Medway NHS Foundation Trust
Corporate Policy: Medicines Management Policy

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MEDICINES MANAGEMENT POLICY

Document Control / History	
Revision No	**Reason for change**
1 New	Existing medicines policies to be amalgamated into one Medicines Management policy
1 Minor amendment	Addition of training requirements for prescribing and administration of medication, monitoring the effectiveness of the policy and current prescription pro forma
2	Full review and update.
3	Addition of information regarding loading doses
4	Complete review; removal of procedural details into separate policies
5	Addition of Medicines Protocol details, full review to occur April 2016
6	Full review and update
6.1	Extended review date to enable full review
7	Full review and Update

Consultation
Medicines Management Group

MEDICINES MANAGEMENT POLICY

Table of Contents

To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 Medicines are used in all areas of the Trust and are the responsibility of all healthcare professionals. The importance of appropriate procedures to ensure the quality and safety of all aspects of medicines usage is paramount, and is a key component of clinical governance. All members of staff dealing with medicines need to contribute to maximising their effective use and minimising medicine-related harm and morbidity for our patients.

2 Aim

2.1 To ensure that medicines are correctly stored, properly prescribed, and correctly administered in a safe and timely manner.

2.2 To support the Trust's strategic objective of delivering safe, high-quality care and an excellent patient experience.

2.3 To detail the responsibilities of all staff groups involved with prescribing, dispensing, carriage, safe storage, and administration of medicines.

2.4 The key components of this policy include:

- 2.4.1 Storage, security and ordering of medicines
- 2.4.2 Prescribing (and other legal mechanisms for authorising supply/ administration of medicines)
- 2.4.3 Administration of medicines
- 2.4.4 Dispensing and issue of medicines
- 2.4.5 Monitoring of medicines management processes
- 2.4.6 Safe disposal of medicines

3 Definitions

3.1 "Medicines Management is a system of processes and behaviours that determines how medicines are used by the NHS and patients. Good medicines management means that patients receive better, safer, and more convenient care. It leads to better use of professional time, and enables practitioners to focus their skills where they are most appropriate. Effective medicines management also frees up resources which means that NHS money can be used where it is most effective, Good medicines management benefits everyone." (National Prescribing Centre).

3.2 Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'. Medicines optimisation embodies the principles of Medicines Management, as applied to individual patients.

4 Relevant Legislation

4.1 The control of medicines in the United Kingdom was primarily governed by the Human Medicines Regulations (2012) and associated European legislation. This legislation was updated in 2019 to reflect the UK leaving the EU in January 2021. The NMC standards for medicines management were withdrawn in January 2019, as nurses felt "it was no longer their remit as a regulator to provide this type of clinical practice guidance". This was replaced by the Royal Pharmaceutical (RPS) guidance "Professional guidance on the safe and secure handling of medicines" and the collaborative Royal College of Nursing (RCN) and RPS guidance "Professional guidance on the administration of medicines in healthcare settings"..."

4.2 Doctors, other prescribers and pharmacists are reminded of their responsibilities as stated in relevant legislation and the Codes of Ethics produced by the GMC, NMC and GPhC.

4.3 The *Non-Medical Prescribing Policy* (POLCPCM039) sets out the guidelines for non-medical prescribing.

4.4 The GMC's revised guidelines on *Good Medical Practice (2013)* outlines the principles that doctors must follow when prescribing medicines. The GMC provides further ethical guidance in *Good Practice in prescribing and managing medicines and devices* (2013)

4.5 You must give patients, or those authorising treatment on their behalf, sufficient information about the proposed course of treatment including any known serious or common side effects or adverse reactions. This is to enable them to make an informed decision (for further advice, see *Consent Guidance: Patients and Doctors Making Decisions Together* (GMC 2008).

5 Policy Framework

5.1 **Medway NHS Foundation Trust** is committed to complying with statutory, mandatory and best practice requirements through a supporting framework of documents:

POLCMM007 - Medicines Management Sub-Policy 1 – Safe and Secure Handling of Medicines
This document outlines the safe and secure handling of medicines within Medway NHS Foundation Trust aims to ensure compliance with current legislation, and good practice guidance, whilst managing the risks to patients and staff arising from the use of medicines.
POLCMM008 - Medicines Management Sub-Policy 2 – Prescription Writing This document details the prescribing standards and procedures.

POLCMM009 - Medicines Management Sub-Policy 3 - Controlled Drugs Procedure This document provides detailed procedures on the safe use and security of Controlled Drugs and appropriate availability.
GUCMM018 - Self Administration of Medicines Guidelines This document describes the key components for successful implementation of self-administration. The document works in conjunction with national and local policies on medicine storage and administration.
POLCPCM034 - Unlicensed Products Policy This document describes the trust policy for the procurement and use of unlicensed medicinal products (often called "specials").
POLCMM002 - Medicines Reconciliation on Admission To Medway Foundation Trust Policy This document describes the types of Medicines Reconciliation which are undertaken at Medway NHS Foundation Trust. Medicines Reconciliation (MR) is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer and discharge of patients requiring medicines.
PDGCMM004 - Patient Group Directions - Development and Use Policy and Procedure This document provides good practice recommendations for the systems and processes used when Medway NHS Foundation Trust is considering the need for, developing, authorising, using and updating Patient Group Directions (PGDs).
POLCPCM039 - Non-Medical Prescribing Policy This document describes Non-medical prescribing, it is the prescribing of medications by Nurses, Midwives, Health Visitors, Pharmacists and Allied Health Professionals (AHP) who have successfully qualified as prescribers.
SOP0173 - Use Of FP10 Prescriptions at Medway NHS Foundation Trust Procedure This SOP covers the management of FP10 prescription stock for Medway NHS Foundation Trust, including stock control, ordering forms from suppliers, delivery, receipt, storage and distribution of the forms, and destruction and disposal of forms that are no longer needed.

PROCMM001 - Returning Patient's Own Controlled Drugs or 'Ward Stock' to pharmacy This document details the process for returning Patient's Own Controlled Drugs or 'ward stock' to pharmacy.
SOP0010 - Ward Staff Authorised to Order Controlled Drugs From Pharmacy This document details the procedure to ensure that the person requesting ward controlled drugs as stock are authorised to do so.
POLCMM012 - Antibiotic Stewardship Policy - POLCMM012 This policy aims to ensure correct antibiotic treatment is given.
OTCGR072 - Pharmacy - Business Continuity Plan Pharmacy - Business Continuity Plan sets out the preparations for the department/section to manage and recover from service disruptions.
OTCS025 - COSHH HSE: A Brief Guide to the Regulations Sets out the regulations for using chemicals and other hazardous substances.
POLCOM001 - Medical Gas Pipeline Systems and Associated Equipment Operational Policy This document details how we management medical gases.

6 Roles & Responsibilities

6.1 GOVERNANCE PRINCIPLES

6.2 Establish assurance- say what we do and why we do it

6.3 Ensure capacity and capability- train people and ensure they have the competencies and resources

6.4 Seek assurance- do what we say and prove it

6.5 Continually improving- improve what we do.

6.6 Chief Executive Officer

6.6.1 The Chief Executive is the responsible officer for the Trust and is legally accountable for medicines management and the associated risks across the organisation

6.6.2 It is the responsibility of the Chief Executive to ensure there are clear lines of accountability established and maintained throughout the organisation, defining interpersonal relationships between the Board, relevant committees (including the Medicines Management Group and the Patient Safety Group) and heads of department/ service

6.6.3 The Chief Executive must ensure the Board is kept fully informed of any medicines management risks and any associated medicines management issues

6.7 Executive Directors

6.7.1 The Director of Nursing and the Medical Director are responsible for overseeing the professional standards of nurses and doctors employed by the Trust.

