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<th><strong>Title</strong></th>
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<td><strong>Developed by</strong></td>
<td>NHS Borders Pharmacy Service, Area Drugs and Therapeutics Committee</td>
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| **Approved by** | Area Drugs and Therapeutics Committee  
Borders Executive Team Operational Group |
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NHS Borders Code of Practice for the Control of Medicines
1. INTRODUCTION

This Code of Practice lays down guidance for all staff who may be involved in the prescribing, supply and administration of medicines.

For the purpose of this code a medicine is defined as a substance that is introduced into the body, or externally applied to the body, for the purpose of:

- treating disease
- preventing disease
- diagnosing disease
- ascertaining the existence, degree or extent of a physiological condition
- contraception
- inducing anaesthesia, or
- otherwise preventing or interfering with the normal operation of a physiological function
- and includes all licensed medicines, unlicensed medicines, medicines used off label, contrast media, medical gases, medicines licensed as medical devices, wound products, stoma bags, catheters, aromatherapy oils (Policy in Section 10), herbal medicines and other complementary medicines.

The Code of Practice for the Control of Medicines document should be read in conjunction with the policies/documents included in section 10.

The Code provides broad guidelines and some procedures. Detailed local procedures may be required in specific areas and some are listed in Section 10.

Managers/Heads of Department are responsible for ensuring staff follow the guidelines laid down in the Code. Each individual member of staff must ensure that they comply with the code and with their respective professional guidelines.

The code has been mapped to appropriate local and national legislation/guidance such as the ‘NMC Guide for Medicines Management’.

The bibliography at the end of this document includes references used to compile this Code of Practice and can be used as extra reading for staff involved in medicine usage.

Patient Involvement and Consent

All staff should appreciate the importance of involving the patient in their treatment as much as possible. This includes ensuring that informed consent to treatment has been given, either by the patient or the parents (if the patient is under 12 years). Consent should be informed, i.e. the person should have an adequate understanding of their condition and proposed treatment to enable them to make an informed decision.

If the patient is unable to give consent due to diminished capacity, use of the ‘Adults with Incapacity Act’ is mandatory by law in non-emergency situations.
Emergency medication may need to be prescribed and administered without consent in certain circumstances; this is covered under ‘Common Law’.

Special provisions apply under the Mental Health (Care and Treatment) (Scotland) Act 2003, in relation to treatment for mental disorder. Advice should be sought from the Psychiatric Liaison Service or other appropriate staff from the mental health service in these circumstances.

In certain cases the consent must be written, e.g. for participation in clinical trials.

It is important that the patient (or carer/parents if appropriate) receives adequate information about their medicines prior to discharge unless their care plan deems it inappropriate.

The patient should know as a minimum:

- why the medicine is being prescribed and its purpose
- how and when to take it
- how long it is to be taken for
- what side-effects they may experience

When advising patients on medicines related matters appropriate medicines information can be provided in leaflet form. This must be in addition to, and not instead of, fully explaining the medication to the patient during the consultation. Medicines information leaflets may be provided in large print/braille/electronically and the use of a translator should also be considered if required.

<table>
<thead>
<tr>
<th>The information in this Code can be made available:</th>
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<tbody>
<tr>
<td>in large print</td>
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<tr>
<td>on audio tape or CD</td>
</tr>
<tr>
<td>in Braille and Community Languages</td>
</tr>
</tbody>
</table>

We accept requests on tape and in alternative formats.

Patients should be encouraged to assume greater responsibility for taking their medicines in preparation for their discharge. Self-medication should be encouraged wherever appropriate and local procedures agreed with medical, nursing and pharmacy staff.

2. GENERAL MEDICINES ISSUES

2.1 Purchasing Medicines

Medicines may only be purchased on behalf of NHS Borders by a pharmacist acting in accordance with laid down procedures. Samples or clinical trial material must not be left on NHS Borders premises without being taken to the Borders General Hospital Pharmacy Department for issue.
2.2 Clinical Trials

No clinical trial may commence until approval has been given by the Research Ethics Committee and NHS Borders Research Governance Committee. All medicinal supplies (including placebos) must be issued through the pharmacy department. A full protocol and code breaks must be held by the trial organiser and the pharmacy (if hospital based). NHS staff must not knowingly administer or supply trial material if informed consent has not been given. It is the responsibility of the trial organiser to ensure informed consent has been obtained (There are some mechanisms by which drugs in trials may be given where informed consent is not possible i.e. patient unconscious, these mechanisms must be stipulated within the trial protocol)

2.3 Patient’s Own Medicines

Patients should be encouraged to bring their own medicines into hospital with them to aid identification of current treatment and to continue using within the Patient’s Own Drug (POD) dispensing system. Patient’s own medicines must go with the patient if they are transferred. Patient’s own medicines will be assessed, according to procedure and continue to be used, if appropriate. Medicines no longer appropriate should be disposed of via the usual route for disposal/return of medicines.

Some patients will be taking complementary medicines, eg. Herbal or supplements. The prescriber should assess whether to prescribe these products according to their competence and using current peer reviewed literature as a basis for sound decision making. If they are prescribed then they should be treated as any other medicine under the Code of Practice. It may be necessary for patients to continue taking their own complementary medicines whilst an inpatient

When managing patients’ own controlled drugs please refer to the information in section 3 as well as the Policy for the Management of Controlled Drugs in Secondary Care.

Patients’ own Controlled Drugs must be entered into the ward/department CD register and stored in the CD cupboard. Where patient’s own CDs have been approved for reuse, standard operating procedures must be followed and use must be in accordance with Patients Own Drug Guidance. When the patient is discharged the drugs should either be returned to the patient or to pharmacy for destruction, either action should be clearly recorded and witnessed in the CD register.

2.3.1 Compliance Aids

Guidance on the use of compliance aids is available on the NHS Borders intranet. Patients who are using a medicines compliance aid (e.g. MTS, Dossett, Nomad, Venalink) when admitted to hospital must have this recorded in their notes as part of their drug history/admission details. Admission checklists should include a prompt for identifying those patients who will require a compliance aid at the point of
Patients may be referred to a community pharmacy for assessment for supply of a compliance aid.

Discharge arrangements should ensure that a system is set up for a medicines compliance aid to be refilled in the community and that the pharmacy filling the aids is informed regarding changes in medication.

Staff will ensure that patients are assessed for their ability to use compliance aids. This assessment should be carried out during initial prescribing, at the point of any changes in condition, and on discharge or transfer from hospital.

### 2.4 Cytotoxic Chemotherapy

Cytotoxic chemotherapy must only be prescribed and administered within the local policies (Guidelines for Handling Cytotoxic Drugs (BGH Pharmacy) and the national guidelines (The Safe Use of Cytotoxic Chemotherapy in the Clinical Environment HDL(2005)29) by trained staff.

*Intrathecal cytotoxic chemotherapy* is the subject of specific local policies and procedures (Policy for Intrathecal Chemotherapy BGH) and may only be prescribed, dispensed and administered by trained and authorised staff on the register held within BGH pharmacy.

### 2.5 Pharmacy Services

The pharmacy department is responsible for procurement, storage, dispensing, labelling and distribution of medicines for NHS Borders. It is also responsible for ensuring the quality of medicines supplied.

Pharmacists also play a role in providing advice and information on all aspects of the use of medicines.

### 2.6 Medicines in Wards and Departments

The staff member in charge of a ward or department which holds medicines is responsible for safety and security of those medicines.

