Medicine Handling Policy

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Background

This document outlines an effective system to ensure that medicines are handled in a safe and secure manner. The policy covers those medicines kept as stock on Hope Citadel premises covering Emergency contraception, Emergency medications, vaccinations and LARC contraceptives (Depo injections and IUCDs), Oxygen cylinders.

Principals

As part of Clinical Governance Hope Citadel has a responsibility to ensure the safe and effective use of medication. The prescribing and supply of medication is controlled by statutory regulations. The transport, receipt, storage and disposal of medicines along with the administration of medicines (provided such administration is in accordance with a doctors instructions) are not subject to the same statutory control and therefore these activities may be undertaken not only by nursing staff and doctors but also by appropriately trained staff authorised by Hope Citadel Healthcare as part of Patient specific directives, acting on the instructions of an appropriate registered healthcare professional.

Nurse Practitioners in addition to administering medications can prescribe medications as per their competencies and their prescribing Portfolio which is under regular review by the Lead GP at each site.

Each practitioner is personally accountable for their own knowledge and competence and should not act outside their level of competence. Decisions concerning professional practice shall be based on each Professions code of professional conduct. Practitioners should also practice in accordance with any local/national guidelines or requirements of Hope Citadel Healthcare.

Safe handling and administration of medicines policy

Compliance with this policy rests with the Chief Executive Dr. Laura Neilson and the Operational responsibility rests with the Executive Management Team.

It is the responsibility of the Clinical Director Dr John Patterson to monitor advice and amend as appropriate any aspects of the policy with approval of any amendments being agreed by the Clinical Leads Group and implemented by the EMT group.

The EMT group will ensure that all staff engaged in any activity covered by this policy will receive appropriate training and supervision and update training.

All staff engaged in any activity covered by this policy is required to adhere strictly to this policy and failure to do so may result in disciplinary action.

Standard Operating Procedures (SOPs) for the handling of each medication have been developed by the Clinical Director and are to be adhered with any subsequent changes implemented by the EMT group.

SOPs must be Comprehensive, reproducible, and unambiguous. They must indicate who is authorised to undertake the procedure.

Legislation

The Following medication is mandatory regarding the use of medicinal products and will be referred to where appropriate in the policy.

- The Medicines Act 1968
- The Misuse of Drugs Act 1971
- Misuse of Drugs (Safe Custody)Regulations 1973 as amended by
- Misuse of Drug Regulations Act 2001
- The Poisons Act 1972
- Medicinal Products (Prescription by Nurses Act) 1992
- The Controlled Drugs (Supervision and Management and use) Regulations 2006

Supply, transport, receipt & storage

The responsibility for establishing and maintaining a system for the security of the medicines at each Hope Citadel site will rest with the Manager at each site following instruction from the EMT group and Medical Director and CEO prior to this.
The Manager will work closely with a named Practice Nurse at each site to ensure the Policy is adhered to and training of all staff involved is undertaken.
The Named Practice Nurse will be the designated practitioner at each site and will control access to the medications at each site and have responsibility for ensuring that the clinical system is followed and that the security of the medicines at the site they work is maintained.

Ordering and supply

All medicine Products must be obtained from an approved supplier and will be limited to an agreed stock list (please see appendix 1 for medical products and their suppliers).
The designated practitioner at each site is responsible for checking and maintaining stocks and making an order list of required stock. This list will be checked and authorised and signed by the Lead GP at each site.
Stocks will be reviewed on a regular weekly basis by the Practitioner.
Any deletions or additions to the stock list can only be made after prior approval at the Clinical Leads Group.

Transporting Medicines to Clinical/Service Areas

All medicines should be transported to healthcare settings in sealed tamper evident containers.
Delivery containers must indicate the destination of the delivery and any hazard warnings relevant to the medicines being delivered. Medicines should be signed for by the designated practitioner or if not available the Manager at each site and immediately stored in the appropriate secure site either the locked Clean Utility Room ,Clean Utility Room locked Cupboards or the Lockable vaccine Fridge, for Oxygen Cylinders, Emergency Drugs/Contraception, and Vaccines respectively.

Oxygen Cylinders

Active Oxygen Cylinders are stored in the same treatment/Consultation room as the Emergency drugs. Two Kinds of cylinder exist a Portable cylinder and a large standalone standard cylinder (HX).
The designated practitioner will check the levels of Oxygen in each Cylinder on a daily basis and order further supplies as required always ensuing there is sufficient Oxygen on site to allow for delivery time of further supplies. An oxygen stock log will be kept an updated by the designated Practitioner at each site.

