Policy:

Medicines Optimisation Policy Risks and Processes MD 013

Executive Director Lead	Medical Director
Policy Owner	Chief Pharmacist
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Summary of policy
This policy covers the management of medicines within Sheffield Health & Social Care NHS Foundation Trust. The Medicines Optimisation Policy is a comprehensive document designed to be read "online" and available through the Trust intranet.
The policy provides the legislative, professional and background information for staff to enable them to prescribe, administer, supply, transport, store and dispose of medicines legally and safely.

Target audience	All Trust staff who have any involvement with medicines

Keywords	Medicines, management, risks, processes, Medicines optimisation

Storage & Version Control

This is version 11 of the Trust Medicines policy. This is a routine update as the policy was scheduled for a review. It replaces version 10

Policy to be updated on to the Trust Policy intranet page. Medicines Management/Optimisation training to be updated in line with this policy. Previous versions of the policy are archived in Pharmacy on the w; drive.
Update details: Version 11. Appendix updated in learning disability, insulin section, community medicines management, training, trust SOPs updated. Terminology switched to EPMA and medical notes rather than JAC and Insight.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
10	Policy Updated, approved and issued	09/2019	New template and update of contents
11	Approval and issue	02/2023	Amendments made during consultation, prior to ratification. All SOPS updated, All guidelines reviewed, updated and approved Locality medicines policies reviewed and approved Change across entire policy from JAC to EPMA Review and update with Head of MHA legislation to MHA information contained within the policy, Updated information and strengthening guidance regarding STOMP and use of medicines in LD Update NMP protocol Revised Incidents flowchart Inclusion of information relating to status of cannabinoid based medication in SHSC Insulin Section updated Medical notes now instead of Insight. All links reviewed and updated in policy

Medicines Optimisation Policy easy read guide

This policy covers the management of medicines within Sheffield Health & Social Care NHS Foundation Trust.

The Medicines Optimisation Policy is a comprehensive document designed to be read “online” and available through the Trust intranet.

The policy provides the legislative, professional and background information for staff to enable them to prescribe, administer, supply, transport, store and dispose of medicines legally and safely.

The detailed procedures that staff are expected to follow can be found in either their agreed standard operating procedure (SOP) or as part of published national guidance that has been adopted by the Trust. Agreed SOP’s will be found on the Trust intranet, and in the SOP section of this document.

Other guidance that is not covered by the national guidance below may be found by checking the index of this policy.

All staff dealing with medicines should be familiar with the following key reference sources

Guidance from the National Institute for Health & Care Excellence
See http://www.nice.org.uk/

For Nursing procedures
The Royal Marsden Manual of nursing procedure –
Standards of Medicines Management were withdrawn in January 2019 and replaced by the below
https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines
https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567

There is also Health Education England Guidance for medicines administration by Nursing associates
https://www.hee.nhs.uk/sites/default/files/documents/Advisory%20guidance%20-%20administration%20of%20medicines%20by%20nursing%20associates.pdf

For Prescribers
GMC guidance on good prescribing practice
http://www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp

Pharmacy staff
Must be familiar with relevant standard operating procedures, these are found on the Trust intranet,

By acting in line with their sphere of competence and underpinned by guidance on best practice staff will prevent patients from medicines related harm.

Unfortunately, there may be circumstances where the complexities of care and our usual systems and safeguards fail. By reporting these incidents through the Trust incident system, lessons can be learnt, and processes adapted or changed to prevent further occurrences of harm. At a national level this is through NHS England– patient safety (and successor organisations) and locally through the review and dissemination of medicines related incidents.

The reporting of medicine related incidents is an important element of keeping patients safe from medicine related harm. For example these processes have helped us understand that errors are more likely at transition or handover points between care settings. The process of medicines reconciliation described in the policy is designed to minimise the risks of such problems occurring.

Patient choice is an important theme running through this policy. Procedures for self-medication and details of the questions service users should ask about their medication are all part of our process to support patient choice.

Prescribing and using medicines in line with their marketing authorisation will reduce the risk of unintended harms from drug treatments. More detailed guidance on prescribing and the monitoring of side effects using systematic assessment tools such as GASS is contained within the policy.

Many areas of prescribing are routinely and regularly reviewed and monitored through our participation with the Prescribing Observatory in Mental Health (POMH). The results of POMH audits are fed back through a variety of forums and individual clinical teams, through their governance processes are encouraged to discuss and reflect on their results. POMH results are available through the pharmacy Trust intranet page.

Over and above their pharmacological effects medicines are chemical substances which must be handled, stored and disposed of safely. It is important to follow the systems and process contained within this policy to protect staff, service users and our environments from the incorrect handling or disposal of medicinal products.

There is no provision for the supply of medication to staff for any other purpose than the care or treatment of current patients in line with current legislation and best practice.
Medication must not be taken or supplied to staff from ward stock for personal use by themselves or their family. Dispensing or supply of prescribed medication may only occur legally if it is in line with the course of the business of the Trust.

Nicotine Replacement Treatment (NRT) and specific vaccines are provided to staff as part of the business of the Trust.

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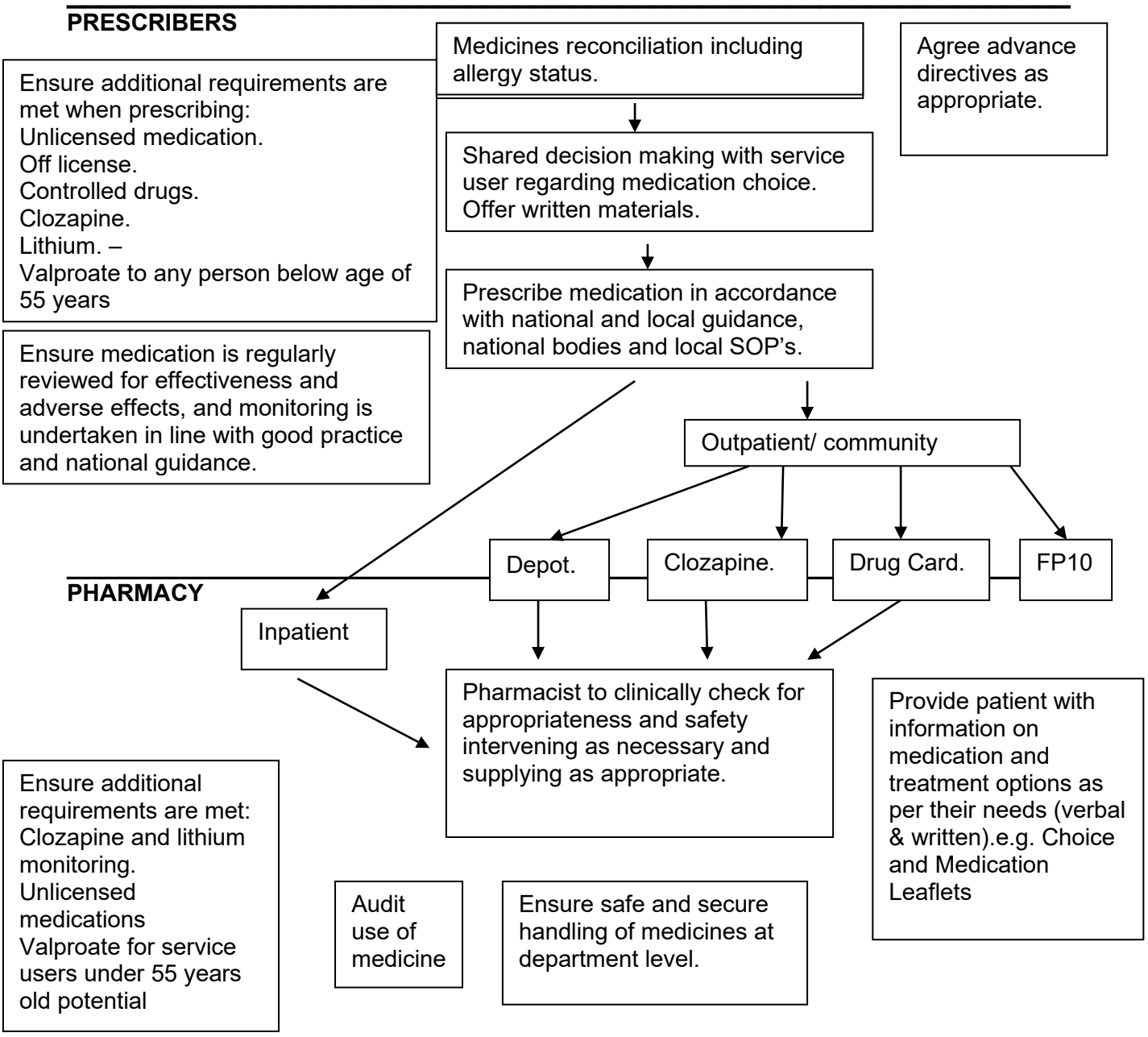
Flowchart


PRESCRIBERS
Medicines reconciliation including allergy status.
Agree advance directives as appropriate.
Ensure additional requirements are met when prescribing:
Unlicensed medication.
Off license.
Controlled drugs.
Clozapine.
Lithium. –
Valproate to any person below age of 55 years
Shared decision making with service user regarding medication choice. Offer written materials.
Prescribe medication in accordance with national and local guidance, national bodies and local SOP's.
Ensure medication is regularly reviewed for effectiveness and adverse effects, and monitoring is undertaken in line with good practice and national guidance.
Outpatient/ community
Depot.
Clozapine.
Drug Card.
FP10
PHARMACY
Inpatient
Pharmacist to clinically check for appropriateness and safety intervening as necessary and supplying as appropriate.
Provide patient with information on medication and treatment options as per their needs (verbal & written).e.g. Choice and Medication Leaflets
Ensure additional requirements are met:
Clozapine and lithium monitoring.
Unlicensed medications
Valproate for service users under 55 years old potential
Audit use of medicine
Ensure safe and secure handling of medicines at department level.
NURSING
Administer medications in line with National and local policies and procedures in line with professional bodies.
Monitor for effectiveness of medication and any adverse effects.
Feedback any concerns to MDT.
Ensure safe and secure handling of medicines at a ward/ team level.

1 Introduction

The Department of Health requires that all NHS Trusts establish, document and maintain effective systems to ensure that medicines are handled appropriately.

This Medicines Optimisation Policy is designed to guide health care professionals within SHSC on all aspects of medication including prescribing, supply, storage, administration, monitoring and destruction of medicines. It also advises on the actioning of safety alerts, medicines re-calls and incident reporting.

Use of medicines throughout the Trust should be line with the four principles of medicines optimisation.

- Aim to understand the patient's experience
- Evidence based choice of medicines
- Ensure medicines use is as safe as possible
- Make medicines optimisation part of routine practice

All staff must follow the different sections of this policy and be familiar with the policies and guidance (including how to access these) contained within it.

Evidence Based Treatments & Patient treatment choice

Staff should follow the national guidance issued by NICE (this includes accessing patient information in an understandable format) .

Nursing Procedures

The latest guidance contained within the https://www.rmmonline.co.uk/contents/procedures should be followed.

Social Care

Best practice guidance is available from the Social Care Institute for Excellence (SCIE).

Guidance for staff involved in handling medicines in social care is available from the Royal Pharmaceutical Society of Great Britain under the related documents – The Handling of Medicines in Social Care (2007).

NICE NG67 - Managing medicines for adults receiving social care in the community

NICE SC1 - Managing medicines in care homes (as some SHSC beds in care homes)

Medicines and issues relating to professional practice

Staff should consult and follow guidelines within their own professional guidance.

Nurses should follow guidance issued by the Nursing and Midwifery Council (NMC). www.nmc-uk.org/

Prescribers should follow GMC guidance on good prescribing practice http://www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp

Pharmacists & Pharmacy technicians should follow the GPhC standards for practice http://www.pharmacyregulation.org/standards .

Pharmacy staff must also be familiar with and follow relevant standard operating procedures, these are found on the Trust intranet.

For information on medicine alerts refer to the https://www.gov.uk/drug-device-alerts website. Patient Safety is now part of NHS Improvement and Patient Safety Alerts will be issued by NHS Improvement (and subsequent successor organisations)

Further information

If you have any doubts about any aspect of medication use within the Trust, you can:

- Contact the Pharmacist attached to your team.
- or contact the Pharmacy Department (based at the Michael Carlisle centre) if you do not have a pharmacist attached to your team. Tel: 2718632 or 2718633.
- or go to the Pharmacy Trust intranet for more information.

If you notice any out-of-date links, or medicine related issues that are not covered in the policy – please contact the Chief Pharmacist.

2 Scope

This document encompasses the processes of medicines management and optimisation within the Trust including:

- Prescribing
- Controlled Stationery (FP10)
- Procurement, Storage and Stock Control
- Dispensing
- Distribution and Delivery
- Administration
- Disposal of medicines waste
- Education and Training
- Risk Management
- Clinical Trials

It is applicable to all staff employed by the Trust, whether working within the Trust or elsewhere (including those staff employed by other organisations or agencies as well as students, voluntary workers or other staff on placement within the Trust).

This document is not intended to cover every eventuality and health care professionals are expected to both follow their own Professional Codes of Conduct and use their clinical judgement in the application of these standards to the individual patient under their care.

Note: there are sections of the policy which are area specific – staff must ensure they follow the relevant section for the areas in which they work. It is recognised that due to the diverse nature of the Trust, new services and departments will be added at times.

3 Purpose

The medicines optimisation policy is a comprehensive document designed to be read “on line” as this provides access to the underpinning reference material through the comprehensive series of hyperlinks throughout the policy. The current version of the policy is available through the Trust intranet. The policy provides the legislative, professional and background information for staff to enable them to prescribe, administer, supply, store and dispose of medicines legally and safely in line with the requirements of the NHS Resolution, the Care Quality Commission and other national regulatory and advisory bodies.

4 Definitions

Medicines management: Describes the processes by which medicines are selected, procured, delivered, prescribed, administered and reviewed, disposed of to optimise the contribution that medicines make to producing desired outcomes of patient care.

Medicines optimisation: 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines. Medicines optimisation applies to people who may or may not take their medicines effectively. Shared decision-making is an essential part of evidence-based medicine, seeking to use the best available evidence to guide decisions about the care of the individual patient, taking into account their needs, preferences and values.

Medicine: covers those substances defined in the 1968 medicines act and now consolidated within the Human medicines regulations 2012 see http://www.legislation.gov.uk/uksi/2012/1916/contents/made.

If any staff are unsure if the issue they are dealing with is related to a medicine or not, contact the pharmacy department for advice.

Pharmacist: A title restricted in law to a person registered with the General Pharmaceutical Council (GPhC). The GPhC regulates Pharmacists and pharmacy technicians within Great Britain.

Pharmacy Technician: A title restricted in law to a person registered with the General Pharmaceutical Council (GPhC). The GPhC regulates Pharmacists and pharmacy technicians within Great Britain.

Nurse: A person registered with the Nursing & Midwifery council

Prescriber: A person defined in law with the authority to prescribe medicines. This includes Non-Medical Prescriber (NMPs)

The Trust: Sheffield Health and Social Care NHS Foundation Trust (SHSC)

Medicines reconciliation: The process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies and documenting any changes – resulting in a complete list of up-to-date medicines accurately communicated.

Restrictive Practice:
The trust is committed to reducing restrictive practice. Restrictive interventions are ways staff may intervene in crisis situations to prevent harm which includes rapid tranquillisation (Please refer to Trust's rapid tranquillisation policy). Any restrictive intervention must be legally and ethically justified to prevent serious harm and it must be the least restrictive option.

Medicines Optimisation Strategy

The Medicines Optimisation Strategy guides the development of medicines optimisation within the Trust and relates how the principles of medicines optimisation are integrated into the Trust's systems, work practices and culture at all levels. Medicines Safety is one of the key priorities to focus on individual responsibility and accountability for the safe administration of medicines.

Medicines Optimisation vs Medicines Management:
Medicines optimisation differs from medicines management in a number of ways but most importantly it focuses on outcomes and patients rather than process and systems. Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety. Ultimately medicines optimisation can help encourage patients to take ownership of their treatment.

Conflict of interests:
As a general principle, healthcare professionals of all grades, including trainees, should not meet with representatives from the pharmaceutical industry during working hours in their professional capacity without prior approval from a Clinical Director or the Executive Medical Director. Please refer to the managing conflicts of interest policy.

Patient Group Directions (PGDs):
Patient Group Directions (PGDs) provide the legal framework which allows named healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription or an instruction from a prescriber. The healthcare professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD. PGDs should be limited to situations where this offers an advantage to service user care without compromising service user safety and be consistent with appropriate professional relationships and accountability. Individual services should follow locally agreed PGD's.

5 Detail of the Medicines Optimisation Policy (See purpose of the policy also)

The medicines optimisation policy is a comprehensive document designed to be read "online" as this provides access to the underpinning reference material through the comprehensive series of hyperlinks throughout the policy. The current version of the policy is available through the Trust intranet.

The policy provides the legislative, professional and background information for staff to enable them to prescribe, administer, supply, store and dispose of medicines legally and safely in line with the requirements of the NHS Resolution, the Care Quality Commission and other national regulatory and advisory bodies.

6 Duties

The Trust Chief Pharmacist is the person responsible for medicines throughout the Trust. The Executive Medical Director line manages the Chief pharmacist and carries the executive responsibility for this policy.

The policy does not alter the professional responsibilities or duty of care of any other health care professional when dealing with medicines.

All staff employed by the Trust or any staff working or seconded to work within the Trust when dealing with medicines all staff should follow the relevant SHSC medicines related policies, procedures and where applicable their own professional body's code of practice.

Any health care professional choosing to deviate from these standards will be expected to do so knowingly and be able to justify their course of action as being in the best interest of safer care to their peers and managers. Adherence to the standards contained within the policy should be the norm.

All staff that have any involvement with medicines are always expected to work within their own sphere of competencies. All staff should be aware of and have access to this Medicines Optimisation Policy and related guidance.

Managers
To ensure all staff have access to and work in line with current Trust policies and guidance relating to medicines.
To support staff through the appraisal and training process relevant to their activity and to ensure their staff work within their medicine related competencies.

Pharmacists
To participate in and support the processes of medicines management and optimisation throughout the Trust and across organisational boundaries. This will include providing advice to all SHSCFT staff including cultural & adaptations for service users with specific needs.

Pharmacy Technicians
To participate in and support the processes of medicines management and optimisation throughout the Trust. This will include providing advice to SHSC staff and service users

Chief Pharmacist
Responsible for medicines management and optimisation throughout the Trust.

Medicines Optimisation Committee
To provide multidisciplinary advice and guidance on medicines optimisation within the Trust.

Accountable officer (Controlled Drugs)
To provide assurance that sound systems of governance relating to controlled drugs and relevant people are in operation throughout the Trust. This relates to drugs controlled under the Misuse of Drugs Act.

Medicines Safety Officer
To provide assurance that learning is maximised following medication incidents. They will link with the national and local medication safety networks to support local medication error reporting and learning and feedback to the Medicines Optimisation Committee.

Medicines Safety Group
To provide multidisciplinary learning and consider actions to reduce risks associated with medicines use and to prevent incidents.

Trust Board
The Trust is expected to make sufficient resources available to enable the Accountable Officer to discharge his/her responsibilities as Accountable Officer (Controlled Drugs) for the Trust. They must ensure the CQC is informed of any changes to the named accountable officer (controlled drugs) and must ensure that's s/he is removed from office if s/he wilfully fails to carry out her/his role. The Trust board must also be assured of medicines management/optimisation processes within the Trust.

7 Procedure

The principles of medicines storage and their handling within this policy are based on the underlying principles and guidance issued from the Royal Pharmaceutical Society - https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines (RPS, 2018). Medicines must be prescribed, dispensed and administered safely and effectively and equally important, their storage and handling within the Trust must be safe, secure and comply with current legislation.

A clear medicines trail will exist from the point of entry of medicines into the Trust to their final endpoint. All medicines supplied or administered to patients will be either prescribed by an authorised practitioner or administered under a patient group directive.

The Pharmacy Service of the Trust is responsible for the procurement of medicines. Unless there are exceptional circumstances such as specialist hospital only medication) or by prior agreement on a case-by-case basis medicines. Medicines should not be issued or administered to in-patients that have been obtained by any other route, unless patients own medication.

Medication prescribed on FP (10) HNC (green prescriptions) will be dispensed by community pharmacists in line with GPhC council standards and as such this element of supply is not covered by this policy.

6.1 Pharmacy Stock

The Pharmacy department will aim to stock a reasonable range of medicines, taking account of the primary care SY ICB Sheffield formulary, historical use, local availability, special storage requirements, cost, the clinical indications for use and the convenience of patients.

Trust Standing Financial Instructions will apply to all aspects of medicines procurement with separation of ordering, invoicing and receipt of medicines occurring whenever possible.

However, due to the small number of staff available, there may be occasions when the same person may undertake the ordering and receipt of medicines.

The Chief Pharmacist will ensure systems are in place to obtain the best price for medicines taking account of the cost to the NHS as a whole. Pharmacy stock levels will be amended according to usage patterns; generally, the aim will be to achieve a six-week level of stockholding within the Pharmacy department of certain medicines. Other medicines will have a stockholding of up to 2 weeks dependent on space availability

The Pharmacy department will have sufficient levels of security to both deter and prevent unauthorised access. All visitors to the pharmacy department must show their identity badges and sign the visitors' book before being allowed to enter. Security levels will be reviewed in the light of the general experience within the NHS as a whole, with advice from Trust Security advisors.

6.2 Drug Distribution

Supply to the inpatient wards

Stock medications will be supplied to the ward via either a 'Medicines Management Technician (MMT)/Assistant Technical officer (ATO) top-up service' or by the ward ordering required medicines by completing an 'electronic requisition' or ordering via the Electronic Prescribing and Medicines Administration (EPMA) system.

Stock drugs may only be transferred from other wards/departments, in an emergency, on the authority of the Nurse in charge of the shift and must be recorded in the transfer of medication book. Please note this does not cover any controlled drugs (schedule 2,3,4 and 5). If transfer occurs, medications should be issued in their original packs and a requisition emailed to Pharmacy documenting the request to replace stock that has been transferred. Staff should not attempt to return any transferred stock – this should always be arranged through the pharmacy service. Please refer to Standard Operating Procedure NCD1 ordering of stock controlled drugs on inpatient wards for information regarding controlled drugs including schedule 2, 3, 4 and some schedule 5 CD's

Pharmacy top-up system

The pharmacy technician and ward pharmacist will review medicine use on a regular basis. Routinely used medicines will be stocked on wards. These will be assessed by the pharmacy ward teams e.g. pharmacists, technicians, MMT's on a regular basis to ensure correct drugs are stored in each locality. The frequency of visits will be weekly or fortnightly depending on the clinical need of the service. The ward/department staff should be aware of the day the top up is due although this may change due to service requirements.

During the course of the visits, the technician/MMT/ATO will check expiry dates, storage conditions including temperature monitoring recording by ward staff, and, where EPMA/treatment cards are reviewed, that prescribed dosages are within the BNF recommendations. The Pharmacy team will bring any concerns to the attention of ward staff and a pharmacist.

Where resources do not allow for a technician top-up service, ward or departmental staff will order medicines via an electronic requisition or requisition emailed to pharmacy using the available technology where appropriate.

E-requisition

Any medicines required in addition to the top-up are currently ordered via an e-requisition (e-form) sent to pharmacy. Unless prescribed through the electronic prescribing system a copy (or original) of the patient's prescription is sent to pharmacy using the available technology where appropriate.

Controlled Drugs

In the case of drugs controlled under the Misuse of Drugs Act, the authorising pharmacist must have the original prescription for leave/discharge medication or the ward CD order book.

Nursing staff should follow the appropriate SOPs found on the Trust intranet and in the SOP Section of this policy.

Out of hours

There are currently emergency medicine cupboards at Longley (Decisions Unit), Dovedale 1, G1 and Forest Close. This should be the initial method of out of hours medicine requirements and access is obtained through contacting the Out of Hours Flow Co-ordinators (for Longley and Dovedale only) For G1 and Forest Close contact should be made with the ward manager or the senior staff to ascertain availability. There are lists of medicines available to all wards on what is stocked in each location. Wards will routinely stock multiple strengths of regularly used drugs. This will allow for measuring doses out of hours until pharmacy is open again. Multiple strengths should not be ordered out of hours when doses can be measured at ward level. Additionally, medicines can be obtained out of SHSC Pharmacy opening hours via an agreement with the Pharmacy Department at the Northern General Hospital (NGH)- Sheffield Teaching Hospitals (STH). This should only be used in an emergency and not for all drugs. Additional charges are incurred when ordering via STH. The nurse/ward staff should make contact with NGH pharmacy and make arrangements for this to be dispensed and supplied on a wholesale dealing basis (except clozapine – See Out of Hour processes advice).

In some circumstances it may be appropriate for a doctor to write a FP10 (HP) prescription which may then be dispensed by a community pharmacy. See Appendix A for further information.

Dispensing

The preparation of clinically appropriate medicines for a patient for self-administration or administration by another member of staff will be undertaken by appropriately trained pharmacy staff. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient and assembly of the product).

During normal working hours requests for supply of medication should be made via the Trust's Pharmacy Department.

The specific processes of dispensing are covered by the Pharmacy SOP'S

Non pharmacy dispensing of urgently or emergency needed ''LEAVE MEDICATION'

In exceptional circumstances when the pharmacy is closed, where the registered practitioner judges a patient may be harmed by a delay in obtaining medicines by the usual route, the responsible person may supply no more than three days medication as leave or discharge medication from ward stock.

Medicines must be labelled with the patient's name, date, place of dispensing and name and strength of the drug, together with instructions for use. Two nurses must be involved in the decision to make an **emergency** supply and a record made of the details of the supply by the nurses involved.
A leave prescription signed by a prescriber must be written or the authority to supply must be confirmed by a verbal request by a prescriber. Schedule 2 controlled drugs cannot be issued via this method. Buprenorphine, Tramadol (schedule 3) and Morphine sulphate solution (schedule 5) are treated as schedule 2 drugs within the Trust therefore may not be issued by this method.

*Note: It is the **prescriber** who carries responsibility for the dispensing of medicines outside of the normal pharmacy system.*

Although all leave medication should be routinely signed by a prescriber and sent to Pharmacy using the available technology where appropriate, it may be acceptable to dispense an unsigned leave medication, following verbal confirmation from the prescriber. This will only be done if it is judged by a SHSC pharmacist to be in the patient's best interest. A doctor will need to sign this on the next working day.

Please refer to the 'procedure for non-pharmacy dispensing of urgently needed "leave medication" for further guidance in Appendix A.

6.3 Delivery

Transportation/ Delivery

Medicines will be supplied by pharmacy wherever possible in tamper evidence packaging. This may include, tamper evident wallets, containers or other sealed packaging.

Medicines are normally delivered by the dedicated pharmacy transport driver or general hospital transport systems. Medicines in transit must be handled in a way that maintains the security and integrity of the medicine and medicines must not be left unattended and unsecured.

Cold chain control within the limits appropriate to the individual product must be maintained for items requiring refrigeration.

It is imperative that there is a clear medicines trail in existence throughout the trust.

Audit trail:

All packages are logged when leaving Pharmacy and sealed wallets are signed for on receipt (all staff receiving medicines should check the package seal is still intact and they are signing for the correct package).

When dispensed items for leave/discharge prescriptions are received on the ward:

- The package should be signed for receipt at ward level and the contents checked immediately
- The prescription (electronic or drug card) should be checked to ensure the correct items have been selected for leave/discharge and received on the ward.
- A record must be made of this check by the person receiving the items.
- When medications are handed to patients, the nurse should also confirm the prescription is still up to date and to complete the documentation of the medicines trail.
- A copy of the discharge/STL should also accompany the medicines for communications to service users prior to discharge.

Posting medication

In specific circumstances, and after an individual risk assessment, postal services (recorded delivery) /Royal Mail Signed for® may also be used. Where wards or departments use other systems for the delivery of medicines a clear audit trail should exist for their use. The name of the patient, full address including postcode should be recorded with the collection time, signature and company used. It should be checked that someone is able to receive the medication otherwise medication should be returned immediately to the issuing department.

Community teams

Prior to posting medication into a service users property, agreement should be obtained from the receiver and wherever possible only staff who have previously visited/ knowledge of area should deliver the medication. If agreed method of receivership is not available, a follow up call should be arranged to ensure the medication has been received. Please refer to 'guidelines for community team bases regarding the storage, handling and administration of medicines' for further information in Appendix E.

Pharmacy

Pharmacy staff should follow the department SOP for the posting of medication to clients (including clozapine).

Taxi or third person delivering medication

If delivery of medication via normal routes is not available and there is an urgent need for medication, following discussion with senior colleagues, consideration of using a taxi service may be made. A clear audit trail needs to be present and confirmation that the delivery was received safely. Please see the Appendix G delivery of medication' guidance for further information. Pharmacy staff should follow the department SOP for delivering medicines via taxi.
Note: Taxis delivering medication to a service users home must be accompanied.

Domiciliary visits

When medicines are issued to nursing staff for use in the community, these medicines become the responsibility of the person to whom they are issued. All medicines carried by a CPN should have been prescribed at a specific dose for a named patient by an authorised prescriber or covered by a PGD under which the CPN may supply or administer the medication. Please refer to 'guidelines for community team bases regarding the storage, handling and administration of medicines' for further information (Appendix E).
For deliveries, all medication should be handed over in person and not posted though the letter box. Medication unable to be delivered or received in person should be returned to the issuing team/ department.

Collection of medication from pharmacy

Ward staff may also collect medicines from pharmacy but means of staff identification will be requested. Medicines will only be handed to inpatients or community patients themselves by prior agreement with the ward. All collected medicines must be signed for on collection.

Tampering

If any member of staff has reason to suspect that medication has been tampered with in any way, they should report this to a senior member of staff in the ward/department, giving the reasons for their suspicion. The senior person will take the decision on whether to isolate the stock of medication and will alert their service manager urgently if further investigation is necessary. The Chief Pharmacist should also be contacted at the earliest opportunity and an incident form completed to capture the events.

6.4 Administration of Medicines (applicable to SHSC inpatient areas)

Please also refer to other policies and standards in particular the Royal Marsden Guidelines and Nursing and Midwifery Council medicine guidelines (**superseded by the professional standards for administration of medicines (RPS)).**

For other parts of the Trust, staff should refer to relevant locally agreed policies/guidelines/operating procedures contained within this policy.

Nursing Staff should follow the administration procedure as defined in the Annual medicines management framework. Nurses and Nurse Associates will also be expected to take an annual calculations test as part of ensuring competency to administer medication.

Wristbands as means of patient identification are impractical within the Trust. Photographs may be used to confirm patient identities in some areas where there may be difficulties in confirming patient identities through other means. Staff must ask clear and open questions to identify the patient e.g***. what is your name? what is your date of birth and what is your address. If unable to answer, the service user's identification must be confirmed by another mechanism, for example confirmation of identity by another member of staff prior to starting administration of medicines.***

In administering a medicine to a service user, the responsible people will act in accordance with their own Code of Professional Practice. The administration of medicines should be recorded on the Trust electronic prescribing system or drug card. If the administration is not possible for whatever reason this should be documented accordingly via the use of the reasons for non-administration (on e-prescribing system) or codes on the medication card. The reasons for non-administration should also be recorded in the patient's clinical records and reviewed as part of the multidisciplinary team reviews.

A medicine will only be administered to a patient if it has either been prescribed by an authorised practitioner or in accordance with a patient group directive.

Ward stock (including medication awaiting return to pharmacy) must not be taken or supplied by staff for personal use.

Verbal Order In exceptional circumstances (but not including a schedule 2 controlled drug) the prescription may be made verbally by a prescriber.

Medications for verbal orders should only be authorised for urgent items that avoid patient harm.

The person administering the medicines 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 /electronic prescription is received.

The person taking the verbal order should be a qualified nurse who will document the prescription and a second person (ideally another registered nurse) will read this back to the prescriber in order that the drug, dose and circumstances of use are correct.

Verbal order should be added as a note on EPMA and in the medical notes stating the nurse receiving the verbal order and the name of the nurse second checking the verbal order. The note should include the authorising doctors name and GMC number.

Prescribers authorising a verbal order

Prescriber must have access to the patient medical notes prior to making the decision to prescribing a verbal authorisation and must clearly document the rationale for making the verbal order.

What prescribers need to consider before giving a verbal order?

- Can you remotely prescribe the medication?
- What harm would be caused to the patient if they did not receive the medication?
- Prescribers and nurses should check detained patients are covered by an appropriate T2/T3/section 62 prior to prescribing and administering.
- Under no circumstances should verbal orders be accepted for Controlled Drugs under schedule 2 of the Misuse of Drugs Act. This also includes certain schedule 3 controlled drugs (buprenorphine, temazepam, tramadol) and morphine sulphate solution 10mg in 5ml (schedule 5).

Regular prescriptions should not be commenced on a verbal order. **A prescriber must countersign all verbal orders within 24 hours if possible if the verbal order has been made on a drug card.**

Verbal orders should be brought to the attention of the prescribers within that team so they can review the suitability of the request of the prescription.

Medicines' usage trends will be reported through the Trust Medicines Optimisation/Clinical Governance reporting systems at least annually.

Medicines labelled with a patient's name must only be used for that patient, unless authorised by a pharmacist.

Administration of Medication in the Community Setting

Medication is generally not administered in the community unless there is a specific care plan in place. The authority to administer should be written on the trust drug card (or electronic prescribing system where available) and the qualified nurses who administer should also record administration on the Trust approved medicine card (or electronic prescribing system where available). See section 6.12 for the administration of depots.

Please refer to the 'guidelines for community team base regarding the storage, handling and administration of medication' SOP for further information.

6.5 Guidelines for non-qualified staff - working in community teams

Community mental health team workers such as occupational therapists, social workers and support staff are generally not trained or qualified to check or advise on medication, although they can have a role in some teams. They can prompt and support service users with medication but must work within the boundaries listed below.

A prompt is defined as a verbal reminder to the person to take their medicines and support is defined as a process of verbal and practical measures used to encourage the person with the taking of their own medicines e.g. helping with accessing the medicines, getting a drink or ensuring the safe delivery of medicines to a client.

