Tower Hamlets GP Care Group CIC

Safe and Secure Handling of Medicines Policy and Procedures

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Title	Safe and Secure Handling of Medicines Policy
Supersedes	All previous Policies
This policy will impact on	All staff
Related Documents	
Policy Area	Quality & Safety
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Issued By	Governance Team
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	Committees / Groups / Individual	**Date**
Approved by		
Approved by	THGPCG Board	

1 Introduction

1.1 The Department of Health requires that NHS providers establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner.

1.2 In order to meet this requirement, the THGPCG must ensure that:

 Professional practices concerning the use of medicines are current and up-to-date and that they remain subject to review and further development.

 All healthcare practitioners dealing with medicines remain aware of current policy.

 The concepts of patient focused care and patient empowerment are acknowledged and, where possible, are built in to policy and practice.

 Medicines Management is seen as a high priority within the Clinical Governance of the THGPCG.

1.3 This policy aims to offer practical advice and steps that must be taken to ensure that medicines are handled safely and securely within services provided by the THGPCG by all employed staff.

1.4 When referring to this document care should be taken to understand the limitations on individuals mentioned in the different sections.

1.5 This document is subject to the THGPCG's policy on equality and diversity

1.6 A full review of all existing procedures shall be performed every 2 years. However, individual sections may need to be amended sooner than this where necessary, and monitored for satisfactory performance.

2 Purpose

2.1 The purpose of this policy is to provide standard operating procedures (SOPs) and policy guidance to all THGPCG staff involved in the handling of medicines.

2.2 The core guidance encompasses reconciliation of patient's medicines on prescribing, ordering, storage and administration of medicines.

2.3 As far as possible, rules and procedures have been standardised within the THGPCG to avoid confusion when staff move from one place to another.

2.4 All staff are required to observe these rules and any local rules that also apply. If you are in any doubt your immediate manager will advise you.

3 Duties

3.1 THGPCG's Deputy Clinical Director has overall responsibility for all aspects of medicine handling by staff employed by THGPCG.

3.2 This includes the quality of medicines used in the THGPCG, establishment of procedures following consultation with appropriate medical and nursing staff and the organisation of safe and secure systems for all stages of medicine's transit. This responsibility extends to monitoring, and reporting on, the effectiveness of these systems.

3.3 Some of the duties listed in 3.2 above are at least partially dependent on the service provided by the supplier of medicines to the THGPCG. For these aspects, the Deputy Clinical Director will ensure that the appropriate safeguards are built in to the Service Level Agreement (SLA) for pharmacy supply services and that there is adequate monitoring of service provision related to this contract.

3.4 Following the Health Act (2006), all organisations that handle Controlled Drugs (CDs) must have appointed an "Accountable Officer" responsible for the safe management of CDs within their organisation. For THGPCG the Accountable Officer is Deputy Clinical Director who is responsible for ensuring that all statutory and best practice issues relating to CDs are being complied with (see CD Standard Operating Procedures).

3.5 The guidance defines individual responsibilities of personnel involved in medicines management, including those of doctors and other prescribers, nurses, pharmacists and support staff.

4 Definitions

4.1 Staff Definitions

4.1.1 Throughout this document, certain specialist titles describe healthcare staff who have defined responsibilities regarding the management of medicines.

4.1.2 Only staff with contracts (or honorary contracts) of employment to work in THGPCG are recognized as having any involvement with medicines.

4.1.3 Throughout, the term "Practitioner" is used. This is a general term used to describe a qualified medical practitioner, nurse, pharmacist or other authorized healthcare employee.

4.1.4 Prescriber – a registered professional authorised through training and registration to prescribe medication.

4.1.5 Independent Prescriber – Medical Practitioner, Dentist, or "Non-medical Prescriber" (NMP). A NMP is usually a nurse or pharmacist who has completed the non-medical prescribing course as an independent prescriber or who qualified as a supplementary prescriber and has undertaken the conversion course (see Non-Medical Prescribing Policy).

