Liverpool Women's
NHS Foundation Trust

Administration of Medicines

Version	6.0
Designation of Policy Author(s)	Deputy Chief Pharmacist
Policy Development Contributor(s)	Medical Director
Designation of Sponsor	Medical Director
Responsible Committee	Medicines Management Group (MMG)
Date ratified	12/01/2023
Date issued	05/04/2023
Review date	01/02/2026
Coverage	Trust Wide

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

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1 Executive Summary

1.1 Policy Scope

i. This document lays down the legal requirements and national good practice guidelines laid down for the administration of medicines in secondary care. There has been a redesign of the administration of medicines process and a review of the tools used to monitor compliance with the standards laid down
   - To update to comply with Trust standards on policy construction
   - Incorporate a proposed self-administration of medicines procedures and templates.
   - Incorporate audit tools into the assurance framework
   - To provide a proposed guidance document for quantifying administration of medication errors.
   - To incorporate learning events gained from medication incidents and medicines intervention reports.
   - Incorporate a proposed checklist to review the suitability of patients own medicines before using.

ii. This section of the policy document should describe where in the organisation the policy is applicable, whether it is Trust-wide, a particular ward or department or number of areas.

iii. This policy applies to all employees of the Trust, including bank staff and agency staff working in the Trust.

iv. For the purpose of this document, the Liverpool Women's NHS Foundation Trust will be referred to as the LWH.

v. This policy is to be read in conjunction with the trust policies for:-
   - Prescribing of Medicines
   - Non-Medical Prescribing
   - Safe Storage of Medicines
   - Unlicensed Medicines
   - Management of Controlled Drugs
   - Patient Group Directions
   - Procurement of Medicines

vi. This document exists to provide guidance to all Trust staff on the standards relating to the administration of medicines.

vii. This policy aims to describe the medicines management framework in place at Liverpool Women's NHS Foundation Trust

viii. Managers have a responsibility to ensure that staff are aware of the procedure and the role. This section gives an overview of the guidance within the document

ix. This policy outlines the corporate standards concerning the administration of medicines which are in line with current legislation and national guidelines of good practice. It incorporates the Standards for Medicines Management (NMC 2007), legislative frameworks (including the Medicines Act 1968 and the Misuse of Drugs

Act 1971), Government guidelines and other professional regulations. The policy defines the monitoring processes around the administration of medicines as well as clarifying the roles and responsibilities of Trust staff around policy activity.

x. This policy applies to all employees of the Trust, student nurses, trainee nurse associates (TNA), student ODP's & midwives, bank staff and agency staff working in the Trust. For the purpose of this document, the Liverpool Women's NHS Foundation Trust will be referred to as the Liverpool Women's Hospital, (LWH). The electronic prescribing system and electronic prescribing, (EP), will refer to the Meditech Inc. Electronic Prescribing Module.

2 Introduction

i. The physical act of administration may be by an authorised ODP, nurse, midwife, registered pharmacy staff member or prescriber or by the patient themselves, (e.g. for inhalers or inserting a suppository), following a valid written or electronically generated prescription, or, when authorised to do so following an approved Patient Group Direction, (PGD) or patient specific direction.

ii. Since the task of administering medicines rests largely with the nurses and midwives and OPD's, this document has been written to reflect this. The procedures laid down in this document however also apply to other staff authorised to administer medicines, including medical and non-medical prescribers. Specific circumstances relating to prescriber administration is clarified under the section "Prescriber Administration". (See Glossary of Terms section).

iii. Activity concerning Patient Self Administration requires additional strict guidelines to be followed and as such is referred to in this document under the heading "Patient Self Administration of Medicines". See Appendix 5

iv. Medicines Management is the clinical, cost effective and safe use of medicines to ensure patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm. The Safe and Secure Handling of Medicines, A Team Approach published in March 2005, gives definitive and detailed guidance on medicines management within all NHS organisations in the UK.

v. This policy articulates the framework in place at Liverpool Women's NHS Foundation Trust in order to safely and effectively manage medicines

vi. It is standard practice to allow patients to handle their own respiratory inhalers, e.g. salbutamol, and GTN sprays for angina. This is also authorised practice at the LWH provided that systems are in place to ensure that patients are aware of the need to communicate any changes in their normal administration patterns to medical or nursing staff in order that potential deterioration in the patient's condition can be more actively monitored.

3 Policy Objectives

i. The objectives of this document are to ensure that :-

- Staff are clear on their roles and responsibilities with respect to the administration of medicines.

- Staff are clear about the standards that are expected of them in relation to the process for the administration of medicines.
- Risks associated with the administration of medicines are reduced.
- Patients safely receive the correct medication at the correct dose and time.
- The principals by which the administration of medicines at the Liverpool Women's NHS Foundation Trust are in line with legal and the Department of Health, (DOH), documents, or documents supported by the DOH such as the NMC, those written by the Care Quality Commission, (CQC), formally known as the Healthcare Commission, and the National Patient safety Agency, (NPSA).
- To ensure staff complete correct documentation and apply the correct ratification processes for all new and amended medicine management policies.

4 Duties / Responsibilities

4.1 Executive Level

i. The overall corporate management responsibility for this policy is held by the Chief Executive who designates responsibility to the Director of Nursing and Midwifery. It is their responsibility to support the senior pharmacy manager in providing leadership with regards to the importance of safe and effective administration of medicines.

4.2 Senior Medical and Nursing / Midwifery Staff

i. It is the duty of the senior medical and nursing / midwifery staff to support the senior pharmacy manager and their own risk managers in ensuring that the policy is complied with and a culture is created whereby the administration of medicines process is respected and adhered to.

