

# KATHARINE HOUSE HOSPICE DRUG POLICY

5th EDITION

Approved by:

Date of Approval:

Originator: Medical Director

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### Preface

The use of drugs is an essential part of Palliative Care, but drugs are potentially dangerous if used without due care and attention. This Drug Policy collates a range of policy and multiple drug-related procedures into one document in a way that is intended to minimise the risk of drug-related harm at Katharine House Hospice. Because of the interrelatedness of much of this information, the document is extensively cross-referenced. However, every effort has been taken to make each separate section complete in itself and, in order to achieve this, certain key points may have been repeated in different parts of the document.

This Policy has taken account of all appropriate pieces of national legislation. Every relevant standard in the Department of Health National Minimum Standards for Independent Health Care 2002 has also been considered in drawing up this policy, as well as all pertinent advice contained in any correspondence we have had with the HealthCare Commission. Guidance from a range of advisory bodies has also been considered. The hospice is now regulated by the Care Quality Commission. However, reference is still deliberately made to the now defunct Health Care Commission when this specifically relates to correspondence with that organisation that helped to clarify aspects of hospice policy and procedure.

A number of in-house procedures and clinical guidelines supplement the Drugs Policy. These include:

- Procedure for the Procurement, Handling and Storage of Oxygen Cylinders (Clinical Policies Folder).
- Patient Self-Administration of Medicines Policy and Procedure (Clinical Policies Folder)
- Procedure for Access to Specialist Advice & Support, including out-of-hours access (Clinical Policies Folder).
- Syringe Driver Guidelines (Clinical Guidelines Folder).
- Enteral tube policy and procedure (Clinical Policies Folder).
- Enteral tube guidelines (Clinical Guidelines Folder).

In order to check our compliance with regulations regarding the prescribing of Schedule Two Controlled Drugs, it was felt necessary to ascertain whether or not the hospice drug charts were “prescription” charts. Both the Royal Pharmaceutical Society and Nursing and Midwifery Council avoid the term “prescribing” with regard to inpatients and they describe such charts as “drug administration charts”. We have therefore taken the same approach, and spoken about “drug instructions” for inpatients and “drug orders” for the medication that patients require on being discharged from the unit (TTOs). Only drug orders for Schedule Two Controlled Drugs need fully comply with the regulatory prescribing requirements for such drugs.

The safe use of therapeutic drugs is an important professional responsibility. Any member of staff with a concern about the administration of any drug to any patient is actively encouraged to raise this with a member of the medical team (ideally the doctor responsible for writing the drug instruction) and/or the Pharmacist as soon as possible. Any doctor who is approached about such a matter is expected to deal with it immediately and carefully, typically through careful joint exploration of the perceived problem with the person raising the concern so that a safe and satisfactory outcome can be achieved. Likewise, any member of staff with concerns about any aspect of the Drug Policy is advised to bring these to the attention of the Medical Director. All such concerns will be considered very carefully.

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## **Appendix**

1. List of National Minimum Standards for Independent Health Care that relate to drugs and the Drugs Policy.
2. List of drugs considered cytotoxic or cytostatic that cannot be destroyed with other non-Controlled Drugs.
3. Inpatient Drug Administration Chart.
4. An example of a personalized “Medication Summary Sheet”.
5. A list of off-licence medication uses that can be considered part of the established practice at Katharine House.
6. Drug Error Reporting Form.

## **Frequently used abbreviations in this document**

CD	Controlled drug
CDDDB	Controlled Drug Disposal Bin
IV	Intravenous
NMC	Nursing and Midwifery Council
non-CD	Non-Controlled Drug
non-CDDDB	Non-Controlled Drug Disposal Bin
PIL	Patient Information Leaflet
POD	Patient’s Own Drug
TTO	“To Take Out” (i.e. A supply of medicines supplied to the ward by Pharmacy for the sole purpose of being given to the patient on their discharge from the ward)

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## A: Responsibilities, Regulations, Drug formulary and drug administration rights

### A.1: Responsibilities

#### A.1.1 The Director of Nursing:

- Ensures that there is an up to date Drug Policy that is adhered to by staff and that meets the Independent Health Care National Minimum Standards Regulations that relate to drugs (Appendix One).
- Is responsible for establishing with the Senior Nurse (Inpatients) that any policies and procedures that involve nurses are safe, secure and in line with all relevant legislation and any guidance or directives from the Nursing and Midwifery Council (NMC).
- Is Accountable Officer under the Controlled Drugs (Supervision of Management and Use) Regulations 2006 (<http://www.opsi.gov.uk/si/si2006/20063148.htm>). The extensive responsibilities of this role are detailed in those regulations, but they include:
  - Routine reporting of all incidents related to Controlled Drugs on a quarterly basis to the Accountable Officer of the Local Intelligence Network.
  - Immediate reporting of any serious concerns regarding Controlled Drugs, such as major theft or known abuse by a member of staff, to the Lead Accountable Officer for the Local Intelligence Network.  
(The Lead Accountable Officer for the Local Intelligence Network is presently Val Messenger at Oxfordshire PCT).
- Holds a register of all drug incident reports and, in the interests of transparency and improved patient safety, reports these to the Clinical Practices Committee and the Health and Safety Committee. Serious incidents only are reported to the Trustees, and the Care Quality Commission is kept appropriately informed.
- Is responsible for any follow-up issues relating to drug errors by nursing staff.
- Delegates day-to-day responsibility to the Quality and Education Lead Nurse and Senior Nurse (Inpatients) as follows:

#### A.1.2 The Quality and Education Lead Nurse

- Nominated witness for the destruction of Controlled Drugs.

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A.1.3 The Senior Nurse (Inpatients)

From this point on, the “Senior Nurse (Inpatients)” is simply referred to as “Senior Nurse”. The Senior Nurse:

- Holds the drug keys and delegates this responsibility to the nurse in charge of the inpatient unit when not on duty themselves.
- Is responsible for the security, safe keeping and movement of medicines, including ordering, administration and destruction procedures and all records relating to these.
- Inducts new nurses in all medication procedures.
- Is responsible, with the Medical Director, for writing and maintaining the Drug Policy.
- Receives all incident reports and investigates them in the first instance, reporting to the appropriate Clinical Director and ensuring that incident forms are completed.

A.1.4 The Medical Director:

- Is responsible, with the Director of Nursing, for helping all parties agree a contract for pharmacy services that is mutually satisfactory to the purchaser (currently Oxfordshire PCT), the provider (currently Oxford Radcliffe Hospitals NHS Trust via Horton Hospital Pharmacy) and the hospice.
- Is responsible for procedures and issues relating to therapeutic drug usage.
- Is responsible, with the Senior Nurse for writing and maintaining the Drug Policy.
- Follows up any medical-related issues surrounding reported drug errors.

A.1.5 The Pharmacist:

- Is responsible for helping all parties agree a contract for pharmacy services that is mutually satisfactory to the purchaser (currently Oxfordshire PCT), the provider (currently Oxford Radcliffe Hospitals NHS Trust via Horton Hospital Pharmacy) and the hospice.
- Oversees the pharmacy service and ensures it is in line with the contract and Drugs Policy.
- Advises the Medical Director or Director of Nursing about any matters of concern in the Drugs Policy. The Pharmacist may also advise the hospice of ORH Trust Policy and Procedure that the hospice may wish to consider replicating.
- Advises the Medical Director or Director of Nursing about any potential changes to Pharmacy Services.
- Provides a Medicines Information Service, and advises the hospice of any local or national drug supply issues.
- Advises doctors of any concerns regarding their therapeutic use of drugs.

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A.1.6 The Medical Team and Qualified Nursing Team:

- Must abide by their professional codes of conduct, be aware of any guidance from their professional bodies regarding medicines, and be aware of their accountability with regard to the storage, handling and administration of medicines.
- Follow the policy and procedures outlined in this document.
- Advise the Medical Director or Senior Nurse about any matters of concern in the Drugs Policy. These matters might be dealt with immediately or taken to the Clinical Practices Committee for further discussion.
- Report any drug errors they become aware of.

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## A.2: Regulations

A.2.1 The Drug Policy has been designed to comply with the following legislative documents:

- The Medicines Act 1968
- The Misuse of Drugs Act 1971
- The Misuse of Drugs Regulations 1975
- Statutory Instrument 1999 No. 1403 The Misuse of Drugs (Safe Custody) (Amendment) Regulations 1999
- Statutory Instrument 2001 No. 3998 The Misuse of Drugs Regulations 2001
- Statutory Instrument 2001 No. 3997 The Misuse of Drugs (Designation) Order 2001
- Statutory Instrument 2003 No. 3201 The Misuse of Drugs Act 1971 (Modification) (No. 2) Order 2003
- Statutory Instrument 2003 No. 2429 The Misuse of Drugs (Amendment) (No. 3) Regulations 2003
- Statutory Instrument 2003 No. 1243 The Misuse of Drugs Act 1971 (Modification) Order 2003
- The Misuse of Drugs (Amendment) (No. 3) Regulations 2005
- Statutory Instrument 2005 No. 271 The Misuse of Drugs (Amendment) Regulations 2005
- Statutory Instrument 2005 No. 2864 The Misuse of Drugs and the Misuse of Drugs (Supply to Addicts) (Amendment) Regulations 2005
- Statutory Instrument 2005 No. 3178 The Misuse of Drugs Act 1971 (Amendment) Order 2005
- Statutory Instrument 2006 No. 0028 The Health Act 2006
- Statutory Instrument 2006 No. 986 The Misuse of Drugs (Amendment) Regulations 2006
- Statutory Instrument 2006 No. 1450 The Misuse of Drugs (Amendment No. 2) Regulations 2006
- Controlled Drugs (Supervision of Management and Use) Regulations 2006
- Non-medical prescribing and mixing medicines in palliative care and other areas of clinical practice (MHRA, 9 July 2009)

A.2.2 Every effort has been made to write the Drug Policy in a way that complies with all the relevant standards (C22, C23, C24, H8, H9, H10, H11 and H12) in the following regulatory document:

- Independent Health Care National Minimum Standards Regulations.

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A.2.3 The following guidance documents have been considered in compiling this Drug Policy:

- Safer Management of Controlled Drug A Guide to good practice in Secondary Care (England) 2007
- Safer Management of Controlled Drugs: Guidance on Standard Operating Procedures for Controlled Drugs (January 2007)
- Safer management of Controlled Drugs: Changes to Record keeping Requirements (October 2006)
- Safer management of Controlled Drugs: Private CD Prescriptions and other changes to the prescribing and dispensing of Controlled Drugs (June 2006)
- NMC Standards for Medicines management (2008)
- A Guide to good practice in the management of Controlled Drugs in Primary Care (England) Second Edition
- Health Technical memorandum 07-01 Safe Management of Healthcare Waste (November 2006)
- Royal Pharmaceutical Society of Great Britain Maintaining Running Balances of Controlled Drug Stock (May 2005)
- Association for Palliative Medicine Guidelines on the use of IV fluids and artificial nutrition

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**A.3: Drug formulary**

A.3.1 Katharine House Hospice obtains its drugs from Horton Hospital Pharmacy as described in Sections C and J of this policy. Lists of the non-CD stock drugs in the hospice are readily available in the clinical areas of the hospice. Hospice doctors are encouraged to write drug instructions using drugs from this list whenever possible, but they are nonetheless entitled to request any appropriate drug in the management of hospice inpatients. In practice, the therapeutic drug choices of the doctors at the hospice are remarkably uniform and well established. Whilst an overly-dictatorial attitude towards therapeutic drug use is not considered at all helpful, the following factors help to maintain a cohesive approach in this area:

- Along with all other hospices in the Thames Valley Cancer Network, Katharine House Hospice has agreed to adopt the therapeutic drug practices described in the most up to date version of the “Palliative Care Formulary” by Twycross et al (Oxford: Radcliffe Medical Press). However, the Network acknowledges that certain differences in habit and “preferred drugs” are likely to remain between the various hospices.
- Any national or local therapeutic drug guidance that is relevant to our patient group is distributed internally amongst the medical team and a copy of all such guidance is kept in a folder in the Medical Director’s office.
- Questions and issues relating to drug instructions are regularly and openly discussed within the medical team as well as the wider clinical team at the hospice.
- Advice from the Pharmacist is always available.
- We believe that it is undesirable to alter the prescribing decisions of the patient’s General Practitioner unless changes are necessary to improve drug compliance by the patient, ensure patient safety or achieve good symptom management.
- The procedure for use of a drug in a manner not described in its Product Licence is discussed in Section L of this policy.

A.3.2 All doctors and qualified nurses in the hospice have ready access to the most recent copies of the British National Formulary and the Palliative Care Formulary, both in print and online.

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A.4: Drug administration rights

- A.4.1 The Katharine House Hospice clinical team have:
- full drug administration rights for hospice inpatients.
  - limited drug administration rights for Day Hospice patients or patients attending the hospice for outpatient services (see Section V).
  - no drug administration rights for patients seen in the community, NHS hospitals or private hospitals.
- A.4.2 Hospice drugs must not be provided for administration by members of staff or non-patient visitors to the hospice. The only exception to this rule might be in the lifesaving management of an acute medical emergency (See Section U.3)

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**A.5: Payment for Hospice Pharmacy Services**

- A.5.1 On 16 May 2002 the Department of Health released the guidance document “Q & A – Hospice Funding Issues”, which included the following advice:

“Hospices should be reimbursed the full agreed pharmacy costs including costs incurred for medicines to be supplied, dressings, appliances and chemical reagents listed in part IX of the Drug Tariff and associated professional costs for treating patients for whom the hospices have clinical responsibility as set out in EL(94)14 through contractual arrangements. It is important to note that supply of medicinal products to a hospice may be zero-rated provided it is a registered charity and it issues a certificate of zero-rating. They should not therefore be chargeable for VAT. PCTs should ensure that their Chief Pharmacists/ Pharmaceutical Advisers are made aware of EL(94)14 and that they are involved in decisions on funding for hospices and monitoring of services provided to hospices by either community or hospital pharmacists. PCT Chief Pharmacists/Advisers need to work collaboratively with pharmacists providing services to hospices to ensure that they are influencing drug usage and are involved in the development guidelines to ensure clinical and cost effective use of medicines. Cancer Network lead teams will also wish to work with PCT Chief Pharmacists/ Advisers and hospices on this issue. EL(95)22 provides guidance for pharmacists working with voluntary hospices.”

- A.5.2 In 1995, Katharine House Hospice received a copy of the agreement reached between Oxfordshire Health Authority and Horton Hospital for the latter to provide a pharmacy service to the hospice, paid for by the former. This agreement also included all relevant ancillary services and costs.

Following the dissolution of Oxfordshire Health Authority, these same costs were met by Cherwell Vale PCT and then North East Oxfordshire PCT and most recently by Oxfordshire PCT.

Oxfordshire PCT provide the hospice with a copy of the annual service level agreement for this service.

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## B: Procedure for safe and secure storage of medicines on the ward.

### B.1: Accommodation for medicines.

B.1.1 The Senior Nurse has overall responsibility for the security and safekeeping of medicines.

B.1.2 The unit has the following separate lockable cupboards secured to the wall of the locked Treatment Room:

- An oral medicines cupboards for the storage of stock non-Controlled Drug (non-CD) medicines that are taken orally but are not currently in use by any inpatient.
- An internal medicines cupboard for the storage of all stock non-CD medicines that are administered to patients by injection (including medicines for epidural administration), whether they are in current use or not.
- A Controlled Drug (CD) cupboard, which must only be used for the storage of Controlled Drugs owned by the hospice and must always be kept locked when not in use. It is found *inside* the locked cupboard for non-CD medicines that are administered by injection. The lock is not the same as any other within the hospice and the key is only available to authorised members of staff. At all times the key-holder must be readily identifiable. The Ward Controlled Drug Order Book, Ward Controlled Drug Record Book and the “Record of Patient’s own Controlled Drugs that they continue to use during the hospice admission” are locked inside the cupboard for non-CD medicines that are administered by injection when not in use. The storage of Controlled Drugs must comply with the Misuse of Drugs (Safe Custody) Regulations (See Section J for further information on Controlled Drugs).
- An external medicines cupboard for the storage of topical preparations (lotions, creams, ointments), mouthwashes, rectal preparations (gels, suppositories and enemas) and products used per urethrum (anaesthetic gels) that are stock items but not in current frequent use by an inpatient.
- A cupboard for Patients’ Own Drugs (PODs) that are being stored but not used by the hospice during an admission. This has a further locked cupboard inside for Patients Own Controlled Drugs. The Patients’ Own Drugs Record Book for non-Controlled Drugs and Controlled Drugs is stored underneath this cupboard in the locked treatment room when not in use.
- A locked refrigerator for medicines requiring refrigeration, that is only used for this purpose. This is fitted with a temperature recording device that is checked daily by a designated member of ward staff to ensure that the temperature has been maintained between +2 and +8°C over the preceding 24 hours. The record of the refrigerator temperature is recorded on a form specially designed for the purpose, which is stored in the front of the Drug Administration Chart folder.

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- B.1.3 There is a lockable medicines trolley for the storage of all drugs taken orally or externally that are currently in use by any hospice inpatient that is not self-medicating. The drugs on this trolley generally comprise a mixture of stock items and non-stock items. The majority of non-stock items will be Patients' Own Drugs (PODs). The medicine trolley is immobilised by being locked to the wall of the Treatment Room when not in use. Supplies of relevant Controlled Drugs can be placed in the medicines trolley during drug rounds but none must ever be stored in the trolley between drug rounds.
- B.1.4 Two of the bedside lockers have small lockable medicine cabinets on them. These are for the storage of the medicines (excluding Controlled Drugs) of patients who are self-medicating during their admission. (Please refer to the "Self-Administration of Medications Policy" for more details).
- B.1.5 Drug cupboards for internal and external medicines must comply with the latest British standards (currently BS2881).
- B.1.6 All medicines must be stored according to manufacturers' instructions.
- B.1.7 The only diagnostic reagents routinely kept in the hospice are test strips for blood and urine. We occasionally have pH indicator paper. These need not be kept in a locked cupboard and can be found on a high shelf in the sluice where they are safe from children and confused adults.
- B.1.8 With the exception of those in current use or ready for imminent use, gas cylinders are kept in a locked shed in the grounds of the hospice in accordance with the guidance contained in Health Equipment Information No. 163.2/87. [See Section S and the separate Oxygen Policy and Procedure].

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**B.2: Custody and safe keeping of keys.**

- B.2.1 Medicine cupboards, drug trolleys and refrigerators must be locked when not in use and never left unattended when open.
- B.2.2 The Senior Nurse must ensure that the locks in use on the unit provide secure storage for medicines.
- B.2.3 The Senior Nurse has ultimate responsibility for controlling access to the keys for all medicine cupboards.
- B.2.4 Access to medicine cupboards must be restricted. The Senior Nurse may delegate responsibility to a qualified nurse who must ensure the safe custody of keys during their span of duty. The keys may be rotated between qualified nurses if necessary during a shift. A Health Care Assistant must not hold the keys in any situation.
- B.2.5 At their own discretion, the nurse with responsibility for the safe custody of keys can temporarily delegate this responsibility to another registered practitioner (e.g. Pharmacist, Pharmacy Technician or other designated pharmacy staff, doctor) in order for them to undertake a specific task, on completion of which the keys must be returned immediately to the nurse delegated responsible for the safe custody of keys.
- B.2.6 All keys for the medicine cupboards, medicine trolley, storage areas and medicine delivery boxes from Pharmacy must remain together as a complete set.
- B.2.7 The set of keys must be handed over at the change of duty to the nurse in charge of the next shift or other person who has been delegated to take responsibility for the safe custody of the keys during the next shift.
- B.2.8 If medicine keys go missing, every attempt must be made to retrieve them as a matter of urgency. If this is unsuccessful the loss must be reported immediately to the Senior Nurse or, if unavailable, to the Director of Nursing or, if both are unavailable, to the Medical Director.
- B.2.9 If the keys have been stolen, the nurse in charge of that particular shift must immediately inform the Senior Nurse or, if unavailable, the Director of Nursing or, if both are unavailable, the Medical Director. The police must also be informed.

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**B.3: Drugs that may be kept at a patient's bedside rather than in a locked medicine cupboard.**

B.3.1 With the exception of the items listed below in Section B.3.2 and B.3.3 and any items being self-administered by the patient in accordance with the hospice's "Patient Self-Administration of Medicines Policy and Procedure", all medicines must be stored in locked cupboards on the unit.

B.3.2 As it is recognised that some patients require quick access to certain medicines, the following medicines can be stored unlocked at an individual patient's bedside:

- Inhaled preparations.
  - Glyceryl trinitrate tablets or sprays.
  - Hypromellose eye drops.
  - Creams, ointments and mouth care preparations that are in regular personal use.
  - Nifedipine capsules for the management of tenesmus or oesophageal spasm.
- This list balances the need for quick access against the potential consequences of misuse of medicines not securely locked away. If there is ever felt to be a need to store any other medications unlocked at an individual patient's bedside, then the approval of the Medical Director and/or Senior Nurse must be obtained first.

B.3.3 Occasionally it is considered necessary to have an emergency supply of another drug immediately available at a patient's bedside (e.g. midazolam in case of possible catastrophic haemorrhage.) Instructions relating to such supplies must be specifically written by a doctor on the patient's drug administration chart. The drug(s), in ampoule form, together with suitable injection equipment are placed in a Pharmacy Drug Bag with a label indicating the contents showing in the window of the bag. The bag is sealed with a plastic seal (available from the Pharmacy) and kept on the highest part of the bedside locker where they are safe from children and confused adults. On the rare occasions when this is not considered sufficiently safe, a note is left on top of the bedside locker that says where the drugs are being kept. (See Section U.2)

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**B.4: An audit trail for all drugs**

- B.4.1 A complete record will be made for all drugs that come into or pass through the possession of the inpatient unit, either as part of the inpatient stock of drugs or as Patient's Own Medicines that are handed over to the inpatient unit for safe storage and potential use during the admission. The audit trail will demonstrate where every medicine came from, how it was stored, and where it went. The reference points for the various audit trails are summarised below.