6.7.2 Directorate management teams (Directors of Operations and Divisional Directors) are accountable to the Chief Executive for ensuring that all staff under their control fully implement this policy, and any related sub-policies/ documented procedures. They are required to ensure, so far as is reasonably practicable, that:

6.7.2.1 There are adequate resources available to meet the medicines policy requirements

6.7.2.2 All managers are competent to discharge their medicines management responsibilities

6.7.2.3 The effectiveness of the policy and arrangements for implementation are regularly monitored and reviewed

6.7.2.4 Appropriate instruction, training and supervision is provided for staff under their control and working in their area of responsibility.

6.8 Executive Lead for Medicines Management

6.8.1 The Executive Lead for medicines management has overall accountability for the safe and secure handling of medicines, supported by the Chief Pharmacist and Medicines Management Group.

6.9 Medicines Management Group

6.9.1 All aspects of medicines management within the Trust are accountable to the MMG, which reports to the Quality Assurance Committee.

6.9.2 See also MMG Terms of Reference.

6.10 Director of Nursing and Chief Pharmacist must:

6.10.1 Ensure safe systems and practices are implemented, maintained and monitored

6.10.2 Ensure staff are made aware of this policy and its contents. New staff must be informed at induction.

6.11 Controlled Drugs Accountable Officer

6.11.1 The Trust, as a 'designated body' under the Health Act 2006, must appoint a fit, proper and suitably experienced person as it's accountable officer for controlled drugs. The Accountable Officer at MFT is the Chief Pharmacist, who must:

6.11.1.1 Establish and operate appropriate arrangements for securing, monitoring and auditing the safe management and use of controlled drugs by the Trust.

6.11.1.2 Review, or ensure that the Trust reviews, arrangements for the safe management and use of controlled drugs.

6.11.1.3 Ensure that the Trust establishes appropriate arrangements to comply with misuse of drugs legislation.

6.11.1.4 Ensure that the Trust has adequate and up-to-date standard operating procedures (SOPs) in place in relation to the management and use of controlled drugs.

6.11.1.5 Ensure adequate destruction and disposal arrangements for controlled drugs.

6.11.1.6 Ensure relevant individuals receive appropriate training.

6.11.1.7 Ensure monitoring and auditing of the management and use of controlled drugs by relevant individuals, and to monitor and assess their performance.

6.11.1.8 Maintain a record of concerns regarding relevant individuals, taking appropriate action in relation to well-founded concerns regarding individuals.

6.11.1.9 Assess and instruct investigation when there are concerns about the safe management, prescribing and use of controlled drugs and take appropriate action if there are well-founded concerns.

6.11.1.10 Establish arrangements for sharing information with other Trusts and local bodies as part of a CD Local Intelligence Network.

6.12 Chief Pharmacist is responsible for:

6.12.1 Ensuring the procurement of pharmaceuticals of appropriate quality, in accordance with Standing Financial Instructions, Drugs and Therapeutics

Group and Medicines Management Group policies and ensure value for money.

6.12.2 Establishing a system for the safe and secure handling of medicines.

6.12.3 Establishing and maintaining a system for the supply, distribution, return and destruction of medicines.

6.12.4 Establishing a system for advising all healthcare staff and patients on all aspects of medicines management, to ensure the best use of medicines.

6.12.5 Establishing a system for recording and reporting pharmacists' interventions on prescriptions, in accordance with the Trust's Incident reporting procedure (including Serious Incidents Requiring Investigation (SIRIs)) and the Risk Management Strategy and Policy.

6.12.6 Establishing and maintaining a system which ensures the availability of advice and medicines for use in an emergency when the Pharmacy is closed.

6.12.7 Establishing a system for a senior pharmacist to routinely review all medication-related incidents reported via the Trust's reporting systems, and for producing regular reports and trends on these for the Medicines Management Group; ensuring that all staff understand how to raise concerns about the safe and secure handling of medicines.

6.12.8 Developing a system to provide an audit trail of all medicines at points of transfer (e.g. on handover from Pharmacy to clinical area), with particular reference to drugs which require special handling, notably Controlled Drugs (CDs) and drugs requiring refrigeration.

6.12.9 Recommending to the Medicines Management Group on safety and security grounds which drugs must be ordered and supplied in a restricted manner.

6.12.10 Auditing the implementation of medicines handling policies and systems.

6.12.11 Monitoring the use of unlicensed medicines, and the use of licensed medicines for unlicensed indications, and to ensure their quality and suitability for use. The pharmacy shall provide the prescriber with adequate information on the stability of the preparation in clinical practice.

6.12.12 Production, review and updating of this policy on behalf of the Medicines Management Group.

6.12.13 Ensuring that the Trust has a nominated Medication Safety Officer, with a key responsibility to promote the safe use of medicines across the Trust, and to act as an expert in Medication Safety.

6.12.14 Ensuring new staff are made aware of this policy and its contents.

6.13 Clinical Co-Directors are responsible for:

6.13.1 Ensuring operational implementation of this policy within clinical areas

6.14 Senior Sisters/ Senior Charge Nurses are responsible for:

6.14.1 Ensuring that all relevant policies and guidelines are available and followed within the ward/ department, and that these policies and procedures form part of the core induction for new registered nurses/ midwives / nursing associates joining their clinical area.

6.14.2 Ensuring that all medications are kept in a safe and secure manner, according to the provisions of this, and any other relevant policy; ensuring that appropriate procedures are in place for checking adherence to this.

6.14.3 Ensuring that appropriate levels and range of stock drugs for their ward/ department are established, in conjunction with their pharmacy team.

6.14.4 Ensuring that any Patient Group Directions used within their area are used according to the Trust Policy, and are relevant and in date.

6.14.5 Ensuring that access to controlled stationery such as FP10 prescriptions and controlled drug order books/ registers is restricted to authorised staff.

6.14.6 Ensuring that all drug storage facilities, including fridges, cupboards and Patients' Own Drug boxes, are of appropriate design and standard.

6.14.7 Ensuring that deviations from policy and monitoring requirements are acted on promptly and appropriately.

6.15 Registered Nurses, Midwives and Nursing Associates:

6.15.1 Will administer medicines in accordance with a prescriber's directions whilst ensuring the safety of the patient.

6.15.2 Will check that all particulars of the prescription are safe and appropriate before administering any medicine, referring to the prescriber or a pharmacist if necessary.

6.15.3 Nurses and Midwives may supply/administer to patients via a Patient Group Direction following appropriate training and authorisation. Midwives may administer certain medicines within the course of their professional practice (see policy for use of midwife exemptions).

6.15.4 Will identify medicines management issues, particularly, but not excluding, those relating to administration, and bring these to the attention of the pharmacist or prescriber, e.g. inability to take oral medicines, lack of intravenous access, incomplete or incorrect prescriptions.

6.16 Prescribers (doctors and non-medical prescribers):

6.16.1 Will prescribe appropriate medicines for patients in their care.

6.16.2 Will prescribe legally and legibly.

6.16.3 Will only prescribe within their sphere of competence.

6.16.4 Will obtain informed consent (where possible) before prescribing medicines.

6.17 Pharmacists:

6.17.1 Are responsible for ensuring that medicines are prescribed, supplied, stored, prepared and administered correctly.

6.18 Pharmacy Support Staff

6.18.1 Are responsible for undertaking a range of medicines management tasks, some depending on specific accreditation, including medicines reconciliation, dispensing, checking dispensed items and stock control.

6.19 All healthcare staff who handle, supply or administer medicines:

6.19.1 Are accountable for working within current legislation and for working within the code of conduct of their professional body, and within any trust policy.

