Administration of Medicines

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**Explanation of terms used in this policy**

**Administer** - to give to a patient a medicinal product, dressing or medical device, either by introduction into the body, either orally or by injection, etc. or by external application e.g. application of an ointment or dressing

**Medicine** - any substance or combination of substances presented for treating or preventing disease. Any substance or combination of substances which may be administered with a view to making a medical diagnosis or restoring, correcting or modifying physiological or psychological functions

**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

**Nursing Associate** – members of the nursing team, who have gained a foundation degree, typically involving 2 years of higher education. Registered with the Nursing and Midwifery Council.

**Registered Nurse** - any nurse or specialist community public health nurse who is registered with the Nursing and Midwifery Council

**INR** - a measure of how quickly blood clots, the higher the INR is, the longer it takes the blood to clot. A variety of reagents can be used in this process so the result has to be converted into International Normalised Ratios (INR), which are standard units that can be compared regardless of the reagent used

**BM** - Blood glucose (literally it stands for Bohringer Mannheim, a German pharmaceutical company now called Roche) and the BM-Test is a blood glucose testing strip they make

**PRN Medication** – ‘PRN’ is a Latin term that stands for ‘pro re nata,’ which means “as the thing is needed”

**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

**Cytotoxic** - refers to a substance or process which results in cell damage or cell death. Cytotoxic drugs are labelled “cytotoxic” because they treat malignancies by directly killing tumour cells although the ability of these drugs to treat arthritis and related conditions may, be due to their anti-inflammatory effects as opposed to their ability to kill cells.

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

**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

**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

**DATIX** – the name of the incident reporting software system in operation across the Trust
1.0 Introduction
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, it 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.

This policy describes the standards, procedures and good practice to be applied by nurses and other health care individuals involved in the administration of medicines across all services within Black Country Partnership NHS Foundation Trust.

2.0 Purpose
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.

3.0 Objectives
- All nurses and other health care staff practice the ‘6 rights’ of medication administration, right patient, right medication, right dose, right route, right time, right documentation
- Promote a consistent and best practice approach to the safe administration of medicines
- Provide a process that supports registered nurses and other health care staff in their role in the safe administration of medicines
- All incidents relating to the administration of medicines are reported in a timely manner
- Provide a framework for nurses and other health care staff to analyse their experiences, learn from incidents and subsequently improve their practice

4.0 Process
4.1 Who can administer?
4.2 Key Principles
4.3 Best Practice
4.4 Checking the Prescription
4.5 Medicines requiring additional checks
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4.1 Who can administer?
The following staff are authorised to administer medicines providing they have undertaken the necessary training and have been deemed competent:

- A Registered Nurse
- A Registered Medical Practitioner
- A Registered Pharmacist
- A Registered Pharmacy Technician
- A Registered Nursing Associate
- Physiotherapists under the direction of an authorised prescriber and where it is has direct relevance to a specific therapy
- Qualified health professional stipulated in a current Patient Group Direction
- Appropriately qualified and registered bank and agency nurses after having successfully completed the Trust’s Medicines Management Competency Assessment.
- Healthcare Support Workers who have attained NVQ Level 3 or higher and are deemed competent following appropriate training, assessment and regular supervision, may assist in the administration of medicines listed below at the discretion of the ward/departmental manager:
  - Application of topical medicines
  - Installation of ear/eye/nasal drops
  - Inhalers/aerosol devices
  - Oral medicines excluding controlled drugs
  - Epileptic fit rescue medicine (Children’s Division only)
  - Oxygen (Children’s Division only)
• Healthcare Support Workers must adhere to NMC guidance for the administration of medicines in the best interests of their patients.

• In all cases however, a named registered nurse will remain responsible and accountable for the delegation of such duties and any actions taken by a healthcare support worker acting under their authority.

• Nurses in training including return to practice students and overseas registered nurses during their adaptation period are subject to the supervision and accountability of another registered nurse. The supervising registered nurse is responsible for ensuring that the medicine is correctly administered

• Nurses in training must NOT administer medicines using the intravenous route (other than replacing infusion bags without additives) or administration by pump.

• Patient (to him/herself)

4.2 Key Principles
Every authorised person involved in administering a medicine to a patient must have knowledge of the patient’s assessment and be satisfied that the medication and dose are appropriate for the patient. They must also know the therapeutic uses of the medicine, its normal dosage, side effects, precautions and contra-indications.

This is important for ALL medicines but is particularly important for:-
- Anticoagulants where dose is dependent on INR - check INR before administration
- Opioids, where usual starting doses vary depending on the patient and in palliative care, where doses are higher than normally required
- Medicines requiring regular blood level monitoring e.g. Lithium
- Medicines requiring regular blood counts e.g. Methotrexate and Clozapine
- Insulin - check BM

The person administering or checking must examine the dose and formulation of the preparation and be aware of any interacting medication. Information regarding starting doses, formulations and dose conversions may be found in:-
~ Current BNF-individual monographs, also available on intranet
~ BNF section “prescribing in palliative care”
~ Current BNF for children – available on intranet
~ Palliative care formulary or www.palliativedrugs.com
~ Summary of Product Characteristics for individual products (SPC) www.emc.medicines.org.uk

Every authorised person involved in administering a medicine to a patient must always exercise professional judgement and apply knowledge and skill to the situation that applies at that time. This requires the individual to:-

- Have an understanding of substances used for diagnostic, therapeutic and prophylactic purposes
- Ensure that omission or delay of a critical medicine does not occur
- Be able to justify any actions taken
- Be prepared to be accountable for the actions take
For all ‘PRN’ prescriptions, an entry in the nursing records must give the reasons for the administration and patient’s response to treatment.

Where variable dosage is prescribed for a patient, the authorised person involved in administering the medicine must record on the prescription sheet the actual dosage administered.

4.1 Best Practice
The correct drug in the correct dose is always given to the correct person at the correct time by the correct route and that the patient actually takes the medicine and that informed consent has been gained or there is a consent to treatment attached to the drug card.

The process of administering medicines should be explained to the patient, where appropriate.

Staff should not be interrupted during the administration of medicines unless there is an emergency.

Inpatient Units
Two qualified staff should administer medicines and second checks must incorporate the whole administration process. A single registered member of staff nurse may administer medicines where staffing levels do not allow two qualified staff to be available except when administering depot injections, intravenous and subcutaneous infusions, controlled drugs and insulin.

The checking of administration by a second person, who must be a registered nurse or, if not available, a medical officer or pharmacist, is required in ALL SETTINGS *with the exception of the Palliative Care – Children’s Community Nursing Team (Formerly See-Saw team) – please see below

in the following circumstances:-

- Where a patient’s condition makes it necessary
- Where a dose calculation is required e.g. volume of liquid, fraction of reconstituted vial or part of an ampoule or a weight-related dose to be administered
- Administration to a child under 12 years of age
- Any drug administered by pump
- Administration of cytotoxic medicines by any route

Palliative Care – Children’s Community Nursing Team

Within the specialist Palliative care children’s community nursing team, it is expected that where staffing levels do not allow, it would be appropriate for a competent single registered nurse to administer in the following circumstances:

- Where a dose calculation is required e.g. volume of liquid, fraction of reconstituted vial or part of an ampoule or a weight-related dose to be administered

In this case, it is expected that any calculations and dosage checks are conducted at “base” with a 2nd competent checker (registered nurse or, if not available, a medical officer or pharmacist) at before administering nurse leaves to administer the dose. A written record of this calculation check and the name of the checker should be documented within the notes.

- Administration to a child under 12 years of age
- Any drug administered by pump

In this case, it is expected that any calculations and infusion rates are checked as appropriate at "base" with a 2nd competent checker (registered nurse or, if not available, a medical officer or pharmacist) at before administering nurse leaves to administer the dose via pump. A written record of this calculation check and the name of the checker should be documented within the notes.

- Administration of cytotoxic medicines by any route

It is common for the children's palliative community nursing team to administer cytotox agents and that this would not require a second check unless a calculation is required to administer the correct dose.

Community Services

Community staff are required to have a prescription card for the purposes of administration of medication in the community. Where possible, this should be a record of all currently prescribed medication, as far as is practically possible, to enable continuity of care.

All drugs to be administered must have been prescribed for that named patient, by the prescriber concerned, on the patient's individual prescription chart. Records should be completed immediately after the drug is administered, or if a dose is refused or wasted, this must also be recorded, signed and dated.

A copy of the manufacturer's patient information leaflet must be given to the patient when a medicine is administered for the first time, and subsequently if requested.

Where a community nurse is alone when attending a patient's home to administer medication, a second check is not required for the majority of medications, due to the nature of the role and the safeguards in place. The exceptions are listed below:

- Where a patient's condition makes it necessary
- Where a dose calculation is required e.g. volume of liquid, fraction of reconstituted vial or part of an ampoule or a weight-related dose to be administered
- Administration to a child under 12 years of age
- Any drug administered by pump
- Administration of cytotoxic medicines by any route

Specially trained and authorised Outreach Workers may take individual doses to a client's home and witness the administration. The Registered Nurse remains responsible for ensuring that administration is complete.

4.3 Checking the Prescription

Confirm patient identity, by visually checking the name band and verbally by asking the patient their name and date of birth. Where this is not available, particular care must be taken to check by other means e.g. personal knowledge of patient. Local arrangements may include attaching photos to medication charts to assist in the identification of patients e.g. Learning disabilities.

All medication charts currently in use for the patient are available and that the demographics on the medicine chart match those of the actual patient (i.e. name, date of birth, hospital number etc.). All sections of the medication chart are checked e.g. PRN, regular medicines and variable dose section to avoid omissions.