Patients' Own non-Controlled Drugs

Handing over to the hospice	E.1
Temporary transfer to ward supply	E.1
Return to patient	E.1, F.1, N.6
Destruction	G
Loss	H (See N.5 for the reporting system)

Patients' Own Controlled Drugs

Handing over to the hospice	J.4
Use during the admission	J.6
Return to patient	J.6.8
Destruction	J.4, J.13
Loss	J.16 (See N.5 for the reporting system)

Ward stock non-Controlled Drugs

Requisition	C.2, C.3 (D for out of hours)
Administration to patients	Individual drug administration charts
Destruction	G
Loss	H (See N.5 for the reporting system)

Non-ward stock non-Controlled Drugs

Requisition	C.4 (D for out of hours)
Administration to patients	Individual drug administration charts
Destruction	G
Loss	H (See N.5 for the reporting system)

Routine ward stock Controlled Drugs

Requisition	J.7 (D for out of hours)
Administration to patients	J.11 and individual drug administration charts
Stock checks	J.12
Destruction	J.13
Loss	J.16 (See N.5 for the reporting system)

Atypical ward supply Controlled Drug

Requisition	J.6.7 (D for out of hours)
Administration to patients	J.11 and individual drug administration charts
Stock checks	J.12
Destruction	J.13
Loss	J.16 (See N.5 for the reporting system)

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Discharge medication for patients

Ordering TTOs C.6, K.7 (J.17.5 for Controlled Drugs)  
Ordering drugs for periods of ward leave K.8  
Handing over to the patient N.6

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**B.5: Action to be taken in the event of failure of the refrigerator for medicines requiring refrigeration**

- B.5.1 If the drug refrigerator fails, then it must be repaired or replaced as a matter of urgency. The nurse in charge of a particular shift must be informed immediately. Whilst waiting for a repair or replacement, the refrigerator in the Day Hospice kitchen must be emptied and cleaned before all drugs requiring refrigeration are transferred into it. The door to the Day Hospice kitchen must remain locked at all times whenever it is used to store drugs. Whilst it lacks a facility to record minimum and maximum temperatures, the refrigerator does contain an ordinary fridge thermometer and the temperature of the refrigerator will be checked and documented by each new nursing shift immediately after handover has been completed.
- B.5.2 In the event of an emergency refrigeration problem, our supplier is:  
B. Childs and Son (Daventry Refrigeration)  
Telephone: 01788-890469  
Mobile: 07850-631322

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## C: Pharmacy supplies for non-Controlled Drugs

### C.1: Drug supply from Pharmacy.

C.1.1 A drug or intravenous (IV) fluid can be supplied to the ward by Pharmacy in the following ways:

- To the ward as stock.  
This can potentially be administered to any patient for whom there is a signed instruction for such use on the drug administration chart. In addition, all Controlled Drugs supplied to the ward for inpatient use must be provided as stock items, even if they are not usual stock Controlled Drugs (See Sections J.6 and J.7 for further information).
- To the ward dispensed against a signed instruction for such use on a drug administration chart.  
This is only done when the instruction is for a 'non stock' non-CD. In these situations the product can only be administered to the named patient to whom they were dispensed.
- Dispensed directly to the ward as discharge medication (TTO) for a patient.  
Any item specifically dispensed to the ward as a TTO can only be used for three purposes:
  - i Given to the named patient for self-administration purposes during an inpatient stay (See the Patient Self-Administration of Medicines Policy and Procedure).
  - ii Given to the patient for self-administration during a period of temporary absence from the inpatient unit (See Section K.8).
  - iii Given to the named patient at the time of discharge (See Sections K.7 and N.6).

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C.2: Routine top-up service for stock items that are obtained from Pharmacy.

- C.2.1 There is a list of all stock drugs (including details of formulation, dose and quantity) and other stock items (including intravenous fluids) that are obtained through Pharmacy. This is attached to the door of the drug cupboard for non-Controlled Drugs that are taken orally. The Pharmacist, Senior Nurse and Medical Director review this list at least once a year.
- C.2.2 Once a week, typically on a Thursday, a Pharmacy Technician or Assistant visits the inpatient unit and checks stock balances against the agreed stock list. All necessary top-ups are recorded on a pro-forma order form. The master copy of this list is taken back to Horton Hospital Pharmacy whilst a photocopy is stored on the ward. There is no need for this list to be countersigned by a nurse or doctor from the ward. It is the responsibility of the Senior Nurse to ensure that these forms are stored safely for a minimum of eight years. (This is knowingly out of line with what the Health Care Commission expected us to do).
- C.2.3 The Pharmacy Technician or Assistant takes the list of required items back to the Pharmacy. These items are placed in a locked drug transit box, along with a delivery sheet that summarizes all of the items shipped in that consignment.
- C.2.4 The locked drug transit box is brought across to the hospice by courier on the next visit from the hospital transport service. This is typically on the same day as the requisition form was drawn up. There is no need for the delivery of routine non-CD stock drugs to be signed for by a nurse.
- C.2.5 The drug transit box is unlocked in the treatment room by a qualified nurse. The key for the non-CD transit box is kept on the same key ring as all other drug-related keys.
- C.2.6 Only when an item has been removed from the drug transit box, checked and stored in the appropriate place must the checking nurse tick and initial the relevant item line on the photocopy of the original order form. (N.B. It is the ward copy of the pro-forma order form that is used to check the accuracy of the delivered items and *not* the delivery note from Pharmacy.)
- C.2.7 Supplies that are out of stock at Pharmacy will be issued to the unit as soon as they come into stock. The Pharmacy Technician or Assistant will highlight such items on the delivery note with the mark “T/F” (“To follow”). The checking nurse applies the same notation to the ward copy of the original order form. When the item does follow, the “T/F” mark is scored through, dated and signed by the qualified nurse who receives the delayed delivery.
- C.2.8 Empty drug transit boxes remain in the inpatient treatment room until they are picked up by the Pharmacy Technician or Assistant, typically on the next top-up day.

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C.3: Stock items obtained from Pharmacy that are requested between top-up days.

- C.3.1 Whenever stock items need to be topped up before the next routine top-up day, the nurse or member of the Pharmacy staff who has identified the need for the top-up writes this into the Pharmacy Diary that is kept in the treatment room.
- C.3.2 The next time the Pharmacist or a Pharmacy Technician visits the hospice, s/he arranges for the relevant item to be delivered to the hospice on the hospital transport later that day. The procedure for the transport and receipt of such items is described in Section C.7.

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C.4: Ordering non-stock items from Pharmacy.

- C.4.1 The Pharmacist will supply medicines not kept as stock on the unit as part of the ward pharmacy service.
- C.4.2 Non-stock items required urgently may be ordered from the Horton Hospital Pharmacy by leaving a radiopager message (07659-130584) for the palliative care pharmacist to contact the appropriate named nurse on the Katharine House Hospice Inpatient Unit, specifically indicating that a non-stock item is required. Having discussed the request, the pharmacist may require the whole inpatient drug administration chart to be faxed to them on a specified number, for screening. Once the process is complete, the pharmacist will organize the supply as requested.
- C.4.3 Less urgent non-stock items are written into the Pharmacy Diary and dealt with by the Pharmacist or Pharmacy Technician next time they visit the hospice. It may be necessary for a photocopy of the relevant drug administration chart to be taken back to the Pharmacy for screening before the item is supplied.
- C.4.4 Nurses responsible for the care of a patient in the hospice over a weekend or bank holiday must ensure that there is an adequate supply of all Pharmacy items for this period ahead of time. Any potential shortfalls must be discussed with the Pharmacist who will then arrange for the necessary supplies to be delivered. A note of these items must be placed in the Pharmacy Diary.
- C.4.5 There is theoretically no item listed in the Drug Tariff that the hospice cannot order from the hospital pharmacy. This is even the case when the item is not a hospital stock item, although in such cases there may be cost and time-delay issues to consider.
- C.4.6 The procedure for the transport and receipt of non-stock items is described in Section C.7.

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**C.5: Ordering stock items that are not obtained from Pharmacy.**

- C.5.1 A range of clinical items are required by the hospice that are not provided by Pharmacy. A formal list of these items (excluding specialist lymphoedema items) is being drawn up and will be stored on the back of the back-up cupboard door. This will be reviewed at least annually by the nurse responsible for maintaining this stock, the Senior Nurse and the Director of Nursing. *No drug items can be supplied to the hospice by these means.*
- C.5.2 A named nurse is responsible for maintaining the stock of these items.
- C.5.3 The Lymphoedema Nurse Specialist has responsibility for maintaining and ordering specialist lymphoedema items. Again, no drug items can be ordered by these means.

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C.6: Ordering discharge medication from Pharmacy. (See also Section K.7)

C.6.1 Discharge Medications (“TTOs”) must be ordered in duplicate in the TTO Order Book, preferably a whole working day before the planned discharge. The following quantities are routinely ordered:

- A twenty-eight day supply is ordered for all non-CDs.
- A fourteen day supply for non-patch CDs.
- Fentanyl skin patches are ordered in unopened boxes of five, and buprenorphine skin patches are ordered in unopened boxes of four.

The TTO order is clinically screened by the Pharmacist. During this screening process, any TTO items can be made up from Patient’s Own Drugs are marked “PODW” (Patient’s Own Drugs on the Ward) or “PODH” (Patient’s Own Drugs at home) on the TTO order form by the Pharmacist. When PODs will only satisfy part of a seven-day supply of a particular item, this indicated on the TTO order form as “POD + Supply”. Once the TTO order form has been screened and endorsed appropriately, the top copy is taken back to Pharmacy by the Pharmacist or Pharmacy Technician so that the order can be processed. The bottom (ward) copy of the TTO order is kept in the TTO Order Book. When the top copy is taken back to Pharmacy by a Pharmacy Technician or Assistant rather than a Pharmacist, a photocopy of the patient’s drug administration chart is also taken back to the Pharmacy so that it can be screened by a Pharmacist before the order is processed.

C.6.2 When TTOs are required as a matter of urgency from the Horton Hospital Pharmacy, it is necessary to leave a radiopager message (07659-130584) for the palliative care pharmacist to contact the appropriate named nurse on the Katharine House Hospice Inpatient Unit, specifically indicating that urgent TTOs are required. The pharmacist will then reply and make the necessary arrangements with Horton pharmacy, which will involve faxing of both the whole TTO order and whole drug administration chart as directed by the pharmacist.

The TTO sheet must be marked up as follows by the coordinating nurse ahead of being faxed:

1. The word “FAXED” and the signature of the nurse must be placed in the top right corner of the TTO sheet.
2. If a particular item on the TTO sheet can be fully met using Patient’s Own Drugs in storage at the hospice then this must be indicated by writing “POD” on the relevant line of the TTO order.
3. If a particular item on the TTO sheet can be partially met using Patient’s Own Drugs in storage at the hospice then this must be indicated by writing the number of days required on the relevant line of the TTO order.

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- C.6.3 The Pharmacy will only supply the necessary items that, when combined with the appropriate PODs as marked on the TTO order form, will complete the TTO order. If necessary, the pharmacy will relabel for the PODs if the instructions have changed according to the instructions for use on the TTO order. As the manufacturers' "Patient Information Leaflets" (PILs) will have been issued to the patient when the relabeled PODs were first dispensed, no duplicate PILs will be issued for these PODs.
- C.6.4 Pharmacy will contact the inpatient unit if it is unable to supply any of the TTO items that have been requested, to advise the ward what alternative arrangements should be made.
- C.6.5 The procedure for the transport and receipt of discharge medication is described in Section C.7.
- C.6.6 It is the responsibility of the Senior Nurse to safely store old TTO Order Books for a minimum of eight years.

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**C.7: Procedure for the delivery and receipt of discharge medication and any non-Controlled Drugs required between weekly formal top-ups.**

- C.7.1 Ordered items are placed in a drug transport bag that is sealed with a numbered tag. Pharmacy notes the details of the tag onto a duplicate form which the courier signs when picking up the bag. The top copy of this form is given to the courier.
- C.7.2 When the courier arrives in the hospice reception area, the qualified hospice nurse who receives the delivery checks that the number on the seal matches the number on the courier's copy of the delivery form. Having confirmed that this is the case, the nurse signs the courier's form that is then returned to the hospital Pharmacy by the courier. *N.B. It is receipt of an untampered bag that the nurse signs for and not its contents.*
- C.7.3 The drug transit bag is taken to the treatment room on the inpatient unit where the seal is broken and the bag is emptied.
- C.7.4 Only when an item has been removed from the drug delivery bag, checked and stored in the appropriate place (or prepared for handing over to the patient in the case of TTOs) must the checking nurse tick and initial the relevant record for receipt of the item.
- For stock items requested from Pharmacy between top-up days, the appropriate entry in the Pharmacy Diary is initialed and dated.
  - For non-stock items ordered from Pharmacy, the appropriate entry in the Pharmacy Diary is initialed and dated.
  - For discharge medication ordered from Pharmacy, the appropriate line of the ward copy of the TTO order is initialed and dated.
- C.7.5 On the next visit to the inpatient unit, the Pharmacy Technician picks up any empty drug transport bags for return to Pharmacy.

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**C.8: Procedure for handling oral cytotoxic drugs.**

- C.8.1 Some in-patients may be taking oral cytotoxic drugs. Not all of these drugs are used for treating cancers (e.g. oral methotrexate may be used to treat psoriasis or rheumatoid arthritis).
- C.8.2 Oral cytotoxic drugs must be ordered from the hospital Pharmacy.
- C.8.3 Pharmacy will label any bottles or packets of oral cytotoxic drug with appropriate warnings/advice. Appropriate cautionary comments are also written onto the patient's drug administration chart.
- C.8.4 Nurses must ensure that the drug does not contaminate any other medicines in the drug cupboard. However, the bottle can still be stored with the other drugs in a locked drug cupboard or drugs trolley. In practice, oral cytotoxic drugs are typically coated to minimise the possibility of contamination.

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## D: Arrangements for urgent supplies of drugs, including out-of- hours.

### D.1: Urgent supplies of drugs from Pharmacy.

- D.1.1 In exceptional circumstances during normal working hours, it might be necessary to ask a volunteer driver or member of the clinical team to pick up items that have been ordered from Pharmacy. Such an arrangement must be agreed with the Pharmacy before the person on the errand is sent, and this person must have some agreed way of proving their identity. They must take the appropriate requisition/order book with them if this is needed by the Pharmacy in order to process the request. Once the items have been given to the person running the errand (in the same transport bag or box as would be issued to a courier) they must return to the ward *immediately* to deliver the supplies and return the order/requisition book.
- D.1.2 Whenever emergency supplies of drugs are required outside normal Pharmacy hours, the on-call Pharmacist for ORH NHS Trust must be contacted through Horton Hospital switchboard. The on call Pharmacist will advise where the necessary requisition/order form and drug administration chart should be delivered and what delivery/collection arrangements will be made/required for the drugs.
- D.1.3 When next in the hospice, the Pharmacist or Pharmacy Technician should be advised of any occasion since their last visit when the services of an on-call Pharmacist were required for the supply of drugs. They can then examine why this was required and also ensure that a suitable audit trail was completed for the drug(s) in question.

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## E: Patients' Own Drugs.

### E.1: Procedure for dealing with Patients' Own Drugs brought in at the time of admission.

- E.1.1 At the time of admission, the named nurse must ask the patient whether they have brought any medication in with them. If so, it will greatly assist the admitting doctor to see them whilst taking the medication history. The patient must be advised that the hospice has a responsibility to ensure that all drugs are stored safely and securely on the site.
- E.1.2 Patients who do not want their own drugs to be used during the admission or reissued to them at the time of discharge should send their drugs home for the duration of the hospice stay. Alternatively, they can request for them to be destroyed by the hospice (in line with Sections G and J.13) or they can arrange for them to be returned to their Community Pharmacy for destruction.
- E.1.3 Patients who want their own drugs to be used during the admission and/or reissued to them at the time of discharge should hand them over to a qualified nurse at the start of the admission for safe storage. They must be placed in the appropriate locked cupboard in the treatment room if they are simply to be stored during the admission. Alternatively, they are locked in the drug trolley or bedside cabinet for the storage of medicines as appropriate if they are actually to be used by the patient during the admission.
- E.1.4 Any non-Controlled Drugs that a patient gives to the hospice must be recorded in the non-Controlled Drug section of the Patients' Own Drugs Record Book. This book records:
- Date and time of receipt
  - Name of patient.
  - The generic name, dose, formulation and total quantity of each drug given to the hospice.
  - Signature of recipient and witness, both of whom must be qualified nurses.
  - Date and time of release of the drug from the care of the hospice.
  - Description of the ultimate fate of the drug: either "returned to patient", "temporarily moved to ward supply", "used for TTO" or "destroyed".
  - Signature of the two qualified nurses responsible for overseeing the ultimate fate of the non-CD.
- E.1.5 Any Patients' Own Drugs (PODs) that are temporarily moved to ward supply can only be administered to the patient to whom they were originally dispensed.
- E.1.6 Any medications suitable for use in the TTOs will be returned to the patient at the time of discharge, whilst two qualified nurses will destroy all other medicines brought in by the patient that are no longer required by the patient at the end of the admission.

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- E.1.7 In the event of the death of a patient who has handed over their supply of medication to the hospice during their admission, no drugs must be destroyed until at least a week after the death of the patient. This requirement is in case a Coroner demands to inspect the drugs after the patient's death. It holds true regardless of whether the medication was originally given to the hospice for use during the admission; for storage and return at the end of the admission; or in the knowledge that it would simply be destroyed on the patient's behalf whatever the outcome.
- E.1.8 The destruction of Patients' Own Drugs must comply with the relevant procedures laid out in Sections G and J.13.

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E.2: Patient Self-Administration of Medicines

- E.2.1 In the occasional instances when a hospice inpatient self-administers their medication during their inpatient stay, they can only do so using their own drugs and in a manner that complies with the hospice’s “Patient Self-Administration of Medicines Policy and Procedure”.

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## **F: Dealing with unwanted stock drugs and fluids.**

[See Sections G and J.13 for procedures regarding the destruction of drugs]

### **F.1: Patients' Own Drugs that were temporarily moved into ward supply**

- F.1.1 When appropriate, these can be returned to the patient at the end of the admission as part of their TTOs. In order to maintain an audit trail, they need to be written again into the appropriate section of the Patients' Own Drug Record Book with "(returned from ward supply)" appearing immediately after the patient's name, and then signed out immediately as "returned to patient".
- F.1.2 Any Patients' Own Drugs that were temporarily moved into ward supply but are no longer required by the ward or the patient must be destroyed.
- F.1.3 In the event of the death of a patient, no drugs must be destroyed in the first seven days following the death.

### **F.2: Excess Ward Stock**

- F.2.1 Excess ward stock must be brought to the attention of the Pharmacist or Pharmacy Assistant so that they can readjust the stock levels.

### **F.3: Intravenous fluids**

- F.3.1 Intravenous fluids that have passed their expiry date must be drained in the sluice by a qualified nurse, but only when they contain no drug additives. The empty bag is then disposed of in the clinical waste.
- F.3.2 Unwanted intravenous fluids that contain drug additives must be treated as unwanted drugs (See Section G.4.4 if they do not contain Controlled Drugs and Section J.13 if they do)

### **F.4: Drugs that have been prepared on the inpatient unit but not administered to a patient**

- F.4.1 Prepared IV syringes that are no longer required; infusion fluids containing drugs; and any drug which is prepared but not administered to a patient must be destroyed by two qualified nurses. (See Section G.4.4 or G.4.9 if these items do not contain Controlled Drugs and Section J.13.3 if they do).

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## G: The disposal of non-Controlled Drugs

### G.1: Introduction

- G.1.1 The following procedure is the same for drugs owned by the hospice or by the patient.
- G.1.2 No drug can be disposed of in the water sewer.

### G.2: Non-cytotoxic, non-Controlled Drug Disposal Bins

- G.2.1 The ultimate destination for all such drugs is the Non-Controlled Drug Disposal Bin (non-CDDDB) that is locked in the cupboard in the corridor to the patients' smoking room at all times.
- G.2.2 Each non-CDDDB has its own identity number.
- G.2.3 All items that are disposed of in a non-CDDDB are recorded on the non-Controlled Drug Disposal Form that carries the same identity number as the non-CDDDB. Each non-CDDDB must have its own separate form. The form is kept directly underneath the corresponding non-CDDDB. When the pharmacological identity of the product being disposed of is unknown, it can still be disposed of but the name of the drug is replaced by the word "Unknown" on the non-Controlled drug Disposal form.
- G.2.4 Whenever a non-CDDDB becomes full, its lid is locked closed, the bin is labeled with the consignment number "18 01 09", and the bin remains locked in the cupboard in the corridor to the patients' smoking room until such time as it is collected by Grundons, an authorised contractor for the removal of pharmaceutical waste. Only then is a new non-CDDDB and form started.
- G.2.5 Whenever a non-CDDDB is ready for collection, it is placed near the inside of the laundry back door on the morning of the next weekly waste collection visit by Grundon. The associated non-Controlled Drug Disposal Forms are passed on to the Accounts Department for storage in order to ensure that we maintain a complete audit trail for these drugs.

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**G.3:     Cytotoxic and cytostatic non-Controlled Drug disposal bin**

- G.3.1     Certain drugs that are considered cytotoxic or cytostatic must be disposed of separately from other drugs. A list of these drugs can be found in the treatment room and also in Appendix Two to this policy.
- G.3.2     These drugs are disposed of in a separate disposal bin with a purple or black lid, that is labeled “cytotoxic and cytostatic drugs” and carries its own identity number.
- G.3.3     All items that are disposed of in a cytotoxic and cytostatic drugs disposal bin are recorded on the Cytotoxic and Cytostatic Drugs Disposal Form that carries the same identity number as the bin. Each non-CDDB must have its own separate form. The form is kept directly underneath the corresponding bin.
- G.3.4     Whenever a bin becomes full, its lid is locked closed, the bin is labeled with the consignment number “18 01 08”, and the bin remains in the locked in the cupboard in the corridor to the patients’ smoking room until such time as it is collected by Grundons, an authorised contractor for the removal of pharmaceutical waste. Only then is a new cytotoxic and cytostatic drug disposal bin and form started.
- G.3.5     When a bin is ready for collection, the respective Cytotoxic and Cytostatic Drugs Disposal Form is handed to the Accounts Department, who faxes it through to Grundons on the day before a routine waste collection visit. The original form is then stored by the Accounts Department to ensure that a complete audit trail for these drugs is maintained. The bins themselves are placed near the inside of the laundry back door on the morning of the next weekly waste collection visit by Grundon.