The role stops short of handling the medicines themselves but can support the patient with practical tasks in the handling of their own medicines e.g. collecting prescriptions from pharmacy.

The nurse retains overall responsible for the assessment of the patient's safety in handling their own medicines and is also responsible for ensuring the role in relation to medicines of the health care staff is clearly defined in the patient's care plan.
The health care staff member is required to observe and report to the nurse if they have any concerns or doubts about the service users ability to take medicines appropriately (or if is refusing to take).

In the specific example of the delivery of medication by a worker who is not a qualified nurse or doctor - the following systems ***must be in place:***

- The service users has already had advice from medical/nursing staff about all relevant issues relating to taking the medication. This is most important when medication is a particularly complex issue for a service user or there has been a recent change to the prescription/dose.
- A named nurse is contactable by phone during working hours should the client or worker have a concern or query about the medication at the point of delivery.
- There are no issues re: adherence i.e. there is good evidence that the client has been taking the medication as prescribed and is willing to do so. Agreed protocols must be in

place about what to do with medication if the user is not at home to receive it / refuses / the handing over of it appears contraindicated.
- As with all delivery systems of medication, there should be a clearly followed audit trail from the point of prescribing, dispensing and delivery to the client.
- Medicines should not be routinely posted without service users being able to receive them safely (please see 'delivery of medicines' guidance in Appendix G)

6.6 Covert/Disguised Administration

A clear distinction needs to be drawn between covert/disguised administration and the use of foods or drink to aid palatability of medicines.

The Royal College of Psychiatrists (College Statement) and the Nursing and Midwifery Council (NMC in conjunction with the RPS) (https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567) includes guidance on covert administration of medicines and these should be followed by Trust staff. Guidance is also available from the ICB (good practice guidance on covert administration of medication)

It is important that Trust staff recognise that an adult who has the capacity to make treatment decisions and is not detained under the Mental Health Act 1983, has the right to refuse treatment even if it adversely affects his/her health. Therefore covert/disguised administration of medicines should only be undertaken when the patient concerned does not have the capacity to make a treatment decision but will not comply with the treatment regime and the administration of the medicine is assessed as in his/her best interests in line with the Mental Capacity Act. This decision should be made by a MDT and Staff should document the decision accordingly.

The MCA assessment of Capacity and the Record of Best interest meeting documentation should be completed prior to commencing.

The method of administration of the medicines should be agreed with a pharmacist and the details of administration documented in the patients notes. The Trust pharmacists can be contacted on 18632/18633. See general guidance notes (appendix N) for general principles when manipulating standard dosing forms. Changing the form of the medication e.g. crushing tablets thus makes the medicines unlicensed – see unlicensed section (6.29).

The MHA (s63) allows medication to be administered for mental disorder without consent, to detained individuals, whether they lack or retain capacity, modified only after 3 months by s58. MHA s58(3)(b) permits enforcement of medicine for mental disorder on both incapable and capacious, refusing detained service users, subject to SOAD agreement.

Covert/disguised medication might also be considered for urgent treatment under MHA s62. MHA does not refer to patients' best interests and only refers to the treatment of mental disorder. The MCA applies to treatment that is not for a mental disorder.

6.7 Storage/Security of medicines

Pharmacy

The Chief Pharmacist is responsible for ensuring that the physical security in the Pharmacy Department complies with the requirements of the Duthie Report, The Safe and Secure Handling of Medicines 2018. Pharmacy staff will advise on the safety and security of medicines in the clinical area, both at individual patient level and more generally relating to the ward/department.

General

From the time of receipt until use or removal from the organisation, all medicines should be kept secure, with access only by authorised personnel. This includes medicines brought in by

the patient and held prior to possible administration to the named patient after assessment, disposal or return to the patient.

Medicines will be stored in a Medicine Cupboard approved by the Chief Pharmacist/security as meeting current British standards.

The legal requirements related to the category of medicines should be applied. At each stage where a medicine changes hands there should be a clear audit trail for this process.

All medicines should be stored in their original container and not transferred from one container to another by staff.

Inpatient wards
Access to the Medicine Cupboard will be controlled by the Ward Manager who will delegate responsibility for cupboard keys to the person in charge of the Ward. Staff should be aware of and are found in SOP NCD1 to 4 which are found on the trust intranet, and in the SOP section of this document.

Community teams
All medicines are to be locked in a secure environment with restricted access. Appropriate records of stored medication are to be held at all times. Where it is deemed in the patient's best interest for medication to be kept at base for administration, this should be kept in a lockable cupboard and used for that patient only. These should be kept separate from stock medication.

Overall responsibility for the safe keeping of medicines and drug keys remains with nursing staff.

These must be agreement from the team manager if non-nursing staff need to access medication.

Security of medicine stocks will be checked by pharmacy staff periodically. Please refer to 'guidelines for community team bases regarding the storage, handling and administration of medication SOP' for further information.

Temperature monitoring
Medicines must be stored at the appropriate temperature (room temperature is defined as 15 to 25 degrees centigrade). Medicines must not be subjected to temperatures outside of these ranges unless indicated.

Medicines requiring refrigeration must be kept in a locked refrigerator kept solely for the purpose of storing medicines. The fridge temperature should be maintained between 2 and 8^{o}C and the temperatures logged daily. The fridge cabinet should have sufficient space around it for air to circulate.

The current temperature, minimum and maximum temperature should be logged on a daily basis for ambient and fridge storage. Please refer SOP for Temperatures in Medicines Fridges and clinic rooms found on the intranet and in the SOP section of this document.

SHSC Pharmacy should be contacted if the storage is outside of temperature range specified (of either the clinic room or medicines fridge) to review the stability of the medication and any further temperature monitoring actions required. An incident form should also be completed to report the temperature deviation as required in the SOP.

6.8 The Administration of Patient's Own Drug's (POD)

The SHSC POD SOP was approved in June 2020. This can be found in the pharmacy SOP G26 – Assessing and using Patient Own Drugs. This can be found on the trust intranet.

PODs brought in by patients must be given to the registered nurse for safe keeping or returned to the carer/relative if permission has not been given to use. The medicines may need to be seen by the prescriber to undertake medicines reconciliation (please refer to medicines reconciliation inpatient SOP for further information.

Nurses/ Nurse Associates can administer PODs in accordance with Trust MOP defined by the Medicines and the Controlled Drugs SOP/Policy.

All (PODs) deemed suitable for use that are clinically appropriate and prescribed on the medicine chart must be used by nursing staff for administration to that named individual patient only.

Medicines brought in by patients are the property of the patient and must not be destroyed or disposed of without the patient's, or carer's permission. Permission to use must be documented onto EPMA and Patient Notes. Please refer to 'N5 SOP - Removal of medications, prescribed or over the counter, brought into bed-based areas SOP' further guidance in this situation can be found in the SOP section of this document and on the intranet.

If a patient comes in out of hours or if medication is temporarily unavailable from pharmacy, a professional judgement should be made as to the suitability of administering the patient's own medication at that time. The judgement to use the patient's own medication should take into account the condition and expiry of the medication.

1) Medicine container is labelled, and label is clear and legible
2) Label contains, patient name, drug, strength, directions, dispensing date, suppliers name & address
3) Label matches contents of container
4) Medicines were dispensed within last six months or original container displays expiry date

Please also note:

- POD's brought into hospital are the property of that individual and must never be supplied or administered to another patient.
- When patients come into hospital, the pharmacy will visit the ward and assess the medications and deem suitable/unsuitable for use. If suitable for use then these can be administered to the patient on an ongoing basis, if the medication is not routinely stocked by pharmacy then this should be ordered as soon as possible from the trust pharmacy department.

Where there are respite facilities within the Trust it is expected that patients bring their own medicines, and these are used for the period of stay and where appropriate medicines sent back with the patient at the point of leaving the unit/ward following the local policies/ guidance.

6.9 Herbal and Complementary or Alternative Medicine Products

When a patient is admitted to hospital all their medicines should be checked as part of the medicine's reconciliation process (please refer to 'medicines reconciliation on admission to the inpatient ward SOP' found on the intranet and in the SOP section of this document). This should include any medicines bought over the counter or any herbal or other complementary treatments brought in by the Patient or Carer.

Staff must ensure that on admission all patients are required to declare and hand in products such as vitamins, herbal remedies, complementary medicines including essential oils and nutritional supplements (list not exclusive). Any items handed in should be shown to the admitting doctor and documented on the admission summary. Medication should be stored in a locked drug cupboard and recorded in the allocated book (if a CD). Medication will then be held on the patient's behalf, returned to family/ carers, or returned to pharmacy for destruction if permission has been given to destroy. Please refer to SOP N5: Removal of medications, prescribed or over the counter, brought into bed-based areas SOP for further guidance (this can be found on the intranet and in the SOP section of this document).

The responsible doctor and senior nurse will screen all such products in terms of suitability and appropriateness for administration in conjunction with any prescribed medications. A pharmacist should be contacted to check for any potential interactions or safety of the product. This discussion should also incorporate judgements made about the administration process (if it needs to be added to the EPMA or written on a drug card).

As a general 'rule of thumb' products that could affect prescribed and planned treatments should be stopped (and removed from the patient) before medical treatment commences and the use of both and the interplay between them carefully considered before delivery. The prescriber as part of the team should make a judgement on the clinical appropriateness of the preparation.

If the patient decides to continue to self-administer against medical advice, any potential risks to the patient or other patients within that environment should be identified and managed according to the level of risks involved. This must be documented in the patient's medical notes. A note should also be added to the EPMA system or drug card to document this and what the substance being taken is.

6.10 Cannabis-based Medicinal products for the management of Mental Health Disorder

Cannabis-Based Medicinal Products are not prescribed or recommended for the management of mental health disorders within Sheffield Health and Social Care NHS Foundation Trust and is included within the non-approved drugs list in the Trust.

There is a lack of high-quality evidence for the use of CBMPs, which is reflected in the current national guidelines (National Institute for Health and Care Excellence (NICE)) and a review of the literature. It has been suggested that cannabidiol (CBD) may have a role in the treatment of psychosis, certain anxiety disorders, post-traumatic stress disorder (PTSD) and addiction, however evidence is lacking. The evidence currently available comes from studies with a small sample size.

CBMPS containing tetrahydrocannabinol (THC) may cause an adverse effect on mental health, causing symptoms of psychosis and anxiety.

6.11 Self-administration of Medicines

The self-administration of medicines by patients on wards is not routinely undertaken within the Trust and should only occur when agreed with the service user and medical team. The patient's mental state should be documented as being stable and they have the capacity to understand the nature of the treatment. It must be thought to be in the patient's best interest to self-medicate and can only happen with medicines such as creams, inhalers and GTN sprays etc which the patient may need when necessary or when required and has been assessed as competent to do so. Medication items such as those listed above must be agreed with the ward medical team and documented in the patients care plan.

Service users should not self-medicate with other medications on inpatient wards or units unless they are self-medicating under the agreed SHSC Self Administration of Medicines local policy. This policy is found on the intranet. The Self medication policy

currently only covers selected appropriate wards within the Trust. This policy defines the storage of medicines and the inclusion or exclusion criteria of patients. For all other instances where self-medication may be appropriate a case-by-case risk assessment should be agreed with a senior pharmacist prior to starting and a custom made solution devised for the patient having taken account of their individual circumstances.

Patients on insulin should be assessed for their ability to self-administer insulin and be supported by staff to administer safely where possible. Generally staff should avoid administering via insulin penfill devices to avoid the risks of needle stick injuries. The SOP on prescribing and administration of insulin is found on the trust intranet and in Appendix L.

6.12 Homely Remedies (Treatment of minor ailments)

The symptomatic management of minor ailments for inpatient wards is managed by the ward prescribers or via the on-call doctors. Nursing staff should make arrangements for patients to be reviewed appropriately if needing treatment for minor ailments. For other parts of the Trust, they should follow the guidance in their site-specific policy where applicable.

6.13 Antipsychotic depots

The supply and administration (for inpatients) of long-acting antipsychotic depot treatments should be prescribed appropriately on the Trust approved drug cards or the electronic prescribing system.

The prescribing of older generation depots for stable community patients should be ideally done through the patients General Practitioner (GP) unless circumstances dictate otherwise. The authority to administer a depot by SHSC staff should be documented by a prescriber on the SHSC depot card or where available the electronic EPMA prescribing system. Administration should be documented on the drug card/EPMA system, and an entry made onto the service users notes.

6.14 Controlled Drugs (Schedule 2)

Note: This section is applicable to some other CDs from other schedules including buprenorphine (schedule 3) and Morphine sulphate 10mg/5ml (schedule 5).

Controlled drugs when ordered for inpatient stock should be ordered by nursing staff as set out in SOP NCD1, found on the trust intranet.

Receipt and storage of controlled drugs is covered by SOP NCD2, this is also found on the Trust intranet. A confirmation of receipt will be requested when CD's are delivered, this is in the form of a CD delivery and receipt book. The driver/person delivering the CD's will request that the staff accepting the delivery will be expected to check the serial number on the tag matches the serial number on the book. Once this has been approved then the nurse/qualified person will sign the delivery book. The delivery should be recorded into the CD register and locked away immediately upon receipt. **This should include the delivery date, time and serial number from the CD order book.** The controlled drug order book must be stored within the controlled drug section of the medicine cupboard as this is controlled stationary. An entry should be made for every administration and a running balance maintained and checked daily.

Balance checks should be performed as detailed in SOP NCD3 Stock Balance Checks. A balance check must be performed at every receipt, administration or disposal of a CD. In addition a balance check must be performed at handover as per the guidance in NCD3.

Nurses should be familiar with and follow the SOP – CD 4 administration prior to administering any controlled drugs.

If controlled drugs are needed for leave, discharge or outpatient prescriptions they should be written in accordance with current legislation (see current BNF/eBNF for

details). Doctors still considered to be in training (F1) are able to prescribe controlled drugs for inpatients and at the point of leave or discharge (under supervision). However, F1 Doctors are not permitted to prescribe controlled drugs for outpatients unless the prescription was being dispensed through the Trust Pharmacy. They are also unable to prescribe on FP10 prescriptions.

Prescribers should be familiar with and follow the SOP – CD Prescribing prior to prescribing controlled drugs.

Other schedules of Controlled drugs (mainly 3 and 4) are also governed and also monitored by the NCD1 to 4.er.

All processes involving schedule 2, 3 and 4 controlled drugs should be carried out against approved SOP's.

Accountable Officer (for CD's)
The management of controlled drugs within the pharmacy is covered by departmental SOPs found on the intranet. The Trust accountable officer (controlled drugs) is also the Chief Pharmacist. The responsibilities of the accountable officer are listed in the 2009 Health Act These include ensuring:

- Arrangements in place for the monitoring of the use and management of controlled drugs by all healthcare professionals within the Trust.
- Systems in place to alert the accountable officer of any complaints or concerns involving the management or use of controlled drugs.
- An incident reporting system in place for untoward incidents involving the management or use of controlled drugs.

See - Controlled Drugs (Supervision of management and use) Regulations 2013

The accountable officer will also be a member of the Controlled Drugs – Local Intelligence Network (LIN) and will share intelligence regarding the use and potential abuse of controlled drugs, which are prescribed, dispensed, administered or purchased in the geographical area defined by the NHS South Yorkshire integrated Care Board (SY ICB) and Sheffield City Council city boundary.

If any member of staff or service user has concerns about the use or handling of controlled drugs they should contact the Accountable officer for CD's (Chief Pharmacist) Tel: 0114 2718630. In the event of a concern relating to the Accountable officer, the trust Chief executive and the SY ICB Accountable officer should be contacted.

Misappropriation
If any member of staff has suspicions that medication may have been misappropriated, they should raise this suspicion with their line manager, the Trust Security Officer and a senior member of the pharmacy team in the first instance, giving the reasons for their suspicion. Involvement of the police and/or fraud officer should be agreed with the CD Accountable officer /Chief Pharmacist, Security Officer or an Executive Officer if appropriate. The Trust Incident Policy should be followed.

Similarly if anyone has concerns about any other aspects of medicines handling they should be encouraged to speak to the Manager of the appropriate service or to contact the Chief Pharmacist as above. Staff should be aware of the Trusts complaints procedure found on the intranet.

Disposal of Controlled Drugs (CD)
All unwanted medicines (from the inpatient wards,) including all CDs in Schedule 2 and 3 and morphine sulphate 10mg/5ml liquid that are subject to safe custody requirements should be returned to the Pharmacy Department for appropriate destruction as stated in the CD SOP found on the intranet.

The ward should contact the Pharmacy Department to notify them that CD's need to be returned to Pharmacy, the Pharmacist/MMT/ technician should arrange a suitable time to visit the ward to collect the medication. **In no circumstances should CD's be returned directly to the Pharmacy driver**. If the CD is recorded in the CD register, a nurse and Pharmacist/technician/MMT should both countersign the CD register to record they have been returned to Pharmacy.

Once returned to Pharmacy the controlled drugs should be entered in the appropriate section of the CD register (for witnessed destruction). The accountable officer has approved the following people as authorised witnesses: Simon Barnitt and Kirsty Dallison-Perry and Other authorised witnesses will be identified.

Pharmacy staff should follow the departments SOPs related to the disposal of controlled drugs. These SOPs are found on the intranet.

6.15 Prescribing

See also section 6.30. All prescribing should take account of NICE guidance www.nice.org.uk/ and prescribers should also follow the Guidance issued within the Trust: Prescribing and Medicine Use in SHSC. And local guidelines agreed by Sheffield place Area Prescribing Group (APG) or South Yorkshire Integrated Medicines Optimisation Committee (IMOC).

All prescribers should prescribe in accordance with the licensed indications for each medicine where possible. Prescribers should refer to the current version of the BNF (British National Formulary) and the manufacturers SPC (Summary of Product Characteristics) for more details. If prescribers prescribe outside of the recommended indication, conditions or doses above those stated as per the SPC, they should do so knowingly and have discussed with the patient and documented the reasons why in the medical notes. The Prescriber should also be clear as to how long the intended treatment is for or when the treatment review date will be.

Writing the prescription is the means by which the prescriber authorises a medicine to be supplied or administered to a patient. For hospital in-patients, the prescription will be written on the ePMA Electronic Prescribing and Medicines administration (EPMA) system or the standard Trust drug card. Appropriate e-prescribing training (from the Pharmacy Department) is required for all prescribers prior to gaining access to the system. An outpatient prescription form will be used for outpatients. Where there is no Trust pharmacy service available to dispense the medicine then an FP10 (NC) prescription may be used to prescribe a medicine which is then taken to a community pharmacy to be dispensed.

Prescriptions must be clear and unambiguous. They must contain the patient's name, date of birth and Ward/department (or in the case of out-patients/FP10s the patient's address). The name of the drug should be clearly written using the generic or RINN (recommended international non-proprietary name – see current BNF for further details). The dose and frequency must be clearly shown together with the date the medication started and the date the prescription rewritten (if different).

Brand names should be specified for Lithium or combination products where no RINN name exists. This also applies to certain other medications whose brands are not equivalent . Or where it has been locally agreed to prescribe certain brands to deliver cost efficiencies (see BNF for further guidance).

Abbreviations should not normally be used. If there are any doubts or concerns about the medication a prescriber intends the patient to receive, staff responsible for administering medicines or dispensing should ensure the details have been clarified by the prescriber before a medicine is administered or dispensed. Pharmacy staff are also available for advice.

Pharmacists commonly identify prescription errors as part of their review of inpatient, and discharge medicines. Whilst some of these errors need to be brought to the immediate attention of the medical team for management, more minor errors can be rectified with an amendment or clarification to the prescription. This is through the clinical pharmacy enabling guideline found on the trust intranet.

Formulary

The Trust currently does not have a formulary; however one is currently being developed. Currently SHSC follows Sheffield place, ICB formulary, and Sheffield Teaching Hospital formulary for physical health medications where appropriate.

Current practice in the pharmacy department are to stock items as agreed and approved by the Commercial Medicines Unit (CMU) regionally, nationally if available and also follows NICE guidelines. Due to limited storage and limited resource not all brands are stocked in pharmacy.

The trust has a non-approved medicines list, these medications are not first line items, and the current process is that a medication timeline/ overview of what they have previously tried and the rationale for clinically appropriate is shared with the Chief Pharmacist, who will review the rationale and approve/ not approve as per clinical appropriateness. The process is currently under review.

Medicines reconciliation

Medicines reconciliation is the process of identifying an accurate list of a person's current medication and comparing them with the current list in use; recognising any discrepancies and documenting any changes; therefore resulting in a complete list of medication accurately communicated.

NICE recommends that in an acute setting, medicines reconciliation should be carried out within 24 hours or sooner if clinically necessary, when the patient moves from one care setting to another.

Medicines reconciliation should be completed and documented as per the Trust SOP; this can be found on the trust Intranet and in the SOP section of this document.

Stopping or Changing Treatment (inpatient drug cards)

On paper drug cards existing prescriptions should not be modified but should be discontinued and rewritten. When stopping treatments, the prescriber should put a straight line diagonally across the prescription and document the stop date where indicated and sign to document the discontinuation. Any changes to prescriptions should be documented in the medical notes.

Prescriptions may be modified on the electronic prescribing system. Prescribers must ensure their prescribing intentions have been accurately recorded in the medical notes. In all cases there should be a clear record of the reasons for stopping or changing treatments.

Prescribing – other considerations:

All prescribers should avoid treating themselves or close family members. This is good medical practice. Prescribers should also avoid prescribing for any other Trust employees unless they are registered as a patient of the prescriber.

Prescribers should take account of the Trust policies: when prescribing specific types of medication including:

- Prescribing of Controlled drugs (see BNF for more information)
- Rapid Tranquillisation Policy
- Antibiotic Policy

- Anticoagulation Guidelines

Nursing homes and other relevant centres within the Trust should refer to their local policy and the local authority medicine policy for details of prescribing within these care environments.

Outpatient Prescription Pads (including FP10NC)
In some circumstances outpatient prescription pads may need to be used by prescribers for out-patients or domiciliary visits where changes or new medications are needed more urgently. Alternatively, prescription changes should be clearly communicated for the GP to prescribe.

Electronic prescribing systems are in operation within allocated outpatient departments and Prescribing SOP's should be followed for the prescribing system in use within the Substance misuse service.

Security and Safe handling of prescription pads
The security of NHS prescription forms is the responsibility of both the prescriber and the employing organisation. Within the Trust, the Chief Pharmacist is responsible for the procurement of prescription forms.

They should be treated as controlled stationary and issued in line with a complete and secure audit trail. On receipt they should be stored securely (e.g. In a locked cupboard or drawer which is only accessible by authorised persons) and separately from medicines.

Please see the trust SOP FP10 procedure for secure handling and storage of prescription pads found on the trust intranet. This covers all procedures related to FP10 prescriptions, from ordering the prescriptions, storage, monitoring, auditing, destruction and actions if loss, theft or suspected fraud of prescriptions.

Any incident must be recorded and investigated in accordance with the Trusts incident policy.

Pharmacists should be vigilant in scrutinising prescriptions for any signs of alternations not authorised by the prescriber. Pharmacist's should contact the prescriber to verify the changes.

Staff may also report any concerns about fraud to the confidential reporting line- Freephone 08000284060 (lines are open Monday to Friday 8am – 6pm).

6.16 When Required – PRN prescriptions

The 'as required' section of the prescription must only be used for those medicines to be given at a nurse's discretion in line with the prescribers' intentions to meet the needs of the patient. When required (PRN) prescriptions must include the maximum dose and total daily dose, route, frequency of administration and indications for use must also be clearly shown. This should be considered alongside any non-pharmacological support in the patients care plan, in particular to reduce the need to use sedation/medication for behaviour that challenges. Once a patient's medical condition has improved there may be fewer requirements for medicines such as hypnotics, anxiolytics, anticholinergics, analgesics and laxatives. PRN prescriptions should be reviewed regularly and discontinued if they are no longer needed.

Where relevant, staff should follow the Trust Rapid Tranquillisation policy for additional guidance on PRN use. Medications that are prescribed for rapid tranquillisation should be prescribed as PRN and add 'Doses of treatment' as 1. The PRN notes on EPMA should also state for rapid tranquillisation and to contact prescriber once administered.

6.17 Non-Medical Prescribing

All non-medical prescribers should follow the general principles of medicines management outlined within this document and follow the framework for non-medical prescribing agreed within the Trust. For more detailed information consult the SHSC Non-Medical Prescribing framework found in Appendix K. The Trust non-medical prescribing lead (Chief Pharmacist) or the Pharmacy Department may be contacted for further information.

6.18 Leave/Discharge/Out-Patient Prescribing

(see also section **6.30**)The routine quantity of medication to be supplied on discharge is two weeks and outpatient prescriptions one month's supply (a patient pack). However, the prescriber must use his or her clinical judgement in deciding the appropriate quantity of medication to be handed to a patient, for example patients who are considered at risk of self-harm or have previous episodes of self-harm should only be prescribed limited quantities of medication (e.g. no more than 7 to14 days or less). In most cases for periods of short-term leave - a full patient pack (28 days) would not normally be considered appropriate.

6.19 Special considerations

In April 2016, the statutory patient safety functions previously delivered within NHS England transferred to NHS Improvement. In June 2022, NHS Improvement was dissolved and the patient safety functions transferred back to NHS England. NHS England are responsible for operating the National Reporting and Learning System (NRLS) and using information from the NRLS, and elsewhere, to develop advice and guidance for the NHS on reducing risks to patients. Previous patient safety alerts have been issued by NHS England - alerts relating to actions or special considerations to be taken with medicines.

The Chief Pharmacist will ensure Alerts relating to medicines are actioned through the pharmacy team and directorates as appropriate (Refer to section 6.26 and 6.27).

The following are highlighted as being of particular concern within NHS

Potassium Concentrate

This Patient Safety Alert aimed to reduce the risk of accidental overdose of intravenous potassium arising from use of potassium chloride concentrate solutions (2002). Within the Trust all such products were removed from the wards.

Medicines Reconciliation

NICE and the NPSA issued guidance on medicines reconciliation in response to the number of medicine related errors that occur at the point of admission (or transfer between services).
Please be aware that the risks of making a prescribing error are high at the point a patient is admitted to hospital or transferred across boundaries of care.
Please also see Medicines Reconciliation section.

Oral anticancer medicines

No injectable or oral cytotoxic drug will be supplied unless this has been discussed with a pharmacist and a clear plan is in place to ensure the safe administration of the drug. Fatalities are still occurring over confusion with cytotoxics. The NPSA have issued alert notices on oral cytotoxic drugs (including methotrexate).

Treatment should be initiated by a cancer specialist and all anti-cancer medicines should be prescribed only in the context of a treatment plan. Non-specialists who prescribe or administer on-going oral anti-cancer medication should have ready access to appropriate treatment plans including guidance on monitoring and treatment of toxicity. It is essential for Prescribers to be aware of who is undertaking the monitoring.

Within SHSC, F1 doctors are not authorised to prescribe cytotoxic medication. Nursing staff should follow the guidelines for administration by the Royal Marsden Guidelines

Pharmacy staff should be familiar with and follow the SOP for dispensing of oral anti-cancer medicines.

Anticoagulants

Anticoagulants need to be prescribed safely and staff should refer to the Trust anticoagulation guidelines (appendix F & G). Generally the instructions for the dosing of warfarin should be obtained from the anticoagulant clinic. Patients should be referred to the Anticoagulation clinic for dosing and monitoring (click here for referral form). Prescribers and Pharmacists should check there are up to date INR results before prescribing or dispensing prescriptions for anticoagulants. Pharmacists and Pharmacy technicians should refer to the SOP – Dispensing of anticoagulant prescriptions.

Opioid Medicines

When opioid medicines are prescribed, dispensed or administered the healthcare practitioner concerned, should confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. Refer to the relevant CD SOP's prior to prescribing, dispensing or administering.

If a patient is currently prescribed methadone - always contact their community pharmacy directly to cancel any existing prescription to prevent double prescribing. Fatalities have occurred due to patients receiving double doses of substitute treatments (see also NICE guidelines Methadone & Buprenorphine http://guidance.nice.org.uk/TA114)

Prescribing of methadone or other opioid substitute should be in consultation with the specialist substance misuse services. As a general principle, at any one time, no more than 2 or 3 days supply with an absolute maximum of 300ml methadone should be prescribed. The majority of people requiring methadone, who are admitted as an in-patient, are likely to have a regular prescription; therefore there should be no requirement for a prescription to be issued on discharge. Discharge arrangements and initiation or changes to opioid substitution treatments should be discussed with the substance misuse service.

Lithium

Lithium is a drug which needs to be initiated and monitored in accordance with NICE guidance. Failure to monitor can lead to harmful adverse effects. Patients initiated on lithium within the Trust should receive verbal and written information and a record book to track lithium blood levels and relevant clinical tests. The Pharmacy Department will ensure with lithium that blood test results are up to date for all prescriptions received in the Department and that the patient has a lithium booklet issued to them. Contact the Pharmacy department if you need a lithium patient book. Prescribers, nurses and Pharmacists within the Trust should ensure that prescriptions are safe to be prescribed, administered and dispensed according to current valid blood test results. Blood test results can also be accessed through the electronic medical notes system (via Pathology and ICE).

Medical-Gases

All medical gases used in the SHSC are Licensed Medicines and as such are subject to the Medicines Act 1968 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 unless it is a medical emergency. This authority must include the name, and concentration of the medical gas (where appropriate), the method of administration and the rate of flow. This should be prescribed / documented on an inpatient drug card. On wards where there is electronic prescribing – the medical gas

should be cross referenced to the prescription on the drug card. Refer to the Trust Oxygen Policy

Safer Administration of Insulin

Administration of the wrong dose of insulin is reported to occur commonly and has led to severe adverse consequences. Two common reasons for incidents occurring have been the inappropriate use of IV syringes to administer insulin and the inappropriate use of abbreviations (e.g. U or IU) has led to the wrong doses administered. Within the Trust the supplies department will rationalise standard equipment available. Wards and departments should ensure they have adequate supplies of insulin syringes. Prescribers should ensure that they prescribe appropriately using "units" instead of any abbreviations.

Nursing staff should never withdraw insulin from a cartridge or pre-filled pen device due to potential for harm to occur as per the NHS patient safety alert 'Risk of severe harm and death due to withdrawing insulin from pen devices'. Consider prescribing insulin as vials if available and follow the procedure for the administration of the Magellan insulin safety syringe. Certain individual insulins are only available as pre-filled pen device. In this situation, BD Autoshield duo pen needles and BD Autoshield Duo device should be used. Please refer to the Insulin use with SHSC Trust found in Appendix L.

Reducing Harm from Omitted and Delayed Medicines in Hospital

Medicine doses are often omitted or delayed in hospital for a variety of reasons. While these events may not seem serious, for some critical medicines or conditions delays or omissions can cause serious harm or death. Those drugs considered to have greater risks associated include anti-infective drugs, anticoagulants, insulin, medicines used for resuscitation, and medicines for Parkinson's disease. Other locally identified medicines include methadone, clozapine and benzodiazepines.

For all medicines (particularly those listed above):

- Recognition of the need to ensure that medicines are prescribed, supplied and administered in a timely manner.
- If medicines are delayed nursing staff should seek advice from a senior colleague and then seek advice from the prescriber (or on call doctor if appropriate). The administration of medicines should be documented in the normal way, but any subsequent discussions should be documented in the clinical notes.
- The ward should follow the out of hours procedure to obtain medication at the earliest opportunity (from the NGH). Staff should consider the use of the patients own medication if appropriate (or available) if medicines are not obtainable from the usual sources.
- **Staff should complete a Trust incident form where medicines have been delayed or omitted inappropriately.**

Low Molecular Weight Heparins

This group of drugs have been implicated with harm following inappropriate doses prescribed - the dose prescribed needs to be based on the individual's current weight and renal function. Under dosing may have an increased risk of further thromboembolic events and overdosing can increase the risk of bleeding. When these drugs are prescribed within the Trust, the patients weight must be recorded (on the drug card or entered on the EPMA system) and reviewed where applicable. Prescriptions will only be issued by the Pharmacy Dept when the dose, weight, renal function, indication and length of treatment have been confirmed (Pharmacy staff should refer to the LMWH SOP). However, treatment should not be delayed in the absence of a renal function test but should be obtained as soon as possible. This information regarding doses relative to weight and duration of treatment should also be communicated during transfer of care. Staff should refer to Appendix I – Guidance for use with anticoagulants.
Patient safety alert – Harm from using Low Molecular Weight Heparins when contraindicated

Loading Doses
Some medicines have been linked with increased harm following incorrect use of loading doses. The drugs most likely to cause harm are warfarin, amiodarone, digoxin and phenytoin. These drugs and others where loading doses are involved are rarely initiated within the Trust. However, caution must be exercised when initiating these drugs on advice from the physicians from a General Hospital and clear communication obtained for the loading doses and subsequent maintenance doses. Copies (or electronic mail via secure information governance transference means) of the prescription charts should be requested and the plan (including treatment length and monitoring needed) documented in the medical notes. This information should also be communicated during transfer of care.

Safer Use of Insulin – Adult Patient Passport
Insulin incidents involving the administration of the wrong preparation, wrong dose or frequency can cause harm to patients. Insulin passports are not used in Sheffield, however were used historically, and some patients may have them. Healthcare professionals need to be aware that patients admitted on insulin, may have the passport which could be a useful tool in the medicine's reconciliation process. Clarifying the dose administered is key to ensuring safe prescribing. This can be verbally from the patient if they are self-administering, and corroborated. If someone else is administering the medication, clarification from the person administering the dose is vital.

Patient safety alert to improve reporting and learning of medication incidents
Following the alert, a medicines safety officer was appointed and a Medicines Safety Group is in place. The purpose is to increase incident reporting and learning from medication incidents. This includes the use of national networks and analysis of local incidents and trends to increase learning from incidents.

Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid or opiate treatment
Following the alert, naloxone was removed from the emergency trays in use within the inpatient areas. Naloxone is still available on Burbage and Substance Misuse Services where the potential need for naloxone would be greater.

Risk of death or serious harm from accidental ingestion of potassium permanganate
Medication generally only advised for use by external specialists (dermatology/infection control) – prescribing system alerts and labelling requirements added to the system to prevent the ingestion of the product.

Addressing antimicrobial resistance implementation of antimicrobial stewardship
The consequences of Antimicrobial Resistance (AMR) include increased treatment failure for common infections and decreased treatment options. Antimicrobial stewardship is key to combating AMR and will be addressed by policy review, training and audits to monitor the safe and effective use of antibiotics.

Valproate- Update on MHRA review into safe use of valproate - GOV.UK (www.gov.uk)
Valproate is approved in the UK to treat epilepsy and bipolar disorder. Because of the known risk of birth defects and neurodevelopmental disorders following use of valproate in pregnancy, valproate should only be used in women of child-bearing potential if a Pregnancy Prevention Programme is in place, which includes a requirement to use effective contraception. Valproate should not be used in female children and women of childbearing potential unless other treatments are ineffective or not tolerated.

Following advice from the Commission of Human Medicines (CHM) - the CHM has advised that no one under the age of 55 (male or female) should be initiated on

valproate unless two specialists independently consider and document that there is no other effective or tolerated treatment. Where possible, existing patients should be switched to another treatment unless two specialists independently consider and document that there is no other effective or tolerated treatment or the risks do not apply.

Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Medication related never events include overdose of insulin due to abbreviations or incorrect device and overdose of methotrexate for non-cancer treatment. For further information please refer to trust Incident Policy.

Restricted use of open systems for injectable medication

Open systems for injectable medication (which include gallipots and molded plastic procedure trays) should not be used given the risks of harm from one medication being confused with another, and medication intended for injection being confused with other substances, such as skin antiseptics. The only exception is for embolisation procedures involving embolic agents that need to be prepared openly.
Injectable medicines must be drawn directly from their original ampoule or container into syringes, and then either administered immediately or, if they are not for immediate use, the syringe is labelled and checked before later use.

Stopping over medication of people with a learning disability, autism or both (STOMP).

The goal of STOMP is to improve the quality of life of people with a learning disability, autism or both by reducing the potential harm of inappropriate psychotropic drugs this includes being used wholly inappropriately, as a "chemical restraint" to control challenging behaviour, or in place of other more appropriate treatment options. Individuals prescribed psychotropics should have periodic medication reviews with a view to challenge continued need for psychotropics, implementing planned supervised dose reductions and stopping of inappropriate psychotropic drugs.
Please see STOMP resources from NHS England and NICE guidelines. Please also see the guidance for medicines management of patients with a learning disability in Appendix J

High dose and combination antipsychotics

The Trust has a High dose Antipsychotic Therapy (HDAT) policy. This should be consulted for guidance on the procedure to be followed for patients who are HDAT. There is additional guidance provided in the BNF and the Royal College of Psychiatrists report on high dose (HDAT) and combination. NICE CG178 states that "regular combined antipsychotic medication should not be commenced, except for short periods e.g. when changing medication". There is little evidence that high dose or combination prescribing of antipsychotics offers clinical therapeutic advantage and there is a greater side effect burden, therefore appropriate monitoring must be in place as detailed by NICE and in the BNF. Prescribing of high dose or combination antipsychotics should be seen as an explicit time limited trial, with a clear plan for review and monitoring. High dose or combination antipsychotic therapy should only be continued if evidence of benefit is not outweighed by tolerability or safety concerns.

6.20 Clinical Trials involving pharmaceutical products

All clinical trials that take place within the Trust cannot proceed unless the research has been logged and that it has been approved by the appropriate director and has Research and Ethics Committee approval. UK policy framework for health and social care research:(DH, 2017)

All investigational medicinal products (IMPS) will need to be manufactured to Good Manufacturing Practice (GMP) Standards and trial sites will be subject to MHRA Good Clinical Practice (GCP) inspection.

(see http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice/index.htm)

Records must be kept of receipt, dispensing, issue, administration, and disposal of all IMPS to facilitate reconciliation and to comply with GCP and statutory requirements. The handling, storage, dispensing should be covered by Standard Operating Procedures (SOP's) and follow guidelines prepared by the Institute for Clinical Research booklet, SOP's and checklists for Pharmacy personnel.

Once a medicine trial has received ethical committee approval, the researcher must approach the Chief Pharmacist and seek agreement for the clinical trial supplies to be made within the Trust from the Pharmacy Department. The Pharmacy Department must ensure that all legal issues are covered before agreeing to the trial proceeding.

Refer to SOP (Clinical trials checklist) before starting any involvement with the clinical trial.

6.21 Medical Emergencies

Emergency medicines (tamper evident) with selected agreed treatments for medical emergencies have been provided to inpatient wards and selected departments. These should only be used where there are trained staff available to prescribe and administer them appropriately. All staff should work within their own sphere of competence. If staff are in any doubt they should seek further medical advice or call an ambulance if a patient's condition is causing medical concern.

All emergency drugs should be checked routinely by ward staff and if they have been used/tampered with they should be returned to Pharmacy for a replacement. It is the Pharmacy Department's responsibility to replace out of date medicines. The emergency medicines should be stored in a locked clinic room within the grab bag (not locked in a drug cupboard) so they can be accessed readily in an emergency.

Pharmacy staff should refer to the dispensary SOP D22 SOP - Assembling and Distribution of Emergency Trays for more details.

Ward staff should check the contents are intact and the dates of the emergency medicines on a weekly basis.

6.22 Pharmaceutical Waste

For the disposal of Pharmaceutical waste the Trust Waste policy should be followed.

General
Medicines (except for CD's) no longer needed on inpatient wards and units should be returned to Pharmacy via the technician, ATO/MMT,or pharmacy driver and assessed prior to disposal if appropriate to be reused.

Patient's own drugs
In the event of services users bring their own drugs (including OTC) onto the ward please refer to the 'Removal of medications, prescribed or over the counter, brought into bed based areas SOP' and the SHSC PODs policy

Dropped or refused medications
Medicines which have either been dropped or refused should be disposed of via the sharps bin – please refer to 'disposal of medicines on in-patients wards SOP'.

CD's
For the disposal of Controlled drugs please refer to Section 6.13 and refer to 'SOP CD 5 – Destruction of out-of-Date Drugs'.

Community
Medicines no longer required by service users in the community should be returned to the issuing community pharmacy for destruction. Such medicines are the property of the patient and removal of the medicines must be agreed with the patient first, unless advisable on safety grounds.
If removed medications are unable to be returned to a community pharmacy; they can be returned to SHSC pharmacy.

In the event medicines are not able to be returned to a pharmacy straight away these should be returned to base and stored in the medication cupboard; ensuring medication is logged in and back out according to local procedure.

A clear record of the medicines taken and returned to community pharmacy must be made. Please refer to SOP for guidance on the disposal of unwanted medication from service users in the community.

6.23 Key Storage

The medicine cupboard keys are the responsibility of the assigned nurse in charge of the ward/department and are responsible for controlling access to the medicines' cupboards, refrigerators and trolleys.

Authorisation to hold the keys may be given to other designated nurses or authorised pharmacy staff in order to carry out the duties of the pharmacy service - the responsibility remains with the appointed nurse, even if he/she decided to delegate the duty.

Medicine keys must not be handed to medical staff, student nurses, team members from non-clinical backgrounds, secretarial or clerical staff. All medicine keys must be kept on the person of the nurse or authorised employee.

At community bases, keypad access will house the drug cupboard key which will be located close to the medicines cabinet. Note: The cabinet code should be known to authorised members of staff and as per safety protocols should be changed regularly with a maximum of a 6-month time frame.

The Nurse in charge is responsible for the CD keys which must be kept separate from the other medicine cabinet keys (key-holding may be delegated to another Registered Nurse, but the legal responsibility rests with the Nurse in Charge). The key holder should be readily identifiable at all times. On occasions, for the purpose of stock balance checks or the return of CD's for destruction, the CD keys may be handed to an Authorised member of the Pharmacy staff, who must return them immediately after use.

No other Practitioner should have access to the Controlled Drug cupboard except in the presence of the Practitioner officially holding the key. All processes involving controlled drugs should follow the nursing CD SOPS.

A second set of keys should be kept secure in a designated place with approved and identifiable access. In the event of missing keys please refer to 'NCD2 Receipt and Storage of Controlled Drugs SOP'.

If a ward or department closes overnight it is the responsibility of the nurse in charge to ensure drug keys are stored securely, preferably in a manned clinical area or in a locked key cupboard with access-controlled entry.

6.24 Preceptorship

The SHSC Preceptorship Guidelines & Workbook sets out the specific requirements with regard to medicines management for newly qualified nurses/nurses returning to

practice. It is recommended all nurses in Preceptorship undertake the Trusts medicines management/rapid tranquillisation and administration assessment training as part of their sign off to give medicines safely. Refer to the Preceptorship Policy found on the trust intranet. Student Nurses will be able to have read only access to the electronic prescribing system.

Physicians Associates
Physician associates support the medical team in the assessment and management of patients. Students currently undertake experience in the Trust and the role of qualified physician associates is under review. There is currently no statutory regulation for physician associates which means that they are unable to prescribe at present. Assistant physician associates and physician associates will be able to have read only access to the electronic prescribing system.

Nurse Associates (NA):
Registered nurse associates can undertake the same roles as registered nurses with respect to medicines underpinned by the necessary training and competency assessment (the medicines aspects of the NA Job Description is based on the NMCs 'Standards of Proficiency for nursing associates').
The exception being with respect to PGDs.
A registered nurse would also be involved in CD administration by virtue of the two registered nurse CD administration process. Parenteral administration is not currently included. Trainee nursing associates by the virtue of their training having undergone the appropriate module will be able to undertake medicines administration under the guidance of a qualified nurse. This will be reviewed in line with any change in legislation TNA will be able to have read only access to the electronic prescribing system.

6.25 Medicine Incidents

A medicine incident is a preventable incident or error associated with the use of medicines which may put a patient at risk. Such incidents may be related to any of the steps involving medicines including the prescribing, dispensing, administration of the medicine and any adverse events or adverse events relating to medicines.

This section supports the Trust Policy for Incident Reporting and Investigation. The objective of a reporting system is improvement in patient safety and not the disciplining of staff. Medicine incidents should be reported wherever they occur in the Trust. All patient safety incidents get fed nationally to the National Reporting and Learning System (NRLS). Safety alerts are issued by NHS Improvement (patient safety).

All medicine incidents must be reported to the Risk Management department using the electronic incident reporting system (paper incident forms may still be in operation in some areas). **Staff should pay particular importance to documenting the circumstances and contributory factors involved** and the management of the incident (what medical attention (if any) was needed following the incident).
All incidents involving Controlled drugs (CD) get sent for the attention of the Accountable Officer for CD's. See section 6.14 for more details relating to the accountable officer and the SOPs.

Incidents involving other medicines get copied to the Pharmacy Department for review by the Medicines Safety Officer. Incidents and trends will be reviewed by the Medicines Safety Group and give an assurance report to the Medicines Optimisation Committee (See Incident flow charts Appendix H). Incidents are shared for review by the Networks.

6.26 Deaths

Deaths whether expected or unexpected should be documented as incidents as per the Trust incident policy. The details and contributory factors (including details of relating to medicines) should be documented.

In the event of the unexpected death, the coroner may request examination of the individual's medication. Following the unexpected death of an individual the medication should be retained and should be stored securely, until a decision has been made regarding inquest proceedings or a death certificate has been issued.

As an employee of Sheffield Health and Social Care NHS Foundation Trust we should adhere to the following: SHSCT Risk Department advice;

If the death of an individual is expected and the death certificate has been signed by a medical Practitioner stating natural causes, the medication of the individual must be retained for 7 Days. If the death of an individual is unexpected and the death certificate is not signed by a Medical Practitioner the medication of the individual must be retained for 14 days or until the coroners has completed the inquest and the death certificate has been issued.

In both of the above expected or unexpected deaths a death certificate must be issued before the individuals medication may be returned to the pharmacy for disposal.

The family or relatives should be advised to return medication to the dispensing pharmacy for safe disposal once the coroner has completed the inquest satisfactorily and a death certificate has been issued. If staff are involved in this process they should document all the medicines returned for safe disposal including all Controlled drugs.

6.27 Adverse Drug Reactions

Any drug may produce unwanted or unexpected adverse reactions. Detection and recording of these is of vital importance. Healthcare professionals are urged to help by reporting suspected adverse reactions to the Medicines and Healthcare Products Regulatory Authority (MHRA) through the yellow card scheme (see https://yellowcard.mhra.gov.uk/). Yellow cards can still be completed via the sheets at the back of the BNF or via the website. For intensively monitored medicines (identified by a black triangle in the BNF) all adverse reactions should be reported. For established drugs report all serious reactions in adults and all reactions in adolescents under 18 years old.

Serious adverse drug reactions should be treated as Medicine Incidents and the procedure followed as in 6.24. It is essential that all medicine related patient adverse reactions are reviewed by a Doctor.

6.28 Drug Alerts and Recalls

The Trust receives Alerts from the Central Alerting System (CAS). It enables alerts and urgent patient safety guidance to be accessed at any time.

Safety alerts, emergency alerts, drug alerts, Dear Doctor letters and Medical Device Alerts are all available on the https://www.cas.mhra.gov.uk/Home.aspx. They are issued on behalf of the Medicines and Healthcare products Regulatory Agency, the National Patient Safety Agency, and the Department of Health

Within the Trust the Medical Director, the chief pharmacist and links within the Risk Department receive alerts from CAS. The Medical Director (or their PA) will circulate the alert to the pharmacy team who will advise on further action or cascade – this will depend on the nature of the alert and the circulation list, but it will be cascaded to staff where relevant and appropriate to their sphere of practice and the nature of the alert. Blanket cascade of alerts will be avoided.

For urgent recalls out of hours The Chief Pharmacist will be contacted through the MHRA communication cascade.

Where the alert involves medicines in use within the trust, the Pharmacy department will log the alert and will put procedures in place to trace batches of affected medicines and contact relevant wards and departments to recall them and quarantine any affected batches. Pharmacy staff will follow the detailed pharmacy department procedure, (SOP G8 – Actioning Drug Recalls and Alerts).

6.29 Medicine Defect

The following procedure applies when a defect is found or is suspected in any medicine:

- The Pharmacy department should be informed who will advise on all reporting, recording and investigating on the defect.
- Remove and isolate any found or suspected defective medicines. It should be returned to the Pharmacy Department and kept there until further information has been obtained from the manufacturers.
- Record the details of the medicine and defect.
- If the medicine has been administered to a patient, inform the doctor responsible for the patient and record the medicine defect in the patient's notes.
- Complete an Incident form (see Incident Reporting and investigation).

Pharmacy staff will liaise with the manufacturers and/or the Medicines and Healthcare Products Regulatory Authority (MHRA) via the Yellow card reporting scheme which receives and assesses complaints and reports of actual or suspected defects (or counterfeit) medicinal products.

If a medicine defect is suspected after the Pharmacy Department's normal opening hours contact the on-call pharmacist who is available for emergencies via the Trust switchboard.

6.30 Off Label and Unlicensed Medicines

The pharmacy will record all purchases of unlicensed medication. Prescribers should ensure that the patient/service user is made aware and has the opportunity to fully discuss the implications of using medicines that are either unlicensed or used in an off label way.

Prescribers should follow the guidance published by the Royal College of Psychiatry (College report CR 210) prior to commencing unlicensed or off label medicines.

Nurses similarly should follow the guidance issued in the Professional Guidance on the Administration of Medicines in Healthcare Settings prior to the administration of medicines. Nurses must also bear in mind that changing the form of a medication e.g. opening of capsules or the crushing of tablets prior to administration constitutes off-label administration. See Guidance notes (Appendix N) for further details.

Pharmacy staff should follow the SOP D17, found on the trust intranet.

6.31 GUIDELINES ON PRESCRIBING

GENERAL PRINCIPLES

Good prescribing can be defined as prescribing that meets the clinical needs of the patient, taking all their individual circumstances into account.

The following should be assessed and recorded:

- Target Symptoms
- Potential contraindications including drug interactions
- Expected timescales to response

- Explanation of possible side effects and adverse effects to the patient (and or carer where appropriate).
- Patients should be monitored regularly and systematically evaluated for side effects to drug treatments. For antipsychotic treatments this should be done by using an approved rating scale e.g. GASS Prescribers are encouraged to send a copy of the GASS to patients (for self-completion) prior to out-patient appointments or CPA reviews. There is also a Learning Disabilities GASS found in Appendix J.

Wherever possible the plan and choice of treatment should be discussed and agreed with the patient.

When writing a prescription by hand, write in black ink, in block capitals and specify the name of the drug using the approved name. Medicines can only be prescribed on the Trust electronic prescribing system once a prescriber has received the appropriate training and designated access authorised.

Approved names should not be used when a brand specific drug (e.g. Lithium) is required.

Inpatient Prescriptions
All medicines prescribed in an inpatient setting is prescribed on the Electronic Prescribing and Medicines Administration system (EPMA). If access to EPMA is not available, a drug card can be used temporarily until the issue with EPMA is resolved. Unless otherwise stated each medicine prescribed will be valid for as long as a patient remains an inpatient. The only exceptions will be:

- Injectable cytotoxic drugs – no cytotoxic drug that can be given by injection will be supplied by SHSC pharmacy – even if prescribed. If one of these agents were to be prescribed a pharmacist would contact the prescriber and will only supply the drug if the pharmacist is satisfied that arrangements are in place for the safe administration of that drug. Similarly oral cytotoxic drugs will only be supplied with a note added to the prescription either on EPMA or drug card of the current treatment plan or after discussion with the initiating prescriber. F1 Doctors have been advised not to prescribe cytotoxic/anticancer drugs. Supply maybe requested from the homecare provider or their usual provider. However there maybe exceptions due to circumstances.

If the prescriber's intention is that a drug should be for a specific period of time then that MUST be specified by the prescriber on the prescription. Antibiotic prescriptions should be reviewed after 5 days (unless otherwise specified).

Long-acting Depot injections (Paliperidone and aripiprazole) during the inpatient stays should be prescribed as every 30 days rather than monthly/or 4 weekly.

All patient's medication must be reviewed at appropriate intervals, no less than every month. Ideally weekly (including when required medications (PRNs) as part the MDT. The results of the review MUST be clearly documented in the patient's medical notes with any notes added to EPMA or to the drug card.

Discharge/Leave Medication
The amount of medication to be supplied for leave or discharge is a matter of CLINICAL JUDGEMENT. It is important that discharge medications are provided to allow for continuity of care until new supplies can be made by the GP (or other arrangements are made).

The following should be taken into account:

1. The likelihood of self-harm by the patient

Current risk assessment. Increased risk of suicide during the first few weeks of antidepressant therapy.
The national data, which indicates patients are more likely to self-harm within the first few weeks of discharge.

2. How long the patient will be away from the ward?
   Does any medication need to be supplied at all? e.g. if the patient is only out during the day can all medication be prescribed for night-time?

3. When can the patient reasonably expect a further supply of medication.
4. If the patient is NOT judged to be at risk of self-harm than TWO WEEKS supply of medication should be prescribed on discharge. This will allow sufficient time for correspondence to reach the G.P. which will allow them to prescribe further quantities of medication. The time scale of dose/medication review.
5. If dose or medication changes are required in less than ONE MONTH, this information should be communicated to the G.P. Note: Two weeks supply of medication will be provided unless there is a specific request for a supply beyond this timeframe. These exceptions maybe courses of medication.
6. Clozapine prescriptions will be for 30 days to allow time for an outpatient prescription to be organised, along with a transfer of care from consultant to consultant.
7. Patients under substance misuse team may require medication that is usually supplied in limited amount and/ or supervised will not normally be provided by SHSC pharmacy. They will issue one day's supply in exceptional circumstances only.
8. General practitioners in Sheffield would expect patients to be discharged with two weeks supply of medication.

GUIDELINES

Having considered the appropriateness for the INDIVIDUAL patient, prescribe TWO weeks supply of medication for those patients who are discharged from SHSC Inpatient wards.

Any patient who is considered at significant risk of self-harm should not be prescribed medication to be supplied for leave from ward.

A patient who MAY be at risk of self-harm must be assessed each time a prescription for SUPPLY is considered. Generally, it would be UNWISE to prescribe and supply more than ONE WEEK supply of medication to such patients.

Transferred patients to outside units
If a patient is transferred to an outside unit that is non-SHSC, the transferring unit may request two weeks supply. Two weeks supply will be issued.

Outpatient prescriptions
Outpatient prescriptions are generally not used in the trust, except for clozapine for community patients. However, in some circumstances outpatient prescriptions maybe required, contact and discuss with the pharmacy team.

Community prescriptions
Prescriptions written in the community teams are currently written on drug cards. Regular medication should be provided by the GP, only medication that is being managed by the community team and where dose changes are occurring should be provided by SHSC pharmacy. If there is a risk of harm to the patient limited supply by SHSC pharmacy maybe required. The minimum of 3 days supply should be requested in this circumstance. Depot medication should be prescribed on depot cards.
Long-Acting Depot Injections should be prescribed as monthly.

Different FP10 prescription types are used depending on the team.
FP10NC (green) are utilised by the Substance Misuse Team**.**
FP10HNC (green) are utilised by the SHSC community teams.
FP10PN (lilac) are utilised by the Health Inclusion Teams for nurse prescribers.
FP10MDA (Blue) are utilised by the Substance Misuse Team.

Decisions Unit (DU) currently uses EPMA for service users, an SOP for the processes in the DU SOP can be found on the trust intranet and in the SOP section of this document.

Suite 136 use drug cards for services users, PODs should be utilised where possible. If PODs unavailable, critical medications items maybe utilised from Maple ward stock. If the item is not stocked on Maple, the drug card can be emailed to pharmacy for urgent supply of critical medications.

6.32 Treatment of those Detained under the Mental Health Act 1983 (MHA)

The arrangements for the administration of medication in order to treat the mental disorder of patients detained under the MHA are described under Parts 4 and 4A of the Act. The arrangements apply only to medication aimed at relieving the symptoms of the mental disorder, or which is ancillary to the core treatment for mental disorder that the patient is receiving. Treatment for physical conditions which are not ancillary to the core treatment for the mental disorder are excluded.

For in-patients detained under longer-term sections (those which require 2 medical recommendations, most usually Sections 2; 3; and 37) Section 58 MHA 1983 provides the prescriber with a three-month period in which to develop a treatment programme to meet the patient's needs. Medication may be given, against the patient's will if necessary, for 3 calendar months from the date the medication was first administered. However, on admission the patient's capacity to consent, and whether they do consent, should be recorded on the appropriate Form (currently CAT2).

The 3-month period is a single continuous period occurring once in any period of detention; the 3-month period is not repeated if a patient subject to a Community Treatment Order has the order revoked.

At the end of the 3-month period, non-urgent medication may be lawfully administered only if the correct section 58 certificate (T2 or T3) is in place.

The Responsible Clinician must assess the patient's capacity to consent to the prescribed treatment prior to the expiry of the 3-month period and complete the appropriate Form (currently CAT3) in order to determine what is then required. Patients will fall into 2 categories:

1 - Section 58 (3a) – Patients who have capacity and consent to the prescribed treatment – Form T2.

The Responsible Clinician must:

- Seek the patient's consent to continuing the prescribing of medicines.
- Record the discussion in the medical notes including an assessment of the patient's capacity to consent
- If the patient consents to continued treatment, complete a Form T2

NB Certificates remain valid until there is a permanent change of RC, or there is any addition to the treatment plan. Any new medicine prescribed must appear on the certificate. The patient may withdraw consent at any time; it is unlawful to administer medication under Form T2 if consent has been withdrawn, Form T3 (or Section 62 if the need for medication is urgent) is required in order to proceed.

It is unlawful to administer a medication which is not detailed on the Form T2

2- Section 58 (3b) – Patients who lack capacity to consent to the prescribed treatment, or who have capacity but refuse – Form T3.

The Responsible Clinician must:

- Request a Second Opinion Appointed Doctor (SOAD) visit from the Care Quality Commission (CQC) via the CQC portal

- If the SOAD agrees with the Responsible Clinician that it is appropriate for the treatment to be given, the SOAD will complete a Form T3.

NB Certificates remain valid until there is any addition to the treatment plan, even if there has been a change of RC. Any new medicine prescribed must appear on the certificate.

It is unlawful to administer a medication which is not detailed on the Form T3

The Trust has a system in place to remind the Responsible Clinician (RC) before the expiry of the 3-month period. The Mental Health Act office informs the Responsible Clinician and Pharmacy - 3 weeks before consent is needed to continue treatment via electronic communication.

This is followed up by a phone call if documented consent is not received 1 week prior to the end of the 3-month period.

Nurses must not administer medicines to patients detained under the Mental Health Act 1983 after the 3-month period without first ensuring that a valid Form T2 or T3 indicates that the treatment can lawfully be given.

Community Treatment Order (CTO) patients who are not recalled or revoked

Where a patient subject to CTO consents to medication it must be certified by the RC on Form CTO 12. The RC should also complete an Form (currently CAT4) to explain this decision.

If the patient lacks capacity to consent, medication can only be given if approved by a SOAD on a 'part 4A certificate' - Form CTO11. There are exemptions where a certificate for medication is not required
1) during the period of one month starting with the day on which the patient became a CTO patient or
2) if less than three months has passed since the patient was first administered medication during an unbroken period of detention and CTO.

Urgent Treatment

Urgent treatment not covered by Section 58 may be given under Section 62 MHA if it is immediately necessary to: save the patient's life; or (not being irreversible) to prevent a serious deterioration of his or her condition; or (not being irreversible or hazardous) to alleviate serious suffering by the patient; or (not being irreversible or hazardous) represents the minimum interference necessary to prevent the patient behaving violently or being a danger to themself or others.

CTO patients who are recalled to hospital or whose CTO has just been revoked

Medication can be administered under the following circumstances:

The SOAD certificate (CTO 11) includes the appropriate medication in the section for medication to be used on recall; or

CTO began less than 1 month ago; or

It is less than 3 months since medicine was first administered in this period of detention – Sec 58 (1b); or

A form T2 or T3 is put in place (as appropriate)
The treatment is immediately necessary - Sec 62 (as above)

Staff should be aware of the relevant sections of the Code of Practice – Mental Health Act 2005.

6.33 Clinical Information

The Pharmacy Department provides a medicines information service for health care professionals, patients and carers. Medicines information can be obtained by contacting the Pharmacy department, information will be documented in the relevant areas.

Patient friendly information on medicines can be obtained from the pharmacy intranet page. This includes the link to the Choice and Medications website for information on mental health conditions and medicines.

NICE guidance (where applicable) should be taken into account in the management of all patients. A range of user-friendly information resources are available for patients and carers and provides information about some of the main mental health illnesses and gives evidence-based information on e.g. treatments options and length of treatment.

All prescribers (including non-medical prescribers) should ensure they have access to the most up to date information. The electronic BNF 'app' can be accessed via the 'SHSC Apps' folder.

6.34 Compliance aids

The act of filling a compliance aid involves re-dispensing. The administration from these devices should not happen (medicines should be ordered from the Pharmacy Department where applicable).

Compliance aids (e.g. Medidose) should not be routinely assembled by nurses within the Trust, but where a patient chooses these devices as a mechanism to aid administration **it is reasonable for nursing staff to support and prompt a service user to fill their own compliance aid**. Longer term compliance aids should be organised through the patient's GP and community Pharmacy.

Prior to requesting/initiating a compliance aid other possible solutions may be more appropriate: reminder charts, large print labels, non-child proof tops.
If a compliance aid is needed, the assessment form for requiring a compliance aid should be completed. This ensures all options have been reviewed. This should be sent to pharmacy to review. The assessment form can be found on the intranet. The pharmacy will discuss with the team the suitability of the request.

6.34 Critical Medicines (omitted/delayed) within the SHSC NHS Foundation Trust

The NPSA originally issued a safety alert in 2010 (Reducing harm from omitted and delayed medicines), highlighting the risks of medications that were considered as critical and would lead to potentially greater levels of harm if omitted or delayed significantly. **It is recognised that all medications are considered important and**

could have implications on their physical and mental health if omitted or delayed. However, the risks are greater with some medications and the safety alert requires Trusts to consider medications that would lead to greater levels of harm.

The Trust Medicines policy contains a list of medicines which are considered as critical in terms of the potential harm that could be experienced from the service user if omitted or significantly delayed. Generally, it is expected that medications would be administered within a 2-hr window before considered as being delayed.

Updated resources available to support actions around missed doses.

As part of a previous incident review, the medical staff agreed the updates to the Trust list of critical medicines for missed/delayed doses:

Critical Medicines (Medicines Policy-Sept 18)	Updated list for Medicines Optimisation Policy
insulin	Insulin
anti-infective	Anti-infectives in Sepsis, Antibiotics and antifungals
medicines used for resuscitation	Resuscitation medicines (naloxone/flumazenil)
Anticoagulants	Anticoagulants (oral and injectable)
Antiepileptic's	Anticonvulsants prescribed for epilepsy
Parkinson's medicines	Medicines for Parkinson's disease
Methadone	
Clozapine	Clozapine if missed >48 hrs (needs to be given ASAP within 48hr window. Risk of relapse and re-titration if > 48hrs)
Diazepam	Benzodiazepines in alcohol withdrawal.
	Antiarrhythmics, nitrates, beta-blockers, antiplatelet agents
	Immunosuppressant therapy
	Oral antidiabetic medication
	Glaucoma treatment (topical or oral)
	Oral Steroids
	Paroxetine, venlafaxine, reboxetine - Although not life-threatening omission of these may cause serious distress to patients/service users
	Opiates (see below for methadone)- Although not life-threatening omission of these may cause serious distress to patients/service users
	Salbutamol inhaler and nebules
	Medicines for the treatment of cardiac arrest
	Medicines for the treatment of anaphylactic shock
	Glucagon and glucose gel
	Glyceryl trinitrate (GTN) spray
Methadone	Methadone - Although not life-threatening omission may cause serious distress to patients/service users

References:

- Resources to reduce the incidence of delayed and omitted medicines (NHS Improvement)
- Treatments and conditions where missing a single dose can be fatal or catastrophic (specimen examples)
- Tool to reduce harm from omitted and delayed medicines (April 2017)
- Birmingham and Solihull MH NHS Foundation Trust Critical medicines list.

8 Development, Consultation and Approval

- This policy has been developed using current best practice/evidence practice - Policy in in line with current national guidance from CQC (Care Quality Commission) , NICE (National Institute for Health and Care Excellence, RPS

(Royal Pharmaceutical Society), Health Education England (HEE), General Medical Council (GMC), Royal College of Nursing (RCN)

- Sections of the policy have been through appropriate consultation with specialists in the different areas, Heads of Nursing Acute and Community and Specialist and Rehabilitation services, Acute inpatients, LD Services, Step down services (Manager at Beech), Physical Health Committee, identified pharmacy leads and the Medicines Optimisation committee.
- Medicines Optimisation Committee reviewed the policy and approved it in February 2023

9 Audit, Monitoring and Review

Systems of medicines management are regularly reviewed by;

1) SHSC pharmacy team
   a. Technician ward visits/Top ups
   b. Medicine Management Technicians (MMT)
   c. Pharmacists clinical checking/verification of prescriptions SOP
   d. Pharmacists working within multidisciplinary teams. Please see link to pharmacy clinical standards

2) Senior Pharmacist involvement in the process of review of medicines related incidents (Appendix H)

3) Audits and benchmarking
   a. Accountable officer CD reports and annual report to the Trust Board of Directors)
   b. Membership of POMHUK

   For all clinical audits an action plan must be developed which should address all recommendations made in the clinical audit report. The action plan needs to be regularly reviewed and discussed within the governance structures.

4) Acute care pathway standards include medicines' reconciliation.

5) Chief Pharmacist will report to the Trust Board of Directors or other assurance committees on request

Monitoring
The monitoring of prescribing and the administration of medicines (under the scope of this policy) will be undertaken by Pharmacists, technicians or assistant technical officers where they are working in individual teams or scrutinising medicines prescribing, administration and storage as part of the routine pharmacy function.

In the absence of Pharmacists as members of clinical teams the management of medicines should be reviewed as part of the team's normal governance arrangements.

A senior pharmacist should be involved with the development of any new medicine related policy. All policies related to medicines should be agreed by the Trust medicines optimisation committee before submission for approval in line with the trust policy on policies.

Directorates should ensure a medicines management/optimisation impact statement is produced as part of any new proposal for service development.

The Chief Pharmacist is responsible for ensuring that all aspects of medicines management/ optimisation (including documentation) is regularly reviewed and remains in line with any significant new or changes in national guidance or legislation.

Electronic prescribing system

The EPMA electronic prescribing system is available in some parts of the trust including all inpatient wards. This system includes a decision support element. This technology highlights potential drug interactions and incompatibilities to the prescriber.

NHS Resolution Risk Management Standards - Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
How medicines are prescribed	In addition to the personal responsibility of the prescriber Pharmacists and technicians checking prescriptions as part of top up, dispensing and MDT review	Pharmacists and technicians	Varies – depends on top up/dispensing /MDT schedule.	Areas of concern/ambiguity fed back to prescriber	Prescriber expected to act/amend prescriptions in light of feedback	Technicians /pharmacists Highlight areas of concern to Chief Pharmacist. Chief Pharmacist liaise with relevant group individual where necessary e.g.. responsible medical officer/clinical director/consultant/ accountable officer etc.
How the organisation makes sure that all prescription charts are accurate	In addition to the personal responsibility of the prescriber Majority of in-patient prescriptions are generated electronically through EPMA system which includes decision support which issues alerts at the time of prescribing Prescriptions are also scrutinised as outlined above	Director of SHSC Digital responsible for ensuring electronic infrastructure is adequate to support EPMA system. EPMA is a commercial electronic prescribing system - Chief Pharmacist responsible for ensuring appropriate threshold is set as part of decision support system.	EPMA system is a live system – alerts flagged at the point of prescribing. As above additional scrutiny as part of top up/dispensing and MDT review	Areas of concern/ambiguity fed back to prescriber through 1) EPMA decision support e.g., alerts flagged 2) Verbal feedback from pharmacists/ technicians to prescribers	Chief Pharmacist responsible for ensuring commercial EPS system is fit for purpose any proposals /updates are fed through to EPMA through national user group	Changes to EPMA software overseen through national EPMA user group

		Pharmacists and technicians responsible for scrutiny of prescriptions.				
How the side effects of prescribed medication are monitored	By prescribers and nurses assessing for side effects. For patients prescribed antipsychotics The use of standard side effect monitoring systems should be used where appropriate GASS and LUNSERS	Prescribers and nursing staff	Dependent on patient need e.g. Lithium; – 3 monthly for antipsychotics "regularly and systematic "is taken as at least annually for patients on long term antipsychotic pharmacotherapy	Person undertaking assessment of side effects	Extent of Side effect monitoring is audited as part of our POMH program (Topic 2, topic 6 and topic 7) – other audits include national audit of schizophrenia	POMH – quality improvement group, medicines management committee and clinical directors
How the organisation learns from medication errors	See section 6.24 Incidents fed back to relevant network Pharmacy incidents reviewed as part of Pharmacy senior management and governance group – prescribing incidents fed back to medicines Optimisation committee All incidents relating to controlled drugs fed back to CD accountable officer Medicines related incidents discussed as part of ward team governance	Medicines Safety Officer (pharmacist) and network lead pharmacists where appropriate	In addition to the trust safeguarding alert system managed by the trust governance department Incidents are triaged for level of concern by medicines manage pharmacist and flagged for immediate attention of chief pharmacist if necessary – otherwise –, monthly senior pharmacist and governance group , monthly medicines optimisation committee, quarterly report to the LIN (controlled drugs) Monthly network meetings with lead pharmacists (Scheduled and	Process collated by network lead pharmacists, ward pharmacists and Medicines Safety Officer for assurance by Chief pharmacist	Networks responsible for implementation of any agreed action plans	Chief pharmacists responsible for assurance Networks for implementation

			planned care network plus Urgent care network			
How medication is administered including patient identification	EPMA system ensure all medicines administration (or not) is recorded. Patient identification is described in section 6.4	Person responsible for safe administration of medicines to an individual service user	Process assumed to be safe – monitored by exception reporting i.e. scrutiny of medicines incidents relating to patient misidentification or incorrect administration	Incidents scrutinised and fed back as described in section above "How the organisation learns from medication errors"	As above	As above
Patient self-administration	See section 6.10. Self-medication systems monitored as part of routine pharmacist and pharmacy technician activity – including where appropriate MDT discussion	In addition to professional responsibility of all Self-medication systems are monitored as part of routine pharmacist and pharmacy technician activity – including where appropriate MDT discussion	Dependant of "stage" of self-medication program stage (between daily and monthly)	MDT review of self-medication	MDT	MDT – for individual service users – for organisational issues related to self-medication Chief pharmacist supported by medicines management committee and clinical directorates where appropriate.
How a patient's medicines are managed between care settings	In line with NICE medicines reconciliation – see section 6.19 medicines reconciliation is part of the acute care pathway and should be logged through Electronic patient records	In addition to the admitting doctors' responsibilities Medicines should be reconciled within 24 hours of admission where possible. The process of medicines reconciliation is verified by a pharmacist involved within a MDT review. (usually weekly)	Monitored as part of Pharmacists responsibility within MDT – also monitored through POMH topic 8	POMH topics fed back through medicines optimisation committee, Quality improvement group and directorates. POMH also features with ward team governance report	Networks supported by pharmacists	Chief Pharmacist for assurance Networks for implementation supported by pharmacy team
How drugs are disposed of safely	See section 6.22 and CD SOP 5 (See http://xct/images/stories/departmen	Deputy director of Pharmacy (CD's) Senior pharmacy technician non-CD	Process as defined by SOP assumed safe – monitoring is on an exception	SOP signed off by Deputy director of pharmacy –	Deputy director of pharmacy – supported by senior technician and pharmacist	Chief pharmacist/CD accountable officer for assurance Deputy director of

	ts/Pharmacy/ SOP/Controlled Drugs/ CD5RecordingAndDestruction Of Controlled Drugs Which Are Out of Date or Not Required.		basis any incident involving destruction of CD's triggers a review of SOP	supported by senior technician and pharmacist senior manageme nt team	senior management team	pharmacy supported by senior technicians & Pharmacy team for implementation

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. Review date: February 2026

10 Implementation Plan

Where pharmacists are integral members of clinical teams they will take a lead in implementing sound systems of medicines management. In all other areas the directorate governance systems should be used to implement medicines management (supported where possible by the pharmacy team and directorate lead pharmacists).

Action / Task	Responsible Person	Deadline	Progress update
Medicines optimisation committee approval	Abiola Allinson	13/02/2023	
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	March 2023	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11 Dissemination, Storage and Archiving (Control)

The policy should be disseminated through the trust clinical governance structures, supported where possible by pharmacists within clinical teams and if available the lead pharmacists.

The policy will be available for all staff on the Trust Intranet via the Medicines Optimisation policy link and the Pharmacy site. The previous version (10) will be archived in Pharmacy. Reference to the policy will be included in the Junior Doctor induction process and the Mandatory Medicines Optimisation training sessions.
Dissemination of the policy will be through the mandatory training sessions on Medicines optimisation and learning from incident processes. Archiving mechanisms for documents held on the Trust intranet are beyond the scope of this policy.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
11				

12 Training and Other Resource Implications

All newly qualified nursing and nurse associates working on the inpatient units should complete the Inpatient Annual Medicines Management Inpatient framework, and the 3 yearly Medicines Optimisation Training as part of their induction and ongoing training needs. The training includes Controlled Drugs and Rapid Tranquillisation.

Community staff are currently following the 3 yearly Medicines Optimisation Community training (online), and the Medicines with Respect training. This is currently being reviewed and planned to be switched to an Annual Medicines Management Community Framework and a 3 yearly face to Face Medicines Optimisation Training Community based.

Managers should ensure that their staff receive the appropriate training and are competent in medicines management issues relevant to their role. The competency frameworks are found on the intranet.

Qualified nurses and Nurse associates are additionally expected to complete an annual calculations test.

Medical prescribers receive Medicines Optimisation Training during their Trust induction. Non-medical prescribers should follow the SHSC non-medical prescribing (NMP) framework.

EPMA
All staff who may need to use the electronic prescribing systems in the Trust will receive the appropriate training during the induction period. Following training the staff will be issued username and password. In some cases (such as locums, agency staff), the staff can complete the online training and be issued a username and password. In some situations, a usernames and password maybe required prior to completing the training, the manager authorising this takes responsibility for ensuring the training is completed prior to using the EPMA system.

13 Links to Other Policies, Standards (Associated Documents)

- Violence prevention and reduction standard
- Minimum Standard for Recording Capacity and Consent
- Mental Capacity Act Deprivation of Liberty Safeguards (DoLS)
- Mental Health Act (1983)
- Resuscitation policy
- Incident Management (including Serious incidents) Policy and Procedure
- Safe, Supportive and Engagement Observation Policy
- Physical Health Policy
- Seclusion and Segregation Policy

The management of medicines throughout SHSC should be based on relevant evidence-based guidance and alerts about medicines management and good practice published by appropriate expert and professional bodies.

The Human Medicines Regulations 2012
(http://www.legislation.gov.uk/uksi/2012/1916/introduction/made)

- The Human Medicines Regulations 2012 repeal or revoke most of the former United Kingdom legislation which regulates the authorisation, sale and supply of medicinal products for human use. This Act comprises a large number of statutory instruments and consolidate their effect in one place and in rationalised form. For more details of the changes brought about by this act see MHRA guidance see http://www.legislation.gov.uk/uksi/2012/1916/contents/made

Guidance formerly issued by the NPSA has been integrated within the medicines management policy and wider Trust practice. For example the Joint NPSA & NICE guidance on medicines reconciliation (Published December 2007) is being included in the Acute Care Pathway. This guidance helps reduce the risk of medication errors when patients are admitted to hospital/Mental health services. National Institute for Health and Care Excellence (NICE) NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In areas where NICE has issued guidance, this should be taken into account and form the basis of treatment choice throughout SHSC.

Medicines and Healthcare products Regulatory Agency (MHRA)
They enhance and safeguard the health of the public by ensuring that medicines and medical devices work and are acceptably safe. No product is risk-free – the MHRA work to provide robust and fact-based judgements to ensure that the benefits to patients and the public justify the risks.

European Medicines Agency
The European Medicines Agency is a decentralised agency of the European Union. The Agency is responsible for the scientific evaluation of medicines developed by pharmaceutical companies for use in the European Union.

Department of Health
Provides health and social care policy, guidance and publications for NHS and social care professionals.

Royal Pharmaceutical Society (RPS)
The Royal Pharmaceutical Society of Great Britain (RPS) is the professional leadership body for pharmacy, providing leadership and support to the profession in England, Scotland and Wales.

The General Pharmaceutical Council (GPhC)
The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain.

Royal Collage of Psychiatrists
The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the United Kingdom and the Republic of Ireland. Their main aim is to set standards and to promote excellence in psychiatry and mental healthcare.

General Medical Council (GMC)
The GMC registers doctors to practice medicine in the UK. Their purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. All Doctors (members of the GMC) should refer to the GMC Standards for Good Medical Practice.

Nursing and Midwifery Council (NMC)
The Nursing & Midwifery Council exists to safeguard the health and wellbeing of the public by registering all nurses and ensures that they are properly qualified and competent to work in the UK. They also ensure that nurses keep their skills and knowledge up to date and uphold the standards of the professional code. The Medicines policy states that all staff should work within their sphere of competence and to their own professional code of practice. Nurses should refer to the https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567

Social Care Institute for Excellence (SCIE)
Identifies and spreads knowledge about good practice to the large and diverse social care workforce to support the delivery of transformed personalised social care services. The aim is to reach and influence practitioners, managers and the sector leadership who have responsibility for service delivery in adults' and children's services.

The Handling of Medicines in Social Care (RPSGB, 2007)
See link for full text. The purpose of this guidance (provided by the Royal Pharmaceutical Society) is to provide professional pharmaceutical guidance for people in every aspect of social care who are involved in handling medicines. These principles of safe and appropriate handling of medicines should be used as a starting point for medicine policies in social care settings.

Professional guidance on the safe and secure handling of medicines (RPS, 2019)

Medicines must be prescribed, dispensed and administered safely and effectively. And, equally important, their storage and handling within NHS organisations must be safe, secure and comply with current legislation. This report is an updated version of the comprehensive guidance on safe and secure handling of medicines which was last issued by RPSGB in 2005

Safer management of controlled drugs: Guidance on strengthened governance arrangements (DoH, 2007)
The purpose of the guidance is to promote the safe, secure and effective use of all CDs. The guidance sets out strengthen governance arrangements for CD's. These arrangements were underpinned by the Health Act 2006 and the Controlled Drugs (Supervision of Management and Use) regulations 2006 ("the Controlled Drugs Regulations") made under provisions in the Act.

Following the Shipman enquiry the Government introduced strengthened measures to make sure controlled drugs are managed safely. Regulations made under the Health Act 2006 required each healthcare organisation to appoint an Accountable Officer (controlled drugs), responsible for the safe and effective use of controlled drugs in their organisation. The Regulations also introduced the need for standard operating procedures (SOPs) for the use and management of controlled drugs. These are one of the practical measures that will help to ensure good practice throughout the health and social care system.

Department of Health (2006). *Final Guidance Safer Management of Controlled Drugs (CDs) Changes to Record Keeping Requirements*. London: Department of Health. See http://www.legislation.gov.uk/ukpga/2006/28/contents for revisions and updates to the act.

Informs and supports relevant healthcare professionals and organisations in implementing changes to the record keeping requirements for controlled drugs required by recent changes to the Misuse of Drugs Regulations 2001 - SI 2006/1450 (July) and SI 2006/2178 (September) www.opsi.gov.uk/si/si2006/20062178.htm). Allows computerised controlled drug registers.

Health Act 2006
The legislation which includes changes in the laws relating to controlled drugs and the statutory responsibilities on organisations and the accountable officer.

UK Policy framework for health and social care research (Health Research Authority 2018)
The policy framework applies to health and social care research involving patients, service users or their relatives or carers. This includes research involving them indirectly, for example using information that the NHS or social care services have collected about them. The policy framework sets out principles of good practice and management and conduct of health and social care research. The principles protect and promote interests of patients, service users and the public in health and social care research, describing ethical conduct and assurance-based management of health and social care research.

Medicines Act 1968
Now incorporated into the Human medicines regulations 2012. The Medicines Act 1968 was introduced by the DHSS following a review of legislation. At the time it brought together most of the previous legislation on medicines and introduced a number of other legal provisions for the control of medicines. All medicines and medicinal products prepared for administration to patients and including the manufacture and distribution of medicines were controlled by the Medicines Act 1968.

Misuse of Drugs Act 1971
(See also the Human medicines regulations 2012). Drugs, controlled under the provisions of the Misuse of Drugs Act 1971, with stringent requirements for supply, storage and administration. The main purpose of the Act is to prevent the misuse of controlled drugs and achieves this by imposing a complete ban on the possession, supply, manufacture, import and export of controlled drugs except as allowed by the regulations.

Healthcare Commission. (2007). *Talking about medicines; the management of medicines in trusts providing mental health services*. London: Commission for Healthcare Audit and Inspection. Now under the, The Care Quality Commission - who are the new health and social care regulator for England. They look at the joined-up picture of health and social care with the aim to ensure better care for everyone in hospital, in a care home and at home.

This document describes the key elements of medicines management in mental health Trusts and gives recommendations to Trust for action. SHSC executive team have agreed that that this document should form the basic template for the Trusts' medicines' management strategy.

Audit Commission (2001). A spoonful of sugar – Medicines Management in NHS Hospitals. London Audit Commission.
Provides a good overview of the processes involved in medicines management, mainly from an acute general hospital perspective but some recommendations are relevant to mental health. Raises the profile of medicines management in hospitals.

Highlights issues of making the most of community contractor pharmacy services. Recognises key role of Chief Pharmacists in ensuring safe use of medicines. Describes modernising workforce and re-engineering services around the needs of patients, non-medical prescribing and efficient and using the pharmacists skills to enable best use of medicines.

Provides guidance on reducing and avoiding medicine related harm. Specific reference to mental health is to reduce the quantity of medication supplied to ask risk patients on discharge. General guidance on cytotoxic and other drugs (see also current guidance from NPSA). Highlights technologies such as electronic prescribing which will reduce risks of medicine related harm

A brief guide to good practice, highlighting appropriate mechanisms that can be used when developing new/enhanced roles or redesigning services. Includes patient group directions and non-medical prescribing.

Health and Social Care Act 2001. London: The Stationery Office
http://www.opsi.gov.uk/acts/acts2001/ukpga_20010015_en_1

The legislation covering the NHS. Includes references to general pharmaceutical services (community pharmacy contractors). Includes reference to care trusts but no specific mention of pharmacy services in mental health.

The Controlled Drugs (supervision of Management and Use) regulations 2013. SI2013/373 London: The Stationary Office http://www.legislation.gov.uk/uksi/2013/373/contents/made Statutory instrument amended from previous version from 2006. Underpins safe management for use of controlled drugs, describing responsibilities of accountable officers, inspection and organisation responsibilities.
http://www.legislation.gov.uk/uksi/2013/373/contents/made

University of Manchester. *National Confidential Inquiry into Suicide and Safety in Mental Health* The study has collected information on suicides since 1996. Recommendations have resulted in improvements in patient safety. A wide variety of related publications are available https://sites.manchester.ac.uk/ncish/

The Royal Marsden Hospital Manual of Clinical Nursing (access through SHSC intranet link tab under the useful links widget)
Covers all nursing procedures – including administration of medicines within a hospital – or hospital type environment.

Control of Substances Hazardous to Health (COSHH) Regulations, 2002
COSHH is the law that requires employers to control substances that are hazardous to health.

The management of medicines in SHSC is underpinned by the following local documents and policies. All these are found on the intranet.

- Rapid tranquillisation Policy
  Provides Guidance on the use of medicines involved in the process of rapid tranquillisation for in patients.

- Antibiotic policy
  Provides guidance on the appropriate use of antibiotics on the inpatient wards.

- Managing substance misuse and harmful substances in bed-based service policy
  Guidelines for the management of illicit substances found on inpatient wards and the action to take if they suspect a patient is in possession or under the influence of a harmful substance.

- Diabetes Monitoring for patients. There is a card to monitor patients sugar levels, with the appropriate actions when out of the expected range. This can be found on the intranet. Guidance on diabetes is also found on the Trust intranet.

- Capacity and Consent to Care Support and Treatment Policy
  This policy sets out the standards and procedures in this Trust, which aim to ensure that health and social care professionals are able to comply with the guidance about consent for all aspects of treatment.

- Annual Medicines Management framework, and 3 years Medicines Optimisation Training (including rapid tranquillisation)

- Incident Management (including serious incidents) Policy and procedure is a policy for the reporting of incidents.

- Guidance on decisions made in advance and in joint advance care plan is Guidance on the use of advance statements in clinical practice.

- Royal College of Psychiatrist Consensus statement on high-dose antipsychotic medication CR 190 November 2014
  https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx

- Provides guidance on the use of antipsychotic drugs BNF or licensed doses

- Safer management of controlled drugs: https://www.nice.org.uk/guidance/NG46
  This document promotes the safe and effective use of controlled drugs in healthcare organisations except care homes

Application of the policy
Although this medicines policy defines the core policies and procedures to be followed for the prescribing, ordering, dispensing, storing and administering of medicines, in some situations staff may also need to refer to additional local policies.

Given the complex nature of medicines optimisation and links to a substantial number of additional local policies staff must be aware that these local (or national) policies may at times be past their review date. In these circumstances local judgment will be required to guide staff on action. In case of doubt pharmacy staff should always be contacted for advice.

All staff working within the Trust, who are involved in some way with the use of medicines, must;
1) Familiarise themselves with the correct procedures contained in this policy.
2) Advise the chief Pharmacist of any missing of outdated links

Those in charge of wards and departments are responsible for ensuring that their staff and locum staff follows procedures in this medicines optimisation policy, which may differ from procedures elsewhere. Copies of the policy will be available on the SHSC Intranet.

Note: There will inevitably be links to other policies/documents that become out of date or broken. Staff should report these to the chief pharmacist.

In situations where access to a key document of reference is lost staff should contact SHSC Pharmacy or their line manager for advice.

14 Contact Details

Title	***Name***	***Phone***	***Email***
Chief Pharmacist	Abiola Allinson	0114 2718630	abiola.allinson@shsc.nhs.uk

15. Standard Operating Procedures

14.3 Nursing controlled drugs SOP
14.4 Removal of medications, prescribed or over the counter, brought into bed-based areas SOP
14.5 Disposal of medicines on inpatient wards SOP
14.7 Controlled drugs prescribing SOP
Appendix W -Decisions Unit Medicines management SOP

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Abiola Allinson 08/02/2023	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**N**		
Disability	**N**		
Gender Reassignment	**N**		
Pregnancy and Maternity	**N**		

Race	**N**		
Religion or Belief	**N**		
Sex	**N**		
Sexual Orientation	**N**		
Marriage or Civil Partnership	**N**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date Abiola Allinson 08/02/2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	
5.	Has the policy been discussed and agreed by the local governance groups?	
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Y
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y

Procedure for non-pharmacy dispensing of urgently needed leave medication

The normal procedure for the dispensing of leave/discharge medication is for the prescription to be emailed to pharmacy where the medication will be dispensed and delivered back to the ward.
The dispensing of all medication should normally be the responsibility of the SHSC Pharmacy Service.

Leave
If leave medication is required when the SHSC pharmacy is shut, and it is too short notice for it to be dispensed. The prescriber should review the times of the medication and see if the timings can be amended to allow administration on the ward. If this is not possible then to follow the discharge process as stated below.

Discharge
When patients are discharged at short notice and the SHSC pharmacy is shut, in some circumstances it may be appropriate for a doctor to write a FP10(HP) prescription which may then be dispensed by a community pharmacy.
It must be recognised that, within Sheffield Health and Social Care NHS Foundation Trust, circumstances will occasionally arise which require a Nurse to make the decision to dispense medication.
The dispensing of medicines involves the preparation of a dosage form (tablet, mixture, capsule etc) in such a way that it is handed to the patient, or their representative, to take at a later time. Strictly speaking any medication that is not administrated is in effect "dispensed".

No procedure can cover every eventuality, but the following procedure will help the Nurse to act properly, safely and legally within the provisions of the Medicines Act.

1. If it is not possible to obtain leave medication in the usual way before a patient leaves the ward, the Nurse may make the decision that it is in the best interest of the patient for the Nurse to dispense medication. It is unlikely that there will be any circumstances, which will justify the Nurse dispensing more than **three** days supply of medication. ***No schedule 2 controlled drugs can be issued via this method. Buprenorphine, Tramadol (schedule 3) and Morphine sulphate solution (schedule 5) are treated as schedule 2 drugs within the Trust therefore may not be issued by this method.*** Therefore, these controlled drugs will in all circumstances be supplied, in accordance with a legally written prescription, by Pharmacy.
2. If a Nurse makes the decision to dispense medication, it is legal to do so under the provisions of the Medicines Act, if they do this in the course of business of a hospital, in accordance with the **written instructions** of a Medical Practitioner and subject to the labelling requirements of the Medicines Act.

   NB: It is the prescribing doctor who carries responsibility for the dispensing of medicines outside the normal pharmacy system.
3. In the unlikely event of a Doctor not being immediately available to issue a signed prescription, then the prescriber may authorise by telephone up to **three days** supply of medication as written on the drug card or the EPMA system. A Doctor will sign this on the next working day.
4. Dispensed medicines must be placed in suitable and separate containers, clean unused bottles. Old tablet bottles should not be used.
5. It is a legal requirement that the container of a dispensed medicine must be labelled to show the following particulars:
   - The name of the person to whom the medicine is to be administrated.
   - The name and address of the location from which the supply is made.
   - The date of dispensing.

- The directions of use.
- The words “keep out of reach of children”.
- The words “For external use only” If the medication is for external use.

In addition, it is good practice to add additional labelling as directed in the BNF. All preparations listed in the BNF have recommendations as to appropriate additional labelling. The wording for this is found in Appendix 3 “Cautionary and Advisory Labels for Dispensed Medicines” in the BNF. Small-printed labels are available for the most commonly used additional label 2.

6. If the nurse makes the decision to dispense, it is recommended that two qualified Nurses are involved in the process. One Nurse will prepare the medication and a second Nurse will check this.
7. It is recommended that on every occasion where a medicine is dispensed, the details are recorded in a book or file used solely for the purpose of recording the dispensing of medicines, and that the two qualified nurses involved should sign the entry. The book or file will be inspected at intervals by Pharmacy to ensure that Nurse Dispensing is not used as a means of getting round the normal procedure for the supply of medicines.
8. Small quantities of bottles and labels will be held on wards where Nurse Dispensing is likely to occur (Acute admission Wards).
9. Where a Nurse is unsure how to act in a particular situation, they should contact their Nurse Manager and/or the Pharmacy service (via switchboard if necessary out of hours).

Abiola Allinson, Chief Pharmacist
February 2023

Prescribing and Medicines Use in Sheffield Health and Social Care NHS Foundation Trust

It is not possible to produce a document which covers prescribing for all service users in all circumstances.

On occasions, there will be situations when other factors will need to be taken into account. However, this document should be considered as the basis of good prescribing for most situations, most of the time.

This document is not intended to be used in isolation, prescribers should also be aware of both local and national documents and texts such as the NICE guidelines, the current British National Formulary, the relevant manufacturer's summary of product characteristics, Sheffield Health and Social Care Trust medicines optimisation committee statement on medicines

General Principles of Good Prescribing

1. Establish and document target symptoms.
2. Agree the most appropriate treatment plan with the service user. This should be based on:
    i. The informed health outcomes that the service user desires.
    ii. Current best evidence – including NICE guidance or trust guidelines if available.
    iii. An informed discussion with the service user of the risks and benefits of the proposed treatments or alternatives.
    iv. Other factors including the patient's cultural and religious beliefs and lifestyle.
    v. Informed discussion with carers or other health professionals where appropriate.
    vi. The licensed indications (prescribing medicines outside of their marketing authorisation alters and increases the prescriber's professional responsibilities).
    vii. Contra indications and special precautions including the potential food/drug interactions, the patient's age and other existing medical conditions.
    viii. Previous experience with medications taking in to account any previous adverse drug reactions, allergies and intolerances.
3. Be clear about timescales and explain to the service user:
    i. Likely timescale for full therapeutic response.
    ii. Likely timescales for emergence of common adverse effects.
    iii. Likely duration of treatment and when treatment should be reviewed.
    iv. Rate at which the dose or treatment can be safely increased, decreased or discontinued

Other important points

Adherence

It is important that a service user is given the opportunity to be actively involved in the choice of treatment. When this is not possible, the views of carers should be taken into account.

Information about medicines or alternative treatments

Good medicines information is available from a variety of sources. Sheffield Health and Social Care NHS Foundation Trust Pharmacy Service is available for prescribers, service users and carers who require detailed information or an in-depth discussion about pharmacological treatments. Contact can be made by referral from the prescriber or directly by the service user or carer.

If a medicine is prescribed outside of its marketing authorisation, the service user must be informed and the implications explained. Nurses and other health professionals are another valuable source of information. Many long-term medicines will increasingly be prescribed by non-medical prescribers.

All dispensed medicines should include a standard patient information leaflet. These can be viewed online at http://emc.medicines.org.uk

Service user should be made aware of access to the Choice and Medications website for information on mental health conditions and medicines. The website has information in different languages. The information is there to give:

- Accurate and independent information and education about medicines to other healthcare professionals, service users and carers.
- Clinical and dispensing activities to facilitate the management of medicines by service users within inpatient and community teams.
- Support to ensure that medicines management resources are used cost effectively within Sheffield Health & Social Care NHS FT.

The website address is http://www.choiceandmedication.org/sheffieldhsc/

An electronic version of the BNF is also available on the internet at https://bnf.nice.org.uk/

An internet search will also reveal a substantial number of sites providing information about medicines. Unfortunately, there is no way of knowing how accurate many of these are and some may even provide misleading information.

Adverse reactions

It is important to report all serious adverse reactions to the MHRA through the yellow card reporting scheme. Health professionals as well as patients can report reactions using the yellow card found in the BNF or directly, online at https://yellowcard.mhra.gov.uk/

Anticoagulation Guidelines for Patients Treated within SHSC

1. Background

This guidance refers to the use of oral anticoagulants such as warfarin, Direct-acting oral anticoagulants (DOACs) and LMWH used as inpatients. They are not usually initiated at SHSC, however there may be situations where they are indicated. Anticoagulants can be indicated for a variety of reasons such as pulmonary embolism (PE), venous thromboembolism (VTE), atrial fibrillation (AF). This is not an exhaustive list.

The National Patient Safety Agency (NPSA) in 2007/08 issued a safe medication work programme for anticoagulants. Anticoagulant medicines have been identified as one of the most frequent medicines causing preventable harm. These guidelines were written in line with the original NPSA safety alert with the aim of reducing the risks associated with anticoagulants within the Trust.

2. Purpose and outcome

Ensure the safe use of anticoagulant within SHSC.

3. Key Responsibilities

Prescribers, nurse, nurse associates, pharmacy team.

4. Prescribing anticoagulant

Prior to starting anticoagulation: It is essential to obtain a pre-treatment:

- full blood count
- liver function tests
- urea and electrolytes
- coagulation screen
- baseline INR, (If the baseline INR is greater than 1.4, seek advice from haematology if starting warfarin)
- Height and weight
- Blood pressure
- Renal function using calculated creatinine clearance (CrCl). is required for DOACs. Do not use eGFR
- Calculation of CrCl requires weight and age when using the Cockcroft and Gault equation

It must be recognised that the calculated CrCl is an estimate and should not be considered in isolation. Decisions on dosing should always take into account the calculated renal function in conjunction with an estimate of thrombosis risk, bleeding risk and individual patient factors.

Clearly document in the medical notes; drug name, indication, dose, target INR if warfarin is prescribed, duration of planned treatment, interval of planned monitoring.

For VTE prophylaxis, inpatients should be assessed using the trust physical health form and treated accordingly (see prophylaxis below (LMWH"s).

If warfarin is newly commenced it may require to be loaded, follow the Sheffield Teaching Hospital (STH) guidelines for this. The use of anticoagulants for VTE should follow STH guidance. This can be found on the STH intranet page in the clinical guidelines section.

The use of anticoagulants for non-valvular atrial fibrillation the joint primary and secondary care guideline can be found here.

If the patient is already on an anticoagulant, ensure the dose is confirmed. This Information can be found in the yellow book (for warfarin), on ICE, the anticoagulant clinic or on SCR (dose for DOACs). If unsure contact the anticoagulant team for advice.

All anticoagulants should be prescribed on the EPMA system, or on a drug card if in the community.

On the EPMA system a note should be attached by the prescriber or pharmacist stating:

- Name of anticoagulant (warfarin or DOAC which is either: edoxaban, rivaroxaban, apixaban or dabigatran)
- Clinical indication and duration of treatment
- Age and current weight
- the target INR required (if applicable)
- what and when was the last INR result (only applicable for admission
- information only)
- the frequency of monitoring of INR (if applicable)
- Last date of and any noted issues with FBC, U&Es and LFTs
- Creatinine level and date taken (for LMWH)
- Current renal function (calculate CrCl when reviewing the dose of a DOAC– do not use eGFR).
- Who is responsible for requesting and reviewing the INR results if applicable? If a patient is an inpatient it is the ward consultant.
- Generally, all SHSC patients should be referred to the STH anticoagulation
- Clinic on discharge.
- Any clinically significant drug interactions and their management.
- Any information for discharge follow-up included on EPMA as part of a discharge note.

Counselling

All patients initiated or restarted on an anticoagulant should have received counselling about the treatment. This may have already been done by the prescribing clinician but should also be offered by a healthcare professional during the admission or at the point of discharge. Contact Pharmacy if you would like a pharmacist to discuss warfarin or the DOAC with a patient.

All patients should also be issued with an oral anticoagulant therapy information booklet at the point of initiation of warfarin or a DOAC. The Pharmacy Department will check the patient has the anticoagulant booklet when the first prescription is received and at the point of discharge. Please contact the Pharmacy department if a booklet is required.

If there any concerns about the patients understanding of the treatment, the treatment should be reviewed, and the patient's carer counselled if appropriate. This or any other patient specific advice should be documented in the medical notes.

For patients who lack capacity, a decision should be taken in line with GMC guidance.

5. Discharge process

Discharge – Doctors (Prescribers) Responsibilities

Warfarin will be prescribed on the discharge prescription as normal. Where the dose to be taken after discharge is known it should be prescribed on the discharge prescription.

Alternatively, where appropriate, write the doses in milligrams to be taken up to the next INR test, this should also be documented in the patient's anticoagulant record book. The prescriber must be aware of the current anticoagulation status and the follow up arrangements for monitoring prior to discharge.

Ensure follow up arrangements are in place for prescribing warfarin and for monitoring of INR's at the point of discharge. Contact one of the STHFT anticoagulation clinics for advice on prescribing or monitoring or if needing to refer for follow up arrangements

Discharge – Pharmacy's responsibility

All discharge prescriptions for warfarin will receive a clinical check prior to dispensing (for DOACs see above). The Pharmacy Department will follow the D27 SOP to ensure the patients will receive the medication safely with the appropriate monitoring.

The Pharmacist performing the clinical check will:

- Check that all patients have an anticoagulation book if on warfarin.
- Have received counselling to the anticoagulant medication.
- Check that the INR monitoring is up to date and the arrangements for monitoring at discharge are in place if on warfarin.

Routinely, 1mg and 3mg warfarin tablets will be supplied. Instructions may be labelled as "to be taken as directed at 6pm", with written instructions clearly documented in the patients" oral anticoagulation book.

Discharge – nurses' responsibility

- Check that all patients initiated or restarted on anticoagulant have been counselled. If not contact Pharmacy or the ward Doctor (if not already under the anticoagulant clinic).
- Ensure that an anticoagulant follow up appointment has been provided to the patient.
- The patient leaves hospital with their anticoagulant and anticoagulant record.

- If taking warfarin ensure the patient, understands the dose to be taken until their next INR test and the arrangements for their next INR test.
- It is advised to avoid including warfarin in any existing or new compliance aids as these systems can be inflexible to facilitate frequent dose changes. It is recommended that anticoagulants are administered from the original packs dispensed for individual patients.

6. Low Molecular Weight Heparins

Sheffield Teaching Hospitals (STH) use Dalteparin as their current treatment and prophylaxis of choice for thromboembolic disease.

Sheffield Children's Hospital (SCH) use Enoxaparin as their current treatment and prophylaxis of choice for thromboembolic disease in children and adolescents.

If a patient is known to suffer from Heparin Induced Thrombocytopenia (HIT), contact haematology for advice. When administering LMWH ensure monitoring for HIT. Guidance is found on the STH guidelines page.

LMWHs are often initiated/used until longer term anticoagulation is established. Prescribed doses of low molecular weight heparins (LMWHs) for the treatment of a thromboembolic event are dependent on the weight of the patient and renal function. Follow STH guidelines found on the STH intranet page.

SHSC Summary of Prescribing Guidelines for Prophylaxis of Thromboembolism

- Dalteparin is the recommended treatment choice for thromboprophylaxis
- See dosing information below (from STH guidelines):

	Patient's weight	eGFR greater than or equal to 20 mL/min/1.73m^2	eGFR less than 20 mL/min/1.73m^2
Standard	Less than 44kg	2500 units once daily	2500 units once daily
	45-99kg	**5000 units once daily (standard dose)**	
	100-149kg	7500 units once daily	
	Greater than 150kg	5000 units twice a day	

7. Useful contacts

For further information contact SHSC Pharmacy on 2718633

STH Anticoagulation Clinic – 13820

STH Anticoagulation Clinic clinical staff: Call 13820 and request to speak to Clinical staff

If any problems or concerns about the treatment or the doses to be used, contact the relevant specialist who recommended/initiated treatment.

On-call haematology SpR via RHH switchboard: 11900

Haematology Con: 2712500

Anticoagulant Clinic RHH: 13820

Monitoring and Audit:

Date Reviewed	Reviewed by
December 2022- format changed, old charts removed and referred to STH guidelines.	S Moerman (Pharmacist)

Approved by: **Abiola Allinson .....**

Signed: **AAllinson.....** **Date: 01/2023 .....**

Glasgow Antipsychotic Side-effect Scale (GASS)

Name: **Age:** **Sex: M / F**

Please list current medication and total daily doses below:

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects.
Also tick the end or last box if you found that the side effect was distressing for you.

Over the past week:	*Never*	*Once*	*A few times*	*Every day*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. My muscles have been tense or jerky					
6. My hands or arms have been shaky					
7. My legs have felt restless and/or I couldn't sit still					
8. I have been drooling					
9. My movements or walking have been slower than usual					
10. I have had uncontrollable movements of my face or body					
11. My vision has been blurry					
12. My mouth has been dry					
13. I have had difficulty passing urine					
14. I have felt like I am going to be sick or have vomited					
15. I have wet the bed					
16. I have been very thirsty and/or passing urine frequently					
17. The areas around my nipples have been sore and swollen					
18. I have noticed fluid coming from my nipples					
19. I have had problems enjoying sex					
20. **Men only:** I have had problems getting an erection					

Tick yes or no** for the **last three months	*No*	*Yes*	*Tick this box if distressing*
21. **Women only**: I have noticed a change in my periods			
22. **Men and women**: I have been gaining weight			

Staff Information

1. Ask people to fill in the questionnaire themselves. All questions relate to the previous week.

2. **Scoring**

   For questions 1 to 20 award the following:
   1 point for the answer "once"
   2 points for the answer "a few times"
   3 points for the answer "everyday".
   Zero points for an answer of "never".

   For questions 21 and 22 award the following:
   3 points for "yes"
   0 points for "no"

   Total score for all questions = _____

3. For completed questionnaires (male & female), scores indicate the following side effect severity:

0-21	**absent/mild side effects**
22-42	**moderate side effects**
43-63	**severe side effects**

4. Side effects covered include:

1-2	sedation and CNS side effects
3-4	cardiovascular side effects
5-10	extra pyramidal side effects
11-13	anticholinergic side effects
14	gastro-intestinal side effects
15	genitourinary side effects
16	screening question for diabetes mellitus
17-21	prolactinaemic side effects
22	weight gain

The column relating to the **level of distress** experienced with a particular side effect is not scored, but is intended to inform the clinician of the **person's** views and condition.

Guidelines for community team bases regarding storage, handling and administration of medication

Version:	V2
Effective Date:	February 2023
Review Date:	February 2025
Reference:	Medicines Optimisation Policy Appendix E
Related Documents:	Medicines Optimisation Policy
Author:	Simon Barnett, Head of Nursing; Shrewti Moerman, Deputy Chief Pharmacist
Reviewer:	Medicines Optimisation Committee
Approved:	Medicines Optimisation Committee
Dissemination:	The SOP was disseminated via Intranet

Guidelines for community team bases regarding storage, handling and administration of medication

Purpose:

- To maintain the security of medication stored in a community setting.
- To ensure that professionals maintain an awareness of their accountability/responsibilities in relation to medication storage, handling and administration within the community.
- To ensure that non-professionally accountable staff receive adequate support and training regarding medication issues including recognising and responding to side effects.
- To maintain the safety of service users whilst being able to meet their needs in an efficient and timely fashion.
- Ensuring that appropriate records are maintained and referred to in the handling, storage and administering of medication.
- To comply with the standards set out in Outcome 9 – Management of Medicines of the Care Quality Commission (CQC) and the Trust's Medicines Optimisation Policy.

Scope

This procedure covers all medication use at all community -based services. These guidelines attempt to address the needs of most eventualities however, there may be exceptional circumstances where further advice is needed from medical or pharmacy staff and this should be sought as appropriate.

Currently the use of controlled drugs in community teams is under review and is not specifically covered within this guidance.

There should be a clear audit trail from the point of prescribing, dispensing and delivery of medication to the service user.

Risks associated with medication handling, storage, dispensing

- Unauthorised access
- Theft
- Incomplete or inaccurate audit trail
- Duplicate dosing from multiple routes of prescription
- Staff being unfamiliar with procedures
- Medication being handed or administered to wrong service users
- Old/out of date medication remains in local storage.

Responsibility

- The responsibility for establishing and maintaining a system for the security of medicines should be that of a Senior Pharmacist in consultation with Head of Nursing and appropriate clinical staff.
- At each clinical base, the nurse team leader should be responsible for control of access to the medicines and should therefore have responsibility for ensuring that the system is followed and that the security of medicines in the clinical base is maintained.
- Individual teams should have access to there medication, but not to other teams medication. Multiple teams should NOT have shared access to cupboard containing medication.
- In the absence of a nurse team leader, the nurses should bear the responsibility individually.
- Systems for recording, storage and administering medication need to be easy to understand and implement by all disciplines to foster safe, efficient and timely service for users, which can be audited and accountability established.

Procedure

Storage

- All medication to be stored in their original containers.
- All medications to be locked in a secure environment with restricted access (prescribers, registered nurses and senior staff) – in this case a keypad access strongbox will house the drug storage cupboard key(s) and to be located close to the medicine cabinet. The keypad entry number should be changed periodically (ideally every 6 months).
- There should be a regular review of all stock medicines stored in the clinic room and named patients medication. Any medicines that are surplus to requirements should be disposed of appropriately.
- The clinic and fridge should have daily temperature monitoring as per the Trust temperature monitoring SOP.
- Clinic rooms should have air conditioning to maintain temperature.
- The security and management of medicine stocks will be checked by Pharmacy Assurance checks.
- Where it is deemed in the patients best interests for medication to be kept in the clinic room for administration, this should be kept in a lockable cupboard and used for that patient only.
- These medicines should be kept separate from stocks.

Ordering

- Regular medication used by community teams will be supplied as stock, this will only be depot medication.
- Named patient depots will only be supplied via a valid prescription.
- Regular oral medication should be supplied by the GP, if a service user is switching medication, they may require oral medication. This will be supplied as named patient medication ordered via the drug card or electronic prescribing and medication administration System (EPMA system) it is prescribed on.
- Recommended that the minimum amount of medication requested is 3 days, and the maximum 14 days.

- Once a service user is established and stable on medication, the supply should be requested by the GP; unless in special circumstances. Special circumstances does not include to limiting supply for the service user.

Handling of medication

- Overall responsibility for safe keeping of medicines and the drug keys remains with nursing staff.
- There must be agreement from the team manager if non-nursing staff need to access medicines. These staff need to be aware of SHSC's Medicines Optimisation Policy.
- Medications transported from SHSC pharmacy by pharmacy staff delivered to the individual team. Medication should be in locked or sealed containers. If there is any evidence of tampering contact the Pharmacy department and speak to a senior pharmacy staff.
- When receiving medication, medication should be checked to ensure any discrepancies of medicine received should be queried immediately by the nurse receiving the supply.
- If no drug card is available to document receiving, the medication, medication received should be recorded in the medical notes. This ensures a clear audit trail of the medication.
- If a registered nurse is not available to sign then the medication should be returned to pharmacy by the driver.

Transporting medication to a service user house

- Transportation should be done in a safe manner.
- Member of staff must have business insurance for the vehicle being used for transportation.
- Depot medication should be stored in non-identifiable carriers such as insulated lunch boxes. Please note insulated does not ensure the medication will be kept at the correct temperature.
- Medication should not be stored overnight at a staff members home or car.
- Temperatures of medication cannot be monitored when transporting to a service users house. Medication is only deemed safe if kept at its recommended storage conditions, SHSC can support the transportation of the depot medication if used within 12 hours of removal from the clinic room it is normally stored in (and temperature monitoring has remained in range in the clinic room).
- If temperatures have gone above 25 degrees (as per the weather report), whilst transporting medication. The staff member should seek advice from pharmacy of the procedure if the medication was not administered and requires returning to the clinic room.

Before any staff who is not a qualified nurse, prescriber or pharmacist can take medications to a service user the following systems must be in place:

- The service user has already had advice from medical/nursing staff about all relevant issues relating to taking the medication.
- A qualified nurse is contactable by phone should the service user or worker have a concern or query about the medication at the point of delivery.
- Any issues of concordance have been discussed with a medical or nursing professional and a plan is in place to manage this.

Posting Medication

Prior to posting medication in to a service user's property, agreement should be obtained from receiver regarding the method of receiving medication.

Only staff who have visited/have previous knowledge of service users address should deliver medication.

If agreed method of receivership is not available – staff should contact receiver/qualified nurse prior to leaving/posting any medication and a follow up call should be made to ensure the medicine has been received.

If it is not possible to follow the above process – advice should be sought via the qualified nurse on duty and all undelivered medication should be:

a) Returned to the office and stored according to storage procedures

b) returned to pharmacy (issuing pharmacy where possible)

Accurate documentation in service users medical notes to reflect the process of delivery and to include:

i. Accurate documentation of medication/prescription delivered (can refer to prescription scanned)

ii. If prescription is dispensed, then record issuing pharmacy.

iii. If medication/prescription is undelivered record where stored/taken.

Administration

Medicines will only be administered on the instruction of a valid prescription.

Depot administration should be accompanied by the written prescription on the Trust drug card/Trust depot card and the dosage given should be recorded. As with all legal prescriptions, the prescription is valid for 6 months, and will have to be rewritten every 6 months.

Prior to administration - Name of service user should be checked with the prescription, allergy status should be confirmed, when last administered and where possible the calculation and drawing up of depot medication for administration should be second checked by a prescriber or another nurse.

The registered nurse should record administration along with a note of any medicines refused, wasted or returned to stock.

Administration to be recorded on depot cards/drug cards or EPMA system where available.

Domiciliary visits: When medicines are issued to nursing staff for use in the community, these medicines become the responsibility of the person to whom they are issued.

All medicines carried by the CPN should have been prescribed as a specific dose for a named patient by a qualified medical practitioner/authorised prescriber (record made in medical notes) or covered by the terms of a Patient Group Directive under which the CPN may supply or administer the medicine.

Untrained staff cannot administer medication. Administration of Medication means any one of the following activities: handling, storing, preparing, or pouring of medication; conveying it to the service user according to the medication order; observing the service user inhale, apply, swallow, or self-inject the medication, when

applicable; documenting that the medication was administered; and counting remaining doses to verify proper administration and use of the medication.

Removal of medication

Medication prescribed for a service user remains the service users property. The person removing the medication must gain consent from the service user and document if they have been authorised to remove medication or not. If the removal of medication is deemed necessary due to the risk to themselves or others; this should be documented within the medical notes.

- All obsolete medication to be returned to the issuing pharmacy.
- Medication removed from a service user should be clearly documented in the medical notes, stating the quantities and the names of the medication removed.

Reasons for removal without consent can be where there is a concern that:

- the service user may be `hoarding` medication inappropriately or keeping large amounts of out of date.
- If the visiting community worker has concerns regarding the service user's capacity to do so then the medication may be removed in the person's best interest.
- Advice should be sought from a Senior Nursing colleague if there are any doubts. All medicines returned and actions taken should be fully documented in medical records.

Other

Telephone conversations with pharmacy for verification of prescriptions should only be undertaken by a suitably qualified medical or nursing professional from the workplace.

Compliance aids

- Compliance aids/ NOMADs should be accessed via community pharmacies and not filled by staff at base.
- Compliance aids support service users when they have several medications or may find it supportive for checking if they have taken the medication. Service can purchase their own compartmentalised daily dispensers if they are capable to fill their own in or have family who can support.
- When setting up a NOMAD for a service user, it is suggested to find a local community chemist. The chemist may wish to assess the service user before agreeing to provide one. It can take up to a month for some chemists to set this up.
- GPs should be contacted if a NOMAD is required as the prescription may have to be changed to support this.
- Not all medications are suitable for compliance aids, this should be considered when reviewing if a compliance aid is the best option.
- Compliance aids are not usually recommended for patients with cognitive dysfunction, or if they have poor manual dexterity.
- Other options are available such as reminder charts. Speak to pharmacy for options that may help in the individual case.

Medicines reconciliation

The following standards should be adhered to

- All new referrals should include a list of all current medication from the GP.
- All new referrals should have information regarding existing medical conditions and
- prescriptions from the GP.
- GP's should inform of any known allergies to medicines or anything else (e.g., nuts, eggs)
- For all service users (whether CPA or Standard care) there should be an annual review of medication, seeking clarifying information from the GP regards medication confirmation.
- If the CMHT make changes to a service user prescription, they will always inform the GP as soon as possible.
- Where service users are accessing other services within SHSC; clear communication regards medicines and who is supplying which medication (e.g., substance misuse service, memory service etc.)

Detention/Compulsion under the MHA

For all service users who are detained under those sections of the Mental Health Act to which Part 4 of the Act applies, or subject to CTO, to which Part 4A of the Act applies:

- Ensure medicines are authorised and administered as per code of practice
- Ensure correct certification procedures occur, Approved Clinician in charge of treatment or
- Second Opinion Appointed Doctor (SOAD)
- Keep copy of certificate with drug card/electronic prescription.

Reporting of incidents and near misses

- All incidents related to storage and administration of medicines, or near misses, to be reported
- via SHSC incident reporting system.
- Patient safety alerts to be actioned.
- Incidents and alerts to be discussed and recorded at Team Governance meetings.

Note: - Both the Nursing and Midwifery Council Standards and the Royal Marsden Manual of Clinical Procedures, sanction the delegation of certain aspects of medication handling to other workers however, nurses should be aware that primary responsibility and accountability remains in their hands and they may be called upon to justify any act or omission with regard to the receiving, storage and administration of medication.

In preparation of this risk assessment/guideline, consideration and weight has been given to the following documents: -

- Sheffield Health & Social Care: Medicines Optimisation Policy Risks and Process.
- RPS Professional guidance on the administration of medicines in Healthcare Settings
- RPS Professional guidance on the Safe and Secure Handling of medicines
- Royal Marsden Hospital (Clinical Procedures, drug administration general principles).
- Care Quality Commission Guidance

Guidance: Manipulation of drug dosage forms

Definition of Manipulation

A manipulation is defined as the physical alteration of a pharmaceutical drug dosage form for the purposes of extracting and administering the required proportion of the drug dose. In this context it does not include the manipulation of a medicine solely for the purpose of ease of administration.

Ensure that you have the correct equipment to carry out any manipulation of medication. This can be from pharmacy or the supplies department.

Reconstitution of injections

Some parenteral medications are supplied in powder form and need to be reconstituted prior to administration. The package inserts, and the Summary of Product Characteristics, will normally give full instructions regarding this process. Staff involved in reconstitution of injectable medications must familiarise themselves with the instructions for the product in question.

Some general principles apply:

- Reconstitution should take place immediately prior to administration.
- Aseptic technique must be employed.
- Precautions against needlestick injury must be taken.
- Appropriate equipment must be used, e.g. suitable sterile needles and syringes. It is generally advised to use the smallest size syringe possible to improve accuracy of measurement.
- Only the recommended diluent should be used.
- Equipment should be disposed of safely according to policy.
- Similar principles should be applied if liquid injectable preparations require dilution.
- The Royal Marsden Handbook also gives general guidance on clinical procedures and should be referred to as appropriate.

Crushing tablets/ opening capsules prior to administration

If a patient cannot tolerate solid dose forms a suitable liquid or dissolvable/dispersible tablet alternative should be prescribed where possible. Where such an alternative is not available, crushing tablets or opening capsules may be possible.

Some general principles apply:

- Contact pharmacy for advice, if possible, before deciding to change a dose form for administration.
- Modified release tablets or capsules should not be crushed or opened.
- Tablets with specific coatings, e.g. enteric coating, should not be crushed.
- Some medications have an unpleasant taste, and the patient may be unable to tolerate this if not swallowed whole.
- Water should be used as the vehicle to assist administration, unless it has been confirmed that other vehicles, e.g. fruit juice, may be used.
- Any covert administration of medication must follow the Trust policy.

Making up liquid medications

Some liquid medications are stored as dry powders which require reconstitution before administration.

The required diluent and volume will be specified on the packaging.

- The volume of diluent must be accurately measured using an appropriate measure.
- The operator must ensure that all the powder has been dissolved/dispersed.
- Any required expiry date after reconstitution must be recorded clearly on the package.

Drawing up liquid medication

- For accuracy a syringe is recommended for drawing up liquid, ideally for volumes under 20ml. Some medication e.g., lactulose can be measured in the provided measurer
- When drawing up a liquid medication a correctly fitted bottle adaptor (bung) should be used. These sundries should be ordered by procurement. Discharge and Short-term Leaves (STL) will be provided by pharmacy.
- If measuring a large volume such as for a methadone dose, a glass conical flask should be utilised.
- Below is guidance on measuring benzodiazepines (Schedule 4 controlled drugs)

Insulin

Please follow the insulin guidance and use an insulin syringe.

Measuring Benzodiazepine liquids

When checking the balance of benzodiazepine liquids- when, how and what to do if it's wrong.

When

Liquid benzodiazepines can be visually checked. You do not need to measure the liquid volume in each bottle every time there is a check. This would result in a small loss as some will remain in the measurer used.

You should only measure the actual amount whenever you finish a bottle or the register is zero and there is any stock left.

How to measure

You can check the balance using an oral syringe or a glass conical measurer (approved by pharmacy)

Checking with a syringe:

- Prepare a dose or a balance check using a syringe (with a bung).
- Shake bottle well making sure the cap is firmly on the bottle.
- Remove the cap, insert rubber bung (if not already in place), ensure it is fully into the neck of the bottle.
- Take the syringe and pull the plunger so that the top of the ring is on the volume for the dose you need to give or the amount you think is in the bottle (if measuring what is left).
- Push the tip of the syringe into the hole in the middle of the rubber bung.
- Turn the whole bottle with the syringe upside down.
- Slowly push the plunger slowly back to the volume you need for the dose. If measuring a large volume, you may need to do this in stage so as to avoid too much pressure in the bottle -push a small amount of air in and then withdraw liquid then push more air in and withdraw more liquid and so on until you have the dose you need.
- Turn the whole bottle with the syringe the right way up and take the syringe out of the bottle.

Checking with a glass conical:

- Shake bottle well.
- Remove cap and pour liquid into glass conical.
- Check the volume by looking at the conical measurer at eye level. Volume is at the lowest part of the curve.

What to do if the balance is incorrect

Whenever you measure the balance in stock you should record the exact volume (whole bottles as stated volume plus measure part bottle(s) in the register e.g. **'Stock checked, and balance corrected to……**'. Scan the entries in the register to ensure all calculations are correct.

The entry should say – 'Stock checked and balance corrected to ……. (and state the actual amount held). A discrepancy up to 10% is acceptable. Scan the entries to ensure all calculations are correct.

Any discrepancy that is greater than this should be reported as an incident, to the ward manager and the ward pharmacist.

Please note: This guidance does not cover Schedule 2 and 3 controlled drugs.

Sheffield Health and Social Care
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Delivery of medicines

Delivery of Medicines (including the use of taxis)

Medication will be delivered in line with the Trust Medicines Optimisation Policy. There needs to be a clear audit trail for the delivery of medicines. This also includes an assurance of safe receipt, especially if sending via taxi drivers or other third parties that are not accountable within teams Governance systems.

To ensure that medication reaches the intended service user/destination, options can include:

- Collection by service user/carers
- Delivery by staff members in the team if resources allow.
- Reviewing if appropriate to be accessing from the service user GP and collection/delivery from the community pharmacy.
- Discuss availability of delivery options with the Trust Transport services and the Pharmacy team.

If none of these methods of delivery are available and an urgent need for medication is required, options should be discussed with a senior member of staff (ideally clinical to consider the clinical impact and alternate options). When considering delivering medication to a service users house using a taxi, the following factors should be considered.

- If the medication contains controlled drugs.
- If the items require specific storage conditions (e.g. refrigeration)
- Consideration should be given to the options and the risks of not supplying medication urgently (actions should be documented in clinical records).

If a taxi service or third party is used, confirm that someone will be able to receive the medication. A record of:

- Date and time of delivery.
- The delivery firm used and the drivers call/log number.
- Medication should not be delivered directly to a service users home via taxi unless a member of SHSC staff is delivering the medication.
- For deliveries, all medication should be handed over in person and not posted through the letter box.
- Medication unable to be delivered or received in person should be returned to the issuing team/department

Pharmacy staff should follow the departmental SOP for delivery of medicines.

Sheffield Health and Social Care NHS Foundation Trust

Beech (Step Down Unit)

Medicines Management Local Policy

Executive or Associate Director lead	Mike Hunter, Medical Director
Policy author/ lead	Tracy Robinson
Feedback on implementation to	Tracy Robinson

Version	3
Date of ratification	February 2023
Ratified by	Medicines Optimisation Committee, Policy Governance Group
Date of issue	February 2023
Date for review	February 2025

Target audience	Beech staff

This is an updated version of the local medicines policy for Beech but the first version in line with the new Trust policy format.

This Policy provides local guidance to Beech Step Down and links to the Sheffield Health and Social Care 'Medicines Optimisation Policy – Risks and Processes and to meet the requirements of the CQC Regulation 12 – Safe Care and Treatment

To store this document on the Policies section of the Trust intranet web site and in the Medication policy file at Beech.

Contents

1. Introduction

The policy is intended to give instruction for the staff at Beech on all aspects of medication including the supervision, recording and storage of them. This policy is intended to be read and used in conjunction with the Trust Management of Medicines policy.

Beech is a 10-bed unit providing a citywide residential resource to adults with mental health needs.

Aim is to provide a step-down service from the acute wards.
One of the core tasks is to promote mental health and well-being and to enable and empower service users to monitor their own medication, prescriptions and medical/clinical appointments.

There are circumstances and situations where the service user will not manage their own medication and their access to their medication will be supervised by staff.

If you have any doubts about any aspect of medication, use within the unit, you can:

- Contact the Pharmacy Dept (based at the Michael Carlisle centre)
- Go to the Pharmacy intranet page for more information.

For advice relating to clinical issues the SHSC team involved or the GP should be contacted.

2. Scope of this policy

This document encompasses the processes of medicines management within Beech. It is applicable to all staff working at Beech (including those staff employed by other organisations or agencies as well as students or other staff on placement within the Trust).

This document covers the majority of issues relating to medicines within the unit but should be read in conjunction with the Trust Medicines policy. For medication issues out with this policy, advice can be obtained from services documented in section 1.

3. Definitions

Medicines management describes the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed, to optimise the contribution that medicines make to producing desired outcomes of patient care.

4. Purpose of this policy

To describe the local processes for all aspects of the safe management of medicines at Beech

5. Duties

All staff employed by the Trust, or any staff working or seconded to work within the Trust when dealing with medicines should follow the relevant SHSC medicines management policy and the local medicine policy at Beech.

Managers

- To ensure all staff are aware and have access to all the current Trust and local policies relating to medicines.
- To support staff through the PDR and Supervision processes to ensure they are working within their medicine related competencies.

6. Specific details

6.1 General Principles

The principles of medicines storage and their handling within this policy are based on the underlying principles and guidance issued from the Royal Pharmaceutical Society - https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines (Dec 2018)
Royal Pharmaceutical Society
www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567 (Jan 2019)
Similarly, pharmaceutical guidance for people who are involved in handling medicines in social care is available from the Royal Pharmaceutical Society of Great Britain – The Handling of Medicines in Social Care (2007). Medicines must be managed safely and effectively.

6.2 Responsibility/Accountability

Managers

- To ensure all staff, who handle medicines are fully aware of, and carry out competently the safe management of medication.
- To ensure all staff have received appropriate instruction (based on these guidelines), to handle medicines.

Designated Medication Officer/s

- This person/s will be a member of the team within the unit and is responsible for the safe custody of the medication keys.

6.3 Storage

All medicines must be safeguarded against loss or possible misappropriation, and should be stored in a locked cabinet in the service users bedroom

Medicines must be stored at the appropriate temperature. Medicines must not be subjected to temperatures outside of these ranges unless indicated

- Medicines requiring refrigeration must be kept in a locked refrigerator kept solely for the purpose of storing medicines.
- The fridge is located in the locked clinic room.
- The fridge temperature should be maintained between 2-8ºC.
- The medicine fridge and clinic room temperature are monitored daily, and staff follow the Trust Standard Operating Procedure.

6.4 Custody of medication

Two levels of custody apply dependent on the risk assessment and nature of support required by each individual.

- Self-custody – where the individual has full responsibility for their own medication. The medications will be stored in a locked safe in the service user's room.
- Staff supervision – Medicines will be stored in a locked medicine cabinet in the locked clinic room and supervised and managed by staff.

6.5 Admission

At the point of referral to Beech and admission, the service users' risk and ability to manage their own medicines is assessed.
This is done by completing the Medicines Safety Form which includes the assessment, the custody and consent (Appendix A).
For service users who are unable to manage their own medications, staff will complete a medicines supervision record (MSR1 and MSR2- Appendix B).
Services users are monitored by staff during their stay and the degree of risk may change during an admission. The storage and recording of medicines will be updated accordingly.

6.6 Discharge of a Service user

All medicines will be discharged from the unit in the care of the service user.

6.7 Medicines kept by user (Self Custody)

The service user retaining their own medicines is responsible for looking after them.
A lockable safe is available in every room. The keys to the medicine lockable safe must be kept safe at all times and secured by the service user.
The service user will provide an up-to-date list of medications / allergies for use in an emergency.
Controlled Drugs prescribed for a service user who is responsible for Self custody need not be stored in the Unit's Controlled Drugs Cabinet.

6.8 Staff supervision of medicines

(Refer to Appendix C for the full details)

- Medicines should not be left unattended. Staff to maintain an observation role until medication has been taken.
- The MSR record should be completed immediately after the medicine has been observed to have been taken.
- Where a variable dose is prescribed e.g., 'take one or two tablets' details of dose administered should be entered on the MSR.
- If medicines are not given, use the following codes and record in the service user daily notes.
  - S when service user asleep and the decision has been made not to wake them
  - A when service user is temporarily absent
  - R medication refused
  - L when given for a period of leave
  - O omitted medication

H Handed to the service user
X not given for any other reason

- A service user has the right to refuse a dose of his/her medicine, and no-one should ever be forced to consume a medicine or receive a specific treatment against their will.
- If a code is used it will be documented in the medical notes.

6.9 PRN (when required) medication

All medication used on a when required basis needs to be clearly recorded on Medicines Supervision Record (MSR), with an indication for its use and a maximum dose allowed in 24hrs. Where staff are supervising service users medication a PRN medication supervision record (Appendix D) will be completed.
An assessment of need for PRN medication should be addressed and discussed with the service user. Alternative strategies may be considered first – this should be recorded in the service user's notes and fed back to appropriate workers as part of discharge.

6.10 Controlled Drugs

The term "Controlled Drug" is used in the legal classification of medicines to identify medicines which are addictive or have serious abuse/misuse potential. All aspects of medicinal use of Controlled drugs are regulated under the misuse of Drugs act (and regulations). For all issues relating to controlled drugs – 2 support workers need to be involved in each process. For further details relating to controlled drugs staff should refer to the Trust Medicines Management policy.

All local procedures involving controlled drugs are covered in detail in Appendix E– Standard Operating Procedure for Controlled Drugs.

The Chief Pharmacist is the Accountable Officer (for controlled drugs) for the Sheffield Health and Social Care NHS Foundation Trust. Any member of staff who has any concerns regarding Controlled drugs or staff who deal with controlled drugs should make their concerns known directly to the Chief Pharmacist. All incidents involving controlled drugs must be reported immediately to the Accountable Officer as well as to the Risk Dept using the SHSCT incident forms.

6.11 Covert Medication

Covert administration of medicines will not be undertaken at Beech.

6.12 Keys

Where staff is supervising medications and the service user has restricted access, the keys will be kept in a locked key safe in the clinic room.

6.13 Verbal order

Staff at the unit are not permitted under normal circumstances to accept verbal orders relating to changes in drug treatments. However, a verbal order may be permitted in the following circumstances.

- From the prescriber responsible for the treatment i.e. GP or another authorised prescriber.
- This would only be intended for dose alterations or to stop treatment. Verbal orders should not be used to start new treatments.

The member of staff receiving the telephone message should record the details in writing. This information should then be shared with a colleague who should then read the message back to the prescriber.

- Record the new directions legibly and on the MSR.
- Record the date, time, both staff taking the verbal order and the prescriber who gave the new instructions on the MSR if appropriate. This should also be recorded in the service user medical notes.
- Ask for confirmation to be recorded in written form.

6.14 Common Remedies

The unit does not store common remedies.

6.15 Crushing tablets or opening capsules.

Medicines should never be crushed before administration (or capsules opened) without the authorisation of the prescriber and a pharmacist.

6.16 Errors in supervision of medicine

If a member of staff becomes aware of having made an error in the supervision of a medicine, or notices that an error has been made by someone else, the following action should be taken

- If there could be potential risk to the health of the individual, the GP and /or other should be contacted immediately.
- The error should be reported to the manager as soon as possible.
- If a dose has been missed, you must contact the GP or referrer who will give advice on that particular medicine for the individual concerned. All directions received from either party must be documented in the service user Insight notes and on the MSR.
- If an individual has been given the incorrect medication or wrong dose staff must seek advice from appropriate services.
- Staff to ensure that all information is well documented in service user notes.
- If a dose has been missed, advice should be sought.

6.17 Incident Reporting and Investigation

Any incident involving medicines, e.g., prescribing, dispensing, supervision, storage of medicines, including near misses must be reported to the SHSC Risk Department using the SHSC incident form.

6.18 Disposal of unwanted medicines

Beech has a Medicine Disposal System for the disposal of unwanted or spoiled medicines, in the first instance all medications should be given back as part of the discharge procedure. Service

users have the primary responsibility to return any unwanted medicines to a community Pharmacy for appropriate destruction. (Appendix F)

6.19 Death of a service user
Staff should refer to the Trust Medicines Optimisation policy and other related Trust policies.

6.20 Disposal of sharps
Follow the Sheffield Health and Social Care Trust Infection Prevention and Control Policy regarding the use of and disposal of sharps.

7 Dissemination

The policy will be disseminated to the staff by the Manager at Beech. The policy will be placed on the SHSCT intranet site and copies kept on the unit.

8 Training

In house training is required for this policy. It generally reflects current practice at the unit. New staff starting at the unit will be given local training in the operation of the policy and period of assessment and observation using the competency assessment tool. Staff will go through the competency tool yearly with designated managers (Appendix H). This is currently under review as the trust is introducing an annual competency framework and a three yearly Medicines optimisation Training.

9 Audit, monitoring, and review

The policy will be reviewed by the manager of the unit via team governance meetings monthly as a standard agenda item.
The policy will be reviewed in 2 years or sooner if new national guidance or standards have changed.
A monthly Audit is completed by the leadership team to maintain overview and assess any issues.

10 Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
1. New policy to be submitted to MOC	Tracy Robinson	Feb 2023	Approved
2. Add new policy onto intranet	IT		

3. Ensure and launch the new policy to the team	Unit manager		
4. Review training & competency tool	Unit manager		

11 Links to Other Policies

This policy should be read in conjunction with the Trust's Medicines Optimisdation Policy.

12 Contact details

Title	*Name*	*Phone*	*Email*
Unit Manager	Tracy Robinson	01142716692	tracy.robinson@shsc.nhs.uk

13 Bibliography

1) SHSC Trust's Medicines Optimisation Policy.
2) Royal Pharmaceutical Society https://www.rpharms.com/recognition/setting-professional-standards/safe- and-secure-handling-of- medicines/professional- guidance-on-the-safe-and-secure-handling-of-medicines (December 2018)
3) Royal Pharmaceutical Society - https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567 (January 2019)
4) Royal Pharmaceutical Society of Great Britain – The Handling of Medicines in Social Care (2007).

Appendix A

BEECH

MEDICINES SAFETY FORM

Service User Name: _____

One of the core tasks at Beech is to promote mental health and wellbeing and to enable and empower service users to monitor their own medication, prescriptions, and medical/clinical appointments.

We will discuss medication management with your care team (the ward and/or your care -co-ordinator) and you at your referral meeting, and Admission.

At times we will also have a period of assessment where we supervise your medication until it is assessed by Beech staff or Care co-ordinator that you are safe manage your own medication.

It may have also been assessed that you need support to manage your medication throughout your stay at Beech. This will have been discussed with you and the reasons for this.

Consent – Option A

- **I wish to retain possession of my own medication.**
- I understand the risks and have capacity make decisions about my medication. I know the medicines I take when I take them and what dose to take.
- I agree to store medicines safely in the lockable facility in my room, and not to share with any other service users.
- I will provide Beech with an up-to-date list of what medication I am taking. I will also inform staff of any changes to my prescriptions.
- I will work with staff, ensuring I have ordered prescriptions, and have sufficient supplies.
- I understand that if the staff assess and find that it is in my best interest to hand in my medication, I will be informed of the reasons for this.
- I understand that staff may request to check my medications at any time.
- I understand that I must take my medication as prescribed.
- I understand that I must talk to staff before stopping any medications.
- I understand that whilst staying at Beech I am expected to comply with my medications, Staff at Beech will support me to discuss concerns with my GP or care team.
- If I choose not to agree to the above, I may be unable to stay.

Consent – Option B

- **I give consent to Beech staff to safe store and supervise my medications.**
- My medication will be safe stored in the clinic room at Beech.
- I am aware that it is my responsibility to ask staff for my medication at the times they are due.

- I agree to take my medication in the clinic room
- I agree to inform staff of all medications including self-purchased medicines.
- I give consent for staff to dispose of medication that is discontinued, overstocked damaged or spoilt doses.

Option	Date	Signature of Service User	Signature of Staff

Appendix B

Medication Supervision Record - 1

Surname	DOB	Hospital Number:
First name	Allergies to food &/or Drugs	
Special Instructions		
		TeL

Medicine Name & Strength	Dose Frequency	Time of Dose: Break	Lunch	Tea	Bed		Dr Ints	Date & Quantity of Medication Received & Discharged				
								Date				
								Qty				
								Date				
								Qty				
								Date				
								Qty				
								Date				
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								Qty				
								Date				
								Qty				

Medicine Supervision Record 2

			Pages:				Page of				
Surname			Forename				Hospital Number:				
Medicine name & strength	**Dose**	**Sig**	**Frequency/ Time**	**Week Beginning**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
			B								
			L								
			T								
			N								
			B								
			L								
			T								
			N								
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			L								
			T								
			N								
			B								
			L								
			T								
			N								

Appendix C

Procedure for the Supervision of Medicines

Environmental factors

1. Free from distractions At the point of supervising medication, the environment should be as free from distractions as possible (e.g. noisy environment, people wandering in and out or engaging in conversation.)	It is generally accepted that people when undertaking a specific activity should do so with the least interruptions and distractions. Errors in medication supervision often occur when the person is distracted or of increased activity around the administration times when the support worker is distracted (Community Health Sheffield Risk Management 1999).
2. Well-lit area The area should have adequate lighting for the safe administration of medication	Ensuring adequate light and space will enable the staff and service user to view the medications and reduce the opportunity for error (Medicines working party 1999)
3. Clean and tidy On completion of supervision the equipment should be washed and returned to its designated storage place.	Quality begins by having things in the right place and of the correct quantity. Putting something back incorrectly leads to wasted time for another person looking for the item.

Preparation prior to supervising medication

4. Prepare Medication Supervision Record Check MSR for: • name • legibility • dates/times • dose and frequency • Route • Name of drug to be supervised • All equipment should be gathered together i.e. water, medicine pots,	It is recommended that people take a full cup of water with their medicines as this improves the absorption of the medicine and prevents damage to the oesophagus.
5. Wash hands	To prevent cross infection

6. Ask the service user to attend the clinic room	To minimise any distractions and aid communication with the client. Evidence shows that if service user has regular and quality contact during this procedure, they are more likely to ask questions about their medicines (Community Health Sheffield 2000, Harris 1998).
7. With the service user check that you have: • the right medication • the right time • the right dose • the right amount Without touching the medication • Check that each tablet matches the description on the medication container.	To promote independence To prevent cross infection and any allergic reactions to a drug through skin contact. If direct contact is required gloves must be worn.
8. Medication in liquid Form. Check expiry date on the bottle and relate to MSR as with other medications and follow the procedure. • When pouring liquids always pour away from the label • Clean the bottle before replacing in the medicine cupboard • Use bungs to avoid loss of medication	To avoid spillage onto the label and possible distortion of the instructions To prevent dripping onto the label
9. Giving of PRN Medication: • The use of PRN medication must be clearly recorded on the PRN / MSR • Prior to administering PRN medication all alternative strategies must be discussed with the service user.	To prevent over reliance on PRN medication To ensure therapeutic levels are maintained
10. If any medication is not supervised whatever the reason, complete MSR using the recognised codes.	This is imperative for continuity of the treatment

• Fully document the reasons for this in the services user daily notes. • Inform all staff when handing over to next shift. • Inform the service users worker	

House keeping

11. Check individual cabinet is locked and keys are returned to office key safe box.	Quality begins with everything in its correct place. Preparing for the next medication and is good practice.
12. Wash and dry any pots used	Hygiene is an essential part of practice. Washing and drying tots reduces the risk of mixing medication residue and cross infection. It also facilitates the next medication administration.
13. Check all medication supervision recording sheets are correct	Medication recording cards should be kept in the appropriate designated place to enable access to records.

Appendix D

BEECH
PRN Medication

Name:		DOB:		
Medication:				
Prescribed for:				
Date	Time	Dose	Reasons why	Staff signature

Appendix E

Beech
Sheffield Health and Social Care NHS Foundation Trust

STANDARD OPERATING PROCEDURE (SOP)
All Schedule 2 Control Drugs – e.g. methadone, morphine, fentanyl
Schedule 3: Buprenorphine, Temazepam, Midazolam, Gabapentin and Pregabalin
Schedule 5: Oramorph (morphine) oral solution 10mg/5ml

January 2023

Purpose

- To ensure that all schedule 2 and the specified schedule 3 and 5 controlled drugs (CD) are managed in a safe and consistent manner.
- To ensure that all legal requirements and good practice recommendations are met in respect of these drugs e.g. Care Quality Commission, Handling of Medicines in Social Care (Royal Pharmaceutical Society).
- To provide a robust audit trail for these drugs, from entry to exit of Wainwright Crescent.

Scope

This procedure covers all aspects of controlled drug management for these drugs in Beech. Changes should be agreed by the Trust Accountable Officer for Controlled Drugs who is currently the Chief Pharmacist.
Aspects of management covered are:

- Admission
- Administration
- Record keeping
- Stock checking
- Disposal/Wastage
- Responsibilities

1. Admission

At the point of admission to Beech, the admitting worker will record all medicines brought in and the medicines will be transcribed on to a medicines recording card. The medication should be checked with the client and transcribed on to the card in accordance with the directions on the original label. As with all medicines – the staff will keep all the medication until they are assessed to be safe to look after their own medication.

2. Storage

Clients admitted to Beech generally take responsibility for the storage of their own medications. They can only do this once they have been assessed as competent to do so by the recovery worker and signed the medicines safety form. For all admissions medications are supervised until they have been assessed and the client has signed to agree to the safe use/storage of medicines.

Clients who are prescribed controlled drugs (as with all other medicines) can be stored in the clients locked medicines cupboard in their own room.
For clients who are waiting assessment or who are unable to manage their own medication, the controlled drugs must be stored in a designated Controlled Drugs cupboard

3. Administration / Supervision

All medicines must be supervised following the guidance provided within the Beech Local Medication Policy.

- Controlled drugs should be supervised by 2 recovery workers who have been instructed and competent to do so.
- If the client self-administers their own medicines, this should be risk assessed and have signed the medicines safety plan including Option B.

4. Record keeping (Ref. NMC Standards)

- All specified controlled drugs must be recorded in a Control Drug Register
- The book must be stored along with the individuals Medication charts MSR.
- The book is used to record the balances of the specified medications as they are administered.
- Record receipt, return, supervision or disposal, of medication in the Control Drugs book along with signatures of 2 competent staff involved with each process involving CD's.
- Entries in the book should be made in chronological order.
- Mistakes made should not be obliterated. They may be crossed with a single line, or bracketed, such that the original entry is still legible. This should be signed and dated and witnessed.
- Before every supervision the stock balance must be checked as correct and after the stock balance must be recorded. Any discrepancies much be immediately reported to the manager who will then follow the medication incident procedure. The Trust accountable officer (Chief Pharmacist) for the SHSC must be informed.
- Any spillage, refused medication that has been taken out of the packaging for administration, or otherwise spoilt medication, must be documented in the Controlled Drugs Register.
- Record books must be retained for 2 years

5. Disposal/Wastage

When a controlled drug is no longer needed by the individual they have the responsibility to return the medication to the community pharmacist. If the client is unable or unwilling to do this – consent to take the clients medication should be obtained and recorded in the notes. When returning the medication to the local pharmacy 2 competent staff must record the following:

- Date of disposal/return to pharmacy
- Name and strength of medicine
- Quantity removed
- Person for whom medication was prescribed
- Signatures of the staff members who arrange disposal of the medicines.
- Obtain a receipt from the pharmacist and attach to the CD register.

Record any doses, or part doses, wasted, or spoilt for any reason, in the register.

6. Discharge

- At the point of discharge 2 competent staff with the service user will count and record the amount of medication given back to the service user or identified other.

7. Responsibility

- The Manager and Deputy are responsible for the safe and appropriate management of medication.
- Will ensure compliance with the Standard Operating Procedure.

8. Known risks

- Cupboard security
- Failure of recording or if drugs are known to be controlled drugs.
- Misappropriation of drugs

Appendix F

BEECH

Medication – disposal sheet for medications disposed of in specified medication bin

Service user name (initials) and Medication been disposed of.	Quantity	Reason for disposal	Amount checked by x2 staff		
			Signature	Signature	Date

Appendix G

Beech

Competency Assessment Tool

Competence Assessment Tool – section 1

Name of Staff	
Name of Assessor	
Date of Assessment	

Admission	**Yes**	**No**	**Comments**
Ask the service user if they are to hold own medication, if this is yes, complete a list of medications taken to place on file for emergency purposes.			
If Staff are supervising medication complete MSR1 and MSR2			
Complete Medicine Safety Form/Consent			
Record medication outcome in admission notes and record on Collaborative care plan goals and steps to promote self-management			

Procedure for the Supervision of Medicines

Environmental factors	**Yes**	**No**	**Comments**
Free from distractions			
Well-lit area			
Clean and tidy			

Preparation and supervising medication	Yes	No	Comments
Prepare medication supervision Record Check MSR for: • name • legibility • dates/times • dose and frequency • name of drug to be administered • GP • Allergies			
Wash hands			
Ask the service user to attend the clinic room.			
With the service user check that you have: • the right medication • the right time • the right dose • the right amount • water Without touching the medication check that each medication matches the description on the medication container.			
Ask the service user to take out their own medication, observe and supervise they take them correctly.			
Complete MSR 2			
Medication in liquid Form. Check expiry date, pour liquids away from the label and **c**lean the bottle before replacing in the medicine			

Preparation and supervising medication	Yes	No	Comments
If any medication is not supervised / taken whatever the reason, • complete MSR2 form • document the reasons for this in the services user daily notes • Inform staff at handover • Inform the service user's worker if required. • If omitted by staff error, complete an incident form and record in daily notes.			
PRN Medication: • record details on the PRN form and complete MSR2 form. Prior to administering PRN medication all alternative strategies must be discussed with the service user.			
Check medicine cupboard is locked, and the keys are returned to medication key safe.			
Check all medication recording sheets are correct.			

Discharge of a service user	Yes	No	Comments
If supervising medication count out the balance of medication and record on MSR1 form.			
Assess risk of returning medication on discharge and document in daily notes and on the discharge summary any risks or work required to be continued in the community.			

Questions: Medication

1 How should medicines be stored?
Key facts
- original container
- secure

2 What checks should be made before supervising medicines?
Key facts
- right person, medicine, time, dose

3 What actions would you take if the individual refused the prescribed medicine?
Key facts
- s/user has the right to refuse dose
- record on MSR
- inform worker
- document in service user notes

4 Why is it important not to touch medicines when supervising them?
Key facts
- prevention of cross infection

5 What are the key points to observe when supervising liquid preparations?
Key facts
- shake bottle, pour away from label
- wipe bottle after use.

6 What would you do where a variable dose is prescribed e.g., 'take one tablet per day
Key facts
- ask the service user when they usually take it
- record details on MSR
- document in daily notes

7 What do you understand by the term PRN medication and what information would you need before supervising this?
Key facts
- whenever required
- when and why, it may be given must be fully documented

8 How would you find out what a medicine is for and its side effects?

Key facts

- ask the service user

- BNF
- internet
- pharmacy
- information leaflet
- choice and medications website

Standard Operating Procedure – Controlled Drugs

9 If supervising medication what do you need to document?

- **risk assessment**
- record in the Control Drug Register

10 Why do we have a Controlled Drug Register?

- to record the balances of the specified medications as they are administered

11 Where is the Controlled Drug Register stored?

- stored in medication cabinet.

12 What would you check before and after the supervision of medication

- the stock balance must be checked as correct and after the stock balance must be recorded

13 What do you record in the Control Controlled Drug Register?

- record receipt, return, administration or disposal, of medication book along with signatures of 2 competent staff involved with each process involving CD's.

Action points/Additional comments

……..

……

……..

……..

Signed Assessor	**Signed member of Staff**

Assessment Tool – section 2

Name of Assessor	
Name of Staff	
Date of Assessment	

Questions **Has the staff member**	**Yes**	**No**	**Comments**
Completed all the practical sections of the competency tool.			
Sufficient knowledge to ensure safe management of medicines			
Used safe practices throughout the procedure			
Clear about the SOP for Controlled drugs			
Completed the assessment questions			
Understand PRN medication			

Signed Assessor	**Signed member of staff**

If you have answered YES to all the above questions, please complete section A below

If you have answered NO to any of the above questions, please complete section B below

SECTION A:

I have supervised: …… who has successfully worked within the Unit Policy and covered all of the criteria in the competency tool and competent to safe manage medication in the unit.

Signed assessor:
Designation:
Date:

Signed member of staff:
Designation
Date:

SECTION B:

I have supervised: …… who has not covered all of the criteria in the competency tool on this occasion.
Therefore, they are not competent to safe manage medication in the unit and action plan will be completed.

Signed assessor:
Designation
Date:

Signed member of staff:
Designation
Date:

ACTION PLAN

Areas of development/ observations/opportunities:	Actions:	Date:	Outcome:

Signed Assessor	**Signed member of staff**

Sheffield Health and Social Care NHS Foundation Trust

Supplementary Section A - Stage One Equality Impact Assessment Form

Please refer back to section 6.5 for additional information

1. Have you identified any areas where implementation of this policy would impact upon any of the categories below? If so, please give details of the evidence you have for this?

Grounds / Area of impact	People / Issues to consider	Type of impact		Description of impact and reason / evidence
		Negative (it could disadvantage)	Positive (it could advantage	
Race	People from various racial groups (e.g. contained within the census)	no		
Gender	Male, Female or transsexual/transgender. Also consider caring, parenting responsibilities, flexible working and equal pay concerns	no		
Disability	The Disability Discrimination Act 1995 defines disability as *'a physical or mental impairment which has a substantial and long-term effect on a persons ability to carry out normal day-to-day activities'.* This includes sensory impairment. Disabilities may be visible or non visible	no		
Sexual Orientation	Lesbians, gay men, people who are bisexual	no		
Age	Children, young , old and middle aged people	no		
Religion or belief	People who have religious belief, are atheist or agnostic or have a philosophical belief that affects their view of the world. Consider faith categories individually and collectively when considering possible positive and negative impacts.	no		

2. If you have identified that there may be a <u>negative impact</u> for any of the groups above please complete questions 2a-2e below.

2a. The negative impact identified is **intended** ☐ **OR** **2b**. The negative impact identified **not intended** ☐

2c. The negative impact identified is **legal** ☐ **OR** **2d**. The negative impact identified is **illegal** ☐ **OR (see 2e)**
(i.e. does it breach antidiscrimination legislation either directly or indirectly?)

2e. I **don't know** whether the negative impact identified is legal or not ☐
(If unsure you must take legal advice to ascertain the legality of the policy)

3. What is the level of impact?

☐ HIGH - Complete a **FULL** Impact Assessment (see end of this form for details of how to do this)

☐ MEDIUM - Complete a **FULL** Impact Assessment (see end of this form for details of how to do this)

☐ LOW - Consider questions 4-6 below

4. Can any low level negative impacts be removed (if so, give details of which ones and how)

5. If you have not identified any negative impacts, can any of the positive impacts be improved? (if so, give details of which ones and how)

6. If there is no evidence that the policy promotes equality and equal opportunity or improves relations with any of the above groups, could the policy be developed or changed so that it does?

7. Having considered the assessment, is any specific action required - Please outline this using the pro forma action plan below
(The lead for the policy is responsible for putting mechanisms in place to ensure that the proposed action is undertaken)

Issue	Action proposed	Lead	Deadline

8. Lead person Declaration:

8a. Stage One assessment completed by : ……..……(name) ……..……(signature) ……(date)

8b. Stage One assessment form received by Patient experience and Equality Team ……..(date)

8c. Stage One assessment outcome agreed ☐ ……*(sign here)*……..….. *(*Head of Patient Experience and Equality)

OR …… (date agreed)

8d. Stage One assessment outcome need review ☐ …….. ……*(sign here)*……..….. *(*Head of Patient Experience and Equality)

…….. (date returned to policy lead for amendment)

(if review required – please give details in text box below)

If a full EQIA is required the stage 1 assessment form should be retained and a completed EQIA report submitted to the relevant governance group for agreement by the chair. The chair will forward the completed reports to the Patient Experience and Equality team for publication.

Any questions relating to the completion of this form should be directed to the Head of Patient Experience and Equality.

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Supplementary Section B - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a persons Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.sct.nhs.uk/humanrights-273.asp (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including caselaw) or policy?

☑ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.

1.1 What is the policy/decision title? …Wainwright Crescent Medicines Management Local Policy. **1**

1.2 What is the objective of the policy/decision? Safe management of medicines at Wainwright Crescent. **1**

1.3 Who will be affected by the policy/decision? Service Users in Respite. **1**

Will the policy/decision engage anyone's Convention rights? **2.1**

NO → **Flowchart exit**

There is no need to continue with this checklist. However,

- Be alert to any possibility that your policy may discriminate against anyone in the exercise of a Convention right
- Legal advice may still be necessary – if in any doubt, contact your lawyer
- Things may change, and you may need to reassess the situation

YES

Will the policy/decision result in the restriction of a right? **2.2**

NO → Flowchart exit

YES

Is the right an absolute right? **3.1**

YES → Policy/decision ***is*** likely to be human rights compliant

NO

Is the right a limited right? **3.2**

NO → **4 The right is a qualified right**

1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

YES

Will the right be limited only to the extent set out in the relevant Article of the Convention? **3.3**

YES → Policy/decision ***is*** likely to be human rights compliant

NO → **Policy/decision is *not* likely to be human rights compliant please contact the Head of Patient Experience, Inclusion and Diversity.**

BUT

Get legal advice

Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.

Access to legal advice <u>MUST</u> be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.

Supplementary Section C - Development and consultation process

This section should include details of:

- *Who was involved in developing the policy and any guidance followed.*
- *Groups and individuals consulted (including staff side groups and service user / carer involvement).*
- *Any changes made as a result of the consultation process.*
- *Which governance group approved the document*
- *Dates for consultation and approval.*

Prescribing, administration of medications and essential monitoring of patients with a Learning Disability at SHSC

1. Introduction

This guidance has been produced to inform clinical staff at SHSC of the considerations needed when prescribing or administering medications to patients with a Learning Disability within the Trust. This guidance should be read in conjunction to relevant NICE guidelines such as NG11[1] and other resources including the British National Formulary (BNF).

People with a Learning Disability, autism or both are more likely to be prescribed psychotropic medications than people without a Learning Disability.[2] Appropriate usage and regular review of these medicines is essential to keep our patients safe and well. This is part of the STOMP (Stopping the over medication of people with learning disabilities) initiative nationwide.[3]

2. Aims and Objectives

To provide safe and effective advice on the prescribing and monitoring of psychotropic medication, including to manage behaviours that challenge in the absence of psychiatric disorder.

3. General Principles of prescribing and good practice

Psychotropic medications can sometimes be given in response to behaviour that challenges, this may include verbal aggression, physical aggression to self, others, or property. There can be various reasons for behavioural problems including physical or mental health problems, maladaptive coping strategies, environmental factors (over or under stimulation) which need to be explored before prescribing. For some, challenging behaviour may be a form of communication that they are in pain, distress or confused.

As per NICE guidance[1] (NG11): Consider antipsychotic medication to manage behaviour that challenges only if:

- Psychological or other interventions alone do not produce change within an agreed time or
- Treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour or
- The risk to the person or others is very severe (for example because of violence, aggression, or self-injury).

Psychotropic medications including antipsychotics, should be offered in combination with psychological or other interventions. The use of these medicines is considered off-label as it is outside of current product licence. Guidance on the use of off-label medication in the main SHSC medicines optimisation policy should be followed and considered.

The British Pharmacological Society[4] has described ten principles of good prescribing which prescribers should follow when prescribing:

1. **Be clear about the reasons for prescribing.**

a. Clear trial periods should be set, and target symptoms documented in patient notes. Rating scales such as the Aberrant Behaviour Checklist or the Adaptive Behaviour Scale may be appropriate as part of monitoring of efficacy.

2. **Take into account the patient's medication history before prescribing.**

a. Previous adequate trials of psychotropics may inform future prescribing.

b. Low starting doses are advised especially if a patient is antipsychotic-naïve and minimum effective doses should be used.

3. **Take into account other factors that might alter the benefits and risks of treatment.**

a. This may include long term metabolic side effects of second-generation antipsychotics, physiological changes with age and more.

4. **Take into account the patient's ideas, concerns and expectation.**

a. The patient and their carers should be involved in the prescribing decision and be informed of the possible risks and benefits of prescribing. Accessible information through Choice and Medication and support from other professionals such as pharmacists should be offered.

5. **Select effective, safe and cost-effective medicines individualised for the patient.**

a. Prescribing should be patient centred and meet the needs of the patient. Monotherapy should be tried where possible as combinations of medications have limited evidence of efficacy for management of behavioural problems in adults with learning disabilities and likely to contribute to side effects.

b. Reviewing the effectiveness and side effects after 3-4 weeks and stop the medication if no response at 6 weeks.

6. **Adhere to national guidelines and local formularies where appropriate.**

a. Prescribing should be within BNF recommended doses and follow relevant NICE guidelines.

7. **Write unambiguous legal prescriptions using the correct documentation.**

a. Use of FP10s, electronic prescribing and drug cards may be needed for different clinical areas.

8. **Monitor the beneficial and adverse effects of medicines.**

a. Accessible side effects monitoring using tools such as the SHSC LD GASS (appendix 1) with the patient and their carers is essential and should be part of medical reviews.

b. Medical reviews of medication should document any benefits from therapy, comparison to target symptoms identified at the start of prescribing and consider whether medication can be slowly discontinued if ineffective as per STOMP.

9. **Communicate and document prescribing decisions and the reasons for them**

a. Clear discharge and medication plans should be conveyed to GPs and other professionals involved in the patient's care at every care transition. Documentation should be accessible in medical notes and in care plans.

10. **Prescribe within the limitations of your knowledge, skills and experience.**

a. Specialist advice from the Learning Disabilities service is available for patients who may be under other mental health services but have a Learning Disability.

4. Special considerations

Patients with a Learning Disability may have other co-morbidities which need to be considered when prescribing or administering medication. This includes mental health problems, physical health problems such as epilepsy and sensory impairments.

Epilepsy is common in people with a Learning Disability and more prevalent as the severity of Learning Disability increases.[5] Medications can lower seizure threshold and be initiated and monitored carefully with an Epilepsy care plan. Prescribers should be alert for drug interactions and

potential contraindications in prescribing as detailed by the BNF/Summary of Product Characteristics.

Some anti-epileptics are brand-specific (see BNF treatment summary for epilepsy)[6] and potential harm can be caused if a stabilised treatment plan is changed in error. Nursing staff are advised to check antiepileptic medications carefully and seek pharmacy support if unsure.

Dysphagia can be a common issue for people with a Learning Disability and the clinical team should assess this with guidance from speech and language therapy (SALT). Oro-dispersible, liquid and buccal preparations may be options for prescribers to meet this need.

Any impairment in a patient's communication and subsequent ability to effectively report adverse effects of medication should also be considered when prescribing medication.

When prescribing medication to manage challenging behaviour the following must be clearly documented within the patient notes:

- identified target behaviour / symptomology.
- the plans to review and monitor the medication.
- the plan to discontinue if inadequate response is seen.

5. Consent and capacity

Good practice guidelines from NICE guidelines[7] and clinical knowledge summaries[8] (CKS) recommend a capacity assessment with the patient before any medication is prescribed. Any assessment of a person's capacity should be personalised and should take into account variables such as:

- Physical and mental health.
- Communication needs.
- Previous experience (or lack thereof) in making decisions.
- The involvement of others and the possibility of undue influence, duress, or coercion regarding the decision.
- Situational, social, and relational factors.
- Cultural, ethnic, and religious factors.
- Cognitive (including the person's awareness of their ability to make decisions), emotional, and behavioural factors, or those related to symptoms.
- The effects of prescribed drugs or other substances.

When giving information to the person to help them make a decision, it should be:

- Accessible, relevant and tailored to their specific needs.
- Sufficient to allow the person to make an informed choice about the specific decision in question.
- Supported by tools such as visual materials, visual aids, communication aids and hearing aids, as appropriate. Easy read patient information leaflets can be accessed via the Choice and Medication website.

When interacting with a person with a suspected/confirmed learning disability:

- Use clear, straightforward and unambiguous language.
- Use concrete examples, visual imagery and practical demonstrations to explain concepts.
- Communicate at a pace that is comfortable for the person.

- Use different methods and formats for communication (written, signing, visual, verbal, where possible), depending on the person's preferences.
- Regularly check the person's understanding.

Make a written record of the decision-making process, which is proportionate to the decision being made. Share the record with the person and, with their consent, other appropriate people (such as a carer or advocate). Include:

- What the person is being asked to decide.
- How the person wishes to be supported to make the decision.
- Steps taken to help the person make the decision.
- Other people involved in supporting the decision.
- Information given to the person.
- Whether on the balance of probabilities a person lacks capacity to make a decision.
- Key considerations for the person in making the decision.
- The person's expressed preference and the decision reached.
- Needs identified as a result of the decision.
- Any further actions arising from the decision.
- Any actions not applied and the reasons why not.

6. <u>Medications and relevant considerations:</u> (see BNF monographs and summary product characteristics for up-to-date drug information)

Antipsychotics

- Antipsychotics prescribed for behaviour that challenges should only be offered in combination with psychological or other interventions[1]
- Atypical (second generation antipsychotics) are associated with weight gain and other metabolic changes. These long-term risks should be considered carefully especially for patients with syndromes affecting weight and cardiac profiles such as Prader Willi.
- Hyperprolactinaemia is associated with the use of several antipsychotics including amisulpride and risperidone. The effects of hyperprolactinaemia may vary between individuals with long term effects linked to osteoporosis.
- Extrapyramidal side effects such as stiffness, tremor and gait/posture changes are commonly linked to the use of typical (first generation) antipsychotics but can also be observed with atypical antipsychotics. Patients with mobility or movement disorders should be carefully titrated to mitigate risks.
- Antipsychotics are known to decrease seizure threshold and caution is advised when prescribing in epilepsy.

Benzodiazepines (including diazepam, lorazepam, clonazepam *etc*.)

- Benzodiazepines may sometimes be prescribed for the short-term management of agitation and aggression. Long term usage may lead to dependence or tolerance. Ensure that its use is recorded and reviewed.
- Benzodiazepines should be used with caution for individuals with organic brain impairments as it can cause disinhibition and irritability.

- Durations of action vary between benzodiazepines and nurses should be aware of the differences when administering 'when required' medications.
- Benzodiazepines are also used in the emergency treatment of seizures and may be administered rectally (rectal diazepam) or buccal (buccal midazolam preparations). Support workers can access training to administer rescue medication through their line manager before escorting service users with a diagnosis of Epilepsy on short term leave.

Antidepressants

- Antidepressants may be used as first line alternative to antipsychotics for aggression and impulsivity. However, evidence base for its use in challenging behaviour alone has been very limited. [9]
- Antidepressants should be avoided in patients with known bipolar disorder due to risk of precipitating hypomania. [10]

When required 'PRN' medicines

- 'When required' medications may include psychotropic medications and should be regularly reviewed for effectiveness and continued need.
- Prescribers must ensure the indication for use clear and how the medication fits in with the patient's care plan. Other interventions to use before medications should be documented in care plans.
- Nurses should use their clinical judgement on whether the use of 'PRN' medication is indicated based on the indication from the prescription chart and how to monitor for efficacy or adverse effects. Excess 'PRN' usage will need to be escalated to the multidisciplinary team for review.

Mood stabilisers

- Mood stabilisers may rarely be used (unlicensed) for various indications, including aggression and self-injurious behaviour. Similar to other psychotropics, the evidence base use of these medications is limited and should be reviewed.
- Physical health monitoring for these medications is detailed in its summary product characteristics (SPC).

Promethazine

- Promethazine is a sedating antihistamine which can be used for short term sedation. Notable cautions for use are epilepsy, prostatic hypertrophy, pylorodurinary retention, severe coronary artery disease and susceptibility to angle-closure glaucoma.

Interventions for sleep

- Where possible, non-pharmacological strategies such as improving sleep hygiene, bedtime routines and environmental considerations should be considered first.
- Short term use of hypnotics may be indicated when these strategies have not helped. Hypnotics should not be continuously prescribed without review and planned withdrawal should be considered.

7. Administration of medicines

Nurses should follow ward standard operating procedures for administration of medicines and relevant administration parts of the Trust medicines optimisation policy.

Medicines should only be administered by qualified nurses trained through the annual medicines management training programme and the 3 yearly medicines optimisation training. Inpatient prescribing is done via the EPMA system. Interruptions to the administration round causes errors and must be avoided.

Nurses should follow the '5 Rs' check (right drug, right route, right time, right dose and right patient) to avoid administration errors and follow Trust procedures for reporting if incidents occur. Self-administration of medicines may sometimes be appropriate for service users, but each item should be risk-assessed for competency and ability by the nursing team in MDT before approving self-administration. Any self-administration of medicines should be clearly documented in the patient's notes, electronic prescribing chart and care plan.

The administration of when required 'PRN' medication is under the clinical judgement of the nurse and should follow the indication, frequency for use and dose decided by the prescriber on the prescription chart and care plan. These medications may also be subject to legal framework such as Mental Health Act related forms T2/T3 or section 62. If a prescription is unclear or incorrect, they should seek clarification with a prescriber or pharmacist.

Administration of Midazolam as an emergency treatment of seizures in epilepsy can be given by trained non-registered staff whilst a service user is on section 17 leave. Training information and full guide can be found in the guideline: "Administration of buccal midazolam for epilepsy to named patients by non-registered staff". The ward manager should contact nursing leads and SHSC pharmacy if they require support with nurse or support worker medicines administration training.

8. Monitoring adverse effects-

Every professional involved in the care of the patient may identify possible side effects from medications and promote reporting of adverse effects to the prescriber. It is important to monitor and review the benefits and potential harms or side effects, using agreed outcome measures considering the patients communication needs. These concerns should be explored with the patient and their carer, recorded onto their clinical notes, and escalated to nursing and medical staff. Resources such as LD GASS can be used with the patient and their carers by a staff member. This is accessible at the end of this guidance in appendix 1.

Frequency of monitoring should be agreed and documented when the medication is prescribed. The efficacy and adverse effects of antipsychotics should initially be monitored after 3-4 weeks. Appendix 2a summarises the physical health monitoring required when starting antipsychotics

Clozapine may be used to provide treatment in a person with a Learning Disability who has a diagnosis of Treatment Resistant Schizophrenia. A Clozapine GASS would be more suitable for monitoring adverse effects associated with Clozapine. Please refer to the SHSC Clozapine Guidelines for more information on prescribing and monitoring and appendix 2b for Clozapine monitoring.

9. Monitoring treatment

To monitor the efficacy of a treatment plan, clear target behaviours, frequency and severity of symptoms should be established and documented beforehand. The use of appropriate checklists, rating scales and observations from staff and family during treatment will inform future prescribing and reviews. Healthcare professionals should involve the patient in decisions about their prescribed medication and discuss any perceived benefits or side effects from treatment with their team.[11]

In an inpatient setting, this may take place in multidisciplinary team meetings and through outpatient clinics in the community.

Clinicians should aim to prescribe the minimum effective dose whilst considering the potential for adverse effects and the difficulties the patient may have in reporting them. This should also be balanced against sub-therapeutic doses which may not treat the problem effectively. At each follow-up, reduction or withdrawal of medication should be considered.

Side effects of antipsychotic medications should be reviewed with the patient and their carers at least annually when treatment is stable. This should include checks on extrapyramidal side effects, metabolic syndrome and any other monitoring specified by the drug manufacturer. The Trust LD GASS is an example suitable for use with some patients. Others may prefer a verbal discussion or interview setting with a nurse, pharmacist or prescriber instead.

The patient should be encouraged by staff to attend annual physical health checks through their local GPs and work collaboratively to meet monitoring needs if they struggle to attend their GP surgery. Advice and support can be sought from the community LD team.

10. Monitoring Medication Adherence

According to NICE: "Non-adherence should not be seen as the patient's problem."[11] It represents a fundamental limitation in the delivery of healthcare, often because of a failure to fully agree the prescription in the first place or to identify and provide the support that patients need later on."

All professionals involved in patient care can support medication adherence by asking about adherence and any perceived barriers. Some patients may benefit from more information given about their medication available in more accessible ways or practical support such as alarms or reminders. These can be discussed with a local pharmacist or specialist pharmacy services at SHSC.

The Choice and Medication website provides information sources such as easy read leaflets for service users, handy guides to medication and other information sheets suitable for carers and healthcare professionals to use. It can be accessed here:
https://www.choiceandmedication.org/sheffieldhsc/

11. Switching Medications (Cross-titrating)

Occasionally, medications are switched during treatment due to inefficacy or side effects. The speed of cross titrations will vary between medicines and advice can be sought from specialist pharmacists in the Trust. Clinicians should be alert for possible discontinuation effects, additive side effects from cross titration and possible deterioration in mental state.

Current NICE guidelines advise that only one medication is switched at a time to identify any beneficial effects from treatment.

12. Discontinuation

When reviewing patients' medication, active consideration must be sought to reduce or discontinue treatment if it is no longer showing therapeutic benefit. A clear summary of the trial and any beneficial or adverse effects should be documented in the medical notes. The decision must be made with the patient and their carers on how to discontinue medication safely. Carers may have concerns which should be discussed, and care planned for during down titration.

Clinicians can consider the use of short term when required 'prn' medication for use during discontinuation of other psychotropics. Increased use of 'prns' may indicate a slower withdrawal is needed. Clear indications of prn medication use from prescribers and accessible referral pathway for support must be present before discontinuing medicines in the community. GPs should be

informed of any changes to their prescribing and any associated changes to physical health monitoring from psychotropics.

13. Discharge planning and handover

Discharge planning should be a part of every MDT meeting and consider factors including medication administration and support in the community. Some service users may self-administer medications in the community when well whilst some may need support of care staff to take medicines. Nursing staff should consider this with the ward team and engage the patient in future planning and build skills where appropriate.

Residential care homes and nursing homes may require medicines administration record sheets (MARs) which can be requested from their local pharmacy. MAR sheets can be requested on discharge from inpatient settings on the discharge prescription and produced by SHSC pharmacy.

14. References

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11. National Institute for Health and Care Excellence. Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [Internet]. [London]: NICE; 2009 [cited 2021 Jul 15]. (Clinical guideline [CG76]). Available from: https://www.nice.org.uk/guidance/cg76

Name: Age: Sex: Date:

Current medications:

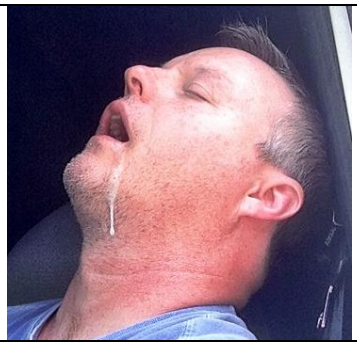
These questions will ask you about how you have been feeling and will help us to know if you are getting side effects from your medication.

If you are not sure about a question, you should discuss it with a carer or at your medication review.

Please put a tick in the box which describes how often you have the side effect and put a tick at the box on the end if the side effect upsets you.

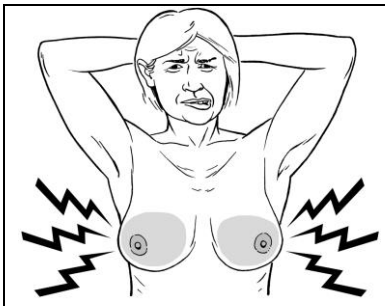
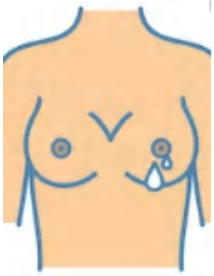
	In the last week….	Never	Once	A few times	Every day	This side effect upsets me 
	I felt sleepy in the day					
	I felt drugged up or ‘like a zombie’					

	In the last week….	Never	Once	A few times	Every day	
	I felt dizzy when I stood up or fainted					
	I felt my heart beating faster					
	My muscles felt tight/tense or jerky					

	My arms/hands have been shaky					
	In the last week….	Never	Once	A few times	Every day	
	I felt restless/ can't sit still					
	I have been drooling					

	I have been moving/walking slower					
	I have or other people have noticed my face or body move differently					
	In the last week….	Never	Once	A few times	Every day	
	My vision has been blurry					
	I have a dry mouth					

	I have had difficulty having a wee					
	I have felt sick or vomited					
	I have wet the bed					
	In the last week….	Never	Once	A few times	Every day	
	I have been very thirsty and weeing more					

	My nipples have felt sore and swollen					
	I have noticed fluid coming out from my nipples					
	I have had problems having sex					
	Men only: I have had problems getting an erection					

Tick Yes or No for the next questions

In the last 3 months	Yes	No	This has upset me 
(Women only): My period has changed 			
(Men and Women) I have been gaining weight 			

Appendix 2a: Antipsychotic Monitoring (Excluding Clozapine)

Parameter	At Baseline	At 1 Month	At 3 Months	At 6 Months	At 12 Months	Then Annually	Last Reviewed	Clinician
Response to Drug	X	YES	YES	YES	YES	YES		
Adherence	X	YES	YES	YES	YES	YES		
Side Effects (GASS / SESCAM)	X	YES	YES	X	YES	YES		
Blood Glucose	YES	X	X	YES	YES	YES		
Lipid Profile	YES	X	YES	X	YES	YES		
HbA1c	YES		YES	X	YES	YES		
Prolactin	YES	X	X	YES	X	YES		
Smoking Status	YES	X	X	X	YES	YES		
ECG	YES	X	X	X	YES	YES		
Blood Pressure + Pulse	YES	X	YES	X	YES	YES		
Weight	YES	X	YES (Olanzapine 3 Monthly for first year)	X	YES	YES		
Waist Circumference	YES	X	X	X	X	YES		
Overall Physical Health	YES	YES	YES	X	YES	YES		

Increase frequency of monitoring dependent upon clinical judgement – e.g. repeat prolactin sooner if raised or symptomatic

Side Effects

- **Metabolic** (including weight gain and diabetes)
- **Extrapyramidal** (including akathisia, dyskinesia and dystonia)
- **Cardiovascular** (including prolonging the QT interval)
- **Hormonal** (including increasing plasma prolactin)

- **Other** (including unpleasant subjective experiences)

Appendix 2b

Clozapine Monitoring

Parameter	At Baseline	At 1 Month	At 3 Months	At 6 Months	At 12 Months	Then Annually	Last Reviewed	Clinician
Response to Drug	X	YES	YES	YES	YES	YES		
Adherence	X	YES	YES	YES	YES	YES		
Side Effects (C-GASS)	X	YES	YES	YES	YES	YES		
Clozapine Level	Stops smoking or switches to E-Cig Other medications may increase blood levels Current infection Reduced Metabolism or Toxicity Suspected							
FBC (Differential WCC)	Baseline Weekly for 18 Weeks Then Every 2 Weeks for 1 Year Then Monthly							
Blood Glucose	Baseline At 1 Month Then Every 6 Months							
Lipid Profile	Every 3 Months for 1 Year Then Yearly							
HbA1c	YES		YES	X	YES	YES		
Prolactin	YES	X	X	YES	X	YES		
Smoking Status	YES	YES	YES	YES	YES	YES		

ECG	YES	X	X	X	YES	YES		
Blood Pressure + Pulse	YES	X	YES	X	YES	YES		
Weight	Every 3 Months for 1 Year Then Annually							
Waist Circumference	YES	X	X	YES	X	YES		
Overall Physical Health	YES	YES	YES	YES	YES	YES		

Increase frequency of monitoring dependent upon clinical judgement – e.g. repeat prolactin sooner if raised or symptomatic

Side Effects

Agranulocytosis:

Neutropenia and potentially fatal agranulocytosis reported. Leucocyte and differential blood counts must be normal before starting; monitor counts every week for 18 weeks then at least every 2 weeks and if clozapine continued and blood count stable after 1 year at least every 4 weeks (and 4 weeks after discontinuation); if leucocyte count below 3000 /mm3 or if absolute neutrophil count below 1500 /mm3 discontinue permanently and refer to haematologist. Patients who have a low white blood cell count because of benign ethnic neutropenia may be started on clozapine with the agreement of a haematologist. Avoid drugs which depress leucopoiesis; patients should report immediately symptoms of infection, especially influenza-like illness.

Myocarditis and cardiomyopathy:

Fatal myocarditis (most commonly in first 2 months) and cardiomyopathy reported.

- Perform physical examination and take full medical history before starting
- Specialist examination required if cardiac abnormalities or history of heart disease found clozapine initiated only in absence of severe heart disease and if benefit outweighs risk
- Persistent tachycardia especially in first 2 months should prompt observation for other indicators for myocarditis or cardiomyopathy
- If myocarditis or cardiomyopathy suspected clozapine should be stopped and patient evaluated urgently by cardiologist
- Discontinue permanently in clozapine-induced myocarditis or cardiomyopathy

Intestinal obstruction:
Impairment of intestinal peristalsis, including constipation, intestinal obstruction, faecal impaction, and paralytic ileus, (including fatal cases) reported. Clozapine should be used with caution in patients receiving drugs that may cause constipation (e.g. antimuscarinic drugs) or in those with a history of colonic disease or lower abdominal surgery. It is essential that constipation is recognised and actively treated.

SHSC NON-MEDICAL PRESCRIBING Protocol

Executive Director Lead	Executive Medical Director
Policy Owner	Chief Pharmacist
Policy Author	Chief Pharmacist

Document Type	Protocol
Document Version Number	V2
Date of Ratification	November 2022
Ratified By	Medicines Optimisation Committee
Date of Issue	January 2023
Date for Review	09/2025

Summary of policy

There are different types of Non-Medical Prescriber qualification. The type of qualification awarded depends on an individual's professional qualification and the subsequent Non-Medical Prescribing training course undertaken.

The Department of Health's definition of Independent Prescribing is prescribing by a practitioner (e.g. Doctor, Dentist, Nurse, Pharmacist, Podiatrist, Physiotherapist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. This protocol covers the process of requesting to undertake the course, prescribing scopes of practice and expectations etc

Target audience	NMP's, Nurses, Pharmacists, doctors, managers

Keywords	Non-medical prescribing

Storage & Version Control

Version 2 of this protocol is stored and available through the SHSC intranet/internet. This version of the protocol supersedes the previous version (V1). Any copies of the previous protocol held separately should be destroyed and replaced with this version.

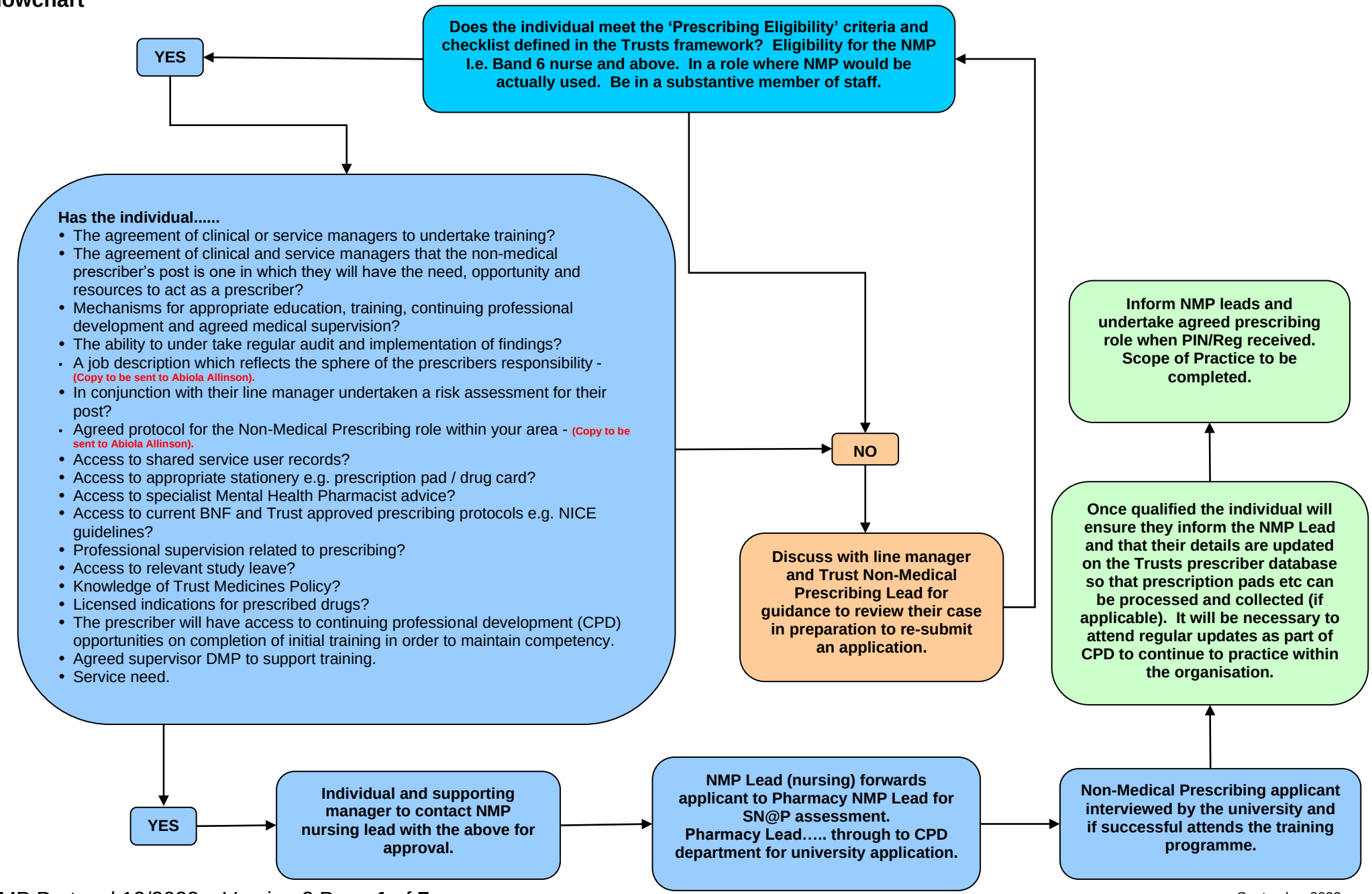
Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
1.0	Approval and issue	2016	Amendments made during consultation, prior to ratification.
2.0	Review and approve	12/2022	Review undertaken to update the protocol in order to comply with new requirements.

Contents

Applying to become a Non-Medical Prescriber (NMP) / Pharmacist Independent Prescriber (PIP)

Flowchart



Sheffield Health and Social Care NHS Foundation Trust (SHSC)

SCOPE OF PRACTICE FOR NON-MEDICAL / INDEPENDENT / SUPPLEMENTARY PRESCRIBING

Service Name: .....

Location: ……

HEALTH CARE PROFESSIONAL NAME:

NMC PIN / GPhC No:

LINE MANAGER:

PROTOCOL SUPERVISOR:

AREA OF PRESCRIBING:

CLIENT GROUP:

RANGE OF TREATMENTS ANTICIPATED / SCOPE OF PRACTICE:

SUPERVISION AND CONTINUING PROFESSIONAL DEVELOPMENT:

Please sign below:

Name: ..... Signed: ..... Date: .....

Clinical Supervisor

Name: ..... Signed: ..... Date: .....

1 Introduction

This protocol will provide an overarching governance framework to support non-medical prescribing across the Trust that where appropriate will enable wider and faster access to medicines and more flexible use of the workforce. Non-medical prescribing relates to prescribing by professional groups other than doctors or dentists, as defined by the legislation, who have undertaken and successfully completed an accredited non-medical prescribing training programme and who are registered with their professional body. This protocol applies to those healthcare professionals who, in accordance with their registration, with their professional bodies, have gained the necessary independent or supplementary prescriber qualification in order to undertake prescribing as part of their role. For nurses: this is the V300 qualification; for other professions as named within the legislation.

The Key principles of non-medical prescribing are:

• That patient safety is paramount

• To make better use of the skills of health professionals and contribute to more flexible team working across the NHS

• To benefit patients by enabling faster access to medicines and to benefit the service by optimising professionals' time.

There are different types of Non-Medical Prescriber qualification. The type of qualification awarded depends on an individual's professional qualification and the subsequent Non-Medical Prescribing training course undertaken.

The Department of Health's definition of Independent Prescribing is prescribing by a practitioner (e.g. Doctor, Dentist, Nurse, Pharmacist, Podiatrist, Physiotherapist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

The types of prescriber covered by this protocol are:-

- **Supplementary prescribers (Nurse, Pharmacist)** – can prescribe medication (includes controlled and unlicensed drugs) in accordance with a Clinical Management Plan as part of a voluntary prescribing partnership with an Independent Medical Prescriber (Doctor or Dentist)
- **Independent Nurse Prescribers (NI&SP V300)** – can prescribe any licensed or unlicensed medication, including controlled Drugs (CDs), within the practitioner's professional scope of practice, except diamorphine, dipipanone or cocaine for addiction. Can also act as supplementary prescribers where necessary.
- **Independent Pharmacist Prescribers** – can prescribe any licensed medicine for any medical condition, within the practitioner's professional scope of practice, including Controlled Drugs, except diamorphine, dipipanone or cocaine for addiction.

2 Scope

This protocol applies to all areas of the Trust which employ non-medical prescribers and for all prescribing activity carried out by a non-medical prescribers.

This includes:

- Independent prescribers
- Supplementary prescribers
- Members of staff considering application to a non-medical prescribing training programme (refer also to section 6)
- Members of staff approved to go on a non-medical prescribing training programme
- Members of staff in the process of registering with professional bodies and the organisation as non-medical prescribers
- Line managers who manage non-medical prescribers
- Non-medical prescribing leads

All NMPs within SHSC must prescribe within the context of:
NMC requirements (applicable to those on NMC register):

The NMC Code:
Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015 as updated 2018. The NMC published an updated version of the Code on 10 October 2018. The updated version is substantially similar to the 2015 version, but now reflects the NMC' new responsibilities for the regulation of nursing associates.

All pharmacy prescribers within SHSC must prescribe within the context of RPS (Royal Pharmaceutical Society) requirements and guidelines and their competency

The NMC Standards for medicines management standards were withdrawn on 28 January 2019 with NMC registrants now referred to RPS guidance which also applies to Pharmacy professionals:

- Professional guidance on the safe and secure handling of medicines 2018
- Professional Guidance on the Administration of Medicines in Healthcare Settings 2019

Further guidance:

- Improving Patients Access to Medicines (DH, 2006)
- General Pharmaceutical Council- Standards for Pharmacy Professionals (GPhC May 2017)
- The Royal Pharmaceutical Society Medicines- Code of Ethics and Standards (RPS, 2022)
- Standards of Conduct, Performance and Ethics (Health Professionals Council, 2016
- Royal Pharmaceutical Society's A Competency Framework for all Prescribers 2021.
- All SHSC policies and processes

3 Purpose

The aim of this protocol is to outline Sheffield Health and Social Care NHS Foundation Trust (SHSC) processes and quality assurance for Non-medical Prescribing.
This Protocol also applies to bank staff, with Non-medical Prescribing qualifications, where prescribing is seen as integral to their role and prescribing has been sanctioned by their line manager.

4 Definitions

SHSC- Sheffield Health and Social Care NHS Foundation Trust
NMP- Non-medical Prescriber
CMP- Clinical management Plan
IP- Independent Prescriber
SP- Supplementary Prescriber
NMC-Nursing and Midwifery Council
RPS- Royal Pharmaceutical Society
DMP – Designated Medical Practitioner
DPP – Designated Prescribing Practitioner

5 Detail of the protocol

This document sets out the SHSC protocol for non-medical prescribing and provides a framework for the prescribing of medicines by appropriately qualified and registered non-medical prescribers employed by the Trust. This policy applies to all activity by qualified non-medical prescribers employed by SHSC, who carry out the duties of prescribing in their clinical role. The protocol describes the processes which are required to ensure safe and legal prescribing. Prescribing rights have been extended to nurses, pharmacists, physiotherapists, chiropodists/podiatrists, dietitians, paramedics, optometrists and radiographers. In order to prescribe, individuals must have undertaken the appropriate training and have their qualification annotated against their registration with the relevant professional body. Prescribing should be reflected in the main duties and responsibilities in an individual's job description, which may be through the addition of an "addendum

6 Duties

Chief Pharmacist

Designated Non-medical Prescribing Lead and Pharmacy Lead at SHSC

Has overall responsibility for ensuring that the appropriate processes are in place for:

- A current register of prescribers and line managers
- Monitoring prescribing by Non-medical Prescribers
- Reporting to Trust Board as required
- Ensuring investigations into concerns identified are undertaken including personal involvement if necessary

The Pharmacy Lead

Is responsible for:

- Ensuring legislation is disseminated appropriately and that the non-medical prescribers are working within the parameters of their competence and the legislative frameworks.
- Developing new practice in line with new legislation/national guidance.
- Being the lead for product knowledge and prescribing advice.
- Developing, maintaining, and monitoring clinical practices (via audit and spot-checks) to ensure adherence to Trust protocol
- Dissemination of prescribing reports, highlighting areas of best or poor practice
- Joint responsibility for undertaking investigations into prescribing practice.
- Ensuring all staff applying for the non-medical prescribing course are suitable/appropriate in conjunction with the Nurse professional lead
- Joint responsibility to provide an annual report of prescribing practice to Medicines Optimisation Committee
- Joint responsibility for production and review of non-medical Prescribing Protocol
- Ordering and distribution of prescription pads
- Security of prescription pads prior to dissemination
- Maintaining the non-medical prescribing register – ensuring pharmacy has an up-to-date list of signatures where appropriate.

The Nursing Professional Lead

Is responsible for:

- Ensuring any professional changes (related to non-medical prescribing) are disseminated (and acted upon).
- Developing new practices in line with new professional guidance/service changes/re-provisions.

- Championing practitioner led services – ensuring high level support for new and innovative ways or working.
- Ensuring client satisfaction with non-medical prescribing activity
- Providing professional advice and support
- Ensuring all non-medical prescribers are made aware of relevant CPD events provided by SHSC
- Ensuring all staff applying for the non-medical prescribing course are suitable/appropriate in conjunction with the Pharmacy Lead.
- To put processes in place to track non-medical prescribers around the organisation (if moved from area to area) ensuring individuals are still prescribing within their sphere of competence.
- Joint responsibility for undertaking investigations into prescribing practice.
- Joint responsibility for the production and review of non-medical Prescribing protocol
- Providing assurances to the Trust that all non-medical prescribers are undertaking appropriate CPD and having regular supervision relating to prescribing.

Non-Medical Prescribers

Must:

- Ensure they have read SHSC's "Non-Medical Prescribing Protocol" and that they act in accordance with this document and their professional scope of practice
- Ensure they are aware of all source documents as listed in Reference Section.
- Ensure they provide appropriate, safe and cost effective and where possible evidence-based prescribing
- Ensure an appropriate holistic assessment of the patient is made, a diagnosis made and documented as per Trust Policy
- Contact the NMP lead if leaving the organisation, moving clinical areas or if stopping/restarting prescribing
- Seek regular prescribing related supervision
- To ensure attendance at all mandatory training as required by SHSC.
- To identify knowledge and skills gaps and discuss with line manager.
- Take responsibility for their own CPD and maintaining their competency.
- Take responsibility to keep themselves up to date with clinical and professional developments, the management of conditions for which they may prescribe and the use of medicines to ensure that prescribing is undertaken competently and safely.
- Be responsible for their own CPD requirements and should make full use of the support processes that are already in place such as those listed below.
    - E-learning
    - Appraisal
    - Prescribing forums
    - Mentorship
    - Shadowing
    - Attendance at training events

- All non-medical prescribers should reflect on their prescribing practice and maintain a portfolio that demonstrates CPD and ongoing needs through reflection. All prescribers must receive clinical supervision related to their prescribing role.

- Provision of evidence of CPD and clinical supervision to the NMP Professional lead, for inclusion on the NMP register. **If this is not submitted annually the NMP could be removed from the SHSC NMP register and would not be able to prescribe until this information is received.**

- Ensure prescription pads which are no longer required are securely returned to the NMP Lead

- Where a non-medical prescriber has not practiced for two years or more (prescribing and/or involvement in prescribing decisions) or has not prescribed within 1 year of first qualifying as a non-medical prescriber, the prescriber should notify their manager and NMP Lead. They should not prescribe independently until any support and/or training needs have been identified and actioned. This will normally require them to attend an interview with the Non-Medical Prescribing Lead and their manager to assess competency to resume prescribing. The non-medical prescriber will be required to provide evidence that the criteria for maintaining prescribing competency in the intervening period have been met (through completion of training/CPD/supervised practice etc) and/or any additional training and development they intend to undertake to ensure that the level of competency criteria are met to resume prescribing. Authorisation to prescribe can be withdrawn by the Trust in response to any unresolved issues regarding gaps in prescribing, competency to prescribe or concerns about fitness to practice.
- For nurses with V300 qualification and all other Independent Non-Medical Prescribers, areas of agreed competence must be reviewed every two years using the Scope of Practice document to record any changes. Confirmation that this has been completed will be required at the time of completion). Specific training/development requirements should be discussed at the annual appraisal and included in the individual's Personal Development Plan. A Competency Framework for all Prescribers (2021) is available to support this process
- If NMPs are absent from work for a prolonged period (6 months) ensure prescription pads are returned to the NMP Lead.

Line-Managers

- Ensure they have read SHSC's "Non-Medical Prescribing Protocol".
- Provide a locked facility, to which only the NMP has access, for storage of prescription pads
- Ensure access to a prescribing budget is available, where required
- Ensure prescribers are assessed against Prescribing Competencies (Appendix 10)
- Ensure each NMP has a Personal Development Plan in relation to prescribing
- Ensure that any Non-Medical Prescribers they line manage receive regular recorded clinical supervision in relation to their prescribing, as a minimum this should occur quarterly, and PDR at least once a year.
- Support NMPs with identifying training needs and relevant development opportunities
- Report any prescribing concerns or issues to the NMP leads and work with them to develop an action plan and outcome measures to provide assurance to the organisation
- Must ensure the clinical need for the NMP role and support NMP in challenging poor practice
- Ensure prescription pads which are no longer required are securely returned to the NMP lead
- Allow newly qualified NMPs to access support both before and initially after receiving their prescription pad.
- Amend job description as detailed below.
- If NMPs are absent from work for a prolonged period (6 months) ensure prescription pads are returned to SHSC Pharmacy.

Named service leads (if appropriate)

Are responsible for:-

- Receiving and disseminating quarterly prescribing analysis.

- Supporting the NMP Leads with data collection and updating.
- Notifying the NMP Leads of new starters and leavers.
- Ensuring NMP is included in the annual appraisal process.

SHSC
The trust will hold vicarious liability for all NMPs where the following criteria are met:
• All NMPs are registered with their professional bodies with an annotation signifying the individual as a prescriber.
• The role of all NMPs is approved by the line manager and included within the individual's job description.
• The NMPs are included in the NMP register held by the Trust NMP Lead.
• The NMPs work within the legal framework of the role.
• The individual must also ensure they have adequate professional indemnity insurance in accordance with advice from their professional registration body and staff side representatives; most healthcare union subscriptions include access to indemnity insurance.
• All NMPs must be aware of their professional accountability and responsibility when dealing/negotiating with companies and their representatives. Please refer to the Trust Medicines Optimisation Policy and Code of Practice for the Trust and the Pharmaceutical Industry document.

7 Procedure

PRESCRIBING LEGISLATION

Off Licence medication
Nurse and Pharmacist Independent Prescribers can prescribe medicines outside their licensed indications where this is accepted clinical practice in the area in which they work. The Independent Prescriber accepts professional, clinical and legal responsibility for that prescribing. The Independent Prescriber must then monitor and review the patient in line with local policy and best practice guidelines.
The prescriber must explain the rationale for prescribing off label to the patient/carer and must gain consent (this process should be recorded in the clinical records). In the instance where consent cannot be sought from the client or carer, the prescriber should consider acting in accordance with best practice and the local policy/guidelines.
NB: Supplementary Prescribers can prescribe any medicine, including an unlicensed and off licence medication, which has been instigated by a Medical Prescriber and agreed as part of the Clinical Management Plan (CMP).

Unlicensed medication
Nurse and Pharmacist Independent Prescribers are able to prescribe and authorise others to administer unlicensed medicines for those in their care.

An Independent Prescriber can prescribe an unlicensed medication providing:
- They are satisfied an alternative, licensed medication would not meet the patient's needs
- They are satisfied that there is enough evidence base and/or experience to demonstrate the medication's safety and efficacy for that particular patient
- They are prepared to take full professional, clinical and legal responsibility for prescribing an unlicensed medication
- The patient agrees to the prescription in the knowledge that the medicine is unlicensed and understands the implication of this (if appropriate)
- The medication, rationale and patient consent are clearly documented
- The IP should consult with the patient's medical practitioner/consultant prior to initiating an unlicensed medication.

Mixing medication

The mixing of medicine is the combining of two or more medicinal products for the purposes of administering them to meet the specific (care planned) needs of a particular patient. The act of mixing results in an unlicensed medication. An example of this is the mixing of medicines in a syringe for administration via a syringe driver.
Only medication recognised as compatible should be prescribed to be mixed prior to administration. Contact pharmacy for more information before prescribing or mixing.
Following the Misuse of Drugs (Amendment No2) (England, Wales and Scotland) Regulations 2012

Independent Prescribers can prescribe Controlled Drugs to be mixed with other medication prior to administration.
The mixing of medicinal products to produce an unlicensed product can also be undertaken by another qualified nurse on the written instructions of an

- Independent Prescriber
- Medical Prescriber
- Supplementary Prescriber (where medicine mixing forms part of the CMP).

Those undertaking the prescribing and/or mixing of medicine must be competent to do so and must take full professional, clinical and legal responsibility for their actions.

Controlled Drug Prescribing

Independent pharmacist prescribers and independent nurse prescribers are able to prescribe, administer and give directions for the administration of schedule 2, 3, 4 and 5 controlled drugs. Neither independent pharmacist nor nurse prescribers are able to prescribe diamorphine, dipipanone or cocaine for treating addiction.

Within SHSC only nurses who have been assessed by the substance misuse Consultants as competent and are identified on the non-medical prescribing database are able to prescribe methadone and/or buprenorphine for addiction.

Operational procedure for Training Applications
Applications for V300 NMP training will be assessed by the NMP Professional Lead in terms of their appropriateness, and the benefits (patient related and cost) to the particular service area. Particular attention will be paid to how the individual (once qualified) will contribute to improved clinical outcomes for the patient group

All applications must be supported by the individual's Manager and Service Manager – applicants must be afforded the time off to study and to receive appropriate university and service based training and supervision from their designated medical supervisor. The Manager and Service Manager must ensure that the individual will have appropriate prescribing opportunities during and post qualification, and that the correct support processes have been adopted by the clinical area in order to ensure safe and effective prescribing practices. The relevant Manager will be contacted by the NMP Professional Lead to discuss any NMP Implications for the service.

SHSC staff who fail or withdraw from the Non-Medical Prescribing Course may re-sit the course ONCE more at the discretion of their manager. A discussion with the NMP lead must take place at this point and an action plan produced to support the member of staff in this second attempt. Any staff failing the course after a second attempt will not be supported by the organisation to undertake the module again.

Eligibility to Prescribe
On successful completion of the prescribing module, the NMP will inform the NMP Leads and the higher education institute will notify the relevant professional body.
On completion of the relevant documentation the individual's entry on the professional register will be annotated to indicate the level of prescribing which the individual is qualified to undertake.
A professional registration fee is required and payment is the responsibility of the NMP.

An application to prescribe- ("scope of practice"((see appendix X) must be completed by the NMP and submitted to the NMP lead. The line manager should also then:

- Amend the individual's job description to reflect the NMP role and responsibilities.
- Amend the NMP's personal file/training records.

The NMP is not authorised to prescribe until the annotation on their professional register has been made and scope of practice approved. *(NB: The NMC 24 hour telephone line, or online at http://www.nmc-uk.org, www.pharmacyregulation.org will confirm to any enquirer whether or not a Nurse, Pharmacist is eligible to prescribe)*

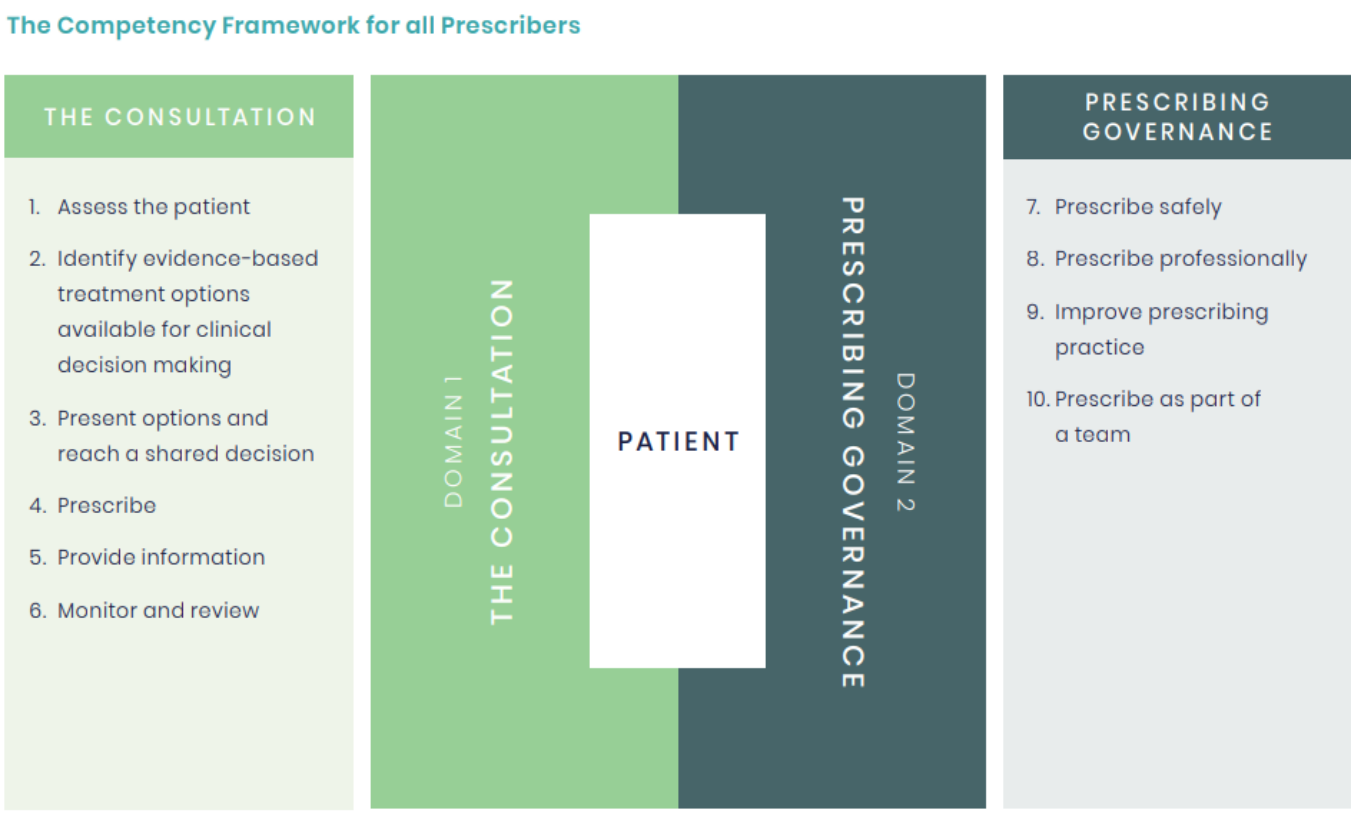
Individual practitioners must ensure their prescribing registration remains current and up to date.
Any issues pertaining to the NMP i.e. drug errors/prescribing after not following process/ or unsafe prescribing (list not exhaustive) will need to be reported by the NMP or the line manager using the appropriate Trust processes. The NMP Lead must also be informed. Initial/further investigations into the reported 'incident' may lead to the 'local' suspension of the individual from prescribing. The NMP will be suspended from the local NMP register, pharmacy department will be informed, where necessary, and the prescription pad removed and stored safely in pharmacy. If the incident warrants further investigation, then Trust policy will be followed. A number of possible outcomes from any 'investigatory processes' maybe considered inclusive of work performance or capability monitoring.

Please note that the Trust can suspend an NMP for an indefinite period or remove them completely from the local register based on investigatory evidence. If deemed appropriate the individuals regulatory body may also be informed of the incident.

For prescribers who wish to re-commence prescribing after a period of absence of six months or more from the role, an action plan will be instigated, to include a pre-determined number of prescribing observations by their medical/peer supervisor to assess competence
When assessed as competent the prescriber will be required to fill out Appendix X (Scope of Practice) and will be added to the local register. If deemed not to be competent the prescriber will need to consider the following options, in conjunction with their line manager/medical supervisor:

- A further action plan to develop/improve competence
- Attendance at relevant training/development
- Continued prescribing supervision by the medical prescriber
- Whether they are fit to practice

Competency Framework
The competency framework below for all prescribers sets out what good prescribing looks like. Its implementation and maintenance are important in informing and improving practice, development, standard of care and safety (for both the prescriber and patient). Prescribers should use their professional codes of conduct, standards and guidance alongside this framework. Prescribers are also responsible for practising within their own scope of practice and competence, including delegating where appropriate, seeking support when required and using their acquired knowledge, skills and professional judgement (RPS Competency Framework, 2021)



DOMAINS
The competencies within the framework are presented as two domains and describe the knowledge, skill, behaviour, activity, or outcome that prescribers should demonstrate:

- **Domain one** - The consultation
  This domain looks at the competencies that the prescriber should demonstrate during the consultation.

- **Domain two** - Prescribing governance

  This domain focuses on the competencies that the prescriber should demonstrate with respect to prescribing governance.

Competency and Supporting Statements

Within the two domains there are ten competencies. Each of these competencies contains several supporting statements related to the prescriber role which describe the activity or outcome that the prescriber should actively and routinely demonstrate in their practice
Due to the generic nature of the framework, it may be that not every competency or supporting statement is relevant to your practice or setting. As an NMP, you should still be able to consider how you could demonstrate the supporting statement.

Prescribing in Mental Health Supporting guidance

https://www.e-lfh.org.uk/wp-content/uploads/2020/05/Prescribing-Competency-Implementation-Guidance-for-MentalHealthV1.0.pdf

NMPs transferring from their area of clinical competence to a new area of practice, e.g. from drug and alcohol team to Community mental health teams or Inpatient services, **must** inform the NMP Leads. They should not prescribe until an action plan has been put in place to develop their competence within the new field of practice. It should be noted that this should be a carefully managed process – which should be guided by the NMP, their supervisor and on-going assessment of competence.
NMP transferring from other organisations, into a role requiring prescribing must inform the NMP Lead. All NMPs new to SHSC, or newly qualified, will be appraised by the NMP Lead as to local prescribing arrangements, i.e. formulary information, policy, Sheffield traffic light system. Following this, the NMP will need to be assessed as competent by a medical or peer prescriber and a scope of practice completed and approved prior to prescribing themselves.

Supplementary Prescribing

The Clinical Management Plan (CMP)

This is the cornerstone of supplementary prescribing. There are no legal restrictions on the clinical conditions which can be managed under these arrangements.
The experience and degree of expertise of the SP must be taken into account when formulating the CMP.
A CMP should be used in all instances of supplementary prescribing. -
Before supplementary prescribing can take place, it is *obligatory* that:

- A full assessment has been undertaken and a diagnosis made by the Medical Prescriber
- The CMP has been agreed by the Medical Prescriber, SP and patient/carer (as appropriate)
- The CMP relates to a named patient and to the specific condition(s) to be managed under the plan
- The agreed CMP is in written or electronic format
- The SP is aware of where to file the CMP

When working within a supplementary prescribing relationship the clinical management plan is the foundation stone of the prescribing partnership. The independent prescriber (doctor) must ensure that the supplementary prescriber has the necessary skills, knowledge and experience to prescribe in the defined clinical area and in accordance with the CMP

Responsibilities within the CMP

The Medical Prescriber is responsible for:

- The initial clinical assessment of the patient, the formulation of the diagnosis and determining the scope of the CMP, which should be agreed with the SP and where possible the patient.
- Reaching an agreement with the SP about the limits of their responsibility for prescribing and review – which should be set out in the CMP.
- Providing advice and support to the SP as requested
- Carrying out a review of the patient's progress at appropriate intervals, depending on the nature and stability of a patient's condition, preferably with the SP being present.
- Sharing the patient's record with the S Report any suspected adverse drug reactions arising from the medication to the Medicines and Healthcare products Regulatory Agency via the Yellow Card Scheme
- Locum Psychiatrists cannot act as the Medical Prescriber within a Supplementary Prescribing arrangement.

Driver, Vehicle & Licensing Agency (DVLA) NMPs have a responsibility to ensure they are aware of the legal requirements around prescribing for a person who may drive whilst taking medicine, and the advice and guidance they have to give around the effects of the medicine. For further information all NMPs should access the following website: http://www.dft.gov.uk:80/dvla/medical/medical_professionals.aspx

Independent Medical and Supplementary Prescribers may work in more than one prescribing partnership, providing that in each case they work as detailed above.

Patients Detained Under The Mental Health Act
Despite the patient's legal status, non-medical prescribers continue to play an important role in the treatment of patients who are detained under the Mental Health Act.
Non-medical prescribers are permitted to prescribe treatments for a patient's mental disorder but only if the prescribing complies with legislation. In other words:

• If a patient has been receiving treatment for mental disorder for 3 months or less, then the treatment must be authorised via CAT2 form.
• If a patient has been receiving treatment for mental disorder for 3 months or more, then any prescriptions for the treatment of mental disorder can only be written by a non-medical prescriber if the treatment is listed on a valid T form. This includes only prescribing the medication in the form, and dosage, stipulated on the T form. This ultimately means if a treatment for mental disorder is not listed on a T, or CAT2, form, the non-medical prescriber cannot prescribe the treatment they were proposing.

Occasions may arise when a detained patient needs urgent treatment in relation to their mental disorder. Section 62 of the Act allows for some treatments to be given even if a CAT2 or T certificate, which may ordinarily be needed, are not in place. Non-medical prescribers should familiarise themselves to the legal definition, in section 62, of what constitutes 'urgent treatment'. If a non-medical prescriber believes treatment for the patient's mental disorder is immediately necessary and meets the threshold set out in section 62, they should attempt to contact the patient's Responsible Clinician for authorisation to prescribe under s62. If the Responsible Clinician agrees, they will be responsible for completing the relevant s62 monitoring form and submission to the Mental Health Act office.
If a patient's situation is such that making attempts to contact the Responsible Clinician would result in significant risks to either the patient or others, then the non-medical prescriber could prescribe treatment they consider is needed. In these situations, the non-medical prescriber must always contact the patient's Responsible Clinician as soon as possible following the prescribing of urgent treatment for mental disorder. The non-medical prescriber must ensure they document in full the reasons for prescribing under these circumstances
If a patient who is subject to the Act requires treatment for a physical health issue which is not related to, or part of, the patient's mental disorder, the non-medical prescriber can

prescribe as they would for any non-detained patient (ensuring compliance with the requirements of the Mental Capacity Act). However, it should be noted that Responsible Clinicians ultimately have overall responsibility for a detained patient's care. This means that non-medical prescribers and Responsible Clinicians should have frequent contact with each other and ensure there is ongoing communication between them.

Writing and Ordering Prescriptions
Medicine Optimisation Policy, describes the procedure for writing prescriptions and should be followed at all times. The NHS Business Services Authority (NHSBA) website contains a step-by-step educational resource on the completion of NHS FP10 prescriptions.
www.nhsbsa.nhs.uk/PrescriptionServices.aspx

NMPs working within mental health teams or substance misuse services may also use the team FP10 pad for prescribing. Please refer to SOP P1 - Procedure for Secure Handling and Storage of Prescription pads (Controlled Stationery)
Each CMHT manager/ team manager/ team leader is responsible for appointing a nominated person and deputy for the ordering, storage and issuing of prescription pads for the team and for ensuring that the appropriate records are maintained. NMPs should liaise with the nominated individual to ensure availability is maintained.

Where it is intended that the medicine will be supplied from the hospital pharmacy a specialist medicine chart e.g. clozapine maintenance chart, depot prescription chart, outpatient prescription should be used.

Computer generated prescribing
Non-medical Prescribing was introduced to ensure that care is organised and delivered around the needs of the patient at the point of care. We currently have computer generated prescriptions in the Substance misuse service but not in the CMHT setting. When it becomes more widely available it may be used in situations where this does not inconvenience the patient, it is not expected that NMPs prescribe exclusively using computer generated prescriptions.
When computer generated prescriptions are utilised, the following points should be noted:

- You may prescribe via a computer generated prescription provided the necessary software is available
- A visible audit trail of your prescribing actions must be maintained
- Prescriptions must be signed immediately NEVER sign a prescription pad generated with someone else's details
- Prescriptions must never be written or signed in advance and then stored for future use
- The prescriber must provide a telephone number so you can be contacted in the event of a query

Remote prescribing by email or fax
There should be no remote prescribing by NMP's by email or Fax. If working in the inpatient setting, there is the electronic prescribing system available. NMPs need to ensure they are conversant with the patient and the prescribing decision is recorded in the patient/service users notes

Security of Prescription Pads
Prescription pads are 'controlled stationery', the security of prescription forms is the responsibility of both the employing organisation and the prescriber.
Storage of prescription pads:

- Prescriptions should be stored as securely as possible, for example, in a locked cupboard within a locked storeroom and accessible by Non-Medical Prescribers or identified members of staff only (See SOP P1 for more information).
- Keys for the prescription storage area should be controlled (using a locally devised system) and access to prescriptions restricted to the relevant prescribers only

Using Prescription Forms (This section should be read in conjunction with SHSC SOP1)
The prescriber should keep a record of the serial numbers of prescriptions 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 of an, in-use pad at the end of the working day. Such steps will help to identify any prescriptions that are either lost or stolen overnight.

- Blank prescription forms must NOT be pre-signed. Please see SOP P1 for record forms.
- Prescription forms/pads should only be produced when needed and never left unattended.
- All unused forms should be returned to the secure storage area at the end of the session or day.
- **Under NO circumstances should prescription pads be left in unattended cars**. Where return to the office is not possible at the end of the working day prescription pads should be stored securely within the prescriber's home.

Lost or stolen prescription forms
All prescribers should report any loss or theft of prescription forms to the SHSC Pharmacy Team and their Senior Manager as soon as possible after the theft/loss is confirmed. (Out of hours this should be the senior manager on call). The following details should be provided by the prescriber:

- Date became aware of the incident.
- Type of prescription e.g. computerised (FP10C), non-computerised (FP10NC) etc.
- For non-computerised prescriptions the prescribers details as they appear at the bottom of the prescription.
- The number of prescriptions concerned.
- The serial number(s)
- Place stolen or lost from.

The pharmacy team will then instigate the lost prescription cascade as per SOP01.
Prescribers leaving SHSC or no longer prescribing
Where a Non-medical Prescriber ceases to carry out prescribing duties, e.g. has left SHSC employment, or had their approval as a Prescriber withdrawn, it is the responsibility of the line manager, via the exit interview, to inform the NMP Trust Lead, who will remove the prescriber's name from the Trust NMP register. The Manager shall ensure that any prescription pads are returned to the Pharmacy by secure means as per SOP P1.

Ethical and Legal Issues
Non-medical prescribers cannot recommend a particular dispensing pharmacist, this is a matter of patient choice.
The non-medical prescriber must take into consideration any professional and/or ethical issues relevant to the prescribing needs of the patient.
The non-medical prescriber is accountable for all prescriptions they sign.
NMPs have a responsibility to ensure they are aware of the legal requirements around prescribing for a person who may drive whilst taking medicine, and the advice and guidance they have to give around the effects of the medicine. For further information all NMPs should access the following website: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

Non-medical Prescribers cannot issue prescriptions on behalf of a colleague who is not a Prescriber.
All NMPs to follow SHSC advice around no visiting to units by drug representatives and should declare any hospitality received to the Trust board secretary.

Specialist Areas of practice:

- Caution should also be taken when prescribing for pregnant and lactating women.
- Caution should be taken when prescribing for the elderly. A full holistic assessment should be undertaken prior to prescribing, in particular when initiating medications.

Record Keeping
Good communication and teamwork are essential for effective prescribing and patient safety. Medical records and clinical systems should be made available to any prescriber. It is however the NMP's responsibility to undertake training in any clinical system which they are unfamiliar.

Clinicians are required to meet their professional guidelines with regard to the quality of written notes.
Recording: The clinical record should clearly indicate:

- The date
- The name of the item prescribed
- Route of administration
- Dosage
- Frequency
- The quantity prescribed
- The name of the prescriber
- Signature (electronic if electronic patient record)

Prescribed items for community patients must be communicated to the General Practitioner within 2 working days or according to locally agreed arrangements. It is the responsibility of the prescriber to agree communication arrangements with each General practice.

Incident Reporting
The Trust places a duty on all staff to report untoward events. It is vitally important that staff with prescribing authority report all incidents, to ensure that human error and systems failure can be examined and thereby minimised. Further guidance can be found in the SHSC Appendix H1 - Staff Guide to Electronic Incident Reporting June 2020.pdf. In the event of a serious adverse drug reaction the prescriber should record it in the patient's notes and report this **immediately** to the General Practitioner and the patient's consultant (if an in-patient).
A yellow card should be completed and submitted to the MHRA for all serious adverse drug reactions, or all adverse reactions associated with Black triangle drugs. An electronic Yellow Card, together with instructions on how to use it, is available at: www.yellowcard.gov.uk. Yellow cards found at the back of the British National Formulary are also acceptable.
The bulletin *"Drug Safety Update"* issued by the Medicines & Healthcare products Regulatory Agency (MHRA) and the Committee on the Safety of Medicines (CSM), contain advice and information on drug safety issues. All prescribers are encouraged to consult the bulletin as a matter of routine. Copies are also available from the MHRA's website, found at: www.mhra.gov.uk

Clinical Supervision
All prescribers will adhere to SHSC Supervision policy
Prescribing supervision should be undertaken a minimum of 4 times per year and must be documented. Supervision sessions will be documented and signed by both the NMP/SP and supervisor as a true account of the discussion. These should be collated by the Local managers and provided to the NMP Professional Lead every 12 months as per NMC requirements

- Prescribing supervision **needs to be** undertaken with a medical supervisor or prescribing peer/colleague, in either a 1:1 or group setting.
- A selection of client's notes/ prescribing decisions should be available for discussion and audit purposes within prescriber's supervision.
- The NMP/SP must contact their medical supervisor/lead for support if a prescribing issue is out of their area of competence.
- It is considered good practice for the supervisor to clinically/peer appraise the NMP's prescribing competence on a yearly basis (either via direct observation or through discussion in the supervision process) With any areas for development being highlighted on the action plan and monitored through the supervision process.

Continuous Professional Development

All NMPs have a professional responsibility to keep themselves abreast of professional developments (e.g. via NMP meetings or the NMP conference) and should maintain personal documentation to evidence this.

NMPs will be expected to keep up to date with best practice in the management of conditions and medicines for which they may prescribe. They will also be expected to attend at least three of the update sessions run at SHSC (currently quarterly) per annum (and provide evidence of CPD undertaken at least every three years in line with NMC requirements. All CPD activity should be communicated to the NMP lead in order for it to be recorded on the NMP register, in line with NMC requirements.

NMPs should incorporate details of additional training into their personal professional profile - for the purpose of renewing their registration with the NMC or General Pharmaceutical Council.

The training and developmental needs of a NMP should be considered as an integral part of the individual personal development plan, with maintaining prescribing competence being a key area for discussion during the appraisal process and managerial supervision.

Useful websites to support personal development include:

www.bnf.org
http://www.doh.gov.uk/nurseprescribing
www.pharmacyregulation.org
www.npc.nhs.uk
www.yellowcard.gov.uk
www.mhra.gov.uk
www.nice.org.uk
www.evidence.nhs.uk

The Role and Responsibilities of the Designated Medical Supervisor (DMS) for NMP Trainees

Nurses, pharmacists, are required to have a Designated Medical Supervisor (DMS) to provide the student with supervision, support and opportunities to develop competence in prescribing practice during their training.

The curriculum for preparing nurse, pharmacist prescribers include no less than 90 hours of learning in practice. This period of learning in practice is to be directed by a medical practitioner, who will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired certain competencies. Normally, these outcomes and competencies will be identified by the Higher Education Institution.

Criteria for becoming a DMS:-

- Normally has at least three years recent clinical experience for a group of patients/ clients in the relevant field of practice
- Is a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer or is within a GP practice and is either vocationally trained or is in possession of a certificate of equivalent experience from the Joint Committee for Post-graduate Training in General Practice
- Has the support of the employing organisation in order to provide supervision, support and opportunities to develop competence in prescribing practice
- Has some experience or training in teaching and / or supervising in practice
- Normally works with the trainee prescriber. If this is not possible (such as in nurse-led services), arrangements can be agreed for another doctor to take on the role of the DMS, provided the above criteria are met and the learning in practice relates to the clinical area in which the trainee prescriber will ultimately be carrying out their prescribing role

Expectations of the DMS

- The DMS has a crucial role in educating and assessing non-medical prescribers. This involves:
- Establishing a learning contract with the trainee
- Planning a learning programme which will provide opportunities for the trainee to meet their learning objectives and gain competency in prescribing Facilitating learning by encouraging critical thinking and reflection Providing dedicated time and opportunities for the trainee to observe how the DMS conducts a consultation / interview with patients and / or carers and develops a management plan
- Allowing opportunities for the trainee to carry out consultations and suggest clinical management and prescribing options, which are then discussed with the DMS
- Allowing opportunities for the student to 'write up' consultations and prescription options within the clinical notes, which are then reviewed by the DMS
- Helping ensure that the trainees integrate theory with practice
- Taking opportunities to allow in-depth discussion and analysis of clinical management using a random case analysis approach, when patient care and prescribing behaviour can be examined further
- Assessing and verifying that, by the end of the course, the trainee is competent to assume the prescribing role
- Training new prescribers will undoubtedly take up some time. As the approach to teaching and learning should be developed on an individual basis, it is difficult to predict how much time this will involve. It is unlikely that the trainee will need to spend all of the period of learning in practice with the DMS, as other clinicians may be better placed to provide some of the learning opportunities. However, the DMS remains responsible for assessing whether the learning outcomes have been met.

- **Working with Higher Education Institutions (HEI)**
- It is essential that the DMS and the Higher Education Institution (HEI) running the prescribing programme work closely together. Most HEIs offer DMS's a range of support to facilitate this, which may include:
- An orientation session and / or information before the start of each programme
- A handbook / briefing notes, including information on the course content, learning outcomes, timetable and assessment strategy
- An assessment workbook / log

- **Training requirements associated with this Protocol**
- **Mandatory Training**
- There is no mandatory training associated with this protocol

- **Specific Training not covered by Mandatory Training**
- Ad hoc training sessions based on an individual's training needs as defined within their audit outcomes, annual appraisal or job description.

8 Development, Consultation and Approval

- SHSC Non-medical Prescribers
- Medicines Optimisation Committee
- Clinical Directors
- Clinical Operations
-

9 Audit, Monitoring and Review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the protocol is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date should be written here.

10 Implementation Plan

All policies should include an outline implementation plan (this will summarise sections 7, 8 and 9 above). It should include consideration of:

- *Dissemination, storage and archiving*
- *Training and development requirements and who will provide the training*
- *Any new job roles and responsibilities and how these will be implemented*
- *Resources needed*
- *Timescales*
- *Lead role and responsibilities for implementation*
- *Audit or monitoring of implementation planned*

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans however; an example layout for the plan is shown below:

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
e.g. Upload new policy onto intranet and remove old version	*Chief Nurse*	*01/12/2016*	*Completed 30/11/2016*
e.g. Make team aware of new policy	*Team manager*	*17/12/2016*	*On agenda for team meeting 17/12/2016*

11 Dissemination, Storage and Archiving (Control)

This section should describe how the new policy will be disseminated. It says where the policy will be made available and to whom. This will normally be that the policy is available on the Trust's intranet and available to all staff.

It makes it plain that any previous versions must be deleted and describes the archiving and storage arrangements for the current and previous versions of the policy.

It says who is responsible for archiving and version control, and what they should do.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0				
2.0				

12 Training and Other Resource Implications

The policy must include a consideration of any training and development requirements for its effective implementation. Where training needs are identified, these must be discussed with the Education, Training and Development Team and reflected in the Trust's Training Needs Analysis.

Other resource implications to consider include the cost of dissemination and any new job roles or functions which are not in current job descriptions or work plans.
Any anticipated savings and efficiencies as a result of implementing the policy should also be considered.

13 Links to Other Policies, Standards (Associated Documents)

Any policies, procedures, guidelines which link to this policy should be indicated here. The document should include key references for the evidence base, and relevant legislation or government policy.

14 Contact Details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Chief Pharmacist	Abiola Allinson	0114 2718630	Abiola.allinson@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**N**		
Disability	**N**		
Gender Reassignment	**N**		
Pregnancy and Maternity	**N**		

Race	**N**		
Religion or Belief	**N**		
Sex	**N**		
Sexual Orientation	**N**		
Marriage or Civil Partnership	**N**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date Abiola Allinson 08/11/2022

Insulin use within SHSC Trust

Version:	V2
Effective Date:	December 2022
Review Date:	December 2024
Reference:	Medicines Optimisation Policy Appendix L
Related Documents:	Medicines Optimisation Policy
Author:	Shrewti Moerman, Deputy Chief Pharmacist
Reviewer:	Medicines Optimisation Committee, Physical Health Committee
Approved:	Medicines Optimisation Committee
Dissemination:	The SOP was State how and when the SOP was disseminated, stored and/or archived

Definition:

This protocol refers to the use of insulin within the Trust for service users who are inpatients. In November 2016 a patient safety alert was raised due to the risks of severe harm and death due to the withdrawal of insulin from pen devices. Insulin patient safety alert

Purpose and Objective:

Ensure the use of insulin within SHSC is done in a safe manner.

Scope:

1. Key Responsibilities/Duties

Nurse administering insulin, Prescribers of insulin, Pharmacy team to ensure insulin available, Procurement team – ensure correct equipment ordered, medical devices person for consumables, Sharps Safety Management Group and Infection control nurse.

2. Prescribing Insulin

Ensure that the dose is confirmed, prescribe the dose in UNITs. Check on ICE if a diabetic nurse has done a recent review as this may give you some guidance on dosing. If unsure -contact the diabetic team for advice (contact details below in section 12). Please note: **Doses on Summary Care Records are not usually accurate**.

When a service user is initially admitted with insulin, the nurse when administering should assess if the service user is capable to administer their own insulin. Guidance on this is found on Diabetes UK document.

Consider:

1. Do they normally self-administer?
2. Do they pose a risk to themselves self-medicating insulin at present?
3. Does the service user have the physical ability to self-administer?

Record if they can administer insulin in the electronic patient records, additionally document how often the blood sugars need to be monitored. If the service user can administer their own insulin safely, continue using the device they normally use. This should be reviewed on regular basis in the Multiple Disciplinary Team or if there is any change in the patients' ability/capacity or health.

Self-administration is defined as 'the patient is fully capable of carrying out the whole procedure from start to finish'. This includes being able to attach a needle and prime the device if necessary, dialling up the required dose, administering insulin and disposing of the used needle safely into a sharp's container.

If the service user is unable to administer the insulin, the medication should be prescribed in a vial form. If no vial is available in the insulin required, then a cartridge or pen can be used. Insulin should not be drawn from a pen device or cartridge.

3. Devices and equipment used in Trust

Insulin syringes to measure UNIT doses

Insulin in a vial [or a pre-loaded insulin device (usually a pen either prefilled or requires cartridges) with appropriate needle - only for patients self-administering]

BD Auto Shield Duo for Nurse and self-administration

Sharps box

Blood glucose meter. Blood glucose monitoring strips (including ketones strips)

Insulin can be ordered through Pharmacy

All accessories such as needles are ordered through procurement team.

(BD Auto Shield Duo pen needle)

4. Considerations prior to administration

Has the insulin prescribed been dispensed in vials? If yes, follow procedure for administration of insulin with Magellan insulin safety syringe. If the insulin has not been prescribed or is not available in vials, ensure that the insulin has been prescribed for use in the appropriate pre-loaded disposable pen and follow procedure for pen use.

(Magellan Insulin Safety Syringe)

- **Never withdraw insulin from a cartridge or prefilled pen using a needle and insulin syringe.** *The process of withdrawing insulin from pen devices can cause the potential for:*
  - *Wrong doses to be administered. (Insulin extracted from a pen or cartridge can lead to a significant and potentially fatal overdose as the insulin concentrations are different).*
  - *Addition of air to cartridge resulting in inability to use the device properly.*
  - *Sharps injury*
  - *It is an unlicensed process*.

- **Note pre-meal analogue insulin (e.g. Humalog, NovoRapid) is rapid acting and the person with diabetes requires to eat immediately after insulin administration.**

- **The insulin must never be drawn up in an insulin syringe and stored in advance of the procedure.**

5. Preparing the insulin

Syringes:
All types of insulin - invert the vial of insulin backwards and forwards and roll gently between your hands approximately 20 times to ensure the insulin is well mixed. Do not shake!

Take the insulin syringe and pull back the plunger to measure the amount of air equivalent to the amount of insulin to be drawn up. Expelling air into the vial prior to an injection makes it easier to draw out the insulin

With the vial standing upright insert the needle straight through the centre of the rubber cap of the insulin vial and push the plunger down

Turn the vial upside down. Make sure that the point of the needle inside the vial is well beneath the surface of the insulin to avoid unnecessary air bubbles

Pull back the plunger until you have measured slightly more than the required dose of insulin

Flick or tap any air bubbles to the top of the insulin syringe, then push the plunger back to the desired dose expelling the bubbles into the vial. Air bubbles are not dangerous if injected into the recommended subcutaneous injection sites. This procedure ensures an accurate dose of insulin. If bubbles persist, expel all the insulin back into the vial and draw up again. Remove the needle from the vial and recheck the dose.

How to use the BD Auto Shield Duo video
How to draw, use and dispose of BD Auto Shield Duo

PEN devices:
Insulin is increasingly being prescribed to be administered by use of prefilled PEN devices. A Registered Nurse may use the pen device for those patients.

The nurse must use the Trust BD Auto Shield Duo needle and not the patient's own needles as these may not be safe devices. Patients may need an alternative pen/pen needle during their stay in hospital. All have a similar mechanism and are easy to demonstrate and use.

Novomix 30 (Flexpen), Levemir (Flexpen), Humalog Mix 50 (Kwik Pen), Toujeo & Tresiba are only available for PEN devices.

The insulin must **never** be drawn up into an insulin syringe.

The pen should not be dialled up and stored in advance of the procedure.

Preparing preloaded pen device for administration by nurses

Attach a BD Auto Shield Duo 5mm pen needle. (Recommended for the majority of patients).

Gently roll the pen in your palms ten times and invert the pen ten times.

Prime pen by dialling up 2 units. Point pen upwards and depress injector button

Ensure insulin is expelled from needle – repeat priming process if no insulin seen

Turn the dose knob to the number of units prescribed to be administered
*The correct administration technique with BD Auto Shield needles can be accessed using the following link. All staff involved in the administration of insulin should be familiar with this technique. Please watch the short videos.
How to administer using BD Auto shield needles

The BD Auto Shield needle retracts and seals itself protecting the needle at both ends therefore unscrew and dispose directly into sharps box.

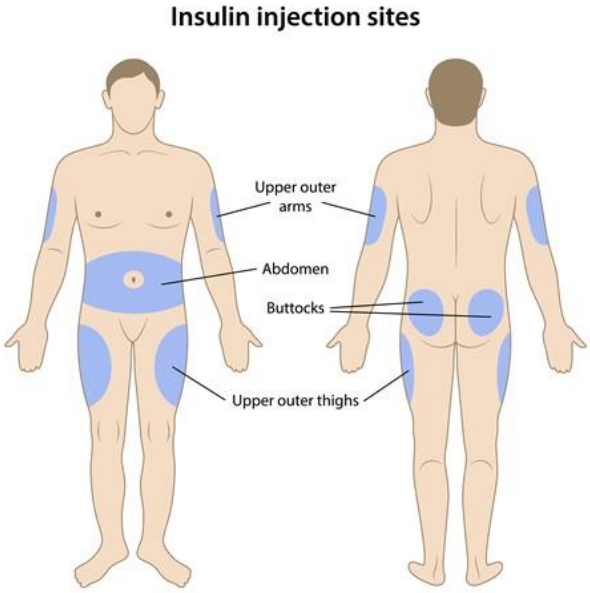
Replace Pen lid/cover until next use. The Pen cartridges inside the Pen are self-sealing.

6. Administration procedure

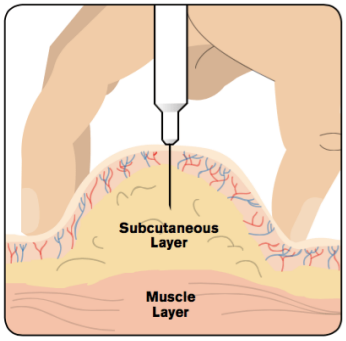
All staff administering insulin should be appropriately trained.

- Clinical staff must seek consent before any intervention.
- Ensure prescription is complete, correct, legible and unambiguous prior to administration
- Confirm the identity of the patient prior to administering the insulin
- Check the name of the insulin and dose against the insulin prescription and agree with the patient
- Check correct storage as per manufacturer's instructions and expiry date of insulin. Keep medication out of direct sunlight and avoid extreme temperatures >30 degrees Celsius
- Check that it is the correct insulin as per prescription and in the correct delivery device.
- Check the insulin has not already been administered by someone else
- Perform hand hygiene.
- Check the blood glucose level according to care plan and record the result before administration.
- Prepare the insulin syringe/ needle/pen
- Select injection site - rotate injection sites, never use the same site for consecutive injections to prevent lipohypertrophy (lumps and bumps under the skin). Avoid damaged and bruised skin.

- If using the abdominal area try to inject at least 2.5cm from the previous one



- Inject into clean skin. Alcohol wipes are not recommended. Alcohol is an astringent and can make the injection more painful as well as hardening the skin. If cleaning of the skin is required apply gloves and wash with soap and water.
- Insulin should be injected into sub-cutaneous tissue or soft fat, not muscle. To avoid intramuscular injection, evidence suggests that raising the skin is best practice and, in some cases, the specialist clinician will recommend use of a smaller needle.
- Continue to raise the skin and hold the insulin syringe in place for a count of 10 to ensure that the insulin disperses from the site of the injection



- Remove the needle and insulin syringe and dispose as per safe disposal of sharps
- Record the dose, timing and site of insulin injection on EPMA
- Report to nurse in charge or doctor if the patient bleeds from an injection site, insulin appears at the injection site, or the patient complains that the injection is painful.

7. Monitoring

Blood glucose testing – lancets

All healthcare staff should use single use lancets when involved in blood glucose monitoring. If patient/service user is taking doing their monitoring they may use a reusable device, this should not be used by staff.

Blood Glucose monitoring machines

It is advised that there is one machine per ward/department. This will make for ease of maintenance, quality assurance checking, and also minimise costs (control solution, test strips, etc). This should be control checked at least weekly (and where not used daily control checks should additionally happen prior to use).

8. Storage

- Unopened insulin vials/preloaded pens should be stored in the main body of the fridge at 2 to 8°C. If stored in this way the insulin remains useable up until its expiry date.
- Insulin vial & pens in use should be stored at room temperature. Stored in this way, the insulin remains stable and useable for 28 to 42 days only - dependent on insulin. Note - Write date of expiry on vials & pens i.e. 28 days from removing from the fridge and date when the insulin vial was opened.
- Partly used insulin pens should never be returned to the fridge to be reused.

9. Disposal of medication

Insulin syringe and needle – dispose directly into the sharps box to avoid needlestick injury

If needlestick injury occurs take prompt first aid action as follows:

BLEED IT - Encourage wounds to bleed by gently squeezing the area - DO NOT SUCK the area

WASH IT - Thoroughly wash the affected area with soap and warm running water - DO NOT SCRUB the area

COVER IT – Cover with a waterproof dressing to protect the area

REPORT IT – Report to your line manager/person in charge. Complete a Ulysess report and contact Occupational Health, details can be found here:

https://jarvis.shsc.nhs.uk/documents/post-blood-and-body-fluid-exposure-management-eg-needlestick-injury

10. Useful contacts

STH Diabetic Nurses Centre, Mon-Fri 8:00 – 16:00 on Tel: 0114 2715380
Email: sth.diabetesinpatient@nhs.net
SHSC Pharmacy Department via switch board or the usual contact number

11. High Risk drug

Insulin is a high-risk drug and errors in the prescribing and administration of insulin can be fatal. Three of the main causes for incidents to consider are:

MAIN CAUSES OF WRONG DOSE INCIDENTS

- Incorrect prescription of Insulin on admission
- Abbreviation of UNITS (when prescribed on a drug card)
- Incorrect monitoring of blood glucose and dose adjustment of insulin
- Poor documentation of dose administration on inpatient medicine charts
- Duplicate dose administration
- Errors in calculation of insulin for intravenous administration (IV use does not occur at SHSC)
- Incorrect programming of electronic infusion devices

MAIN CAUSES OF OMITTED OR DELAYED INSULIN

- Insulin not prescribed on hospital admission
- Failure to prescribe or supply the correct insulin preparation, vial, cartridge or pen
- Prescribed insulin not available in the clinical area
- Confusion over insulin dose administration when patients are nil by mouth
- Insulin not administered at an appropriate time to the administration of feeds

MAIN CAUSES FOR SELECTING WRONG INSULIN PRODUCT

- Look alike and sound alike proprietary names

Monitoring and Audit:

Date Reviewed	**Reviewed by**
December 2021 -Format changed and information regards prescribing, and administration updated with current standards.	S .Moerman (pharmacist)

Approved by: **MOC (Abiola Allinson) .....**

Signed: **AAllinson .....** **Date: 12/2022 .....**