MEDICINES POLICY

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Document Administration

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	1997
2	Revised Version of 1997 Document	July 2002
3	Updated Document	Dec 2004
4	Revised Version of 2004 Document	March 2014
5	12 Month Extension Applied	March 2016
6	Full review. Updates throughout document. Additions throughout document. Links added and updated throughout document.	Jan 2020 not live
7	Fully revised and updated document	August 2022

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Chief Pharmacist
Head of Community Services Medicines Management/Pharmacy

Circulated to the following for Consultation

Date	Role / Designation
11/08/22	Medical Director
to	Director of Nursing
25/08/22	Director of Therapies
	Assistant Medical Directors
	Deputy Director of Nursing
	Assistant Director of Therapies
	Clinical Director for Mental Health & Learning Disabilities
	Professional Head of Nursing
	Head of Nursing - Mental Health
	Head of Learning Disability & MH Continuing Health Care
	Head of Therapies & Professional Head of Occupational Therapy
	Professional Head of Physiotherapy
	Professional Head of Podiatry and Orthotics
	Professional Head of Dietetics
	Professional Head of Radiology
	Women & Children's Service Manager
	Assistant Director of Women's & Children's Services
	Assistant Head of Midwifery & Sexual Health
	Consultant Midwife
	Assistant Director of Quality & Safety
	Community Services Managers
	Service Manager for Unscheduled Care
	Senior Nurse Unscheduled Care
	Senior Nurse Manager Outpatient Development
	Associate Dental Director
	Assistant Clinical Director – Community Dental Service/Oral Surgery
	Theatre Co-ordinator – Lead Operating Department Practitioner
	Specialist Practitioner Infection Control
	Lead Clinician – Quality and Safety (Mental Health)
	Medical Device & Point of Care Testing Manager
	Dental Therapist – Newtown Park Street Dental

	Area Senior Dental Nurse – Newtown Park Street Dental
	Estates Officer Engineering Specialist
	Assistant Director of Estates & Property
	Assistant Head of Children's Nursing
	Head of CAMHS & Learning Disabilities
	Women & Children Risk Governance Lead
	Head of Children's Public Health Nursing & Paediatric Services
	Medicines Management Nurse & Non Medical Prescribing Lead
	Lead Counter Fraud Specialist
	All Members of the PTHB Area Prescribing Group
	All Pharmacy & Medicines Management Team Members

Evidence Base

Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area?

- Human Medicines Regulations 2012
- Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008
- Misuse of Drugs (Amendment) No 2 – Ordering controlled drug stock for community use.
- NICE. Controlled drugs: safe use and management (NG46)
- RCN and RPS. Guidance on Prescribing, Dispensing, Supplying and Administration of Medicines (2020). Provides information on the RCN/RPS position on the prescribing, dispensing, supplying and administration of medicines.
- RCN and RPS. Professional guidance on the administration of medicines in healthcare settings (2019). Provides principles-based guidance to ensure the safe administration of medicines by healthcare professionals. This guidance has been endorsed by the Royal College of General Practitioners.
- RPS. Safe and Secure Handling of Medicines (SSHM) (2018).
- NICE. Patient Group Directions. Guidance providing good practice recommendations for individual people and organisations involved with PGDs
- Patient Safety Wales – implementation of recommendations from patient safety notices and incidents

Impact Assessments

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differentia**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impacts that may arise from the implementation of this policy***
Age	X				
Disability	X				
Gender reassignment	X				
Pregnancy and Maternity	X				
Race	X				
Religion or Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and Civil Partnership	X				
Welsh Language	X				

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?

No risks identified

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?

No risks identified

Have you identified any training and / or resource implications as a result of implementing this?

Training requirements for policy implementation

All staff involved in medicines administration must receive initial face to face (virtual) Medicines Management education / training as part of

their induction to the Health Board and update their knowledge of Medicines Administration, Recording, Review, Storage and Disposal (MARRS) practices every three years by completing the All Wales e-learning MARRS education Programme available through ESR.

Medicines practice must also form part of any individuals annual review process (PADR), giving both the reviewer and practitioner opportunity to identify any learning needs and actions required around medicines and in the intervening years, between undertaking the required learning programme.

Specific training courses and resources exist which must be utilised by all members of staff involved in any aspect of: -

- Refrigerated medicines or vaccines – Via ESR - 070 Cold Chain Training - The safe and secure management of refrigerated medicine
- Patient Group Directions – Patient Group Directions - elearning for healthcare (e-lfh.org.uk)
- Medical Gases – via BOC Online Learning
- Independent Prescribing via University Based course
- Antimicrobial prescribing – via TARGET Antimicrobial Toolkit hub https://elearning.rcgp.org.uk/course/view.php?id=553
- Controlled drugs management – via Faculty of Pain Management 'Opioids Aware' https://fpm.ac.uk/opioids-aware
- Immunisation/Vaccine Training - https://phw.nhs.wales/topics/immunisation-and-vaccines/vaccine-resources-for-health-and-social-care-professionals/immunisation-training-resources-and-events/

Policy Statement / Introduction

The safe and secure handling of medicines is the responsibility of every healthcare professional, who must ensure that they work within their professional guidelines and organisational policies and procedures.

This document sets policy for all healthcare staff (including associate practitioners, bank/agency staff and students) involved in any aspect of the use of medicines and defines the mandatory requirements of the Health Board.

The document has many sections which demonstrate the wide range of activities and requirements associated with the handling of medicines. This policy offers practical advice and outlines steps that must be taken to ensure medicines are handled safely and securely within all care environments and services and by directly employed or engaged staff.

The policy is underpinned by key legislation, for example, the Human Medicines Regulations 2012, the Misuse of Drugs Act and associated regulations, NICE guidance, professional codes of ethics and guidelines, the Control of Substances Hazardous to Health Regulations (COSHH) and the regulations relating to the disposal of hazardous and other controlled wastes.

This policy predominately relates to PTHB provider teams - but it is anticipated that as current services develop across sectors (including primary care) and new services are established, this policy will support the safe use of medicines by detailing expectations, but allowing local implementation depending on circumstances.

Objective

This policy defines the processes associated with the physical handling of medicines and controlled stationery, including storage, supply, transport, prescribing, administration, recording, security and safe disposal, and applies to all care environments.

This policy aims to ensure that:

- medicines are correctly and appropriately prescribed by an authorised practitioner;
- medicines are safely and appropriately supplied, transported, stored, monitored and destroyed;
- medicines are accurately and appropriately administered or supplied;
- medicines are stored securely and are appropriately recorded to prevent loss, inappropriate access and misuse by patients, residents, staff or members of the public;
- practitioners involved in any aspect of medicines understand their responsibilities, are competent and have access to training if required;
- systems for routine audit, reviews of incidents, errors and patient complaints relating to the handling of medicines are in place.
- good governance is in place to support the choice of medications utilised with medicines optimisation, safety and cost effectiveness in mind.

It must be recognised that compliance with this policy does not override any individual responsibility of healthcare workers to ensure that their practice:

- complies with current legislation;
- follows guidance issued by the Department of Health/Welsh Government, professional bodies or other government departments such as the Home Office;
- manages the risks to patients, relatives, carers and staff arising from the use of medicines;

The policy document is supported by a set of operating procedures that assist staff to work safely. The procedures are found on the Medicines Management internet site https://pthb.nhs.wales/services/pharmacy-and-medicines-management/

This medicines policy applies to all registered health care professionals and their support staff working in hospital and community settings within PTHB including mental health services, paediatric services, GP Out of Hours Services, Community Nursing services, PTHB managed primary care services.

It includes all staff involved in the ordering, supply, storage, distribution, prescribing, administration and disposal of medicines.

Medicines include:

- Prescription Only Medicines (POM),
- Pharmacy Medicines (P),
- General Sales List Medicines (GSL)
- Controlled Drugs (CD).

The Policy includes statements on complementary and herbal medicines, pharmaceuticals (non-therapeutic items) and certain medical devices which have been traditionally managed by hospital pharmacy departments.

Definitions

Accident:	An unplanned, unwanted, uncontrolled event or sequence of events that results in loss or harm.
Adverse/clinical incident or event:	Any occurrence, which is not consistent with the routine treatment or care of the patient or the routine operation of PTHB.
AWMSG	All Wales Medicines & Strategy Group https://awttc.nhs.wales/ The All-Wales Medicines Strategy Group (AWMSG) advises Welsh Government about the use, management and prescribing of medicines in Wales.
Appropriate date	The appropriate date is either the signature date or any other date indicated on a prescription (by the prescriber) as a date before which the drugs should not be supplied/administered – whichever is later
Black triangle drugs:	Newly introduced drugs are subject to intensive monitoring for potential side effects by the Medicines and Healthcare Regulatory Agency (MHRA). These are identified by ▼in the British National Formulary. Any adverse effects to these drugs should be reported using the Yellow Card scheme – www.yellowcard.mhra.gov.uk
CASPA	The Comparative Analysis System for Prescribing Audit (CASPA) software system collates and provides prescribing information from WP10 prescriptions
CDAO	A person (defined as fit, proper and suitably experienced) who is appointed to ensure that systems for the safe management and use of controlled drugs are secure within their own organisation or in those they have a contract with. Controlled Drugs Accountable Officer (CDAO)
CDLIN	Controlled drug local intelligence network- A local intelligence network is drawn from representatives of designated and responsible bodies. It is for the CDAO to determine the number and membership of the CDLIN. Local intelligence network members have certain duties and functions set out in the regulations. These include a duty to cooperate with other

	CDLIN members in identifying cases where action may be appropriate.	
Community:	Includes the non-hospital sites where drugs are stored, supplied and administered by community health teams. This can include patient's homes.	
Community Teams:	Includes all healthcare professionals working in the community setting; health visitors; district nurses, specialist nurses, school nurses, midwives, community psychiatric nurses, learning disabilities and drug and alcohol services**,** therapists and community palliative care team.	
Complementary medicines:	The use of complementary or alternative therapies such as herbal or homeopathic remedies.	
Controlled Drugs:	Includes those drugs classified under the 'Misuse of Drugs Act 1971' and its associated regulations.	
Controlled Stationery:	Any stationery that needs to be locked away where only authorised staff can access. Includes prescription pads and forms, requisition books, prescription charts and Controlled Drug order books and registers.	
DATIX	The Datix Incident Reporting System is used by the organisation to record and manage risks, all incidents, concerns, claims, medical devices and alerts including those involving medications. https://adfs.wales.nhs.uk/adfs/ls/	
Dentists:	Refers to Dentists registered by the General Dental Council GDC working in Powys.	
DGH	District General Hospital	
Direct Supervision	Observation by a fully registered practitioner (who takes accountability for an unregistered practitioners' actions) throughout all medicines processes	
Doctor:	Includes all Doctors who are fully registered with the General Medical Council (GMC) employed directly by PTHB or contracted under a service level agreement with their employing organisation. Provisionally registered doctors (F1 and F2's) and doctors with limited registration (overseas qualified Doctors) may	

	only prescribe in connection with their employment.	
ESR	Electronic staff record https://my.esr.nhs.uk	
General Sales List medicines (GSL):	Those that can be sold over the counter at any establishment.	
Hospital:	Includes acute, community and rehabilitation hospitals unless stated otherwise.	
IPFR	Individual Patient Funding Request https://www.awttc.org/ipfr	
License	Drugs used outside product licence are drugs used in a manner e.g. different dose or route of administration, or in conditions or in-patient types, which are outside the Summary of Product Characteristics – this is often known as off-label use. Drugs without product licenses, commonly known as unlicensed drugs or specials do not have a marketing authorisation for use in the UK.	
NICE	National Institute for Health and Care Excellence www.nice.org.uk	
Non Medical Prescribers (NMP):	Non Medical Prescribers (NMP). The title 'Non Medical Prescriber' refers to health care professionals who are qualified to prescribe, either as independent or supplementary prescribers. Supplementary prescribing is defined as: "a voluntary partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed patient specific clinical management plan (CMP) with the patients' agreement". Independent Prescribing is defined as: "prescribing by a practitioner (e.g. doctor, dentist, pharmacist, nurse or other allied healthcare professionals) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing". https://bnf.nice.org.uk/guidance/non-medical-prescribing.html	

New Treatment Fund (NTF)	The New Treatment Fund ensures that patients have faster access to medicines recommended by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicines Strategy Group (AWMSG). The fund enables health boards and trusts to make new medicines available as soon as possible. Once it has been approved, health boards and trusts have a 60-day deadline to make a newly recommended medicine available for prescription.	
NWSSP	NHS Wales Shared Services Partnership nwssp-primarycareservices@wales.nhs.uk	
NWOS	North West Ostomy Supplies. https://www.nwossurgical.co.uk/ suppliers of ostomy, incontinence, hosiery and woundcare products.	
Medicines / Drugs:	All substances defined under the Medicines Act as being medicinal products. These include those restricted to supply on prescription (POM), those that can only be sold by a Pharmacist (P), and those that can be sold at any establishment, General Sales List medicines (GSL). The term 'medicines' is used throughout the document as a generic term that covers all products administered by mouth, applied to the body, or introduced into the body for the purpose of treating or preventing disease, diagnosing or monitoring illness, contraception or inducing anaesthesia.	
MHRA:	Medicines and Healthcare Products Regulatory Agency www.mhra.gov.uk. The agency responsible for ensuring that medicines meet acceptable standards of safety, quality and efficacy and that the supply chain is safe and secure.	
Midwife:	Refers to an individual who is registered with the Nursing & Midwifery Council as a midwife.	
MIU:	Minor Injury Unit	
Near Miss:	Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people.	
NMC:	The Nursing & Midwifery Council	

Nurse prescribers Formulary ('Limited List'):	Registered nurses working within the community, employed by the NHS, who have successfully completed an approved competency training course and are legally entitled to prescribe items from the Nurse Prescribers formulary for community practitioners. https://bnf.nice.org.uk/nurse-prescribers-formulary/ V100/V150 qualification	
ONPOS	Online Non-Prescription Ordering Service – currently being used to obtain dressings in PTHB community settings	
Off Label	Drugs used outside their product licence are drugs used in a manner e.g. different dose or route of administration, or in conditions or patient types, which are outside the Summary of Product Characteristics	
Prescription Only Medicines (POMs):	Are those medicines restricted to supply on prescription	
Pharmaceuticals:	Includes non-therapeutic items covered by the Policy on Prescribing, Supply, Ordering, Storage, Security, Administration and Disposal of Medicines (e.g. disinfecting and sterilising agents).	
Patient Group Directions (PGDs):	A Patient Group Direction is a written direction relating to the supply and administration (or administration only) of a licensed prescription-only medicine (including some Controlled Drugs in specific circumstances) by certain classes of healthcare professionals Patient Group Directions	
Patient Specific Directions (PSDs):	A written statement defining the management of a named patient which has been agreed by the clinician responsible for the patient and by other appropriate health professionals. Effectively a Prescription	
P Medicine	A class of medicine defined as one which can only be sold through a registered pharmacy under the personal supervision of a pharmacist	
PrescQIPP	https://www.prescqipp.info/ NHS funded not-for-profit organisation that produces evidence-based medicines resources and tools for primary care commissioners, and provide a platform to share innovation and	

	prescribing dashboards to support quality and optimised prescribing for patients.	
PTHB	Powys Teaching Health Board	
Registered nurse:	A registered nurse may be on sub part 1 or 2 of the Level 1 NMC register for nurses. Sub part 1 of the Level 1 NMC register will include all nurses trained to the sub part 1 standard and currently practicing in adult, paediatric, mental health or learning disabilities nursing. Sub part 2 of the Level 1 NMC register for nurses, will include registered nurses who have not converted to the sub part 1 standard required for inclusion at Level 1 (best described as former enrolled nurses). https://www.nmc.org.uk/registration/staying-on-the-register/legal-basis-of-registration/	
Registered Operating Department Practitioner (RODP)	A Registered Operating Department Practitioner (RODP) refers to an individual who is registered with the Health and Care Professions Council (HPC) and participates in the provision of individualised care during the perioperative period. https://www.hcpc-uk.org/standards/standards-of-proficiency/operating-department-practitioners/	
SPS – Specialist Pharmacy Service	SPS provides impartial advice for pharmacists and other professionals using medicines. https://www.sps.nhs.uk/	
Supplementary Medication Charts	Charts used alongside the All Wales Medicines Administration Record - their use has to be clearly recorded on the All Wales Medicines Administration Record. A number of supplementary charts are recognised for use in PTHB: anticoagulation chart, insulin chart, syringe driver chart, supplementary infusion chart and patient-controlled analgesia/epidural chart.	
Unlicensed Medicines:	Drugs with no UK Product Licence.	
Untoward incident:	Any event that has given or may give rise to actual or possible personal injury, to patient dissatisfaction, or damage to property.	

Responsibilities

Chief Executive (CEO)

The Chief Executive is legally accountable for medicines management and the associated risks across PTHB.

It is the responsibility of the Chief Executive to ensure that there are clear lines of accountability established and maintained throughout the organisation, defining relationships between the Board, Executive Team, relevant committees and Heads of Departments/services.

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

Controlled Drugs Accountable Officer (CDAO)

The Chief Pharmacist is the CDAO for the Health Board. This is a legally required role under the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008.

The CDAO is responsible and accountable for all aspects of the safe and secure management and use of controlled drugs. This includes responsibility for ensuring that adequate and up-to-date standard operating procedures, covering all aspects of controlled drug use and management, are in place; that monitoring and audits of the management and use of CDs are undertaken and that adequate destruction and disposal arrangements are in place.

The CDAO is required to maintain records of concerns regarding relevant individuals and to assess and investigate concerns and establish arrangements for sharing information.

The CDAO is responsible for setting up and managing the CD Local Intelligence Network, receiving Quarterly Occurrence Reports and for performance managing local providers with regard to controlled drugs.

The CDAO is required to ensure that organisations that are not required to appoint an Accountable Officer, such as GP practices and pharmacies, follow good practice in relation to how they manage controlled drugs. The CDAO will request periodic self-assessment declarations (every 2 years) from providers and GPs on the Health Board's Performers List.

The CDAO is required to ensure periodic inspections of premises which are not subject to inspection by a regulatory body (e.g. GPhC, HIW).

In addition to monitoring the management and use of CDs within local NHS services, the CDAO is responsible for monitoring CD drug use and management by private practitioners operating within the boundaries of PTHB and for taking steps to protect patients and the public if there are concerns about inappropriate or unsafe use of CDs by private practitioners.

The register of all CDAOs across Wales is maintained by Health Inspectorate Wales (HIW) and can be accessed via: https://hiw.org.uk/accountable-officers-controlled-drugs

The Health Board has a legal responsibility to notify HIW of any change to the CDAO immediately.

Chief Pharmacist

The Chief Pharmacist is organisationally and professionally accountable for the day to day operation of safe and effective systems for medicine, medical gases, pharmaceutical and vaccine use within PTHB and the Powys area.

The Chief Pharmacist is the officer responsible for directing and delivering pharmaceutical services and for the procurement of medicines and medical gases across PTHB.

It is the responsibility of the Chief Pharmacist to:

- Oversee the professional standards of pharmacy professionals employed and engaged by PTHB
- Provide professional leadership around pharmacy practice, risk management and clinical governance relating to medicines
- Ensure the procurement of pharmaceuticals of appropriate quality and safety.
- Establish robust systems for the safe and secure handling of medicines.
- Ensure appropriate environmental medicines storage conditions including management of the 'cold chain'.
- Establish and maintain a system for the supply, distribution, return and destruction of medicines.
- Ensure the procurement of unlicensed pharmaceuticals of appropriate quality.
- Establish a system for the safe and secure handling of unlicensed medicines.
- Monitor the use of unlicensed medicines and the use of licensed medicines for unlicensed indications. Ensure their quality and suitability for use. Ensure that prescribers are provided with adequate

information on the use and suitability of the preparation in clinical practice.

- Establish a system for collecting signatures for the ordering and receipt of categories of drugs that require special handling (e.g. controlled drugs)
- Ensure that medicines and other pharmaceuticals are transported safely, securely and in a way that does not compromise the integrity of the product.
- Establish a system for monitoring medicine usage and advising on appropriate stock range and stock holding levels
- Establish systems for good medicines administration practice.
- Establish and maintain a system for advising health and social care staff, patients and members of the public on all aspects of medicines management, to ensure the best use of medicines
- Establish a system for recording and reporting pharmacy interventions.
- Provide advice on medicine administration errors and near misses reported via the Datix incident reporting system and ensure that appropriate learning is shared.
- Establish and maintain a system which ensures the availability of advice and access to medicines in an emergency during the out of hours period when the Medicines Management Team is not available.
- Establish robust processes for the development, review, monitoring and audit of Patient Group Directions and protocols relating to medicines use.
- Establish a robust clinical pharmacy service that is delivered consistently across all hospital sites.
- Establish robust systems for the management of controlled stationery across the health board.
- Establish mechanisms to monitor medicines use.
- Financial management of the health board's drug budgets. Ensure that prescribing is evidence-based and cost effective to ensure appropriate use of NHS resources.
- Audit the implementation of medicines handling policies and procedures.
- Ensure that decision making processes relating to medicines and medicines management services are robust and transparent.
- Establish the Antimicrobial Stewardship Group and ensure that systems and processes are in place to promote appropriate use of antimicrobials and to monitor compliance with the antimicrobial formulary and related guidelines.
- Provide professional guidance on the development of non-medical prescribing across the organisation and within primary care.

Medical Director

The Medical Director is the Clinical Executive Lead representative for medicines management and is responsible for organisational clinical governance and for overseeing the professional standards of medical staff employed and engaged by PTHB

Director of Nursing

The Director of Nursing is the Clinical Executive Lead for Non Medical Prescribing and Infection Prevention and Control (including antimicrobial stewardship) and is responsible for overseeing the professional standards of nursing staff employed and engaged by PTHB.

Director of Therapies

The Director of Therapies is responsible for overseeing the professional standards of all Allied Health Care professionals employed and engaged by PTHB

Ward/Department Managers/Heads of Service/Community Services Managers

Ward/department managers and Heads of Service are responsible for:

- ensuring that all relevant policies and guidelines are available and followed within the ward/department.
  - all staff are able to refer to relevant documents on the PTHB Medicines Management Internet site
  - these documents form part of the core induction programme for all staff. All new staff must undertake the ESR medicines training package.
  - audits are carried out and actions identified are implemented.
- ensuring that an up-to-date list of authorised signatures to order medicines and controlled drugs is maintained and supplied to pharmacy
- ensuring that all medications are kept in a safe and secure manner and that robust, auditable processes are in place to prevent inappropriate access to medicines.
- ensuring that appropriate levels and range of stock drugs are established in conjunction with the Pharmacy team
- ensuring that Patient Group Directions are used according to guidelines approved by PTHB
- ensuring that controlled stationery is managed safely and securely, restricting access to appropriate authorised staff and ensuring that appropriate records are maintained to provide a robust audit trail.

- ensuring that fridges used to store medicines are of appropriate design and standard, that they remain locked when not in use and that the temperature is monitored (and action taken if a variance is recorded) to ensure the safety of medicines stored within.
- ensuring that medicines related incidents are reported promptly and clearly via the Datix system.
- responding to datix incident reports and ensuring wider team learns from medicines incidents.
- ensuring that controlled drugs related incidents are reported to the Controlled Drugs Accountable Officer immediately.

All HealthCare Professionals

All registered clinical staff are responsible and accountable for their own professional practice.

All staff involved in the prescribing, supply, dispensing, handling, transporting, storage, administration and disposal of medicines, including controlled drugs, are accountable for:

- working within current legislation and within the Code of Conduct of their professional body
- incorporating this Medicines Policy and associated procedural documents into their working practices
- undertaking appropriate training and assessment of competence as detailed in associated procedural documents and/or by their line manager.
- ensuring that medicines are prescribed and administered only to patients that fall within the scope of PTHB clinical services.
- reporting any incidents relating to medicines use through the Datix incident reporting system and for sharing any learning from that incident.

Assistant practitioners/Healthcare Support Worker Band 4

Will only undertake tasks in the medicines process where:

- suitable approved policies and procedures are in place and a clear process for delegation and escalation of medicines related tasks has been identified
- the staff member has been suitably trained for the specific task and competencies have been assessed and documented
- the scope of the staff members involvement in medicines related tasks is defined within their job description
- the staff member is aware of their limitations and will seek advice or support from appropriate health professionals if in doubt.
- medicines-related tasks are not further delegated to others.

Pharmacy professionals

Registered pharmacy professionals are responsible and accountable for ensuring that medicines, medical gases and vaccines are prescribed, supplied, stored, prepared, disposed and administered correctly and effectively and undertake day to day tasks on behalf of the Chief Pharmacist.

Pharmacists and pharmacy technicians provide specialist knowledge, medicines management and clinical expertise and will work in collaboration with other healthcare staff and patients in the implementation of all aspects of this policy.

Assistant Technical Officers (Pharmacy Assistants)

Pharmacy assistants are non-registered members of the pharmacy team who have undergone General Pharmaceutical Council approved training in a range of pharmacy tasks. Pharmacy Assistants support services by ensuring correct storage of medication, medicines stock ordering and management and may carry out other tasks when trained and competent to do so and agreed by their supervising registered pharmacy professional.

Students/Overseas Nurses/Returning to practice practitioners

Whilst working towards gaining experience to seek registration with the Nursing and Midwifery Council or Health and Care Professions Council (HCPC) or to gain a competency in a new area of practice, students or staff undergoing an overseas nursing or return to practice programme may administer a range of medication under the supervision of a registered practitioner. This is to gain experience if medication administration is a task required for their role.

The registered practitioner must supervise the whole process and is accountable for the medicines administration.

See Administration - training section.

Physicians Associates

Physicians Associates (PAs) are healthcare professionals with a generalist medical education who work alongside doctors, physicians, GPs and surgeons to provide medical care as an integral part of the multidisciplinary team. PAs are dependent practitioners working with a dedicated consultant

or GP supervisor but are able to work autonomously with appropriate support.

Due to the lack of statutory regulation, PAs cannot currently prescribe medications unless they have professional registration and prescribing rights in another profession which is retained. The NMC have provided guidance on registered nurses working as Physicians Associates.

In certain circumstances PAs who have been trained and deemed competent may transcribe medications (which must be countersigned by a prescriber (see transcribing section) or administer medication (see administration section)).

PAs working to this policy in PTHB must be registered on the Physician Associate Managed Voluntary Register.

For further information about Physician Associates see: https://www.nhsemployers.org/articles/physician-associates

Staff Working Across Organisations

Where staff work across more than one organisation they should comply with the Medicines Policy for the host organisation.

Powys Primary Care Contractors

Primary Care contractor services with independent health professionals should use this Medicines Policy as a model for good practice. This will include General Practitioners, Dental Contractors, Community Pharmacists, Optometrists, Practice Nurses and others.

Primary care contractors who are contracted to provide services to PTHB hospitals or community services are required to comply with this policy.

PRESCRIBING OF MEDICINES/INITIATION OF TREATMENT

To ensure the best possible outcomes from medicines, there must be an ongoing, open dialogue with the patient and/or their carer about the patient's choice and experience of using medicines to manage their condition; recognising that the patient's experience may change over time even if the medicines do not.

Prescribing Choice

All prescribers must act in accordance with local prescribing recommendations which are reflected in the PTHB formulary and associated guidelines, which can be accessed via the Medicines Management pages of the Health Board's website.

Drugs not included in the PTHB formulary should not be prescribed without prior authorisation. All requests for new drugs to be added to the PTHB formulary must be submitted on a formulary proposal form available via the formulary website https://powformulary.wales.nhs.uk/ under Formulary Forms on the front page. This form must be submitted to the Formulary Working Group via newmedicines.powys@wales.nhs.uk for consideration. This group will make a recommendation to the Area Prescribing Group.

Requests for one off specialist treatments should be submitted for consideration via the All Wales Individual Patient Funding Request (IPFR) procedure.

AWTTC have summarised access to medicines in Wales https://awttc.nhs.wales/accessing-medicines/access-to-medicines-in-wales/

When prescribing for patients the principles of prudent health care should be followed. Advice on avoiding polypharmacy can be found in the AWMSG guide Polypharmacy: Guidance for prescribing.

The Academic Health Science Network (AHSN) has also published information to support healthcare professionals to identify patients at potential risk of polypharmacy and to support better conversations about medicines.

Antimicrobial Prescribing

All antimicrobial prescribing must follow Health Board or All Wales approved guidelines.

PTHB uses Microguide app and website for the antimicrobial formulary content. This reflects the All Wales Primary Care Antimicrobial Guidelines

Prescribers who are likely to prescribe antimicrobials should refer to the RCGP Target antibiotics toolkit materials.

Low Value Medicines

AWMSG have identified medicines as low value for prescribing in NHS Wales to minimise the prescribing of medicines that offer a limited clinical benefit to patients and where more cost-effective treatments may be available. These Low Value Medicines must not be routinely prescribed in Powys.

Gluten Free Prescribing

AWMSG has produced a guide to Prescribing Gluten-free Products which should be used by prescribers managing patients with coeliac disease, and to aid the decision-making process in relation to prescribing Advisory Committee on Borderline Substances (ACBS)-approved gluten-free foods.

National Prescribing indicators

National prescribing indicators show how the different health boards in Wales prescribe certain medicines and highlight any differences in prescribing patterns. National prescribing indicators are developed to promote rational prescribing of medicines in Wales. The choice of indicators is evidence-based and the indicators are designed to be clear and easily understood by prescribers and healthcare professionals.

The indicators allow health boards, primary care clusters, GP practices and prescribers to compare their current prescribing practice against an agreed standard of quality.

The priority areas identified must be followed in Powys and AWMSG provide resources to support implementation in these areas.
https://awttc.nhs.wales/medicines-optimisation-and-safety/medicines-optimisation-guidance-resources-and-data/national-prescribing-indicators/

Local Prescribing indicators

National prescribing indicators, local prescribing data, national and local priorities are used to identify local prescribing priorities which then inform the local prescribing indicators.

Local prescribing indicators are included in the annual Medicines Management Incentive Scheme (MMIS) and appropriate Service Level Agreements. Local prescribing indicators are monitored regularly and reports are provided to clinicians.

More information can be found on the PTHB Medicines Management internet pages.

Prescribing by Brand or Generically

Generic prescribing is encouraged where possible and brand name prescribing is supported in line with national guidance for clinical or safety reasons https://www.sps.nhs.uk/articles/which-medicines-should-be-considered-for-brand-name-prescribing-in-primary-care/

The routine use of branded generics is not supported unless agreed through the Area Prescribing Group.

Environmental impact prescribing considerations

In line with the NHS Wales Decarbonisation Strategic Delivery Plan - which has a target of increasing the use of low global warming potential inhalers to 80% of the total inhalers issued by 2025 - PTHB has agreed a range of inhalers which meet this aim and are agreed for use in Powys. The agreed inhalers can be found in the PTHB formulary.

AWTTC has produced a dashboard to provide a summary of carbon footprint inhaler use within primary care – available https://spira.uk/spira_decarb.html

Other resources include

- NICE Patient Decision Aid: Inhalers for Asthma
- All Wales Asthma Diagnosis and Management Guidelines
- All Wales COPD Management and Prescribing Guidelines

PTHB Medicines Formulary

The medicines formulary ensures evidence based, rational prescribing and must be followed when prescribing for patient in Powys. The current contents of the formulary can be found on the internet via this link http://powysteachinghb.inform.wales.nhs.uk/

The PTHB formulary is compiled from AWMSG and NICE TAs or HTA guidance in accordance with the Welsh Government New Treatment Fund (NTF) arrangements, One Wales Interim Commissioning Process agreements or through local application and decision making. The PTHB Formulary Working Group selects products and assigns prescribing position

in consultation with local Consultants, and General Practitioners (GPs). These decisions are ratified by the Area Prescribing Group.

Requests for additions or a review of PTHB formulary choices can be made to the Formulary Working Group via the Formulary Forms links on the front page of the formulary website.

Prescribing Non-Formulary Medicines

If a non-formulary drug is being considered, then advice must be sought from the Medicines Management team to ensure funding is agreed for the treatment or in the PTHB hospital setting that the medication is available. This may mean requesting approval from the Individual Patient Funding Request (IPFR) Panel for a single named patient supply. PTHB follows the All Wales IPFR process. No precedent for further supplies will be set.

If it is necessary to initiate a non-formulary drug e.g. because formulary options have been exhausted, the prescriber must ensure that clear reasons are stated in the patient record. Use of non-formulary medications will be subject to audit by the Medicines Management team. If it is anticipated that the drug will be needed for other patients, then a formal request must be made for consideration for addition to the formulary.

The Chief Pharmacist or Medical Director cannot give approval for named patient use of a drug that has been previously rejected for formulary approval unless significant new evidence supporting use is available, in exceptional cases the IPFR process should be followed.

Specific Medicines Choice Considerations

Tramadol

Following a number of tramadol-related deaths and other harms, safety concerns around the use of tramadol were highlighted in 2013 and tramadol was reclassified as a Schedule 3 controlled drug in 2014.

To support the review of the use of tramadol AWMSG have produced a helpful resource, educational tool and patient information which should be followed when reviewing patients prescribed tramadol. AWMSG Tramadol Educational Resources September 2021

Hypnotics and Anxiolytics

AWMSG have produced materials to support appropriate prescribing of hypnotics and anxiolytics across Wales which must be considered when initiating or reviewing prescribing for hypnotics and anxiolytics. AWMSG

Material to Support Appropriate Prescribing of Hypnotics and Anxiolytics 2021

The Bruyere Research Institute have produced a Benzodiazepine & Z Drug (BZRA) Deprescribing Algorithm

High Dose Opioids

Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation). The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration. If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential. AWMSG have provided updated endorsed resources on the use of opioids around alternative options and approaches, in light of patient safety alerts including: -

- Persistent Pain Resources
- Safeguarding users of opioid patches by standardising patient and caregiver counselling

Other resources:

- The Faculty of Pain Management of the Royal College of Anaesthetics: Opioids Aware: a resource for patients and healthcare professionals to support appropriate prescribing of opioids for pain management
    - Opioids Aware: Tapering and stopping opioids
    - Opioids Aware: Checklist for Prescribers
- NICE (2021) NG193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain.

Pregabalin and Gabapentin

The risk of dependence, misuse and diversion of pregabalin and gabapentin have been highlighted to prescribers for a number of years.

Patients with a known or suspected propensity to misuse, divert or become dependent on drugs are at greater risks from their use. Prescribers must make a careful assessment to balance the potential benefits against the risks before prescribing.

WHC/2016/030: Advice for prescribers on the risk of misuse of pregabalin and gabapentin

Proton Pump Inhibitors

The evidence base around the adverse effects from long-term use of Proton Pump Inhibitors (PPIs) is increasing. Prescribers should only use PPIs for recognised indications and appropriate durations to minimise PPI overuse and the associated increased risk of harm.

Adverse effects include diarrhoea, increased risk of fractures, hypomagnesaemia, pneumonia, *Clostridioides difficile* and impaired vitamin B12 absorption. Older people may be more susceptible to the adverse effects of long-term PPI use. AWMSG have produced resources to support the safe use of PPIs when initiating and reviewing patients. AWMSG – Safe Use of PPIs Feb 2018

Deprescribing guidelines and algorithms that can be adapted for local use can be accessed from a Canadian resource: deprescribing.org

Valproate and Valproic Acid

Valproate (Belvo, Convulex, Depakote, Dyzantil, Epilim, Epilim Chrono or Chronosphere, Episenta, Epival, and Syonell▼): new safety and educational materials have been produced to support regulatory measures in men and women under 55 years of age.

- valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply. For the majority of patients, other effective treatment options are available.
- a risk acknowledgement form must be completed for all patients initiated on valproate: -
  Risk acknowledgement form for Female patients starting Valproate
  Risk Acknowledgement Form for Male patients starting Valproate
- at their next annual specialist review, women of childbearing potential and girls receiving valproate should be reviewed using the revised valproate Annual Risk Assessment Form. A second specialist signature will be needed if the patient is to continue on valproate, however subsequent annual reviews will only require one specialist.
- general practice and pharmacy teams should continue to prescribe and dispense valproate and if required offer patients a referral to a specialist to discuss their treatment options.
- Valproate preparations must be dispensed in the manufacturer's original full pack.

