagulants, anti-epileptic therapies, insulin, antiarrhythmic, and resuscitation drugs used in advanced life support.

1.3.12 **Critical Medication. Medication which must be given at the prescribed time, and not omitted. This includes** any parenteral doses, oral chemotherapy, Parkinson's disease medication, regular opiate analgesics, fluid resuscitation, or any oral "stat" doses.

1.4 Roles and Responsibilities

1.4.1 **Reconciliation of Medicines**

Every time a patient is transferred from one healthcare setting to another it is essential that accurate and reliable information about their medication is conveyed at the same time, to limit the risk of medication error.

It is the responsibility of all clinical staff involved in the admission and discharge of patients requiring medicines. For further guidance see the Medicines Reconciliation Policy.

1.4.2 **General Information on Prescribing and Administering Medicines – Who May Prescribe:**

Medical staff, licensed to practice by the General Medical Council. They must comply with appropriate legislation, the Medicines Management Policy and professional guidance when prescribing;

Dentists who are licensed to practice by the General Dental Council. They must comply with appropriate legislation, the Medicines Management Policy and professional guidance when prescribing.

Nurses, pharmacists and other Allied Healthcare Professionals who have successfully completed the appropriate nationally recognised prescribing course and are registered with their professional body as a person qualified to prescribe, and are Manx Care approved non-medical prescribers may prescribe according to their designation of supplementary or independent prescriber (See Non-Medical Prescribing Policy).

2. Related policy, strategy, legislation or guidance

See also the following Manx Care documents:

- Manx Care Unlicensed Medicines Policy
- Manx Care Medical Gas Policy
- Manx Care Non-Medical Prescribing Policy
- Noble's Hospital Controlled Drugs Policy
- Manx Care Policy for the Management of Controlled Drugs in non-hospital Settings
- Shared Care Policy for Mental Health Services Within the Isle of Man
- Manx Care SOP for handling temperature excursions affecting medicines stored in ward refrigerators
- Delirium: Diagnosis, Prevention and Treatment, hospitals Directorate Isle of Man
- Management Guidelines for Persons Suspected of Having Controlled Drugs Concealed Internally and Local Protocol for the Treatment of Patients suspected of Conealing Controlled Drugs Internally with Isotonic Solutions
- Policy for the Implementation, Utilisation and Authorisation of Patient Group Directions (PGDs), DHSC

And see the following external references:

- NMC (2008) Standards for Medicines Management, The Nursing and Midwifery Council NMC (2008)
- Future nurse: Standards of Proficiency for Registered Nurses, The Nursing and Midwifery Council NMC (2018)
- The Code, Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, The Nursing and Midwifery Council Department of Health (2018 update)
- An Organisation with a Memory, DoH, London Department of Health (2005)
- Building a Safer NHS for Patients, Improving Medication Safety, DoH London Department of Health (2004)
- HSC 2003/10 Updated National Guidance on the Safe Administration of Intrathecal Chemotherapy, Department of Health, London. HSE (2003)
- Safe Handling of Cytotoxic Drugs in the Workplace, Health & Safety Executive, accessed 2023 from www.hse.gov.uk
- Clinical Negligence Scheme from Trusts, NHS Litigation Authority, (2014 update)
- Patient Safety Alert PAS01, National Patient Safety Agency NPSA (2007) Safety in Doses: Medication Safety Incidents in the NHS, National Patient Safety Agency

3. Policy

3.1 Prescribing Medicines

The prescription must ordinarily be written in advance of the administration of the medicine.

Medicines that have not been prescribed by an authorised prescriber must not be administered to a patient, noting the following:

- Verbal orders are not permitted as regular practice within Manx Care.
- Patients on the 'stroke thrombolysis pathway' will be managed by specialist nurses utilising the PGD for the authorisation to administer medication.
- Staff working in a specific area which may rely upon verbal orders, including the prison should use verbal instructions by a medical prescriber in exceptional cases of clinical emergency (NMC 2007). Staff should consult their local policies for accepting verbal orders.
- Where a patient group direction is in place to enable administration of named medicines in an identified clinical situation - see the Patient Group Direction Policy;
- A registered chiropodist or podiatrist, whose name is recorded in the relevant register, may administer a limited range of medicines.
- Midwives, or student midwives under the direct supervision of a midwife, are administering in the course of their professional practice and from the limited range of medicines specified by the NMC. They may administer any General Sales List (GSL) or Pharmacy-only (P) medicines. Also any Prescription Only Medicines (POMs) for parenteral administration containing any of the following substances but no other substance that is classified as a product available on prescription only:
  - Adrenaline
  - Anti-D Immunoglobulin
  - Carboprost
  - Cyclizine lactate
  - Diamorphine – not by a student midwife

- Ergometrine maleate
- Gelofusine
- Hartmann's solution
- Hepatitis B vaccine
- Hepatitis immunoglobulin
- Lidocaine hydrochloride - only while attending on a woman in childbirth
- Morphine – not by a student midwife
- Naloxone hydrochloride
- (n) Oxytocins, natural and synthetic
- Pethidine hydrochloride – not by a student midwife
- Phytomenadione
- Prochlorperazine
- Sodium chloride 0.9%

- a person who holds an ALS Resuscitation Council (UK) certificate (or equivalent) and needs to administer IV adrenaline or amiodarone in an emergency involving cardiac arrest.
- the medicine is exempt from the requirements of the Medicines Act 2003 for parenteral administration in an emergency (i.e. lifesaving) IM adrenaline 1mg in anaphylaxis, glucagon, glucose, naloxone, chlorphenamine, hydrocortisone, atropine.

Manx Care also supports the following specialist healthcare professionals to write on the inpatient medication chart, to request other healthcare professionals of the need to supply / administer:

- a dietician for dietetic products; and
- a speech and language therapist for thickeners.

3.2 Patient Specific Direction (PSD)

A patient specific direction is written in advance by a qualified registered prescriber. It is for a specific medicine or appliance and must specify the dose, route and frequency of administration. It can apply to an individual patient i.e. the use of the patient's medication chart, or to a group of named patients, i.e. the administration of a routine vaccine where a list of patients due a vaccine may be identified beforehand.

3.3 Medicine Related Incidents

All medicine related incidents must be reported on the Patient Safety reporting system (Datix) and to the senior staff member on duty; and documented in the nursing notes.

Please refer to local policies for submitting reports of medicine-related incidents.

All medicine-related incidents must be reported into Datix.

Medication errors: All medication errors must be reported in line with local policy, this includes reports being submitted to Datix for investigation.

4. Prescription Writing

When writing prescriptions you must:

- write clearly using a black pen. Prescribing in pencil is illegal
- date and sign (using full signature) all prescriptions. Prescribers must also include their bleep number or telephone number, and professional registration number (i.e. GMC, NMC) on all outpatient prescriptions, and at least for the first item they have prescribed on each individual patient's inpatient prescription chart, and all discharge prescriptions; it is good practice to use an identity stamp;
- state the patient's full name, date of birth, sex, hospital/NHS number and allergy status;
- state the dose, frequency, route and duration of medication;
- not use abbreviations for drug names, e.g. write Isosorbide Mononitrate not ISMN;
- clearly state "consultant and ward / department" or primary care setting in order to accurately cost the medicines to the correct cost code;
- not use a pre-photocopied prescriber's signature, this is illegal; and
- where a complex calculation is required to determine a dose, it is advised that another health care professional undertake the calculation independently as a second check.
- Manx Care advocates prescribing in block capitals to reduce the risk of errors

4.1 Prescribers

Prescribers working within specialist areas i.e. hospice, prison must follow local prescribing guidelines.

4.2 Medical and dental students are not permitted to write prescriptions

4.3 Generic Prescribing

Approved names must be used for all medicines except when bioavailability issues require that a named brand be given. In such cases, the brand name or manufacturer must be stated as well as the approved drug name. Examples are listed in the British National Formulary (BNF) and include some anticonvulsants, lithium, theophylline, diltiazem modified-release preparations and opiate preparations e.g. morphine, oxycodone, buprenorphine / fentanyl patches.
Where a biosimilar version of a medicine is available, Manx Care may make a decision to use this in preference over the originator product with the patient's consent.

