# The Medicines Policy

## Chapter 6: Standards of Practice

## MISCELLANEOUS and DISCHARGE

**V2.1**

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## CHAPTER 6

## CONTENTS

## 6.5 Miscellaneous

### 6.5.1 Patients Moving Between Healthcare Trusts

#### 6.5.1.1 Transfer of Patients to Hospitals and Hospices in Cornwall

Where discharging a patient to a community hospital or hospice the patient should be transferred with a TTO supply except for certain medicines. When sending a TTA for a patient to pharmacy, the destination should be added so that the pharmacy department can ensure that an appropriate supply of medicines is made.

When completing the electronic TTA for the patient the prescriber should also, where possible, adjust the inpatient drug chart to match what medications the patient should take after their transfer to the community hospital or hospice.

The patient should be discharged with the following documents:

- Medication Administration Profile (MAP) from the JAC EPMA system which gives the history of medication administrations during the inpatient stay
- Medicines Administration Chart (MAC) from the JAC EPMA system which the receiving unit will administer from until it is re-written onto an appropriate prescription chart by a doctor.
- A copy of the electronic discharge which will give information about the patient's inapatient treatment and ongoing therapy requirements as well as the medicines that the patient should continue on discharge.

#### 6.5.1.2 Transfer of Patients to Secondary Care Outside Cornwall

The patient should be discharged with the following documents:

- Medication Administration Profile (MAP) from the JAC EPMA system which gives the history of medication administrations during the inpatient stay
- Medicines Administration Chart (MAC) from the JAC EPMA system which the receiving unit will administer from until it is re-written onto an appropriate prescription chart by a doctor.

It may be appropriate to discharge the patient with a supply of medicines but this will depend on the circumstances of the transfer and should be discussed with the ward pharmacist on a case by case basis.

#### 6.5.1.3 Discharging Patients and Discharge Prescriptions

For the correct procedure for discharging patients with discharge prescriptions (TTOs) please refer to the Clinical Guideline for Ward Medicines Management in the documents library.

### 6.5.3 Unlicensed medicines

This term is usually applied to those medicines which do not have Marketing Authorisation (more commonly known as product licence) or when licensed medicines are used for unlicensed indications. For example many medicines used to treat children only have licensed indications for use in adults.

For good clinical reasons the use of unlicensed medicines and the use of licensed medicines for unlicensed indications is widespread in hospitals. There are risks, however, and medical and nursing staff need to be aware of these and take precautions to minimise them.

If a prescriber uses an unlicensed medicine or a medicine for an unlicensed indication they do so on their own responsibility. Consequently they carry the burden of the patient's welfare and in the event of an adverse reaction or under clinical governance arrangements he/she may be called upon to justify their action. To minimise the risk the following steps should be followed:

- Ensure there is no licensed alternative available.
- Initial requests to use an unlicensed medicine must be made by completing a 'Formulary Request' form (available from the Pharmacy) and approved by the Newly Licensed Drug Sub Committee.
- Initial prescribing must be undertaken by a consultant.
- The prescriber must ensure that the unlicensed use meets Bolam principles i.e. that the practice is supported by a respectable body of medical opinion, is logical and not outdated. 'Respectable body of medical opinion' includes reputable journal articles and peer consensus guidelines.
- The prescriber must advise nursing staff and make them aware. As independent practitioners they may wish to be provided with more detailed information concerning the treatment and medicine.
- The patient should be informed of the unlicensed status of the medicine and discuss the risks and benefits.
- GPs may be reluctant to take prescribing responsibility. The prescriber is responsible for keeping the GP properly informed and for providing him with all the information to allow him to make an informed decision.

### 6.5.4 Monitored Dose Systems

#### 6.5.4.1 Tamper Evident (Blister Packs)

Some patients in the community have their medications dispensed into tamper-evident packs, known as monitored dose systems (MDS) containing each daily dose of the majority of their solid-dose medications, in order to aid their compliance and give a visual indication of whether doses have been taken. For continuity of device and supply these packs need to be ordered via the patient's usual community pharmacy, however they generally require 48 hours notice which is not always possible.

When this is not possible, the outpatient pharmacy (Lloydspharmacy at the time of writing) can undertake a limited number of MDS on a daily basis with a turnaround time of 4 hours.

If a blister pack cannot be arranged via the community pharmacy or Lloyds in time for discharge, a 14 day blister pack can be supplied from the RCH pharmacy.

Ward staff must inform their ward pharmacist or medicines management technician when an admitted patient usually uses an MDS so that they can perform

a needs assessment and when necessary liaise with the community pharmacy and highlight on the medicine chart that an MDS is used at home.

Ward staff must advise pharmacy staff immediately when discharge is being planned – if there has been any change in medication, at least 24 hours notice is needed to arrange for new packs to be produced.

