This policy supersedes all previous issues.
## Version Control

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1 Introduction

Medicines administration is a key activity in the medicines use process. There may be considerable potential for deviation from the desired practice. Activities covered include identification of the patient, selection of the medicine, administration of the medicine and recording of the medicine administered.

Some form of manipulation of the medicine may be necessary immediately prior to its administration. This is particularly the case with parenteral medicines. The activities associated with this are fundamental in ensuring the correct medicine is administered to the patient. Although high risk parenteral medicines are prepared aseptically in a controlled environment under pharmaceutical supervision whenever possible, many other parenteral medicines continue to be prepared in ward utility/clinical rooms.

2 Policy scope

This policy applies to all registered nurses, midwives and medical staff employed in the trust. Only these individuals have general authority to administer medicines for patients.

It is recognised that it will be appropriate for other health care professional groups to administer medicines in some specific settings.

All staff who administer medicines must familiarise themselves with the correct procedures contained within this document.

3 Aim of policy

To promote the safe preparation and administration of all medicines across the Trust.

The use of Injectable medication has many healthcare benefits for patients. However the complexities associated with the prescription, preparation and administration of injectable medicines means that there are greater potential risks for patients than for other routes of administration. Weak operating systems increase the potential risk of harm, and safe systems of work are needed to minimise these risks.

4 Duties - roles and responsibilities

Trust Board
To ensure there is a safe and effective medicine management system that meets the requirements of the Care Quality Commission

Executive Director
The Medical Director is the executive lead for the safety of medicines across the Trust.
Divisional Managers and Divisional Directors
The Divisional managers and Directors are responsible for ensuring that their staff, particularly new starters and locums, follow the procedures within this document, which may differ significantly from elsewhere they may have worked.

Heads of Department/Assistant Divisional Managers.
Heads of Department are responsible for ensuring that their staff, particularly new starters and locums, follow the procedures within this document, which may differ significantly from elsewhere they may have worked.

All staff
All staff in the Trust who manage or handle medicines must familiarise themselves with this document and attend training updates so that they maintain their skills and are familiar with procedures. All staff should ensure any documentation pertaining to medicines should be accurate, comprehensive and legible and stored securely in line with local guidance. It is the responsibility of all staff to ensure they are competent to carry out specific medicines handling tasks relevant to their role.

Responsibilities of the Nurse/ Midwife
The sister/charge nurse is accountable for the safe custody and administration of medicines kept on the ward/department and for ensuring that stocks of controlled drugs, if held, are safe and secure and correspond with the details shown in the register.

The nurse caring for the individual patient is responsible for liaising with pharmacy to ensure the timely supply, safe storage and administration of all medicines required.

In addition the nurse in charge of each ward/department is jointly responsible with pharmacy staff to agree which medicines are held as permanent ward stock.

Responsibilities of the Pharmacy Service
Pharmacy staff are responsible for the safe & effective procurement of all medicines to be used in the Trust.

Pharmacy staff are responsible for the stock of medicines held in the pharmacy and that there is a supply and distribution process in place which ensures medicines are provided in a safe, accurate and timely manner.

Dispensing processes are managed through a range of standard operating procedures held within the pharmacy department. The Chief Technician and the Pharmacy Operational Services manager are jointly responsible for ensuring these reflect best practice and are kept up to date.

It is the responsibility of Pharmacy staff to provide evaluated, independent information and advice to patients and health care professionals, and to monitor and evaluate prescriptions for appropriateness of prescribing.

Pharmacy staff oversee the safe, effective and economic use of medicines across the trust. This process includes regular monitor of prescriptions to ensure
appropriateness, accuracy, safety and clarity of prescribing. This is further
described in MM04, Pharmacy Standards for chart annotation.

**Responsibilities of Prescribers: Medical and Non-medical Prescribers**
Medical staff are responsible for the majority of prescribing of medicines for
patients. They and other authorised prescribers must adhere to the standards
described in MM04.

Prescribers must sign all prescriptions for medicines and it is essential that the
identity of the prescriber is known. Prescribers should print their name and/or
professional registration pin number on all prescriptions for this purpose.

Non-compliance with the prescribing policy will be reported to the clinical lead and
discussed at the multi-disciplinary team meeting.

**Responsibilities of Other Registered Healthcare Staff**
Some other healthcare staff may be involved in the medicine supply and
administration processes. The healthcare professional will be authorised to
undertake a specific role and will do so in accordance with the directions of a
prescriber, prescription or patient group direction and follow appropriate training and
assessment, eg radiographers, operating department assistants. Access to
medicines and responsibilities for medicine stocks must be clearly defined in all
clinical areas and be in line with the requirements of medicines legislation.

5 Definitions

For the purpose of this document the following definitions apply:

The **Trust** refers to Gateshead Health NHS Foundation Trust.

The **Patient** refers to a patient in hospital, in their own home, health centre,
attending a clinic, in school, GP surgery or an employee attending the occupational
health department who is under the care of the Trust.

**Medicine/Medication** is defined as any substance, internal or external, used for the
therapeutic, diagnostic or preventative purposes in the above settings.

**Nurse** is defined as a registered nurse or midwife whose name appears on the
appropriate part of the Register and reflects the area in which they are practicing.
They will have a valid NMC Pin Number.

**Nurse preceptee** is defined as a newly registered practitioner, who with support
by a preceptor, is undergoing a period of structured support during which he or
she will develop confidence as an autonomous practitioner, refine skills, values and
behaviours and continue on their journey of lifelong learning. During this period
the preceptee will not administer medicines unsupervised until satisfactory
completion of their drugs assessment. Throughout this policy where there is an
identified requirement for two qualified nurses, one **must** have completed a drugs
assessment. A preceptee who has NOT completed their drugs assessment should
only be used as the second checker in exceptional circumstances, and only if the
first nurse is confident that they are competent to carry out the checking procedure.
**Medical Practitioner** is a provisionally or fully registered medical or dental practitioner.

**ODP** is defined as an Operating Department Practitioner who has completed a 2 year training programme to achieve a Dip HE in Operating Department Practice (previously NVQL3)

**Pharmacist** is defined as a person registered with the General Pharmaceutical Council.

**Anaesthetic Practitioner** is defined as a non-medical anaesthetist, trained to UK qualifications, working under the supervision of a consultant ie not an independent practitioner.

**Administration** To give a medicine either by introduction into the body, whether by direct contact with the body or not (eg orally or by injection), or by external application eg application of an impregnated dressing.

