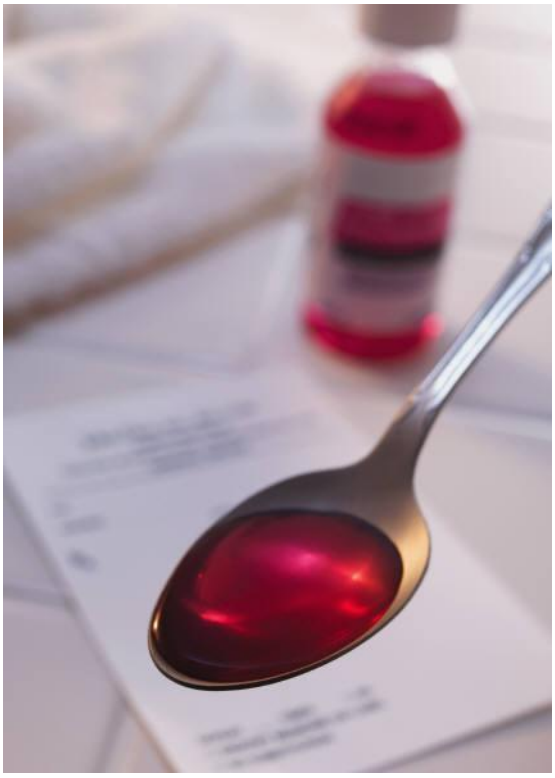
Wairarapa DHB
Medicines Management Policy



Approved by:
Wairarapa Medicine Advisory Committee

Note: Only the electronic version is controlled. Once printed, this may become out of date rapidly.
Review date: September 2018

1. INTRODUCTION

This policy details the Medicines Management Policy for the Wairarapa District Health Board (Wai DHB) provider arm and the standards for services provided under Service Level Agreements to local PHOs, mental health and nursing community services. **All** staff (Including **ALL** locum & casual staff) working within these areas are required to adhere to the procedures described within this document. It has been compiled by a multi-disciplinary team and is intended to be used by all individuals who deal with medicines within the DHB.

This is a generic policy covering all the medicines management issues across the DHB, where appropriate specific guidance has been given for patient groups. Additional clinical policies, protocols and guidelines may be required for specific issues e.g. standing orders, intravenous therapy.

It is the responsibility of the individual to read the policy and acquaint themself with the correct procedure.

During the life cycle of this policy Wairarapa DHB may be moving towards electronic prescribing. This will necessitate various elements of the policy to be updated as necessary. In all cases electronic systems will be at least as safe and secure as existing systems.

AIM

The aim of the policy is to act as a procedural guide for the prescribing, storage, supply and administration of medicines. It is intended to minimise the risk of errors occurring in the use of medicines. The correct administration of prescribed medicines involves medical, nursing, midwifery and pharmaceutical disciplines and requires vigilance and caution.

The term medicine also includes such items as lotions, some nutritional products, intravenous infusions and interactive dressings.

THE POLICY DOCUMENT

This policy will be reviewed upon its expiry date. If difficulties are encountered in implementing this policy it should be discussed with your line manager, Chief Medical Officer, the Executive Nursing and Midwifery Leaders or the Pharmacy Team Leader.

All incidents involving medicines will be reviewed through the Reportable Events process which will identify actions required to reduce risk and share good practice.

Compliance with the requirements of this policy will be reported to the relevant Clinical/Governance Group by the Medicines Advisory Committee together with any associated actions required.

Health care professionals should read this policy in conjunction with their own Code of Conduct and any relevant DHB documents that relate to the use of medicines including:

- Reportable Event Policy
- Waste Management Policy
- Infection Control Policy

RELATED REFERENCES

The following documents were used as a basis for producing this policy: -

Medicines Act 1981
Misuse of Drugs Act 1975
New Zealand Bill of Rights Act 1990
Mental Health Act 1992
Medicine Regulations 1984
Medicines Regulations 2011
Medicines Amendment Act 2013
Misuse of Drugs Regulations 1977
Misuse of Drugs Amendment Regulations 2014
General Disposal Authority for District Health Records; Archives New Zealand, 2006
3DHB PML (2012)
New Zealand Nurses Organisation (NZNO) Guidelines for Nurses on the Administration of Medicines (2014)
Nursing Council of New Zealand. (2004). Notice of scopes of practice and related qualifications prescribed by the Nursing Council of New Zealand.
http://www.nursingcouncil.org.nz/index.cfm/1,22,0,0,html/Scopes-of-Practice
Medicines (Standing Orders) Regulations 2002 & Amendment 2016
Standing Order Guidelines (2nd edn) 2016, MoH
Mninstry of Healthedicines
The Code of Health & Disability Service Consumer Rights Regulations, 1996
Medicines Management Policy 2014; Hutt Valley DHB
Wai DHB Waste Management Policy*****
Wai DHB Reportable Event Policy. *****
NZ Universal List of Medicines 2016
NZHPA Notes on Injectable Drugs. 7th Edition *****
Medical Council of New Zealand (2010) Good prescribing practice
https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf
Ministry of Health (2012) National Guidelines for vaccine storage and distribution, Wellington:MoH.

***** These documents must be available in all areas prescribing, storing or administering drugs

2. PRESCRIBING GUIDELINE

The prescription form-

a. Provides a permanent legal record of the patient's medication.
b. Facilitates the provision of the correct medicine from Pharmacy.
c. Directs administration of the medicine to the patient.

For In-patients and 'Hospital at Home' patients
Use the National Medication Chart **and** additional specific prescribing documents including IV treatment chart; Anaesthetic record.

For Discharge
Use the appropriate Wai DHB electronic discharge prescription. This is accessible through the Concerto portal. If the patient requires a Special Authority or Named Patient Pharmaceutical Assessment for exceptional circumstances, for specific medicines these should be completed before discharge.

For Out-patients
Use the appropriate Wai DHB outpatient prescription form.
When outpatients do not require immediate prescriptions or GPs are requested to prescribe their choice of a particular class of agent ONLY individual drugs or classes of drugs approved within the PHARMAC Pharmaceutical Schedule are to be recommended.

PRESCRIBING GUIDELINES
Prescribing must conform to the Medicines Act, Regulations and Misuse of Drugs Act and Regulations.

Medical Council of New Zealand guidelines must be adhered to in particular Good Prescribing Practice – which states "Appropriate prescribing practice requires that a doctor's customary prescribing conforms within reason to patterns established by the doctor's peers in similar practice. Inappropriate prescribing is unacceptable, both clinically and ethically."

The Medical Council of NZ guidelines also state that prescribers should "Avoid writing prescriptions for yourself or those with whom you have a close personal relationship. It is never appropriate to prescribe or administer drugs of dependence or psychotropic medication to yourself or someone close to you."
self prescribing will only be accepted in exceptional circumstances.

Only *"bona fide"* and current patients of DHB may be prescribed drug therapy at the hospitals expense.

2.1 LEGIBILITY OF PRESCRIPTION

The prescription must be an accurate and unambiguous description of medicine treatment.

If the prescription is ambiguous or illegible, then the medicine MUST NOT be administered. The prescriber must be contacted immediately and the prescription must be re-written.

Hospital pharmacists may clarify a prescriber's intentions, e.g. adding the generic name, clarifying ambiguous prescribing. However, this must be undertaken in a different coloured ink to the original prescription and initialled. Other unsigned alterations invalidate a prescription.