If a monitored dose system is considered necessary for a new patient, the ward pharmacist should liaise with the patient's regular community pharmacist who will conduct an assessment of the suitability of the patient and their medication before agreeing to fill the monitored dosing device.

For established patients that use compliance aid devices that we do not support within the hospital (e.g. PIVOTAL), this is referred back to their community pharmacist. Where there have been changes to their medication, the ward pharmacist or technician will contact the community pharmacy, fax the TTO prescription and also forward an FP10HNC for the drugs required. The TTA should be sent to the community pharmacy with the FP10HNC and should clearly state any changes in the patient's medication regimen.

#### 6.5.4.2 Non-Tamper Evident (Refillable Devices)

Some patients use refillable, non tamper evident, compliance aids which contain compartments for the daily doses of the majority of their solid dose medications. These usually contain enough medications for a day or a week and may be refilled by the patient, the patient's family or a carer.

These devices must not be filled by hospital staff and must only be used by patient's family or carers where a blister pack provision in the community is awaited

### 6.5.5 Paraffin Containing Products

The NPSA has advised all healthcare staff involved in the prescribing, dispensing or administration of paraffin based skin products of a potential fire hazard. Bandages, dressings and clothing in contact with paraffin based products for example white soft paraffin, yellow soft paraffin, emulsifying ointment, white soft paraffin 50% liquid paraffin and Epaderm®, are easily ignited with a naked flame or cigarette.

- If a patient insists on leaving the ward to smoke they should be told of the risk and advised to wear a thick outer coat free of paraffin-containing products.
- The patient/family should be advised to change any clothing or bedding which becomes impregnated with paraffin products.
- The nurse should record that this advice has been given, on the first occasion.
- Fire safety notices should be prominently displayed in areas where paraffin-containing products are frequently used.
- More details can be found on the National Patient Safety Agency website.

### 6.5.6 Home Delivery of Medicines

The Trust supports a number of home delivery arrangements for selected medicines. Each homecare provider company must undergo the appropriate 'bona fide' checks by the pharmacy department and an appropriate SLA and contract monitoring

arrangements agreed before the company can begin to deliver a service. Under no circumstances should a prescriber initiate a new home delivery arrangement without authorisation from the pharmacy department.

### 6.5.7 Loading doses

A loading dose is an initial large dose of a medicine used to ensure a quick therapeutic response. It is usually given for a short period before therapy continues with a lower maintenance dose. The use of loading doses of medicines can be complex and error prone. Incorrect use of loading doses or subsequent maintenance regimens may lead to severe harm or death. (*NPSA RRR018 - Preventing fatalities from medication loading doses*).

To help medical, nursing and pharmacy staff prescribe, check the doses and administer these medicines safely, loading dose worksheets have been developed. The loading dose worksheets contain information on dosage, follow up prescriptions, administration and any monitoring that is necessary. They can be accessed electronically via the intranet (in the Pharmacy folder of the Document Library). Loading dose worksheets are available for the following medicines which were judged to be the highest risk and therefore more prone to error:

- Acetylcysteine
- Aminophylline
- Amiodarone (IV and oral)
- Argatroban
- Bivalirudin
- Danaparoid
- Digoxin (IV and oral)
- Eptifibatide
- Phenindione
- Phenytoin
- Tirofiban.

### 6.5.8 Collection of Prescription Charges

All patients, unless exempt, should pay a prescription charge for each item they receive on an outpatient prescription.
Where a patient is unable to pay or there are no arrangements in place to collect payment, a promissory note should be given to the patient.

### 6.5.9 Medical/ Drug Representatives

Please refer to the Trust Policy on Representatives. Important aspects relating to medicines are:

- Providing samples of medicinal products for use on Trust patients is prohibited. Any offer of free stock for formulary medicines must be agreed with the pharmacy procurement department.

- The price RCHT pays for any drug or usage figures must not be divulged to anyone outside the Trust without the Chief Pharmacist's permission. This information is commercially sensitive and disclosure may compromise the Trust's contract prices.

### 6.5.10 Parenteral Nutrition

All requests for all adult patients to receive Parenteral Nutrition should be through the Trust Nutrition Team.

Completed TPN is placed in the refrigerator at the top of the Pharmacy slope by 17:50 hrs each evening for collection by the ward when needed.

The initiation of TPN is not considered an emergency out of hours; however, any clinical enquiries out of hours should be channelled initially to the on-call pharmacist.

### 6.5.11 Adverse reactions, near misses, incidents and risks in prescribing, administration and custody of drugs

The Trust believes in an open and fair culture when reporting incidents and risks to ensure that patient safety is not compromised. All staff should be encouraged to log incidents on Datix and complete risk assessments when incidents, near misses or risks are identified.

Incidents and near misses must be reported in accordance with the Trust's incident reporting policy.