4.3 Directorate Managers & Matrons

i. Directorate Managers and Matrons have a duty to ensure that there is a robust system in place for the distribution, and dissemination of the policy's existence throughout their directorates and that the standards laid down are met.

4.4 Prescribers

i. Prescribers have a duty to ensure that they prescribe accurately and clearly so that safe administration of medicines can be conducted effectively. It is their duty to ensure that all medication which is intended for the patient to take during their hospital stay is written up and that any medication they administer is recorded accurately.

4.5 Medicines Management Group

i. The Medicines Management Group is responsible for approving policies relating to Medicines Management practice, including the Administration of Medicines Policy. They must ensure that the policy is effectively monitored and any deficiencies noted and acted upon. The Medicines Management Group has a duty to ensure that this policy complies with the Trust's Policy on Policies, "A Framework for Policy Development" before the document is approved.

4.6 Chief Pharmacist

i. The Chief Pharmacist has overall professional responsibility for establishing and maintaining systems for safe administration of medicines and monitoring the policy across the Trust. This is in consultation with the Medical Director and Deputy Director for Nursing and Midwifery. It is the duty of the senior pharmacy manager to provide support and advice to Trust staff on issues pertaining to the administration of medicines.

4.7 Pharmacists and Clinical Technicians

i. It is the duty of the clinical pharmacy staff to support the Senior Pharmacy Manager by identifying any deficiencies of the policy, by way of audit, intervention reporting and medication incident forms, and reporting these deficiencies and outcomes back. They have a duty, by way of training, monitoring and auditing policies at clinical directorate level and working with the clinical risk managers on assessing risk level and supporting any action plans undertaken following the identification of any deficiencies.

4.8 Governance Facilitators

i. It is the duty of the Governance Facilitators to liaise with their directorate pharmacists with respect to risks associated with the administration of medicines and to help identify training requirements of their directorate staff.

4.9 Nursing/ ODP & Midwifery Staff

i. The nurse/ODP or midwife has a duty to ensure that prescriptions are legible, correct and safe before administering any medicines prescribed. They have a duty to question any issue they have concerns about with respect to the medicine they are to administer, either with the prescriber, or via the pharmacist or senior clinician.

5 Main Body of Policy

5.1 General Principles

i. Prior to administering a medicine, a nurse or midwife, or other authorised health care professional, must be clear on what has to be administered, why and how. The nurse or midwife must consider the appropriateness of the prescribed medicine for the patient for whom the medicine is intended.

5.2 Administration of Medicines Process

i. The administration process consists of six main steps
   - Know the patient
   - Know the medicine
   - Check the medicine against the prescription
   - Administer the medicine
   - Record the administration
   - Monitor the patient

   Note: Oxygen requires a prescription.

5.2.1 Know the Patient

i. Make sure that you have identified your patient correctly.
   - Ask the patient to tell you their name and date of birth when it is possible for them to do so.
   - Check this on their wrist band and check the ID number on the wristband to see if this matches with the patient ID number on the prescription or EP screen.

ii. Check the patient's allergies and that the patient is not allergic to the medicine that is prescribed. Ask the patient if they are allergic to anything and check for any allergy cards - e.g. penicillin type antibiotic in a penicillin sensitive patient.

iii. Make sure you are fully conversant with the patient's care plan.
   - It could be that the prescription was intended for another patient and this was prescribed in error for the patient you are about to give it to.

iv. Consider if the medication dosage and method of administration of the medication are appropriate for the patient's needs taking into account their weight? - (eg.PR route in a patient with a colostomy)

v. Check the last time the patient received a dose of this medication in either this form or another.

5.2.2 Know the Medicine

i. Make sure you have knowledge of the medicine, its normal dose and side effects, precautions and contra-indications.

ii. Presentation of the Medicine.
When checking medication prior to administration, things to consider in respect of the presentation should include:-
   - Drug name.
   - Been stored appropriately
   - Drug form, e.g. tablet/pessary, etc. Strength
   - Expiry
   - Liquid should have date of opening

iii. Formulation
   a. E.g. Plain tablet, enteric coated, slow release.

iv. Quality
Medicines must be of a suitable quality. A product must not be given if there is any question as to the integrity of the presentation, (e.g. a liquid containing suspect particulate matter or a damaged label).

v. Label identifier
Is the label clearly written and unambiguous and date of opening.

5.2.3 Check the Medicine against the Prescription

i. Prior to administration, the medicine must be checked against the prescription.

ii. The written or electronic prescription must be available at the patient's bedside when checking the administration.

iii. When reviewing the product to be administered, check it against the prescription and that they are the same:-

- Drug name?
- Drug Form?
- Strength?
- Formulation?

iv. Consider

- Extra vigilance must be observed when dealing with medicines, which have more than one presentation. e.g. aspirin soluble and aspirin EC or nifedipine capsules versus nifedipine tablets. (It is worth noting that bioavailability differences may occur between different preparations. This is particularly so between differing brands of slow release preparations. Pharmacy is available to give advice over these issues.)
- Is the preparation you are about to give appropriate for the route you are about to administer it by? Licensed route of administration - e.g. Has an injection been written up for SC and is only licensed for IM route?
- Is the preparation you are about to give an appropriate design for the way you want to use it?