4.1.6 Supplementary Prescriber – A registered professional, other than a doctor or

dentist, who through training and registration can prescribe in accordance with a clinical management plan agreed between the supplementary prescriber, independent prescriber and patient

4.1.7 Designated Practitioner (e.g. Registered Nurse) - Any registered practitioner identified as competent and appropriate to perform a specific function. The designation as such has been communicated to and accepted by the Designated Practitioner. If the practitioner is based in the community the term used is Designated Community Practitioner.

4.1.8 Authorised Pharmacy Staff - Any qualified pharmacist or pharmacy technician authorised as competent and appropriate to perform a specific function by the lead Pharmacist employed by THGPCG.

4.1.9 Authorised Employee – (e.g. Nursing Assistant or assessed carer) - A member of staff who following training, (which may take place locally), has been authorised by the Appointed Practitioner in Charge to undertake specific duties in relation to medication, (e.g. witnessing the administration of controlled drugs). Note: Any additional unit-specific policy must be taken into consideration.

4.2 Other Definitions

4.2.1 Patient - A person prescribed medicines irrespective of the environment in which they are residing.

4.2.2 Medicine/drug - Any substance or combination of substances presented for treating or preventing disease. Any substance or combination of substances which may be administered with a view to making a medical diagnosis or restoring, correcting or modifying physiological or psychological functions.

4.2.3 Prescribe - To authorise in writing the supply, and if appropriate administration of a medicine to a named patient.

4.2.4 Dispense - To prepare a clinically appropriate medicine for a patient for self-administration or administration by another. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product). Only pharmacy staff, doctors or designated practitioners should perform these functions.

4.2.5 Supply / issue - To supply a medicine to a patient/carer for administration. Only pharmacy staff, doctors or designated practitioners should perform these functions (see section 13).

4.2.6 Administer - To give a medicine by either introduction into the body, (e.g. orally, inhaled or by injection) or by external application (e.g. cream, ointment or application of a patch).

4.2.7 Patient Group Direction (PGD) - A written procedure for the supply and/or administration of a specific medicine, including prescription only medicines, in an identified clinical situation, to a clearly identified group of patients, by named competent practitioners in the absence of a written prescription. It has been drawn up within the THGPCG by doctors, pharmacists and other professionals and approved on behalf for the THGPCG by the Deputy Clinical Director.

4.2.8 Next Working Day – For the purposes of this policy working day means Monday to Friday except Bank Holidays. Therefore "Next Working Day" at weekends and Bank Holidays means Monday unless this happens to be a Bank Holiday.

5Non-Controlled Drugs & Medicines

5.1 Ordering and Receipt

THGPCG will ensure that at least two senior staff (one from the Nursing Team and one from THGPCG Board) have appropriate qualifications / training and competencies and will be responsible for ordering, receipt and care of Non-controlled drugs, medicines and vaccines.

Wherever possible orders will be placed on THGPCG approved Suppliers List

Orders for stock medicines should be made using the THGPCG ordering systems through approved supplier list .These orders are normally placed either electronically or by fax.

On receipt of these medicines, the supply made must be checked against the order and any discrepancies investigated, documented and reported to both the Supplier and THGPCG designated Nurse Practioner

5.2 Vaccines

Ordering and Receipt

Orders for vaccines will be made in sufficient time to ensure there is an adequate supply for clinics and will be placed via the ImmForm website. Staff responsible for ordering vaccines will pre-register on ImmForm at https://www.immform.dh.gov.uk/registration/.

Nominated Staff will ensure that:

- Vaccines are promptly stored in a fridge after delivery, maintaining the cold chain at all stages.
- There are no leakages, damage or discrepancies in the delivered vaccine
- Stock is properly rotated – vaccine with the shortest expiry date will be used first.
- A stock information which keeps track of orders, expiry dates and running total of vaccines is implemented and maintained.

