Lincolnshire Community Health Services NHS Trust

Safe and Secure Handling of Medicines Policy

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Safe and Secure Handling of Medicines Policy

Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		Amalgamated policies – CIG04, PCIG12 and CCS50.	August 2016	Lorna Adlington
	13	Addition of guidance from NPSA alert re: open systems. New Section – procedure for prescribing / preparing and administering injectable medicines	September 2016	Lorna Adlington
1.1	12.4 Covert administration	Update in line with NICE guidance NG67 – defined processes for covert administration	May 2017	Lorna Adlington
1.2	Section 11.1	Storage and security of medicines	October 2017	Lorna Adlington
2	Scope Section 10. Prescription Stationery Appendix 3 Appendix 4 Appendix 5	Updated to include Nursing Associates. Updated to recognise new guidance from the Counter Fraud Authority New SOP – security of prescription stationery. SSHM SOP for Imms and Vaccs service SOP for opening and closing a new service	May 2018	Lorna Adlington
3	Section 10	Updated process regarding transfer and security of FP10 stationery	June 2018	

4	Throughout document	Wording of Non- Medical Prescriber removed and changed to Independent/ Supplementary Prescriber	June 2019	Helen Oliver
4	Throughout document	Wording of nurse removed and changed to registered healthcare professional	June 2019	Helen Oliver
4	Section 10	Delivery of secure stationery must be by secured and tracked document bag.	June 2019	Helen Oliver
4	Section 11	Information on ambient temperature used to store medicines including monitoring, recording and escalation	June 2019	Lorna Adlington
4	Section 11	Controlled drug cupboard keys should be kept separate to other	June 2019	Helen Oliver
4	Section 12	Addition of considering all aspects of patient consent	June 2019	Helen Oliver
4	Section 12	Addition of checking allergies or previous adverse drug reactions	June 2019	Helen Oliver
4	Section 12	• Raising ambiguities or concerns with a prescriber • Calculations to be double checked where practicable possible with a second person • Information regarding minimising disruptions • opening date should be written on the bottle label		
4	Section 12	New section giving advice on remote prescribing	June 2019	Lorna Adlington
4	Section 12	New section giving information on transcribing	June 2019	Lorna Adlington

4	Section 13	• Use of safety blunt needles when drawing up from vials • Need for PPE	June 2019	Helen Oliver
4	Section 16	To reduce medicine errors prescribing, dispensing/ supply and administration should be performed by separate healthcare professionals. Healthcare records should be completed as soon as possible	June 2019	Helen Oliver
4	Section 17	Additional requirements for independent / supplementary prescriber to complete an annual audit of their prescribing practice and have specific prescribing objectives in their annual appraisal	June 2019	Helen Oliver
4	Section 18	Information regarding storing vaccines, thermometers and transport updated in line with LCHS G-IPC-34	June 2019	Helen Oliver
4	Section 21	References updated	June 2019	Helen Oliver
5	Throughout document	Non-Medical prescribers (NMPs) changed to Independent / Supplementary prescribers	May 2020	Helen Oliver
5	Section 2	Addition of Definitions/explanations	May 2020	Helen Oliver
5	Section 3	Audit tool renamed	May 2020	Karen Leggett
5	Section 5	Addition; completed FP10 receipt and bearers note should be returned to medicines management team (via scanning or post within the red bag without delay.)	May 2020	Karen Leggett

5	Section 7	Removed information regarding dispensing services Addition; Transferring medicines from one container to another denotes dispensing , this requires a contractual requirement and additional SOP	May 2020	Karen Leggett
5	Section 8	Changes to stock lists should be made formally through DTC Local Standard Operating Procedures (SOPs) should be developed to ensure clear standards of accepting patient own medication		Helen Oliver Karen Leggett
5	Section 10	Addition; Prescriptions are CONTROLLED stationery and therefore must be managed safely and securely Addition ; access to central store being limited and auditable to authorised personnel only Clarification: receiving orders Addition; The courier driver should only deliver to LCHS Trust addresses Keeping records of prescriptions destroyed corrected from 18 months to 2 years Addition: nominated person should be responsibility for managing and overseeing the whole process - from ordering, checking, storage and transfer of Controlled stationery New information: home visiting teams regarding overnight storage of prescriptions pads	May 2020	Helen Oliver Karen Leggett

		Addition: return of prescription logs to ensure triangulation of ordering, sent, received and use of individual scripts. Addition; Controlled stationery should be stored separately and never with medication Clarification on Controlled stationery FP10SS which must be removed from printers when they are not in use		
5	Section 10	Addition; staff and visitors should never be left alone with prescription forms, stock Addition; information on prescription fraud Clarification ; Destruction of prescriptions using a cross-shredder and completing a Destruction form Addition; return of destruction form to ensure triangulation of prescriptions, issued and used Audit requirements updated to include systems being in place to recover all unused prescription forms		
5	Section 11	Clarification that medicines must be stored at 25°C and less. Removed; sentence relating to reduction of expiry dates expected to be weeks for every 1 week stored at up to 30°C (4 weeks if up to 35°C).	May 2020	Helen Oliver Karen Leggett

5	Section 11	Fans and air conditioning units replaced with the wording ventilation or air cooling devices Digital data loggers should be downloaded at least weekly and information stored locally Addition; do not use ; dispose of patients own medication which is 'date of opening' sensitive	May 2020	Helen Oliver Karen Leggett
5	Section 12	Removed expectation of wearing a red tabard during a medicine round Process of using fax removed Removed section on how to measure/administer liquid medicines via oral or other enteral routes	May 2020	Helen Oliver Karen Leggett
5	Section 13	Removed; how to prepare, mix, administer, withdraw a solution/ suspension, how to reconstitute, dilute, label medicines for injectable, administration and IV related procedures	May 2020	Helen Oliver
5	Section 14	New information on use of PGDs for remote consultations and during exceptional circumstances or in times of pandemic when the service has implemented business continuity plans	May 2020	Helen Oliver
5	Section 16	Addition; Duty of Candour applies	May 2020	Helen Oliver

5	Section 17	Addition ; information on refrigeration USB data logger Addition;Vaccines/medicines should not be discarded until directed to do so as they may still be viable. Addition; mark medicines that are taken out of the cold chain and subsequently returned back into the refrigerator this could affect their stability and efficacy Addition ;alternative medicine fridge for potential breakdowns Addition; section on information for 'service specific' Medical device/ fridge related information moved to G-IPC-34	May 2020	Helen Oliver Maria Turner
5	Section 18	Training section rewritten and relevant sections amalgamated	May 2020	Helen Oliver
5	Section 20	Removed; random survey of relevant practitioner groups	May 2020	Helen Oliver
5	Appendix	Addition; Controlled Stationery appendices , explanation of onward delivery, daily checks	May 2020	Helen Oliver
5	Appendix	Addition of Ambient Room Temperature flow chart	May 2020	Helen Oliver
5	Appendix	Addition of Request for Addition to Stock List form	May 2020	Helen Oliver
5	Appendix	Addition of Appendices 3 and 4 (Amalgamated policy G-CS-92)	13th May 2020	Maria Turner
5.1	Appendix 15	Updated competency assessments for registered and non-registered staff	September 2020	Helen Oliver & Maria Turner

6	Section 11	Addition:Extra Storage considerations in instances where the risk of achieving this is reduced due to service restrictions. Addition: 3 monthly digital code changes instruction for COWS (Medicine trolley)	December 2020	Medicine Management Team
6	Section 12	Whole section rewritten to cover 10 key principles of remote prescribing, clarification on electronic remote prescribing to registered practitioner and direct to a patient, use of technology, administering medicines which have been prescribed by another organisation, verbal orders/ telephone instruction	November 2020	Medicine Management Team
6	Section 12	Information on Verbal orders deleted and now states; is a potentially unsafe practice, other alternatives must be considered	November 2020	Medicine Management Team
6		References updated	November 2020	Medicine Management Team
6	Appendix 15	Information inserted about the frequency of School Age Immunisation service training, storage of competencies statement of competency	December 2020	Helen Oliver Maria Turner

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Safe and Secure Handling of Medicines Policy
Procedural Document Statement

Background Statement	The purpose of this guidance is to implement a co-ordinated and standardised approach to strategic, operational and clinical management of all processes involving medicines and their use. This policy offers 'best practice' advice and guidance to ensure that medicines are handled safely and securely.
Responsibilities	Compliance with the policy will be the responsibility of all staff and providers of services involving medicines. Managers and service leads are responsible for ensuring that Standard Operating Procedures are in place for all clinical situations involving handling of medicines.
Training	It is the responsibility of operational managers and service leads to ensure that appropriate mechanisms are in place to support the implementation of this policy, including appropriate training and maintenance of competency.
Dissemination	Organizational website, via operational managers and service leads, published through medicines management forums
Resource implication	This policy has been developed in line with Department of Health and wider National guidance to ensure the appropriate and safe management of medicines within all services within Lincolnshire. There are no identified additional resource implications
Consultation	Workforce

1. Introduction / Scope of the policy

1.1 This policy aims to offer practical advice and outline steps that must be taken to ensure medicines are handled safely and securely within all care environments and services and by directly employed staff.

1.2 The policy is underpinned by key legislation, for example, the Medicines Act, the Misuse of Drugs Act and associated regulations, the Health and Safety at Work Act, the Control of Substances Hazardous to Health Regulations and the regulations relating to the disposal of hazardous and other controlled wastes.

1.3 It is recognised that whilst individuals have a duty to ensure that medicines are handled safely and securely, the Organisation also has statutory responsibilities and a duty of care to staff and patients.

1.4 This policy provides outlines key responsibilities and expectations of all staff working within LCHS including nursing associates and bank and agency staff.

1.5 Senior managers will define the systems to ensure that:

- Standard Operating Procedures are validated for all service areas / health care settings;
- Staff involved in any aspect of medicines understand their responsibilities, are competent and have access to training if required;
- Suitable devices and clothing to protect the patient and staff from identified, avoidable hazards is provided;
- Facilities and equipment being utilised are provided and maintained to the required standards;
- Systems for routine audit, reviews of accidents, errors and patient complaints relating to the handling of medicines are in place.

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

- complies with current legislation;
- follows guidance issued by the Department of Health, professional bodies (e.g. Nursing and Midwifery Council, Royal Pharmaceutical Society (RPS), General Pharmaceutical Council (GPhC)) or other government departments such as the Home Office;
- Manages the risks to patients, relatives, carers and staff arising from the use of medicines;

1.7 It is therefore anticipated that as current primary care services develop and new services are established, this policy will support the safe use of medicines by detailing what must be done, but allowing local implementation depending on circumstances.

1.8 The policy considers the processes associated with the physical handling of medicines, including storing, supplying, transporting, prescribing, administering, recording and disposing safely of medicines, and applies to all care environments. Each area is outlined in generic terms and must be supported by service / health care setting specific Standard Operating Procedures (SOPs) which will detail the local operational implementation.

Additionally this policy details the appropriate measures to ensure security and confidentiality of content of all prescription forms and prescription stationery.

1.9 It is the responsibility of operational managers and service leads to ensure that SOPs are in place which:-

- Describe processes so that the SOP is comprehensive and reproducible
- Describe each element precisely, comprehensibly and unambiguously and indicate who is authorised to perform it
- Specify the equipment, facilities and data associated with the process
- Include the acceptable form(s) in which instructions can be given.
- Specify the appropriate written and / or oral supporting information or instructions required in passing to the next stage

1.10 Ratification of service SOPs will be through the relevant assurance structures.

1.11 A list of all SOPs being used operationally must be approved and recorded with the relevant service by the Service Head / Operational Lead.

2. Terminology

Definitions/explanations

DP designated person is the Medical Director
DTC Drugs and Therapeutic Committee
FP10PN – Prescription pad used by Community Nurse Prescribers
FP10SS – Prescriptions used by GPs and Independent prescribers, generated by computer
FP10HP – Prescription pads used by GPs
I/SP- Independent/ Supplementary Prescriber
LCHS – Lincolnshire Community Health Services
MM Medicine Management
NHS CFA – NHS Counter Fraud Authority
SOP – Standard Operating Procedure

Within the policy the term FP10 is used to cover all types of prescriptions written by prescribers within LCHS

2.1 The term ‘medicines’ is used throughout the document as a generic term that covers all products administered by mouth, applied to the body, or introduced into the body for the purpose of treating or preventing disease, diagnosing or monitoring illness, contraception or inducing anaesthesia.

2.2 The generic term ‘patients’ is used throughout to refer to people receiving medicines although individual services may refer to them for example as service users or clients.

2.3 Any paperwork such as requisition forms or prescription pads that can be used to obtain medicines is designated ‘Controlled Stationery’. Any unauthorised use may lead to the fraudulent acquisition of medicines.

3. Initiation of treatment / Prescribing

3.1 A patient's treatment must be initiated through a formal process, which may be the production of a prescription or Patient Specific Direction (PSD) by an authorised prescriber or by an approved Patient Group Direction (PGD).

3.2 Any person issued with a blank prescription form / pad will be held accountable for its security. All prescription stationery should be kept secure

3.3 When writing a prescription the current guidelines for prescription writing, as documented in the British National Formulary (BNF), will be followed. Prescriptions are to be written legibly in ink or otherwise so as to be indelible, will be dated and will state the full name and address of the prescriber and provide an indication of the type of prescriber. Each prescription will be signed in ink by the prescriber.

3.4 It is mandatory that the NHS number be used as the national unique patient identifier (NPSA 2008). To ensure correct patient identification, the NHS number should always be used in conjunction with the other identifiers (usually first name, last name and date of birth) when identifying a patient.

3.5 It is a legal requirement to state the age of children under 12 if a prescription only medicine (POM) is being prescribed. It would be preferable to always state the age and date of birth of the patient.

3.6 The following are held to be good practice:-

- the unnecessary use of a decimal point should be avoided e.g. 3 mg and not 3.0 mg. Quantities less than 1 mg should be written in micrograms. Where decimals are unavoidable a zero must be written in front of the decimal point where there is no other figure e.g. 0.5 ml and not .5 ml;
- 'micrograms' and 'nanograms' shall always be written in full.
- Similarly 'units' should be written in full. Abbreviations such as 'U' and 'IU' should never be used;
- medicines should be prescribed by approved names unless the brand name is clinically significant;
- instructions shall be in English without abbreviations;
- due regard should be taken of any known hypersensitivity to medicines;
- dose and dose frequency should be stated; avoid vague dosage direction, i.e. as necessary, as before, as directed.

3.7 For computer-issued prescriptions the recommendations of the Joint GP Information Technology Committee should also be noted. Reference should be made to page 5 of the BNF (BNF 78).

3.8 Community Hospital prescribing will be on the authorised Community Hospital E-Prescription Charts and will be audited on a monthly basis using the Community Hospital Prescribing Quality Audit tool (Appendix 8B); this process will be monitored by the Safeguarding and Patient Safety Committee.

3.9 If treatment is being initiated for administration or supply under a Patient Group Direction (PGD), then the requirements of that PGD must be adhered to as a legal document authorising medicines use under the Medicines Act (and amendments).

3.10 Supplementary / Independent prescribers must only prescribe within their scope of practice and competency and supplementary prescribers only under clinical management plans

(individualised for each patient) and within their scope of practice. Further guidance is available in the Supplementary / Independent Prescribing Policy (P-CIG-20).

3.11 Supplementary / Independent prescribers are prohibited from using Latin abbreviations on FP10 prescriptions. The use of Latin abbreviations by other prescribers is discouraged on FP10 prescriptions, directions should preferably be in English without abbreviation (BNF 78).

3.12 Prescribing for self, family or colleagues should only be done in emergency or exceptional circumstances.

3.13 Supplementary / Independent prescribers are advised not to issue private (non NHS) prescriptions due to the lack of a clear audit trail.

4. Who may prescribe?

4.1 Medical staff, licensed to practice with the General Medical Council, are responsible for the majority of prescribing of medicines for patients. They must comply with appropriate legislation, the Medicines Policy and professional guidance when prescribing.

4.2 Registered Healthcare Professionals who have successfully completed an appropriate nationally recognised prescribing course, who are registered with their professional body as a person qualified to prescribe, and are Trust approved non-medical prescribers, may prescribe according to their designation of supplementary or independent prescriber in accordance with the Trust Supplementary / Independent prescribers Prescribing Policy.