5.2.4 Administer the Medicine

i. Prior to administering the medicine, check that the time for administration corresponds to the current time. Inform the patient what you wish to give and why.

ii. The physical act and witnessing of the medicine administration

iii. Directly observe the patient taking the medication or administer the medication yourself

- When a medicine is administered to a patient, the authorised person and the witness must ensure that the medicine is “introduced into the body of the patient” and by the appropriate route. This would include watching the patient ingest or applying the medicine.
- Administrations which are undertaken by patients themselves to protect their dignity, e.g. the insertion of a suppository can be verbally confirmed with the patient that the administration has been successfully achieved. This may require an initial administration by a staff member to familiarise the patient with the administration method.

- Alternatively the authorised person must undertake the administration themselves e.g. by injection, insertion etc.
- Should a patient be missing from the bedside, medicines must not be left at the bedside for the patient to take on their return. This act would constitute patient self-administration and also contravenes the Policy on the Storage of Medicines.

iv. The administration of the medicine must be witnessed by a second staff member unless there is an authorised system, within the clinical directorate, of one nurse / midwife/ ODP administration in place.

- One nurse administration is not authorised in the following instances: -

- When there is no authorised system in place for one ODP/ nurse / midwife administration, within the clinical directorate.
- When the administration involves the calculation of a dose
- Administration to children under 12 years (See also Special Circumstances NICU)
- Weight related doses
- Controlled Drugs
- Administration via * intravenous, epidural or intrathecal route. These require specialist training for authorised staff
- Cytotoxic drugs administration
- Pump infusions (at each shift change) – and countersign on the prescription/ fluid balance charts or patients records
- *Flushes to lines are to be considered in their own right as an administration.

Appendix 3 details the roles of student nurses, student midwives, TNAs and student ODP's in the administration of medicines.

Notes

i. Cleanliness is of the utmost importance when handling and administering medicines to the patient. Medicines are not to be physically handled. Use an authorised clean receptacle to place medication in.

ii. Liquid medicines should be thoroughly mixed prior to measuring the dose required. Measurements must be made using an authorised measure, which is the smallest possible for measuring the dose. Volumes of less than 5ml are to be measured using an appropriate sized oral syringe to prevent risk of accidental injection.

iii. All enteral meds should be measured in purple colour coded non-iv compatible syringes as per NPSA guidance also see enteral nutrition policy for drugs whose bio-availability/action is altered by crushing etc.

iv. Topical, rectal and vaginal preparations are to be applied/ inserted wearing protective gloves.

v. Injectable (see Trust injectable medicines policy) are to be prepared in an authorised clean area and prepared immediately prior to administration unless the preparation is of an authorised multi-use presentation. Aseptic Non Touch Technique, (ANTT) must be used to prepare injectable medicines. Staff must have received education and competency assessment prior to administration of parenteral medicines. When multiple parenteral medicines are prepared, they must be labelled and checked. IV flushes, both pre and post administration must be prescribed and administered if infusions are not in progress. IV flush infusions must be prescribed as per NPSA guidelines.

vi. Administration should follow the guidelines laid down on the prescription. When no time is specified, then the administration must be divided evenly between the "waking hours" for regular doses. "When required" doses must have a specified interval between doses which must not be exceeded. The person in charge must be contacted when dosing frequency is unclear or the patient refuses their regular medication.

vii. Regular doses must be administered within one hour of the required time. This is particularly important for antibiotics and other medicines that require maintained blood levels. e.g. certain antiepileptic medicines. Other medicines may require rigid administration timing e.g. some medicines used in Parkinson's disease, and certain instances of acute pain control. In these circumstances it is imperative that doses are given on time.

5.2.5 Record the Administration

i. The administration is to be marked on or against the administration record along with the time of administration. The record must contain the written or electronic signature of the person administering and that of the second authorised nurse or midwife witnessing when required.

ii. A record, with the actual time of administration, (electronically, the timing will be automatic), must be made using the 24hr clock. If the time administered is outside the normal dosing schedule.

iii. Where a dose can be variable (e.g. 1 or 2 tablets: 30mg or 60mg), the actual quantity administered must be endorsed on the chart (or electronically in the identification of dose section in EP administration).

iv. When administration of the medicine does not occur within the specified time, or not at all, a note must be made on the administration chart to this effect and why. Follow the EP guidelines on how to record the actual time given when the entry is by electronic means.

v. If the medicine was not administered, either intentionally withheld or refused by the patient, a record must be made on the administration record as to reason for withholding the dose.

vi. When a medicine is to be administered via a pump e.g. a syringe driver, the person attaching the pump and witness are to sign the administration sheet. Should a pump run for a time period that overlaps a changeover of staff, and then it is the responsibility of the new staff to recheck any pump and contents in accordance with the syringe labels, the pump setting and the prescription. Such a check should be endorsed on the administration chart or nursing notes in accordance with the ward unit procedure. It would be good practice to have such a check witnessed.

vii. At LWH, One nurse administration is NOT authorised in the following instances: -

- When there is no authorised system in place for one nurse / midwife administration, within the clinical directorate
- When the administration involves the calculation of a dose
- Administration to children under 12 years
- Weight related doses
- Controlled Drugs
- Administration via * intravenous, epidural or intrathecal route. These require specialist training for authorised staff
- Cytotoxic drugs administration
- Administration is undertaken by an authorised student nurse (in all instances)
- *Flushes to lines are to be considered in their own right as an administration.