In writing prescriptions, the following advice must be observed: -

a. As per National Medication Chart guidelines all persons involved in the medication charting process (prescribing, checking and administering) should endeavour to complete the 'Sample Signature' section on the medication chart. Details must include the person's full name, sample signature, registration number and designation.

b. The In-patient's medication chart should always be available. Not more than one medication chart must be in use at any one time for any one patient, unless the number of items prescribed exceeds the available spaces. Cross-reference must be made to medicines prescribed on specific charts, e.g. anticoagulants, IV fluids, IVN etc. If a patient requires TWO or more medication charts the number of charts should be clearly identified in the box on the front of the chart.

c. When the chart is full, all current prescriptions must be cancelled and the cancellations must be signed and dated by an appropriate prescriber. The current therapy must then be entered by appropriate prescribing staff on a new chart. Cancelled charts must be retained with the patient's notes.

d. All prescription's must be printed in **indelible ink** and comply with the following: -

i. The patient's full name, sex, weight on admission (if aged 12 and under or prescribing a weight based medication), date of birth, ward, hospital, NHI, and responsible lead clinician (Affix address labels if available). The first prescriber must also write the patients name and NHI on the front of the chart. Information relating to drug allergies/ ADRs must be recorded in the appropriate section by the prescriber when initially completing a medication chart. If none are known then this should also be indicated.

ii. Be signed and dated by the prescriber who must be a registered prescriber employed by the DHB (i.e. cannot be a medical student).

iii. The medications prescribed in the approved generic name written in printed letters (except where prescribing by trade name specifies a particular combination or sustained release product. If you are uncertain please contact your pharmacist).

iv. The dose stated in terms of the quantity of active ingredient not, for example, the number of tablets or volume of liquid except in the case of compound preparations.

v. The route of administration and an indication of where the treatment (e.g. topically to leg) must be given. Combinations of routes e.g. PO/IV are not acceptable in the 'Regular' medicines section. To reduce risk these must be prescribed separately. Specified routes 'intrathecal' and 'epidural' must be written out in full.

vi. Indicate clearly, by the prescriber, the time that each drug must be administered, utilising the 24-hour clock.

vii. Give an indication and frequency of administration of '*as required*' (PRN) drugs by clearly defined stated intervals with maximum dose over 24 hours to be included (PRN alone is unacceptable). A maximum duration and indication must also be stated.

viii. Any alteration must result in the re-writing of that prescription. (Apart from clarification by a pharmacist refer 2.1).

ix. Variable dose prescribing must clearly state the dosage range and the criteria, which determines the dosage given.

x. If abbreviations are used, only those on the following approved list are permitted: -

Buc	Buccal	**Prn**	When required (as needed)
BD	Twice daily	**PR**	Per Rectum
IM	Intramuscular	**PV**	Per Vagina
Inh	Inhalation	**QID**	Four times a day
IV	Intravenous	**q4h**	Every four hours
Mane	Morning	**q6h**	Every six hours
Midi	Midday	**q8h**	Every eight hours
NG	Nasogastric	**q12h**	Every twelve hours
NJ	Nasojejunal	**Subcut**	Subcutaneous
nocte	Night	**Subling**	Sublingual
Neb	Nebuliser	**STAT**	Immediately
PEG	Percutaneous endoscopic gastrostomy	**TDS**	Three times a day
PO	Oral	**TOP**	Topical

When using abbreviations the prescriber should ensure that the initials used are clear and unambiguous.

***ONLY AUTHORISED, APPROVED OR DESIGNATED PRESCRIBERS MAY PRESCRIBE MEDICINES FOR ADMINISTRATION BY OTHER HEALTHCARE PROFESSIONALS*.**

2.2 ALLERGY STATUS

Guidance for completion of patient allergy/adverse drug reactions (ADR's)

Wai DHB requires all prescribers to enter known drug allergies and sensitivities on prescribing documents together with their manifestations OR specify that there are no known allergies. Each prescribing document includes a section on the front page that must be completed.

Nursing staff must not administer medications unless this information is completed.

A **true allergy** may be classified as one or more symptoms consistent with an immune reaction, including breathing difficulties, swelling, rash, itching, and loss of consciousness or anaphylaxis.

Intolerance may be classified as an adverse effect that may be predicted from the known side effect profile or pharmacological action of a drug or an idiosyncratic or unpredictable reaction to a drug, e.g. GI bleeding secondary to a NSAID or neutropenia with clopidogrel.

An **adverse drug reaction** is a response to a medicine which is noxious and unintended and which occurs at doses normally used in man.

When taking a medical history it is important to:

a. Verify the allergy status, drug intolerance or ADR.

b. Establish the length of time the patient has had the reported allergy/intolerance and whether there is a record of when the drug was prescribed or administered in the patient's notes.

c. Document the allergy/ADR clearly in the notes and on the medication chart when taking the patient's history, indicating the type of reaction/ intolerance or ADR described by the patient.

d. Decide whether you would consider it appropriate to administer that drug or a drug in the same class to the patient based on the information available.

e. Document the allergy/drug intolerance/ADR details on the prescription chart providing sufficient information for other prescribers to be able to make appropriate prescribing decisions.

e.g. Severe penicillin allergy (anaphylaxis) – this may be a warning to prescribers that they need to avoid all penicillins and take great care with cephalosporins.

Acute renal failure or GI bleed with NSAIDS – avoid – this gives a clear message for prescribers to avoid NSAIDS.

Mild diarrhoea with erythromycin – if the antibiotic is needed, reassurance that the symptoms are a common side effect may be all that is needed.

2.3 VERBAL INSTRUCTIONS VIA THE TELEPHONE

In **exceptional** circumstances, verbal instructions for the administration of medicines can be given by a prescriber familiar with the patient's current diagnosis and treatment to a registered nurse (RN)/midwife (MW).

When accepting verbal prescriptions, the dose must be stated by the prescriber and confirmed by the RN/MW in words and numbers, for example fifteen (one five) milligrams.

The RN/MW has the unconditional right to refuse to give a drug ordered verbally. When doing so they must notify the prescriber of their refusal and document the reasons according to local guidelines.

2.3.1 Hospital setting

The RN/MW must always get a second RN/MW to speak to the prescriber in order to confirm the instructions. If a second RN/MW is not available to take the message in the hospital the prescriber must visit and write up the prescription.

Such prescriptions must be recorded **indelibly,** including the name of the prescriber and written by the RN/MW on the patient's medication chart in the verbal order section and witnessed by the second RN/MW. Verbal orders for fluids are to be documented on the fluids page of the medication chart; it should clearly indicate it is a verbal order with the details of the witness recorded. **The ORIGINAL prescriber must confirm the telephone order by signing the medicine/fluid on the medication chart before the end of the nurse or midwifes shift.**

VERBAL INSTRUCTIONS VIA THE TELEPHONE MUST NEVER BE GIVEN OR ACCEPTED FOR CONTROLLED DRUGS IN A HOSPITAL SETTING.

2.3.2 Community setting

Whilst it is recommended that two RN's hear a telephone verbal order it is recognised that this is not always possible in the community setting. Where able, the RN/MW should get a second RN/MW to speak to the prescriber in order to confirm the instructions.

Such prescriptions must be recorded **indelibly,** including the name of the prescriber and written by the RN/MW on the patient's medication chart in the verbal order section or in the patient's clinical record clearly indicating it is a verbal order. **The ORIGINAL prescriber must confirm the telephone order by signing the medicine chart within two days.**

In certain circumstances verbal instructions via the telephone, for a change to the 'directions' of a controlled drug in the community, is permitted providing they meet the following criteria:

- The patient is known to the doctor and they are under their care.
- The patient has previously been prescribed the same controlled drug (strength and form) by that doctor.
- The patient already has a supply of the same controlled drug (strength and form).

IF THEY DO NOT MEET THE ABOVE CRITERIA THEN A VERBAL ORDER FOR A CONTROLLED DRUG CAN NOT BE GIVEN OR ACCEPTED.

2.4 VERBAL INSTRUCTIONS FACE TO FACE

In an emergency situation, medicines (except controlled drugs) may be given
by medical/nursing/midwifery staff prior to a formal prescription on an approved medication chart. It is the responsibility of the prescriber to ensure that this is recorded on the approved chart, and for the administering staff to then sign as necessary.

2.5 MEDICINE FORMULARY & ANTIBIOTIC POLICY

Wai DHB operates under PHARMAC schedules to ensure evidence based, rational prescribing occurs across the organisations. An antibiotic policy has also been developed in conjunction with Capital & Coast DHB.

Prescribers should specify products from the Hospital Medicines List (HML). Where alternatives are not available patients admitted on non-formulary drugs will usually have further supplies made to maintain treatment unless the drugs are deemed unacceptable for use within the Wai DHB health economy. In such cases alternative therapies will be discussed with the hospital prescribers.

