Southern Hampshire
PRIMARY CARE ALLIANCE

Medicines Management Policy

1.2

Purpose of Agreement	This policy sets out standards to ensure safe and secure prescribing, ordering, storing, and administration of medicines within Southern Hampshire Primary Care Alliance.
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Version	Date	Author	Change Summary
1.2	21/07/2022	L Busher	Formatting changes and review

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1. INTRODUCTION

1.1 Southern Hampshire Primary Care Alliance (SHPCA) is committed to the safe and secure handling of medicines. This policy sets out the standards which SHPCA expects its employees to adhere to in relation to the care and control, prescribing, ordering and administration of medicines across all services provided. Individual services can develop local procedure within this framework in consultation with the lead clinical pharmacist and approved by the relevant lead clinical director.

1.2 This Policy takes account of current legislations, national guidance, recommendations and professional code of conducts with the best interests of patients to whom medicines are administered. As these change with time, all staff has responsibility to identify where new guidance may conflict with this policy.

1.3 All healthcare professionals within SHPCA must understand their requirement to maintain currency and to work within their professional boundaries in order to deliver safe and effective clinical care.

2. SCOPE

2.1 This policy applies to bank, locum, permanent and fixed term contract employees (including apprentices) who hold an employment contract with SHPCA, Clinical Directors, external contractors and other workers who are appointed to SHPC.

2.2 The Policy explains the activities intrinsically linked to prescribing, administration, ordering, storage and disposal. This Policy plays important role in the treatment of all clients receiving care across all services provided by the organisation.

2.3 SHPCA is committed to creating and implementing policies and procedures that meet the diverse needs of our clients and workforce. We will strive to ensure that our service users, staff and the wider community are treated fairly and have equal opportunities, in accordance with the Equality Act 2010. Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

3. CONTROLLED STATIONERY

3.1 Prescription forms should be considered as assets that have financial value. Their theft and misuse can lead to significant financial loss for the NHS and potentially result in harm. Prescription forms must be treated as 'blank cheques'. Individual prescribers are responsible for the security of prescription forms once issued to them and must ensure that they are locked away securely when not in use.

3.2 Any person issued with a blank prescription form/pad will be held accountable for its security and arrangements for security must be documented in a Standard Operating Procedure (SOP).

3.3 All services must maintain clear and unambiguous records of FP10 prescription pads ordered, received and distributed. As a matter of best practice prescribers must keep a record of serial number of prescription forms issued to them.

3.4 Blank prescriptions must never be pre-signed.

3.5 The Organisation's SOP for Ordering, Supply and Security of FP10 Prescription Pads must be followed where one or more prescriptions are believed to be lost or stolen. An incident form must be completed and reported.

3.6 When reporting an incident to the NHSCFA, as much detail as possible is to be given, this includes:

- Practice name
- Reporter's contact details
- Date and time of incident
- Where the incident occurred
- Type of prescription form
- Serial numbers
- Quantity
- Details of individual from whom forms have been stolen
- Whether the police have been notified
- Have local pharmacies and practices been notified?

3.7 Such incidents can be reported online at https://cfa.nhs.uk/reportfraud or by telephone 0800 0284060.

4. PRESCRIBING

4.1 For the purpose of this document, Prescribing relates to production of a signed prescription form or an electronic prescription for the purpose of a patient's treatment by an authorised prescriber.

4.2 There should be shared decision making between prescribers and patients (including children, young people and their parents or carers) in discussions about their medicines. Risks and benefits of treatment should be discussed, considering patient beliefs and ideas.

4.3 Authorisation to Prescribe

4.3.1 Doctors are the largest group of prescribers, followed by Dentist who are able to prescribe on registration. Independent and Supplementary prescribers from a range of other healthcare professionals are also permitted to prescribe medicines for patients within their scope of practice. Within SHPCA services these will be Acute Nurse Practitioners and Pharmacist Prescriber.

4.3.2 Prescribers hold different prescribing rights. The Royal Pharmaceutical Society has a competency framework which includes a common set of competencies that form the basis for prescribing, regardless of professional background.

4.3.3 SHPCA encourages all staff who are Non-Medical Independent Prescribers (NMIP) to attend all the Prescribing Forums hosted by the CCG which are held quarterly and expect staff to attend a minimum of 3 forums within a year as a mandatory requirement.