5.2.6 Monitor the Patient

i. All staff are to be vigilant in their monitoring of post dose adverse events. Medicines should always be considered as a cause of adverse events in patients, even if the patient has had no experience of problems in the past with the same medication. (See section on the Adverse Clinical Event following the Administration of a Medicine.)
   - Ensure your patient is responding well to the treatment
   - Be extra vigilant when the patient is receiving a “black triangle” medicine A (a newly introduced medicine which requires extra monitoring).

ii. Ward pharmacists and ward pharmacy technicians check the prescription charts as part of their daily clinical ward duties. A pharmacist will always be available to give advice on any issues concerning medicines.

iii. No medication is to be administered to a patient against an ambiguous prescription. Medicines must not be administered when there is any doubt about the appropriateness, safety etc. of the administration.

iv. When doubt has been raised concerning a prescription, the prescriber responsible for the patient must be informed immediately and the prescription verified and /or rewritten or (re-entered) by the prescriber prior to administration.

v. Should a prescriber fail to respond to such a request then a senior member, (SpR or above), of the medical team should be contacted and informed that the medication has been withheld and why.

vi. Medicines must only be administered to patients from an approved source of supply (i.e. from a supply originating from pharmacy or patient’s own medicine which has been assessed by ward staff and/or pharmacy. Supplies from pharmacy are supplied as ward stock or labelled non stock intended for that named patient.

vii. Medicines belonging to patients must not be used for other patients.

5.3 Professional Groups Administering Medicines

5.3.1 Administration of Medicines by Nurses and Midwives/ODPs/Nurse Associates

i. Only authorised ODP’s, nurses, midwives and nurse associates are allowed to administer medicines. Authorised staff must have and maintain the required competencies to undertake the administration task safely. Students and trainees who have reached a defined level of experience and competency in the specific policies are authorised to administer medicines, but must be witnessed on all occasions by a second qualified staff member, both during and after training.

ii. Following the NMC’s publication of ‘Future Nurse; standards of proficiencies’ (2018) and Standards of proficiencies for midwives’ (2019), student nurses and midwives will now have administration and management of intravenous fluids and medications included within their training programme and can therefore administer medicines via these routes once they have reached a defined level of experience and competency.

iii. Nurse Associates are a new profession in England and are accountable and registered with the NMC. As a registrant, they are accountable for their actions, are required to continue to meet their standards of proficiency and are subject to the regulatory functions of the NMC. Competencies required for administering medicines

safely are included as part of the NMC nursing associate proficiencies and therefore it is expected that they will play a role with medicines. Trainee Nurse Associates (TNA's) are included in those professions able to administer medicines under the direct supervision of a registered health professional, once deemed competent to do so (Standards of proficiency for nursing associates, NMC, 2018).

iv. Nursing associates must complete and maintain the required competencies for medicines administration in line with other staff e.g. nurses and midwives.

v. Nursing associates can administer medication via oral, enteral, topical, intramuscular, subcutaneous, inhalation routes and administer enemas and suppositories in line with a valid prescription.

vi. Nursing associates will **not** manage medicines in the following circumstances;

a. under a Patient Group Direction
b. administer intravenous medications
c. administer controlled drugs as the primary administering nurse but may act as second checker
d. be responsible for the controlled drug keys
e. check and supply controlled drugs at the point of discharge
f. will not delegate the administration of medicines
g. will not administer any medicine prescribed as part of a clinical trial.

vii. The MMG have ratified student nurse & midwives, student ODPs and trainee nurse associates in medicines administration policies and in the fullness of time their role will be incorporated within this policy.

5.3.2 Prescriber Administration

i. Prescribers, including non-medical prescribers, must also follow the above policy. A prescriber must also obtain a second check for the administration process when the circumstances for one nurse administration do not apply. i.e. :-

- When administration involves the calculation of a dose.
- Administration to children under 12
- Weight related doses
- Controlled Drugs
- Administration is via intravenous, epidural, intrathecal route. (This also relates to any flushes administered)
- Cytotoxic drugs

ii. In these instances, a second check is required from an authorised person.

iii. NOTE

- Administration to a neonate will thus always require a second check
- The person administering and checker must be competent and authorised to administer by the route prescribed.
- Single ODP/ nurse / midwife administration may occur provided that the service has in place an approved audit process

5.3.3 Patient Self Administration of Medicines

i. Patient self-administration of medicines occurs when the patient themselves, or their guardian administer the medicines to the patient without the direct supervision of an authorised staff member physically monitoring the administration process. This will still require the need for a written or electronically generated prescription. Careful assessment of a patient's suitability for self-medication especially in the surgical environment must be undertaken and reviewed frequently.

ii. The Trust acknowledges the positive benefits of self-administration of medicines, and is working towards implementation using a risk based approach.

iii. One stop dispensing has been initiated as a precursor to self-administration in selected areas. A self-administration policy has been drafted with a view to implement in the near future.

iv. Note - The endorsing of an administration record is primarily to ensure that an accurate record of administered medication is maintained.

- It is acceptable standard practice to allow patients to handle their own respiratory inhalers, e.g. salbutamol, and GTN sprays for angina. This is also authorised practice at the LWH provided that systems are in place to ensure that patients are aware of the need to communicate any changes in their normal administration patterns to medical or nursing staff in order that potential deterioration in the patient's condition can be more actively monitored.
- Medicines which patients are already taking on admission, (from their GP or other specialist), and are referred to as patient's own medicines, (POMs), still require a prescription to be written prior to administration.
- Leaving patient's own medicines with the patient to administer themselves constitutes patient self-administration and is not currently permitted in this hospital other than those stated above.