The medicine has been prescribed by an authorised prescriber or is administered in accordance with an approved patient group direction.
Be aware of the patient’s care plan

The prescription has not expired, is legally valid – see some typical examples in the table below:

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<tr>
<td>Use by 31.5.19</td>
<td>Do not use after 31st May 2019</td>
</tr>
<tr>
<td>Use by end of September 2021</td>
<td>Do not use after 30th September 2021</td>
</tr>
<tr>
<td>Expires May 2020</td>
<td>Do not use after 31st May 2020</td>
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Further information is contained within “Supply, Storage and Safe Disposal of Medicines Policy” available on the Trust intranet

Things to check on a prescription prior to administration (not exhaustive):

The allergy status is completed and the patient does not have an allergy or intolerance to the medicine. This must include any known drug/food/chemical/dressing hypersensitivity, and any information which may affect medicine selection or dosage e.g. previous gastro-intestinal bleed with non-steroidal anti-inflammatory drugs.

The prescriber must sign and date the drug allergies and sensitivities box. If the ‘drug allergies and sensitivities’ box has not been completed appropriately, medicines should NOT be administered and the prescription referred back to the prescriber. A DATIX incident form should be completed so the incident can be followed up by the prescriber's supervisor.

The due dose has not already been given

The prescription and the label on the medicine must be clearly written and unambiguous

PRN medication states the reason/indication, maximum dose in 24 hours and minimum interval between doses - the time of the last dose must be checked before administration.

Be aware of any special guidance relating to the dose offered, e.g. dilution with water, before food etc.

Check that the dose has not already been administered/self-administered.

The correct medicine, formulation, dose and route have been selected; be aware of any precautions and special instructions

4.4 Medicines requiring additional checks

The medications identified in the table below have been the subject of Patient Safety Alerts and therefore additional checks should always be undertaken. Wherever there is any doubt or uncertainty about the administration of these medicines, practitioners should consult the latest BNF in the first instance and seek further advice from the Pharmacy team.
### Name of Drug and Key Actions

#### Warfarin
- Ensure the patient has up to date yellow booklet (available from pharmacy).
- In inpatient areas prescribe Warfarin on anticoagulant chart and ensure it is also prescribed on the regular medication section. Ensure that clinical indication, target INR and duration of treatment are all completed.
- Aim to keep the daily dose the same
- On discharge/leave ensure the yellow book is completed and handed to the patient

#### Methotrexate
- Unless administered as part of chemotherapy all doses are **once weekly**.
- Ensure when prescribing the treatment chart is blocked out appropriately to prevent incorrect administration. Methotrexate tablets are only available in the Trust as 2.5mg tablets.
- Check folic acid regimen patient is on. This is usually 5mg **once weekly** three days after the methotrexate. Other folic acid regimens are followed but methotrexate and folic acid are **never** given on the same day
- Check patient has a monitoring booklet (available from pharmacy) and is aware of symptoms that require medical follow up

#### Opioid Medicines for pain relief
Outside of an acute emergency observe the following:-
- Confirm any recent opioid dose, formulation and any other analgesic medicines prescribed for the patient
- Ensure where a dose increase is intended that the calculated dose is safe for the patient- usually this would be not more than 50% higher than previous dose
- Ensure you are familiar with the following: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side-effects, and the use of reversal agents e.g. Naloxone

#### Lithium
- Ensure all patients initiated on lithium are provided with an NPSA Lithium resource pack (available from wards, clinics or pharmacy) and that it is completed by a competent practitioner. It is the responsibility of the prescriber starting the treatment to ensure this happens.
- Always prescribe lithium by brand - the Trust brand is Priadel. Complete prior to treatment blood tests and then weekly blood levels until dose is stabilised as per Trust policy.
- Check for interactions in the BNF

#### Insulin
- Only use insulin syringes to administer insulin. Always check patient’s insulin passport to confirm correct dose and identity of insulin product before prescribing or administering insulin.
- Always ensure the insulin passport is up to date and correct
- Patients can self-medicate using Pen devices
- **Always write as UNITS in full**
- All nursing staff involved in the administration of insulin must undertake the online training accessed at [Safe use of insulin - Safe use of insulin - e-learning course - NHS Diabetes](#)

### 4.6 Loading Dose Medicines
A loading dose is an initial dose of a medicine used to ensure a quick therapeutic response. It is usually given for a short period before therapy continues with a lower maintenance dose. The use of loading doses of medicines can be complex and error
prone. Incorrect use of loading doses or subsequent maintenance regimens may lead to severe harm or death.

Please refer to Appendix 1, which provides a risk assessment of a list of critical medicines approved by the Trust’s Medicines Management Committee, that are likely to cause harm if loading doses and subsequent maintenance doses are not prescribed and administered correctly.

4.7 Medicine Calculations
Some medicine administrations can require complex calculations to ensure that the correct volume or dose is administered. The nurse responsible for the administration of the medicine must ensure the calculation is correct. A second practitioner must check the calculation in order to minimise the risk of error.

All calculations must be conducted independently and the results of the calculations must correspond. If they do not, calculations must be repeated independently; if there is still a discrepancy between the two calculations, assistance should be sought from a third nurse, doctor or pharmacist. Medicines of any kind must not be given if there is any doubt over the accuracy of the calculation.

Nurses administering medicines in patients own home may do the calculation without a second check, if they are competent to do so. If the calculation is complex, or unfamiliar, it is the responsibility of the nurse to ensure a second check is obtained, as above.

4.8 Preparing Medicines in advance of Administration
Medicines must not be prepared in advance of administration except:-
- for antibiotic syrups requiring reconstitution
- compliance aids (e.g. Dosette Boxes, Nomad Trays, Compliance Pre-packs)
- individual doses prepared by a Registered Nurse for an Outreach Worker to take to a Client’s home. The tablet bag must be labelled with details of the medicine(s), name, strength and dose, date and the name of the patient.
- when undertaken by pharmacy staff
- when authorised by the Trust Chief Pharmacist or his deputy

The filling of compliance aids e.g. Dosette Boxes, Nomad Trays, Compliance Pre-packs must only be undertaken by an external pharmacy contractor, a community pharmacy or the patient or carer themselves.

4.9 Consent
Valid consent must be obtained before starting any treatment including the administration of medicines.

Informed consent applies when a person can be said to have given consent based on a clear appreciation and understanding of the facts, and the implications and consequences of an action.

Consent can be either explicit (specific consent to carry out a specific action) or implied (not expressly given by a patient, but inferred from their actions, the facts and circumstances of a particular situation, and sometimes a patient’s silence or inaction). Generally, there is no legal requirement to obtain written consent but it may be advisable in some circumstances.

Every effort should be made to obtain consent from the patient to accept the prescribed medication but consent must be given voluntarily and not under any form of duress or undue influence from health professionals, family or friends.
Consent is a continuing process rather than a one-off decision. It is important that a patient be given continuing opportunities to ask further questions and to review the decision.

All people aged 16 and over are presumed, in law, to have the capacity to consent to treatment unless there is evidence to the contrary. A patient who is suffering from a mental disorder or impairment does not necessarily lack the competence to consent to treatment. To demonstrate capacity individuals should be able to:
- understand what the medical treatment is, its purpose and nature and why it is being proposed
- understand the benefits, risks and alternatives
- understand the consequences of not receiving the proposed treatment.
- retain the information and be able to weigh up the pros and cons in order to arrive at a decision
- communicate the decision

Decisions subsequently made on behalf of patients without capacity always need to be in the patient’s best interest and also need to be the least restrictive on their basic rights and freedoms.

Please refer to the Trust’s Consent Policy for further details.

4.10 Patients detained under The Mental Health Act

The Mental Health Act 1983 provides the prescriber with a 3-month period to develop a treatment programme to meet the patient’s needs. The 3-month period starts on the occasion when medicines for the mental health illness were first prescribed.

The 3-month rule

The Mental Health Act Administrator for each site will remind the approved clinician at least 4 weeks before the expiry of the 3-month period. The approved clinician should:

- Seek the patient’s consent to continuing medication.
- Record the discussion in the medical notes including an assessment of the service user’s ability to consent.
- If the patient refuses consent or is deemed unable to provide a reliable consent the approved clinician must request a second opinion appointed doctor (SOAD) visit from the Mental Health Act Commission.

Validity checks of T2, T3 and Section 62 forms

T2, T3 and Section 62 forms apply to medication used to alleviate the symptoms of mental illness and their side effects as detailed in the Mental Health Act 1983.

Practitioners must not prescribe or administer medicines to patients detained under the Mental Health Act 1983 after the 3 month period without first ensuring that a valid T2, T3 or Section 62 form has indicated that the treatment can be given. It is good practice to check these prior to each administration.

Pharmacy staffs have a responsibility to conduct a verification of T2, T3 and Section 62 forms where available, in line with CQC and Royal Pharmaceutical Society guidance.

T2, T3 and Section 62 forms where applicable should be retained with the medication charts.
Please refer to Mental Health Act Policy and associated documents on Trust intranet

4.11 Refusal of Medication
In general, patients have a right to refuse medicines. If a patient is having difficulty swallowing an oral solid dose of medication, advice about liquid preparations, alternative products or appropriateness of crushing the tablet should be sought from pharmacy and the designated doctor or consultant contacted immediately for advice and direction.

A competent patient’s decision to refuse medication must be respected even when it is considered their decision is wrong or irrational. Healthcare professionals can advise the patient of their clinical opinion, but must not put pressure on them to accept their advice and be careful that their words and actions do not imply judgement of the patient or their beliefs and values.

However, there may be times when severely incapacitated individuals can neither consent nor refuse treatment. Treatment should be made available to severely incapacitated individuals judged according to their best interests and administered in the least restrictive manner.

4.12 Covert Administration of Medicines
In exceptional circumstances, it may be necessary to administer medication covertly in foodstuffs without the individual’s awareness that it is being done. Any decision to covertly administer medication must be based on what is in the best interests of the patient rather than for the convenience of health professionals. Please refer to Appendix 2, which provides separate detailed instruction and guidance on this specialised area of administration.

4.13 Medicines brought into Hospital by Patients
Medicines brought into hospital by patients may include prescribed medications, ‘over the counter’ medication (OTC), herbal medications and topical creams etc. These medicines must be checked for suitability and appropriateness before use, by a suitably qualified healthcare professional. Please refer to Appendix 3 - Patient’s Own Drugs Flowchart.