- Patient card: Provides key information for female patients receiving valproate on contraception and pregnancy prevention.
- Updated Healthcare Professional Guide: Provides updated information for healthcare professionals on the risks of valproate in pregnancy and the risks for male patients, the new conditions for valproate prescribing and key points for patient discussions.
- Updated Patient guide: Provides those taking valproate (or their parent, caregiver, or responsible person) with updated information on the risks of valproate in pregnancy and the risks to male patients and what they need to do.
- This webpage provides a continually updated collection of information and guidance for patients and for healthcare professionals https://www.gov.uk/government/collections/valproate-safety-measures
- The MHRA Drug Safety Update - Jan 2024 can be accessed via the link & the PTHB webpage also contains Sodium Valproate resources and information.
- The PTHB Valproate prescribing policy can be accessed here (add link when approved & finalised)
- Valproate is subject to black triangle reporting; ALL suspected adverse reactions should be reported via the Yellow Card Scheme.

Topiramate

The MHRA introduced new safety measures for Topiramate in June 2024. It is now contraindicated:

- in women of childbearing potential unless the conditions of a Pregnancy Prevention Programme are fulfilled for all indications
- in pregnancy for prophylaxis of migraine
- in pregnancy for epilepsy unless there is no other suitable treatment

A risk awareness form must be completed for all patients of childbearing potential initiated on Topiramate for Migraine or Epilepsy . Prior to starting treatment with topiramate a negative pregnancy test must be obtained from the patient to ensure that pregnancy is excluded.

Existing patients of childbearing potential receiving Topiramate treatment should receive an annual review, during which the annual risk awareness form for Migraine or Epilepsy should be completed, and the patient provided with the appropriate patient guide.

patient guide for Topiramate & Migraine
patient guide for Topiramate & Epilepsy

Further information can be found MHRA Topiramate drug safety update 20.6.2024

Isotretinoin

The MHRA has made recommendations to strengthen the safety of isotretinoin treatment. In addition to pregnancy prevention requirements, recommendations include new warnings, the need for consistent monitoring requirements for psychiatric side effects, the introduction of new monitoring requirements for sexual side effects, and additional oversight of the initiation of treatment for patients younger than 18 years.

- isotretinoin is only indicated for **severe forms** of acne (such as nodular or conglobate acne or acne at risk of permanent scarring) resistant to adequate courses of standard therapy with systemic anti-bacterials and topical therapy.
- **Prescribing must be undertaken by a Dermatology specialist only** and strict precautions on prescribing isotretinoin, including the conditions of the **isotretinoin Pregnancy Prevention Programme** must be followed.
- patients should be advised to seek advice if they feel their mental health or sexual function is affected or is worsening – patients with a serious side effect should be told to stop their treatment and seek urgent medical advice.

Further information can be found in the MHRA Drug Safety Update – Oct 2023

Prescribing Types and Exemptions

The majority of clinical care, involving medicines, should be provided on an individual, patient-specific basis via a prescription.

The legal mechanisms available for the prescribing or supply and administration of medicines are:

- Medical Prescribing
- Dental Prescribing
- Non-Medical Prescribing
    - Independent Prescribing
    - Supplementary Prescribing
- Exemptions in the Human Medicines Regulations 2012
- Administration for the purpose of saving life in an emergency
- Patient Group Directions
- Local Protocols (P and GSL medicines)
    - Homely & Discretionary Medicines Policy
    - Oxygen protocol

Authorised Prescribers

Only those employed or formally engaged (either through an SLA agreement or honorary contract) by PTHB or Powys independent contractor are authorised to prescribe on Powys prescriptions, or administration authorisation charts, e.g:-

- Medical Prescribers – GPs, hospital doctors.
- Dental Prescribers
- Non-Medical Prescribers
  - Independent prescribers
    - Nurses/Midwives, Pharmacists, Physiotherapists, Podiatrists, Paramedics, Optometrists, Therapeutic Radiographers
  - Supplementary Prescribers
    - diagnostic radiographers, dietitians or staff groups able to work as independent prescribers with dual qualification
- Community Practitioner Nurse Prescribers
  - Health Visitors and District Nurses – "Limited List Prescribers"

It is essential that all staff who prescribe ensure they have appropriate knowledge and experience to prescribe and all prescribers are required to restrict their prescribing to their area of competence.

Non-Medical Prescribers

Non-medical prescribers who have achieved V300 qualification must be registered with the Medicines Management team and work to a formulary and scope of practice, agreed with their line manager/service lead and the Medicines Management team. Further information can be found in the Non Medical Prescribing Policy

Community Practitioner Nurse Prescribers

Community Practitioner Nurse prescribers who have achieved V100 or V150 qualification and registered with the Medicines Management team are able to prescribe a limited list of medications as identified in the current version of the BNF Nurse Prescribers' Formulary

Community Practitioner Nurse Prescribers should not prescribe unlicensed medicines, that is, medicines without a valid marketing authorisation or product licence. Neither should they prescribe licensed medicines for uses, doses, or routes that are outside the product licence (unlicensed use, 'off-label' use, or 'off-licence' use). The only exception is nystatin which may be prescribed for neonates under certain circumstances.

A Community Practitioner nurse prescriber should not prescribe medicines for pregnant women (except folic acid and, in some circumstances, nicotine replacement therapy); the patient should be referred to her doctor.

Medical staff

Doctors must be fully registered with the General Medical Council (GMC) before they prescribe. Provisionally registered doctors and doctors with limited registration (overseas qualified Doctors) may only prescribe in connection with their employment to inpatients only under supervision of a fully registered doctor. Limited registration or provisionally registered doctors must not prescribe on outpatient prescriptions WP10(HP).

For primary care medical staff the name of the individual must appear on their respective professional register and on the NHS Wales Performers List before prescribing for Powys patients.

Physicians associates (PA's)

Physician's Associates currently **cannot legally prescribe** - this also includes prescriptions for fluids and oxygen. Physicians Associates may transcribe in limited circumstances see Physicians Associates Transcribing

This is unless the Physician Associate has professional registration and prescribing rights in another profession which is retained. The NMC have provided guidance on registered nurses working as Physicians Associates.

Dentists

Dentists can legally write prescriptions for any POM. The General Dental Council advises that dentists should restrict their prescribing to areas in which they are competent and generally only prescribe medicines that have uses in dentistry.

When prescribing on NHS dental prescriptions, dentists are restricted to the medicines listed in the Dental Formulary - https://bnf.nice.org.uk/guidance/prescribing-in-dental-practice.html

Summary of Mechanisms of Prescribing

The Specialist Pharmacy Service (SPS) has a summary around the mechanisms for the prescribing, supply and administration of medicines, which is also applicable to Wales - https://www.sps.nhs.uk/articles/medicines-mattersa-guide-to-mechanisms-for-the-prescribing-supply-and-administration-of-medicines-in-england/

Self-Care

Prescribers are advised not to routinely write prescriptions for medicines/products that are available over-the-counter medicines (OTC)

Wherever possible, if a patient presents with a common ailment that can be managed with a medicine that is available OTC, the patient should be signposted to a local pharmacy where advice from a pharmacist can be sought and the medicine can be purchased or, if appropriate, supplied by the pharmacist under the Common Ailment Service.

Self-care is extremely important to a person's health and wellbeing as it has been shown to empower the individual to have control over their health, improving quality of life and improving disease outcomes. Medicines for self-care are a central part of this approach. Individuals that care for themselves have better health and reduced demand for services.

Community Pharmacies offer a readily accessible alternative healthcare pathway for patients. They are able to give free advice on many common ailments, and stock a wide range of treatments including through the All Wales Common Ailments Service. There is no need for an appointment and many pharmacies are open longer hours including weekends.

The Self Care forum http://www.selfcareforum.org/ provides fact sheets (including Welsh translations) for common ailments, with the aim to help clinicians and patients discuss issues around self-care within a consultation and especially how to handle the symptoms in the future. They provide patients with information around: -

- Useful facts
- What patients can expect to happen (the natural history)
- What people can do to help themselves – now and in the future
- When to seek medical help (the 'red flags')
- Where to find out more

Smoking Cessation Services

Those looking to access smoking cessation services can self-refer to Help me Quit Wales via: https://www.helpmequit.wales/

Prescribing dilemmas

The AWMSG Prescribing Dilemmas document provides guidance for healthcare professionals in Wales on common prescribing dilemmas and scenarios such as:

prescribing duration; foodstuffs; complementary medicines and alternative therapies; fertility treatment, erectile dysfunction, prescribing for self and family, visitors from overseas, travel and occupational health vaccines, prescribing situations not covered by the NHS including private care and private prescriptions, unlicensed

medicines and prescribing outside national guidance are also included.

Exemptions in the Human Medicines Regulations

Professional Group Exemptions

A number of health professions have specific exemptions in medicines legislation to supply or administer specific licensed medicines. Currently exemptions are available for the following registered healthcare professionals:

- Nurses for occupational health schemes
- Midwives
- Optometrists*
- Orthoptists
- Chiropodists/podiatrists*
- Paramedics

*Optometrists and chiropodists/podiatrists can train to use a wider range of medicines under a list of additional exemptions. More information about working under exemptions can be found via the professional bodies' websites and Human Medicines Regulations 2012 Schedule 17 and Human Medicines (Amendment) Regulations 2016.

There are further exemptions for certain parenteral medicines which can be administered by anyone for the purpose of saving life in an emergency; these can be found in Human Medicines Regulations 2012 Schedule 19

It should be noted that not all drugs recommended for emergency situations are covered by these exemptions. The exemptions only cover parenteral administration of the listed medicines.

It is considered good practice to have a local policy or procedure to support practitioners when working under an exemption to the Human Medicines Regulations e.g. local anaphylaxis policy.

In the Human Medicines Regulations 2012 and subsequent amendments, there are other situations where a prescription only medicine may be used without a prescription: -

- the administration of medicines in nuclear medicine
- using emergency adrenaline auto injectors in schools
- using emergency asthma inhalers in schools
- widening the availability of naloxone
- access to medicines in a pandemic

Further detail on Prescription Exemptions is available from the Specialist Pharmacy Service - https://www.sps.nhs.uk/wp-content/uploads/2018/10/Medicines-Matters-september-2018-1.pdf

Or via https://www.gov.uk/government/publications/rules-for-the-sale-supply-and-administration-of-medicines/rules-for-the-sale-supply-and-administration-of-medicines-for-specific-healthcare-professionals

Administration for the purpose of saving life in an emergency

Regulation 238 of the Human Medicines Regulations 2012 allows for certain prescription only medicines to be administered by anyone for the purpose of saving life in an emergency without a prescription. These include, for example, naloxone, glucagon and hydrocortisone.

Adrenaline 1 in 1000 (1mg/mL) by intramuscular injection can be administered for the emergency treatment of anaphylaxis – locally a PGD is in place to facilitate the authorisation to possess adrenaline 1 in 1000 when working in community settings. Refer to PTHB PGD

Current emergency clinical guidelines should be followed. The full list of exemptions can be found at: http://www.legislation.gov.uk/uksi/2012/1916/schedule/19/made

School medication – emergency inhalers

From 1 October 2014 UK schools have been allowed to purchase a salbutamol inhaler without a prescription for use in emergencies when a child with asthma cannot access their own inhaler. See guidance - https://gov.wales/sites/default/files/publications/2018-12/guidance-on-the-use-of-emergency-salbutamol-inhalers-in-schools-in-wales.pdf

Adrenaline autoinjectors in schools

Schools may obtain adrenaline autoinjectors without a prescription, for use in emergencies. This change applies to maintained nurseries, primary, secondary and special schools, referral units and independent schools. See guidance - https://gov.wales/sites/default/files/publications/2018-12/guidance-on-the-use-of-emergency-adrenaline-auto-injectors-in-schools-in-wales.pdf

Naloxone

Schedule 17 of the Human Medicines Regulations 2012 allows the injectable and nasal forms of naloxone to be distributed without a prescription by

people who work in drug treatment services that are commissioned by either the NHS, a local authority, Public Health England (PHE) or the Northern Ireland Public Health Agency (PHA), where the supply may be made only in the course of provisions of lawful drug treatment services and only where required for the purpose of saving life in an emergency. Naloxone is also included in the midwifery and paramedic exemptions.

In Powys Naloxone training and supply are provided by Kaleidoscope.

For further information see: Widening the availability of naloxone

Transcribing

Transcribing is defined as the act of making an exact copy, usually in writing. In the context of this guidance, transcribing is the copying of previously prescribed medicines details to enable their administration in line with legislation (i.e. in accordance with the instructions of a prescriber).

The PTHB Transcribing by Pharmacists Policy (under development) [link]. is underpinned by risk assessment and is clear about who can transcribe, when it can be used, and the difference between transcribing and prescribing. Safeguards must be in place to ensure that transcribed information is not inadvertently used as a prescription.

Since transcribing is the copying of medicines information for the purposes of administration, it cannot be used in place of prescribing to issue or add new medicines or alter/change original prescriptions.

Transcribing is used only in the patient's best interests to ensure safe and continuous care: ensuring the medication is administered accurately, without undue delay.

Those undertaking transcribing must be appropriately trained and assessed as competent to do so and an audit trail must exist for all transcribed medicines.

Medicines must not be transcribed where details are illegible, unclear, ambiguous or incomplete. Particular care is taken in transcribing details of high-risk medicines such as insulin, anticoagulants, cytotoxics, or controlled drugs.

Further information on transcribing can be found on the SPS website Understanding transcribing for medicines administration in healthcare – SPS - Specialist Pharmacy Service

The current PTHB procedure supporting the use of medicines transcribing by agreed PTHB Healthcare professionals can be found PTHB Transcribing by Pharmacists Policy (under development) [link].

Physicians Associates Transcribing

The Royal college of Physicians/Faculty of Physician Associates (PAs) has made statements on transcribing for this group of workers. https://www.fparcp.co.uk/employers/guidance

Where competency has been assessed and confirmed, PAs may transcribe medications to drug charts, but each transcription requires the countersignature of a fully registered doctor who assumes ultimate responsibility for the prescription. **Each transcribed medicine must be countersigned BEFORE it is administered to the patient**. It is strongly recommended that PAs do not use any form of electronic prescribing, in order to prevent any practice outside their competence.

In line with the 'Employer's guide to physician associates' published by the Faculty of Physician Associates, PAs must not transcribe controlled drugs (locally defined as Schedule 1-3 controlled drugs) or cytotoxic medicines.

Serious Shortage Protocols (SSPs)

If the Department of Health and Social Care (DHSC) decide there is a serious shortage of a specific medicine or appliance, then an SSP may be issued. These allow a community pharmacy contractor to substitute the patient's prescribed order within the parameters of an active SSP. The patient also has to agree to the alternative supply for that dispensing month.

Current SSPs can be found at https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/serious-shortage-protocols-ssps

Patient Group Directions

This is not a form of prescribing but can provide a legal framework for the administration and supply of medicines by defined registered staff groups, without the need for a prescription in restricted circumstances.

When practicing under a PGD, healthcare professionals cannot delegate the responsibility for supplying or administering a medicine to anyone else.

Further information on Patient Group Directions can be found in Administration and Supply of Medicines - Patient group directions section

Discretionary/Homely Medicines

This is not a form of prescribing. The PTHB Discretionary or Homely Medicines policy allows the administration of agreed P or GSL legally classified medication within defined parameters and for a short period of time without the need for a prescription.

The policy outlines the staff groups and requirements to administer in accordance with the policy.

Non- Prescription Substances

The following substances may be used without a prescription:

(i) Disinfectants
(ii) Cleansing agents
(iii) Urine testing and other reagents
(iv) Preparations used in oral toilet (GSL only)
(v) Barrier creams for personal care – administration must be documented in the patient's nursing notes.

Dietetic Products

Dietitians are authorised to initiate the use of formulary dietetic products by writing them on the patient's All Wales Medication Administration Record. The same standards are expected as for prescription writing including volumes to be taken, frequency, flow rates (if an enteral feeding pump is being used) and any special instructions for use. Entries should be signed by the dietitian and include name in printed letters and the phrase "registered dietitian".

Wound Management Products

The prescribing/supply of wound cleansing and management products should be guided by the PTHB Tissue Viability and Wound Management Guidelines which can be accessed via [link (under development)]

It is not necessary for dressings included within this document to be prescribed before use. It is however essential that ALL dressings used and the rationale behind their use are documented within the individual patient's care plan and discharge requirements considered as part of the discharge planning process.

Potassium Permanganate Soaks

Incidents of inadvertent ingestion of the concentrated form of potassium permanganate are still occurring – see national patient safety alert.
Potassium permanganate use must be risk assessed and any prescribing in line with the British Association of Dermatology recommendations.
Where potassium permanganate is prescribed:-

- prescriptions are only issued by an appropriate prescriber – see BAD recommendations
- if potassium permanganate is to be used in a patient's home, a risk assessment must be undertaken before prescribing all patients must be supplied with a patient information leaflet.
- patients are not on repeat prescriptions for potassium permanganate
- prescriptions include clear instructions to dilute before use
- dispensing label includes the warning 'HARMFUL IF SWALLOWED
- in care settings – supplies will only be made on an individual named patient basis and stored separately from any oral/internal use medications and dilution will occur away from the patient in the sluice.

Further information is available via the link Minimising risk of harm from potassium permanganate soaks (bmj.com) – accessed via an NHS Wales connection or Athens password.

Stoma Products

The prescribing of stoma products should be guided by the PTHB Stoma Formulary Guidelines (under development).

Medical Gases and Nebulised Medicines

Medical gases include oxygen, entonox, nitrous oxide, carbon monoxide and special gases.

Medical gases are legally classed as medicines but most are legally categorised as P medicines, oxygen is categorised as a GSL medicine and can therefore be administered without the need for a prescription.

It is good practice to have a protocol in place to support the use of medical gases and any practitioner working to a protocol must undertake the whole administration process under the protocol and not delegate administration to another member of staff.

Any authorisation of medical gas administration to be delegated to other healthcare professionals must be made by a prescriber and state:

- The medical gas required (Write name in full – NOT abbreviation).
- The delivery device i.e. mask, nasal cannula.
- The rate OR, for Oxygen, the required saturation.
- Other instructions.

Further information on the safe use of Medical Gases can be found in the PTHB Medical Gas Policy

Oxygen

Oxygen should be used in line with the British Thoracic Society guidelines. Refer to the BTS Guideline for oxygen use in healthcare and emergency settings (2017 Update 2019) for full details: https://www.brit-thoracic.org.uk/quality-improvement/guidelines/emergencyoxygen/

Oxygen may be administered in an emergency situation by anyone competent to administer. A protocol is in place to support non-prescribed use and use in an emergency. Use may be documented retrospectively.

Home Oxygen

Provision of oxygen in the Community should comply with: BTS Guidelines for Home Oxygen Use in Adults (2015): https://www.brit-thoracic.org.uk/quality-improvement/guidelines/homeoxygen/

The community respiratory team is responsible for assessing patient requirements for and for arranging the provision of home oxygen

All equipment is requested on a Home Oxygen Order Form (HOOF), and is provided by Baywater Healthcare, delivered directly to the patient's home. Surgeries should refer patients for oxygen assessment electronically, via the Welsh Clinical Communications Gateway (WCCG), to the respiratory teams [link to referral template].

The Community Respiratory team can be contacted as follows:

- Mid/NW team- 01686 414227
- NE team- 01686 617208
- South team- 01874 712503

For children receiving oxygen at home and school the HOOF will be completed by the Children's Community Nursing team who can be contacted on Powys.ccn@wales.nhs.uk

Inpatient Oxygen

In the inpatient setting Oxygen must be authorised for planned administration by a prescriber in the specified section of the inpatient medication chart ensuring that either the flow rate or the required saturation level is specified.

Entonox

Entonox may be administered by midwives utilising their HMR2012 exemption, for management of incidental pain. A protocol is in place to

support other healthcare professionals who need to administer Entonox in defined circumstances.

Nebulised Medicines

In order to eliminate the risk of inadvertent connection to medical air via a flowmeter, as identified in Patient Safety Notice PSN059 Sept 2021, electrically powered nebuliser devices should be used wherever possible. Where this is not possible, the clinical considerations for when oxygen or medical air should be used for nebulisation (particularly for patients who retain CO_2) must be critically reviewed and documented in the patient's notes.

Healthcare Professionals are referred to the British Thoracic Society Guideline for oxygen use in adults in healthcare and emergency settings.
Driving gas for nebulised treatments

Unlicensed/Off Label Use of Medicines

Licensed medicines should usually be prescribed in accordance with the terms of their licence. The General Medical Council has produced guidance around the prescribing of unlicensed medicines.

The Area Prescribing Group has been charged with monitoring and risk assessing unlicensed and "off label" use of medicines within PTHB and ensures appropriate governance arrangements are in place for use.

The Medicines Management team have collated a database of current unlicensed and "off label" use drugs. A copy of the unlicensed drug database and registration form for requests for additions to the database can be found on the PTHB Medicines Management internet pages (under development).

A registration form is not required where the current editions of the BNF, BNF for Children, NICE Guidance or Immunisation of Infectious Diseases (Green Book) suggests a use (indication, route, dose or age group) that is outside of the licensed indication of a product. This will be accepted as peer group approved.

The registration forms, once received, will be risk assessed by a pharmacist before being referred to the Area Prescribing Group for a decision. Where approved, the drug will be entered onto the database.

Risk assessments on individual drugs and decisions or further actions required will be fed back to prescribers.

Definition of unlicensed and off-label use

The term 'unlicensed medicine' is used to describe medicines that are used outside the terms of their UK licence (also known as off-label) or which have no licence for use in the UK.

Situations in which a medicine may be classed as unlicensed include: -

- Items used on a named patient basis before commercial release.
- Products imported on a named patient basis.
- Products manufactured or assembled to a practitioner's order i.e., "specials".

Situations in which a medicine may be classed of off-label

- Items used outside the terms of their product licence, i.e. not indicated in the Summary of Product Characteristics (www.medicines.org.uk). This unlicensed use of a licensed product is commonly termed 'off-label' use.

Situations that may Require Unlicensed or Off-label Prescribing

It may be appropriate to prescribe unlicensed/off-label medicines where, on the basis of an assessment of an individual patient, it is concluded that, for medical reasons, it is necessary to do so to meet the specific needs of the patient.

Prescribing unlicensed medicines may be necessary where:

- There is no suitably licensed medicine that will meet the patient's need. Examples include (but are not limited to) where:
    - there is no licensed medicine applicable to the particular patient. For example, if the patient is a child and a medicine licensed only for adult patients would meet the needs of the child; or
    - a medicine licensed to treat a condition or symptom in children would not meet the specific assessed needs of the particular child patient, but a medicine licensed for the same condition or symptom in adults would do so; or
    - the dosage specified for a licensed medicine would not meet the patient's need; or
    - the patient needs a medicine in a formulation that is not specified in an applicable licence; or
    - where a suitably licensed medicine that would meet the patient's need is not available. This may arise where, for example, there is a temporary shortage in supply; or
    - the prescribing forms part of a properly approved research project.

Requirements when prescribing an unlicensed/off-label medicine

The prescriber must:

- Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
- Take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable clinician to do so. This may include a shared care arrangement to handover care.
- Make a clear, accurate and legible record of all medicines prescribed and the reasons for prescribing an unlicensed medicine.
- If the unlicensed/off-label use is not documented in the BNF, BNF-C, NICE Guidelines or Immunisation against infectious diseases guidance (Green Book) then the Medicines Management Team must be consulted before treatment is initiated – as per the unlicensed medicines procedure (under development). The request may necessitate an IPFR application.
- Inform the patient or their carer than at unlicensed/off-label medicine is being used and ensure that they have sufficient information about the medicines to allow them to make an informed decision about the treatment.

Monitoring the prescribing of unlicensed medicines

The Medicines Management Team will routinely monitor the prescribing of unlicensed medicines and specials, through prescribing data and audit, advising prescribers on alternative options where appropriate.

The MHRA has produced guidance around the supply of unlicensed medicinal products - https://www.sps.nhs.uk/articles/wp-content-uploads-2020-03-the_supply_of_unlicensed_medicinal_products__specials_-pdf/

Anti-cancer medicines

The prescribing of cancer medication must not be initiated by PTHB prescribers. For inpatients who are receiving agreed anti-cancer medicines, treatment must be confirmed with the patient's treating specialist and a PTHB Pharmacist and the treatment plan and any administration instructions must be clearly documented.

Controlled Drugs

See Prescribing Controlled Drugs

Intravenous (IV) and Parenteral Medication

When prescribing injectable medication it must be ensured that the prescription also contains information about:

- Any diluent required
- Any flushes required
- Rate of administration
- Any infusion fluids
- Any compatibility considerations
- Any monitoring requirements
- Syringe size if appropriate
- Any filters required

Diluents, Flushes and Infusions fluids must also be prescribed if required.

See injectable medicines policy [link]

PRESCRIBING – Prescription Writing

Prescription Writing Training

All prescribers must undertake the ESR training package [**000 Prescribe 01: Prescription Writing**] on induction to the Health Board, this package includes prescribing in both hospital and general practice settings.

Handwritten prescriptions

Each prescription must be legal, legible, unambiguous, and written or printed in black indelible ink that can be photocopied (NB: erasable pens must not be used). Upper or lower case may be consistently used. It is good practice for prescribers to add their appropriate professional registration number to the prescription.

Computer generated prescriptions

A computer-generated prescription is acceptable, however, in Wales the prescriber's signature must be handwritten.

The planning, development and implementation of any electronic prescribing system for PTHB inpatients must be approved by the PTHB Executive Team.

Electronic prescribing is limited to prescribers trained in use of the system and authorised to prescribe.

INPATIENTS

All Wales Medication Administration Record

The current version of the agreed All Wales Long-Stay Medication Administration Record and additional specific prescribing documents (supplementary charts e.g. anticoagulant, insulin, infusion or syringe driver) must be used for all prescribing for inpatients in general wards and the All Wales Mental Health Medication Administration Chart in mental health wards.

Details of charts can be found in the Inpatient Medication charts section

Inpatient Transfers

When a patient is transferred into Powys from another organisation (including English NHS Trust), to ensure continued medication administration, good planning is necessary to ensure a PTHB inpatient medication administration chart is in place. See SOP – Medication Chart on Transfer of Patients to PTHB from External Organisations (under development).

Most NHS Medicines Policies preclude organisations from sending an original medication chart to another organisation for governance and contemporaneous record keeping arrangements. Many organisations are now moving away from paper medication charts to electronic prescribing and administration systems.

PTHB Care Transfer Co-ordinator, ward, Pharmacy and Medical teams should work together with the transferring hospital to ensure a PTHB medication chart is in place for when the patient arrives on a PTHB ward e.g advance notice of current medication which can be prescribed on a PTHB inpatient medication chart by a PTHB doctor.

Absence of Inpatient Medication Chart

Receiving teams should work with any transferring DGH and Care Transfer Co-ordinators to ensure that medicines information is received by the receiving ward whilst the doctor is still on the ward, so that an inpatient medication chart can be prepared.

If a patient arrives out of hours without a medication chart in place the following should be considered to mitigate the clinical risk to the patient of missed doses: -

- Use of the Homely/Discretionary Medicines Policy by trained registered ward staff if appropriate.
- ShropDoc have a supply of PTHB inpatient medication charts and may be able to supply remotely and send to the ward by taxi.
- If the patient has arrived with a supply of medication which is labelled for that patients with clear directions for use and has been

dispensed within the last 28 days and there is nothing to suggest a change in treatment (discuss with medical staff as necessary). This medication may be used without a medication chart in place, where the dispensing label provides the authority to administer. The administration must be clearly documented in the WNCR or the patient's paper nursing record and in the patient's medical notes and crossed checked and annotated on the medication chart when it arrives. This process should only be used for a few hours whilst awaiting the medication chart to arrive.
- Verbal orders may be considered – see Verbal Order section.

Medical staff should be requested to prepare an inpatient medication chart at the earliest opportunity.

Special Additional (Supplementary) Charts

The following supplementary charts are recognised for use in PTHB:-
- Anticoagulation chart
- Insulin chart
- Syringe driver chart
- Supplementary infusion chart
- Patient controlled analgesia/epidural Chart

Where a separate additional (supplementary) chart is used, the medicine must still be prescribed on the All Wales Medication Administration Record. A time can be specified but no dose should be recorded and the words "see additional chart" must be written across the record of medication administration boxes. This minimises the risk of the medication, on the supplementary chart, being missed on the medication round. The use of any supplementary charts should be clearly marked on the front page of the All Wales Medication Administration Chart.

Prescribing on both the inpatient medication administration record and supplementary chart must be by an authorised prescriber.

Charts must not be photocopied for use, they must be ordered via standard stationery orders – see Stationery and Records section

Accepted Abbreviations

Accepted Abbreviations - Routes of administration

Abbreviation	Meaning
PO	oral
SL	sublingual
IV	intravenous
IM	intramuscular

SC	subcutaneous
PR	rectal
PV	vaginal
INH	inhaled
NEB	nebulised
PEG	via PEG tube
PEJ	via PEJ tube
NG	via nasogastric tube
NJ	via nasojejunal tube
TOP	topical

Accepted Abbreviations - Frequency of administration

Abbreviation	Latin	Meaning
a.c.	ante cibum	before food
p.c.	post cibum	after food
o.d.	omni die	every day (once a day)
b.d.	bis die	twice a day
t.d.s.	ter die sumendum	Three time a day
q.d.s.	quarter die sumendum	four times a day
o.m.	omni mane	every morning
o.n.	omni nocte	every night
q.q.h.	quarta quaque hora	every 4 hours
p.r.n.	pro re nata	when required
stat	statim	immediately

Accepted Abbreviations – Dosage Units

Abbreviation	**Meaning**
Dosage units	
kg	kilogram
g	gram
mg	milligram
L	litre

ml or mL	millilitre
Units must be written in full	
Micrograms must be written in full	

- Make a clear separation between numbers and letters that form part of the unit of measurement
- The only acceptable abbreviations for weight are 'g' and 'mg'
- 'Units' (with regard to insulin, heparin, etc.) must always be written in full, never as 'u' nor 'IU'
- Avoid decimal points (i.e. use '500 mg' not '0·5 g'). If a decimal point cannot be avoided, always put a '0' in front of it (i.e. '0·5 micrograms' not '·5 micrograms'). Don't use a decimal point if the number is a round number (e.g. '7 mg' not '7·0 mg')
- For liquid preparations write the dosage unit e.g. 'mg' or 'microgram'. The only exceptions when 'mL' can be written are if the product is a combination product (e.g. Gaviscon® liquid), or if the strength is not expressed in weight (e.g. adrenaline 1 in 1000)

COMMUNITY PATIENTS

For patients requiring medicines administration in the community, by PTHB community teams, the dispensed medication label provides directions and legal authority for use.

The All Wales Long-Stay Medication Administration Record and supplementary charts (e.g. anticoagulant, insulin or syringe driver) can also be used to document administration. Transcribed or prescribed?

For end of life patients the All Wales Care decisions, for the Last Days of Life pathway should be used.

For patients receiving domiciliary care level 2 medicines administration support, the All Wales Community MAR chart may be in use, which will be provided by the dispensing community pharmacy or GP practice.

OUTPATIENTS – WP10 or WP10(HP) prescriptions

Prescribing for PTHB outpatients, community or primary care patients should be through use of the relevant legal prescription document (WP10) and in accordance with - SOP - Specific Requirements for Receipt, Storage and Distribution of WP10 Prescription Pads (under development) [link] and controlled stationery section

When considering prescribing in an outpatient setting, prescribers are reminded about the Welsh Health Circular – Medication Supply to Hospital Patients (WHC (2002) 71)

> *Hospital outpatients should only receive their initial supply of medication from the hospital when there is an urgent clinical need. The consultant should request that the General Practitioner considers initiating or continuing treatment. In order to facilitate a General Practitioner's compliance with local prescribing formularies, consultants should, wherever appropriate, recommend a class of drug to be prescribed by the General Practitioner, rather than a specific individual drug or brand.*

In view of the above PTHB prescribers should initiate prescribing using their WP10 prescription pads: -

- Where the need for the medicine is urgent (i.e. where the treatment needs to be started before the GP can reasonably be expected to issue a prescription after receiving full details of the requirements).
- Where the treatment choice requires assessment or adjustment and the prescriber is keeping the patient under their care.
- The level of medical risk indicates that prescribing responsibility should be initiated and retained by the specialist.
- Where management is under shared care guidelines where it has been agreed initiation and initial management will be commenced before handing over prescribing for that particular medicine to the GP.

Medication not required under the circumstances above should be recommended by letter to the GP for them to prescribe.

Where a WP10 prescription is required: -

- The prescriber must have access to the patient's full medical and drug history to ensure no unintentional drug interactions.
- Generally, the same prescribing requirements as for prescribing on the All Wales Medication Administration Record apply to outpatient prescriptions. See Prescribing Controlled Drugs
- The prescription must be signed and dated by the prescriber.
- Unless a course of treatment is required, a prescription should be issued for an original pack of medication (normally 28 days' supply).
- Where a course of treatment is required (e.g. antimicrobials), the full course of treatment should usually be prescribed
- Prescribing of medications on a WP10 form must be in line with the PTHB formulary.
- Prescribing by non-medical prescribers must be in line with their approved scope of practice and formulary.

- Community nurse or 'limited list' prescribers must prescribe in accordance with the Nurses Prescribing Formulary.

Valid WP10 prescriptions:-

https://psnc.org.uk/dispensing-supply/receiving-a-prescription/is-this-prescription-form-valid/

Form type	Colour of form	Who can use or what they are used for	Further information
WP10 WP10SS WP10SP WP10HP WP10HSP	Green	GPs, hospitals and supplementary prescribers.	Forms annotated with the initials RD are repeat dispensing forms. Forms annotated with the initials RA are repeat authorisation forms. • WP10(HP) prescriptions – prescriptions stamped with a Powys tHB Hospital name, address and V number • WP10(IP) prescriptions – prescriptions stamped with independent prescribers name, address (may be a GP practice or hospital address) and J number for GP practice addresses.
WP10D	Green	Dentists in primary care.	Only items listed in the dental formulary can be prescribed on this prescription. https://bnf.nice.org.uk/guidance/prescribing-in-dental-practice.html
WP10CN WP10PN	Green	Nurse prescribers.	Only items listed in the relevant formularies can be prescribed on this prescription - https://bnf.nice.org.uk/nurse-prescribers-formulary/ • WP10(CN) prescriptions – prescriptions stamped with the nurse prescribers name, address and Q number.
WP10MDA WP10HP(AD)	Green	Instalment dispensing prescription form.	More information on can be found on the PSNC Instalment Dispensing page.

Antimicrobial Prescription Requirements

Antimicrobial treatment must not be started in the absence of clinical evidence of infection. Antimicrobial prescribing should be in accordance with the national antimicrobial guidelines.

Prescribers must ensure the following is documented for all antimicrobial prescriptions, on the medication chart or patient record as appropriate:

- Indication (for inpatients include on the medication chart)
- Course start date, duration or review/stop date
    - For inpatients add an X in the administration section after the last dose is due.
    - IV antimicrobial therapy should be reviewed 48 - 72 hours after initiation and switched to oral treatment after this time wherever possible. IV antibiotics should only be continued beyond 48-72 hours if recommended by local guideline or microbiologist. Rationale for continuing IV must be clearly documented and reviewed every 48-72 hours.

If the All Wales antimicrobial inpatient medication record is not in use then the PTHB agreed antimicrobial sticker must be applied to the prescribing section of the inpatient medication chart. The stickers are available from the ward Pharmacy team and guide the prescriber to include, indication for use, course length and review dates.

Prescriber's signature

A single prescriber's signature confirms the prescription of all items prescribed on a WP10 or WP10(HP) prescription form.

For inpatients - all items on the All Wales Medication Administration Record or additional charts must bear the date and full signature of the authorised prescriber and their contact telephone number. The name of the prescriber must be clearly identifiable.

The signature of a medical student is not acceptable.

Specific Prescription Requirements – Inpatients

- For regular medication the prescriber must use the 24-hour clock or preset drug round times to indicate administration time. With the exception of time critical medication e.g. in Parkinson's disease medication, where the exact time of administration should be indicated.
- For "as required" medicines the times of administration must be written by the prescriber where relevant, e.g. hypnotics. The maximum frequency must be stated, as well as the maximum dose,

within 24 hours. It is good practice to also state the indication for "as required" medication e.g. for the relief of pain.