5.3.3.1 Special Circumstances

i. Emergency Prescribing and Administration

- Administration of medicines should never occur without a written or computer generated prescription. The only exception to this would be if the patient was in a life threatening situation or in a situation, which would result in permanent injury, should the treatment be withheld. In these circumstances, the most senior nurse or midwife in charge would need to verbally speak to the clinician. Refer to the Policy on Prescribing). Only one dose administration is permitted. A document of the full episode (including circumstances and administration), must be made in the patient's clinical notes. The episode will also require the documentation on a clinical incident report form. If feasible a faxed, electronic or emailed direction would be preferable to a verbal direction.
- In the instances where the Resuscitation team is called, a retrospective record of the therapy given is to be recorded. This therapy must follow the guidelines from the Resuscitation Council (UK) as stated in the Trust's Cardiopulmonary Resuscitation policy, (both adult and paediatric).
- An approved Patient Group Direction may be appropriate when there is a specific course of therapy required in an identified emergency, e.g. emergency oxygen. This will enable a medicine to be legitimately administered without the need for a prescription

5.3.3.2 Midwives Exemptions.

- Under the Human Medicines Regulations 2012, medicines are stratified into various classifications (GSL, P, POM) for which there are different controls and regulations
- Exemptions from the general rules are permitted for midwives.
- A Patient Group Direction is not necessary for midwives to be able to supply and/or administer any of those substances that are specified in medicines legislation under the 'midwives exemptions'.

5.3.4 Errors on Administering Medication

i. Should at any time during or post administration of a medicine it is suspected or proven that an error has occurred in the process, (e.g. wrong medicine, wrong patient, wrong time, wrong dose etc.) the senior nurse or midwife in charge must be informed immediately.

ii. It is the responsibility of the senior nurse or midwife to inform the most senior doctor available of the incident as soon as this is possible. More serious events may require consultant involvement at an early stage. Appropriate steps must be taken in the meantime to ensure patient safety. A pharmacist must be informed of the event as soon as possible so that they can give advice when necessary.

iii. A medication incident must be completed on Ulysses. A full review of the incident must be undertaken in accordance with Trust policy. The procedure on incident reporting must be followed.

iv. Out of Hours'- an adverse event must be related to the person in charge of the relevant area.

v. Ensure that relatives and carers are informed of the error where appropriate.

5.3.5 Administration of Unlicensed Medicines

i. Unlicensed medicines are those items which do not have a product licence (PL) issued by the MHRA.
Definition of off label/unlicensed medication:-

Off Label medicine is the use of pharmaceutical **drugs** for an unapproved indication or in an unapproved age group, unapproved dosage, or unapproved form of administration

Unlicensed- is when doctors are aware of how a medicine works and its possible side effects, and wish to use the drug for other illness or conditions. If a medicine is used in this way that does not meet the strict rules set out in the licence, this is described as an 'unlicensed drug'.

ii. Administering unlicensed/off label medicines follow the same guidelines as licensed medicines.

5.3.6 Administration of Medicines on the Neonatal Unit

i. Due to the complexity of medicines handling required for neonates, the neonatal unit has a specific policy for medicines, including the administration process. Such a procedure must be in line with Trust Policy. Should disagreements as to acceptable

practice occur, these issues must be raised at clinical governance following guidance feedback from the relevant professional bodies.

ii. Administration of low-risk medicines on the low dependency unit (LDU) also involves clinical support workers (CSW) and parents. The neonatal unit have developed a local policy which details the local framework under which CSWs and parent medication administration may operate within the Trust. It is therefore important that CSWs and parents are assessed, and that administration of medicines only occurs within the context of defined local and national policy and guidance.

5.3.7 Administration of Medicines in Theatres

i. Immediate access to a variety of medicines can sometimes be essential in theatres, such that even short delays in medicine availability can make a difference to patient outcome.

ii. Anaesthetic room medicine cupboards and fridges cannot, in the interests of patient safety, be locked during surgical procedures and practices can be followed that may minimise medicines security risks, e.g. medicines prepared in advance for procedures can be kept in closed cupboards/fridges or be under the direct supervision of the anaesthetist.

iii. It is accepted practice that medicines used during anaesthesia require preparation before the patient has entered the anaesthetic room. This ensures the medicines are prepared in a controlled, quiet environment with no distractions. This practice minimises medicine incidents and ensures the anaesthetists are not diverted from their responsibilities. These medicines are labelled appropriately and will be under the direct supervision of the anaesthetist prior to administration to the patient.

iv. It is also accepted practice to prepare a selection of “emergency medicines” (this list is not exhaustive but may include atropine, ephedrine, glycopyrronium, metaraminol, thiopentone, suxamethonium, phenylephrine, IV fluids) that should be immediately available during the course of an anaesthetic. These will often accompany the patient from the anaesthetic room into the operating theatre but, if this is not possible, they should be stored in the anaesthetic room in a manner that maintains their immediate availability.

v. These “emergency medicines” should be adequately labelled, and disposed of appropriately if not used. Once prepared these medicines must not be used after 24 hours.

5.3.8 Adverse Clinical Event following the Administration of Medicines

i. Should a patient experience an adverse clinical event following the administration of medicines, the medication must always be considered as a suspect cause, even if the medication has not previously caused a problem. Please refer to the adverse event policy.

ii. The handling of such incidents will depend on the severity of the symptoms encountered.

iii. Any symptoms experienced by a patient must be reported to the senior nurse or midwife in charge of the ward so that he / she can initiate any appropriate action should this be necessary. The doctor caring for the patient must always be informed of any suspected reaction. All events must be reported on Ulysses and the pharmacy informed.

iv. Certain medication may require the reporting of adverse events to the MHRA on the "yellow card system". Guidance of Yellow Card Reporting is given in the most recent BNF available. Such incidents include new medicines on the market which have a black triangle against their name in the literature. Pharmacy is always available to give guidance.