4.3 Midwives (Prescription-Only Medicines (Human Use) Order 1977) may prescribe from a limited range of medicines.

4.4 The law contains ‘exemptions’ for certain professionals on the HPC register to administer, sell or supply from a list of specific medicines on their own initiative, when that would normally be restricted to independent prescribers. These groups include Paramedics, Podiatrists and Orthoptists.

5. Licensed / Unlicensed Medicines

5.1 Unlicensed medicines may be prescribed by medical prescribers; however responsibility for the use of these medicines rests with the prescriber, who remains professionally accountable for their judgement. The prescriber should inform the patient that the product does not have a marketing authorisation.

5.2 Registered healthcare professional and Pharmacist, Independent prescribers can prescribe unlicensed medicines for their patients, on the same basis as medical prescribers and dentists (DH 2010). The responsibility for the use of these medicines rests with the prescriber, who remains professionally accountable. Licensed products should be used for preference. The prescriber should agree the treatment choice with the patient and a clear rationale for choice of medicine should be documented.

5.3 Supplementary prescribers may prescribe an unlicensed medication as part of a clinical management plan however the following criteria must be followed:

- The doctor / dentist acting as the independent prescriber must have agreed the plan and must agree to take responsibility for prescribing the unlicensed medicine;
- Ensure an alternative, licensed medicine would not meet the patient’s need;
- There is sufficient robust evidence to support use;

- The patient has agreed to the use of an unlicensed product;
- The medication chosen and the reason for doing so is clearly documented;

6. Specials

6.1 Special-order products (more commonly known as “specials”) are made-to-order unlicensed medicines designed to meet the needs of individual patients.

6.2 Specials are unlicensed and, like any unlicensed medicine, should ONLY be prescribed where a licensed alternative does not meet the clinical needs of the patient.

6.3 Prescribers are potentially liable for any adverse event or harm arising from the use of an unlicensed special and are professionally accountable for their judgement in prescribing an unlicensed product for their patient.

7. Dispensing

7.1 Transferring medicines from one container to another (i.e. split boxes) denotes dispensing and should not be performed without an agreed medical or pharmaceutical contractual framework and as a minimum standard, individual service / healthcare setting to have an additional Standard Operating Procedures (SOPs) in place as detailed in the relevant contractual arrangements.

8. Ordering and receipt

8.1 Nominated staff, with appropriate qualifications and competencies may order medicines from a number of sources including:

- a local community pharmacy;
- a pharmaceutical wholesaler;
- directly from the manufacturer;
- a hospital pharmacy;
- a dispensing doctor.

8.2 Orders for stock medicines should be made on an official requisition, signed and dated by the authorised person ordering the medicine.

8.3 Verbal requests should not be made for any medicines supply.

8.4 Additional request for medications should not be written on stock sheets. Formal request for change in stock list should be made through DTC (Appendix 1) Request for Additional to Stock List)

8.5 Order records should be retained for a period of 2 years for audit purposes by wholesaler.

8.6 On receipt of the medicines, the supply made should be checked against the requisition and any discrepancies investigated and documented. Depending on the outcome of the investigation, consideration should be given to reporting an untoward incident in accordance with local policy.

8.7 Products such as vaccines should have additional quality checks to ensure, for example, that the storage requirements through the 'cold chain' have been maintained. Reference should be made to the 'Green Book' through the following link https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223753/Green_Book_Chapter_3_v3_0W.pdf

8.8 Other products such as controlled drugs will require confirmation of compliance with legal and / or local requirements. Reference should be made to the Organisations Controlled Drugs Policy.

8.9 If patients own drugs are being received for use, local procedures will document, where possible, the steps to be taken to ensure their integrity. As a minimum expectation the quality and accuracy of the labelling should be checked; it should be visibly intact and the packaging clean. The packaging should be clearly labelled with the patient's name, medicine name, strength of medicine, name and address of the supplier and the date of dispensing or the expiry date.

8.10 Local Standard Operating Procedures (SOPs) should be developed to ensure clear standards of accepting patient own medication. Integrity of the medicines accepted ensures medicine related incidents are reduced; e.g. batch numbers and number of strips of pills should correspond to the box and part used bottles of liquid Controlled drugs only being accepted if there is no stock available

8.11 Samples of medicines (including dressings) must not be used to treat patients. Manufacturer's supply of identified wound management products may be used for evaluation stock for use in work associated with regional evaluations only. Reference should be made to the East Midlands Steering Group Standard Operating Procedure (SOP) for management of local evaluations (2010).

9. Transport and security

9.1 Medicines should not be transported unless it is absolutely necessary to do so and transfers should be initiated through a system in which all orders and dispatches are recorded.

9.2 If staff are authorised to transport medicines in the course of their duties, the competencies and equipment required to ensure that this occurs with minimum risk must be documented in the service SOP as dependent on local circumstances.

9.3 Medicines in transit, whether professionals' own stock or an individual supply, should not be left unattended even in a locked vehicle.

9.4 Cold chain control, within the limits appropriate to the individual product, should be maintained for items requiring refrigeration. (Specific vaccination information can be found in the 'Green Book' through the following link) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223753/Green_Book_Chapter_3_v3_0W.pdf

9.5 Arrangements for the transport of controlled drugs must comply with the current legal requirements and as specified in the Controlled Drugs Policy. Reference should be made to the Trust Controlled Drugs Policy for specific issues in relation to the transportation of controlled drugs.

10. Secure Handling of Prescription Stationery

10.1 Prescription Stationery

10.1.1 Prescriptions are CONTROLLED stationery and therefore must be managed safely and securely, as would controlled drugs. Inappropriate use may also have a financial impact on the Trust. Reference should be made to 'Counter Fraud Authority, Management and control of prescription forms. A guide for prescribers and health organisations 2018'.

10.1.2 Outlined below are the appropriate measures to ensure security, and confidentiality of content, of prescription forms from printing by Xerox (UK) Ltd to LCHS, onwards to medical and Independent and Supplementary prescribers and finally to NHS Business Services Authority, (NHSBSA).

10.1.3 The prescribing, dispensing and pricing of prescriptions in the community setting currently relies on paper. The move to electronic prescribing may in time lead to a paperless system.

10.1.4 The Councils of the British Medical Association (BMA) and the Royal Pharmaceutical Society (RPS) joint statement on the security and validity of prescriptions is quoted in the British National Formulary (BNF 78). The statement particularly highlights that prescription forms should not be left unattended at reception desks, should not be left in a car where they might be visible and should be kept in a locked drawer when not in use.

10.1.5 The Counter Fraud Authority highlight that prescription stationery has a financial value and is effectively a blank cheque that is open to misuse.

10.2. Terminology

10.2.1 The term 'Prescription Stationery' is used primarily to refer to many different versions of FP10. 'Prescription Stationery' also refers to associated forms such as FP57 (the receipt for NHS prescription charges), and any forms used to requisition medicines. The term 'Prescription Stationery' can be considered interchangeable with the term 'Controlled Stationery'.

10.2.2 A 'secure central store/ safe' with access limited to those responsible for prescription forms, with secured windows, security locked doors and door keys strictly controlled, access being limited and auditable to authorised personnel . The secure central store should be intruder alarmed and linked to a central alarm monitoring area

10.3 Ordering, receipt and secure storage of prescription stationery

10.3.1 The Medicines Management team have the responsibility for ordering from the printers Xerox (UK) Ltd, taking delivery and secure storage

10.3.2 Upon delivery to Beech House, a full check should be made against the delivery note that the correct number of boxes / pads have been received. The delivery should only be signed for and accepted if the packaging is sealed and unbroken and appropriate assurance is received that the correct delivery has been received. If there is a discrepancy, contact should be made to Xerox to advise of the issue**.**

10.3.3 Prescription stationery should be treated as controlled stationery and should never be left unattended; it should be moved to a locked cabinet within a locked room as soon as possible. Access to central store being limited and auditable to authorised personnel only.

10.3.4 Designated staff will be available at central store to receive the delivery of prescription forms. (Appendix 2; Accepting Controlled Stationery)

10.3.5 Clear records of prescription stationery ordered, received and distribution will be held on a central database held by the medicines management team.

10.3.6 Records of serial numbers received and issued should be retained for at least three years.

10.4 Distribution and onward delivery

10.4.1 The individual prescribers and services are responsible for contacting the medicines management team to notify that stationery is required and to arrange onward delivery from Beech House (Appendix 3; Onward Delivery).

10.4.2 Items waiting to be collected will be stored securely in areas where there is supervised access.

10.4.3 Prescription stationery is designated a secure item and should be stored in a separate locked and secure vessel/container within the delivery vehicle which cannot be accessed when the vehicle is in transit. The courier driver should sign date and time the bearers note/ receipt of prescription stationery identified by serial numbers. The courier driver should only deliver to LCHS Trust addresses.

10.4.4 Prescription stationery must be kept secure in transit and not visible within the vehicle.

10.4.5 A secure lockable container/ red tamper proof bag should be used to transport prescription forms from the central store to the prescriber. The container should be sealed during transit, to prevent access to the forms whilst in transit.

10.4.6 A clear record will outline the process of internal distribution of prescription stationery. – This will include serial numbers, where, when and by and to whom the prescriptions have been distributed. (See Appendix 3 Onward distribution)

10.4.7 Each prescription pad will have a register of prescription numbers attached at the point of distribution. The use of each individual prescription should be identified and the stock record signed to ensure an accurate record of all stationery in use, supplied and destroyed. (Appendix 4; Stock Management of FP10s at service level and Appendix 5; Checking of Controlled Stationery)

10.4.8 The named prescriber or other nominated person should sign for the receipt of prescription forms and note the relevant serial numbers. Any discrepancy should be highlighted to the medicines management team.

10.4.9 The named prescriber or other nominated person should be responsibility for managing and overseeing the whole process - from ordering, checking, storage and transfer of Controlled stationery including access and issuing of the prescription pads within service teams to ensure to following:

- Prescription stock received is transferred to secure storage immediately.
- Clear and unambiguous records on prescription stock received and used are maintained

(on appropriate records, see appendices) including daily checks

- It is advisable to hold minimal stock of controlled stationery
- Ensure upon delivery of controlled stationery the appropriate documentation is completed to record serial numbers delivered and signed. Specifically the first and last number of the box of FP10SS should be recorded. The completed FP10 receipt and bearers note should be returned to medicines management team without delay.
- Report and investigate irregularities at delivery stage immediately with Medicine Management team.
- Ensure the Controlled stationery is stored securely when not in use; never being left unattended on a desk or in a clinical area

10.5. Use of Prescription Forms

10.5.1 Prescription forms have a legal status, remain the property of the NHS and should be used appropriately.

10.5.2 Prescription forms have a number of functions including:

- legal entitlement to possession of a prescription only medicine
- transfer of confidential data from prescriber to dispenser
- claim/authorisation of payment for goods and services

10.5.3 Individual prescribers or services should ensure the security of prescription forms on receipt by:

- keeping storage of all prescription pads and individual batches of FP10SS (approx.50) to a minimal depending on service need
- record the number of the first remaining prescription form on the ‘in use’ pad at the end of each working day
- adding the date, name and signature to the order delivery form.
- retaining a copy of the order delivery form and returning the original to the MM team.

10.5.4 Any further transfer of prescription forms e.g. from secure store to individual prescriber should also be on the basis of signatures and recording of serial numbers. (See Appendix 6; Daily FP10 Checklist, Appendix 7; Prescription Log for FP10 prescriptions and Appendix 8 Prescription Log for computer generated prescriptions)

10.5.5 Patients should not be left unattended in any area where they could potentially access prescription forms (either blank or completed). FP10s must never be left unattended on a desk or in a clinical area

10.5.6 The secure storage of prescription stationery should be assured at all times – patients, temporary staff and visitors should never be allowed access to or left alone within areas where prescription stationery is stored.

10.5.7 Where it is necessary for prescribers to carry prescription forms e.g. for home visits, the number carried should be kept to a minimum. Prescription forms should be carried in a

locked case. Where it is necessary to leave prescription forms in a car they should be stored out-of-sight in the boot of a locked car.

10.5.8 At the end of the day / session prescription forms should be stored as securely as possible, as a minimum this should be in a locked drawer. The serial number of the top and bottom prescription form should be recorded for prescription pads in drawers or prescription forms in printer trays, and checked at the next session to ensure that no prescription forms are missing.

10.5.9 In multi- prescribing settings i.e. community hospitals and urgent care services prescription pads should be kept in a designated secure store / safe, used only for secure stationery. In line with guidance from NHS Counter Fraud Authority (March 2018) the following information should be kept to track secure stationery (Appendix 6, 7 and 8)

- Date of delivery
- Name of the person accepting delivery
- What has been received (quantity and serial numbers)
- Where it is being stored
- When it was issued
- Who issued the prescription forms
- To whom they were issued
- The number of prescriptions issued
- Serial numbers of the prescriptions issued
- Details of the prescriber

10.5.10To ensure clarity regarding the identity of prescriber and the organisation for which they are working:

- GP Locums / agency staff should use the prescription forms of the service, and legibly add their own name, as well as signing the prescription.
- Independent and Supplementary Prescribers should only use a prescription pad which clearly shows their name, prescribing status and individual PIN / registration number.
- Prescribers using prescription forms that carry an organisation's name and prescribing code in place of an individual prescriber's name and code should legibly add their own name as well as signing the prescription.
- Prescribers working for more than one service must use the prescription stationery appropriate to that setting.

10.5.11 The FP10 register of individual prescriptions should be completed when each prescription is written / supplied or spoilt.

10.5.12 Blank prescriptions should never be pre-signed

10.5.13 Any completed prescriptions should be stored in a locked drawer / cupboard.

10.5.14 A process of daily checking should be completed for all FP10 stationery. The register of prescriptions and the individual prescriptions should be checked and counted to ensure a clear trail is maintained of prescriptions used. This should be recorded in the daily checks register and signed by both the checker and the witness. Any discrepancies should be reported through Datix and escalated in line with local policy (See Appendix 5 Checking of Controlled Stationery)

10.5.15 All completed controlled stationery stock check documents should be scanned and emailed to the Medicines Management team to ensure the triangulation of ordering, sent, received and use of individual scripts.

10.6 Home visits

10.6.1**.** In order to prevent loss or theft, when making home visits, prescribers within the community should ensure that prescription pads are carried in lockable transport container and kept out of site during home visits.

10.6.2 Before commencing visits the serial numbers of any prescription pads / forms that are being carried should be recorded. Only a small number of prescription forms (6 – 10) should be taken on home visits to minimise any potential loss.

10.6.3 All prescription forms must be stored out of sight during home visits. If they have to be left in a vehicle, they should be stored within the car boot and the car should be appropriately secured.

10.6.4 The prescriber will return any pads or prescriptions they have at the end of the clinic/day for secure storage. Where possible, all unused forms should be returned to stock at the end of the session or day. Where return to base is not possible at the end of the working day prescription pads should be stored securely in the prescriber's home e.g. in a lockable cash box. Under NO circumstances should prescription pads be left in vehicles overnight.

10.6.5 The prescriber will store any completed prescriptions in a locked cupboard within a locked room

10.6. 6 Appendix 9 provides an Aide Memoire for prescribers regarding security of prescription stationery.

10.7 Physical storage

10.7.1 Access to a lockable room or area where prescription forms are kept should be restricted to authorised individuals. In the main central storage area access should be controlled and a record kept of who accesses and when.

10.7.2 Controlled stationery should be stored separately and never with medication

10.7.3 In areas where there are multiply prescribers – for example out of hours / urgent care services – there should be a named person who is responsible for management of prescription stationery, ordering and storage and maintaining a record of all prescription stationery in use in that area.

10.7.4 All prescribers are responsible for prescription form stock issued to them and should ensure that it is securely locked away when not in use. Records of serial numbers issued and received should be maintained.

10.7.5 In those areas where FP10SS are in use the stationery should be secure at all times. FP10SS must be removed from printers when they are not in use.

10.8. Destruction

10.8.1 When a prescriber leaves the service or organisation, any unused prescription forms printed with that prescribers name should be shredded before being put into the confidential waste. The first and last serial number of the prescription pad should be recorded, register of individual prescriptions completed and all prescriptions cross- shredded by the individual prescriber and witnessed by line manager or appropriate senior member of staff.

10.8.2 A staff member and witness should shred controlled stationery. A record of the serial number of the scripts destroyed. (Appendix 10: Destruction Form) should be sent to Medicine

Management team to ensure triangulation of prescriptions, issued and used

10.8.3 Records of prescription forms destroyed should be kept for 2 years

10.8.4 For those staff remaining as 'bank (temporary) staff' prescription pads should be securely stored by the line manager until required.