IT IS UNACCEPTABLE TO REQUEST GENERAL PRACTITIONERS TO PRESCRIBE NON-FORMULARY OR UNFUNDED MEDICINES WITHOUT CLEAR CLINICAL JUSTIFICATION.

2.6 PRESCRIBING OF MEDICAL GASES

Medical gases are regarded as medicines and as such must be prescribed in writing by authorised prescribers on Wai DHB approved stationery e.g. in-patient medication chart, Emergency Department notes or Anaesthetic record sheet.

The prescription must state:

- The medical gas required
- The delivery device i.e. mask, nasal cannula
- Rate and percentage of oxygen
- Other instructions

Only oxygen may be administered in an emergency (cardiac arrest or respiratory distress) without a prescription.

2.7 DISCONTINUING MEDICINES

Prescriptions should be cancelled by drawing a single bold line through the prescription and administration section. The cancellation should be signed and dated by the prescriber AND the action and rationale recorded in the patients medical notes.

2.8 PRESCRIBING DRESSINGS

It is not necessary for dressings to be prescribed before use. It is however essential that ALL dressings used and the rationale behind their use are documented within the individual patient's clinical record/care plan if the dressing is not prescribed.

2.9 PRESCRIBING WITHOUT PATIENT CONSENT

Drugs for treating psychiatric disorders may be given without the patients consent if the patient is detained under the Mental Health Act 1992.

Someone placed under a Community Treatment Order (CTO) has to accept treatment for the first month. However even during this first month the health professional should:

- Still try to obtain the persons consent and explain the benefits and side effects of treatment
- Ensure that the only treatment which can be forced on a patient is that therapy required to treat a person's mental illness.

After the first months treatment a person does not need to receive treatment unless:

- Consent is in writing
- It is in the person's best interest as decided by a second opinion or an independent review tribunal as under the relevant section of the Mental Health Act.
- It is for emergency treatment.

2.10 REGISTERED NURSE INITIATED MEDICINES

Refer to the 'Standing Orders - Medicines' policy. Click here for link.
A full list of Registered Nurse initiated Standing Orders is available electronically on the intranet under the '3DHB SharePoint Collaboration Site'. Click here for link.
All Standing Orders must be countersigned by the prescriber within the timeframe stated on the Standing Order.

2.11 TRANSCRIBING

Traditionally, transcribing has been the responsibility of the prescriber. However, there are situations in which transcribing by regulated health professionals who are non-prescribers may facilitate improved access to and continuity of care.

Any queries in regards to this should be directed to the Executive Leader Nursing. Please also refer to the 'New Zealand Nurses Organisation (NZNO) Practice Guidelines: Transcribing Medicines' (2016)

2.12 MEDICINES RECONCILIATION

Medicines reconciliation is an evidence-based process of obtaining the 'most accurate' list of all medications a patient is currently taking within 24 hours of admission (Safe Medication Management Programme, 2011). Medicine reconciliation has three core steps:

1. Collecting the 'most accurate' medicines list using at least two different information sources, the primary source being the patient;
2. Comparing the 'most accurate' medicines list against the current medication chart and clinical notes for any documented changes to medicines;
3. Communicating any discrepancies (i.e. undocumented changes, whether intended or not) to the prescriber to reconcile and action.

   (Safe Medication Programme, 2011)

The **prime responsibility** for ensuring medicines reconciliation is undertaken remains that of the prescriber. The RN/EN, Midwife (MW), Pharmacist may assist in this process by undertaking reconciliation on admission or at pre-admission, and noting any resulting discrepancies in prescribing on the medicines reconciliation form. The RN/EN, MW, Pharmacist **will not** undertake any resultant transcribing practices.

3. SUPPLY OF MEDICINES

Pharmacy staff may only dispense prescriptions that comply with all legal requirements and are completed in accordance with the procedures outlined in this policy.

Within the Pharmacy department a full range of Standard Operating Procedures are in place – in compliance with Ministry of Health standards.

The issue to a patient of pre-packed containers of medicine, supplied by Wai DHB (e.g. PACU), is the responsibility of the relevant medical, nursing and midwifery staff in accordance with local procedures, which identifies the responsibilities of these staff.

3.1 PHARMACY TEAM

Each ward and clinical teams at Wai DHB have a designated pharmacist and technician who will visit the ward regularly, at times agreed between the pharmacy and the senior nursing staff.

Pharmacy staff will monitor the medication charts both in the dispensary and on the ward; assessing prescribing for accuracy, legibility; interactions and appropriateness of therapy in line with department standards and evidence based clinical practice. Any clarification of a prescription made by a pharmacist will be carried out in a different colour ink to the original prescription and initialled, following, where appropriate, consultation with the prescriber.

Pharmacists record interventions made and any major (life threatening) will be recorded using the Reportable Events process.

Pharmacy staff will assess the need for non-imprest medicines and arrange their requisition from pharmacy. All medication will be labelled with the approved 'generic' name of the preparation except where a proprietary name defines a specific formulation or combination.

3.2 PHARMACY IMPREST TOP-UP

Specific wards will be visited at a designated time each week by a pharmacy technician or assistant. This person will ensure stocks of pharmaceutical products for that area are replenished to agreed imprest levels. The imprest levels will be agreed after discussion between the relevant ward pharmacist, technician and appropriate medical and nursing staff. These levels will be reviewed at regular intervals by the staff concerned. Pharmacy staff must be notified by nursing & midwifery staff if unusual amounts of any item are being utilised to allow imprest levels to be re-calculated.

3.3 DELIVERY OF MEDICINES TO WARDS/DEPARTMENTS & COMMUNITY TEAMS

Medicines are delivered to the ward/department by orderly staff. The nursing/department staff are responsible for the security of medications upon receipt. Items requiring special storage conditions (e.g. refrigeration) will be clearly labelled and must be stored appropriately in the ward/department. (*For Controlled Drugs see section 6).*

3.4 EMERGENCY SUPPLY

Out of hours the Duty Nurse Manager (DNM) can access the pharmacy to obtain medicines required. The medication chart must be faxed to pharmacy indicating which medication is required. Details of medicines taken are recorded on the After Hours form held in pharmacy. DNM to supply original packs or small repacks. Individual tablets or strips of tablets MUST NOT be taken.

During After Hours, imprest medicines may be borrowed from another ward/unit under the instruction of the Duty Nurse Manager.

Borrowing from wards must not occur whilst the pharmacy is open.

3.5 PHARMACY OPENING TIMES

The Pharmacy department is open Monday-Friday 0800-1630 for clinical advice and newly prescribed items.

3.6 OUT OF HOURS PHARMACEUTICAL SERVICE

The pharmacy provides an on call pharmacy service through a team of pharmacists who, when on duty, will be able to respond to requests for information and attend the department for clinically urgent supply requests, when they can not be sourced through alternative routes.

Prescribers requiring pharmaceutical advice can contact the on call pharmacist through the hospital switchboard. Nursing staff requiring the supply of additional medicines in an emergency should contact the Duty Nurse Manager.

Discharge, leave and outpatient prescriptions are not available via the 'On Call' service.

3.7 SAMPLES

Pharmaceutical companies will sometimes provide samples of newly available pharmaceutical products, including dressings, to allow medical and nursing staff to 'try' products before the hospital decides to commence using the products.

All samples are to be left at the pharmacy department. Leaving, delivering or requesting samples is **not** permitted in any clinical area. This applies both to vendor-initiated and Wai DHB staff initiated initiatives. The Medicines Advisory Committee (MAC) will review any physician request for samples on an annual basis.

3.8 CLINICAL TRIAL DRUGS

The contents of this policy apply equally to clinical trial medication. Trial medicines will not be administered to patients unless approved and supplied by the pharmacy, in accordance with Central Ethical & Research Governance approval.

When a patient currently taking medication as part of a clinical trial is admitted medical staff must assess the risk/benefit of continuing/stopping trial medication. This may involve contacting the principal investigator for the trial, and, if deemed appropriate, these patients should be allowed to take their own trial medication whilst a patient within the hospital.