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**G.4:    The disposal procedure**

- G.4.1    The disposal procedure depends upon the formulation and the packaging of the drug that needs destruction:
- G.4.2    **Tablets/capsules in blister packs** are kept in their blister packs and put straight into the non-CDDB. The original packaging that contained the blister packs has all patient identifiers removed/obliterated from it before being placed in the ordinary rubbish.
- G.4.3    **Loose tablets/capsules** are emptied directly into the non-CDDB. The original packaging that contained the loose tablets/capsules has all patient identifiers removed/obliterated from it before being placed in the ordinary rubbish.
- G.4.4    **Liquids** are mixed with cat litter and the resultant slurry is disposed of in the non-CDDB. The container from which the liquid medication had been removed is then disposed of in the clinical waste or recycled as appropriate, having removed/obliterated any patient identifiers.
- G.4.5    **Medication management systems** such as “Dosett Boxes” must be emptied and all the non-Controlled Drugs they contain must be emptied into the non-CDDB. The name and quantity of each particular drug product in the medication management system must be documented on the non-Controlled Drug Disposal Form. For single-use medication management systems, remove the patient’s name from the packaging and place it in the ordinary rubbish. Otherwise, return re-useable systems to the patient or family. Any drugs that are unidentifiable are destroyed as described in Section G.2.3.
- G.4.6    **Inhalers** Up to 2 inhalers can be placed in a non-CDDB once any patient identifiers have been removed from the devices. The original packaging can be placed in the ordinary rubbish once any patient identifiers have been removed.
- G.4.7    **Suppositories** Place directly in the non-CDDB. Any cardboard packaging has all patient identifiers removed/obliterated from it before being placed in the ordinary rubbish.
- G.4.8    **Creams** Place the whole tube into non-CCDB. Any cardboard packaging has all patient identifiers removed/obliterated from it before being placed in the ordinary rubbish.
- G.4.9    **Injections** Inject onto cotton wool and place this in the non-CDDB.
- G.4.10   **Miscellaneous items** If it is unclear how to destroy a particular item, then clarify the arrangements with the Senior Nurse.

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## H: Procedure for missing drugs other than Controlled Drugs.

- H.1 Discovery of drugs missing from the ward must be reported to the nurse-in-charge of the nursing shift.
- H.2 If the loss seems suspicious in any way, the nurse in charge of that shift must urgently contact the Senior Nurse or, if not available, the Director of Nursing or, if neither of these are available, the Medical Director.
- H.3 The Nurse in charge of the shift must contact the Senior Nurse or other named person as soon as possible.
- H.4 In the event of medical staff involvement in the drug loss, the Medical Director must routinely be informed.
- H.5 The Pharmacist should normally be informed of the loss of drugs as soon as possible.
- H.6 The Director of Nursing should inform the Medical Director and Business Director when appropriate.
- H.7 An incident form must be filled out by the nurse in charge of the nursing shift before the end of that shift, and the relevant copy sent to the Director of Nursing. Incident forms are kept on the inpatient unit. (See Section N.5 for more information on drug errors).
- H.8 For the suspected loss of Controlled Drugs, see Section J.16.

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## J: Procedure relating to Schedule Two Controlled Drugs.

### J.1: What is a Controlled Drug?

- J.1.1 The manufacture, distribution, storage and use of a range of drugs are more closely monitored than others because of their potential for misuse and abuse. Many of these drugs are addictive and some have no proven clinical value. There are several categories (or “Schedules”) of Controlled Drug (CD), and the Department of Health has released a non-exhaustive list of these items at [http://drugs.homeoffice.gov.uk/publication-search/drug-licences/CDList\\_-\\_2009-04-22.pdf?view=Binary](http://drugs.homeoffice.gov.uk/publication-search/drug-licences/CDList_-_2009-04-22.pdf?view=Binary) .
- J.1.2 No Schedule One CDs are used clinically.
- J.1.3 Schedule Two CDs include several drugs used widely in palliative medicine, including ketamine and virtually all strong opioid preparations. There are five CD Schedules in total. When the term “Controlled Drug” or CD is used without referring to a particular schedule, it is universally accepted that reference is being made to Schedule Two CDs only. Such practice is followed throughout this Drug Policy.
- J.1.4 Although morphine liquid 10mg/5mls is not a Schedule 2 CD, it is hospice policy to treat it as one.
- J.1.5 In April 1996, temazepam was rescheduled as a Schedule 3 CD. At Katharine House Hospice, it is ordered as a Schedule 2 CD, recorded in the Ward CD Record Book and stored in the CD cupboard.

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**J.2: Controlled Drug Legislation, Regulation and Guidance.**

- J.2.1 CDs are regulated by the Misuse of Drugs Act 1971 and accompanying Regulations. There are stringent requirements for their procurement, storage, administration and destruction, much of which is outlined in The Act and the Misuse of Drugs (Safe Custody) Regulations 1975 and 2001.
- J.2.2 Regulation 8(2)(d) of The Misuse of Drugs Regulations 2001 states that independent hospices, which are charities and not companies, do not require licences to hold stocks of CDs. Formally and legally, the authority to possess CDs devolves to the Director of Nursing. Therefore Katharine House Hospice does not require Home Office Licences to hold stocks of CD listed in Schedule 2 of the Misuse of Drugs Act.
- J.2.3 In addition to extensive legislation, the safe management of medicines (including CDs) in Independent Health Care Settings must meet a number of standards laid down in the National Minimum Standards for Independent Health Care 2002, including the need for a clear audit trail for all CDs that enter the hospice.
- J.2.4 Furthermore, there is much guidance on good practice with regard to CDs. Whilst the hospice has respected and considered this guidance, it has adapted some of it to better meet the particular needs of the hospice. This includes the guidance contained in “Safer management of CDs A Guide to Good Practice in Secondary Care (England)”.
- J.2.5 “Safer management of CDs A Guide to Good Practice in Secondary Care (England)” specifically highlights its use of the term “should” for recommendations that relate to good practice and the term “must” for legal requirements. Its subsequent comment that “this guidance should also be of value in a number of settings outside the secondary sector such as hospices” would appear to indicate that whilst the guidance in the document might helpful to hospices, it is not binding in its entirety because hospices are not viewed as sitting within the secondary sector. The same document also appreciates that some of its guidance might fit uneasily in certain local situations, and it has therefore provided some principles to be used as a basis for policy formulation when this is the case. These principles have occasionally been used in the formulation of the following procedures, for example in the disposal of the contents of part-used syringe drivers that contain CD.
- J.2.6 It is implicit from J.2.1 to J.2.5 that the Katharine House Hospice Procedure relating to CDs comprises a combination of non-negotiable legislative requirements, a number of non-negotiable regulatory requirements and the application of various pieces of guidance regarding good practice. Some of the guidance has been adapted to better suit the culture and needs of the hospice. However, for the purposes of clinical governance, it is imperative that all clinical staff strictly follow all aspects of the Katharine House Procedure relating to CDs, even when a particular clause is ultimately based upon the application or deliberate non-application of guidance.

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**J.3: Responsibility for Controlled Drugs in the hospice.**

- J.3.1 The Director of Nursing is the Accountable Officer for ensuring the safe and secure management of CDs at Katharine House Hospice, including monitoring and auditing activities and the investigation of any concerns or incidents relating to CDs, as described in the CDs (Supervision of Management and Use) Regulations 2006.
- J.3.2 The Senior Nurse has overall responsibility to ensure that all CDs are stored, administered, recorded and handled securely, in accordance with the relevant Act or Regulations.
- J.3.3 The day-to-day responsibilities associated with holding the keys to the CD cupboard are delegated to the nurse in charge of each particular shift. The Senior Nurse must ensure that all nurses understand what these day-to-day responsibilities are. However, ultimate legal responsibility always remains with the Senior Nurse.
- J.3.4 The Accountable Officer is responsible for ensuring that members of staff who are involved in ordering, supplying, writing drug instructions for, administering or disposing of CDs receive appropriate training to enable them to carry out their duties. All clinical staff must receive appropriate training on all relevant hospice policy and procedure in this area during their induction period and this must be repeated at a suitable frequency. Staff must be fully informed and trained as appropriate whenever CD policy and procedure changes or whenever new CD products or systems are introduced.

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**J.4:     The handling of Controlled Drugs that come from the patient.**

- J.4.1     The hospice must always administer CDs that come from its own ward stock of CDs whenever this is an option. It must not administer Patient's Own CDs as a substitute for ward stock, except in exceptional circumstances when a patient needs a CD that the ward does not hold as stock. The Healthcare Commission has advised us that in this situation, a patient can be administered their own CD so long as the procedure in Section J.6 is strictly adhered to in order to ensure a full audit trail.
- J.4.2     If the hospice is given a patient's supply of CDs for safekeeping during an inpatient admission, these must be stored securely for the duration of that admission. If required by the patient at the end of the admission, they will be returned to the patient. Otherwise they will be destroyed in accordance with Section J.13. If the admission ends in the death of the patient, then destruction of the CDs must not take place until at least seven days after the death in case they are requested by the Coroner.
- J.4.3     If a patient's own supply of CDs is given to the hospice, this is documented in the CDs section of the Patients' Own Drugs Record Book. This book records:
- Date and time of receipt
  - Name of patient.
  - The generic name, dose, formulation and total quantity of each CD given to the hospice.
  - Signature of recipient and witness, both of whom must be qualified nurses.
  - Date and time of discharge of the CD from the care of the hospice
  - Description of the ultimate fate of the CD: either "returned to patient", "processed for ward use", "returned from ward use" or "destroyed".
  - Signature of the two qualified nurses responsible for overseeing the ultimate fate of the CD.

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J.5: Controlled Drugs used in clinical trials.

- J.5.1 Any CDs that are specifically being used in a clinical trial must be stored separately from stock CDs, but not necessarily in a separate CD cupboard. In order to maintain a clear audit trail, a separate page in the Ward CD Record Book must be used for these CDs regardless of whatever other clinical trial documentation is being kept.

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**J.6: Use of a patients own supply of Controlled Drug when their requirements cannot be immediately met from ward stock.**

- J.6.1 It is likely that the ward stock of CDs will contain all the necessary items for the majority of hospice inpatients. However, there will inevitably be occasions when an inpatient is using a CD that does not form part of ward stock. Only on these occasions can the hospice administer CDs from a patient's own supply to that same patient. However, it is essential to note that:
- A patient's own supply of CDs must never be administered to any person other than the named person to whom they were originally dispensed.
  - This practice must cease as soon as the ward stock contains a supply of the CD in question, and efforts to obtain such a supply for ward stocks must be made at the earliest opportunity.
  - The following procedure, approved by the Healthcare Commission, must be followed to ensure a satisfactory audit trail.
- J.6.2 The CD is entered onto the next available line in the CDs section of the Patients' Own Drugs Record Book as described in Section J.4.3.
- J.6.3 Once entered into the CDs section of the Patients' Own Drugs Record Book, it is immediately transferred into the "Record of Patient's Own CDs that they Continue to Use During the Hospice Admission." by writing "processed for ward use" in the outcome column and signing and dating this transfer appropriately.
- J.6.4 The CD is entered into the "Record of Patient's Own CDs that they Continue to Use During the Hospice Admission." As each transfer of CD into this record will be a unique event, a new page must be used each time. The following details are filled in at the top of the sheet:
- Name of the patient
  - Name, form of preparation and strength
  - Amount brought in by the patient
  - The signature of the two nurses processing this move and the date it was processed.
- J.6.5 After processing for inpatient use, such CDs can be stored in the CD cupboard that is used for CDs that form part of the ward stock until such time as they are no longer needed for this purpose. At this time the instructions in Section J.6.8 must be followed if appropriate.
- J.6.6 On subsequent drug rounds, the administration of the CD to the patient is recorded in the "Record of Patient's Own CDs that they Continue to Use During the Hospice Admission." Each entry in this record requires the signature of two nurses and a recalculation of the remaining stock balance.
- J.6.7 A supply of the CD in question must be ordered for ward stock at the earliest opportunity. In order to avoid waste, no more than fourteen days supply should be ordered at any one time. When this stock arrives it is recorded in the standard CD Register for the ward as for any other CD (see Section J.9), and any remaining CD from the patient is dealt with as described in Section J.6.8.

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- J.6.8 At the end of the admission or as soon as a supply of the CD in question arrives from pharmacy to enter ward stock, any remaining CD that came from the patient is returned to the Patient's Own CD cabinet in the treatment room. A fresh entry is made on the next available line in the CDs section of the Patients' Own Drugs Record Book as described in Section J.4.3. The name of the patient is recorded, followed by the comment "returned from ward use". The ultimate fate of the CD is recorded as for any other Patients' Own CD in due course.
- J.6.9 In the event of the patient being discharged home, CD from ward stock must not be used in the Take Home Medication for the patient. Following discharge or death of the patient, any remaining CD in ward stock can be stored until it reaches its expiry date. Alternatively, it can be destroyed at any point (as described in Section J.13) at the discretion of the Director of Nursing.
- J.6.10 There is no satisfactory legislative framework to cover the eventuality described in this section, and the procedure described above is arguably not the only possible one to deal with it. However, it is the one that must be followed at Katharine House Hospice as it has been approved by the Healthcare Commission.

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- J.7: The ordering, supply, delivery and receipt of Controlled Drugs into ward stock.
- J.7.1 With the exception of the rare situations where the conditions in Section J.6 apply, the hospice can only administer CDs and temazepam that form part of its ward stock or ward supply.
- J.7.2 CDs can only be ordered from Pharmacy using the Ward CD Order Book. Photocopies or faxes of the relevant pages are not acceptable. Each order page is in duplicate, with the top copy (white) being for Pharmacy and the bottom copy (pink) being for the ward. A separate order page must be used for each item ordered.
- J.7.3 CD Order Books are controlled stationery. They must be ordered in writing from the hospital Pharmacy, via the ward Pharmacist, and only the Senior Nurse has the authority to make such an order. A record must be kept of all pieces of controlled stationery ordered from the pharmacy, and this must include the following details:
- Date of the order
  - Ward/department
  - Name of person ordering the stationery
  - Type of stationery issued
  - Quantity
  - The serial numbers of the stationery
  - Signature of the member of pharmacy staff making the supply
  - Signature of member of staff receiving the stationery.
- It is the responsibility of the Senior Nurse to maintain this record.
- J.7.4 Only one Ward CD Order Book must be in use at any one time, and this must be stored in a locked cupboard when not in use. Loss or theft of any controlled stationery must be reported immediately to both the Director of Nursing and the ward pharmacist (or, in their absence, their deputies).
- J.7.5 The Healthcare Commission required us to place the hospice address on all pages in the CD order book.
- J.7.6 The order for a CD must detail the name of the drug, formulation, strength and quantity required. Only qualified nurses for the ward can order CDs [Signature 1], but a doctor must countersign all orders [Signature 2] on the same line of the order page. Both signatures must appear on both copies of the order.
- J.7.7 The Pharmacy Department holds copies of the signatures of all qualified nurses and doctors attached to the inpatient unit, and will query any other signature on an order form. Doctors and qualified nurses who are newly employed by the hospice or who get married and change their name must ensure that a copy of their current signature is held in Pharmacy.
- J.7.8 The whole Ward CD Order Book is taken to the Hospital Pharmacy. A Pharmacist is required to authorise the supply of CDs against the appropriate order and only signs both copies of the order form once the CDs have been dispensed [signature 3].

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- J.7.9 All CDs are dispensed from Pharmacy and delivered to the hospice reception desk by an authorised messenger, in bags with tamper-proof plastic seals that carry a unique identity number. CDs can only be dispensed from the hospital pharmacy with the authorization of a Pharmacist. During the dispensing process, the unique identity number of the seal is written on to the CD order form. The authorised messenger signs both copies of the relevant CD order forms [signature 4] when taking receipt of the CDs in Pharmacy. Once Pharmacy has removed its copies of the CD orders it has just handed over to the messenger, the messenger brings the CDs and Ward CD Order Book back to the hospice.
- J.7.10 When the CDs arrive at the hospice reception desk, the Senior Nurse or nurse in charge of a particular shift goes to the reception desk to receive them, unless this was the same person that wrote the order in which case another registered nurse must receive them. Before signing for their receipt [signature 5] on the pink copy only, the nurse checks that the seal is undamaged and carries the correct identity number before opening the bag to check that the supplied drug, formulation, strength, quantity and expiry date all match the details on the pink order form. Pharmacy has agreed that whole sealed boxes of CD *injections* that they dispense can be assumed to contain the quantity specified on the label for as long as the original wrapping remains on the box and the seal remains unopened. In such instances, the box does not need to be opened to check the quantity inside. On the other hand, the quantity of CDs contained in boxes of injections where the seal is opened, and the quantity of CDs in all other boxes or bottles, must be counted before the nurse acknowledges receipt of the CD. The checking procedure and the signature for receipt takes place in front of the authorised messenger in the reception area and it is only then that the CD Order Book is handed over to the nurse.
- J.7.11 The order form must only be signed if everything is in order. Any discrepancies must be reported to Pharmacy immediately and the pink order form must be left unsigned to indicate that the faulty order was not accepted for receipt by the hospice. The nurse must not handle the CDs any more once a discrepancy has been confirmed. If the pink form remains unsigned, it is clear that the discrepancy took place before the safe custody of the CDs became the official responsibility of the hospice. The investigation and further management of such a discrepancy is primarily the responsibility of the Pharmacy department and perhaps other outside agencies. However, as there is a theoretical risk that it arose from an event in hospice reception, all such discrepancies must also be reported internally as an adverse drug event (Section J.16).
- J.7.12 If there are no problems with the delivery and the nurse signs for receipt of the CDs, s/he takes the CD transit bag and CD Order Book immediately to the treatment room in the inpatient unit. Two qualified nurses then recheck that the delivery is correct and complete before entering the CDs into the Ward CD Record Book. Only then must they be locked into the CDs Cupboard. When more than one CD item has been delivered at the same time then the checking, recording and storing procedure must be fully completed for one item before moving on to the next.

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- J.7.13 On the rare instances when a doctor or qualified nurse collects CDs for ward stock direct from Horton Hospital Pharmacy, s/he assumes the role of authorised messenger and signs both copies of the CD order form [signature 4] to this effect. S/he must present the Pharmacy staff with some proof of identity when collecting the CDs from pharmacy and must then follow the procedure for the authorised messenger as detailed in Sections J.7.9 and J.7.10 but brings the CD transit bag directly to the treatment room on the inpatient unit rather than waiting at the hospice reception desk. The Senior Nurse or nurse in charge of a particular shift “receives” the CDs and signs for them [signature 5], in accordance with the procedure described in Section J.7.10. They are then rechecked, recorded and stored as described in Section J.7.12.
- J.7.14 All ward copies (pink) of completed orders must remain attached to the Ward CD Order Book. It is the responsibility of the Senior Nurse to ensure that full CD Order Books are retained securely for eight years after the date of the last entry.

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**J.8:     The orderly use of Controlled Drugs from ward stock.**

- J.8.1     The ward must finish one box of CDs before opening the next box of the same CDs. When there is a choice of boxes to open, the one with the shortest expiry date must be used first. When a box of CD injections is opened for the first time, if any of the ampoules are found to be broken, this must be recorded on the appropriate stock page of the Ward CD Record Book by a qualified nurse and a second person and the remainder of the breakage must be disposed of as described in Section J.13. A Pharmacist must also be notified if there is no identifiable explanation for the breakage.

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- J.9: Record keeping for Controlled Drugs that form part of ward stock.**
- J.9.1 All CDs that are stock items are entered into a bound Ward CD Record Book. There is a separate book for recording the storage and fate of CDs brought into the hospice by a patient (See Section J.4). Between them, the Ward CD Order Book, Ward CD Record Book and the Patients' Own CD Record Book provide a complete audit trail for all CDs that are brought into the hospice and declared to the clinical staff.  
The remainder of this section only deals with record keeping for CDs that form part of ward stock.
- J.9.2 Ward CD Record Books are controlled stationery. They must be ordered in writing from Pharmacy via the ward Pharmacist and stored in a locked cupboard when not in use. Only the Senior Nurse can order new Ward CD Record Books.
- J.9.3 The ward must only have a maximum of two Ward CD Record Books in use at any one time. There must be an index at the beginning of each register and each page must be clearly headed to indicate the drug and preparation to which it refers. No formulation of any one drug must appear in more than one register. A new Ward CD Record Book will only be issued when Page 99 of an existing book has been used.
- J.9.4 Whenever CDs are received into stock, the name of the supplier and the requisition number must be recorded in the register, and the number of units of supplied CD must be entered in words rather than figures.
- J.9.5 The total for each preparation in stock must be easily identifiable
- J.9.6 Once a page in the Ward CD Record Book is full, the total stock balance must be carried forward to a new page and that page number then entered in the index alongside the previous page number. The new page number to which the stock balance has been forwarded must also be noted on the bottom of the completed page.
- J.9.7 All entries in the Ward CD Record Book must be made in indelible black or dark blue ink. Only Pharmacists can write in green ink.
- J.9.8 Registers, requisitions and orders for CDs must be preserved for two years. It is the responsibility of the Senior Nurse to ensure that all relevant books, once full, are stored securely in a locked cupboard. It is routine practice at the hospice to store such records for eight years from the date of last entry.
- J.9.9 No cancellations can be made to any entry in a Ward CD Record Book, nor can any entries be crossed out or altered using correcting fluid. If a mistake is made it must be bracketed in such a way that the original entry is still clearly legible. This must be signed, dated and witnessed by a second registered nurse or a doctor, who also signs the correction.
- J.9.10 When a new Ward CD Record Book is started, the running totals carried over from the previous Ward CD Record Book must be checked and signed as correct. It is good practice for this to be done by the Pharmacist or by the Senior Nurse. The transfer process must also be witnessed.

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**J.10: Controlled Drug Storage and Controlled Drug keys.**

- J.10.1 CDs are stored in a locked cupboard that is firmly fixed to the wall at all times. There is no legal requirement for the CD cupboard to have a light or be within another locked cupboard, but both measures are considered good practice.
- J.10.2 The hospice has two CD cupboards: one for stock CDs and the other for Patients' Own CDs that are being stored but not used on the ward.
- J.10.3 There must only be one set of keys to the CD cupboards that is available to clinical staff. They are kept together with the other drug cupboard keys.
- J.10.4 The key ring with the CD cupboard keys should be kept in the possession of the nurse in charge of the shift, who is responsible for controlling access to the CD Cupboards at all times during that shift. Whilst the task of key holding can be delegated to a deputy, the responsibilities remain with the nurse in charge of the shift.
- J.10.5 Qualified nurses requiring access to the CD cupboard must return the CD keys back to the responsible nurse when they have finished using them.
- J.10.6 If the nurse in charge of the shift has to leave the ward for any reason, s/he must delegate the duty of holding the CD keys to another qualified nurse.
- J.10.7 CD keys must not be handled by Health Care Assistants. At the discretion of the Director of Nursing, Bank or Agency nurses who regularly work on the ward may handle the CD keys.
- J.10.8 Medical staff that require access to the CD cupboard must be accompanied by a qualified nurse who will witness the administration and ensure that the Ward CD Record Book is correctly completed.
- J.10.9 If the CD keys are lost or stolen, see Sections B.2.8 and B.2.9.
- J.10.10 In the event of temporary ward closure, measures must be taken to ensure the safety and security of the stock CDs and the controlled stationery. In such a circumstance, the keys for the CD cupboard must remain in the charge of the Director of Nursing, although access to them might be rarely required by the day hospice staff during working hours. Routine CD stock checks must still be performed. If there are any concerns about CD security, or if the ward is likely to remain closed for a considerable period of time, serious consideration should be given to destroying much or all of the ward CD stock.

