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Royal Cornwall Hospitals NHS Trust

Good Medicines Management Clinical Guideline

V4.0

March 2019

1. Aim/Purpose of this Guideline

1.1. This guideline applies to all staff that are involved with medicines on a day to day basis on the wards and in clinical areas.

1.2. The guideline sets out the practical aspects of how medicines should be handled on the ward/ clinical area, on transfer and on discharge.

1.3. The guideline aims to ensure there is a consistent approach to medicines management across all wards and clinical areas to minimise the risk of missed doses and to reduce waste.

1.3. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

The DPA18 covers how the Trust obtains, hold, record, use and store all personal and special category (e.g. Health) information in a secure and confidential manner. This Act covers all data and information whether held electronically or on paper and extends to databases, videos and other automated media about living individuals including but not limited to Human Resources and payroll records, medical records, other manual files, microfilm/fiche, pathology results, images and other sensitive data.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

2.1 Stock, non-stock and patient's own drugs

2.1.1 Stock Drugs

- Each ward/ clinical area has designated stock drugs.
- These drugs are stored in the treatment room cupboards and drugs trolley.
- Each area is provided with a stock list that nurses should refer to if they are unsure of what is stocked in their area.
- Each ward receives a minimum of a weekly ward stock top-up service from pharmacy.
- Non-ward clinical areas are generally not on top-up and place stock requests as required with the pharmacy department
- To order ward stock outside of the top-up service, order in the A4 ward stock book (CHA49) or using the electronic Pharmacy Ordering Portal.
- The stock list should be reviewed on a periodic basis with the ward sister and ward pharmacist to ensure the list remains appropriate for the clinical area.

2.1.2 Non-Stocks

- Non-stocks are those drugs that are not stocked by the ward/ clinical area.
- Non-stocks are supplied on a named patient basis and will generally be labelled with directions to allow them to be used on discharge.
- Non-stock drugs must be stored in the patient's bedside locker where available.
- Non-stock drugs must be ordered using the electronic non-stock ordering process on EPMA or the Pharmacy Ordering Portal (POP).
- If the non-stock drug is urgent please indicate this on the electronic order note.
- When EPMA or POP is not available, non-stocks should be ordered using the paper non-stock request form; these will be circulated by pharmacy as part of their business continuity plans.
- Please be aware of the missed and delayed dose policy available on the document library and make yourself familiar with those medicines

deemed ‘critical medicines’, where a missed or delayed dose can quickly lead to patient harm. Most critical medicines are available in the ‘emergency drugs cupboard’, accessed via the site co-ordinators out of hours, or contact the pharmacist on-call via switchboard.

2.1.3 Patient’s Own Drugs

- Patient’s Own Drugs (PODs) are those drugs brought in by the patient on admission.
- PODs should be utilised to dose patients during their admission once they have been assessed as suitable to use.
- PODs are patient’s property and therefore verbal consent must be given before they are used. They must not be used for other patients.
- Where a POD has been stopped on admission, permission should be given by the patient before disposing of the medicine. If the patient refuses to give permission, the drug should be placed in a bag in their locker and a sticker added to say ‘do not use’.
- PODs must be stored in the patient bedside locker where available.
- Either the ward pharmacist/ technician or the ward nurse can assess the PODs for suitability of use. Please check:
  - The packaging is intact and expiry date has not been passed
  - The label is clearly readable and contains the following information:
    - Name and strength of medication
    - Dose and frequency
    - Patients name
    - Date dispensed (must be within the last 6 months)
    - Name and address of dispensing chemist or doctor.

2.2 Safe Storage of Medicines

- Detailed guidance on safe storage of medicines can be found in the Medicines Policy.
- As a general rule, all medicines (including patients’ own medicines) must be locked away. The exceptions to this are inhalers, eye drops, GTN sprays and creams that can be stored at the patient bedside.

2.3 Transfer of Patients and their Medicines between Wards and at Discharge

- All non-stock medicines and PODs should be moved with the patient when they are transferred to another ward using the green bags provided.
- Failure to do this increases the risk of patient harm through missed doses, and results in unnecessary waste.

- All non-stocks medicines and PODs should be sent down to pharmacy with the TTO using the green bags provided to ensure these medicines are utilised on discharge and not wasted.
- For patients being transferred to a community hospital, a paper copy of the electronic prescription (MAP) and administration record (MAC) must be printed off and sent with the patient at the time of the patient transfer. The receiving community hospital uses this paperwork to continue treatment until a prescriber is on-site to write-up an new drug chart.
- For transfers to community hospitals RCHT will provide any medicine for the patient that is not stocked at the community hospital or that the patient already has as a POD.
- For further information please refer to the RCHT Adult Discharge and Transfer Policy.