### 6. Medicines Administration

#### 6.1 Overview of process

6.1.1 Medicines may only be given to patients against an individually written prescription by a doctor or a dentist or an approved ‘Patient Group Direction’.

6.1.2 The majority of medicines should be administered on an individual patient specific basis.

6.1.3 The administration of medicines by ‘Patient Group Direction’ should be reserved for those limited situations where this offers an advantage for patient care and where it is consistent with appropriate professional relationships and accountability.

Specific policy information on patient group directions is held in MM04, Section 6.7.

6.1.4 In the majority of circumstances medicines will be administered without involving a second person. The exceptions to this are:-
- Administration of controlled drugs – see Section MM 05.
- Intravenous medications – see Section 6.3 of this policy.
- When administering to children under the age of 16.
- Administration of cytotoxic medication - see MM06
- When practitioners are instructing students.
- Where local circumstances require the involvement of two people in the interest of patient safety. For example, when bank, locum or agency staff are used and they are unfamiliar with the area in which they are working or for all staff in high risk areas.

6.1.5 If the prescription does not adhere to the requirements laid down in MM 04 or is covered in MM 04 but the clarity of the prescription is in
doubt, the nurse MUST NOT administer the medication, until the prescription has been clarified.

6.1.6 The nurse must maintain and improve professional knowledge & competence in order to meet the standards outlined in the ‘Standards for the Administration of Medicines’ (NMC). If the nurse has any doubt about the prescription, the drugs MUST NOT be administered until advice is sought from medical staff, nurse in charge and/or pharmacist and the nurse is confident that the prescription is correct.

6.1.7 In an emergency a medicine may be administered once only on the verbal instructions of a doctor to a qualified nurse. In this event the instructions must be repeated back to the doctor in the presence of another nurse who acts as witness to receipt of the message.

This must be recorded in the ‘Once Only section’ of the drug kardex and the ‘verbal order’ stated in the doctor signature column. The nurse/midwife receiving the instructions must sign to give the dose and the second nurse/midwife must sign the checked by column.

The doctor must countersign the prescription with 12 hours of giving the instruction.

Controlled drugs must not be administered in this way.

6.1.8 POSITIVE PATIENT IDENTIFICATION AND ALLERGY STATUS.

6.1.8.1 It is imperative that the identity of the patient is correctly confirmed and any allergies are known.

6.1.8.2 The correct method of positive patient identification is described in RM40. All in-patients must have a printed ID wristband produced using the PAS system. The only exception are new born babies which will change when a printed alternative is available.

6.1.8.3 Before any medicine is either prescribed, administered or a named patient supply initiated a positive patient identity must be confirmed. Generally speaking, the patient knows better than anyone who they are, where ever possible ask the patient to confirm their identity.

- ASK the patient for their full name and date of birth. NEVER ask the patient "are you" Mr/Mrs Jones" as the patient may have misheard you and mistakenly agree.

- ALWAYS check the patients verbal reply against prescription sheet AND the patient’s ID wristband, which must say exactly the same. Never assume a minor difference is not important. Patients can have very similar names and dates of birth.
• NEVER assume the patient is in the right bed as the name above it suggests. The patient may be sat on the wrong bed, the board above the bed may not have been updated or the drug chart may have been put back on the wrong bed end.

6.1.8.4 It is a mandatory requirement that the documented allergy status of patients is available at the point of drug prescribing, administration or named patient supply and must always be verbally confirmed immediately prior to any of these actions.

6.1.8.5 Nurses, midwives and pharmacists are authorised to complete the allergy box of the prescription chart. This is not solely the responsibility of medical staff. The date and identity of the person completing the allergy box must be stated. The nature of the allergy/intolerance should be crosschecked from two sources wherever possible. This can include:-

- Patient
- Patient’s hospital notes
- Patient’s next of kin
- GP referral letter.
- Direct contact with GP.

6.1.8.3 It is NEVER acceptable to leave the allergy box blank. The Kardex must be marked with either of the following:

The specific medication or substance to which the patient is known to be allergic/intolerant must be documented clearly.

No Known Allergies - suitable documentation if the patient is able to confirm

Unknown - only suitable in situations in which it is not possible to verify the allergy status of the patient.

6.1.8.4 In order to distinguish between serious allergy and less harmful drug intolerance, the symptoms of any reported allergy must be documented. Eg. mild skin rash, GI disturbance, anaphylactic shock. If a patient experiences a new or different reaction during a later episode of care the medical record MUST be updated to reflect the most recent allergy status.

6.1.8.5 PHARMACOLOGY OF THE MEDICATION. All staff must make themselves aware of the medications they are prescribing and administering to patients with allergies including knowledge of the pharmacology of the medication.

6.1.8.6 Errors have occurred even when the allergy status of a patient has been clearly documented, because both the prescriber
and the person administering the medicine were unaware of the constituent products. This is particularly the case for penicillins where many products have names that do NOT immediately suggest they contain a penicillin.

6.1.8.7 There is currently no requirement for manufacturer’s drug labels to include the warning “CONTAINS A PENICILLIN”. Orally dispensed drugs for an individual patient by the Trust pharmacy will carry this supplementary label but this facility is not available on I V or oral products held as ward stock.

6.1.8.8 Approximately 10% of penicillin- sensitive patients may also be allergic to cephalosporins and other beta-lactam antibiotics, which are structurally similar to the penicillins.

6.1.8.9 The list of current formulary Penicillins & Cephalosporins is available on the medicines Information site of the Trust intranet.

6.1.9 Timeliness of medicines administration

Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. Patients going into hospital with chronic conditions are particularly at risk. For example, patients with Parkinson’s disease who do not receive their medicines on time may recover slowly or lose function, such as ability to walk.

Between September 2006 and June 2009, the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines. Of the 95 most serious incidents, 31 involved anti-infectives (antibiotic and antifungals), and 23 involved anticoagulants. Wider evidence suggests that the true rate of harm may be much higher, as events such as these are often not reported.

6.1.9.1 To ensure ward staff understand where and how to access medicines not available at the time of drug administration the following tools have been issued to each ward and are available on the Trust intranet:-

A critical list of medicines that are required to be given within 2 hours of the scheduled dose indicating which wards stock these medicines.

A list of medicines held in the EMERGENCY DRUG Cupboard. The cupboard is located in the staff entrance to pharmacy.
An updated FLOW CHART for administering medicines, helping nurses to decide what action to take when medicines are not available (Appendix 1)

Whenever, despite maximising the tools provided medicines are not available, a Datix incident must be submitted.