5.3 Transport and Security

Medicines should not be transported unless it is absolutely necessary to do so and transfers should be initiated through a system in which all orders and dispatches are recorded.

Medicines in transit should not be left unattended, at any time, even in a locked vehicle.

Cold chain control, within the limits appropriate to the product should be maintained for items requiring refrigeration.

5.4 Storage and Security of Medicines

All medicines must be stored at a level of security appropriate to their proposed use.

Each service location has a nominated person and a deputy responsible for the safekeeping of all medicines stored .
All medicines, with the exception of medicines for emergency use and wound care products must be stored in lockable cupboards/rooms, which comply with the current British Standards for Medicines Storage (BS2881), at a temperature not exceeding 25°C.

Medicines that are for internal and external use, should where appropriate, be stored separately from each other, either in different rooms / lockers or different parts of the room/locker,

Access to the rooms / lockers / cupboards containing drugs should be restricted to authorised staff only. All managers are to be aware of the signs that may indicate abuse or diversion of medicines (e.g. changes in an individual's behaviour, regular unexplained absences from the work area, loss of stock or excessive ordering) and take appropriate action.

All medicines must be stored in their original containers and should not be transferred from one container to another. Part packets given to patients should be dispensed in plain boxes / bottles and not the original container and include a copy of the medicine information leaflet.

Injectable ampoules and vials must be stored in the outer packaging in which they are supplied. It is best practice to only remove ampoules from their outer packaging at the time they are required and to avoid returning ampoules to boxes.

If medicines are used by GPs during domiciliary visits their use must be recorded in both the GP Bag Drug Register and within the patient record on return to the surgery.

5.5 Storage of Refrigerated Medicines and Vaccines

Medicines that require storage below room temperature should be stored in a lockable medicines fridge, kept in their original packaging and stored to allow sufficient space around the packaging for air to circulate. Should the fridge not lock, they are to be sited in areas that are securable when unoccupied. By definition refrigeration is a temperature of between +2 and +8°C.

Where possible, the fridge will have two thermometers, one of which is a max / min thermometer independent of mains power.

In the event that the fridge has only one thermometer, a monthly check will be undertaken to confirm that the calibration is accurate, using an independently powered external thermometer.

The temperature of all fridges storing medicines is to be recorded at the same time every day during the working week, using the thermometers provided. Both the minimum and maximum temperatures are to be recorded. The person making the reading will sign each record and reset the thermometer after each reading.

The power supply to the refrigerator is to be clearly identified to ensure that accidental isolation does not occur. In the event that a medicine has not been stored at the correct temperature, or is suspected of not having done so, the matter should be investigated and advice sought.

Food and drink or samples must not be stored in medicines refrigerators. Medicines must not be stored in a food or samples fridge.

All refrigerators are to be maintained and defrosted, where necessary, in accordance with manufacturers' instructions. Additionally, they are to be tested and inspected annually.

5.5.1Fridge failure

In the event of a fridge failure, nominated Staff will ensure:

- The local NHS England screening and immunisation team is advised;
- All vaccines affected are quarantined from others, but are maintained in the cold chain)
- All details of the incident are recorded
- The incident is reported on the ImmForm website at www.immform.dh.gov.uk

5.6 Storage of Emergency Medicines

Adequate provision must be made to access medicines in an emergency.

The storage arrangements will be, by necessity, a balance between quick access and the risks associated with misappropriation or misuse.Custody and Safekeeping of Keys

Clinical Managers will be responsible for the custody of keys to medicine cupboards. Where practical, keys will be kept securely in key cupboards with restricted access to authorised staff.

Clinical managers will be responsible for the safe custody of controlled stationery.

6.7 Loss of Controlled Stationery, Keys or Medicines

On discovering a loss of Controlled Stationery, Keys or Medicines THGPCG Lead Nurse Practioner is to be informed immediately, who will immediately investigate any loss and follow the incident reporting procedure. This may include notifying the local police. If duplicate keys are not available, or if the lost keys are not found, consideration must be given to fitting new locks to the affected area.