### 2.7 Unauthorised Drugs or Suspicious Substances

If patients are found to be in possession of drugs or substances which may be illegal or for the purposes of abuse follow the ‘Procedure for Dealing with unauthorised drugs or other suspicious substances found in NHS Hospital premises’

### 3. Controlled Drugs Governance

#### What are controlled drugs?

Controlled drugs (CD’s) are those which, because of their potential for misuse and harm, have additional controls and restrictions placed on them under the misuse of
drugs legislation.

They are categorised into schedules which define the level of control, including storage, prescription writing requirements and record keeping.

Those with the highest level of control are schedule 2.

**Schedule 1 (CD License)**
- Have no recognised medicinal use and include hallucinogenic drugs.
- Examples include coca leaf, cannabis & LSD
- Production, possession and supply of these drugs are limited to research or other special purposes.
- GP’s and pharmacists may not lawfully possess Schedule 1 drugs except under licence.

**Schedule 2 (CD)**
- Of therapeutic use but have a large potential for addiction, abuse and criminal activity.
- Examples include diamorphine, morphine, pethidine, methadone, oxycodone, cocaine & methylphenidate.
- Subject to safe custody & prescription writing requirements.
- A register must be kept which must comply with the relevant regulations.

**Schedule 3 (CD No Register)**
- Includes a small number of minor stimulants and other drugs which are less likely to be misused than the drugs in Schedule 2.
- Examples include buprenorphine, midazolam, phenobarbitone & temazepam.
- Exempt from safe custody requirements except for temazepam, buprenorphine, diethylpropion and flunitrazepam, which must be stored in a locked CD receptacle.
- No legal requirements for CD register.
- Invoices must be retained for a minimum of two years.

**Schedule 4 Part 1(CD benzodiazepines)**
- Examples include most of the benzodiazepines, plus some other substances including fencamfamin, mesocarb & zolpidem.
- No safe custody or CD register requirements.

**Schedule 4 Part 2 (CD anabolic steroids)**
- Subject to abuse by athletes & bodybuilders.
- Examples include nandrolone, stanozolol, testosterone & certain growth hormones.
- No safe custody or CD register requirements.

**Schedule 5 (CD Invoice)**
- Exempt from full control when present in medicinal products of low strengths as their risk of misuse is reduced.
- Examples include codeine linctus, co-proxamol, kaolin & morphine mixture.
- No safe custody or CD register requirements.
- Invoices must be kept for a minimum of two years.

**The Shipman Enquiry**
Dr Harold Shipman was found guilty of murdering 250 of his own patients by misuse of controlled drugs (CD’s).
The resulting Shipman Enquiry exposed gaps in the overall management of CD’s and the government’s response was to produce a command paper - ‘safer management of controlled drugs’.
This outlined ways to strengthen and co-ordinate existing CD monitoring and inspection arrangements.

**What does the new legislation cover?**
Tightened arrangements have been introduced and there is now a legal requirement for each Health Board to have appointed an Accountable Officer for CD’s who is the Director of Pharmacy and a Controlled Drug Governance Team (CDGT) which includes a Controlled Drug Governance Officer.

The responsibilities of the Accountable Officer include:
- Ensuring safe & effective management of CD’s
- Routine monitoring of the use of CD’s
- Inspection of relevant premises
- Ensuring suitable arrangements for disposal of CD’s
- Gathering & sharing intelligence
- Investigating concerns

**Controlled Drug Governance Team (CDGT)**
The Deputy Accountable Officer and the Controlled Drug Governance Officer (who is also the authorised witness for controlled drug destructions) are both based within the BGH Pharmacy Department.
The overall aim of the team is to support practitioners and pharmacists to adopt and maintain good CD practices and to sign-post practitioners in the development of standard operating procedures.

**Incidents or concerns**
Any concerns regarding the prescribing, handling or administration of a CD in the Borders should now be raised with the CDGT.

**Policy for Management of Controlled Drugs in Secondary Care**
This document is based on a Scottish policy document and covers all aspects of controlled drug usage and is located at: [http://intranet/microsites/index.asp?siteid=5&uid=9](http://intranet/microsites/index.asp?siteid=5&uid=9)
4. ORDERING

Medicines are obtained from the Pharmacy service.

In most wards and departments a stock list of medicines has been agreed between nursing and pharmacy staff. These medicines will be ordered either by a top-up system operated by pharmacy staff or requisitions signed by the person in charge of the ward or department. Supplies of other medicines will be ordered either by a pharmacist or pharmacy technician or the person in charge of ward/department, on the appropriate form and may require pharmacy to view the medicine chart or a copy.

4.1 Controlled Drugs (CDs)

Controlled Drugs are ordered using a controlled drug order book, signed by a registered nurse (or ODP in Theatres) using a separate page for each item. The drugs received must be entered into the ward controlled drug register and the stock regularly checked against the register (at least every 24 hours, unless the unit is open less than 7 days a week). Tamper evident seals on containers of CDs should not be broken in order to count stock. Controlled drugs may only be removed and signed out of the register from the ward/department/practice by an authorised member of pharmacy staff, witnessed by a member of ward/department staff.

Medicines issued are the responsibility of the person in charge of that ward, department, clinic or practice.

4.2 Out of Hours

BGH site (including Mental Health Inpatient units and Community Hospitals): When the pharmacy is closed medicines may be obtained from the emergency drug cupboard (the key is held by the senior nurses on duty for the BGH). Medicines may only be borrowed from a ward/department when the pharmacy is closed and they are not obtainable from the emergency cupboard. A record of medicines transferred will be completed and kept on the ward.

If necessary, Controlled Drugs may be transferred from one ward to another and the transaction recorded in both wards Controlled Drug registers.

If a medicine is unavailable when the pharmacy is closed then a doctor or nurse in charge may contact the on-call pharmacist for advice via the BGH switchboard. The pharmacist will use their discretion regarding appropriate action to supply.

5. STORAGE AND SECURITY

The pharmacy service is responsible for ensuring that storage facilities for medicines comply with the appropriate standards.

- All medicines cupboards and fridges should be locked unless they are in use.
- It is the responsibility of the receiving staff in a ward/department to ensure
medicines are stored safely and securely in a timely manner (especially CDs and fridge items).

- All medicines must be stored in accordance with the “The Safe and Secure Handling of Medicines” (Duthie Report 2005), which recommends the following locked storage facilities (These arrangements will be audited periodically):

<table>
<thead>
<tr>
<th>5.1 Hospitals/ Health Centres/ Other Departments</th>
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<tbody>
<tr>
<td>♦ Controlled Drug Cupboards</td>
</tr>
<tr>
<td>♦ Internal medicines cupboard</td>
</tr>
<tr>
<td>♦ External medicines cupboard</td>
</tr>
<tr>
<td>♦ Medicines fridge</td>
</tr>
<tr>
<td>♦ Urine testing reagent cupboard</td>
</tr>
<tr>
<td>♦ Medicines trolley (for medicines in current use only) - must be fixed securely to the wall when not in use.</td>
</tr>
<tr>
<td>♦ Individual patient drug lockers – fixed to wall or furniture.</td>
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</tbody>
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**Separate storage should be provided as follows:**

- Area for intravenous and sterile topical fluids
- Area for inflammable gases and liquids.