6.19.2 Are accountable for ensuring that medicines are prescribed and administered only to treat patients of the Trust.

6.19.3 Anyone prescribing, supplying, preparing, administering or disposing of medicines is personally responsible and accountable. That accountability cannot be delegated or shared with another person. Anyone involved in any aspect of medicines management is responsible for bringing to the attention of their line manager any educational needs they may have in relation to ensuring safe practice, and for undertaking the necessary training.

6.20 Medicines Management Group

6.20.1 Will oversee all medicines management policies and procedures.

6.20.2 Will bring to the attention of the Quality Assurance Committee (or equivalent Committee/Group) any issues which it believes are relevant.

6.20.3 Will oversee all medicines management audits, including compliance with Patient Safety Alerts, NICE guidance and CQC registration requirements.

6.20.4 The Medication Safety Officer will be a key member of the MMG.

6.21 Medical Gas Group

6.21.1 To provide assurance to the Trust Medicines Management Group which in turn reports to the Trust Board of Directors, that there are appropriate risk management infrastructure and controls in place to minimise the risk of harm from the use of medical gases and medical gases piped systems.

6.21.2 Provides a forum for those individuals with delegated roles and responsibilities to take collective ownership for ensuring it identifies medical gases-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols.

6.21.3 To ensure the Trust has robust processes in place to meet its regulatory requirements in relation to Medical Gases.

6.21.4 To review and monitor the Trust Medical Gas budget.

6.22 Drugs and Therapeutics Group

6.22.1 To apply a multi-disciplinary and multi-organisational approach to decision-making regarding medicines provision.

6.22.2 To promote clinically and cost-effective, safe and equitable use of medicines.

6.22.3 To ensure that robust standards and governance are observed.

6.22.4 To engage stakeholders beyond the Trust and membership organisations as required.

6.23 Safe Sedation Group

6.23.1 The main objective of the Safe Sedation group is to promote and provide the highest standard of quality of care for patients receiving sedation for various procedures outside of theatres.

6.24 Infection Control & Antimicrobial Stewardship Group

6.24.1 The purpose of this group is to maintain an overview of infection prevention and control / Antimicrobial prescribing priorities within the Trust.

6.25 Directorate Management Teams

6.25.1 Will implement policies and procedures as directed by the Medicines Management Group

6.25.2 Will identify medicines management issues and bring these to the attention of the Medicines Management Group.

7 Procurement of Medicines

7.1 The Pharmacy Department is responsible for developing, maintaining, implementing and reviewing the Trust's 'procurement processes. Part of this involves ensuring the procurement process delivers medicines of suitable quality which are well designed for use. Factors include product identification, reconstitution, administration and disposal. Moreover, it is essential that the procurement process assesses the capabilities of the supply chain to the hospital to ensure that products are genuine, have been correctly stored and are available when required.

7.2 All medicines on NHS contracts have a product licence and before a product is included on a PaSA contract it is assessed by NHS PharmaQA staff and given a MEPA (medication error potential assessment) score which reflects its suitability for use. Contracts should be adhered to for both financial reasons and because these assessed products present a lower risk. Purchasing "off contract" should only be undertaken with caution and risk assessment. The PharmaQC database contains a list of assessments and should be used to help decide on suitable alternatives to unavailable contract lines.

7.3 Purchasing should use appropriate, trusted sources of supply to ensure the suitability of products purchased to minimise the possibility of counterfeit medicines. Suppliers and wholesalers are required to hold an appropriate licence from the MHRA and this should be checked for authenticity. NHS PaSA holds a list of inspected suppliers who hold or have successfully held a PaSA contract. This database (NHS SID) is held on their website. PharmaQA and procurement staff inspect potential pharmaceutical suppliers and these reports can be used to assess new suppliers. Pharmacy procurement specialists can give advice about potential new suppliers. It is important that the entire supply chain has been assessed since there are a number of stages often involved in obtaining medicines.

7.4 All medicines will be procured by Pharmacy, with the exception of certain dressings and disinfectants which will be supplied via NHS Logistics. The Trust will have a formulary of medicines and pharmacy will only procure non-formulary items in exceptional circumstances. Records will be kept of such purchases.

7.5 Patients' own medication may be used on the wards provided they have been checked to ensure their appropriateness.

7.6 Medicine samples may not be left by company representatives and staff must not accept them. Samples are rarely an effective way of assessing a product and if a prescriber wishes to prescribe a medicine not currently on the formulary this should be discussed with Pharmacy.

7.7 Medicines used in clinical trials are subject to a different policy – Research and Innovation Policies.

7.8 Pharmacy will ensure they procure medicines with safety in mind and will review the packaging of all new products to ensure they conform to necessary standards. They will report to the regional procurement specialist/ the Commercial Medicines Unit any identified problems.

7.9 Unlicensed medicines will only be procured when no suitable licensed alternative exists and the Unlicensed Medicines Policy will be adhered to at all times.

7.10 Pharmacy will adhere to national and regional contracts as agreed by the NHS Purchasing and Supply Agency (PaSA); they will only break these contracts in exceptional circumstances.

7.11 Trust staff are aware of anti-Bribery legislation and always act in accordance with this law. Staff work legally and fairly at all times and as such no bribe will ever be offered, or accepted. We expect the same behaviours from those we do business with. If an employee suspects they have been offered a bribe they will report the matter which will be fully investigated. This may lead to the Trust terminating any future business dealings with the organisation offering the bribe.

8 Security of Medicines

8.1 All medicines on wards and departments must be stored in appropriate locked cupboards, cabinets, refrigerators or trolleys. Exceptions to this include intravenous

fluids, diagnostic reagents and cardiac arrest boxes. Please refer to separate policy (medicines management sub-policy 3 – safe and secure handling of medicines) for comprehensive details on the storage and security of medicines.

8.2 Controlled drugs: the nurse in charge of a ward or department is responsible for the safe custody of controlled drugs held by that ward or department, and for the controlled stationery used for the ordering/ recording of controlled drugs. They are also responsible for all supplies made from the ward CD cupboard. The controlled drugs cupboard keys must be under his/her control at all times. Controlled drugs must be stored in a controlled drugs cabinet and all receipts and issues must be recorded in a controlled drugs register, including patients' own controlled drugs. (See Medicines Management Sub-Policy 3 – Controlled Drugs Procedure); A controlled drugs balance check must be carried out by ward/ department staff at least every 24 hours.

8.3 Controlled drugs in the pharmacy department: the dispensary manager or deputy are responsible for the safe custody of the controlled drug cupboard key at all times. Controlled drugs must be stored in the controlled drugs cupboard at all times, and on procurement should be recorded in the CD register, and locked away within 30 minutes. A controlled drug audit should be carried out in the pharmacy department every 3 months.

8.4 A controlled drugs check will be carried out by pharmacy, on the wards, at least every 3 months.

8.5 Ward stocks will be based on a defined list of those medications in regular use on that ward, plus items held for use in emergency situations. The stock list should be reviewed at regular intervals (at least every 6 months) by the senior sister/ charge nurse and ward pharmacist.

8.6 The safe, secure and tidy storage of medicines in the clinical setting are the responsibility of the nurse in charge of the ward. Pharmacy services, including the 'top-up' service, provide support in this function, but do not remove this responsibility from nursing personnel.

8.7 The medicines keys are the responsibility of the nurse in charge although they may be held by any registered nurse or member of pharmacy staff. The key for the controlled drug cupboard must be separated from all other keys and be kept on the person of the nurse-in-charge of the ward when not being used by another registered nurse. Clinical support workers or student nurses must not hold the keys at any time.

8.8 Medicines security checks for all wards and departments will be carried out at least every 6 months by Pharmacy. These checks assess compliance with the storage requirements for medicines and controlled stationery. A report on the findings of each check will be produced and distributed to the relevant ward manager, Matron and Clinical Co-Directors, so that an action plan can be produced if needed. These may be escalated to Deputy Directors of Nursing and Director of Nursing, if appropriate.