10.8.5Independent / Supplementary prescribers, who leave the organisation, are new to the organisation or who move clinical areas should refer to the guidance outlined in the Trust Independent / Supplementary Prescribing Policy.

10.8.6 It is the services responsibility to inform the Independent / Supplementary Prescriber Lead of new prescribers joining and / or leaving a service (e.g. resigns, retires or dies), systems should be in place to recover all unused prescription forms on the last day of their employment or on the notification of their death

10.9. Audit on prescription stationery

10.9.1 There should be an audit trail for controlled stationery of serial numbered forms received into LCHS stock and which have been issued to each service/ prescriber/consulting room.

10.9.2 The prescription form's journey from printer (Xerox (UK) Ltd) to LCHS Services, prescriber and ultimately to the patient should provide an auditable trail. This auditable trail should also enable unused, duplicate or wrongly issued and destroyed prescriptions to be tracked and recovered.

10.9.3The Medicines Management team should maintain an up-to-date record of its prescribers, and their associated prescribing code numbers. This record should be regularly reviewed for accuracy.

10.9.4 It is the responsibility of the Independent / Supplementary Prescriber Lead to maintain an up to date database of all prescribers, their work address and prescribing qualification.

10.9.5 It is the responsibility of the individual prescriber to ensure any changes to registration details are reported to the Medicines Management Team to allow for updating of the databases.

10.9.6 The NHS BSA prescription service will be advised by the Medicines Management team or any prescriber changes; all new prescribers being registered on the NHS Business Services Authority (NHS BSA) Prescription Services database before prescription forms can be ordered

10.9.7 A random monthly check should be conducted to ensure storage of stationery at central stores matches the data base.

10.9.8 An annual review should be completed or sooner if discrepancies have been discovered in the random monthly check of all Controlled stationery being stored at central stores

10.9.9 Records of controlled stationery received into stock should be kept for three years, and records of prescriptions destroyed should be kept for at least 2 years

10.9.10 Audit quarterly through Safe and Secure Handling audit to ensure that storage at service level of controlled stationery is monitored on a regular basis (on appropriate tracking record (Appendix 4,5,6,7,8).

10.9.11 A quarterly report is included in the Quarterly Medicine Report to give assurance that Trust policy on good storage are adhered to.

10.10. Prescription Fraud

10.10.1 Prescriptions for medicines are at risk of being stolen / forged or otherwise fraudulently obtained or amended. All staff should be alert to this possibility. All services involved must have systems in place to ensure that prescriptions are obtained only by the patient designated on the prescription form, or an appropriate deputy.

10.10.2 Locks should be on all printers containing Controlled stationery

10.10.3 Pre- stamping on Controlled stationery is not permitted

10.10.4 Signed repeat prescriptions must not be left in an accessible location– they must be kept out of sight and reach of patients and visitors to the clinical area.

10.10.5 If the name or address of the team or contact details on the pad are incorrect or change, the nominated person must notify the Medicines Management team by emailing the Team

10.10.2 Pharmacists have particular responsibility for verifying prescriptions for authenticity. Unusual expensive items, large quantities or doses, evidence of alteration (that are not signed and dated by the prescriber) should always be queried with the prescriber. The level of suspicion should be raised for medicines liable to abuse or where the prescriber is not local / not known. Verifying the prescription includes checking prescriber details including registration and phone number. Specimen signatures of the non-medical prescribers can be obtained from the Independent / Supplementary Prescribing Lead.

10.10.3 If a Pharmacist has concerns regarding a prescription which cannot be allayed by contact with the prescriber, the concern should be reported in the first instance to the Medicines Management Team, prior to the Local Counter-Fraud Specialists (LCFS) and / or the NHS Fraud and Corruption Reporting Line. If it is warranted, for example, if there has been an attempt to fraudulently obtain a Controlled Drug (CD), the police should be contacted immediately. Any action taken should not compromise staff safety.

10.11. Lost or Stolen Prescription Forms

10.11.1 See Section 11.9 below and Appendix 11 Loss or theft of Controlled Stationery

10.11.2 Independent / Supplementary prescribers should refer to guidance outlined in the Independent / Supplementary Prescribing Policy (P-CIG-20).

10.11.3 Where prescription forms are lost (whether or not theft is suspected), this must be reported immediately to the appropriate manager of the premises / Service Manager or line manager, Medicines Management Officer and to the Trust CDAO

10.11.4 The appropriate manager should immediately inform the local counter fraud specialist (Tel No: 01522 308972) and NHS England, Lincolns Contracting Team via email - england.primarycarelincoln@nhs.net This generic email is monitored daily.

10.11.5 The NHS England Contracting Team at Lincoln are responsible for:

- requesting the practitioner signs prescriptions in a designated alternative colour (usually red)
- alerting the NHSBSA Pharmaceutical Fraud Team

- informing the CD Accountable Officer,
- informing the Medicines Management Officer.
- informing Clinical Risk Management
- notifying the CD Liaison Officer at Lincoln Police Headquarters
- alerting local pharmacies

10.11.6 The NHS England Contracting Team at Lincoln maintain contact with their opposite numbers in bordering Trusts to ensure cross-border intelligence is shared regarding lost prescription forms and suspected drug users (see 9 below), and to ensure that relevant information reaches all appropriate individuals and organisations.

10.11.7 The incident will be reported to CD LIN by CDAO or designate.

10.11.8 The incident should be reported to the local NHS Counter Fraud Authority – reporting line 07591989713 taelor.martin1@nhs.net or online https://cfa.nhs.uk/reportfraud

10.11.9 A Datix should be completed. Any report of loss of prescription forms should as a minimum include: date and time of loss / date and time of reporting loss / place where loss occurred / type and quantity of prescription stationery / serial numbers / details of to whom the incident has been reported

10.11.10 Patients, temporary staff and visitors should never be left alone with prescription forms, stock or allowed into secure areas where forms are stored.

10.11.11 Should the lost prescription have been reported by a patient a risk assessment should be undertaken to ensure that the loss is genuine before a replacement prescription is issued. The process for reporting a lost prescription should be followed as above and escalated as appropriate.

10.11.12 It is good practice to undertake a post incident review including consideration of the security measures in place following any incident involving prescription stationery

10.12. Suspected Drug User Alerts

10.12.1 Where an individual is suspected of attempting to fraudulently obtain prescriptions or medicines this should be reported to the Medicines Management Team. A process similar to that for lost or stolen prescription forms will then be instigated.

10.12.2The NHS England Contracting Team at Lincoln are responsible for alerts regarding persons trying to fraudulently obtain prescriptions or medicines. Mechanisms should be in place to alert all prescribers and NMPs in the defined appropriate geographical area.

10.13. Investigation

10.13.1 Where a Datix is submitted, this is subject to investigation in line with organisational policy and procedures.

10.13.2 The Medicines Management Team should be alerted to loss of any prescription forms.

10.13.4 Depending on the nature of the incident it may be decided that the investigation would be more appropriately carried out by the local service. This should incur an initial fact finding investigation. Prior to such an investigation, consideration should be given to any potential hampering of a possible police investigation.

11. Storage of medicines

11.1 Storage and security of medicines

11.1.1 Every service will store medicines at a level of security appropriate to their proposed use and at a level appropriate to the staff present at any time

11.1.2 At any time there will be a nominated person responsible for the safekeeping of all medicines stored in the health care setting.

11.1.3.All medicines ordered as stock items will be from an approved LCHS formulary (Appendix 1 Request for Addition to Stock List)

11.1.4 Medicines should be stored in their original containers so that they retain their batch number and expiry date. The packaging also protects the product from light

11.1.5 All medicines, with the exception of medicines for emergency use and wound care products, must be stored in lockable cupboards, which comply with the current British Standards for Medicines Storage (BS 2881), at a temperature not exceeding 25ºC. For controlled drugs the Misuse of Drugs (Safe Custody) regulations apply as detailed in the Controlled Drugs policy. Refrigerated medicines should be stored as outlined in section 16.2.

11.1.6 All medicines must be storage according to manufacturers' recommendations. Failure to do so can invalidate the expiry date and cause manufacturers to disclaim responsibility for any apparent failure of the medicine as the safety and efficacy of such medicines can be significantly compromised or unknown. This can cause avoidable waste, often at considerable expense.

11.1.7 Refrigerated medicines must be stored at 2-8ºC. Most non-refrigerated medicines must be stored at 25°C and less. However, some medicines can be stored at up to 30°C. Sensitivity to changes in temperature varies depending on the medicine.

11.1.8 Medicines that are for internal use (e.g. oral, injectables) and medicines for external use (medicated dressings, topicals) should be stored separately from each other in different medicines cupboards or different parts of the cupboard.

11.1.9 Storage requirements for controlled drugs are detailed in the Controlled Drugs Policy and must be adhered to.

11.1.10 Access to the cupboards should be restricted to authorised staff only. Staff in any supervisory position should be aware of signs that may indicate abuse or diversion of medicines (e.g. changes in an individual's behaviour, regular unexplained absences from the work area, loss of stock or excessive ordering) and take appropriate action as locally defined.

11.1.11 The location of medicines cupboards should be based on the following recommendations:

- in a room without direct access (i.e. door or window) to the exterior of the building;
- where it is not obvious to 'prying eyes' (e.g. not in front of a window);
- adjacent to storage units of similar appearance;
- in a room that can be secured when unattended;

- away from sources of heat and humidity (e.g. radiators and sinks).

Any additional security advice can be obtained from the Local Security Management Specialist (LSMS).

11.1.12 In circumstances where location and service provision does not allow the above recommendations, the risk of public gaining access to any medications must be reduced by;

- Limiting the amount of different medicines within the medicine cupboard
- Reduced level of stock of medicines especially high-risk Schedule 5 medications and above
- Regular stock checks to be maintained
- Encourage the use of FP10s instead of supplying medications
- Ambient room / fridge temperatures to be maintained and recorded
- No patient should be left alone in the room
- The room should be locked when not in use or when staff leave the room.

11.1.13 Drug cupboards & trolleys may not be left unlocked and unattended at any time. When not in use the drug trolley should be immobilised by securing to a wall. It is the leader's responsibility to ensure medicine trolleys with coded locks are changed 3 monthly to maintain security. A record of change should be logged

11.1.14 If medicines are stored in readiness for domiciliary visiting, there must be clear procedures for access to these, and for their replacement if used during the visit.

11.1.15 Adequate provision must be made to facilitate access to medicines in an emergency. The local storage arrangements will by necessity be a balance between quick access and the risks associated with misappropriation.

11.1.16 Once an emergency drug kit has been used it should be checked and missing items replaced as soon as possible. There must be a system of checks in place for emergency kits that are assembled and stored ready for use, to ensure that they are complete and any medicine included is correct and within its expiry date.

11.1.17 Regular expiry dates checks should be carried out for all medicines. Stock must be rotated according to the expiry date so that the oldest stock is used first.

11.1.18 All medicines must be stored in their original containers. They should not be transferred from one container to another.

11.1.19 Injection ampoules and vials must be stored in the outer packaging in which they are supplied. It is good practice only to remove ampoules from their outer packaging at the time they are required and to avoid returning ampoules to boxes.

11.1.20 If medicines are stored in readiness for domiciliary visiting, there must be clear procedures for access to these, and for their replacement if used during the visit.

11.1.21 Community staff have responsibility to advise patients and their carers on the safe and secure storage of medicines in the home.

11.1.22 All incidents involving a breach of security that cause actual or potential loss or theft of medicines should be investigated and the appropriate corrective and preventative action taken in accordance. This may involve contacting the police.

11.1.23 Medicines Cupboards / Rooms with keypad entry access:

- Keypad codes must only be provided to staff who have authorised access to the cupboards.
- It is the team
- leader's responsibility to ensure codes are changed 3 monthly to maintain security. A record of change should be logged.
- Medicines management team will collect audit data on compliance with this requirement.

11.2 Ambient Room temperature monitoring

11.2.1 The ambient temperature of any room used to store medicines outside of a refrigerator must be monitored and recorded at least once daily using a thermometer with a digital display and max/min reading. This should be documented on the temperature recording sheet.

11.2.2 It is best practice to record ambient temperature at the hottest time of the day for each site e.g. early afternoon. This time may vary according to site characteristics.

11.2.2 Where the ambient clinic room temperature is at risk of exceeding 25°C, action should be taken locally to reduce this by e.g. removing any heat sources, or implementing a Trust approved ventilation or air cooling device (advice from medical device lead should be sought and G-IPC 46) or moving medicines to alternative secure storage sites

11.2.4 A digital data logger should be implemented and will give additional evidence, aid tracking and probable causes of spikes in temperatures, especially when the area is not in use (e.g. weekends). This should be downloaded at least weekly and information stored locally. Advice should be sought from the Estates and facilities department and medicines management team to ensure medicine integrity is maintained. Each circumstance will be assessed individually and actions taken will depend on the medicines involved. Most medicines must be stored at 25°C or below.

11.2.5 A Datix should be completed to provide a clear audit trail of the incident.

11.2.6 Medicine cupboards with a risk of temperatures above 25°C should have an internal electronic data logger to provide central continuous monitoring of temperature. This will provide an electronic record of temperature measurement over a 24 hour period which can be used to highlight times of peaks and sustained raised temperature. To reduce the risk of impact to stock ensure limited stock and adequate, clear stock rotation especially during the warmer summer months (See Appendix 12 Ambient Room temperature monitoring).

11.3 Patients own medicines

11.3.1 Where patients own medicines are used in their treatment they should be accurately checked for quality and accuracy of the labelling prior to use.

11.3.2 Previous storage of medication in patients home cannot be guaranteed, do not use and dispose of 'date of opening' sensitive medication e.g. insulin pens

11.3.2 Reference should be made to the local standard operating procedures (SOP) for administration guidelines and audit processes.

11.4 Storage of refrigerated medicines

11.4.1 Reference should be made to Section 17 of this document 'Vaccines, storage, distribution and disposal'.

11.5 Storage of emergency medicines

11.5.1 Adequate provision must be made to facilitate access to medicines in an emergency.

11.5.2 The local storage arrangements will by necessity be a balance between quick access and the risks associated with misappropriation.

11.6 Custody and safe keeping of keys

11.6.1 At all times a designated member of staff will have responsibility for custody of keys to medicines cupboards/controlled stationery.

11.6.2 Keys will be kept securely in key cupboards with restricted access to authorised staff.

11.6.3 Controlled drug cupboard keys should be kept separate to other medicine keys

11.7 Loss of controlled stationery, keys or medicine

11.7.1 On discovering a loss, the member of staff must immediately inform the designated manager. The member of staff should complete a relevant incident report form on Datix

11.7.2 The designated manager will immediately investigate any loss (including consideration of notifying the police) and follow the organisational incident reporting procedure.

11.7.3 The LSMS should be immediately notified of any incident reported to the police. Information to be provided to the LSMS should include the nature of the incident, police incident reference number and police officer in charge of case, collar number and name.

11.8 Loss of keys

11.8.1 If necessary a duplicate set of keys may be issued, to allow continued provision of clinical services, until such time as the original keys are located.

11.8.2 If duplicate keys are not available or if the lost keys are not found, the authorised person in charge in conjunction with their manager should arrange for new locks to be fitted and for the cupboard to be effectively secured. Maintenance staff should not be allowed to work on the cupboard unsupervised.

11.9 Loss of Prescription Pad

11.9.1 In the event of loss or suspected theft of a prescription pad the prescriber must report this loss or theft immediately it has been confirmed to the Trusts Local Security Management Specialist (Tel No: 01623 622515 or the main office number 01623 622515 ext. 3792). In matters relating to incidents of suspected fraud, these should be reported to the organisations counter fraud specialists.

11.9.2 The incident should also be reported in line with the above policy to ensure the appropriate information cascade is initiated and that prescribers are informed of any further action required.

11.9.3 The NHS England Contracting Team will be responsible for notifying local Pharmacists and deciding upon action to minimise the abuse of prescriptions. This will include instructions to the prescriber to sign all scripts in a particular colour (usually Red) for a period of two months. The NHS England Contracting Team will also inform the Compliance Unit at the Business Services Agency. This whole process will normally be in writing and within a 24 hour period (excepting weekends).

11.9.4 An incident report form should be completed as soon as possible and in all cases the LSMS should be notified of the incident immediately.

11.9.5 For Independent/ Supplementary prescribers further information on this process can be found in the Independent/ Supplementary Prescribing Policy (P-CIG-25).