4.4 Strengths and Quantities

Clarity is essential to avoid medication errors and the following practices must be adopted:

- avoid unnecessary use of decimal points e.g. 3mg, not 3.0mg
- write quantities less than 1 gram in milligrams e.g. 500mg, not 0.5g
- write quantities less than 1mg in micrograms e.g. 100micrograms, not 0.1mg
- put a zero in front of a decimal point where there is no other figure e.g. 0.5ml, not .5ml
- do not abbreviate 'micrograms', 'nanograms' or 'units / international units'
- for all liquids, state the dose of the drug and not the volume, e.g. mg not ml

4.4.1 Recognised Abbreviations for Route and Dose

- IV Intravenous
- OD Once a day
- IM Intramuscular
- OM Each morning
- SC Subcutaneous
- ON Each night
- PO By mouth
- BD Twice daily
- SL Sublingual
- TDS Three times daily
- Inh Inhalation
- QDS Four times daily
- Ext External use
- Mane Morning
- Neb Nebulisation
- Nocte At bedtime
- PR Per Rectum
- PRN As required
- Top Topical
- Hrly Hourly
- PV Per Vagina

All other routes and doses must be written out in full.

Injections of medicines prescribed for a frequency less than once a week must be prescribed with the time interval expressed using the term 'every' e.g. every 3 weeks rather than 3 weekly.

4.5 Approved Stationery

4.5.1 Secondary Care

In-patient charts are ordered on the pre-printed stationery order form from the Supplies Distribution Centre.

Out-patient prescriptions pads (HS10s) for use in outpatient clinics and wards are ordered from Pharmacy – these are treated as controlled stationery and will only be issued against a signed & dated order (duplicate book from wards & outpatient clinics; typed "signed orders" from individual consultants) – the top copy or the complete signed order respectively will be retained in Pharmacy to provide an audit trail.

Non-medical Prescriber pads for staff based at Nobles Hospital are distributed from the Pharmacy, on behalf of Family Practitioner Services – when the final pad is collected from Pharmacy, further pads must be ordered from Family Practitioner Services

"In-house" outpatient forms (for use only within Noble's Hospital, for outpatient items which are "hospital only") are available from Pharmacy.

Inpatient charts for use in oncology are specific to the regimen and printed on demand by the Pharmacy department.

4.5.2 Primary Care

Non-medical prescribers order their prescription pads via the Community Health team.

5 Drug Allergies

The accurate recording and recognition of a patient's allergies and intolerances is essential to prevent serious adverse effects. All members of the healthcare team have a role in preventing errors relating to allergies. Failure to document and consider a patient's allergy status may have catastrophic consequences.

5.1 All health care professionals are responsible for entering any known allergy or intolerance, including for complementary medicines, iodine, chlorhexidine and latex, on all pages of the inpatient medication chart.

This information must be transferred to subsequent medication charts. This must be recorded as part of the normal clerking process. The medical professional responsible for writing up the medication chart is legally responsible for ensuring this is accurately completed.

Nurses, midwives, AHPs, pharmacists and pharmacy technicians are authorised to complete the allergy box of a prescription chart. This is not just the responsibility of medical staff.

5.2 All entries in the allergy / intolerance section of the patient's notes AND inpatient cards must be initialled and dated.

It is not acceptable to leave the allergy box blank.

You must:

- state 'NKDA / Nil Known' if there is no known allergy;
- state 'Unobtainable' if you are unable to obtain information; or
- state the nature of any allergy, sensitivity or intolerance, the name of the drug / allergen and the date of exposure if known e.g. penicillin causing anaphylaxis, morphine causing itching.

5.3 In the case of an unobtainable history, this must be reviewed at least every 24 hours and the allergy and intolerance section completed appropriately as soon as possible.

5.4 The prescriber must use their clinical judgement as to whether they override a recorded possible reaction, depending on the suspected severity of the reaction and the patient's clinical condition and the rationale for any decision must be clearly documented in the patient's case notes.

5.5 The current prescription chart must be used as the primary source of information about allergy and intolerance information for inpatients, but the information must also be recorded in two further places:

- in the patients notes (clinical case notes held on the ward or in community) on all the electronic records held on the patient (to include EMIS web, RiO for mental health patients, DAWN) .

- For outpatients the allergy or Intolerance information MUST be completed on any outpatient prescription.

5.6 The allergy box must be completed. Medication will not be supplied without this, and prescribers in Primary Care may refuse to action discharge prescriptions if the allergy box is not completed.

5.7 All health care professionals administering medicines must always clarify the allergy status of the patient before administration. Drugs must not be administered until the allergy section has been completed as above. If a health care professional is in any doubt about a possible previous reaction they must refer to the prescriber before administration.

5.8 If a new allergy or intolerance is discovered during a hospital admission or outpatient visit, all documents and electronic systems must be updated and an outpatient letter for the patient and their GP must include the latest allergy/intolerance information.

5.9 Patients must be made aware of any allergies they experience. They must be given a written record of the allergy, symptoms and action to take in the future. It may be appropriate to recommend that they obtain a 'Medic Alert' bracelet / necklace.

5.10 It is important that any new allergies are investigated fully to ensure that there was no failure identifying original status. If such a failure has occurred it must be investigated to inform Manx Care of any system / policy changes that may be necessary.

5.11 If an in-patient is known to have an allergy, a red wrist band (annotated with the patient's name) must be attached to a limb, preferably a wrist where possible, unless exempted by a local SOP.

6 Prescribing Controlled Drugs

Refer to the Controlled Drugs Policy in hospital; or to local policies in the community.

7 Prescribing Unlicensed Medicines

There are strict controls over the manufacture and distribution of medicinal products. There are occasions when products without a product licence may need to be used (or a product used outside of its licensed indication).

Unlicensed products present a risk because:

- the Medicines and Healthcare Products Regulatory Agency (MHRA) has not assessed the safety and efficacy of the product in humans; and
- the quality of the product cannot be assured and the fitness of the product for its intended use needs to be established.

The responsibility for safety and efficacy in using such products in an individual patient will always fall upon the prescriber who may be called upon to justify his/her actions if the product used result in an adverse event.

Pharmacy is responsible for establishing product safety and quality. If a product is demonstrated to be unsafe, or the quality is unsuitable, the prescriber will be informed and the product will not be supplied.

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

All letters and documents relating to the unlicensed medicine supply process must be retained for a minimum of 11 years (adults) and 25 years (midwifery and children).

Use of Licensed Medicines Outside The Terms of The Product Licence

7.1 Wherever possible medicines must be prescribed in line with the most recent Summary of Product Characteristics (SPC). SPCs can be found in the Electronic Medicines Compendium www.medicines.org.uk/emc or at https://products.mhra.gov.uk/

7.2 The prescriber is always responsible for the safety and efficacy of a medicine when using it outside the terms of the current product licence.

7.3 GPs must be informed of the unlicensed use, if asked to prescribe a licensed medicine outside the terms of its current licence.

8 Medical gases

See Manx Care Medical Gas Policy

9 Adherence to the Medicines Formulary

9.1 Prescribers must prescribe products that are available within the island formulary as far as possible as this promotes evidence based, cost-effective prescribing, taking into account local clinical and financial issues relevant to IOM and the local health economy. If an occasion arises where it is felt necessary to prescribe a product outside the hospital formulary range, this must ideally be discussed with the procurement pharmacist.

9.2 If a product has not been approved for use within Manx Care, for example if initiated by a tertiary care provider such situations must be discussed with the procurement pharmacist and the tertiary provider.

9.3 In-patients must not be asked to request a further supply of a medicine from the GP for use during the hospital stay apart from in exceptional circumstances. However, previously dispensed drugs in the possession of the patient [“patient’s own drugs” or PODs] may be brought into hospital for use during an admission episode – see section 15 below.

9.4 If a ‘NHS blacklisted product’ is being prescribed privately by a GP, a decision between medical and pharmacy staff will have to be made regarding how best to meet the patient’s needs.

10 Prescribing Advice

10.1 The British National Formulary (BNF) and British National Formulary for Children (BNFC) – access is provided to each clinical area. Prescribers must ensure that they always refer to the most recent version.