4.3.4 It is the responsibility of the Clinical Director Prescribing Lead at SHPCA to ensure that independent prescribers have the necessary skills and knowledge to carry out the role.

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

4.4 Prescription Writing Requirements

4.4.1 The guidelines set for prescribing by the BNF should be adhered to when writing prescriptions. Prescriptions should be written legibly in ink or otherwise, to be indelible, should be dated, should state the name and address of the patient, the address of the prescriber, an indication of the type of prescriber, and should be signed in ink by the prescriber (computer-generated facsimile signatures do not meet the legal requirement). The age and the date of birth of the patient should preferably be stated, and it is a legal requirement in the case of prescription-only medicines to state the age for children under 12 years. These recommendations are acceptable for **prescription-only medicines**.

Wherever appropriate the prescriber should state the current weight of the child to enable the dose prescribed to be checked

- The strength or quantity to be contained in capsules, lozenges, tablets etc. should be stated by the prescriber.

- The unnecessary use of decimal points should be avoided, e.g., 3 mg, not 3.0 mg. Quantities of 1 gram or more should be written as 1 g etc. Quantities less than 1 gram should be written in milligrams, e.g., 500 mg, not 0.5 g. Quantities less than 1 mg should be written in micrograms, e.g., 100 micrograms, not 0.1 mg. When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, e.g., 0.5 mL, not .5 mL. Use of the decimal point is acceptable to express a range, e.g., 0.5 to 1 g.

- units should not be abbreviated.

- The term ‘millilitre’ (ml or mL) is used in medicine and pharmacy, and cubic centimetre, c.c., or cm^3 should not be used. are recognised SI abbreviations).

- Dose and dose frequency should be stated; in the case of preparations to be taken ‘as required’ a minimum dose interval should be specified. Care should be taken to ensure children receive the correct dose of the active drug. Therefore, the dose should normally be stated in terms of the mass of the active drug (e.g., ‘125 mg 3 times daily’); terms such as ‘5 mL’ or ‘1 tablet’ should be avoided except for compound preparations. When doses other than multiples of 5 mL are prescribed for oral liquid preparations the dose-volume will be provided by means of an oral syringe, (except for preparations intended to be measured with a pipette). Suitable quantities:

  - Elixirs, Linctus, and Paediatric Mixtures (5-mL dose), 50, 100, or 150 mL
  - Adult Mixtures (10 mL dose), 200 or 300 mL
  - Ear Drops, Eye drops, and Nasal Drops, 10 mL (or the manufacturer’s pack)
  - Eye Lotions, Gargles, and Mouthwashes, 200 mL

- The names of drugs and preparations should be written clearly and not abbreviated, using approved titles only; avoid creating generic titles for modified-release preparations.

- The quantity to be supplied may be stated by indicating the number of days of treatment required in the box provided on NHS forms. In most cases the exact amount will be supplied. This does not apply to items directed to be used as required—if the dose and frequency are not given then the quantity to be supplied needs to be stated. When several items are ordered on one form the box can be marked with the number of days of treatment provided the quantity is added for any item for which the amount cannot be calculated.

4.4.2 For computer-issued prescriptions or Electronic Prescription Service (EPS), advice and recommendations from the Joint GP Information Technology Committee (link), must be followed.

4.4.3 Clinicians must be sure to confirm with patient the designated pharmacy is used and in the incidence of night-time prescribing, a list of late-night pharmacies is available for reference below: Late Night Pharmacies

Late Night Opening Pharmacies IPCAS - .xl

4.5 Self-prescribing or prescribing for people that the prescriber has a close relationship to:

4.5.1 GMC Good Medical Practice Guidance updated in 2021 states the following:

- Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship (family, friends or colleagues)

- If you prescribe for yourself or someone close to you must:

a) Make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe.

b) Tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object.

You must not prescribe a controlled medicine for yourself or someone close to you unless:

- no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient's, life or health at risk or cause unacceptable pain or distress, and

- the treatment is needed immediately to save life, avoid serious deterioration or harm.

- you must be able to justify your actions and must document your relationship and the emergency circumstances that necessitated your prescribing a controlled drug for someone close to you.

4.5.2 The regulatory body for nurses (NMC) advises in the Standards for Proficiency for Nurse and Midwife prescribers:

Practice Standard 11.