12. Administration

12.1 Process of administration

12.1.1 This process for administration covers all care environments.

12.1.2 No person should administer any medicine unless they are competent to do so and are acting within their sphere of professional practice. The Standard Operating Procedure (SOP) should define the qualifications and competencies required by service staff, including the provision for nurse associates and training student professionals

12.1.3 A health care professional must not administer medicines without the authorisation of a prescriber, a patient specific direction (PSD) or a dispensed medicine, or a patient group direction (PGD), unless they have legal exemptions during the course of their professional practice (e.g. midwives, podiatrists). Pre-registration practitioners must only administer or supply medicines under direct supervision (NMC 2008).

12.1.4 The identity of each medicine should be clear at all times up to and including the point of administration.

12.1.5 Medicines dispensed for an individual patient must only administer to that patient (supplies labelled for individual patients must not be shared).

12.1.6 When selecting the medicine, the following should be checked and any concerns clarified before proceeding:

- name of the medicine;
- strength;
- form;
- expiry date.

12.1.7 Medication must be prepared for administration at the time it is due to be given. Medication for multiple patients must not be prepared in advance.

12.1.8 Before administration, the following should be checked and any concerns raised with the prescriber before proceeding:

- patient’s name;
- NHS number
- age and weight if appropriate;
- any allergies / hypersensitivities, previous drug reactions;
- date and time the dose is due;

- name of medicine, dose and frequency;
- time of previous dose if any;
- route of administration;
- signature of prescriber or requirements of a patient group direction.

12.1.9 Any drug calculations needed are double checked where practicable by a second person and uncertainties raised with the prescriber or pharmacy professional.

12.1.10 All aspects of patient consent should be considered

12.1.11 A record of each medicine administered to a patient should be made and the administering person identified.

12.1.12 All omitted, refused or wasted doses should be documented and where appropriate recorded on the administration record using the appropriate code as indicated on the prescription chart.

12.1.13 Any dose prepared for administration and subsequently not given should be destroyed. If a controlled drug is prepared and not used it must be destroyed by denaturing and placing in a sharps bin and a record must be made in the register in accordance with the Organisations Controlled Drug Policy.

12.1.14 Medicines shall not be returned to the container from which they were taken.

12.1.15 Omissions and refusals should be reported to the prescriber if it is considered that the non-administration may affect the patient's condition.

12.1.16 When two or more paper prescription charts are in use, it is essential that they are cross-referenced so that practitioners are aware of *all* prescribed medicines.

12.1.17 For further information regarding the administration of injectable medicines further reference should be made to Section 13 within this document.

12.1.18 Medicines reconciliation is a process designed to ensure that all medication a patient is currently taking is correctly documented on admission to a community hospital and at each transfer of care. An audit of medical records will provide evidence that:

- The collection of the medication history from an appropriate source has been checked (usually by a minimum of two) and has been accurately documented.

- Checks on admission to the ward that all medications prescribed are correct and signed for. The 'checking' step must involve assurance that the medicines and doses prescribed accurately reflect the sources consulted. Any discrepancies must be identified and documented.

- Written communication of any changes in medicines must be readily available to the next person (s) caring for the patient.

12.2 Minimising interruptions during medication rounds within ward environments.

12.2.1 To ensure safe and effective administration of medication to patients within the ward environment ---

1. Check at the beginning of the drug round that medicines have not already been administered by someone else (including / patient / carers) (RPS 2019)

2. Check at end of each drug round that there have been no omissions

12.2.2 Interruptions may lead to errors in medicine omissions; to reduce theses errors occurring within the ward environment, staff undertaking the medicines round should not be interrupted unless as a matter of priority; registered healthcare professionals should have protected time to undertaken medicines administration.

12.2.3 If a telephone call is taken or an interruption occurs which requires the attention of the registered health professional undertaking the medicine round ; and the member of staff, if unable to deal with the query directly, the healthcare professional will be expected to take a message for a reply at a more convenient opportunity.

12.2.4 Contact details of the caller / enquiry, should be taken and an explanation offered that the registered healthcare professionals will contact them when the medicines round has been completed.

12.2.5 In the event of an emergency / immediate need for a response, the registered healthcare professionals undertaking the medicines round, before responding to the query, will ensure that the medication trolley is locked and stored away securely in the treatment room, ensure that the patients drug locker is locked and any medication that has been administered has been signed for.

12.2.6 If appropriate, a Datix should be completed giving reasons for the interruption.

12.3 Minimizing interruptions during administration of medicines in the community setting

12.3.1 To ensure safe and effective administration of medication with the community all staff undertaking administration of medicines should try and minimise interruptions by:

- Explaining to patient/ relatives/ carers the need for quiet whilst calculations and preparation of medicines

- Considering preparation of medicines in a different room to patient

12.4 Self administration of medicines

12.4.1 Reference should be made to the Trust Policy for Self- Administration of medicines (P-CS-33) and any SOPs should be adhered to.

12.4.2 The transfer of responsibility should occur on the basis of an assessment of the patient's ability to manage the tasks involved and with the agreement of the patient.

12.4.3 Safe and secure processes will be needed to ensure that the patient has controlled access to an adequate supply of the correct medicines which are appropriately stored and are fit for purpose.

12.5 Covert Administration of Medicines (Disguising Medicine in Food or Drink):

12.5.1 The covert administration of medicines is only likely to be necessary or appropriate in the case of a patient who actively refuses medication but who is not judged to have the capacity to understand the consequences of their refusal.

12.5.2 The decision to administer a medicine covertly should not be considered routine, and

should be a contingency measure. Such a decision may only be made following discussion and agreement between the range of professionals involved in the patients care and with the patient's carers/advocate. Any such decision must be fully documented in the patients notes, detailing the names of all those involved in the decision and regularly reviewed. . More detailed guidance and signposting can be found within the RPS (2019) guidance.

12.5.3 As outlined by NICE CG 67, ensure the process for covert administration clearly defines who should be involved in, and responsible for, decision-making, including:

- assessing a person's mental capacity to make a specific decision about their medicines
- seeking advice from the prescriber about other options, for example, whether the medicine could be stopped
- holding a best interests meeting to agree whether giving medicines covertly is in the person's best interests
- recording any decisions and who was involved in decision-making
- agreeing where records of the decision are kept and who has access
- planning how medicines will be given covertly, for example, by seeking advice from a pharmacist
- providing authorisation and clear instructions for covert administration within the individual patient's care plan
- ensuring health care professionals are trained and assessed as competent to give the medicine covertly
- when the decision to give medicines covertly will be reviewed.

12.6 Remote prescribing

12.6.1 Remote prescribing is described as prescribing by an independent prescriber who authorises administration of a medicine to a patient without face-to-face assessment which must not be at the expense of safe and effective care.

12.6.2 Remote consultations and prescribing provided online, over video-link or by phone can benefit patients, however, there are potential patient safety risks, particularly where services are not linked to a patient's NHS GP, and where there may be limited access to a patient's medical records. Issues include increased attempts to gain access to medicines which can cause serious harm and the need to ensure safe ongoing monitoring of those with long term conditions. Prescribers must be aware of these risks and be clear about their responsibilities for protecting patients.

12.6.3 Prescribers should adhere to national guidelines on prescribing (i.e., National Institute for Care Excellence (NICE) and Royal Pharmaceutical Society (RPS) competency framework for all prescribers while recognising their limitations. The mode of consultation should not interfere with best practice prescribing, and where this cannot be achieved remotely/online, local service pathways must be in place for timely referral.

12.6.4 Registered healthcare professionals must follow ten high level key principles when providing remote consultations and prescribing remotely to patients.

1. Make patient safety the first priority and raise concerns if the service or system they are working in does not have adequate patient safeguards including appropriate identity and verification check

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

12.6.5 Before prescribing for a patient via telephone, video-link or online, the prescriber must be satisfied they can make an adequate prescribing assessment; having adequate knowledge of the patient's health,and are satisfied that the medicines serve the patient's needs. The prescriber needs to consider:

- the limitations of the medium through which they are communicating with the patient/ registered staff member
- the need for physical examination or other assessments
- whether they have access to the patient's medical records relevant to the situation (e.g. past medical history, allergies etc.).
- remote /online prescribing would be expected to follow the same guidance for accessing user records as a face-to-face service.

12.6.6 The prescriber should have sufficient information on which to base their decision to prescribe to:

- Establish the patient's current medical conditions and history and concurrent or recent use of other medications including non-prescription medicines
- Carry out an adequate assessment of the patient's condition
- Identify the likely cause of the patient's condition
- Ensure that there is sufficient justification to prescribe the medicines/treatment proposed
- Ensure that the treatment and/or medicine/s are not contra-indicated for the patient.
- Make appropriate arrangements to follow the progress of the patient

- Monitor the effectiveness of the treatment and/or review the diagnosis

Where all these conditions cannot be satisfied remote prescribing should not occur

12.6.7 If the prescriber does not feel able to prescribe remotely; consultation is deemed inappropriate or there is insufficient information to assist making a safe prescribing decision there should be local service pathways in place for the patient to be seen “face-to-face”

12.6.8 The prescriber must signpost appropriately for emergency situations where rapid access to face-to-face services is required; this includes where professionals might consider the patient requires detaining under the Mental Health Act.

12. 7 Remote (electronic) prescribing to another registered health professional

12.7.1 Every effort should be made to obtain a prescription for a patient through a face-to-face consultation. However, where the need for the medicine is urgent and not to accept a remote prescription would compromise patient safety or care, remote instruction/ prescribing to a registered professional may be accepted for example prescribing through SystmOne

12.7.2 The registered professional is required to inform the prescriber of the patient’s current drug regimen, symptoms and any other relevant information e.g. allergy status. They should request information from the prescriber regarding any contraindications and side effects of the remotely prescribed medicine.

12.7.3 In exceptional circumstances a paper prescription chart is required, this should be replaced by completing the electronic health care records including all the prescribed medications by a prescriber within 24 hours

12.7.4 When administering medicines which have been prescribed by another person (including when the prescribing has been done remotely), the health professional has a responsibility to ensure that patient safety is not compromised

12.7.5 When administering medicines which have been prescribed by another organisation/ out of county provider the health professional has a responsibility to ensure that the prescription/ instruction is up to date, clear and accurate. Any prescription/ instruction should be reviewed by an independent prescriber and changed to LCHS format (electronically / written) within 24 hours

12.7. 7 Remote prescribing direct to patient

12.7.1 Remote prescribing direct to patient, using phone or electronic technology such as QHealth/ QDoctor should ensure a consultation which full- fills all the expected prescribing criteria.

12.7.2 When prescribing remotely to the patient the prescriber must consider whether and how they can identify safeguarding concerns and vulnerable patients and identify patterns of behaviour which may indicate serious concerns so that appropriate steps can be taken to protect patients. Particularly vulnerable patients may include those at risk of self-harm, substance or drug use disorders, those with long term conditions, and children attempting to access services intended for adults.

12.7.3 The prescriber should still be able to identify and manage risks during a remote consultation and act quickly where patients may be at risk of harm

With regards to safeguarding the prescriber should

- have the ability to review healthcare records for any previous safeguarding concerns including mental health, suicidal, overdoses, domestic abuse etc which may be an added risk indicator to any prescribing activity

- have access to support to ensure timely safeguarding referrals (see intranet for links to LCHS/ LSCP/LSAB

12.7.4 All prescribers must take individual responsibility for their prescribing decisions and should recognise that there are certain areas of practice where remote prescribing is unlikely to be suitable, for example when prescribing medicines likely to be subject to misuse or abuse

12.7.5 The minimal amount of medication (seven days) should be prescribed, which will contribute to reducing the risk of vulnerable patients (eg self-harm, substance or drug use disorders) gaining increased access to medications.

12.7.6 Consent and confidentiality must not be compromised during the consultation

12.7.7 Where concerns regarding consent and capacity have been highlighted, these should be clearly documented in the user records

12.7.8 Where patients have consented to carers, parents or relatives communicating with providers using online consultations, a separate verification process must be taken prior to granting authorisation by proxy. The prescriber should undertake the same appropriate assessments to ensure a safe prescribing decision

12.7.9 Face-to-face consultations, or referral to another service, should be arranged if an online consultation is deemed inappropriate or there is insufficient information (eg inadequate safeguarding information) to assist making a safe prescribing decision

12.7.10 Good record keeping ensures that relevant health professionals (including GP) can readily access information to support safe, efficient and high-quality care; ensuring healthcare records relating to the patient including any prescribing decisions are completed at the time of the consultation.

12.7.11 Patients should be given the opportunity at any time in the process to ask questions and clarify any concerns that they may have regarding their prescription. This should include contact details which can be used after the initial consultation is complete.

12.7.12 Patients should be provided with information about the medication and alternative options in a form they understand and tailored to their needs

12.7.13 When using digital systems, triaging tools and symptom checkers, it is important to recognise the prescribing risks associated with the use of these systems

12.7.14 Treatment options and follow up must be made clear to the patient. The implications of not undertaking any, or only a part, of the care must be documented

12.7.15 Prescriptions should not be posted to the patient but sent ideally email /electronically or posted to the pharmacy of choice.

12.10 Administration – Verbal Orders-Telephone Instruction

12.10.1 Instruction by telephone alone to administer a medicine is not acceptable and is potentially an unsafe practice, other safer alternatives must be considered (see above). In the case of a change in dose, route or frequency, re-prescribing of a previously prescribed medication, the prescriber must provide a new prescription / Terms of Reference using an electronic prescribing

system before drug administration.

12.8 Transcribing

12.8.1 Transcribing is the exact copying of previously prescribed medicines and due to electronic health care records and remote prescribing, should only occur in exceptional circumstances

12.8.2 Transcribing can only be used in the best interests of the patient to ensure safe and continuous care ensuring the medication is administrated accurately, without undue delay (RPS 2019)

12.8.3 Transcribing cannot be used to issue or add new medication/ change the original prescription

12.8.4 Medicines cannot be transcribed where details are illegible, unclear, ambiguous or incomplete. Particular care is taken in transcribing details of high risk medications such as insulin and, anticoagulants (RPS 2019)

12.8.5 If transcribing is required staff must have completed the in-house training package and associated competences and standards. Reference should be made to the Trust Transcribing policy.

For further information refer to: Policy to support the transcription of medicines in exceptional circumstances incorporating medicines reconciliation within a community hospital or hospice setting (P-CS-37)

12.9 Transcribing by Pharmacy technicians

12.9.1 Pharmacy technicians may order supplies of medicines from contracted pharmacies by transcribing from the inpatient prescription chart or electronic prescription chart.

12.9.2 Transcribing can only take place if all prescriptions are clearly written and unambiguous.

12.9.3 Orders can be sent to the community pharmacy providing they have been clinically screened by a prescriber / pharmacist.

12.9.4 When ordering medicines, the transcription should be an accurate match of what is written on the drug chart and checked by the prescriber prior to signing

13. Use of Injectable medicines

13.1 Prescribing of injectable medicines

13.1.1 Medicines should only be given by injection when the practicality and appropriateness of other routes of administration have been excluded. The use of this route should be regularly reviewed in favour of switching to oral administration as soon as clinically appropriate (NPSA 2007).

13.1.2 Prescriptions for injections must clearly specify the medicine name, dose, frequency and route of administration. Where relevant, the prescription, or a readily available local protocol, must specify the following: name and volume of dilutent and/or infusion fluid, concentration of final infusion, rate of administration, duration and rate control pump or device to be used.

13.2 Mixing of medicines

13.2.1 The Medicines and Healthcare products Regulatory Agency (2010) (MHRA) states the mixing of two or more separate medicinal products will result in a new, unlicensed product if one product cannot be described as a vehicle for administration of the other e.g. as a reconstitution or diluting agent.

13.2.2 Mixing two licensed medicines, for example in a syringe driver, results in a new, unlicensed product being administered.

13.2.3 Following consultation by the MHRA, medicines legislation was amended:

- To enable doctors and dentists to direct other healthcare practitioners to mix medicines;
- To allow registered healthcare professionals and Independent/ Supplementary Prescribers to mix medicines themselves and to direct others to mix;
- To enable Independent/ Supplementary/ Prescribers to mix medicines themselves and to direct others to mix, only where this is clearly outlined within an individualised patient Clinical Management Plan;
- To allow registered healthcare professionals including Pharmacist independent prescribers to prescribe unlicensed medicines for their patients;

13.2.4 Optometrist prescribers are not authorised to prescribe unlicensed medicines (MHRA 2007).

13.3 Supply

13.3.1 A risk assessment of all injectable medicines must be undertaken by a pharmacist and senior practitioner to determine the safest presentation and location for storage and preparation.