A limited range of medicines where appropriate, for life-threatening emergencies may be kept on a resuscitation trolley in accordance with an agreed list. Drug cupboards for internal and external medicines must comply with the current British Standard (BS2881 (1989) – NHS Estates Building Note No.29)

<table>
<thead>
<tr>
<th>5.2 Medicines Security and Keys</th>
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<tbody>
<tr>
<td>Medicines security and storage are the responsibility of the nurse in charge. Medicines keys must be kept on their person at all times or may be given to another suitably qualified nominated person but the nurse in charge retains responsibility for them.</td>
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</table>

Medicines keys for trolleys, cupboards, fridges and other locked containers in a clinical area should all be kept on a single key ring designated for this purpose. The only exception to this is that **Keys for Controlled Drug Cupboards** must be kept on a separate key ring that can be readily identified.

Keys to patients own drugs (PODs) cupboards may be issued to the patient who signs for receipt of this key. The key that is issued to an individual patient must only open their designated medicine cupboard and must be kept securely by the patient. On discharge or when the patient is no longer self-administering their medicines, the key must be returned to safekeeping and a record made.

The nurse/designated or responsible person in charge is responsible for:

- Rotation of stock
- Balancing, checking, recording and maintaining security of stocks of Controlled Drugs
- Holding keys for medicines storage
Return of excess stock prior to expiry date (in addition to ward staff checks, Pharmacy staff will check expiries of ‘topped up’ stock drugs)

Reviewing stock lists with the pharmacy department

Regular checks of cupboards and records.

The Nurse in Charge must ensure there are robust systems in place for the checking expiry dates of drugs (including stock in drug fridges). Stock should be checked at least once a month.

Medicines cupboards and stocks will be subject to a 3 monthly check by a member of pharmacy staff.

Any losses or discrepancies of medicines stocks must be reported immediately to the Nurse Manager and Pharmacy Department and an incident form completed.

5.3 Medication in the Home

Community Staff are reminded that the responsibility for medication in a patient’s home lies with the patient or carer and they should not assume responsibility for any aspect relating to storage and security of that medication other than giving advice. They should share any concerns with the patient’s Doctor or Pharmacist.

5.4 Transport of Medication by Community Staff

Community Staff should only transport such medications for the purposes of treatment as they would expect to use in exercising their professional duties. In the case of controlled drugs these should not be transported routinely and should only occur where there is no other reasonable mechanism available. All drugs should be kept out of sight during transportation. (See Standard 7, NMC Standards for Medicines Management)

In situations where Controlled Drugs need to be removed following a patient’s death a risk assessment must be carried out by the health professional identifying the risks of other methods of disposal (i.e. a relative removing to a pharmacy) against the risk of the healthcare professional removing the medication.

5.5 Security of Prescription Pads

Prescription pads should either be kept on the person of the prescriber to whom that pad is coded or in a locked drawer/cabinet within health board premises.

In the event of loss, suspected theft or forgery, the prescriber must report this immediately, or as soon as possible, to NHS Borders Pharmacy Service (the Director of Pharmacy) and where appropriate to the NHS Borders Non Medical Prescribing Administrator. Local police in the area from which the pad was lost or stolen should be informed as soon as possible.

A Datix report should be completed by the practitioner concerned. This should include details of the numbers of prescriptions missing, when they were last seen/first missing and whether there were any witnesses to a theft.

NHS Borders Code of Practice for the Control of Medicines
Pharmacy systems will be responsible for notifying local Community Pharmacists and deciding upon action to minimise the abuse of the forms. This will include instructions to the prescriber to sign all scripts in a particular colour (usually Red) for a period of two months.

If the theft occurs during a weekend/Bank Holiday the prescriber should notify the on-call Manager and on-call Pharmacist of the incident. If the prescriber is non medical then the Non Medical Prescribing Administrator will also need to be informed on the next working day.

It is the responsibility of both the prescriber and the employer to ensure that prescription pads are retrieved from prescribers who leave NHS Borders employment. Old pads should be returned to the BGH Pharmacy or NMP administrator where they will be destroyed, by incineration, once the serial numbers have been recorded.

**Prescription Fraud**

Prescribers should be aware that if a fraudulent prescription is suspected by a Pharmacist, they will contact the prescriber in order to clarify that the prescription is genuine. The pharmacist may also contact the prescriber if they or their signature is unknown to them.

**Algorithm for Prescription Pad Loss/Theft**

![Algorithm Diagram]

(All numbered steps to be completed by the prescriber. Steps a), b) and c) will be completed by Pharmacy Staff).
5.6 Cold Chain

To avoid waste is being generated by cold chain medicines that require to be returned to pharmacy but are being left out of the cold chain.

The process of returns of ward/patients own medicines that require storage within the ‘cold-chain’ is detailed below. There is a high risk of expensive waste being incurred when medicines are left out of the cold-chain therefore it is imperative that staff follow this process for returns.

A clearly marked pharmacy returns area is located in all ward cold storage areas. This consists of an orange tray marked “Pharmacy Returns”.

1. Ward staff must place any cold chain items (Including Patients own drugs) to be returned to pharmacy in the returns section of the ward fridge (orange tray).

2. During the ward top-up process the pharmacy ATO will check and collect any items in the fridge returns tray.

3. The pharmacy ATO will then remove the items and return them to pharmacy.

4. Items returned to pharmacy will be stored in the returns section of the main pharmacy cold store for immediate processing.

For further information on the cold chain process/arrangements please refer to the NHS Borders Cold Chain Policy.

Medication fridges should be hardwired to the electricity supply where possible or a secure plug system used to avoid inadvertent disruption to refrigeration from fridges being unplugged.

6. PRESCRIBING

6.1 Authority to Prescribe

Medicines may only be administered on the authority of a prescription, patient group direction or other agreed procedure, approved by NHS Borders. This includes oxygen, which is a Prescription Only Medicine (POM).

All prescribing should follow the guidance in the NHS Borders Joint Formulary and be limited to medicines approved by the Area Drug & Therapeutics Committee.

A range of health professionals have authority to prescribe. This may be a statutory authority, e.g. extended prescribing rights, or supply and/or administration by means of a Patient Group Direction approved by the Area Drugs and Therapeutics Committee (ADTC) and NHS Borders, following the requirements within Patient Group Directions NHS HDL (2001) 7
Provisionally registered medical staff may not write private prescriptions.

Prescribers must not prescribe medicines for staff or visitors unless they are being treated in the normal course of being a patient or under an agreed policy (e.g. needlestick injury).

**Non Medical Prescribing (NMP)** - Registered Professionals from specific groups are able to prescribe if they have qualified from an accredited NMP training program. The scope of their prescribing practice depends on the level of prescribing training they have achieved and any legislative restrictions that may exist. The three levels of prescribing practice are outlined below:

1) Independent Prescribing - Involves the ability to prescribe as an independent practitioner from the full range of the British National Formulary but within the limits of the individual's own competence.

2) Supplementary Prescribing - Prescribing as a supplementary practitioner in partnership with an Independent Medical Prescriber and with the agreement of the patient. Supplementary Prescribers must use an agreed patient specific Clinical Management Plan to inform their practice.

3) Community Formulary Prescribing - This is a nursing specific route of prescribing where following educational preparation a nurse can prescribe from the set Nurse Prescribers Formulary and are limited to prescribing for the specific set conditions laid out within the formulary.

**6.1.1 Pharmacist Amendments**

Within NHS Borders units prescriptions may be amended by pharmacists in respect of drug, dose, route or frequency of administration. Significant amendments will normally be discussed with or reported to the prescriber. Such amendments, signed by the pharmacist, are accepted as the definitive prescription. Prescriptions may also be instituted by pharmacists at the request of a doctor. Pharmacists will write in green, which other professionals should not use.