- You must not prescribe for yourself.
- You should never prescribe for anyone with whom you have a close personal or emotional relationship, other than in an exceptional circumstance.
- If a prescription is necessary, you should refer this to be undertaken by another registered prescriber wherever possible.

4.6 Prescribing Antibiotics

When prescribing antimicrobials, prescribers should follow the relevant local (South Central Antimicrobial Guidelines) and NICE guidelines to minimise the risk of antimicrobial resistance. The following also needs to be considered:

- prescribing the shortest effective course
- the most appropriate dose
- route of administration.

4.6.1 All prescribers prescribing antibiotics must be familiar with and adhere to the relevant local antibiotic policies.

4.6.2 For patients who have recurrent or persistent infections, consider taking microbiological samples when prescribing an antimicrobial and review the prescription when the results are available.

4.6.3 For patients who have non-severe infections, consider taking microbiological samples before deciding about prescribing an antimicrobial, providing it is safe to withhold treatment until the results are available.

4.6.4 Guidance from CCG regarding prescriptions of anti-microbials exists in the form of a downloadable app (telephone/desktop) This must be followed within SHPCA services when prescribing for patients OOH.

4.7 Prescribing Hypnotics and anxiolytics

4.7.1 Hypnotics and anxiolytics should only be prescribed for short courses to alleviate acute conditions after causal factors have been established.

4.7.2 Benzodiazepines should be prescribed for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness. The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress.

4.8 Prescribing NSAIDS

4.8.1 Every time a prescriber signs a prescription for an NSAID, or other drug needing regular monitoring, they need to be sure that the required blood tests and other monitoring have been done within the appropriate time scale and that the results are within the normal range.

4.8.2 The lowest effective dose of NSAID should be prescribed for the shortest period to control symptoms and the need for long-term treatment should be reviewed periodically. (NB a regular audit is run on EMIS as part of the organisation's

clinical audit, to identify those patients on regular & prolonged use of NSAID courses).

4.8.3 DOACs (apixaban, dabigatran, edoxaban, rivaroxaban) have dosing requirements that means monitoring is required. As kidney function can change over time, or with disease, regular monitoring is needed. There is a national guidance to help prescribers monitor kidney function for DOAC dosing.

4.8.4 Disease modifying anti-rheumatic drugs (DMARDs), such as methotrexate and azathioprine, have a number of potentially dangerous side-effects which calls for careful monitoring when prescribed. The British Society for Rheumatology, British Health Professionals in Rheumatology Standards and the British Association of Dermatologists guideline for DMARD therapy (2008) states that, when considering DMARD as a choice of drug, the patient must be carefully monitored so that there is no delay in the detection of any adverse effect of the drug.

4.8.5 Other high-risk medicines which require regular monitoring to ensure safe prescribing include amiodarone, mesalazine, lithium, Valproate

4.8.6 Regular searches and recall systems run by admin will be undertaken and overseen by a clinical pharmacist, GP or practice nurse. This will involve checking blood test results, confirm monitoring and frequency for new patients, dealing with any problems and queries arising, and audit the procedure.

4.9 Controlled Drugs

4.9.1 Within SHPCA, the prescribing of controlled drugs is restricted to medical prescribers only. At present, non-medical prescribers are unable to prescribe controlled drugs held on the SHPCA formulary. Prescriptions for controlled drugs are subject to the principal legal requirements detailed by the Department of Health.

4.9.2 No Controlled Drugs are kept within any of the IPCAS sites. As part of SHPCA's clinical audit periodic prescribing habits audits are carried out to assess trends and rationale for prescribing.

4.9.3 Caution must be exercised when prescribing CDs and rationale for doing so clearly documented in EMIS. Legally, the prescription must always state:

- the name and address of the patient
- in the case of a preparation, the form and where appropriate,
- the strength of the preparation
- either the total quantity (in both words and figures) of the preparation
- or the number (in both words and figures) of dosage units, to be supplied.
- in any other case, the total quantity (in both words and figures) of the Controlled Drug to be supplied
- the dose

- prescription must be indelible and must be signed by the prescriber, be dated and specify the prescriber's address.
- When more than one strength of a preparation exists, the strength required must be specified. The instruction "One as directed" constitutes a dose but "as directed" does not.