A pharmacist must be contacted regarding those patients who are admitted on trial medication at the earliest opportunity.

3.9 SECTION 25 AND SECTION 29 MEDICINES

In order to ensure that medicines are safe, effective and of appropriate quality, their manufacture and sale or supply is controlled by national registration. Accordingly no medical product may be placed on the market unless a marketing authorisation has been granted.

The informed use of some 'unapproved medicines' or 'approved medicines for unregistered indications' is necessary in clinical practice. The decision to use such medicines should only be made if the product offers the best prospect of benefit for the patient. The decision should also be based upon the best practice and evidence available at the time. The use of recognised formularies and textbooks is recommended when making these decisions.

A Section 25 medicine is one which has marketing authorisation but is being used for an unauthorised indication.

A Section 29 medicine is one which does not have marketing authorisation by MEDSAFE under the Medicines Act and is unapproved. A Section 29 medicine is:-

a. Where items are used on a named patient basis before commercial release.
b. Where products are imported on a named patient basis.
c. Where medicines are licensed for approved use in other countries but are unapproved in New Zealand.
d. Where products are manufactured or assembled to a practitioner's order i.e. 'specials'.

The unapproved use of a registered product is commonly termed 'off-label' use.
In the situations (a) to (c) above and where possible in situation (d) a practitioner prescribing (and nurse administering) these products will be advised by pharmacy staff that the product is unapproved.

If any unapproved medicine in (a) to (c) above, originally prescribed in the hospital, is to be continued in the community, the clinician responsible must continue to manage the patient unless the patient's General Practitioner is happy to accept clinical responsibility for the treatment

In general, it is not necessary to take any additional steps when using such medication, beyond those taken when prescribing registered medicines. However the prescriber should obtain the informed consent of the patient, parents, carers or children to prescribe or administer any unapproved medication. This must be recorded within the patient's notes.

Where the use of the medicine is considered to be experimental, the clinician must ensure they discuss potential treatment with a peer and document all conversations and outcome in the notes. They must also obtain informed consent of the patient, parents, carers or children to prescribe or administer the medicine. This must also be recorded within the patient's notes.

Additional information regarding the use of experimental treatments can be found in the Human Subjects Research Approval Guidelines. Click here for link.

4. PROCEDURE FOR THE ADMINISTRATION OF MEDICINES

A doctor, registered nurse/enrolled nurse, midwife or RAT must only administer a medication when it has been prescribed by an authorised prescriber, using an official medication chart, provided by Wai DHB unless special arrangements exist, as identified in section 2.3, 2.4. This also applies to medicines brought into hospital by a patient and medicines administered by registered nurses in the patient's own home.

Medicines must be administered by a doctor, registered nurse/enrolled nurse, midwife or RAT who is qualified to do so, with an appropriate witness where required. Agreement to use self-medication protocols must be part of the operational policy for defined units.

Student nurses may administer medication (except IV medication) under the direct supervision of a registered nurse/midwife. The supervising nurse/midwife remains accountable for the administration.

Where casual nurses are involved it is the responsibility of the clinical/charge nurse manager or afterhours the duty nurse manager to decide if it is necessary that they should be accompanied for checking purposes when administering medicines to a patient.

4.1 INDEPENDENT DOUBLE CHECKING

Independent Double Checking - means a procedure in which two clinicians separately check (alone and apart from each other, then compare results) each component of prescribing, dispensing, and verifying the medication before administering it to the patient. An **Independent Double Check** is conducted independently by a second person to reduce the risk of bias that occurs when the person preparing and checking the medication is likely to see what they expect to see. The second person does not simply verify the first person's work; they follow a series of steps to arrive at a conclusion which can then be compared against that of the first person's to ensure that they are in agreement.

The second independent check may be provided by:

- A registered nurse/midwife/anaesthetic technician
- A doctor
- A pharmacist

Independent double checking (including any setting up of an infusion device with a programmed rate) is required for:

- All blood and blood products – Refer to NZ Blood Service, Clinical Guidelines and Policies
- All controlled drugs
- IV heparin
- IV insulin
- All IV antiarrhythmics
- All IV thrombolytics
- All epidural additives
- IV bronchodilators
- IV glucose >10%
- Patient Controlled Analgesia (PCA)

Cont…

- All IV cytotoxics
- Medications where the dose required needs to be calculated (not including number of tablets/capsules)

For medications administered to children - Refer Section 4.6 *Administration of Medicines to Children*

NB: This list is not exclusive. Any clinician may at any time request an independent double check – in particular if they are unfamiliar with the medicine, the clinical environment and/ or patient diagnosis. Some clinical areas may also have their own requirements in regards to Independent Double Checking.

4.2 ADMINISTRATION

The person administering a medicine will: -

a. Ensure that any special storage requirements have been adhered to (refer to 6.1).
b. Perform a calculation if required:

4.2.2 Administration

a. Take the medication chart to the patient
b. Perform a bedside check, 5 Rs + 3 (right patient, right medicine, right dose, right time, right route, right to refuse, right indication, right documentation) and confirm allergy status
c. Ensure the patient has swallowed the medicine, received an injection or suppository or received the total amount of prescribed inhalation/ spray

4.2.3 Post Administration

a. Monitor the patient for any side effects and document in the patient record if necessary
b. Document on medication chart – date (PRN meds), time, dose and signature (including second signature if required). If the prescription includes variable doses, the amount given must be recorded.
c. In outpatients or home settings a record must be made in the appropriate patient notes.
d. If medicine is not administered/ omitted it must be documented on the medication chart using appropriate non-administration code. Document in notes reason for non-administration and discuss with appropriate prescriber.
    U- Patient unavailable
    N- Not administered – document reason in notes
    R- Patient Refused.
    SM- Self Medicating
    D – Prescribers instructions

    N.B: If a medicine is not available record as N – and document reason in patient record.
    Destroy immediately any medication or remainder not administered.
e. If the preparation of the medicine is in a multi-dose container, then the patients name and time and date of its first use must be clearly recorded on the container. Multi dose containers of parenteral products must only be used for single patients.
f. Where a maximum number of doses to be given is stated, or a specified maximum length of treatment, that number or length must not be exceeded, without the prescription being re-written.
g. Where the administration of liquid preparations involves the use of volumes other than 5ml spoonfuls, then only **ORAL** syringes must be used.

h. Where controlled drugs (CD) are administered both administrator and the person checking must sign the CD register.
i. Administration of medicines prescribed on an Emergency Department record sheet, Outpatients notes or Anaesthetic record sheet must be recorded adjacent to the signed prescription including the date/time and the signature of the person who has administered the medicine.

4.3 REQUESTS TO CLARIFY OR RE-CHART PRESCRIPTIONS

- Where a prescription does not comply with the prescribing guidelines outlined in Section 2, the drug must not be administered and the chart returned to the prescriber for re-writing.
- Where there is any doubt regarding the prescription, it is the responsibility of the administrator to notify the prescriber, stating the reason for concern, seek clarification and recommending re-charting if required.
- If the original prescriber is not available the administrator should approach their senior e.g. registrar or consultant or the medical staff on call.
- A prescriber must respond professionally to all requests to clarify or re-chart prescriptions. If a satisfactory response is not obtained, the administrator must notify the clinical/ charge nurse/midwife manager or the duty nurse manager and raise the issue with the relevant consultant.
- Any unresolved concerns relating to prescribing must be raised with the Chief Medical Officer by the senior staff involved i.e. medical and/or nursing
- All discussions and actions must be clearly documented in the patient's clinical record.

4.4 PATIENTS CLASSIFIED AS NIL BY MOUTH (NBM)

Patients classified as NBM prior to a diagnostic procedure or operation should still have their prescribed oral medicines administered to them at the prescribed time unless specifically advised AND documented otherwise. It is the responsibility of the prescriber to provide clear written instructions to nursing staff concerning omission of prescribed doses.

4.5 ADVERSE DRUG REACTIONS

If a patient suffers a suspected adverse reaction to a prescribed, over-the-counter or herbal medicine, the adverse reaction should be reported via the Reportable Events and Centre for Adverse Reactions Monitoring (CARM) systems.