Any incidents where medicines have been stored inappropriately (e.g. wrong patient's medicines in Patient's Own Drugs (POD) locker, controlled drugs not locked in Controlled Drug cupboard) must be reported using the Trust's incident reporting systems, DATIX.

8.9 Any apparent loss of medicines must be reported to the nurse in charge, Pharmacy, and security and an incident reporting form completed. If there is reason to believe that medicines may have been stolen, then appropriate investigations must be undertaken. This includes contacting the Head of Nursing/Midwifery for the specialty and the Chief Pharmacist, and may include contacting the police.

8.10 If a member of staff is believed to be using medicines inappropriately, this must be managed by the head of department for the specialty in a sensitive manner.

FP10 prescription pads are of particular interest to parties who want to steal medicines. They must be stored securely in a similar manner to medicines. Any loss must be reported to the Chief Pharmacist, the police, Local Counter Fraud Service (LCFS), NHS Business Services Authority, and to the local Clinical Commissioning Groups who can send out an alert to all local pharmacies. FP10 pads will only be issued to a prescriber if the Chief Pharmacist is satisfied that they can be stored and managed securely. They should be held securely by the clinic and issued to the prescriber on arrival. See SOP0173 - Use Of FP10 Prescriptions at Medway NHS Foundation Trust Procedure

Pharmacy will always be secured via a swipe card system. When pharmacy is closed the department is alarmed and locked by key. Keys are held by security and the on-call pharmacists as well as by various members of pharmacy staff. Non-Pharmacy staff must be accompanied at all times when in Pharmacy.

9 Prescribing of Medicines

9.1 Prescription Only Medicines (POMs) may be sold or supplied only in accordance with the written directions of an appropriate practitioner. An appropriate practitioner may be a doctor, dentist or non-medical prescriber. The written direction may be a patient-specific direction (PSD - e.g., an entry on the patient's drug chart) or an individual prescription. It is preferable for the actions of prescribing, dispensing/supply and administration to be separated and performed by different health care professionals. Where clinical circumstances make it necessary and in the interests of the patient, the same health care professional can be responsible for the prescribing and supply/ administration of medicines. Where this occurs, processes should be in place to limit errors along with an audit trail and clinical documentation.

9.2 Other methods of issuing and administering medication:

- Pharmacy-Only (P) and POM medication may also be supplied or administered using a Patient Group Direction (PGD), in accordance with the Trust's PGD policy and procedures.

- Certain groups of healthcare professionals may supply or administer medicines in the course of their professional practice, without the need for an individual prescription/PSD/PGD, if there is a specific exemption to medicines legislation to allow them to do this (e.g., midwife exemptions).

9.3 Medicines Protocols can be used to supply or administer the following; administration and supply of General Sales List (GSL); administration of P medicines; medical gases; dressings; appliances; medical devices; and chemical agents. Within the Trust, the same prescribing rules are applied to General Sales List (GSL) and Pharmacy-Only (P) medicines.

9.4 Prescribers are responsible for:

9.4.1 Issuing a prescription or patient-specific direction that is legible, unambiguous and complete, for the dispensing and administration of the medicines

9.4.2 Monitoring the effects of the treatment

9.4.3 Reviewing the prescription for ongoing need

9.4.4 Informing the patient about their drug treatment (including potential adverse effects)

9.5 All prescribing must adhere to the prescription writing policy and be written on the appropriate stationery. Organisational policies and procedures for transcribing must be underpinned by risk assessment. Such policies are clear about who can transcribe, when it can be used, and the difference between transcribing and prescribing. In clinical circumstances where transcribing occurs it must be underpinned by training, risk assessment, an audit trail, and have processes in place to limit errors.

9.6 Prescriptions may only be written for patients of the Trust.

9.7 Non-registered doctors, i.e., Foundation Year 1 (FY1) doctors, are allowed to prescribe; they must, however, be appropriately supervised. Mistakes are more likely if they have insufficient knowledge to undertake the task safely. They may **not** prescribe on FP10 prescriptions. They may not prescribe any cytotoxic drug, including for non-cancer conditions (for example, methotrexate for rheumatoid arthritis).

9.8 Nursing staff are not allowed to transcribe discharge prescriptions or new drug charts. Pharmacists are authorised to re-write existing drug charts if the administration section is full, or if the prescription chart has become damaged/ unusable. Pharmacists may transcribe discharge prescriptions if they have been authorised to do so by the Chief Pharmacist or delegated Deputy. They may also make changes to discharge prescriptions written by doctors as necessary to clarify the prescription or to correct discrepancies; the reason for any changes should be endorsed in full and documented in the medical records if necessary.

9.9 Under no circumstances can a verbal order, or an order sent via a text message, be accepted as authorisation for the administration of medicines. Only written orders on the appropriate stationery are acceptable.

9.10 Medicine protocols may be used to allow appropriately qualified staff who are not qualified prescribers to write instructions for the administration of certain medications to inpatients, if this is deemed appropriate and necessary by the Medicines Management Group.

9.11 All prescribers must prescribe within the formulary. Prescribing recommendations made to primary care prescribers must also be on the formulary. Primary care clinicians should not be asked to prescribe medicines not on the formulary. If a hospital prescriber initiates a non-formulary drug, the ongoing prescribing responsibility may need to remain with the secondary care prescriber.

9.12 Non-medical prescribing: non-medical prescribers are legally and professionally accountable for all items prescribed (including controlled drugs), and are required to work within demonstrated competencies, and within their individual scope of practice. They are required to adhere to the provisions of this and any other relevant Trust policy relating to medicines; they are also required to adhere to the Trust formulary and the Non-Medical Prescribing Policy.

10 Administration of Medicines

10.1 Responsibilities for drug administration.

10.1.1 The administration of medicines, including medical gases and intravenous fluids, will be undertaken by either:

10.1.1.1 A registered nurse or registered midwife

10.1.1.2 A registered Nursing Associate

10.1.1.3 A radiographer

10.1.1.4 Registered Operating Department Practitioners

10.1.1.5 Registered Medical Officers

10.1.1.6 Pre-Registration Medical Officers

10.1.1.7 Student nurses or midwives under supervision.

10.1.1.8 Any other healthcare professional acting in accordance with a Trust-approved Patient Group Direction.

10.1.2 It is the responsibility of line managers to ensure that staff participating in the administration of medicines are competent. Practitioners bear responsibility for maintaining their own competence, and must ensure they decline tasks that they are not able to undertake on a safe and skilled manner, or for which they do not feel they are adequately supervised.

10.1.3 It is recognised that there are situations where checks by a second person may be required and this need should be assessed by the registered practitioner who is responsible for the administration. Such situations may be due to the status of the patient or where a drug dose needs calculation.

10.1.4 The following specific situations require a second person check whatever the circumstances:

10.1.4.1 Controlled drugs (Schedule 2 or 3)

10.1.4.2 Where a calculation of dose is required

10.1.4.3 Administration to children under 12 years of age

10.1.4.4 Cytotoxic agents

10.1.4.5 Specific medicines as defined in individual policies e.g. thalidomide.

10.1.4.6 A second person (a registered nurse, student nurse, doctor or pharmacist) must check all intravenous drugs and all epidural/ intrathecal drugs.

10.1.5 Drugs must only be prepared by the person who is to administer them and must be given immediately after preparation. Drugs prepared for infusion via a medical device and which are checked appropriately may only be prepared in advance under local agreements that have been approved by the Medicines Management Group e.g. in Critical Care units.

10.1.6 Items may be prepared by pharmacy Central Intravenous Preparation Service (CIPS – including prepared doses of intravenous antibiotics, intravenous chemotherapy and total parenteral nutrition) for later use on wards.