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**J.11: Administration.**

- J.11.1 All CDs to be administered to a patient must be checked by two persons, one of whom (the administrator of the CD) must be a qualified nurse. The second person (the witness) can be another qualified nurse, a doctor, or the Pharmacist. Health Care Assistants must not participate in this procedure.
- J.11.2 The process of witnessing the administration of a CD starts as the CD cupboard is unlocked. However, it does not finish until after the patient has actually received the CD in line with the written instruction on the drug administration chart. Only then is the process of witnessing the administration complete and *only then must the witness sign the "witnessed by" column of the Ward CD Record Book.*
- J.11.3 The qualified nurse and the second person must be present throughout the whole procedure (i.e. until the CD has actually been administered).
- J.11.4 The record of administration must be signed on the correct page of the Ward CD Record Book by both persons each time a CD is administered to a patient. The date, time, name of patient, quantity of CD used, quantity of remaining stock and signature of the CD administrator must be made when the appropriate dose of CD is removed from the CD cupboard. The signature of the witness must only be made when the drug has actually been given to the patient in line with the written instruction on the drug administration chart.
- J.11.5 *Only when the witness has signed the Ward CD Record Book to confirm that the CD was correctly and successfully administered to the patient can the qualified nurse administering the CD sign the drug administration chart to confirm that the administration is complete.*
- J.11.6 When the administration of a CD requires the use of more than one strength or formulation of CD, all the necessary entries must be made on each appropriate page of the Ward CD Record Book.
- J.11.7 When CDs are administered routinely during a formal drug round, the entire ward stock of the CD items required for patient administration is removed from the locked CD cupboard, along with the ward CD Record Book, and placed in the medicines trolley for the duration of the drug round. As soon as the drug round is complete, the remaining CD stock, and the ward CD Record Book, is returned to the locked CD cupboard in the treatment room.
- J.11.8 The correct, successful and safe administration of CDs to patients is of the utmost importance and errors in the associated documentation are taken seriously.

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**J.12: Stock checks of Controlled Drugs.**

- J.12.1 The Pharmacist and a qualified nurse must perform a stock check of CDs at least every three months. Confirmed totals must be signed and dated by both the Pharmacist and the nurse.
- J.12.2 In addition, all CD stocks must be checked by two qualified nurses at least once a week and the confirmed totals must be signed and dated to this effect. If there is a real or perceived concern about CD security then a daily check must be undertaken.
- J.12.3 When checking the CD stock, it is essential that the stock balance recorded in the Ward CD Record Book is checked against the contents in the CD cupboard rather than the contents in the CD cupboard being checked against the Ward CD Record Book.
- J.12.4 Stock balances of liquid medicines should generally be checked by visual inspection, but periodic volume checks may be helpful. It is appreciated that a small amount of variance might arise between the documented volume of remaining medication and the actual volume of remaining medication as the end of the bottle is reached. The HealthCare Commission has advised us that any variance in excess of 10% is unacceptable and must be reported, in the first instance to the Senior Nurse who must advise the Director of Nursing.
- J.12.5 Confirmed totals must be initialed in the right hand margin on the line of the last entry for each preparation in the Ward CD Record Book. In addition, a record of each time a CD stock check is performed is maintained on the inside back cover of the Ward CD Record Book. The two nurses performing the stock check sign and date the next entry in this record when the stock check has been completed.
- J.12.6 Any discrepancies must be reported immediately to the ward Pharmacist and Senior Nurse or, in her absence, the Director of Nursing or, in the absence of both, the Medical Director (See also Section J.16).

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J.13: Disposal and destruction of Controlled Drugs by the unit.

J.13.1: Introduction.

- J.13.1.1 A CD ceases to be classified as a CD once it has been rendered irretrievable.
- J.13.1.2 It is not permissible to dispose of CDs down a water sewer.
- J.13.1.3 Destruction of CDs can only be performed at Katharine House Hospice by a qualified nurse, and only in the presence of a Home Office-approved witness for CD destruction. In accordance with present Home Office guidance, the Director of Nursing, in her capacity as Accountable Officer under the CDs (Supervision of Management and Use) Regulations 2006, has nominated the Quality and Education Lead Nurse as the sole approved witness of CD destruction at Katharine House Hospice until further notice. All CD destruction must be documented in the CD record book and CD destruction book, and these entries must be signed by the person who performs the destruction and the witness to the destruction.
- J.13.1.4 The ultimate destination for all CDs that are disposed of in the hospice is the Controlled Drug Disposal Bin (CDDDB) that is locked in the cupboard in the corridor to the patients' smoking room at all times.
- J.13.1.5 Each CDDDB has its own identity number. It has a label explaining what it is and what it can be used for.
- J.13.1.6 All items that are disposed of in a CDDDB are recorded on the CD Disposal Form that carries the same identity number as the CDDDB. The form is kept directly underneath the corresponding CDDDB. In addition to CDs, a maximum of two inhalers can be added to the CDDDB.
- J.13.1.7 All destroyed CDs must also be recorded in the appropriate place in the appropriate CD Record Book.
- J.13.1.8 Whenever a CDDDB becomes full, its lid is locked closed, the bin is labeled with the consignment number "18 01 09", and the bin remains locked in the cupboard in the corridor to the patients' smoking room until such time as it is collected by Grundons, an authorised contractor for the removal of pharmaceutical waste. Only then is a new CD Disposal Bin and Form started.
- J.13.1.9 When a bin is ready for collection, the respective CD Disposal Form is handed to the Accounts Department, who store it in order to maintain a complete audit trail for the disposed CDs. The bin itself is placed near the inside of the laundry back door on the morning of the weekly Grundon waste collection visit.

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**J.13.2: Documentation of the disposal procedure.**

- J.13.2.1 CDs meeting the descriptions in the following list can be destroyed on the inpatient unit. (In each case, the correct place for the person destroying the CD and the witness to record the destruction is described. The name and quantity of CD being destroyed must always be clearly described, along with the new stock balance when appropriate).
- J.13.2.2 **CDs brought in by patients.** The destruction of these CDs is recorded on the relevant line of the Patients' Own CD Record Book.
- J.13.2.3 **The remainder of a part-used ampoule or sachet of CD from ward stock.** The doctors should try to minimize the frequency with which this scenario arises by instructing the use of doses of CD that do not require fractions of ampoules to be used whenever this is possible. When part of an ampoule or sachet is administered to the patient and the remainder is destroyed, the amount that is given to the patient and the amount that is destroyed are recorded on the same line on the relevant stock page of the Ward CD Record Book, under the name of the patient who received the drug. The standard two signatures are required for the entry in the Ward CD Record Book.
- J.13.2.4 **Damaged drug products.** Any broken ampoules must be recorded on the appropriate stock page of the Ward CD Record Book. The words "BROKEN AMPOULE" must be placed in the space for the patient's name and two signatures are still required.
- J.13.2.5 **Left over syringe driver contents.** These are recorded on a special page at the back of the Ward CD Record Book that is reserved for the documentation of "discarded medications". The name of the patient, nature and quantity of the discarded CD and two signatures are required.
- J.13.2.6 **CDs that have been prepared from stock for a named patient but then not used.** These are recorded as "NOT GIVEN" next to the patient's name on the relevant stock page of the Ward CD Record Book. Two signatures are required and the nurse who was going to dispense the CD must document why the CD was not given in the patient's nursing records.

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**J.13.2.7 CDs that have passed their expiry date.**

For practical reasons, there can be a delay between identifying that stock CDs have passed their expiry date and their actual destruction. Therefore there are two steps to the destruction process: “Transfer onto the CD destruction pathway and safe storage” and “CD destruction”. The documentation for these two steps is as follows:

**Transfer onto the CD destruction pathway and safe storage**

The quantity of expired CD is recorded in the “Amount Given” column on the relevant stock page of the Ward CD Record Book and the words “EXPIRED DRUGS (B\*, P\*)” are placed in the space for the patient’s name, where B\* and P\* are respectively the number of the Ward CD Record Book and the number of the page in that book where the destruction process is documented. Whilst awaiting destruction, expired CDs are moved from the ward stock CD cupboard into the patients own CD cupboard, so that they are no longer available for use. Two signatures are still required on the line to demonstrate that the CD was transferred into the destruction pathway correctly.

A record of the CD awaiting destruction is made on the page used to document the destruction process of expired CD stock, which has been amended in the following ways for the purpose:

- At the top of the page, the “Name, form, preparation and strength” is entitled ‘Expired CD Stock for destruction’.
- In the “Amount(s) obtained section”, the “Amount” column is changed to “Transferred From” and is completed by writing B\*, P\*, where B\* and P\* are respectively the number and page of the Ward CD Record Book where the expired CD stock had previously been documented. Also in this section, the “Date Received” column is used to document the date upon which the expired CD was entered onto the CD destruction pathway.
- In the “Amounts Administered” section the “Patient’s name” column is renamed “Name and formulation” and the “Amount Given” is renamed “Amount for destruction”. These columns are completed as part of the transfer process onto the CD destruction pathway.

For security purposes, all expired CDs awaiting destruction must be counted in the weekly CD check.

**Documentation of CD destruction**

The following amendments are made to the columns in the “Amounts Administered” page in order to document the actual destruction process: “Given By” is changed to “Destroyed By” and “Stock Balance” is changed to “Bin Number”, At the time of the CD destruction process, the “Date”, “Time”, “destroyed by”, “Witnessed By” and “Bin Number” details are completed for the expired CD in question.

- J.13.2.8 Surplus stock CDs.** If all the procedures relating to CDs are followed properly, then surplus amounts of stock CDs should rarely, if ever, arise. However, if they do arise, they must simply be stored until their expiry date. Alternatively, some or all surplus can be destroyed at any point at the discretion of the Senior Nurse.

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**J.13.3: The CD destruction procedure.****J.13.3.1 Liquid formulations**

These are mixed with cat litter and the resultant slurry is added to the CDDB.

**J.13.3.2 Solid dose formulations, including tablets and capsules**

These are crushed and mixed with a small amount of hot soapy water until fully dissolved or dispersed. This is then mixed with cat litter and the resultant slurry is added to the CDDB.

**J.13.3.3 Parenteral formulations**

Ampoules must be crushed with a pestle and mortar. Any powder must be dissolved in hot soapy water and this mixture must then be mixed with cat litter. The resultant slurry is added to the CDDB.

**J.13.3.4 Unused transdermal patch preparations of Controlled Drug**

Unused patches that have passed their expiry date are cut up into small pieces whilst still in their wrappings, and these fragments are dropped into the CDDB.

**J.13.3.5 Used transdermal patch preparations of Controlled Drug**

The adhesive layer of a used patch is folded over onto itself when the patch is removed from the patient. The patch is then disposed of in the sharps bin, which must then be labeled ***“Contains mixed pharmaceuticals waste and sharps – for incineration”***.

**J.13.3.6 Part-used ampoules and unused syringe driver contents**

The Department of Health and Royal Pharmaceutical Society of Great Britain have allowed for small amounts of CD, such as the unused part of an ampoule of CD, to be rendered irretrievable by disposing of it in the sharps bin. Whenever this happens, a label must be placed on the sharps bin that reads: ***“Contains mixed pharmaceuticals waste and sharps – for incineration”***.

Part-used ampoules are avoided wherever possible by instructing doses of CD that can be made up using whole ampoules. However, whenever part of an ampoule is used, then the remaining quantity of CD is squirted onto cotton wool and this is disposed of in the sharps bin on the inpatient unit. The amount given and the amount wasted must both be recorded in the CD Record Book, and this whole entry must be witnessed by another person in the standard way.

Whenever a syringe driver is taken down before the syringe is completely empty, the syringe contents are squirted onto cotton wool and this is also disposed of in the sharps bin on the inpatient unit. The syringe itself is disposed of in the clinical waste once patient identifiers have been removed from it.

**J.13.3.7 CD Suppositories**

The suppository is fully dissolved in hot soapy water and this is then mixed with cat litter. The resultant slurry is added to the CDDB.

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**J.14:    Lending Controlled Drugs.**

- J.14.1    Requests are sometimes made by General Practitioners, District Nurses, other hospices or even outpatients and their families to borrow CDs in an emergency. Katharine House Hospice is not in a position to help in these circumstances. People making such requests must be advised that it is illegal for us to lend drugs in this way. Professional colleagues should be directed towards the duty chemist shop in the community or the Hospital Pharmacist on-call. Patients and their families should be advised to contact their GP or out-of-hours Primary Care Service Provider.

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**J.15: Obtaining urgent stock supplies of Controlled Drug for the ward.**

- J.15.1 It is sometimes the case that a particular inpatient has a demand for a CD that is not held routinely as stock and/or has a demand for a stock CD item in quantities that far exceed the normal rate of demand.
- J.15.2 In such instances it is important to try and anticipate the likely need for CDs, particularly overnight, at weekends and over Bank Holidays. Steps can then be made to requisition the necessary CDs ahead of time using the normal requisition procedure.
- J.15.3 Every attempt must be made to sort out matters of CD supply to the hospice during normal working hours for the Pharmacy. However, there will almost certainly be rare occasions when it proves necessary to contact the on-call Pharmacist out-of-hours via the Horton Hospital Switchboard for help with the urgent delivery of CDs to the hospice. This service is included in the contract for the supply of drugs to the hospice from Horton Hospital Pharmacy. (Section D describes the urgent supply of drugs out of hours)
- J.15.4 Even when the increased demand for a particular CD relates to one individual inpatient, the CD itself must be dispensed into the general ward stock and not to the individual patient (See Sections J.4.1 and J.7.1)

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**J.16: Suspected loss of Controlled Drugs.**

- J.16.1 Any suspected loss of CDs must be reported immediately to the nurse in charge of the shift on the ward.
- J.16.2 The nurse in charge of the shift must immediately contact the Senior Nurse or, if not available, the Director of Nursing or, if neither are available, the Medical Director.
- J.16.3 In the event of possible medical staff involvement in the suspected loss of a CD, the Medical Director must be informed immediately along with the Senior Nurse.
- J.16.4 Even the *suspected* (rather than just the verified) loss of CDs from the ward is a critical incident that requires an Incident Form to be completed by the nurse-in-charge of the unit before the completion of the shift. This form must be used to document the exact loss or discrepancy that has been discovered or suspected. Incident forms are kept on the inpatient unit.
- J.16.5 If the loss of a CD is confirmed, the Pharmacist must be informed as quickly as possible.
- J.16.6 The Director of Nursing should inform the Medical Director, Business Director, Chairman of the Trustees and the police when appropriate.

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**J.17: Written instructions for the administration or dispensing of Controlled Drugs to patients.**

J.17.1 Extra legal requirements apply for the prescribing of CDs.

J.17.2 It is illegal to issue or respond to verbal orders for the supply, administration or dispensing of CDs.

J.17.3 There are no supplementary or independent prescribers within the hospice and all prescriptions must be written by doctors who have been authorised to do so by the hospice.

J.17.4 On hospice premises, CDs are administered to patients against written instructions on drug administration charts, and these written instructions are not formally regarded as prescriptions. In addition to the written instruction, the patient's name, date of birth, hospice number and allergy status must also be written on the drug administration chart.

J.17.5 The written instructions for TTOs for Schedule Two Controlled Drugs are formally regarded as prescriptions and they must satisfy all the following requirements:

- Only doctors who are fully registered with the GMC can prescribe TTO prescriptions for CDs. All the following are required for a TTO prescription for a CD to be valid:
  - The whole prescription, including the patient's name and address, must be written in the prescriber's own handwriting and in indelible ink. They must be dated, signed and specify the prescriber's address.
  - The generic name of the CD must be used rather than a trade name (e.g. "Morphine sulphate modified release" rather than "MST").
  - The strength of the preparation, when more than one strength exists.
  - The form of the preparation (e.g. tablets, capsules, granules, suspension, skin patches, suppositories) must be included even if it is implicit in the generic name.
  - The dose and the frequency (e.g. 10mg bd)
  - The total quantity of the preparation in both words and figures (e.g. 140mg (one hundred and forty milligrams)) or the number of dose units in both words and figures (e.g. 14 tablets (fourteen)). Where the number of dose units is stated, the doctor must ensure that the correct strength of tablets is requested (e.g. 40mg of morphine modified release may be supplied as 4 x 10mg tablets or 1 x 30 mg and 1 x 10 mg tablet).
  - The prescription must be signed and dated by the prescriber.

It is hospice policy to prescribe a fourteen-day supply of most CD TTOs. Notable exceptions to this are fentanyl skin patches (dispensed in unopened boxes of 5 patches) and buprenorphine patches (dispensed in unopened boxes of 4 patches).

J.17.6 This hospice does not issue any outpatient prescriptions, including for CDs.

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J.18: Storing TTO Controlled Drugs

- J.18.1 When CD discharge medicines (TTOs) arrive at the hospice several hours before the patient leaves, these can be stored in the CD section of the cupboard for Patients' Own Drugs. They must be segregated from ward CD stock, clearly marked as TTOs for the named patient, and kept in a sealed bag.

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J.19: Common questions from patients and families regarding Controlled Drugs

- J.19.1 It is expected that hospice staff will appropriately inform and counsel patients and their families about CDs ahead of their introduction into the treatment regimen, whenever this is possible and appropriate. Therefore any questions that arise should ideally be dealt with in a personalized manner, and backed up with appropriate personalized written information.
- J.19.2 There is a section on the “NHS Direct” website entitled “What is a Controlled Drug (Medicine)?” This is intended to help give patients and their families a better understanding of what CDs are and how the various regulations apply to them. This can be accessed at <http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1391> .
- J.19.3 The regulations regarding the taking of CDs abroad were changed significantly on 1 January 2007. Up to date advice for patients needing to take CDs abroad, and their prescribing doctors, can be found on the “Drug Laws and Licencing: Personal Licences” web page on the Home Office Web Site. At the time of writing, this was at: <http://www.drugs.gov.uk/drugs-laws/licensing/personal/?version=2>

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**J.20: Illicit substances**

- J.20.1 Section 5.10 of “Safer Management of Controlled Drugs - A Guide to Good Practice in Secondary Care (England)” states: “The Health Care Organisation should take advice from the local police and if necessary The Serious and Organised Crime Agency concerning appropriate procedures for dealing with patients who bring suspected illicit substances into the hospital.” This hospice pre-emptively sought advice from Thames Valley Police.
- J.20.2 The Misuse of Drugs Act 1971 makes it an offence for a person to possess an illicit drug unlawfully; to offer or supply such a drug, even in the absence of a payment; or to allow illicit drug use on any premises they occupy or manage. Illicit drug use on hospice premises could potentially result in separate prosecutions against the patient, supplier and hospice managers.
- J.20.3 Cannabis, presently a Class C drug, has not been decriminalised. However, individual police officers have individual discretion over individual offences. A user may simply receive a verbal warning but could risk up to two years imprisonment, an unlimited fine or both. A dealer could face up to 14 years imprisonment, an unlimited fine or both. The Crown Prosecution Service would determine the appropriate action against hospice managers.
- J.20.4 Class A drug use on hospice premises is illegal under any circumstances. A user could risk up to seven years imprisonment, an unlimited fine or both. A dealer could face up to life imprisonment, an unlimited fine or both. The Crown Prosecution Service would determine the appropriate action against hospice managers.
- J.20.5 Hospices can store, supply and administer Controlled Drugs from their own stock to inpatient drug addicts as part of a Controlled Drug maintenance programme if the staff has appropriate expertise and authority to do so.
- J.20.6 On no account must hospice staff turn a blind eye to illicit drug use on hospice premises, whether suspected or confirmed. Patients have no special dispensations in this area. Any concerns must be immediately brought to the attention of the Clinical Directors. In addition to spelling out the legal situation with regard to illicit drug use, the police were keen to highlight the risks to security and reputation of a hospice allowing illicit drug use on its premises.

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## K: General guidelines for writing drug instructions.

### K.1: Introduction.

- K.1.1 Doctors write drug instructions on drug administration charts for the administration of medicines to patients on hospice premises by hospice staff or by self-medicating patients. They write TTO orders for drugs which are to be administered to patients by non-hospice staff or the patients themselves off the hospice premises.
- K.1.2 For identification purposes, all doctors with authority to write drug instructions in the hospice must provide a specimen signature for the hospice and pharmacy records at the start of their employment.
- K.1.3 Any drug instruction written by a doctor whose signature does not feature in the collection of specimen signatures in the back of the drug administration chart folder must not be honoured.
- K.1.4 All inpatient, Day Hospice and (rarely) outpatient drug instructions must be written on a Katharine House Hospice drug administration chart (Appendix Three). TTO orders are written in the hospice TTO book. All drug instructions and orders must be written in indelible black or dark blue ink and be in the doctor's own handwriting.
- K.1.5 The patient's name, date of birth and hospice number must be written on all drug administration charts and TTO orders. In the case of TTOs for CDs, the address of the patient must also be in the doctor's own handwriting (See Section J.17 for full details).
- K.1.6 Except for the drugs listed in Section K.1.6, all drugs must be described by their generic names.
- K.1.7 The following drugs must *always* be described by trade name rather than generic name:
- Modified release antiepileptics.
  - Ciclosporin preparations.
  - Lithium preparations.
  - Mesalazine preparations.
  - Diltiazem and nifedipine preparations.
  - Theophylline preparations.
  - Insulin mixes and certain other combination products.
  - All potentially incriminated drugs administered to a particular patient in those rare instances where the patient has an idiosyncratic intolerance to one or more particular excipients that must therefore be avoided.
- The following drugs may *sometimes* be described by trade name where this avoids potentially dangerous confusion or drug administration errors:
- Morphine preparations.
  - Other CD preparations.
- K.1.8 Abbreviations for drug names (e.g. FeSO<sub>4</sub>) can lead to confusion and must not be used.
- K.1.9 All drug instructions and orders must be clearly signed and dated.