5.8 Return and Disposal of Unwanted Medicines

The return of pharmaceutical waste is governed by the Hazardous Waste Regulations 2005.

For medicines which are no longer required by patients, the service location should advise patients to return such unwanted medicines to the Chemist /GP Practice responsible for the original dispensing, or another local Chemist for disposal.

For non-dispensing Patients, where it is not possible to return the medicines to a Chemist, and as a last resort - the Patient may return them for disposal by the Practice.

Most pharmaceutical waste is not classified as hazardous waste. The green, 6 litre and 22 litre (DOOP) bins are to be used for all non-hazardous waste.

When disposing of solid non-hazardous waste (e.g. tablets and capsules) blister packs can be removed from cartons and individual tablets subsequently removed from the blister packs. Patches should be opened and folded together, then placed in the DOOP bin.

Tablets should be destroyed using the denaturing kit. If there are a small amount of tablets, use a bag that is able to take water and tip an amount of powder out of the denaturing kit. Place the tablets in the bag with the powder and add water. This will then solidify. It should then be placed in the green DOOP bin.

Lozenges should be destroyed with the denaturing kit.

Ampoules should be carefully destroyed by breaking the top off and tipping the liquid into the denaturing kit

When disposing of liquids, these should be poured into denaturing containers.

When dealing with returned or out-of-date cytotoxic or cytostatic medication, gloves must always be worn to ensure the drug does not come into contact with skin. These drugs can be absorbed through the skin. Gloves should be disposed of in the DOOP bin and hands washed after each contact. The drugs should be disposed of in purple topped sharps bins.

5.9 Storage of Waste

Waste medication being stored prior to destruction / disposal is to be treated in the same manner as medicines which are yet to be dispensed, until removed from the premises by an authorised contractor.

6 -Untoward Incidents Involving Medicines

If there is any risk or harm to an individual due to an incident involving medicines, priority must be given to the clinical care of that person or persons.

Any incident or near miss in which medicines are involved must be reported in accordance with THGPCG incident reporting policy.

7 Administration Errors

As soon as it is realised that there has been a medication error, the appropriate practitioner should be informed and, where necessary, remedial action should be taken to ensure the safety of the patient.

Supporting statements are to be obtained, either in the form of a Significant Event Form or a signed declaration, in view of the seriousness of the incident.

8 Adverse Reactions to Drugs

Any drug may produce an adverse, unwanted or unexpected reaction. Detection and reporting of these incidents is important.

Practitioners are urged to report adverse reactions on yellow cards to the Medicines and Healthcare products Regulatory Agency (MHRA). The yellow cards are available in the BNF.

All suspected adverse reactions to drugs whether established or otherwise should be reported in addition to noting the reaction in the patient's medical record.

9 Defective Medicines

During manufacture or distribution of a medicine, an error or accident may occur whereby the finished product does not conform to its specification. Any suspected defect in a medicine should be reported to the MHRA.

Reports on the suspected defective medicine should include the brand or generic name – the name of the manufacturer or supplier, the strength and dosage form of the product, the product licence number, the batch number and the nature of the defect.

All Drug Alerts are to be dealt with promptly on receipt and are to be returned to THGPCG Lead Nurse Practioner for appropriate action

10. Monitoring Compliance and Effectiveness

THGPCG Quality & Safety Committee in conjunction with Deputy Clinical Director will be responsible for establishing appropriate processes to monitor compliance of this policy through a combination of audits, review, survey, etc and outlining which tier of staff will have responsibilities for conducting the monitoring/audits, including the methodology to be used for monitoring/audits and frequency of monitoring/audits.

The Quality & Safety Committee will receive quarterly review and audit reports and will identify systems and organizational improvements , and make recommendations to the THGPCG Board