4.14 Patient Self-Administration
Self-administration of medication is considered by the Trust to be an important aspect of rehabilitation. Patients who take responsibility for their own medication can increase independence, confidence and compliance. The Nursing and Midwifery Council supports and welcomes the self-administration of medication within safe, secure parameters. The aim is that patients are able to administer their own medication safely and independently by the time they are ready for discharge.

4.14.1 Supervising Administration of Medicines by Patients
It may be appropriate for some patients to administer certain of their own medicines under supervision of a Registered Nurse. This is distinct from participation in a recognised self-administration scheme and may apply to the following categories:-

- Inhalers
- Glyceryl trinitrate sublingual tablets and spray
- Topical preparations e.g. ointments or creams
- Insulin preparations, the patient’s own device i.e. pen/syringe
If the patient has their own labelled insulin pen, they should self-administer the insulin if the patient is assessed to be safe please refer to the NPSA alert Insulin. A nurse may assist or teach the patient to administer their own insulin using their own pen. Insulin and other injectable treatments should be stored in an appropriate drug cupboard/fridge in between administration.

There must be a valid prescription for the medicine. The prescriber may specify that the patient should have ready access to the preparation (inhalers or glyceryl trinitrate), otherwise it is the registered nurse’s decision, which should be documented, on whether to have the medicine in the patient’s bedside locker if available.

The patient must consent to participation in this arrangement, and such consent documented. However, this does not mean that all responsibility for drug administration has been transferred from nurse to patient.

In ensuring the patient has sufficient understanding and ability to perform this task, he/she must be provided with supportive education and written information, and their competence assessed. This must all be documented. The manufacturers’ standard patient information leaflets must be made available to the patient.

The patient must be willing and able to communicate to the registered nurse when a dose has been taken or used. The patient must also be capable of administering the medicine correctly. If this is not the case, the prescriber should be informed and advice from a pharmacist sought. It is the responsibility of the registered nurse to encourage the patient to tell her/him when a dose has been self-administered to record this on the prescription sheet and to review these records to ensure the medicine is being taken appropriately.

4.14.1 Self-Administration Scheme
A clear process is required to ensure that patients are able to administer their own medication safely and independently by the time they are ready for discharge. The process will cover several stages of self-administration, allowing the patient to gradually progress within a safe and supported environment. This should be developed in conjunction with the pharmacist and be approved by the Medicines Management Committee. An initial assessment will cover:-

- current medication – is it appropriate or does it need changing/rationalising?
- patient’s attitude towards the medication.
- history of non-compliance with medication.
- history of risk relating to medication.
- any disabilities that might impact on the patient’s ability to self-administer, e.g. vision; dexterity; swallowing difficulties; confusion.

The decision for a patient to enter a self-administration programme must be based on an MDT-discussion, including the patient and carer, if appropriate. The nature and purpose of the programme must be fully explained to the patient.

As with any other administration of medication, recording must be clear and accurate. Assessment and decision for the patient to commence the self-administration programme must be recorded in the care records. The medicines chart must clearly indicate that the patient is self-medicating.

The multidisciplinary team will decide whether the self-administration is fully independent, or supervised as part of a medicine training programme. If the latter, then
this should be implemented in stages:-

Stage 1: The patient’s medication, dispensed by Pharmacy with the patient’s name and details of administration on the label, is kept in a separate bag in the ward drug cupboard/trolley. At administration time, the nurse will hand the complete bag to the patient, and supervise the selection and taking of the individual medicines. Administration is recorded on the in-patient prescription chart as normal. The patient’s progress, and any problems will be recorded by the nurse in the patient record. (N.B. Ward stocks must not be used for self-administration)

Stage 2: Follow stage 1, but the patient has to ask for the medication at the appropriate time.

Stage 3: Administration is recorded on the in-patient prescription chart as normal. The patient is allowed a limited supply of medication. The level of supply is determined by factors arising within the assessment, and is the decision of the MDT. The drugs must be kept in a designated safe place. Compliance will be monitored and reported back to the MDT.

Stage 4: The patient becomes totally responsible for taking her/his own medication at the appropriate times. Storage requirements and compliance checks as for Stage 3.

4.14.2 Patients unable to self-administer medication
Staff caring for or managing patients who are self-administering medication should be aware of factors affecting patients’ ability to self-medicate. Self-administration from dispensed containers may not be possible for some patients. In such cases the advice of a community pharmacist or the patient’s GP must be sought so the most appropriate form of help can be identified.

If a patient requires a compliance aid such as monitored dose container, this must be dispensed, labelled and sealed by a Pharmacist.

4.15 Tablet Crushing and Capsule Opening
Tablet crushing or opening of capsules should be avoided if at all possible by:-

Checking in the patient’s notes as to whether any previous dose of the medicine for this patient has been administered in this way. If so, was the procedure approved by a pharmacist? Has the patient’s condition improved or deteriorated since then?

Checking in the BNF for a suitable oral liquid/orodispersible preparation of the same drug(s) and, if available, ordering this from pharmacy. In some cases a dosage adjustment may need to be made when the oral liquid is substituted- check with a pharmacist or prescriber.

Checking with the prescriber or, if unavailable, another prescriber as to whether another chemically different but clinically similar drug in the desired form could be prescribed.

Checking with the prescriber or, if unavailable, another prescriber as to whether administration by injection would be more appropriate. Any change to the route of administration of a medicine MUST be prescribed.

Checking with pharmacy whether the tablets can be dispersed/ crushed/ dissolved/ sprinkled on food etc.
Checking whether pharmacy is able to obtain the product from a specials manufacturer.

Any such product will be unlicensed and expensive and there may be a delay in obtaining this medicine, which may delay timely administration to the patient.

Record details of the action taken in the patient’s nursing notes to help to guide the administration of the next dose.

Under some limited circumstances, it may be deemed necessary to crush a tablet or open a capsule. This can be potentially hazardous and puts the medicine outside the product licence.

Under no circumstances does tablet crushing or opening capsules mean that the medicine can be given by another route without another prescription. Medicines must be given by the route prescribed and a new prescription is needed for a change in route.

Because of the potential product toxicity to staff, before crushing a tablet or opening a capsule a COSHH risk assessment should be completed for that product on the ward concerned. Appropriate personal protective equipment, (e.g. a specially designed crushing syringe) and/or clothing might also be required in some cases.

Never use a hypodermic syringe for either crushing or administration.

Always contact the Pharmacy department for more detailed guidance or advice.

4.15 Oral Medicines
Orally administered medicines must be offered to the patient accompanied by a drink (excluding sub-lingual administration), as appropriate.

The patient should be observed until the medication has been taken. Medication is not to be left in a ‘tot’ on a table or on a patient’s bedside etc.

4.16 Oral Liquids
A 5ml medicine spoon should be the first choice for liquid oral medicines that are to be given in 5ml doses. This is the most cost-effective option and should be used if suitable for the patient.

A purple oral syringe should be used for doses that are less than 5ml or do not fall into 5ml graduations or if deemed more suitable for the patient. They are available as 1ml, 3ml, 5ml, 10ml, 20ml and 50ml syringes and can be administered directly into the patient’s mouth.

Graduated medicine tots can be used for larger volume liquids such as Peptac and Lactulose but they should not be used where an accurate dose is vital.

Paper tots should not be used for measuring/administering liquid medicines. Medicines have been known to soak into the paper tots, even if left for a short amount of time.

Do not measure a liquid with a spoon/syringe, and then transfer it into a plastic tot for administration. A small amount of the dose will be lost in the process, leading to suboptimal dosing.

Never use an IV syringe to measure an oral liquid medicine.
Medicine spoons, oral syringes and medicines tots are single dose only and should NEVER be washed for re-use.

In the rare circumstance that a patient is receiving both oral liquids via a syringe and IV injections via a cannula, extreme care must be taken to ensure the correct syringe is used for each type of administration. This avoids the possibility of giving medicines intended for oral use intravenously.

Always contact the Pharmacy department for more detailed guidance or advice.

4.17 Oxygen
The registered nurse must check that the patient is receiving the prescribed flow rate at each medicine round and must initial the prescription sheet accordingly. In an emergency, oxygen should always be given immediately, medical assistance must be summoned and all actions documented later. Please refer to the ‘Prescription and Administration of Oxygen to Adults Policy’ available on the Trust intranet for more detailed information.

4.18 Intravenous Therapy
Please refer to Appendix 4 - Administration of Intravenous Therapy, which provides separate detailed instruction and guidance on this specialised area of administration.

4.19 Ophthalmic Preparations
A dropper bottle or ointment tube must be used only for a particular named patient to minimise the risk of contamination. On hospital wards, where infected eyes are being treated, those patients must have separately labelled bottles for each eye, if both eyes require treatment. Where the indication for ophthalmic preparations is not infection related, a single bottle may be issued for both eyes. Use of any one container will be limited to fourteen days on wards, and four weeks for out-patients. A new supply must be obtained every two weeks and for issue to the patient on discharge home.

4.20 Safe Handling of Cytotoxic Drugs
Handling of cytotoxic drugs is hazardous. Methotrexate is a cytotoxic drug. Any member of staff involved in preparation or administration by any route should have undergone specific education and training recognised by the Trust. Those clinical areas where these drugs may be handled will have available a detailed chemotherapy procedure folder approved by the Chief Pharmacist.

Injectable chemotherapy is restricted to the palliative care team only.

Injectable chemotherapy is restricted to IV administration of Cytarabine via a central line only.

Please refer to Palliative Care Policies and Waste Policies on the Intranet for more detailed guidance; reference should also be made to the RCN Clinical Practice Guidelines ‘The Administration of Cytotoxic Chemotherapy Recommendations’.

The Pharmacy reconstitution service must always be used.

Pharmacy on-call staff may not have received training in this specialist area of work.