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- K.1.10 In October 2001, the medical team at Katharine House agreed some principles of responsible drug use (Box One) which remain pertinent and should be followed.
- K.1.11 All patients must be offered opportunities to receive any information they would like to receive on the indications, potential benefits and potential harms of any medications that they are recommended to take. This must be offered at the time of admission and whenever a new drug instruction is made. It is the responsibility of the relevant doctor present at the time to undertake this activity.
- K.1.12 An empirical approach to drug use is an essential and well-established part of good palliative care: if a particular drug does not result in good symptom management then it is appropriate to discontinue it and try another therapeutic approach, which might involve the use of an alternative drug. However, this is not the same as a clinical research trial. There is a separate policy on clinical research.

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**Box One: Principles of Responsible Drug Use**

1. Keep it simple:
  - a. Avoid unnecessary polypharmacy.
  - b. Avoid unnecessarily splitting drugs into multiple daily doses.
  - c. Avoid writing dose ranges for drugs that are given regularly.
  - d. Use the initiation of medication administration by syringe driver as an opportunity to review the appropriateness of all oral medications.
2. When writing drug instructions:
  - a. Be aware of any drug allergies or side effects that the patient has previously experienced.
  - b. Know the specific clinical indication for each drug that you write up.
  - c. Stick to formulary drugs whenever possible.
  - d. Consider potential drug interactions.
  - e. It may be appropriate for patients admitted on non-formulary drugs to remain on them.
  - f. Consider whether any current medications can be discontinued.
  - g. Ensure all inpatients are written up for a minimum set of core PRN drugs at appropriate doses.
  - h. Try to anticipate potential clinical problems that may arise over time so that appropriate medication is available if required.
  - i. Print the names of medicines on the drug administration chart.
  - j. With certain exceptions (see Section K.1.6), only use generic drug names on the drug administration chart.
3. When writing instructions for antimicrobials:
  - a. Indicate what is being treated
  - b. State the start and review/end date for the treatment course.
4. When treating a symptom:
  - a. Symptom management is easier if the underlying cause has been sought and understood.
  - b. Stick to any treatment pathways that have been approved by the in-house medical team.
  - c. Generally aim for one medication change at a time.
  - d. Ensure that therapeutic trials are of sufficient duration for any possible benefit to materialise.
  - e. Discontinue drugs that do not help the patient.
5. When offering medication-related advice to the patient:
  - a. Keep explanations simple. Explain what the treatment is for and consider carefully how much information on mechanisms and side effects will actually be helpful for the patient.
  - b. Bear in mind that the majority of your message will be conveyed non-verbally.
6. Keep yourself and others up to date:
  - a. Try to maintain an up-to-date medication list in the patient's notes.
  - b. Communicate medication changes promptly with relevant team colleagues and GP.
7. To ensure continuity of treatment at the time of transfer to the hospice from a hospital, request that patients come with a seven-day supply of medication.
8. All of the following considerations are important when determining which member of a class of drugs to include in a formulary: clinical efficacy, side effect profile, potential drug interactions, ease of administration, availability and cost.

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**K.2:    Dosage.**

- K.2.1    With the exception of compound preparations (e.g. co-codamol, co-amoxiclav), dosages must be stated in terms of the weight of the active ingredient. In the rare instances where the dose of an active ingredient is measured in International Units rather than by weight, then it must be written in full as “UNITS”.
- K.2.2    For compound preparations, the dose of drug in each tablet or equivalent unit (e.g. sachet) must be specified when a range of strengths is available. The actual dose to be given to the patient must be specified as a number of tablets or equivalent units.
- K.2.3    Doses of 1 gram or more must be written in full or using the abbreviation 'g' and a decimal point if required.
- K.2.4    All other doses must be expressed in whole metric units, avoiding decimal places whenever possible. Whenever decimals are unavoidable, a zero must be written in front of the decimal point when there is no other figure.
- K.2.5    Only the abbreviation 'mg' may be used for milligram.
- K.2.6    Quantities less than 1 mg must be written as 'micrograms' or 'nanograms', written in full.
- K.2.7    The dose of liquid medications (e.g. digoxin syrup, morphine liquid) must be stated in terms of the weight of the active ingredient (e.g. mg or micrograms) rather than the volume to be given. It is imperative that the dose is not written as a combined dose *and* volume, as this could be mistaken for a concentration.
- K.2.8    Whenever liquid medications have to be written by volume (e.g. lactulose), this must be written in millilitres written as 'ml', using decimal places as required.
- K.2.9    If the dose of a regularly administered drug is changed, the time and date of the change must be absolutely clear and signed by the doctor making the alteration. The first dose to be given at the revised dose should be highlighted with a \*. Should there not be space to correct a drug instruction or should there be any possibility of uncertainty about the date or time of the change or about any other detail of the instruction, it must be rewritten in full.

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**K.3:    Route.**

K.3.1    The following accepted abbreviations are permitted for describing routes of administration in drug instructions:

PO	Orally
INH	Inhaled
NEB	Nebulised
TOP	Topically
SL	Sublingually
SC	Subcutaneously
ID	Intradermally
IM	Intramuscularly
IV	Intravenously
EAR	Administered to the auditory canal
EYE	Administered to the eye
PR	Administered per rectum
PV	Administered per vagina
L (circled)	Left
R (circled)	Right

K.3.2    Other instructions (e.g. Intranasal, intrathecal, etc) must be written in full to avoid confusion.

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**K.4:    Formulation.**

K.4.1    For many oral medications, a range of dose-equivalent oral formulations exists. These can include:

- Capsules
- Caplets
- Solid tablets
- Dispersible tablets
- Effervescent tablets
- Preparations that melt in the mouth
- Syrups
- Solutions.

Sometimes it is important that a particular oral formulation is administered to a particular patient. For example, phenytoin capsules and phenytoin syrup are not bioequivalent, nor are citalopram tablets and citalopram drops. On such occasions the doctor must specify the formulation to be used in the comments section of the drug instruction box.

K.4.2    For the majority of instructions for drugs to be taken orally, the doctor concerned does not specify a particular formulation for the drug. As such instructions are perfectly acceptable, it is implicit in these circumstances that the doctor is satisfied that any oral formulation meeting the description given can be dispensed to the patient. If this subsequently proves not to be the case, then default starting point for any enquiry is to view it as an instruction error rather than an administration error (See Section N.5).

K.4.3    Sometimes the patient has a distinct preference for one particular oral formulation and may even be unable to swallow certain products (e.g. some patients can swallow capsules but not tablets or they can tolerate tablets but retch at the taste of a liquid equivalent, etc). In such circumstances, a doctor or Pharmacist can indicate this patient preference in the “comments” section of the instruction box, using the wording “Preference for XXX”, where XXX represents the formulation. This comment must be initialed and dated.

K.4.4    Whenever one particular oral formulation must be dispensed to a patient, this must be indicated in the “comments” section of the instruction box using the wording “XXX only”, where XXX represents the formulation. The comment must be initialed and dated. If a doctor or Pharmacist has specified a particular formulation in this manner but it cannot be dispensed due to lack of stocks, then a doctor must be consulted before dispensing an alternative formulation in case there are important bioequivalence issues to consider.

K.4.5    There may be occasions when there is a perceived need to change an oral formulation out-of-hours (e.g. the patient requests such a change or the patient’s physical condition changes so that they can no longer take the original formulation). With the exception of situations where a particular formulation has been specified to the exclusion of all others (Section K.4.4), the nurse may give an alternative oral formulation provided s/he is confident that a bioequivalent dose is being administered. However, if there is any concern or doubt on the part of the nurse, any proposed change of formulation should be discussed with the on-call doctor.

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**K.5:    Frequency.**

- K.5.1    The following accepted abbreviations are permitted for describing the frequency of administration in drug instructions:
- |            |                              |
|------------|------------------------------|
| 4H, 6H, 8H | 4-hourly, 6-hourly, 8-hourly |
| OD         | Once a day                   |
| BD         | Twice a day                  |
| TDS        | Three times a day            |
| QDS        | Four times a day             |
| mane/om    | In the morning               |
| nocte      | At night                     |
| stat       | Immediately                  |
| prn        | When required                |
- K.5.2    The frequency of “when required” (prn) drugs must be indicated by a clear and definitely stated minimum interval between doses. In some cases it may also be appropriate to specify a maximum daily dose in the comments box.
- K.5.3    All frequencies not listed above must be written in full to avoid confusion.
- K.5.4    If specific times of administration are required (e.g. for nitrates) the instructing doctor must indicate the times of administration clearly on the drug administration chart. If the doctor does not specify the times on the drug administration chart but does specify the daily dosage frequency, then the nurse can choose the times of administration. However, this is not considered best practice.
- K.5.5    If a skin patch must only be applied for part of a day (e.g. 18 hours) then the time of application must be circled on the drug instruction box and the time of removal indicated in the comments box
- K.5.6    If a skin patch must remain on the skin for more than 24 hours between changes (e.g. every 3 days), then the time at which the patch needs changing must be circled on the drug instruction box, but the days on which the patch must not be changed must be crossed out on the administration record by the instructing doctor at the time of writing the instruction.
- K.5.7    If continuous oxygen therapy is required, then the flow rate and mask requirements must be specified; all the available times of administration must be enclosed in a single circle; and the words “continuous administration” placed in the comments box.
- K.5.8    Pharmacists can change the times of administration on the drug administration chart if they believe it is in the patient's interest. This must be discussed with the nurse and doctor looking after the patient ahead of making the change. Any such changes must be initialed and dated.

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**K.6:     Administering drugs to inpatients.**

- K.6.1     The inpatient drug administration chart is designed to provide a permanent, concise, unambiguous and legal record of all drugs administered to a patient on the instructions of a doctor (including oxygen) during their stay in the hospice. Drug administration charts must be maintained for each inpatient. Furthermore, they must always be used whenever the hospice dispenses and administers medication from its own stock to patients in other hospice settings, such as outpatient clinics or Day Hospice.
- K.6.2     The drug administration chart has separate sections for:
- Regular medication.
  - As required medication.
  - One-off drug instructions.
  - Syringe drivers.
- Separate specific charts must be used for monitoring syringe driver sites and for monitoring fentanyl patch sites.
- K.6.3     The section of the drug administration chart used for syringe driver instructions can also be used to write instructions for epidural or regional anaesthesia (See Section T), so long as:
- The heading for this section of the drug administration chart is boldly re-titled, to indicate the nature and purpose of the infusion, and
  - The same drug administration chart is not concurrently being used for a subcutaneous syringe driver instruction.
- If an epidural infusion *and* a syringe driver are needed for the same patient then two separate drug administration charts must be used.
- K.6.4     Nurses can only administer drugs to inpatients against the written instructions of a doctor, as found on the relevant drug administration chart.
- K.6.5     Pharmacists can only dispense drugs to inpatients against the written instructions of a doctor, as found on the relevant drug administration chart or TTO order as appropriate.
- K.6.6     If a patient has any drug sensitivities or drugs that should be avoided, the names of these drugs must be written clearly in the box marked “Drug hypersensitivities, allergies & special requirements” on the front page of the drug administration chart. If no such drugs exist, then 'none known' should be written in the box. The nature of the problem must be documented in the appropriate section in the front of the patient’s clinical notes.
- K.6.7     In order to minimize the risk of drug errors, consecutive use of two drug administration charts must be avoided whenever possible. If it is possible to fit all medication instructions onto one chart then this must be done, even if this means rewriting a chart. When it is essential to have two or more contemporaneous drug administration charts for the same patient, each must be marked on the front page in such a way to indicate that more than one chart is in use (e.g. “Chart 1 of 2” and “Chart 2 of 2”).

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- K.6.8 When all the administration columns have been filled for a particular drug, a fresh instruction for that drug must be written, on a new drug administration chart if necessary. Continuation strips must not be attached to a drug administration chart when a particular area is full.
- K.6.9 If a particular dose of a drug instruction is not to be administered, (e.g. warfarin dose when INR is too high), the doctor must put a 'X' in the relevant administration boxes for the number of administrations that should be omitted. The doctor must also note the reason for omitting the doses in the medical records.
- K.6.10 In all cases, the “principles of responsible drug use” apply.

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**K.7:     Ordering “To Take Out” drugs (TTOs).**

- K.7.1     A TTO order provides a permanent list of instructions for all the drugs that the patient should take on discharge from the hospice, written by a hospice doctor.
- K.7.2     TTO orders must be written in the duplicating “TTO Order Book” on the ward.
- K.7.3     Ideally, the Pharmacist screens all TTO orders at the hospice so that any queries can be clarified and any appropriate PODs identified. The identification of PODs ensures that unnecessary items are not dispensed by Pharmacy and that any necessary relabelling of PODs will be undertaken by the Pharmacy. The Pharmacist then takes the top copy of the TTO order to the Horton Hospital Pharmacy for dispensing and the duplicate is kept on the ward.
- K.7.4     Whenever a TTO order has to reach the Horton Hospital Pharmacy so quickly that the procedure described in Section K.7.3 cannot be performed, it is necessary to leave a radiopager message (07659-130584) for the palliative care pharmacist to contact the appropriate named nurse on the Katharine House Hospice Inpatient Unit, specifically indicating that urgent TTOs are required. The pharmacist will then reply and make the necessary arrangements with Horton pharmacy, which will involve faxing of both the whole TTO order and whole drug administration chart as directed by the pharmacist.
- K.7.5     It is important that full details of all patients’ medications on discharge are communicated to the appropriate general practitioner as soon as possible in the typed discharge letter. This applies even if no medication changes were made during the admission. Any important instructions must also be included in this letter. It is sometimes also necessary to alert the general practitioner by telephone ahead of the discharge if there are particularly important drug issues to make them aware of.
- K.7.6     With the exception of skin patches and Schedule Two Controlled Drugs (e.g. buprenorphine, fentanyl or hyoscine hydrobromide patches), 28-days treatment must routinely be ordered.
- K.7.7     When ordering non-skin patch Schedule Two Controlled Drugs for TTOs, enough must be ordered to cover the first fourteen days at home.
- K.7.8     When ordering skin-patch Controlled Drugs for TTOs, fentanyl skin patches are ordered in unopened boxes of 5 and buprenorphine skin patches are ordered in unopened boxes of 4.
- K.7.9     Whenever PODs are returned to patients at the time of discharge, this must be documented appropriately in the Patients’ Own Drug Book (See Section E.1.4) to complete the relevant audit trail. If necessary, the pharmacist will supply new labels for the PODs if the instructions for their use on the original packaging is not the same as the instructions for use on the TTO order. As the manufacturers’ “Patient Information Leaflets” (PILs) will have been issued to the patient when the reused PODs were first dispensed, no duplicate PILs will be issued for these PODs.
- K.7.10    Nursing and medical staff must not decant ward stock into other containers and give this to patients as TTOs. (See Section K.8).
- K.7.11    In all cases, the “principles of responsible drug use” apply.

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- K.8: Ordering drugs for patients taking short periods of leave from the inpatient unit.
- K.8.1 If it seems likely that a patient will take one or more short periods of absence from the inpatient unit which will require supplies of medication (including outpatient visits to hospital or weekend leave at home) the Pharmacy should be advised with as much warning as possible.
- K.8.2 If the PODs that the patient brought in with them do not cover the patient's medication requirements and/or they are no longer labeled correctly, then a routine 28-day TTO order must be written for the patient prior to their first period of leave from the hospice, which is then processed in the standard way. These TTOs are then given to the patient on each occasion they leave the unit and are returned for storage by the hospice between each trip out. The writing of such a TTO order is necessary in order to demonstrate a complete audit trail for the items in question.
- K.8.3 The dispensed drugs, with the exception of CDs, must be stored in the POD cupboard until the patient leaves the inpatient unit for any period of absence, when they should be given to her/him for their use during the absence. S/he should be requested to bring the remaining supply back with them on return, when they should again be stored by the hospice in the same manner and made available during future absences from the ward. The quantities and whereabouts of all such drugs are entered into the Patients' Own Non-CD Record Book.
- K.8.4 CDs must be stored locked in the CD compartment of the Patients' Own Drug cupboard until required. The quantities and whereabouts of all such drugs are entered into the Patients' Own CD Record Book. It is acceptable to give a patient back their own supplies of CD that they entrusted to the hospice for safekeeping during their inpatient stay, so long as these are labeled with dosage instructions that are accurate with respect to the time that leave is taken from the inpatient unit. All CDs must be signed in and out of the Patients' Own CD Record Book appropriately.
- K.8.5 When supplies of drugs are handed over to a patient or their relatives or friends even for a short absence from the inpatient unit, it is still important that there is careful discussion with the patient about their use, and a personalized "Medication Summary Sheet" should be issued (See Appendix Four and Section N.6).
- K.8.6 At the end of the admission, this same supply of drugs can be used for the patient's final TTOs, subject to any minor revisions that must be included on a TTO order at that time.

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- K.8.7 Only in very exceptional circumstances (e.g. a patient announces that they must temporarily leave the inpatient unit to deal immediately with an urgent matter) can drugs be decanted from the ward drug trolley and/or CDs cupboard into separate labelled bottles for use by the patient off the ward. Such a line of action must be considered *a last resort* when the only alternative would be for the patient to leave the unit without any of the drugs they require for good symptom management. The relevant entries on the drug administration chart must be marked with an “L” (to indicate “given to a patient on ward Leave”), and initialled by the dispensing nurse. An “L” should also be placed in the “route” box for any PRN drug issued to the patient for potential use during a period of ward leave.

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**K.9: Amendments and cancellations to doctors' instructions on Drug Administration Charts.**

- K.9.1 In general, instructions on Drug Administration Charts must not be amended. It is preferable to write a new instruction.
- K.9.2 The following staff are allowed to make the following amendments to an instruction, so long as such amendments are made in accordance with Sections K.2.9, K.4.3, K.5.4, K.5.8 and M.6:
- Nurse: Specify a particular formulation when a choice is available, and specify the time at which a dose can be given when this has been omitted.
- Pharmacist: Specify a particular formulation when a choice is available, and amend the timing of a dose.
- Doctor: Specify a particular formulation when a choice is available, amend the timing of a dose, and change the dosage.
- K.9.3 When a doctor changes the dose of an instruction on a drug administration chart, the nurse check box for which the dose change takes place must be highlighted with a \*. This helps the nursing team appreciate that a dosage change is taking place. It also allows doctors to retrospectively compare changes in symptomatology with medication changes.
- K.9.4 Changes to drug instructions must be clearly written in ink, signed and dated.
- K.9.5 *Only one amendment* to a drug instruction is allowed before the whole instruction has to be rewritten.
- K.9.6 If the drug instruction becomes ambiguous or illegible in any way, then it must be rewritten before any more medication is administered.
- K.9.7 Cancellations to drug instructions must be signed and dated. A diagonal line must be drawn through the name of the drug. Also, a vertical line must be placed through the unused section of the administration record for the day the drug was discontinued, and a diagonal line must be put through the administration record for all subsequent days for that drug. This method ensures that the actual administration record is not obscured and that no subsequent administrations can be covertly or accidentally made.

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K.10: The storage of old drug administration charts.

- K.10.1 Old drug administration charts are potentially important legal documents. They must be stored in the “Consent Forms/Old Notes” section of the multidisciplinary clinical notes.
- K.10.2 Drug administration charts must be kept for a minimum of eight years from the date of discharge from the service or death of the patient.

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## L: The use of Licenced Drugs beyond their Product Licences.

- L.1 All marketed drugs require a Product Licence. Amongst other things, this defines the clinical conditions for which a drug company can promote its product, along with the appropriate doses and routes of administration that the drug company can promote.
- L.2 A Product Licence does not limit the clinical or prescribing freedom of doctors as described in The Medicines Act 1968. The responsibility for the consequences of prescribing outside the Product Licence lies with the prescribing doctor. Drugs prescribed for use outside their Product Licence can be dispensed by Pharmacists and administered by nurses and midwives. It is good practice for Pharmacists to ensure that doctors are aware that they are prescribing beyond the Product Licence.
- L.3 Up to 25% all prescriptions in palliative care do not comply with the respective Drug Licence, typically for one or more of the following reasons:
- The clinical indication is not listed in the Drug Licence.
  - The route of administration is not listed in the Drug Licence.
  - The prescribed dose does not fall within the Drug Licence.
  - The original formulation is altered (e.g. crushed/dispersed) before administration.
- L.4 In a survey of Palliative Care Specialists in the United Kingdom, the majority of palliative care physicians considered it impractical to advise patients every time a drug was prescribed beyond the Product Licence. Furthermore, they considered it potentially harmful to the patient to act in such a way, as it would unnecessarily raise patient anxiety in many cases. Therefore, it seems reasonable to conclude that it is *not* standard practice in palliative care to obtain written informed consent each time a drug is prescribed in a way not described on the Product Licence. The Trustees and clinical staff at Katharine House Hospice agree with this general approach but appreciate that there are occasions when it is important to inform the patient more fully about prescribing issues and choices, *just as this can equally be the case for drugs prescribed within their Product Licences.*
- L.5 Our procedure for informing patients about prescribing issues and choices is outlined below:
- 1) We inform all patients and relatives that we are always happy to discuss any aspect of their care and management with them and we always try to tailor our discussion of such matters to the expressed wishes of the patient. This approach is also highlighted in the following passage, taken from the Patient Information Leaflet entitled “A Way of Caring”:  
“We try our best to put the patient at the heart of all discussions and decisions regarding their management. In conversation, we try to relate to people in ways that meet their individual needs. For example, whilst some people like as much detail as possible regarding their care, we are sensitive to the fact that others prefer to keep such conversations to a minimum... We hope that we succeed in our efforts

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to care and we always welcome feedback and suggestions about how we might further improve.”

A similar message is contained in the leaflet entitled “Information for Health Care Professionals”.