4.9.4 When opioid medicines are prescribed, in circumstances other than acute emergencies, the healthcare practitioner involved:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records.
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g., for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).
- Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.

4.9.5 It is good practice for NHS prescriptions for Schedule 2 to 4 CDs to be limited to a total of 30 days' supply. In exceptional circumstances where a prescriber believes a supply of more than 30 days is clinically indicated and does not pose an unacceptable risk to patient safety, an extended amount may be prescribed. In such cases the reason for the extended supply must be recorded on EMIS in the patient's notes and the prescriber must be able to justify their decision.

4.10 Repeat Prescribing

4.10.1 Repeat medication requests in out of hours services, are a common presentation. Points to consider prior to prescribing include:

- When the medication was last taken
- What dose and the circumstances of the medication having been stopped
- Whether the patient requires a further supply of this medication
- If no contraindications for repeat prescribing
- Does the patient have sufficient left?
- Ascertain if it's more appropriate for patient's own GP to review patient in hours

4.10.2 The potential for abuse when medication is requested by patients should be considered. Considerations to mitigate over prescribing include:

- Previous out of hours' encounters highlighting as opposed to seek care from own GP Practice
- Clear lack of continuous monitoring and review from own practice for medication
- The possibility of fabricated and induced illness may need to be considered in the case of parents or carers attempting to obtain medication(s) for a child from an out of hours' service.

4.10.3 In the case of drugs with the potential for abuse, GPs caring for patients in the out of hours' setting should consider prescribing the minimum possible dosage and quantity of drugs. For drugs such as antibiotics, it is usually advisable to issue the full course of treatment.

4.10.4 Repeat prescriptions are not permitted for schedule 2 or 3 Controlled Drugs.

5. ORDERING MEDICINES/MEDICAL DEVICES

5.1 Nominated staff, with appropriate qualifications and competencies may order medicines and medical devices such as dressings using approved prescriptions and/or order forms (as agreed between each service and the Medicines Management Team) from a pharmaceutical wholesaler or directly from a manufacturer.

5.2 Patient's themselves, or their carer, are generally responsible for ensuring their medicines are ordered in good time via their local community pharmacy. For dressings, SHPCA nurses who will apply the dressings are responsible for ordering appropriate supplies.

6. EMERGENCY MEDICINES

6.1 Drugs are held in each IPCAS site to help manage medical emergencies. These medications should be held in safe and appropriate storage conditions, not exceeding 25°C.

6.2 The list of Emergency Medicines can be found in the service Lead Agreement (SLA), which is subject to appropriate routine risk assessments and review. This is to identify a list of medicines that are **no longer** suitable to be stocked.

6.3 There should be a process and system in place to check that drugs are in date and equipment is well maintained. The policy and procedure to store and secure medicines should be followed at all times for these medicines.

7. TRANSPORT AND RECEIPT OF MEDICINES

7.1 All medicines/medical devices will be transported in such a way as to take account of their safety of staff and storage requirements. All orders and dispatches must be recorded, and tamper evident containers shall be used where possible. Dispatches from a central stock site which is currently at Waterlooville Health Centre, should be recorded on individual transport sheets which will be signed by the delivery driver upon receipt. A copy of the transport sheet will be retained by the head of clinical service.

7.2 Medicines in transit shall only be left unattended if they are placed out of sight in a locked vehicle and only for the period of delivery to another unit. Medicines must never be left in a delivery vehicle overnight.

7.3 SHPCA does not currently handle any medicine/medical device that require refrigeration and cold chain control.

7.4 Upon delivery, the appointed lead for the service will be asked to sign for the delivery. A delivery note shall accompany each delivery of stock medicines. The authorised member of staff receiving the order shall check the medicines against the delivery note and sign for receipt. Discrepancies shall be notified to the supplier as soon as possible and an incident form completed.

8. STORAGE AND SECURITY OF MEDICINES

8.1 SHPCA service sites do not currently keep medicines with the exception of medicines for emergency use, and non-prescription-only wound care products. Where other medicines are handled by services within the alliance, they must be stored in a robust, lockable medicine cupboard or medicines trolley not exceeding 25°C. Medicines cupboards should be securely fixed to the floor or wall and not accessible to the public. Medicines that are for internal use (e.g., oral, injectable) and external use (e.g., medicated dressings, topical preparations) must be stored separately from each other in different medicines cupboards or different parts of the same cupboard. Medicine cupboards must be reserved solely for the use of medicines and must not be used for any other product.