Additional guidance on how the CARM forms should be completed is available from Pharmacy. Please note ANY health care professional may complete a CARM form.

4.6 ADMINISTRATION OF MEDICINES TO CHILDREN

In the context of this policy, children will be defined as any patient under the age of 15 years. The policy will apply to any clinical area where children are cared.

Where children's medicine doses are calculated according to the weight of the child, it is essential that this is recorded in kilograms on the prescription chart. The child's weight must be checked at regular agreed intervals, according to their plan of care.

4.6.1 Checking

All parenteral medications administered to children will be independently double checked (whether a dose calculation is required or not).
Where two staff are on duty it is strongly recommended that all medicines administered to children will be independently double checked (whether a dose calculation is required or not). When this is not available, for administration of a dose that involves a calculation (not including number of tablets/capsules) it is strongly recommended that another nurse/midwife, doctor or pharmacist checks the calculation.

Any clinician may at any time request an independent double check – in particular if they are unfamiliar with the medicine, the clinical environment and/ or patient diagnosis.

4.6.2 Children who refuse medication

All staff administering medication to children should take into account their age and understanding. Where it is considered that a child recognises the implications of refusing medication medical staff will be informed and the incident recorded in the medical records. If the child is considered incapable of recognising the implications of refusing medication, provided parental consent is given, medication should be administered.

4.6.3 Consent

Written consent for administration of vaccinations by school nurses/health visitors must be obtained from children's parents or guardians **UNLESS** the child is deemed 'Gillick competent' and can therefore sign their own consent.

4.6.4 Self or Parent/Guardian administration to children

In the case of patients under 15 years, parents/guardians may administer the prescribed medicine to their child, but the nurse must take the overall responsibility for ensuring the medication has been given to the child.

Where appropriate and with appropriate assessment and nursing supervision self-administration by children is permitted.

4.7 SELF-ADMINISTRATION OF MEDICATION BY PATIENTS

Refer to the procedure 'Medication - patient self-administration'. Click here for link.

4.8 DISCHARGE MEDICATION

Each patient may be given a discharge prescription that can be taken to their local community pharmacy. It is acceptable for the ward staff to make contact with the community pharmacy before the patient is discharged and fax a copy of the prescription to the pharmacy. This will ensure timely availability of the patient's medicine after discharge.

For emergency supply of medications 'after hours' from the Emergency department, refer to procedure 'After Hours Dispensing of Outpatient Prescriptions'. Click here for link.

Under no circumstances may ward imprest or inappropriately labelled in-patient supplies be given to patients to take home.

Supplies specifically dispensed by pharmacy for an individual in-patient in preparation for discharge (i.e. with directions included on the label) may be supplied directly from the ward to that patient upon discharge provided their supply is requested on the discharge prescription and checked by the prescriber at the time of generating the prescription.

Pharmacy will supply patients leave medications for short courses if they receive notification at least 24 hours before the leave commences.

Leave medicines require secure storage at ward level until the patient leaves the hospital and must be locked in an appropriate cupboard.

Refer to section 6.6 for advice on the return of patients own medication on discharge.

4.9 INTRAVENOUS ADMINISTRATION

This remains the joint responsibility of nursing/midwife/anaesthetic technicians and medical staff. Nursing and midwifery staff must:

- Work within their Scope of Practice.
- Not administer a medicine by the intravenous route unless they are IV certified and satisfied with their competence.
- Comply with the DHB's Intravenous and Related Policies and documents.
- Be familiar with the patient, the medicine and the administration device.
- Be available to monitor the response to treatment and administer further care.

NB: If these criteria cannot be met, consideration must be given to alternatives to ensure safe and timely administration (See Appendix 1: IV Decision Making Flowchart)

4.10 CYTOTOXIC DRUGS

4.10.1 Intravenous administration of cytotoxic drugs

The administration of cytotoxic drugs is not part of the routine administration of medicines within all areas of the DHB. The fundamental principles of intravenous therapy apply to administration of cytotoxic drugs. Where cytotoxic drugs are to be administered by nurses, there must be a local approved training package.

Cytotoxic drugs may only be administered in designated ward/department areas.

4.10.2 Oral administration of cytotoxic drugs

A minimal touch technique must be used and hands washed immediately before and afterwards. Tablets must not routinely be crushed; contact pharmacy for further advice.

4.10.3 Subcutaneous and intra-muscular administration of cytotoxic drugs

The standard administration technique is used.

4.10.4 Cytotoxic administration by other routes

Cytotoxic drugs to be given by other routes will only be administered by medical staff unless locally approved training packages are adhered to. e.g. bladder instillation.

4.11 INFUSION DEVICES

All medicines (categorised as high risk) which require administration by an infusion device must be administered using a pump/infusion device of the appropriate risk category according to the classification of the drug risk (see Appendix 1 for examples of high risk meds)

4.12 USE OF STRONG POTASSIUM CHLORIDE INJECTION

The Health Quality & Safety Commission (HQSC) national guidance stipulates the controls required for the safe administration of potassium chloride concentrate and other strong potassium solutions.

Wai DHB Safety Controls for potassium chloride concentrate and other strong potassium solutions will be followed at all times.

Commercially available, ready to use solutions of potassium are available from the stores department and shall be used whenever possible.

4.13 MEDICATION INCIDENT/ERROR REPORTING

A culture of reporting on all medicine related incidents/errors and/or near misses is to be encouraged across all disciplines involved in the medicine process (prescribing, dispensing and administration). Such reporting and the subsequent investigation is not about apportioning blame but to ensure that learning occurs and to reduce the risk of same/similar incidents happening in the future.

The following *may be considered as examples* of incidents/ errors and near misses that may generate a Reportable Event:

Prescription

- Failure to date prescription
- Failure to indicate time of administration
- Incorrect dose, drug or route charted
- Failure to chart medicine
- Illegible charting
- No signature

Administration

- Incorrect patient, drug, dose or route
- Incorrect date or time, including when the medicine has not been administered within one hour of prescribed time.
- Omission of a dose.

Note: A ‘medication event’ does not occur if there is a valid reason for delay or omission documented in patient notes.

Dispensing

- Incorrect drug, dose, strength or patient name
- Incorrect or confusing labelling

All incidents/errors/near misses relating to the use of medicines must be reported using the online reportable event system SQUARE (Safety, Quality And Reportable Events)

Notification of all such incidents will be sent to the Pharmacy Team Leader via an alert system within SQUARE.

4.14 DISPENSING LABELS

If a pharmacy label on any container is damaged, altered or obliterated, the container must be returned to the pharmacy for replacement. Staff must not make any alterations to labels except to indicate the addition of a prescribed drug to a container of intravenous fluid or to mark the date of first use on a container. If the appearance of the product differs from normal, the advice of a pharmacist should be sought.

4.15 TRANSFER

Transfer of any medicinal item from one labelled container to another is not allowed, except by pharmacy staff. All medicines must be kept in their original container where possible and NOT decanted into other boxes or drawers etc.

4.16 INTER-WARD TRANSFER

When patients transfer to another ward or hospital within the DHB it is important to ensure that any medicines issued specifically for that patient accompany them.

Any Patient's Own Medicine OR individually dispensed medicines for a patient held on the ward MUST be transferred with the patient if they move to another ward.

A patient transferred temporarily (for special treatment e.g. chemotherapy OR investigation) must have their medication chart sent with them, along with any specifically required medicines (NOT including controlled drugs).

4.17 EXTERNAL APPLICATIONS

In view of the possible hazards inherent in the use of such preparations the nurse or midwife must not administer external applications unless they have been either prescribed or specified in a written protocol, e.g. Ametop Gel.

4.18 STAFF REQUIRING MEDICATION

Self-medication with medicines which are the property of Wai DHB by nursing, medical and all other staff is strictly prohibited. Medical staff may not self prescribe other than in exceptional circumstances. Small supplies of paracetamol/strepsils will be supplied by the pharmacy department for personal use by staff. These should be stored in an appropriate manner under the direction of the Clinical Nurse Manager or nominated representative.