13.3.2 Risk assessment is required to identify those products representing the highest risk to patients at the time of preparation. Consideration must be given to the use of safer products and systems, for example, double-checking.

13.3.3 Injectable cytotoxics and parenteral nutrition must be supplied to clinical areas only as ready-to-administer products.

13.3.4 Prescribing – All prescriptions for injectable medicines must specify the following:

- patient's name;
- the date;
- prescriber's signature;
- the approved medicine name;
- the dose, route and frequency of administration;
- the allergy status of the patient.

13.4. Labelling injection and infusion containers

All injections should be labelled immediately after preparation, except for syringes intended for immediate push (bolus) administration by the person who prepared them. Under no circumstances should an operator be in possession of more than one unlabeled syringe at any one time, nor must an unlabeled syringe be fitted to a syringe driver or similar device.

14. Administration and / or supply of medicines under a PGD

14.1 Reference should be made to the Trust Policy for the development and control of PGDs (P-CIG-13).

14.2 The supply and administration of medicines under Patient Group Directions (PGDs) should only be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety (HSC 2000/026).

14.3 When supplying or administering a medicine under a Patient Group Direction, the patient must fall exactly into the criteria determined by the PGD. If not the patient must be referred in line with the guidelines outlined within the individual PGD.

14.4 If a medicine is unlicensed it should only be administered against a patient specific prescription and not under a PGD.

14.5 Medication that is licensed but used outside of its licensed indications may be administered under a PGD if such use is exceptional, justified by best practice and the status of the product clearly described. In such circumstances the patient should be informed that it is an unlicensed use and of any alternative treatments that are licensed.

14.6 Service leads have responsibility for ensuring that only fully competent, qualified and trained professionals operate within the PGD.

14.7 The use of PGDs does not remove inherent professional obligations or accountability. It is the responsibility of each practitioner to practice only within the bounds of their own competence and in accordance with their own Code of Professional Conduct

14.8 Before using a PGD each registered healthcare professional must undertake specific training on using PGDs and must:
(a) have received training on the assessment and treatment of the condition being treated under the PGD and on the medicines being administered or supplied under the PGD, and
(b) be authorised to practice under the PGD by their Service Manager and Authorising Person.

14.9The health professional using the PGD should be familiar with the side effects, cautions, drug interactions, risks and advantages of medicinal product being supplied

14.10 The health professional must not supply or administer medicines in situations where they do not feel competent and confident to supply or in situations where the PGD criteria's are not all met. Advice/ referral to an prescriber is recommended

14.11PGDs can only legally be used once all three signatures i.e. service manager; authorising person and individual healthcare professional have been completed

14.12 Registered healthcare professional working within a PGD should have access to a current copy (electronic or paper) of the PGD at all working times.

14.13 Registered healthcare professional must not delegate their responsibility when using a PGD. The assessment of the patient, provision of information, the administration and/or supply of the medicine and record keeping must all be completed by the authorised registered practitioner. It cannot legally be delegated to another.

14.14Healthcare records should indicate that medicine has been supplied/ administrated using a PGD

14.15 It is good practice to perform the consultation face to face but in exceptional circumstances or in times of pandemic when the service has implemented business continuity plans; alternative safe and effectively consultations can be concluded. The legal framework for PGDs does not state the patient must be present for a supply of a medicine to be made (PGD 2020).

14.16 Remote consultation prior to making a supply under a PGD is permissible and a supply can also be made in the absence of the patient. In both scenarios a telephone or other remote consultation with the patient should be sought. Where it is not possible to speak with the patient directly (i.e. where it concerns a young child or where an adult lacks capacity) then assessment should include discussion with a parent/relative/carer where appropriate.

14.17 The process that the practitioner follows in such circumstances would need to ensure that an adequate assessment can still be conducted, in line with the requirements for PGDs.

14.18 The act of making a supply to the patient's representative or posting a medication supplied under a PGD to a patient does not constitute delegation. The health professional supplying the medicine must undertake the whole episode of care under the PGD. This includes the handing over of the medicine to the patient's representative or personally undertaking the packaging and posting/dispatch of the medicine – this responsibility cannot be delegated

14.19 Where remote consultation is undertaken and supply is made without the patient being present staff should ensure;

- That an adequate assessment including medical history , allergies, can still be conducted
- Clear evidence of decisions made concerning whether to supply / administrate medication
- Clear audit trail of PGD against clinical diagnosis
- Clear audit trail of individual stock supplied to individual patients through use of stock control records (electronic or paper)
- Record of when PGD could not be used and the referral process made

15. Return and Disposal of Unwanted Medicines

15.1 Guidance on the disposal of pharmaceutical waste is governed by the 'Environment and Sustainability Health Technical Memorandum 07 – 01: Safe Management of Healthcare Waste (2016). Reference should be made to this document.

15.2 Ensure that disposal of all medicines waste is in line with relevant legislation including the provision of a robust audit trail. A record (green log book) of medicines waste should be maintained in all service areas.

15.3 Medicines that are no longer to be administered to a patient, for whatever reason, should be returned to the relevant community pharmacy or dispensing doctor for disposal.

15.4 Medicines that have been issued directly to a patient should not be reused.

15.5 The storage, carriage and consignment of waste are all subject to stringent controls via Environmental, Waste, Transport and Health and Safety legislation.

15.6 Trust premises wishing to dispose of waste medicines will need to arrange for them to be collected by a suitable waste contractor.

15.7 Waste medicines should, as far as possible, be disposed of in their original packaging. Further guidance can be found in the 'Safe Management of Healthcare waste'

15.8 The waste medicines should be deposited in a rigid medicines container; blue lidded for non – hazardous medicines and purple lidded for hazardous medicines / Cytotoxic and Cytostatic medicines.

15.9 The definition of cytotoxic and cytostatic used in waste classification is much broader than the term 'cytotoxic' as used in the BNF. The BNF should be used for waste classification. An example list of cytotoxic and cytostatic medicines is provided in chapter 11 of the 'Safe Management of healthcare waste' – but note this list is not conclusive. For further information refer to Appendix 13 Waste Poster

15.10 Protective equipment such as gloves will also need to be provided and used.

15.11 When the rigid container containing hazardous medicines is transferred to the Trusts waste contractor, a separate list of the medicines and their hazardous properties should accompany the waste as per the instructions in 'Safe management of healthcare waste'.

15.12 When disposing of solid non-hazardous pharmaceutical waste (e.g. tablets and capsules) blister packs can be removed from outer cartons, but individual tablets and capsules should not be removed from blisters.

15.13 Liquids should generally not be decanted and mixed. Where liquids are being discarded they should be retained within their individual containers and placed in leak proof waste bins provided for the purpose.

15.14 For all matters relating to the return and disposal of Controlled Drugs, reference should be made to the Trust Policy relating to the prescribing, supply, storage and disposal of controlled drugs (P-CIG-18). This information should also be detailed within local operating procedures relating to the management of controlled drugs.

16. Untoward incidents

16.1 Untoward incidents involving medicines

16.1.1 To reduce medicine errors prescribing, dispensing/ supply and administration should be performed by separate healthcare professionals. Exceptionally where clinical circumstances make it necessary and in the best interests of the patient the same healthcare professional can be responsible for the prescribing and supply / administration of medicines. Where this occurs an audit trail, documents and processes are in place to limit errors (RPS 2019).

16.1.2 To prevent duplication of the administration of medicines healthcare records should be completed at the time of administration/ refusal or as soon as possible thereafter and are clear , legible, accessible and auditable (RPS 2019)

16.1.3 If there is any risk of harm to an individual due to an incident involving medicines; priority must be given to the clinical care of that person(s). Duty of Candour applies; refer to LCHS Open and Honest Care Policy (P-CIG-16).

16.1.4 **Any** incident or near miss in which medicines are involved must be reported in accordance with the Organisations incident reporting policy.

16.1.5 The incident must immediately be reported to and investigated by the appropriate line manager, or person delegated to act on their behalf.

16.1.6 A Datix must be completed and a copy forwarded to the Clinical Governance Manager and monitored by the Medicines Management Officer. If the incident is linked to security then the Local Security Management Specialist should also be informed.

16.1.7 Governance managers and the Medicines Management Officer will identify any trends or recommended actions to ensure that risks relating to medicines are minimised and reported to the relevant business unit.

16.1.8 Lessons learned from incident analysis will be monitored at the Drugs and Therapeutics Committee and reported to Quality Assurance Groups, the Effective Practice & Assurance Group and Safeguarding and Patient Safety. Lessons learned will be disseminated by Matrons to the respective workforce.

16.2 Administration errors

16.2.1 As soon as it is realised that there has been an error of medicine administration:-

- The appropriate prescriber should be contacted and when necessary, remedial action taken to ensure the safety of the patient. The patient and or carer should be informed of the error, remedial action and possible consequences;

- Supporting statements may be required from all staff concerned. These are essential if there is any possibility of serious injury to the patient or of litigation. This is in addition to the responsibilities outlined above. Refer to the Policy for the Management of Medication errors (P-CIG-18).

16.3 Adverse reactions to drugs

16.3.1 If any patient experiences an adverse drug reaction (ADR), action must be taken to remedy any resulting harm caused by the reaction. The reaction must be recorded in the patient notes and the prescriber should be notified.

16.3.2 Any drug may produce unwanted or unexpected adverse reactions. Detection and reporting of these is of vital importance. Doctors, dentists, coroners, therapists, registered healthcare professionals including nurses and pharmacists, are urged to report suspected adverse reactions on yellow cards and to the Medicines and Healthcare products Regulatory Agency (MHRA). Patients and carers can also now report ADRs to the MHRA using the yellow card system http://www.mhra.gov.uk

16.3.3 Yellow cards can be found in the back of the British National Formulary (BNF) and online at the following link http://www.yellowcard.gov.uk.

16.3.4 All suspected adverse drug reactions to “black triangle” drugs and any serious or unusual suspected reactions to established products should be reported.

16.3.5 Reporting should be carried out for all prescribed drugs, medicines obtained over the counter and herbal medicines.

16.3.6 Any adverse reactions should also be reported in line with the Trust Incident reporting policy and procedure.

16.4 Defective medicines

16.4.1 During the manufacture or distribution of a medicine an error or accident may occur whereby the finished product does not conform to its specification. Any suspected defect in a medicine should be reported to the Prescribing and Medicines Management team or the Defective Medicines Report Centre at the MHRA.

16.4.2 Reports on suspected defective medicinal products should include the brand or the non-proprietary name, the name of the manufacturer or supplier, the strength and dosage form of the product, the product licence number, the batch number and the nature of the defect.

16.4.3 If the defective medicine has been administered to a patient the prescriber should be notified and reported in accordance with the Trust incident reporting policy.

17. Vaccines -storage, distribution and disposal.

17.1 Management of vaccines

17.1.1 This section should be read in conjunction with Chapter Three of the 'Green Book' (DH 2006) accessible via

https://www.gov.uk/government/publications/storage-distribution-and-disposal-of-vaccines-the-green-book-chapter-3

and Public Health England's document 'Protocol for Ordering, Storing and Handling Vaccines (2014) accessible via https://www.gov.uk/government/publications/protocol-for-ordering-storing-and-handling-vaccines

These resources are updated periodically and all practitioners should ensure they keep themselves up to date with changes.

17.1.2 This section outlines a summary of guidance provided by the 'Green Book', on storage, transport and equipment necessary for maintenance of the cold chain as well as highlighting the need for monitoring and audit.

This section outlines a summary of guidance contained in LCHS 'Maintaining the Cold Chain: The control and monitoring of storage temperatures of medicinal products Cold Chain' policy G_IPC_34

17.1.3 To ensure that the trend of low levels of disease notification continues into the future, it is essential to maintain the efficacy of the vaccines used. This requires maintenance of the 'cold chain' to ensure that the optimum temperature range for vaccine storage (between +2°C and +8 °C) is maintained throughout the distribution process from manufacture to user. Fluctuations and breaks in the cold chain can result in a reduction of the efficacy of the vaccine and a potential failure to produce satisfactory levels of immunity.

17.1.4 Vaccines are biological substances that may lose their effectiveness quickly if at any time they become too hot or too cold. Vaccines are biodegradable over time and storage outside the recommended temperature range may cause a loss of potency which cannot be reversed.

17.1.5 It is essential that all those handling vaccines follow appropriate recommendation and policy to ensure cold chain compliance. Appropriate guidance and policy includes 'National Patient Safety Agency advice on Vaccine Cold Storage and the associated Rapid Response Report January 2010';Public Health England Protocol for ordering, storing and handling vaccines.

17.1.6 At least two named, trained people need to be responsible for ordering, receipt and care of vaccines including rotation and checking of expiry dates as well as safe storage of vaccines and recording of refrigerator temperatures (PH England 2014)

17.1.7 All procedures being followed for storage, distribution and disposal of vaccines should be monitored and regular audits undertaken to ensure they comply with expected standards.

17.1.8 Some vaccines are packaged in multiple quantities. Care should be taken to order correctly to avoid waste.

17.1.9 Vaccines for routine immunisation programmes must be ordered via the ImmForm website as set out in the 'Public Health England Protocol for Ordering, Storing and Handling Vaccines' published March 2014 accessed via

https://www.gov.uk/government/publications/protocol-for-ordering-storing-and-handling-vaccines

17.1.10 All other vaccines are ordered directly from the manufacturer or through pharmacies and wholesalers. Details of suppliers are shown in the associated chapters of the 'Green Book'.

17.2 Storage of vaccines and other refrigerated medicines

17.2.1 In general vaccines / medicines should be stored at temperatures between +2° - +8°C a mid range of +5°C is good practice. Further guidance refer to G-IPC-34

17.2.2 Vaccines should be appropriately stored to protect from the light. Exposure to ultraviolet light is known to cause loss of potency.

The refrigerator must be located inside a locked room not directly accessible to the public.

- Vaccines must not be stored in the door, or next to the freezer plate.
- The fridge must not be overfilled - allow space around the packaging for air to circulate.
- The fridge must be regularly defrosted (if not self-defrosting).
- Records must be maintained with regard to defrosting (if not self-defrosting), servicing, calibration, and maximum/minimum /actual temperatures.

17.2.3 All vaccines are sensitive to extremes of heat and cold. Heat will speed up the decline in potency of most vaccines and will therefore reduce shelf life whilst freezing causes deterioration and can give rise to increased adverse reactions due to alteration of the composition of the vaccine or contamination as a result of cracks appearing in the vial or syringe.

17.2.4 Avoid over ordering, stockpiling and overfilling refrigerators. It is important that air must be able to circulate around the packages.

17.2.5 All vaccines are Prescription Only Medicines (POMs) and must be stored under locked conditions. Refrigerators must be lockable or within a room that can be kept locked when not occupied by a staff member. Vaccines should never be left unattended.

17.2.6 Vaccines should be kept in their original packaging to retain batch numbers and expiry dates. The package also helps to protect against changes in light and temperature.

17.2.7 During defrosting or cleaning, vaccines should be transferred to another refrigerator or placed in an approved cool box to ensure that they remain under 8°C. They should not be left in the refrigerator where the temperature will fluctuate and water could leak onto packaging.

17.2.8 Vaccines should only be replaced in the refrigerator once it has returned to the correct temperature

17.2.9 Food, drink and clinical specimens must never be stored in the same refrigerator as vaccines.

17.2.10 Opening the refrigerator door should be kept to a minimum to ensure maintenance of a constant temperature.

17.2.11 A sample refrigerator temperature record chart can be accessed via NHS England Policy and procedure for maintaining the Vaccine cold chain and / or via 'The Green Book'. This can be accessed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223753/Green_Book_Chapter_3_v3_0W.pdf

For further information refer to Cold Chain Policy (G-IPC-34)

17.3 Monitoring of Vaccine Stock

17.3.1 Appropriate documentation should be completed to record receipt of vaccines. This includes vaccine types, brands, quantities, batch number and expiry dates.

17.3.2 Fridge stocks should be monitored once per week by the designated person to avoid over ordering and accumulation of waste / stockpiling.

17.3.3 Vaccine stock should be audited and recorded every month.

17.3.4 It is best practice to order small quantities on a regular basis and hold no more than two weeks supply of vaccines at any time as per the Protocol for ordering, storing and handling vaccines (Public Health England 2014).