10.2 The electronic Medicines Compendium (eMC) contains the summary of product characteristics (SPC) for many medicines. The website can be accessed from: www.medicines.org.uk/emc

10.3 Medicines Information is available for Manx Care staff Monday to Friday 9am to 5pm and is staffed by pharmacists. Phone number is 01624650818, or medinfo@gov.im

10.4 An antimicrobial formulary is available on the intranet for hospital settings and a community policy is available to community practitioners

11 Self-Prescribing Medicines and Prescribing for Family Members

11.1 Health Professionals are not permitted to use any Manx Care medicines for personal use except in emergencies. This will be regarded as theft and will be subject to disciplinary procedures.

11.2 All prescribers are advised (GMC, NMC, GPhC) not to self-prescribe prescription medicines and to seek independent medical care for themselves or someone with whom they have a close personal relationship. Further information is available from the professional bodies concerned.

11.3 They and their close family members must be encouraged to register with a GP. Referral for consultant advice or care must be made via the patient's GP. Private prescriptions written by a prescriber for his/her relative will not be dispensed.

12 Transcribing

12.1 Transcribing is the duplication of the details of a prescription for therapy that has already been prescribed by a registered prescriber.

12.2 Transcribing by pharmacy or nursing staff is not permitted under any circumstances within Manx Care.

12.3 Non- Medical Prescribers may re-prescribe medicines prescribed by another prescriber, but only if within their competence.

13 Use of Patients Own Drugs (PODs) within in-patient settings

This section provides healthcare professionals with a clear framework for managing patients own drugs, which patients bring in from home, in a safe and effective manner.

The benefits are numerous:

- reducing medicines related errors on admission by increasing the accuracy and timeliness of medication histories, (Medicines Reconciliation)
- reducing confusion by allowing patients to maintain the familiarity of their own medicines;
- reducing omitted and delayed doses
- reducing waste by preventing the unnecessary re-supply of medicines; and
- reducing discharge delays by having PODs available to reconcile with the discharge prescription.

All healthcare professionals - nurses, doctors, pharmacists and paramedics - must encourage patients to bring their medicines into hospital with them, or request that a relative brings them in at the earliest opportunity.

All PODs must be prescribed on the patients' medication chart before they can be used on the ward.

Consent must be obtained from the patient or their carer before PODs are either used on the ward, or destroyed.

Following prescription, it is possible to use the patient's own supply of medication during her / his stay in hospital (Standard 5, NMC, 2007) as long as these medicines:

- Can be positively identified
- Are in their original labelled containers from the dispensing pharmacy
- Have been dispensed within the last three months for the patient concerned
- Are in date, and
- Are in a clean condition

In the event that a patient's own supply of medication has been used during their hospital stay, any remainder should be utilised during discharge. When a date for the patient's discharge has been confirmed, the contents of the bedside medication locker must be put into the green bag and sent to pharmacy, alongside the discharge prescription and the medicines reconciliation form if appropriate. This will have a number of benefits including: cost saving; reduced risk of duplication of medication (which could cause misunderstanding); reduced delay in discharge.

13.1 Storage of PODs on wards

All medicines labelled for an individual patient, whether their own medication or medication that has been supplied by the hospital pharmacy, must be stored in the bedside locker, ward refrigerator, or ward Controlled Drugs Cupboard as appropriate. See policy for the use of bedside medication lockers for medicines storage, 2018, for further information.

13.2 Assessment of PODs

A suitably qualified, trained member of staff e.g. nurse, pharmacist will assess the suitability of PODs for use on the wards, within 24 hours of the patient's admission to the ward or 48 hours if admitted at the weekend. They will document this clearly in the nursing notes once complete. Those medicines not suitable need to be destroyed or returned to the patient – see 'consent and destruction of unsuitable medication' below.

13.3 The Use of Compliance Aids

Sealed compliance aids (e.g. dosette boxes) must not be routinely used to administer medication to in-patients. However, in individual circumstances (e.g. in medically stable non-elective or short stay surgical / elective patients where no changes to their regular medications are anticipated) a suitably qualified, trained member of staff may assess the medicines in the compliance aid as being suitable for use. If the patient is self-administering a suitably qualified member of staff will also assess if the patient is clinically suitable to use the compliance aid. This authority to use the compliance aid must be documented on the 'self-medication assessment form' – see 'self-medication' below. If the patient's medical condition significantly changes then the patient must be re-assessed. If a patient is admitted out of hours and brings a compliance aid as PODs, nursing staff may administer from it provided that: the contents can be unequivocally identified and the contents match the medication chart.

13.4 Consent and destruction of unsuitable medication

PODs that do not meet the criteria set above must not be kept in the hospital. They remain the property of the patient and consent for their use or destruction must be obtained. Verbal consent must be sought from the patient or their representative by the nurse and recorded in the nursing notes before the items are returned in the pharmacy green transfer bags (with the exception of controlled drugs – see Controlled Drugs Policy). In the case of multiple or complex medicines, a form should be completed and the patient asked to sign to demonstrate consent – see appendix A.

Patients have the right not to agree to the use or destruction of their medicines. If consent is not given the medicines must not be used or destroyed. The medicines must be returned to the patient who must arrange for them to be sent home as soon as possible. If patients refuse to give their medicines to staff or insist on self-administering against policy, this must be documented in their medical and nursing notes.

13.5 Self-medication

Patients may want to self-medicate whilst in hospital – this is encouraged to maintain patient ownership of medicines, but the patient must first have an assessment to ensure they are safe to do so.

To allow this to happen, the following criteria must be met;

Each bed space will have an individual bedside medication locker.

Each patient will be assessed on the ward with regard to their capability to self-medicate; this will be done using the allocated self-medication risk assessment score. A record should be made in the patient's notes if they are self-medicating. If the patient is assessed as being unable to self-medicate, medication will be administered according to the medication policy.

All medication (with the exception of controlled drugs, fridge items and certain medications) will be stored in the patient bedside medication locker – see policy for the use of bedside medication lockers for medicines storage, 2018, for further information.

Patients will not maintain the bedside medication locker key – this is the responsibility of the nurse. At appropriate times, the nurse will open the bedside medication locker to facilitate self-medication.

The medication must be assessed before use – see 13.2, 13.3 and 13.4 for further information.

Medications which may not be self-administered are controlled drugs, variable-dose anticoagulants and 'when required' analgesics, unless this has been risk assessed following a local SOP (e.g. stroke rehabilitation).

Changes in patients prescriptions must be monitored i.e. discontinued medications are retrieved from the patient

A daily evaluation should be made of the effectiveness of the self-administration programme. Difficulties or interventions should be recorded in the patients care plan. Self-medication may be ceased at any time if the assessing nurse deems this necessary

A self-medication risk assessment proforma can be found in Appendix B.

13.6 Drugs Excluded

The following medicines must not be placed in the bedside medication locker to prevent patients being mistakenly given them at discharge. These medicines must be stored in the ward stock cupboards:

- medicines given by injection
- chlordiazepoxide when being used for alcohol withdrawal
- 'as required' night sedation, that the patient did not take before admission
- 'once only' medicines, and

The following classes of controlled drugs are excluded:

- schedule 1, drugs such as cannabis
- schedule 2, drugs such as diamorphine, morphine, oxycodone, methadone
- schedule 3, barbiturate drugs such as buprenorphine, temazepam, tramadol

Patients own supplies must either be stored in the ward's CD cupboard or returned to a relative to take home. If they are kept on the ward they must be entered into the 'Patient Own Drugs' page of the CD Register, which must be completed when they are administered to the patient and when they are given to the patient on discharge.

If a patient dies their controlled drugs must not be returned to the relatives, but must be returned to the Pharmacy Department for destruction.

14 Medicines Supply for Nobles Hospital

14.1 Medicines for use in hospital wards may only be obtained from the Pharmacy Department, unless patients bring in their own medicines for use during their stay. Pharmacy will only supply regular repeat medicines to patients admitted for a scheduled operation / procedure in

exceptional circumstances, or if the length of hospital stay is longer than planned. Wherever possible the Pharmacy Department will always purchase medicines that are labelled as safely as possible, to reduce the risk of medication mis-selection errors by healthcare professionals. This is particularly true for injectable medicines and for high risk medicines. For medicines supplies out of hours please refer to Out of Hours Drug Availability Guideline on the SharePoint site.