10.1.7 Labels used on injectable medicines prepared in clinical areas should include the following information (MHRA Device Bulletin: Infusion Systems DB2003(02) v2.0, Nov 2010; NPSA Promoting Safer Use of Injectable Medicines, March 2007):

10.1.7.1 Name of the drug

10.1.7.2 Date and time of preparation and date and time of expiry

10.1.7.3 Total amount of drug used

10.1.7.4 Name and total volume of diluent used

10.1.7.5 Final volume of preparation

10.1.7.6 Route of administration

10.1.7.7 Batch numbers of all ingredients

10.1.7.8 Names of persons preparing and checking the solution

10.1.7.9 Name of patient

10.1.8 Intravenous flushes may only be administered against a valid prescription or via a PGD.(NPSA Rapid Response Report, April 2008)

10.2 Administration of cytotoxic drugs

10.2.1 Only nurses who have undertaken appropriate Trust training and have been signed off as competent may administer intravenous cytotoxic agents (chemotherapy). Doctors may not administer intravenous chemotherapy unless they have completed appropriate training.

10.1.1 Any registered nurse may administer oral cytotoxic agents, but they should ensure that they understand what precautions need to be taken to handle and dispose of such medicines safely.

10.1.2 Intrathecal chemotherapy may only be administered by a consultant haematologist or a haematology specialist registrar whose name appears on the 'Administration of Intrathecal Chemotherapy Register of Authorised Staff 1B'. For full details please refer to the Intrathecal chemotherapy policy (POLCPCM010B).

10.2 Administration using Medicines Protocols

10.3.1 Staff administering medicines using a Medicines Protocol should adhere to the following:

- 10.3.1.1 The protocol must state that its purpose is to administer a medicine to a patient
- 10.3.1.2 They must be listed on the protocol as an authorised healthcare professional
- 10.3.1.3 have been trained to use the protocol
- 10.3.1.4 deemed competent to use the protocol by their line manager
- 10.3.1.5 be authorised to use the protocol
- 10.3.1.6 have a copy of the protocol available to follow when administering medication

10.2.1 Medicines Protocols should be created using the Trust Medicines Protocol template. Available on the intranet.

10.2.2 Medicines Protocols will receive approval from the Medicines Management Group before use.

10.2.3 Pharmacy will retain a database of Medicines Protocols authorised for use in the Trust and a copy available on Q-Pulse.

10.3 Consent and covert administration

10.4.1 Registered practitioners should, where possible, confirm and document that a patient has given informed consent to taking any prescribed medication. Where patients have been unable to give informed consent or lack capacity e.g. they are unconscious, a best interest's decision is taken by the person in charge of their care. Due regard must be given to any known wishes or advance directives. Where appropriate, relatives or carers should be consulted.

10.3.1 Covert administration directly against a patient's wishes must only occur if it is in the patient's best interests and they lack mental capacity. Assessment of capacity and best interests decisions must be documented on the appropriate form before covert administration takes place. These forms and further guidance are available in the Safeguarding Vulnerable Adults policy (GUCPCM001-7). Where covert administration has taken place an incident report form must be submitted. All professionals have a duty to comply with the Mental Capacity Act (2005).

10.4.3 In exceptional circumstances restraint may be required to administer medication; this is only lawful if the patient lacks capacity to consent to the medication, a best interest's decision has been made and documented, and the restraint is proportionate. A DATIX report must be submitted. See Mental Capacity Policy (POLCGR099-2)/ Safeguarding Vulnerable Adults policy (GUCPCM001-7) for further information.

10.4 Non-administration of Medicines

10.4.1 Doses of medication may be omitted or delayed in hospital for a variety of reasons. For certain types of medicines there is potential for delayed or omitted doses to have serious, or even fatal consequences.

10.4.2 It is important that the correct 'medicine not administered' code is recorded on the drug chart if a dose is omitted. A blank space in the medication administration section of the drug chart when a medication should have been administered is unacceptable practice. Such incidences should be treated as a drug error.

10.4.3 When any drug has been omitted for more than two doses, other than because that drug is not required e.g. analgesia, actions must be escalated to prevent further omissions. This may involve contacting the prescriber to prescribe an alternative drug/ route of administration, or pharmacy in order to arrange urgent supply of that, or an alternative, item.

10.4.4 Any omission or excessive delay of a drug on the critical list must result in escalation of action to prevent any further omissions/delays, using the SBAR process if necessary. On every occasion of such an omission/delay, an incident report should be completed.

10.5 Self-administration of medicines

10.5.1 The practice of patients being responsible for self-administering medication in the acute hospital setting has been shown to be beneficial in terms of patient education and rehabilitation, and allows the patient to maintain/ develop more control over their own care.

10.5.2 The Self Administration of Medicines guidelines should be referred to for full operational details; the **Adult In-patient Diabetes Policy**-GULPCM205 - Insulin Safety Guidelines (1 attachment) also provides additional guidance on self-administration of subcutaneous insulin.

10.5.3 General principles of safe self-administration of medicines include;

10.5.3.1 There should be a multi-disciplinary approach to the practice

10.5.3.2 There should be a formal assessment of each patient's desire and ability to self-administer, considering the degree of support and supervision the patient requires; evaluation of self-care should continue throughout the patient's stay

10.5.3.3 The patient should provide written consent to take part in the scheme

10.5.3.4 There must be facilities for the safe storage of patients' own medicines

11 Supply of Medicines

11.1 Dispensing, checking and supervision within Pharmacy

11.1.1 Every in-patient, discharge and out-patient prescription will be screened and validated by a pharmacist before medication is dispensed. The pharmacist is responsible for resolving any pharmaceutical or pharmaceutical care issues, and for ensuring that the instructions to the staff who will be responsible for dispensing are completely clear.

11.1.2 A pharmacist must always be present in the department to give advice to any patient, if required.

11.1.3 The supply of appropriate, accurately dispensed medicines is the responsibility of all those involved in the process, who must each accept responsibility for the quality of their own work. Accurate working and self-checking of dispensed items are as important as the final check in ensuring that medicines are correctly dispensed.

11.1.4 Liability: The GPhC requires that pharmacists "make sure that all your work, or work that you are responsible for, is covered by appropriate professional indemnity cover". Indemnity cover is provided by the Trust under the NHS Indemnity Scheme. The Trust takes full financial responsibility for any negligence by health professionals, and should not seek to recover any vicarious liability costs from health professionals involved, providing that staff are working within agreed procedures. Pharmacists may still wish to take out their own professional indemnity insurance.

11.2 Dispensing and checking outside of pharmacy

11.2.1 *Unplanned absence/ hurriedly arranged discharges*: In the event that there is not time to have a discharge prescription dispensed by Pharmacy, or a patient decides to self-discharge, all attempts should be made to ensure that the patient receives a supply of discharge medication. A registered nurse/ midwife or doctor should urgently contact their ward pharmacist or the Pharmacy department (or the on-call pharmacist if this occurs outside of Pharmacy opening hours) to discuss the most appropriate solution.

11.2.2 *Routine discharges from specific areas*: some areas of the hospital keep a supply of TTO packs for medicines commonly used in those areas, to expedite discharges, particularly with day-attenders or where planned discharges frequently occur outside of Pharmacy opening hours. For such patients, there must still be an eDN, and the supply may only be made in accordance with the directions on the eDN. The registered practitioner managing the discharge is responsible for supplying medicines.

11.2.3 Dispensing from ward stock, other than TTO packs, must not occur, this will not meet the legal requirements for labelling of dispensed medicinal products

11.2.4 *Dispensing from Pharmacy 'satellite' stock locations:* in order for ward-based Pharmacy teams to expedite the processing of discharge prescriptions, there are several Pharmacy stock cupboards in ward locations, which are available to Pharmacy staff only. The use of such cupboards, and associated ward-based

dispensing, must be risk assessed to ensure standards of quality and security will be maintained. The quality of dispensing from these locations must meet the same professional standards as any medicine dispensed within the Pharmacy.