17.3.5 Out of date stock should be labelled clearly, removed from the refrigerator and destroyed as soon as possible in line with local procedures.

17.3.6 Vaccines must never be used when past their expiry date.

17.4 Thermometers

17.4.1 Temperatures in the refrigerator should be monitored and recorded as described for best practice in the Protocol for Ordering, Storing and Handling Vaccines' (Public Health England 2014) and LCHS G-IPC-34

17.4.2 The refrigerator must be capable of maintaining the temperature of its contents between 2°C and 8°C with the minimum of intervention. Temperature monitoring should be by electronic max/min thermometer, with an accuracy of + 0.5°C, which should where possible be readable from outside the refrigerator. The data logger should be placed within the load to record the load rather than the air temperature, and the max/min temperatures should be recorded daily.

17.4.3 The device must be calibrated annually against a certificated thermometer. Records of such should be maintained and stored locally for a period of 2 years.

17.4.4 The thermometer must be reset after recording and after any prolonged period of opening

17.4.5 Additionally a refrigeration USB data logger should be in place in all medicines fridges. These should be set to record 6 hourly and be downloaded as a minimum every 7 days. This device will provide secondary information regarding any potential breaks in the cold chain and confirm temperature range over a sustained period of time. Escalation and appropriate action should be taken whenever any break in the cold chain is suspected or evidenced. These devices can be obtained through the NHS Supply Chain NHS Supply Chain

17.4.6 Temperature monitoring charts and downloads from USB data loggers must be held locally for a period of 2 years. Advice should always be sought from the Medicines Management team when the temperature recordings fall outside of the required range of 2 – 8^{o}C.

17.5 Storage in a cool box

17.5.1 Domestic cool boxes should not be used to store, distribute or transport vaccines.

17.5.2 For transportation of small quantities of heat labile medicines (e.g. vaccines) needed for a domiciliary visits, further information refer to LCHS G-IPC-34

17.6 In the event of a fridge failure

17.6.1 The NHS England screening and immunisation team should be informed and any follow up advice given should be acted upon. The PH England team covering Lincolnshire, Leicestershire and Northamptonshire can be contacted via telephone number 01138253495 or england.llimms@nhs.net (Note this is the generic email for all immunisation enquiries).

17.6.2 All vaccines affected by the incident should be maintained within the cold chain but separated from all other vaccines. These vaccines should be labelled to ensure clear identification. Vaccines/medicines should not be discarded until directed to do so as they may still be viable.

17.6.3 Where appropriate, medicines that are taken out of the cold chain and subsequently returned back into the refrigerator must be clearly marked specifying how long the medicine spent outside the cold chain (and the expiry date if different from the manufacturer's expiry). This is because any subsequent breach of the cold chain occurring for these medicines may have a cumulative effective which could affect their stability and efficacy

17.6.4 Incidents should be reported via Datix and appropriate actions taken. Any medicines destroyed must be named within the Datix and financial loss detailed.

17.6.5 The incident will be notified to the Medicines Management Team who will support any subsequent investigation. Further information refer to G-IPC-34

17.6.6 To ensure least impact in episode of potential refrigerator breakdown or interruption in electricity supply, service managers should ensure easy access to a backup fridge/ storage facility, with assurance of daily and quarterly monitoring

For further information refer to Maintaining the Cold Chain: The control and monitoring of storage temperatures of medicinal products (G_IPC_34)

17.6.6 The incident should be reported on the ImmForm website www.immform.dh.gov.uk

17.7 Spillage

17.7.1 Reference should be made to local policy and COSHH which should outline all cleaning requirements when dealing with spillage.

17.7.2 Initially the spillage should be soaked up with paper towels. Appropriate personal protective equipment (PPE) should always be worn. Care should be taken to avoid puncture wounds from associated glass or needles.

17.8 Disposal / Vaccine Waste

17.8.1 All vaccines should be used within the period recommended by the manufacturer or should be disposed of by sealing in a puncture – resistant sharps box intended for this purpose if not used within the manufacturers recommended time period. Disposal bins must be disposed of when two thirds full or following six weeks of being in use.

17.8.2 Any wastage of vaccine as a result of disruption of the cold chain must be reported to the NHS England Screening and Immunisation Team via the Immunisation Coordinator on 01162 950890. If the vaccine has been ordered from ImmForm then the wasted vaccine needs to also be recorded on the ImmForm site.

17.8.3 Any disruption to the cold chain must be recorded as an incident in accordance with the Organisations incident reporting policy.

17.9 Storage of Immunoglobulins

17.9.1 Immunoglobulins should be refrigerated immediately upon receipt and stored at temperatures of 2°C to 8°C.

18.9.2 They should be protected from light and should not be frozen.

17.10 Equipment suppliers

17.10.1 Advice on suppliers of refrigeration equipment and accessories is available from:

Immunisation Policy, Monitoring and Surveillance.
Department of Health
Area 512
Wellington House
133 – 155 Waterloo Road
London
SE1 8UG
Tel: 020 7972 1227

17.11Service Specific

17.11.1Immunisation and Vaccination team refer to;

Appendix 14 SAIS - Post vaccination Reaction Pathway

Appendix 15 Competence assessment tool: registered and non-registered staff

18. Medicine Management Training

18.1 All healthcare professionals and other staff who deal with medicines must undertake regular training as identified through the local training matrix (Appendix 16) to ensure they have the appropriate competencies to carry out their role safely and in line with local SOPs and service specific requirements.

18.2 All individuals are responsible for maintaining their professional knowledge and working within the limits of their competence. Individual training relating to medicines will be monitored at appraisal and training records held on ESR.

18.3 Medicine Management Competence Framework (available on the intranet) is to be used as part of a tool to assure knowledge, competence, safe practice and confidence in a specialist area and to be used or revisited as and when required by either the healthcare professional or their line manager. The Competency Framework must be completed and recorded on ESR by non and registered healthcare professionals on;

- Initially joining a specific team / area e.g. community or palliative care
- Annually as part of Appraisal
- If the healthcare professional moves to a new area of expertise (e.g. moving from hospital to community)
- Prolonged absence from the workplace (e.g. maternity leave or sickness)
- Following an untoward incident
- In conjunction with Medicine Errors Policy (P-CIG-15)

18.4 Individual training competencies for specific medicine related tasks are acknowledged at one to one/ appraisal; training should be supported by the line manager and agreed as described in related policies e.g. IV Policy

18.5 Independent / Supplementary prescribers have an additional requirement to complete an annual audit of their prescribing practice and have specific clinical supervision; prescribing objectives in their annual appraisal (see Independent/ Supplementary Prescribing Policy).

18.6 Competent staff should supervise newly trained staff to ensure they have the necessary work competences to undertake their duties safely and effectively. Additional training may be required when changes are made to procedures or devices used.

18.7 School Age Immunisation Service staff are required to participate in annual update training in order to meet the required competencies for immunisation programme delivery relevant to their role (see Appendix 15 Competence assessment tools for registered and non-registered staff).

19. Implementation Strategy

19.1 Following approval the policy will be posted on the Trust website to aid dissemination.

19.2 Staff will be advised that this policy replaces all previous policies.

19.3 Service leads will be requested to disseminate to all appropriate staff groups.

20. Audit / Monitoring / Review

20.1 The implementation of this policy will be audited by the service managers overseen by the Drugs and Therapeutics Committee. Audit tools are both service specific and also available in the Management of Errors Policy, Independent/ Supplementary Prescribing Policy and Controlled Drugs Policy.

20.2 should be undertaken to assess whether the policy has been implemented / actioned. All monitoring and operational audits should be presented to the Drugs and Therapeutics Committee for information and action as appropriate.

20.3 Service Managers should ensure that they have systems in place for routine audit and review of medicine incidents

20.4 This policy should be reviewed in light of changes with local guidance, national guidance, national legislation and best practice.

21. References

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- Faculty Sexual and Reproductive Healthcare' Standards for Online and Remote providers of Sexual and Reproductive Health Services (Jan 2019)
- General medical Council Remote prescribing via telephone, video-link or online https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/remote-prescribing-via-telephone-video-link-or-online
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- NHS England 2015 Policy and procedure for maintaining the vaccine cold chain. https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2015/07/cold-chain.pdf
- NHS Protect Security Management Manual of Guidance 'Medicines and Controlled Drugs'.
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- Public Health England (2014) 'Protocol for Ordering, Storing and Handling Vaccines' accessed via http://www.gov.uk/government/publications/protocol-for-ordering-storing-and-handling-vaccines.
- Public Health England (2014) 'ImmForm Helpsheet 18. Fridge failures and stock incidents'
- Public Health England (2014) 'What to do if issues with vaccine storage management are identified during a Care Quality Commission inspection'.
- Royal Pharmaceutical Society (2018) Professional guidance on the safe and secure handling of medicines.
- Royal Pharmaceutical Society (Jan 2019) Professional guidance on the administration of medicines in healthcare settings.
- Royal Pharmaceutical Society of Great Britain (2005) The safe and secure handling of medicines: A team approach.

LCHS policies and documents

- Maintaining the Cold Chain: The control and monitoring of storage temperatures of medicinal products Cold Chain (G_IPC_34)
- LCHS Controlled Drugs (P-CIG-18).
- LCHS Independent / Supplementary prescribing policy (P-CIG-25).
- LCHS Policy for the development and control of Patient Group Directions (PGDs) (P-CIG-13)
- LCHS Serious incident policy (P-RM-06).
- LCHS Open and Honest Care Policy (P-CIG-16)
- Standard Operating Procedure for Management of Central Venous Access Devices (CVADS) for Adult Patients in the Community (G-CIS 113)

Appendix 1 **Request for Addition to Stock List**

Service/Ward requesting change:

Requested by: Name: Date:

Drug Name:
Reason for request :
Has an alternative solution been discussed with pharmacy? Yes / No Has an alternative solution been discussed with MM team? Yes/ No Outcome of discussions
Supporting local evidence: *e.g. local pathways/ SOP, PACEF, Lincs.Formulary*
Supporting national evidence: *e.g. NICE*
State expected use and cost:

State potential financial risks:
State benefit to patients:
Request agreed by HOC Name : Date:
Send to Medicine Management Lead for Pharmacy agreement and authorisation through Drugs & Therapeutic Committee

Appendix 2

Accepting delivery of Controlled Stationery at central storage (Beech House)

Arrangements should be made as soon as possible to move the delivery of the controlled stationery into a locked cabinet within a locked room as described in policy (P-CIG-20)

Check for any discrepancies

- The serial numbers should be checked against the delivery note.
- The suppliers must be notified of any discrepancies immediately

Accurately complete the electronic data base as soon as possible

The electronic database will show a central stock control record of receipt (and issue) of prescriptions. The following information should be recorded:

- Date of delivery
- Name of staff entering details on database
- What has been received (Top and bottom serial numbers/ box number)
- Details of the prescriber printed on the FP10 scripts

Appendix 3 ONWARD DISTRIBUTION OF PRESCRIPTON STATIONERY

All FP10 stationery will be stored in Beech house at Central Store until requested by services

A record should be kept of the serial numbers of the prescribing forms, including where and when (date/ time) and by whom the prescriptions have been distributed.

All stationery sent for onward distribution to services will be accompanied by a prescription pad register of all individual prescription numbers within the pad.

A Bearers Note and FP10 Receipt will accompany all FP10 stationery for the receiving service to check and sign for

FP10 stationery will be sealed into lockable distribution bags along with associated stock and checking documents
A Bearers note should be attached to the outside of the bag ready for internal courier transportation to the requesting service.
In exceptional circumstances if controlled stationery has to be transported by a member of the MM team the same checks and use of a Bearer's note should be used

FP10 stationery is distributed to services by the MM team.
Secure courier will be used where available
Secure storage will be maintained during onward distribution
An email confirming that the stationery is due to be delivered will be sent to the person who requested the stationery

If a delivery of prescription forms is expected, but does not arrive as anticipated then LCHS Medicines Management Team should be notified of potential missing prescription forms via lhnt.LCHSSecretaries@nhs.net so that enquiries can be made at an early stage

Upon receipt into service the prescription stationery should be checked against the Bearers note and the FP10 receipt completed, only being signed for if the packaging is sealed and unbroken. Any discrepancies should be noted and queried with MM Team. The Bearers note, FP10 receipt and transfer envelope should be returned as soon as possible to the MM team to provide an audit trail of transfer.

Prescription pads should be recorded onto the local service prescription log – recording date / time of receipt, first and last number received and signed into the register.
All FP10 stationery should be locked immediately into the storage safe.

An individual prescription pad register should be maintained for each FP10 pad.
For storage of unused pads see Stock management of FP10s at service level (Appendix4)

All FP10 stationery in services will be included in the daily checking processes to ensure there are no discrepancies.

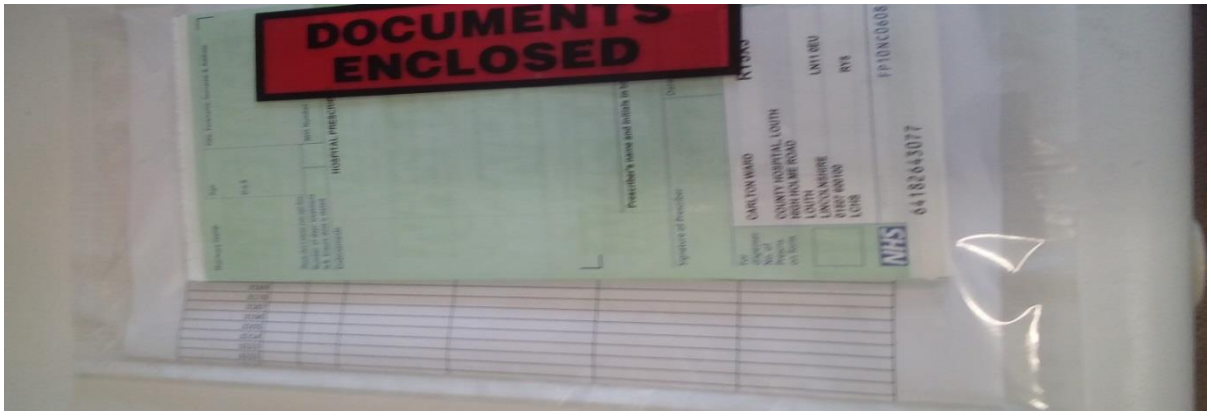
Appendix 4

Stock management of FP10s at service level.

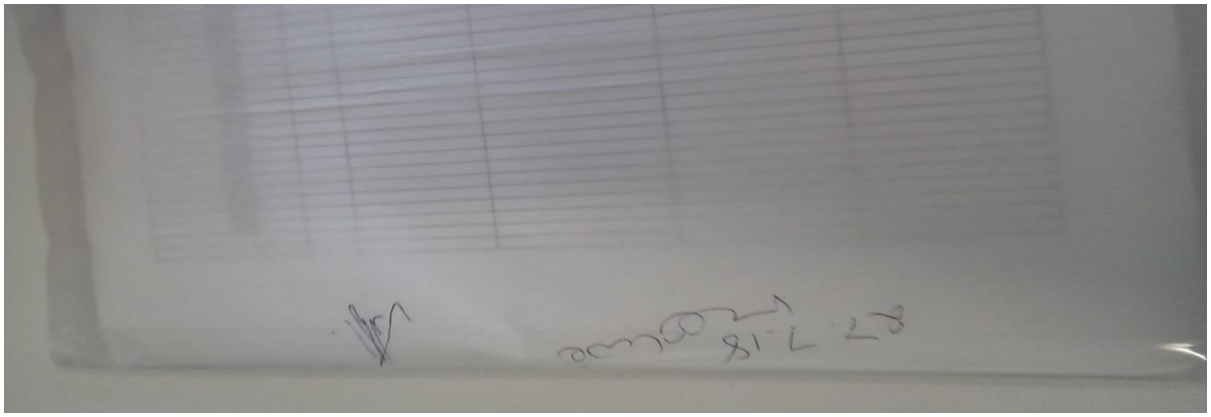
For ease of checking unused, whole FP10 pads should be sealed (signature x 2 and dated) in a transparent envelope along with its log sheet. Sealed envelopes do not need individually counting

Check the first and last numbers against the received log sheet, and then seal in the bag. If not sealed immediately upon receipt then the FP10 pad will need to enter the prescription count.

