**An Organisation-Wide Policy for Medicines Management**

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Equality statement

This document demonstrates commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals and communities. This document is
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1 Rationale

All medicines are potentially hazardous to someone.

The safe and secure handling of medicines is the responsibility of every healthcare professional, who must ensure that they work within their professional guidelines.

All healthcare professionals are accountable for their actions. This accountability cannot be delegated, nor can anyone else answer for the actions of an individual healthcare professional. All healthcare professionals must work within the codes of conduct of their professional bodies.

This document is a guide to good practice for all healthcare staff involved in any aspect of the use of medicines. It defines the mandatory requirements of the Trust. The document has many sections which demonstrate the wide range of activities associated with the handling of medicines and the special care that is needed. Much of the policy is drawn from legal and regulatory frameworks:

- The Medicines Act 1968
- The Misuse of Drugs Act 1973
- The Health Act 2006
- Professional codes of ethics
- Department of Health policy, including NICE and NPSA
- Home Office Policy
- Department of the Environment Policy

The policies and procedures aim to ensure that:

- medicines are correctly and appropriately prescribed by an authorised practitioner;
- medicines are safely and appropriately supplied, transported, stored, monitored and destroyed;
- medicines are accurately and appropriately administered;
- medicines are stored securely correctly recorded to prevent the loss, inappropriate access to and misuse of medicines by patients, residents, staff or any member of the general public;
- practitioners involved in the delivery of care are responsible for their actions;
- patients receive their medicines at the appropriate time

The policy document is supported by a set of operating procedures that assist staff to work safely. The procedures are found on the pharmacy intranet site link.
2 Scope
This policy applies to all Doctors, Nurses, Pharmacists and associated support staff working for SaSH or in partnership with SaSH staff on SaSH premises.
The policy applies to all medicines whether they are for use for the Trust patients, outpatients, private patients or for another organisation.

3 Policy

3.1 Procurement of Medicines
No-one other than the pharmacy department is permitted to order medicines, including free stock, from an external supplier.
External suppliers include manufacturers, wholesalers and other hospitals.
If a named-patient, named supplier medicine is required, the order must be placed through the pharmacy procurement team or in exceptional circumstances, through the on-call pharmacist.

3.2 Medicines Supply
All medicinal products for use in the Trust must be obtained from an approved supplier.
Approved suppliers are:
- Hospital pharmacy department
- Community pharmacy (for patients in the community only)
- Patient's own supplies unless assessed as unsuitable to use or specified by the Trust on safety grounds as a medicine or group of medicines for which patients own must not to be used

Generic substitution of medicinal products, by the hospital Pharmacy Department, can take place without consultation with the prescriber provided that suitable steps are taken to assure the quality safety, clinical efficacy and equivalence of the medicine in question.
Medicines must not be transferred from an original dispensing container to another for the purposes of storage except by pharmacy staff.
Only pharmacy staff may dispense medicines from one container to another for the purpose of supply.

3.2.1 **Role of doctors and nurses**
When a patient is admitted, the doctors and nurses who clerk in the patient must ensure that any medicines remain with the patient and that whenever possible the patient’s own medicines are brought in from home.

3.2.2 **Stock Medicines**
A ward stock list shall be compiled by the pharmacy technician in conjunction with the ward pharmacist, ward manager and clinicians. It shall specify the usual quantities and type of medicines to be kept as stock, and reviewed at least annually.

3.2.3 **Ordering Medicines from pharmacy**
Qualified/Registered Nurses or a member of the pharmacy staff shall be responsible for ordering ward or department stock items, and medication for individual patients, (non stock items), through the Pharmacy Top-up system, Medicines Management systems or the Pharmacy Store answer service.

Methotrexate for non-cancer indications for in-patients and on discharge must be ordered as a Controlled drug (see below).

Drug charts should not leave the ward unless requested by a pharmacist or pharmacy support staff. All attempts should be made to have the drug chart checked on the ward before supply.

3.2.4 **Ordering Controlled Drugs**
Controlled drugs may only be ordered for stock by a Registered Nurse or by a registered Operating Department Practitioner in Theatres.

Nurses and Operating Department Practitioners with Authorised Signatures may order Controlled Drugs. Authorised signatories are deemed to be those which have been recorded on a form and authorised by the Ward or department Manager (who has checked that registration as valid). The completed form must then be sent to the Pharmacy.

Agency staff are not permitted to be authorised signatories for ordering or receiving Controlled Drugs.

Controlled Drug orders for ward or department stock must be made on the stationery supplied for this purpose. Controlled Drug (CD) Order Books are classified as Controlled Stationery and must be kept securely on the ward. It is the Manager’s responsibility to ensure this occurs.

Only one CD order book should be in use for each location at any one time.

The Pharmacist will ensure that medication is only supplied against orders from authorised signatories or legal prescriptions.
A list of nurses and Operating Department Practitioners who are designated to order controlled drugs, together with their signatures and initials, will be held in Pharmacy. Pharmacy and the ward or department manager are responsible for ensuring that the list is regularly reviewed and updated.

3.2.5 Drugs brought into hospital by patients

Patients are encouraged to bring their own drugs (PODs) into hospital. These should be handed over to the authorised Health Care Professional for safe keeping in a lockable bedside cabinet and continue to be administered if appropriate.

Patient’s own methotrexate must not be stored on the ward but should either be sent to the pharmacy or to the Emergency Drugs Cupboard when the pharmacy is closed.

If a patient is moved to another ward or a different bed on the same ward, the medicines must be transferred with the patient.

Medicines brought in by the patient may only be used for that patient and must not be administered to nor supplied to another patient.

The Pharmacy Technician or Pharmacist will endorse the prescription chart to indicate that the patient’s own medicines should continue to be used whilst on the ward.

Medicines no longer required by the patient must be returned securely to the pharmacy department for destruction. All PODs brought into hospital remain the property of the patient and should not be destroyed or otherwise disposed of without the patient’s permission. The patient’s permission should be documented as part of the healthcare record. If the patient is unable to give valid consent, the Mental Capacity Act should be followed. Disposal of the medicine can occur if it is in the best interest of the patient.

PODs should be held together in a locked drug trolley/cupboard or bed side locker until they have been assessed for use. A prescriber may refer to them for obtaining a medication history but must return them to the patient.

Patient’s own drugs may not be used if the Drugs and Therapeutics Group and Medicines Safety Group decides that patient safety could be compromised by such use of that drug or group of drugs. Weekly methotrexate for non-cancer indications is one such drug.

The use of patient’s own medicines does not reduce the responsibility of Trust staff to ensure that the prescription details are safe and appropriate.

When medication brought in by a patient cannot be positively identified, that medication may not be administered.

Patient’s own medicines must be stored securely.
When a patient has used all of their own medicines the pharmacy will normally dispense 28 days supply, unless it is for a fixed course or the prescription is changed.

When the patient is discharged, their own medicines must be returned to them unless they have previously agreed to have them destroyed.

Once the patient has left the hospital it is reasonable to assume that the medicines are not required and they must be returned to the pharmacy for destruction.

3.2.6 Illicit substances brought into hospital by patients

It is illegal to possess or supply illicit drugs, or for them to be on the premises.

Illicit substances will not usually be easily positively identifiable, but are likely to be materials which are suspected to be substances of abuse and may include cannabis, ecstasy, L.S.D., crack, etc., and non-prescribed amphetamines, benzodiazepines, cocaine, heroin (diamorphine), etc.

If a patient is discovered to be in possession of an illicit substance, contact the ward/on-call pharmacist for advice.

As long as the patient gives authority for removal and destruction of the drug the pharmacist can take possession of the substance.

The patient’s confidentiality should normally be maintained.

The police should be informed by the Accountable Officer for Controlled Drugs or their deputy.

Following the advice of the police it is usual practice to destroy the substance.

A record should be made by the pharmacist in the Destruction of Controlled drugs register of the substance, and destruction carried out at the appropriate time by a pharmacist and Director of the Trust.

If the patient refuses to hand over the substance the police must be informed.

If the above occurs out of hours the substance should be locked in the ward controlled drugs cabinet and the ward pharmacist informed at the earliest opportunity.

If the quantity of the drug is obviously so large it is not for personal use the Chief Pharmacist should be informed. If the Chief Pharmacist is not the Accountable Officer then they must also be informed. It may be decided, following discussion with the other health care professionals involved in the patient’s care (including hospital legal adviser and Department of Health) that it is in the public interest to identify the substance and follow up accordingly.

For clinical reasons the doctors looking after the patient must also be informed.
3.2.7 Admission involving controlled drugs (CD’s)
Patients own CD’s when brought into hospital with the patient, must be stored securely in the ward Controlled Drug Cupboard and recorded in the Controlled Drug Register.

Record the destination details of unused CD’s, e.g. If they are returned to the patient, transferred to a new ward with patient or sent to pharmacy for destruction.