11.2.5 *Supplying medicines in accordance with a Medicines Protocol:* refer to section 8.3 for criteria needed to supply a medicine. The protocol must state that its purpose is to supply a medicine to a patient.

11.3 Issue of medicines to patients

11.3.1 Medicines should only be issued to patients by staff with an appropriate level of training (medical practitioners, registered nurses, pharmacists, pharmacy technicians, and trainees under supervision of any of the former).

11.3.2 Anyone issuing medicines to a patient or their representative must ensure that:

11.3.2.1 The medicines being issued are for that patient, and that the identity of the person to whom medicines are issued is assured through appropriate checks

11.3.2.2 The medicines being issued are those requested on the prescription

11.3.2.3 That the patient, or carer, is given sufficient information and advice to ensure safe and effective use of the medicine, plus any other information that the patient would like to receive

12 Risk Management

12.1 Managing errors or incidents in the use of medicines

12.1.1 A medication error is a preventable incident associated with the use of medicines that has resulted in harm or potential for harm to a patient. Such incidents may be related to any step in the medicines use process, including prescribing, dispensing, administration, storage or transfer of medication information.

12.1.2 Medication incidents must be reported via the Trust's incident reporting system, currently DATIX. It may also be necessary to report incidents to an individual's line manager.

12.1.3 Staff should also report any near misses or potential hazards relating to any part of the medicines management process (including potential or actual prescribing errors, medicines reconciliation discrepancies) via DATIX, with special reference to reporting any near miss relating to medication that is subject to a previous NPSA alert.

12.1.4 Following a medication incident, the well-being and safety of the patient is the prime concern, and must be assured first and foremost. The incident must be reported as soon as possible to a member of medical staff, who will decide whether any further action is needed clinically.

12.1.5 Potential safeguarding implications must be given due consideration when an incident involves a child or a vulnerable adult.

12.1.6 In terms of investigating medication-related incidents, the Trust policy should be followed. Serious incidents must be reported and investigated. If a medication incident that may fall within the definition of a Department of Health 'Never Event' occurs, this should be escalated immediately to the relevant Head of Nursing/ Clinical Director/ Head of Governance and Risk.

12.1.7 The patient/ carer should be informed that an error has occurred. The member of staff informing the patient should be a member of the immediate care team, who will be able to have an open and honest discussion with the patient e.g., ward pharmacist, senior doctor, nurse in charge of the ward. (Further details are provided in the Duty of Candour Policy (Being Open))

12.2 Learning from incidents

12.2.1 The Medication Safety Officer or delegated senior pharmacist will review all reported medication incidents for accuracy of the medication-related details, to provide professional input, and to escalate incidents for further investigation if necessary.

12.2.2 If any trends are identified, this will be escalated via the Medicines Management Group.

12.3 Adverse Drug Reaction Reporting

12.3.1 Any drug may produce unwanted or unexpected adverse drug reactions. Detecting and reporting of these is of vital importance.

12.3.2 Prompt reporting should be carried out for any suspected adverse drug reactions to new drugs that are subject to additional monitoring by regulatory bodies. These medicines are identified in the BNF and in product literature by the inverted black triangle symbol (▼). Reporting must also be undertaken for unlicensed medicines and for any serious or unusual reactions to established products. Reporting should be carried out for prescribed drugs, and for medicines obtained by patients over the counter/ herbal products.

12.3.3 Suspected adverse reactions related to a drug or combination of drugs should be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) using the national yellow card reporting scheme. Copies of the card can be found at the back of the British National Formulary (BNF), or from the MHRA website (www.mhra.go.uk)

12.4 Medicine Defect Reporting

12.4.1 A defect is present if the product, as supplied by the manufacturer, is not of the expected standard. Defects may relate to inadequate or incorrect labelling, ineffective packaging, contamination, discolouration, breakage, or incorrect contents.

12.4.2 If a defect is found or suspected in a medicine, it should be reported to Pharmacy. Any remaining product and associated equipment should be retained and quarantined. If the product has been administered to a patient, the patient's doctor should be informed, and details of the defect should be recorded in the patient's medical record. The incident should be reported via DATIX.

12.5 Medication Safety Alerts and Drug Recalls

12.5.1 If a defect is identified in a medicinal product that may pose a hazard to health, the MHRA may issue a 'drug alert' letter. These drug alerts will be actioned by Pharmacy; out of hours, this will be led by the on-call pharmacist. (See internal Pharmacy Drug Alerts Policy)

12.5.2 Medication safety alerts may be issued from various sources, included NHS England, the MHRA, or direct from pharmaceutical companies. The responsibility for ensuring such alerts are actioned rests with the Medicines Management Group, who will make decisions as to what actions the Trust needs to take, and who will be responsible for these actions. The Chief Pharmacist and delegated senior pharmacists will provide professional guidance on dealing with medication safety alerts, and the Pharmacy Procurement manager is responsible for highlighting any issues, and recording alerts as dealt with.

12.5.3 Some medicines are, by their nature, hazardous. COSHH regulations (2002) is the UK legislation on chemical hazards at work. The main legal duties of employers under COSHH are contained in regulations 6 -12, which cover risk assessment, prevention or control of exposure, use and maintenance of controls, monitoring exposure, health surveillance and provision of information and training.

13 Safe Disposal of Medicines

13.1 Medicines that are no longer to be administered to a patient, for whatever reason, should be returned to Pharmacy for disposal. Pharmacy will comply with all relevant legislation and good practice around the handling of unwanted medicines.

13.2 All out-of-date medicines and any stock no longer required must be returned to Pharmacy.

13.3 Medicines brought into the Trust by the patient remain the property of the patient and may only be returned to Pharmacy for destruction with the prior agreement of the patient and/or his/her representative. Consent for this destruction should be documented.

13.4 Where a patient has died, the items should generally be returned to Pharmacy for destruction. Where this includes controlled drugs they must, wherever possible, be returned to Pharmacy. In the unlikely event that a relative insists on taking them they must all be signed out of the controlled drugs register by the nurse in charge and by the relative. They must never be returned to any other healthcare professional other than Medway Pharmacy staff.

13.5 Some medicines are cytotoxic or cytostatic and must be disposed of in containers separate to those used for routine waste drug disposal, with appropriate identification. Spills of these medicines can represent a risk to healthcare workers. Any area handling liquid cytotoxic agents must have access to cytotoxic spill kits at all times. A list of cytotoxic/ cytostatic medication can be obtained from Pharmacy Distribution.

13.6 Destruction of controlled drugs must comply with the "The Human Medicines Regulations 2012" and "The Misuse of Drugs Act (1971)". Refer to the Medicines Management Sub-Policy 3 – Controlled Drugs Procedure

13.7 Pharmacy will not normally accept pharmaceutical waste that is not generated by Medway NHS Foundation Trust or by patients admitted to the Trust.

13.8 In the case of product recalls, the drug must be quarantined until a decision has been made about disposal. The drugs will be kept in the designated area of pharmacy until disposal is arranged. The pharmacy drug recall procedure will be followed at all times.

14 Medical Representatives and Standards of Business Conduct

14.1 Trust staff should refer to the ABPI (The Association of the British Pharmaceutical Industry) code of practice.

14.2 Representatives must not visit wards, clinics or departments unless the relevant manager has given prior agreement. Casual visits are not acceptable. Appointments must be made with the relevant nurse manager, head of department or consultant. Visits should be limited to providing information regarding significant product changes.

14.3 Details of new products should be provided to the Pharmacy. Introduction of new products may only be permitted in accordance with the procedures of the Drugs and Therapeutics Group.