8.2 All medicines will be stored safely under the guidance of the Lead Clinical Pharmacist and the Quality and Governance Lead. Site manager/service lead is responsible for ensuring that all medicines/medical devices in their department are currently in date, and that regular checks are carried out to remove out of date items. Practitioners are personally responsible for the security of all medicines while they are in their possession. Separate stock control policies can be found under the IPCAS SOP.

8.3 Adequate provision must be made to enable access to named medicines in an emergency. The local storage arrangements must take account of the need for quick access compared to the risks associated with misappropriation.

8.4 The Service lead, with support from the Head of Clinical Services, will make checks to ensure compliance with the Medicines Management Policy every month. A monthly total stock check is required by the Clinical Service Team to ensure that the stock is in line with the Stock Control Management System. Any Discrepancies are to be brought to the attention of the Lead Clinical pharmacist and medical Director.

8.5 Dressings

8.5.1 All dressings used in IPCAS must be on the Hampshire and Isle of Wight Formulary and ordered through the Online Prescription Ordering Service (ONPOS). Two central accounts exist for SHCA, one for Fareham and Gosport CCG and the other South East Hants CCG. Orders must be submitted to Service Manager for approval and further details can be found within the IPCAS SOP.

8.5.2 Patients with particularly complex dressing needs (non-formulary) will be expected to provide these dressings. Examples of which include Pico pump and burns dressings.

8.5.3 All dressings stock is stored in a designated lockable place in the host site and robust stock control processes in place to monitor and maintain stock levels. Refer to the organisation's stock control policy for more information.

9. REMOTE PRESCRIBING

9.1 The GMC's guidance on remote prescribing is set out in the Good Practice in Prescribing medicines and devices. Prior to prescribing remotely by telephone, video-link or online, the clinician should be satisfied that:

- an adequate assessment can be made
- that a dialogue can be established with the patient
- that it is possible to obtain the patient's consent

9.2 Doctors and other non-medical prescribers must consider the limitations of electronic communication (phone, internet, Skype etc) when consulting remotely. They must also consider the following:

- the need for physical examination or other assessments
- whether you have access to the patient's medical records
- You are satisfied that you are in a position to prescribe safely
- You are satisfied that the medication you prescribe serves the patient's needs
- non-surgical cosmetic products, e.g., Botox, cannot be prescribed remotely, as a physical examination of the patient must be undertaken prior to prescribing these preparations.

9.3 When prescribing for a patient in a care/nursing home or hospice, there must be communication with the patient, or if this is not possible, with the person caring for the patient, in order to make an assessment, and deliver the appropriate information and advice.

9.4 Clinicians must ensure that any instructions, such as regarding administration or monitoring of the patient's condition, are understood, and that written confirmation is sent as soon as possible.

9.5 The GMC states that if the patient has not been referred by their GP, there is no access to their medical records, and the doctor has not previously provided the patient with face-to-face care, doctors must:

- Give their name and, if prescribing online, their GMC number
- Explain how the remote consultation will work, and what to do if they have any concerns or questions
- Follow the advice on sharing information with colleagues, issued by the GMC in the guidance.

9.6 The GMC emphasises that continuity of care is a key patient safety issue when conducting remote consultations and that when the episode of care ends, the doctor must handover the following to the patient's own GP:

- Changes to the patient's medication (existing medication changed or stopped, and new medication commenced), with reasons
- Length of planned treatment and any monitoring requirements
- If any new allergies or adverse reactions have been identified unless the patient objects or if privacy concerns override the duty, for example, in sexual health clinics.

9.7 Patients accessing GP care remotely may be located overseas, in which case doctors should consider how they, or healthcare professionals locally, will monitor the patient's condition. Further considerations for clinicians include local differences in a product's licensed name, indications, and recommended dosage regimen. One may also need to consider MHRA guidance on import/export requirements and safe delivery; indemnity cover; and whether one must be registered with the regulatory body in the country in which the prescribed medication is to be dispensed.

10. ADMINISTRATION OF MEDICINES, INCLUDING INJECTABLES

10.1 No person should administer any medicine unless they are competent to do so and are acting within their sphere of professional practice.