If a patient is moved to another ward or a different bed on the same ward, their own Controlled Drugs must be transferred with the patient.

When the patient is discharged, their own Controlled Drugs must be returned to them unless they have previously agreed to have them destroyed.

3.2.8 Obtaining medicines when pharmacy is closed
Pharmacy Out of Hours and On-call Arrangements

Normal Pharmacy opening times are published on the pharmacy intranet site.

Opening times over Bank Holidays will be notified separately on each occasion prior to the holiday.

If a drug is required outside of normal working hours and before the Pharmacy next opens, then it may be available in the emergency drug cupboard.

**Medicines that the patient was taking before admission to hospital should be obtained from home as the first priority. This reduces the risk of duplication when discharged and ensure continuity for the patient while they are in hospital.**

Weekly methotrexate must always be supplied by the pharmacy; the on-call pharmacist should be contacted as described below.

All wards at Crawley have a current emergency drug cupboard stock list.

On the East Surrey site copies of the emergency drug cupboard stock list are with the Clinical Site Coordinators and in the Emergency Drug Cupboard.

Check the list of drugs contained within the cupboards as above and if the drug you require is listed, then obtain the drug.

Access to the Emergency Drugs Cupboard at:

**East Surrey Hospital**
Bleep the Clinical Site Co-ordinator who will check availability in the emergency drug cupboard and obtain if contained therein. See also SASH ‘Drug not available’ algorithms on the pharmacy intranet page for Procedures [link](#)
Crawley Hospital
Check emergency cupboard list, available on ward, if the drug is listed as contained in the Emergency Drugs Cupboards, bleep the Clinical Site Co-ordinator to obtain from emergency cupboard

If the drug is not available in the emergency drug cupboard, then contact the East Surrey Hospital the Clinical Site Co-coordinator who will bleep the on-call pharmacist. For Crawley Hospital request that switchboard bleep the on-call pharmacist.

To contact the on-call Pharmacist from either site, then the Doctor, Clinical Site Coordinator or Pharmacist should telephone the appropriate Switchboard and ask for the on-call Pharmacist, giving an extension number or bleep number on which they can be contacted.

The borrowing of drugs from other wards or departments outside normal Pharmacy hours is permissible under the SASH ‘Drug not available’ algorithms.

If the medicine required is not available from the emergency cupboard, the medication may be borrowed from another ward.

The practice of dispensing medication borrowed from another ward, into a temporary container is dangerous, and should never occur. The medication should be transferred in the original container.

Controlled drugs may only be borrowed in an emergency. This should only be done with the authorisation of the Clinical Site Coordinator. One nurse from each area should be involved in the transfer and documentation of the relevant medicine.

Pharmacists will only be able to supply drugs, listed in the Trust Formulary.

On-call Pharmacists will not usually supply take home medication since discharge should be planned previously while pharmacy is open.

Pharmacists may suggest obtaining the drug you require from another ward or department, and will assist you if necessary.

If urgent drug related information is required outside of these times, then the On-call pharmacist should be contacted via the switchboard.

3.2.9 New Products
The Trust manages entry of new products via the pharmacy department and the Drugs and Therapeutics Group (D&TG). D&TG will consider applications for the entry of new medicinal products onto the Trust formulary. The group uses a form that is found by going to the front page of the Trust Formulary here.

The form must be submitted electronically to the Formulary Development Pharmacist and must be fully completed. A hard copy must be signed by the lead clinician and sent to the Formulary Development Pharmacist.
Note: A new product is defined as one that is not listed in the Trust Formulary, although it may have been on the market for some time. Forms for use by Consultant Medical Staff to request the introduction of a new product can be found on the Trust Intranet or can be requested from the Pharmacy Administrator ext.1685.

Each application requires a referenced summary of evidence that the new product provides at least improved effectiveness or improved safety and that it is cost effective.

DTG may decide to approve or reject the application. Approvals may be restricted to specific clinical circumstances or prescribing by specific doctors.

DTG is an internal expert committee with medical and pharmaceutical representatives from primary care. Decisions that have a major impact on primary care will be referred to the local Prescribing Clinical Network (PCN) Committee for ratification.

3.2.10 Samples/ ‘Free goods’

Samples of medicines, dressings or devices are not allowed to be used for Trust patients or for use within the Trust. Samples must not be left with any member of Trust staff.

Dummy packs can be left with the pharmacy purchasing staff for assessment of the packaging and appearance of the product.

Free goods may only be ordered by the pharmacy department and may only be used in accordance with a formal procurement agreement, linked to an evaluation of the product, which is approved by the Chief Pharmacist and ratified by the Drugs and Therapeutics Group.

Offers are sometimes made to Medical Staff to participate in so called ‘clinical trials’, when in fact these are really only evaluation of a drug already on the market, but not as yet on the Trust Formulary.

In order to proceed, the Consultant should apply to the Drugs and Therapeutics Group to take part in a drug evaluation. The application must include details of continuing treatment in the event of the drug NOT being added to the Trust formulary.

Pharmacy will not accept ‘evaluation material’ prior to the Drugs and Therapeutics Group approval. If the committee agrees that this evaluation can proceed, the following will apply:–

- A clear method will be agreed between the Consultant and the Pharmacy Department for identification of those patients involved in the evaluation

AND
- At the conclusion of the evaluation, if appropriate, an application will be made in the approved manner to the Drugs and Therapeutics for the preparation to be added to the Trust Formulary.

### 3.2.11 Receipt of medicines onto Wards/clinical areas

All medicines coming into the ward must be delivered to a designated area and an authorised Health Care Professional informed of their arrival. This individual accepts responsibility for and ensures that the medicines are then placed in safe storage. This must take place as soon as is reasonably practicable, but Controlled Drugs and those requiring refrigeration must be put away immediately.

Medicines which have been dispensed for patients to take home (TTOs) must be checked by a trained Health Care Professional and stored in the locked bedside drug locker.

The Authorised Staff, who must be substantive staff (i.e. not agency staff) on the ward must sign for receipt of medicines that are:

- Controlled Drugs (including methotrexate for non-cancer indications)
- Products that need storage in the fridge or freezer

All delivery notes for ward stocks must be checked by a member of the ward staff. Any anomalies must be brought to the attention of the Pharmacy Stores staff as soon as possible.

Controlled drugs must be delivered to the department separately. They must be handed to a registered nurse. The registered nurse must sign the Controlled Drugs Order Book in the presence of the messenger to verify that the controlled drugs have been received as ordered and supplied. Controlled drugs must be transported in a sealed container and the receiving nurse must ensure that the seal is intact.

Immediately after receipt, the drugs must be put away in the controlled drugs cupboard. Record the date and time of register entry; the name, dosage, form, strength and quantity of each CD. This must be entered into the Controlled Drugs Register in **black** ink accompanied by the signatures of the receiving nurse and a second checker. The entry must include the serial number from the order book, the time, date and amount of drugs, which have been delivered. The closing stock balance must also be amended.

### 3.3 Security of Medicines

An individual could potentially use any medicine to harm themselves or another individual, either accidentally or deliberately. The Trust has a responsibility to ensure that the risk of deliberate or accidental harm is minimised by ensuring adequate security of medicinal products, including tablets, liquids, injections and other formulations.
3.3.1 Custody of keys
The ward manager is accountable for the development, implementation and maintenance of an effective system, which ensures the secure management of the drug keys.

The authorised Health Care Professional in charge of the clinical area is responsible for controlling access to the medicine storage facilities including cupboards, fridges, bedside lockers and trolleys.

Drug cupboard keys should be kept separate from other keys and kept on the person of the nurse in charge, to ensure the security of medicines.

The keys may be given to other authorised staff, when required, for legitimate purposes but responsibility for the custody of the keys and medicines remains with the nurse in charge.

A student nurse must not accept custody of the medicine keys or the controlled drugs keys.

The drug keys must never be left unattended.

Controlled Drug cupboard keys must be kept on a separate key ring from the other drug cupboard keys.

Controlled drug cupboard keys must, whenever possible, be kept on the person of the nurse in charge of the ward or department (i.e. the person accountable for the custody of controlled drugs). The keys must otherwise be kept on the person of a qualified nurse or, in theatres an ODP.

Keys for bedside medication lockers are the responsibility of the nurse in charge and may be given to patients only as part of a formal and approved Self Administration Scheme.

3.3.1 Loss of Keys
The loss of keys must be immediately investigated by the nurse in charge who must, in turn, report the loss at once to the senior nurse/manager and to the pharmacist responsible for the area. (This includes situations where it is believed that the keys were taken home in error by a member of staff on a previous shift and that person cannot be contacted). An Incident Report must be completed by the nurse in charge in every case.

In situations where a member of staff takes keys home in error, it is their responsibility to return them immediately and in person. The departmental manager must be informed of the incident and any suspicious circumstances investigated.