14.4 It is accepted that liaison with pharmaceutical companies can sometimes be beneficial to the Trust and individual practitioners, but due probity must be observed. Staff must ensure they are not placed in a position which risks conflict between their private interests and their NHS duties, or gives the appearance of such a conflict. It is an offence for a member of staff to corruptly accept gifts as an inducement. No purchase order may be issued for any item for which an offer of gifts or hospitality has been received from the person interested in supplying goods and services. Any offers of gifts, conference attendance or hospitality should be discussed by members of staff with their line manager (or the Medical Director for consultants), and if approved should be entered in the register of hospitality. Overt disclosure of any hospitality offered to a consultant, or to any member of the Drugs and Therapeutics Group, from a pharmaceutical company in relation to a new product must be disclosed to the Drugs and Therapeutics Group.

14.5 All posts funded (or part-funded) by drug company sponsorship must be notified to the Chair of the Trust's Medicines Management Group. If a nursing post, the Director of Nursing must be notified directly.

15 Training Requirements for Prescribing, Administration and Dispensing of Medication

15.1 Training will be provided to all staff groups including medical, nursing and pharmacy personnel as outlined in the tables below.

Table 1: Medical Staff

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
FY1 and FY2 Doctors	Training in safe prescribing practice	To ensure accurate and safe prescribing of medication	Divisional induction, consultant mentoring and pharmacy-led teaching. Part of curriculum for foundation years. FY1 prescribing assessment	In-house plus use of BMJ eLearning packages and SCRIPT modules where appropriate. Assessed by educational supervisors. Delivered in-house by pharmacy and medical education	Ongoing Once only, at induction
Haematology Consultants and Specialist Registrars	Intrathecal chemotherapy	To ensure correct administration of intrathecal chemotherapy.	Local training package including video, presentation, reading policy and short assessment.	Lead nurse for chemotherapy/ aseptic services manager	Annual

Table 2: Nursing Staff

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
All registered nurses, midwives and	Drug dose calculation	To ensure the correct calculation of	At interview for Band 5 posts IV study day	In-house	Once

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
nursing associates		drugs before administration	CCU supervised drug calculation test		
All registered nurses, midwives and nursing associates	Safe administration of medicines and knowledge of medicines management	To ensure the safe administration of medication	Competency based assessment and identification of training needs	In-house	Annual
All registered nurses and midwives required to give intravenous drugs	IV drug administration	To ensure the safe administration of IV medication	In-house training programme including a period of supervised practice	In-house	Once
Chemotherapy trained registered nurses	Administration of cytotoxic medication	To ensure the safe administration of cytotoxic regimens	Training programme including a period of supervised practice	Canterbury College	Once
Chemotherapy-trained nurses administering intrathecal chemotherapy	Intrathecal chemotherapy	To ensure correct administration of intrathecal chemotherapy	Local training package including video, presentation, reading policy and short assessment.	Lead nurse for chemotherapy/ aseptic services manager	Annual
Registered nurses and midwives delivering care through the use of PGDs	Patient Group Directions	To ensure that PGDs are used legally and that all supplies made via PGD are safe.	CPPE E-Learning certification Competency Based Training relevant to working under the PGD	In-house	Once

Table 3: Pharmacy staff – see POLLMM003 - Pharmacy Department Education and Training Policy

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
Pharmacy Assistants	The Dispensing Assistant Course (Level 2 Equivalent)	GPhC Requirement	Apprenticeship through Buttercups	Training Provider plus in-house training	Once
Medicines Management Pharmacy Assistants	Medicines Management	To improve patient care through completion of medicines reconciliation process	HEE LaSE Pharmacy Accredited Medicines Management qualification with portfolio collection and OSCE assessment.	HEE LaSE Pharmacy and in-house	Once
Pre-Registration Trainee Pharmacy Technicians	National Diploma and NVQ – level 3	GPhC Requirement	BTEC National Diploma and National Vocational Qualification level 3	Buttercups	Once
Medicines Management Pharmacy Technicians	Medicines Management	To ensure the safe management of medicines on wards without supervision	HEE LaSE Pharmacy Accredited Medicines Management Qualification with portfolio collection and OSCE assessment	HEE LaSE Pharmacy and in-house	Once
Accredited Checking Pharmacy Technicians	Accredited Checking	To ensure the safe checking of dispensed medicines	HEE LaSE Pharmacy Accredited Accuracy Checking Pharmacy Technician qualification with documentation of 1000 accurately checked items and OSCE assessment.	HEE LaSE Pharmacy (Provided by CPPE) and in-house	Once
Aseptic services Pharmacy	Preparation of intravenous	To ensure the safe preparation	In house training manual, to include calculations	In-house	Repeated every 2 years

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
Technicians	medicines, cytotoxic medicines and parenteral nutrition solutions	of medicines			
Aseptic Services Pharmacy Technicians	Pre- and in-process checking	To ensure the safe checking of aseptically prepared products	HEE LaSE Pharmacy PIPC course with documentation of 1000 accurately checked items and OSCE assessment.	HEE LaSE Pharmacy and in-house	Once
Warfarin counselling assistants, technicians and pharmacists	Warfarin counselling	To provide patients newly started on oral anticoagulants on how to take their medication safely plus clinic monitoring arrangements	In-house programme	In-house	Once
All pharmacists and MM techs	Warfarin counselling	To provide patients newly started on oral anticoagulants on how to take their medication safely plus clinic monitoring arrangements	In-house programme	In-house	Once
All pharmacist's and MM techs	DOAC counselling	To provide patients newly started on oral anticoagulants on how to take their	In-house programme	In-house	Once

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
		medication safely plus clinic monitoring arrangements			
Pharmacists	Clinical pharmacy practice	To ensure the safe management of patients' medication in order to facilitate optimal outcomes	Diploma in General Pharmacy Practice or Clinical Pharmacy Practice Diploma Competency based assessments	Medway School of Pharmacy or Keele University and in-house training	Once
Pharmacists working in aseptic services	Checking CIPS, cytotoxics and TPN		In-house training programme	In-house	Once- then repeated if >6 months has elapsed since last aseptic rotation.
Pharmacists working in aseptic services	Intrathecal Chemotherapy	To ensure correct administration of intrathecal chemotherapy	Local training package including presentation, reading policy and short assessment.	Lead nurse for chemotherapy/ aseptic services manager	Annual
TPN Pharmacists	Prescribing adult TPN	To ensure that TPN solutions are prepared safely and meet the clinical needs of the patient.	Local training package and short assessment.	Lead pharmacist for aseptics	Once

Table 4: Other Staff Groups

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
HCPs administering	Patient Group Directions	To ensure that PGDs are used	CPPE E-Learning certification	In-house	Once

medicines using PGDs		legally and that all supplies made via PGD are safe.	Competency Based Training relevant to working under the PGD		

15.2 Ongoing competency assessment will be undertaken for pharmacy and nursing staff.

15.3 Ensuring the ongoing competency of medical staff is the responsibility of the clinical department employing them, and is overseen by the Medical Director.

16 EQUALITY IMPACT ASSESSMENT STATEMENT

16.1 All public bodies have a statutory duty under the Race Relations (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." This obligation has been increased to include equality and human rights with regard to disability, age and gender.

16.2 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This strategy was found to be compliant with this philosophy.

16.3 Equality Impact Assessments will also ensure discrimination does not occur on the grounds of Religion/Belief or Sexual Orientation in line with the protected characteristics covered by the existing public duties.