6.1.9.2 STAT one time doses are prescribed on the ‘Once only and premedication’ section on the front of the inpatient prescription chart, and are intended to be administered outside the normal drug administration times. For these drugs

- The prescriber is responsible for writing the prescription and verbally informing nursing staff that they have prescribed a ‘stat’ medicine. Unless communication of these prescriptions are passed to nursing staff they may go unnoticed for several hours before they are identified during the next regular medicines administration round.

- Nursing staff are responsible for ensuring that ‘stat’ doses of medication are administered as soon as possible or within 60 minutes from the time they are prescribed on the inpatient prescription chart. Where this is not possible it is the responsibility of the nursing staff to inform the prescriber and to take steps to ensure the matter is resolved.

6.1.10 Covert drug administration.

In the event that a patient refuses to take medication prescribed for him no medication should be given unless specifically documented in the patient notes. A competent adult has the right to refuse treatment even if such refusal is likely to adversely affect his health or shorten his or her life.

In certain exceptional circumstances the notes may indicate that essential medication for a particular client can be disguised in food or drink. The notes will only give this indication if the particular client has been seen by a medical practitioner and been assessed to lack capacity to make an informed decision on the acceptance of medication. The Medication Care Co-ordinator will have addressed this in the care plan.

Medication should never be disguised unless the care plan indicates that is it appropriate and a pharmacist has given guidance. If the care plan indicates that medication can be disguised, any occasion on which it is given in disguised form must be documented together with details of the person giving it, time given and amount given.

It must not be routine to disguise medication even if the care plan indicates that it may be appropriate in certain circumstances. The patient must always be offered medication first and only in the case
of refusal can the medication be disguised if this is documented in the notes.

6.1.11 CALCULATIONS. Some drug administrations can require complex calculations to ensure that the correct volume or quantify of medication is administered. In these situations it is good practice for a second practitioner (a registered professional) to check the calculation independently in order to minimise the risk of error. The use of calculators to determine the volume or quantity of medication should not act as a substitute for arithmetical knowledge or skill.

6.2 Non Parenteral Route Drug Administration

6.2.1 Prepare necessary equipment.

6.2.2 Wash hands.

6.2.3 Check prescription for any drug allergies/sensitivities/precautions. Ensure you understand what this drug is prescribed for and aware of any contraindications.

6.2.4 Verify:-

the name of the medicine on the prescription is clear

the prescription is dated and signed.

the drugs have not already been administered

the time of drug administration is correct.

the dose and route by which the drug is to be given.

6.2.5 Select the correct medicine container ensuring the labels corresponds exactly with the medicine required on the prescription sheet.

6.2.6 Check the drug is within the expiry date.

6.2.7 Identify the correct patient, checking the prescription sheet corresponds with the patient’s identity band and allergy box is complete and does not indicate incompatibility. Check patient’s identity band does not signify allergy to any drug or substance or that patient has any other necklace or bracelet stating allergy to particular substances. Verbally confirm allergy status with the patient.

6.2.8 Check the required dose and place in an appropriate receiver.

6.2.9 Administer the medication to the patient. If an oral preparation, observe the patient swallow the medication. Do not leave the medication unattended.
6.2.10 Sign the prescription sheet. Any discrepancies in administration must be entered in the appropriate column at the time using the correct code.

6.2.11 On completion of the medicine round the trolley should be locked securely to it’s anchorage point, restocked as necessary and the equipment washed and dried.

6.2.12 If medication is omitted/refused, this must be recorded on the chart and the nurse in charge and the medical staff informed.

6.2.13 If the prescribed drug is NOT available this must be recorded and measures taken to ensure resolution of the problem (see MM03 paragraph 6.1.2 biii and Appendix 1)

6.2.14 If an error has occurred, you must inform the nurse in charge, medical staff and complete a Datix incident form.

6.2.15 If the patient does not receive the full dose, you must inform that nurse in charge and the medical staff.

6.2.16 If there is any sign of an adverse reaction to the drug, you must ensure the patient is safe, then inform the nurse in charge and the medical staff. The incident should be reported via the yellow card scheme (See MM01).

6.2.17 Safer measurement and administration of medicines for doses less than a single tablet.

6.2.17.1 Tablets which are scored by the manufacturer may be broken where the dose prescribed demands the administration of half or quarter tablets. If this is for a regularly prescribed medicine the remaining part tablet may be retained in the container for the next medicine round. For once only and when required medicines the remaining part tablet must be immediately disposed of into a sharps bin. When the bin is sent for destruction it should be labelled” contains mixed pharmaceutical waste and Sharps – for incineration. For unscored tablets contact the pharmacy for advice.

6.2.17.2 The mechanism of crushing medicines may alter their therapeutic properties rendering them ineffective and no longer covered by their product license. Medicinal products should not routinely be crushed unless approved by the pharmacy department. See Trust Intranet > Medicines Information > Clinical Info > Guidelines for the Administration of Drugs Through Enteral Feeding Tubes

6.2.17.3 For oral liquid medicines, where a medicine spoon or graduated measure cannot be used, a purple oral/enteral
syringe must be used. Female luer sterile, single packed, purple enteral syringes must be held as permanent stock on all ward areas to be on regular replenishment by Supplies Material Management service. These syringes are NOT compatible with intravenous devices but will fit NPSA compliant nasogastric tubes with a male luer feeding connector for enterally fed patients. Oral/Enteral syringes must be labelled with the name & strength of the medicine, the patient’s name and the date and time it was prepared by the person who has drawn the medicine into the syringe, unless preparation and administration is one uninterrupted process and the unlabelled syringe does not leave the hands of the person who has prepared it. Only unlabelled syringe may be handled at any one time.

6.3 Preparing and Administering Injectable Medicines in Clinical Areas

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<th>KEY POINTS</th>
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<tr>
<td>Preparation of all Injectable medicines must be checked by two practitioners.</td>
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<tr>
<td>All the injectable medicines required for an individual patient, should be prepared and administered before preparing injectable medicines for another patient.</td>
</tr>
<tr>
<td>Under no circumstances should more than one injection be left unlabelled.</td>
</tr>
<tr>
<td>Practitioners must wash their hands and put on a pair of disposable protective gloves and apron before preparing injectable medicines.</td>
</tr>
<tr>
<td>Ampoules/vials, syringes and needles should be assembled in a tray disinfected with 2% chlorhexidine and 70% alcohol. The rubber septum of vials must also be disinfected with a 2% chlorhexidine and 70% alcohol wipe. Allow to dry for at least 30 seconds.</td>
</tr>
<tr>
<td>A ‘non-touch’ technique must be used.</td>
</tr>
<tr>
<td>All injections should be labelled immediately after preparation, except for syringes intended for immediate push (bolus) administration by the person who prepared them.</td>
</tr>
<tr>
<td>The nurse/midwife must not prepare substances for injection in advance of their immediate use.</td>
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<tr>
<td>The nurse/midwife must not administer medication drawn into a syringe or container by another practitioner when not in their presence.</td>
</tr>
<tr>
<td>Before administering any injection, the identity of the patient and allergy status must be confirmed. This should be undertaken by both nurses involved in the preparation of the injection.</td>
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Infusions should be checked to ensure they are free of haziness, particles and discolouration.