\textit{NB If transport issues prevent immediate return then the police may be able to assist on request from the clinical site co-ordinator, matron on duty or the Chief Pharmacist.}

Spare keys for some locations are available to the Clinical Site Co-ordinator from a central point. In the event of the loss of the ward keys and the absence of a spare
set of keys, the on-call engineer must be called via the Clinical; Site Co-ordinator, to change the locks.

It is important to maintain patient care with timely administration of medicines so medicines may have to be obtained from a neighbouring ward while the cupboards are not available.

3.3.2 Ward storage facilities
There shall be separate cupboards which must be lockable for the following;

- Medicines which are taken internally
- External medicines
- Medication requiring refrigeration (a separate locked drugs fridge)
- Controlled drugs. A separate cabinet contained within a locked cupboard must be provided with separate keys.
- Medication currently in use for the purposes of drug rounds, either as locked bedside lockers or a separate drug trolley.

All cupboards must conform to at least current British Standards, where available. Controlled drugs cabinets must conform to the standards specified in the Misuse of Drugs (Safe Custody) Regulations, available from the Accountable Officer for Controlled Drugs.

Separate storage must also be available for:

- Intravenous fluids and bulk sterile topical fluids.
- Epidural infusions which must be kept separate from other infusions.
- Diagnostic reagents, including blood and urine testing.
- Flammable gases and liquids.

Medicines refrigerators and freezers must be monitored daily to ensure that they are within acceptable temperature ranges, in accordance with the procedure on the pharmacy intranet site.

3.3.3 Medicine security in ward/clinical areas
The accountability for the safe and secure storage of medicines rests with the ward manager.

Responsibility is delegated to the person in charge in the manager’s absence.
Medicines should be kept in a cupboard, a medicine fridge or trolley or a lockable bedside cabinet. All medicines storage areas must be kept locked unless they are in use at the time.

Storage on the shelf below the medicine trolley or on top of cupboards is not acceptable.

The medicine trolley must be locked and secured to the wall when not in use and must not be left unattended when open.

When medicines are received onto the ward they must be put away quickly. Controlled Drugs and items to be stored in the fridge must be put away immediately.

Medicines, including injection ampoules, should be stored in the intact original container, not decanted into other storage boxes or cartons (except by the pharmacy).

The security of ward stocks is regularly monitored by pharmacy top-up staff.

3.3.4 Controlled drug stock checks and records

Ward staff must reconcile the records in the CD registers against the stock holding of controlled drugs at least once daily. The counts must be documented and signed on the each page in the CD register.

At least once each month the check must be undertaken by the ward manager.

Operating theatres must count Controlled Drugs at the start and end of each day the Controlled Drugs are in use.

The first counter must be a qualified nurse but the second counter may be untrained.

A member of the Pharmacy staff must check the stock holding of Controlled Drugs against the records in the register, at least every 3 months. The checks must be documented and signed for each product.

All Controlled Drug stock checks must include the presence of two signatures for each entry and reconciliation of balances.

Controlled Drug Order Books must be returned to the pharmacy where they will be kept for a minimum of two years after the date of the last entry and may be destroyed as confidential waste after this time.

Ward Controlled Drug Registers must be returned to the pharmacy for storage.

All controlled drug register and order books will be destroyed as confidential waste by the pharmacy, two years after the date of the last entry.
3.3.5 Medicines for emergency use
For clinical emergencies all departments must have access to medicines clearly marked for this purpose. It is the responsibility of every Health Care Professional to know the location of the nearest Emergency Drug Box, or alternative facilities within or near to their department.

The manager is responsible for ensuring that procedures are in place for checking that medicines for emergency use are complete and in date.

Medicines for emergency use must be stored in a tamper evident container and be kept in an easily accessible place.

Once a container has been opened, it is the responsibility of the authorised Health Care Professional in charge to obtain a replacement.

3.3.6 Bulk IV fluids
It is impractical to lock IV fluids away but they must not be stored in public areas.

3.3.7 Transport
Medicines shall be transported around and between hospitals in the Trust in sealed, tamper evident containers unless they are in the direct possession of a Healthcare Professional and will not be left unattended at any stage.

Medicines in transit must be handled in a way that maintains the security and integrity of the medicines.

Medicines must not be left unattended and unsecured while in transit.

When a community nurse employed by SASH, has to transport a medicine to a patient in the community, they shall deliver it immediately. Medicines in transit must be locked in the boot of the car and not left unattended at any time.

3.3.8 Storage of medicines during ward closure
The safety of all medicines must be ensured during ward/clinical area closure. The ward manager must consult the ward pharmacist or pharmacy technician for advice.

Controlled drugs should normally be returned to Pharmacy when a ward closes.

3.4 Prescribing
For the purpose of this document, prescribing includes authorising administration to inpatients by writing on a drug chart, the record of drugs administered by an
anaesthetist during an operation or emergency procedure, prescriptions for
discharge, outpatients, day cases, day hospitals and all similar situations.

The prescriber is responsible for their actions in prescribing any medicine, whether
or not they have initiated the treatment.

The prescriber is responsible for having a reasonable working knowledge of the
medicine they are prescribing before authorising the supply or administration of that
medicine.

If the required drug is excluded from Payment by Results, the prescriber is
responsible for obtaining written authorisation from the Pharmacy Department for
each new patient before prescribing.

The prescriber is responsible for giving the patient and/or their carer sufficient
information about the medicine they have prescribed, the intended benefits and the
risks. The patient must have the opportunity to ask questions so that they are able to
make a reasonable judgment about whether or not they will take the medicine as
prescribed. (ref NICE CG 76 Medicines Adherence, GMC Guidance on Good
practice in prescribing and managing medicines and devices, January 2013).

The prescriber is responsible for checking if the patient has any allergies,
intolerances or sensitivities to medicines. The discussion and outcome must be
recorded in the patient medical record and any medicines to be avoided recorded on
the drug chart.

The prescriber is responsible for checking if the patient has any religious or dietary
restrictions on the medicines they are prescribed, including medicines of animal
origin. The discussion and outcome must be recorded in the patient medical record.

The Trust does not support the use of covert medicines administration other than in
the most exceptional circumstances. If covert administration is considered then the
conditions of the Mental Capacity Act must be taken into account and discussions
held with the Trust Safeguarding team and the patient’s carer or next of kin.

3.4.1 Authorisation

Authorised prescribers include Medical and Dental Practitioners and qualified Non-
Medical Prescribers.

Non- Medical Prescribers who are qualified to prescribe must adhere to the Trust
Non-Medical Prescribing Policy (link)

Other healthcare professionals may be authorised to administer medicines under
the approval of a Patient Group Direction.

A prescription may only be written for:

- a registered patient of the Trust who is under the care of the prescriber at the
time or the prescriber is covering for the absence or unavailability of a
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colleague. This includes any Doctor who is assisting with the care of a registered patient under the main care of another Consultant e.g. referrals for advice or Anaesthetists;

- a private patient of the Consultant;

- exceptional circumstances where a relative or carer of a patient needs immediate treatment e.g. contacts of meningococcal meningitis patients who need antibiotic prophylaxis; a family that needs scabies treatment.

An Anaesthetist may record, on the Anaesthetic chart, drugs administered after they have personally administered them. This record acts as the authorisation and record of administration.

A Pharmacist may amend or delete a prescribed item to ensure safety or efficacy. A record must be made in the patient's clinical record and must be signed and dated. The pharmacist must complete a pharmacy intervention form on each occasion. The pharmacist must inform the prescriber.

Pharmacy stop orders are in place for selected antibiotics.

### 3.4.2 Restrictions on prescribing

Only drugs approved by the Trust Drugs and Therapeutics Group for inclusion on the Trust Formulary may be initiated by a Trust doctor, other than in exceptional circumstances;

The Drugs and Therapeutics Group might decide that specific drugs may be prescribed by specific individuals, e.g. named Consultants or their team.

If a Consultant needs to prescribe a non-formulary drug, The Drugs and Therapeutics Group procedure for approving one-off uses must be followed.

FY1 Doctors are not allowed to prescribe or administer cytotoxic drugs or immunosuppressants (excluding corticosteroids).

FY2 Doctors should never initiate or administer cytotoxic drugs or immunosuppressants (excluding corticosteroids).

Unlicensed medicines will be risk assessed as part of the application process and prescribing restrictions will apply according to the risk rating [LINK](#).

The Outpatient Prescribing policy must be followed [link](#).

Dieticians may prescribe Borderline Substances on drug charts in accordance with the conditions approved by the Advisory Committee on Borderline Substances, providing they comply with the Trust Formulary.

Dietitians may amend or delete a prescribed borderline substances item to enhance patient compliance or in reference to products available in the Trust. The Dietitian must document this in the medical notes. When the formulation or presentation of
the feed is significantly changed, the Dietitian must inform the prescriber. If appropriate the Dietitian should complete an incident report.