14.2 An appropriate order (written or electronic) is necessary. The order may take the form of:

- An authorised prescription
- An agreed pharmacy stock list
- A CD requisition
- An order generated by pharmacy staff during ward visits or review of prescriptions; and
- A written pharmacy requisition using the Pharmacy order book

14.3 Hospital wards requiring stock items must contact the pharmacy.

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

14.5 A patient information leaflet (PIL) must be provided with medicines dispensed for outpatients and for patients going home. The pharmacy department may supply 'in-house' patient leaflets in the absence of a pharmaceutical company product specific PIL e.g. for unlicensed medicines.

15 Stock Medicines to Clinical Areas

15.1 For the majority of clinical areas, medicines that are used regularly are supplied as stock items via the pharmacy top-up system. These areas can obtain further stock items if required by contacting the Pharmacy or sending a written order. However, some areas self-order stock on an agreed stock list, and areas that use very few medicines order stock using a pharmacy requisition book. Stock lists must be agreed between the ward manager and a pharmacist. When stock is received it must be checked against the pharmacy computer system issue sheet and any discrepancies notified to pharmacy immediately. Stock items will not be supplied at the weekend or out of hours unless required due to clinical urgency.

15.2 For supply of controlled drugs refer to the Controlled Drugs Policy.

16 Supply of Medicines for Individual Patients within Manx Care Hospitals

Both nursing and pharmacy staff must be alert to treatment changes. This includes changes to dose, frequency and the prescribing of new medicines. Nursing staff must inform pharmacy staff of any medicines they require.

16.1 If the item is listed as a stock item for the ward, the nurse should use the stock item in the first instance.

16.2 If treatment stops, the medicine must be removed from the patient's locker and an explanation of the change in treatment given to the patient. The medicine must then be disposed of with the patient's permission, in line with local procedures.

16.3 Before placing any drug in the bedside medication locker the registered nurse, pharmacist or technician must check carefully that the locker is free from previous patient's medication and that supply is labelled with the correct patient's name and that the drug label and directions match with those on the medication chart.

Note: This does not apply to ward prepacks.

16.4 Eye Drops All patients must receive a new supply of eye-drops after eye surgery but otherwise patients can use their own eye drops if opened within the last 14 days; these will be replaced following their expiry. Eye drops issued by pharmacy will be also given a 14 day expiry except anti-infective eye-drops will be given a 7 day expiry. A separate bottle for each eye will only be supplied if the patient has an eye infection.

16.5 'As required' medications must routinely be administered from ward stock. Only when it becomes apparent that treatment may go on for some time or the item is not ward stock will the item be dispensed as "named" stock.

17 Discharge Procedures

17.1 A discharge prescription must be produced for all in-patients going home. The discharge prescription also doubles as the GP letter and therefore needs to be completed even if the patient is taking no medicines home with them. Boxes on the discharge form should be completed, detailing the following:

- Any changes to regular medication, including any stopped while in hospital;
- Whether a medication review has been completed while an in-patient;
- Any follow-up arrangements or further information;
- Any known compliance issues
- Any allergies the patient suffers from

17.2 Pharmacist

A pharmacist will clinically check the discharge prescription against the medication chart. The patient will then be sent home with the appropriate medication, which will include PODs and items from the dispensary. Generally, the patient will not be supplied with regular medication unless in exceptional circumstances; they will continue their usual supply from the GP. Ward Pharmacists can counsel patients on discharge medication as appropriate.

17.3 Registered Nurse

A registered nurse or other suitably trained member of the healthcare team must check the discharge prescription with the patient after it has been dispensed by the pharmacy department. The nurse must ensure that the patient has all the medication that they need and understands any changes that have been made. They should explain how any new medications work and potential side effects.

17.4 Compliance Aids

Compliance aids are not suitable for all patients and all patients must be assessed by community pharmacists before one is initiated.

This is ensure funding is in place, to ensure capacity and to check which medications are suitable to be put in the compliance aid.

Patients cannot be initiated on a compliance aid by Noble's Hospital Pharmacy, but should be instead referred to their community pharmacy.

Patients that have an existing compliance aid, and are discharged with no changes to this will have their compliance aid returned to them on discharge, once this has been checked is in date, for the correct patient and contains the correct medications at the correct times. For those with medication changes on admission, the nurse must contact the community pharmacy with 48 hours' notice for a new compliance aid to be dispensed. A HS10 prescription must be sent to the community pharmacy to allow them to do this.

18 Transport and Receipt of Medicines in Hospital

18.1 Medicines will normally be transported in security sealed transit bags. Exceptions to this are supplies of bulk fluids. The container must be either handed to a member of ward staff or left in a locked ward area and be brought to the attention of the nursing staff. Medicines requiring refrigeration will be brought to the attention of the nursing staff for immediate unpacking and placing in the refrigerator (in some cases this is done by the use of a separate labelled container).

18.2 When patients are transferred between wards any medicines that have been individually dispensed for them, including patient's own medication, must be transferred with them in a green 'patient's own medication' bag. The way they are transferred must be in a manner that prevents loss or improper use.

18.3 Ensure that the patient's bedside medicine locker is emptied. Any member of Manx Care staff may transport medicines within the hospital provided that they have an appropriate reason to do so, providing the person who entrusts them with the medicines is satisfied that they are an appropriate person to accept responsibility for them whilst in transit.

18.4 Medicines received from the Pharmacy must be checked against the accompanying prescription/original order on receipt. Any discrepancy must be reported to Pharmacy immediately. Anyone collecting medicines from Pharmacy must produce a valid Manx Care identity badge. Failure to do so may result in Pharmacy refusing to supply the medicines.

18.5 For transport and receipt of Controlled Drugs, see the Controlled Drugs Policy.

19 Supply of Medicines to Clinical Areas Within Acute When the Pharmacy is closed

19.1 In accordance with robust stock management, it is the responsibility of the registered nurse / midwife in charge of a clinical area to ensure that controlled drugs and general ward stocks are

sufficient to cater for out-of-hours periods. An on-call pharmacist is available for medicines advice out-of-hours and for access to emergency medicines needed for an urgent clinical condition – see Out of Hours Drug Availability Guideline.

19.2 Obtaining Medicines from Other Clinical Areas. The borrowing of medicines from other clinical areas, when Pharmacy is open, must only occur in exceptional circumstances i.e. urgent clinical need. The borrowing of medicines from other clinical areas must not occur as a matter of routine when the Pharmacy is closed. Only complete packs or blister strips, which display the batch number and expiry date, may be borrowed. Transfer of individual doses of medicines that are not in their original container must not take place as it may lead to a medication administration error. In each case, a medicine transfer form must be completed, to provide an audit trail. See the Controlled Drugs Policy about borrowing doses of controlled drugs. To ensure safe administration nurses must, if not familiar with the use of the borrowed medicine, contact the on-call pharmacist for clinical advice. Instructions on obtaining drugs when the Pharmacy is closed can be found on the hospital intranet site, in the Pharmacy's SharePoint section – this also includes an instructional PowerPoint presentation, for training purposes.

20 Discharging patients from Nobles when Pharmacy is closed

20.1 **Supply of medication for discharge when the Pharmacy is closed.**

If a discharge prescription has been written when the pharmacy is closed and there are compelling reasons why the discharge needs to be processed out-of-hours, the following procedure must be followed.

NB: Medical/nursing teams need to assess whether it is more appropriate for the patient to be discharged the following morning or return at a later time to collect their medication

The first option is for when there are correctly labelled PODs (either from home or an inpatient supply from pharmacy) and/or pre-packed medications available – the nurse can dispense each item on the prescription as long as it is done to the same standard as would be done by pharmacy. If a labelled box is available for the patient, the name, drug, dose, directions and expiry should be checked against the prescription – no amendments can be made to directions on the box. For pre-packs the patient name, date and directions should be clearly written on the box. PODs need to be taken into account, and should be returned to the patient as appropriate. A second nurse must independently check the items. Both nurses must sign and date the discharge prescription.