Vinca Alkaloids must NEVER be administered by syringe and NEVER by a route other than IV and ALWAYS in a minibag of at least 20ml for paediatric use and 50ml for adult use - please refer to the NPSA alert ‘Using Vinca Alkaloid Minibags’.
Self-medication with oral cytotoxic medication is not permitted

The prescribing or administration of intrathecal medication is not permitted

4.21 Immunisation

The key principles relating to administration of medicines (see 4.1) should be followed when administering immunisation. It is essential that all staff administering immunisations are competent, with up to date knowledge of contra-indications and the recognition and treatment of anaphylaxis. Always ensure Resuscitation facilities or an anaphylaxis emergency box is available when administering immunisations and that there is access to the current edition of the Green Book – ‘Immunisation against Infections and Disease’ (HMSO)

A record must be kept of the vaccine batch number and the site of the injection if more than one injection is administered. In hospitals, this should be recorded in the patients’ notes. In primary care, childhood vaccines will be recorded on the ‘patient held record,’ child health computer and GP record. Other community-administered vaccines will be documented in the GP record.

Patient Group Directions are in place so that immunisations may be administered by appropriately trained registered nurses without an individual, patient specific prescription.

4.22 Day Care

Patients who attend services to receive Day Care will normally obtain their medicines via their General Practitioner as they would when at home.

Primary care and hospital-based practitioners must be aware of all the medicines to be received by the patient and who is responsible for the prescription, supply and administration of each medicine.

While the prescribing of medicines for patients who attend day care is usually the responsibility of the General Practitioner, in some situations a hospital prescriber may wish to take responsibility for part or all of the prescribing. These situations may include:-

- If the hospital prescriber wishes to start a new medicine and stabilise the patient on that medicine before requesting the General Practitioner to take over the responsibility.
- If arrangements to continue supervision of the prescribing of medicines still remains with the hospital prescriber.
- If the prescription is subject to continual change.
- If there is no other reliable method of ensuring that the patient receives the medicine.

In such situations the prescriber will prescribe the medicines using an appropriate medicine card and if the medicine is to be administered at the day hospital it will also be used to provide a record of medicine administration.

Patients who attend day care will be encouraged to self-administer their own medicines received from their community pharmacy and prescribed by their General Practitioner.
In some situations it may be necessary for some or all of the medicines to be administered by a Day Hospital Designated Practitioner. In such situations the following should occur:-

- Confirmation with the patient's carers and General Practitioner and inspection of the patient's own medicine as explained above in section 4.1.19
- Completion of a prescription/administration sheet for only the items that are to be administered or supplied to the patient.
- Recording in the care notes of the complete list of medicines that the patient is receiving at other times.

Where a patient receives medicines other than those administered at day care, cross-reference must be made on the front of the medicine card to those medicines.

If for any reason a difference between the medicine provided by the patient and those prescribed on the medicine card occurs the prescriber should be contacted to clarify the prescription.

If medicines are to be administered at the day hospital it is usual for the patient or home carers to provide the medicines from the patient’s own supply. In some situations the medicines may be supplied from the Trust Pharmacy. These situations include:-

When the patient or carer fails to provide a suitable supply
- When a hospital prescriber wishes to initiate a short course of treatment or a new medicine
- When arrangements for the General Practitioner to take over the responsibility for prescribing have not been completed

4.23 Respite Care
For patients admitted for respite care, it is usual for the patient or home carers to provide the medicines from the patients’ own supply. The Designated Practitioner should:-

- Confirm with the carers prior to admission that the necessary medicines to span the period of respite care will be provided by the carer
- Confirm with the patient's General Practitioner prior to admission the medicines to be prescribed for the patient
- Confirm with the hospital prescriber that the patient’s own supply agrees with the account provided by the carer and the General Practitioner. Once the confirmation has taken place, the medicines will be prescribed using a hospital prescription sheet.

If all attempts to receive a supply from the carer fail, or the supply of medicines is thought unsuitable to use, an emergency supply will be obtained from the Trust Pharmacy.

4.24 Transfer of patients’ medication between inpatient wards/units
When a patient is transferred from one inpatient ward/unit to another within the trust, to ensure administration compliance is maintained and to reduce wastage, named patient medication can be transferred along with the patient to the receiving ward. This procedure does not cover the transfer of controlled drugs. Please refer to the procedure and form ‘Transfer of patient’s medication between BCPFT Inpatient wards/units’ for more detailed information.
4.25 Non-availability of Medication
In cases of non-availability of a drug, every effort must be made to source/obtain the drug within a reasonable amount of time. The reason for non-availability must be recorded in the patient’s records and on the drug chart. The doctor or consultant should be contacted regarding alternative treatment or the possibility of delaying administration until the drug is available.

4.26 Patient Group Directions
These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. They should be reserved for those limited situations where they offer an advantage for patient care (without compromising patient safety) and where they are consistent with appropriate professional relationships and accountability.

The patient group direction must be signed by a senior doctor and a senior pharmacist, both of whom should have been involved in developing the direction. In addition, the patient group direction must be authorised by the Trust’s Medicines Management Committee.

Qualified health care professionals who may legally supply or administer medicines under a patient group direction include nurses, health visitors, pharmacists, physiotherapists but may only do so as named individuals.

Copies of approved Patient Group Directions will be held:-
- in the clinical area where it is to be used
- by the Pharmacy Department
- where necessary for each approved practitioner (in the event of a specialist or supply direction)

All copies of approved PGDs are stored on the Trust Intranet.

4.27 Disposal of Individual Doses of Unused or Discarded Medicines
No medicinal product may be removed from its container/packaging except for immediate administration or for counting purposes, (when only one container may be checked at a time).

Individual doses which are unused or discarded must not be returned to the container but disposed of into the appropriate pharmaceutical waste bins.

Benzodiazepines
Benzodiazepines must be denatured before being placed in the clinical waste bin. They do not have to be witnessed, nor signed for, just denatured but blister packs of benzodiazepines may not be disposed of in the clinical waste bin.

Controlled Drugs
A similar procedure should be used for Controlled Drugs, with appropriate witnessed entries in the ward Controlled Drugs Register. Where an ampoule or tablet is partly used, the excess must be discarded and recorded as “wasted” in the Controlled Drug’s Register. Similar entries should be made for used topical Controlled Drugs patches, which should be rendered unusable by removing the backing and folding the patch over upon itself before disposal in a pharmaceutical waste bin.
Controlled drugs provided in ready-prepared syringes such as patient controlled analgesic devices may be disposed of by injecting the contents of the syringe into a clinical waste bin, which contains absorbent material from which the controlled drug cannot be recovered or directly into a DOOP bin. This should be carried out in the presence of a witness, registered nurse, doctor or pharmacist and an entry made in the Controlled Drug Register stating the volume and strength of drug destroyed. The entry should be countersigned by the witness - please refer to Controlled Drugs CD Policy for more guidance.

### 4.28 Hazards
Some medicines are hazardous on contact to staff and patients e.g. Cytotoxics.

Handling of these substances, plus caustic or toxic materials should be in accordance with COSHH Regulations and extra care always taken.

Medicines labelled as flammable must not be used near a naked flame or any equipment which may emit sparks; do not store in a refrigerator.

Paraffin impregnated dressings and ointments are a potential fire hazard

### 4.29 Raising Concerns

#### 4.29.1 Regarding the prescription
If there is any doubt about the content or clarity of a prescription the nurse or other person authorised to administer must contact the prescriber or deputy before proceeding to administer the medicine. If there is still uncertainty a pharmacist must be contacted (including the on-call pharmacist out of pharmacy working hours if required). In an emergency, if a prescriber or pharmacist is unavailable, the nurse may cancel the doubtful prescription. This should be recorded in the notes and medical advice sought at the earliest convenience.

#### 4.29.2 Regarding appropriateness
Where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to it, or where assessment of the patient indicates that the medicine is no longer suitable, contact the prescriber or deputy without delay.

#### 4.29.3 Regarding the medicine
Any suspicion that a medicine may be defective, counterfeit or that a dispensing error has occurred should be discussed with the Pharmacy Department in the first instance. Alternatively please contact the on-call pharmacist out of pharmacy working hours. They will inform the relevant pharmacy providing the medication under a service level agreement (SLA). A DATIX entry should be completed for confirmed cases. If there is suspicion that the product is defective the product must be quarantined immediately, until advice has been sought from Pharmacy.

### 4.31 Documentation
A record must be made, immediately after each administration, by initialling the prescription sheet. Where a check of the administration is required by a second person their initials must also be recorded and for Controlled Drugs they both must sign the register entry.

The record should include drug administered, dose, route, site if applicable, date of administration, time and signature. Batch number and expiry date of injection (if applicable, patient consent according to Trust policy) batch numbers are required for all vaccines given.
4.32 Delayed and Omitted Medicines
Omission of a dose must always be recorded on the prescription chart using the appropriate omission code. If an appropriate code is not listed, the administrator must indicate at the base of the prescription sheet the reason for omission. All missed doses must be recorded with a red pen.

The Trust’s Medicines Management Committee has compiled a list of critical medicines where the timeliness of administration is crucial. This list of medicines are set out in Appendix 5 of this policy.

It is the responsibility of all clinical staff to ensure that no patients miss doses of critical medicines by sourcing the medication as soon as possible.

If a dose of a critical medicine is omitted or delayed by greater than 24 hours a DATIX report must be completed and medical advice sought.

4.33 Medication Administration Errors
A medication error is a preventable incident, associated with the use of medicines, which may put a patient at risk. Although this list is not exhaustive, some examples of administrative errors could be:-

- Wrong dosage
- Wrong patient
- Wrong medicine
- Administration of an expired medication
- Administration of a medication not covered by consent
- Extra dose given - any dose given in excess of the total number of times ordered by the prescriber
- Unauthorised medicine given - the administration to a patient of any medicine not authorised for that patient e.g. against an expired, unsigned or incomplete prescription
- Wrong dosage interval - any medicine given at a time that reduces or extends the dosage interval before the next dose of the same medicine by more than 25% “As required” orders are not included.
- Wrong administration - administration of a medicine by a different route or in a different form from that specified by the prescriber
- Failure to sign the medicine chart to confirm administration or intentional omission of a medicine
- Signing for a drug that has not been given nor accepted/swallowed

The Trust operates a ‘fair blame’ policy to encourage all errors to be reported and investigated to determine the cause.