3.4.3 Valid prescriptions

**Every prescription must:**

- Be written on Surrey and Sussex Healthcare NHS Trust approved stationery;
  - Inpatient drug chart or electronic prescribing system
  - Intensive Care chart
  - Electronic discharge letter
  - Outpatient or A&E prescription
  - Emergency Department notes
  - Under exceptional circumstances in the medical notes, providing the instruction to administer is signed and dated
  - When there is no pharmacy outpatient dispensing service available, on an FP10.
- Clearly identify the patient by name (except GUM clinics) and their verified NHS number; If it is unknown the MRN (Medical Record Number) must be used
- Be written by an authorised prescriber;
- Be printed, preferably in block capitals, using black ink;
- Specify the drug by the approved name, strength, dose, frequency of administration, administration route, and when relevant, duration of treatment;
- Ensure that any additional instruction(s) are specified in writing;
- Be signed and dated by the prescriber;
- Be cancelled by drawing a single line through the name of the medicine, initialled and dated by the person cancelling the item.

3.4.4 Correct use of the in-patient prescription sheet

Any known drug allergy or severe drug reaction MUST be entered in the box provided. The detail must include date of recording, allergen, reaction and severity. If there are no known drug allergies, the sheet must be marked NKDA.
In the interests of safety all prescribers are required to clearly PRINT, in full (no abbreviations), ALL treatment details, with ENGLISH (not Latin) instructions.

The approved name of the drug MUST be used.

The required time(s) of the drug administration is indicated in the appropriate time column 24-hour clock.

Other specific instructions, e.g. before food, well diluted with water, intravenous reconstitution, can be given under “Additional Instructions”.

Prescriptions MUST be written in a precise manner such as:

- For solids, quantities of 1 gram or more should be written as 1g etc.
- Quantities less than 1 gram should be written in milligrams, e.g. 500mg, not 0.5g.
- Quantities less than 1mg should be written in micrograms, e.g.100 micrograms, not 0.1mg.

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 1g.

‘Micrograms’ and ‘nanograms’ MUST NOT be abbreviated.

‘Units’ MUST NOT be abbreviated.

It is a legal requirement that the prescriber signs for all treatments prescribed.

When a prescription needs amending, the original wording and/or instructions MUST NOT be altered, but cancelled and the prescriber is required to rewrite the whole entry for the drug, recording the ‘start date’ as the date of change of dose, frequency, etc.

When a treatment is to be discontinued, the prescriber should draw a line through the prescription section and subsequent administration record, date and sign the deletion.

Wherever possible all current medicines for a patient should be on one treatment sheet, thus canceling prescriptions on previous sheets.

Administration of ‘as required’ medicines should be tailored to individual patients need whilst remaining within the manufacturers recommended maximum dosage and frequency.

The route of administration should be clearly shown.

The special instructions column of the ‘Once Only’ section allows details such as “1 hour pre-op” to be entered, or exact time stated, if appropriate.
Antibiotics and variable dose prescriptions must be prescribed on the relevant section of the drug chart.

Weekly prescriptions must be prescribed on the regular side of the drug chart, with the days when the medicine is not to be administered crossed out. An additional instruction must be added “once weekly on xxxday”.

3.4.5 Review of in-patient prescriptions
All in-patient prescriptions must be reviewed regularly by the prescriber or other designated practitioner:

- Routine oral medication: maximum of fourteen days;
- Oral antibiotics: five days or sooner if indicated by a review date;
- Intravenous medication: daily

The Trust does not support administering medicines without a written prescription. Verbal orders must only be used in accordance with the regulations outlined in Section 3.6.

Any drug chart must be considered “expired” when the prescription lines become full. At this point the entire chart must be re-written. If administration record continuation sheets are used the chart must be reviewed and re-written after twenty eight days i.e. only one continuation sheet can be used.

Where the number of medications any individual patient is receiving, requires the use of more than one drug chart, these must be clearly labelled with full patient details and numbered: 1 of 1, 1 of 2, 1 of 3 etc.

All the active cards labelled in this way, must be stapled together to ensure that they are not separated and that all relevant medications are given at each appropriate drug round.

3.4.6 Prescribing for controlled drugs
Discharge, outpatient and A&E prescriptions for controlled drugs must be written entirely in the doctor’s own handwriting, including:

- the patient’s name and address.
- name, strength and dosage form for the drug.
- The total quantity of the preparation, or the number of dose units, in both words and figures
- dose and frequency must be detailed.
- the prescriber's signature.
- the date on which the prescription is written.

The above requirements apply to methotrexate for non-cancer indications when prescribed for discharge.

### 3.4.7 Outpatient / A&E / Day case prescriptions

The Trust Outpatient Prescribing Policy must be followed. [link](#)

Formulary and other restrictions apply as above in section 5.16.2

### 3.5 Preparation of medicines

All professionals involved in any aspect of the preparation of medicines, are responsible for:

- Having a clear understanding of the diluents, volume, safety precautions and method of preparation before preparing the medicine.

- Following control of infection procedures, such as hand washing and ANTT, to reduce the risk of contamination of the medicine and infection risk for the patient.

- Preparing the medicine immediately prior to use, except when prepared in the pharmacy. It is not acceptable to prepare doses for more than one patient at a time.

- Preparing and administering one dose at a time.*

- For drugs to be placed in a pump or for infusion, or when there is any delay before administering, ensuring that a prepared injectable medicine is properly labelled with:
  
  - The name and verified NHS Number of the patient
  
  - The name, strength and volume
  
  - The diluent
  
  - The date and time of preparation
  
  - The initials of the person preparing and checking the medicine

* Current Anaesthetic practice is to prepare several medicines for one patient in advance of use to ensure prompt administration as the medicines are needed. Anaesthetists must consider the risks of this practice for each product, including labelling, risk of contamination and of deterioration of the product.
Some Anaesthetic Practitioners both Operating Department Practitioners and Anaesthetic Nurses, will prepare medicines for anaesthetists to administer. This is only acceptable if:

- The ODP or anaesthetic nurse has a current Trust recognised certificate of competence in the preparation of intravenous injections and has completed a Trust ANTT assessment
- The anaesthetist has checked that the correct drug, strength and volume has been drawn up.

3.6 Administration of medicines
All professionals involved in any aspect of the administration of medicines, are responsible for:

- Taking all reasonable steps to administer all doses of medicines, unless the prescriber or clinician responsible for the patient has agreed that the dose should be withheld, subject to the requirements below.
- Obtaining the medicines for administration either from the patient’s own supply, another clinical area, emergency drug cupboard or the pharmacy service.
- Ensuring that any missed doses of the following critical drugs (ref NPSA alert 1183) unless agreed by the clinician, result in an incident report being completed by the nurse undertaking the drug round:
  - anti-infectives,
  - anticoagulants,
  - insulin,
  - medicines for Parkinson’s disease,
  - anticonvulsants
  - resuscitation medicines
- Checking that they have a clear understanding of the correct dose, frequency, route, rate and method of administration, main effects and main side effects of the medicine. Administration may not proceed unless the professional has a clear understanding of the above.
- Being aware of medicines that are not administered daily.
- Obtaining advice or information about a medicine so that they gain a clear understanding of the drug.
• Checking that the medicine name, dose, frequency, route, method date and time for administration are clearly identifiable.

• Checking that the medicine name, dose, frequency, route, method date and time for administration are appropriate for the patient, considering their age, weight and condition.

• Checking that there are no contra-indications to administration of the prescribed medicine, in particular known allergies or physical incompatibilities.

• Checking that the medicine has not reached its' expiry date.

• Using the appropriate measuring device to ensure accuracy in dosing while keeping risk to a minimum.

• Correctly identifying the patient by checking their name, date of birth and Verified NHS Number or if unavailable their hospital number on their identity band, with the details on the prescription chart or clinical record.

• Any doubt should be confirmed verbally with the patient. If the patient is unconscious or unable to confirm their identity, it is the responsibility of the Health Care Professional administering the medicine to take steps necessary to identify the patient. The Health Care Professional must then take appropriate steps to ensure that the patient can be clearly identified in the future.

• Taking care to ensure the privacy and dignity of the patient.

• The limits and restrictions set out in a Patient Group Direction must be adhered to.

• Complete all records of drug administration using black ink to ensure that the records can be photocopied later.

Where a prescription or drug chart is available

• Checking that the prescription has been signed by an authorised prescriber.

• Checking that the medicine for administration corresponds with all aspects of the prescription.

3.6.1 Administration of medicines in the absence of a written prescription

Medicines may be legitimately administered without a written prescription when:

• A Patient Group Direction is in use

• In certain emergencies (see below)
• A Healthcare Professional is permitted to administer a medicine by a specific legal exemption. This includes Midwives, Podiatrists and Paramedics but future regulations may add other staff groups.