16.4 Refer to appendix 1.

17 MONITORING & REVIEW

What will be monitored	How/ Method/Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions	Implementation of any required change
Contents of policy for accuracy and legality	To be checked against new legislation or good practice guidance	Chief Pharmacist	Chair of MMG	Policy to be rewritten as needed	Changes advertised to all relevant staff
Incident reports of adverse drug events	Report compiled quarterly	Medication Safety Officer	MMG	Actions implemented as needed	Usually via pharmacy staff. Or specific group set up to action changes.
Various aspects of Medicines Management as per audit plan, including audits as required by MHRA and audits of various aspects of antimicrobial therapy.	Regular Audit	Lead Pharmacist Quality, Governance & Education	Clinical Effectiveness	Depends on results of audits	By pharmacy or Directorates
Antimicrobial prescribing	Regular audit	Lead antimicrobial pharmacist	Director of Infection Control	Monitored via Quality Steering Group	By directorates and reviewed by pharmacy and infection control teams

What will be monitored	How/ Method/Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions	Implementation of any required change
Controlled Drugs	Audit of CD registers by pharmacy every 3 months. Annual audit of incident reports relating to CDs. Quarterly feedback of CD incidents by CDAO to CDLIN Annual audit of aspect of care by Accountable Officer	CD Accountable Officer	Trust Board	CD Accountable Officer	Accountable Officer
Dispensing errors/ near misses	Continuous reporting via near miss reporting forms and dispensing error forms	Dispensary manager and aseptic services manager	Chief Pharmacist and Pharmacy Governance Group	Error trends identified and measures identified to reduce risk of reoccurrence.	Dispensary manager/ aseptic services manager via change in local procedure and dissemination to staff
Administration errors	Continuous reporting via DATIX and drug error pack. To be reviewed/ compiled quarterly.	Director of Nursing	MMG NMAS	Any necessary change in procedure/ need for additional training identified.	Director of Nursing via Deputy Directors of Nursing and Clinical Co-Directors
Safe storage of medicines	Continuous reporting via DATIX. To be reviewed/ compiled quarterly	Chief Pharmacist	MMG	Gaps identified by MMG and necessary actions feedback to Directorates/ pharmacy	By wards or pharmacy
Training requirements	To be reviewed at annual appraisals for pharmacy and nursing staff by line managers.	Chief Pharmacist & Director of Nursing	MMG	Gaps identified by MMG and necessary actions feedback to Directorates/ pharmacy	Nursing/ Pharmacy Management
Safe disposal of medicines	Audit of practice	Wards Senior Sister / Pharmacy Operational Manager	MMG	Gaps identified by MMG and necessary actions feedback to Directorates/pharmacy	Directorates

What will be monitored	How/ Method/Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions	Implementation of any required change
Non-administration of medicines	DATIX to be reviewed quarterly. Audit of missed doses	Chief Pharmacist	MMG	Gaps identified by MMG and necessary actions feedback to Directorates	Directorates
Covert administration of medicines (Rare)	DATIX	Chief Pharmacist	MMG	Any inappropriate actions to be reviewed with Directorates	Directorates

18 Equality Impact Assessment Tool – Appendix 1

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	▪ Race	No	
	▪ Disability	No	
	▪ Gender	No	
	▪ Religion or belief	No	
	▪ Sexual orientation including lesbian, gay and bisexual people	No	
	▪ Age	No	
2	Is there any evidence that some groups are affected differently?	No	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4	Is the impact of the policy/guidance likely to be negative?	No	
5	If so can the impact be avoided?		
6	What alternatives are there to achieving the policy/guidance without the impact?		
7	Can we reduce the impact by taking different action?		

19 References

Document	Ref No
References:	
CQC Fundamental standards	Regulation 12
Health and Social Care Act 2008	
Nursing and Midwifery Council 2015 “The Code”	
Building a Safer NHS for Patients: Improving Medication Safety	DoH, January 2004
The Human Medicines Regulations 2012	
The Misuse of Drugs Act 1971	
The Misuse of Drugs Regulations 2001	
A Spoonful of Sugar: Medicines Management in NHS Hospitals	The Audit Commission, December 2001
Medicines, Ethics and Practice 43: a guide for pharmacists and pharmacy technicians	RPSGB, July 2019
Guidance on Prescribing, Dispensing, Supplying and Administration of Medicines	RCN March 2020
An Organisation with a Memory	DoH, June 2000
Good Medical Practice	GMC, 2013
Medicines Matters: a guide to mechanisms for the prescribing, supply and administration of medicines	SPS, September 2018
Patient Group Directions: Who can use them	MHRA, December 2017
Patient Group Directions	NICE MPG2, March 2017
To PGD or to not PGD?	SPS Nov 17
The Safe and Secure Handling of Medicines: a team approach	RPSGB, March 2005
Professional Guidance on the safe and secure handling of medicines	RPSGB, December 2018
Professional Guidance on the administration of medicines in healthcare settings	RPSGB and RCN, January 2019
Advisory Guidance on administration of medicines by nursing associates	Health Education England, December 2017
Standards for Infusion Therapy	RCN, January 2010
Modernising Medicines Management: a guide to achieving benefits for patients, professionals and the NHS	National Prescribing Centre, April 2002
NPSA Rapid Response Report: Intravenous Heparin Flush Solutions	NPSA, April 2008
NPSA Patient Safety Alert: Promoting Safer Use of Injectable Medicines	NPSA, March 2007 and update 2016
Hazardous Waste (England and Wales) Regulations 2005	ISBN 0110726855
NPSA Patient Safety Alert: Preventing fatalities from Medication Loading Doses (NPSA, November 2010)	NPSA/2010/RRR018
Bribery Act 2010	

Trust Associated Documents:	
Antimicrobial Prescribing Policy	POLCPCM041
Consent Policy	POLCGR034
Duty of Candour Policy (Being Open)	POLCGR064
COSHH HSE: A Brief Guide to the Regulations	OTCS025
Covert Administration of Medicines	SOP0627
COVID-19 POD pathway	DOC326
Management of Stock Shortages by the Pharmacy Department	P.DIST.22 (Pharmacy procedure)
Endorsement of Prescription Charts by Pharmacy Staff	Pharmacy Procedure
Intrathecal Chemotherapy Policy	POLCPCM010
Non-Medical Prescribing Policy	POLCPCM039
Oral Anticoagulants in the Perioperative Period Policy	POLCMM005
Overactive Bladder OAB and Mixed Urinary Incontinence UI in Women	OTLPCM029
Patient Group Directions - Development and Use Policy and Procedure	PDGCMM004
PGD – Administration of Misoprostol	PGDCMM004
PGD – Administration of PlasmaLyte 148 IV infusion	PGDCMM005
PGD – Administration of Sterile Water Injections	PGDCMM006
Pharmacological management of Chronic Non-Malignant Pain in Adults in Non-Specialist Settings	GUCMM021
Pharmacy - Business Continuity Plan	OTCGR072
Pharmacy Department Education and Training Policy	POLLMM003
Prescribing - Assessment and Management of Falls	GUCMM022
Prescribing Anti-Thrombotic and Anticoagulation in Patients with Acute Coronary Syndromes	OTCMM004
Prescribing of Oral Nutritional Supplements (ONS) for Adult Inpatients	PROTLMM002
Prescribing Policy - Drugs and Devices used in the treatment of Erectile Dysfunction	POLLMM002
Research and Innovation Policy	POLCGR075
Returning Patient's Own Controlled Drugs or 'Ward Stock' to pharmacy	PROCMM001
Safe Disposal of Waste Procedure	PROCS002
Safe Disposal of Waste Policy	POLCS026
Safe Prescribing of Rivaroxaban	GUCMM023

Safeguarding Vulnerable Adults	GUCPCM001
Self-Administration of Medicines Guidelines	GUCMM018
Supplying Discharge Medication in Dosettes - Multi-compartment Compliance Aids	POLCMM011
Unlicensed Medicines Procedure	POLCPCM034
Use Of FP10 Prescriptions at Medway NHS Foundation Trust Procedure	SOP0173
Ward Staff Authorised to Order Controlled Drugs From Pharmacy	SOP0010

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