Infusions administered via infusion pumps must be monitored according to RM 58 to minimise risks to patients.

If an error occurs the nurse/midwife in charge of the ward and the medical staff must be informed and the incident reported via the DATIX system.

6.3.1 General Points of consideration for Preparation of Injectable Medicines in Clinical Areas.

6.3.1.1 Wherever possible, ready-to-administer or ready-to-use injectable products will be supplied from pharmacy but it is recognised that the majority of these medicines will still be made on wards, in theatres or in other clinical areas. All cytotoxic and parenteral nutrition (TPN) products MUST be prepared in the pharmacy department.

6.3.1.2 Multiple use of an unpreserved injectable medicine should be eliminated. Most injectable medicines are licensed for “once-only” use. Unless the manufacturer’s label specifically indicates that the injection contains a preservative the container should only be used to prepare a single dose for a single patient on one occasion.

6.3.1.3 All the injectable medicines required for an individual patient, must be prepared and administered before preparing injectable medicines for another patient. If more than one injectable medicine is required for an individual patient, all the injections can be made one after the other and then administered – in these circumstances all injections, including syringes and flushes should be labelled. Under no circumstances should more than one injection be left unattended and unlabelled (see section 6.3.7).

6.3.1.4 Preparation of all injectable medicines must be checked by two practitioners who must be a registered nurse, midwife or medical doctor.

- Newly registered nurses/midwives may check the preparation but before administering they must have completed their preceptorship period and undertaken the Trust’s IV Drug Administration training programme and be subsequently registered as competent on the Trust’s data base held in the Nursing Directorate.

- Registered bank nurses and midwives may administer injectable medicines after completing the Trust’s IV
Drug Administration training programme and undertaking supervised practice in the clinical area prior to being subsequently registered as competent on the Trust’s data base held in the Nursing Directorate

- Registered bank staff who have not undertaken the Trust’s IV Drug Administration training programme and been registered as a competent practitioner may not administer injectable medicines but may act as second checker

- In theatres, all medicines administered to the patient are the responsibility of the Anaesthetist. With the approval of the anaesthetist and following his/her verbal instructions, the approved anaesthetic assistant may prepare drugs, in accordance with the criteria described in Section 6.3.11 of this policy, in readiness for treatment. Prior to use the anaesthetist must check the prepared drugs and any uncertainty must be resolved.

6.3.1.5 The checker must check the whole preparation process i.e. ingredients, any calculations, volumes measured etc.

6.3.1.6 Read all prescription details carefully and confirm that they relate to the patient to be treated.

6.3.1.7 Ensure that the area in which the medicine is to be prepared is as clean, uncluttered and free from interruption and distraction as possible. Ideally, preparation should take place in an area dedicated to this process.

6.3.1.8 Assemble all materials and equipment: sharps bin for waste disposal, medicine ampoule(s)/vial(s), diluent, syringe(s), needle(s), alcohol wipes, disposable protective gloves, clean re-usable plastic tray*. Check the following:
- expiry dates;
- damage to containers, vials or packaging;
- that medicines were stored as recommended, e.g. in the refrigerator.

*Note – in theatres, local anaesthetic drugs (e.g. for epidural or nerve blocks) must be placed in a yellow tray.

6.3.1.9 Beware of the risk of confusion between similar looking medicine packs, names and strengths. Read all labels carefully.

6.3.1.10 All ampoules including water for injection and sodium chloride 0.9% must be stored in the original manufacturer’s packaging. Once an ampoule is removed from the original
packaging, it is not advisable to put it back into the packaging if it is no longer required. This may be done in exceptional circumstances where a thorough check of drug name and strength is made to ensure it is put in the correct box.

6.3.1.11 Check that:
- the formulation, dose, diluent, infusion fluid and rate of administration correspond to the prescription and product information;
- you understand the method of preparation. (Hard copy general guidelines are available on all wards and further information can be obtained online at http://medusa.wales.nhs.uk. The username is qehuser and the password is angel9) (Appendix 4)

6.3.1.12 Calculate the volume of medicine solution needed to give the prescribed dose. Write the calculation down and obtain an independent check by another qualified healthcare professional.

6.3.1.13 Prepare the label for the prepared medicine (see section 6.3.7)

6.3.1.14 Cleanse your hands according to infection control policy [IC4]

6.3.1.15 Put on a pair of disposable protective gloves and an apron

6.3.1.16 Use a 2% chlorhexidine and 70% alcohol wipe or spray to disinfect the surface of the plastic tray.

6.3.1.17 Assemble the syringe(s) and needle(s). Peel open wrappers carefully and arrange all ampoules/vials, syringes and needles neatly in the tray.

6.3.1.18 Use a ‘non-touch’ technique, i.e. avoid touching areas where bacterial contamination may be introduced, e.g. syringe-tips, needles, and vial tops. Never put down a syringe attached to an unsheathed needle.

6.3.1.19 Prepare the injection by following the manufacturer’s product information or local guidelines, and the relevant guidance in points 6.3.2 to 6.3.7.

6.3.1.20 If the injectable medicine is also a controlled drug (CD), refer to MM 05 for additional instructions.

6.3.2 Withdrawing solution from an ampoule (glass or plastic) into a syringe

6.3.2.1 Tap the ampoule gently to dislodge any medicine in the neck.
6.3.2.2 Snap open the neck of glass ampoules, using an ampoule snapper if required.

6.3.2.3 Attach a needle to a syringe and draw the required volume of solution into the syringe. Tilt the ampoule if necessary.

6.3.2.4 Invert the syringe and tap lightly to aggregate the air bubbles at the needle end. Expel the air carefully.

6.3.2.5 Remove the needle from the syringe and fit a new needle or sterile blind hub. Label the syringe if not immediately administering to the patient. (See section 6.3.7)

6.3.2.6 Keep the ampoule and any unused medicine until administration to the patient is complete to enable further checking procedures to be undertaken.