Emergency Drugs

Emergency medications will be stored in the Locked Clean Utility room in the locked appropriate cupboard. When supplies of Emergency drugs are required for the Emergency drugs trolley the

designated practitioner will take the required stock from the Clean Utility room as required. A log of stock taken will be entered by the designated practitioner in the Emergency drug Log sheet each time stock is required for the Trolley. This will be triggered by a weekly Emergency drug trolley stock checks made by the designated practitioner.
Stock will be ordered by the designated practitioner as required always ensuring sufficient stock on site to allow for delivery time of further supplies.

Vaccinations

Vaccinations are stored in the lockable vaccine fridge at each site and storage and temperature are subject to the Hope Citadel Cold Chain Policy. On a daily basis the stock is checked by the designated practitioner who will check the log of vaccines used which is in a fixed location near or on the vaccine fridge.
Vaccination stocks are redeemed by the issuing and collection of prescriptions of those patients given the said vaccines and as a result there should be an automatic ongoing re-stocking of supplies. This will however be monitored by the designated practitioner who will ensure stock levels are correct.

The only exceptions to this are the Influenza Vaccinations and the Children's Vaccinations.
Influenza Vaccines are ordered in advanced based on Practice population estimated needs from a named supplier (this may be different each year). The designated practitioner will, as part of the Hope Citadel Seasonal Vaccination policy, ensure that any further supplies of Influenza Vaccination required during the campaign are met by close monitoring of stocks using the influenza stock log.
Children's Vaccinations are supplied as required from the CCG via their subcontracted preferred supplier. The designated practitioner will monitor and ensure that stock will be ordered allowing for delivery time of the said further supplies.

Transporting Medicines for Visits

When the health professional transports medication to patients' homes for administration, consideration must be given to the safety and security of medicines in transit.
It is the responsibility of the health professional that is transporting the injection/vaccine to ensure it is maintained according to manufacturer's instructions in relation to storage temperature and contained within an appropriately labelled robust container. Whenever practicable, the transport of injections/vaccines should be undertaken as a single journey; medicines must never be left unattended unless locked within the boot of a car. Vaccines must be transported in a validated 'cool box' (See Immunisation Policy).
Medication must be kept out of sight in a locked car during visiting rounds, except when it is carried on the person of the health professional.
Medicines must not routinely be stored in a car as temperature fluctuations will make storage conditions unsuitable. Adrenaline should only be carried when specifically needed e.g., during immunisation sessions. Similarly, a stock of dressings should not routinely be stored in a car.
Hope Citadel GPs undertaking visits where medications are required to be taken with them must not take these medications home with them and must return them to their Practice prior to going home.
Controlled drugs should not be transported by Hope Citadel staff (Please see the Controlled Drugs policy). It is the responsibility of the patient/relative/carer to arrange for dispensed medicines to be collected from or delivered by pharmacy on receipt of the patient's prescription.
Transportation of controlled drugs must only be undertaken in emergency situations and staff must be working under an agreed SOP.

Medical gas Transport

Medical gases must not be transported by Hope Citadel professionals.

Receipt of Orders

The signature of an authorised member of staff either clinical or non-clinical will be required for receipt of medicines. This does not need to be the designated practitioner.

The member of staff who receives the order must sign for it, acknowledging the 'tamper proof' packaging was intact (if used) and check the delivered order against the copy order. Where 'tamper proof' packaging has been used and is not intact, the relative pharmacy department must be notified immediately.

No samples of medicinal products may be accepted in clinical areas.

No clinical trial materials may be accepted in clinical areas without Medicines Management approval.

Checking Orders

It is the designated practitioner's responsibility to check the order is correct, received in good condition and with reasonable shelf life.

The designated practitioner must notify the relevant approved supplier if there are any discrepancies in the order.

The designated practitioner must also report any discrepancies to the practitioner in charge. A written, signed and dated record must be maintained of stock received into the department.

Order forms and delivery records must be kept for a period of two years as a record that the supply was complete.

Storage – General

It is the designated practitioner's responsibility to ensure correct storage, stock rotation and expiry date checking as new stock is received. Stock should be rotated to ensure that the stock with the shortest expiry date is used first.

Refrigerators and cupboards designated for the storage of medicines and pharmaceutical supplies must on no account be used for the storage of food, valuables, or other items.

All medicines to be taken orally and those for external use must be stored separately in locked cupboards, all reserved solely for medicinal products (it is acceptable for medicines to be taken orally and externally products to be stored on separate shelves in the same cupboard).