4.19 ORAL LIQUID MEDICINES

Where oral liquid medicines require measurement of a dose that is not a multiple of 5mL an **ORAL** syringe will be used to measure the dose.

Standard sterile injection syringes **WILL NOT** be used for measuring or administering oral liquid medicines.

4.20 CRUSHING OF SOLID ORAL MEDICINES

Where patients are unable to swallow solid oral medicines the pharmacy should be contacted about the availability of alternative liquid formulations. Where a liquid is not available tablets may be crushed using a tablet crusher available from pharmacy. To prevent cross contamination a mortar & pestle must not be used.

Advice on the crushing of solid oral medication and guidance on administering medications via enteral feeding tubes is available from the pharmacy department.

4.21 COVERT ADMINISTRATION OF MEDICINES

The covert administration of medicines is not to be confused with the administration of medicines against a person's will, which may be considered unlawful.

As a general principle, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication, when in fact they are. This covert administration of medicines is only likely to be necessary or appropriate in the case of patients who actively refuse medication **but** are judged not to have the capacity to understand the consequences of their refusal.

Where adult patients are capable of giving or withholding consent to treatment, no medication should be given without their agreement. A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect their health or shorten their life. The exception to this principle concerns treatment authorised under the relevant mental health legislation, when specialist advice is necessary.

Every adult must be presumed to have the mental capacity to consent or refuse treatment, including medication, unless they:

- Are unable to take in and retain the information about it provided by the treating staff, particularly as to the likely consequences of refusal
- Or is unable to weigh up the information as part of the process of arriving at a decision.

The assessment of capacity is primarily a matter for the treating clinicians, but nurses and midwives retain a responsibility to participate in discussions about this assessment.

The DHB recognises that there may be exceptional circumstances, in the absence of informed consent, in which covert administration may be considered necessary to prevent a patient from missing out on essential treatment. However:-

- The best interests of the patient must be considered at all times.

- The treatment must be necessary in order to save life or to prevent deterioration or ensure an improvement in the patient's physical or mental health, or for the safety of others.
- The decision to administer a medication covertly should not be considered routine and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient individually.
- There should be a broad and open discussion among the multi-professional clinical team and the supporters of the patient and agreement that this approach is required in the circumstances. It is inadvisable for the nurse or midwife to make a decision to administer medication in this way in isolation. Those involved should include carers, relatives, advocates, and the multidisciplinary team. Family involvement in the care process should be positively encouraged.
- The method of administration of the medicines should be agreed with the pharmacist.
- The decision, the reasons for it and the action taken, including the names of all parties concerned, should be documented in the care plan and reviewed at appropriate intervals.
- Regular attempts should be made to encourage the patient to take their medication. This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual.

The administration of medicines to patients who lack the capacity to consent and who are unable to appreciate that they are taking medication (unconscious patients, for example) should not need to be carried out covertly. If such patients recover awareness, their consent should be sought at the earliest opportunity.

4.22 ADMINISTRATION OF MEDICATION TO PATIENTS WHO REFUSE TREATMENT

Medicines, as with all form of treatment must only be administered with the patients consent. This is in the main implied – by the fact that the patient takes the prescribed medication. The only situation in which medicines may be administered without the patients consent is under the Mental Health Act 1992 – see 2.9

4.23 ADMINISTRATION OF MEDICATION BY COMMUNITY NURSES

Community nursing staff must ensure that as they do not have a second person to check doses they must double check ALL doses before administration. Records of medications administered must be recorded on the community home prescription chart (where appropriate), within the nursing record or on the GP record. Any wasted doses must be recorded on the medication chart and countersigned by a carer in the home – if possible.

4.24 MEDICATION DELIVERY AND SUPERVISION IN THE COMMMUNITY

NURSING

Refer to Community Nursing procedure 'Registered Nurses –Medication Delivery and Supervision'.

COMMUNITY SUPPORT WORKER

Refer to Community Nursing procedure 'Medication Supervision HCSW Community'.

5. CONTROLLED DRUGS

5.1 PRESCRIBING OF CONTROLLED DRUGS

The prescriber is referred to the Misuse of Drugs Act 1975 and the Misuse of Drugs Regulations 1977 for full guidance.

As a summary, prescriptions ordering controlled drugs should be in the prescriber's own handwriting, using indelible ink on the MOH triplicate prescription form (H572) for a Class A or B controlled drug and state: -

a. The name and address of the patient.
b. The age of the patient if under 12.
c. The full name of the preparation, e.g. morphine sulphate.
d. The form and strength of the preparation e.g. tablets 10 mg.
e. The dose and frequency.
f. Dangerous doses must be underlined and initialled by the prescriber
g. The total number of dose units to be dispensed, preferably in words. e.g. fourteen (14) or if a liquid preparation the total volume in word e.g. One Hundred (100)ml.
h. Prescribers address, date and signature.
i. All alterations on the prescription must be initialled by the prescriber.

5.1.1 Length of supply

Medical practitioners can prescribe for patients for:

a. Up to one month's supply for Class A or B controlled drugs
b. Up to three months' supply for Class C controlled drugs

Dentists can prescribe to patients under their care and must be for dental treatment only and for no more than SEVEN days supply.

Midwives can prescribe to patients under their care and for no more than ONE month.

Nurse Practitioners can prescribe for patients **within their scope of practice** for:

a. Up to one month's supply for Class A or B controlled drugs
b. Up to three months' supply for Class C controlled drugs.

Self-prescribing of controlled drugs is not permitted.

5.2 CONTROLLED DRUG REGISTER

The controlled drug register must be completed at the time of administration of the controlled drug within an inpatient setting.

The charge nurse/ midwife of the department / ward is responsible for the register

- All entries must be clearly written in ink.
- Information in the register must not be deleted, crossed out or over-written.
- Correction fluid must not be used under any circumstances.

- Corrections to entries in the register are made by a footnote at the bottom of the page, giving a brief explanation of the error and the correct particulars, dated and signed.
- Each page shall have entries relating only to one form of one controlled drug. All receipts, drugs used, drugs returned and destruction details must be recorded.

5.2.1 Documentation of controlled drugs used

All entries must be written on a separate line in the controlled drug register and include the following:

- Date and time
- Surname and first initial of the first name of the patient
- Quantity of the controlled drug removed from stock
- Balance of the controlled drug remaining
- Surname and first initial of the first name of the prescriber
- Signatures of any two of: RN/EN, MW, Registered Anaesthetic Technician (RAT), doctor, pharmacist

5.3 ADMINISTRATION OF CONTROLLED DRUGS

The Misuse of Drugs Act (1975) and Regulations (1977) strictly controls 'dangerous drugs' together with some other drugs subject to abuse or liable to cause addiction, collectively referred to as CONTROLLED DRUGS. The individual doctor/nurse/midwife/RAT must be aware of the drugs under this heading.

All controlled drugs at the time of removal from the controlled drugs safe must be checked by a RN/EN, MW, RAT, doctor. Controlled drug register entries must be completed at the same time.

The keys to the controlled drugs cupboard must be kept on the person of a nurse/midwife/RAT at all times.

It is good practice for medical staff who do not commonly undertake complex drug calculations to have any drug calculations checked prior to administration.

Hospital setting:

- Controlled drugs must only be checked out for one patient at a time
- Controlled drugs, once checked, must not be left unattended at any time – including in the locked drug room or at the patient's bedside
- All syringes of 'In use' controlled drugs e.g. bolus analgesia, must be placed inside the locked controlled drug safe and clearly labelled with the contents and a patient label on the syringe when not required

Community setting:

With the home administration of controlled drugs it is recognised that a second check will not be available. It is the nurse's responsibility to confirm the correct drug & dosage required are administered and documented.

5.4 ORDERING OF CONTROLLED DRUGS

The standard controlled drug requisition form should be used. Controlled drugs can be ordered weekly. The nurse/midwife must print their name next to their signature.

5.5 RECEIPT FROM PHARMACY OF CONTROLLED DRUGS

Nursing staff and midwives may come to pharmacy for CDs when required. Both the recipient and the pharmacist must sign in both the main controlled drug register and the ward/unit register.