6.3.2.7 If the ampoule contains a suspension rather than solution, it should be gently swirled to mix the contents immediately before they are drawn into the syringe.

6.3.2.8 The neck of some plastic ampoules is designed to connect directly a syringe without use of a needle, after the top of the ampoule has been twisted off.

6.3.3 Withdrawing a solution or suspension from a vial into a syringe

6.3.3.1 Remove the tamper-evident seal from the vial and wipe the rubber septum with a chlorhexidine & alcohol wipe. Allow to dry for at least 30 seconds.

6.3.3.2 With the needle sheathed, draw into the syringe a volume of air equivalent to the required volume of solution to be drawn up.

6.3.3.3 Remove the needle cover and insert the needle into the vial through the rubber septum.

6.3.3.4 Invert the vial. Keep the needle in the solution and slowly depress the plunger to push air into the vial.

6.3.3.5 Release the plunger so that solution flows back into the syringe.

6.3.3.6 If a large volume of solution is to be withdrawn, use a push-pull technique. Repeatedly inject small volumes of air and draw up an equal volume of solution until the required total is reached. This ‘equilibrium method’ helps to minimise the build-up of pressure in the vial.

6.3.3.7 Alternatively, the rubber septum may be pierced with a second needle to let air into the vial as solution is withdrawn.
The tip of the vent needle must always be kept above the solution to prevent leakage.

6.3.3.8 With the vial still attached, invert the syringe. With the needle and vial uppermost, tap the syringe lightly to aggregate the air bubbles at the needle end. Push the air back into the vial.

6.3.3.9 Fill the syringe with the required volume of solution then draw in a small volume of air. Withdraw the needle from the vial.

6.3.3.10 Expel excess air from the syringe. Remove the needle and exchange it for a new needle or a sterile blind hub. Label the syringe if not immediately administering to the patient. (See section 6.3.7)

6.3.3.11 The vial(s) and any unused medicine should be kept until administration to the patient is complete.

6.3.3.12 If the vial contains a suspension rather than solution, it should be gently swirled to mix the contents, immediately before they are drawn into the syringe.

6.3.4 Reconstituting powder in a vial and drawing the resulting solution or suspension into a syringe

6.3.4.1 Remove the tamper-evident seal from the vial and wipe the rubber septum with a chlorhexidine & alcohol wipe. Allow to dry for at least 30 seconds.

6.3.4.2 Use the procedure in 6.3.2 above to withdraw the required volume of diluent (e.g. water for injections or sodium chloride 0.9%) from ampoule(s) into the syringe.

6.3.4.3 Inject the diluent into the vial. Keeping the tip of the needle above the level of the solution in the vial, release the plunger. The syringe will fill with the air which has been displaced by the solution (if the contents of the vial were packed under a vacuum, solution will be drawn into the vial and no air will be displaced). If a large volume of diluent is to be added, use a push-pull technique (see above).

6.3.4.4 With the syringe and needle still in place, gently swirl the vial(s) to dissolve all the powder, unless otherwise indicated by the product information. This may take several minutes.

6.3.4.5 Follow the relevant steps in 6.3.3 above to withdraw the required volume of solution from the vial into the syringe.

6.3.4.6 Alternatively, the rubber septum may be pierced with a second needle to let air into the vial as solution is withdrawn. The tip of the vent needle must always be kept above the solution to prevent leakage.
6.3.4.7 If a purpose-designed reconstitution device is used, the manufacturer’s instructions should be read carefully and followed closely.

6.3.4.8 Label the syringe if not immediately administering to the patient. (See section 6.3.7). The vial(s) and any unused medicine should be kept until administration to the patient is complete.

6.3.5 Adding a medicine to an infusion

6.3.5.1 Prepare the medicine in a syringe using one of the methods described above.

6.3.5.2 Check the outer wrapper of the infusion container is undamaged.

6.3.5.3 Remove the wrapper and check the infusion container itself in good light. It should be intact and free of cracks, punctures/leaks.

6.3.5.4 Check the infusion solution, which should be free of haziness, particles and discolouration.

6.3.5.5 Where necessary, remove the tamper-evident seal on the additive port according to the manufacturer’s instructions or wipe the rubber septum on the infusion container with a chlorhexidine & alcohol wipe and allow to dry for at least 30 seconds.

6.3.5.6 If the volume of medicine solution to be added is more than 10% of the initial contents of the infusion container (more than 50ml to a 500ml or 100ml to a 1litre infusion), an equivalent volume must first be removed with a syringe and needle.

6.3.5.7 Inject the medicine into the infusion container through the centre of the injection port, taking care to keep the tip of the needle away from the side of the infusion container. Withdraw the needle and invert the container at least five times to ensure thorough mixing before starting the infusion.

6.3.5.8 Do not add anything to any infusion container when it is hanging on the infusion stand since this makes adequate mixing impossible.

6.3.5.9 Check the appearance of the final infusion for absence of particles, cloudiness or discolouration.

6.3.5.10 Label the infusion (see section 6.3.7).
6.3.6 Diluting a medicine in a syringe for use in a pump or syringe-driver

6.3.6.1 Prepare the medicine in a syringe using one of the methods described above.

6.3.6.2 Draw the diluent into the syringe to be used for administration by the pump or syringe-driver. Draw in some air (slightly more than the volume of medicine needed) and remove the needle.

6.3.6.3 Stand the diluent syringe upright. Insert the needle of the syringe containing the medicine into the tip of the diluent (administration) syringe and add the medicine to it. Alternatively, a disposable sterile connector may be used to connect two syringes together directly.

6.3.6.4 Check the following:
- the total volume of injection solution in the syringe is as specified in the prescription and that the infusion can be delivered at the prescribed rate by the administration device chosen;
- the rate of administration is set correctly on the administration device and according to the manufacturer’s instructions.

6.3.6.5 Fit a blind hub to the administration syringe and invert several times to mix the Contents.

6.3.6.6 Remove the blind hub. Tap the syringe lightly to aggregate the air bubbles at the needle end. Expel the air and refit the blind hub.

6.3.6.7 Carefully check the syringe for cracks and leaks and then label it (see section 6.3.7), especially noting the requirements specific to syringe drivers.

6.3.6.8 Check that the rate of administration is set correctly on the device before fitting the syringe, priming the administration set and starting the infusion device.