Where there is no correctly labelled box or pre-pack available, a HS10 should be written for the patient.

20.2 **Counselling and Filing**

- The nurse or doctor must discuss medication with the patient; as a minimum explaining the nature of the medicine, how to take it, and any common side effects to be aware of
- Two additional copies of the IDS TTO (unverified by pharmacy) must then be photocopied.
- The other two copies are for 1) the patient, 2) the notes

21 National Notifications and Recall of Defective Medicines

The MHRA issues alerts to healthcare professionals regarding recalled or defective medicines.

Alerts are circulated to clinical leads via Datix. These alerts must be actioned immediately and the response indicated on Datix. Clinical leads are responsible for ensuring there are robust systems in place for reaching all appropriate areas.
During the manufacture or distribution of a medicine an error or accident may occur whereby the finished product does not conform to its specification.

If it is suspected that a medicinal product is defective, contact the Pharmacy immediately, so that the national notification process may be initiated, if appropriate. The on-call pharmacist must be contacted out-of-hours.

22 Storage of Medicines

Within the clinical area, the senior nurse has overall responsible for the safe storage, custody and administration of all drugs used within his/her clinical area, in accordance with this policy. In departments, e.g. physiotherapy where there may be no registered nurse / midwife, the professional head of service is responsible.
In each case, members of staff dealing with medicines as part of their role will bear some of the responsibility for appropriate medicines storage.

22.1 **Storage of Medicines within Clinical Areas**

In line with the Duthie report and NMC guidelines, all medicines must be stored in a lockable cupboard and Medicine storage areas / treatment rooms must have a key or keypad entry and doors must be kept locked when medicines are unattended. Medicines must be locked up in a cupboard or refrigerator that complies with the current British Standard:

- Refrigerators must be locked at all times. However, in areas such as ICU, Emergency Department and Theatres, where urgent access to critical medicines may be required at any time, the fridge may be left unlocked if a suitable person is in the immediate vicinity and takes responsibility for safe custody of the medicines within it.
- For bedside medication lockers a system must exist to ensure that keys cannot easily be matched, e.g. key-ring numbers must be randomly assigned to each bed. This means that key number 1 will not fit the locker by bed number 1.
- Bedside medication locker master keys have been supplied to each ward and their pharmacy team Master keys must be accounted for at the beginning of each shift.
- Individual bedside medication locker keys, when not in use must be locked inside the ward key cupboard.

22.2 Products must be stored separately according to the following categories: Products for External Use - All products intended for external use including diagnostic reagents must be stored separately from other medicines.

Products for Internal Use - All products intended for internal use must be stored separately from other medicines.

Products for Parenteral Use - Medicines for parenteral administration must be stored separately or in a separate section of the cupboard where medicines for internal use are stored. All local anaesthetic preparations must be stored separately from intravenous infusions.

22.3 **Controlled Drugs**

All CDs must be kept in the CD cupboard, which must only be used for the storage of CDs plus other specific drugs e.g. Strong Potassium Chloride Injection (see below). The construction must meet current design specification standards - See Controlled Drugs Policy.

22.4 **Medicines Refrigerator**

All medicines marked “store below 15ºC” or “store in a refrigerator” must be stored in an appropriate lockable medicines refrigerator. It is unacceptable to use a refrigerator that is not specifically designed for this purpose. The temperature of the refrigerator must be maintained at 2 to 8ºC and be monitored and recorded daily using a maximum/ minimum thermometer. This is the responsibility of senior nursing staff in the clinical area concerned.

The medicines refrigerator must not be used to store food. It must not have a freezer compartment. Vials, penfills and prefilled pens of Insulin must be stored in the refrigerator until opened or used. Once opened and in use insulin pens, cartridges and vials (except for Actrapid vials) must be stored at room temperature in the bedside medication locker. They must be clearly labelled with an addressograph, on the barrel of any pens, and the date of opening and be discarded after 4 weeks.

22.5 **Patients Own Drug Boxes**

Where patients’ own drugs (PODs) or patient self-medication is in operation, all medicines must be stored in a lockable medication cabinet. This must be securely attached to either the wall or bedside locker. See policy for the use of bedside medication lockers for medicines storage, 2018, for further information.

22.6 Ambient Temperature

Medicines must be stored at appropriate temperatures. Areas where medicines are stored must be monitored to ensure the temperature does not exceed 25 degrees C. Should this temperature be exceeded, remedial measures put in place to reduce the temperature. Advice on the use of medicines which have been exposed to high temperatures may be sought from Medicines Information the next working day (01624 650818, or medinfo@gov.im).

23 Medicines Needed in Medical Emergencies

23.1 All clinical areas must have immediate access to an emergency drug box, which must be kept on the resuscitation trolley in an open space to facilitate rapid resuscitation of the patient in cardiopulmonary arrest, and an anaphylaxis kit. These boxes and kits are supplied by pharmacy in tamper evident containers. Once the seal is broken they must be stored in a secure area and returned to pharmacy. A new box must then be immediately delivered to the ward via the porters.

Note: No other medicinal products may be stored on the resuscitation trolley.

23.2 Hypo boxes are also available for use in hypoglycaemia emergencies but these must be checked and topped up from ward stock by ward nursing staff.

23.3 All wards stocking opiates must ensure that they have a stock of naloxone.

23.4 All wards stocking Midazolam must ensure that they have a stock of flumazenil.

24 Keys

The safekeeping and whereabouts of drug cupboard keys, including bedside medication locker keys given to patients when self-medicating, is the responsibility of the most senior registered nurse, midwife or clinical professional on the ward, theatre or department at any given time.

Staff working in community, prison or other healthcare settings must refer to their local policy for safe handling of keys.

24.1 For management of Controlled Drugs keys, see the Controlled Drugs Policy.

24.2 Within Nobles the keys may be temporarily handed to medical and pharmacy staff, as necessary, for fulfilment of their duties. On such occasions, that particular clinical professional is responsible and accountable for ensuring that all relevant medicines policies and procedures are correctly adhered to, including the safe return of any keys to the registered nurse or midwife in charge. However, the most senior registered nurse/midwife retains the overall responsibility for drug security for that area.

24.3 **Procedure for lost keys**

If a nurse takes a key home every effort must be made to retrieve it as soon as possible.

If a bedside medication locker master key cannot be found, the locks on all lockers MUST be changed. Staff must contact supplies to organise procurement but the cost will be borne by the ward. A Datix should also be completed.

If the master key is lost by pharmacy staff then the cost will be borne by the pharmacy department.

25 Securities of Medicine Containers in Clinical Areas

25.1 Medicines must be stored in the containers in which they are supplied by the Pharmacy Department. They must never be transferred to another container.

25.2 Medicines dispensed for a named in-patient, must be stored in their bedside medication locker. They must also be kept with the patient if they are transferred to another clinical area. If they are no longer required they must be returned to Pharmacy, via the green medicines transfer bags.

25.3 With the exception of CDs, all drugs that are out of date or no longer required must be returned to pharmacy in the green transfer bag – see 15.4 Consent and destruction of unsuitable medication 15.4 above. See Controlled Drugs Policy for information about expired CDs.

25.4 All medicines coming into a ward or department must be received by a registered nurse / midwife who must:

- put them in a locked safe clinical area / treatment room and lock in the appropriate medicine cupboard as soon as practical; and
- report any losses/errors/discrepancies to the pharmacy.

25.5 Controlled Drugs See Controlled Drugs Policy.

25.6 Guidance for The Removal of Illegal or Suspicious Substances From Patients See the Management of Illicit Drug Users Policy. Management Guidelines for Persons suspected of having controlled drugs concealed internally

26 Misappropriation of Medicines

It is imperative that when medicines are identified as missing, actions are taken to discover where they are or what has happened to them as soon as possible.

26.1 Whilst medicines are widely used and stored safely and securely throughout Manx Care, staff are required to deal honestly with all medicines.