In these situations the healthcare professional must record what has been administered in the clinical record.

Drugs administered in emergency situations, usually resuscitation, do not have to be prescribed before administration, but, after the emergency is controlled, the person administering must record which drugs and doses they have administered.

The Trust does not support giving medicines without a written prescription, other than in the circumstance listed above. Verbal orders are not permitted. All authorised Health Care Professionals involved in any part of the checking and administering process must ensure that they complete and sign their entry on the prescription chart/record sheet.

The Trust does not support the use of covert medicines administration other than in the most exceptional circumstances. If covert administration is considered then the conditions of the Mental Capacity Act must be taken into account and discussions held with the Trust Safeguarding team and the patient’s carer or next of kin.

3.6.2 Second checker role

A Second Checker is deemed to be any Registered Nurse, Doctor, Pharmacist or Operating Department Assistant employed by the Trust. Student Nurses and Return to Practice Nurses may act as Second Checkers in certain circumstances (see Single Person Administration).

Any individual who performs the role of Second Checker is responsible for witnessing the administration process from preparation of the medicine, through to its administration to the patient, and the appropriate disposal of any surplus medicine. The Second Checker must sign in the appropriate documents providing evidence of their role in the check procedure.

3.6.3 Cases of doubt

Where there is any doubt as to the accuracy, safety, completeness or appropriateness of an individual prescription, it is the responsibility of the healthcare professional to confirm the details with the prescriber and/or a pharmacist before administering the medicine.

Medical practitioners should refer to their Registrar or Consultant.

If the healthcare professional is still not satisfied, they should not administer the medicine, and notify their line manager immediately. The member of staff or the pharmacist must contact the next more senior member of the medical team about the concern.
Any concerns and details of the action taken must be recorded in the nursing record or case notes.

If the medical practitioner insists that the medicine must be given, that medical practitioner shall be responsible for administration and any resulting consequences. The healthcare professional involved must complete an all-purpose report form.

### 3.6.4 Oral and enteral administration

Most oral medicines can be given as tablets or capsules with a glass of water.

An oral liquid medicine must be measured using a measuring spoon or graduated measure, or using a purple oral/enteral syringe; it must not be measured or administered with an injection syringe.

An appropriate oral/enteral syringe must be marked for oral/enteral use only, or similar wording.

### 3.6.5 Administration of Intravenous fluids and medicines

The administration of IV medicines and fluids must be in accordance with the Administration of Intravenous Medicines Policy [link](#).

Medicines may be administered via intravenous injection or infusion only by a suitably trained, competent and authorised Healthcare Professional.

The following prescribed IV fluids can be administered via an established route by any competent, registered Health Care Professional following local induction:

- Sodium Chloride 0.9%
- Glucose 4% and Sodium Chloride 0.18%
- Glucose 5%
- Gelatine
- Hartmann’s Lactate

Any licensed product of the above containing potassium added at the point of manufacture (i.e. not added on the ward).

Intravenous infusions prepared on the ward must be changed at least every 24 hours.

Parenteral nutrition bags must be changed at least every 24 hours.
3.6.6 **Epidural administration**
Medicines may be administered via epidural injection or infusion only by suitably trained, competent and authorised Healthcare Professionals.

Epidural injections and infusions must be administered through suitably labelled and clearly distinguishable giving sets.

Epidural infusions must be administered through infusion devices that are specifically designed and reserved for the purpose.

All syringes and bags for epidural infusion must be labelled “For Epidural Use Only”.

3.6.7 **Single person administration**
A Registered Nurse, medical practitioner or other authorised practitioner may undertake single-person administration of medicines with the following exceptions in the hospital settings. A second authorised person must be involved:

- in all stages of the checking process for Controlled drugs.
- with the administration of all non injection medicines to children, except for administration by an Anaesthetist or a Registered Sick Children’s Nurse who has completed a single nurse administration training session and assessment.
- in the administration of all blood and blood products.
- in all situations where the dose, concentration or rate of administration has to be calculated, except for anaesthetists.
- in the administration of all parenteral cytotoxic drugs.
- in the administration of all intravenous injections or infusions

Registered Nurses provided by recognised agency partners, who are working on agency shifts, are authorised for single-nurse administration of medicines, except in the situations described above, providing they have a:

- Good understanding of the NMC Code: Standards of conduct, performance and ethics for nurses and midwives, and Standards for Medicines Management;
- Good understanding of the Trust policies and procedures relating to the administration of medicines;
- Experienced in administering medicines in an acute care setting;

Staff who do not fulfil the above criteria must have a second authorised person involved in all medicine administration.

Any nurse may ask a second nurse to check medicines with them if they wish.
Student Midwives and Student Nurses may be involved as a second checker in the administration of medicines as outlined previously, except for any involvement in Controlled Drugs.

First and second year Student nurses, should be encouraged to participate in the administration of medicines under the supervision of a Registered Nurse. The student must be observed for the entire administration process. This must be regarded as a learning opportunity and these student nurses will not be acting in a formal Second Checker role. The registered nurse retains sole responsibility for the administration of the medicine.

Return to Practice and nurses under supervision should be encouraged to participate in the administration of medicines under the supervision of a Registered Nurse as often as possible. This must be regarded as a learning opportunity and they will not be acting in a formal Second Checker role.

Return to Practice and nurses under supervision may be involved as a Second Checker in the administration of medicines as outlined previously, once they have achieved appropriate level of competency.

3.6.8 Administration of controlled drugs

In the appropriate section of the Controlled Drug Register, record in black ink the date and time of removal from register, the patient’s name, verified NHS Number or if unavailable their hospital number and the quantity of the CD being removed.

The nurse, doctor or ODP must sign the CD register along with a second checker.

3.6.9 Cytotoxic chemotherapy

Cytotoxic drugs are extremely dangerous to the patient if administered incorrectly and to the staff if handled poorly so every precaution must be taken to ensure safe handling. The Regional Chemotherapy Policy and procedures must be followed.

Only authorised staff should handle, prescribe, prepare or administer cytotoxic drugs.

3.6.10 Clinical trials

All clinical research trials must have prior approval of the Trust Research and Development Committee.

When medicines have been prescribed as part of a clinical trial, the Health Care Professional must ensure that they are aware of the potential safety issues, including side effects.
The patient must be made aware that the medicine prescribed for the trial may not be available at the end of the trial.

A copy of the protocol for the trial must be available for any member of staff involved in the patient’s care, to read.

Medicines for clinical trials must be stored under appropriate conditions for that medicine and must remained locked.

3.6.11 Homeopathic medicines and herbal medicines

If patients express their intention to use complementary medicines, this must be documented in the healthcare records and the health professional responsible for their care notified accordingly.

Pregnant women may choose to self administer homeopathic remedies antenatally, during labour or postnatally. Her wishes should be respected. However, if the midwife believes that the substances might be an inappropriate response to the presenting symptoms or could negate or enhance the effect of prescribed medicines, it must be discussed with the woman (Midwives Rules and Code of Practice NMC 1999). Advice should then be sought from the relevant expert practitioner.

3.6.12 Self administration

Self administration may be important to help a patient to manage their own medicines to ensure timely dosing, e.g. for Parkinson's Disease.

Patients may be able to self administer their own medicines in accordance with the Trust Self Administration Policy (link)

If a Trust scheme is not in place on the relevant ward or area, and in circumstances that permit safe storage, a patient may keep inhaler devices and emollient creams with them and self administer. The nurse caring for the patient must be confident in the patient's ability to look after the medicines concerned and to use them appropriately.

3.7 Medicines and discharge or transfer

The authorised Health Care Professional responsible for each patient's discharge will ensure that any remaining medicines brought in by the patient, are returned on discharge.
Medicines brought in by patients are the property of the patient and must not be destroyed or disposed of without the patient’s, or carer’s agreement, except in the situations listed below:

- There are situations where it may be potentially harmful to the patient to return their medicines to them:
- Neither the pharmacist nor the patient can positively identify the medicines, so they cannot be regarded as safe to use.
- The patient’s therapy has changed so that continued custody of their previous medication could lead to confusion and possible inappropriate therapy.

In these circumstances, following discussion between a pharmacist and a senior nurse or medical practitioner, the medicines may be destroyed providing the patient’s consent has been obtained. If the patient does not have the capacity to make a decision then, in accordance with the Mental Capacity Act, the medicine might be disposed if it is in the best interests of the patient.

Where patients are transferred from one ward to another during an inpatient episode, the authorised Health Care Professional co-ordinating the transfer must ensure that the medicines stored on the ward for that patient, are transferred to the receiving ward.

When a patient is discharged they must have at least 14 days’ worth of new or changed medicines that they have been using on the ward. Supply of medicines that the patient was taking before admission will depend on the length of time the patient was in hospital. The Pharmacist is responsible for ensuring that supplies are not duplicated if the patient has their own medicines at home.