Place the FP10 pad's log sheet in the envelope so the last four digits are visible and correspond to the pad (as below)



Pull the strip from the back of the envelop, seal, sign (x 2 signatures) and date over the sticky strip (as below)



Once the seal is broken individual scripts will then be counted and recorded as per usual log.

Transparent envelopes (175mmx 235mm code WYO 2825) can be ordered through NHS Supply Chain.

Appendix 5 Checking Controlled Stationery

Every time the FP10 pad is removed from the secure storage complete the log sheet with:

- Date and time removed, record the starting serial number on the top of the pad and the final serial number on the bottom of the pad and sign.

When replacing the pad complete the form with the date and time replaced, Prescriber name, the starting serial number on the top of the pad and the serial number on the bottom of the pad and sign.

The prescriber using hand written FP10s:

Additionally complete the Prescription stationery register to show a record of the individual patient NHS number and the name of prescriber and date used against the script number (form provided by MM when pad distributed).The prescription number is required in case the pad is lost or stolen

The prescriber will return completed record of prescription stationery register to MM Team, when ordering a new pad

The prescriber using printed FP10SS

Every time the FP10 SS are removed from the secure storage to place into printers, complete the computer generated prescriptions log sheet (Appendix 8) with: date and time removed, Printer number (in stances where more than one printer is used) , number of individual prescriptions placed in printer, starting serial number and the final serial number and name and signature. (Appendix 4)

When replacing the FP10SS back into storage complete Appendix 6 with the date and time replaced, the starting serial number and the final serial number and sign. Store completed forms locally for 2 years

Daily Checks

FP10s will be counted to identify the correct number of <u>unopened pads</u> are in stock and identify any anomalies / missing documents. (Appendices 3 and 4)

FP10s which are in use (part pads) will need scripts to be individually counted to identify any anomalies

FP10SS stock should be checked **daily,** boxes being identified and recorded as unopen
FP10SS boxes which are open should be recorded as Appendix 4

Checks must be recorded either within the CD blue daily checks book, starting at the rear of the book or attached daily checks log

The number in stock should be identified and signed by both checkers.

Appendix 6: Daily FP10 Checklist

Month:

Date	*No. of FP10 in Pad/Box*	*Does the quantity remaining correspond with the FP10 register?*	*What actions have been taken?*	*Signed*	*Witness*
1st		*yes / no*			
2nd		*yes / no*			
3rd		*yes / no*			
4th		*yes / no*			
5th		*yes / no*			
6th		*yes / no*			
7th		*yes / no*			
8th		*yes / no*			
9th		*yes / no*			
10th		*yes / no*			

Date	No. of FP10 in Pad/Box	Does the quantity remaining correspond with the FP10 register?	What actions have been taken?	Signed	Witness
11th		**yes / no**			
12th		**yes / no**			
13th		**yes / no**			
14th		**yes / no**			
15th		**yes / no**			
16th		**yes / no**			
17th		**yes / no**			
18th		**yes / no**			
19th		**yes / no**			
20th		**yes / no**			

Date	No. of FP10 in Pad/Box	Does the quantity remaining correspond with the FP10 register?	What actions have been taken?	Signed	Witness
21st		**yes / no**			
22nd		**yes / no**			
23rd		**yes / no**			
24th		**yes / no**			
25th		**yes / no**			
26th		**yes / no**			
27th		**yes / no**			
28th		**yes / no**			
29th		**yes / no**			
30th		**yes / no**			
31st		**Yes/no**			

Appendix: 7 **PRESCRIPTION LOG – FP10 PRESCRIPTION----Record of all FP10 prescriptions received into service**

DATE + TIME TAKEN OUT	DATE +TIME RETURNED	HEALTH CARE PROFESSIONAL NAME	STARTING SERIAL NUMBER	FINAL SERIAL NUMBER	SIGNATURE
20.01.17 09.30HRS		*JOE BLOGGS*	*67011501203*	*67115014444*	
	20 .01.17 17.45 hr	*JOE BLOGGS*	*67011501789*	*67011505555*	

Separate sheet required for each pad of controlled stationery

Appendix 8 **PRESCRIPTION LOG – COMPUTER GENERATED PRESCRIPTIONS**

DATE+TIME OUT+RETURNED	PRINTER / ROOM	NUMBER OF PRESCRIPTIONS	STARTING SERIAL NUMBER	FINAL SERIAL NUMBER	NAME+SIGNATURE
20.04.18 06.30 hrs	*Printer 2*	*50*	*12345678345*	*12345680121*	
20.04.18 23.00HRS RETURNED	*Printer number 2*	*45*	*12345678911*	*1234567888*	

Separate sheet required for each box of controlled stationery

Appendix 8B - Medication Chart-Checker:

Audit Area: **Date Completed**

Observations	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Total
Has the medication been reviewed within the last 14 days by a Prescriber?																					
If the medication was omitted, has the reason for omission been recorded?																					
Have oral antibiotics been prescribed for no longer than 5 days (or 7 days for male UTIs) in the first instance?																					
Was a review undertaken for antibiotics after 5 (or 7) days?																					
Has correct antibiotic for presenting condition been prescribed? (Indication in notes)																					
Have IV antibiotics been prescribed for no longer than 48 hours in the first instance?																					
Was a review undertaken after 48 hours?																					
Has a specimen been taken for culture?																					
Has a review of medication been undertaken following lab result availability?																					
Have any interventions been made by Pharmacist?																					
Has a VTE assessment been undertaken?																					
Has VTE prophylaxis been prescribed appropriately where required?																					
Total number of Yes answers per chart																					
How many of the 20 charts scored														Total number of inaccuracies							

Please see action plan overleaf/below for completion following your audit

Action Plan

Please annotate chart below with an action plan and status for any observations completed with 'NO' on the Chart Checker.

Observations	Action Plan	Status/Assurance
Has the medication been reviewed in the last 14 days by a Doctor or Prescriber?		
If the medication was omitted, has the reason for omission been recorded?		
Have oral antibiotics been prescribed for no longer than 5 days (or 7 days for male UTIs) in the first instance?		
Was a review undertaken after 5 (or 7) days?		
Has correct antibiotic for presenting condition been prescribed? (Indication in notes)		
Have IV antibiotics been prescribed for no longer than 48 hours in the first instance?		
Was a review undertaken after 48 hours?		
Have any interventions been made by Pharmacist?		
Has a VTE assessment been carried out?		
Has VTE prophylaxis been prescribed appropriately where required?		
Has a specimen been taken for culture?		
Has a review been undertaken following lab result?		

Appendix 9 - Security of prescription forms

Aide-mémoire for prescribers

- Be aware that blank prescription forms in the wrong hands are like a blank cheque with an extremely high street value.
- Prescription form stock in possession of prescribers should always be stored securely when not in use.
- Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded.
- Prescribers should be encouraged to use prescription forms in number sequence order to aid tracking of usage, should a potential loss occur
- To reduce the risk of misuse, blank prescriptions should never be pre-signed.
- Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.
- Prescribers on home visits should, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying. Only a small number of prescription forms should be taken on home visits – ideally between 6 and 10 – to minimise the potential loss.
- Prescribers on home visits/working in the community should take suitable precautions to prevent the loss or theft of prescription forms. Keep them out of sight when not in use and do not leave any prescription forms in vehicles overnight.
- Prescribers using the FP10PCD forms should exercise extra caution as there is greater potential for misuse of these forms.
- Blank or signed prescription forms should never be left at patients' homes, care homes or community pharmacies for GP or locum visits.
- Personalised forms which are no longer in use should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept.
- Spoiled or cancelled prescription forms should be retained for audit purposes.

- In the event of a loss or theft of prescription form stock, local procedures should be followed and the practice manager, area team, Controlled Drugs Accountable Officer and the police should be notified as required. The incident should also be recorded on the organisation's incident reporting system.

Appendix 10 Prescription Destruction Log

DATE of DESTRUCTION	NAME ON PRESCRIPTION PAD (If applicable)	NUMBER OF PRESCRIPTIONS	STARTING SERIAL NUMBER	FINAL SERIAL NUMBER	SIGNATURE ONE	SIGNATURE TWO

Return form to Medicine Management Team at Beech House for scanning into database

Appendix 11 Loss or theft of Controlled Stationery

Following loss or discrepancy before distribution (i.e. from Beech House)

- Check discrepancies against stock receipts and electronic data base
- Check previous stock audits so discrepancy can be more accurately dated
- Check access to stock room and check with individuals possible discrepancy
- Check with bases what orders have been received
- Inform manager
- Compete Datix with above findings

Loss or theft after delivery to service or individual prescriber

- Check discrepancies against prescription logs
- Check previous daily logs so that discrepancy can be more accurately dated.
- Inform manager
- Compete Datix with above findings

The appropriate manager of the premises / Service Manager or line manager should where prescription forms are lost (whether or not theft is suspected), report immediately to;

- Medicines Management Officer
- Security Officer
- Trust CDAO
- Local counter fraud specialist (Tel No: 01522 308972) and NHS England, Lincolns Contracting Team via email - england.primarycarelincoln@nhs.net This generic email is monitored daily

Appendix 12 **Ambient Room temperature monitoring**

All medicines must be stored according to manufacturers' recommendations.

Sensitivity to changes in temperature varies depending on the medicine.

Failure to store correctly can invalidate the expiry date and cause manufacturers to disclaim responsibility for any apparent failure of the medicine

What temperature should medicines be stored at?

Most non-refrigerated medicines must be stored up to 25°C. However, some medicines can be stored at up to 30°C and even higher.
Check with individual manufacturers,
www.emc,medicines,org.uk

How do I know the medicines are kept within the temperature range?

The temperature of any room used to store medicines outside of a refrigerator must be monitored and temperature documented on the daily temperature recording sheet.

What if the room temperature is at risk of exceeding 25°C?

Remove any heat sources or move medicines to alternative secure storage sites if possible.
Escalate you findings/ action and concerns to your line manage/ Contact Pharmacist/

What if the room temperature is consistently exceeding 25°C?

A digital data logger will give additional evidence, aid tracking and probable causes of spikes in temperatures, especially when the area is not in use (e.g. weekends). This electronic record of temperature will help Estates

What is the quick way to ensure medicines are stored consistently within

Limit stock to no more than 3 months especially in the summer months, this will ensure medicines are used before they are harmed by increased

How?

Stock must be rotated according to the expiry date so that the oldest stock is

Regular expiry dates checks should be carried out for all medicines

Your stock control record will help to show if medicines have been stored in your cupboard for longer than 3 months

Appendix 13: Pharmaceutical Waste Bins

All unwanted /expired Controlled Drug medications should highlighted for disposal by pharmacy staff.
Expired or unwanted medications should be recorded in the green Waste Recording book, outer packaging disposed of in recycling and medication / strips of pills in the correct waste bin.
Empty medicine containers must be disposed of in the correct bin.

USED SHARPS (non-cytotoxic/ cytostatic)
MUST be placed in YELLOW LIDDED pharmaceutical waste bins

Medicine for disposal (except CDs (placed in the blue waste in after they have been denatured by a pharmacist) and cytotoxic drugs as below) must be placed in a BLUE LIDDED waste bin

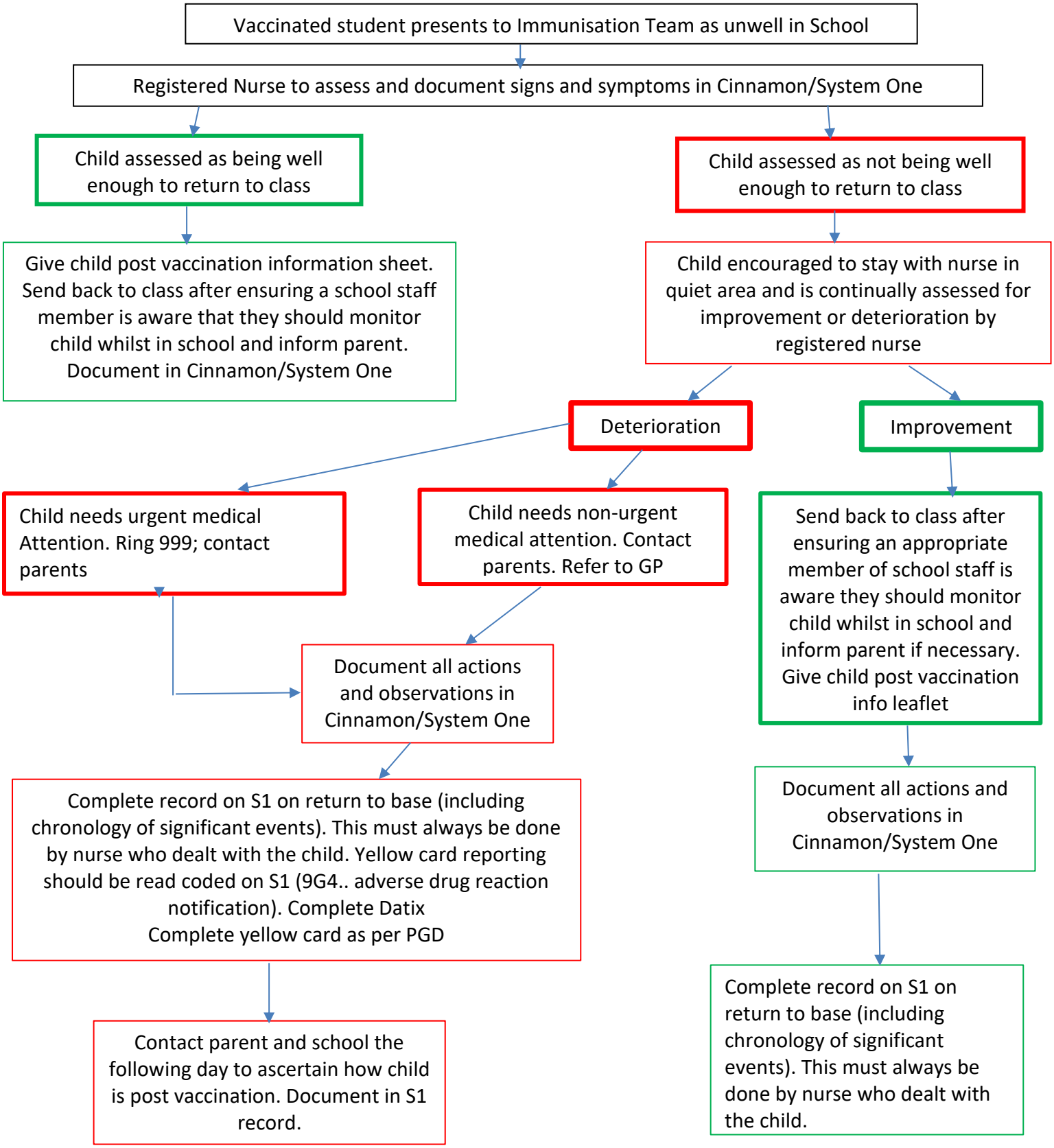
Cytotoxic and Cytostatic USED medicine containers and sharps (please see list below) MUST be placed in PURPLE LIDDED pharmaceutical waste bins

List of Hazardous (cytotoxic / cytostatic) Drugs (not exhaustive)

Anastrozole (ARMIDEX)
Azathioprine
Bicalutamide (CASODEX)
Chloramphenicol Ciclosporin
Coal-Tar containing products
Colchicine
Diethylstilbestrol
Dutasteride
(AVODART) Estradiol
Exemestane (AROMASIN)
Finasteride (PROSCAR)
Ganciclovir
Goserelin (ZOLADEX)
Interferon products
Letrozole
Medroxyprogesterone
Megestrol
Zidovudine
Methotrexate
Mycophenolate mofetil (CELLCEPT)
Nafarelin
Ostrogen containing products
Progesterone containing products
Raloxifene (EVISTA)
Ribavirin
Sirolimus
Tacrolimus (PROGRAF)
Tamoxifen
Testosterone
Thalidomide
Toremifene citrate
Valganciclovir

Appendix 14

SAIS - Post vaccination Reaction Pathway



Appendix 15: Competence assessment tool: registered staff – for staff who are on a professional register such as NMC, GMC, HCPC, GPhC

	Competence assessment tool: registered staff – for staff who are on a professional register such as NMC, GMC, HCPC, GPhC **Practitioner Name:**	**Not applicable (NA) to current area of practice**	**Self-assessment record: need to improve (NI) or met (M) (initial and date)**	**Mentor review record: needs to improve (NI) or met (M) (initial and date)**	**Record action plan for any assessed as needs to improve (as agreed with mentor)**
	Part 1: knowledge		**Self-assessment**	**Mentor review**	
1a	Can provide evidence of attendance at a specific, comprehensive immunisation training course. The course should cover all of the topics detailed in the Core Curriculum for Immunisation Training and/or provide evidence of completing an immunisation e-learning programme (state the name of course/type of training attended).				
1b	Has successfully completed a knowledge assessment e.g. an e-learning course assessment, end of course test or the PHE online quiz.				
1c	Able to access the online Green Book and is aware of the electronic update nature of this publication.				
1d	Able to access other relevant immunisation guidance e.g. DH/PHE/NHS England letters, vaccine update, Q&As on new or revised vaccine programmes, the PHE algorithm for persons with unknown or uncertain immunization status.				
1e	Knows who to contact for advice if unsure about vaccination schedules, vaccine spacing and compatibility, eligibility for vaccines or if a vaccine error occurs (e.g. local screening and immunisation team, PHE health protection team or other locally available immunisation lead)				

1f	Able to access current information on other countries' schedules if required (e.g. WHO or ECDC websites) and can advise patients and/or parents/carers if any additional vaccines are needed.				
1g	Able to discuss the relevant national and local immunisation programmes and the diseases for which vaccines are currently available. Aware of programmes for specific clinical risk groups and use of vaccination in outbreak situations. Knows where to refer to if vaccines are not available locally (e.g. BCG or travel vaccines).				
1h	Is able to advise on appropriate safe, timely administration of the vaccine(s) required by the patient.				
1i	Understands the different types of vaccine, is able to state which vaccines are live and which are inactivated and is aware of the different routes of administration e.g. injected, intranasal or oral.				
1j	Able to explain the general principles of immunisation e.g. why multiple and/or booster doses are required, why intervals need to be observed between doses and why the influenza vaccine needs to be given annually.				
1k	Aware of local and national targets for immunisation uptake and why vaccine uptake data is important.				