26.2 Any misappropriation of medicines by a member of Manx Care staff, or someone employed to provide independent contracted services is theft. The theft of medicines is a serious criminal offence under current legislation. It will be dealt with accordingly by Manx Care, professional regulatory bodies and the police.

26.3 Misappropriation of medicines, breaches of security or potential medication security risks must be reported via senior line management to the Executive Leadership Team.

26.4 Medicines most likely to be misappropriated are those with the greatest abuse potential. These include analgesics with opiate qualities such as Codeine, Tramadol, and sedatives which are not subject to the controls in the Misuse of Drug Act 1971, such as benzodiazepines, 'Z' drugs. Also those medicines with recreational or lifestyle potential, such as Viagra (Sildenafil).

26.5 The storage requirements, register entries and daily stock checks make it more difficult to misappropriate those medicines which are covered by the Misuse of Drugs act 1971, Controlled Drugs. Most of these medicines have addictive properties and all have a 'street' value.

27 Breaches of Security

27.1 Breaches of medicine security can be:

- Finding a cupboard or a door open that is normally kept locked.
- Finding broken locks to cupboards or doors.

- Finding medicines that may appear to have been tampered with.
- Medicine keys going missing.

27.2 Any breaches in security of medicines must be reported to the senior line management immediately. These must be investigated as soon as possible, the pharmacy team at Nobles and the Pharmaceutical Adviser are willing to help and may be contacted directly. An incident must be raised through the appropriate incident reporting system (primary care, secondary care, mental health systems). If staff work in an area with specific security requirements e.g. the prison then local policies must be consulted.

27.3 The area must be made secure and remaining medicines moved to a secure place if necessary.

27.4 **Potential Medicine Risks**

Identifying any situation that raises concerns over the safe and secure handling and storage of medicines, must also be reported to the senior line management and to pharmacy immediately. If possible the risk must be dealt with immediately. If the risk cannot be mitigated an entry must be made in the Manx Care Risk Register.

27.5 **Missing Medicines - Raising Concerns**

If staff suspect that medicines are missing they must raise the matter with their line manager or the ward or department manager as soon as possible. The ward or department manager must inform the senior management. Checks must be undertaken to verify that the medicines are actually missing. The incident must be entered on the appropriate incident reporting system.

27.6 When managers are informed that there are concerns that medicines cannot be accounted for, or may have been misappropriated, they must take action to ensure they are actually missing, as soon as possible.

27.7 If needed, the area must be made secure and medicines moved to a secure place if necessary.

27.8 Initially the investigation must include checking all stock cupboards, patient's bedside medication locker, treatment rooms, green pharmacy transfer bags and nursing stations to see if the medication has been put away in the wrong place. Medication charts must be checked to see if the medication has been given, pharmacy delivery boxes must be checked to see if the medication is still in there.

27.9 If controlled drugs are involved stock must be recounted, record books must be checked, including checking arithmetic, checking that the correct medicine has been issued from the record book, checking patients own medication and registers. If the medication still cannot be found then an incident form must be completed.

27.10 During normal working hours the manager must inform the senior management. A member of the team will help with any actions needed to find the medicines.

27.11 If the incident occurs in Nobles hospital between 8.45am and 5.15pm on weekdays or from 9am to 12.30pm on a Saturday or a bank holiday, the pharmacy department must be contacted. During working hours the Pharmaceutical Adviser can also be contacted for advice.

27.12 If the medicines cannot be found or an acceptable, appropriate explanation of where they have gone is not discovered, or if on other recent occasions medicines have been identified as missing from the area, or if other property has gone missing from the area, then it must be considered that they may have been stolen. A report must be sent to the senior management team for that clinical area, including the Care Group Manager and Clinical Director.

27.13 If staff suspect that medicines are being misappropriated, or have seen someone remove medicines from stock, they must raise the matter with their line manager or the ward or department manager as soon as possible. Any concerns raised must be treated in confidence.

27.14 If staff suspect their line manager or ward or department manager is involved they must take their concerns to a more senior manager.

27.15 The ward or department manager must undertake checks to verify that medicines are actually missing.

27.16 Report the incident via the appropriate incident reporting system (paper or electronic)

27.17 If on other recent occasions medicines have gone missing and could not be adequately accounted for, or other items have gone missing from the ward or community setting, it may be appropriate to treat reports of missing medicines as theft of medicines.

27.18 If controlled drugs are involved the Chief Pharmacist or the Pharmaceutical Adviser as appropriate will be informed immediately and will contact the hospital managers for Nobles or Director of Primary Care. There may be a requirement to contact the Police Liaison Officer.

27.19 If after making the checks, the missing medicines cannot adequately be accounted for, or someone was seen removing medicines from stock or if on other recent occasion's medicines have gone missing and could not be adequately accounted for, or other items have gone missing from the ward, it must be assumed they have been stolen:

- The Chief Pharmacist at Nobles or Pharmaceutical Adviser (for community settings) should be informed immediately. The appropriate Senior Nurse, Head of Nursing or Senior Manx Care Manager must also be informed
- Any evidence found in the initial checks must be retained for further investigation
- All investigations must be undertaken in a discrete manner
- If it is felt necessary the pharmacy department will contact the police. The ward/community unit must not contact the police directly
- A report regarding the incident will be sent to the senior management

27.20 **Tampering With Medicines**

The ward or department manager has a suspicion that a medicine has been tampered with. This information may have come from another member of staff or from a patient, e.g. a patient may say a medicine tastes different or not as strong as usual.

27.21 The ward manager must quarantine (in the CD cupboard) the suspected medicine, escalate to their Head of Nursing, report the incident formally and inform a member of the senior management team.

27.22 The Chief Pharmacist will arrange for collection of the suspect medicine if this relates to an inpatient setting. For those reports originating in primary care the Pharmaceutical Adviser should be informed and will arrange collection of the suspect medicine.

27.23 The Chief Pharmacist/Pharmaceutical Adviser will arrange with Quality Control North West for testing and arrange the timescale for the return of the results.

28 Medicines Administration and Checking of Administration

Nurse and midwife responsibilities and accountabilities are stipulated in NMC The Code Professional standards of practice and behaviour for nurses and midwives, April 2015. Medicines must be administered at all times within the guidelines laid down in the NMC's Standards for Medicines Management.

Line managers are responsible for ensuring staff are adequately trained and competencies are assessed and reviewed, and that appropriate supervision is in place if necessary. All Manx Care employees and agency staff must seek advice or assistance if they are required to administer or check the administration of a medicine with which they are unfamiliar. The process of administering medicines must always be explained to the patient, where appropriate.

28.1 Authorisation to Administer and Check the Administration of Medicines

The following staff are authorised to administer medicines providing they have undertaken the necessary training:

- a registered nurse
- a registered midwife
- a registered medical practitioner or dentist, and
- other professional staff groups provided they have undertaken appropriate Manx Care approved training e.g. ODP, pharmacists, physiotherapists, dieticians, radiographers

28.2 Only health professionals who have undergone specialist training are permitted to administer cytotoxic medicines.

28.3 Manx Care acknowledges that in the majority of circumstances, single person medicines administration is acceptable, providing that the person has demonstrated the necessary level of knowledge and competence. Exceptions include:

- administration in paediatric and neonatal medicine
- where a practitioner is instructing a learner
- where a patient's condition makes it necessary
- where a controlled drug is involved
- where a chemotherapy agent is involved
- where a complex calculation is required. The use of calculators to determine the volume or quantity of medication must not act as a substitute for arithmetical knowledge and skill (NMC 2002)
- administration of IV medicines, and
- where local circumstances make the involvement of a second person desirable, in the interests of minimising the potential for error.

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

28.4 Health care professionals must not be interrupted during the preparation and administration of medicines wherever practicable. Bank and Agency Staff

28.5 Bank and agency staff can administer medicines, according to the policy, if it is within their scope of practice.

28.6 **Controlled Drugs**

See Controlled Drugs Policy.