6.3.7 Labelling injection and infusion containers

6.3.7.1 All injections should be labelled immediately after preparation, except for syringes intended for immediate push (bolus) administration by the person who prepared them. Under no circumstances should an operator be in possession of unlabelled syringes for more than one patient at any one time, nor must an unlabelled syringe be fitted to a syringe driver or similar device. Medicines delivered via infusions must always be labelled. Additionally epidural
drugs must have an orange “epidural use only” sticker on the syringe /infusion.

6.3.7.2  Labels used on injectable medicines prepared in clinical areas should contain the following information:
   •  name of the medicine;
   •  strength;
   •  route of administration;
   •  diluent and final volume;
   •  patient’s name;
   •  expiry date and time;
   •  name of the practitioner preparing the medicine.

6.3.7.3  Place the final syringe or infusion and the empty ampoule(s)/vials(s) in a clean plastic tray with the prescription for taking to the patient for administration.

6.3.8  Pre administration checks for Injectable medicines.

6.3.8.1  Identify the correct patient, checking the prescription sheet corresponds with the patient’s identity band. Check patient’s identity band does not signify allergy to any drug or substance or that has any other necklace or bracelet stating allergy to particular substances. Wherever possible the second nurse who has checked the preparation of the parenteral medicines should also be involved in the positive identification of the patient.

6.3.8.2  Check the prescription contains the following information:
   •  patient’s name, hospital/NHS Number or date of birth or address;
   •  prescriber’s signature;
   •  the approved medicine name;
   •  the dose and frequency of administration;
   •  the date and route of administration;
   •  the allergy status of the patient (see point 6.1.8 above ).

6.3.8.3  Also check, where relevant:
   •  brand name and formulation of the medicine;
   •  concentration or total quantity of medicine in the final infusion container
   •  or syringe;
   •  name and volume of diluent and/or infusion fluid;
   •  rate and duration of administration;
   •  type of rate-control pump or device(s) to be used;
   •  the age and weight of any patient under 16 years of age, where relevant;
   •  date on which treatment should be reviewed.
Information on the different methods of administering IV medicines can be found in appendix 4. or through the medusa link at http://medusa.wales.nhs.uk

6.3.8.4 Check that the medicine is due for administration at that time and has not already been given. If the prescribed drug is not available this must be recorded and measures taken to ensure resolution of the problem.

6.3.8.5 Assemble everything you need including any flushing solution(s) and any protective clothing required as specified by hospital policy e.g. infection control policy, administration of cytotoxic drugs policy etc.

6.3.8.6 Explain and discuss the procedure with the patient.

6.3.8.7 Check any infusion already in progress. It should be free of haziness, particles and discolouration.

6.3.8.8 Prior to any IV drug administration, the cannula/lumen/port must be checked for patency, malfunctions and signs of extravasation or infection.

6.3.8.9 The needle free device must be decontaminated with a 2% chlorhexidine & 70% isopropyl alcohol swab and allowed to air dry before use unless specified by other Trust Policies/Guidelines e.g. Hickman Lines. The practitioner should flush the cannula/port/multi-lumen with 5mls of normal saline prior to the drug being administered in between multiple drug administration and on completion of the drug administration unless otherwise contraindicated and care should be taken to ensure that normal saline is compatible with the drug being administered.

6.3.9 Administration of injections – general

6.3.9.1 The nurse/midwife/medical practitioner administering the drug must have been involved in the preparation or checking process.

6.3.9.2 Check infusions. They should be should be free of haziness, particles and discolouration.

6.3.9.3 Use aseptic (non-touch) technique at all times.

6.3.9.4 Attach administration sets to infusion containers carefully, on a flat surface and using the technique appropriate to the type of container.

6.3.9.5 Prime the access device immediately before starting an infusion.
6.3.9.6 Patients must be monitored appropriately during administration of the IV drug for signs of discomfort or adverse reaction and should be made aware of the importance of reporting any abnormal or unusual sensations.

6.3.9.7 Administration of infusions prepared in clinical areas should be completed within 24 hours of preparation. There should be a record of those involved in the monitoring as well as the original set up of the medication.

6.3.9.8 Infusions administered via infusion pumps must be monitored according to Trust policy RM 58 to minimise the risk to patients.

6.3.9.9 If there is any sign of an adverse reaction to the drug, ensure the patient is safe; inform the nurse/midwife in charge and the medical staff. The incident should be reported via the yellow card scheme. (MM 01)

6.3.10 After administration

6.3.10.1 Sign the drug chart/IV prescription sheet/nursing notes/fluid balance charts as appropriate. Any discrepancies in administration must also be documented using the correct code from the drug chart if appropriate.

6.3.10.2 If the medication is refused or omitted or the patient does not receive the full dose, the nurse/midwife in charge of the ward must be informed along with the medical staff.

6.3.10.3 If an error occurs the nurse/midwife in charge of the ward and the medical staff must be informed and the incident reported via the DATIX system.

6.3.10.4 Discard the empty ampoules/vials from which the injection was prepared and any unused medicine. Ampoules or vials should never be used to prepare more than one injection unless specifically labelled by the manufacturer for ‘multi-dose’ use.

6.3.10.5 Re-check the administration site for signs of leakage, infection or inflammation and continue to monitor the patient, contents of the infusion container and the rate of infusion according to the Trust Core Care Plan.

6.3.10.6 Check that arrangements for monitoring fluid balance or clinical parameters have been made. Ensure that relevant documentation is made available for subsequent regular monitoring to take place.
6.3.11 Specific arrangements for theatres

6.3.11.1 All medicines administered to the patient are the responsibility of the anaesthetist.

6.3.11.2 With the approval of the anaesthetist and following his/her verbal instructions, the approved anaesthetic assistant may prepare all drugs in readiness.

6.3.11.3 Careful consideration is given to the appropriate usage of drugs and correct dosage:
- The anaesthetist prior to use must check the prepared drugs
- Any uncertainty must be resolved with the anaesthetist

6.3.12 Preparation in theatre

6.3.12.1 Drugs must be prepared in an aseptic manner as described in sections 6.3.2 to 6.3.6 of this policy. All ampoules including water for injection and sodium chloride 0.9% must be stored in the original manufacturer’s packaging. Once an ampoule is removed from the original packaging, it is not advisable to put it back into the packaging if it is no longer required. This may be done in exceptional circumstances where a thorough check of drug name and strength is made to ensure it is put in the correct box.

6.3.12.2 Each drug that is required is selected and drawn into a syringe one at a time & labelled as described in 6.3.13 before the next medicine is drawn up.