Flammables, disinfectants, reagents, and intravenous and topical fluids (sterile) must be stored separately).

Medicines must not be transferred from an original dispensing container to another container for the purposes of storage.

Security

Cupboards designated for medicines must be lockable and the designated area ideally should not be accessible to the public.

Refrigerators and cupboards designated for the storage of medicines and pharmaceutical supplies must be kept locked and the keys kept within a designated safe place, ideally held personally by the designated practitioner. The designated practitioner is responsible at all times for the safekeeping of all medicines in their department.

The keys for the medicine's cupboard must be kept on one key ring solely for this purpose and clearly identified.

The designated practitioner must immediately report any breaches of security (e.g., theft of controlled stationery, keys, or medicines) to the clinical manager of the service. An incident form must be completed.

Storage Temperature

The recommended temperature for storing medicines will be indicated on the container issues by the manufacturer.

Medicines that do not require storage in a refrigerator should be stored at temperatures between 9°C to 25°C. Cupboards used to store medicines must therefore not be located near radiators or hot water pipes or in areas of high humidity.
The room used to store medicines must be monitored with a room thermometer that measures maximum and minimum temperatures.
Medicines requiring storage in a refrigerator must be stored in a lockable fridge manufactured specifically for the storage of medicines. Medicine fridges must be monitored, and temperatures recorded each working day with maximum minimum thermometers to ensure temperatures are maintained between 2°C and 8°C.
When refrigerator temperatures occur outside this temperature range, advice as to whether the medicines are fit to use must be requires from the Manufacturer or the Approved supplier responsible for supply. The medicines must not be given until advice has been received. If this occurs at a weekend or bank holiday the appropriate body must be contacted on the first working day and medicine not used in the interim period. If there are any potential problems with the storage of medicines, it must be communicated to all staff and a notice displayed until advice has been sought. Any advice given must be documented for audit purposes.
Vaccines and any other medicines requiring refrigeration must be placed immediately on receipt in a refrigerator specifically designed for the storage of medicines. The cold chain must be maintained. (Appendix 2)
Vaccines should be administered directly from the refrigerator. If this is not possible the 'cold chain' must be maintained by the use of a cool bag.
Vaccinations must not be returned to a refrigerator once the seal has been broken.
For further details regarding appropriate storage of vaccines, refer to Immunisation Policy.

Medical Gases

The following precautions must be observed:

- The number of cylinders held as stock in any department should be as small as practicable.
- Cylinders must be firmly secured at all times to prevent them falling over and be stored in a well-ventilated area.
- Cylinders must be stored away from radiators and electric fires.
- Naked lights must not be allowed within the immediate vicinity of a cylinder.
- No oil or grease must be applied to the cylinder or tap connector.
- Ensure that after use the outlet valve of the cylinder is closed.
- Cylinders with damaged valves and defective equipment must be labelled appropriately and withdrawn from use.
- Cylinders which have been emptied must be clearly marked to distinguish them from full ones.
- Excessive force or any tools must not be used to open or close a cylinder valve.
- Check flow meter and pressure of cylinder daily.
- Appropriate hazard sings must be displayed where gases are stored.

Monitoring Storage

An inspection of the storage of medication in all areas of the Hope Citadel Healthcare sites should be undertaken at approximately six-monthly intervals. Any anomalies will be brought to the attention of the Clinical Director and a copy of the report will be sent to the designated practitioner responsible for each service area e.g., podiatry, dental etc.
The member of staff involved with the inspection will be required to complete an action plan within two weeks of receiving the inspection.

Disposal of Medication

All out of date products will be taken to the local Pharmacy for disposal. A log of what has been take to the local Pharmacy will be kept by the designated practitioner.

Prescribing – Authority to Prescribe

Under the Medicines Act 1968 a registered medical practitioner is allowed to prescribe a medicinal product as defined under the Act.

Under the Prescription by Nurses Act 1992 a community or practice nurse who is identified as a nurse prescriber on the NMC register is allowed to prescribe those items as listed in the Nurse Prescriber's Formulary.

Nurse Independent Practitioners (formerly known as Extended Formulary Nurse Prescribers) are able to prescribe licensed medicines for any medical condition within their own level of professional competence and expertise. Nurse Independent Prescribers are also able to prescribe independently specified controlled drugs for specified medical conditions (see Central Lancashire Non-Medical Prescribing Policy).

Non-medical prescribers who have undergone training as supplementary prescribers may prescribe under an agreed clinical management plan.

Authorised practitioners may only prescribe within the scope of their own professional practice and competencies. The authorised practitioner must be aware of the accountability pathway and must have read and follow this policy.