Medication errors and near misses are reported and dealt with under the DATIX incident reporting system and will be reported to the pharmacy team.

Whenever an error in the administration of a medicine is found the following action should be taken, by the health care professional discovering the error:-

• Contact the prescriber in charge of the patient with appropriate urgency so that, if necessary, remedial action can be taken to ensure the safety of the patient. In hospital, the notified medical officer has a duty to inform the appropriate Consultant during normal working hours unless he/she has been called to take remedial action.
• Immediately report the incident to the Assigned Nurse in Charge of the area.

• Ensure that the incident is documented in the patient’s notes along with details of any remedial action taken and the individuals informed.

It is the responsibility of the nurse in charge to ensure that the patient and/or relatives dependent on circumstances are advised at an early stage. How this occurs, and by whom, will need to take account of the nature of the error and any adverse consequences suffered by the patient. Any discussions should be documented in the patient’s case notes.

The Assigned Nurse in Charge must ensure that an incident on DATIX is completed with any supporting statements of witnesses, if appropriate. Please refer to the Flowchart on the next page for more detailed guidance.

Please refer to the Trust’s Medication Errors Policy on the intranet for more guidance.

4.34 Controlled Drug Registers
When a Ward Controlled Drug register is full it must be sealed and retained on the ward or clinical area for two years after the date of the last entry or seven years if the register contains records of destruction after which it should be destroyed as confidential waste. Please refer to the Controlled Drugs Policy and associated SOPS for more information.

5.0 Procedures connected to this Policy
• Transfer of patient’s medication between BCPFT Inpatient wards/units

6.0 Links to Relevant Legislation

■ 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.

■ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
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. They enable the Care Quality Commission to pinpoint more clearly the fundamental standards below which the provision of regulated activities and the care provided to people must not fall, and to take appropriate enforcement action where we find it does.

Part 3 has two sections: Section 1 describes the requirements relating to persons carrying on or managing a regulated activity.

Section 2 introduces the fundamental standards below which the provision of regulated activities and the care people receive must never fall. They came into force for all health and adult social care services on 1 April 2015.

Regulation 8: General
Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 12: Safe care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 14: Meeting nutritional and hydration needs
Regulation 15: Premises and equipment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 18: Staffing
Regulation 19: Fit and proper persons employed
Regulation 20: Duty of candour
Regulation 20A: Requirement as to display of performance assessments

The Human Rights Act 1998

One of the main laws protecting human rights in the UK, it contains a list of 16 rights (called articles) which belong to all people in the UK, and outlines several ways that these rights should be protected. These rights are drawn from the European Convention on Human Rights, which were developed by the UK and others in the aftermath of World War II.

The Human Rights Act may be used by every person resident in the United Kingdom regardless of whether or not they are a British citizen or a foreign national, a child or an adult, a prisoner or a member of the public.

The Human Rights Act has two main aims, to promote a ‘culture of human rights’ by making sure that basic human rights underpin the workings of government at the national and local level and enabling access to human rights here at home, instead of only being able to go to the European Court of Human Rights.

It does this by placing a legal duty on all public authorities, including NHS organisations and staff and mental health tribunals carrying out public functions, to respect and protect human rights in everything that they do. This means that public authorities have legal responsibilities for respecting, protecting and fulfilling human rights. This duty is important in everyday situations because it enables individuals to challenge poor treatment and to negotiate better solutions.
6.1 Links to Relevant National Standards

- Care Quality Commission’s Fundamental Standards introduced 1 April 2015

**Regulation 11: Need for consent**

Where a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Discussions about consent must be held in a way that meets people’s communication needs. This may include the use of different formats or languages and may involve others such as a speech language therapist or independent advocate. Consent may be implied and include non-verbal communication such as sign language or by someone offering their hand when asked if they would like help to move. Consent must be treated as a process that continues throughout the duration of care and treatment, recognising that it may be withheld and/or withdrawn at any time.

When a person using a service or a person acting lawfully on their behalf refuses to give consent or withdraws it, all people providing care and treatment must respect this.

**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.

6.2 Links to other Key Policies

- Medicines Prescribing Policy
- Medication Errors Policy
- Controlled Drugs Policy
- Safe Supply, Storage and Disposal of Medicines Policy
- Subcutaneous Infusion Devices Policy

6.3 References

- Building a safer NHS for patients. Implementing an organisation with a memory.
Department of Health. (2001)


- Standards of conduct, performance and ethics for nurses and midwives. Nursing and Midwifery Council (2008)


- Guidance for Providers on Meeting the Regulations (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended) Care Quality Commission March 2015

### 7.0 Roles and Responsibilities for this Policy

<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Key Responsibilities</th>
</tr>
</thead>
</table>
| Medical Director                           | Executive Lead                | - lead responsibility for the implementation of this policy  
- allocation of resources to support the implementation of this policy  
- Chair of the Trust’s Medicines Management Committee  
- any serious concerns regarding the implementation of this policy are brought to the attention of the Board of Directors |
| Chief Pharmacist                           | Medicines Lead                | - ensure the Trust complies with national guidance relating to the prescribing of medicines  
- ensure that Groups are fully informed of their role in maintaining the required standards of practice relating to prescribing  
- day to day management for all aspects of the safe and secure handling of medicines within the Trust  
- lead on strategies and innovations to improve current prescribing practice  
- policy lead/author of this policy |
| Clinical Directors/Heads of Nursing/General Managers | Operational Leadership | - to ensure policy distribution, implementation and compliance throughout relevant wards, units and services within their group  
- staff have received sufficient training and/or are competent to implement the policy  
- professional standards of record keeping are maintained  
- lead discussions around this topic area and policy at Group Quality and Safety Group meetings  
- oversee the completion of audits in respect of this topic area and policy  
- provide updates on this area of practice and policy within their Group to the Quality and Safety Steering Group |
| MH/LD/CYPF Quality and Safety Groups | Monitoring                    | - monitor and review all incidents, complaints and claims relating to this area of practice and policy within their Group  
- review practice to ensure that it is applied appropriately and in line with this policy  
- 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 |
| Medicines Management Committee         | Scrutiny and Performance     | - oversee the governance of medicines management across the Trust  
- receive specific issues in relation to the delivery, development and monitoring of medicines management  
- review all policies, guidelines and procedures including PGD’s, SOP’s and prescribing documentation affecting drug use or medicines management  
- ensure adherence to the joint health economy medicines formulary including antibiotics |
| Ward/Unit Managers/Trust Pharmacy Team | Day to Day Monitoring         | - supporting the implementation and monitoring of this policy  
- provide support and advice to all staff involved in the administration of medicines as necessary  
- all incidents, complaints and claims relating to this area of practice and policy are reported |
| All staff involved in the day to day administration of medicines | Implementation and Adherence | - 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  
- always treat patients with dignity and respect their right to make decisions even when you may disagree with them  
- attend training applicable to their role  
- ensure they are competent to carry out their responsibilities to administer medicines and be accountable for their actions  
- compliance with all Trust policies is a condition of employment and a breach of this policy may result in disciplinary action  
- any errors or incidents relating to this policy and area of practice are reported on DATIX, the Trust’s electronic incident reporting system  
- if a member of staff has concerns about the way this policy is being implemented or about this area of practice in general, they should raise this with their line manager. If they feel unable to raise the matter with them, he/she may write to an |
Title | Role | Key Responsibilities
---|---|---
day to day administration of medicines cont’d/… | and Adherence | 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

| 8.0 Training |

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

| 9.0 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 bcpft.equalityimpactassessment@nhs.net

| 10.0 Data Protection and Freedom of Information |

Data Protection Act provides controls for the way information is handled and to gives legal rights to individuals in relation to the use of their data. It sets out strict rules for people who use or store data about individuals and gives rights to those people whose data has been collected. The law applies to all personal data held including electronic and manual records. The Information Commissioner’s Office has powers to enforce the Data Protection Act and can do this through the use of compulsory audits, warrants, notices and monetary penalties which can be up to €20million or 4% of the Trusts
annual turnover for serious breaches of the Data Protection Act. In addition to this the Information Commissioner can limit or stop data processing activities where there has been a serious breach of the Act and there remains a risk to the data.

The Freedom of Information Act provides public access to information held by public authorities. The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities; unless there is a good reason for them not to. The Freedom of Information Act applies to corporate data and personal data generally cannot be released under this Act.

All staffs have a responsibility to ensure that they do not disclose information about the Trust's activities; this includes information about service users in its care, staff members and corporate documentation 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. The Information Governance Team provides a central point for release of information under Data Protection and Freedom of Information following formal requests for information; any queries about the disclosure of information can be forwarded to the Information Governance Team.