All incidents regarding medicines are reviewed by the pharmacy team and actions implemented to reduce the risk of recurrence.

Incidents must also be reported to the most senior nurse on the ward as soon as possible, who will liaise with the Ward Manager/Matron for that area, as well as with appropriate medical and pharmacy staff.

Allergic reactions to drugs should be reported and documented in line with the *Procedure for Allergies or Idiosyncrasies to Medicines*. Suspected adverse drug reactions should be reported to the MHRA via the yellow card system- please refer to the back if the BNF.

Where a risk has been identified concerning medicines then a Trust risk assessment form must be completed and the risk logged on the Trust risk register. An action will need to be put in place to remove or mitigate the risk.

### 6.5.12 Reference sources to assist with prescribing and administration

It is important that all staff involved with prescribing and administration have access to up-to-date medicines information and clinical reference sources.

There is a wealth of information available on the internet e.g. NHS evidence, the map of medicine and the NELM. Please note that Trust policies and procedures may differ from advice given on the internet. Trust polices should always take precedent.
Common reference sources used in the Trust are:

- British National Formulary
- www.medicines.org.uk – for patient information leaflets and summary of Product Characteristics

- Medusa Injectables Guide - http://medusa.wales.nhs.uk/

**The Cornwall & Isles of Scilly Formulary** - details which drugs can be used and restrictions around their use
**The UCLH injectable Guide** - for information on how to administer injectable medicines
**The Alder Hey Children's Injectables Guide** - for use in paediatrics
**Trust policies** - available on the document library
Advice can also be sought from the ward pharmacist or from Medicines Information on Extension Number 2587.

### 6.5.13 Using Patients' Own Medicines

Medicines brought into hospital are the property of the patient. They may, with the patient's permission or the permission of their carer, continue to be used provided they have been prescribed on a hospital prescription and they have been examined and approved in accordance with the standards set out below.
When a medicine brought in by a patient is not to be used again or is not found to be suitable for use *and* with the explicit agreement of the patient or their carer it should be sent to pharmacy for disposal.

When a medicine which is brought in by the patient will not be administered while the patient is in hospital but will be used after discharge it should be stored securely on the ward for return to the patient on discharge.

Patients' medicines that have been prescribed and approved for use must be stored in the patient's own locked medicines cabinet on the ward or where there is no such cupboard, in the ward drug trolley.

The ward manager is responsible for ensuring that a patient's own medicines remain with the patient at all times when they are moved within the hospital.

Before a patient's own medicines can be administered in hospital they must be checked by a nurse, pharmacist or pharmacy technician to ensure that:

- The medicines are clearly labelled with:
  - The name of the patient
  - The name and strength of the medicine
  - Method and frequency of administration
  - Date dispensed (do not use if dispensed more than six months ago)
  - Name and address of the supplier (pharmacy).

- The directions on the label match those on the inpatient prescription chart. The doctor or pharmacist must be alerted if the label does not match the prescription chart.

- If the medicine has no dispensing label it must not be used unless:
  - The identity of the medicine is beyond doubt.
  - The batch number and expiry date of the medicine can be read.

- Confirmation is required that the medicines have been stored appropriately, e.g., in a refrigerator.

- The overall appearance of the bottle, label and medicine must be acceptable.

- At discharge the patient's own medicines together with additional hospital medicines stored in the patient's medicines cabinet must be checked against the discharge prescription by the pharmacist or doctor before being handed to the patient.

### 6.5.14 Retention Of Records

Requisition books (CHA49) and computer issues notes must be stored on the ward for two years after the date of last entry. Prescription sheets and continuation sheets should be filed in the patient's notes.

Records relating to Controlled Drugs are retained in accordance with The Trust's policy on controlled drugs. Guidance on retention of pharmacy documentation such as enquiries and batch documentation can be found in the pharmacy records policy.

### 6.5.15 Ward Moves Or Closures

The pharmacy must be contacted in advance of any permanent or temporary ward closures or location transfer.

Separate arrangements exist for Controlled drugs, see the relevant Trust Policy.

For short-term closure (not exceeding 7 days) the pharmacy will conduct a risk assessment before deciding whether to remove stock. The risk assessment will be conducted with the assistance of the security advisor.

Other medicines may be moved by any member of the team under the supervision of an appointed member of pharmacy staff.

### 6.5.16 Defective Medicines

If any medicine, label or container is suspected of being defective, the medicine should not be administered. It should be isolated, retained, reported and returned to Pharmacy after having been clearly marked to show that it is thought to be defective.

### 6.5.17 Other Matters

#### 6.5.17.1 Medicine Labels

Medicine labels must NOT be amended by hand. If necessary, the medicine should be returned to the pharmacy team for re-labelling.

#### 6.5.17.2 Transfer of Medicines between Containers

Medicines must not be transferred from one storage container to another.