	Competence assessment tool: registered staff – for staff who are on a professional register such as NMC, GMC, HCPC, GPhC	**Not applicable (NA) to current area of practice**	**Self-assessment record: need to improve (NI) or met (M) (initial and date)**	**Mentor review record: needs to improve (NI) or met (M) (initial and date)**	**Record action plan for any assessed as needs to improve (as agreed with mentor)**
	Part 2: core skills for immunisation Self-assessment Mentor review		**Self-assessment**	**Mentor review**	
2a	Is up-to-date with local requirements for anaphylaxis and CPR training (normally recommended annually).				
2b	Aware of the whereabouts of anaphylaxis and emergency care equipment, how and when to use it and the follow-up care required.				
2c	Can explain incident response and reporting process in case of a procedural error, needle stick injury as per local protocol.				
2d	Demonstrates good practice in hand hygiene and relevant infection prevention techniques.				
2e	Disposes of sharps, vaccine vials and other vaccine equipment safely in line with local guidance.				
2f	Demonstrates knowledge and understanding of the rationale for maintaining the vaccine cold chain. Familiar with local protocols for cold chain management and the action to be taken in case of cold chain failure and who to contact.				

	Part 3: clinical process and procedure		**Self-assessment**	**Mentor review**	
3a	Checks patient's identity and patient's records prior to vaccination to ascertain previous immunisation history and which vaccines are required e.g.to bring patient up-to-date with national schedule, for planned travel, for specific identified risk, post-exposure prophylaxis etc.				
3b	Can explain which vaccines are to be given and able to answer patient's and/or parents' questions, referring to leaflets to aid explanations/discussion as appropriate and using interpreter if necessary to ensure patient/parent informed. Knows who to refer to or who to contact if further detail or advice is required.				
3c	Able to clearly and confidently discuss the risks and benefits of vaccination and able to address any concerns patients and/or parents may have.				
3d	Aware of, and able to discuss, any current issues, controversies or misconceptions surrounding immunisation.				
3e	Demonstrates knowledge of consent requirements and the particular issues relevant to the area of practice, such as the capacity to consent, Mental Capacity Act and the age of the individual. Ensures consent is obtained prior to vaccination and is appropriately documented.				
3f	Demonstrates knowledge and understanding of contraindications and is able to assess appropriately for contraindication or, if necessary, the need to postpone vaccination.				

3g	Checks that the vaccine has been appropriately prescribed via a Patient Specific Direction (PSD) or is authorised to be supplied and/or administered via a Patient Group Direction (PGD).				
3h	Checks the presentation of vaccine products, the expiry date how they have been stored prior to use and prepares them according to the summary of product characteristics (SPC).				
3i	Positions patient appropriately and chooses appropriate vaccination site(s) outer aspect of upper arm in children and young people for injectable vaccines.				
3j	Chooses the correct administration route for the vaccine(s) to be delivered.				
3k	Demonstrates correct subcutaneous injection technique – only used as indicated within PGD for those with bleeding disorders				
3l	Demonstrates correct intramuscular technique e.g. for administration of DTaP vaccine.				
3m	Demonstrates correct intranasal technique e.g. for administration of live influenza vaccine to children.				
3n	Demonstrates an understanding of practice/clinic procedures for the reporting of vaccine reactions and knows how and when to report using the Medicines and Healthcare products Regulatory Authority's (MHRA) Yellow Card Scheme.				
3o	Completes all necessary documentation, recording type and product name of vaccine, batch number, expiry date, dose administered, site(s) used, date given and name and signature.				

3p	Demonstrates good record keeping and understands the importance of making sure vaccine information is recorded on GP data system, reported to local Child Health Information System (CHIS), in the Personal Child Health Record (PCHR) and the use of appropriate methods for reporting unscheduled vaccinations or where vaccines are given outside of GP premises.				
3q	Advises patient/parent on potential post-vaccination reactions as appropriate (e.g., rash, pyrexia) and management of these. Provides patient/parent with a copy of post-immunisation advice sheet such as the NHS leaflet What to expect after vaccination or the product's Patient Information Leaflet (PIL), if appropriate.				

Appendix 15a

Statement of Completion for School Age Immunisation Service Competence

Name of Healthcare professional:

I have the required theoretical knowledge on and practical skills relating to School Age Immunisations to ensure I work safely and efficiently. I acknowledge my responsibility to maintain my own competence.

Profession: Registration No (if applicable):

Assignment Number *(payslip)*:

Name of Sign off Assessor:

Date of completion: Time:

Location of assessment: Initial training / Refresher (delete as appropriate)

Declaration:

I have witnessed the above healthcare professional in practice and discussed their required competencies (as identified in LCHS P_CIG_20 Safe and Secure Handling of Medicines Policy).
I am signing to confirm they have shown appropriate knowledge, skill, clinical judgement, confidence and competence in the safe and secure handling and administration of School Age Immunisations.

Signature: Designation: Date:

If you deem the healthcare professional does not meet the above competencies, please detail below areas for development, notifying SAIS service lead of these at time of statement completion:

Once completed please send a copy to the training and development team lhnt.learninganddevelopementteam@nhs.net to log on to ESR. A copy can be shared with your line manager.

This document should be kept with the completed competency document by the practitioner as evidence of competency

Appendix 16 - Competence assessment tool: non-registered staff. - For staff trained to administer or support the delivery of a vaccination programme but who are not registered on a professional register such as NMC, GMC HCPC or Ph.C.

	Competence assessment tool: non-registered staff. For staff trained to administer or support the delivery of a vaccination programme but who are not registered on a professional register such as NMC, GMC HCPC or GPhC **Practitioner Name:**	**Not applicable (NA) to current area of practice**	**Self-assessment record: need to improve (NI) or met (M) (initial and date)**	**Mentor review record: needs to improve (NI) or met (M) (initial and date)**	**Record action plan for any assessed as needs to improve (as agreed with mentor)**
	Part 1: knowledge		**Self-assessment**	**Mentor review**	
1a	Can provide evidence of attendance at a specific, comprehensive immunisation training course (the course should cover all of the topics detailed in the Core Curriculum for Immunisation Training and/or provide evidence of completing an immunisation e-learning programme. (State the name of course/type of training attended.)				
1b	Has successfully completed a knowledge assessment e.g. MCQ or other assessment at end of a taught course.				
1c	Able to access the online Green Book and is aware of the electronic update nature of this publication.				
1d	Knows who to refer to for advice if unsure about vaccination schedules, vaccine spacing and compatibility, eligibility for vaccines or if a vaccine error occurs (e.g. registered health care professional.)				
1e	Familiar with the relevant national and local immunisation programmes and the diseases for which vaccines are currently available.				

1f	Understands the different types of vaccine, is able to state which vaccines are live and which are inactivated and is aware of the different routes of administration e.g. injected, intranasal or oral.				
1g	Able to explain the general principles of immunisation e.g. why multiple and/or booster doses are required, why intervals need to be observed between doses and why the influenza vaccine needs to be given annually.				
1h	Aware of local and national targets for immunisation uptake and why vaccine uptake data is important.				
	Part 2: core skills for immunisation		**Self-assessment**	**Mentor review**	
2a	Is up-to-date with local requirements for anaphylaxis and CPR training (normally recommended annually).				
2b	Aware of the whereabouts of anaphylaxis and emergency care equipment, how and when to use it and the follow-up care required.				
2c	Can explain incident response and reporting process in case of a procedural error, needlestick injury as per local protocol.				
2d	Demonstrates good practice in hand hygiene and relevant infection prevention techniques.				
2e	Disposes of sharps, vaccine vials and other vaccine equipment safely in line with local guidance.				
2f	Demonstrates knowledge and understanding of the rationale for maintaining the vaccine cold chain. Familiar with local protocols for cold chain management and the				

	action to be taken in case of cold chain failure and who to contact.				
2g	Works within local protocol or standard operating procedure (SOP), understands limitations of own role and able to refer on for advice appropriately.				
	Part 3: clinical process and procedure		**Self-assessment**	**Mentor review**	
3a	Checks patient's identity and patient's records prior to vaccination to ascertain previous immunisation history.				
3b	Can explain which vaccines are to be given and is able to answer patient's and/or parents' questions, referring to leaflets to aid explanations/discussion as appropriate and using interpreter if necessary, to ensure patient/parents informed. Is able to refer to the relevant registered practitioner for further detail or advice.				
3c	Able to clearly and confidently discuss the risks and benefits of vaccination and able to address any concerns patients and/or parents may have. Refers to the relevant registered practitioner for further detail or advice.				
3d	Aware of, and able to discuss, any current issues, controversies or misconceptions surrounding the immunisations they are giving.				
3e	Demonstrates knowledge of consent requirements and the particular issues relevant to the area of practice, such as the capacity to consent, Mental Capacity Act and the age of the individual. Ensures consent is obtained prior to vaccination and is appropriately documented.				
3f	Demonstrates knowledge and understanding of contraindications and uses assessment form/check list to check for contraindications and precautions prior to				

	immunisation. Refers to relevant registered professional if in doubt.				
3g	Demonstrates that they check the vaccine has been appropriately prescribed through a Patient Specific Direction (PSD). The intranasal influenza vaccine can be supplied by a registered practitioner via a Patient Group Direction PGD for subsequent administration where appropriate to the setting.				
3h	Demonstrates that they know how to use PSDs, checking that the patient is named to receive the specific vaccine, that it is appropriately dated and signed and that they know who to refer to if this is not the case.				
3i	Checks the presentation of vaccine products, the expiry date, how they have been stored prior to use and prepares them according to the summary of product characteristics (SPC).				
3j	Positions patient appropriately and chooses appropriate vaccination site.				
3k	Chooses the correct administration route for the vaccine(s) to be delivered.				
3l	Demonstrates correct intranasal technique e.g. for administration of live influenza vaccine to children.				
3m	Demonstrates an understanding of practice/clinic procedures for the reporting of adverse incidents, vaccine reactions and knows how and when to report using the MHRA's Yellow Card Scheme.				
3n	Completes all necessary documentation, recording type and product name of vaccine, batch number, expiry date, dose administered, site(s) used, date given and name and signature.				

3o	Advises patient/parent on potential post-vaccination reactions as appropriate (e.g., rash, pyrexia) and management of these. Provides patient/parent with a copy of post-immunisation advice sheet if available, e.g. the NHS leaflet What to expect after vaccination or the product's Patient Information Leaflet (PIL), if appropriate.				

Statement of competence	
Name of individual:	
Has shown appropriate knowledge, skill and competence to safely administer/advise about vaccinations under the direction of a registered nurse.	
Name of mentor/line manager:	**Date:**
Signature of mentor/line manager:	

Appendix 16 MEDICINES MANAGEMENT TRAINING MATRIX – 2020 – 2021

LEVEL ONE

- **MEDICINES MANAGEMENT FOR ALL:**
  - Medicines management as part of Mandatory training curriculum
  - Base line level for all clinical mandatory training on an annual basis.
  - Antimicrobial stewardship
  - Link to mandatory review of medicines comptencies ,recorded on ESR; competencies as part of appraisal, revalidation, professional updating.

LEVEL TWO

- **TARGETED MEDICINES MANAGEMENT TRAINING:**
  - Completion of on-line Grimsby course - Distance Learning Level 2 Understanding the Safe Handling of Medicines for all staff who handle medicines
  - On - Line PGD training - available to all staff who use / develop / review PGDs.
  - Antibiotic training - targeted training / updating / revision for prescribers and all practitioners who administer antibiotics On- line CD training with targeted support around controlled drug management - service specific.
  - Clinical supervision - targeted at specific area of medicines error / incident / practitioner performance requirement / individual identified support - both team and individual supervision.
  - Targeted medicines mangement support through forums / medicines champions.
  - Clinical competencies - injectable medicines, PGDs, Antibiotics, NMPs, diabetes management

LEVEL THREE

- **SUPPORT TO SPECIALIST AREAS:**
  - Annual Independent/ Supplementary Prescriber's conference
  - Independent/ Supplementary prescriber support forums
  - Independent/ Supplementary targetted supervision
  - Medicines management for specialist services (for development)
  - Electronic Stock management within urgent care settings - IM&T
  - E-prescribing - prescribing within SystemOne
  - Targetted service specific PGD training
  - Service / individual medicines training related to medicines errors / incidents, competency requirements and practitioner performance requirements

Equality Impact Analysis Screening Form

Title of activity	Safe and Secure Handling of Medicines		
Date form completed	04.03.2021	Name of lead for this activity	Helen Oliver

Analysis undertaken by:		
Name(s)	Job role	Department
Helen Oliver	MM Skills Facilitator	Medicine Management

What is the aim or objective of this activity?	The purpose of this policy is to implement a co-ordinated and standardised approach to the strategic, operational and clinical management of all practices involving medicines and their use within all services within Lincolnshire Community Health Services NHS Trust
Who will this activity impact on? *E.g. staff, patients, carers, visitors etc.*	The content is relevant to all staff and service users

Potential impacts on different equality groups:

Equality Group	Potential for **positive** impact	**Neutral** Impact	Potential for **negative** impact	Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Age	☐	☐	☐	No differences within age groups
Disability	☐	☐	☐	No differences with disability groups
Gender reassignment	☐	☐	☐	No differences
Marriage & civil partnerships	☐	☐	☐	No differences
Pregnancy & maternity	☐	☐	☐	No differences
Race	☐	☐	☐	No differences
Religion or belief	☐	☐	☐	No differences

Sex	☐	☐	☐	No differences
Sexual Orientation	☐	☐	☐	No differences
Additional Impacts ***(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)***	☐	☐	☐	This document has considered all groups of staff employed and patients being cared for within LCHS

If you have ticked one of the above equality groups please complete the following:

Level of impact

	Yes	No
Could this impact be considered direct or indirect discrimination?	☐	☒
If yes, how will you address this?		

	High	Medium	Low
What level do you consider the potential negative impact would be?	☐	☐	☒

If the negative impact is high, a full equality impact analysis will be required.

Action Plan

How could you minimise or remove any negative impacts identified, even if this is rated low?
How will you monitor this impact or planned actions?
Future review date:

Monitoring Template

This template should be used to demonstrate compliance with NHSLA requirements for the procedural document where applicable and/or how compliance with the document will be monitored.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals /group /committee	Frequency of monitoring /audit	Responsible individuals / group / committee (multi-disciplinary) for review of results	Responsible individuals / group / committee for development of action plan	Responsible individuals / group / committee for monitoring of action plan
The compliance with the Safe and Secure Handling of Medicines Policy	Self-audit and quarter Medicines Management audit	Medicines Management	Quarterly audit	Individual service quality and governance groups	Individual service Quality and Governance Group	DTG