2.4 Discharge Prescriptions (TTOs)

2.4.1. The ward pharmacist should be contacted when a TTO is required.

2.4.2. Where the ward pharmacist is not available, **send the TTO and any drugs in the bedside locker** down to pharmacy.

2.4.3. Please indicate on the TTO the expected discharge time of the patient and to where the patient is being discharged e.g. home, care home, community hospital, hospice.

2.4.4. You can track the progress of a TTO in pharmacy by logging onto the TTO tracking system:

- Go to the Trust Intranet page
- The link is available on the homepage or click on 'A-Z resources'
- Click on TTO tracking
- Click on 'all wards' and filter for your ward
- Enter your ward username and password (if unknown contact pharmacy)
- You will then be able to see what stage the TTO is at in the process.

Pharmacy aims to process all TTOs within 2 hours, with 50% completed in one hour.

2.4.5. A minimum of 14 days' worth must be supplied on discharge, with the exception of medicines required for a specific course length or when required medicines.

2.4.6. When a patient has sufficient supply of a medicine at home and there has been no change to the doses during the admission, no further supply will be given on discharge. The eTTO print out sent up with the patient's drugs will state 'patient's own'.

2.4.7 he nurse should always do a final check of the drugs supplied against the most up to date version of the TTO to ensure no last minute changes have been made and that all the required drugs have been supplied and that all medicines (including controlled drugs and fridge items), have been added to the bag. This is an important final safety check. Nurses are recommended to utilise the TTO reminder check-list that is attached to the outside of every TTO bag to prompt the necessary steps to ensure a safe medicines discharge.

2.4.7. The nurse should go through the medicines with the patient to confirm they understand what they are meant to be taking and refer to the ward pharmacist as appropriate. Ideally the nurse should cover what the medicine is

for and any basic counselling such as how often to take them and common side-effects. This information can be found on the TTA reminder sheet in the patients TTA bag.

2.4.8. Lastly the nurse should complete the 'ready to leave' screen on Maxims e-discharge and provide the patient with a print out of the e-discharge. Completing this screen automatically sends a copy of the e-discharge to the GP and is a vital step in ensuring good communication between primary and secondary care. **Remember, this should only be done at the point of discharge.**

2.5 Expiry Date Management

- Pharmacy will undertake monthly expiry date checks to those areas where pharmacy provides a top-up service i.e. most wards. This expiry date check is limited to the treatment room top-up area and does not include decant stores such as drug trollies, clinic rooms, anaesthetic rooms and ward bay decant stores. It also does not cover IV fluids, feeds and the CD cupboard.
- Any clinical area that stores medicines must have a monthly process in place for checking expiry dates of medicines which are not covered by the pharmacy top-up process.
- Paperwork to support this process can be found in Appendix 3. These records should be kept in a folder in the clinical area as evidence that expiry date management is in place.
- This task can be delegated to pharmacy with the appropriate funding but managing expiry dates remains a team responsibility as it is a dynamic situation where expiry dates change when products are reconstituted, liquids and creams are opened and patients bring in their own supply. Therefore all staff need to remain vigilant to the risk of expired medicines
- On identifying expired medicines, staff should segregate the stock immediately and return it to pharmacy as soon as possible for appropriate storage.

3. Monitoring compliance and effectiveness

Element to be monitored	All elements of this policy will be monitored
Lead	The matron, ward sister, ward pharmacist and ward technicians will monitor the policy as part of their daily working practice.
Tool	Datixes will be completed where non-adherence to the policy has resulted in an incident. Quantity of medicines returned from wards to dispose of. Clinical screening of the TTAs
Frequency	Ongoing. An annual medicines management report is submitted to the Board which will include reference to medicines management performance
Reporting arrangements	Aspects of the report will be reported to: The Senior Nurse and Midwifery Committee The Medication Practice Committee The Medication Safety Group
Acting on recommendations and Lead(s)	The Senior Nurse and Midwifery Committee The Medication Practice Committee
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1 Governance Information