5.6 INSPECTION & CHECKING

In-patients: Once a week a designated registered nurse will check the stock balance of all ward controlled drugs with a second nurse in a format agreed by the CNM.

In theatres, stocks are to be checked at the end of each day by two staff. One of these must be a RN and the other a nurse, RAT, doctor or pharmacist. A record must be made of each stock check in a format agreed by the theatre manager.

NB: A physical stocktake of the controlled drug register will be undertaken six monthly on the 30th June and 31st December, as per requirements specified in the Misuse of Drugs Regulations, 1977.

5.7 DISCREPANCIES IN CONTROLLED DRUGS STOCKS

Any of the following circumstances must be reported immediately to the senior nurse/midwife who must investigate immediately. If the discrepancy can't be reconciled promptly then the pharmacist must be informed and a reportable event completed.

- Any incorrect entry in a register (do not erase or alter except by a further note)
- Any error
- Any actual or suspected drugs loss.

If outside normal office hours the DNM must be informed immediately. It will be their responsibility to notify the on call pharmacist who will advise the pharmacy team leader as appropriate.

5.8 DISPOSAL OF CONTROLLED DRUGS

Any doses of controlled drugs (tablets or liquids) spilled or dropped or not required by the patient, or balances remaining from part doses must be discarded down the sink and witnessed.

An entry must be made in the controlled drug register specifying the date and time of destruction, quantity destroyed, and full signature of any two of RN/EN, MW, RAT, doctor, pharmacist.

The exception is syringes or bags from an epidural or Patient Controlled Analgesia (PCA), the disposal of these controlled drugs is documented on the Patient Controlled Analgesia chart/ Epidural infusion chart (double signing required).

5.9 CONTROLLED DRUGS & ILLEGAL SUBSTANCES BROUGHT INTO HOSPITAL BY PATIENTS

When a patient is admitted with a controlled drug in his possession, the doctor must be informed.

Drugs dispensed previously (by their GP or community pharmacist) are the property of the patient to whom they are supplied. The patient may send the controlled drug home in the custody of a responsible adult otherwise the drug must be handed over to the nurse in charge and stored immediately in the controlled drug safe. An entry must be made in both the controlled drug register and the patient's clinical record. Upon discharge the controlled drug can be returned to the patient if appropriate. Otherwise, with patient consent they can be returned to pharmacy who will destroy them one month after receipt from the ward.

An illegal or suspicious drug or substance is defined as a "drug suspected of being obtained illegally or an illicit substance".

It is an offence to possess an illegal substance. Contact a pharmacist for advice if any doubt exists over the legality of a substance.

5.9.1 Patient in possession or suspected of being in possession of an illegal substance

If a patient is in possession or suspected of being in possession of an illegal substance, they should be advised that possession is unlawful and should be instructed to have the illicit substance removed from Wai DHB premises as soon as reasonably practicable.

It is essential that the person in charge and the clinician responsible for the patient are informed. A Reportable Event must be completed and the incident documented in the patients clinical record.

If a patient continues to possess, use, or supply an illegal substance on Wai DHB premises the patient must be assessed to determine whether they are competent to understand the consequences of their actions. If the patient is competent, they are advised that further treatment may be terminated if the illegal behaviour continues. The patient must be informed of the potential risks associated with termination of treatment.

The options for the patient include:

- To continue treatment within a plan agreed to with the patient and clinical team
- Referral e.g. to Alcohol and Drug Services
- Compulsory treatment under legislation (where this is applicable)
- Development of an appropriate discharge plan and termination of treatment if the illegal behaviour continues.

The patient must be medically assessed and appropriate arrangements made for follow-up care before treatment at Wai DHB premises is terminated. Any decision to terminate treatment must be made by the senior clinician responsible for the patient's treatment.

If the patient lacks the capacity to understand the consequences of their actions, Wai DHB will take all reasonable steps to ensure that the patient is not supplied with illegal substances while on Wai DHB premises. If the illegal behaviour continues legal advice should be sought from Wai DHB legal processes.

5.9.2 Disposal of illegal substances

Because of culpability issues, it is generally inadvisable for staff to touch any illegal substance discovered on Wai DHB property. In the first instance the patient should be asked to immediately dispose of the substance or have the substance removed from Wai DHB premises. Two staff members should witness the disposal and record events in the clinical notes and through the Reportable Event system.

If the patient is not able to dispose of the substance, or have the substance disposed of, two members of staff may take possession of the substance for the purpose of preventing the patient from committing an offence in connection with the substance. The person who is in possession of the substance must as soon as possible take all reasonable steps to destroy the substance or where applicable hand the substance to the police (Misuse of Drugs Act section 7(3)). Wai DHB staff should not take possession of an illegal substance for any other purpose. Advice should be sought from Wai DHB's legal counsel where there is any doubt. The events must be documented in the clinical notes and through the Reportable Event process.

5.9.3 If a patient denies possession or use of an illegal substance but staff continue to believe that the patient has an illegal substance in his or her possession

Prior to undertaking any search or seizure of a patient's property the patient's consent must be sought. It will only be lawful to undertake a physical search of, and seize, a patient's property without the patient's consent where it is **reasonable and necessary** to do so. The following factors should be taken into account when deciding if the situation is reasonable and necessary in law:

- Staff must weigh up all considerations of public and private interest. That is the public interest and Wai DHB's responsibility for ensuring the safety of the patient, other patients and third parties, against the private interests of the individual patient;
- Staff must **believe** that it is necessary to search and/or seize the substance and the belief must be based on **reasonable** grounds;
- The purpose for the search (and therefore why the information is being collected) should be made plain. The patient must be kept informed, if at all possible, of the circumstances of the case;
- It is important to act in a reasonable manner from the start of the search and seizure process.

5.9.4 The Search Procedure

The search must be carried out in a reasonable manner having regard to the purpose of the search and the circumstances of the case.

The search must be carried out in private and in a manner which otherwise respects the patient's privacy and with at least one member of staff of the same gender as the patient where possible.

5.9.5 Seizure/possession of an illegal substance

There must always be two staff members present when a staff member is taking possession of an illegal substance. The illegal substance must be destroyed immediately, preferably in front of the patient, and **always** with at least one other staff member as a witness to the actions taken.

The actions taken must be recorded in the clinical notes and through the Reportable Events process.

5.9.6 Visitors Rights

Wai DHB staff do not have the right to search visitors or their property. However, where it is strongly suspected or witnessed that a visitor is supplying a patient with an illegal substance, the visitor may be asked to leave the premises, and may if the circumstances warrant it be issued with a trespass notice.

If visitors do not leave when asked, security or the police should be contacted as necessary.

5.9.7 Recording events

A Reportable Event must be completed if a patient is searched and/or an illegal substance is removed from, or found on a patient.

5.9.8 Security and the Police

Any decision to contact the police is the responsibility of the consultant clinician in charge of the patient's care, or after hours the Duty Nurse Manager.

5.10 RETURN OF UNWANTED/OUT OF DATE CONTROLLED DRUGS TO PHARMACY

Expired controlled drugs must be returned to the pharmacy. A record of the return must be made in the ward/unit register as per the Misuse of Drugs Regulations, 1977.

5.11 COLLECTION AND TRANSPORT OF CONTROLLED DRUGS

Return of patient's own controlled drugs from pharmacy

If the person collecting the controlled drug is the patient or the patient's representative the pharmacy staff will request evidence of that person's identity and may refuse to supply the CD if they are not satisfied as to the identity of the person. Pharmacy staff have the discretion to decide whether to ask for proof of identity and also the discretion to supply the CD, even if there is no ID available, or refuse to supply if they are not satisfied that the person collecting is who they say they are.

Health Professional

If the person collecting the CD is a Health Professional the Pharmacy staff may request evidence of that person's identity and may refuse to supply the CD if they are not satisfied as to the identity of the person.

6. MANAGEMENT & STORAGE OF MEDICINES

This section applies to inpatient units, out-patients and other clinical settings (including clinical trials areas) where medicines are stored. It does not apply to patients homes however; advice should be given to individual patients with regard to appropriate storage of medicines within their home.