### 11.0 Monitoring this policy is working in practice

<table>
<thead>
<tr>
<th>What key elements will be monitored? (measurable policy objectives)</th>
<th>Where described in policy?</th>
<th>How will they be monitored? (method + sample size)</th>
<th>Who will undertake this monitoring?</th>
<th>How Frequently?</th>
<th>Group/Committee that will receive and review results</th>
<th>Group/Committee to ensure actions are completed</th>
<th>Evidence this has happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>How medication is administered safely and effectively, including patient identification</td>
<td>4.0</td>
<td>Every incident is routinely reported on DATIX Trust's Incident Reporting System and collated into a report</td>
<td>Chief Pharmacist reviews all DATIX medication entries to detect trends and provides a report</td>
<td>Quarterly</td>
<td>Medicines Management Committee</td>
<td>Medicines Management Committee</td>
<td>Completed Action Plans and minutes of Meetings</td>
</tr>
<tr>
<td>Patient self-administration</td>
<td>4.14</td>
<td>The multidisciplinary team includes a pharmacist, will decide and whether it is fully independent, or supervised as part of a staged programme</td>
<td>Trust Pharmacy Team</td>
<td>On an individual basis</td>
<td>Medicines Management Committee</td>
<td>Medicines Management Committee</td>
<td>Completed Action Plans and minutes of Meetings</td>
</tr>
<tr>
<td>How a patient’s medicines are managed on handover between care settings</td>
<td>4.0</td>
<td>Every incident is routinely reported on DATIX Trust’s Incident Reporting System and collated into a report</td>
<td>Chief Pharmacist reviews all DATIX medication entries to detect trends and provides a report</td>
<td>Quarterly</td>
<td>Medicines Management Committee</td>
<td>Medicines Management Committee</td>
<td>Completed Action Plans and minutes of Meetings</td>
</tr>
<tr>
<td>All incidents relating to the administration of medicines are reported in a timely manner</td>
<td>4.33</td>
<td>Every incident must be reported at the earliest opportunity but no later than 24 hours after it occurs</td>
<td>MH, LD, CYPF Quality and Safety Groups</td>
<td>Monthly</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>Completed Action Plans and minutes of Meetings</td>
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</tr>
<tr>
<td>Nurses and other health care staff analyse their experiences, learn from administration errors and subsequently improve their practice</td>
<td>4.33</td>
<td>The action taken to improve learning will vary according to the situation e.g. policy review, review of training needs, review of staffing and skills mix, or review or re-allocation of duties to staff in post, introduction of new procedures, increase in the frequency of audits etc.</td>
<td>MH, LD, CYPF Quality and Safety Groups</td>
<td>Monthly</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>As above plus ‘Lessons Learnt’ Bulletins and ‘Medicines Management’ Newsletters published each quarter</td>
</tr>
<tr>
<td>Nurses and other health care staff are supported in their role in the safe administration of medicines</td>
<td>4.0 7.0 8.0</td>
<td>Process, roles and responsibilities and training are monitored as indicated above and explained in sections 7.0 and 8.0</td>
<td>MH, LD, CYPF Quality and Safety Groups</td>
<td>As indicated above</td>
<td>Medicines Mgt. Committee and Workforce Development Group</td>
<td>Medicines Mgt. Committee and Workforce Development Group</td>
<td>Completed Action Plans and minutes of Meetings</td>
</tr>
</tbody>
</table>
### Risk Assessment for Critical Loading Dose Medicines

**Trust List of Critical Loading Dose Medicines**

- Amiodarone, Digoxin, Phenytoin, Warfarin

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Route of administration and indication</th>
<th>Harms and contributing risk factors</th>
<th>Consequence score</th>
<th>Mitigating harms and risks</th>
<th>Local Risk Assessment Score*</th>
<th>Priority for action</th>
</tr>
</thead>
</table>
| Amiodarone| By oral or intravenous routes for arrhythmias in adults and children        | • Serious harm or death if omitted or under-dosed
          |                                                                              | • Serious harm or death if continued inadvertently or over-dosed
          |                                                                              | • Complex calculation required
          |                                                                              | • Complex administration procedure required
          |                                                                              | • High likelihood of communication failure                                                      | 5                              | - Availability restricted not stocked on inpatient wards
          |                                                                              | - Not available in the emergency cupboard                                                        |                   | - IV amiodarone not used
          |                                                                              | - Oral amiodarone only under guidance of acute Trust                                              |                   | 10 (5x2) On critical loading dose list |
| Digoxin    | By mouth or intravenous route for supraventricular arrhythmias and chronic heart failure in adults and children | • Serious harm or death if omitted or under-dosed
          |                                                                              | • Serious harm or death if continued inadvertently or over-dosed
          |                                                                              | • High likelihood of communication failure                                                       | 5                              | - Availability restricted not stocked on inpatient wards
          |                                                                              | - Digoxin tablets only available in the emergency cupboard                                      |                   | - IV digoxin not used
          |                                                                              | - On critical loading dose list                                                                 |                   | 10 (5x2) On critical loading dose list |
| Phenytoin  | By mouth or intravenous injection for status epilepticus and subsequent control of epilepsy in adults, children and neonates | • Serious harm or death if omitted or under-dosed
          |                                                                              | • Serious harm or death if continued inadvertently or over-dosed
          |                                                                              | • Complex calculation required
          |                                                                              | • Complex administration procedure
          |                                                                              | • High likelihood of communication failure                                                       | 5                              | - Availability restricted not stocked on inpatient wards
          |                                                                              | - Oral phenytoin only available in the emergency cupboard                                       |                   | - IV phenytoin not used
<pre><code>      |                                                                              | - On critical loading dose list                                                                  |                   | 10 (5x2) On critical loading dose list |
</code></pre>
<table>
<thead>
<tr>
<th>Medicine</th>
<th>Route of administration and indication</th>
<th>Harms and contributing risk factors</th>
<th>Consequence score</th>
<th>Mitigating harms and risks</th>
<th>Local Risk Assessment Score</th>
<th>Priority for action</th>
</tr>
</thead>
</table>
| Warfarin | By mouth for the treatment and prophylaxis of thrombotic episodes in adults and children | • Serious harm or death if omitted or under-dosed  
• Serious harm or death if continued inadvertently or over-dosed  
• High likelihood of communication failure | 5 | - Restrict availability – not stocked on the inpatient wards  
- Only available in the emergency cupboard  
- Anticoagulant Policy available on the intranet and in the emergency cupboard  
- Anticoagulant chart for use in inpatient areas  
- Anticoagulant books available for patients  
- Pharmacy Anticoagulant therapy SOP | 15 (5x3) | On critical loading dose list |
Covert Administration of Medication

Principles
The Trust believes that patients must be treated with respect and dignity in all areas of their care.

Whenever possible, patients should be actively involved in the planning of their care and give informed consent to treatment. If clinical judgement indicates this is not possible, staff must defer to appropriate legislation, guidelines and Trust policy to ensure safe effective practice. It is therefore it is important that a clear policy is in place in relation to covert administration of medication.

The decision to use covert medication must be made by the full multidisciplinary team including the pharmacist and taking into account the views of relatives and carers and any advanced statement or directive made by the patient.

Consideration will include recognition that if medication is crushed, dissolved or otherwise tampered with, the product will be rendered unlicensed and may result in the need to increase or decrease the dose. It is also important to consider the effect covert administration of medication may have on the therapeutic relationship, especially where patients may regain capacity, and/or develop an understanding of the covert administration.

In deciding what treatment may be reasonably considered as being in the best interests of a patient who lacks capacity to consent, the General Medical Council recommends that the following be taken into account:-

- Options for treatment which are clinically indicated
- Evidence of the patient’s previously expressed preferences, including any advance statements or directives
- Knowledge of the patient’s background, including their cultural and religious beliefs
- Third party views about the patient’s preferences given by those who may have other knowledge of the patient, e.g. partner, relative, carer or advocate
- Where more than one option (including non-treatment) seems reasonable and in the patient’s best interest, consideration should be given to that which least restricts the patient’s choice

All practitioners must reflect on the treatment aims of disguising medication and be absolutely confident that they are acting in the best interests of the patient. The treatment must be considered necessary in order to save life, prevent deterioration in health, or to ensure an improvement in the patient’s physical or mental health status. In some circumstances, the named consultant may obtain further advice from the Trust solicitor.

The Nursing and Midwifery Council (NMC) position statement on the covert administration of medicines (2006) states:-

“Disguising medication in the absence of informed consent may be regarded as deception. However, a clear distinction should always be made between those patients or clients who have a capacity to refuse medication and whose refusal should be respected, and those who lack this capacity. Among those who lack this capacity, a further distinction should be made between those for whom no disguising is necessary
because they are unaware that they are receiving medication, and others who would be aware if they were not deceived into thinking otherwise.”

The disguising of medication in food and drink cannot be encouraged as it exposes the patient to risk. Every effort must be made to obtain the patient’s consent to be administered prescribed medicines in the normal way. However, it is recognised that in exceptional circumstances, covert administration may be justified as being in the best interests of the patient.

In circumstances where a consenting patient has difficulty in swallowing medication or they find it unpalatable, the medication may be given in food or drink with their knowledge, as a last resort, provided alternative dosage forms such as liquids or dispersible tablets have also been found unsuitable. The pharmacist should be asked to advise on alternative preparations, and it may be appropriate to refer the patient to a speech and language therapist for further assessment. In these circumstances, the food or drink is acting as an aid to administration with the patient’s consent. This is not covert administration.”

**Procedure**

Where it is decided that medication should be given in food or drink then, except in an emergency, a Pharmacist must be consulted about what type of preparation should be used to ensure appropriate delivery of treatment. Ideally the advice and recommendations of the Pharmacist should be received in writing to be added to the person’s medical notes or should be entered directly into the notes by the Pharmacist.

Wherever possible, a suitable licensed liquid, soluble or orodispersible (“melt”) preparation should be used. Crushing tablets or opening capsules should be regarded as a last resort as this is likely to alter the bioavailability of the medication. Dose adjustment may be necessary. Particular risk is possible if slow-release or enteric-coated tablets are crushed as this will change the way the medication is absorbed into the body.

Any medical, cultural or religious dietary requirements should be complied with.

Where necessary medicines should be mixed with a small amount of food or liquid rather than in a whole drink or portion of food. People receiving medication administered in food or drink should not be left by the nursing staff administering the medication until the medication has been consumed.

Any method of administration which is outside the product license of that medication is unlicensed and can only be authorised by an approved prescriber who may be liable if harm ensues. The prescriber must document any authorisation to administer a medication by an unlicensed method, having first considered the safety of the person being treated, the requirement for that particular medication and alternative treatment or means of administration.

Any instructions regarding how to administer the medicines should be clearly annotated on the person’s medication chart to aid nurse administration and the instructions conveyed verbally to the relevant nurse. In addition the recommendations should be documented in the notes.