6.3.12.3 All ampoules used are retained until the end of the case.

6.3.12.4 If for any reason the injection/ infusion cannot be given immediately or used within the same theatre list it must be discarded.

6.3.13 Labelling in theatre

6.3.13.1 All boluses (including flushes) should be labelled. Small colour-coded labels are available in theatres for the majority of commonly used drugs. Completion of the solution strength on the label should be considered. **Syringes must not be pre-labelled before the medicine is drawn into the syringe**

6.3.13.2 All infusions must be labelled with a yellow infusion sticker stating: drug, dose/strength, patient’s name, date & time of preparation.

6.3.13.3 Additionally, epidural drugs should have an orange ‘epidural use only’ sticker on the syringe/infusion.
6.3.13.4 Double check that the drug name and strength on the label attached to the syringe is the same as the drug name and strength on the empty ampoule.

6.3.13.5 Place the labelled syringe/infusion into a tray with the empty ampoules/vials used in the preparation. Local anaesthetic drugs (e.g. for epidural or nerve blocks) must be placed in a yellow tray.

6.3.13.6 Where drugs are prepared under aseptic conditions it is not possible for these to be labelled. Following preparation, they must remain stored in an aseptic tray. Different drugs should be drawn into different sized syringes to aid identification.

6.3.14 Decanting vials in theatre

6.3.14.1 Where a vial is being divided into smaller volumes for multiple infusions (e.g. propofol, remifentanil), this should be done before infusions are attached to administration sets and/or patients. All infusions should be labelled with a yellow infusion sticker and all details.

6.3.14.2 Decanted drugs must be disposed of 12 hours following initial opening of the vial.

6.3.15 Preparation of Drugs for Theatre Lists

6.3.15.1 If it is necessary to prepare different patients’ drugs in advance, they must be prepared separately and then kept separately (i.e. placed in a tray, which is then placed inside a drug cupboard), to ensure they are not used by mistake. Previous patient’s drugs must be discarded prior to the next patient being admitted to the anaesthetic room. **No more than two patients’ drugs can be prepared at any time.**

6.3.15.2 All drugs should be properly labelled and must state the patients’ names clearly.

6.3.15.3 Any drugs remaining must be discarded at the end of the list.

6.3.16 Checking Procedure for parenteral medication in theatre

6.3.16.1 A second qualified member of staff must check both the drug and the flushing solution. The checker may be a doctor or registered nurse.

6.3.16.2 The name of the drug and the strength on the labelled syringe must be matched with the empty vial.
6.3.16.3 Drug and diluents should be checked to ensure they have not exceeded the expiry date.

6.3.16.4 Check the syringe/bag for visible particles, and ensure the syringe/bag is thoroughly mixed.

6.3.17 Administration of Intrathecal Chemotherapy

6.3.17.1 To optimize patient safety Intrathecal Chemotherapy will be administered at Sunderland Royal Hospital following the policy in place at City Hospitals Sunderland FT. The operational arrangements are described in MM06.

6.4 Mixing of Medicines prior to administration

6.4.1 Historically the mixing of medicines (other than those licensed to be mixed together, or in situations where one product is a vehicle for the other) was restricted to:

- Doctors and dentists mixing and then administering medicines to a patient
- Pharmacists mixing medicines to the specifications of a doctor or dentist
- Holders of a manufacturing licence

This is because mixing renders the products unlicensed.

6.4.2 Recent changes to legislation have enabled the common practice of mixing medications to be allowed under the following conditions:

- Doctors and dentists can direct others to mix
- Nurse, midwife and pharmacist independent prescribers can mix medicines for themselves and direct others to mix for administration purposes
- Supplementary prescribers may direct others to mix as long as this is covered in the clinical management plan

6.4.3 The following examples of mixing are not covered by the Legislation

- More than one liquid preparation administered either in the same medicine pot or down an enteral line without a flush in between
- Y-site intravenous infusion compatibilities
- Subcutaneous syringe drivers containing more than one drug, where the diluent is not specified
- Dialysis fluids
- Non-injectable preparations (e.g. nebules, creams) mixed with other non-injectable preparations
- Injectable drugs being mixed and administered together unless licensed to do so, e.g. cefuroxime and metronidazole are not licensed to be mixed, however ceftriaxone and lidocaine are.
6.4.4 It has been custom and practice for some commonly used medicines to be mixed prior to administration. It is recognised that it would not be practical for prescribers to endorse these on each occasion to indicate that the medicines can be mixed.

6.4.5 The Medicines Governance Group have reviewed the current position and approved the following for routine practice:-

- Liquid or dispersible medication should be administered in separate pots and never mixed together
- Liquid or dispersible medication administered down an enteral line must be administered individually, with an appropriate flush between drugs
- Intravenous infusions being administered at a Y-site should be compatible according to Medusa, the injectable medicines guide, (Appendix 4) Infusion combinations not found on Medusa, or those requiring more data, should be discussed with the Medicines Information department. A note should then be made in the medical records detailing the advice given.
- Subcutaneous drugs (including infusions in syringe drivers) and their diluents should be checked against an appropriate reference source such as the Palliative Care Formulary, the Syringe Driver Handbook, or the website www.palliativedrugs.com. Combinations not found in these references should be discussed with the ward pharmacist or Medicines Information department. A note should then be made in the medical records detailing the advice given.
- IV and SC compatibility charts should be readily available in the areas frequently mixing their medicines this way, e.g. critical care units, cancer wards.
- Non-injectable preparations (e.g. creams, nebulers) should not be mixed without specific authorisation from the Medicines Governance group (see note below)
- Medicines that have been mixed should be administered immediately.
- It is acknowledged that the mixing of salbutamol and ipratropium nebulers prior to administration, and also cefuroxime and metronidazole injection, are routine practices in many areas. Authorisation is granted by the Medicines Governance Group for this practice to continue.

6.4.6 No other medicines should be mixed together prior to administration unless the prescriber specifically indicates this on the prescription.

6.4.7 It is recognised that some areas may mix specific medicines for legitimate reasons not recognised in 6.4.5. Where there is a good clinical reason to mix these medicines, this should be highlighted to, and authorisation sought, from the Medicines Governance Group.
6.5 **Self Administration**

6.5.1 There is increasing literature evidence of benefit from patient’s retaining or assuming responsibility for some or all of their medicines during their stay in hospital. Any transfer of responsibility should occur on the basis of an assessment of the patient’s ability to manage the tasks involved and with the patient’s agreement. Schemes for this transfer of responsibility may incorporate a stage in which the patient undertakes self-administration under direct supervision of an authorised member of staff.