- For some medications it may be easier to define a maximum 24 hour dose (e.g. for nebulised salbutamol). In these situations the frequency of dosing must be prescribed but the time may be determined locally, in accordance with an agreed protocol or procedure.
- The duration of treatment must be clearly indicated by the prescriber where this is less than the number of day/time spaces available on the prescription sheet, e.g. five days for oral antibiotics or 48 hours for IV antibiotics.
    - In line with good practice, a cross should be made through the administration section of the chart from the day the course should have completed. This will avoid inadvertent administration.

Specific Prescription Requirements

Theatres/Endoscopy/Day Case

Pre-medication is medication prescribed prior to surgical procedures and should be prescribed in the 'once only' section of the All Wales Inpatient Medication chart or within the appropriate PTHB agreed surgical pathway document.

Pathway documents may include pre-printed prescriptions which must be signed by the anaesthetist/surgeon to confirm authority to administer to the individual named patient.

The anaesthetist should prescribe any pre-medication (before surgical procedures) that are anticipated will be needed.

Where separate charts are used e.g. epidural, anaesthetic or patient-controlled analgesia charts, these must be cross-referenced on the patient's main prescription chart or pathway document.

Where medications or pharmaceutical products are included in procedure pathway documents, these pathways must be agreed with the Medicines Management team and meet PTHB governance requirements.

Multiple Medication Charts

When more than one All Wales Medication Administration Record exists the front of each should state '1 of 2', or '2 of 2' and these should be attached or kept (e.g. ring binder folder) together.

If multiple changes have been made to a prescription chart, or it is not possible to fit all medicines onto one chart, it is more appropriate to write a fresh one to minimise the number in use for the patient.

Medication Specific Requirements

Insulin

In addition to all the usual prescribing standards, the following must also be clearly identified on the prescription for all prescriptions for insulin:

- Brand
- Source of the insulin if not human eg. porcine.
- Strength of the insulin ie 100 units/mL, 300 units/mL
- Type of insulin device i.e.10ml vial, 3ml cartridge or 3ml disposable pen
- Date and time / frequency that insulin should be administered
- Dose or dose-range, and route of administration
- Dose ranges must be expressed with the word "to". e.g. "6 to 8 units" and not "6-8 units".
- The word 'units' must be written in full and clearly away from the dose to avoid misinterpretation of the 'u' as a zero.
- A new insulin chart, (rather than a new line on the same chart), must be started for the prescribing of insulin when the administration section boxes have all been completed.

Oral Anticoagulants

When prescribing warfarin or phenindione for inpatients, the additional PTHB anticoagulant chart must be completed and crossed referenced to the All Wales inpatient administration chart. The following should be recorded on the All Wales inpatient administration chart – the drug name in a medication box, the administration time and the words "see anticoagulation chart" must be written across the record of medication administration boxes (the dose must not be specified). This minimises the risk of the medication, on the supplementary chart, being missed during the medication round.

The oral anticoagulant chart must be used to prescribe the individual daily doses of anticoagulant and for recording the INR results as appropriate.

In addition to all the usual prescribing standards, all sections of the additional oral anticoagulant chart (warfarin or phenindione) should be completed as directed. These include:

- Date and time for administration of anticoagulant
- Indication for use
- Record of the baseline INR
- The approved name of the drug

- Target INR for the patient and an indication of whether the anticoagulant is newly commenced or continuation therapy, or whether the anticoagulant should be given at its usual maintenance dose
- Indication of when the next INR test is due
- INR on the specified date and the dose of anticoagulant to be administered on that date
- When doses of anticoagulant are to be omitted, this should be indicated on the anticoagulant chart and the appropriate non administration code used and initialled against.

Direct-Acting Oral Anticoagulants (DOACs) i.e apixaban, rivaroxaban, edoxaban or dabigatran must be prescribed on the All Wales inpatient administration chart in the same way as for other medications.

Prescribing in Pregnancy & Lactation

The UK Teratology Information Service provides information about medication in pregnancy, including information for patients, this can be accessed via: https://www.medicinesinpregnancy.org/

Information relating to the safety of medicines in pregnancy can be accessed via: https://www.sps.nhs.uk/home/guidance/safety-in-pregnancy/

Information relating to prescribing in breastfeeding can be accessed via: https://www.sps.nhs.uk/home/guidance/safety-in-breastfeeding/

High Risk Medicines

High risk medicines are those medicines that have a high risk of causing significant patient harm or death when a prescribing, dispensing, administration or monitoring error is made, eg methotrexate.

Although errors may or may not be more common than with other medicines, the consequences of errors with these medicines can be devastating.

AWMSG and PrescQipp have produced useful resources for critically reviewing medication, including medicines defined as high risk. Patient Safety Wales issues patient safety alerts and advice relating to high risk medicines where necessary.

See Incidents involving medicines section.

Prescribing for patients detained under 'The Mental Health Act 1983'

Circumstances may arise where a patient is detained under The Mental Health Act and will need medication prescribed either by consent or against the patient's wishes. The prescribing clinician must ensure that any prescribing will be in accordance with the current legislation set out under the Mental Health Act (1983). See Mental Health Policies

Validity of Prescription – Prescription Length

All prescriptions should be reviewed regularly based on clinical need, for example when clinical condition changes, another drug is added or stopped, monitoring is required, side effects are experienced, guidelines suggest review points or when a new prescription chart is started.

All Wales Medication Administration Record

- Long stay All Wales Medication Administration Records have a duration of 33 days, with a prompt to review and rewrite at 31 days.
- The duration of the course of treatment should be clearly indicated on the patient's medication record using the prescription and administration sections to indicate course lengths. Unless the duration of the course of treatment is clearly specified the prescription will be considered to be valid until cancelled.
- The prescription must be rewritten by a PTHB employed or engaged prescriber if the patient is readmitted or transferred from another organisation or hospital external to PTHB – see Inpatient Transfers
- The use of the medication chart when all administration boxes have been filled is prohibited.
- Pharmacists may transcribe unchanged medication to a new medication chart in accordance with the PTHB Transcribing by Pharmacists Policy (under development) [link].

Antimicrobial Prescribing

Antimicrobial prescription length must be in accordance with agreed formulary guidance and Start Smart then Focus principles. The course duration or review date must be clearly stated on the medication chart (inpatient) and patient record (all areas) at the outset of treatment.

IV antimicrobial therapy should be reviewed 48 - 72 hours after initiation and switched to oral treatment after this time wherever possible. IV antibiotics should only be continued beyond 48-72 hours if recommended by local guideline or microbiologist. Rationale for continuing IV must be clearly documented and reviewed every 48-72 hours.

WP10 & WP10 (HP) Prescription Validity

Prescriptions, **excluding** Schedule 1 to 4 controlled drugs, are valid for 6 months from the date of the prescription.

The date on the prescription can be:
- The date it was signed by the health professional who issued it, or
- A date that the health professional has indicated the prescription should not be dispensed before.

If the prescription shows both of these dates, the 6 months starts from the later date.

For outpatient and discharge prescriptions, unless a course of treatment is required, a prescription should usually be issued for an original pack of medication (normally 28 days' supply). Where a course of treatment is required e.g antimicrobials then normally the whole course would be prescribed.
Patients should be discharged from Powys community hospitals with a minimum of 14 days' supply of medication, unless advised by a pharmacy professional that other arrangements are in place.

See CD section for specific legal requirements for controlled drug prescription lengths and validity.

The PSNC have produced guidance on: -
Note FP10 quoted on the website is equivalent to WP10 in Wales
- Period of prescription validity
- https://psnc.org.uk/dispensing-supply/receiving-a-prescription/is-this-prescription-form-valid/

Where patients are stable on their prescribed medication, 56 day prescribing is encouraged in primary care. GP practices are also encouraged to work with community pharmacies to maximise the appropriate use of repeat dispensing for prescriptions (not including Schedule 2 or 3 controlled drugs), where repeatable prescriptions are valid for 12 months from the signed date.

Controlled Drugs

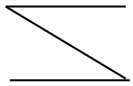
See Controlled drugs section

Discontinuing Medicines (Inpatients)

The date when a medicine is discontinued must be entered in the administration box with the prescriber's full signature.

A diagonal line must be drawn through the prescription so that cancellation is obvious, but the prescription is not obliterated. It is also advisable to cross through the administration side of the All Wales Medication Administration Record.

– *e.g.*



Incorrect entries must be scored through and the word 'cancelled' written against it by the prescriber.

Medicines prescribed on authorised separate (supplementary) charts must be discontinued on both the supplementary chart and any cross reference on the inpatient medication administration chart.

Course lengths, where appropriate, must be defined and the administration record space be crossed through (as above) for dates beyond the course length.

Clarification of Prescriptions and Amendments

Pharmacy Professional Inpatient Interventions or Endorsements

Hospital pharmacy professionals may clarify a prescriber's intention, e.g. adding the generic name or clarifying ambiguous prescribing. These endorsements are usually written in green ink (Pharmacist) or red ink (Pharmacy Technician or Pre-registration Pharmacy Technician) and initialled by the Pharmacist/Pharmacy Technician. Trainee Pharmacists (working under supervision of a Pharmacist) will endorse with purple pen. Other unsigned alterations invalidate a prescription.

Hospital Pharmacists or Pharmacy Technicians will also help to ensure the appropriate, safe, evidence-based and cost-effective use of medicines in Powys.

The PTHB Transcribing by Pharmacists Policy (under development) [link]. defines the amendments and endorsements that PTHB Pharmacists can make to the inpatient medication chart.

The Procedure for Amending Inpatient Medication Charts (under review) [Link] by PTHB Hospital Medicines Management Technicians defines what amendments and endorsements a PTHB Pharmacy Technician can make to the inpatient medication chart.

The pharmacy professional will make a record of any intervention made through the PTHB agreed Pharmacy interventions tool or other nationally or locally agreed database.

Prescription Amendment by a Pharmacy Professional

Any alteration made by a pharmacy professional must be legible, dated and it must identify the pharmacy professional who made the change. It will specify, when appropriate, the clinician who agreed the amendment.

Where amendments would decrease readability, the entry can be rewritten by a pharmacist (this is referred to as transcribing). It is permissible to administer the medicine without a medical countersignature if the medication has been transcribed by a Pharmacist. See Transcribing section

Rewriting Inpatient Prescriptions

If a change of dose, frequency or route of administration is required the All-Wales Medication Administration Record allows for one amendment to be made. If further amendments are required, the whole prescription must be rewritten, and the original entry cancelled. It should be indicated on the record that the treatment was reviewed and the date of rewriting.

It should be ensured that any original course lengths e.g. antibiotics are maintained when re-writing prescriptions, as appropriate.

It is the responsibility of the prescriber to make nursing staff aware of any changes to a patient's prescribed medication to ensure that they are familiar with the change and any administration arrangements and arrange any new medication from pharmacy if necessary.

The medication chart must be rewritten by a PTHB employed or engaged prescriber if the patient is readmitted or transferred from another organisation or hospital external to PTHB. Care Transfer Coordinators must facilitate this process to ensure a PTHB medication chart is in place at transfer of care – see inpatient transfer section.

Clinical pharmacists may use their discretion to transcribe medications for patients readmitted or transferred from an organisation or hospital external to PTHB in accordance with the PTHB Transcribing by Pharmacists Policy (under development) [link].

Verbal Orders and Remote Prescribing

A registrant has the unconditional right to refuse to give a drug ordered verbally. When doing so they must notify the prescriber of their refusal and reasons and document their reasons within the patient record.

It is emphasised that verbal / faxed or e-mailed orders from prescriber's involve significant risk and therefore the reasons requiring the use of a verbal order must be clearly stated in the patient's notes.

Verbal Orders – Inpatient Setting

The RPS and NMC have produced joint professional guidance on the administration of medicines which advises that verbal orders should only be used in exceptional circumstances, where a change or addition to the administration details is required and a delay in administering a medicine would compromise patient care.

The person administering the medicine(s) must be satisfied that it would not be in the patient's best interest for the administration of the medicine to be delayed until a written prescription was received.

Verbal orders can amend, delete or add a prescription item, but must not be utilised for Schedule 2 or 3 controlled drugs or from non-medical prescribers.

- The registered nurse taking the verbal order must ensure the prescriber is aware of the full medical history of the patient, patient's current clinical condition, any other medication prescribed and any documented allergies.
- The registered nurse taking the verbal message must be familiar with the medicinal product and the name of the drug.

The registrant taking the verbal order should document the instruction onto the 'once only' section of the front of the inpatient medication chart or in the administration section of the chart if omitting a medication (using the appropriate administration code) and a second registrant must read this back to the prescriber, ensuring that the following are confirmed:

- the patient identity – name and DOB (hospital or NHS number if possible)
- name of medicine – name spelt out to avoid confusion
- dose to be administered – (numbers given as individual digits to avoid confusion e.g 50mg as five zero milligrams)
- frequency of administration
- route of administration
- circumstances of use e.g for pain relief or any other requirements for administration
- Any instructions to delay or omit a medication
- the prescriber's identity

Verbal orders must be backed up by a documented message from the prescriber e.g by e-mail to an NHS e-mail account, which must be printed and kept in the patient's medical record.

Regular prescriptions must not be commenced on a verbal order.

The entry documented in the 'once only' section must be clearly marked as a "verbal order", clearly naming the prescriber making the order and all normal documentation concerning the administration must be completed. The witness to the verbal order should countersign the entry on the 'once only' section of the All Wales Medication Administration Record.

In areas where doctors are not on site, the telephone / verbal order entry on the inpatient medication chart for prescription only medicine must be signed as soon as possible, ie the next working day. This will usually be within 72 hours (though it could be longer over public holidays) or when a local review can be undertaken by an approved prescriber of PTHB.

Where a GP Out of Hours service is in operation, the prescriber giving verbal instructions can arrange for a second prescriber to countersign the verbal order. It is the responsibility of the prescriber giving the verbal order to arrange for the medication to be countersigned.

In areas where doctors are not on site, doses may be administered for up to 72 hours without the doctor's signature until the verbal instructions are signed by a prescriber. In the absence of a doctor's signature no further doses should be administered on the basis of a verbal order beyond 72 hours of the verbal order being received and a doctor must attend the ward to sign the prescription.

Verbal Orders – Life Saving Situations

The policy on verbal orders does not apply to the verbal face to face order given in person during a resuscitation situation, where the authorised prescriber is present at the time of the request. In a life saving situation, drugs (including Controlled Drugs) may be given by healthcare professionals prior to formal authorisation to administer on an approved medication chart.

It is the responsibility of the prescriber to ensure that this is recorded on the approved chart immediately after the event, and for the administering staff to then sign and document as necessary.

Administration of medicines in an emergency may be covered by Administration for the purpose of saving life in an emergency

Verbal orders to pharmacists – corrections

Corrections by telephone can be given by a prescriber to a pharmacist to amend delete or add a prescription item. This need often results from a pharmacist-initiated query. Having confirmed the identity and name of the

patient with the prescriber, the pharmacist must confirm the following details:

- the patient identity – name and DOB (hospital or NHS number if possible)
- name of medicine – name spelt out to avoid confusion
- dose to be administered – (numbers given as individual digits to avoid confusion e.g 50mg as five zero milligrams)
- frequency of administration
- route of administration
- circumstances of use e.g for pain relief
- the prescriber's identity

The pharmacist must have access to sufficient information to assure themselves of the appropriateness of the medicine and dose. The pharmacist must read the alteration or addition back to the prescriber who must then affirm the original instructions. The pharmacist will then amend the in-patient medication record, recording the name of the prescriber who has been contacted, then sign and date the amendment.

If the alteration is to formulation, frequency or timings of dose, then that part of the prescription may be crossed out and altered to ensure that the alteration is clear.

If the alteration involves any other changes e.g. new medicine, change in dose, then the whole prescription for that item must be written out as a new entry on the in-patient medication record. This change must be countersigned by the prescriber within 72 hours of the entry being made.

Remote Prescribing

Remote consultations provided over the phone, via video-link, online, or using any other non face-to-face medium can benefit patients, save resources and help meet the demands of the service user. However, there can be safety risks, particularly when services are not linked to a patient's NHS GP or regular healthcare provider, and where there may be limited access to a patient's medical record.

Registered healthcare professionals are expected to follow ten high level key principles when providing remote consultations and prescribing remotely to patients :-

1. Make patient safety the first priority and raise concerns if the service or system they are working in does not have adequate patient safeguards including appropriate identity and verification checks.
2. Understand how to identify vulnerable patients and take appropriate steps to protect them.

3. Tell patients their name, role and professional registration details, establish a dialogue and make sure the patient understands how the remote consultation is going to work.
4. Explain that:
    a. They can only prescribe if it is safe to do so.
    b. It's not safe if they don't have sufficient information about the patient's health or if remote care is unsuitable to meet their needs.
    c. It may be unsafe if relevant information is not shared with other healthcare providers involved in their care.
    d. If they can't prescribe because it's unsafe they will signpost to other appropriate services.
5. Obtain informed consent and follow relevant mental capacity law and codes of practice.
6. Undertake an adequate clinical assessment and access medical records or verify important information by examination or testing where necessary.
7. Give patients information about all the options available to them, including declining treatment, in a way they can understand.
8. Make appropriate arrangements for after care and, unless the patient objects, share all relevant information with colleagues and other health and social care providers involved in their care to support ongoing monitoring and treatment.
9. Keep notes that fully explain and justify the decisions they make.
10. Stay up to date with relevant training, support and guidance for providing healthcare in a remote context.

Remote prescribing should only ever be used when all other options have been exhausted. E.g. anticipated need prescribing (e.g end of life drugs), independent or supplementary (with a clinical management plan in place) prescriber, supply under Patient Group Direction (PGD) assessment, or administration of an authorised P or GSL medication under the discretionary medicines policy.

The prescribing of schedule 2 and 3 controlled drugs is never allowed by remote prescription

Complementary and Alternative Therapies

NHS Wales through AWMSG does not endorse the use of complementary or alternative therapies. Complementary and alternative therapies include, but are not limited to:

- Acupuncture
- Alexander technique
- Aromatherapy
- herbal medicine
- homoeopathy
- hypnosis

- massage
- nutritional therapy
- reflexology

Public Health Wales publication 'Complementary Therapies and Alternative Medicines' (2012) stated:

> '*Complementary medicines/alternative therapies are generally NOT used by the NHS. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. On existing available evidence the LHB will not support referral outside of the NHS for these services. Prior approval is required on a case by case basis for any requests outside the above criteria. The request for referral would need to be supported by evidence of the clinical effectiveness of the treatment and be to appropriately trained and qualified practitioners with recognised qualifications.'*
>
> 'The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up-to-date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of the NHS library.'

An IPFR request is required for all other circumstances

Physiotherapy use of Complementary Therapies

The Chartered Society of Physiotherapy (CSP) have produced advice on the place of complementary therapies as part of physiotherapy practice and notes some complementary therapies lack evidence base and are no longer considered part of the scope of practice of Physiotherapists.

The CSP do recognise the effectiveness of acupuncture, exercise, massage and Pilates and AWMSG notes in the Prescribing Dilemmas document:

> *Please note physiotherapists can decide to use certain alternative therapies (acupuncture, Alexander Technique, massage) as part of their NHS treatment plan if they consider it appropriate*.

Self administration of Complementary Therapies

If a patient chooses to self-administer their own supply of a complementary medication whilst an inpatient or while under PTHB care in a community setting. Then if the doctor looking after the patient does not have good

knowledge of the complementary medication, the Medicines Management team or DGH pharmacy should be contacted regarding the safety and quality of the product and any interactions with other medications or disease state. Any recommendations should be discussed with the patient.

If it is decided that it is safe for the patient to continue administering, the prescriber should make an entry on the All Wales Medication Administration Record of the preparation, with a note stating that the patient has chosen to self-administer and include any recommendations discussed.

End of Life Anticipatory Prescribing – Just in Case Scheme

Also known as 'Just in Case' boxes/bags these can be prescribed in advance to patients in the community for whom it is anticipated that their medical condition may deteriorate into the terminal phase of illness. The pack contains medications necessary to help alleviate symptoms.

Further information on anticipatory prescribing and the 'just in case scheme' can be found at https://collaborative.nhs.wales/implementation-groups/end-of-life-care/

It is important to ensure that anticipatory medicines are prescribed well in advance to ensure that there are not difficulties in sourcing medication at the point of patient deterioration. These 'Just in Case' medicines should usually be made available in the last two to three months of life.

Shared Care

Shared Care Agreements aim to facilitate the sharing of care and treatment of more complex conditions/treatments between specialists and primary care clinicians. Shared care agreements allow treatments that have been started by a specialist to be continued in primary care, providing patients' with more convenient access to care.

Shared Care Agreements are intended for medicines that are not routinely initiated in primary care and require long-term regular monitoring. The responsibilities of the specialist and the primary care clinician, along with the monitoring requirements/arrangements are set out in a formal shared care agreement for the specific treatment.

Where a medicine has a shared care agreements in place; the agreement or protocol can be found alongside that medication in the Powys Formulary.

It is the responsibility of the specialist who initiates treatment to provide the primary care clinician with a copy of the shared care agreement and invite them to participate in shared care. Both the specialist and the primary care clinician need to agree the conditions specified in the Shared

Care Agreement. If an agreement is not reached, treatment will continue to be provided by the specialist.

AWMSG has provided best practice guidance and templates on Shared Care Prescribing.

Medicines Reconciliation

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list(s) in use, recognising any discrepancies and documenting any changes, thereby resulting in a complete list of medicines that is accurately communicated.

'Medicines Reconciliation' is one of the basic principles of good medicines management.

Every time a patient is transferred from one healthcare setting to another it is essential that accurate and reliable information about the patient's medication is transferred at the same time. This enables timely, informed decisions about the next stage in the patient's treatment.

NICE Guidance NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes recommends sharing relevant information about medicines when people move from one care setting to another. Medicines errors can happen when people move between services.

It is important that all healthcare professionals involved in the admission of a patient actively support establishing an accurate medication history. PTHB Pharmacists and Pharmacy Technicians are responsible for ensuring that all inpatients have undergone a Medicines Reconciliation process, ideally within 72 hours of admission as recommended in the NICE guidance, utilising information from at least two different recent and reliable resources. Additionally, the patient, relatives or carers must be included, in the process where possible, to provide information regarding compliance and any medication purchased over the counter (OTC).

Further information can be found in the PTHB Medicines Reconciliation Procedure (under review)

Documenting Medication Allergies

All healthcare professionals must ensure that the patient's allergy status has been determined and recorded in any medical, nursing or clinical notes and for inpatients on the All Wales Medication Administration Record. Where possible details of the nature and severity of the allergy must be

ascertained and documented in the entry. The entry must be signed and dated.

Where no known allergy exists, it is good practice to also note this, where the All Wales Medication Administration Record is in use, the 'Allergies box' should be annotated 'No known allergies' (NKA or NKDA **are not** acceptable abbreviations) and this must be signed and dated.

- It is critical that patient's allergies are identified as soon as possible and on any admission to hospital. Every effort should be made to clarify the allergy status from any reliable source including relatives/carers/GP/community pharmacy.
- Any registered medical, nursing, pharmacy or other registered health professional staff who regard themselves as competent, may take measures to ascertain the allergy status of a patient.
- Any healthcare professional encountering an All Wales Medication Administration Record or other clinical record, prior to administration or supply of a medicine, that does not have a documented allergy status should **not** administer or supply medication until the allergy status has been determined.
- For patients whose allergy status cannot be determined appropriate medical or senior healthcare staff should be contacted so that a decision may be taken on whether administration or supply of medicine should proceed.
- All information should be documented by the administering or supplying healthcare professional, including from whom advise was obtained and communicated to colleagues as appropriate.

Note: the above advice does NOT apply in the emergency situation for patients requiring potentially life-saving medication.

Self Prescribing/Prescribing for Friends or Family

PTHB follows guidance provided by the professional group regulatory bodies covering prescribers:

- Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with. The professional judgement of the prescriber may be impaired or influenced by the person they are prescribing for.
- The GMC advises within the "Good Practice in Prescribing and Managing Medicines and Devices Updated March 2022"
    - Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with.
    - If you prescribe any medicine for yourself or someone close to you, you must:
        - make a clear record at the same time or as soon as possible afterwards; the record should include your

relationship to the patient, where relevant, and the reason it was necessary for you to prescribe
        - follow advice on information sharing and safe prescribing
    - You must not prescribe controlled drugs for yourself or someone close to you unless:
        - no other person with the legal right to prescribe is available to assess and prescribe without a delay
        - emergency treatment is immediately necessary to avoid serious deterioration in health or serious harm.
- The NMC Code advises: wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribers are reminded that medications available in PTHB clinical areas are for the sole use of administering to current PTHB patients and use by members of staff will be considered theft. Prescription pads (WP10 forms) are controlled stationery and must only be used for prescribing to PTHB registered patients.

CONTROLLED DRUGS

This is a dedicated section around the management of controlled drugs and pulls all controlled drugs aspects together but still links with the other sections of this Medicines Policy.

Much of this section is based on NICE Guidance NG46 and any legislative updates

This section should be read in conjunction with the PTHB standard operating procedures for controlled drugs management

Controlled Drugs Accountable Officer (CDAO)

The Accountable Officer for Controlled Drugs is the PTHB Chief Pharmacist.

This is a legally required role under the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008. The CDAO has accountability for the safe management and use of controlled drugs in the local area, including responsibility for the investigation and action around concerns about individuals and controlled drugs management. The CDAO is also responsible for setting up a Local Intelligence Network (CDLIN) to have oversight of the management and use of controlled drugs.

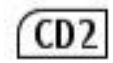
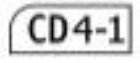
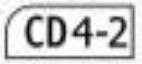
The current list of Controlled Drugs Accountable Officers can be found - https://hiw.org.uk/accountable-officers-controlled-drugs

Controlled Drugs Local Intelligence Network (CDLIN)

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 require arrangements to support the safe management and use of controlled drugs in Wales. One of those requirements is to establish a CDLIN as a network to share information between organisations and agencies regarding the handling and use of controlled drugs. PTHB has an active CDLIN in place – see PTHB Controlled Drugs webpage

Controlled Drugs Schedules

Schedule 1 (CD LIC POM) - Most Schedule 1 drugs have no therapeutic use and a licence is generally required for their production, possession or supply. Examples include hallucinogenic drugs (e.g. 'LSD'), ecstasy-type substances and raw opium.

	Schedule 2 CD POM	**Schedule 3 CD No Register POM**	**Schedule 4 Part 1 CD BENZ POM**	**Schedule 4 Part 2 CD ANAB POM**	**Schedule 5 CD INV POM CD INV P**
Drugs	Opioids e.g. • Diamorphine • Morphine • Methadone • Oxycodone • Pethidine Major stimulants e.g. • Amfetamines • quinalbarbitone (secobarbital) cocaine ketamine cannabis-based products for medicinal use in humans.	Barbiturates (except secobarbital, now Schedule 2), buprenorphine, gabapentin, mazindol, meprobamate, midazolam, pentazocine, phentermine, pregabalin, temazepam, and tramadol hydrochloride.	benzodiazepines (except temazepam and midazolam, which are in Schedule 3) Diazepam zaleplon zolpidem zopiclone Sativex	Androgenic and anabolic steroids, clenbuterol, chorionic gonadotrophin (HCG), non-human chorionic gonadotrophin, somatotropin, somatrem, and somatropin	Controlled Drugs (such as codeine, pholcodine or morphine) which due to their low strength are exempt from controlled drugs requirements Nitrous oxide added to this schedule Nov 2023
BNF symbol					
CD Prescription requirements	Yes	Yes	No	No	No
Prescription Valid for	28 days after appropriate date	28 days after appropriate date	28 days after appropriate date	28 days after appropriate date	6 months

Safe Custody	Yes (except secobarbital and some liquid preps)	Yes (except phenobarbital, gabapentin, mazindol, meprobamate, midazolam, pentazocine, phentermine, pregabalin, tramadol)	No	No	No
CD register required	Yes	No	No (except Sativex – records required)	No	No
CD requisition required	Yes	Yes	No	No	No
Emergency supply allowed	No	No (except phenobarbital for epilepsy)	Yes	Yes	Yes

The BNF utilises symbols throughout the BNF to identify the different controlled drug schedules of medicines as noted above.

Controlled drug Prescribing Restrictions & Prescriber Types

Type of Prescriber	Can Prescribe Controlled drugs (Sch 2 to 5)	Can Authorise an Emergency Supply	Other considerations
Doctor registered in the UK	Yes. A Home Office licence is required to prescribe cocaine, dipipanone, or diamorphine for treating addiction Address of prescriber must be within the UK	Yes. Includes phenobarbital for epilepsy but not Schedule 1, 2 and 3 CDs	Within clinical expertise
Pharmacist Independent Prescriber	Yes (but not cocaine, dipipanone or diamorphine for treating addiction). Address of prescriber must be within the UK	Yes. Includes phenobarbital for epilepsy but not Schedule 1, 2 and 3 CDs	Medicines for any medical condition within their competence
Physiotherapist Independent Prescriber	Only the following CDs: • diazepam, • dihydrocodeine, • lorazepam • oxycodone • temazepam for oral administration only • morphine for oral administration or for injection • fentanyl for transdermal administration	Yes, but not Schedule 1, 2, and 3 CDs, including phenobarbital	Medicines for any medical condition within their competence
Podiatrist Independent Prescriber	Only the following CDs for oral administration: • diazepam • dihydrocodeine • lorazepam and • temazepam	Yes, but not Schedule 1, 2, and 3 CDs, including phenobarbital	Medicines for any medical condition within their competence

Dentist registered in the UK	Yes (but not cocaine, dipipanone or diamorphine for treating addiction) Address of prescriber must be within the UK unless prescribing Schedule 4 or 5 CDs	Yes. Includes phenobarbital for epilepsy but not Schedule 1, 2 and 3 CDs	Should restrict prescribing to treatment of dental conditions but legally can prescribe within clinical expertise. NHS dental prescriptions are restricted to medicines within the Dental Formulary (See BNF)
Supplementary Prescriber (Pharmacist, Midwife, Nurse, Chiropodist, Dietitian, Podiatrist, Physiotherapist, Radiographer or Optometrist)	Yes (but not cocaine, dipipanone or diamorphine for treating addiction) Address of prescriber must be within the UK unless prescribing Schedule 4 or 5 CDs	Yes. Includes phenobarbital for epilepsy but not Schedule 1, 2 and 3 CDs	Prescribed items are subject to clinical competence and inclusion within a clinical management plan agreed
Nurse Independent Prescriber	Yes (but not cocaine, dipipanone or diamorphine for treating addiction) Address of prescriber must be within the UK unless prescribing Schedule 4 or 5 CDs	Yes. Includes phenobarbital for epilepsy but not Schedule 1, 2 and 3 CDs	Medicines for any medical condition within their competence
Optometrist Independent Prescriber	No	Yes	For ocular conditions affecting the eye and surrounding tissue only
Therapeutic Radiographer	2023 update	Yes. Includes phenobarbital	Medicines for any medical condition

Independent Prescriber	Therapeutic independent radiographer's prescribers can now prescribe and administer, and direct others to administer, the following six controlled drugs, **by oral administration only**: a) Tramadol (note cautions in use of tramadol) b) Lorazepam c) Diazepam d) Oxycodone e) Codeine **and** a) Morphine by oral administration or by injection.	for epilepsy but not Schedule 1, 2 and 3 CDs	within their competence
EEA or Swiss registered appropriate practitioner	Schedule 4 and 5 CDs only	Yes	Can only prescribe items which have a recognised marketing authorisation within the UK
Community Nurse Practitioner	No	Yes	Restricted to dressings, appliances and licensed medicines which are listed in the Nurse Prescribers' Formulary (see BNF)
Paramedic Independent Prescriber	Changes to legislation 2023:- The Home Office has made changes to the Misuse of Drugs Regulations 2001 to enable the prescribing, supply and administering of controlled drugs by Paramedic independent prescribers.	Yes. Includes phenobarbital for epilepsy but not Schedule 1, 2 and 3 CDs	Medicines for any medical condition within their competence

	They can now prescribe and administer, and direct others to administer, the following five controlled drugs: a) Morphine sulphate by oral administration or by injection. b) Diazepam by oral administration or by injection. c) Midazolam by oromucosal administration or by injection. d) Lorazepam by injection. e) Codeine phosphate by oral administration.		

Prescribing Choice – Controlled Drugs

Making and recording prescribing decisions

When making decisions about prescribing controlled drugs take into account:

a) the benefits of controlled drug treatment
b) the risks of prescribing, including dependency, overdose and diversion
c) all prescribed and non-prescribed medicines the person is taking (particularly any centrally acting agents) and whether the person may be opioid naïve
d) evidence-based sources, such as NICE, Opioids Aware and the British National Formulary (BNF), for prescribing decisions when possible.

When prescribing controlled drugs:

a) document clearly the indication and regimen for the controlled drug in the person's care record
b) check the person's current clinical needs and, if appropriate, adjust the dose until a good balance is achieved between benefits and harms
c) discuss with the person the arrangements for reviewing and monitoring treatment
d) be prepared to discuss the prescribing decision with other health professionals if further information is requested about the prescription.

When prescribing 'when required' controlled drugs:

a) document clear instructions for when and how to take or use the drug in the person's care record
b) include dosage instructions on the prescription (with the maximum daily amount or frequency of doses) so that this can be included on the label when dispensed
c) ask about and take into account any existing supplies the person has of 'when required' controlled drugs.

When prescribing, reviewing or changing controlled drug prescriptions, prescribers should take into account the:

a) appropriate route
b) dose (including when dose conversions or dose equivalence is needed)
c) formulation (including changes to formulations). If guidance on prescribing is not followed, document the reasons why in the person's care record.

d) Prescribe enough of a controlled drug to meet the person's clinical needs for no more than 30 days. If, under exceptional circumstances, a larger quantity is prescribed, the reasons for this must be documented in the person's care record. Be prepared to justify the rationale for issuing a prescription for more than 30 days with other health professionals
e) Use a recognised opioid dose conversion guide when prescribing, reviewing or changing opioid prescriptions to ensure that the total opioid load is considered.
f) When prescribing controlled drugs outside general practice (for example in hospital or out of hours), inform the person's GP of all prescribing decisions and record this information in the person's care record so the GP has access to it.

Opioid Prescribing

Good practice in prescribing opioid medicines for pain should reflect fundamental principles in prescribing generally. The decision to prescribe is underpinned by applying best professional practice; understanding the condition, the patient and their context and understanding the clinical use of the drug.

Initiating, tapering or stopping opioid medicines should be managed in agreement with the patient and all members of their healthcare team.

Before prescribing opioids, discuss the risks and features of tolerance, dependence, and addiction with the patient and agree together a treatment strategy and plan for end of treatment.

Key messages:

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.
4. If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

AWMSG has provided updated endorsed resources on the use of opioids around alternative options and approaches, in light of patient safety alerts including: -

- Persistent Pain Resources
- Safeguarding users of opioid patches by standardising patient and caregiver counselling
- NICE (2021) NG193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain.
- RCoA Faculty of Pain Medicine (2019) Opioids Aware: Tapering and stopping opioids
- RCoA Faculty of Pain Medicine (2019) Checklist for Prescribers

Tramadol

Following a number of tramadol-related deaths and other harms, safety concerns around the use of tramadol were highlighted in 2013 and tramadol was reclassified as a Schedule 3 controlled drug in 2014.

Tramadol should not be used as a first line treatment option (see PTHB formulary)

To support the review of the use of tramadol AWMSG have produced a helpful resource, educational tool and patient information which should be followed when reviewing patients prescribed tramadol. AWMSG Tramadol Educational Resources September 2021.

Hypnotics and Anxiolytics

AWMSG have produced materials to support appropriate prescribing of hypnotics and anxiolytics across Wales which must be considered when initiating or reviewing prescribing for hypnotics and anxiolytics. AWMSG Material to Support Appropriate Prescribing of Hypnotics and Anxiolytics 2021

The Bruyere Research Institute have produced a Benzodiazepine & Z Drug (BZRA) Deprescribing Algorithm

Pregabalin & Gabapentin

All prescribers should be aware of the potential for misuse of gabapentinoids (pregabalin and gabapentin). Particular caution is required

when considering prescribing for patients with a history of substance abuse – use in such patients should be avoided wherever possible. All patients should be regularly reviewed and monitored for signs/symptoms of substance abuse (e.g. appearing to seek larger than prescribed doses, losing prescriptions, over-ordering).

To reduce the risk of abuse, if treatment is ineffective the dose should be reduced gradually and treatment stopped.