The medical prescriber and a pharmacist must always agree to any alterations to standard medication administration practice.
Extreme Situations
In extreme situations such as putting self and/or others at risk due to their behaviour, a person without capacity who does not consent to treatment may have need for a specifically prescribed medication to be administered covertly. When circumstances prevent an impromptu MDT meeting, the nurse may, after discussions with the immediate team, administer the initial dose under Common Law where the person is incapable of consenting.

If the person is detained under the MHA then the nurse should further ensure that any administration of medication for a mental disorder is covered by appropriate certification where necessary, or that Section 62 paperwork is completed.

Treatment Plans
The proposed treatment plan, including the provision for medication to be administered covertly, will be discussed by all relevant practitioners and with those who the MCA requires to be consulted about the person’s best interests. The extent of any discussions will depend upon individual circumstances and the time available and in an emergency discussion may be more limited.

Where a person is living at home with family or carers there should be discussion between the carers, the person’s General Practitioner (GP) and the community mental health team (CMHT) or learning disability community partnership (LDCP)

A record will be made of any discussions that take place including the views of carers who have been consulted.

The treatment plan must be countersigned by the senior health professionals involved. This would normally involve a Consultant Psychiatrist, a Senior Registered Nurse and a Pharmacist.

The treatment plan should normally be subject to weekly review initially and if the requirement of covert administration persists then full reviews may occur at less frequent intervals. Ongoing efforts should be made to obtain the person’s consent to allow open administration of medication.

Appeal
If a member of staff; a relative, carer, friend or representative of the person, or an Independent Mental Capacity Advocate (IMCA) wishes to raise concerns about the use of covert administration of medication to an individual, or about the process by which it was decided to use such means, they can be referred to the Medical Director or Chief Pharmacist.
Covert Administration Flow Chart

Does the patient accept medication?

Yes: Administer medication according to the Medicines Code.

No: Does the patient have the capacity to consent?

Yes: Discuss with multi-disciplinary team, carers, and advocates. Check any pertinent advance statement of living will.

No: Is the patient detained under the Mental Health Act?

Yes: Follow Covert Administration Flow Chart

No: Review medication - Only continue essential medication.

Complete a risk assessment

Agree best method of administration or necessary changes with the Pharmacist

Administer covertly

Does the patient have the capacity to consent?

Yes: Review medication - Only continue essential medication.

Complete a risk assessment

Agree best method of administration or necessary changes with the Pharmacist

Administer covertly

No: Follow Covert Administration Flow Chart

Refer to Medical Director and obtain legal advice

Follow Covert Administration Flow Chart
**Medication Assessment for Covert Administration**

To be completed by a pharmacist

Patient name……………………………..…NHS Number……………………………..……Hospital Number……………………………..……DOB……………………………..……


**NB medication must not be crushed unless there is no alternative; doing so makes the medication unlicensed**

<table>
<thead>
<tr>
<th>Prescribed medication</th>
<th>Liquid available Y/N</th>
<th>May be crushed Y/N</th>
<th>Reference source</th>
<th>Alternative preparation</th>
<th>Additional advice</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Name of Pharmacist……………………………..……Signed……………………………..……Date……………………………..……
**MDT Consensus Agreement to use Covert Administration**

To be completed by prescriber

Patient name………………………………… NHS Number…………………………

Patient DOB………………………………… Hospital Number…………………………

Care Co-ordinator………………………… Consultant…………………………

The named client is refusing to take their prescribed medication and is unable to fully understand the consequences of this.

In the opinion of the following members of the care team, and with the agreement of their carers, it is in their best interests to be given their medication disguised in food or drink to prevent deterioration to their health.

A pre-requisite to this process is receipt of an appropriately completed MEDICATION ASSESSMENT FOR COVERT ADMINISTRATION form which should be signed by a pharmacist.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Name</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Carer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Named nurse/ Care co-ordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unit manager</td>
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</tbody>
</table>

Following completion of this form and review of the pharmacist’s assessment, specific agreed actions and methods for the administration of each medication should be documented in the care plan.

Signed by Prescriber ……………………………

Date ……………………………
Appendix 3

Patient’s Own Drugs Flowchart

Is the medication in a suitable condition? i.e. in a clean and suitable container.  

NO  

Unsuitable for use*

YES

Is the medication in an original dispensed container?  

NO  

Unsuitable for use*

YES

Does the label clearly state patient's name, product name, form and strength, supplier's name and address and date of dispensing?  

NO  

Unsuitable for use*

YES

Is medication within the expiry date on the original container or has been dispensed within the last 6 months?  

NO  

Unsuitable for use*

YES

Does drug name on label match drug inside container, or in the case of loose tablets can they be identified?  

NO  

Unsuitable for use*

YES

Is the medicine a controlled drug?  

NO

Unsuitable for use*

YES

Is the medicine a liquid? Is it unopened or dispensed by a hospital pharmacy.  

NO

Unsuitable for use*

YES

Is the medication still on the current treatment chart?  

NO

Unsuitable for use*

YES

Does it have the correct dose instructions  

NO

Score through label.  

Refer to Pharmacist/technician for relabelling.  

Place in patient's locker/drug trolley.  

*consent for destruction should be obtained if possible. Notify pharmacy at next visit.

YES

Place in patient's drug locker/drug trolley
Administration of Intravenous Therapy excluding Blood Transfusion

The following guidance incorporates advice issued by the Department of Health and the National Patient Safety Agency (NPSA) including the examination of infusion containers, additions of medicinal products to infusion fluids, managements of infusions and reporting of suspected defects.

It is the responsibility of all Prescribers prescribing intravenous medicines to ensure that they are appropriate for this route and for the vehicle of administration, taking account of stability and incompatibility information.

1. Requirements to Administer Intravenous Therapy

Via the Intravenous Route
A registered nurse, or student under the supervision of a registered nurse, is permitted to replace infusion bags if she/he has successfully completed the Trust IV competency training and is mindful of her or his personal accountability. To make additions to an infusion bag or pump the registered nurse must, in addition, have had at least six months of post-registration experience and the appointed nurse-in-charge must be satisfied with the registered nurse’s competence and that she/he has attended appropriate certified training.

It is the responsibility of each nurse to ensure that his/her training is up to date.

An appropriately trained, competent nurse who has successfully completed the Trust anaphylaxis training is able to administer all prescribed intravenous drugs including first dose and should be able to successfully handle any anaphylactic reactions. Administration of medicines intravenously (bolus or infusion) must be checked by a second Registered Nurse.

Via the Intramuscular and Subcutaneous Routes
A registered nurse, or student under the supervision of a registered nurse, is permitted to administer by these routes if she/he is satisfied with her or his competence and mindful of her or his personal accountability. A second check is not required (unless a calculation is required or administering insulin).

Infusion Pump
A registered nurse is permitted to administer medicines in this way provided that:-

- She/he is satisfied with her or his competence and mindful of her or his personal accountability.
- She/he has had at least six months of post-registration experience.
- The appointed Nurse-in-Charge is satisfied with the registered nurse’s competence.
- She/he has received appropriate training regarding the specific pump to be used.

In general, only one addition should be made to each bag or syringe. If two or more drugs are to be added, the nurse should be satisfied about the stability of the mixture by either:-
  - Following pharmacy approved protocols
  - Contacting pharmacy for advice

All lines must be labelled and dated

Appendix 4
A second registered nurse must always check the administration (including the settings on the infusion pump device).

Community nurses attending the patient's home alone do not require a second check.

Frequent checks should be made of infusion rate, volume remaining and prescription and these should be recorded on the appropriate observation chart.

2. Responsibilities
The Registered Nurse will be responsible for:

- Checking the container and fluid show no obvious faults or contamination
- Checking the expiry dates
- Checking that the prescribed product is administered to the right patient
- Observing that the intravenous line remains patent

Change lines:

- Every 72 hours for clear fluids
- Every 24 hours for colloid and blood products
- Inspecting the site of injections and reporting any abnormality
- Maintaining the infusion at the prescribed rate, either manually or electronically*
- In the event of malfunction with possible patient consequences, the nurse must inform the responsible medical officer.
- Observing and reporting on the condition of the patient
- Maintaining records
- Nurses who have received specific training may carry out additional duties as explained above will ensure documentation of procedure are completed

* the nurse must have received appropriate training for the equipment used.

3. Documentation
All intravenous infusion therapy must be given in accordance with the instructions prescribed by the authorised prescriber on the ‘Prescription Sheet for Infusions.’ When using syringe pump/drivers, the size of the syringe to be used must be specified and be in accordance with the manufacturer’s recommendations.

When medicines need to be added prior to administration these must also be prescribed and recorded on the Prescription Sheet for Infusions.

Medicines to be added to the bulk infusion container must be checked and administered in line with best practice.

When a medicine has been added to the infusion, a label must be attached to the container or syringe with the following information, ensuring that no information details/graduation markings are obscured:-

- Patient’s name
- Name and dose of medicines
- Date and time of addition
- Signatures of those making and checking additions

For continuous administration (e.g. via intravenous infusions or pump driven syringes) there shall be a record of those involved in setting up the medication.
On cessation of an infusion containing a Controlled Drug before it has been fully used, e.g. On the death of a patient or discontinuation of the infusion, the remainder should be destroyed and a record to this effect must be made in the Controlled Drug register - please refer to Standard Operating Procedures for Controlled Drugs.

4. **Examination of the Container and Fluid**

Examination of each container must take place immediately before use.

The Container - should be examined for:-
- Cracks
- Faults in the plastic
- Defects in the closure
- Any other damage

The fluid - the container should be examined for:-
- Particles
- Cloudiness
- Change in colour

Invert container and use a good light

Evidence of defects should lead to rejection of the container - it should be labelled and returned to the Pharmacy with the following information:-

a) Nature of defect
b) Time and date of discovery

The Pharmacy will follow the procedures set out for the management of defective products and complete an incident form on DATIX.

5. **General Principles**

Drugs may be given intravenously by one of the following methods:-

- Direct injection (bolus) into a vein
- Direct injection into infusion line/tubing (bolus).
- Intravenous infusion - either continuous or intermittent

Not all drugs may be given by intravenous bolus injection. Some drugs must be further diluted before bolus administration. Some drugs must only be given by infusion. Some drugs must not be diluted before administration.