There must be a valid prescription before any medicine may be administered by any route, unless there is a local procedure with directs otherwise (e.g., a Patient Group Direction).

Prescribers of unlicensed products carry their own responsibility and are professionally accountable for their judgement in doing so. Prescribers are responsible for the patient's welfare and in the case of adverse events they may be called upon to justify their actions. Non-medical prescribers should not prescribe unlicensed medicines.

Signatures

A register of those practitioners who have authority to prescribe will be kept within the CCG and will be available for clarification should the need arise.

Writing a Prescription

Prescriptions must be written in accordance with the directions given under the section of 'Prescribing Writing' within the current BNF.

Patient Group Directions (PGD)

The majority of clinical care should be given using a patient specific direction such as a prescription. However, in certain circumstances, supply and administration of medicines may be appropriate under PGDs.

Any proposed PGD must be authorised in advice. It must be drawn up by a multidisciplinary group in accordance with HSC 2000/026 and must be approved through the appropriate panel listed within the PGD.

It is the responsibility of the Clinical Director of an area to ensure that any medication administered without a prescription is only carried out under a valid PGD by authorised staff.

It is the responsibility of the Clinical Director to ensure that PGDs are developed in consultation with a pharmacist from the Medicines Management Team and are approved by the CCG. Copies of an appropriate PGD must be available within the area of practice and accurately reflect the practice in that area.

It is the responsibility of the Clinical Director to ensure training for staff working under the PGD.

It is the responsibility of individuals working under the PGD to ensure that they are competent to do so and that they are working under a current valid PGD.

For further information consult the CCG Policy for the Development and Implementation of PGDs.

Administration of Medication

General Principles of Administration

Medicines can only be administered to a patient within the Hope Citadel if they have been supplied by one of the following routes:

- Any appropriately licensed hospital pharmacy department;
- Community pharmacy;
- Licensed pharmaceutical supplier;
- NHS supplies in the case of appliances or dressings; or
- Via a prescription prescribed and dispensed for an individual patient.

Where there is any doubt as to the accuracy, completeness, or appropriateness of an individual prescription or to the quality of a medicine, it is the responsibility of the member of staff to confirm the details with the prescriber and/or a pharmacist before administering the medicine.

If the member of staff is still not satisfied their line manager must be notified immediately. Any concerns and details of the action taken must be recorded in the nursing record or case notes for the patient in his/her care. This would also cover situation where a self-medication policy is in operation. The member of staff must be able to justify any action taken in respect of administration and be accountable for any action taken.

The health professional must have a working knowledge of drugs used within his/her sphere of practice. Nurses must adhere to the NMC Standards for Medicines Management (NMC 2008).

The safe and effective administration of medication requires a partnership between various health professionals. To achieve this, the nurse must have access to the prescriber and a pharmacist should the need arise for clarification.

Administration

All staff involved in medicines administration must have access to this Policy and work in accordance with the defined SOP (please see Appendix 3). It is accepted that single nurse administration takes place within the Trust with the agreement of the Clinical Director. In some settings the nurse may be managerially responsible for medicine administration by trained non-clinical staff (e.g., healthcare assistants). In both cases the nurse must:

- Be aware of their accountability.
- Have read the Policy and the relevant Administration Protocols
- Have read the NMC documents.
    - Standards for Medicines Management (NMC 2008)
    - Standards of Conduct Performance and Ethics for Nurses and Midwives (NMC 2008) Record Keeping: Guidance for Nurses and Midwives (NMC 2009).

Newly qualified nurses undergoing a period of preceptorship must be signed off as competent, in accordance with the individual's preceptorship contract before undertaking single nurse drug administration. Registered nursing staff who undertake single nurse drug administration must also fulfil the criteria as stated in this policy.

Where two nurses are involved in the administration process, they are reminded that under the NMC Standards (NMC 2008) each nurse is accountable for his/her actions independently of the other practitioner.

Suspected adverse drug reactions must be reported to the prescriber and, in accordance with the guidance in the BNF, be reported using the 'yellow card' system to the Medicines and Healthcare Products Regulatory Agency (MHRA) (www.yellowcard.gov.uk).