Any occasion where wards or departments wish to change their medicine storage facilities the pharmacy team leader must be contacted for advice and approval.

6.1 STORAGE

- Medicines when not attended are to be stored in a locked cupboard/room specifically designated for the storage of medicines only.
- Medicines are to be stored in conditions that maintain their pharmaceutical stability and prevent contamination.
- Medicines are to be stored in the containers in which they are supplied by the pharmacy department and may not be transferred to other containers.
- Individual ampoules are to be left in the original manufacturer or pharmacy packaging until immediately prior to administration to an individual patient.
- Blister strips may not be cut into individual dose units.

Each ward/department requires separate storage areas **where relevant** as follows:

Controlled drug safe
All controlled drugs (CDs) are to be stored in a CD safe, used only to store CD's plus other specific medicines liable to misuse. Specific construction and location legislative requirements apply.

Internal and external medicines
All medicines for internal and external administration other than CDs are to be stored in a secure medicine cupboard/room that complies with design specification standards consistent with common practice.

Temperature monitored pharmaceuticals refrigerator
For vaccine holding areas, fridge temperatures are to be taken and recorded daily on the daily temperature chart or in the green pharmacy fridge monitoring folder. For temperatures outside 2-8 ^{O}C, contact the pharmacist and follow the pharmacy advice note on the front of the fridge.

Reagents
All substances for clinical tests, for example urine testing are to be stored in a cupboard/room that complies with design specification standards consistent with common practice.

Intravenous fluids and irrigation fluids
Intravenous fluids and irrigation fluids should be stored in such a way to prevent identification/medication errors.

6.2 SECURITY

All health professionals (and anyone in possession of medicines) must take all practical steps to ensure that medicines (including medicines that are self administered) are secured from access by unauthorised persons.

Access to medicine storage rooms are by staff ID card which, must be worn at all times during hours of work. Staff must report a lost or stolen card immediately to their manager (after hours report to the DNM).

The safekeeping and whereabouts of medicine cupboard keys is the responsibility of the nurse/midwife/other health professional currently holding the keys at any given time.

Medical and pharmacy staff may access keys temporarily as necessary for fulfilment of their duties and are responsible for safe return to the registered nurse in charge.

On such occasions, that particular clinical professional is responsible and accountable for ensuring that all relevant medicines policies and procedures are adhered to. The most senior registered nurse retains the overall responsibility for medicine security for that area.

Doors controlling access to medicine storage cupboards/areas are to remain shut and locked at all times.

When an area is closed e.g. overnight or at the weekend, medication keys are to be returned to a place of safe keeping and unauthorised access prevented. For closure of longer than 3 days consult the pharmacy team leader.

The nurse or midwife in charge is to inform the ward pharmacist or pharmacy if:

- Medicine cupboards and/or the locks are replaced or
- Keys are lost and/or new keys are cut.

The area responsible for the loss will incur the cost of all replacements.

6.3 DISCREPANCY OF IMPREST BALANCE

In the event of a suspected discrepancy in the IMPREST balance at ward/department level, the CNM must be informed immediately. They will inform the pharmacist during normal opening hours. If a Controlled Drug is involved, refer to 5.7. If there is a suspicion of 'medicines abuse', then this should be reported to the Clinical Nurse Manager (after hours report to the DNM) and a senior pharmacist (after hours report to the on call pharmacist). A Reportable Event must be completed in line with the DHB event reporting policy.

Where a Community Nurse has concerns regarding inappropriate use of patient's own controlled drugs their manager should be informed.

6.4 ACCIDENTAL LOSS

Any drug spilled or tablet dropped must be destroyed in accordance with the Wai DHB Waste Management Policy. Disposal of dropped/spilled/broken vials of *controlled drugs* must be as carried out in section 5.8.

6.5 CLINICAL EMERGENCIES (i.e. cardiopulmonary arrest)

All wards/departments will have a source of urgent supplementary medicinal products. These supplies will be tamper-evident and must not be held in a locked cupboard but at strategic and accessible sites. Once a pack has been opened, its seal has been broken or its expiry date has been reached a replacement shall be obtained from pharmacy. Nursing/midwifery staff will check daily that these supplies are intact and in date.

6.6 MEDICINES BROUGHT TO HOSPITAL BY PATIENTS

Patients are asked to bring their medication into hospital when they are admitted. This enables the medical, nursing and midwifery staff to determine the patient's current drug therapy. Should the patient self-discharge or abscond, and then return to the ward the patients recent drug history should be re-established.

Medicines brought into hospital are the property of the patient to whom they are supplied, and cannot be taken from them without their consent (unless they are detained under the Mental Health Act).

When a patient is admitted, the nurse/midwife will enquire whether they have any medicines with them. If the medicines are not required for treatment in hospital and the patient agrees, they can be sent home in the care of a responsible adult or placed in a secure storage area until the patient is discharged.

The use of a patient's own medication may only be allowed in certain circumstances: -

a) Where the drug is non-formulary and this or an alternative is not available from pharmacy.
b) Where the ward operates a self-administration medication programme (refer to 4.7)
c) If use of the drug is essential (e.g. overnight) until supplies are available from pharmacy. The person administering the medicine must satisfy themselves that the patient's own medicine is safe to administer, until confirmation is received from pharmacy.
d) Where the medicine is contained within a patients blister pack and not available in the hospital. In these cases the individual medicine must have identifiable markings and the prescription on the patients medication chart annotated with these markings by the prescriber/pharmacist.

On discharge, if any specific patients own medicines are not required (i.e. a change in therapy), staff will offer to dispose of the medicines and record the patients agreement to do so.

All remaining patients own medicines must be returned to the patient, after being checked by the nurse/midwife undertaking the discharge to ensure that the medicines are for that named patient.

6.7 CONTROLLED DRUGS AND ILLEGAL SUBSTANCES BROUGHT TO HOSPITAL

Refer to 5.9.

6.8 CONTROLLED STATIONERY

Controlled stationery is any stationery, which, in the wrong hands, could be used to obtain medicines fraudulently. The following stationery is considered controlled by the Wai DHB and as such must be stored in a secure manner:-

- Out-patient prescription form
- Controlled drug prescription form

6.9 SAFE KEEPING OF CONTROLLED & OTHER MEDICINES BY NURSES WORKING IN THE COMMUNITY

In exceptional circumstances community nurses may need to transport patients own prescribed medicines. These medicines must be kept in a secure receptacle which, when not being carried by the nurse, must be stored securely. During the hours of duty, the secure receptacle may be kept, out of sight in a locked vehicle.

6.10 DISPOSAL OF MEDICINES

All pharmaceuticals must be disposed of in accordance with DHB waste disposal policies.

Ward/department stocks must be returned to the pharmacy. Patients own drugs must only be returned for destruction if approval has been given by the patient or their parent/guardian.

Expired controlled drugs must be returned to pharmacy for destruction in accordance with the Misuse of Drugs Regulations 1977.

Hazardous medicines (e.g. cytotoxic, flammable) are segregated within pharmacy and are disposed of as hazardous waste.

Community nursing staff must not remove any drugs from a patient's home without WRITTEN consent from the patient or authorised carer.

When a patient dies or medication is discontinued the community nurse must either obtain written consent from the family to remove the drugs **OR** instruct the family to dispose of the drugs immediately by returning them to the supplying pharmacy. In exceptional circumstances (e.g. when the patient lives alone) the nurse may return such items for appropriate disposal. Full records of the nature of the medicines, quantity and disposal method must be maintained within the patient's records. All medicines must be stored securely whilst in transit.

6.11 COLD CHAIN STORAGE OF VACCINES AND OTHER PHARMACEUTICAL PRODUCTS

Wai DHB staff that perform duties away from their normal base must ensure that any pharmaceuticals requiring refrigeration are stored in an appropriate temperature controlled container (i.e. cooler bag with ice packs).

Vaccines must be stored and handled in accordance with the MoH's National Guidelines for Vaccine Storage and Distribution 2012.

Items that require refrigerated storage MUST NOT be allowed to return to room temperature before re-chilling. Particular care must be taken during summer months.

Appendix 1: IV Medication Decision Making Framework