5.3.9 Administration of Medicines using a Patient Group Direction, (PGD)

i. For a staff member to administer a medicine via a PGD, that staff member must be authorised, and have signed up to the PGD conditions for the medicine which he / she is administering. In this instance staff must conform to the standards and restrictions laid down in the Policy for PGDs.

5.3.10 Non-Administration of Medicines

i. There may be circumstances when prescribed medicines should not be administered. Medicines should not be administered to a patient:-
   - If a prescription or the medicine to be administered is ambiguous or if there is any doubt as to the appropriateness and / or safety to the patient.
   - If the prescription or medicine to be administered is in any way unclear, illegible or incomplete.
   - If there is any question as to the identity of the patient
   - If the patient is 'nil by mouth' and the medicine has not been approved for administration by an appropriate prescriber, (e.g. anaesthetist)
   - The prescriber prescribes outside his or her authority (e.g. a neonatal doctor or NMP prescribes a medicine which is outside the neonatal drug formulary.)
   - The patient appears to be deteriorating and the medicine for administration could aggravate the problem.
   - When a patient is to receive a treatment regime made up of a number of medicines and the full regime is not prescribed and not so justified in the patient's notes, (e.g. Alberti style insulin regime).

ii. Depending upon the seriousness of the problem, the nurse withholding medication should inform his or her nurse in charge who in turn, informs the prescriber or doctor currently looking after the patient as soon as possible. Circumstances can vary and pharmacy can provide guidance in these instances. However there will be circumstances where the withholding of medication could affect the clinical presentation of the patient (i.e. antiepileptic, pain management, Parkinson's, antibiotics). If the situation is such that the drugs cannot be administered then it is the registered practitioners' responsibility to make contact with the prescriber as a matter of urgency (within the hour) and that the issue is escalated.

6 Key Reference

i. Written in accordance with (DOH, NHSLA, NPSA, CQC) Medicines Management Policy - Neonatal Directorate LWNHSFT
ii. Building a safer NHS for patients – Improving Medication Safety. - DOH 1/ 04 Medicines Management Policy - Neonatal Directorate LWNHSFT
iii. The Safe and Secure Handling of Medicines: A Team Approach Revision of the Duthie Report 1988 - RPSGB 3 /2005

iv. Department of Health (2007*) Safer management of Controlled drugs: A guide to good practice in secondary care (England*) London: Department of Health
v. Nursing and Midwifery Council (2010) *Standards for medicines management*. London: Nursing and Midwifery Council
vi. Medicines Act 1968. London: HMSO
vii. Poisons Act 1972 London: HMSO
viii. Misuse of Drugs Act 1971 London: HMSO
ix. Misuse of Drugs Regulations 2001 (amended) London: HMSO
x. Guidelines on the safe and secure handling of medicines - Duthie 1988 and March 2005
xi. Standards for Medicines Management NMC 2007
xii. CQC Safer Management of controlled drugs (2013)
xiii. Good Practice in Prescribing Medicines (2008)
xiv. NMC Standards for proficiency for nurse and midwife prescribers (2006) amended
xv. The Safe and Secure Handling of Medicines, A Team Approach (2005)
xvi. Royal College of Anaesthetists (RCoA) and Association of Anaesthetists of Great Britain and Ireland (AAGBI). Storage of drugs in anaesthetic rooms (2016)
xvii. NMC: Future nurse: Standards of proficiency for registered nurses (2018)
xviii. NMC: Standards of proficiency for midwives (2019)
xix. NMC: Standards of proficiency for nursing associates (2018)

7 Associated Documents

i. Trust prescribing of medicines policy
ii. Trust safe storage and security of medicines policy
iii. Trust waste management policy
iv. Trust managing incidents and serious incidents policy
v. Trust management of medication related clinical incident or near miss policy

8 Training

i. Training needs related to this policy are defined in the Trust mandatory training policy. Additional training support will be provided to staff if required, on an individual needs basis.

9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment			Not required
GDPR	PGP		

Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes	
External Stakeholders	This policy has been developed to meet the standards set down by, legislation, national professional bodies, CQC and NHSLA Risk Management Standards on activity concerned with the process of administering medicines.	
Trust Staff Consultation	Start date: Jan 22	End Date: Jan 22

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
New staff will be informed on the location of this policy on the hospital intranet at Trust Induction. Rotational doctors will receive a copy of this policy on their induction CD. Permanent staff are instructed of policy location via general medicines management e-learning training. Amendments to the policy are highlighted to key hospital staff as described in the consultation section of this document for dissemination across their specialist areas	Senior Pharmacy Manager and other delegated pharmacy staff. Trust personnel responsible for information dissemination across the Trust

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
Dec 2022	6.0	Deputy Chief Pharmacist	Role titles updated. ACE changed to medication incidents. Details included regarding CSW and parent medication administration on NICU. Nurse associate role in medicines administration clarified.
Oct 2020	5.3	Deputy Chief Pharmacist	Changes made to reflect updated NMC guidance for student nurses & midwives and trainee nurse associates. Appendices updated with activities. References updated.
Feb 2020	5.2	Deputy Chief Pharmacist	Information added regarding administration of medicines in theatres (section 5.3.7). Clarification of taking the prescription to the patient's bedside when administering medicines. References updated. Supervisors of midwives section removed.