Nursing staff must familiarise themselves with the method of administration of the drug which they are to give, by reference to the BNF Pharmacy or manufacturer’s literature. Package inserts should not be removed from ampoule boxes. Two or more drugs should not be mixed together unless the compatibility has been confirmed.

Where more than one drug is given intravenously, the line should be flushed between drugs (with sodium chloride 0.9%). Prepared infusions and reconstituted products will have a different expiry date to that given by the manufacturer.

For further guidance the BNF and the manufacturer’s literature should be consulted. The BNF advises a maximum time of 12 hours between addition and completion of administration for drugs added to infusions outside a pharmacy department.

Nursing staff must also consider infection prevention in vascular access. Please refer to Subcutaneous Infusion Devices Policy on the Trust intranet.
6. Preparation of Intravenous Fluids for Use (Administration)
Use strict aseptic technique

Addition of medicines to intravenous fluids:-

a) Medicines should only be added to the infusion when the intravenous route is prescribed

b) When continuous infusion is prescribed, the medicine must be THOROUGHLY mixed with the fluid and given slowly. Prepare the solution immediately before administration and use within time stated on the package insert.

c) Solutions with Potassium Chloride included are available and must be used whenever possible to avoid the need to add concentrated solutions of Potassium Chloride to infusions. The Trust does not stock Potassium Chloride ampoules.

d) For intravenous use most antibiotics should be given intermittently

e) Multiple additions of medicines to a fluid should be avoided

f) Medicines should not be added to, or run through the same giving set as: Blood Lipid Preparations, Plasma Mannitol, Parenteral Amino Acids, Sodium Bicarbonate

g) Where specific information is not available (e.g. BNF) the Pharmacist should be consulted.

h) Repeat the examination procedure after addition and mixing of any medicine and again during administration, rejecting if any opalescence or precipitation is present, and immediately inform the prescriber.

i) The container with added medicine must be labelled

7. Medicine Administration by Direct Intravenous (Bolus) Injection via Peripheral or Central Venous Cannula

This is used to give a small volume of drug into the cannula or injection site of the administration set, using a syringe and needle. This may take a few seconds, as in an emergency, to get maximum concentration of the drug to vital organs, or a number of minutes, as for most antibiotics.

Administration into the injection site of a fast running infusion may be advised if the infusion is compatible. Alternatively, a stop-start procedure is employed. If the infusion is incompatible with the drug, the line may be switched off and 2ml Sodium Chloride Solution 0.9% used as a flush. If a number of drugs are being administered flush, as above, between each, to prevent interactions, and also at the end of the administration. The insertion site should be checked throughout the procedure for swelling or redness. Patients must be consulted constantly about any pain or discomfort they may be experiencing.

This procedure may be carried out via: -
- The injection site of any intravenous administration set
- The capped port of the peripheral cannula
- A non-returnable valve such as BIO CONNECTOR if absolutely necessary
- A ‘Y’ extension line is preferable to a 3-way bio connector to reduce bacterial contamination.
Always check:
✓ For any incompatibilities prior to administration
✓ After administration of drug, or between more than one prescribed drug, line or port is flushed with 2 - 5ml 0.9% Sodium Chloride to maintain potency of line and reduce risk of incompatibility
✓ Injection port of cannula is recapped after use; if caps have been removed to administer drugs, replace with sterile caps
✓ Infusion is restarted
✓ If it is necessary to administer I.V. drugs by means of a syringe pump then either the syringe pump should be connected to an I.V. access separate from a normal drip or, if venous access is difficult, use a 3-tailed device with non-return valves.

8. If an Infusion Is Unsatisfactory after Administration has Started
- Take it down and replace it from another batch if possible - the giving set as well as the fluid container should be replaced
- The nature of the defect and time of discovery should be recorded
- Record name and manufacturer of fluid, batch number and expiry date
- Complete an Incident Reporting DATIX entry

9. Adverse Reaction during Administration of Intravenous Drugs or Infusions
If a patient exhibits any adverse reaction during an infusion it must be stopped and the prescriber notified - it should only be continued on the prescriber’s instruction.

The prescriber will undertake a full clinical history and list signs, temperature, all medicines and the times and batch number of any infusion fluids given.

If a defect in the infusion is suspected, take specimens for blood culture from another vein.

Monitor closely any patients having infusions of the same batch. The order of use of the containers concerned should be noted. When the infusions are complete, the containers should be retained for a period of 24 hours to ensure that they can be examined should any reaction follow.

All suspect containers and accessories should be labelled and kept and:-
✓ The Pharmacist should be informed immediately
✓ All products with the same batch number should be quarantined
✓ A yellow card should be completed (www.yellowcard.gov.uk)
✓ An Incident Reporting DATIX entry must be completed

10. Treatment of Anaphylaxis during/following Intravenous Therapy
Signs and symptoms of Anaphylactic Shock:-
 a) Patient may complain of feeling faint (must be distinguished from a psychological reaction to the injection)
 b) Patient will be cold and clammy
 c) Pale, cyanosed with weakening pulse
 d) Loss of consciousness
 e) Acute urticaria, including swelling of the glottis, laryngeal stridor

Management
✓ Call for immediate assistance (999)
✓ Lay patient down left lateral position
✓ Give adrenaline as per the Trust resuscitation guideline
Critical Medicines List - Reducing Harm from Delays or Omissions

Background

Medicine doses are often omitted or delayed for a variety of reasons. Although only a small percentage of these occurrences may cause harm or have the potential to cause harm, delays or omissions in prescribing or administration of some critical medicines can cause serious harm or death. This may be as a result of errors during prescribing, dispensing, supply or administration.

The National Patient Safety Agency (NPSA) issued a Rapid Response Alert NPSA/2010/RRR009 in February 2010, asking all Trusts to identify a list of critical medicines where timeliness of administration is crucial. A complete record of all doses administered is also essential to avoid repeated doses and support evaluation of response to therapy. The Trust's Medicines Management Committee has approved the list of medicines in the table below:

| List A: MEDICINES WHICH MUST NOT BE DELAYED OR OMITTED (TIME CRITICAL MEDICINES) |
|---------------------------------|--------------------------------|
| Anaesthetic agents              | Glyceryl trinitrate, sublingual |
| Analgesics, post-operative      | Insulin: all preparations      |
| Anaphylaxis medicines           | Intravenous Anti-infectives    |
| Anti-parkinsonian agents (medicines containing levodopa, entacapone or tolcapone) | Opioids for severe chronic or acute pain |
| Anti-platelets and thrombolytics (for acute coronary events only) | Oxygen |
| Benzodiazepines (for acute alcohol withdrawal and status epilepticus only) | Procyclidine (reversal of acute dystonic reactions only) |
| Bronchodilators, nebulised      | Rapid Tranquillisation medicines |
| Dextrose 40% gel (GlucoGel, Dextrogel®) | Resuscitation medicines |
| Glucagon                        | Reversal agents e.g. flumazenil, naloxone |
| Reliever Inhalers (short acting B2 agonists) | |

| List B: MEDICINE DOSES WHICH MUST NOT BE OMITTED (delays are not critical but can significantly affect future management - seek advice from a prescriber or pharmacist) |
|---------------------------------|--------------------------------|
| Anti-epileptic agents           | Contraceptives, oral           |
| Prophylactic Anticoagulants     | Cytotoxic chemotherapy         |
| Anti-infectives, oral           | Hypoglycaemic agents, oral     |
| Clozapine                       | Lithium                        |
| Drugs for opioid dependence     |                                |

(The Medicines Improvement Group reviews Lists ‘A’ and ‘B’ annually)

Report all omissions or delays in administering these medicines using DATIX incident reporting system
Definitions

Omitted Medicines
× Failure to prescribe in a timely manner
× Failure to administer a dose before the next dose is due or
× For once only (stat) doses, failure to administer a medicine within 2 hours of the time the dose is due (prescribed)

Delayed Medicine
× Administration of a medicine 2 hours or more after the prescribed time

Actions to Minimise Omitted or Delayed Administration of Critical Medicines
1. Review of medicines stored in clinical areas at least annually to ensure they reflect likely patient needs and in accordance with local policy and national guidance
2. Complete medicines reconciliation within 24 hours of admission for inpatient areas where possible
3. Check that patient’s own medicines (PODs) are fit for purpose for administration of prescribed medicines rather than wait for a new supply to be dispensed
4. Avoid interruptions during medicines preparation and administration as much as possible
5. Ensure medicines administration records are complete by checking all prescription charts at nursing handover i.e. before nurses working on the outgoing shift leave the hospital
6. Contact the responsible doctor as soon as an unintentional administration delay or omission is identified and agree appropriate and timely action. If unavailable, contact a pharmacist. Clinical significance will depend on medicine characteristics and patient’s condition.
7. Refer to the patient information leaflet (PIL) in each medicine pack for information on a missed dose
8. Consider administering intravenous medicines, especially the first few doses, at the beginning of regular medicines administration rounds, leaving oral and other medicines until afterwards
9. Ensure prescribers communicate effectively with nurses when once only (stat) doses are prescribed
10. All staff involved in medicines use should be made aware of the Critical Medicines List and its purpose i.e. a copy of the list should be visible in all clinical areas where medicines are used
11. Report omissions or delays in prescribing, dispensing or administration of medicines on the Critical Medicines List to ensure learning and avoidance of repeated incidents
Policy Details

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

Review and Amendment History

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<td>2.2</td>
<td>Sept 2019</td>
<td>Introduction of Nursing Associate Role and administration of medicines. Update of References. Other minor changes and update to linked policies.</td>
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<td>2.1</td>
<td>March 2017</td>
<td>Changes relating to Children’s Palliative Care Nursing Teams and single/dual practitioner administration.</td>
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<td>Significant revision of policy to align practice and comply with guidance</td>
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<td>Minor changes to policy to adhere to NHSLA requirements</td>
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<td>Policy for the new organisation BCPFT</td>
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