**6.1.2 Prescribing for Children**

Prescribing for children should follow the recommendations of the BNF for Children, Simpsons Memorial Maternity Pavilion guidelines for neonates and the Royal College of Paediatrics and Child Health ‘Drugs for Children’.

**6.1.3 Prescribing Unlicensed Medicines/Outside Licensed Indications**

Prescribers may require to prescribe medicines that are unlicensed or for indications outside the licensed indications of a medicine. Prescribers will be taking responsibility for the effects of that medicine rather than the manufacturer. See NHS Borders Policy for the use of unlicensed (and off-label use) Medicines. For paediatrics refer to: THE USE OF UNLICENSED MEDICINES OR LICENSED MEDICINES...
FOR UNLICENSED APPLICATIONS IN PAEDIATRIC PRACTICE (a statement from the Standing Committee on Medicines, a joint committee of the Royal College of Paediatrics and Child Health and Neonatal and Paediatric Pharmacists Group).

Non-Medical Prescribers should refer to the NHS Borders Non Medical Prescribing Policy.

Unlicensed medicines should not be used until approved by the ADTC.

The General Medical Council provides guidance for prescribers in their document ‘Good Practice in Prescribing and Managing Medicines and Devices’ (2013) when either prescribing a medicine outside the terms of its licence (off label) and when prescribing unlicensed medicines. This guidance can be accessed on the GMC website at: [http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp](http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp)

### 6.2 In-Patients

**Use of the Medicine Chart**

When writing prescriptions, the advice given in the British National Formulary (under “Guidance on Prescribing”) should be observed.

The following important points must be adhered to when using the medicine chart:

a) **Ensure that all personal details** of the patient, including the unit number and the weight, if available, are entered.

b) **The date** of prescribing must coincide with the date of commencement of regular prescriptions, or the date on which once-only prescriptions are given.

c) **The name of the medicine** must be clearly legible, preferably in capital letters.

d) **The approved name** must be used for a medicine wherever possible. Where applicable, the proprietary name may also be used, eg combination products and in cases where different brands are not equivalent.

e) **The dose** must be written clearly in the metric system. Wherever possible the use of decimal points must be avoided by the use of micrograms (or nanograms).

The abbreviations ‘g’ and ‘mg’ may be used for grams and milligrams respectively.

Micrograms, units or nanograms must not be abbreviated.

f) **The time of administration** must be specifically indicated, using the 24 hour clock.
g) The **route** of administration must be clearly indicated.

Only the following **abbreviations** may be used:

- IV Intravenous
- IM Intramuscular
- SL Sublingual
- TOP Topical
- PR Per Rectum
- INH Inhalation
- SC Subcutaneous
- NEB by Nebulisation
- PV Per Vaginum

Other routes of administration must be written in full.

h) **“As required”** prescriptions shall:
- Include the **symptom** to be relieved.
- State the **exact minimum time** between doses.
- Where appropriate, the **maximum daily dose** should be indicated. This may be endorsed by the pharmacist.

i) The prescriber must **sign** the prescription and **print** their name on the medicine chart, if their signature is not clearly legible.

j) ♦ The minimum number of medicine charts should be in use for each patient at any one time.
♦ The original date of commencement of each prescription must be used.
♦ When re-writing a medicine chart it is good practice to have it checked by a second member of staff.
♦ Please note that there are different formats of the Borders Medicine Chart available depending upon the clinical area:

k) **Supplementary Sheets**
When used for prescribing, the prescriber must indicate the supplementary sheet in use on the **main medicine chart**. For example: warfarin chart, continuous infusion chart.

l) **Discontinuation or Cancellation of Medicines**
Medicine charts should be reviewed frequently by medical staff with particular reference to cancellation of treatments which are no longer required. Prescriptions should be rewritten rather than amended when a change is required.

**To discontinue a “Regular” or “As required” prescription:**
- a straight line must be drawn through the drug name,
- the date discontinued written in the appropriate box,
- the discontinuation must be initialled,
- a diagonal line may be put through the remaining spaces for drug administration recording.
- If a dose(s) to be given on day of discontinuation this must be made very clear on the chart.
Do not make the drug being discontinued unreadable.

m) **Regular Medicine Check**
The medicine chart may have prescriptions written on several pages of the form and these may not all be visible at the same time. To avoid the potential problem of prescriptions being overlooked **all users must check all pages** of the chart when administering or prescribing medicines.

n) Medicine charts are **controlled stationery**. Reasonable precautions must therefore be taken to ensure that blank documents are not available to non-authorised persons.

o) Any weight related doses need to be documented on the inpatient medicine chart.

p) Completed or old medicine charts should be filed in the patient notes.

**Verbal Instruction**

a) Verbal prescriptions by **telephone** are permitted for situations when the prescriber cannot be present immediately. This does **not** include Controlled Drugs which must be prescribed in person.

**Inpatient Units**

The message must be taken by a registered nurse/midwife and verified by a second registered nurse/midwife (or other competent member of staff if not available).

- inform the doctor of the name and dosage of other medicines currently prescribed for the patient,
- write the full details of the verbal prescription on the appropriate section (once only, regular or PRN) of the medicine chart, entering “V/O” (for verbal order) and the doctor’s name in the signature box.
- the second member of staff reads the prescription back to the prescriber to ensure the message has been understood correctly.
- the doctor must subsequently sign and date the prescription on the medicine chart within 24 hours (up to 72 hours in community/mental health units).
- the need for the prescription to be signed will be highlighted by marking/affixing a red dot in the box requiring signing.

b) In the case of an emergency situation, where a doctor present in the ward/department gives a verbal instruction for administration of a medicine, the nurse/midwife must check the medicine and measured dose with the doctor before administration.

The normal procedure for recording the prescription and administration of medicine must be followed.
6.3 Patient Group Directions (PGDs)

It is usually necessary that all medicines administered or supplied to a patient by a practitioner be done so on the authority of an authorised prescriber. Patient Group Directions allow specific professional groups of staff to administer and/or initiate a supply of medicines without the authority of an authorised prescriber. Patient Group Directions must be authorised by the Medical Director, Director of Pharmacy, clinical lead (i.e. Director of Nursing and Midwifery for PGDs used in Nursing/Midwifery), and Area Drugs and Therapeutics Committee on behalf of NHS Borders.

Patient Group Directions (PGD) must contain the following requirements:

- Details of the condition or situation to which the PGD applies.
- Details of which patients are included and excluded from the PGD and what action to take if patients are excluded.
- A description of the treatment available under the PGD including dose, frequency and the aims of the treatment.
- Characteristics of the professional staff authorised to supply or administer treatment.
- Details of records to be kept for audit purposes.
- Details of practitioners responsible for drawing up the PGD.
- Signatures of the Medical Director, Director of Pharmacy, and Lead Practitioner of Profession(s) eligible to work under the PGD.
- Date for Review.

When developing PGD’s the NHS Education for Scotland resource: ‘To PGD or not to PGD’ should be used to identify whether the planned implementation of the PGDs fits within the legislative framework.

It is the responsibility of the appointed practitioner in charge of each clinical area to ensure that if medicines are administered or supplied under a PGD that it is valid, the practitioner is authorised to work under the PGD and all appropriate documentation is completed.

Copies of approved PGDs must be available in the areas they are to be used.

A practitioner working under a PGD cannot delegate responsibility for administering and/or supplying a medicine under the PGD.

The Area Drugs and Therapeutics Committee are responsible for monitoring all Patient Group Directions in use and for ensuring the Patient Group Directions are reviewed in a timely manner (usually 2 years).