6.5.2 To introduce this practice in any clinical setting within the Trust there must be an agreement between senior representatives of all disciplines involved (managers, nurses, doctors and pharmacy staff) to ensure safe and secure processes are established.

6.5.3 Each area will have different requirements, as such there can be no single Trust policy. However all local policies must adhere to the following principles:

(i) There is a facility for safe storage of the individual’s medication. This must ensure the patient has controlled access to an adequate supply of the correct drugs AND that the medicines cannot be subject to unauthorised removal eg by other patients. This will usually be a locked drawer or POD cabinet.

(ii) There is an approved pharmacy service which includes assessment of PODs and consideration of storage conditions to ensure all medicines taken are fit for use.

(iii) Patients should be formally assessed for their ability to administer their own medicines. This assessment should be documented.

(iv) Where the programme is intended to provide a period of supervised medicines administration to achieve competence by the time of discharge; the degree of training/education of the patient should be documented.

(v) How patients will be monitored/supervised/further trained and assessment should be documented. The patient must agree and provide written consent.

(vi) Where full unsupervised self administration is planned, arrangements must be approved for the safe holding of keys by patients and ensuring their return on discharge.

(vii) A full protocol is approved by the Medicines Governance Group.
6.5.4 Insulin

The Trust recognises the benefits of supporting self administration of insulin during inpatient stay. At the present time there are no approved protocols for either competency assessment of the patient or safe storage of keys by the patient. Until these are developed:

- Insulin should be stored in the locked bedside medicine cabinet
- At administration time the nurse will open the bedside medicine cabinet and encourage the patient to self administer their insulin under supervision.

7. Training

In addition to mandatory training described in MM01 nurse preceptees will be supported in a process of skills development and assessment by Ward Managers and Senior Nurses to enable them to safely discharge their duties with respect to medicines administration. A range of tools are available to support this development:

- Medicines Management Study Day for Nurse Preceptorship
- “Safe-Medicate” e-learning/assessment
- IV administration theoretical training

8. Equality and diversity

An equality analysis has been undertaken for this policy, in accordance with the Equality Act (2010).

9. Process(s) for monitoring compliance with the policy

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10. **Consultation and review**

Members of the Medicines Governance Group and the Equality and Diversity Co-ordinator.

11. **Implementation of policy (including raising awareness)**

All members of staff will be informed via e-mail and the Medicines Management Newsletter as and when the policy is reviewed and re-implemented.

12. **References**

- Medicine Act 1968
- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Misuse of Drugs Safe Custody Regulations 1973
- Health Act 2006
- Equality Act 2010
- Controlled Drug (Supervision of Management and Use) Regulations 2006
- The Government’s response to the Shipman Inquiry’s Fourth Report
- The Duthie Report – Guidelines for the Safe and Secure Handling of Medicines (March 2005 revision The Safe and Secure Handling of medicines: A Team approach RPSGB
- NMC Standards of Conduct, Performance and Ethics for Nurses and Midwives
- NMC Standards for Medicines Management
- NMC Midwives Rules & Standards
- NMC Standards for proficiency for Nurse and Midwife Prescribers
- The Best Medicine - Health Care Commission 2007
- British National Formulary,, BMJ Group & RPS Publishing, UK
- A Spoonful of Sugar: Medicines Management in NHS Hospitals.
- Audit Commission 2001
- Building a Safer NHS for Patients – improving medication safety (DH 2004)
- NHS Litigation Authority
- An Organisation with a Memory (DoH, 2000)
- Medicines Management: Everybody’s Business
- A guide for service users, carers and health and social care practitioners (DH, 2008)
• Medicines Adherence: involving patients in decisions about prescribe medicines and supporting adherence. NICE Clinical Guideline 76 (2009)
• National Prescribing Centre, Mixing of medicines prior to administration in clinical practice – responding to legislative changes, May 2010
• Department of Health, Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing, May 2010
• Thames Valley Y-Site Intravenous Drugs Compatibility Chart (March 2011), Thames Valley critical care network pharmacists group
• Palliative care Formulary
• The Syringe Driver: Continuous Subcutaneous Infusions in Palliative Care
• National Cancer Peer Review Programme – Chemotherapy Measures
• Updated national guidance on the safe administration of intrathecal chemotherapy
• NCEPOD Systemic Anti-Cancer Therapy: For better, for worse? (2008)
• NCAG Chemotherapy Services in England: Ensuring quality and safety (2009)

13. **Associated Documentation**
   
   MM02: Ordering, Supply, Transport and Storage of Medication Policy
   MM03: Medicines Administration Policy
   MM04: Prescribing Policy
   MM05: Safer Management of Controlled Drugs Policy
   MM06: Anticancer Medicines Policy
   
   RM04: Incident Reporting and Investigation Policy
   RM40 Positive patient identification.
**Appendix 1**

**Medication unavailable?**

**What you should do before you ‘3’ it**

- **Drug available?**
  - **Yes**
    - Administer dose
  - **No**
    - Does the drug require parenteral administration? or Would missing a dose compromise the patient’s treatment (e.g. diabetes, epilepsy etc.)? Refer to *Critical Medicines List* to aid decision-making?
      - **Yes**
        - Immediate action must be taken to obtain a supply
      - **No**
        - 1st missed dose
        - 2nd or subsequent missed dose
          - Document No. 3 on drug chart
          - Take action to obtain a supply of medication. If not possible and out of hours send temp stock to pharmacy.
          - Document TS ordered, date and sign in other instructions box on drug chart

**How to obtain a supply**

- During pharmacy opening hours: Contact ward pharmacy team
- Out of hours:
  - Ask family / carer to bring PODs into hospital
  - Check emergency drug cupboard list (Copy on ward or Medicines Information page on the Intranet)
  - Bleep 1200 to obtain supply from emergency drug cupboard
  - If you know that a specific ward stocks the item, you can borrow whole, original packs from them, but do not spend time ringing around the wards
  - Bleep the emergency duty pharmacist, via the switchboard, who will be able to advise you on how a supply of the medicine may be obtained, or whether or not the dose could be missed

**When the drug becomes available, administer the dose after first clarifying with a pharmacist or medical staff if this is appropriate**

**Do everything you can to avoid missed doses**

Missing doses of important medication compromises patients’ treatment, can be potentially harmful and may lengthen their stay in hospital.

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*Critical Medicines List*  
Trust Intranet > Medicines Information > Clinical Info > Critical Medicines List