Where gabapentinoids are used in the management of pain, AWTTC have suggested tools and resources to support appropriate prescribing – these include:

- a pain scale to assess whether the patient's pain is neuropathic in nature. This will also assist in determining response to treatment. The Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) Pain Scale
- PrescQIPP Neuropathic Pain – 2021
- SIGN 136 – Management of Chronic Pain 2019

Cannabidiol oral solution – Epidyolex®

- NICE has approved the use of the cannabidiol oral solution, epidyolex for severe treatment resistant epilepsies – in conjunction with Clobazam for adjuvant treatment of seizures associated with Lennox-Gastaut (TA615) and Dravet (TA614) syndromes and AWMSG have approved for adjunctive therapy of seizures associated with tuberous sclerosis complex (TSC) for patients 2 years of age and older (December 2021, Ref 3201).
- Prescribing of cannabis-based products for medicinal use is restricted to those Clinicians listed on the specialist Register of the GMC.
- This product was re-scheduled to Schedule 5 from June 2020
- Further information can be found in the FAQs

PTHB formulary should be consulted for formulary status

Controlled Drugs and Driving

In March 2015, a new driving offence came into force. The law also includes prescription drugs, for example opioids and benzodiazepines.

Anyone found to have any of these drugs above specified limits in their blood will be guilty of an offence, whether their driving was impaired or not. The legislation does however provide a statutory 'medical defence' for

patients taking drugs for medical reasons in accordance with instructions, but only if their driving was not impaired.

Guidance has been published by the Department of Transport for Health Care Professionals on Drug Driving if a patient has a medical condition or is undergoing treatment that could impair their fitness to drive:

- explain this to the patient – it is the patient's legal duty to inform the DVLA
- advise the patient that you may be obliged to disclose relevant medical information about them, in confidence, to the DVLA if they continue to drive when they are not fit to do so
- make a record of any advice you have given to a patient about their fitness to drive

Patients who are prescribed high doses of medicines, i.e. above the maximum dose listed in the BNF/summary of product characteristics (SPC), are at a greater risk of being impaired when driving. Prescribers have a responsibility to ensure that these patients are made explicitly aware of the increased risks associated with driving whilst taking their medication. This should be considered when carrying out medication reviews and when re-authorising repeat prescriptions.

Prescribing Controlled Drugs

The above table describes who is able to prescribe controlled drugs and any restrictions that may apply.

The Misuse of Drugs (Supply to Addicts) Regulations 1997 require that only medical practitioners who hold a special licence issued by the Home Secretary (or Scottish Government's Chief Medical Officer) may prescribe, administer, or supply diamorphine hydrochloride, dipipanone, or cocaine for the treatment **of drug addiction**. This does not apply if these drugs are being used for relieving pain from organic disease or injury.

Prescribing Controlled Drugs for Inpatients

Inpatient prescriptions for controlled drugs are written in the same way as for general medications and as outlined in the Prescribing section. However, prescriptions for schedule 2, 3 and 4 controlled drugs are only valid for 28 days from the 'appropriate' date. NB: the inpatient medication chart supports administration of medicines for 33 days and therefore, as this is longer than the validity of the controlled drugs prescription, provision must be put in place to ensure that the controlled drug prescription is rewritten every 28 days where treatment beyond 28 days is required.

Where controlled drugs are prescribed with the option to be administered by different routes, each route must be prescribed as separate items and clearly stated when each should be used to avoid administration errors. Consideration must be given to different dose requirements or potencies dependent on the route of administration.

Prescribing Controlled Drugs for Outpatients or Discharge

Controlled drug Prescription Forms and Validity

The PSNC have produced useful guidance on the types of prescriptions for controlled drugs and validity.
Controlled Drug prescription forms and validity - PSNC Website

Prescriptions for CDs in Schedules 2, 3 or 4 are valid for 28 days from the appropriate date i.e. the date that the prescription was signed or any other date indicated on the prescription (by the prescriber) as a date before which the drugs should not be supplied – whichever is the later.

Prescriptions for Schedule 5 CDs are valid for 6 months from the appropriate date in line with other prescription only medicines.

Prescribing Controlled Drugs on discharge prescriptions (TTOs), Outpatient or WP10 prescriptions

The prescriber is referred for full guidance to the current edition of the British National Formulary.

Medicines that are not CDs should not be prescribed on the same form as a Schedule 2 or 3 CD (BNF).

As a summary, prescriptions ordering schedule 2 or 3 (see below for temazepam) Controlled Drugs should be:

- In the Prescriber's own handwriting, in indelible black ink OR be computer generated from an approved prescribing or electronic discharge system (the prescriber's signature must be handwritten).

- Advanced electronic signatures can be accepted for Schedule 2 and 3 Controlled Drugs where the Electronic Prescribing Service (EPS) is in place (not currently available in Wales).

- **All prescriptions must state: -**

    - The ***name and address of the patient***

        - If a person does not have a fixed address - "no fixed abode" (or "NFA") is allowed
        - use of PO Box is not acceptable
    - **Age if under 12**
    - The **preparation**, e.g. morphine sulphate.
    - The **form** of the medicine
        - The form of the medicine must be on the prescription, e.g. tablets, capsules, ampoules, vials, patches, oral solution, etc irrespective of whether it is implicit in the proprietary name
        - Abbreviations such as "tabs", "caps" etc can be used
        - It should be clear and unambiguous if the prescriber intends a supply of m/r , s/r etc.
    - the **strength** of the preparation e.g. tablets 10 mg.
        - The strength needs to be written on the prescription if the medicine is available in more than one strength
        - Where more than one strength of a medicine is prescribed on a prescription, each strength should be written separately to avoid ambiguity, meaning there should be a separate dose, form and quantity written for each strength.
    - The **dose**
        - There must be a clearly defined dose on the prescription
        - It can't be written as "to be taken as directed" or "when required". It can be written as "one to be taken as directed" or "two when required"
        - The dose doesn't need to be in both words and figures.
    - The **frequency**
        - The actual dose must be specified e.g. **one patch** every 72 hours rather than 'change patch every 72 hours' or **one** as directed rather than 'as directed'.
        - If prescribed "when required" the dosage interval between required doses must be specified (e.g. every four hours when required).
    - The **quantity to supply**
        - The total quantity must be written in both words and figures
        - Written as the total number of dose units, in both words and figures, e.g. fourteen (14) or if a liquid preparation the total volume in word & figures e.g. One Hundred (100) mL for liquids, the total volume in millilitres (in both words and figures) of the preparation to be supplied

        - for dosage units (tablets, capsules, ampoules), state the total number (in both words and figures) of dosage units to be supplied (e.g. 10 tablets [of 10 mg] rather than 100 mg total quantity);

        - The total quantity can be expressed as the multiplication of two numbers provided both components are clearly and unambiguously written in both words and figures (e.g. “2 packs of 30 tablets; two packs of thirty tablets” or "10mg x 10 (ten)").

    - **Quantity prescribed**
        - The Department of Health and the Scottish Government have issued a strong recommendation that the maximum quantity of Schedule 2, 3 or 4 Controlled Drugs prescribed should not exceed 30 days; exceptionally, to cover a justifiable clinical need and after consideration of any risk, a prescription can be issued for a longer period, but the reasons for the decision should be recorded on the patient’s notes.
          The prescriber must be prepared to justify to other health professionals why a prescription for more than 30 days supply was issued and supplies in excess of 30 days may be subject to audit.

    - The prescription must be **dated and signed** by the prescriber.
    - Where controlled drug prescriptions are written by a dentist, the words “for dental treatment only” should be present.
    - For WP10 prescriptions – state the prescribers address (must be in the UK)

Changes to Legal Classification of Codeine Linctus (P to POM)

2024 due to recent safety information revealing that codeine linctus is being used recreationally for its opioid effects, rather than for its intended use as a cough suppressant. This carries a serious risk of addiction and overdose, potentially fatal. Therefore, codeine linctus is to be reclassified from a pharmacy-only medicine (P) to a prescription-only medicine (POM).

Codeine linctus is only authorised for the treatment of dry cough and is only considered to be effective in the treatment of chronic cough lasting over 8 weeks.

Further information can be found in the Drug Safety Update.

Technical amendments of Controlled Drug Prescriptions by a Pharmacist

A pharmacist is legally not able to dispense a controlled drug if the prescription does not include all the information required to meet the legal requirements.

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

Providing the pharmacist is satisfied that they know what the prescriber intended, they can:

- Amend minor typographical errors or a spelling mistake
- Add in either the words or the figures for the total quantity if the prescriber has written one but not both

The prescription should also be marked to show that the amendments are attributable to the pharmacist (e.g. name, date, signature and GPhC registration number). If there is more than one amendment on the same prescription, each amendment must be countersigned.

Where an amendment is made by one pharmacist and another pharmacist makes the supply, the Home Office has advised that the second pharmacist should also mark the amendment to indicate that they are also satisfied and it is attributable to them as well.

No other amendments can be made to a CD prescription, e.g. if the date, strength, form, dose is missing or incorrect then the item will need to be correctly represcribed.

Prescribing for People Who Use or Inject Drugs

- No doctor may administer or authorise the supply of cocaine, diamorphine or dipipanone to registered addicts, except for the purpose of treating organic disease or injury, unless licensed to do so by the Secretary of State.
- If a newly admitted patient states that they are a person who uses or injects drugs and on medication for this, then the medication and dosage must be confirmed by a third party before prescribing or supplying.
- The third party must be either of the following:
    - The patient's GP
    - The patient's community pharmacy
    - A member of the patient's substance misuse team

- The supplier of medication in the community must also be informed of the patient's admission so that they do not dispense any more medication until informed to do so by the hospital.

Controlled Drugs – Private Prescriptions

All private prescriptions for Schedule 1, 2 and 3 CDs that are presented for dispensing in the community must be written on a standardised private controlled drug prescription form which must include the prescriber's unique six-digit private prescriber code issued specifically for their private CD prescribing activity only. The private CD prescriber code is different from the six-digit NHS prescriber's code.

NWSSP manage the process for any practitioner requesting to be able to prescribe controlled drugs on a private prescription within Wales. All requests for authorisation to prescribe privately should be referred to NWSSP via their e-mail address nwssp-primarycareservices@wales.nhs.uk and they will advise on the process and required identity and professional checks to be undertaken.

If agreed the prescriber will then be permitted to obtain private prescription forms, known as WP10PCD forms, to prescribe CDs privately

Private prescriptions for schedule 4 and 5 CDs can be issued in the same way as any other private prescription and do not require the special WP10PCD form.

The health board monitors the use of private CD prescriptions as part of its governance process.

Supply and/or administration of Controlled Drugs under a Patient Group Direction (PGD)

Not all professions listed in the PGD legislation can administer controlled drugs under a PGD. The following regulated professions groups **cannot** administer or supply any controlled drugs in any of the five schedules under a PGD:

- Dietitians
- Speech & language therapists
- Dental therapists
- Dental hygienists
- Pharmacy technicians

For the professions listed in the PGD legislation, other than those listed above, the following controlled drugs can be included in a PGD:

- Schedule 2: Morphine and diamorphine – only by registered nurses and pharmacists for the immediate necessary treatment of a sick or injured person. Not for treating addiction.
- Schedule 2: Ketamine
- Schedule 3: Midazolam
- Schedule 4: All drugs except anabolic steroids and injectable medications used for treating addiction.
- Schedule 5: All drugs

Since their reclassification as Schedule 3 controlled drugs (CD No Register POM) tramadol, gabapentin and pregabalin may not be supplied and administered under a PGD.
https://www.sps.nhs.uk/articles/who-can-supply-or-administer-controlled-drugs-under-the-terms-of-a-patient-group-direction-and-under-what-circumstances/

Nitrous oxide under a PGD

The reclassification of nitrous oxide as a Schedule 5 controlled drug does not affect its Pharmacy Only (P) legal categorisation.

P medicines do not require a PGD for administration, including those which are Schedule 5 CDs. A PGD may be used for the supply of P medicines where no other legal mechanism for supply is available (e.g. an exemption in Schedule 17 or Schedule 223 of the HMR 2012 or prescribing). For more information refer to P and GSL medicines with PGDs.

Use of a PGD for the supply of nitrous oxide is legal.

Midwifery Controlled Drug Exemptions

Midwives can possess, in their own right, and administer parenterally, without a prescription, diamorphine, morphine and pethidine provided it is in the course of their professional midwifery practice. GPs should not be asked to prescribe pethidine for use in labour. The records of a midwife related to administration of medicines should be regularly reviewed by their team leader, line manager or clinical supervisor for midwives, a minimum of annually, for example as part of the annual appraisal process.

Monitoring of Controlled Drugs Prescribing & Use

The PTHB Medicines Management Team will carry out regular routine monitoring of prescribing of controlled drugs (including private prescriptions), through various means, including CASPA, control charts and PrescQIPP data, hospital supply data and occurrence reports and audits.

Through the Controlled Drugs Accountable Officer, oversight of controlled drugs will include:

- a local intelligence network (CDLIN) which will work with CDLINs in other areas when needed, to share information and data around the use or management of CDs or any concerns or incidents raised. Membership of the CD LIN will include police, General Pharmaceutical Council, HIW, CIW and lead officers for local organisations using or supplying controlled drugs.
- providing feedback (such as actions from controlled drugs related incidents and occurrence reports)
- sharing learning including trends or around significant incidents.
- requiring primary care contractors to complete a self-declaration on controlled drug management at least every two years.
- Review of prescribing data, including private prescriptions and requisitions. Community hospitals will be monitored through pharmacy supply records, out of hour's requests, analysis of WP10 (HP) and CD register audits and checks.
- ensuring approved SOPs are in place covering all aspects of controlled drugs use and management.
- inspections of primary care contractors and community hospital sites.
- ensuring that there are sufficient trained and competent authorised witnesses in place to meet the needs of the organisation and that a register of authorised witnesses is maintained.

Administration of Controlled Drugs

The principles and processes for the safe administration of any medication are the same for controlled drugs – see administration section.

Hospital Administration of Schedule 2 (and some schedule 3) Controlled Drugs

In the hospital setting there must be a witness to the controlled drug administration process for any controlled drugs requiring storage in the CD cupboard and entry into the CD register. The witness can be a second registered nurse, Midwife, Pharmacist, Pharmacy Technician, Medical or Dental Officer, Registered Operating Department Practitioner (RODP), Radiographer Senior 1.

The witness must observe the whole processes, this includes witness to the removal of the controlled drug from the controlled drugs cupboard, carriage to the patient, administration to the patient and confirmation that the patient has taken/received the medication, return of any excess controlled drug to the CD cupboard and resulting stock balance check. Any disposal of excess must also be witnessed.

Both the administering professional and witness must then sign the controlled drug register against the administration. The register entry must: -

- Be completed in blue or black indelible ink
- Be on the correct page of the register for the preparation(s), including form and strength (and brand where appropriate).
- Each different drug and preparation (i.e. form, strength etc.) must have a separate page in the CD register. Therefore, if a dose requires the use of 2 strengths of a preparation both pages of the CD register must be completed
- Include the patient name, quantity administered and amount discarded.
- New running balance total. Remaining stock in the CD cupboard must be checked to ensure this the total reflects the actual balance.
- Signed by the administering professional and countersigned by the witness once the whole administration process is complete.
- Any errors in the entry should be noted with an asterix (*) and a footnote made and counter-initialled by both the person administering and the witness. Errors must not be crossed through.

The administration record on the medication administration chart must be signed at the time of the administration.

Single nurse administration of controlled drugs – hospitals

If, due to staffing reasons, a witness check is not possible at the time of administration, a complete controlled drug stock level check (reconciling the physical stock level balance with the CD register for everything held in the CD cupboard) must be carried out by a registered nurse and witness at each shift change.

Unavailability of a Controlled Drug

It is key that ward and pharmacy teams work together to anticipate the controlled drugs stocks required for a ward/department to ensure that clinical need is met. This is particularly important at weekends and bank holidays, where patients are receiving high or increasing doses and that there is clear handover of any new patients or new prescribing to enable ordering of stock from Nevill Hall Hospital Pharmacy within normal working hours.

A nurse in charge of a clinical area is only permitted to hold a stock of CDs for administration to patients under their care. This means that a nurse/midwife/RODP is not legally permitted, under the Misuse of Drugs Act 1971, to make a stock supply to another practitioner, whether this

request comes from another ward/department or is a request from a doctor.

In hours, staff may: -

(i) Establish if Nevill Hall Pharmacy can make an urgent supply – this may include the use of Blood Bikes or a taxi service.
(ii) Establish if relatives or carers can bring in a supply from the patient's home (see section on patient's own drugs to ensure the controlled drug is suitable to use).
(iii) Request a WP10 prescription from the patients GP or utilise a ward/department WP10 (HP) to be dispensed at the local community pharmacy.
(iv) In exceptional and clinically urgent circumstances Bronglais Hospital (BGH) pharmacy may be able to supply controlled drugs to a named patient in north Powys hospitals at the discretion of the senior pharmacist on duty. A WP10 (HP) or hospital discharge prescription must be supplied to legally allow the supply. BGH Pharmacy will require the original prescription before releasing the supply.

Any controlled drugs obtained by (ii) or (iii) must only be administered to the patient for whom it is labelled and must **not** be administered to other patients under any circumstances. The drug should be entered on a separate page of the controlled drug register and should include the patient's name. Any administration of the drug must be entered on that page.

In exceptional circumstances, a single dose of another ward/department's stock CDs (where available) can be administered to another patient on another ward/department, in the same hospital site, if there is no other means of obtaining the controlled drug in a timely manner. The nurse/midwife/RODP from where the CD is stocked must witness and be part of the whole administration process. A record of administration is to be made in the originating ward/department's CD record book and the record must be made or witnessed by the registered Nurse/RODP in the original ward/department who must accompany the CD to its place of administration.

Further supply of CDs must be obtained from the pharmacy when next open or in an emergency contact the on-call pharmacist for advice or urgent supply.

Administration of Controlled Drugs in the Community

In the community, controlled drugs are dispensed for a named patient and therefore, unlike stock controlled drugs in a hospital, may be administered in the community without a witness.

A registrant may request a second check e.g. where a calculation is involved or when setting up a syringe driver. Consideration should be given to using patient's or carers as a witness to administration.

Administration within a patient's home, must be recorded on the patient's medication administration chart or care pathway as appropriate. Where the medication is not given, the reason for not doing so must be documented. Where there is a witness to the administration this should also be documented.

Where only part of an ampoule containing a Controlled Drug is used, the unused drug should be disposed of in a sharps box and the amount used and the amount destroyed must be recorded. Where there is a witness to the administration, this person must also witness the destruction of the unused drug.

Care Support Worker Administration of Controlled Drugs in the Community

The law does not prevent care support workers from administering medicines in any setting providing they are acting in accordance with the directions of an appropriately regulated prescriber.

Any care support worker responsible for supporting an individual with their medicines must be suitably trained and competent; competency must be assessed annually and the task referred to in their job description. Care support workers who have been delegated the task of medicines support must follow the organisation's policies and procedures. Refer to AWMSG, All Wales Guidance for Health Boards/Trusts and Social Care Providers in Respect of Medicines and Care Support Workers, June 2020

Any care support worker responsible for supporting an individual with their medicines can administer patient's own controlled drugs. There are no specific legal requirements regarding the storage or administration of controlled drugs once they have been dispensed for a specific service user. In a patient's home, controlled drugs are viewed in the same way as any other prescribed medicines and are not subject to any specific safe storage or administration requirements.

Students and Trainees – Controlled Drugs

Where medication administration is a required part of the trainee or students agreed training, students and trainees may participate in the preparation of controlled drugs and observe the administration and documentation process.

Where a student or trainee is involved, a witness is still required.

Patient's Own Controlled Drugs

Patient's own controlled drugs may be used for the patient that they were intended for, providing that they meet the criteria for use and have been assessed and authorised by an appropriately trained staff member. See patient's own drugs section

Ensure that all medicines brought in by the patient are checked for any Controlled Drugs and that all storage and documentation requirements are met.

All Schedule 2 and any Schedule 3 controlled drugs requiring safe custody must be stored in the ward Controlled Drug cupboard and entered into the ward Controlled Drug register under a separate patient's own medicine section at the **back** of the ward controlled drug register. When entering into the Controlled Drugs register: -

- A separate page must be used for each individual patient and each individual preparation for that patient.
- The page number of the Controlled Drugs register entry must be clearly annotated onto the outer packaging of the patient's own item and circled e.g.:

  This makes it easier to locate the Controlled Drug register entry when stock checking or returning to the patient.
- The entry for the patient's own controlled drug is clearly stated in the contents page of the Controlled Drug register.

Note Schedule 4 Sativex does not require safe custody, but a CD Register entry is required.

Any administration of a patient's own controlled drug must be in accordance with this policy, with an entry of administration made in the CD register against the patient's own supply.

At the time of discharge, if the medicines are to be returned to the patient, an entry to that effect shall be made in the Controlled Drug register and the patient/carer should countersign receipt of the medication.

If the patient no longer requires the Controlled Drug, and has consented, it may be destroyed on the ward by arrangement with a pharmacy

professional. An entry to that effect must be recorded in the Controlled Drug register.

If a patient is transferred between wards/hospital the patient's own controlled drugs must be signed out of the original ward Controlled Drug register. There must be a witness to this entry, which could be the patient, second registrant or for patient's being transported by hospital transport the WAST driver.

The balance of all patient's own controlled drugs will be reconciled in the same manner that stock balances are reconciled in accordance with the CD procedure.

If it is expected that there is a controlled drug in a monitored dosage system then the whole pack must be stored in the Controlled Drug cupboard and refer to a pharmacy professional to clarify.

Controlled drugs not subject to safe custody requirements may be stored in the patient's bedside locker.

Self-Administration of Controlled Drugs

The PTHB Self-administration of Medicines policy supports the self-administration of Controlled Drugs not subject to safe custody requirements and once an assessment of the patient's ability to self-administer medicines has been made in line with the policy. Self Administration Policy (under development) [link]

Requisition of Controlled Drugs

Primary/Community Care Controlled Drug Requisitions

Generally controlled drugs for use in primary/community care will be obtained via a named patient prescription and individually dispensed for a patient.

When obtaining stock controlled drugs for use in the community, health professionals in primary care must use the approved mandatory WP10 CDF form for the requisitioning of controlled drugs in Schedule 2 and 3, in line with Regulation 14 of the 2001 Regulations and the Misuse of Drugs (Amendment) (No. 2) (England, Wales and Scotland) Regulations 2015.

The regulations permit requisitions for CDs to be computer generated or handwritten. The signature of the recipient (i.e. the person ordering the

CDs) must be handwritten. The requisition form must contain the following:

- The name, address and profession or occupation of the recipient
- The purpose for which the drug is supplied
- The name, form and strength of the drug and the total quantity to be supplied
- The date on which it was supplied

CD requisition forms can be obtained by sending an email, marked FAO the Business Support team, to nwssp-primarycareservices@wales.nhs.uk or by contacting 01792 860428.

Requisitions (originals not copies) must be submitted by contractors to NHS Wales Shared Services Partnership in the same way as private prescriptions.

The health board monitors the use of CD requisitions as part of its governance process.

Any PTHB employee seeking to obtain stock controlled drugs must be in agreement with the Powys Controlled Drugs Accountable Officer – consideration must also be given to whether a Home Office license is required to hold a stock of Controlled Drugs https://www.gov.uk/government/publications/domestic-controlled-drug-licensing-in-healthcare-settings

Hospital Controlled Drug Requisitions

Stock Schedule 2 & 3 controlled drugs, for use within PTHB hospital wards, departments and maternity settings must be obtained using the agreed CD requisition book. The CD requisition book is available on request from NHH Pharmacy.

- Each area that may order controlled drugs must supply NHH Pharmacy with a sample signature list of registrants who can order controlled drugs on behalf of the ward or department. This list must be agreed and countersigned by the ward/department manager. The ward/department are responsible for notifying NHH Pharmacy to changes in this list and NHH Pharmacy will work with PTHB Medicines Management team to regularly spot check this list.
- Only agreed and authorised registrants may order controlled drugs for the ward/department.
- Each ward/department will have an agreed controlled drug stocklist and an annual overarching order, signed by a PTHB doctor will have been submitted to NHH Pharmacy – wards/departments are therefore

only able to order against the pre-agreed list. This is in line with Regulation 14 of the 2001 regulations

- A separate page must be used for each item ordered. This includes separate pages for different strengths of preparation.
- Ensure the carbon paper is in place to duplicate the order onto the pink page.
- The entry must clearly detail:
    - The name of hospital, ward / department and the date.
    - Drug name, form, strength and ampoule size if more than one available. State brand required if necessary.
    - Total quantity required in dosage units e.g. number of tablets, ampoules or millilitres
    - The order must contain the signature and printed name of the Registered Nurse or suitably qualified Practitioner who is authorised to order.
- The order book should be sent to NHH Pharmacy within a secured pouch or secured pharmacy transport box – see Controlled Drug Ordering SOP [Link]

Delivery of Controlled Drugs – Hospitals

NHH pharmacy ensures an audit trail for the transport of controlled drugs to Powys, including requiring the signature of any 'messenger' (porter, driver), who carries the controlled drug (including any logistics handover signatures) and the use of tamper evident uniquely numbered seals on the outer package. The number of the seal is documented on the transport document.

Controlled drugs must be kept secure at all times and once at the required destination handed directly to a registered staff nurse, midwife, or RODP.

Receipt of Controlled Drugs – Hospitals

The registered professional (nurse, midwife, RODP) receiving the controlled drug must check that the tamper evident seal is still in place and the serial number matches the transport document – if not this must be immediately escalated to NHH Pharmacy for advice. If everything is in order, sign to confirm receipt of the controlled drug and release the driver or porter.

The registered professional must check the controlled drug received matches the order, including, drug, strength, form and quantity. if not, this must be immediately escalated to NHH Pharmacy for advice.

If the controlled drug requires safe custody and/or register entry then it must be entered into the controlled drug register on the appropriate page

for the preparation, form and strength (and brand where appropriate). This controlled drug entry must be witnessed by a second registrant (registered nurse, Midwife, Pharmacist, Pharmacy Technician, Medical or Dental Officer, Registered Operating Department Practitioner (RODP), Radiographer Senior 1) and a stock balance check undertaken.

The following must be recorded in the CD register: -

- Date of entry
- Serial number of the requisition
- 'received from Pharmacy'
- Quantity received
- Signature and printed name of the registrant making the entry
- Signature and printed name of witness
- Stock balance

If the controlled drug pack arrives unsealed, then the contents must be checked and drug and quantity confirmed. Sealed packs/bottles with a tamper-evident seal do not need to be opened on receipt. To do so could lead to damage to the packaging and/or contents and increases the risk of breakage or loss of medication. When sealed containers are opened for the first time for use this should be done in the presence of a witness.

Any discrepancy must be reported to NHH Pharmacy.

Delivery and Collection of Controlled Drugs in the Community - Prescriptions

It is the responsibility of the patient to collect their prescriptions from a community pharmacy or dispensing practice. In situations where this is not possible, it may be possible for the patient to make arrangements to have the community pharmacy/practice deliver their medication (NB this is a private arrangement between the pharmacy/practice and the patient, it is not a service that is commissioned by the NHS).

Only in exceptional circumstances, e.g. urgent requirement to administer medication, should the practitioner organise to collect and deliver the Controlled Drugs themself.

Healthcare professionals should not routinely transport Controlled Drugs in the course of their practice. This must only be undertaken in circumstances where there is no other reasonable mechanism available and only dispensed medication should be transported. Stock controlled drugs must only be transported via PTHB agreed transport teams and with a clear audit trail.

During transport of dispensed controlled drugs all drugs must be kept out of sight. On arrival at the patient's home, if documentation is in place, the healthcare professional must sign and record the stock in the patient record, and it should be witnessed that the CD has been received by the patient. Where a second nurse is not available another competent person may witness receipt e.g. a family member.

The person collecting the medicine from the dispensing pharmacy/practice will be required to sign the back of the prescription form when collecting Schedule 2 or 3 CDs. Legislation states that the dispensing contractor must ascertain whether the person collecting is the patient, patient's representative or healthcare professional. If the person collecting the Schedule 2 controlled drug is a healthcare professional, acting in their professional capacity on behalf of the patient, the pharmacist/dispensing practice must also obtain the name and address of the healthcare professional and evidence of identity (unless he/she is acquainted with that person).

Controlled Drug Requisition Books and Registers

All stationery relating to controlled drugs is classified as controlled stationery, subject to enhanced security requirements. Both controlled drug requisition books and registers must be stored in a locked drawer / cupboard only accessible to registered staff authorised to manage controlled drugs. They are recommended to be kept near the controlled drug cupboard.

For PTHB Hospitals, CD Registers and CD Order books should be ordered via NHH Pharmacy.

Registers must be bound (not loose leaf) no pages should be removed from the controlled drugs register and no pink pages removed from the controlled drugs order book. Each page is numbered and the chronological order must be retained.

The CD register must not be used for any other purpose. And only one active stock CD register should be in use per CD cupboard at any time.

Entries and orders must be made in indelible ink. Each page must only contain entries for one preparation.

The CD register must contain a running balance and all controlled drugs regularly checked against this balance - see stock balance check.

CD order books and registers must be retained for 2 years from the date of the last entry/order https://www.sps.nhs.uk/articles/retention-of-pharmacy-records/

The above table describes which controlled drugs require a CD register to be maintained. The CDAO may advise further monitoring of certain drugs outside of the legal requirements and therefore that a register entry is maintained for a wider range of drugs.

Theatres and endoscopy must use the specified Theatre Controlled Drug register which is available to order via NHH Pharmacy.

CD Register Stock Balance Checks

All wards and departments possessing stocks of Controlled Drugs must carry out a stock balance reconciliation at least once every day that the ward/department is open. The Registered Nurse/Midwife in Charge is responsible for ensuring that this is carried out.

Two registered nurses, midwives or other authorised registered health professionals should perform this check. Where possible the staff undertaking this check should be rotated periodically. The following procedure must be followed:

- Each page of the CD register must be checked against the contents of the CD cupboard, not the reverse, to ensure all balances are checked.
- The physical stock of each item should be counted. It is not necessary to open packs with intact tamper-evident seals for stock checking purposes, e.g., manufacturer's complete sealed packs.
- When undertaking the daily stock check, the stock balances of liquid medicines should generally be checked by visual inspection. An accurate stock check of liquid medicines (i.e. by measuring the volume in a measuring cylinder/s) should be undertaken once a week and when there is any concern, on visual inspection, during the daily stock check that there is a discrepancy between the balance in the register and the volume of liquid in the bottle. In addition to this, the balance must be confirmed to be correct every time the contents of a bottle has been used (i.e. when the bottle is empty). NB: Some liquid medications may contain a small overage volume. Guidance is available on acceptable discrepancy levels (Appendix One).
- A record must be made that the stock check has been carried out. This record must include the date and time of the reconciliation check and it must be signed by both members of staff to declare that they have carefully and accurately checked all stock. This record must be kept in a bound log book e.g 'exercise book' – dedicated for this purpose.

Any discrepancy must be investigated in accordance with Dealing with Discrepancies.

A check of all CDs stocked within wards and departments must be completed every 3 months by a PTHB Pharmacist and authorised ward/department registrant, unless otherwise specified by the CDAO for a ward or department.

Sealed packs/bottles with a tamper-evident seal do not need to be opened to undertake a contents check. To do so could lead to damage to the containers and increases the risk of breakage or loss of medication. When sealed containers are opened for use this should be done in the presence of a witness.

Measuring cylinders for measuring controlled drug liquids will be approved and provided by the Medicines Management team. SOP for Measuring Liquid CDs (under development) [link]

Errors in the CD Register

If a mistake is made in the CD register, it should be bracketed ([]) or asterixed (*) in such a way that the original entry is still clearly legible, it must not be crossed out or obliterated. The words 'entered in error' should be written on the same or next line or as a footnote, this should be signed, dated and witnessed by a second Registered Nurse or Midwife, the witness should also sign the correction.

Dealing with Discrepancies

The balances in the CD register must always tally with the amounts of CDs in stock. If they do not, the discrepancy must be fully investigated immediately. In the first instance the following should be carefully checked:

- All calculations are correct since last agreed balance.
- Re-check CD cupboard or GP bag with second person (remember to include date expired stock and exclude patient returns which may have become mixed with stock).
- Other register sections of same drug class for erroneous entries.
- Other holdings, eg GP bags for stock which may have been transferred but not recorded.
- Sense-check register (correct pack sizes, patterns of entry for potential missing entries, and unusual quantities).
- All orders have been entered by checking delivery notes/invoices/stock orders for discrepancies.
- All CDs administered have been entered into the register.

- Check diary/off duty and contact all relevant practitioners who have worked at the ward/clinic/department during the relevant period to verify any supplies made that may have not been entered or been entered erroneously or medication inappropriately stored.
- Hold all waste bins until a check has been made. If safe to do so check waste bins in case inadvertently disposed of.

If the error or omission is traced, the healthcare professional in charge must make an entry in the CD register clearly stating the reason for the entry and the corrected balance. This entry must be witnessed by another registrant and both must sign the CD register. This entry must be agreed and countersigned by a Pharmacist on their next visit with confirmation of the stock balance. The discrepancy, actions, outcome and learning from the incident must be recorded on Datix and the CD Incident Report form.

If the discrepancy cannot be resolved – this must be urgently escalated as a Controlled Drug Incident, the healthcare professional in charge must make an entry in the CD register clearly documenting the discrepancy, (including the actual balance) and stating that this is under investigation. The entry must be witnessed by another healthcare professional and both must sign the CD register.

Controlled Drug Incidents

There is a legal requirement for the CDAO to be notified of all incidents and concerns involving CDs. The PTHB CD Incident process SOP must be followed

- In a PTHB setting all incidents involving controlled drugs that are not locally resolved within 2 hours must be reported to the Controlled Drug Accountable officer (Powys.CDAO@wales.nhs.uk), senior ward/department manager (silver on call at weekends) and hospital pharmacist (on-call Pharmacist during the out of hours period). The CD Incident process SOP must be followed.
- All incidents involving CDs must also be recorded on the Datix incident reporting system, ensuring that the incident is marked as involving a controlled drug.
- A CD Incident report form must be completed and forwarded to the CDAO, via Powys.CDAO@wales.nhs.uk , within 48 hours of the incident occurring.
    - All CD Incident Reports must include details of the actions taken, including immediate steps to prevent or reduce harm to patients, any investigations undertaken and actions taken to prevent recurrence.

- Any concerns regarding the management or use of CDs must be raised with the CDAO.
- Where there is suspicion or evidence of criminal activity, Counter Fraud and the Police may need to be notified.

Examples of CD Incidents and Concerns (this list is not exhaustive): -

- All events or near misses involving prescribing, administration, supply or dispensing of CDs (any schedule).
- Any concern(s) about professional practice or behaviour of staff in relation to CDs e.g. unusual prescribing patterns.
- Complaints from patients/carers/service users relating to CDs
- Unexplained losses/discrepancies of any CD, regardless of schedule.
- Any discrepancy in CD stock which, although resolved, raises concerns.
- Events or near misses involving CD destruction.
- Loss of CD Register/Order Book or other relevant controlled stationery.
- Any suspected illegal activity relating to CDs e.g. theft, patients attempting to obtain CDs by deception.
- Lost or stolen prescription forms.
- Attempts to fraudulently produce prescriptions.

Controlled Drug Storage

Controlled Drug Cupboards – Hospital

Specified Controlled Drugs cupboards must be used to store preparations containing drugs subject to the safe custody requirements of the Misuse of Drugs Act 1971. The Controlled Drugs cupboard must meet the requirements of the "The Misuse of Drugs (Safe Custody) Regulations 1973" and must be rigidly and securely fixed to a wall or floor by means of at least two rag-bolts that are not accessible from outside the cupboard, this may require fixing to a steel anchor plate. In some situations, automated dispensing cabinets may be used for storing CDs, however this requires a risk assessment to be completed and advice and agreement obtained from local police CD liaison and home office inspectors. See Patient Safety Notice – PSN 055 for further detail.

NHS framework CD cupboard manufacturers will advise if the CD cupboard needs to be installed inside another cupboard or if it meets the specification as a standalone cupboard.

A local risk assessment should be undertaken, in conjunction with the Medicines Management team and Counter Fraud, to establish if additional security measures are required, such as alarms, lights or CCTV.

Storage of Controlled Drugs within the CD Cupboard

Care should be taken on the storage of high strength opiates (diamorphine and morphine). It is a requirement that low strength products (5mg, 10mg) are stored on a separate shelf, bag, or box than high strength products.