Individual practitioners are responsible for ensuring that they maintain their competency to work under a PGD and that they access any appropriate training required.
6.4 **Patient Specific Directions (PSD’s)**

A PSD is a written instruction from a qualified and registered prescriber for a medicine to be supplied or administered to a specific named patient. This should include full written details of dose, route and frequency. Details of any appliance to be used will also need to be detailed.

A PSD can be written in patients notes, on a patients medicines chart or, with the example of routine vaccinations could be written for a list of patients as long as each patient to be treated is specifically named on the PSD.

PSD’s differ in their application to PGDs as they can be used in planned care situations. PGDs are developed specifically as an option for unplanned care.

In the case of controlled drugs it is essential to comply with full prescription requirements.

6.5 **Medicines Act Exemptions**

Exemptions allow specific groups of healthcare professionals to sell, supply and administer specific medicines directly to patients. Professionals may only supply and administer under an Exemption order where the order pertains to them. Examples of professional groups that have access to exemptions include; Midwives, Occupation Health Nurses and certain Allied Health Professionals.

6.6 **Patients’ Relatives**

**Borders General Hospital**

Although relatives or visitors of patients should not routinely have medication prescribed for them by BGH staff, there are rare exceptions when prescribing is appropriate. For example, if a relative has left essential medication at home and cannot obtain it in a reasonable time and it is deemed important for them to receive it, then sufficient doses may be prescribed and administered, until they can retrieve their own medication. This is not available for other members of the public or staff.

Prescribing should be by fully registered doctors and on a patient medicine chart (which can be filed in the pharmacy if the relative does not have BGH case notes) in line with the NHS Borders Code of Practice for the Control of Medicines.

Prophylaxis for infectious diseases may be prescribed by public health doctors or the Consultant Microbiologist.
6.7 Out-Patients

6.7.1 Out-Patient Clinics (BGH and Outreach)

a) Changes in medication required for patients attending out-patient clinics will be referred to their general practitioner and should be in accordance with the Joint Formulary.

b) In exceptional circumstances, when prescribing and dispensing is necessary, the Borders General Hospital out-patient prescription form may be used or an HBP prescription which can be taken to a community pharmacy for dispensing. HBP prescriptions may be dispensed by a Community Pharmacist or the BGH Pharmacy. Prescribing should normally be for a maximum of 4 weeks unless the consultant is treating the patient on an ongoing basis. Routine repeat prescribing will not normally be provided from out patient clinics, responsibility for repeat prescribing remains with the patients G.P.

Prescription charges will be applied where appropriate.

c) Once only medicines which are required to:
   i) be given to facilitate investigations being carried out, or
   ii) for urgent treatment.

These must be prescribed and the administration recorded in the patient’s case notes. Prescribing and administration must be carried out in accordance with this Code of Practice.

d) Where repeat administration of medicines is required for patients attending clinics, the BGH Medicine Chart must be used, e.g. Dermatology dressing clinics.

The guidance given in Sections 1 and 2 should be followed.

6.8 Emergency Department (ED) & Borders Emergency Care Service (BECs), BGH

6.8.1 Medicines Required In ED or BECS, BGH

ED - “Once only” prescriptions may be prescribed and the administration recorded on the Emergency Department record, otherwise the Borders General Hospital Medicine Chart should be used.

BECs - All medicines must be prescribed on the GP10 prescription forms, either electronically or on paper forms if in patients’ homes and recorded on Adastra.

There are specific arrangements for the prescribing of controlled drugs within the Emergency Department setting. This includes restrictions around the prescribing of strong opiates by prescribers working within the department unless signed by the ED consultant in person. For full details please see the Emergency Department
Analgesia and Benzodiazepine Policy.

The guidance given in Sections 1 and 2 should be followed.

6.8.2 Medicines Required At Discharge

The prescriber will use the BGH Outpatient Prescription Form (which comes to the Pharmacy for dispensing) or HBP/GP10 (for community pharmacy to dispense) to prescribe medicines at discharge.

When prescribing in this context a 7 day supply should be the standard amount supplied at the point of discharge.

Out with Pharmacy hours, a doctor or registered nurse may issue these drugs from those available as pre-packs for this purpose. The nurse or doctor must complete the required details on the pre-pack label.

Where other drugs are required for A&E attenders at discharge outwith Pharmacy hours the prescriber may use prescription form HBP. This prescription may be dispensed by a Community Pharmacist.

6.9 Prescribing of Medicines in Hospital - Discharge Medications

6.9.1 At discharge from hospital in-patients receive a minimum of a 7 day supply of medicines and other required products, unless a shorter period completes a treatment course, or if it is a part of the patients care plan. These medicines are prescribed on the NHS Borders Immediate Discharge Letter or appropriate community documentation and dispensed in the BGH Pharmacy. For patients going home on warfarin the Warfarin Prescribing and Monitoring Form must be completed and sent with the immediate discharge letter. For patients going home ‘on pass’ (i.e. to return in a few days) medicines must be prescribed in the same way as discharge medicines.

♦ When prescribing, prescribers must:
  a) rationalise all drugs being prescribed
  b) indicate the period of continuation for therapeutic courses
  c) record which drugs have been discontinued during the inpatient episode and why
  d) ensure that any items for ongoing use that are not included on the inpatient Kardex are provided at point of discharge e.g. wound products, catheters, stoma products etc.

For Controlled Drug prescriptions the following additional legal requirements apply:

  a) the prescription must be printed or written in ink.
  b) it must be signed and dated by the prescriber.
It must state the following:

c) the name and address of the patient
d) the form of the preparation (eg tablets, injection, solution).
e) the strength of preparation
f) the dose and frequency of administration
g) the total quantity to be dispensed in **both words and figures**, e.g. Twenty (20) tablets or TWO hundred (200) ml.

♦ All 3 copies of this form should be sent to Pharmacy for dispensing along with the patient’s medicine chart and warfarin chart, if on warfarin. Interventions made by pharmacists to clarify prescriptions must be written and initialled on the prescription

♦ See Community Hospital Discharge Policy

**Short Notice Discharge - Community Hospitals**

If insufficient notice is given of a patient being discharged from a community hospital, a general practitioner or non-medical prescriber may prescribe medication on prescription form GP10 or GP10 (NMP). The prescription is then dispensed by a community pharmacist.

**6.10 Doctors Own Prescribing**

Doctors own prescribing is not permitted within the Borders General Hospital. This has been allowed in the past but following de-registration of the BGH Pharmacy in 2012 private prescriptions can no longer be dispensed.

**7. DISPENSING**

All medicines prescribed should be dispensed in a form suitable to go to a patient or to a health care professional for administration to a patient. This includes the provision of stock medicines to wards and departments, dispensing of medicines for out-patients, in-patients and for discharge. Only pharmacy staff may dispense medicines for patients, except where an alternative policy has been agreed with NHS Borders.

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Some medicines may be dispensed in “pre-packs” ready for patients to take home from the emergency department and some wards. A registered nurse may issue these medicines after receiving a signed prescription and completing any details required on the pre-pack.

**7.1 When Pharmacy is closed** the following arrangements apply for discharge medications. These arrangements should only apply in **exceptional circumstances** as normal practice should encourage the early prescribing of discharge prescriptions for evening or weekend discharge, so that these may be dispensed in Pharmacy and the use of POD/Patient Pack medicines already dispensed by Pharmacy.
A discharge prescription form is written as above.