10.2 A practitioner must not administer medicines without the authorisation of a doctor or a non-medical prescriber. In addition, individual services may enable qualified practitioners to administer a small number of non-prescription items, at their discretion such as topical applications administered at the discretion of nurses.

10.3 Where medicines have been lawfully dispensed for an individual and are labelled with instructions, practitioners can legally administer the medicines without separate authorisation. Local procedures need to outline where this may be undertaken within each specific service.

10.4 Practitioners within SHPCA do not currently administer medicines or injectables. If this changes in the future, this policy will be adapted to reflect changes.

11. SELF-ADMINISTRATION OF MEDICINES

Any medicine self-administered by a patient in the presence of a clinician must be documented on the EMIS record. It is unlikely that this will happen in IPCAS however there are instances such as checking patient's technique on Inhalers or Clexane use.

12. RETURN AND DISPOSAL OF UNWANTED AND EXPIRED MEDICINE

12.1 Medicines dispensed for a patient are the property of that patient. Community practitioners/pharmacists should encourage patients / carers to return unwanted or obsolete medicines to their community pharmacy for the purpose of disposal.

12.2 The disposal of pharmaceutical waste is governed by the Hazardous Waste Regulations 2005 and compliance must be ensured within each service. All medicines waste must be separated into hazardous and non-hazardous waste.

12.3 The majority of medicines used within the organisation will be non-hazardous. Non-hazardous medicines waste including the primary drug packaging can be disposed of in blue lidded containers which are obtained from stores. They must be sealed when no more than three quarters full. The removal of the box is then arranged as per local procedure. It will then await collection by the waste contractor. Refer to the organisation's COSHH policy and process to deal with hazardous waste

13. INCIDENTS AND ADVERSE EFFECTS OF MEDICINES AND MEDICAL DEVICES

13.1 Any risk of harm to an individual due to an incident involving medicines, must be taken seriously and the clinical care of that person(s) must be a priority.

13.2 Any incident or near miss in which medicines including prescribing incidents are involved must be reported in accordance with the organisation's incident reporting policy. The incident must immediately be reported to and investigated by the appropriate person.

13.3 All prescribing and medication errors are reviewed by the Medication Safety Officer/Lead Clinical Pharmacist and common themes and shared learning are discussed at the Clinical Assurance meeting

13.4 All staff and patients are urged to report suspected adverse drug reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card Scheme. All suspected adverse drug reactions to "black triangle" drugs and any serious or unusual suspected reactions to established products should be reported.

13.5 Any suspected defect in a medicine or medical devices must be reported to the supplier. Reports must include the brand or the non-proprietary name, the name of the manufacturer or supplier, the strength and dosage form of the product, the product licence number, the batch number and the nature of the defect. If the defective medicine has been administered to a patient, the prescriber must be notified, and the incident reported in accordance with the organisation's incident policy.

13.6 All incidents relating to the prescribing, of Controlled Drugs must be reported by Organisation's accountable Officer for Controlled Drugs.

14. REPORTING OF LOSSES / MISUSE OF MEDICINES

Any potential or suspected loss and misuse of medicines must be reported according to the Incident Reporting Policy no later than the next working day.

15. ANAPHYLAXIS AND RESUSCITATION

15.1 The organisation policy for The Management of Resuscitation must be followed and all staff who administer medication must be familiar with the particular protocol for the clinical setting in which they work.

15.2 Practitioners must take responsibility for updating their training on how to recognise the signs and symptoms of anaphylaxis and its treatment.

15.3 All service sites where medicines are administered, must have access to Adrenaline 1:1000 Injection plus associated needles and syringes to administer the medicine intramuscularly. See policy above emergency medicines.

16. PRESCRIBING UNLICENSED AND OFF-LABEL MEDICINES

16.1 A prescriber may prescribe a medicine that does not have a UK or EU product licence (an unlicensed medicine) or may be a medicine that has a product licence for an alternative condition or at an alternative dose to the one being recommended (off-label use).

16.2 Clinicians working within IPCAS may prescribe unlicensed and off label medicines where, on the basis of an assessment of the patient, they conclude, for medical reasons, that it is necessary to do so in order to meet the needs of the patient.

16.3 Where appropriate the patient or their parent/carer must be informed before an unlicensed or off-label medicine is being prescribed or recommended and the

clinicians must be prepared to answer questions asked by the patient. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence.