Different strengths must be clearly differentiated, and staff should be made aware of the similarities in packaging. Unpackaged ampoules should not be stored or transported and should always be contained within their original outer packaging.

Morphine Sulfate 10mg/5ml is legally classified as a Schedule 5 controlled drug, thus does not need to be stored as a full CD, however higher strengths of Morphine Sulphate solution e.g. 100mg/5ml and all strengths of Morphine tablets, capsules, injections, sachets, suppositories still legally need to be ordered and treated as a schedule 2 Controlled drug.

Storage of Controlled Drugs in Patient's Homes

Unless the risk assessment highlights a need, there is no legal requirement for controlled drugs dispensed for a patient and stored in their own home to be treated differently, or stored separately, from other medicines. The storage should be risk assessed in line with NICE guidance NG67. There is no requirement to keep a controlled drug cupboard or register in a person's own home.

As with any medicines patients/family/carers should be given instructions to store the medicines securely within their own home, where they are not on display to others and out of the reach of children.

Controlled Drug Cupboard Keys - Hospital

Responsibility for CD Keys

The Registered Nurse, Midwife or RODP in charge is responsible for the CD keys. Key holding may be delegated to other suitably trained, registered healthcare professionals, but the legal responsibility rests with the Registered Nurse, Midwife or RODP in charge. The CD keys should be returned to the nurse, midwife or RODP in charge immediately after use by another registered member of staff.

Where key holding is delegated by the nurse, midwife or RODP in charge, a clear audit trail of the movement of the CD keys must be maintained.

The CD keys should be kept on a separate key ring from other keys and only given access to staff when access to CDs is required. This ensures that only staff that require access to the CD cupboard have access to the keys.

For the purpose of stock checking, the CD keys may be handed to a member of pharmacy staff.

No more than one set of CD keys should be in use on the ward.
A spare set can be kept and arrangements for their secure storage must be in place e.g CD cupboard of another ward or department on site and is the responsibility of the ward or department manager in agreement with Pharmacy.

Missing CD Keys

If the CD keys go missing, this must be reported immediately to the Registered Nurse/Midwife/RODP in Charge, who must ensure that the following steps are taken as a matter of urgency:

- Ask all staff on duty to check if they have the keys on their person.
- Contact staff who have left the premises. If one of them has the key, they must return it immediately.
- Conduct a thorough search of the environment.
- If the keys remain missing (either assumed lost or with a member of staff unable to return it).
    - If CDs are required the Estates department must be contacted to enter the CD cupboard – under supervision of a registrant authorised to access the CD cupboard.
    - Carry out a full controlled drug stock check with two registrants
    - If the keys cannot be found, then the controlled drug cupboard area must be kept secured and the cupboard must not be left unsupervised. It may be necessary for controlled drugs to be temporarily transferred, following a stock check, by two authorised professionals, to another secure cupboard. The Estates Department may need to be contacted for assistance.
    - If the keys still cannot be found then the ward manager must arrange for the locks on the controlled drug cupboard to be changed urgently. Replacement locks for a controlled drugs cupboard must conform to BS3621. In some cases a new CD cupboard may be required, if locks cannot be retrofitted.

- Complete a Datix report and CD Incident report recording all relevant details and actions taken. All Incident Reports involving a CD must be tagged as a CD Incident on the Datix Incident Reporting System to ensure that the report is automatically forwarded to the CDAO.

Destruction and disposal of Controlled Drugs

Controlled Drug Authorised Witness

An amendment to the Misuse of Drugs Regulations 2001 requires CDAOs to authorise people (the authorised witness) to witness the destruction of Schedule 1 and 2 controlled drugs to render them irretrievable. The authorised witness is a person who is not involved in the day-to-day handling of controlled drugs who has been appointed by the CDAO to oversee the management and governance of activities related to controlled drugs.

Appointed authorised witnesses are subject to a professional code of ethics and/or DBS checks and will have undertaken appropriate training and been assessed as competent to witness CD destruction. The legislation does not allow the CDAO to act as an authorised witness.

The Medicines Management Team holds the list of individuals appointed as 'authorised witnesses' by the CDAO.

Stock controlled drug destruction

It is a legal requirement for expired and no longer required stock (i.e. CDs that have not been dispensed for a named patient) Schedule 1 and 2 CDs to be destroyed in the presence of an authorised witness.

The date of destruction and the quantity destroyed must be recorded in the CD register and signed by the member of staff destroying the drug and the authorised witness.

All stock controlled drugs in schedules 1, 2, 3 and 4 (Part 1) must be denatured before disposal and it is considered good practice for an witness to be present for the denaturing of schedule 3 and 4 (part 1) controlled drugs. At the discretion of the 'authorised witness' they will support this whilst on site for witnessing the denaturing of schedule 1 and 2 controlled drugs.

When a community pharmacy, GP practice, hospital ward or other appropriate body has stock Schedule 1 or 2 CDs requiring destruction,

contact should be made with the Health Board's Medicines Management Team. A sector appropriate CD Destruction Request and Record form must be completed and emailed to Powys.cdao@wales.nhs.uk. The requesting party will be contacted within 5 working days of receipt of the form to arrange a mutually suitable date and time for an authorised witness to attend to witness the destruction (ideally within 28 days of the request being received).

Controlled Drugs awaiting destruction should be clearly marked and segregated within the CD cupboard so they are not used for patients.

Disposal of Doses Prepared for Administration

Any medicine left over of an unusable quantity is considered waste. Medicine is also considered 'waste' if it has been prepared for administration but not actually used. For example, a quantity of medicine which has been 'drawn up' into a syringe from its original container, but not all of it was used. Such waste must still be recorded, and the medicine denatured prior to disposal; but the disposal can be witnessed by a pharmacist, pharmacy technician, registered nurse, RODP, doctor or, in a patient's home, by the patient or a carer (i.e. disposal does not need to be formally witnessed by an 'authorised witness' appointed by the CDAO).

If the patient refuses the administration of a controlled drug this should be quarantined in a medicines bottle (supplied by Medicines Management) in the controlled drug cupboard. The bottle should be labelled with the contents (drug name, strength and quantity) date and state 'patient' refusal. The controlled drug will then be denatured when an Authorised Witness next attends the ward for a CD destruction. It is good practice to establish with the patient before preparing the dose of controlled drug for administration, that they will consent to the administration.

The quantity must be reflected in the controlled drug register as a patient refusal and the entry witnessed.

Examples of stock vs. waste

- 1 ml single use vial – 0.6 ml drawn up and used leaving 0.4 ml remaining – this is considered waste and does not require formal witnessing of disposal.
- 10 ml vial – 2 ml drawn up and used leaving 8 ml remaining. Due to the 'useable' quantity this is considered stock and formal witnessing of disposal is required.

The CD to be discarded must be rendered irretrievable by emptying the contents of the ampoule/vial, syringe or infusion bag into a pharmaceutical

waste bin (generally blue lidded). Liquids should be rendered secure by use of a self-setting compound (e.g using a Doop kit – available from the Medicines Management team) and can be undertaken when an Authorised Witness attends for a scheduled controlled drug destruction.

Full details of the destruction must be recorded in the CD register (for part ampoules or other unused doses) including the names and signatures of those involved.

Patient's Own Controlled Drugs

Although it is not a legal requirement for patient's own controlled drugs to be destroyed in the presence of an 'authorised witness', it is PTHB's policy that an 'authorised witness' must be present when patient's own controlled drugs (Schedule 1,2,3 and 4 (part1)) are denatured and destroyed in any Powys community hospital setting. The destruction must be documented on the relevant patient's own page of the controlled drug register.

For other settings it is good practice for two people to witness the destruction of patient returned controlled drugs. One witness should be a registered Healthcare professional. At the discretion of the 'authorised witness' they may agree to oversee the destruction of patient returned controlled drugs if already attending the site.

Patient's own or patient returned CDs should be destroyed as soon as practically possible. Where destruction is not immediately practicable, the patient's own or returned controlled drugs should be segregated and stored in the controlled drugs cupboard until they can be destroyed appropriately.

Disposal of Controlled Drug Transdermal Patches Removed from a Patient

Used medicated patches may still contain a small quantity of active drug and should therefore be folded in half (sticky sides together) and disposed of in a pharmaceutical waste bin (generally blue lidded).

Disposal of Controlled Drugs – Community

Dispensed drugs including CDs are the property of the patient and remain so even after death. In the first instance the patient/relative/carer should be advised that all CDs no longer required must be returned to a pharmacy for safe destruction. In situations where, in the professional opinion of the practitioner, leaving the medicines behind would constitute a risk to others, the medication may be removed by the practitioner for destruction. Consideration should be given to:

- discussing the removal of controlled drugs with a family member or carer
- any requirements of the coroner to keep medicines in the person's home for a period of time
- discussing with the Safeguarding Team and /or raising a safeguarding report

A record should be made in the patient held notes, indicating what medicines have been removed and where they have been removed to, this record should be signed and dated. The record should be signed by a witness wherever possible.

Controlled Drug Destruction Process

The Controlled Drug Destruction SOP (used by the Medicines Management Team) can be found on the website: Controlled Drug Destruction requiring an Authorised Witness

The controlled drugs must be rendered irretrievable prior to disposal:

- Solid dose formulations should be removed from blister strips or bottles and the instructions on the denaturing kit followed. Ideally denaturing kits that do not require tablets to be crushed or capsules to be opened up should be used.
- For parenteral formulations, ampoules should be opened and the liquid poured into a CD denaturing kit. Ampoules containing powder can have water added to dissolve the powder, and the resulting mixture can be poured into the CD denaturing kit. Empty ampoules should be disposed of in a sharps bin suitable for pharmaceutical waste.
- Liquid dose formulations should be poured into a CD denaturing kit.
- For transdermal patches (e.g. fentanyl patches), the backing should be removed and the patch folded over on itself (sticky sides together) before disposing of in a CD denaturing kit.

The denaturing kit must be prepared as indicated on the packaging and disposed of in a suitable pharmaceutical waste bin (generally blue-lidded). NB: Some kits may require storage in the CD cupboard for 24 hours before disposal.

Documenting Controlled Drug Destruction

Documenting Stock Controlled Drug Destruction

The destruction of the controlled drug must be documented on the relevant page of the controlled drug register. The entry must specify;

- the name, strength and form of the product, (usually specified on the correct page header of the register)
- date of destruction,
- reason for destruction e.g date-expired, no longer required
- quantity destroyed,
- printed name and signature of the person destroying the controlled drugs
- Printed name and designation (include professional registration number if appropriate) of authorised person witnessing the destruction followed by their signature,
- the balance remaining

Documenting Patient's Own or Returned Controlled Drugs

If in the controlled drug register – record destruction as for stock controlled drugs

If return is documented in a dedicated patient returns record book the following must be recorded.

- Date of return
- Patient's name & address (if known) & role of person returning CDs (if known)
- Address of the dispensing Pharmacy/Practice (if known)
- Drug details (name, strength, form) and quantity returned
- Name & signature of person accepting the return
- Name & signature of person destroying the CDs
- Name & signature of person witnessing the destruction
- Date of destruction

Retention of Records of Controlled Drug Destruction

NICE NG46 recommends that records of destruction of CDs (including patient returns and out of date stock) should be retained for a minimum of 7 years.

T28 Waste Exemption for Controlled Drug Denaturing

All areas where CD denaturing may take place must have a T28 exemption in place. The register for T28 exemptions can be checked to ensure all sites where destruction take place have the requisite exemption. https://nrwregulatory.naturalresources.wales/Exemptions/PublicRegister/Search

Transfer of patients with controlled drugs attached

When a patient is discharged to another care facility, e.g. hospital, care home, or another ward with controlled drugs, the following information must be provided as a minimum:

- Copy of the current administration and monitoring chart.
- Medical / nursing summary as per local immediate discharge guidance.
- Syringe driver chart if appropriate, detailing product prescribed, dose, rate, time started.
- Topical positioning chart if a transdermal patch and date applied.

Where patients are being transferred home with syringe pumps attached, it is essential that there is timely transfer of information to the services who will be responsible for ensuring continuity of care, e.g. out of hours service, district nursing service.

Hospital Ward/Department Closure

Controlled drug stocks must not be moved without the involvement of a pharmacist.

For wards/departments permanently closing, the Medicines Management Team must be notified in advance so that arrangements can be made for an 'authorised witness' to attend to witness the destruction of the controlled drugs. The safe custody of drug cupboard keys should be ensured e.g by storing in a controlled drugs cupboard of another ward/department on site.

Where a ward/department is closing for a short periods of time (e.g. over Christmas), the Medicines Management Team must be notified in advance so that arrangements can be made for a pharmacist to attend to safely and securely transfer all controlled drugs for storage in a controlled drug cupboard in a neighbouring ward/department. Staff and the Pharmacist must perform a full stock check and sign in the relevant section of the CD register. On re-opening, the drugs and CD register must be returned to the ward/department under the supervision of a pharmacist and a full stock check undertaken immediately. If there is no suitable alternative controlled drugs cupboard on site, consideration must be given to arrange for destruction of the controlled drugs.

Controlled Drug Stock for Doctors Bags

A doctor's bag (bag/box/case), if locked, is considered a suitable receptacle for storing CDs. However, a locked car is not. The doctor's bag should be

kept locked at all times except when in immediate use. The person in lawful possession of this bag (i.e. the GP) should always retain the keys to it. A digital combination lock would provide an acceptable alternative and removes the problem of lost keys. When transported the bag must be kept out of sight. A doctor's bag containing CDs must not be left in a car overnight or for long periods of time. When the doctor's bag is in the practice, it should be stored in a safe place away from patient areas.

A separate CD record book must be maintained for the CDs held within the bag and the GP is personally responsible for recording the receipt and supply/administration of CDs from their bag. Each entry in the doctor's personal CD record book must be signed and dated by them.

If a GP makes a domiciliary visit and either administers a CD from the bag or issues a handwritten prescription for a CD, they should make a note of this in the patient's record as soon as possible after the event. It is good practice to write a prescription for the item administered, endorse it with the word 'administered' and date it.

The stock balance of all controlled drugs entered in the CD record book should be checked and reconciled regularly (at least monthly), with the amounts in the bag to ensure that discrepancies can be identified in a timely way. A record indicating that this reconciliation check has been carried out and confirming the stock is correct should be kept in the CD record book. This record should as a minimum state the date and time of the reconciliation check and include wording such as "check of stock level" and be signed by the doctor.

If a discrepancy is found it should be investigated without delay as outlined in Dealing with Discrepancies

Restocking of a 'doctor's bag' from practice stock, should be witnessed by another member of staff, as should the appropriate entries into the practice's CD register.

Illicit or Illegal Substances Brought into PTHB Facilities

If a patient is admitted with a drug or a substance which is known or suspected to be illegal, then it must be handed to the nurse in charge who, with an approved witness, will describe the drug as an "unknown substance" in the nursing record and store the substance immediately in a signed, sealed container, e.g. envelope, and place in the Controlled Drug cupboard, with a record made in the back of the register. At the earliest opportunity, the drug must be collected by a police officer. Return to the patient is NOT permitted.

The incident must be recorded on a Datix Incident Reporting system and a CD Incident Report completed.

If the patient is unwilling to hand the substance over, the nurse must contact the senior duty nurse.

In general the patient's right to confidentiality must be preserved and the identity of the patient must not be divulged to the police. However this would not be the case when the quantity of substance involved may imply dealing.

When handing over the substance to the police officer:

a) Check that the police officer has appropriate identification
b) Items MUST be signed out and witnessed from the CD register.

MEDICATION SUPPLY

Ordering Stock Drugs

Stock drugs are those that are in routine and sufficiently frequent use to warrant being available prior to being prescribed. Stock drugs will reflect the nature of patients on the ward/department and are supplied in anticipation of a prescription or authorisation to administer.

The PTHB Chief Pharmacist is accountable for securing a suitable stock medicines supplier for PTHB facilities and for ensuring the supplier meets legal and contractual obligations. Stock medicines supplies must not be obtained by any other route without prior approval from the Chief Pharmacist.

Different arrangements are in place for medicines individually dispensed for a patient (see sections on use of Patient's Own Drugs and discharge prescriptions).

The current medicines stock supplier for PTHB hospitals is Nevill Hall Hospital under a service level agreement.

Ward/Department Medicines Stocklist

Each ward or department has a stocklist in place agreed between the ward/department and with the PTHB medicines management team. The stocklist details the range and quantity of products that can be ordered by staff.

Non formulary drugs cannot be added as a stock item and unlicensed drugs can only be added in certain circumstances approved by the Medicines Management team and agreed by Nevill Hall Hospital Pharmacy.

A separate stock list exists in wards and departments for Controlled Drugs.

Revision of Stockholding

The stockholding should be subject to continuous assessment and evaluation by the pharmacy team in conjunction with the ward/department manager and any clinicians who regularly prescribe for patients attending the ward/department.

This review will include analysis of supply data from the supplying pharmacy and consideration of loss of stock, due to expiry without use, and the urgency by which a particular medication may need to be initiated. There must be a formal review and agreement concerning the total stock holding at least twice a year.

Stock Drugs in Community Bases and Clinics

Community healthcare professionals are not authorised to be in possession of a stock of prescription only medicinal products, except for those where they are signed up to an appropriate PGD e.g. Adrenaline injection 1 in 1000.

All other medications for administration should be obtained on prescription on a named patient basis and therefore via a community pharmacy, hospital pharmacy or GP dispensary.

Ancillary items, such as glucose or urine testing strips, may be obtained via Nevill Hall Pharmacy.

Dressings ordered via the ONPOS or NWOS system are not classed as medicinal products for the purposes of this document and may be held as stock.

See also Community Teams – Access to Pharmacy Items

Ward/Department Stock Top up by Pharmacy Staff

A Pharmacy Assistant Technical Officer (ATO) or Pharmacy Technician will ensure stocks of pharmaceutical products are replenished to agreed stock levels, ensure good stock rotation and will expiry date check the cupboards.

- The pharmacy team will provide each ward/department with the details of the arrangements applicable to that ward/department. These details will include the frequency of the top-up service (e.g. the usual service days and times), and the names of the usual pharmacy staff members assigned to service that ward/department. There will be an annual review of these arrangements, with the ward/department team.
- A signature from the ward/department registrant will not be required where a pharmacy top-up service is in place.
- Controlled drugs stocks are not included in the pharmacy top-up service. Controlled drugs need to be ordered by the registered nurse in charge of the ward/department, using the controlled drug requisition book.

- Nursing staff must ensure that the pharmacy team is notified if there is an above normal need for a particular stock item. This will allow additional stock to be ordered if necessary/appropriate.

Electronic Top Up – Omnicell cabinet (where applicable)

In some areas of the health board Omnicell cabinets are in place. These provide an electronic storage and ordering system which automatically order items that go below an agreed threshold quantity. Staff working with Omnicell cabinets will be provided will specific training and procedures are in place for staff to use [link to Omnicell SOPs].

Ward/Department Stock Orders

If a top-up service is not in place, or additional stock is required before the agreed pharmacy top-up, then an order for stock drugs must be made by a request directly to NHH pharmacy department through an electronic ordering system. Staff required to use an electronic ordering system will receive training from the Pharmacy team [link to WOREQ2 SOP].

The agreed stock ordering process is via the WOREQ2 system or via e-mail to ABB.NHHPharmacy@wales.nhs.uk

If sending by e-mail the e-mail must clearly state, name, strength, form, quantity of medication required and delivery location.

If e-mailed from a non-registered member of staff the body of the e-mail must state the name and designation of the registrant authorising the stock request and this will be subject to audit.

Non-Stock Pharmacy Orders – Named Patient Supplies

Pharmacy and nursing teams should collaborate to order non-stock pharmacy items, which will be ordered via the agreed electronic system – currently the 'Pharmacy Order' function of MTeD or via an agreed paper system.

The supplying pharmacy will need further information for non-stock items, such as:-

- Patient's name, drug, dose, frequency and length of course.
- If the item(s) is not being ordered by a pharmacy team member or has not been clinically checked by a PTHB Pharmacist (annotated by initials in green pen in the pharmacy box), then the supplying pharmacy will require an electronic copy of the All Wales Medication Administration Record.

The supplying pharmacy will require authorisation from the Medicines Management team to fulfil any requests for unlicensed medication or medication not included in the Powys Drug Formulary or the pharmacy may be able to suggest a formulary alternative.

Authorised Staff Who Can Place Pharmacy Orders

Orders should either be placed electronically, via an NHS Wales e-mail address or via a paper copy. Pharmacy orders can be placed by:

- a pharmacy professional or a pharmacy assistant
- a registered nurse in charge or delegated to another registered nurse
- a Registered Operating Department Practitioner (ROPD)
- a midwife
- a dentist or dental therapist or dental nurse
- medical staff
- in clinics by an appropriately registered Healthcare Professional (e.g. Physiotherapist, Podiatrist)

If an order is e-mailed from a non-registered member of staff the body of the e-mail must state the name and designation of the registrant authorising the stock request and this will be subject to audit.

Names and sample signatures of registered staff eligible to order medicines on behalf of the ward/department/theatre/clinic must be supplied to the supplying pharmacy.

This signature list should be countersigned by the ward/department/theatre/clinic manager and will be agreed by the Medicines Management Team. Ward and department managers should ensure that this list is updated with any change in staff.

Telephoned Pharmacy Orders

Urgently required medicinal products will only be supplied against telephoned order/requisition in exceptional circumstances.

The name of the member of staff placing the order will be recorded and kept in both the pharmacy and requesting hospital ward/department (e.g. daily diary).

Telephone orders must be followed up with a written or electronic requisition request. This request must indicate that it is confirmation of a telephoned order.

Items to be ordered via Oracle

For hospital services, the following will be obtained via Oracle and are no longer pharmacy items: -

- Sip and enteral feeds
- Polycal
- Non-medicated dressings
- Barrier creams, cleansing foam
- Pre-injection swabs
- Nail varnish remover
- Disinfectants

Further information on how to order via Oracle is available on the Oracle Sharepoint page

Transport of Medicines and Pharmaceuticals

PTHB Community Hospitals & Services from supplying pharmacy

Medicines are normally transported from the supplying pharmacy through an external contract with Welsh Health Couriers, operated by NHS Wales – Shared Services. Agreed processes are in place to ensure clear documentation of transport and any handover of medications.

Transport drivers have received approved training on the correct transport of medicines, to ensure that requirements for temperature and security are maintained.

In urgent circumstances it may be necessary for a hospital porter to obtain medication supplies from a supplying pharmacy or a community pharmacy – the agreed SOP describes the process and documentation to use [link].

Stock medication must never be given to patients or other members of the public to deliver. Named patient supplies must only be given to the named patient or their representative.

PTHB Community Hospitals internal stock transfers

Where excess or short dated stock is unlikely to be used by a particular ward or site but may be utilised on another site. In order to reduce wastage, the pharmacy team will lead on a stock transfer process. The process will follow the agreed stock transfer SOP [link] and transport will be via WHCs using agreed audit trail paperwork.

Stock controlled drugs (schedules 2 to 5) must not be moved between hospital sites under any circumstances. A PTHB Pharmacist may move controlled drugs (in agreement with the PTHB CDAO) within a hospital site, but with no Home Office licence in place, stocks must not be moved to a different site.

Urgent Transport of Pharmacy Items – Blood Bikes/Taxi

Where there is an unanticipated and urgent need for a pharmacy item to meet a clinical need e.g out of hours or at weekend.

It may be possible to engage Blood Bikes to support supplies from the supplying pharmacy or another Powys Hospital, if Blood Bikes are not available then a trusted taxi service may be used.

Blood Bikes

Can be contacted on Controllers number 0300 303 1733

Taxi Service

NHH Pharmacy utilise Shelia's Cars, Abergavenny on 01873 857954

Pharmacy Transport documentation

Medication delivered to a ward or department must be delivered to and signed for by the relevant registered healthcare professional to ensure a complete audit trail of the transport.

Agreed transport documentation will be provided by the supplying hospital pharmacy or the PTHB Pharmacy Team. Once the delivery handover is completed the signed documentation must be returned to the supplying pharmacy or medicines management team as appropriate.

The transport documentation should be retained for a period of 3 months in line with SPS Retention of Pharmacy Records.

Packaging and Transport

The supplying pharmacy will ensure that medications are packaged appropriately and safely and within agreed transport boxes or bags.

Controlled drugs will be segregated.

Any products that require refrigerated storage will be supplied for transport in a validated pharmacy cool box.

Any internal transfers or medicines transported in the community need to meet this requirement

Transport of Medical Gases

Medical gas cylinders larger that CD (Oxygen) or ED (Entonox) size or equivalent, must NOT be transported by any member of PTHB staff, transport must be undertaken by a recognised medical gas courier (e.g. BOC).

CD/ED size cylinder (e.g oxygen or Entonox) may be carried by certain teams such as midwifery, respiratory or dental teams when providing home visits or community sessions. Anyone carrying medical gases in their vehicle must ensure that: -

- they have received appropriate medical gases training and that their training is up to date.
- the vehicle the cylinder(s) is being carried in is covered by the car insurer for carrying medical gases
- the cylinder is carried in a designated carry bag and secured in the boot of the vehicle.
- the cylinder is fully switched off and is not leaking.
- there is no smoking in the vehicle whilst the cylinder is being carried
- there are no more than 3 ED/CD size cylinders carried at any one time.
- Once the journey has completed the cylinders should be removed from the vehicle to secure designated storage.
- It is not a legal requirement, but good practice to display a magnetic green warning label when transporting cylinders to alert emergency services in the case of emergency.

Liquid Nitrogen

Liquid Nitrogen must only be transported from sites by an approved provider, this includes storage dewars and cannisters, transport in Health Board or personal vehicles is prohibited. For further information refer to the PTHB SOP CDP020 Safe Use and Storage of Liquid Nitrogen.

Transport of Refrigerated Drugs

The supplying pharmacy is responsible for ensuring that any pharmaceuticals requiring refrigeration are clearly identified and transported in a validated temperature-controlled container (i.e. validated cool bag with ice or cold packs).

The supplying pharmacy must ensure that the driver is aware that refrigerated items are being transported and that they must be handed over directly to a member of healthcare staff with instructions to refrigerate immediately on receipt.

If there are any concerns that the cold chain may have been compromised then the Pharmacy or Medicines Management Team must be contracted. Further information can be found in the Cold Chain Policy and Procedure

Transport of Controlled Drugs

See also controlled drugs section

The supplying pharmacy will supply stock controlled drugs in a secure package and will require the transport driver to sign that they have received controlled drugs for transportation.

The controlled drugs must be kept secure at all times and once at the required destination and must be handed directly to a registered staff nurse, midwife or RODP who must sign to confirm receipt of the controlled drug.

Receipt of Pharmacy Items

All areas receiving pharmacy items should have a designated place for their receipt.

- Drugs requiring refrigeration will have their outer transport containers suitably labelled. These must be unpacked immediately and the medicines placed in the medicines storage refrigerator.
- Any controlled drugs must be unpacked, checked and, if required, entered into the controlled drug register, with a witness, and locked into the CD cabinet immediately upon receipt – see controlled drug section.
- Medicines stored at room temperature must be put away without delay and security maintained at all times.
- Wards and departments utilising electronic storage systems will be provided with training on how to receipt and store medications in the systems.

- A member of the ward / department staff should check the items received against the delivery note and sign the delivery note, indicating receipt.
- Any discrepancies must be reported immediately to supplying pharmacy.
- If medicinal products are damaged upon receipt contact the supplying pharmacy as soon as possible who will advise on their safe handling and return. Note that damaged refrigerated drugs and controlled drugs must be stored appropriately in the meantime, but labelled and segregated (quarantined) to avoid inadvertent use.

Delivery notes (picking tickets) should be retained for 3 months on the ward in accordance with SPS Retention of Pharmacy Records Guidance

Out of Hours Access to Urgent Pharmacy Items

It is essential that ward and pharmacy staff work together to anticipate the pharmacy stocks required for a ward/department to ensure that clinical need is met. This is particularly important at weekends/bank holidays and where patients are receiving high or increasing doses. It is important that there is clear handover of any new patients or new prescribing to enable ordering of stock from NHH Pharmacy within hours.

If an unanticipated medication need arises outside of NHH or BGH opening hours then the following should be considered:-

- Establish if relatives or carers can bring in a supply from the patient's home (see section on patient's own drugs to ensure the medicine is suitable to use).
- Establish if Nevill Hall Pharmacy can make an urgent supply – this may include the use of Blood Bikes or a taxi service.
- Request a WP10 prescription from the patient's GP or utilise a ward/department WP10 (HP) to be dispensed by a local community pharmacy.
- In exceptional and clinically urgent circumstances BGH pharmacy may be able to supply a medicine to a named patient in North Powys hospitals at the discretion of the senior pharmacist on duty. A WP10 (HP) or hospital discharge prescription must be supplied to legally allow the supply.

An out-of-hours on-call pharmacist service is available. The on-call pharmacist can be contacted via their hospital main switchboards and ask for the "on-call pharmacist".

Nevill Hall Hospital Pharmacy

Bronglais Hospital Pharmacy

Community Teams – Access to Pharmacy Items

See also Stock Drugs in Community Bases and Clinics

- Medicinal products required for use in the community are normally obtained:
    - via a prescription (WP10) issued by the GP or non-medical prescriber and dispensed through a community pharmacy or dispensing practice
    - via a WP10(HP) prescription issued by a hospital prescriber and dispensed by a hospital pharmacy, homecare delivery company, community pharmacy or dispensing practice.
- Community nurses who have successfully completed V100/V150 training may issue WP10CN/WP10PN prescriptions for medicines included in the Nurse Prescribers Formulary (as outlined in the current BNF)
- Community teams may also obtain formulary dressings via the ONPOS or NWOS systems.

Emergency Supply by Community Pharmacy

In the community patients may be able to access a supply of their previously prescribed medication without a prescription if there is an immediate need for the supply and it is impracticable to obtain a prescription without delay.

The supply will only be made following consultation with a pharmacist working in a community pharmacy who will need to agree the supply.

The service is available from all Pharmacies in Powys during the normal opening hours.

The Emergency Medicines Supply service specification is available.

A range of medicines can also be purchased over the counter or supplied in defined circumstances for common ailments (All Wales Common Ailments Service) via the Community Pharmacy.

Community Midwives – Access to Pharmacy Items

Midwives in Powys will obtain medicines and medical gases through a PTHB Birth Centre (ordered through Nevill Hall hospital pharmacy).

Patient's Own Drugs (PODs)

To minimise waste – patients should be encouraged to bring their own medication into hospital with them. This supports an accurate medication history and where a Patient's Own Drug scheme is operating these will be utilised during their inpatient stay.

The Policy For the Use of Patient's Own Drugs includes an assessment criteria to assess medication for suitable use. As a minimum standard, PODs should only be used if the medication looks in good condition and clearly states the patient's name, drug name, strength and dosage and the medication is within its expiry date. Any medication that does not meet this minimum standard, must not be used.

If a PODs scheme is in place on the ward, a PTHB pharmacy professional (pharmacist or pharmacy technician) will confirm medication as suitable for use and the medicine will be annotated for use with a green POD sticker and the All Wales Medication Administration Record will note "POD".

Transfer of Patient's Medicines Between Hospitals

When transferring a patient to another hospital, the outgoing hospital should send the patient's medication and a copy of the inpatient medication chart with them. The only exception to this would be if the outgoing hospital is assured that the receiving hospital has a supply of all of the medicines that the patient requires. This must be confirmed by a registered nurse or pharmacy professional at the receiving hospital.

Patient transfers to another Powys Hospital

Pharmacy professionals across Powys should liaise to establish needs, or if transfer occurs when Pharmacy are not on the ward, liaison with nursing staff to check if any additional medications need to be obtained by the receiving ward.

All PODS should be sent with the patient to the new hospital location. Any that are already assessed by a Powys pharmacy professional (as indicated by an initialed green sticker) do not need to be reassessed. Any unassessed or interim assessed (as indicated by a blue sticker) must be assessed by a pharmacy professional.

Pharmaceutical Samples

Pharmaceutical companies will sometimes provide samples of newly available pharmaceutical products, including dressings, to allow medical

and nursing staff to 'try' products. However, the quality of product and an auditable supply chain cannot be assured.

The use of medication samples, including emollients and dressings without authorisation from the Medicines Management Team is therefore prohibited.

Clinical Trial Drugs

When a patient currently taking medication as part of a clinical trial is admitted to a PTHB hospital or becomes under the care of a community healthcare team, medical staff must assess the risk/benefit of continuing/stopping trial medication. This may involve contacting the principal investigator for the trial. If deemed appropriate, such patients should be allowed to take their own trial medication whilst under PTHB care.

The trial medication should be added to the All Wales Medication Administration Record, indicating any special precautions required for use, as advised by the trial investigators, and annotating with 'patient's own drug'. If the trial medication is known by a code, it must be ensured that the healthcare team have an understanding of what this refers to.

STORAGE OF MEDICINAL PRODUCTS

All medicinal products issued for use shall be safeguarded against loss or improper use and must (with the exception of cardiac arrest and emergency drug boxes) be stored in a locked cupboard, trolley, medicines/vaccines refrigerator, patient's own locker or other secure receptacle (agreed with the PTHB Medicines Management Team), as appropriate. Well designed and appropriate storage of medicines can reduce waste, incorrect medicine selection and missed doses.

Within PTHB clinical areas, safe and secure handling of medicines is a joint responsibility of the nurse in charge of the ward or department and the Medicines Management/Pharmacy team.

Members of the Medicines Management/Pharmacy team are authorised to inspect drug stocks on any PTHB premises at any time to ensure safe, secure and appropriate storage of medicines.

It is the responsibility of the Chief Pharmacist to ensure that all PTHB medicines storage facilities meet the required minimum standards under current legislation and that the area is adequately maintained and kept clean. The Chief Pharmacist must be involved in the planning of refurbishments or new builds of any areas where medicines are stored.

General Principles for Medication

The following is taken from:

- Patient Safety Notice - PSN055 – The Safe Storage of Medicines
- Royal Pharmaceutical Society Professional Standards for the Safe & Secure Handling of Medicines

Storage Areas and Cupboards

The physical dimensions of medication storage and preparation areas should be appropriate for the volume and characteristics of the medication being stored and prepared in those areas and must take account of any legal requirements or specific risks identified by staff with knowledge of the clinical area. Risk assessments, carried out by pharmacy staff in collaboration with ward staff, should be repeated on a periodic basis (minimum twice yearly) to confirm that medication storage and preparation areas remain suitable for the stored and prepared medicines. Such assessments will include, but are not limited to, the physical dimensions

and layout of the area, and any changes to the type or quantity of medicines stored and prepared.

All clinical areas require distinct, appropriately sized and well-designed medication storage facilities to encourage good practice; and to ensure medication is clearly displayed and accessible in order to prevent missed doses and errors from incorrect medication selection.

Location of Medicines Cupboards

Medicine cupboards should be:

- Located in a clean utility room with no free access by patients. The room must be locked when not in use.
- Positioned so as not to be visible from an outside window at ground level.
- Fixed to a solid wall wherever possible. If this is not possible, cupboards should be constructed so that medicines cannot be accessed from the rear of the cupboard.
- Situated so that there is running water and a sink nearby.
- Designed so that the height of the top shelf is safely accessible to staff.

Construction of Medicines Cupboards

With the exception of patients' bedside medication cabinets, medicines should be stored in metal cupboards or automated dispensing systems that comply with British Standard - BS 2881.

Where a risk assessment has been completed and it is determined to be safe to do so, bulk intravenous fluids can be stored in lockable HTM63 modular storage units

Automated dispensing systems

Automated dispensing systems require mains power and IT connectivity and procedures should be in place to allow appropriate access to medicines in the event of interruption to power supply or IT connection.

All staff who are required to use automated cabinets will be appropriately trained.

Automated dispensing systems do not necessarily need to be installed within a locked room provided they meet the other security requirements described in this policy.

PTHB currently uses Omnicell Automated Dispensing Systems.

Layout of Medication Storage Areas

'Health Building Note 00-03 – Clinical and clinical support spaces' provides guidance on the design and layout of medicines storage areas and preparation rooms in a hospital setting, including standardised dimensions for room layouts and components (e.g. cabinets). The size of rooms and medicines storage systems can be adapted based on the number and clinical needs of patients in the clinical area.

All clinical areas require adequately sized and designed storage facilities and preparation areas.