Supplies of medicines may be issued by a registered nurse/midwife and checked by a second registered nurse/midwife (or other competent witness if in a situation where a second qualified nurse is not available) both of whom must initial the prescription.

Containers and labels supplied by pharmacy must be used.

Ward medicines stocks should be used.

The container must be labelled with the following details:
- a) name of patient,
- b) date of issue,
- c) name and strength of medicine,
- d) quantity issued,
- e) directions for use,
- f) “Keep out of reach of children”,
- g) appropriate supplementary labelling instructions as detailed in the British National Formulary (BNF), eg with or after food,
- h) the ward and hospital address.
- i) The medicines patient information leaflet included where possible.

A record of these issues must be made on the discharge prescription form.

Discharge prescriptions with Controlled Drugs must not be dispensed from stock, the On-Call Pharmacist must be contacted.

8. ADMINISTRATION AND RECORDING OF MEDICINAL PRODUCTS

Actual administration to the patient shall be accomplished in one of the following ways:

a) Administration by a registered nurse/midwife/AHP or other appropriate registered health professional (practitioner).
   (Student nurses/midwives will participate in the administration and recording of medicinal products, at the appropriate level for their training, as outlined in the relevant practice placement assessment documents. This will be under the direct supervision of a registered nurse/midwife.)

b) Self-administration by an in-patient in designated areas, in accordance with policies approved by medical, nursing and pharmacy staff.
8.1 Where a system of one practitioner administration is used the practitioner must follow full checking procedures.

Medicines may be administered by a single practitioner except administration that involves:

a) Controlled drugs

b) Calculation of dose (or calculation of the quantity of drug to be administered)
   A calculation includes a weight related dose, multiple vials or syringes are required to make up a dose, withdrawing a set dose/volume from a vial and not using the whole contents.

c) Administration to children under 16

d) Weight-related dose

e) IV administration

In which case a second registered practitioner must check all aspects of administration.

When a second registered practitioner is not available for checking then a suitably trained unregistered professional e.g. healthcare support worker may provide the second check.

Lone practitioners administering medicines in the community e.g. on domiciliary visits, may administer subcutaneous, intramuscular and non-complex intravenous medicines and controlled drugs within their own level of competency.

In community practice where there is an NHS Borders approved protocol for a specific medicine or medicines, then the requirement for a second practitioner check can be mitigated by the use of appropriate checks within the protocol, which must be clearly documented. (e.g. Treatment Dose Low Molecular Weight Heparin: Protocol for Transfer of Care to Home (Short Term)).

♦ Where calculations are made it is important that each person carries out the calculation separately. This avoids two people making the same mistake.

♦ A record of administration must be made and the administering nurse/midwife identified. Where a second nurse/midwife checks the administration of a medicine the identity of the checking nurse/midwife must also be recorded. The ultimate responsibility remains with the administering nurse/midwife. In addition, where a Controlled Drug is administered, a record must be made in the Controlled Drug register by the nurse administering and the checker.

♦ Medication refused or wasted must be similarly recorded as detailed on the
medicine chart and if a **Controlled Drug** a record must be made in the Controlled Drug register.

- One registered nurse/midwife may administer intravenous additives for infusion, which have been prepared in a ready to use form as follows:-
  - by the pharmacy department
  - by medical staff
  - by nursing/midwifery staff in specific areas under an approved policy.

**Weight-related dose**
Standard 8 of the NMC Standards for Medicines Administration (2010) states:
- “you must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications”
- “you must have considered the dosage, weight where appropriate, method of administration, route and timing”.

Weight may not always be available and in emergency or exceptional circumstances it may be necessary to use judgement to estimate weight.

**IV Administration**
Standard 20 of the NMC Standards for Medicines Administration (2010) states:
- “Wherever possible two registrants should check medication to be administered intravenously, one of whom should also be the registrant who then administers the intravenous (IV) medication”.

This includes calculation of flow rates for administration of intravenous drugs. A record is made on the IV charts of the persons involved in the setting up of the medication which is administered continuously.

A suitably trained unregistered support worker may provide a second check when a second registered practitioner is not available. When a witness is required to administer medicines all steps of the procedure must be witnessed independently and both must sign all relevant documentation.

Where it is not possible for a second person to check administration e.g. administration takes place in the patient’s home, a risk assessment must be undertaken, and the action taken to minimise the risk must be documented. For example, a nurse administering a drug they are unfamiliar with in the community should double check the details with a suitably qualified registered practitioner before administering. For palliative care this will be the Margaret Kerr Unit or a Marie Curie nurse.
8.2 Administration

Before administering a medicine the nurse/midwife must ensure that the prescriber’s instructions concerning drug, dosage, time and route of administration are clearly written and UNDERSTOOD. If there is any uncertainty or doubt about the prescription the nurse/midwife must not administer the medicine and must IMMEDIATELY consult a prescriber.

The nurse/midwife should satisfy themselves that the patient has consented to receive treatment.

In addition, each registered nurse/midwife is accountable for her/his practice and is individually responsible for ensuring that she/he has up to date knowledge of the drugs being administered and their side effects as detailed in the NMC Guidelines for Administration of Medicines.

a) Ensure that all personal details including the CHI number and weight, if available, are entered on the medicine chart.

b) Read each prescription carefully. The prescription must be clearly written and unambiguous.

c) Check that the prescribed dose has not already been administered.

d) Select the medicine required and check the label with the prescription, noting any special instructions regarding administration or any drug sensitivities/allergies and checking the expiry date of the medicine where available.

e) If administering staff are reasonably concerned that they are unable to identify a medicine by its’ appearance/packaging then this should be discussed with a clinical pharmacist (in hours) or on call pharmacist (out of hours) who, with the administering staff, will identify if there is a further supply of the medicine available and/or assess the potential risk of omitting the medicine(s) and advise accordingly.

f) Check the dose prescribed and the route of administration and perform any necessary calculations with a second nurse/midwife.

g) Take the medicine and the prescription to the patient.

h) Check that the name and CHI number on the patient’s medicine chart corresponds with the name and unit number on the patient’s identity bracelet or use an alternative method of confirming the patient’s identity if bracelets are not in use (eg. patient photograph).

Nurses/midwives should always stay with the patient until the medicine has been taken. Medicines must not be left on a patient’s bedside locker unless special instructions have been given (eg. glyceryl trinitrate, inhalers).
At the bedside the nurse/midwife must then make a clear, accurate and immediate record of medicines administered, intentionally withheld or refused on the medicine chart. The current date must be entered in the column across the top of the page of the medicine chart. The initials of those involved in the administration of a medicine must be recorded in the appropriate space.

**Controlled Drugs:**

Administration and/or wastage should be recorded in the Controlled Drug register.

i) If a medicine is not given, the appropriate code number for the reason must be recorded. Substances prepared for administration and subsequently not given to the patient concerned must be rendered irretrievable by emptying into a sharps bin in the presence of the person checking the drugs, where appropriate. They **must not** be returned to the container from which they were removed. If Controlled Drug injections are wasted this must be recorded in each section from which drugs were issued (i.e. if Diamorphine 10mg and 30mg injections were used to make up the injection then it should be recorded on both pages).