28.7 **Dose Calculations**

Some preparation of drug doses require complex calculations. If a healthcare professional is in any doubt of their calculation skills they must get a second independent check. The authorised administering practitioner can obtain a second check from:

- another health care professional in the clinical area who is familiar with the medicine and its calculation
- Medicines Information in the Pharmacy Department

The calculation must be recorded in the patient's documentation (nursing or clinical notes or medication charts). The second person may be:

- a registered nurse
- a registered midwife
- a registered medical practitioner or dentist, and
- other professional staff groups provided they have undertaken appropriate Manx Care approved training e.g. ODP, pharmacists, physiotherapists, dieticians, radiographers
- a student nurse, midwife or ODP who has satisfied the ward nurse/midwifery manager of his/her knowledge and competence with drug administration procedures

28.8 **Checking the Prescriptions**

All sections of the prescription chart must be checked before administering a medicine. The prescription chart must be legible and include the following:

- patient's full name, date of birth and hospital number
- the ward
- medicine and food allergies/intolerances including alternative medicines, iodine, chlorhexidine and latex
- the date the drug is to be commenced, and
- the signature of the prescriber

The prescription must be checked for the following information:

- the approved name of the medicine
- the route of administration
- the dose to be administered
- the frequency and time of administration of the medicine
- the duration of treatment
- the rate of administration; and any special instructions (e.g. administer with food)

If a nurse / midwife is in any doubt or needs clarification of the dose or method of administration, this must be done with the prescriber or pharmacist before administration. If it is necessary to rewrite the prescription, the prescriber must do so before the medicine is given.

29. Administration of a Medicine

In accordance with NMC Standards for medicines management any healthcare professional in exercising their professional accountability in the best interests of their patients must:

- be certain of the identity of the patient to whom the medicine is to be administered;
- check that the patient is not allergic to the medicine before administering it
- know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- be aware of the patient's plan of care (care plan or pathway)
- check that the prescription or the label on medicine dispensed is written clearly and unambiguous
- check the expiry date (where it exists) of the medicine to be administered
- have considered the dosage, weight where appropriate, method of administration, route and timing
- administer or withhold in the context of the patient's condition, (for example, Digoxin not usually to be given if pulse below 60bpm) and co-existing therapies, for example, physiotherapy
- contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable, and
- make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible

It is also the responsibility of the professional administering medicine to ensure that a record is made when delegating this task. In addition, healthcare professionals must ensure the patient receives the prescribed medication and takes it at the time of administration.

Do not leave medicines unattended on lockers or in unlocked containers, e.g. tablet pots, at any time.

In some settings there may a requirement for an appropriately trained and assessed Health Care Support Worker (HCSW) or Healthcare Assistant (HCA) to supervise patients.

On wards this may be required if it is anticipated that the patient will take some time and result in a significant delay on the medicine round. The medicines must be handed over to the HCSW/HCA at the patients' bedside and the HCSW/HCA must remain present with that patient until the observation is complete.

In some community settings a HCSW/HCA may be responsible for administering medication, and these staff must be trained as per local policy and be assessed as competent to do so.

If the medicines are not administered the nurse must code the reason why a drug has not been administered

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

Liquid oral medicines:

- Oral/enteral (purple) syringes must be used to administer liquid oral medication that cannot be administered using a medicine pot. Clear (iv) syringes must never be used for this purpose.
- Oral medications and injections must not be prepared at the same time, and oral medications and injections should not be taken to the patient at the same time.
- Medications for injection must be prepared one at a time and administered to the patient as soon as possible after preparation.

29.1 Witnessing the Preparation and/or Administration

If it is considered that a witness is necessary, the following guidelines are optional (except for intravenous medication administration) and may or may not be used in their entirety. However, they represent good practice when witnessing medicine preparation and/or administration:

- verify the patient's identity against the prescription
- check the prescription
- have sufficient knowledge of the patient's condition in relation to the prescription;
- witness the reconstitution of the drug
- check the diluent used
- check the rate of administration if necessary
- check all expiry dates
- check any calculations;
- witness the safe administration or disposal of the medicine, and
- sign the prescription chart/other documentation, as appropriate

29.2 Delayed and Omitted Medicines

Delays or omissions to medication administration can lead to patient harm (NPSA Alert 2010). Best practice in the administration of medicines means that staff must endeavour to administer medication as near to the prescribed time as they can, however, it is recognised that this is not always possible and therefore certain medications must take priority.

The first parenteral dose of any life-saving medication (see definitions section for clarification) must be administered within 1 hour of the prescribed time. Prescribers must be reminded to use the "stat / time critical / first doses" section at the front of the medication chart for this initial

dose and to inform the nurse looking after that patient that a new drug has been prescribed. All other medications must be given as soon as possible but within 2 hours of the prescribed time, paying particular attention to critical medication (see definitions section for clarification).

29.3 **Drug Administration with a Student Nurse / Midwife**

Within Manx Care student nurses / midwives may be involved in any aspect of medicines administration, providing that they are under the direct supervision of a registered practitioner or other authorised person. Where this is done, both the student and the registered nurse must sign the medication chart. The accountability for the correct checking and administration remains the responsibility of the registered nurse / midwife. Student nurses and midwives are not permitted to administer or supply medications under PGDs even if under direct supervision.

29.4 **Mixing of Medicines**

The law defines "mixing" as the "combination of two or more medicinal products together for the purposes of administering them to meet the needs of a particular patient – this renders the resulting product unlicensed. Where one product is a vehicle for another is not included in this definition. However, it does include medicines which mix at a "Y site", where two or more intravenous infusions join. Compatibility for all products that are to be "mixed" before administration, must be confirmed with a pharmacist – includes oral medicines, topical treatments, inhaled drugs, injections, infusions etc.

29.5 **Administration of Medicines Without a Medical Prescription (Standing Orders or Homely Medicines)**

The use of homely remedies on in-patient wards is not permitted. Where suitable the medicine may be given on PGD if appropriate for the area. The use of homely remedies on specific units e.g. Ramsey Cottage District Hospital requires staff to follow local procedures.

29.6 **Covert Administration of Medicines**

For full guidance please refer also to the NMC position statement on covert administration of medicines.

The regulatory body for nursing, midwifery and health visiting states that disguising medication in food and drink can be justified in the best interests of patients who actively refuse medication but who lack the capacity to refuse treatment. When this is carried out a strict adherence to procedure must be followed (see below).

It must be a contingency measure rather than regular practice. Medication must never be disguised simply for convenience of the health care team.

The NMC recognises that this is a complex issue that has provoked widespread concern. It involves the fundamental principles of patient and client autonomy and consent to treatment, which are underpinned by the Isle of Man Human Rights Act 2001.

<u>Disguising medication in the absence of informed consent may be regarded as deception.</u>

However, a clear distinction must always be made between those patients or clients who have the capacity to refuse medication and whose refusal must be respected, and those who lack this capacity.

Among those who lack the capacity, a further distinction must be made between those for whom no disguising is necessary because they are unaware that they are receiving medication, and others who would be aware if they were not deceived into thinking otherwise.

In certain exceptional circumstances, in which covert administration may be considered to prevent a patient from missing out on essential treatment and where the patient is incapable of informed consent, the following considerations must apply:

- the medication must be considered essential for the patient's health and wellbeing, or for the safety of others. Disguising medication simply for convenience of the health care team is totally unacceptable
- the decision to administer medication covertly must be considered as a contingency measure in an emergency rather than as regular practice
- there must be broad and open discussion among the clinical team and the patient's relatives, carers or advocates before the decision is taken to administer medication covertly
- the involvement of the pharmacist is especially important as adding medication to food or drink can alter its chemical properties and thereby affect its performance
- the decision and action taken, including the names of all parties concerned, must be documented in the patient's care plan and regularly reviewed
- regular attempts must be made to encourage the patient to take medication voluntarily

29.7 **Insulin**

Inpatients with diabetes may continue to use their own pen devices to deliver insulins, providing they can attach and remove the pen needle independently, and discard it in a sharps box.

Patients who are able to self-administer insulin should have individually labelled disposable pens made available to them.

The use of U100 syringe for insulin administration would be appropriate for single (stat) doses or when required doses (prn) administration but not for ongoing regular insulin administration by staff

The diabetes team advocate the use of Novorapid® as prn insulin instead of Actrapid® due to shorter duration of action for Novorapid®, and therefore a reduced risk of hypoglycaemia.