The Medicines Management/Pharmacy Team must be consulted for advice on medicines storage facilities and no changes to medicines storage should be made without involving the Medicines Management/Pharmacy Team. The Medicines Management/Pharmacy Team will work in collaboration with estates and the clinical team to ensure that medicines storage facilities are designed to meet local requirements.

Storage facilities must be designed to ensure medicines can be appropriately segregated, clearly displayed and easily accessed to reduce the risk of medication selection errors. Within storage facilities, physical barriers (e.g. dividers) should be used to separate medicines with similar names. Distinct storage facilities are recommended for different categories of medicines including:

- Oral solid medicines.
- Oral liquid medicines.
- Injectable medicines.
- Injectable cytotoxic medicines – Injectable cytotoxic medicines should be stored in designated storage cupboards or refrigerators clearly labelled with a cytotoxic warning label. These storage facilities should be designed and carefully stocked to minimise the risk of containers falling and spillages.
- Rectal and/or vaginal medication.
- External medicines and dressings.
- Medicines to take home.
- Controlled drugs (CDs)
- Epidural medicines – Patient Safety Alert PSA003 (May 2016), which updated the National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices, requires that epidural medicines are stored separately from intravenous medicines.

- Flammable medicines – These must be stored in a lockable metal cupboard clearly labelled with flammable warning labels. A risk assessment should be undertaken to ascertain whether a fire resisting cupboard is required. This will depend on the quantity and flammability of the medicines. Further information on requirements for storage of flammable substances is available from the Health and Safety Executive (www.hse.gov.uk/index.htm) and local fire officer.
- Medicines requiring refrigerated storage – Specifically designed lockable medicines refrigerators must be used that meet the requirements of Patient Safety Notice PSN015 (July 2015) – The Storage of Medicines: Refrigerators and PTHB cold chain policy.
- Intravenous fluids – Lockable closed storage units with trays or baskets; or open shelving can be used for bulk storage of fluids. Where open shelving is used, it should be located in a locked room. Storage facilities for fluids must be designed to minimise double handling and lifting at height
- Patient's own medicines including at the bedside – Patient's own medicines may be stored in lockable medicines cabinets by the patients' bedsides. These medicines cabinets may be wall-mounted or integrated within patients' bedside cupboard/locker. Medicines cabinets integrated within mobile patient bedside cupboards/lockers should be secured to an anchor point on the floor or wall that staff can detach when necessary to allow cupboards to be transferred with patients. Care is needed if medicines cabinets are integrated into bedside cupboards/lockers to ensure that transposition of lockers between patients does not occur.

Workspace for Medication Preparation

Work surfaces should be easily cleaned and free of clutter. There should be adequate space to prepare medication (i.e. worktop area of $2m^2$ for a 24-bed ward and adequate space to accommodate a sterile field in areas where a medicine is prepared for an individual patient including at the bedside) and to protect staff from injury during the opening of medicine preparation area doors. Where automated drug dispensing cabinets are in use there should be adequate space around the cabinet to allow complete opening of doors and drawers.

Medication Storage Temperature Requirements

The Specialist Medicines Service have produced good practice advice around medication storage temperature requirements Temperature management for medicines storage – SPS

Refrigerated Medication

Refrigerated medication should be stored between 2°C and 8°C. Ongoing monitoring is required with procedures in place to deal with any deviation from acceptable temperatures. In accordance with PTHB Refrigerated medicines policy

Refrigerators used for the storage of medicines or vaccines must be designated specifically for that purpose - ordinary domestic fridges must not be used.

The operating temperature of the fridge must be between 2°C and 8°C (ideally 5°C) and a daily record of fridge temperatures must be kept, with action taken if there is any variance outside of 2°C to 8°C for any of the temperatures – actual, minimum or maximum. Each medicines fridge should have a data logger installed to keep a running log of fridge temperatures.

The drug refrigerator must be locked when not in use and/or kept in a locked room with access restricted to those who are authorised to have access to the medicines in the fridge. Only medicinal products should be stored in the fridge – it must not be used to store food products, blood or clinical specimens.

Refrigerators, thermometers and data loggers must be tested annually in accordance with their maintenance contract to minimise the risk of failure. Medicines Management currently manage the annual servicing contract through Labcold.

The frequency that the fridge door is opened and the duration that it is open for should be kept to an absolute minimum.

It is the responsibility of anyone who moves an item in or out of the refrigerator to ensure that all refrigerator temperatures (actual, minimum, maximum) are within range before using the item and to revisit the refrigerator once the temperature has restabilised (max 1 hour), to reset the thermometer to counteract rises in temperature from the door opening.

The Medicines Management/Pharmacy Team must be contacted in the event of a fridge temperature excursion. The team will be able to offer advice regarding the suitability to use any products that have been exposed to temperatures outside of 2°C to 8°C. The team will need to know the temperature range the product has been exposed to and the duration of exposure.

Further information can be found in the Refrigerated Medicines Policy and SOP.

All staff involved in the management of medicines or vaccines requiring refrigerated storage must compete the E-learning package which can be found on ESR. [070 Cold Chain Training - The safe and secure management of refrigerated medicine]

Ambient (Room) Temperature

All other medication, regardless of storage solution (i.e. cupboard, trolley, automated drug dispensing cabinet etc) should be stored at a temperature between 8°C and 25°C.

A daily log of the room (ambient) temperature of the medication storage areas must be kept. Agreed paperwork is supplied by the Medicines Management team.

Regular audits of medication storage are undertaken by the Medicines Management team, using dataloggers placed in medicines cupboards.

Areas must notify the Medicines Management Team when temperatures above 25°C are recorded on 3 consecutive days. The Medicines Management team will review information retrieved from the relevant data logger and use this to decide whether any adjustment needs to be made to the manufacturer's expiry date (in line with national guidance).

Lighting

Clinical area and task level lighting should be sufficient to minimise errors from the incorrect selection and/or preparation of medication.

In general higher levels of lighting are associated with a reduction in medication errors, therefore the minimum level of lighting recommended for medication storage rooms and areas is 500 Lux.

Additionally task level lighting of 1000 Lux is recommended for verifying and preparing selected medication e.g injectable medication.

Where there are concerns about inadequate lighting, the Medicines Management/Pharmacy Team should be notified.

Storage of Medicines in PTHB Operating Theatres

Epidural medicines – Patient Safety Alert PSA003 (May 2016), which updated the National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices, requires that epidural medicines are stored separately from intravenous medicines.

The Royal College of Anaesthetists provides guidance on the Storage of Drugs in anaesthetic rooms

- Anaesthetic room drug cupboards must be locked when the operating theatre is unoccupied.
- Decisions about drug security in anaesthetic rooms must reflect a balance between patient safety, staff protection and security. This may mean that in defined circumstances, drug cupboards (excluding those containing Controlled Drugs) may remain unlocked when the anaesthetic room is temporarily unoccupied and the operating theatre is in use.
- It is common practice to prepare a selection of 'emergency drugs' that should be immediately available during the course of an anaesthetic. These will often accompany the patient from the anaesthetic room into the operating theatre but, if this is not possible, they should be stored in the anaesthetic room in a manner that maintains their immediate availability.
    - The drugs must be adequately labelled, preferably using pre-printed stickers, and must specify: drug name, strength, date and time drawn up and initials of person drawing up and checker.
    - The drugs must be disposed of appropriately if not used.
- Certain rarely-used emergency drugs may be stored in a central location, serving the entire theatre suite, e.g. dantrolene and intralipid. Local SOPs should be compliant with relevant legislation and should ensure that the locations of these drugs are conspicuously signposted.
- The use of effective access control systems for all routes that allow entry into operating departments, limiting access to only those with legitimate reasons for access.

Medicine Trolley

Medicine trolleys are used for administration of medical products to inpatients where a Patient's Own Drugs (PODs) scheme is not in place or where a PODs scheme is in place and a trolley is used for commonly used stocks e.g as required medication, low molecular weight heparins.

When not in use the medicines trolley must be locked and secured by being anchored to the wall or locked in a medicine room where access is restricted.

During the process of administering medicines the registered nurse must be able to supervise the medicines trolley at all times (i.e. the trolley must be kept within sight and reach). If the medicines trolley cannot be supervised at all times it must be locked.

Bedside Medication Cabinets (PODs Lockers)

Where it has been assessed as appropriate, each patient or his or her carer should have access to a bedside medication cabinet to facilitate self or carer administration of medication. Each cabinet within the clinical area must be fitted with unique access controls (e.g. key, swipe card, electronic key code or similar mechanism). A master control/override must be in place for nursing and pharmacy staff working in the clinical area.

There is no agreed British Standard for a Patient's Own Drug (PODs) locker. Most PTHB ward areas have individual medication lockers in place.

PODs lockers must be kept locked at all times and the code for the lock kept secure. Patient's must only be given the code for their locker if a 'Self Administration of Medicines' policy is in place on the ward and the individual patient has been assessed as competent to manage their own medicines. See PTHB Self Administration of Medicines Policy (under development [Link].

If a PODs scheme is place on the ward, all drugs for that patient should be kept in this locker with the exception of Schedule 2 & 3 Controlled Drugs, requiring safe custody, refrigerated or oversized items. It may also be decided not to store 'as required', temporary or injectable medication in the locker.

Nursing staff must ensure that all PODs lockers are emptied, and all drugs are transferred with a patient if they are moved to a different bed within the ward or sent to a different ward or hospital.

Any drugs remaining after a patient has been discharged must be removed immediately and assessed by the pharmacy team for appropriateness for return to stock or destruction. If a pharmacy professional is not on the ward, the drugs should be stored in a central medicines cupboard until they can be reviewed by the hospital pharmacy staff.

Further information on PODs Lockers can be found in the PTHB Patient's Own Drugs Policy

POD Locker Digital Locks

Only registered nurses and the hospital pharmacy professionals must have access to the PODs locker master code which must be kept confidential at all times.

Patient's may be given an individual code to their POD locker if self administration has been agreed. The code on the lock must be changed when the patient is no longer using the locker.

If there is concern that a POD locker code has become known, the Pharmacy Team must be contacted to advise on how to change the code.

Emergency Drug Boxes

It is recognised that the medicinal products stored in these sealed boxes are designed to be used in emergencies and therefore, to allow immediate access, they must NOT be stored in locked cupboards. They should be stored in an appropriate area approved by the Medicines Management/Pharmacy team and PTHB Resuscitation Officer.

It is the responsibility of the Medicines Management team to maintain a record of the location and expiry of emergency boxes and to ensure that they are replaced before any of the content of the box expires.

It is the responsibility of the ward/department to ensure a replacement is obtained from the PTHB Medicines Management/Pharmacy team if a box is used before its expiry.

Contents of Blue Cardiac Arrest Boxes

Blue – Cardiac Arrest Box

ITEM	QUANTITY
Epinephrine/ Adrenaline 1mg in 10ml pre-filled syringe	6
Amiodarone 300mg in 10ml pre-filled syringe **OR** Amiodarone 150mg 3ml amp & Glucose 5%	1 OR 10 + 1
Atropine 1mg in 10ml pre-filled syringe OR Atropine 600mcg in 1ml amp	1 OR 5
Calcium Chloride 10% 1g in 10ml pre-filled syringe	1

Magnesium Sulphate 50% amp	2 X10ML
Syringe 5ml	1
Syringe 10ml	1
Safety (green) needles Ref 305895	5

Pre-filled syringes will be supplied where possible, but at times of product shortages, these may need to be substituted with alternative ampoule preparations.

Further Emergency Drugs

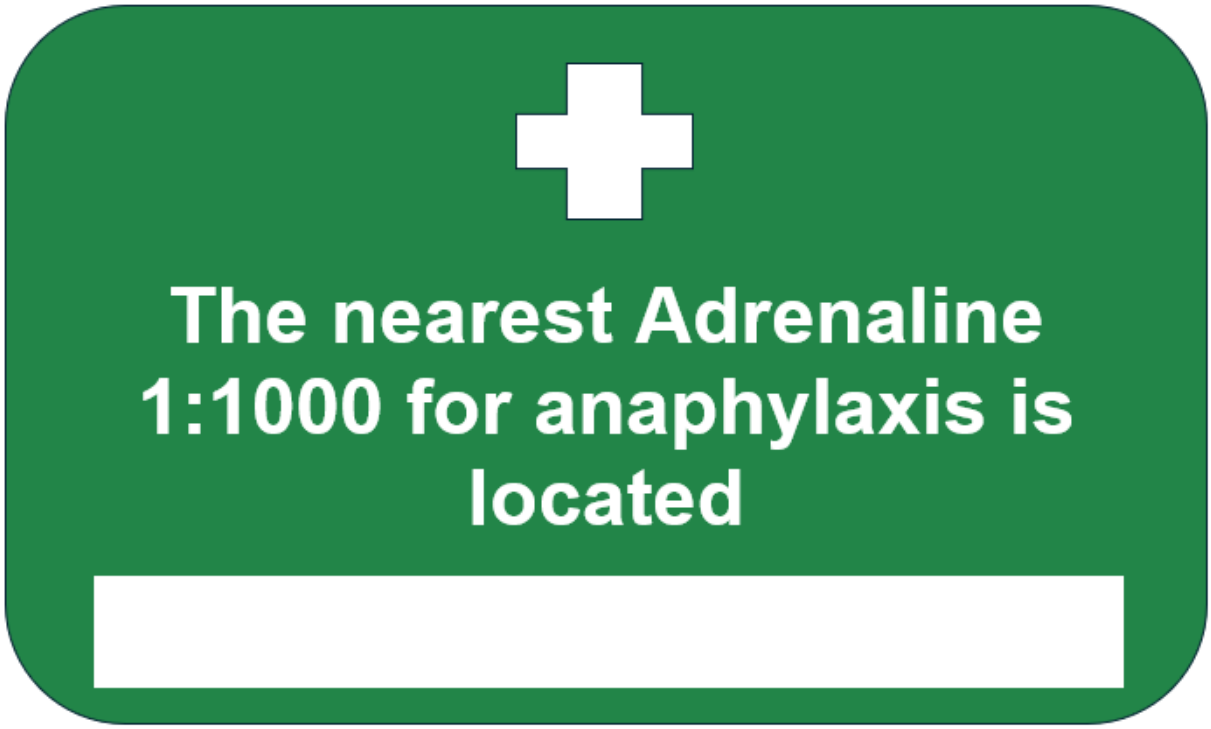
PTHB no longer has in place the 'black box' system for emergency drugs and instead the general ward for each hospital site is required to maintain a stock of the following items: -

ITEM	QUANTITY
ADENOSINE 6MG IN 2ML VIAL	4
EPINEPHRINE (ADRENALINE) INJECTION 1MG IN 1ML 1:1000 1ML	5
AMIODARONE INJECTION 150MG IN 3ML	4
ATROPINE INJECTION 600MCG IN 1ML	5
CHLORPHENAMINE INJECTION 10MG IN 1ML	2
DIAZEPAM INJECTION 10MG IN 2ML	2
DIAZEPAM RECTUBES 10MG IN 2.5ML	2
GLUCOSE 20% 100ML VIAL	1
HYDROCORTISONE SODIUM PHOSPHATE INJECTION 100MG IN 1ML	5
NALOXONE INJECTION 400MCG IN 1ML	5

These items and stock levels will be maintained by the Pharmacy team as part of the weekly stock checks.

Anaphylaxis Kits

Each ward/department that may administer medications or vaccines should clearly have available and identify where adrenaline 1 in 1000 is located, if required in an emergency for the management of anaphylaxis. To do this each ward/department have been supplied with the following poster to note in key places where to find.



Medicinal Products in Patient's Homes

The community healthcare professional, including pharmacy professionals should advise patients or relatives on safe storage of medicinal products in the home e.g. out of the reach and sight of children, away from a hot radiator or areas with steam such as kitchens or bathrooms.

If PTHB community teams or Social Care providers are responsible for the storing a person's medicines then the following should be considered from NICE Guidance NG 67:-

- identifying who should have authorised access to the medicines
- seeking advice from a pharmacy professional about how to store medicines safely, if needed
- ensuring there is a safe storage place or cupboard for storing medicines, including those supplied in monitored dosage systems
- assessing the need for secure storage, for example, in a lockable cupboard
- identifying the need for fridge storage
- reviewing storage needs, for example, if the person has declining or fluctuating mental capacity.

Storage of Vaccines

Vaccines and other drugs requiring refrigeration or cool storage must be stored and transported in a manner that ensures their potency is not compromised.

Where vaccines and other drugs requiring refrigeration are routinely stored or are to be transported, cold chain protocols, as defined in the "Green Book Chapter 3" (Immunisation Against Infections Diseases) and PTHB Refrigerated medicines policy, must be implemented and followed.

Vaccines should be stored in the original packaging, retaining batch numbers and expiry dates.

Vaccines should be stored according to the manufacturer's summary of product characteristics (SPC) – usually at 2°C to 8°C and protected from light. Prolonged exposure to ultraviolet light may cause loss of potency.

Within the refrigerator, sufficient space around the vaccine packages should be left for air to circulate. Vaccines should be kept away from the side and back walls of the refrigerator; otherwise the vaccines may freeze, rendering them inactive and unusable.

Examples of good practice include:

- aiming for +5°C, the midpoint in the +2°C to +8°C range
- designating areas within the refrigerator for different vaccines so that all staff know where specific vaccines are stored. Glass doors or labels on the outside of fridges can reduce the time the door needs to be open, and
- rotating vaccine stocks within the refrigerator so that those with shorter expiry dates are at the front and used first

The frequency and duration that the vaccine fridge door is opened should be restricted and kept to an absolute minimum.

Storage of Medical Gases

All staff involved in the storage and movement of medical gases must have undergone agreed medical gases training and updates.

Each site storing medical gases will have defined storage areas and protocols which must be followed.

See Medical Gases Policy [link]

See Site specific medical gas operational guidelines (under development) [link]

SPS have also provided guidance on appropriate storage and security of Medical Gases

Transfer of Medicinal Products from Original Containers

The transfer of medicinal products from original containers must only be undertaken by the pharmacy team under the supervision of a pharmacist and in accordance with the agreed PTHB Labelling and Dispensing Procedure [link].

See also Dispensing Medication by the Pharmacy Team

Expiry Date of Medications

The following is agreed for expiry date management of medicines kept in PTHB or Care Home settings.

Recommended Expiry Dates of Medicinal Products Once Opened

Formulation	Expiry Details*	Comments
Tablets and Capsules In original blister strips or manufacturer's bottle with printed expiry date	Manufacturer's expiry as it is printed on the original packaging or strip of medication (unless otherwise indicated in patient information leaflet)	Keep all medication in original packaging so the printed expiry is always accessible
Tablets and Capsules Dispensed by pharmacy in amber bottles	6 months from date of dispensing by the pharmacy	Unless directed otherwise by the dispensing pharmacy
Dispersible Tablets Dispensed by pharmacy in amber bottles	As per dispensing pharmacy	Check patient information label if unsure or contact dispensing pharmacy
MDS Trays	8 weeks from date of dispensing	
Oral Liquids In manufacturer's original bottle OR dispensed by pharmacy in amber bottle	6 months from date of opening or manufacturer's recommendation where shorter – mark date of opening on container. Antibiotic liquids have a shorter expiry date once made up. Check with patient information leaflet or with dispensing pharmacy	Check storage requirements – many liquids need to be stored in the fridge once opened/made up
External Liquids (Lotions, Shampoo, Bath Additives)	6 months from first opened	Or as per manufacturer as may be shorter – check packaging or patient information leaflet
Creams Tubes or Pump Dispensers	3 months from first opened	Or as per manufacturer as may be shorter – check packaging or patient information leaflet
Creams Pots, Tubs, Jars	1 month from first opened	
Ointments Tubes or Pump Dispensers	3 months from first opened	Or as per manufacturer as may be shorter – check packaging or patient information leaflet
Sterile Eye/Ear/Nasal drops (bottles)	28 days from opening or as per manufacturer	Check storage requirements may or may not require fridge storage once opened - check packaging or patient information leaflet
Rectal Diazepam	Manufacturer's original expiry date	Individual foil-wrapped tubes
	6 months from first opened	Non-foil wrapped
Feeds	As per manufacturer	Check storage requirements – many liquids need to be stored in the fridge once opened

Inhalers	Reduce expiry as needed as per manufacturer	Check packaging and patient information leaflet carefully for each inhaler
GTN Sprays	As per manufacturer	
Insulin	As per guidance on packing or patient information leaflet	Check information carefully – different products will have different expiries once removed from the fridge
Any product which looks unfit for purpose should be disposed of following your procedure regardless of the expiry date. Check with dispensing pharmacy or if unsure. ***Always check manufacturers' advice on packaging or information leaflet before administering medication. This is a guide and may not be applicable to ALL medicines.**		

Adapted by Sarah Kelsall for PTHB 18.07.22 with kind permission of John Dicomidis ABUHB

Procurement of Cupboards and Fridges for Medication Storage

To ensure that the correct standard of product is purchased and any maintenance or servicing contracts put in place as appropriate, the Medicines Management/Pharmacy team must be involved in and agree any purchase of:

- Medicines cupboards
- Controlled drug cupboards
- Medicines trolleys
- Patient's own drug lockers
- Medicines refrigerators

Security of Medicines

The responsibility for establishing and maintaining a safe system for the security of medicines for PTHB facilities is with the Chief Pharmacist in consultation with CounterFraud and local police liaison as required.

The appointed practitioner in charge of the ward/department and their assigned Pharmacy Professionals shall have the responsibility for ensuring that the system is followed and that the security of medicines on the ward is maintained.

The appointed practitioner in charge may decide to delegate some of the duties but the responsibility always remains with the appointed practitioner in charge.

Security of medication storage areas

All cupboards, trolleys, closed storage units, automated dispensing systems, medicines storage rooms with doors, and medicines refrigerators must be lockable and should be locked at all times when not actively being used. Doors should locked as soon as they are unoccupied.

Locks and Keys

Locks for metal cupboards, other than patients' bedside medication cabinets, and within automated dispensing systems must comply with BS 3621.

Stock medication cupboards (other than controlled drug cupboards) in a clinical area, ward or department should have locks that use identical keys or the same type of keys. Multiple keys may be made available to reduce the time needed for authorised staff to unlock cupboards and administer medicines. The number

of keys available for medication cupboards in clinical areas should be determined following risk assessment.

Multiple keys should not be available for controlled drug cupboards.

Override keys for automated dispensing systems should be securely stored and access restricted to specified individuals.

Electronic locking systems are commercially available and may be considered for medicine cupboards, other than those storing controlled drugs, provided they comply with BS 3621. Electronic locking systems use electronic keys or swipe cards that open the lock and then lock automatically on closing the door.

Electronic card or key systems must be allocated to each authorised individual to allow access to medicine cupboards to be audited. Individuals' electronic cards and keys should be regularly changed.

Use of standard keypads, where the number is shared with a number of users, are not considered secure and are not recommended.

The keys for the medicine cupboards, drug trolley and drug refrigerator will be kept on the person of the practitioner in charge or designated deputy. The keys for the Controlled Drug cupboard must be kept on the person of the nurse in charge of the area, which may mean that they need to be kept **separately** from the other keys.

The manager of the ward/department is responsible for ensuring the security of all medicine keys. In clinic areas where there is not 24 hour nursing cover, arrangements must be made and agreed with the Medicines Management/Pharmacy Team to ensure safe custody of keys during the hours that the area is not operational, for example arranging for the keys to be securely stored in a medicines cupboard in an area that operated 24 hours a day.

Keys or lock codes for individual patient lockers where medication is stored (where a Patient's Own Drugs scheme exists) should only be given to the patient where they are deemed suitable to self-administer their own medication and where a self-administration policy is in place.

<u>Operating Theatres Keys</u>

The keys for the drug cupboards must be kept separately from the keys to cupboards used to store other items.

The overall responsibility for these keys lies with the designated nurse in charge or RODP of the theatre who must be identified on the duty rota. To ensure that controlled drugs are readily available, the designated person in charge of the theatre may devolve responsibility to a registered nurse or RODP.

When the theatres are not in use, keys must be locked in a secure area as agreed with the Medicines Management/Pharmacy team.

Apparent Excessive Use or Loss of a Medicinal Product

PTHB has a zero tolerance anti fraud and theft culture and is committed to the principle that the NHS resource of medicines is always put towards the patient in need of that prescribed medicine. PTHB will seek to reduce medicine losses from fraud and theft and if necessary will undertake sanctions which may include criminal, civil or disciplinary proceedings, and PTHB will seek to recover the cost of stolen or defrauded medicines.

Any suspected discrepancies or concerns must be reported to the Chief Pharmacist and CounterFraud Officer at the earliest opportunity. A Datix incident report should be completed and submitted as appropriate/necessary.

Inspection and Checking of Stock and Storage of Medicinal Products

Hospitals

The Ward Pharmacy team or Medicines Management team will regularly inspect medicines cupboards, trolleys, fridges and other medication storage facilities accompanied by the person in charge or the designated deputy.

This should be done at intervals not exceeding six months.

Support will be provided if policy is not followed and poor practice is observed with a remedial action plan put in place and agreed with the Chief Pharmacist

Ward/Department Closure

The Medicines Management/Pharmacy team must be informed of any intended ward or department closures and a risk assessment and action plan put in place to ensure the ongoing security of medicines.

For Controlled Drugs see Hospital Ward/Department Closure

Suspected Tampering of Medicines

Incidents have occurred across the NHS where it is suspected that medicines have been tampered with. Examples of this may include the introduction of a contaminant into a fluid or other infusion, injection or other medicine dose form.

The motive for such action may well be unclear but could include deliberate harm to others.

If such an incident is suspected the nurse manager and Chief Pharmacist must be immediately informed and if suspicion of tampering is evident the Police must also be immediately informed. Each suspected item must be retained in a separate plastic bag and labelled so to preserve the chain of evidence.

Security of Medical Gases

NHS Protect has produced guidance on the security and storage of medical gas cylinders. Key guidance is that:-

- as far as reasonably practicable, all stages of the delivery and receipt of cylinders should be witnessed and supervised by an appropriate member(s) of NHS staff
- processes should be in place to verify the identity of supplier (driver), the number of cylinders delivered and collected, and accompanying paperwork to enable discrepancies to be detected at an early stage
- a risk assessment should be undertaken to establish the physical security requirements for the storage facility and a multi-layered approach to security applied
- any new builds or refurbishment of storage facilities should have due regard to incorporating security measures into the early stages of the design process, in discussions with the local police Designing Out Crime Officer/Crime Prevention Design Advisor, involvement of the Local Security Management Specialist and taking account of relevant guidance
- suitable arrangements should be put in place for tracking cylinders from point of receipt into the NHS organisation to their return empty to the supplies
- appropriate arrangements should be made for recording, assessing and investigating concerns of theft and/or misuse of cylinders

- appropriate training should be made available to all staff to equip them to recognise security risks

Further information is available from:-
https://www.sps.nhs.uk/wp-content/uploads/2021/01/guidance-on-the-security-and-storage-of-medical-gas-cylinders.pdf

Stationery and Records

Controlled Stationery

Controlled stationery includes WP10 and WP10(HP) prescription pads, controlled drug requisition books and registers.

The term 'controlled stationery' refers to stationery which is sequentially prenumbered to provide a robust audit trail, usually used to record and process items of a financial nature, the use of which has to be regulated, because of risk of potential misuse.

Other stationery may not be classified as 'controlled stationery' but can still potentially be misused if it falls into the wrong hands, such as Inpatient Medication Charts and PTHB internal discharge prescriptions and so also require secure storage and management.

Inpatient Medication charts

All medicines for inpatient must be prescribed on authorised medication charts, including supplementary medication charts. Agreed stationery will be authorised on an All Wales or local basis and will be advised by the Pharmacy/Medicines Management team.

Inpatient medication or supplementary charts must not be photocopied for use but should be ordered via standard stationery orders through Oracle.

The current inpatient medication charts in use are:-

- Medical wards – All Wales Long Stay Inpatient Medication Chart. AWMR05.16
- Mental Health Wards – All Wales Mental Health. Code:

PTHB Discharge Prescriptions

Wards and departments not using the Medicines Transcribing and electronic Discharge (MTeD) system should use the PTHB Discharge Prescription which is available to order via Oracle.

PTHB Pre-Printed Pathways Including Medication

These must be agreed through PTHB Governance processes and made available to order via Oracle.

Pathways should not be photocopied and original documents used for each patient

Community Medication Charts

Medications administered in the community e.g in a patient's home or care home are dispensed with labelled directions for use and so legally a medication administration chart is not required. However, use of such a chart can be good practice where multiple carers are administering medication and therefore an administration chart provides a record of that medication administration.

Charts in use include: -

- PTHB Medication Administration Record (MAR) – available from dispensing community pharmacy or GP Dispensary
- MAR Chart provided by a community pharmacy – these will have different layouts depending on the company.
- All Wales Inpatient Medication Administration Chart – used by District and Community Nursing Teams
- Syringe Driver Chart – mainly used for palliative care syringe drivers
- All Wales Care Decisions for the Last Days of Life Guidance Pathway

Prescription Pads – WP10, WP10(HP)and WP10 (CN)

All types of WP10 prescription pads are classed as controlled stationery, uniquely numbered and centrally controlled.

NHS Counterfraud have developed a guide around safe management of prescription forms [Management and Control of Prescription Forms March 2018] and this is reflected in the PTHB Prescription Pad Management SOP (under development) [link]

Prescription Pads for PTHB Staff

The Medicines Management Team manages the ordering and receipt of prescriptions centrally for PTHB services via Xerox (UK) limited and will only issue to agreed wards, departments and individual clinicians where a need for prescribing on a WP10 (HP) prescription pad has been clearly identified and agreed.

Prescription Pads for Ward Use

WP10 prescriptions should only be used for obtaining supplies from a community pharmacy for hospital inpatients in limited circumstances:

- To obtain medication for discharge:
  - when a patient has been assessed and deemed suitable for a monitored dosage system (MDS) (see section on monitored dosage systems) or
  - where assisted medicines administration from a care worker using a MAR chart is appropriate
- To obtain supplies for a PTHB inpatient for use in the inpatient setting where the supply is clinically urgent and all other normal supply routes have been exhausted and in agreement with a PTHB Pharmacy professional.
  To use WP10 Prescriptions for inpatients contravenes VAT (Value Added Tax) regulations and circumvents agreed medicine supply routes.
  Use of WP10 prescriptions for inpatient use must be Datix reported outlining the reason for use.

Prescription Pads for Independent Contractors

Prescription pads for GP and independent Dental practices and Community Pharmacies will be ordered directly by the contractor.

For independent contractors the name of the individual must appear on their respective professional register, including non-medical prescribing annotation (if applicable) and for GP's, Dentists and Optometrists on the NHS Wales Performers List

Receipt of delivery of Prescription Pads to Central Store

The Medicines Management Team will also manage the ordering of prescription pads for Health Board employed Community Nurses, Independent Prescribers and services such as the continence service.

Prescription pads are held centrally in secure storage by the Medicines Management teams and a log of receipt and serial numbers kept.

On issue from the Medicines Management team the prescription pad will be stamped with the name of the ward or department. For independent and

community prescribers the prescriptions will be pre-printed with their prescribing number.

Checks Required Before Issuing Prescriptions

The PTHB Medicines Management team will maintain a register of all PTHB employed medical and non-medical prescribers.

Prescribers intending to prescribe within PTHB services must be registered with the Medicines Management Team on joining the organisation or on qualifying as a prescriber. Proforma applications can be found in the Non Medical Prescribing Policy [Link] and the application form to obtain a prescribing number can be found on the NWSSP Prescribing Services website.

The MM Team will validate the prescribing credentials of the applicant via the respective GMC, NMC, GDC, HCPC, GOC or GPhC professional register annotations.

For PTHB services a designated person will be identified and will be responsible for requesting prescription pads from the Medicines Management Team for each site, for either a ward or department or an individual named prescriber. This responsible person will receive awareness training from the Medicines Management team detailing how to order, maintaining security, the process of issuing to individual practitioners or wards or departments and ensuring that robust, auditable records are kept.

Prescription Pad Stock Control

A record is maintained on prescription stationery stock received and distributed.

The agreed PTHB log must include, as a minimum:

- Date of receipt
- Name or person accepting the delivery
- what has been received, along with serial number data and quantity
- where items are being stored
- when prescription forms are issued to the authorised prescriber
- details of who issued the forms
- to whom prescription forms were issued, along with the serial numbers of these forms and quantitiy
- the serial numbers of any unused prescription forms that have been returned

- For Medicines Management Team only - details of prescription forms that have been destroyed

These records should be kept for 3 years from the last entry in line with the recommendations in the SPS Retention of Pharmacy Records guide.

Distribution of Prescription Pads

Prescription pads for the Bronllys site may be collected by the responsible person from the Medicines Management Team or they will be delivered by a member of the Medicines Management Team; for all other sites, prescription pads will be transported via Health Courier Wales transport drivers.

The drivers will be required to sign for receipt of the prescription pad and obtain a signatory from the responsible person at the end destination to ensure an audit trail of the prescription pad journey, the completed signature list is returned to the MM Team. The agreed form will be provided by the Medicines Management Team who will have sealed the prescription pad into a designated transport bag with secure uniquely numbered seal, which is recorded on the transport log. The Medicines Management team will ensure that the prescription pad is only sent on a day when the responsible person is available to receive.

The responsible person must receipt the prescription pad(s) into their log and issue from the log and deliver the prescription pad to the intended ward or department. For prescription pads for named individuals the identity of the individual must be checked before handing over the prescription pad.

Security of Prescription Pads

Wards and departments should identify a secure location, where access is restricted, for the storage of prescription pads. The controlled drugs cupboard may be used to store prescription pad or another locked location that has been agreed with the Medicines Management team.

Where prescription pads are provided for an individual named prescriber, it is the responsibility of that individual to ensure safe and secure handling of these prescription pads.

As a matter of best practice, prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded. It is also good practice to record the

number of the first remaining prescription form in an in-use pad at the end of the working day. This will help to identify any prescriptions lost or stolen overnight.

Prescription pads should be stored securely at all times (in a locked drawer or cupboard) and not left unattended. If transported in the community they should be stored out of sight e.g. in a car boot. They should not be left in a car overnight.

Where prescriptions are printed, there have been known cases of theft of blank prescription forms from printer trays. Risk assessments should be undertaken which take account of where the printer is located, who has access to the area, whether the area is shared with another service and levels of surveillance etc. If new printers are being installed for computerised prescribing, or there is concern over existing printer security, consideration should be given to fitting a security device to the printer to prevent theft of forms from the printer tray or placing the printer in a secure part of the building, away from areas to which patients and the public have access.

All prescriptions must be removed from printer trays and locked away when not in use or out of hours.

To reduce the risk of misuse, blank prescriptions should never be pre-signed. Where possible, all unused forms should be returned to stock at the end of the session or day; they should not, for example, be left in patients' notes. Prescription forms are less likely to be stolen from (locked) secure cupboards.

Any completed prescriptions should be stored in a locked drawer/cupboard. Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.

Home visits and Prescription Pads

When making home visits, prescribers working in the community should take suitable precautions to prevent the loss or theft of forms, such as ensuring prescription pads are carried in a lockable carrying case and kept out of sight during home visits until they are needed. Prescribers on home visits should also, before leaving the office premises, record the serial numbers of any prescription forms/pads they are carrying. Only a small number of prescription forms should be taken on home visits – ideally between 6 and 10 – to minimise the potential loss.

Storing prescription forms in vehicles

Storing prescription forms in vehicles whilst working in the community is not without risk. During home visits, community staff should take precautions to keep their prescription forms out of sight when not in use. This includes not leaving prescription forms on view in a vehicle.

If prescription pads have to be left in a vehicle, they should be stored in a locked compartment such as a car boot and the vehicle should be fitted with an alarm.

Prescriptions must never be left in a vehicle overnight.

Visits to care homes

Blank or signed prescription forms should never be left at care homes as this provides opportunity for theft and means that the NHS has failed in the role of protecting this asset. Neither should the care home's CD cupboard be used for storing prescription pads. Each prescriber should carry his/her own supply of prescription forms as a matter of course when making care home visits.

Prescription Pads in Multi-Prescriber Settings

Extra precautions need to be undertaken in areas where several prescribers might be working and sharing a prescription pad, such as in outpatients.