Where tablets need to be halved to administer the correct dose, the remaining half must be disposed of, as detailed above.

j) If a **missed** dose is given later to a patient, the date and time of administration must be recorded in the ‘Administration Comments’ column of the medicine chart.

k) Patients who have been ordered “nil by mouth” prior to surgery or other procedures should have their regular medication administered with a small amount of fluid, unless there is a specific instruction to the contrary.

l) If a decision has been taken that a patient may self-medicate this must follow a written protocol drawn up after discussion locally by nurses, doctors and pharmacists. The prescriber must record the prescription by writing it in the usual manner, with “Self-admin” noted on the medicine chart. For each day that the patient self-administers, this must be written across the administration record. Where insulin is self-administered the patient must record the dose given and time of administration on the diabetic chart to ensure there is a clear record of each administration.

If an error or near miss is made or observed in drug administration or prescribing, then it must be reported via the DATIX electronic reporting system as a medication error.

**8.3 Covert Administration of Medication**

This section should be read in conjunction with the Mental Welfare Commission for

Covert administration of medication should only ever be considered as a last resort and only in situations where the Mental Welfare Commission Guidance can be applied in its entirety.

Types of covert administration:
- Administration of medication where the medicinal product in hidden such as in a drink or food without their knowledge/awareness.
- If administration within a food/drink/yoghurt for swallowing difficulty has not been fully disclosed and discussed with the patient/their carers/relatives.

Not classed as covert administration:
- Medicine that is given in a food/drink/yoghurt purely to aid swallowing on the advice of a specialist (Speech and Language Specialist/ Pharmacist/ Medical Staff) and where the patient understands what they are being given and the reasons for it being given in this way.

Any incidence of covert administration of medication where the Mental Welfare Commission guidance is not followed could result in disciplinary action for any staff involved.

9. ADMINISTRATION OF PARENTERAL MEDICINES

Intravenous (IV) Cytotoxic Chemotherapy should only be administered by a chemotherapy trained nurse, appropriate consultant or appropriately trained other grade of hospital doctor and only reconstituted for use/dispensed by the BGH Pharmacy Chemotherapy and Aseptic Dispensing Unit (see Guidelines for the Safe Use of Cytotoxic Chemotherapy in the Clinical Environment).

Parenteral Nutrition solutions must only have additions made to the bag by the BGH Pharmacy.

Prescribing and administration of IV drugs by anaesthetists in Theatres should follow locally agreed professional standard operating procedures.

9.1 Prescriber’s Responsibility

- It is the prescriber’s responsibility to ensure that all routes of administration are considered before prescribing intravenously.

- That the medicine to be given by the intravenous route is appropriate for this method of administration and for the vehicle in which it is to be given.

- Prescribers must ensure that they are fully competent to prescribe IV medicines as the prescriber holds responsibility for that prescription.

- The prescriber must ensure when they write prescriptions for this form of therapy that their instructions are complete and clear. They should also be
aware of the extent to which this policy allows them to delegate responsibilities concerned with the addition or administration of medicines via intravenous infusion fluids.

9.2 Responsibility for Administration

Registered health professionals who have completed IV therapy training may administer intravenous drugs. It is the practitioner’s responsibility to achieve the competencies within the NHS Borders IV Therapy Program before being considered to be competent in administering or preparing medications for administration by the IV route.

The NHS Borders IV therapy programme is comprised of the following constituent parts:

- Pre-training online numeracy assessment
- Anaphylaxis Training
- Infusion Device Training
- Intravenous Therapy training day

All IV practitioners must undertake IV Therapy Theory Update training every 3 years

I.V. Practitioners must demonstrate practical competence annually through PDP
Formal reassessment of practical competence must be undertaken every 3 years

- One of each relevant intravenous preparation and administration methods must be supervised and assessed by a peer I.V. supervisor/assessor
- Intravenous therapy supervisors/assessors must meet the standards for theoretical and practical update.

Before undertaking the preparation of a drug additive to an intravenous infusion or the administration of an intravenous drug, the practitioner must ensure that the prescriber’s instructions are clear and complete.

A practitioner must exercise professional judgement in determining the suitability of IV administration and must be prepared to seek further advice if necessary before administration (For nurses/midwives - NMC The Code (2010), NMC Guidelines for administration of Medicines (2010) HPC – Standards of Conduct, Performance and Ethics (2008) (Also see the professional standards of proficiency developed for each profession registered with the HPC)).

Practitioners involved in checking, preparing and administering medication by the intravenous route should witness the whole process from preparation to administration.

Registered health professionals that may administer IV medicines after completing IV Therapy training are: nurses/midwives, AHPs and doctors.

Registered staff may delegate IV practice to appropriately trained unregistered staff when supported by an organisationally approved framework. This must take into consideration the competence of the unregistered staff and have been
reflected within a clinical service risk assessment.

Any of the above practitioners plus pharmacists may check IV medicine administration.

Anaesthetists in operating theatres may calculate doses and administer IV drugs alone within the framework provided by the Controlled Drug Theatres Standard Operating Procedures.

### 9.3 Pharmacy Service Responsibility

It is the pharmacy service’s responsibility to provide an intravenous additive service for those products identified as requiring preparation in a pharmacy aseptic unit.

- The pharmacist must provide advice on all aspects of intravenous therapy and should direct health care workers to appropriate literature sources for information. The pharmacist must help maintain any information required for their ward policies.

- The pharmacist also has an important role to play in monitoring prescriptions and in highlighting problems concerning safety, stability and compatibility.

### 9.4 Dosage Calculations by the Intravenous Route

Two persons must always be involved in all aspects of administration of medicines when given by the intravenous route. This is particularly important when complex dosage calculations are involved. (Complex calculations are defined by the NMC for the purposes of administration as any calculation which involves two stages or more), (Also see; NPSA – Safer administration of medications for injection).

- these must be independently calculated and the dosage verified before administration
- additional care must be taken with neo-natal, paediatric and low weight adults (below 50kg) dosage calculations
- particular care must be taken when calculations involve a decimal point
- all calculations should be written on paper, not solely done by mental arithmetic or electronic calculator
- a record of the calculation should be filed in the patient’s case notes
- all practitioners involved in IV calculation must meet NHS Borders standard for numeracy competence

### 9.5 Authority to Prepare IV Additives

- Medicines may be added to intravenous infusion fluids by:-
  a) pharmacy department as part of an intravenous additive service
  b) practitioners who have completed specific NHS Borders approved training on the Principles of Intravenous Therapy Management

- In an inpatient setting the nurse in charge must be satisfied that the nurse having been trained is proficient to administer medicine by the IV route. Registers must be kept of all participants of the above training.
All practitioners are required to complete an IV therapy and numeracy update every 3 years and review competencies as part of their annual Personal Development Plan/Appraisal.

The training programme must be approved by the Director of Nursing and the Director/Deputy Director of Pharmacy.

Being IV Therapy trained authorises a practitioner to add a single drug to:
- a standard infusion fluid container (bag/bottle) of appropriate volume for continuous or intermittent infusion
- an appropriate sized syringe with or without diluent for continuous, intermittent or bolus injection in an existing cannula

Some methods of administration and appliances used are specific to certain clinical areas. There is both an individual and managerial responsibility to ensure that competence is maintained for the appropriate methods/appliances.

9.6 Other Parenteral Routes

Departments that administer drugs via other parenteral routes must have local policies and procedures in place.

9.7 Infusion Pumps and Drivers

This section should be read in conjunction with the NHS Borders Infusion Device Guidelines which can be located on the Medicines Intranet site.

Only registered nurses who have received training in the use of IV pumps and who have demonstrated their proficiency in the use of this equipment may administer medicines intravenously by this means, provided clear and unambiguous written directions are given on the patient’s continuous Drug Infusion Chart or Intravenous Prescription and Fluid Balance Chart.