### 3.7.1 Medicines to take out (TTOs)

Medicines for patients to take home will be supplied only in a response to a prescription written on the Trust approved discharge documents and signed, either physically or electronically by an authorised prescriber.

Nurses/midwives may only write prescriptions for take home medicines after successful completion of SASH accreditation or if they are a qualified prescriber.

When prescribing discharge medicines the prescriber must consider the duration of the inpatient stay and the extent of changes to the medicines for the patient.

If there are no changes to the regular medicines and the patient has been in hospital up to 7 days then the prescriber can write “No change to regular medicines” and only list those items that have been added,

All changes, including medicines started, changed or stopped must be listed, with reasons in the relevant section of the discharge letter.

The prescription MUST be specifically written for this purpose.
Medicines labelled for inpatient use, that do not have instructions on the label MUST NOT be given to the patient to take home.

To save unnecessary patient delay at the time of going home, discharge prescriptions should be prescribed in order to be dispensed in pharmacy at least one working day in advance of the patient’s discharge.

If the patient is being discharged to one of the acute trust units or a Priority Care Trust e. g. East Surrey, Crawley, Horsham, Caterham Dene or Dorking Ranmore Ward, the Doctor must state this on the discharge prescription so that the Pharmacy can liaise with the receiving hospital on what is needed.

On discharge from the ward/department TTOs must be checked by a Registered Nurse/Midwife against the written discharge prescription or the patient copy of the discharge letter.

Medicines that are no longer prescribed should be removed with the patient’s agreement.

Before the patient leaves the ward a registered nurse or midwife must explain to the patient what medicines have been prescribed, the dose, frequency and duration (if applicable) and any special instructions on the label. For all changed and new medicines a handy summary patient information leaflet must be produced via the MaPPs database. The discharging nurse must explain to the patient details of the uses, common side effects and main precautions for each new medicine and give the patient the leaflet to take home.

All queries about discharge medicines must be referred to the prescriber or a clinical pharmacist.

Discharge involving controlled drugs

Prescribing controlled drugs as discharge medication should follow the procedure detailed in section 3.4.6.

Controlled drugs dispensed as discharge medication must be stored, recorded and passed to the patient in the same manner as if the patient had brought the medication into hospital themself.

A record of who the drugs have been given to must be made in the Controlled Drug Register and witnessed by a Second Checker. A patient’s own drugs, which are not for returned to the patient, must removed by a Pharmacist for destruction.

### 3.8 Disposal of medicines

All out of date medicines, medicines issued to individual patient and stocks no longer required, with the exception of controlled drugs must be returned to the Pharmacy in a sealed container, usually via the locked pharmacy stock box.
3.8.1 Disposal of medicines prepared but not used

Individual doses of medicines that have been prepared for administration but not given must be destroyed in the clinical area, by emptying the medication into a Waste Medicines container.

Medications must never be disposed of into the mains sewerage system (includes liquid medicines and medicines in aqueous solution).

3.8.2 Disposal of controlled drugs

Individual doses of controlled drugs, which have been prepared but not administered, should be destroyed in the clinical area in the presence of a witness. A witness is regarded as another Registered Nurse, an ODP/ODA, a Doctor or Pharmacist.

The destruction must be entered into the Controlled Drug Register and signed by both participants. This procedure refers equally to the destruction of part doses.

Other Controlled Drugs must be removed from the ward by a Pharmacist, for return to Pharmacy prior to destruction. A record must be made in the Controlled Drug Register and signed by the pharmacist and a qualified nurse.

3.8.3 Disposal of cytotoxic drugs

In order to ensure safe disposal of cytotoxic drugs, consideration must be given to the safety of patients and of the equipment used during the process of preparation and administration and any cytotoxic drug residue.

Specific procedures are available for the safe disposal of cytotoxic drugs including in circumstances where spillage or extravasation occur. [Link](#)

The disposal of cytotoxic drugs must be carried out in line with local guidelines that comply with Health and Safety regulations and environmental considerations.

In all healthcare settings advice must be given to the patient and their care(s) on the safe disposal of body waste and any special treatment of the toilet that might be needed.

3.9 Spillage

If a medicine spills, wear personal protective equipment before cleaning. Check for any special precautions with the Pharmacy team before proceeding.

3.10 Medication incidents

Any incident that occurs which falls outside the guidelines and regulations set out within this policy, must be reported immediately to the appropriate line manager using Datix.
Such incidents will include administration errors, prescription errors, failure to administer prescribed medications and those situations in which medications are given in extra ordinary circumstances (as outlined within the policy).

All incidents relating to the prescribing, supply, transport, storage, preparation, administration, disposal or recording of Controlled Drugs must be reported by the risk management team to the Trust Accountable Officer for Controlled Drugs

3.11 Medicine defects

The Chief Pharmacist is responsible for establishing a re-call procedure for defective medicines and informing staff of their responsibilities.

The reporting and re-call of medicines which are known or suspected to be defective must be carefully and promptly controlled, documented and carried out to ensure that patients are not put at risk.

3.12 Disposal of records

All healthcare records will be disposed of in line with the Department of Health Records Management: NHS Code of Practice Part 2

Ward ‘handover’ sheets will be disposed of as confidential waste by the pharmacy at the end of each working day.

4 Roles

Chief Executive Officer

The Chief Executive is the responsible officer for the Trust and is legally accountable for medicines management and the associated risks across the organisation.

It is the responsibility of the Chief Executive to ensure that there are clear lines of accountability established and maintained throughout the organisation, defining interpersonal relationships between the Board, relevant committees (including Drugs and Therapeutics and Medicines Safety), and heads of department / service.

The Chief Executive must ensure that the Board is kept fully informed of any medicines management risks and any associated medicines management issues.
Executive Directors

The Chief Nurse and Chief Medical Officer are responsible for overseeing the professional standards of nurses and doctors employed by the Trust.

Lead/Clinical Directors and Senior Managers are accountable to the Chief Executive for ensuring that all staff under their control fully implements the Surrey and Sussex Healthcare NHS Trust Medicines Management Policy and documented procedures. They are required to ensure, so far as is reasonably practicable, that:

- there are adequate resources available to meet the medicines management policy requirements;
- all managers are competent to discharge their medicines management responsibilities;
- the effectiveness of the policy and arrangements for implementation are regularly monitored and reviewed; and
- appropriate instruction, training and supervision is provided for staff under their control and working in their area of responsibility.

The Accountable Officer for Controlled Drugs reports, for the purposes of governance of controlled drugs, to the Chief Nurse.

Chief Nurse and Chief Pharmacist

- ensure safe systems and practices are implemented, maintained and monitored;
- ensure staff are made aware of this policy and its' contents. New staff must be informed at induction.

The accountable officer for controlled drugs

The Trust, as a ‘designated body’ under the Health Act 2006 must appoint a fit, proper and suitably experienced person as its accountable officer for Controlled Drugs. The Accountable Officer must:

- establish and operate appropriate arrangements for securing the safe management and use of controlled drugs by the Trust;
- ensure that the Trust operates appropriate arrangements for securing the safe management and use of controlled drugs;
review, or ensure that the Trust reviews, arrangements for the safe management and use of controlled drugs;

establish that the Trust establishes appropriate arrangements to comply with misuse of drugs legislation;

ensure that the Trust has adequate and up-to-date standard operating procedures in place in relation to the management and use of controlled drugs;

ensure adequate destruction and disposal arrangements for controlled drugs;

ensure monitoring and auditing of the management and use of controlled drugs;

ensure relevant individuals receive appropriate training;

monitor and audit the management and use of controlled drugs by relevant individuals, and to monitor and assess their performance;

maintain a record of concerns regarding relevant individuals;

assess and investigate concerns about the safe management, prescribing and use of controlled drugs;

take appropriate action if there are well-founded concerns;

establish arrangements for sharing information with other Trusts and local bodies as part of a Local Intelligence network

Chief Pharmacist

The Chief Pharmacist is accountable for:

- ensuring the procurement of pharmaceuticals of appropriate quality, in accordance with Standing Financial Instruction, Drugs and Therapeutics Group and Medicines Safety Group policies and ensure value for money;
- establishing a system for the safe and secure handling of medicines;
- establishing and maintaining a system for the supply, distribution, return and destruction of medicines;
- establishing a system to indicate the supply status of all medicines supplied from pharmacy;
- establishing a system for advising all healthcare staff and patients on all aspects of medicines management, to ensure the best use of medicines;
- establishing a system for recording and reporting pharmacists' interventions on prescriptions, in accordance with the Trust’s Incidents (inc SUIs) Management, Reporting and Investigation Policy and the Risk Management Policy.
• establishing and maintaining a system which ensures the availability of advice and medicines for use in an emergency when the pharmacy is closed;
• developing a system for collecting signatures for the receipt of categories of drugs which require special handling, notably Controlled Drugs and drugs requiring refrigeration;
• recommending to the Drugs and Therapeutics Group and Medicines Safety Group on safety and security grounds, which drugs must be ordered and supplied in a restricted manner;
• auditing the implementation of medicines handling policies and systems;
• monitoring the use of unlicensed medicines and the use of licensed medicines for unlicensed indications and to ensure their quality and suitability for use. The pharmacy shall provide the prescriber with adequate information on the use and stability of the preparation in clinical practice.