16.4 When prescribing an unlicensed medicine prescriber must:

- Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
- Take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so
- Make a clear, accurate and legible record of all medicines prescribed and, where prescribers are not following common practice, their reasons for prescribing an unlicensed medicine

16.5 Where a prescriber directs administration of an off-label medicine. Practitioners administering the off-label medicines must be satisfied they have sufficient information to administer the medicine safely and that there is acceptable evidence for the use of the medicine for the intended indication by actively seeking information from the prescriber and other appropriate sources.

17. MEDICINES FOR CLINICIANS

Clinicians must not take medicines from stock for personal use as this constitutes as theft. Normally all clinicians should consult their General Practitioner if they need personal medical care. Medication prescribed should only be issued for patients registered with the Out of Hours Service and prescriptions not written for any other use.

18. MEDICINES REVIEW AND MEDICINES OPTIMISATION

18.1 The review period for repeat medication rests with the prescriber. Within IPCAS services, this will be a task that is carried out at own practice level. That said, the prescriber has a responsibility to highlight to the patient's own practice if they feel optimisation of medications is not being carried out or if patient's adherence to follow a particular regimen is tricky. Medication reviews should be carried out at least annually or, in cases of complex repeat prescriptions, every six months.

18.2 Medicines optimisation is defined as "a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines". The Royal Pharmaceutical Society (RPS) has introduced four guiding principles for medicines optimisation, prescribers should:

- Aim to understand the patient's experience
- Evidence-based choice of medicines
- Ensure the use of medicines is as safe as possible
- Make medicines optimisation part of routine practice

19. PRESCRIBING AUDITS

19.1 Prescribing audits should be carried out continually, at an organisational and individual level. Every GP and non-medical prescriber must demonstrate that they prescribe effectively and safely, by regularly evaluating and changing their practice where necessary.

19.2 Significant-event audits and clinical audits are regularly undertaken by an appointed clinical director and the Lead Clinical pharmacist respectively. Audit tools and resources used but are not limited to include: NICE audit tool, The Healthcare Quality Improvement Partnership (HQIP), RCGP guidance, CCG recommended audit guide.

19.3 Refer to the Organization's Clinical Audit Policy for more information.

20. ROLES AND RESPONSIBILITIES

20.1 The Chief Operating Officer (COO) has overall responsibility for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

20.2 The Clinical Directors, Head of Governance and Quality and Head of Clinical Services on behalf of the COO, will ensure that clinicians and their practice comply with this policy.

20.3 The Combined Assurance Group (Board Committee) is responsible for ratifying this policy and ensuring it represents best practice and is based on current evidenced based information.

20.4 Service/Site leads, or managers will ensure that:

- The requirements of this policy are brought to the attention of all employees working within the service/site
- Employees are supported in the identification of training and development needs and have access to training if required.
- Staff involved in any aspect of medicines use understand their responsibilities and are competent to undertake those responsibilities.
- Facilities and equipment being utilised are provided and maintained to the required standards.
- Systems for routine audit, review of adverse events and patient complaints relating to the handling of medicines are in place.

20.5 The Lead Clinical Pharmacist is responsible for managing this policy and advising on best and current evidenced-base practice.

20.6 All staff must be aware of their roles and responsibilities under the current legislation and adhere to the safe practices outlined in this policy. Persons not complying with this policy will be subject to disciplinary procedures. Staff must also

make themselves familiar with local standard operating procedures for specific areas of work.

20.7 Clinicians have a responsibility to maintain their competency in the management of medicines and to ensure their familiarity with changes to therapeutic guidelines as the organisation adopts them.

20.8 Any breach of this policy must be reported immediately to their head of clinical Services.

20.9 Compliance with this policy does not override any individual responsibility of clinicians to ensure that:

- Their practice complies with current legislation.
- They follow guidance issued by relevant professional bodies (e.g., General Medical Council, Nursing and Midwifery Council, General Pharmaceutical Council) or other government departments such as the Home Office.
- They manage the risks to patients, relatives, carers and staff arising from the use of medicines.

20.10 Copies of the Medicines Management Policy are available to all clinicians working within SHPCA services

21. TRAINING

21.1 Healthcare Professionals who prescribe or administer medicines must be trained to the appropriate level for their duties and must be able to demonstrate competence.