Practitioners must have achieved the clinical competency assessment relevant to the IV device being used.

A second registered nurse/midwife/appropriate person who has been trained in the use of IV pumps must check that the correct preparation in the prescribed dose is introduced into the syringe and that the syringe is fitted to the correct patient’s pump and set at the correct rate. Both must sign the continuous Drug Infusion Chart or intravenous Prescription and Fluid Balance Chart to verify that these checks have been carried out.

the manager will ensure that a register is kept of nurses/midwives who have received training in the use of IV pumps

a similar procedure should be adopted for subcutaneous pumps
9.8 Prescribing Process and Documentation of Medicines To Be Added To Intravenous Infusion Fluids

- Medicines, which are to be added to intravenous infusion fluids, must be entered legibly and indelibly, on the medicine prescription sheet along with the words “As Charted”. The entry must be signed and dated by a doctor or non medical prescriber with the appropriate level of competence.

- The medicines and the fluid into which they are to be added must also be entered, legibly and indelibly, on the Continuous Drug Infusion Chart or Intravenous Prescription and Fluid Balance Chart and signed and dated by the prescriber.

- The prescription must clearly state:-
  a) The name, strength and volume of the intravenous fluid to be administered.
  b) The name and dose of any medicines to be added to the intravenous infusion fluid.
  c) The rate at which the resultant mixture of medicines and fluid is to be administered.
  d) The time at which administration of the medicines in the infusion is to commence.
  e) The duration of the infusion.

9.9 Labelling and Checking of Medicines Added to Intravenous Infusion Fluids

All containers (bags/bottles/syringes) must be clearly labelled using an intravenous drug additive label. All sections of the label must be complete.

All injections should be labeled immediately after preparation, except for syringes intended for IV flush administration by the person who prepared them.

Under no circumstances should an operator be in possession of more than one unlabelled syringe at any one time, nor must an unlabelled syringe be fitted to a syringe driver or similar device.

Labels used on injectable medicines prepared in clinical areas should contain the following information:

- Name and CHI Number of Patient
- Name of the medicine;
- Strength;
- Route of administration;
- Diluent and final volume;
- Signature of qualified practitioner
- Batch number
All additions to intravenous infusion fluids must be checked before administration commences by registered nurses who are included in 8.2 first paragraph or by a doctor or pharmacist.

Continuous infusions containing drugs must be changed every 24 hours or less if the stability of drug demands this, unless specific recommendations allowing use for longer periods have been agreed by Pharmacy or the IV Therapy Group.

### 9.10 IV Safety Checks

It is expected that the following checks are undertaken every 4 hours for patients undergoing continuous IV infusions:

- All label details (see section 9.9)
- Expiry
- Patient ID
- Device
- Rate
- Volume

### 9.11 Records

- A record of all additions must be recorded in the appropriate sections of the Continuous Drug Infusion Chart.
- A record of intravenous infusion fluids given must be made on the fluid balance chart after the fluid has entered the patient.
- All bolus drugs given must be recorded in the medicine chart as normal.
- Batch numbers must be recorded, for bolus injections this should be recorded on either the Medicines Chart or the Drug infusion chart, and in all other cases this should be recorded in the IV Fluid chart.

### 9.12 Subcutaneous Infusions

A similar procedure to IV pumps should be followed for subcutaneous syringe drivers.
- the NHS Borders Syringe Driver Protocol must be followed. The Subcutaneous Syringe Driver Chart must be completed.
10. **LOCAL PROCEDURES AND GUIDANCE:**

- Standard Operating Procedure for the preparation of medications by injection in near patient areas
- NHS Borders Consent to Treatment Policy
- NHS Borders Symptomatic Relief Policy
- NHS Borders Non Medical Prescribing Policy
- NHS Borders Procedure for Dealing with Unauthorised Drugs or other Suspicious Substances found in NHS Hospital Premises
- NHS Borders BTS Emergency Oxygen Prescribing Guideline
- Hickman care guidelines
- Day Hospital (BGH)
- Day Procedure Unit (BGH)
- Acute Pain Service Protocols (BGH)
- Eye Unit/Hostel (BGH)
- Guidelines for Handling Cytotoxic Drugs (BGH Pharmacy)
- In Use Expiry of eye drops for Hospital In-patients (BGH Pharmacy)
- Patient Group Directions (PGDs) – there are a range of PGDs which are approved and in use in NHS Borders – these can be accessed via the NHS Borders Intranet or the Director of Pharmacy’s office
- Policy For Intrathecal Chemotherapy
- Patients Own Drugs and One Stop Dispensing Procedures (BGH Medical Wards)
- NHS Borders Syringe Driver Protocol
- Aromatherapy For Patients With Cancer
- Clinical Aromatherapy In NHS Borders Mental Health Network
- Palliative Care Medicine Chart Procedure
- NHS Borders Policy for the use of unlicensed (and off-label use) Medicines
- Borders Emergency Care Service Manual
- Controlled Drugs in Community Hospitals Policy
- NHS Borders Policy on the management of Controlled Drugs in Secondary Care
  - Controlled Drug Standard Operating Procedures (Developed for individual clinical services)
♦ NHS Borders Patient Identification Policy
♦ Completion of Health Records Policy
♦ Public Information Policy (PILs)
♦ Registered Nurse Core Competencies
♦ Drugs and Therapeutics Industry Engagement Policy
♦ NHS Borders Infusion Device Policy
♦ NHS Borders Joint Prescribing Formulary
♦ NHS Borders Antimicrobial Guidelines for Hospitals/Community Hospitals
♦ NHS Borders Unlicensed, Off label and Individual Patient Treatment Requests Policy
♦ Emergency Department Analgesia and Benzodiazepine Policy
♦ Medical Treatment Guidelines for Drug Misusers in the Borders Prescribing Protocol
♦ Treatment Dose Low Molecular Weight Heparin: Protocol for Transfer of Care to Home (Short Term)
♦ NHS Borders Cold Chain Policy

All of these documents can be found on the NHS Borders Intranet.
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NHS Borders Code of Practice for the Control of Medicines
12. BIBLIOGRAPHY (not exhaustive)

- Patient Group Directions NHS HDL (2001)
- NMC Code of Professional Conduct, Standards for Conduct, Performance and Ethics Current Edition
- NMC Standards for Medicines Management
- NMC Standards for Nurse Prescribing
- Medicines Act 1968 (and subsequent amendments)
- Poisons Act 1972
- Misuse of Drugs Act 1971
- Standards for NHS Pharmacy - Hospital and Community Services Health Services Accreditation 1998.
- Safe Administration of Intrathecal Cytotoxic Chemotherapy HDL(2002)22
- THE USE OF UNLICENSED MEDICINES OR LICENSED MEDICINES FOR UNLICENSED APPLICATIONS IN PAEDIATRIC PRACTICE: a statement from Standing Committee on Medicines, a joint committee of the Royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists Group
- Royal College of Paediatrics and Child Health ‘Drugs for Children’ 1999
- Good Practice Statement for the Preparation of Injections in Near-patient Areas including Clinical and Home Environments: CRAG Dec 2002
- Mental Health (Care and Treatment Act) (Scotland) 2003 Act
- Adults With Incapacity Act (2000)
- NPSA Promoting the Safer Use of Injectable Medicines; Patient Safety Alert 20 (March 2007)
- NHS Education for Scotland 2006; Guidance for Practitioners in the Preparation and Administration of Injections in Near Patient Areas; Quality Education Framework