Ward Manager

The Ward Manager is accountable for:

- ensuring that all relevant policies and guidelines are available and followed within the ward/department. The Ward Manager must ensure that:
  - all staff are able to refer to relevant documents on the trust intranet
  - these documents form part of the core induction programme for all Registered nurses joining their clinical area.
  - audits are carried out and actions identified are implemented.
- ensuring that an up to date list of authorised signatures is maintained;
- ensuring that all medications are kept in a safe and secure manner;
- ensuring that appropriate checking procedures are in place to monitor adherence to these points;
- ensuring that appropriate levels and range of stock drugs are established in conjunction with the Ward Pharmacy team;
- ensuring that Patient Group Directions are used according to guidelines approved by the Trust;
- ensuring that access to controlled stationery such as prescriptions and controlled drug stationary is restricted to authorised staff;
- Ensuring that fridges used to store medicines are of appropriate design and standard, that they remain locked when not in use and that the temperature is monitored to ensure the safety of medicines stored within.
Ensuring that deviations from policy and monitoring requirements are acted upon promptly and appropriately.

All Healthcare Professionals

Each healthcare professional that prescribes, handles, supplies or administers medicines is accountable for:

- working within current legislation and to work within the Code of Conduct of their professional body;
- ensuring that medicines are prescribed and administered only to treat the Trust's patients.

Anyone prescribing, supplying, preparing, administering or disposing of medicines, must act within the framework of current legislation and in accordance with their professional Code of Conduct and Standards and in line with Trust policy and Guideline documents.

Anyone prescribing, supplying, preparing, administering or disposing of medicines is personally responsible and accountable. That accountability cannot be delegated or shared with another person. Anyone involved in aspect of medicines management is responsible for bringing to the attention of her line manager any educational needs she may have in relation to ensuring safe practice in this important function, and undertaking necessary training.
Pharmacists

Pharmacists are responsible for ensuring that medicines are prescribed, supplied, stored, prepared and administered correctly. This means that the right medicine should be prescribed and administered in the right dose at the right times and via the correct process.

A pharmacist should review the drug chart of each hospital in-patient:

- As soon as possible after admission
- When changes are made to prescribed drugs
- At appropriate intervals during the inpatient stay, depending on the medicines prescribed

When reviewing discharge prescriptions

The standards for prescription review and actions are set out in relevant pharmacy procedure and standards documents.

A pharmacist should verify each outpatient prescription, day case or discharge prescription received in the dispensary before it is dispensed.

Pharmacy Support Staff

Pharmacy support staff can undertake delegated tasks including dispensing, stock control and suitably accredited Pharmacy Technicians, final checking of dispensed items and medicines reconciliation.
5 Definitions

Appointed Nurse in Charge
The nurse in charge carries continuing responsibility for the ward, department or healthcare setting. At times when he/she is not on duty, delegated responsibility is carried by another qualified nurse.

Authorised Staff/Practitioner
Individual practitioners/members of staff are authorised in one or more of the following ways:
1. By terms and conditions of appointment and as defined in the job description or

By possession of a recognised professional qualification which is used to carry out the duties defined in the job description or

By being recognised as competent to carry out specific functions
2. With authority of first-line Manager and/or Senior Manager.
3. By definition within individual procedures.

In the community or community hospitals unqualified/unregistered staff may be authorised to undertake some activities that would not normally be allowed, e.g. checking Controlled Drugs prior to administration.

Authorised Prescriber
Authorised prescribers include Medical and Dental Practitioners, Nurse Prescribers and Non-Medical Prescribers who are qualified to prescribe under the Trust Non-Medical Prescribing Policy

BNF British National Formulary.

Borderline Substances
Some foods and toilet preparations that, in certain conditions, have characteristics of drugs and the Department of Health Advisory Committee on Borderline Substances (ACBS) advise can be considered as drugs in those conditions.

Clinical Trial
An investigation or series of investigations consisting of the administration of one or more medicinal products, where there is evidence that it may be beneficial to the patient, by one or more doctors or dentists for the purpose of ascertaining what effects, beneficial or harmful, the products have.

Community Nurse
A District Nurse, Health Visitor or Registered Nurse who provides nursing care for people in their own home, including those employed by SASH.
**Community Pharmacy**
A retail pharmacy in the private sector, i.e. not attached to an NHS hospital.

**Complementary Therapies**
Homeopathic and herbal medicines for the purposes of this document are considered as medicines.

**Controlled Drugs**
Medicines that are subject to the prescription requirements of the Misuse of Drugs Regulations 1985, Schedules 2 and 3.

**Controlled Stationery**
All stationery which could be used to obtain medicines fraudulently.

**Cytotoxic**
A medicine, which acts principally by interfering with cell division at various stages in the cell cycle, for the treatment of neoplastic disease or other associated disorders.

**Designated Manager**
The person who carries managerial responsibility for a specific area. This may be a first-line manager or a senior manager depending on the level of responsibility.

**Drug**
This term is interchangeable with the term medicine.

**Healthcare Setting**
Any building or area designated for the delivery of healthcare. This will include acute or long stay hospitals, residential homes and health centres within the Trust.

**Healthcare Staff**
Any staff who work within a Healthcare setting as defined above.

**ISO Standards**
Standards set by the International Standards Organisation.

**Locality Manager**
Manager for all specialities of Community Nurses with responsibility for a distinct geographical area.

**Locally Agreed/Approved**
Policies and procedures for local use that have been agreed/approved by the Medicines Safety Committee (MSC). The term 'local' may apply to a small work unit (e.g. a ward) or to a large healthcare setting (e.g. a residential home or an acute hospital).
**Medical Practitioner**
This covers all pre-registration and post-registration doctors and dental practitioners who have clinical responsibility for the patient/client at any given time.

**Medicines**
Medicinal products as defined in section 130 of the Medicines Act 1968. A substance supplied or administered to a patient for the purpose of:
- treating or preventing disease.
- diagnosing disease.
- ascertaining the existence, degree or extent of a physiological condition.
- Contraception.
- inducing anaesthesia.
- otherwise preventing or interfering with the normal operation of a physiological function.

**Medicine Defect**
This term covers:
- Visual evidence of deterioration e.g. colour, smell, taste, physical damage, bacterial/fungal contamination
- Unexplained lack of action or adverse reaction to a medicinal product.
- Packaging errors.

**Medicine Error**
Any occurrence that contravenes the policies and procedures laid down in this document.

**NMC**
Nursing and Midwifery Council

**Patient Group Directions (PGDs)**
Documents which make it legal for medicines to be given to groups of patients - for example in a mass casualty situation - without individual prescriptions having to be written for each patient. They can also be used to empower staff other than doctors (for example paramedics and nurses) to legally give a medicine if a doctor is not available to prescribe. There are strict limitations on the use of PGDs.

**PODs**
Patient’s Own Drugs (brought in with patient)

**Qualified Nurse**
A qualified/registered nurse is one who is listed on the NMC Register and has a current PIN number.

**Return to Practice Nurse**
A nurse who is involved in a university based update programme and working a minimum number of clinical hours in practice, following a career break for five years or more.

**SI Units**
Systems international units.
6 Compliance Monitoring arrangements

Monitoring policy implementation

Pharmacy staff routinely monitor aspects of this policy, in particular:

- Medicine security
- Prescribing
- Administration including missed doses and instructions for safe administration of medicines
- Transfer of medicines with patients when moving to a new ward or on discharge

Regular audits will confirm that the policy is being followed. The following audits are regularly carried out within the Trust and will be reported via the Medicines Safety Committee:

- Medicines Security
- Medicines Administration
- Missed doses
- Health Records
- Controlled Drug checks
- Pharmacist interventions

7 Training to ensure compliance with this policy

The Trust process for dissemination of policies will be followed as described in the Organisation Wide Policy for the Management and Development of Procedural Documents.

This includes:
- posting on the dedicated Policies and Procedures page of the Intranet
- notification to all staff of the new policy on the next available E-Bulletin

This revised policy will be disseminated through Matrons and Lead Clinicians.
Because this is the sixth version of the policy, a summary of changes to be brought in will be prepared and will form the basis of training and awareness sessions, with three key target audiences:

- Doctors
- Nurses
- Pharmacy staff

Training needs are assessed from the implementation plan and are reviewed by the Medicines Safety Group.