- 2) The only times we routinely highlight the prescription of a drug in a manner not described in its Product Licence is when one or more of the following conditions apply:
  - The patient has clearly expressed a wish to know every relevant detail regarding their ongoing care.
  - If other treatment options exist that do not require prescribing beyond the Product Licence.
  - If the potential benefit of the proposed treatment is considered small or is even unsubstantiated.
  - If the potential risks of the proposed treatment are considered large.
  - If the proposed treatment has not been used in this hospice before.
  - If the drug has no Product Licence at all.
- 3) With as many as 25% all palliative care prescriptions falling outside the relevant Product Licence, it is self evident that certain examples of prescribing beyond the Product Licence can be considered “established practice” in this clinical context. Specialist palliative care clinicians have developed a good understanding of the indications, alternatives and potential risks of such prescribing, as is clearly demonstrated in “Palliative Care Formulary 3”. A list of off-licence prescribing regularly performed or recommended by Katharine House Hospice is summarised in Appendix Five, all of which is detailed in Palliative Care Formulary 3. We believe that patients need not be routinely and specifically advised each time such established practice is employed.
- 4) Whenever it is felt that a particular patient might benefit from the prescription of a drug in a manner not described in its Product Licence and the prescription in question is not part of our “established practice” as detailed in Appendix Five, the hospice Consultant must be generally in favour of the proposed line of management. The consultant must be satisfied that more established management options have already been considered and tried as appropriate. This being the case, it is therefore fitting for the Consultant to take the lead in discussing the proposed treatment option with the patient unless this task has been clearly delegated by the Consultant to another member of the medical team. If a doctor decides to prescribe a drug beyond its Product Licence without advising and receiving the support of the Consultant beforehand, then the Consultant cannot be held responsible if there is subsequently a serious adverse outcome that is attributable to this act before the Consultant becomes aware of it.

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- 5) In the community or hospital setting, a Clinical Nurse Specialist might advise a doctor to prescribe a medicine in a manner not described on the Product Licence. As prescribing doctors are responsible for the potential consequences of prescribing outside the Product Licence, it is likely that the doctors concerned might express reservations or even refuse outright to follow such advice from time to time. Obviously, the hospice Consultant will support and endorse any prescribing suggestion made by the Clinical Nurse Specialist that clearly follows established practice at the hospice. However, suggestions that clearly fall outside established practice at the hospice should be discussed with the Consultant first if it is felt that Consultant backing might later be appreciated.
- 6) In discussing the use of drugs beyond their Product Licence with a patient, the level of information exchange must obviously be carefully tailored to the wishes, needs and cognitive abilities of the patient. The whole conversation must be carefully documented in the medical notes, and written consent must be obtained from the patient if the doctor considers this to be remotely appropriate.
- 7) Whenever written consent is sought, this must be on a typed form, individualised to the patient, that includes a description of:
  - The drug, dose and route of administration.
  - The clinical indication for this treatment.
  - A brief description of the nature of the evidence that supports this treatment.
  - An estimate of the likelihood of success, when this is known.
  - Possible side effects and the likelihood of these occurring.These same areas must also be covered appropriately in any discussion with a patient regarding the use of a drug beyond its Product Licence, even if written informed consent is *not* obtained. If, in tailoring the advice to the patient, it is felt that this level of information is inappropriate, then this must be documented in the notes.
- 8) The signed and dated consent form must be stored on the back spine of the medical records and a photocopy must be given to the patient.

L.6 There is an information leaflet entitled “Information for Patients on the Use of Unlicensed Medicines in Palliative Care”, that staff can give to patients if they consider it helpful.

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## M: Administering medication from a remote instruction.

- M.1 Standard 11 of the 2008 Nursing and Midwifery Council document “Standards for Medicines Management” indicates that nurses must not accept verbal orders from doctors for:
- (i) the addition of new drugs to a patient’s drug administration chart, or
  - (ii) amendments to the existing drug instructions on a patient’s drug administration chart.
- M.2 However, in both these instances in the context of palliative care, if the doctor cannot immediately come in to directly assess the patient and hand-write the relevant instructions on the patient’s drug administration chart, then the use of Information Technology may be used to provide the inpatient nursing staff with a printed instruction that must be stapled to the patient’s drug administration chart until such time as the doctor can come in and hand-write the instructions onto the drug administration chart.
- M.3 The doctor has a maximum of 24 hours (72 hours at weekends and Bank Holidays) to come in and replace these printed instructions with hand-written instructions on the drug administration chart.
- M.4 The NMC considers the inpatient nurse accountable for ensuring that all relevant information is communicated to the doctor whenever remote instructions of this nature are performed, and the nurse may refuse to accept a remote instruction if it compromises patient care. In this instance, the nurse should document accurately the communication that has taken place.
- M.5 Any instructions received using Information Technology must be received in a secure place and the printout must include the complete text message, telephone number or email address it was sent from and the time it was sent. It must be dated and signed by the receiving nurse and a second signatory upon receipt.
- M.6 The transmitted instructions themselves must be regarded as a patient contact and should be handled in keeping with the NMC Guidelines on Record Keeping.
- M.7 In order to maintain high standards of confidentiality, the incoming message must be deleted from the machine that received it once it has been printed off.
- M.8 If the doctor is sending the message from their own home, then they can use a Personal Computer to email the required information to ward@khh.org.uk. Alternatively they can fax it to 01295-811768.
- M.9 If the doctor has no immediate access to a computer with email facilities but they do have a mobile telephone with text facilities, then they can send a text-to-email message via the number 07766-404142. The first word in the text message must be ward@khh.org.uk , followed by a space and then the message.
- M.10 Whether an email, fax or text-to email message is sent, the recommended and simplest layout of the message is:  
“From (Name of Doctor), regarding Hospice Number (XXXX). Please start: Drug name, drug dose, dosage frequency, route of administration”.  
*Any message lacking any of these details will not be acceptable.*

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- M.11 Before any drug instruction transmitted by email, fax or text-to-email is acted upon by ward staff, a member of the nursing team must ring the instructing doctor back and read out the instruction to check that it has been received correctly.
- M.12 Particular care must be taken with the text message if it contains instructions for starting, changing or stopping more than one drug, and in such instances the sending of more than one message may be preferable. As this is a legal document, clear English must be used and no texting abbreviations or “smileys” must be used. The basic template for this text can be programmed into a mobile phone, and the text-to-email telephone number can be added to its telephone directory. There is a charge for each text-to-email message but, as this service is for the convenience of the on-call doctor rather than the patient or the hospice, it is expected that the on-call doctor will bear the cost of this.

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## N: Procedure for administering medicines by clinical staff.

### N.1: Responsibility.

N.1.1 Medicines may only be administered to patients by:

- Qualified nurses.
- Qualified doctors.

All aspects of medicines administration must be in accordance with the NMC's "Standards for Medicines Management".

N.1.2 Each individual nurse or doctor is accountable for her/his own professional actions when administering medicines to patients.

N.1.3 A nurse or doctor must only administer a medicine to a patient against a signed and dated instruction on a Drug Administration Chart, written by a medical practitioner. Exceptions to this are stated in the following Procedures:

- Administering medication from a remote instruction. (See Section M).
- Drugs administered in clinical emergencies (See Sections B.3.3 and U).

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**N.2:     Administration.**

- N.2.1     Drugs must be administered to patients by 2 qualified nurses, or a qualified nurse and a doctor. One of these assumes the primary role of drug administrator and the other assumes the primary role of drug checker.
- N.2.2     Before administering any medicine, the staff administering the medicine must:
- Read the drug instruction carefully and ensure that a doctor has signed it. If the drug instruction causes any ambiguity, doubt or concern, the nurse must consult the instructing doctor or the doctor on call for an opinion. (See Section M for information on remote instructions, if these are required).
  - Select the medicine required from the drug trolley or medicine cupboard, check the label with the drug instruction and check that the medicine looks right (e.g. some injections may discolour). Any uncertainties must be checked with Pharmacy.
  - Prepare the medicine and check with the drug instruction:
    - The name of the patient
    - The name and form of the medicine
    - The route of administration
    - The calculation (if any)
    - The measured dose
    - The date and the time of dosage
    - The time of the last dose
    - That the instructed dose has not been already given (including recent PRN administrations).
    - The manufacturer's expiry date has not been exceeded.
      - In the case of non-stock items, unless otherwise stated on the container:
        - The expiry date for liquids is 3 months from the date of dispensing printed on the bottle.
        - The expiry date for tablets is 1 year from the date of dispensing printed on the container.
    - No sensitivities, drug interactions or contraindications to the medicine are known.
  - Check the patient's identity (N.B. Patients at Katharine House do not wear identity bracelets) before administering the medicine.
  - Be aware of the speed of onset of action of the medicine and any side effects the patient may experience.
- N.2.3     Patients Own Drugs that are used on the ward can only be administered to the named patient to whom they were originally dispensed, even in the very exceptional circumstances of them being temporarily moved into ward stock (e.g. Certain CDs that are not routinely kept as stock on the ward, see Section J.6).

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**N.3: Record of administration.**

- N.3.1 The staff administering the medicine must ensure that it is administered to the patient in the appropriate way. If administration involves the patient's co-operation (e.g. swallowing) then it must be ensured that this has occurred before initialing the patient's drug administration chart.
- N.3.2 In all cases, the staff administering the medicine must only record the administration after the drug has been administered to the patient. The nurse must initial in the appropriate column of the drug administration chart.
- N.3.3 Where the administration has involved an IV, SC or epidural infusion, the record of administration must be recorded as in Section N.3.2 above on the appropriate section of the drug administration chart and also include a record of infusion start and finish time.
- N.3.4 Medicines must never normally be left at the patient's bedside by a nurse if a patient does not take them immediately. An exception might be if a patient was finding difficulty taking a liquid preparation such as an indigestion mixture or a laxative, when it may be appropriate to leave the preparation. In these circumstances the nurse-in-charge of the drug round is still responsible for ensuring that the drug is taken.
- N.3.5 See Section B.3 for information regarding medicines can be stored at an individual patient's bedside for rapid PRN use.

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N.4: Missed doses.

N.4.1 If a patient misses a medicine, the nurse must record this clearly in the place on the drug administration chart where the record of administration would have been. The following abbreviations are acceptable:

U Drug unavailable  
 X Do not give (An instruction from a doctor)  
 R Drug refused by the patient  
 N Drug not given  
 S Patient unable to swallow

Whenever clarification is necessary, a note of the circumstances must be made in the nursing notes for other team members and/or in the “comments” box for the drug in question.

N.4.2 If a patient refuses a drug on more than one occasion or, if on first refusal, the nurse is concerned about the potential consequence to the patient of refusing the medicine, the nurse must contact the instructing doctor or doctor on call.

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**N.5: Drug errors (See also Sections H and J.16).****N.5.1: Introduction**

N.5.1.1 Drug errors fall into two main categories: instruction errors and administration errors.

Instruction errors include:

- Failure to write up a drug that is required by the patient. (This is most commonly encountered when a new drug administration chart is written up).
- Failure to supply all the necessary information to make the instruction complete. (e.g. No dosage is specified, the times of administration are not indicated, or a concentration of liquid is specified rather than a dose).
- Specification of the wrong dose. (This can be particularly hazardous if milligrammes and microgrammes are confused).
- Failure to discontinue a short course of treatment. (e.g. courses of antifungal or antibiotic treatment)

Administration errors include:

- Giving a drug intended for one particular patient to the wrong patient.
- Giving an incorrect dose of a drug that had correctly written instructions.
- Failing to administer a drug to a patient when there were correctly written instructions to do so.
- Failing to record whether a drug has or has not been given to a patient on a drug round.
- Recording the administration of a drug on the wrong part of a drug administration chart.
- Administering a drug with correctly written instructions at the wrong time or by the wrong route.
- Equipment failures that compromise the correct administration of the drug to the patient.
- Drugs that have been lost or otherwise unaccounted for.

N.5.1.2 Whilst some types of drug error might seem too trivial to report, any of them have the potential for very serious consequences in slightly different circumstances. Therefore all drug errors must be reported and followed up.

N.5.1.3 It is possible for one catastrophic drug error to result from the domino effect of multiple small contributory factors, each of which seems inconsequential when considered in isolation. Simple corrective measures learnt from one or two small incidents might prevent a very serious adverse event in the future.

N.5.1.4 An open reporting culture in which the clear primary focus of enquiry is the identification of system failures will work better than one where individuals fear blame and reprimand as the inevitable and only consequences of identified errors. Every effort must be made by those investigating the drug error to make those involved in the error feel supported.

N.5.1.5 Patient safety is the immediate and overriding concern whenever a drug error is first identified.

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- N.5.1.6 Once patient safety has been established, attention must turn to discovering how the error arose and determining how to minimize the risk of further similar errors. This is dealt with by following an error reporting procedure.

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**N.5.2: Procedure for reporting and dealing with drug errors.**

- N.5.2.1 Whenever an error is identified, it must be reported immediately to the nurse in charge of the shift or the most senior nurse who is on duty.
- N.5.2.2 The nurse in charge of the shift must inform:
- The Senior Nurse so that appropriate investigation can be undertaken of the circumstances surrounding the error.
  - The most senior member of the medical team that is on duty and readily available so that the medical safety of the patient can be appropriately assessed.
- N.5.2.3 Not all drug errors require the prompt involvement of a Pharmacist. However, when this is considered necessary, the Senior Nurse or doctor who has been advised of the error will make the necessary contact.
- N.5.2.4 A Drug Error Reporting Form must be completed jointly by the person who reported the error and the nurse in charge of the shift (Appendix Six). This must be completed as soon as possible and certainly before the end of the shift. It is then delivered to the Senior Nurse. The Director of Nursing should be informed of *all* drug errors at the earliest opportunity. Whenever the error sequence appeared to involve the action or omission of a member of the medical team, the Medical Director must also be provided with a copy of the reporting form.
- N.5.2.5 The Senior Nurse or, in her/his absence, the Director of Nursing, investigates the broader general circumstances that led to any drug error, regardless of who was involved in it. S/he also fully investigates all parts of an error sequence that relate to the actions or omissions of a member of the nursing staff. S/he shares any conclusions constructively and openly with those who need to know.
- N.5.2.6 The Medical Director fully investigates all parts of an error sequence that relate to the actions or omissions of a member of the medical staff. S/he also discusses the broader general circumstances in which these drug errors arose with the Senior Nurse. S/he shares any conclusions constructively and openly with those who need to know and provides the Director of Nursing with the relevant follow up documentation.
- N.5.2.7 The complete investigation process for any drug error (instruction error or administration error) will include the following steps as an absolute minimum:
- The identification of system failings.
  - A review of any policies, procedures or guidelines that should have provided a failsafe approach to avoiding such errors. Suggestions for the amendment of such documents should be discussed at the next Clinical Practices Committee Meeting.
  - The sharing of important learning points with all staff who might benefit from them. This might be done on a one-to-one basis, in a group meeting or by circulating a memo.
  - A record of the error in the Drug Error Records Folder.
- The purpose of these steps is to enhance patient safety in the future by minimising the risk of a similar drug event happening again.

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- N.5.2.8 By the end of the investigation of any drug administration error, the drug incident form must contain a signed statement by all parties involved, as well as a signed statement by the investigating Senior Nurse of her/his investigation as well as any recommendations and/or actions. The incident form is delivered to the Director of Nursing who may wish to make further comments or very occasionally in the light of the Senior Nurse's report and the interests of transparency investigate further. The incident form is serialised and stored in the Drug Error Record Folder in the Director of Nursing's Office.
- N.5.2.9 Whilst an open, non-blame approach to the investigation of drug errors is always to be preferred, there will potentially be occasions when a degree of individual culpability is identifiable, and it is in nobody's interest to ignore this. More obvious examples might include:
- Flagrant professional misconduct or recklessness.
  - Performing one's duties to an unacceptably low standard.
  - Repetition of the same error by the same member of staff.
- Such problems will be taken seriously and not treated as system failings. They will be dealt with by the appropriate Clinical Director. The same holds true of deliberate attempts to conceal drug errors from others.
- N.5.2.10 On the occasions when individual culpability is identifiable, the steps to be taken might include:
- Identification of areas for personal improvement. These might be written down and given to the person concerned but, unless clearly stated to the contrary, they will not be placed in the personnel file.
  - Tailored individual re-education programmes.
  - Monitoring of future activities until the relevant Clinical Director is satisfied that there has been sufficient and sustained change for the better.
- Such situations are to be treated in a sensitive and individualised manner. Whilst the Clinical Directors reserve the right to follow disciplinary procedures outlined in the Employment Handbook, such steps will never be undertaken lightly. It is prudent for the Director to have discussed the situation at senior management level or above before proceeding in such a way.
- N.5.2.11 All drug errors are discussed at the subsequent Clinical Practices Committee Meeting, and summarized in the minutes of these meetings. Important generalisable learning points are highlighted, but individual staff members involved in any adverse drug event, no matter how serious or well known, are not identified by name in this process.

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**N.6:     Handing over TTOs to patients on the ward.**

N.6.1     The pharmacy will only issue Manufacturer's Patient Information Leaflets (PILs) for drugs that it dispenses and not for reused PODs.

N.6.2     A nurse must produce a personalized "Medication Summary Sheet" of all the drugs to be taken at home. This list must contain the following information:

- Generic name of the drug.
- Dose and formulation. (A fuller physical description may sometimes be required).
- Quantity to be taken at each dosage.
- Time of each dosage.
- Reason for the medication.

Regular medications, "as required" medications and medications by syringe driver are placed in separate sections of the list. Tablets and capsules must not be stuck to the Medication Summary Sheet. Other important information (e.g. home care package details, follow up arrangements at the hospice and/or hospital and pending investigations) can be added at the bottom of the sheet. A computer template is available to help with the whole process (Appendix Four). Once the list has been prepared, it must be checked and signed by another nurse or a doctor.

N.6.3     When TTOs are delivered back to the ward from Pharmacy, two nurses must allocate a period of time to check the drugs and associated PILs. One nurse then carefully discusses the TTOs and the procedure for obtaining further supplies with the patient and/or relatives prior to discharge from the ward.

N.6.4     Before talking to the patient and/or relative, two nurses must check that there are no discrepancies between the TTO drugs supplied by the Pharmacy, the ward copy of the TTO order, the patient's drug administration chart and the personalized "Medication Summary Sheet". Any discrepancies must be discussed with the doctor who ordered the TTOs and/or the Pharmacist/Technician who checked the TTOs in Pharmacy (or another Pharmacist if the latter is not available).

N.6.5     When satisfied that there are no errors or ambiguities in the TTO medication or accompanying documentation for the patient, the responsible nurse carefully discusses the TTOs with the patient and/or relatives. Any questions or concerns raised by the patient must be addressed. As far as possible, the nurse must be protected from distractions during this process.

N.6.6     The patient should be advised not to leave until after this discussion has taken place.

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**N.7:     Medication compliance aids.****N.7.1     Introduction**

- N.7.1.1 A Monitored Dosage System (MDS) is any medication storage system that holds more than one drug in a way that is intended to help patients take their authorized medicines at the correct dosages and correct times. Several such systems are available, including the “Dosette”, “Medidos” and “Nomad” systems.
- N.7.1.2 The patient might use the MDS to self-administer medication, with or without verbal prompts from an informal or professional carer. Alternatively a friend or relative might use the MDS to help them administer medication to a patient. Under no circumstances can a professional carer use any MDS to administer drugs to a patient, and they must only provide verbal prompts to a patient regarding the use of a MDS if it is both of a tamperproof variety *and* it was put together in a pharmacy or doctor’s dispensary.
- N.7.1.3 The demand for MDS’s in the community is increasing. They are typically made up by those pharmacies or dispensing doctors who are prepared to issue them on an ongoing basis. They are time-consuming to make up and there is no remuneration for this extra work. Therefore, some pharmacies and dispensing GPs are not prepared to issue them at all, and others feel unable to increase their existing caseload of patients using a MDS.
- N.7.1.4 A small number of people fill up MDS systems for members of their own family and, in some instances, patients fill them up themselves. This is acceptable so long as the person concerned is able to fill up the MDS safely and so long as a professional carer is not expected to help the patient take their medicines.
- N.7.1.5 Horton Hospital pharmacy can issue a tamper-proof 7-day MDS to patients discharged from the hospice.

**N.7.2     Patients who are already using a medication compliance aid**

- N.7.2.1 Some patients admitted to the hospice will already be using a MDS, and this device might contain all of the medication that they possess.
- If such a patient is going to self-administer their medication during the inpatient stay then this presents no problems so long as all labeling and documentation complies with the requirements of the “Patient Self Administration of Drugs Policy and Procedure” and the staff are satisfied that the MDS contains what it is meant to.
  - If the patient is not going to self-administer their medication during the inpatient stay and all of the medicines in the MDS are stock items, then there is no need to use any item from the MDS during the inpatient admission.
  - If the patient is not going to self-administer their medication during the inpatient stay but some of the medicines within the MDS are not stock items, then the necessary stock items must be ordered from the hospital pharmacy for delivery or collection at the earliest opportunity. In the meantime, the relevant medicine can be extracted from the MDS and administered to the patient if the admitting doctor can identify it with certainty.

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N.7.2.2 Extra preparation is required to successfully provide a patient with their discharge medication in a MDS.

At the time of admission

- Ascertain how the MDS is used and review the safety and appropriateness of this.
- Indicate the type of MDS being used on the front of the drug administration chart.
- Indicate who fills and maintains this system in the clinical notes.

Towards the end of the admission, if the patient is returning home

- Alert the GP and, if there is one, the community pharmacist to the hospice discharge date; any medication changes made during the hospice admission; and the date on which a new MDS needs to be issued to the patient.

When writing the TTO

- Get the written TTO to the pharmacy at least 24 hours prior to the discharge date in order to give them time to deal with the request. These TTOs will need to be clinically screened by the pharmacist in the standard manner. Urgent faxed TTOs for medication in MDS *will not be accepted* by the pharmacy. The hospital pharmacy will only provide a disposable tamperproof MDS, regardless of the type of MDS that the patient was using prior to the admission. The patient's own MDS is returned empty to the patient at the end of the admission, to be used again when the disposable tamperproof MDS from the hospital pharmacy has been used up.

Dispensing the disposable 7-day MDS from the hospital pharmacy

- Even when the dispensing GP/community pharmacy has agreed to refill the patient's normal MDS within a week, it avoids unnecessary stress for the patient and family if the disposable MDS dispensed from the hospital pharmacy contains a full 7-day supply.

N.7.2.3 If a patient who formerly had a MDS is being discharged to a hospital or Nursing Home then a MDS is not required at the time of discharge. However, it would still be appropriate to discharge medication in a MDS if the patient is being discharged to sheltered accommodation or a Residential Home.

N.7.3 Patients who might benefit from a MDS

N.7.3.1 If patients are identified who might benefit from the introduction of a MDS upon discharge from the hospice, the first step is to find out if their community pharmacy or dispensing doctor is able and prepared to provide this service for the patient after their discharge. Such input is essential if a professional carer is expected to provide verbal prompts regarding the MDS. If verbal prompts from a professional carer are not required then it might be acceptable for a friend, relative or even the patient themselves to fill a MDS for the patient. All plans regarding the introduction of new MDS's for patients must be discussed with the pharmacist ahead of the hospice discharge.