These include, but are not limited to:

- named individual/manager/responsible person with oversight of prescription forms within the department/area
- standard operating procedure (SOP) in place for management and use of prescription forms specific to the area/department
- keeping a record of prescription pad/s currently in use
- up to date record of permitted prescribers which holds their contact information and details of where and when they work
- not leaving the prescription pads unsupervised in public/patient areas
- not leaving the prescription pads in patients' notes
- ensuring that prescription pads are secure when not in use

Prescriptions Posted in the Mail

Posting prescriptions is not routinely recommended and should only be used as an absolute last resort, after all other options have been explored and exhausted.

The preferred and safest options for patients to obtain a signed prescription form from their prescriber are either face to face during the consultation or collected on their behalf by a named representative from the prescriber or from their nominated pharmacy. Using either of these options reduces the opportunity for fraudulent activity to occur involving a genuine prescription form.

NHS Counter Fraud Authority Guidance states that posting prescriptions should only be carried out in exceptional circumstances following a risk assessment. This should include a process with established checks, to ensure that as far as possible, that the prescription actually reaches the intended recipient.

Where all other options have been exhausted and the only option available is to post the prescription, a postal service with tracking information must be used in all circumstances and the item must be signed for at the point of delivery to ensure it can be traced in the event it was not received by the intended recipient.

Any area using the postal method of sending prescriptions must have a standard operating procedure in place which has been agreed with the Medicines Management team. This SOP must outline clear responsibilities including assigning a member of staff to follow up and confirm that prescriptions have reached the intended recipient.

In all cases, the patients address or confirmation of Community Pharmacy must be checked in advance of posting the prescription and a reconciliation check must be made to ensure that the intended patient received the prescription form.

The contents of the package/envelope should not be easily identified and a return address must be provided for use in the event that the item cannot be delivered.

The following records must also be kept:

- Confirmation that the patient is aware that the prescription is going to be posted and has provided consent for this to happen.
- Confirmation that the delivery address has been checked and is correct.

- The exceptional reason for posting the prescription form
- The serial number of the prescription form
- The date the prescription form was posted and the expected date of delivery.
- The name and address of the recipient
- The name, profession and professional registration number of the prescriber
- Details of the items prescribed including drug name, dose, formulation and quantity.
- The date that the reconciliation check was carried out and confirmation that the prescription form was safely and securely received by the intended recipient.

In the event that the patient reports non receipt of the prescription form, this must be escalated immediately to the Chief Pharmacist and Counter Fraud Specialist.

PTHB services are required to submit details to the Chief Pharmacist (via: info.medicinesmanagement.powys@wales.nhs.uk) of all situations where it has been necessary to post prescription forms. All cases will be subject to audit to ensure compliance with the policy.

Destruction and disposal of Prescription Pads

New prescription forms should not be issued to prescribers who have left or moved employment or who have been suspended from prescribing duties, and all unused prescription forms relating to that prescriber should be recovered and securely destroyed.

Individual prescribers and their line managers must ensure that the Medicines Management Team is notified if a prescriber (including locums) is leaving/has left the organisation or otherwise ceasing prescribing duties. The Medicines Management team will arrange secure collection of any remaining prescription pad forms.

The Medicines Management Team will liaise with the Workforce team every quarter to ensure that individuals with prescribing status are still in post and remain authorised to prescribe.

Secure return of personalised forms which are no longer in use must be arranged with the Medicines Management team. The Medicines Management team will securely destroy the prescriptions (e.g. by shredding) before being put into confidential waste, with a log kept of the serial number of the forms destroyed. Best practice requires these prescription forms are retained for local auditing purposes for a short

period (3 months) prior to destruction. The destruction of the forms will be witnessed by a second member of Medicines Management staff.

Records of forms destroyed should be kept in accordance with local record and retention policies – currently 3 years is recommended (SPS Retention of Pharmacy Records).

Lost or Stolen Prescription Pads

If a prescription pad or any prescription form is thought to be missing every effort should be taken to locate the prescription pad/form, if it is not possible to find:

- Where possible establish the serial number(s) of the pad/form
- Report to line manager/service lead, seek advice from the Medicines Management department: 01874 712641 or on-call pharmacists if out of hours:
    - Nevill Hall Pharmacy 01873732279 / Weekends and Nights 01873 732732
    - Bronglais switchboard 01970 623131.
- If a prescription is missing with a controlled drug prescribed, please report to the PTHB Controlled Drugs Accountable Officer (CDAO) on 01874 712641 or Powys.CDAO@wales.nhs.uk
- Complete an incident report (Datix). This includes any no harm or near miss incidents

The Medicines Management team will:

- Report missing prescriptions to the Business Services team on 01792 860410. This will send out an alert to local community pharmacies to look out for the prescription
- Report to PTHB Counter Fraud Department 07980 701 895 if necessary

Finding a Fraudulent Prescription

Community Pharmacists may be able to claim a financial reward if they identify a fraudulent prescription. The process is management by the NHS Wales Shared Services and can be found here - http://howis.wales.nhs.uk/sites3/page.cfm?orgid=428&pid=77829

Controlled Drug Requisition Books and Registers

All stationery relating to controlled drugs is classified as controlled stationery.

Both controlled drug requisition books and registers must be stored in a locked drawer / cupboard only accessible to appropriate staff.

Controlled drugs requisition books and registers should be retained, in a secure place, for 2 years form the date of the last order or last entry.

See Controlled Drug Requisition Books and Registers

Retention of Records

SPS have produced recommendations for the retention of any records relating to pharmacy and medicines
https://www.sps.nhs.uk/articles/retention-of-pharmacy-records/

ADMINISTRATION AND SUPPLY OF MEDICINAL PRODUCTS

The following is based on joint RPS/NMC guidelines on the administration of medicines in healthcare settings.

Who can administer a Medicinal Product?

Medications can be administered in PTHB by registered healthcare professionals who are deemed competent for the task. Registered healthcare professionals include nurses, midwives, operating department practitioners, radiographers, physiotherapists, podiatrists, pharmacists, pharmacy technicians, paramedics, medical or dental officers, dental nurses and therapists.

For other care staff (for example Health Care Support Workers, Assistant Practitioners, Physicians Associates) to administer medications a written protocol which has been officially agreed and implemented in accordance with this Policy must be in place.

Those administering medicines must be appropriately trained, assessed as competent and meet relevant professional and regulatory standards and guidance.

PTHB has adopted the Royal Marsden Manual of Clinical and Cancer Nursing Procedures as a resource https://www.rmmonline.co.uk/ to aid the administration of medicines, in addition to organisational policies and procedures around aspects of medicines administration.

Responsibility/Accountability for Administration of Medicines

In addition to corporate and clinical governance responsibilities, registered healthcare professionals are responsible for practicing within their own scope of practice and competence, using their acquired knowledge, skills and judgement.

Registered healthcare professionals who administer medicines, or when appropriate and with appropriate policies in place, delegate the administration of medicines (e.g to HCSWs or assistant practitioners), are accountable for their actions, non-actions and omissions, and must exercise professionalism and professional judgement at all times.

When administering medication against a prescription written manually or electronically by a registered medical practitioner or another authorised prescriber the registered practitioner must ensure the prescription meets the criteria detailed in the Prescribing Requirements section.

Delegation of the Administration of Medicines

In delegating the administration of medicinal products to unregistered staff it is the registered practitioner who must apply the principles of administration of medicinal products.

Within agreed and defined policies (under development) [link] a registrant may delegate to an unregistered, but suitably trained and deemed competent member of staff to assist the patient in the ingestion or application of the medicinal product but the registrant will retain accountability for the administration.

Methods of Supplying and/or Administering Medicines

The registered nurse/practitioner must only supply or administer medicinal products in accordance with one or more of the following processes:

Patient Specific Direction (PSD)

Whilst not defined in legislation a Patient Specific Direction (PSD) is the traditional written instruction, signed by a doctor, dentist, or non-medical prescriber "the prescriber") for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.

In practice a PSD is commonly referred to as a prescription by those who write and follow them because this indicates that it is written by a prescriber.
https://www.sps.nhs.uk/articles/patient-specific-directions-qa/

Types of PSD include:

- Patient Medicines Administration Chart (may be called Medicines Administration Record MAR), including inpatient medication chart
- Prescription Forms – Discharge (TTO), WP10
- Electronic means – e g entry in patient GP record

See PRESCRIBING – Prescription Writing

Patient Group Direction (PGD)

See Patient Group Directions

https://www.sps.nhs.uk/articles/when-patient-group-directions-are-not-required/

Medicines Act Exemption

Specified in the Human Medicines Regulations 2012 (Schedules 17 and 19, as amended). MHRA rules for the sale, supply and administration of medicines for specific healthcare professionals.

See Exemptions in the Human Medicines Regulations

Approved Protocol

For medicines that are not POMs and legally classified as P (administration only) or GSL (administration and supply) medicines e.g. PTHB Discretionary/Homely Medicines Policy

See Discretionary/Homely Medicines

Enteral feeds

Enteral feeds are not classed as a medicinal product and authorisation to administer may be written on an All Wales Medication Administration Record by a registered dietitian.

See Dietetic Products

Administering a Medication against a Prescription

Prescription Requirements and Guidelines

If there is any doubt or ambiguity about any aspect of the prescription or authorisation to administer e.g.:

- name of the drug;
- dosage or strength;
- route or administration or form;
- time, frequency or start or finish date of treatment;
- mixing of drugs including diluents;
- allergies or previous adverse drug reactions;
- legibility;
- legal requirements e.g signature of prescriber

the medication must not be administered and a prescriber or pharmacy professional must be contacted for clarification, including out of hours where necessary (clarification must be obtained in writing, electronically if necessary e.g. to an NHS e-mail address).

Process of Medicines Administration

The Royal Marsden Clinical Nursing Procedures Chapter 15 - https://www.rmmonline.co.uk/contents/chapters#chapter-15 includes procedure guidelines on how to administer medication via various routes of administration.

The administering practitioner, in exercising their professional accountability, and in the best interest of the patients must:

- Ensure the direction to administer is based, whenever possible on the patient's informed consent and awareness of the purpose of the treatment in line with the principles of mental capacity.

- Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.

- Be certain of the identity of the patient to whom the medicine is to be administered and check the identity of the patient together with the patient. For inpatients the All Wales Medication Administration Record must be checked against the patient's identity wristband confirming patient's date of birth and name.
  In some instances, where wristbands are not routinely used, photographs of the patient attached to the medication chart may support identification of the patient.

- Be aware of the patient's treatment plan.

- Check medication to be administered:
  - That the label on the container of the medicine to be administered is clearly written and unambiguous. Check the medication label matches with the prescription.
  - If the medication is supplied in a strip pack, check that the strip matches the expected contents according to the label.
  - that the medication appears as expected e.g. the injection preparation is the expected colour and does not contain particles or have cracks in the vial.
  - any specific storage requirements have been maintained
  - the medication is within its expiry date (including any recommendations around reduced expiry dates e.g. once opened).

- 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 not currently suitable for them.
    - Consider the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies.

- Check the patient has no known allergy to the drug (or excipients) to be administered. This can be checked with the package insert (if available) or with the Summary of Product Characteristics (SPC) available at www.medicines.org.uk

- Read the whole prescription/medication chart carefully and make sure the dose has not already been administered. Special care should be taken if more than one medication chart is in use. Confirm that the patient's or carers have not administered the medication.

- Make a clear, accurate and immediate record of all medication administered, intentionally withheld or declined by the patient ensuring that any written entries and the signature are clear and legible and the appropriate drug administration codes, as specified on the All-Wales Inpatient Medication Administration Record are used.
    - Where a medicine is not administered or refused, details of the reason why (if known) are included in the record and, where appropriate, the prescriber and multidisciplinary team are notified

- Where supervising a student nurse or midwife in the administration of medicines clearly countersign the signature of the student.

- When all administration spaces on the All Wales Inpatient Medication Administration Record have been used a prescriber or suitably experienced pharmacist should be asked to transfer all current prescriptions to a new one.

- Under no circumstances should any staff who are not authorised to prescribe or transcribe, rewrite All Wales Medication Administration Records. This includes the rewriting of 'as required/PRN medication. PTHB Transcribing by Pharmacists Policy (under development) [link].

- Any Controlled drug requirements are fulfilled

Remember that there is no short cut to the drug administration process. It is ESSENTIAL THAT THE LABEL should be read in its ENTIRETY on EACH and EVERY occasion.

Minimising interruptions during medication rounds within ward environments

To ensure safe and effective administration of medication to patients within the ward environment, the staff member undertaking the medication round should wear a disposable red tabard indicating that the medicines round is in progress and that they should not be interrupted, unless as a matter of priority.

Tabards alone cannot however be expected to reduce interruptions; they are one tool to support nurses having protected time to undertake medicines administration.

Medicines rounds should not be interrupted unless there is a genuine emergency or immediate need for action from the nurse undertaking the medicine round. With the exception of emergencies/requirement to take immediate action, to avoid distractions, another member of staff should deal with any situation that arises during the medicines round and where this is not possible, a message should be left so that the nurse undertaking the medicines round can respond at a more convenient time. Where appropriate, contact details of the caller/enquiry should be taken and an explanation offered that the nurse will contact them when the medicines round has been completed.

In the event of an emergency/immediate need for action, the nurse undertaking the medicines round, before responding to the situation, will ensure that the medication trolley is locked and stored away securely in the treatment room (or anchored to the wall), ensure that the patients drug locker is locked and any medication that has been administered has been signed for. If appropriate, a Datix incident electronic form should be completed, giving reasons for the interruption.

Drug Calculations

Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations a second practitioner (a competent professional) should check the calculation independently in order to minimise the risk of error. Any

uncertainties should be raised with the prescriber or a pharmacy professional.

Non Administration of Medicinal Products

- When a healthcare professional is unable to, or fails to administer a prescribed medicinal product, the reason for non-administration must immediately be recorded in the appropriate section (using the appropriate code) of the All Wales Medication Administration Record.
- Inform 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.
- If the reason for non-administration is lack of stock, this should be communicated to the prescriber and pharmacy team; if appropriate the supplying pharmacy should be asked if an alternative is available, which can be discussed with the prescriber and/or when stocks of the original drug are likely to be available. A Datix Incident Reporting system report is appropriate where delay compromises patient care.

- It is the prescriber's responsibility to ensure that nursing staff are aware of new medications prescribed or changes in current medication to allow supplies to be obtained in a timely manner.

- Any medicines omitted from administration must be clearly indicated on the medication chart with the appropriate non-administration code (identified on the inpatient medication chart) – it is not acceptable to leave an administration box 'blank'.

Administration by One Registered Nurse in the Inpatient Setting

In the majority of circumstances one registered nurse or midwife who has demonstrated the necessary knowledge and competence may administer medicinal products without reference to a second person.

However, there must be a second person check for the administration of:

- Medicinal products to children **16 years of age and under**
- Any drug requiring a complex calculation to administer.

Ideally there should be a second person check for the administration of:

- Controlled Drugs (schedule 2 and 3)

- All drugs via the parenteral route

The second person may be a registered nurse, midwife, pharmacist, pharmacy technician, RODP, radiographer Senior 1 or a medical or dental officer, where they have appropriate competencies to enable them to act as a second check. In the community, the second check may be provided by a competent carer or patient.

Community Setting Administration against a Prescription

In the community setting, medication will normally have been dispensed for a patient and be available as a patient labelled supply with directions for use.

The dispensed medication provides the legal authority to administer the medication to the patient named on the label, in accordance with the directions on the label.

If the directions are not clear, then this should be referred back to the prescriber for further clarity.

In the community the patient may have a community medication record for completion of the administration elements. If there are differences between the directions on the dispensed medication label compared to the community medication administration record, this must be queried with the prescriber.

Domiciliary carers may also utilise a community MAR chart.

Parenteral medicines administration

Parenteral administration includes the following routes:

- Subcutaneous
- Intramuscular
- Intravenous
- Intrathecal NB: administration of medicines by the intrathecal route is prohibited in PTHB.

Registered nurses or AHPs who have undertaken the Health Board's injectable medicines training programme [ESR link] and achieved satisfactory competence in the administration of parenteral medicines are permitted to administer the first and subsequent doses of a prescribed medicine by this route.

Staff employed from other Health Boards/Trusts or Agencies must either provide evidence that they have undertaken and satisfactorily completed an appropriate training programme or they must undertake the Health Board's training programme and assessment before giving medicines by these routes.

Where intravenous administration is appropriate and necessary, drugs may be only be administered by a peripheral intravenous lines. See PTHB Intravenous Medicines Policy (under development [link]

For parenteral administration:

- Drug administration must be signed for on the patient's prescription chart
- The method of drug administration must comply with either the:
    - Manufacturer's instructions as described in the Summary of Product Characteristics https://www.medicines.org.uk/emc or package insert, or;
    - Current edition of "BNF" https://bnf.nice.org.uk/ , or:
    - Medusa Injectable Medicines guide.
- Any syringes prepared and not immediately used must be labelled with the contents of the syringe. In the theatre setting pre-printed, colour coded labels are available which must be used for this purpose.

Administration Using Infusion Devices

Before using any infusion device the registrant must have undertaken appropriate training and be confident that they have the required knowledge, skills and competence in the selection and use of the pumps and syringe drivers.

All registrants who have not covered the theory during a pre-registration course will be expected to undertake specific training and be able to demonstrate their competence.

Newly qualified registrants and registrants who use infusion devices infrequently must maintain their familiarity with infusion device and associated equipment. In the event of a doctor using infusion devices they must also work to the standards and guidance set out above.

Diluents

Where drugs require reconstitution or dilution, it must be ensured that diluents are added as prescribed and in accordance with manufacturer instructions or as advised by Medicines Management/Pharmacy team.

In some cases displacement values may need to be considered to ensure that the correct volume of diluent is added to get the required concentration of drug. The Medicines Management/Pharmacy Team should be contacted for advice on displacement values and support with calculations.

Administration of Medical Gases

All medical gases used in the Health Board are licensed medicines. They are subject to the Medicines Act and must be treated in the same way as any other medicines.

Before a medical gas is administered to a patient, written authority from a prescriber must be obtained or administration must be under an agreed PGD or Protocol.

All staff involved with medical gases must have undertaken training appropriate to their role and have passed the required competency assessments. An understanding of the safety concerns and how to reduce risks associated with medical gases is essential. Training must be kept up to date.

Staff assigned to the role of Designated Nursing/Medical Officer (DNO/DMO) are required to undertake additional training to ensure that they have the required competencies e.g. to provide permission (via the permit to work system) to interrupt medical gas supplies, to isolate the medical gas pipeline system (MGPS) in an emergency, to understand and ensure that required processes are in place to safeguard patients in the event of a MGPS alarm etc.

In dental clinics Nitrous Oxide and Oxygen are only administered by a dentist who has undertaken further specific training and continue to undertake a recognised minimum number of procedures per annum.

See Medical Gas Policy [link]

See Site Specific Medical Gas Operational Guidelines under development [link]

Critical Medicines

Critical medicines are medicines that must not be delayed or omitted without a clinical reason that has been discussed with a prescriber. Examples of groups of critical medicines are:

- Antimicrobials

- Anticoagulants
- Anti-epileptics
- Insulin
- Parkinson's disease medication

The following list is not exhaustive, but gives examples of medicines that must not be delayed or omitted. Omitting critical medicines may result in serious harm or death and therefore must be reported as a patient safety incident via the Datix incident reporting system.

Time Critical Medicines - Routine Care

- Administration of the following medication is time critical and should not be omitted without a clinical reason discussed with the prescriber and documented in the medical notes.
- Patient self-administration of critical time medicines should be permitted if the patient is assessed as being competent and having capacity.
- Note: this is a general guide and not exhaustive. It does not cover administration of medicines in emergency situations. (e.g. diabetic ketoacidosis, resuscitation, anaphylaxis, status epilepticus etc.)

<table>
<tr><th>Timeframe for time-critical medicines</th><th>Medicine example</th></tr>
<tr><td>GIVE IMMEDIATELY</td><td>

Resuscitation medicine e.g. adenosine, adrenaline, atropine, noradrenaline, IV fluids,
Antidotes and reversal agents e.g. flumazenil, naloxone, vitamin K, prothrombin complex
STAT doses and medicines for emergency situations

<table>
<tr><td>Acute alcohol withdrawal e.g. diazepam, chlordiazepoxide</td><td>Antithrombotics and anticoagulants acute VTE stroke, ACS e.g. heparin, enoxaparin, dalteparin, abciximab, aspirin, clopidogrel</td><td>Hypertensive crisis e.g. IV labetalol, glyceryl trinitrate</td></tr>
<tr><td>Acute arrhythmias e.g. IV adenosine, amiodarone, digoxin, magnesium</td><td>Bradycardia e.g. IV atropine etc.</td><td>Hypoglycaemia treatment e.g. glucose, glucagon</td></tr>
<tr><td>Adrenal crisis e.g. IV hydrocortisone</td><td>Bronchodilators e.g. nebulised salbutamol and/or ipratropium</td><td>Sepsis e.g. antibiotics</td></tr>
<tr><td>Anaphylaxis treatment e.g. adrenaline, hydrocortisone, chlorphenamine</td><td>Diabetic ketoacidosis e.g. insulin</td><td>Status epilepticus management e.g. IV phenytoin, buccal midazolam, rectal diazepam</td></tr>
<tr><td>Acute GI bleed e.g. IV omeprazole, terlipressin</td><td>Electrolyte disturbance (severe) e.g. IV potassium, calcium, magnesium, phosphate etc.</td><td>Neuroleptic malignant syndrome e.g. dantrolene</td></tr>
</table>
</td></tr>
</table>

	Antifibrinolytics in acute haemorrhage e.g. IV tranexamic acid	Fluid overload e.g. IV furosemide	Thyrotoxicosis e.g. IV propranolol, hydrocortisone
GIVE WITHIN **15 MINUTES** OF PRESCRIBED TIME	• **Anti-parkinsonian medicines** e.g. co-beneldopa (Madopar ®), co-careldopa (Sinemet ®), rotigotine, entacapone • **Insulin (rapid acting or intermediate/biphasic)** – within 15 minutes if meals.		
GIVE WITHIN **30 MINUTES** OF PRESCRIBED TIME	• **Anticholinesterase inhibitors** for myasthenia gravis e.g. neostigmine, pyridostigmine • **Antimicrobials – antibiotics, antifungals, antivirals** • **Anticoagulant (treatment)** e.g. heparin, low molecular weight heparins (enoxaparin, fondaparinux, dalteparin), direct oral anticoagulants (e.g. apixaban, rivaroxaban, edoxaban, dabigatran), warfarin • **Antiretroviral** e.g. Darunavir, ritonavir, tenofovir • **Desmopressin** for diabetes insipidus • **Insulin (long acting)** (unless blood glucose levels indicate differently) • **Opioid analgesia (acute pain)** e.g. buprenorphine, fentanyl, morphine, oxycodone		
GIVE WITHIN **1 HOUR** OF PRESCRIBED TIME	• **Anticoagulant (prophylaxis)** e.g. heparin, low molecular weight heparins (enoxaparin, fondaparinux, dalteparin), direct oral anticoagulants (e.g. apixaban, rivaroxaban, edoxaban, dabigatran), warfarin • **Anticonvulsants** e.g. carbamazepine, levetiracetam, phenytoin, sodium valproate • **Antidiabetic medicines** e.g. gliclazide, metformin, dapagliflozin, sitagliptin, repaglinide, pioglitazone • **Antipsychotics** e.g. clozapine • **Immunosuppressant** e.g. azathioprine, ciclosporin, cyclophosphamide, mycophenolate mofetil, sirolimus, tacrolimus • **Steroids (long-term use)** e.g. prednisolone, dexamethasone, hydrocortisone, fludrocortisone		

Patient Group Directions

A Patient Group Direction (PGD) is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. They should be reserved for those situations where they offer an advantage for patient care (without compromising patient safety) and where they are consistent with appropriate professional relationships and accountability.

PGDs allow health care professionals specified within the legislation to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD.

The supply and/or administration of medicines under a PGD cannot be delegated – the whole episode of care must be undertaken by the health care practitioner operating under the PGD.

Each Patient Group Direction must be developed by a multidisciplinary team that includes a representative from the professionals who will be using it, a senior doctor/dentist, and a pharmacist. A PGD is authorised for use within PTHB and some may be authorised for use by services commissioned by PTHB e.g Primary care (GP practice and Community Pharmacy). There are currently 4 authorised signatories for each PGD.

- Chief Pharmacist (Pharmacist legally required)
- Doctor or Dentist (Doctor or Dentist legally required)
- Professional lead for main staff group supplying or administering under the PGD
- Clinical Governance lead for the organization.

All PGDs should be accessed from the Health Board Internet site. Printing PGDs, other than for the purpose of signing that staff have read, understood and are competent to work to a specified PGD, is discouraged due to the frequency that PGDs are updated. If a PGD is printed, the PGD on the Health Board's internet site should be checked to ensure that it is the most up to date version is being used. Staff working to PGDs are responsible for ensuring that they are always working to the most up to date version.

Each clinical area must have a list of those qualified healthcare professionals who are authorised (by their line manager or professional lead) to work under a specific PGD. The individual will sign to acknowledge they are working under the guidance of the PGD and must ensure:

- that they have a good understanding of the whole contents of the PGD
- that they have successfully completed all of the required training
- that they have the required competencies

before supplying or administering a drug.

There must be no deviation from the details/requirements of the PGD.

Inpatient administration under a patient group direction should be recorded in the 'once only' section of the All Wales Medication Administration Record. Any prescription only medication supplied under a PGD, must have clear directions for use and the patient's name and date added to the directions label in the space provided.

Medication must not be supplied without clear written directions for use or origin of supplier – denoted by the directions label (for POMs) or 'shop' address label (for P or GSL categorised medicines).

Further detail on Patient Group Directions can be found on the Specialist Pharmacy Service Website: https://www.sps.nhs.uk/home/guidance/patient-group-directions/ and on the MHRA website https://www.gov.uk/government/publications/patient-group-directions-pgds/patient-group-directions-who-can-use-them [Note this list has not yet been updated to include Pharmacy Technicians]

The PTHB policy on the use of Patient Group Directions can be found – on the PTHB internet site.

Any member of staff involved in developing, authorising or supplying or administering medication or vaccines under a PGD must undergo the PGD training, which can be found via ESR [000 Patient Group Directions]

Recent updates to PGD Legislation

As of 2023 amendment to the Misuse of Drugs Regulations 2001 [explanatory memorandum]

> Possession of ketamine by paramedics and other healthcare professionals that supply or administer controlled drugs under a Patient Group Direction ("PGD"), is lawful.

Pharmacy Technicians and PGDs

From 26th June 2024, registered pharmacy technicians are able to supply and administer medicines under patient group directions (PGDs), following amendments made to the Human Medicines Regulations 2012.
This does not extend to controlled drugs.

Using PGDs in Remote Consultations

The Specialist Pharmacy Service have provided advice on using Patient Group Directions in remote consultations and how the health professional supplying the medicine under a PGD must undertake the whole episode of care, with guidance on how to ensure this https://www.sps.nhs.uk/articles/patient-group-direction-use-in-remote-consultations/

Written Instructions

Under the Human Medicines Regulations 2012 Occupational Health Services (OHS) are exempt from the restrictions that apply to prescription only medicines, where medicinal products are supplied or administered in the course of the OHS by a registered nurse acting in accordance with the written and signed instruction of a doctor; this instruction is commonly documented as a written instruction.

The written instruction is different to a PGD and is an arrangement between the named registered nurse(s) and the authorising doctor and is not subject to the legislated framework of a PGD – PGDs and written instructions are not interchangeable.

More information can be found on the SPS website
https://www.sps.nhs.uk/articles/pgds-and-occupational-health-schemes/

Homely/Discretionary Medicines Policy

Certain GSL and P medicines, agreed by PTHB, may be administered to patients, without a prescription, within defined parameters and for a short period of time.

Any such administration must follow the Homely and Discretionary Medicines policy and registered healthcare professionals working to this policy will receive training.
An entry of any administration must be made in the once only section of the All Wales Medication Administration Record or the MIU patient record, as appropriate. PTHB Policy Homely/Discretionary Medicines

Access to Smoking Cessation Products

From 1 March 2021 it has been illegal to smoke on hospital grounds across Wales (with the exemption of mental health units). Therefore, it is important that adults who smoke are provided with, or signposted to, pharmacotherapy and/or behavioural support to manage the symptoms of nicotine withdrawal.

AWMSG have produced guidelines to support access to nicotine replacement treatment for inpatients.

Initial clinical management of adult smokers in secondary care - All Wales Therapeutics and Toxicology Centre (nhs.wales)

Specific Exemptions in Medicines Legislation for the Supply or Administration of Medicines

See also Exemptions in the Human Medicines Regulations

Schedule 17 exemptions

There are exemptions within Schedule 17 of the Human Medicines Regulation 2012 which allow certain registered professionals to sell, supply and administer the listed medications without a prescription. Further information on exemptions can be found on the MHRA website.

Exemptions are in place for the following professions:

- Paramedics
- Podiatrists/Chiropodists*
- Midwives
- Optometrists
- Orthoptists
- Dental Therapists and Hygienists

*Note changes re codeine for Podiatrists/Chiropodists from 31st December 2023. [Royal College of Podiatry]

Dental Therapists & Dental Hygienists

From 26 June 2024, an amendment to the Human Medicines Regulations made it possible for dental hygienists and therapists to supply and administer certain prescription-only medicines (POMs) under exemptions, without the need for a prescription from a dentist or a patient group direction (PGD).

Those wishing to use the exemptions must be trained and competent and should undertake any education and training identified as being necessary before working in this way.

A range of local anaesthetic and high strength fluoride preparations are included on the list of exemptions, which will appear under Schedule 17 of the Regulations.

Schedule 19 exemptions

Schedule 19 of the Human Medicines Regulation 2012 allows administration of certain parenteral medicine without a prescription in an emergency. Administration should follow national guidance such as the Resuscitation Council guidance on the management of anaphylaxis or a local organisation guideline/protocol.

The MHRA has confirmed that where a preparation listed in Schedule 19 requires reconstitution or dilution prior to administration then this vehicle does not require a separate PSD or PGD.

Exemptions for Occupational Health Schemes

An Occupational Health Scheme (OHS) is a multidisciplinary service that aims to protect and promote workers' physical, mental and social health and well-being through actions related both to the work environment and to the workers themselves.

Under Schedule 17 of the Human Medicines Regulations 2012 OHS are exempt from the restrictions that apply to prescription only medicines, where medicinal products are supplied or administered in the course of the OHS by a doctor, or by a registered nurse acting in accordance with the written (and signed) directions of a doctor. This instruction is commonly documented in a written operating protocol.

Further information see Exemptions in the Human Medicines Regulations

Midwives and Student Midwife Administration of Medicines

At the point of registration, midwives may supply and administer, on their own initiative, any of the substances that are specified in the Human Medicines 2012 legislation under midwives exemptions, provided it is in the course of their professional midwifery practice. They may do so without the need for a prescription or patient-specific direction (PSD) from a medical practitioner. Provided the requirements of any conditions attached to those exemptions are met, a patient group direction (PGD) is not required.

If a medicine is not included in the midwives exemptions then a PGD, or a prescription, or a PSD will be required. GPs should not be asked to prescribe pethidine for use in labour.

Exemption List – The current midwife exemption list is a defined list of medicines that midwives can administer in the sphere of midwifery practice and can be found in the Human Medicines 2012 legislation https://www.legislation.gov.uk/uksi/2012/1916/schedule/17/made.

Administration of Vaccines

Registered nurses acting as School Nurses or Health Visitors employed by Powys tHB are authorised to administer vaccines to children in accordance with the criteria outlined in Patient Group Directions.

Any staff administering vaccines must have undertaken in line with the National Minimum Standards for Immunisation Training (2005) via online training available at: http://www.wales.nhs.uk/sitesplus/888/page/70069

Supervision of Trainees & Students

Trainees can include:-

- Student nurses on university assigned placements
- Student Midwives
- Student AHPs (including Therapies, Podiatry and RODPs)
- Qualified Nursing, Midwifery or AHP staff (therapies and RODP) gaining additional skills and competencies
- Overseas nursing staff undertaking the OSCE programme
- Students on a return to a professional practice course
- Assistant Practitioners

Where medication administration is a required part of the trainee or students agreed training.

Gaining experience in medication administration via a variety of administration routes is an important aspect of developing healthcare professionals. All Healthcare Professionals in training must be supervised by a fully registered professional when administering medicinal products. This supervision extends to all parts of the process – medicines selection, preparation, administration, recording, review, storage and disposal.

An understanding in relation to calculating the prescribed dose and ensuring accurate checking for the right person, right time, right medicine, right dose and right route must be demonstrated. This must also include pharmacological knowledge of the medicines being administered; consisting of the indication, side effects, contra-indications and incompatibilities.

Students must have knowledge inclusive of laws, policies, regulations and guidance which underpin choice for various route prescribing, supplying, dispensing and administering. Students must be able to recognise the potential for any adverse reactions including allergic reactions. Students are expected to have knowledge on how to respond to anaphylaxis.

Students must be aware of the risks that prescribing errors present to the administration process and actions required should an error be identified.

Where supervising a student, in the administration of medicines, all documentation must be countersigned by the authorised registered practitioner.

Responsibility for safe administration lies with the registered professional who signs the prescription sheet.

Students **must not**:

- administer from a patient group direction (PGD)
- administer a schedule 2 controlled drug or act as a second checker (student/trainee may participate in medication preparation and observe the administration and documentation process)
- administer intramuscular injections as part of the rapid tranquilisation process in Mental Health settings

Health Care Support Workers/Assistant Practitioners

Only appropriately trained and assessed HCSWs/Assistant Practitioners, with the appropriate knowledge, skills and competency as outlined in their agreed job description, can provide support with medication and related tasks including administration.

The scope of practice of each HCSW/Assistant Practitioner must be clearly defined and clear to registered colleagues working with them, through identification in a local register [link].

AWMSG has outlined training requirements in All Wales Guidance for Health Boards/Trusts and Social Care Providers in Respect of Medicines and Care Support Workers – June 2020:

> *Where medicines administration forms part of the medicines support, care support workers must have completed one of the identified specific education units at Credit and Qualifications Framework for Wales (CQFW) Level 3 as a minimum, or be able to demonstrate training that is equivalent to, and can map across to, CQFW Level 3. In addition, an appropriate recognised accredited unit of learning in relation to supporting individuals with medication must be achieved. Robust competency assessments must be in place to assure ongoing competency. This will be documented in the organisation's care support worker register, which will be annotated to indicate whether the skills are deemed transferable, or specific to one individual, and will be discussed fully during the care support worker's annual review.*

The practice undertaken must be in accordance with locally agreed written protocols and procedures for designated settings. Delegation of medicines

administration to HCSWs must only be undertaken where it can be evidenced that it will benefit the individual receiving the support. This may be in community setting or inpatient areas across the health board.

In the community setting trained and competent HCSW may administer medicines from original packs – it is not necessary for HCSW to request a monitored dosage system (MDS) (e.g. dosette box). This recommendation is in line with the National Guiding Principles for Medicines Support in the Domiciliary Care Sector.

See MDS section

Administration of Medicines in Theatres

The principles outlined above apply to preparation and administration of medication in theatres with additional requirements outlined below.

- All medicine-containing infusions and syringes must be clearly labelled.
- Where it is necessary to prepare syringes in advance of immediate use, they must be prepared and labelled using the nationally agreed colour system. Pre-printed labels are available in all theatre settings and must be used.
- Medicines must be individually prepared for each patient. The practice of 'batch' preparing medicines when several patients on one theatre list all require the same medicines must not occur.
- If medicines are drawn up and labelled in a theatre setting, this should ideally be done by the person who will administer them.
    - Where this is not possible, the medicine should be:
        - Checked with the requesting practitioner before it is opened
        - Drawn up in the presence of the requesting practitioner and checked (medicine, route of administration, diluent, dose, and expiry date) against the original container (e.g. vials) prior to administration.
- Adequate uncluttered surface space and appropriate trays, clean for each patient, are provided for drawing up, arranging and holding the syringes and drugs used in each procedure.
- Open systems (including gallipots and other types of open container such as moulded plastic procedure trays) are never used as containers for medicines
- Medicines for spinal, epidural or for nerve block injection are presented as prefilled syringes wherever possible and are clearly identifiable (e.g. as different coloured lines, bags and labels). Appropriate connectors are used for epidural, intrathecal and nerve block infusions.