Document Title	Good Medicines Management Clinical Guideline V4.0					
Date Issued/Approved:	October 2018					
Date Valid From:	March 2019					
Date Valid To:	March 2022					
Directorate / Department responsible (author/owner):	Pharmacy (Chief Pharmacist)					
Contact details:	01872 252593					
Brief summary of contents	How medicines are managed on the wards and the processes for ordering, transfer and discharge.					
Suggested Keywords:	Medicines, drugs, medicines management					
Target Audience	RCHT	KCCG	CFT			
	✓					
Executive Director responsible for Policy:	Medical Director					
Date revised:	October 2018					
This document replaces (exact title of previous version):	Clinical Guideline for Ward Medicines Management					
Approval route (names of committees)/consultation:	Medication Practice Committee					
Divisional Manager confirming approval processes	Karen Jarvill					
Name and Post Title of additional signatories	Not Required					
Signature of Executive Director giving approval	Medical Director					
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only			
Document Library Folder/Sub Folder	Clinical / Pharmacy					
Links to key external standards	Care Quality Commission NHSLA					
Related Documents:	No					
Training Need Identified?	Yes Learning and Development department have been informed.					

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
12/12/14	1.7	Changes to reflect the move to electronic prescribing and the electronic ordering of medicines	Iain Davidson Chief Pharmacist
06/12/16	3.0	Changes to reflect arrangements on patient transfer and discharge	Iain Davidson Chief Pharmacist
28/8/18	4.0	Changes to include a section on expired medicines. Change of title to include other clinical areas	Iain Davidson Chief Pharmacist

Appendix 2 Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Good Medicines Management Clinical Guideline V4.0</td></tr>
<tr><td colspan="3">Directorate and service area:
All Clinical Directorates</td><td colspan="3">Is this a new or existing Policy:
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Iain Davidson, Chief Pharmacist</td><td colspan="3">Telephone:
01872 252593</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To ensure consistent processes are followed on all wards for medicines management.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">Nurses are clear on:
• How to order drugs
• How to transfer drugs
• How to discharge patients
• How to use the tracking system</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">Improved medicines management on the wards.</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">Monitoring of Datixes, TTA turnaround times and quantity of waste.</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Patients.</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups

Medication Practice Committee</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">SOP approved.</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		
Sex (male, female, trans-gender / gender reassignment)		**X**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

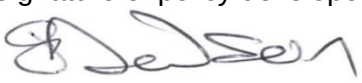
You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

There is no impact on equality,

Signature of policy developer / lead manager / director 		Date of completion and submission 04/03/2019
Names and signatures of members carrying out the Screening Assessment	1. Iain Davidson 2. Human Rights, Equality & Inclusion Lead	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust's web site.

Signed: 

Date: 04/03/2019

Appendix 3: Medicines Expiry Date Checks In Clinical Areas

Background

In clinical areas where pharmacy do not provide an expiry date checking service (for example, outpatient clinics, clinic rooms, anaesthetic rooms, drug trollies and feeds) it is the repsonsilbity of the clinical service to ensure monthly expiry checks are taking place to remove any expired stock, eliminating the risk of patients receiving out of date medicines. It is the responsibility of the clinical lead for that area to ensure these checks are happening.

Process

1. Identify all areas within your department/ward/clinic that hold medicines stock that are not expiry date checked by pharmacy, this includes decant stores such as clinic and anaesthetic rooms, drug trollies and controlled drug cupboards.
2. Undertake a **MONTHLY** expiry check of those areas.
3. Record this monthly expiry check on the 'Expiry Date Check' form for that location.
4. Return any expired stock or stock going out of date that month immediately to pharmacy.
5. In the case of controlled drugs, attach a 'DO NOT USE' sticker to the product (available from pharmacy), segregate it at the bottom of the CD cupboard and contact pharmacy to return it.
6. Record any medicines going out of date in the following three months on the 'Short-dated items' form- allowing for easy identification of these medicines for removal at the next monthly expiry date check.
7. The clinical lead or nominated deputy should sign off the expiry checks have occurred each month and retain this record in the clinical area in an expiry date folder for two years.

Medicines Expiry Date Checks In Clinical Areas

YEAR: 2018 **Clinic/Ward/Department: EXAMPLE**

	LOCATION						
EXAMPLE	Controlled Drug Cupboard	Feeds	Clinic Room 1	Anaesthetic rm 1	Drug Trolley	Ward bay drug storage cabinet	
	Checked by & Date	Checked by & Date	Checked by & Date	Checked by & Date	Checked by & Date	Checked by & Date	Clinical Lead Sign off
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							

Medicines Expiry Date Checks In Clinical Areas

YEAR: **Clinic/Ward/Department:**

	LOCATION						
	Checked by & Date	Checked by & Date	Checked by & Date	Checked by & Date	Checked by & Date	Checked by & Date	Clinical Lead Sign off
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							

Monthly Check of Short Dated Items

Clinic/Ward/Department:

Enter Month Of Checking	Item or Items Short Dated	Expiry Date	Checked By	Removed By