21.2 All staff involved in the handling of medicines require appropriate training. The organization will provide guidance and support to help those to whom it applies to understand their rights and responsibilities under this policy.

21.3 Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy. SHPCA will provide both ongoing face to face and remote support.

22. MONITORING COMPLIANCE VIA AUDITS

The Lead Clinical Pharmacist will routinely monitor aspects of this policy, in particular to prescribing, medicine safety and security. Regular audits will be used to ensure effectiveness and compliance of this policy.

23. REVIEW TIME

This document may be reviewed at any time at the request of either clinicians or management but will automatically be reviewed a triennial basis lest organisational changes, legislation, guidance prompt an earlier review.

24. REFERENCES AND LINKS TO DOCUMENTS

Document Developed in consultation with SHPCA clinical management team and Solent NHS Trust Medicines Committee (Chief Pharmacist).

- General Medical Council. Good practice in prescribing and managing medicines and devices (2013)
- General Pharmaceutical Council. Pharmacist Independent Prescribers. Available at https://www.pharmacyregulation.org/education/pharmacist-independent-prescriber">https://www.pharmacyregulation.org/education/pharmacist-independent-prescriber
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE, March 2015. The Control of Substances Hazardous to Health Regulations (1994)
- Medicines Amendment Orders relating to Patient Group Directions (2000)
- The British National Formulary (BNF)
- The Safe and Secure Handling of Medicines, A Team Approach; A Revision of the 'Duthie Report 1988', Royal Pharmaceutical Society of Great Britain, March 2005.
- NHS Security Management Service Security of Prescription Forms Guidance. • Medicines and Healthcare products Regulatory Agency (MHRA)
- Standards for Medicines Management NMC First published October 2007, updated 2015.
- Medicines, Ethics and Practice, a guide for pharmacists: The Royal Pharmaceutical Society of GB, Edition 39, July 2015
- Medicinal Products: Prescription by Nurses etc. (1992)
- The Medicines Act (1968)
- The Misuse of Drugs Act (1971) and Regulations
- DOH Destruction of controlled drugs in GP practices. Sept 2002
- Human Rights Act 1998
- https://www.themdu.com/guidance-and-advice/guides/prescribing">https://www.themdu.com/guidance-and-advice/guides/prescribing (last accessed July 2018)

LINKS

- NICE – Medicines Optimisation
- NICE Medicines Optimisation Clinical Guidelines
- NHS England Medicines Optimisation
- https://www.nhs.uk/live-well/healthy-body/how-to-find-an-nhs-gender-identity-clinic/
- Good practice in prescribing and managing medicines and devices 2013
- NICE Non-medical prescribing

25. GLOSSARY

- BNF: British National Formulary
- CCG: Clinical Commissioning Group. Clinical Commissioning Groups are responsible for implementing the commissioning services as set out in the Health and Social Care Act 2012.
- Controlled Drugs (CDs). Medicines that are liable to misuse, that are subject to special controls under the Misuse of Drugs Act, 1971.
- Controlled Stationery: Any stationery which, in the wrong hands, could be open to abuse within the system to obtain medicines fraudulently.
- GDC: General Dental Council
- GMC: General Medical Council
- GP: Medical General Practitioner
- GPhC: General Pharmaceutical Council
- Professional A registered practitioner in an occupation which requires specialist education and training in practical skills in health care and is registered with a professional body. For the purposes of this policy, these practitioners are Doctors, Nurses, and pharmacists.
- NMC: Nursing and Midwifery Council (UK).
- NPSA: National Patient Safety Agency (a Special Health Authority of the DoH). Prescribe: To order in writing (or electronically) the supply of a medicinal product (within the meaning of the Medicines Act, 1968, this means a POM) for a named patient (see “Prescription”).

- Prescriber: A healthcare professional that is legally authorised to prescribe a medicinal product, including medical, dental and non-medical prescribers.
- Prescription: An order for the dispensing of a medicinal product. The order is presented to a professional who is legally authorised to dispense. The order must be either: a) in writing in a legally prescribed format and signed by the person authorised by law to prescribe

  b) made, using the organisation's agreed electronic prescribing system, by the person authorised in law to prescribe medicinal substances, and who has been provided with a secure, individual computer access password.
- SOPs: Standard Operating Procedures