March 2019	5.1	Policy Officer	Updated into new automated template
January 2018	5	Deputy Chief Pharmacist	Minor amendment to last sentence in 5.2.4 (iv), associated document headings amended, and inclusion of appendix 3
June 2016	4.1	Senior Pharmacy manager	Minor template and date change
Nov 2014	4	Dr Sarina M Saiger- Interim Associate Director of Nursing	To update to comply with Trust policy writing. Insert a section on patient self-administration and other sections as described below. Insert Midwives exemption reference.
March 2011	3	Eileen Reynolds Senior Pharmacy Manager	To update to comply with Trust policy writing. Insert a section on patient self-administration and other sections as described below.
July 2007	2	Eileen Reynolds Senior Pharmacy Manager	To comply with Trust Policy writing standards.
January 2002	1	Eileen Reynolds Senior Pharmacy Manager	Original copy

9.2 Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Compliance with the medicines administration standards as described,	95%	5 day audit of the medicine administration process using the audit tool provided	Medicines Management Group	Annual	Senior Pharmacy manager.
Codeine administration audit	90%	5 day (minimum) audit using the codeine administration audit tool provided	Medicines Management Group	Annual	Senior Pharmacy manager.
Review of medicine related clinical incident reports described in this policy.	N/A	Production of a quarterly report which reviews medicine incidents where administration contributes to the root cause of the incident report.	Medicines Management Group	Quarterly	Senior Pharmacy manager.

9.3 Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Chief Pharmacist	Medicines Management Group	Quarterly

10 Appendices

10.1 Appendix 1 - Checklist to review the suitability of patients own medicines before using.

When a patient's own medicines can be used.

The use of patient's own medicines can be used provided that the nursing and medical staff are satisfied as to the integrity of the product, its packaging and identification. Medicines are to be inspected by the pharmacist at the next available opportunity.

The use of patients own medicine is acceptable on wards provided that the medication is easily identifiable and is considered to be in good condition.

A suitability assessment checklist (see below) should be available on each ward to ensure only appropriate patients own supply is used on the ward.

Assessing patient's own medicines

Patients own medication must be assessed as soon as possible.

Certain questions need to be considered when assessing patient's own medicines. These include:-

- Is the label clear and not obliterated or incorrect?
- Is the medicine in date?
- Is there more than one type of medicine in the container when there shouldn't be?
- How long ago was the product dispensed or purchased?
- Is it greater than 6 months?
- Are the medicines still being taken in relation to date of dispensing or purchase?
- Was the medicine a liquid supplied from another original container?
- If eye drops how long have they been opened? (discard after 1 week)
- Has the medicines been stored appropriately according to the patients account?
- Is the product suitably packaged?
- Is it possible to identify the medicine?
- Is there anything else that would question the medicines suitability for use?
- When a patient's own medicines cannot be used

Following the assessment of the patient's own medicines, the following criteria should be used to determine the unsuitability for use;

- Patient's own medicine must not be used if there is any query as to the quality or identification of the medicine.
- If the assessment falls outside the category above.
- Any product which has the potential to be "tampered" with must not be used in patients who are registered drug addicts or when addiction is suspected.

NOTE

The assessment above is **not** to be used when assessing patients own medicines presented in dossette boxes or similar compliance aids;

- It should only be acceptable to use such boxes in ***exceptional circumstances*** and when the boxes are prepared and sealed at authorised pharmacies, (retail or hospital).
- These patient's own medicines must then be inspected by the pharmacist or pharmacy technician on the ward visit and deemed acceptable for use.
- Nursing and midwifery staff must also be satisfied with the medicine before administering. If staff administer patient's own medicine, she/he will do so on the understanding that suitability for use has been assessed and accepted.

10.2 Appendix 2

Student Midwives and Medication Administration

Route / activity	1st, 2nd and 3rd year student midwives
Oral	Can administer medications under direct supervision of a registered midwife / nurse (excluding controlled drugs). This is not applicable in NICU placement.
Controlled Drugs	Cannot administer controlled drugs but may participate in the preparation for administration of controlled drugs and observe the checking procedure between 2 registrants.
Intravenous drugs (including flushing of cannula)	Can administer medications under direct supervision of a registered midwife/nurse (excluding controlled drugs) once deemed competent.
Intravenous Fluids	Can prime giving sets and can change crystalloid and colloid fluid bags under direct supervision of a registered midwife / nurse. Can connect or commence intravenous therapy (fluid with medication added) once deemed competent and can titrate Syntocinon infusion already in progress under direct supervision of a registered midwife. Please note this is not applicable in NICU placement.
Subcutaneous / intramuscular	Can prepare and administer under direct supervision of the registered midwife / nurse (excluding controlled drugs). This is not applicable in NICU placement.
Blood and blood products	Can administer (connect or commence) blood or blood products for intravenous administration once deemed competent and participate in the preparation for administration and observe the checking procedure between 2 registrants. Can administer Anti-D under direct supervision of a registered nurse / midwife. Cannot attend training for the Blood Tracking System.
Rectal	Can administer suppositories and enemas under the direct supervision of a registered midwife / nurse. This is not applicable in NICU placement.
Inhaled Therapy	Can prepare and administer under the direct supervision of a registered midwife / nurse. This is not applicable in NICU placement.
Trans Dermal / Topical	Can practice under the direct supervision of a registered midwife / nurse.
Prescribed Impregnated Dressings	Can observe and practice under the direct supervision of a registered midwife / nurse.

Route / activity	1st, 2nd and 3rd year student midwives
Via Nasogastric Tube or Percutaneous Endoscopic Gastrostomy	Observe only.
Patient Controlled Analgesia / epidural	Observe only.