- Infusion pumps for epidural and/or nerve block infusions are permanently dedicated for a single purpose, and appropriately coloured and labelled. They have appropriate security and safety features, such as locks and pass codes.
- Medicines and fluids used in theatre settings must be readily identifiable at all times during a procedure. Pre-labelled empty syringes and unlabelled or poorly labelled presentations are considered unsafe and must be immediately discarded.

Further information can be found in RPS – Professional Guidance on the Safe and Secure Handling of Medicines.

To reduce the risk of wrong route administration with spinal, epidural and regional devices – neuraxial connectors (NRFit) which replace luer connectors on spinal needles, epidural catheters and other regional anaethetic devices must be used. See PSN063 Dec 2021.

Labels and/or packaging for local anaesthetic epidural infusions should use the colour yellow to indicate the neuraxial/epidural route. PSA003 May 2016

Supply and Administration by Nurses working in the Minor Injuries Unit (MIU)

See separate procedure for the supply/administration of medicines in Minor Injury Units. - https://nhswales365.sharepoint.com/sites/POW_comm_miu

Administration of Medicines to Children

All medicinal products administered to children 16 years of age and under, in the hospital setting must be administered by two registered practitioners.

One must be a registered nurse. The second person may be a registered medical or dental practitioner, pharmacist or a registered nurse. Both practitioners must witness the whole process from the preparation to the administration of the medicine.

The dose of the medication should be checked against the latest edition of the BNF for Children or other locally agreed formulary.

Oral/enteral liquid medications where the age of the child or volume of the oral/enteral medication requires the use of a syringe a syringe designed specifically for oral/enteral use must be used i.e purple syringe.

Administration of Medicines to Children in the Community

Community children's nurses must attend educational programmes and have clinical expertise that facilitates the single person administration of medicines. This includes drugs administered via the intravenous route.

In the community, parents or carers can be encouraged to administered to their children when this is appropriate to the clinical condition of the child; if necessary healthcare professionals may provide training and assessment of competency and where this is the case, all training and assessment must be recorded.

Where children require administration of medication in the school setting, please refer to WG Supporting learners with healthcare needs (2017) for advice on supporting the health needs of children in education setting

https://gov.wales/supporting-learners-healthcare-needs-0

Where delegation of the administration of medication to a support worker is required in the school or community setting, the registered nurse should adhere to appropriate national and professional guidance AWMSG . The RCN (2018) Meeting health needs in educational and other community settings" gives advice on the scope of tasks which may be safely delegated including medication

https://www.rcn.org.uk/professional-development/publications/pdf-006634

Non- Prescription Substances

The following substances may be administered without a prescription, but should be documented in the patients nursing record:

- Disinfectants
- Cleansing Agents
- Urine testing and other reagents
- Preparations used in oral toilet
- Nutritional products agreed with the dietetic team
- Barrier creams for personal care.

Care must be taken in ensuring that any allergies identified through use of these products is clearly documented in the patient's notes and where appropriate on the All Wales Medication Administration Record.

Deep Heat Cream for Capillary Blood Gas Testing

Deep Heat cream may be applied to ear lobes ahead of performing capillary ear lobe blood gas testing. Staff must wear gloves and apply a "blob" of

Deep Heat cream to a clean piece of gauze; the cream is applied to the ear lobe with the gauze which is then discarded. If further tests are required at the same appointment a fresh piece of gauze must be used. The tube must be wiped over after use and must never touch a patient. The tube must be appropriately labelled to ensure opening date and disposal date is clear.

Administering medication to patients with swallowing difficulties or with Naso-gastric or Gastrostomy Tubing

Some patients are unable to take medication in solid oral dosage forms.

A stepwise approach should be taken to choose a suitable alternative:

- Where possible, a licensed medicine in a suitable formulation to meet the patient's needs (e.g. a dispersible tablet or licensed liquid medicine).
- In order to use a licensed medicine, consider switching to a different therapeutic agent in the same class, or to a different route of administration. In most cases a suitable licensed preparation will be available to meet the patient's needs.
- If there is no suitable licensed formulation, consider using a licensed medicine in an unlicensed manner (ie off label use), for example by crushing tablets or opening capsules
- In the few situations where the patient's needs cannot be met by licensed medicines, the use of special-order products ('specials') may be considered in agreement with the Pharmacy team.

Many medicines are not available in a form that can be administered via naso-gastric or gastrostomy tubing.

The crushing of a tablet or opening of a capsule changes its licensed status.

If a tablet requires crushing or a capsule requires opening to facilitate their administration, this should be indicated on the patients' medication chart after consulting a pharmacy professional for advice.

Specialist information can be obtained from 'NEWT Guidelines' which can be accessed via the intranet, or from pharmacy or medicines management, click the '*Registered Users Click here*' button to log in and access should be instant when on the NHS Wales network.
However, if you are required to enter a username and password please email elibrary@wales.nhs.uk for the log-in.

The mechanics of crushing medicines or opening up capsules may alter their therapeutic properties rendering them ineffective and therefore not covered by their product license. Medicinal products should not routinely be

crushed or opened up unless specified in an approved reference resource or a pharmacist advises that the medication is not compromised by crushing and crushing has been determined to be within the patient's best interest.

See policy and procedure on management of patient's with Swallowing Difficulties (under development [link].

See also policy on adding Thickeners to medication (under development) [link]

Enteral/Oral Syringes for Liquid Medicines

ENFit syringes which adhere to standard ISO 80369 must be used to administer any liquid medicines via the oral route (where medicines pots or spoons) are not appropriate and all liquid medicines via enteral feeding tubes.

These syringes are available as purple syringes labelled for oral/enteral use.

- Oral, enteral syringes, parenteral syringes and epidural consumables must be stored separately within clinical areas to prevent mis-selection of the incorrect device during medicine administration.
- Doses of liquid medicines that cannot be measured accurately or administered using a medicines pot or spoon must be measured and prepared using an oral/enteral syringe and immediately prior to administration
- Preparation must not be carried out in advance of administration.
- Liquid medicines must never be transferred from an oral/enteral syringe into a parenteral syringe or vice versa but discarded and the product prepared again using the correct device.

For further information see PSN060 September 2021

Covert Administration

Covert administration of medication occurs when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink to people who actively refuse their medication and who are considered to lack mental capacity.

Covert administration of medication can only be necessary and justified in exceptional circumstances when certain legal requirements have been satisfied.

Medicines should never be administered covertly to patients who have capacity to make their own decisions.

Covert medication can refer to medication given to treat either mental or physical health problems. Covert medication should not be confused with enforced medication, where it is given with the person's full knowledge, but not their consent.

If considering covertly administering medication the PTHB policy on Covert Administration of Medicines [link] must be followed. This provides a decision-making framework and clear documentation requirements for medicines to be administered covertly safely and appropriately.

Self- Administration of Medicinal Products

Allowing patients to self-administer their medicines empowers them to remain as independent as possible, participate in their own care and have immediate access to medicines they need on an 'as required' basis, such as analgesia or nicotine replacement therapies and to comply with complex timed regimens e.g. Parkinson's disease medication, which may fall outside of medication rounds.

Self-administration of medicinal products is currently risk assessed on an individual patient basis. See Procedure for the Self Administration of Medicines (under development) [link]

Patients maintain responsibility for the administration of some or all of their medicines, during an inpatient stay, unless a risk assessment indicates otherwise.

The risk assessment incorporates elements such as any risks to the patient or others, the patient's ability to manage the tasks involved and consent.

Such risk assessments should be repeated if the patient's condition changes.

The assessment determines whether:

- the storage and administration of the patients' medicines remain under the supervision of a healthcare professional

- the patients' medicines are stored under the supervision of a healthcare professional and the patient self-administers under supervision

Records are kept of any assessment undertaken and the outcome. The record includes details, including the time and date, of the patient's agreement to assume responsibility of the self-administration of their medicines, where appropriate.

Processes are in place to ensure that the patient has access to a POD locker to ensure an adequate supply of the correct medicines taking into account any changes made to patients' medicines whilst in the healthcare setting.

Medicines are appropriately and securely stored so that they are fit for use, and so that the medicines cannot be subject to unauthorised removal e.g. by other patients or visitors.

Administration of Medicines to Patients in Isolation

Administration of drugs to patients being isolated should be left until the end of the medicine round. Where a second check is recommended the drug should be measured and checked and given to the registrant who will administer it to the patient within sight of the witnessing registrant.

Disposable medicine measures and spoons must be used and the medication chart kept outside the isolation bay if possible.

Administration of Medication in the Community in Residential Settings

PTHB community teams may be required to administer medications in patients' homes or care homes.

The principles described above still apply.

In the case of administration of medications to patients in care homes community staff should be mindful of the care home policy and procedures.

Administration of Cytotoxic Drugs

"The Administration of Cytotoxic Drugs" Procedure (under development) [link] is aimed at ensuring the safe and appropriate handling of cytotoxic drugs for staff and patients.

This includes administering ongoing oral chemotherapy for patients with malignant disease as well as chemotherapy for other indications, including for immunosuppression purposes or the treatment of non-malignant disease, e.g. methotrexate for rheumatoid arthritis or for intraocular use in the treatment of glaucoma.

Supply of Discharge Medication – Hospital Inpatients

In most cases preparing medicine for discharge will be managed by the PTHB Pharmacy Team, utilising patient's own drugs, dispensing at ward level or through the supplying pharmacies at Nevill Hall or Bronglais hospitals.

Ward pharmacy professional and registered nursing staff are responsible for ensuring that the medications, strength, dose, frequency and formulation of discharge medicines match those as intended on the discharge prescription and the All Wales Medication Administration Record. If there are any discrepancies the prescriber should be contacted to establish if they are intentional. If not, the items should be re-prescribed and re-dispensed (by pharmacy) as appropriate.

The All Wales Medication Administration Record and copy of the discharge prescription must be filed in the patient medical records after use.

When handing over discharge medication to a patient it is important that the registered nurse/pharmacy professional ensures that the patient/carer understands the reason for taking, how to take each medication and if appropriate they are given any advice on anticipated side effects. The registered nurse should refer the patient/carer to the ward pharmacy professional or their community pharmacist for further advice and support if considered appropriate.

A national scheme, called a Discharge Medicines Review (DMR), exists through local community pharmacies, which allows them to follow up on medication changes on discharge and to ensure patient understanding and compliance with any changes. The ward pharmacy professional will ensure that an electronic summary is available to the patient's community pharmacy on discharge, through MTeD and the Choose Pharmacy Platform.

Return of Patient's Own Medication on Discharge

In areas where a Patient's Own Drugs (PODs) scheme is in place the ward may use PODs during the inpatient stay in accordance with the PTHB PODs

policy. Providing there is at least 14 days of medication (or less at the discretion of a pharmacy professional) remaining these drugs may then be used for discharge.

The Pharmacy professional will check the medication against the TTO form, ensuring that there have been no changes in medication or dose, strength, frequency. If there are no changes and at least 14 days remaining these may be issued to the patient.

A registered nurse who has received the appropriate training in the use of PODs should only assess pods for discharge against a previously pharmacist clinically checked discharge prescription.

If there are missing or new medications, any changes or less than 14 days remaining these medications then the ward-based pharmacy professional will dispense from ward stock or send to Nevill Hall or Bronglais hospital pharmacy to be dispensed.

If the ward pharmacy professional is not available then the discharge prescription should be sent electronically to Bronglais or Nevill Hall hospitals, along with a copy of the inpatient medication chart.
If there are medicines on the TTO form that are not needed because suitable PODs are available then these should be annotated "not required – PODs available"

Changed medication should not be given to the patient on discharge and should be kept in the ward central medicines cupboard for a pharmacy professional to review for suitability for reuse or disposal.

For wards not operating a PODs scheme it is likely that any medication brought into hospital by the patient will remain in the "patient's own" cupboard on the ward until discharge. This medication is the property of the patient but the registered nurse discharging the patient should go through this medication with the patient and gain consent to destroy any medication no longer required. This is to minimise the risk of confusion between "old" and "new" medications. If the nurse is unable to obtain consent from the patient to destroy medication no longer required, any risks of continuing to take should be explained to the patient. If it is considered that there is a significant risk that the patient will continue to take the medication then nursing and medical staff should decide if it is in the patient's best interests to remove the medication. If this is done the reasons should be fully documented in the patient's notes.

See Managing Medicines on Discharge Procedure [link]

Dispensing Medication by the Pharmacy Team

Ward pharmacy professionals may prepare medication at ward level, this can include re-labelling patient's own medications where there has been a change in directions or by labelling medicines from ward stock (excluding schedule 2 controlled drugs or schedule 3 controlled drugs subject to safe custody requirements).
See labelling procedure and Managing Medicines on Discharge Procedure [link]

The Human Medicines Regulations 2012 regulation 223 allows the dispensing of medicines by the pharmacy team to patient's under the care of the Health Board hospitals and clinics, outside of a registered pharmacy, providing a direction for the medication (s) is in place from a prescriber (e.g. TTO).

Further legislation around the dispensing of medicines within a hospital setting is anticipated through Rebalancing Medicines Legislation and this policy will be updated accordingly.

Alteration of Medicine Container Labels

The labels of dispensed medication must not be altered in any way. If a change is required the pharmacy must be informed and the item must be re-dispensed.

This does not include the supply of 'overlabelled' packs which are supplied to MIU's, day case and some outpatient clinics – these labels have areas that need to be completed e.g. patient name, date, designated eye and frequency e.t.c.

Monitored Dosage Systems (MDS)

MDS e.g. Nomads, Dosettes or similar compliance aids should not be used during an inpatient stay or by community healthcare professionals, because it is not always possible to identify each individual medicine and there are no expiry dates or batch numbers.

If on discharge it is decided that a MDS system may be required, the patient should be referred to their normal community pharmacist. For new MDS patients, the ward based registered pharmacy professional should assess patient suitability for a MDS. Note use of an MDS is not often the most appropriate option and the pharmacy professional may advise alternatives.

It should also be noted that many community pharmacies are reducing the provision of MDS and therefore it is essential that a robust assessment is undertaken and that the patient's requirement for an MDS discussed with the patient's usual community pharmacy.

See ADSS Cymru, National Guiding Principles for Medicines Support in the Domiciliary Care Sector 2019 here:
https://www.adss.cymru/en/blog/post/principles-for-medicines

ADSS Statement on Use of Monitored Dosage Systems (MDS)

> *There is no legal reason why care workers are unable to support with medicines from original packs. MDS should not be seen as the default option and can have many drawbacks.*
>
> *This guidance should be used in conjunction with guidance from the Royal Pharmaceutical Society (Improving patient outcomes through the better use of multi-compartment compliance aids) which gives a balanced and accurate view of the risks and benefits of monitored dosage systems. This is consistent with NICE guideline 67 and NICE Social care guideline. MDS should be used for the benefit of the person receiving care, rather than for the ease of carers or care workers. The provision of MDS should only be provided after an assessment has been carried out by an appropriate individual, in line with legislation and when a specific need has been identified to support medicines adherence.*
>
> *A community pharmacy is under no obligation to supply a compliance aid to meet the needs of the care provider or Local Authority specification. There are risks associated with the use of MDS, some pharmacists feel they are less safe as the medicines in the packaging cannot be identified. Additionally, if a tablet is dropped, there is no replacement. "When required medicines," inhalers and other formulations that are not able to be included within the MDS can be forgotten.*
>
> *The limited evidence base around MDS use, currently indicates a lack of person benefit outcomes. Providing care workers are suitably trained, the supply of medicines in original packs should be promoted as standard.*

If a MDS is the most suitable option for a patient to maintain independence, without the need for carer medicines administration support, then the discharge prescription must be prescribed on a WP10(HP) to be dispensed by a community pharmacy. The WP10(HP) should be available at least 48 hours in advance of discharge and in some cases the community pharmacy may agree to accept a faxed WP10(HP)

initially to speed up the process providing an original copy will follow. A copy of the prescription should be kept for the notes and to inform the GP.

It is advisable to have a second check (e.g. registered nurse, ward pharmacist or pharmacy technician) that the items prescribed on the WP10(HP) match those on the All Wales Medication Administration Record and if not, the differences are intentional.

Ward staff should request that the MDS filled by the community pharmacy is returned to the ward to be checked by a registered nurse/pharmacist/technician that the medications included in the box are as expected.

Patients Requiring Level 2 Assistance with Medicines Administration

The patient should be assessed for the appropriate level of care. The All Wales guidance also includes a tool to use - https://www.adss.cymru/en/blog/post/principles-for-medicines

A pharmacy professional, who has received the awareness training, is deemed suitable to support this process, but the decision is likely to require a collaborative approach with the multidisciplinary team, care manager and pharmacy professional including when a suitable care package is likely to become available.

The community pharmacy or practice dispensary will need as much notice as possible that the patient is going home – to allow time to set up a MAR chart service. A list of participating community pharmacies and practice dispensaries can be found on the PTHB internet site.

Once the assessment has been completed a MAR chart referral form must be sent to the community pharmacy or practice.

The prescriber should complete either a TTO form or MTeD discharge as normal but instead of faxing to the supplying DGH pharmacy the discharge prescription should be faxed to the patient's normal GP practice so they can prepare a WP10 for a community pharmacy or practice dispensary to supply the MAR chart and medication.

Prescriptions should normally be for 28 days supply.

All MAR charts, plus medication, should be returned to the ward so that nursing or pharmacy staff can check the contents against the discharge prescription and the inpatient medication chart.

Further information can be found in the Managing Medicines on Discharge Procedure [link]

Prescribing and Administration/Dispensing by Same Person

The Royal College of Nursing, Royal Pharmaceutical Society and the Specialist Pharmacy Service have advised on the practice of prescribing alongside the dispensing/supply/administration of medicines by the same health care professional where this is a routine part of the package of care in Prescribing and dispensing position statement guidance (rpharms.com)

The prescribing and dispensing/supply and/or administration of medicines should normally remain separate functions performed by separate health care professionals in order to protect patient safety.

The joint RCN/RPS document Professional Guidance on the Administration of Medicines in Healthcare Settings (RCN/RPS, 2019)1 states that:

- wherever possible, the actions of prescribing, dispensing/supply and administration are performed by separate health care professionals
- exceptionally, where clinical circumstances make it necessary and in the interests of the patient, the same healthcare professional can be responsible for the prescribing, dispensing and/or supply/administration of medicines
- where this occurs, an audit trail, documents and processes must be in place to limit errors.

PTHB areas that have prescribers who may subsequently supply or administer the medication they prescribe must agree, via a risk assessment, the process with the Medicines Management team.

PHARMACEUTICAL WASTE

All medication must be disposed of safely in accordance with the PTHB Sustainable Waste Management procedure (2015) the Hazardous Waste Regulations (2005) amended (2009) and the Hazardous Waste (Miscellaneous amendments) (Wales) Regulations 2018.
The current waste collection contractor for PTHB sites is Stericyle.

Non-hazardous medicinal products and items contaminated with non-hazardous medicines

The blue waste stream is used for waste medicinal products that are not cytotoxic or cytostatic.

Blue-stream pharmaceutical waste bins must be sent for incineration at a suitably authorised facility.

Blue-lidded containers are for any waste which contains non-hazardous medicinal drugs that are expired, unused, contaminated, damaged, denatured or no long needed.

Blue lidded sealed units should:

- Be used for:
  - out-of-date, returned or waste medicines, including medicinal bottles or vials and waste tablets
  - IV bags / giving sets and lines that have had medicines added to them.
- Not be used for the disposal of free liquids (dispose of in bottle)

- Not be used for the disposal of Schedule 2 controlled drugs, unless they have been denatured first.
- Not be used for the disposal of sharps or any rigid items that could puncture the unit
- Not be filled with more than 10kg of glass
- Be filled to a maximum of ¾ full OR to the fill line marked on the container OR to the maximum weight of 20kg, whichever is reached first.

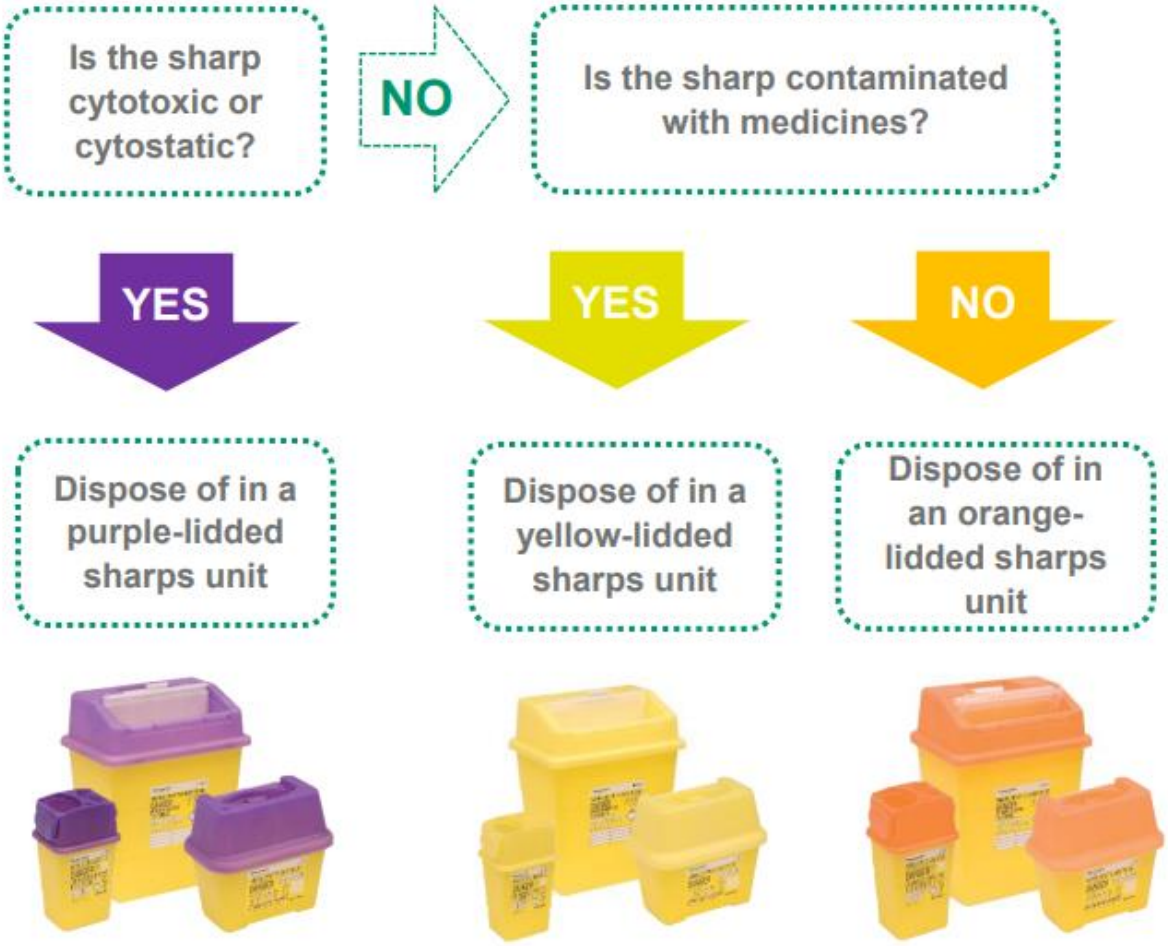
Hazardous medicinal products and items contaminated with non-hazardous medicines

The purple waste stream is used for any waste contaminated by hazardous cytotoxic and cytostatic medicines (e.g. chemotherapy drugs, hormones, chloramphenicol).

Purple-stream pharmaceutical waste bins must be sent for above 1000°C incineration at a suitably authorised facility.

Purple-lidded sharps units are for sharps that have been used in the administration of, or are contaminated by, hazardous cytotoxic and cytostatic medicines. Purple-lidded containers are for any non-sharp waste contaminated with cytotoxic and cytostatic medicines, or hazardous drugs in their original packaging or blister packs, or denatured.

Sharps Disposal



Unwanted Stock Items in Hospital

Where medicines are being destroyed before their expiry date because of non-use, the ward/departmental managers and pharmacy team should critically review if stock items are still required.

Adjustments must be made on the stock lists and the unwanted stock items reused appropriately by another ward/department as appropriate.

Medicinal Products Prepared but not Administered

Medicinal products prepared for use but not administered must be disposed of appropriately and recorded using the appropriate code on the All Wales Medication Administration Record.

Disposal of Medicinal Products in the Community

Community healthcare professionals must not take surplus medicinal products into their possession or make any further use of them.

It is the duty of community healthcare professionals to advise their patients and relatives on the correct destruction/disposal of unwanted medicinal products.

Unwanted medicinal products should be returned to the dispensing community pharmacy or GP dispensary for destruction.

If carers or relatives are unable to return unwanted medications to a community pharmacy, or it is felt by a HCP that leaving the medications with the patient poses a risk to the patient, then the community healthcare professional may do so on their behalf.

Consent to do so should be obtained, if a destruction form is not available then the medication name, strength and quantity taken should be documented in the patient's record and if possible they should sign their consent.

All residual contents of ampoules or vials must be sent for disposal in the appropriate container in accordance with PTHB Policy. PTHB | Clinical Waste (webarchive.org.uk)

Controlled Drugs

Refer to Destruction and disposal of Controlled Drugs

Recommended Pharmacy resources

Prescribing and Administration

A number or resources exist to provide information on prescribing and administration of medicines

BNF

Paper copies of the BNF are now restricted in numbers. Users are recommended to download the app version or access via the internet, this supports reduction in carbon footprint and that the most up to date version is being accessed.
Website - https://bnf.nice.org.uk/
App versions to download - https://www.bnf.org/mobile-access-to-bnf-bnfc/

BNF for Children

Website - https://bnfc.nice.org.uk/
App versions to download - https://www.bnf.org/mobile-access-to-bnf-bnfc/

Medusa Guide for IV Drug Administration

Website - http://medusa.wales.nhs.uk/?ID=24cba7ab215eddcfdaf2d0d9746dd90d2150

Newt Guidelines – Administration of Medicines in Swallowing Difficulties or via Enteral tubes
https://www.newtguidelines.com/

Renal Drug Handbook - Drug dosing in renal impairment is available in the NHS Wales e-Library.
Note the Pharmacy Team have access to the Renal Drug Database, which is an online database which is more frequently updated.

Micromedex – including Martindale

Note Drugdex is an American database and may refer to indications or doses not licensed in the UK
https://elh.nhs.wales/databases/databases/micromedex-healthcare-series1/

Maudsley Prescribing Guidelines – mental health medication
https://onlinelibrary.wiley.com/doi/book/10.1002/9781119870203

Specialist Pharmacy Service

The Specialist Pharmacy service provides a range of advice on medicines and pharmaceutical issues and is available at www.sps.nhs.uk

Prescribing in Pregnancy & Lactation

Information about medication in pregnancy from the UK Teratology Information Service can be found at https://www.medicinesinpregnancy.org/ including information for patients
The Specialist Pharmacy Service have also provided information around safety of medicines in pregnancy
https://www.sps.nhs.uk/home/guidance/safety-in-pregnancy/
Information on prescribing in breastfeeding can be found via the Specialist Pharmacy Service https://www.sps.nhs.uk/home/guidance/safety-in-breastfeeding/

NHS Wales e-Library for Health

A wider range of resources can be found in the NHS Wales e-Library via https://elh.nhs.wales/

PTHB Community Services Pharmacy Team

The medicines management team, Pharmacists, Pharmacy Technicians and Pharmacy Assistants cover each hospital site between Monday – Friday.
The availability of a Pharmacy Professional on site can be found on the Pharmacy Team rota

The team can be contacted via 01874 712641 or Info.medicinesmanagement@wales.nhs.uk

Nevill Hall Hospital Pharmacy

Nevill Hall Hospital Pharmacy are the main medicines and vaccines stock supply for all hospital sites.
All wards and departments ordering medicines will be given login details for WOREQ2 ordering system, new members of staff can be added by contacting Nevill Hall Pharmacy.
Nevill Hall hospital pharmacy also provide an on-call service out of hours and at weekends.

Distribution/Stores	01873 732284	
Dianne Walker – Senior Pharmacy Technician	01873 733102	Dianne.walker@wales.nhs.uk

Dispensary	01873 733080	
E-mail address for orders		ABB.NHHPharmacy@wales.nhs.uk
On-call Pharmacy Service	01873 732732	Switchboard - ask for on-call pharmacist

Bronglais Hospital Pharmacy

Bronglais Hospital Pharmacy supplies named patient medicines supplies, including discharge medication for the four north Powys hospital sites. Bronglais hospital Pharmacy also provide an on-call service relating to patient specific pharmacy issues (not stock issues) for the 4 hospitals in north Powys

Dispensary	01970 635733	
On Call Pharmacy Service	01970 623131	Switchboard - ask for on-call pharmacist

Medicines Management

The Medicines Management team are responsible for all pharmacy services and supplies for PTHB managed services.
The Medicines management team can be contacted:-

Phone	01874 712641
E-mail	Info.medicinesmanagement@wales.nhs.uk

Incidents Involving Medicines, Recalls and Hazards

Patient Safety Incidents

The National Reporting and Learning Systems (NRLS) defines a 'patient safety incident' (PSI) as, 'any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care.'

The NHS Wales Delivery Unit supports organisations in NHS Wales in improving safety and quality, developing safer environments and reducing avoidable harm

The Delivery Unit identifies significant safety risks and concerns and in response develops Patient Safety Solutions at a national level for issue to the NHS in Wales

More information and patient safety solutions and alerts can be found at https://du.nhs.wales/patient-safety-wales/

PTHB Medicines Alerts Policy (under development) [link]

PTHB Medicines Safety Officer (MSO)

In 2014 a network of MSOs was established in NHS organisations across Wales. Each health board has its own MSO.
MSOs work together to share information and learning in medication safety and work with patient safety teams and other health care professionals to action the recommendations of the Welsh Government's Medication Safety Alerts and Notices.

Management of medication errors

Medication errors are any patient safety incidents where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines.

These patient safety incidents can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy.

Immediate action to be taken in event of medication error

Following any medication error:

- Patient safety must be maintained and a member of the medical team informed.
- The patient must be reviewed medically and an action plan put in place which is specific to the nature of the medication error.
- The lead of the clinical area and Medicines Management must be informed.
- In the event of a dispensing or other pharmacy error that has led to inappropriate medication administration, a senior member of the pharmacy staff must be informed.
- The patient or, where appropriate, their carer should be notified of the error.

See 'Procedure for managing and supporting staff following a medication error' for specific guidance on managing medication errors and use of the Bennion Error Scoring System (BESS) to review the causal factors.

Reporting a medication error

All incidents involving medicines that have led to a medication error or inappropriate medication administration must be reported using the Datix incident reporting system.

Dispensing errors discovered in a clinical area

When an apparent dispensing error is discovered in a clinical area, the member of staff discovering the error must contact the supplying pharmacy and the Medicines Management team or their site pharmacy professional as soon as it practical in order to confirm the status of the medication and ensure that, where necessary, a new supply is made available to the patient.

The staff member identifying the error should complete a Datix incident report detailing the error or provide information to the local hospital pharmacy or community pharmacy for completion.

If a patient has wrongly received any medicine, the most senior doctor in charge or GP of that patient will be informed of the incident so that any clinical action needed can be taken and that the patient and/or relatives can be informed.

Serious medication errors

A serious medication error occurs when a patient is harmed or harm is anticipated.

In the event of a serious error the senior doctor must be informed as soon as possible. If this is outside normal working hours, the out of hours service must be contacted.

The Executive Medical Director, the Director of Nursing, Chief Pharmacist and the Quality and Safety Department must be informed of the error and the relevant circumstances at the earliest opportunity. Serious incidents may be deemed notifiable to the NHS Wales Delivery Unit.

In the event of a serious medication error, the Chief Pharmacist in conjunction with the Quality and Safety Department will co-ordinate the preliminary investigation with all relevant parties.

A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. The Never Event List is updated annually by Patient Safety Wales.

Near misses

Any event that would have led to an error but did not actually happen due to last minute intervention should be reported as a 'near miss' in the Datix incident reporting system.

In clinical risk management terms, reporting a near miss is just as important as reporting an actual error. Medication errors are commonly the result of poor processes/systems. The collation of information on near misses can provide valuable data that may indicate poor system design.

Pharmacists' interventions

By the very nature of their work, pharmacy staff provide a significant safety net system in the prevention of medication errors by identifying prescribing errors.

Pharmacists record their interventions as part of the patient's medical record and utilise a separate database for such purposes. PTHB Pharmacy Interventions Database.

Interventions recordings are shared with clinicians at local hospital meetings, Area Prescribing Group and are used to inform development of clear clinical or other guidelines to support optimized prescribing.

Reporting, recording adverse drug reactions and defective medicinal products

An ADR is an unwanted or harmful reaction following the administration of a medication or combination of medications that is suspected to be related to the medication.

The reaction may be a known side effect of the medicine or it may be a new previously unrecognised ADR. In general, these are the essential features of an ADR:

- there is a suspicion that at least one medicine is responsible.
- the effect is unintended.
- it is harmful, or potentially harmful.
- the reaction is seen at normal doses used clinically (to distinguish ADRs from 'toxicity' which is used to describe the symptoms of overdose or poisoning).

If a patient experiences a known or suspected adverse drug reaction, even to an established drug, this must be reported. Reporting should not be delayed even if causality is not certain.

In the UK adverse reactions are reported to the Medicines and Healthcare products Regulatory Agency (MHRA) using the 'Yellow card' reporting scheme.

The easiest way, however, to report an adverse reaction is

- visit the Yellow Card site at http://yellowcard.mhra.gov.uk/ and complete the report online.
- Free Yellow Card app via Apple App Store or Google Play Store
- Via clinical IT system – EMIS/SystmOne/Vision/MIDatabank

Situations where Yellow Cards should be used for reporting adverse events include:

- a person has experienced suspected side effects to a medicine, vaccine, herbal or homeopathic remedy
- a suspected defective medicine i.e. not of an acceptable quality
- a medicine not working as it should
- a medical device is defective e.g. failed to work, broken, caused or might have caused harm or could be a counterfeit product

For an up-to-date list of drugs for which Yellow Cards are required consult the Yellow Card website. Assistance in selecting the appropriate option to select when reporting adverse events with medicines or medical devices is available on the Yellow Card website or by calling 020 3080 6000.

Black Triangle drugs and vaccines

New medicines and vaccines that are under additional monitoring have an inverted black triangle symbol (▼) displayed in their package leaflet and summary of product characteristics, together with a short sentence explaining what the triangle means – it does not mean the medicine is unsafe.

All suspected ADRs for these products should be reported.

Established Medicines

For established medicines and vaccines you should report all serious suspected ADRs, even if the effect is well recognised.

We are particularly interested in receiving Yellow Card reports of suspected ADRs:

- in children
- in patients that are over 65
- to biological medicines and vaccines
- associated with delayed drug effects and interactions
- to complementary remedies such as homeopathic and herbal products

Further information on the Yellow Card reporting scheme, including reporting by patients and Coronovirus vaccine can be found https://www.gov.uk/guidance/the-yellow-card-scheme-guidance-for-healthcare-professionals

Monitoring Compliance, Audit & Review

This document is a working document that will be regularly updated as Medicines Management and Pharmacy services/practices develop.

To ensure that the most up to date version is being accessed, it is recommended that the document is accessed from the Medicines Management pages of the PTHB website.

The Medicines Management team will undertake regular (at least annual) audits around themes contained within this document.

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- RPS. Professional Guidance for the Procurement and Supply of Specials
- RPS. Prescribing Specials Guidance for the prescribers of Specials
- NICE. Medicines and Prescribing Centre provides support for medicines and prescribing
- NICE. Patient Group Directions. Guidance providing good practice recommendations for individual people and organisations involved with PGDs
- NICE. Medicines optimisation – quality standard (QS120)
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- NICE. Giving medicines covertly. A quick guide for care home managers and home care managers providing medicines support

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- General Medical Council. http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp
- General Pharmaceutical Council. High level principles for good practice in remote consultations and prescribing. This information is for all healthcare professionals with prescribing responsibilities. It sets out the shared high level principles of good practice expected of everyone when consulting and or prescribing remotely from the patient
- King's Fund. Polypharmacy and medicines optimisation: Making it safe and sound
- NHS Specialist Pharmacy Service. This website provides tools and resources to help with decision making around prescribing and the legal frameworks and associated processes in relation to medicines management
- NMC. Code of conduct. The NMC code presents the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK
- NMC. Standards of proficiency for nursing associates. These standards set out what nursing associates know and can do when they join our register
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