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**N.8: Patients unable to swallow solid dosage forms.**

- N.8.1 Any nurse who identifies a patient having difficulty swallowing solid formulations of medication must discuss this with a doctor or pharmacist so that appropriate amendments can be made to the medication regimen. In many cases, a liquid equivalent to a tablet or capsule can be administered orally (see Section K.4). Alternatively, another route of administration (e.g. a suppository, patch, injection or subcutaneous infusion) might be more appropriate.
- N.8.2 It is sometimes considered necessary to mix the contents of a capsule or the powder from a crushed tablet with a suitable vehicle to facilitate oral administration. This apparently straightforward approach can be very hazardous in certain situations (e.g. some tablets have special coatings that influence their rate of delivery or protect the stomach from damage). It also takes the product outside of its licence. Therefore such practice is only allowed when a doctor or Pharmacist has endorsed it by writing a suitable instruction in the comments section of the drug instruction box.
- N.8.3 The Handbook for Drug Administration via Enteral Feeding Tubes by R. White and V Bradman is a useful resource regarding the best ways of changing the formulation of a medication for easier ingestion. A reference copy is kept in the inpatient office.

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N.9: Adverse Reactions.

- N.9.1 An adverse reaction is a significant unwanted clinical reaction by the patient to a correctly administered drug. It is not the same as a drug error (See Section N.5 for further information on Drug Errors).
- N.9.2 If the adverse reaction is an anaphylactic reaction or other clinical emergency, then the procedures in Section U must be followed.
- N.9.3 Lesser adverse reactions must be reported immediately to the medical team who will review as appropriate and advise on the subsequent management.
- N.9.4 In general, it is clearly inappropriate for a patient to receive a further dose of a drug that produces adverse reactions. The only exception to this might be when a well-informed patient clearly requests further treatment with the same drug at a future point. Such a situation may arise if the patient believes that the potential benefits of treatment outweigh the evident harms, as in the case of certain chemotherapy regimens.
- N.9.5 It is good practice for a doctor to complete a yellow card for every reported adverse drug reaction.

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## P: Enteral tubes.

- P.1 Enteral tubes are typically inserted via the nasopharynx or percutaneously and their tips are located in the stomach, duodenum or jejunum:
- P.2 Enteral tubes are medical devices. No item, even water or air, must be passed through an enteral tube without it having been written up as a drug instruction.
- P.3 Please refer to the separate enteral tube policy and procedures.

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## Q: Syringe drivers for the administration of drugs by subcutaneous infusion.

- Q.1 Drugs are frequently administered by continuous subcutaneous infusion in hospice care, and combinations of multiple drugs may be used in a single syringe.
- Q.2 The doctor is responsible for:
- Issuing the instructions for the drug(s) that are to be administered over a 12-hour or 24-hour period, using the syringe driver instruction page on the Katharine House Hospice drug administration chart.
  - Ensuring that any mixture of drugs to be co-administered is compatible in a single infusion.
  - Specifying the nature of the diluent to be used, typically water or saline.
- Q.3 The Nurse is responsible for checking at 4 hour intervals (or more frequently if indicated):
- The infusion site.
  - The infusion liquid and giving set.
  - The rate and function of the syringe driver pump and battery.
- Q.4 Any qualified nurse may set up a syringe driver after their competency has been assessed in the Hospice Orientation Programme.
- Q.5 The setting up and running of Syringe Drivers must be in accordance with the “Guidelines for setting up a Syringe Driver”.
- Q.6 As it is important to protect syringe drivers from water, they must be disconnected from patients who are taking a shower or bath and reconnected immediately afterwards. Only qualified nurses and doctors are allowed to disconnect or reconnect syringe drivers.
- Q.7 It is common practice to mix medications in syringe drivers. In July 2009, the Medicines and Healthcare Products Regulatory Agency (MHRA) announced that the law was to be amended before the end of the year in the following ways:
- To allow Doctors and dentists (who can already mix medicines themselves) to direct others to mix (other than a pharmacist under existing legislative provisions, or by a person holding a manufacturer’s licence)
  - To allow Non-medical prescribers to mix medicines themselves and direct others to mix (other than a pharmacist under existing legislative provisions, or by a person holding a manufacturer’s licence)
  - To allow Nurse and Pharmacist Independent Prescribers to prescribe unlicensed medicines for their patients on the same basis as doctors and supplementary prescribers.

Until such time as the law changes, the MHRA has stated that it would not consider taking enforcement action against those prescribing and administering mixtures of licensed medicines in palliative care unless it was in the public interest to do so.

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## R: Intravenous administration of drugs and fluids.

### R.1: Indications for intravenous therapy.

R.1.1 The preferred routes of administration of medicinal products at Katharine House Hospice are the oral, transdermal, rectal, subcutaneous and inhaled routes. A small number of products must be given by intramuscular injection. Nonetheless, it is sometimes considered necessary to administer medicinal products intravenously rather than by any other route.

R.1.2 Indications for intravenous therapy might include:

1. Bolus injections of fast acting medicines.  
For example, in the context of massive haemorrhage in a terminally ill patient, intravenous midazolam can act as a fast-acting sedative and amnesic.
2. Intravenous antibiotics.  
As a general rule, if a patient is sufficiently unwell to require intravenous antibiotic therapy, their care might be better provided in the acute hospital setting.
3. Transfusions of blood products.
4. Infusions of non-blood products.  
Examples include intravenous fluid therapy (for which we have careful selection criteria) and intravenous bisphosphonate therapy.

With regard to intravenous fluid therapy and artificial nutrition we follow the guidelines of the Association of Palliative Medicine, which highlight the general inappropriateness of such measures.

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**R.2: Methods of intravenous administration.**

R.2.1 There are several methods of intravenous administration:

1. Hypodermic needle. This might be appropriate for one-off bolus doses of intravenous medicinal products that do not need to be titrated against the immediate clinical response. The needle is removed immediately after the dose has been given.
2. Butterfly needle. This is appropriate for one-off doses of medicinal product, particularly when:
  - a. the dose has to be titrated against the immediate clinical response (e.g. midazolam).
  - b. the dose has to be administered gradually over a small number of minutes (e.g. ranitidine).
  - c. more than one syringe of intravenous therapy needs to be administered at the same time. In this instance, it is sometimes necessary to flush the butterfly needle between the administration of each separate drug.The butterfly needle is removed immediately after the administration procedure has been completed.
3. Intravenous cannula. This is appropriate when:
  - a. it is known that a series of several bolus injections over a period of a small number of days is required (e.g. course of intravenous antibiotics)
  - b. each administration takes several minutes or hours to administer (e.g. pamidronate infusion).
  - c. the administration takes several hours to perform and requires more than one item for administration (e.g. a multiple-unit blood transfusion)
  - d. the rate of administration has to be finely controlled using a mechanical pump.
4. Peripherally inserted central catheters (PICC line). (See below)
5. Central venous line, which might have an open or a buried port, and might have more than one lumen. There are no clinical scenarios where the insertion of a PICC line or a central venous line is imperative for the provision of specialist palliative care in the hospice setting. However, a small number of hospice patients might have had such devices inserted in other clinical settings, and it might prove helpful to make use of them when they are present. The permission of the oncology or other specialist hospital team and the patient are always required before such a line is used at the hospice. If such devices are to be used in the hospice setting, it is imperative that the handling instructions of the oncology or specialist hospital team are strictly followed. Even if they aren't used for therapeutic purposes, we may be asked to flush them periodically to ensure that the lines remain patent.

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**R.3:     Insertion of equipment for intravenous administration.**

- R.3.1     At Katharine House Hospice, only doctors can administer one-off boluses of intravenous drugs. Therefore the administering doctor is responsible for inserting the hypodermic needle or butterfly needle.
- R.3.2     The frequency of need for intravenous cannulae is so low at the hospice that only a small number of staff will be able to maintain competency in their insertion. All intravenous cannulae are therefore inserted by doctors.
- R.3.3     PICC lines and central venous lines are inserted by appropriately trained staff in the hospital setting. They are never inserted in the hospice, although a small number of hospice patients will have such devices.
- R.3.4     To avoid the risk of contamination with the patient's blood, the person inserting the intravenous equipment must wear gloves.
- R.3.5     An appropriate vein must be chosen. The veins at flexures such as the wrist and elbow are often the most visible ones and these are convenient for the insertion of a hypodermic needle or a butterfly needle. However, in order to improve their longevity, it is preferable to insert intravenous cannulae away from joints, and the veins of the middle forearm or the anterior aspect of the upper arm are preferable. The ipsilateral arm of a patient who has or has had cancer of the breast or lymphoedema of an upper limb must not be used unless it is absolutely essential to do so. Intravenous chemotherapy can damage the veins into which it is administered, rendering them very hard to cannulate even when they still look very prominent. In some instances it can be helpful to induce venodilation in the forearm by immersing it in warm water for a few minutes.
- R.3.6     A proper tourniquet must always be used when cannulating a patient. Disposable gloves, straps for catheter leg bags or other ad hoc devices are unacceptable alternatives.
- R.3.7     The skin over the proposed venepuncture site must be cleaned with an alcohol swab before the procedure is performed using an aseptic technique. When cannulating, a pink (20-gauge) Venflon is typically used for non-blood products and a green (18 gauge) Venflon for blood products. Whilst larger-bore cannulae are sometimes used in drainage procedures such as pleural aspiration, there is no role for them in the intravenous therapies of hospice patients.
- R.3.8     Butterfly needles must be secured with tape, and intravenous cannulae must be secured with a proprietary dressing (e.g. "Veca-C" dressings are used to secure "Venflons").
- R.3.9     To avoid blockage with clot, to ensure their patency; and to confirm their correct positioning, intravenous cannulae must be flushed with 5ml saline or water for injection immediately after insertion and before each therapeutic use. They must also be flushed after each therapeutic use if they are not removed.

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**R.4: Care of equipment that has been inserted for intravenous administration.**

- R.4.1 In addition to securing intravenous cannulae as described above, it can be helpful to secure a sterile dressing over the cannula and to secure the intravenous line to the forearm with bandages. This latter action can prevent the whole apparatus from being inadvertently pulled out. The cannulation site must be inspected at least twice a day (and before each use) for signs of pain, infection or phlebitis. There is no upper limit to the length of time an intravenous cannula can be used so long as it remains correctly positioned, patent, clean and has no associated pain, infection or phlebitis.
- R.4.2 Cellulitis around the cannulation site is typically the result of direct contamination of the puncture site by microorganisms on the skin rather than relating to cannula port hygiene. The same appears to hold true for systemic infections. Swabbing the cannula port with 70% alcohol before use simply reduces the risk of port contamination by about 40% but does not influence rates of cellulitis or systemic infection. Therefore swabbing is not essential practice. If a cannulated patient develops cellulitis at the cannulation point or develops a septicæmia, then the cannula must be removed immediately, and the tip possibly sent to microbiology. If clinically indicated, another cannula can be inserted at another site.

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**R.5: Giving sets for the administration of products through intravenous cannulae.**

- R.5.1 Each giving set is for single patient use only. Different giving sets are used for non-blood products and for blood products. Giving sets are always attached to the end port of an intravenous cannula.
- R.5.2 Multiple bags of fluids can be infused back-to-back, but the non-blood giving set must be taken down if there is no active infusion taking place. If further infusion therapy is needed at a later date, then a new non-blood giving set must be used. No fluid for intravenous infusion must be kept up for more than 24 hours.
- R.5.3 Multiple units of blood product can be transfused back-to-back through the same blood giving set, but the set must be new at the time of giving the first unit and it must be taken down when the transfusion is complete. Blood transfusions should be started as early in the morning as possible, but is acceptable for them to continue running into the night when several units are being given. This is considered preferable to suspending the transfusion overnight and giving a bag of fluid to keep the line open.
- R.5.4 Bolus injections of medication or intravenous flush must be administered through the side port of the cannula, which is kept clean by being capped off when not in use. Whilst only doctors can administer intravenous drugs, appropriately trained nurses can administer flushes via an intravenous cannula.

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**R.6:     The preparation of products to be administered intravenously.**

- R.6.1     There must be a suitable drug instruction for all products for intravenous administration. The instruction must clearly state the type of fluid, any additives to the fluid, its total volume and the rate of administration.
- R.6.2     Intravenous therapies that need mixing up must be made up by a doctor in the presence of a nurse, or by two nurses, and labeled appropriately before administration. Two members of the clinical staff must check all the products used in any intravenous administration. Only products that are clearly labeled, in visibly good condition, and within their expiry date must be used. Medication must only be added to bags of fluid through their re-sealable entry points. Bags of fluid that are punctured at any other point must not be used for intravenous administration. Whenever medication is added to a bag of fluid, an adhesive label must be applied to the bag indicating:
- The name of the patient who is to receive the infusion.
  - The drug added and its dose.
  - The instructions for infusion.
  - The name of the doctor preparing the infusion.
  - The time and date of preparation.
- R.6.3     Intravenous infusions should preferably be given using an infusion pump. Medical and nursing staff responsible for intravenous infusions must make sure that they are familiar with the operation of the hospice's infusion pumps.
- R.6.5     The qualified nurse is responsible for determining the correct rate for administration and for maintaining it throughout the infusion.
- R.6.6     Before commencing or replacing any intravenous infusion, ensure that:
- The intravenous cannula is patent.
  - There is no visible abnormality such as inflammation or extravasation at the site of injection and no complaints of local irritation or pain from the patient.
  - The intravenous containers show no obvious faults, contamination or discolouration and are 'in date'.
  - The infusion is administered in accordance with the doctor's written instructions and any Pharmacist endorsements on the drug administration chart.
  - The infusion pump is correctly set and appears to be functioning correctly.
- The first infusion through an intravenous cannula must be put up by a doctor, but only in the presence of a nurse. Subsequent infusions through the same cannula must be put up in the presence of two clinical staff, neither of which need be a doctor. If there are any concerns at the time of putting up an infusion, then the procedure must be aborted and the concern reported to a more senior nurse or a doctor.

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- R.6.7      Qualified nurses who have undertaken the necessary intravenous therapy training and who have demonstrated their competence to the Senior Nurse may flush intravenous cannulae with normal saline if it has been written up on the drug administration chart. (See also the Guidelines for the Management of Intravenous Therapy and the IV Therapy Training Guidelines in the Clinical Guidelines Folder).

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R.7: Documentation regarding intravenous cannulae.

- R.7.1 The insertion of all intravenous cannulae must be documented in the clinical notes with a dated and timed entry that also indicates who inserted the device. Any changes to the giving set, dressing changes or significant observations about the cannulation site must also be documented in the clinical notes. The date of removal of the cannula must also be documented, along with the name of the person removing it. Documentation of the items administered via the cannula must be documented on the patient's drug administration chart.

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## S: Oxygen and other medical gases.

- S.1 No piped medical gases are used in the hospice.
- S.2 The only gases to be administered to patients are stored in cylinders.
- S.3 Oxygen and all other medical gases are drugs and can only be administered to a patient if a relevant instruction is found on the patient's drug administration chart.
- S.4 Please refer to the Oxygen Policy and Procedure in the Clinical Policies Folder for other information regarding oxygen.

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## T: Epidural analgesia and regional anaesthetic blocks.

- T.1 Local anaesthetic agents, opioids and other drugs are sometimes given by continuous infusion through a catheter into the epidural space or alongside a major nerve for analgesic purposes. The insertion of such catheters must only be performed on a hospice patient by an anaesthetist at the request of the medical staff. The anaesthetist also initiates the epidural infusion and discusses ongoing management plans with the medical staff of the hospice. It is sometimes necessary to temporarily transfer the patient to a hospital setting for the placement of such a catheter and the initiation of therapy.  
Epidural catheters are normally connected through a bacterial filter to an extension tube that is secured to the patient's back. An infusion pump or syringe driver containing the medication is attached to the extension tube.
- T.2. The medical staff are responsible for writing the instruction for the infusion mixture, by modifying the syringe driver section of the inpatient drug administration chart. This must specify the drugs used, their individual volumes, and the rate of administration. At the top of the page, it must clearly state that the drug instruction is for epidural use. If a patient is on an epidural infusion *and* a syringe driver, then a separate drug administration chart must be used for both instructions.
- T.3 The infusion mixture may be prepared by either:
- A doctor.
  - A qualified nurse who has undergone the appropriate training and has demonstrated her/his competence to the Senior Nurse.
- It must be checked by a second person who should be either:
- A qualified nurse.
  - A doctor.
- T.4 The infusion mixture must be prepared in the treatment room using an aseptic technique in either a large syringe if a syringe driver is to be used or a small infusion bag if an infusion pump is to be used. This must be labeled with:
- The details of the drugs used and their volumes.
  - The patient's name.
  - The date and time of preparation.
  - The signature of the person preparing the infusion.
  - The signature of the person checking the preparation.
- T.5. The infusion mixture must be taken to the patient's bedside and the patient's identity again checked against the drug instruction on the drug administration chart and the label on the syringe. The previous syringe or infusion bag may then be removed from the administration line and the new one attached and installed in the syringe driver or infusion pump.
- T.6. The rate of infusion must be checked against the drug instruction on the drug administration chart by both nurses/doctors. It is the responsibility of staff to ensure that they are familiar with the use of any syringe drivers or pumps that they use or check.

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- T.7 The progress of Epidural Infusions must be recorded at least 4 hourly on the Epidural Infusion Monitoring Sheet.
- T.8. If there are concerns about the proper functioning of epidural analgesia equipment or if there is unexpected return of the patient's pain, these must be brought to the attention of the medical staff without delay.

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## U: The treatment of anaphylaxis and other medical emergencies

### U.1: Anaphylaxis

- U.1.1 An anaphylactic reaction is an exaggerated immunological response to a substance that an individual has become sensitised to, in which inflammatory cells (such as histamine and serotonin) are released from basophils and mast cells. Anaphylactoid reactions are clinically indistinguishable from anaphylaxis but they have a non-immunological basis, the reaction being directly mediated by the drug or substance in question. Any drug can potentially cause an anaphylactoid reaction. For the purposes of this policy, “anaphylaxis” and “anaphylactoid reactions” will be referred to collectively as “anaphylaxis”.
- U.1.2 The presentation of anaphylaxis can be variable. For example, it can occur:
- After single exposure to the agent concerned or it may require a history of repeated exposure before it manifests for the first time.
  - Immediately on exposure to the causative agent or after a delay of up to several hours. In some cases it demonstrates a biphasic pattern, apparently improving and then returning again.
  - In mild and severe forms.
- U.1.3 Mild cases may involve little more than some urticaria (skin redness and swelling) and a slight fall in blood pressure.
- U.1.4 In more severe cases, symptoms and signs may include:
- **Facial and cutaneous:** Flushing, erythema, urticaria, angioedema, rhinitis, conjunctivitis.
  - **Cardiovascular:** Hypotension, tachycardia, cardiac arrhythmias, cardiac arrest.
  - **Respiratory:** Oedema of the oropharynx and hypopharynx (causing stridor and airway obstruction) and bronchospasm (causing a tight chest, breathlessness and wheeze).
  - **Gastrointestinal:** Abdominal pain, vomiting, diarrhoea.
  - **Haematological:** Clotting problems.
  - **Psychological:** Sense of impending doom.
- U.1.5 It is important to distinguish between anaphylaxis, vasovagal reactions and panic attacks as the medications used in the management of anaphylaxis could make a vasovagal or panic attack much more serious. The following italicised features may help to distinguish between the three conditions, although *they are not failsafe discriminators and you are advised to urgently seek medical advice if you are in doubt:*

	<b>Anaphylaxis</b>	<b>Vasovagal reaction</b>	<b>Panic attack</b>
Blood pressure	Low	Low	<i>Normal/high</i>
Skin changes	<i>Rash and swelling</i>	No rash or swelling	Possible rash, no swelling
Panic	Yes	Yes	Yes
Breathing problems	<i>Stridor/Wheeze</i>	No	<i>Hyperventilation</i>
Pulse	Fast	<i>Slow</i>	Fast
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- U.1.6 Management of anaphylaxis must be individualised to the patient and to the severity of the reaction. It can include any of the following, preferably adopted in the sequence below:
- 1) Confidently diagnose anaphylaxis.
  - 2) Prevent further exposure to the likely incriminated substance.
  - 3) Maintain a clear airway.
  - 4) Nurse in the head-down position.
  - 5) Administer 100% oxygen at a rate of 10-15 litres per minute
  - 6) *Intramuscular* administration of 0.5mg adrenaline (0.5mL of a 1: 1000 solution) if there are definite clinical signs of shock or breathing difficulties.
    - This dose can be repeated after 5 minutes if necessary.
    - Adrenaline works best when given early after the onset of the reaction.
    - It is advised that *patients who are taking beta-blockers, tricyclic antidepressants or monoamine oxidase inhibitors should receive only 50% of the usual dose of adrenaline* to reduce the risk of potentially dangerous drug interactions.
  - 7) Nebulised salbutamol 5mg for refractory bronchospasm.
  - 8) Intravenous saline to expand circulating blood volume.
  - 9) *Intramuscular* antihistamine (e.g. chlorphenamine 10mg) to help counter histamine-mediated vasodilatation
  - 10) *Intramuscular* corticosteroid (e.g. dexamethasone 8mg), although it must be remembered that it takes several hours for this to have any clinical impact.
  - 11) Emergency transfer by ambulance to the local casualty unit.
- U.1.7 There is a pink pencil case in the injectable medicines cabinet that is clearly labelled "anaphylactic shock". This contains:
- One prefilled 1ml syringe of 1:1000 adrenaline.
  - One nebuliser of salbutamol 5mg.
  - One ampoule of chlorphenamine 10mg.
  - Two ampoules of dexamethasone 4mg.
  - Two syringes, four needles, three sterets and a sterile pack of cotton wool swabs.
  - A copy of Section U (Anaphylaxis) of the hospice Drug Policy.
- U.1.8 In cases of severe anaphylaxis when immediate treatment is required to save life, making contact with a doctor could represent an avoidable and potentially fatal delay in responding to the situation. In such circumstances, it is acceptable for the nurse to position the patient appropriately, administer intramuscular adrenaline and give oxygen before contacting a doctor if s/he is confident of the diagnosis and the procedure for treating anaphylaxis (including the method of administration of any appropriate drugs).
- U.1.9 *Intramuscular injections into the thigh* must be used in the management of anaphylaxis because:
- Adrenaline and chlorphenamine can cause very serious complications if given by the intravenous route.
  - Peak plasma levels are reached faster from injections into the thigh than injections into the upper arm.