In addition, incident reports are collated by the risk management team and reported through the Medicines Safety Group. Where appropriate the Division Governance Groups will be involved in audit, monitoring and taking action.

8 References and associated documents

Associated Trust Policies

- Administration of Intravenous Medicines Policy
- Disposal of Medicines Policy
- Extravasation Policy
- Incident reporting Policy
- Industry Sales Representatives Policy
- Non-Medical Prescribing Policy
- Outpatient Prescribing Policy
- Records Management Policy
- Standing Financial Instructions
## References

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Author</th>
<th>Date of publication</th>
<th>Title of document</th>
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<tr>
<td>Department of Health</td>
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<td>2007</td>
<td>Controlled drugs in secondary care</td>
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<td>NHS London Regional Office</td>
<td></td>
<td>2001</td>
<td>'Guidance for the provision of supervised practice for nurses and adaptation for midwives in London'.</td>
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<td>Royal Pharmaceutical Society</td>
<td>Duthie</td>
<td>2005</td>
<td>Guidelines for the Safe and Secure Handling of Medicines – Duthie revision 2005</td>
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<td>Department of Health</td>
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<td>2008</td>
<td>The Health Act (2008)</td>
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<td>Department of Health</td>
<td></td>
<td>2005</td>
<td>The Mental Capacity Act (2005)</td>
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9 Document Control

This procedural document supports:

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<td>NHS Litigation Authority (NHSLA)</td>
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<td>Standard 5, Criterion 10 – Medicines Management</td>
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<td>Care Quality Commission (CQC)</td>
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<td>Outcome 9 – Medicines Management</td>
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<td>NICE Guideline</td>
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<td>Technical patient safety solutions for medicines reconciliation on admission of adults to hospital (PSG001)</td>
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<td>1.7</td>
<td>Venous thromboembolic diseases (CG144)</td>
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<td>Venous thromboembolism - reducing the risk (CG92)</td>
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<td>Other national guidance</td>
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<td>Standards for Hospital Pharmacy – Royal Pharmaceutical Society</td>
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<td>(e.g. Royal College Guidance) -</td>
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Consultation record

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<td>Other</td>
<td>Medicine Safety Group Drugs and Therapeutics Committee</td>
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<td>Throughout development</td>
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<td>Theatres</td>
<td>Sue Carr</td>
<td>Matron</td>
<td>2013</td>
<td>Feedback on role of ODPs and Anaesthetists</td>
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## Document Control (continued)

### Change History

<table>
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<tr>
<th>Version</th>
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<th>Job title</th>
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<td>1</td>
<td>Jul 2001</td>
<td>David Heller</td>
<td>Chief Pharmacist</td>
<td>New Policy</td>
<td>Management Board</td>
<td>Pharmacy shared drive</td>
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<td>2</td>
<td>Feb 2003</td>
<td>David Heller</td>
<td>Chief Pharmacist</td>
<td>Review and Revision</td>
<td>Management Board</td>
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<td>Jan 2010</td>
<td>David Heller</td>
<td>Chief Pharmacist</td>
<td>Review and Revision</td>
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<td>6</td>
<td>Feb 2014</td>
<td>David Heller</td>
<td>Chief Pharmacist</td>
<td>- Out of hours requirements, patients own drugs is first priority for pre-admission drugs</td>
<td>Clinical Effectiveness</td>
<td>Pharmacy shared drive</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- added requirement to monitor fridges and freezers</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- Added requirement to record allergy reaction type, severity and date of recording</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Added need to discuss and record religious and dietary restriction on medicines</td>
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</table>
- Clarification of preparation of medicines including labelling, preparation by ODPs.
- Clarification of policy on single person administration by agency nurses and role of students as second checkers
- Clarification of verbal order restrictions. No Controlled Drugs, cytotoxics, intravenous medicines or central route administration. Need to record in notes, have a second person hear.
- Discharge medicines. Requirement to give MaPPs handy summary and to explain changes, including uses, side effects and precautions, to the patient.

Other minor wording changes for clarity

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<thead>
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<th>Date</th>
<th>Changed By</th>
<th>Role</th>
<th>Changes</th>
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<tr>
<td>6.1 Dec 2014</td>
<td>David Heller</td>
<td>Chief Pharmacist</td>
<td>Added details of when drugs can be administered without a prescription (in section 3.6). Clarification that approved prescriptions include electronic prescribing systems Minor reorganisation of points in section 3.6</td>
<td>Minor change to Drugs and Therapeutics Committee</td>
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<td>6.2 Jan 2015</td>
<td>Sandhia Finch</td>
<td>Bank Pharmacist</td>
<td>Added policy on handling methotrexate for non-cancer indications (3.2.5; 3.2.8;</td>
<td>Pharmacy shared drive</td>
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| | | | 3.2.11; 3.4.6) and prescribing of unlicensed and off-label medicines (3.4.2) |
| | | | Removal of permission to administer medicines under verbal orders (3.6.1) |
| | | | Clarification of rules around illicit substances in the possession of patients (3.2.6) |
Appendices
Appendix 1  Equality Analysis (EqA)

By completing this document in full you will have gathered evidence to ensure, documentation, service design, delivery and organisational decisions have due regard for the Equality Act 2010. This will also provide evidence to support the Public Sector Equality Duty.

| Name of the policy / function / service development being assessed | Medicines Management Policy |
| Date last reviewed or created & version number | Version 6 (third draft) |
| Briefly describe its aims and objectives: | This policy aims to ensure that all staff are aware of their responsibility for the safe and secure handling of medicines and all associated processes, including prescribing |
| Trust lead | David Heller |
| Target audience (including staff or patients affected) | All staff who have any involvement with medicines |
| Screening completed by (please include everyone's name) | Organisation | Date |
| David Heller | Surrey and Sussex Healthcare NHS Trust | 11.02.2014 |
| Colin Pink | Surrey and Sussex Healthcare NHS Trust | 11.02.2014 |
An organisation wide policy for Medicines Management v.7

<table>
<thead>
<tr>
<th>Equality Group (Or protected characteristic):</th>
<th>What evidence has been used for this assessment?</th>
<th>What engagement and consultation has been used</th>
<th>Identify positive and negative impacts</th>
<th>How are you going to address issues identified?</th>
<th>Lead and Timeframe</th>
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<tbody>
<tr>
<td>Age</td>
<td>The policy covers the use of medicines for all ages including the facility to administer oral liquids if solid products are not appropriate.</td>
<td>No specific consultation</td>
<td>Older patients very young patient may struggle to access packages of medicines, may not understand how to take the medicines or their purpose and side effects. These patients will usually have carers to support them.</td>
<td>Roll out of this revised policy will include an update on where to get advice on medicines issues for this group of patients</td>
<td>Chief Pharmacist</td>
</tr>
<tr>
<td>Disability</td>
<td>Supply meds in a way that supports disabled patients to manage their own meds. Large print labels for eye drops.</td>
<td>No specific consultation</td>
<td>Patients with disabilities may struggle to access packages of medicines and may not understand how to take the medicines or their purpose or side</td>
<td>Roll out of this revised policy will include an update on where to get advice on medicines issues for this group of patients</td>
<td>Chief Pharmacist</td>
</tr>
</tbody>
</table>
## Gender reassignment
- No issues presented by this policy

## Marriage & Civil partnership
- No issues presented by this policy

## Pregnancy & maternity
- Many prescribed medicines present some risk to pregnant patients and to babies who are breast feeding
- On-going discussion with WaCH division
- It is possible that a patient or their baby might be harmed by poor prescribing or other medicines errors. Medicines prescribed before pregnancy may harm a foetus

## Race
- There are very few medicines which work more effectively in one racial group compared to others.
- No specific consultation
- It is possible that a patient might be harmed by prescribing

## Religion & Belief
- Section 3.4 includes reference
- The Medical Division has
- It is possible that a patient might refuse

Roll out of this revised policy will include an update on where to get advice on medicines issues for this group of patients.

Chief Pharmacist
An organisation wide policy for Medicines Management v.7

to checking religious beliefs before prescribing.
discussed this at length in relation to products of animal source. The pharmacy has worked with them to provide an alternative product where necessary
treatment on the basis of the origin of the product, for religious or ethical reasons, leading to harm.
include an update on where to get advice on medicines issues for this group of patients

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<th></th>
<th>to checking religious beliefs before prescribing.</th>
<th>discussed this at length in relation to products of animal source. The pharmacy has worked with them to provide an alternative product where necessary</th>
<th>treatment on the basis of the origin of the product, for religious or ethical reasons, leading to harm.</th>
<th>include an update on where to get advice on medicines issues for this group of patients</th>
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<td>Sex</td>
<td>No issues presented by this policy</td>
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<td>Sexual orientation</td>
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<tr>
<td>Carers</td>
<td>No issues presented by this policy</td>
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