Student Nurses and Medication Administration

Route / activity	1st, 2nd and 3rd year Student Nurses and Return to Practice Nursing Students
Oral	Can administer medications under direct supervision of a registered nurse / midwife (excluding controlled drugs). This is not applicable in NICU placement.
Controlled Drugs	Cannot administer controlled drugs but may participate in the preparation for administration of controlled drugs and observe the checking procedure between 2 registrants.
Intravenous drugs (including flushing of cannula)	Can administer medications under direct supervision of a registered nurse/midwife (excluding controlled drugs) once deemed competent.
Intravenous Fluids	Can prime giving sets and can change crystalloid and colloid fluid bags under direct supervision of a registered nurse / midwife. Can connect or commence intravenous therapy (fluid with medication added) once deemed competent. This is not applicable in NICU placement.
Subcutaneous / intramuscular	Can prepare and administer under direct supervision of the registered nurse / midwife (excluding controlled drugs) once deemed competent. This is not applicable in NICU placement or an emergency arrest call.
Blood and blood products	Can administer (connect or commence) blood or blood products for intravenous administration once deemed competent and may participate in the preparation for administration and observe the checking procedure between 2 registrants. Cannot attend training for the blood tracking system.
Rectal	Can administer suppositories and enemas under the direct supervision of a registered nurse / midwife. This is not applicable in NICU placement.
Inhaled Therapy	Can prepare and administer under the direct supervision of a registered nurse / midwife. This is not applicable in NICU placement.
Trans Dermal / Topical	Can practice under the direct supervision of a registered nurse / midwife.
Prescribed Impregnated Dressings	Can observe and practice under the direct supervision of a registered nurse / midwife.
Via Nasogastric Tube or Percutaneous Endoscopic Gastrostomy	Observe only.

Route / activity	1st, 2nd and 3rd year Student Nurses and Return to Practice Nursing Students
Patient Controlled Analgesia / epidural	Observe only.

Trainee Nurse Associates and Medicines Administration

Route / activity	1st, 2nd and 3rd year student midwives
Oral	Can administer medications under direct supervision of a registered midwife / nurse (excluding controlled drugs) once deemed competent. This is not applicable in NICU placement.
Controlled Drugs	Observe only.
Intravenous drugs (including flushing of cannula)	Observe only.
Intravenous Fluids	Observe only. Cannot connect or commence intravenous therapy (fluid with medication added). Please note this is not applicable in NICU placement.
Subcutaneous / intramuscular	Can prepare and administer under direct supervision of the registered midwife / nurse (excluding controlled drugs) once deemed competent. This is not applicable in NICU placement.
Blood and blood products	Observe only. Cannot attend training for the Blood Tracking System.
Rectal	Can administer suppositories and enemas under the direct supervision of a registered midwife / nurse once deemed competent. This is not applicable in NICU placement.
Inhaled Therapy	Can prepare and administer under the direct supervision of a registered midwife / nurse once deemed competent. This is not applicable in NICU placement.
Trans Dermal / Topical	Can practice under the direct supervision of a registered midwife / nurse once deemed competent.
Prescribed Impregnated Dressings	Can observe and practice under the direct supervision of a registered midwife / nurse.
Via Nasogastric Tube or Percutaneous Endoscopic Gastrostomy	Can observe and practice under the direct supervision of a registered midwife/nurse once deemed competent.
Patient Controlled Analgesia / epidural	Observe only.

Student Operating Department Practitioners and Medication Administration

Route / activity	**1st, 2nd and 3rd year Student Operating Department Practitioners**
Oral	Can administer medications under direct supervision of a registered theatre practitioner (excluding controlled drugs).
Controlled Drugs	Cannot administer controlled drugs but may participate in the preparation for administration of controlled drugs and observe the checking procedure between 2 registrants.
Intravenous drugs (including flushing of cannula)	Observe only.
Intravenous Fluids (saline, glucose, Plasma Lyte and saline / glucose with potassium already added)	Can practice under direct supervision of a registered theatre practitioner.
Subcutaneous / intramuscular	Can prepare and administer under direct supervision of the registered theatre practitioner competent to do so (excluding controlled drugs).
Blood and blood products	Cannot administer (connect or commence) blood or blood products for intravenous administration but may participate in the preparation for administration and observe the checking procedure between 2 registrants. Can participate in the preparation of Cell Saver and can process blood under direct supervision, but cannot administer processed blood.
Rectal	Can administer suppositories and enemas under the direct supervision of a registered theatre practitioner.
Inhaled Therapy	Can prepare and administer under the direct supervision of a registered theatre practitioner competent to do so.
Trans Dermal / Topical	Can practice under the direct supervision of a registered theatre practitioner.
Prescribed Impregnated Dressings	Can observe and practice under the direct supervision of a registered theatre practitioner.
Via Nasogastric Tube or Percutaneous Endoscopic Gastrostomy	Observe only, although rarely required in perioperative practice.
Patient Controlled Analgesia / epidural	Observe only.
Total Intravenous Anaesthesia	Observe only.

11 Initial Equality Impact Assessment Screening Tool

Name of policy/ business or strategic plans/CIP programme:	**Details of policy/service/business or strategic plan/CIP programme, etc:** **Administration of Medicines Policy**	
Does the policy/service/CIP/strategic plan etc affect (please tick) **Patients** ☐ **Staff** ☐ **Both** ✓ ☐		
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**Yes/No**	**Justification/evidence and data source**
Age	No	
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?		**Justification/evidence and data source**
Right to life	No	
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	
EIA carried out by: Dan Collins Quality assured by: PGP	Date March 23 March 23	Contact details of person carrying out assessment.