Hope Citadel Healthcare

APPENDIX 1: APPROVED SUPPLIERS AND STOCK LIST

EMERGENCY TROLLEY		EXP		MONTH :						
DATE	MIN	DATE								
ADRENALINE 1mg in 1ml	5		IM/SC							
AMIODARONE 300mg PREFILLED	1		IV							
ASPRIN (Soluble) 300mg	1 pk		ORAL							
ATROPINE SULPHATE 600mcg in 1 ml	1		IM/SC							
BENZYLPENICILLIN SODIUM 600mg	2		IM/SC/IV							
CEFOTAXIME 1g	1		IM/IV							
CHLORPHENAMINE	1		SC/IM/SLOW IV INJ							

10mg in 1ml											
DIAZEPAM 5mg	2		RECTAL								
DIAZEPAM 10mg	2		RECTAL								
DIAZEMULS 10mg/2ml (5mg/2ml x4)	4		IV								
FUROSEMIDE 20mg/2ml	1		Slow IV								
FLOURESCEIN SODIUM 0.5ml 2%	2		EYE DROP								
GLUCOGEL 25gm	1		ORAL								
GLYCERYL TRINITRATE	1 pk		SUBLINGUAL								

300 mcg										
HYDROCORTISONE 100mg	**1**		**IV**							
IPRATROPIUM 250mcg / ml	**2**		**NEBULISED**							
PARACETAMOL 120 mg/5ml	**0.5l**		**ORAL**							
PARACETAMOL 250 mg/5ml	**0.5l**		**ORAL**							
PREDNISALONE 5mg	**1 pk**		**ORAL**							
PROCHLORPERAZINE 12.5mg in 1ml	**1**		**IM**							
SALBUTAMOL	**5**		**NEBULISED**							

2.5mg / 2.5ml											
SALBUTAMOL 5mg/2.5ml	5		NEBULISED								
SALBUTAMOL 100mcg	2		INHALED Via SPACER								
SODIUM CHLORIDE SOL. 10ml	3		INJ/INF								
WATER FOR INJECTION 5ml	3		INJ								
PRE-FILLED ADRENALINE 10mls, 1:10,000	3		IV								
NORMAL SALINE 500ml bag	1		IV								
HOME VISIT BAG		**EXP**		**MONTH:**							

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DATE	MIN	DATE								
ADRENALINE 1mg in 1ml	5		IM/SC							
DELIBERATELY BLANK										
ASPRIN (Soluble) 300mg	1 pk		ORAL							
ATROPINE SULPHATE 600mcg in 1 ml	1		IM/SC							
BENZYLPENICILLIN SODIUM 600mg	2		IM/SC/IV							
CEFOTAXIME 1g	1		IM/IV							
CHLORPHENAMINE 10mg in 1ml	1		SC/IM/SLOW IV INJ							
DIAZEPAM	2		RECTAL							

5mg										
DIAZEPAM 10mg	2		**RECTAL**							
DIAZEMULS 10mg/2ml (5mg/2ml) x4	4		**IV**							
FUROSEMIDE 20mg/2ml	1		**SLOW IV**							
FLOURESCEIN SODIUM 0.5ml 2%	2		**EYE DROP**							
GLUCAGON HYPO KIT 1mg (in fridge)	2		**SC/IM/IV**							
GLUCOGEL **25gm**	1		**ORAL**							
GLYCERYL TRINITRATE	1 pk		**SUBLINGUAL**							

300 mcg										
HYDROCORTISONE 100mg	1		IV							
IPRATROPIUM 250mcg / ml	2		NEBULISED							
PREDNISALONE 5mg	1 pk		ORAL							
PROCHLORPERAZINE 12.5mg in 1ml	1		IM							
SALBUTAMOL 2.5mg / 2.5ml	5		NEBULISED							
SALBUTAMOL 5mg/2.5ml	5		NEBULISED							
SALBUTAMOL	2		INHALED VIA SPACER							

100mcg										
SODIUM CHLORIDE SOL. 10ml	3		INJ/INF							
WATER FOR INJECTION 5ml	3		INJ							

THE ABOVE STOCK LISTS ARE SUPPLIED BY FARLA AND PHOENIX BOTH APPROVED SUPPLIERS.

APPENDIX 2: Clinical Protocols

Please see the additional protocols listed below in the Clinical Protocols section attached:

Cold Chain Protocols

Travel Vaccinations Protocols

Influenza Protocol

Children's Immunisations Protocols

Emergency Contraception Protocols

Contraception Protocols

APPENDIX 3 : SOPS

Emergency drugs

The Administration of all Emergency medication is to comply with the BNF "Medical Emergencies in the Community" document (please find attached). All Nurses receive training on Emergency medication relevant to their competence. All GPs receive detailed training on Emergency medication during their Foundation Review.

Oxygen

Oxygen is to be Administered as per the BNF and BNF "Medical Emergencies in the Community". NOTE please also refer to the COC Oxygen Policy.