*Regular Novorapid® or other insulin use may be provided via disposable pens for staff ease of use (markings on syringes are very small whereas dials on pens are easier to read)

Intravenous syringes must never be used for subcutaneous insulin administration.

29.8 **Disposal of Medicines**

Pharmaceutical waste is classified as 'special waste'. Therefore:

- it must be disposed of by incineration, in approved containers at high temperatures in order to completely destroy all potentially harmful substances; and prosecution will occur if such waste is consigned as anything other than 'special waste' discovered in landfill tips and it can be traced back to the user. In addition, disposal of pharmaceutical waste must be under the supervision of a registered pharmacist.

29.8.1 **Secondary care settings**

- surplus patients' own drugs and expired medicines may only be disposed of via the Pharmacy;
- Manx Care Waste Manager is responsible for raising a pre-consignment note before any pharmaceutical waste is removed for incineration off site. Refer also to the Noble's Hospital Waste Management Policy.

29.8.2 **Primary care settings**

Ensure any pharmaceutical waste is disposed of appropriately. Please follow your local policies. Note that any medication can be returned to community pharmacy for destruction but larger volumes may pose a problem and Estates should be contacted.

29.8.3 **Charitable Organisations**

Under no circumstances must medicines belonging to Manx Care be donated to or used by any charitable organisation either within the United Kingdom or abroad.

Medicines provided by Manx Care departments are for the exclusive treatment of Manx Care patients. This applies to all medicines, including:

- expired medicines;
- medicines supplied for training purposes; • excess stock, waiting to be returned to pharmacy; and
- medicines returned to Manx Care by patients, which are no longer needed.

30 Duties

30.1 **Manx Care Executive Leadership Team** will bear ultimate responsibility for this policy and will authorise implementation of the Medicines Policy and appendices into the working arrangements of Manx Care.

They will maintain an overview of significant risks via the Risk Register. The Chief Executive will designate an Accountable Officer who will be responsible for all aspects of the safe and secure management of Controlled Drugs.

30.2 **Manx Care General Managers** will ensure their local managers recognise which sections of the Medicines Policy and appendices must be implemented within their areas, that they promote use of the policy by all staff and that they communicate any changes in policy to staff in a timely manner. They will ensure their local managers highlight medicines-related risks specific to their area and consider methods of risk reduction. They will seek advice from the Chief Pharmacist or the Pharmaceutical Advisor when necessary.

30.3 **Clinical Directors** will ensure that the Medicines Policy and its appendices are implemented throughout the areas they control, in order that the risks associated with medicine use are minimised, Manx Care resources are used effectively and our patients benefit therapeutically.

30.4 **Clinical Directors and General Managers** will oversee the application of this policy into their services and ensure its implementation is undertaken within their management structure, with the necessary controls to achieve the policy's aims. They will liaise with the Pharmacy department to obtain expert advice when necessary. They will promote the policy to consultants and they, in turn to their teams.

30.5 **Associate Directors of Nursing and General Managers** will ensure the procedures contained within the Medicines Policy and appendices are followed by all their healthcare professional staff. They will ensure that all staff are aware of how to access the policy, and appendices if undertaking a task that may only occur rarely. They must bring the policy to the attention of all new staff who deal with medicines as part of their daily role. They will identify any areas of significant risk and take action to control this risk. They will be familiar with relevant sections of the policy and appendices and promote and demonstrate good practice associated with medicines use.

30.6 **All health care professional staff** will ensure they are familiar with all relevant sections of the Medicines Policy and appendices and will follow the correct procedure when undertaking any medicine-related task. They will report any concerns relating to medication risk to their line manager or pharmacist so action can be taken. Staff will report any medication incidents or near misses using their appropriate incident reporting system.

31. Reviewers for 2023 Update

- Sarah Hepburn, Chief Pharmacist, Nobles Hospital
- Maria Bell, Pharmaceutical Advisor, Manx Care
- Craig Rore, Specialist Pharmacist, Medicines Information and Medicine Safety

32. Appendices

Appendix A: Record of Consent – destruction of Patients own drugs (PODs)

Appendix B: Self-medication risk assessment form & consent

Appendix C: Equality & Standard of Assessments

Appendix A: Record of Consent – destruction of Patients own drugs (PODs)

Consent Form for the Destruction of Patient's Own Medication

HOSPITAL	
WARD	
Patient's name:	[Or affix addressograph label here]
Patient's Address:	
Patient's Hospital Number:	
Patient's Date of Birth:	

I, _____ , have been advised to send all of my current supply of Medication home or to have them destroyed within the Noble's Hospital Pharmacy Department.

I consent to the permanent destruction of the following Medication (if Controlled Medication – list quantity):

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

I understand that on my discharge from hospital, a limited supply of all new prescribed medication will be supplied to me.

Signature of Patient		**Date**	

Signature of Registered Nurse/Midwife obtaining consent		**Witness (for Controlled Medication**	
Print Name		**Print Name**	

Appendix B: Self-medication risk assessment form & consent

Self-Medication Risk Assessment Score				
Mental State	**12** Very confused, psychiatric illness	**8** Disorientated	**4** Occasionally forgetful	**1** Fully alert and orientated
Number of prescribed items	**4** Eight or more	**3** Five to seven	**2** Three to four	**1** Two or less
Physical condition	**4** Very ill, severely disabled, severe hearing or visual problems	**3** Unwell, poor vision or hearing, disabled	**2** Weakness in limbs or hands or poor condition	**1** Physically able to handle medication
Attitude to medication	**4** Not interested or unhappy with medication, or unable to recall it	**3** Reluctant to ask about medication regime	**2** Knowledge about medication limited	**1** Knowledge about medication and can recall it, Understands regime
Score less than a 6	Minimal risk, suitable to self-medicate			
Score 7 - 12	Moderate risk, may need assistance to self-medicate			
Score 13 - 24	High risk, unsuitable to self-medicate			

Date	Time	Score	Comments	Initials

Information about Self-Medication

On the wall you will find a lockable box in which to keep your medicines. All medicines must be kept locked in this box whilst you are in hospital.

The nurse will open the beside medication locker at appropriate times to allow you to self-medicate.

If you have any queries about your medication please talk to the Nursing staff.

If you need further supplies of your medication tell one of the Nurses who will order more from the pharmacy for you.

If any patient of visitor tries to take your tablets please call the nurses immediately

☐ I have read this information sheet and agree to take part in the self-medication programme	
☐ I agree to have my medication stored in the bedside medication locker whilst in hospital. This must be locked at all times, except when medication is being given	
Name	
Signed	
Date	
RN witness	

Appendix C

EQUALITY & STANDARDS ASSESSMENT

Document title: Date/ version:	Author:

Which best describes this document?

☐ New document ☐ Re-write/amendment of existing document ☐ Review of existing document

Document content:

Aims/objectives clearly stated?	☐ Yes	☐ No	
Relevant stakeholder involvement?	☐ Yes	☐ No	
Appropriate language/terminology?	☐ Yes	☐ No	
Up-to-date references/guidelines/research?	☐ Yes	☐ No	☐ N/A
Procedural clarity (including algorithms)?	☐ Yes	☐ No	

If 'no' selected, provide rationale for decision:

Is the document compliant with IOM Equality and Diversity legislation? ☐ Yes ☐ No

If **'no,'** in which area is the document non-compliant?

☐ Disability ☐ Gender reassignment ☐ Marriage/Civil partnership ☐ Religion/belief

☐ Race ☐ Pregnancy/maternity ☐ Sex/sexual orientation ☐ Age

Reason for non-compliance:

Documents failing to achieve one, or more, of the above CANNOT be ratified.

Date of initial review:	Review undertaken by: Select ratifying body

Review outcome:

☐ Ratified

☐ Ratified - pending minor changes*

☐ Not ratified - significant changes required

☐ Not ratified - rejected

Outcome rationale/recommendations:

**If document is ratified pending minor changes:*

Tick to confirm that changes have since been made as recommended by the ratifying body: ☐

Date of ratification:	Signature/name of P&P Chair/Care Group Manager: