

# Supply, Storage and Safe Disposal of Medicines Policy

Target Audience				
Who Should Read This Policy	 Mental Health	 Learning Disabilities	 Children, Young People & Families	 Corporate
All Nursing Staff	✓	✓	✓	✓
All Consultant/Senior Medical Staff	✓	✓	✓	✓
All Junior Medical Staff	✓	✓	✓	✗
All Pharmacy Staff	✗	✗	✗	✓



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## Explanation of terms used in this policy

**Supply/Procurement of Medicines** - a process through which a medicine is acquired for use in treating a patient

**Dispense** - to prepare a clinically appropriate medicine for a patient for self-administration, or administration by another, usually a healthcare professional. Dispensing must be in response to a legally valid prescription. The act of dispensing includes supply and checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and the provision of advice to the patient on safe and effective use of these products.

**Receipt of Medicines** - the formal activities undertaken when medicines are received by the organisation from an external source or transferred from one department to another; procedures must be in place to ensure product identity, quantity and quality

**Safe Storage of Medicines** - medicines must be stored in a secure manner and in conditions that will not affect their potency; procedures must be in place to ensure compliance with the manufacturer's storage recommendations and any legislation covering for example the storage of controlled drugs

**Administration or Supply of Medicines** - the activities undertaken when a medicine is administered to a patient or given to the patient for administration at a later date to ensure the right patient is given the right medicine at the right time

**Removal/Disposal of Surplus/Waste Medicines** - the activities associated with the removal and disposal of medicines that are no longer required or no longer suitable for their intended use

**Medicine/Medication** - is defined as any substance, or combination of substances, internal or external, which may be administered for therapeutic, diagnostic or preventative purposes

**External Use** - application to the skin, teeth, mucosa of the mouth, throat, nose, eye, ear, vagina or anal canal; it does not include throat sprays, throat pastilles, throat lozenges, throat tablets, nasal drops, nasal sprays, nasal inhalations, teething preparations or dental gels

**Medicines** are classified as follows:-

**Controlled Drugs** - those which come within the Misuse of Drugs Act (1971) and subsequent regulations

**Licensed Medicines** - all medicines, oral, external, prescription only, pharmacy medicines, general sales list medicines, or controlled drugs with a valid Marketing Authorisation for use within the UK.

**Unlicensed Medicines** - any medicine that has not been granted a valid Marketing Authorisation for use within the UK

**Non-medicines** - classified into the following groups:-

- Surface disinfectants
- Urine testing and other reagents
- Medical gases

**Medication error** - any preventable event that may cause or lead to inappropriate medication use and/or patient harm while the medication is in the control of the healthcare professional, patient or carer

**Medicines Management** - encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered, and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care

**Registered Nurse** - a mental health nurse, a general nurse, or a specialist community public health nurse, who is registered with the Nursing and Midwifery Council

**Medicines and Healthcare Products Regulatory Agency (MHRA)** - an executive agency of the Department of Health responsible for ensuring that medicines and medical devices work, and are acceptably safe

**Prescriber** - a healthcare professional that is legally authorised to prescribe a medicinal product, including medical and non-medical prescribers

**Prescription** - an order for the dispensing of a medicinal product. The order is presented to a professional who is legally authorised to dispense. The order must be either:-

- a) in writing in a legally prescribed format and signed by the person authorised by law to prescribe
- b) made, using a Trust-agreed electronic prescribing system, by the person authorised in law to prescribe medicinal substances, and who has been provided with a secure, individual computer access password

**FP10** – term used for the standard NHS prescription form with serial numbers introduced in April 1998. Different types of prescribers use different versions of the standard NHS FP10 prescription form. Each version is a different colour, which helps the dispenser and the NHS Prescription Services to identify the prescriber but in addition, each prescriber has his or her own number so that ultimately the person responsible for prescribing the medicine can be identified.

**TTO (to take out) Medication** – a supply of medicines to take home on discharge from hospital

**Patient Group Directions (PGD)** - a specific written instruction for the supply or administration of medicines to clinical groups of patients who may not be individually identified before presentation for treatment

**Pharmacist** - a person registered in the register of Pharmaceutical Chemists with the General Pharmaceutical Council established in accordance with the Pharmacy Act 1954

#### **Pharmacy Technician**

A person holding an NVQ Level 3, BTEC, SCOTVEC, City and Guilds or Apothecary Hall qualification in Pharmaceutical Science and registered with the General Pharmaceutical Council as a Pharmacy Technician

**PODs Patient's Own Drugs** - the term for medicines that are a patient's own property, brought onto NHS premises for treatment of that patient

**POM** - Prescription only Medicine (Medicines Act 1968)

**COSHH** - the Control of Substances Hazardous to Health Regulations 2002

**Service Level Agreement (SLA)** - is the generic term used for agreements/contracts between the Trust and other NHS organisations for the delivery of services

**Denaturing** - adding an inert substance to adulterate the original substance to render it unfit for use

**Central Alerting System (CAS)** - a Department of Health web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others

**DATIX** – the name of the incident reporting software system in operation across the trust

**Policy** - sets out the aims and principles under which services, groups, or units will operate. A policy outlines roles and responsibilities, defines the scope of the subject covered, and provides a high level description of the controls that must be in place to ensure compliance

## **1.0 Introduction**

A prescribed medicine is the most frequently provided treatment for patients in the NHS. All NHS Trusts are required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner. This policy document outlines the mandatory legal and ethical aspects involved in the procedures for the following aspects of medicines management:-

- the supply of medication
- the storage of medication
- the safe disposal of medication

This includes obtaining, transporting, recording, handling, safe keeping, dispensing, and safe disposal of medicines

## **2.0 Purpose**

The aim of this policy is to inform all health professionals that have any involvement with medicines of the correct procedures for the safe handling, ordering, storage, transportation, and safe disposal of medicines.

## **3.0 Objectives**

- Outline the roles and responsibilities of staff in relation to the ordering, safe storage and disposal of medicines within the Trust
- Make clear that the supply, dispensing, storage and disposal of medicines within the Trust must follow national standards and legislative requirements
- Promote and support the safe and effective management of medicines within the Trust

## **4.0 Supply of Medicinal Products**

Black Country Partnership NHS Foundation Trust obtains all medicinal products that are required in its hospitals through a service level agreement with another local NHS provider of pharmaceutical services. Under the conditions of the agreement, the local provider is responsible for ensuring that all medicines are of a suitable quality and for their timely issue against an appropriate order raised by the trust.

All medicines, except for the patient's own, or those for community use, must be obtained through the service level agreement with the recognised provider of pharmaceutical services. Inpatient staff are not allowed to use medicinal products acquired by any other means unless the medicine has been individually dispensed for the particular patient concerned.

In the Community, all medicines for patients are obtained from one of the following:-

- General Practitioner
- Other suitably authorised prescriber
- Outpatient appointment
- Discharge supplies (TTO)

On receipt of these medicines, they become the property of the patient.

### **4.1 Medicinal Product Samples or Investigational Medicinal Products**

The use of samples or medicines for evaluation is not permitted in the Trust unless sanctioned by the Pharmacy Department. Investigational Medicinal Products for clinical trials may only be received from manufacturers or their representatives by a Pharmacist, following agreement from the Trust's Medicines Management Committee.

## 5.0 Ordering Medicinal Products

The designated nurse in charge in each ward or clinical area, or another professionally qualified person in charge of a section of the hospital is responsible for ensuring that the system for requisitioning medicines is followed.

Only one general pharmacy requisition book or pre-printed current stock list may be held by each ward or clinical area at any given time and must be kept locked in a secure place. Requisition books must be kept in the ward/clinical area for two years from the date of the last entry

A requisition for medicines or 'top up' order staff must be signed by one of the following members of staff:-

- A medical or dental officer
- A registered nurse but the designated nurse in charge still retains responsibility
- Other professionally qualified person in charge of another ward/unit of the hospital
- A registered pharmacy technician or pharmacy assistant
- A pharmacist

Sample signatures of any staff likely to requisition medicinal products must be provided to the local NHS provider of pharmaceutical services and should be updated accordingly.

Before signing the requisition, any blank lines on the form must be cancelled

When medicines have to be requested by fax, the cover sheet should include the name and grade of the person requesting and be accompanied by copies of all relevant treatment sheets.

For medicines to take home please refer to the 'Medicines to Take Home (TTOs) and transfers' section of this policy

For Controlled Drugs each preparation needs a separate requisition. In both cases the whole book is required by the pharmacy. Controlled Drugs ordered for stock the signature on the requisition must be designated nurse in charge in each ward or clinical area, who must indicate her/his status on the form. The requisition must be countersigned by a registered doctor to comply with legislation - please refer to the Controlled Drugs Policy and standard operating procedures in place for more information.

Whenever practicable, prescriptions should be sent to pharmacy at least 24 hours before the medicines are required. When medicines are urgently required from the pharmacy, which is off-site, the staff should first telephone pharmacy, then send a faxed copy of the discharge prescription and a copy of the in-patient chart(s) or take it to the BCPFT Pharmacy team as soon as possible. However, when a discharge medicine is a Controlled Drug, pharmacy will not release it to the ward until the original prescription has been received. A pharmacy receipt form, where issued with the medicine, must also be signed and returned as soon as possible.

When a patient is being discharged at short notice and the hospital pharmacy is closed, it is the medical officer's responsibility to ensure that discharge medicines are provided using the locally agreed procedures (FP10); such dispensing is not part of the pharmacy on-call service.

If a patient chooses to self-discharge against medical advice, a discharge supply of medicines may be made upon the advice of the medical team after assessment of overdose/self-poisoning risk. If the patient refuses to wait for pharmacy to supply, or if out of hours, then an FP10 may be provided if appropriate and a copy or details of the FP10 must be placed in the patient's notes.

### **5.1 Controlled Stationery**

Controlled stationery must be kept in a locked cupboard and the key kept on the person in charge of the ward/clinical area. Blank prescription forms must never be left out unattended. The following items are designated as controlled stationery:-

- Stock requisition books
- Out-patient prescription forms
- Ward Controlled Drug Order books and Ward Controlled Drug Registers
- FP10 prescriptions

Please note FP10 prescriptions are the property of the Trust and prescriptions must only be issued to patients whom the Trust holds responsibility for – please refer to the standard operating procedure MP4 Security of FP10 Pads for more information.

### **6.0 Receipt of Medicinal Products**

The designated nurse in charge, or other professionally qualified person in charge of the ward/unit, must check the medicines supplied against the original requisition and the delivery note for any discrepancies, when stock arrives on the ward and then sign for their receipt. If any discrepancies are identified, please contact the Pharmacy Department, who will notify the local NHS SLA provider. Delivery notes should be retained for two years on the ward.

Where Controlled Drugs are received, two nurses must check receipt and sign the pink copy of the requisition. Any errors must be recorded and countersigned by the witness and the Pharmacy Department must be notified as soon as practicable.

Controlled drugs receipts must also be entered in the ward/unit Controlled Drugs register (CDR), along with the signatures of the person who has received them and the witness. A pharmacy receipt form, where issued with the medicine, must also be signed and returned as soon as possible. Please refer to the Controlled Drugs Policy for more detailed information.

### **7.0 Storage of Medicinal Products**

The designated nurse in charge is responsible for ensuring that sufficient stocks and supplies for individual patients are available on the ward/unit at all times.

For each community team base where medicines are stored, the registered manager in charge of the unit is ultimately accountable for medicines held, ensuring that Medicine policy procedures are followed correctly and that the security of medicines is maintained

Community staff should offer advice on the safe storage of medicines in patients' homes:-

- In a safe place, away from the sight and reach of children
- In a dry atmosphere (preferably not a bathroom)

- Keeping medicines in the containers they were dispensed in

### **7.1 Refrigerated and ambient temperature medication.**

Pharmacy staff will always label medicines to indicate when they will require refrigeration. A separate lockable medicine refrigerator must be available in all areas where medicines may require it. Food and pathological specimens must not be stored in the same fridge. Refrigerated medicines must never be frozen. A maximum /minimum thermometer must be available to monitor room and refrigerator temperatures at least daily and be recorded on a room and fridge monitoring form. The room and fridge maximum and minimum thermometer(s) must be reset on a daily basis.

If the temperature range is exceeded it is the responsibility of the individual to report the incident and immediately seek advice from the Pharmacy team.

Products requiring storage between 2-8°C will be transported in a container able to maintain the cold chain.

Please refer to Medicines Storage SOP (MP1) for further guidance on this section.

### **7.2 Vaccines**

It is essential that all vaccines are stored and transported in a way which preserves the cold chain - Please refer to NPSA guidance and the Safe Handling and Storage of Vaccines Policy for more detailed information.

### **7.3 Storage of Flammable / Hazardous substances**

Some medicines are hazardous on contact to staff and patients. Storage and handling of any hazardous substance should be in accordance with Health and Safety and COSHH Regulations. Medicines labelled as flammable must not be stored near a naked flame or any equipment which may emit sparks.

COSHH data sheets must be available for all flammable liquids kept on the premises. The data sheets must be kept in a central point available to all staff.

To reduce the risk of combustion or explosion:-

- Keep stock levels to a minimum
- Avoid spillage
- Keep bottle closed. Replace the screw cap immediately after use
- Keep well away from naked flame or electrical apparatus
- Do not store in a refrigerator
- Store all flammable liquids in a locked metal cupboard that displays an appropriate hazard notice

Stock levels of flammable materials and medical gases should be minimised and stored in cupboards approved by the Fire Prevention Co-ordinator.

#### **7.3.1 Alcohol Gel**

It should be noted that alcohol gel is a highly flammable substance; the above precautions must be followed. If nursing staff need to store alcohol gel in their car it must not be stored anywhere where it would be subject to direct sunlight. Alcohol gel must therefore be stored in nursing bags, pockets and/or in the boot of the car.

#### **7.4 Storage of Medical Gases**

All medical gases used in the Trust are licensed medicines and are subject to the Medicines Act so must be treated in the same way as other medicines.

Staff that use medical gases in the course of their duties must be fully trained and be aware of related risks such as fire and manual handling. They must ensure that they follow their departmental instructions for the handling of medical gases; in addition the following precautions must also be observed:-

- ✓ The number of cylinders held as stock in any department should be as small as possible
- ✓ Cylinders must be firmly secured at all times to prevent them falling over
- ✓ They should be stored under cover, preferably inside and not subjected to extremes of heat
- ✓ Naked lights must not be allowed within the immediate vicinity of a cylinder
- ✓ No oil or grease should be applied to the cylinder or tap connector, therefore ensure hands are clean before handling cylinders. In particular ensure hands are adequately dried after the use of alcohol gel
- ✓ Segregate full and empty cylinders and separate the different gases within the store
- ✓ Have warning notices posted prohibiting smoking and naked lights within the vicinity of the store
- ✓ Allow for a strict rotation of full cylinders to enable the cylinders with the oldest filling date to be used first
- ✓ The storage should be designed to prevent unauthorised access and to protect cylinders from theft
- ✓ Excessive force or any tools must not be used to open or close a cylinder valve.
- ✓ Cylinders with damaged valves and defective equipment must be labelled appropriately and withdrawn from use

#### **7.5 Medicines Cupboards and Security**

All medicines issued must be stored in a locked cupboard that conforms to British Standards either BS3621 or BS2881.

Medicine trolleys must be secured to the wall, except during the medicine round; they must only be used for medicines in current use, but not controlled drugs. The trolley must not be left unattended during the medicine round. If trolleys are not used, a separate section of the storage cupboard should be designated for medicines in use. Pharmacy boxes for the transportation of medicines are to be locked at all times when containing medicines except during packing and unpacking of the contents and their transfer to the ward/clinical area medicine cupboards.

Each patient involved in a self-administration of medicines scheme must have a lockable receptacle (e.g. drawer), which is not readily portable.

The following do not need to be locked:-

- Medicines in emergency kits/grab bags

- Intravenous fluids
- Antiseptics and irrigation solutions

Each community team manager is responsible for identifying a suitable lockable cupboard for storing medication. The Trust's Pharmacy Department must approve the location and specification of the cupboard. Where a team utilises storage facilities contained within a Trust facility which has qualified nursing staff on duty over each twenty four hour period, then formal arrangements should be made for access to the medicine cupboard. These arrangements must be documented and agreed by both parties. Where the arrangements detailed above are not possible, then the medicine cupboard will be affixed to an internal wall, situated in a discrete location within the team base and only accessible by qualified nursing or pharmacy staff.

Patients should be encouraged, wherever possible, to store their individually dispensed medications in their own homes, subject to appropriate risk assessments. However, where this is not appropriate, they may be kept in the team base, separately from team base stocks (this may be in a separate part of the same cupboard).

Make regular checks of patients' own medication stored in the team base, to ensure uncollected/undelivered medication is returned to its source without delay.

Please refer to Medicines Security SOP (MP2) for more detailed guidance.

### **7.6 Storage of Medicines for External Use**

Medicines stored for external use should be clearly labelled and must be stored in a separate cupboard or, if space does not permit, on a separate shelf to medicines for internal use. External use refers to those medicines used for application to the skin, teeth, mucosa of the mouth, throat, nose, eye, ear, vagina or anal canal. This does not include throat sprays, throat pastilles, throat lozenges, throat tablets, nasal drops, nasal sprays, nasal inhalations, teething preparations or dental gels.

### **7.7 Storage and Management of Controlled Drugs**

Controlled drugs must be stored in a locked cupboard that meets the Misuse of Drugs Safe Custody regulations 1973, reserved solely for this purpose (this must not be a medicine trolley). The controlled drugs key is the responsibility of the nurse in charge and should be kept on their person and stored separately from other drug keys.

A controlled drug register must be maintained and kept locked in a secure place when not in use. When the controlled drug register is full, the stock balances are to be transferred to the new one by a nurse and checked by a pharmacist as soon as possible. The old register is retained on the ward for two years from the date of the last entry (unless it contains a record of destruction, in which case it must be retained for seven years).

Stocks must be kept to a minimum and when disposal is required, the Pharmacist must be informed.

The designated nurse in charge is responsible for checking the stocks of controlled drugs with another nurse at every shift handover. If the balance is correct a dated and initialled record will be made by both nurses in the controlled drugs register.

Whenever a Controlled Drug is administered, the stock of that drug must be checked to verify that the balance is correct. The Controlled Drugs Register must be available at shift handover.

There is no need to open sealed packs for stock balance checking purposes.

Volumes of liquid preparation should not be decanted and measured after every use. A visual check must be performed by nursing staff. Stock balance of liquids should normally only be checked when a bottle has been used up.

Some liquid medications have excess volume in the bottle. This is called overage. A Pharmacist must be contacted to adjust the incorrect stock balance caused by overage.

Report any of the following immediately to the nurse manager (who initiates appropriate investigations) and the Chief Pharmacist:-

- a) Any entry made and found to be wrong (no correction or alteration is to be made)
- b) Any actual or suspected drug loss
- c) Incorrect balance except for liquids unless the volume in the book is more than the actual volume
- d) Any doubt

### **Monitoring of Controlled Drugs by Pharmacists**

Pharmacists will ensure that independent monitoring of Controlled Drug stock balances are carried out, at least every three months. Pharmacy will retain evidence of these checks for 2 years

Please refer to Standard Operating Procedures for Controlled Drugs for further information.

### **7.8 Stock Control and Security**

The Ward/Unit Manager is responsible for making regular formal checks to ensure compliance with stock control and security procedures for their area. In addition, pharmacy staff will undertake formal inspections of stocks and security on every ward/clinical area /community base across the trust at least every six months; they will retain evidence of these checks for 2 years.

### **7.9 'Emergency Cupboards' and obtaining medication out of hours**

Medicines required urgently when the hospital pharmacy is closed may be obtained from an "emergency" cupboard by the designated nurse bleep holder or, in the absence of such a person, the designated nurse in charge of the ward, or a medical officer. The medicine and quantity taken and the patient's name and ward must be recorded on the form/book provided and the entry signed.

For medicines not in the cupboard required in an emergency, an on-call pharmacist is available off-site via the local NHS SLA provider's hospital switchboard. At all times, the on-call pharmacist has the right to refuse requests which are unreasonable and not clinically urgent. The on-call pharmacist, where available, will also provide advice and information on medicinal products for all staff out of hours.

Emergency cupboards are located at:-

<b>1. Penn Hospital</b>	<b>2. Edward Street Hospital</b>
<b>3. Hallam Street Hospital</b>	<b>4. Heath Lane Hospital</b>

### **7.10 'Borrowing' of medicines between wards**

Only in exceptional circumstances, when the patient would otherwise miss a dose of the medicine and the pharmacy is closed, may medicines be given to another ward, with the authority of the registered nurses responsible for the wards concerned.

A signed order from the pharmacy stock requisition book must be given to the nurse in charge of the ward from which the preparation is taken and a receipt obtained and retained on the ward supplying the medicine for not less than two years. It is important that the Pharmacy team are informed as soon as possible on the next working day so that additional supplies can be arranged, and the 'donor' ward does not become depleted.

For Controlled Drugs the administration to the patient is recorded in the register of the ward, which supplies the drug. A nurse from the supplying ward or the designated nurse bleep holder must see the drug administered and signed for it in the register and on the prescription sheet. One of the signatures must be a nurse from the borrowing ward. Please refer to Controlled Drugs Policy for more information.

### **8.0 Safety Alerts for Medicinal Products**

Product safety alerts received via the Central Alerting System are sent directly to the Head of Governance, Chief Pharmacist and the local NHS SLA provider. Upon instruction from pharmacy, the group governance leads will ensure that relevant services are notified of the alert and ensure recommended actions are followed up if they have been issued with a medicine that has been mentioned in a safety alert.

The Pharmacy teams hold copies of all MHRA Drug Alerts and advice issued.

Upon notification from external organisations relating to medicines alerts, a cascade of actions is initiated whereby the Chief Pharmacist, local NHS SLA provider and the Pharmacy team analyse the impact of the alert and determine what action is to be taken to manage any risks to ensure that affected medication is managed effectively.

Please refer to **Appendix 1** for a flowchart on the process for cascading medicines safety alerts.

### **8.1 Defective Product Reporting within the Trust**

If a defective, or suspected defective product has, or is likely to have affected a patient or a member of staff, it should be reported to the person in charge of the ward/team/unit/department and the named consultant to ensure the patient's needs are managed in the first instance. An incident report should also be completed on DATIX and the lead pharmacists informed so that trust-wide action can be instigated if required.

With medicines or medical gases, note the batch number and expiry date of the medicine or the medical gas and retain it, if possible. Report it to the lead pharmacist or their deputy. If outside of normal working hours, professional judgment should be used as to what action to take, either contacting the on call pharmacist, or pharmacy the next working day.

## 9.0 Dispensing of Medicinal products

It is the role of the Pharmacy Department to dispense medication, but recognising the 24-hour nature of many of the Trust's services, the Pharmacy Department is not able to provide such an extended service.

At times when a prescription cannot be dispensed by a pharmacy, doctors and authorised prescribers or registered nurses on wards/units authorised by the Pharmacist, may add dosage instructions and the name of the patient and date of issue to a **pre-pack** of a medicinal product, which has been supplied by the hospital pharmaceutical service for that purpose.

There may be occasions where medication may have to be prepared for delivery to a service user, when the Pharmacy Department is unable to provide this service. In these situations, medication may be prepared by the community team, which must adhere to a procedure that has been agreed by the Pharmacy Team. This procedure may only be used when no other reasonable alternative exists, and only to cover the duration that the Pharmacy Service is unavailable. The procedure may require the training and assessment of staff in specific tasks and skills.

A Chiropodist may supply listed medicinal products to a patient for external use only. In all cases there should be a full record of the issue in the patient's notes.

In general, prescriptions for inpatients who are being discharged should be for a 14 and 28 days' supply respectively, unless a shorter/longer course is indicated, or it is appropriate, at the pharmacist's discretion, to supply the manufacturer's original pack. Medication taken from a 'one-stop' dispensing ward, authorised by pharmacy, will be a minimum of fourteen days' supply.

Before medicines and any compliance/dosage record cards are given to the patient they must be checked against the prescription by a registered nurse, pharmacist or designated pharmacy technician.

Any dispensing errors identified must be reported to the Local NHS SLA provider pharmacy, Trust's Pharmacy team and a DATIX incident report completed.

Patients must not collect their discharge medicines from the Local NHS SLA provider pharmacy except in exceptional circumstances and by prior agreement from the Trust's Pharmacy team. The procedure for checking and issue of medicines for inpatients should be followed on the ward.

Where named patient items have been dispensed for use on the ward, pharmacy will indicate on the TTO prescription if these items are authorised to be taken from the ward for discharge.

As a minimum, it is important to confirm the following information with the patient before allowing them to leave the ward/unit/clinic with medication:-

- Patient's name
- Date of birth
- Address
- Medicines are as prescribed
- Duration of Leave period
- It is the responsibility of the prescriber to ensure patients' Lithium Cards,

Methotrexate Cards, Anticoagulant Cards and Insulin passports are completed prior to discharge.

- Arrangements regarding compliance aids where used

Child resistant containers will normally be used unless otherwise requested on the prescription sheet.

All TTO medication must be stored in a locked medicine cupboard until handed over to the patient or representative.

### **9.1 Patients at Risk from Self-Poisoning / Misuse of Medicines**

If a nurse on a community visit considers that a patient is at risk and capable of planned or accidental self-poisoning they should:-

- Remove the medicines from the home, preferably with the patient's or relative's permission, and store in the hospital medicine cupboard.
- Notify the Consultant and/or GP
- Enter details of medicine, strength and quantity in the patient's nursing record
- If there are mental health capacity issues then the prescriber must be contacted for further discussion

If a patient being discharged or given leave from hospital is similarly at risk, this should be discussed with Pharmacy so the patient is only provided with a **small** supply of medicine e.g. a day, a few days or a week.

If the situation does not warrant immediate removal but the healthcare professional has a concern, it must be documented and shared with the rest of the team and the prescriber.

### **9.2 Labels**

All medicines supplied to the patient in a labelled container should include the name of the patient, date and place of issue, full directions for use and the words "keep out of reach and sight of children".

Labels on medicine containers are not to be altered except by pharmacy staff. If the label is damaged, obliterated or needs amendment, the container is to be returned to the pharmacy as soon as possible, along with the patient's prescription where appropriate.

If the label needs amendment out of hours, it may be altered by an authorised prescriber, must be checked by either another authorised prescriber or a nurse and the label signed as amended.

### **9.3 Patient Information**

All patients should receive advice on how to take their medication, common side-effects and any special dosage instructions e.g. with food, at discharge by the nurse, pharmacy technician or pharmacist present at the time of discharge. The general guiding principle is that patients are entitled to and should receive information about medicines that they are receiving, the aims of the treatment and possible side-effects; this should include both a verbal explanation and a written leaflet.

It should also be noted that the legal requirement to provide the manufacturer's patient information leaflet (PIL) equally applies to patients receiving injections, including depot antipsychotic injections. Consequently, patients should be advised that they may have access to a copy of this leaflet and if they wish, they should be given a copy to keep. Manufacturer provided PILs can be very difficult for patients and carers to understand especially during an acute illness. All staff, patients and carers can access the 'Choice and Medication' website from the internet, which contains information on all medications used within mental health.

The patient should know as a minimum:-

- ✓ The purpose of the medicine
- ✓ How to take it
- ✓ How long it is to be taken for
- ✓ Any side-effects they may experience

Best use should be made of any patient information leaflets supplied with the medicines and any additional leaflets endorsed by the Trust that are available on the Trust's own website.

Patient information is available on request in other formats including large print and electronically. Interpreter and translation services are also available. Many medication leaflets are available in foreign languages where the patient's first language is not English. Please contact Pharmacy as necessary or access the 'Choice and Medication' site for relevant support material.

#### **9.4 Use of Compliance Aids**

Non-compliance with medicines is a major cause of relapse and admission to hospital. For some people a compliance aid may assist them to continue self-medication and remain out of hospital. Medication compliance aids are devices designed to help patients to maintain independence in taking their medication – please refer to **Appendix 2** for more detailed guidance on compliance aids.

#### **10.0 Transporting Medicinal Products**

Any authorised staff member who collects or delivers medicines, accepts responsibility for the safekeeping of those medicines whilst in their possession. Pharmacy accepts responsibility for ensuring that only authorised staff collects medicinal products from the Pharmacy on the production of valid photo identification.

Medication carried by staff will be for:-

- a) direct administration by a nurse to an identified client, or
- b) delivery to an identified client for self-administration over a specified period, or
- c) as a limited stock supply of medication required by nursing and medical members of Home Treatment or Assertive Outreach teams when called to an initial assessment of a new client, or an existing service user whose medication requires urgent review and pharmacy services are not immediately available.

All vehicles used for Trust business must be insured for business purposes and it is the responsibility of each staff member to ensure their vehicle is insured for business purposes.

When items requiring refrigeration are transported, care must be taken to maintain the cold chain at all times, using pharmacy approved cool bags/boxes as appropriate.

### **10.1 Security in Transit**

All Trust employees transporting medicines must carry their Trust identification badge during the transport. This should be shown if requested by a patient, or any other person with reason to check the identity of the employee.

Approved bags, not identifiable as containing medication but preferably marked on the inside with the Trust name and address must be used to carry medication. This includes stocks from the team base for patient administration, and pharmacy dispensed prescriptions for delivery to patients' homes. A container should also be available for sharps and syringes.

Packages including ward boxes must not be left unattended. Delivery vans must be locked when unoccupied.

All medicinal products which are issued from a pharmacy or returned to it must be in a locked or sealed tamper-evident container unless: -

- a) given direct to patient
- b) the messenger is a member of the pharmacy staff, a nurse from the ward/clinical area concerned, a community nurse, medical officer or a nursing support worker acting under direct instructions from a Registered Nurse.

Similar considerations apply to requisitions for medicines.

An audit trail and signatures obtained for every stage of delivery of pharmacy boxes and packages containing medicinal products must be maintained when the messenger is not from the Pharmacy or from the ward/clinical area concerned.

When controlled drugs or stationery are transported, care must be taken to maintain the audit trail and signatures obtained at every point the controlled drug is handed over to another health care professional.

### **10.2 Delivering to a Patient's Home**

A registered nurse, or healthcare assistant acting under direct instructions from her/him, may, if necessary, act as 'messenger' for the patient and obtain medicines prescribed on form FP10 by a General Practitioner or other authorised prescriber from a Community (retail) pharmacy.

Medicines should be in a lockable container either in the possession of the community nurse/nursing support worker, or locked in the boot compartment of a car. Where there is no boot compartment, the lockable container must be hidden from sight in the locked car. The medicines must then either remain in the patient's home or, if part of the treatment plan, be retained in the hospital/ community base, in the community nurse medicine cupboard and given as instructed.

- Trust staff must ensure that dispensed medicines are only handed to the patient or carer
- Posting through letter boxes or leaving medication unsecured is not acceptable
- Leaving medication with a child under 16 is not permissible
- Records must be kept of each prescription delivered and a signature obtained to indicate safe delivery to the patient or carer

Community Nurses must ensure that medicines not used during the day's visits are returned to the hospital/community base for storage in a locked medicines cupboard.

If, in exceptional circumstances e.g. inclement weather, this cannot be done, express permission may be sought from the unit manager for the medicines to be stored in the staff member's home; they must be stored out of sight and reach of children and only for up to 1 working day (24 hours). If the medications involved require refrigeration, or are controlled drugs, they must be returned to the hospital/ community base in all circumstances and not stored in the staff member's home for any period of time.

In the case of adrenaline carried for use in emergency in the CYPD division, the above should apply. However, where safe staffing does not allow or where this might impact on the ability of the team to administer doses of medication to children before or after school etc, it is permitted for nominated staff to take adrenaline home and return to base the following working day (within 48 hours ) after the community visit.

### **10.3 Posting of Medicines**

Medicines should not be sent to patients via the postal system unless the patient or carer is unable to collect and delivery is not possible. In such instances, medicines may only be posted from the pharmacy department and proof of postage must be obtained.

### **11.0 Reporting Losses/Misuse**

The loss or suspected loss or misuse of any medicinal product must be reported by the senior ward/unit nurse to the chief pharmacist in line with the standard operating procedure, 'Medicines Security' (MP2) for controlled drugs.

If accidental damage to any medicinal product occurs, record it on the medication sheet in the patient's records and if possible have it counter-signed by another nurse, or if in the community, the patient, carer or relative. As above, for controlled drugs, the chief pharmacist for must be notified.

The senior nurse is responsible for notifying any loss to the Finance Department in accordance with the Trust's Standing Financial Instructions, but there is no requirement to report losses of a patient's own medicines.

### **12.0 Safe Disposal of Medicines**

The safe disposal of medicines or pharmaceutical waste, is likely to consist of expired or obsolete stock from the wards/units, syringes contaminated with remnant medicines from the preparation of medicinal products and pharmaceutical products, returned by individuals e.g. patients' own medicines that are no longer required. There are 3 types of Pharmaceutical waste:-

1. Hazardous waste
2. Non-hazardous waste
3. Not pharmaceutically active and possessing no hazardous properties e.g. sodium chloride or glucose solutions

Controlled wastes that have a particularly toxic, harmful or dangerous nature are classified as 'hazardous'. These wastes are characterised as having detrimental properties such as being flammable, corrosive, carcinogenic, mutagenic or toxic. These substances, therefore, represent the greatest risk to human health and the environment.

Most pharmaceutical waste is not classified as 'hazardous waste'. The only medicinal products that are deemed hazardous are cytotoxic and cytostatic medicines. These medicines are defined as products that have one or more of the following hazardous properties: Toxic (H6), Carcinogenic (H7), Mutagenic (H11) or Toxic for Reproduction (H10) and should be disposed of in a clearly labelled purple lidded yellow bin, ensuring bins are never overfilled.

The disposal of pharmaceutical waste must comply with 'The Hazardous Waste Regulations 2005'. The storage, carriage, processing and supply of waste are all subject to stringent controls designed to minimise the negative effects of waste on the environment. The regulations prohibit the mixing of hazardous waste with non-hazardous waste. Hazardous waste must be stored separately from other medicines waste and be disposed of using sharps bins with purple lids. Please refer to the Trust's Waste Policy for more detailed information.

### **12.1 Unwanted or Expired Medicines - Inpatient Settings**

Any unwanted medicines must be disposed of in a pharmaceutical waste bin and if one is not available, they must be returned to the Pharmacy Department for safe disposal instead.

Do not use the water system, including the toilet or sluice, to dispose of any medication.

Patients' own medicines returned to Trust Pharmacy for destruction must be accompanied with a completed patient consent form **see Appendix 3** clearly indicating the patient's consent.

When Controlled Drugs pass their expiry date, they should be stored in the controlled drugs cabinet / safe until destruction. They should be segregated and clearly marked as 'expired' stock to prevent them being issued in error to patients. The destruction of controlled drugs must always be witnessed by a pharmacist and recorded in the ward/unit controlled drugs register. Controlled drugs must never leave the ward unless signed out by a pharmacist - please refer to the standard operating procedures on Controlled Drugs for more detailed information.

The possession, handling and supply of controlled drugs are governed by the Misuse of Drugs Act 1972 and the Misuse of Drugs Regulations 1985. Drugs are divided into 5 schedules in the regulations, in decreasing order of restriction. Schedule 4 includes benzodiazepines, which must be denatured before being disposed of. They do not have to be witnessed, nor signed for, nor 'Dooped', just denatured but may not be disposed of by putting blister packs of benzodiazepines in the pharmaceutical waste bin.

Any prepared or partially used vaccines must be destroyed at the end of each immunisation session by placing directly into an appropriate waste bin. All sharps must be disposed of in a sharps bin - please refer to the Trust's Waste Policy for more detailed information.

### **12.2 Unwanted or Expired Medicines - Community**

Medicines must not be removed from the home by a nurse unless it is considered essential for the safety of the patient or they have given their permission. Community staff should offer advice to patients on disposal of unwanted medicines stored in their

own home. If it is considered necessary to remove medication from a patient's home, professional responsibility and judgement should be used, the patient's agreement sought, and removal should be recorded on a patient consent form **see Appendix 3**. The medication should subsequently be taken to the supplying pharmacy department for disposal.

The Trust provides sharps disposal boxes which must be carried (discreetly) and used whenever medication requiring the use of needles and syringes is being administered. Used Sharps boxes must be disposed of according to local arrangements - please refer to Trust "Management of sharps and inoculation policy" for more information.

### **13.0 Procedures connected to this Policy**

- MP1 Medicines Storage SOP
- MP2 Medicines Security SOP
- MP3 Management of Medicines within Crisis Resolution and Home Treatment Teams SOP
- Controlled Drugs

### **14.0 Links to Relevant Legislation**

#### **■ The Human Medicines Regulations 2012**

The regulations replaced most of the Medicines Act 1968 and about 200 statutory instruments with a simplified set of rules following a review of the UK's medicines legislation.

The regulations implemented European directive 2001/83/EC relating to medicinal products for human use (the medicines directive) and set out a comprehensive regime for the authorisation of medicinal products for human use; for the manufacture, import, distribution, sale and supply of those products; for their labelling and advertising; and for pharmacovigilance. The regulations also introduced greater involvement of patients and healthcare professionals in reporting medicine safety issues.

#### **■ The Misuse of Drugs Act 1971**

The Act controls the availability of drugs considered to be dangerous or otherwise harmful, and which have the potential for diversion and misuse. These drugs are listed in the Act and termed 'controlled drugs.' Controlled drugs are further classified according to their perceived harmfulness into Class A, B or C drugs, with Class A drugs being the most harmful.

The Act introduced the concept of irresponsible prescribing and the terms 'controlled drugs' to replace the previously used expression 'dangerous drugs.'

#### **■ The Misuse of Drugs Regulations 2001**

The Regulations authorise and govern certain activities, which would otherwise be illegal under the Misuse of Drugs Act. The Regulations identify those health care professionals who may legitimately possess and supply controlled drugs. They also establish a regime of control around prescribing, administering, safe custody of, dispensing, record keeping and destruction or disposal of controlled drugs.

■ **The Hazardous Waste (England and Wales) Regulations 2005 (as amended by the Hazardous Waste (England and Wales) Regulations 2009)**

- Defines hazardous waste
- Describes how to notify premises producing hazardous waste to the Environment Agency
- Describes the form (consignment note) to be used before hazardous waste can be removed
- Sets out procedures for the multiple collections of hazardous waste
- Describes the records that must be kept
- Sets fees for premises notification and consignments
- Restricts the mixing of wastes
- Sets out penalties for not complying with requirements (fixed penalty notices)

**14.1 Links to Relevant National Standards**

■ **Care Quality Commission's Fundamental Standards introduced 1 April 2015**

These regulations introduce the new fundamental standards, which describe requirements that reflect the recommendations made by Sir Robert Francis following his inquiry into care at Mid Staffordshire NHS Foundation Trust.

**Regulation 12: Safe care and treatment**

The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

■ **Professional Standards for Hospital Pharmacy Services**

Introduced by the Royal Pharmaceutical Society in 2012, there are 10 standards across 3 domains listed below. The standards were developed to help organisations make healthcare safer and to ensure that patients receive a high quality pharmacy service.

Domain 1 Patient experience

Standard 1: putting patients first

Standard 2: episode of care

Standard 3: integrated transfer of care

Domain 2 Safe & effective use of medicines

Standard 4: effective use of medicines

Standard 5: medicines expertise

Standard 6: safe use of medicines

Standard 7: supply of medicines

Domain 3 Delivering the service

Standard 8: leadership

Standard 9: governance and financial management

Standard 10: workforce

**14.2 Links to other Key Policies**

## ■ Administration of Medicines Policy

Medicines play a vital role in the care of the people who use our services. Administering medicines to people should not be regarded as just a mechanical task to be carried out in line with the instructions of the prescriber, but requires thought, application and the exercise of professional judgement; it is a core component of medicines management and encompasses many areas for potential error.

A review of all medication incidents reported to the National Reporting and Learning System in England in Wales from 2005-2010 revealed that of the 526,186 incidents reported, 50% were attributable to the administration of medicines.

The aim of the policy is to ensure that all nurses, including bank and agency staff and other health care individuals, follow safe and best practice in all activities relating to the administration of medicines within inpatient, outpatient, community and residential settings.

## ■ Medicines Errors Policy

Medication is the most common medical intervention within the NHS and particularly within mental health. Whilst every care is taken by individuals and the organisation when managing medication, errors involving medicines are sometimes inevitable due to human involvement. Medication errors are defined as patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred

This policy describes the procedure that must be followed when a medication error occurs. The procedure describes the immediate action to be taken to ensure patient safety, the grading of errors (where appropriate) and longer term actions to ensure that individuals, teams and the wider organisation can learn lessons.

## ■ Control of Substances Hazardous to Health (COSHH) Policy

COSHH Regulations apply to substances that have already been classified as being toxic, very toxic, harmful, corrosive or irritant under the Classification, Labelling and Packaging Regulations and to those substances that have a Workplace Exposure Limit (WEL), biological agents, respirable and inhalable dusts.

The Trust objectives are to take all reasonable steps to secure the health, safety and welfare of its employees and anyone who may come into contact with substances hazardous to health by:

- Protecting people against health risks that may arise from hazardous substances used or encountered whilst at work
- Ensuring that the least hazardous substances are purchased and used within the Trust

The aim of the policy is to provide employees with guidance of how to manage, assess and control the risk to health from hazardous substances and to minimise the risk to staff, visitors, patients and contractors from the exposure to hazardous substances whilst at work.

## ■ Waste Management Policy

The Trust has a legal obligation and a Duty of Care to ensure that all waste generated within the Trust is dealt with in accordance with legal obligations and codes of practice. The Trust is committed to ensuring that, as far as is reasonably practicable, waste is managed, audited and disposed of safely and without risk to people or the environment.

The purpose of the policy is to provide all staff with explicit guidance in the safe handling and disposal of all wastes in line with health and safety and infection control

The policy sets out a framework for the good practice of waste management to help employees of the Trust meet legislative requirements.

The underpinning philosophy of the policy mirrors the recognised hierarchy of waste i.e. prevent, reuse, recycle, recover, disposal and the trust will seek to demonstrate continual improvement in waste management by use of suitable quantitative targets.

### **14.3 References**

- Control of Substances Hazardous to Health Regulations 1988 (COSHH)
- Standards for Medicines Management: Nursing and Midwifery Council (2008)
- Guidelines for records and record keeping, Nursing & Midwifery Council (NMC) 1998
- The Misuse of Drugs Act 1971
- Patient Group Directions HSC 2000/026
- The Safe and Secure Handling of Medicines (Revision of the Duthie Report) Royal Pharmaceutical Society of Great Britain 2005.
- Safer Management of Controlled Drugs: (1) Guidance on Strengthened Management Arrangements January 2007
- Safer Management of Controlled Drugs: a guide to good practice in secondary care (England) (DH 2007)
- British National Formulary

## 15.0 Roles and Responsibilities for this Policy

Title	Role	Key Responsibilities
Medical Director	Executive Lead	<ul style="list-style-type: none"> <li>- lead responsibility for the implementation of medicines policies</li> <li>- allocation of resources to support the implementation of medicines policies</li> <li>- Chair of the Trust's Medicines Management Committee</li> <li>- any serious concerns regarding the implementation of this policy are brought to the attention of the Board of Directors</li> </ul>
Chief Pharmacist	Medicines Lead	<ul style="list-style-type: none"> <li>- ensure the Trust complies with national guidance relating to the prescribing, administration and safety of medicines</li> <li>- ensure that Groups are fully informed of their role in maintaining the required standards of practice</li> <li>- day to day management for all aspects of the safe and secure handling of medicines within the Trust</li> <li>- lead on strategies and innovations to improve current practice</li> <li>- policy lead/author of this policy</li> </ul>
Clinical Directors/ Heads of Nursing/ General Managers	Operational Leadership	<ul style="list-style-type: none"> <li>- to ensure policy distribution, implementation and compliance throughout relevant wards, units and services within their group</li> <li>- staff have received sufficient training and/or are competent to implement the policy</li> <li>- professional standards of record keeping are maintained</li> <li>- lead discussions around this topic area and policy at Group Quality and Safety Group meetings</li> <li>- oversee the completion of audits in respect of this topic area and policy</li> <li>- provide updates on this area of practice and policy within their Group to the Quality and Safety Steering Group</li> </ul>
MH/LD/CYPF Quality and Safety Groups	Monitoring	<ul style="list-style-type: none"> <li>- monitor and review all incidents, complaints and claims relating to this area of practice and policy within their Group</li> <li>- review practice to ensure that it is applied appropriately and in line with this policy</li> <li>- receive the results and recommendations of all related completed clinical audits and be responsible for monitoring action plans to implement changes to current practice until completion</li> </ul>
Medicines Management Committee	Scrutiny and Performance	<ul style="list-style-type: none"> <li>- oversees the governance of medicines management across the Trust</li> <li>- receive specific issues in relation to the delivery, development and monitoring of medicines management</li> <li>- review all policies, guidelines and procedures including PGD's, SOP's and prescribing documentation affecting drug use or medicines management</li> <li>- ensure adherence to the joint health economy medicines formulary including antibiotics</li> </ul>
Ward/Unit Managers/ Trust Pharmacy Team	Day to Day Monitoring	<ul style="list-style-type: none"> <li>- supporting the implementation and monitoring of this policy</li> <li>- provide support and advice to all staff involved in the management of medicines as necessary</li> <li>- all incidents, complaints and claims relating to this area of practice and policy are reported</li> </ul>
All staff involved in the day to day ordering, storage and safe disposal of medicines	Implementation and Adherence	<ul style="list-style-type: none"> <li>- have a responsibility to familiarise themselves with this policy and adhere to its principles in order to be able to respond to the immediate needs of patients</li> <li>- always treat patients with dignity and respect their right to make decisions even when you may disagree with them</li> <li>- attend training applicable to their role</li> <li>- ensure they are competent to carry out their responsibilities for medicines and be accountable for their actions</li> <li>- compliance with all Trust policies is a condition of employment and a breach of this policy may result in disciplinary action</li> <li>- any errors or incidents relating to this policy and area of practice are reported on DATIX, the Trust's electronic incident reporting system.</li> <li>- if a member of staff has concerns about the way this policy is being implemented or about this area of practice in general,</li> </ul>

Title	Role	Key Responsibilities
All staff involved in the day to day ordering, storage and safe disposal of medicines	Implementation and Adherence	they should raise this with their line manager. If they feel unable to raise the matter with them, he/she may write to an Executive Director. If they feel unable to raise the matter with an Executive Director, he/she may write to the Chairman or a Non-Executive Director. If he/she is unsure about raising a concern or requires independent advice or support, they can contact:- - their Trade Union representative - the relevant professional body - the NHS Whistleblowing Helpline - 08000 724 725

## 16.0 Training

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	How will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training?
No specific training is required as competency is achieved as part of the qualification to practice as a nurse practitioner or other healthcare professional	N/A	N/A	N/A	N/A	N/A	N/A
Medicines Management Refresher Training which incorporates aspects of this policy	Inpatient Nursing Staff and Medical Staff, Health Visitors	Yes	Face to Face training	Arranged by Learning and Development	Every 2 years	Workforce Development Group

## 17.0 Equality Impact Assessment

Black Country Partnership NHS Foundation Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Equality & Diversity Team on Ext. 8067 or email [EqualityImpact.assessment@bcpft.nhs.uk](mailto:EqualityImpact.assessment@bcpft.nhs.uk)

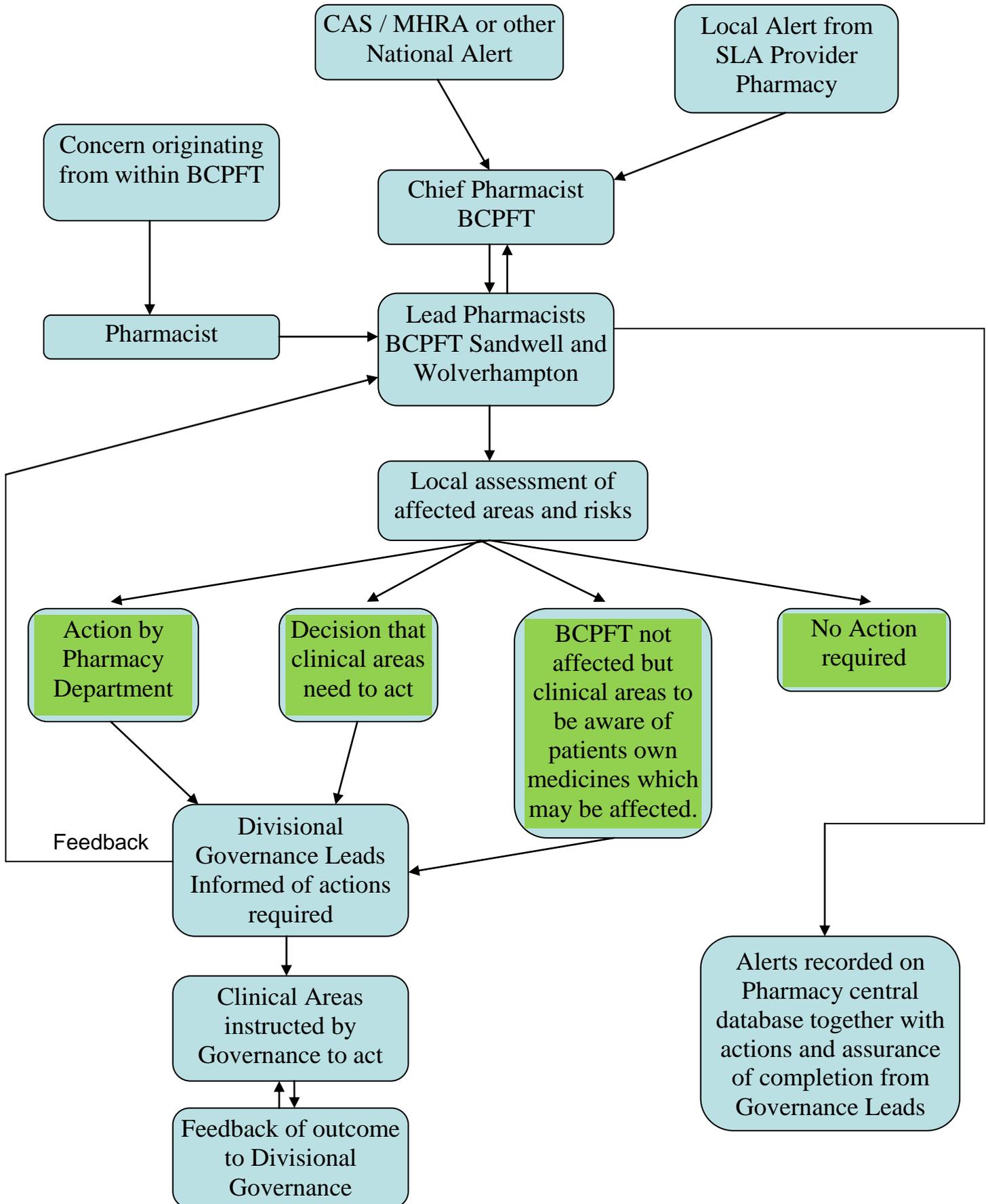
## 18.0 Data Protection and Freedom of Information

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

## 19.0 Monitoring this policy is working in practice

What key elements will be monitored? (measurable policy objectives)	Where described in policy?	How will they be monitored? (method + sample size)	Who will undertake this monitoring?	How Frequently?	Group/Committee that will receive and review results	Group/Committee to ensure actions are completed	Evidence this has happened
Medication of a suitable quality is supplied by a local NHS SLA Provider in a timely manner for the benefit of patients	4.0	The details of the arrangement are set out in a formal agreement between the Trust and the NHS SLA Provider	Chief Pharmacist and Contracts Department	Day to Day basis throughout the year	Medicines Management Committee	Medicines Management Committee	Reports and Minutes of Meetings
Medication is requisitioned/ordered effectively in a timely manner for the benefit of patients	5.0	Ward/Unit staff raise any issues directly with the local NHS SLA Provider	Pharmacy Team liaise with the local NHS SLA Provider	Day to Day basis throughout the year	Medicines Management Committee	Medicines Management Committee	Reports and Minutes of Meetings
Medication is received and stored safely and appropriately	6.0 7.0	Every incident is routinely reported on DATIX Trust's Incident Reporting System and collated into a report	Chief Pharmacist reviews all DATIX medication entries to detect trends and provides a report	Quarterly	Medicines Management Committee	Medicines Management Committee	Completed Action Plans and minutes of Meetings
Safety Alerts for all relevant medicinal products are cascaded effectively to clinical services and actioned in a timely manner	8.0	A return for each safety alert is completed stating the action that has been taken	Corporate Governance Assurance Unit	Monthly	Medical Devices Group	Medical Devices Group	Reports and minutes of meetings
Medication is transported safely	10.0	Every incident is routinely reported on DATIX Trust's Incident Reporting System and collated into a report	Chief Pharmacist reviews all DATIX medication entries to detect trends and provides a report	Quarterly	Medicines Management Committee	Medicines Management Committee	Completed Action Plans and minutes of Meetings
Medication is safely disposed of where this is required	12.0	Every incident is routinely reported on DATIX Trust's Incident Reporting System and collated into a report	Chief Pharmacist reviews all DATIX medication entries to detect trends and provides a report	Quarterly	Medicines Management Committee	Medicines Management Committee	Completed Action Plans and minutes of Meetings

**Appendix 1 - Medicines Safety Alerts Cascade Process**



## Appendix 2                    **Guidance on the use of Compliance Aids**

Non-compliance with medicines is a major cause of relapse and admission to hospital. There are many factors which can lead to non-compliance with medicines. These include:-

- A poor understanding of the need for medicines
- A poor understanding of how to take the medicines
- Forgetfulness
- Inability to open the containers
- Unwanted side-effects
- Poor sight
- A complicated regime of medicines

For some people a compliance aid may assist them to continue self-medication and remain out of hospital. Medication compliance aids are devices designed to help patients to maintain independence in taking their medication.

Compliance aids vary but most require to be replenished on a weekly basis. Community Pharmacists use a variety of compliance aids and the availability of appropriate support should be assessed before commencing to use one particular method. A patient should only be commenced on a compliance aid that they will be able to obtain after discharge to ensure continuity of care. Inpatients requiring a compliance aid must be trained in its use and must be assessed as to their ability to self-medicate prior to discharge.

### **Initiating a compliance aid for a patient**

Before recommending a compliance aid, a full assessment of the reason for non-compliance should take place, **using the Compliance Aid Assessment Tool below**. It may be that the provision of a compliance aid may not be appropriate if there is limited benefit but significant additional costs are incurred and additional risks are imposed. They are generally not childproof, are bulky and many medicines are not suitable for inclusion. Patients and carers are free to purchase them for their personal use. Please refer to the compliance aid assessment tool below.

### **Patients admitted with compliance aids in place**

Where patients are admitted with a compliance aid in place, this should be recorded on the drug chart and in the patient notes.

Nurses are not authorised to routinely administer medicines from compliance aids. Only Pharmacy can authorise medicines to be administered from a compliance aid and only when medication cannot be obtained from a more appropriate source in a timely manner.

Patients may be advised or assisted to fill their own compliance aids in some circumstances. Patients may be assisted to use a compliance aid as part of a rehabilitation/self-administration service where available.

### **Discharge Processes**

If a compliance aid is required at discharge, firstly ask the patient or carers to identify a local community pharmacy, usually their regular pharmacy that dispenses into compliance aids. The prescriber should complete the Discharge TTO form, for information, for the patient, clinical notes and GP, but also issue an FP10 for the patients preferred community pharmacy prior to discharge. This FP10 should be clinically screened by a Trust Pharmacist prior to issue to an external pharmacy where possible. Where the Trust Pharmacy is closed, a copy of the FP10 should be made prior to issue, and sent to pharmacy the next working day so that a retrospective check can be completed.

The nursing team will facilitate communications with community pharmacies and GPs regarding compliance aids, with support from the Trust Pharmacy team.

### Assessing the needs of the service user

If adherence to medication is considered to be a concern for an individual the situation must be discussed by the relevant parties. These may include the service user, a carer and appropriate professionals.

A medication review and compliance assessment should be performed to ensure that the medication taken is necessary and appropriate. The regime should be as simple as possible.

Problem	Action / Possible solutions
Difficulty reading labels	Large print Colour coded bottles Use numbers and not words Use symbols Translation into different language
Difficulty opening and closing bottles	Use non child resistant tops, or winged tops
Difficulty handling boxes and bottles	Use larger bottles or boxes Consider compliance aid
Half tablet dose	Pharmacy will halve tablets if appropriate
Difficulty pushing tablets out of blister pack	Pharmacy will de-blister if appropriate
Difficulty with liquid measurements	Provide alternative formulation
Difficulty swallowing	Change formulation. Many tablets may be dispersed in water
Is Service User confused	Support Synchronise doses to daily events Reduce frequency of doses, if possible all medicines to be taken at same time of day A supplementary medication administration chart with tick boxes may help Supply medicines on a weekly basis, rather than monthly
Does Service User forget to take medicines	Simplify regime or supply a system for reminding Organise support Service User such as an alarm or chart Consider a compliance aid
Understand the risks associated with not complying Unacceptable side effects	Educate and support. Provide verbal and written information. Identify side effects Improve therapy to minimise side effects. Use of slow release, preparations, change administration times Treat side effects
Have poor or no motivation	Provide education about benefits
Understand the need for the medicine	Provide education and consider treatment regime and support.

### The following preparations should not be put in a compliance aid

- × Effervescent tablets
- × Sublingual tablets
- × Buccal tablets
- × Chewable tablets

× Oro-dispersible tablets

Hygroscopic tablets and medicines requiring a desiccant

'When required' doses and variable doses (dose dependent upon biochemistry)

**Risks associated with compliance aids**

- ~ Medidose/Medisure/Nomad systems etc. are not child resistant
- ~ Other systems may be difficult to open
- ~ Swapping from one system to another will be confusing
- ~ Filling compliance aids is time consuming and subject to errors and delays
- ~ The medicines are removed from their packaging thereby removing the batch number, the expiry date and the Patient Information Leaflet
- ~ Some compliance aids are not sealed after filling and there is opportunity for tablets to be added or removed. The aid may be dropped spilling all the tablets, some of which may be difficult to identify easily
- ~ Service Users may obtain medicines from the mental health service and from the GP. It is difficult to ensure that all the medicines are in the one compliance aid
- ~ Risks where dose changes are not communicated effectively or in a timely manner
- ~ Patients may find it difficult to identify individual medicines with some compliance aid systems

## Compliance Aid Assessment Tool

Patient's name: ..... DOB: .....

Current Location (Ward or Community): .....

Permanent Address: .....  
.....

GP..... Community Pharmacist (if known).....

Reason for request (more than one box may be ticked)

Confused ( ) Poor Memory ( )

Difficulty with containers ( ) Difficulty reading label ( )

Previous concordance problems ( )

Other ( ) Please Specify .....

Who will be responsible for administering the patient's medication following discharge?

Patient ( ) Carer ( ) Other ( ) Please specify .....

Who will fill the compliance aid after discharge?

Patient ( ) Carer ( ) Community Pharmacist ( ) Hospital Pharmacy ( )

Other ( ) Please specify .....

Assessment by ..... Designation .....

Ability with labels:

Can read:    Computer { }    Large print { }    Understand instructions { }

Ability with Containers:

Summary of findings

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Patient is competent to self-medicate YES { }    NO { }

Signature of Nurse .....

Date ..... Time .....

Appendix 3



Patient's Own Medicines Destruction Consent Form

[ ] I give my consent to Black Country Partnership NHS Foundation Trust disposing of the medicines brought into hospital.

Patient Name: Patient Signature: Date:
.....
...

[ ] I want my medicines to be returned home.

[ ] I understand I MUST check with my doctor (GP) before using them again. I have had the risks explained to me.

Patient Name: Patient Signature:
.....

Patient told of risks by: Signature:
Designation:
.....

Date .....

Name of person accepting medication for return home: Signature:
.....

Date:.....

[ ] The patient is unable to give informed consent. (Details documented in patients notes).

Nurse Name: Nurse Signature: Date:
.....

....

....

...

[ ] The patient has been discharged from hospital without their own medication

Nurse Name:

Nurse Signature:

Date:

.....

.....

.....

....

....

...

Items Concerned:

1.	2.	3.
4.	5.	6.
7.	8.	9.

Reason for destruction/ Information given:

1.	2.	3.
4.	5.	6.
7.	8.	9.

Medication taken for destruction by:

Pharmacist/ Pharmacy

Pharmacist/ Technician

Date:

Technician:

Signature:

.....

.....

.....

....

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This form should be retained in the patient's medical notes

## Policy Details

<b>Title of Policy</b>	Supply, Storage and Disposal of Medicines
<b>Unique Identifier</b> for this policy	BCPFT-MM-POL-03
State if policy is <b>New</b> or <b>Revised</b>	Revised
<b>Previous Policy Title</b> where applicable	Medicines Policy
<b>Policy Category</b> Clinical, HR, H&S, Infection Control etc.	Medicines Management
<b>Executive Director</b> whose portfolio this policy comes under	Medical Director
<b>Policy Lead/Author</b> Job titles only	Chief Pharmacist
<b>Committee/Group responsible for the approval of this policy</b>	Medicines Management Committee
<b>Month/year consultation process completed *</b>	September 2015
<b>Month/year policy approved</b>	March 2017
<b>Month/year policy ratified and issued</b>	November 2015
<b>Next review date</b>	March 2020
<b>Implementation Plan completed *</b>	Yes
<b>Equality Impact Assessment completed *</b>	Yes
<b>Previous version(s) archived *</b>	Yes
<b>Disclosure status</b>	'B' can be disclosed to patients and the public
<b>Key Words</b> for this policy	medicines, dispense, storage, supply, safe handling, disposal, transportation, pharmacy

\* For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Governance

### Review and Amendment History

Version	Date	Details of Change
V2.1	March 2017	Changes relating to CYPD division realtting to practice with adrenline.
V2.0	Nov 2015	Significant revision of policy to align practice and comply with guidance
V1.1	Nov 2012	Minor changes to policy to adhere to NHSLA requirements
V1.0	Aug 2012	Policy for the new organisation BCPFT