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U.1.10 After successful management of anaphylaxis, any patients who are not urgently transferred to the local casualty department must be monitored closely for the following 8-24 hours to ensure there is no recurrence. This is particularly important for patients who fit into any of the following groups:

- Those who had severe reactions with a slow onset.
- Those with a severe asthmatic component to their anaphylaxis or with a strong history of severe asthma in the past.
- Those who may be at continued risk of exposure to the causative agent.
- Those with a previous history of biphasic reactions.

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U.2: Other medical emergencies in palliative care

U.2.1 Other acute medical emergencies include:

- Acute severe haemorrhage.
- Acute severe dyspnoea.

U.2.2 Whilst such acute medical emergencies are infrequent in the unit, they often prove to be terminal events when they do arise. The most important part of the management of such situations is the prompt administration of subcutaneous midazolam at an anxiolytic and potentially sedating or amnesic dose. All inpatients are written up for PRN midazolam as a matter of routine. If a patient is considered to be at particularly high risk of such an emergency then this drug can be stored at the patient's bedside in accordance with Section B.3.3 of this policy.

U.2.3 There is a separate policy for cardiopulmonary resuscitation

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U.3: Medical emergencies in staff and visitors

- U.3.1 If a member of staff or visitor to the hospice suffers an acute medical emergency in the unit, then the default position is to administer appropriate resuscitative and first aid measures until an emergency ambulance arrives.

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## V: Administration of drugs to patients in the Day Hospice and outpatient setting.

- V.1 Patients attending the Day Hospice or outpatient services are technically living at home and remain under the medical care of their general practitioner during their visit to the hospice. Their drugs will generally have been prescribed for them by their general practitioner and dispensed by a local pharmacist. They should therefore bring any necessary drugs with them to Day Hospice and should normally be responsible themselves for taking their own drugs, including oxygen.
- V.2 This may raise problems of security. The nursing staff in the Day Hospice must be aware of the possible problems.
- V.3 In emergencies or for immediate symptom management, drug instructions may need to be written by hospice medical staff on a hospice drug administration chart, and given by nursing staff under the same rules as for in-patients.
- V.4 If a patient requires help from any member of staff in the administration of any drug whilst in the Day Hospice, then that member of staff must be absolutely sure that the item that they are helping to administer is actually the item that the patient intended to take and that it is being used for an appropriate indication. If the item being administered is from the patient's own supply then this activity must be recorded in the clinical records. If a patient requires a drug item from hospice stock then this requires a drug instruction, written by a hospice doctor on a drug administration chart, before administration.
- V.5 Infusion and transfusion therapy is sometimes undertaken in the Day Hospice. This is acceptable practice. All such treatment requires a suitable drug instruction, written by a hospice doctor on a drug administration chart, and all the necessary policies and procedures must be observed.

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## W: Requests for advice on the use of medication or symptom management.

- W.1 Please refer to the “Procedure for Access to Specialist Advice & Support, including out-of-hours access”
- W.2 Requests are sometimes made by General Practitioners, District Nurses, other hospices or even outpatients and their families to borrow drugs in an emergency. Katharine House Hospice is not in a position to help in these circumstances. People making such requests must be advised that it is illegal for us to lend drugs in this way. Professional colleagues should be directed towards the Community Pharmacy or the Hospital Pharmacist on-call. Patients and their families should be advised to contact their GP or out-of-hours Primary Care Service Provider.

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## Appendices

1. List of National Minimum Standards for Independent Health Care that relate to drugs and the Drugs Policy.
2. List of drugs considered cytotoxic or cytostatic that cannot be destroyed with other non-Controlled Drugs.
3. Inpatient drug administration chart.
4. An example of a personalized “Medication Summary Sheet”.
5. A list of off-licence medication uses that can be considered part of the established practice at Katharine House.
6. Drug Error Reporting Form.

**APPENDIX ONE: LIST OF NATIONAL MINIMUM STANDARDS FOR INDEPENDENT HEALTH CARE  
THAT RELATE TO DRUGS AND THE DRUGS POLICY.**

<b>STANDARD:</b>	<b>C22, Medicines Management</b>	
<b>OUTCOME:</b>	Measures are in place to ensure the safe management and secure handling of medicines.	Coverage in the Drug Policy
C22.1	Medicines are handled according to the requirements of the Medicines Act 1968 and the Misuse of Drugs Act 1971; and with nursing staff following the UKCC <i>Guidelines for the Administration of Medicines</i> (October 2000) and pharmacists their professional Code of Ethics.	Preface, A.1, A.2
C22.2	There is a written medicines policy and procedure, accessible to staff, covering all aspects of medicines systems and medical gases in the establishment/agency, which covers: <ul style="list-style-type: none"> <li>• ordering, procurement, receipt, storage, administration and disposal of medicines;</li> <li>• the action to be taken in case of adverse reactions;</li> <li>• error reporting, to encourage an open reporting system and a non-blame culture.</li> </ul>	Self-administration policy, Oxygen policy, B, C, D, E, F, G, J, N, Q, S N.9, U N.5
C22.3	The medicines required for resuscitation or other medical emergency are accessible and in suitable packaging.	U.1.7
C22.4	All medicine is administered to a patient with a written prescription or, internal to the hospital, a drug administration chart that has been signed by an authorised prescriber.	N.1.3
C22.5	There is a written policy for the steps to be followed in the exceptional circumstances where a medicine is administered without a written direction, for example, a lifethreatening situation.	U
C22.6	All medicine doses are prepared immediately prior to their administration to patients from the container in which they are dispensed.	N.2
C22.7	Medicines prescribed and labelled received against a prescription for a named patient are not used for any other patient.	N.4.2
C22.8	Information is given to patients about the use, benefits and potential harms of medication prescribed.	K.1.9, N.6.1, N.6.2
C22.9	The establishment has access to up-to-date, relevant reference sources, for example the British National Formulary, the Summary of Product Characteristics for every product used and access to evaluated information about medicines.	A.3.2
C22.10	Medicines are used as specified in the Summary of Product Characteristics, unless there is a body of evaluated evidence to support any use outside this licence, in which case patients are informed that the medicine is used outside the Summary of Product Characteristics.	L
C22.11	When clinical trials take place they are undertaken in accordance with relevant legislation and best practice guidelines and with local research ethics committee approval.	K.1.10 plus separate policy
C22.12	When patient group directions are used they comply with Department of Health/Medicines Control Agency guidance.	N/A

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<b>STANDARD:</b>	<b>C23, Ordering and storage of medicines</b>	<b>Coverage in the Drug Policy</b>
<b>OUTCOME:</b>	<b>Medicines, dressings and medical gases are handled in a safe and secure manner.</b>	
C23.1	A record is kept of ordering, receipt, supply, administration and disposal of all medicines dressings and medical gases in order to maintain an audit trail.	B.4, C.5
C23.2	Lockable storage is provided for: <ul style="list-style-type: none"> <li>• controlled drugs in accordance with the Misuse of Drugs (Safe Custody) Regulations 1973;</li> <li>• medicines for external use;</li> <li>• medicines for internal use;</li> <li>• medicines requiring cold storage;</li> <li>• diagnostic reagents (other than test strips);</li> <li>• flammable substances.</li> </ul>	B.1.2 B.1.2 B.1.2 B.1.2 B.1.7 B.1.8 plus oxygen policy
C23.3	The storage of medical gases should be in accordance with guidance set out in Health Equipment Information No 163,2/87.	B.1.8, S, plus oxygen policy
C23.4	The keys of all cupboards used for the storage of medicines are held securely, including spare keys.	B.2
C23.5	Medicines requiring cold storage are not kept in refrigerators used for domestic purposes but in a separate, designated refrigerator.	B.1.2
C23.6	There is daily monitoring of the temperature of the refrigerator, using a maximum/minimum thermometer, which is recorded and signed by the person monitoring the temperature and a written procedure is in place indicating the action to be taken if the temperature is outside the normal range.	B.1.2, B.5



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<b>STANDARD:</b>	<b>C24, Controlled Drugs</b>	Coverage in the Drug Policy
<b>OUTCOME:</b>	<b>Controlled drugs are stored, administered and destroyed appropriately.</b>	
C24.1	Controlled drugs are handled in compliance with the requirements of the Misuse of Drugs Act and its regulations.	A.2, J.2
C24.2	A hospital that holds stocks of controlled drugs listed in Schedule 2 of the Misuse of Drugs Act has a Home Office licence (unless the hospital is wholly or mainly maintained by voluntary funds or by a registered charity).	J.2.2 (N.B. Licence not required)
C24.3	Where a pharmacist is employed, the purchase and issue of controlled drugs must be under his or her direct supervision and includes authorising orders to suppliers.	N/A
C24.4	Where no pharmacist is employed, a medical practitioner or a dentist must countersign orders signed by the registered nurse for a controlled drug.	J.7.6
C24.5	In the case of Schedule 2 controlled drugs (except those in Schedules 4 and 5) an appropriate record is kept of the invoices, receipt, administration and disposal of the drugs in accordance with the Misuse of Drugs Regulations 1985.	B.4, J.6, J.7, J.9, J.11, J.12, J.13
C24.6	Controlled drugs are destroyed in the presence of an authorised person (that is a police officer, an inspector of the Home Office Drugs Branch or an inspector of the Royal Pharmaceutical Society of Great Britain), or the person to whom this function has been formally delegated, such as the registered manager or registered nurse of the hospital.	J.13.1.3

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<b>STANDARD:</b>	<b>H9, Ordering, Storage, Use and Disposal of Medicines</b>	Coverage in the Drug Policy
<b>OUTCOME:</b>	<b>Medicines, dressings and gases are handled in a safe and secure manner.</b>	
H9.1	All medicines, medical gases and interactive wound dressings are obtained by, and stored under the control of, the senior registered nurse, or medical director under the control of the senior nurse, or the pharmacist.	A.1.3
H9.2	The pharmacist or, where there is no pharmacist employed, the senior registered nurse or medical director, authorises any orders to obtain prescription-only medicines from wholesale suppliers.	A.1.3
H9.3	Stocks of medicines in current use on the unit or ward are the responsibility of the senior registered nurses designated for the purpose by the registered nurse manager.	A.1.3
H9.4	<p>A medication record is kept for each patient, the entries signed by the prescriber, showing:</p> <ul style="list-style-type: none"> <li>• the name and date of birth of the patient;</li> <li>• registration number and ward where appropriate;</li> <li>• the name of the medicine;</li> <li>• the dose;</li> <li>• the route of administration;</li> <li>• the frequency and time for administering each dose;</li> <li>• the date of prescribing;</li> <li>• any known medicines hypersensitivity or allergies;</li> <li>• any special requirements.</li> </ul>	<p>Appendix 3</p> <p>Appendix 3</p> <p>Appendix 3</p> <p>Appendix 3</p> <p>Appendix 3</p> <p>Appendix 3</p> <p>Appendix 3</p> <p>Appendix 3</p>
H9.5	Records are kept for eight years from the date of discharge or death of the patient.	K.10.2
H9.6	Medicines brought into the hospice by individual patients, and which are not used, are kept separate from other medicines on the ward and held in a safe place until discharge of the patient when they are returned to the patient or his/her representative. A written policy should exist for the use of patients' own medicines including criteria to assess the suitability of medicines for reuse.	B.1.2, C.6, E, self-administration policy
H9.7	The disposal of waste is carried out by an authorised contractor who is used to complying with the arrangements for pharmaceutical waste, including cytotoxic waste where appropriate.	G, J.13
H9.8	When a patient dies in the hospice the patient's medicines are kept for at least one week in case there is a need for a coroner's inquest.	E.1.7, J.4.2

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<b>STANDARD:</b>	<b>H10, Administration of Medicines</b>	Coverage in the Drug Policy
<b>OUTCOME:</b>	Appropriately trained and qualified health care professionals administer all medicines and drugs to patients.	
H10.1	Medicines are administered by a registered medical practitioner or a registered nurse in accordance with the UKCC's <i>Guidelines for the administration of medicines</i> (October 2000) or by another registered professional assessed as competent to administer those medicines.	N.1.1
H10.2	There is a secure method for transporting medicines from the medicines cupboard to the patient.	B.1.3
H10.3	When medicines are no longer required by the named patient they are returned to the pharmacy or pharmacist for disposal.	G, J.13 (Disposed of on site)

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<b>STANDARD:</b>	<b>H11, Self-administration of Medicines</b>	Coverage in the Drug Policy
<b>OUTCOME:</b>	Patients are assessed, consulted and advised before they are enabled to selfadminister medicines.	
H11.1	There is a written policy and procedure for self-medication, which conforms to the duty of care inherent in the relationship of the hospice to the patient.	E.2, Self-administration policy
H11.2	Where the risks have been assessed and it is deemed appropriate, patients are enabled to self-administer their medicines.	E.2, Self-administration policy
H11.3	Arrangements are made only with the agreement of the senior registered nurse, the patient and the medical practitioner responsible for the patient's care.	E.2, Self-administration policy
H11.4	Medicines dispensed for patients to self-administer have full directions and BNF cautionary warning where appropriate.	E.2, Self-administration policy
H11.5	Regular checks are made on the quantity of medicine given to the patient to ensure the patient is not taking higher doses of medicine than prescribed.	E.2, Self-administration policy
H11.6	The medicine is stored in a personal lockable cupboard or drawer, the keys being held by the patient.	E.2, Self-administration policy
H11.7	There is a spare key to which health care staff have access.	E.2, Self-administration policy

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<b>STANDARD:</b>	<b>H12, Storage and Supply of Medical Gases</b>	Coverage in the Drug Policy
<b>OUTCOME:</b>	<b>Medical gases are stored and supplied appropriately.</b>	
H12.1	Where piped medical gases are used there is a named Authorised Person MGPS (medical gas pipeline systems) responsible for the storage, identification, quality and purity of all gases at the terminal units, and for maintaining gas pipelines, and compliance with HTM 2022; this may be an appropriately qualified employee or through a contract with a medical gas company.	N/A
H12.2	Where the Authorised Person is not employed on site at the hospital there is a named member of staff delegated to be his representative on the site as the Quality Controller of the medical gas pipeline system; this person must have training and familiarity with medical gas systems.	N/A
H12.3	Prior to use of a new system, or resumption of use of a repaired system, the named quality controller is required to indicate that he or she is satisfied with the operation of the pipelines system and the identity and purity of the gases at terminal units alongside the signature of the Authorised Person who accepts responsibility of the correct operation of the pipeline systems.	N/A
H12.4	Any engineers (competent persons) delegated to work on the medical gas pipelines systems have training and are authorised to do so by the Authorised Person.	N/A
H12.5	All work on medical gas pipeline systems is controlled by a permit to work procedure, which includes ensuring that all paperwork with respect to work carried out on the medical gas pipeline system is copied to the Authorised Person.	N/A
H12.6	Policies and procedures are produced for recording the delivery, handling and storage of full and empty medical gas cylinders, with an indication of who is in charge of this procedure at each site.	S, oxygen policy

**APPENDIX TWO: LIST OF DRUGS CONSIDERED CYTOTOXIC OR CYTOSTATIC  
THAT CANNOT BE DESTROYED WITH OTHER NON-CONTROLLED DRUGS.**

Aldesleukin	Cytarabine	Fluorouracil	Menotropins	Ribavirin
Alemtuzumab	Ciclosporin	Fluoxymesterone	Mercaptopurine	Streptozocin
Alitretinoin	Dacarbazine	Flutamide	Methotrexate	Tacrolimus
Altretamine	Dactinomycin	Fulvestrant	Methyltestosterone	Tamoxifen
Amsacrine	Daunorubicin HCl	Ganciclovir	Mifepristone	Temozolomide
Anastrozole	Denileukin	Ganirelix acetate	Mitomycin	Teniposide
Arsenic trioxide	Dienestrol	Gemcitabine	Mitotane	Testolactone
Asparaginase	Diethylstilbestrol	Gemtuzumab	Mitoxantrone HCl	Testosterone
Azacitidine	Dinoprostone	ozogamicin	Mycophenolate mofetil	Thalidomide
Azathioprine	Docetaxel	Choriogonadotropin alfa	Nafarelin	Tioguanine
Bacillus Calmette-Guerin	Doxorubicin	Goserelin	Nilutamide	Thiotepa
Vaccine	Dutasteride	Hydroxycarbamide	Oxaliplatin	Topotecan
Bexarotene	Epirubicin	Ibritumomab tiuxetan	Oxytocin	Toremifene citrate
Bicalutamide	Ergometrine/methylergo	Idarubicin	Paclitaxel	Tositumomab
Bleomycin	metrine	Ifosfamide	Pegaspargase	Tretinoin
Busulfan	Estradiol	Imatinib mesilate	Pentamidine isethionate	Trifluridine
Capecitabine	Estramustine phosphate	Interferon alfa-2a	Pentostatin	Trimetrexate glucuronate
Carboplatin	sodium	Interferon alfa-2b	Perphosphamide	Triptorelin
Carmustine	Estrogen-progestin	Interferon alfa-n1	Pipobroman	Uramustine
Cetrorelix acetate	combinations	Interferon alfa-n3	Piritrexim isethionate	Valganciclovir
Chlorambucil	Estrogens, conjugated	Irinotecan HCl	Plicamycin	Valrubicin
Chloramphenicol	Estrogens, esterified	Leflunomide	Podofilox	Vidarabine
Choriogonadotropin alfa	Estrone	Letrozole	Podophyllum resin	Vinblastine sulfate
Cidofovir	Etoposide	Leuprorelin acetate	Prednimustine	Vincristine sulfate
Cisplatin	Exemestane	Lomustine	Procarbazine	Vindesine
Cladribine	Finasteride	Chlormethine	Progesterone	Vinorelbine tartrate
Colchicine	Floxuridine	hydrochloride	Progestins	Zidovudine
Cyclophosphamide	Fludarabine	Megestrol	Raloxifene	
		Melphalan	Raltitrexed	

This list is taken from “The Hazardous Waste (England And Wales) Regulations 2005 Interim Guidance for the NHS Hospital Sector for England and Wales and Information for Scotland” (Royal Pharmaceutical Company of Great Britain).  
<http://www.rpsgb.org.uk/pdfs/hazwastehospphguid.pdf>

Drug Administration Chart	Patient Name
	D.O.B. Hospice No
	Drug hypersensitivities, allergies & special requirements

Asilone 10ml PRN PO	Chlorhexidine Mouthwash 0.2% 10mls QDS
Lactulose 10-20ml BD PO	Effervescent Vitamin C Tablets ¼ tablet on tongue QDS
Senna 7.5-15mg OD PO	Simple Linctus 10ml PRN PO
Glycerin Suppository 1 OD PR	Nebulized Saline 5ml 4-hrly PRN
Bisacodyl Suppository 10mg OD PR	Clotrimazole 1% Cream topically BD
Arachis Oil Enema 1 OD PR	Aqueous Cream with/without Menthol topically PRN
Fleet Phosphate Enema 1 OD PR	50:50 White Soft Paraffin: Liquid Paraffin topically PRN
Anusol Ointment PRN PR	Normal saline bladder washout 50-100ml BD via catheter
	Instillagel topically OD

Date:

[illegible][illegible]



### APPENDIX THREE: INPATIENT DRUG CHART.

[illegible]

**APPENDIX THREE: INPATIENT DRUG CHART.**

<b>REGULAR MEDICATION</b>				*	Dosage change	U	Unavailable
				X	Do not give	R	Refused by patient
				N	Not given	S	Patient unable to swallow
Month and year in which this page was started:				Day:			
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				
Drug and Dose				01 <sup>00</sup>			
				05 <sup>00</sup>			
Route	Signature	Date	09 <sup>00</sup>				
			13 <sup>00</sup>				
Comments			17 <sup>00</sup>				
			21 <sup>00</sup>				

### APPENDIX THREE: INPATIENT DRUG CHART.

“AS REQUIRED” MEDICATION					Patient Name												
			Time & date		Dose, route & sig			Time & date		Dose, route & sig			Time & date		Dose, route & sig		
Drug and Dose Paracetamol 1g																	
Route PO/PR	Frequency 4-hrly	Date															
Comments		Signature															
Drug and Dose Morphine Sulphate																	
Route PO	Frequency 1-hrly	Date															
Comments		Signature															
Drug and Dose Temazepam 10-20mg																	
Route PO	Frequency Nocte	Date															
Comments		Signature															
Drug and Dose Haloperidol 1.5-5mg																	
Route PO/SC	Frequency 4-hrly	Date															
Comments		Signature															
Drug and Dose Diamorphine																	
Route SC	Frequency 1-hrly	Date															
Comments		Signature															
Drug and Dose Midazolam 2.5-10mg																	
Route SC	Frequency 1-hrly	Date															
Comments		Signature															
Drug and Dose Hyoscine Butylbromide 20mg																	
Route SC	Frequency 1-hrly	Date															
Comments		Signature															

**APPENDIX THREE: INPATIENT DRUG CHART.**

<b>“AS REQUIRED” MEDICATION</b>						Patient Name									
---------------------------------	--	--	--	--	--	--------------	--	--	--	--	--	--	--	--	--

  

			Time & date	Dose, route & sig			Time & date	Dose	Initials		Time & date	Dose, route & sig		
Drug and Dose														
Route	Frequency	Date												
Comments		Signature												
Drug and Dose														
Route	Frequency	Date												
Comments		Signature												
Drug and Dose														
Route	Frequency	Date												
Comments		Signature												
Drug and Dose														
Route	Frequency	Date												
Comments		Signature												
Drug and Dose														
Route	Frequency	Date												
Comments		Signature												
Drug and Dose														
Route	Frequency	Date												
Comments		Signature												

# SYRINGE DRIVER PRESCRIPTION.

PATIENT NAME:

Make up with	DRUG	DOSE	Date							
Water/Saline			Time changed							
& administer over			Butterfly site							
124 hours.			Battery change (Y/N)							
			Site change (Y/N)							
	Signature:	Date:	Initials							
Make up with	DRUG	DOSE	Date							
Water/Saline			Time changed							
& administer over			Butterfly site							
124 hours.			Battery change (Y/N)							
			Site change (Y/N)							
	Signature:	Date:	Initials:							
Make up with	DRUG	DOSE	Date							
Water/Saline			Time changed							
& administer over			Butterfly site							
124 hours.			Battery change (Y/N)							
			Site change (Y/N)							
	Signature:	Date:	Initials							

**APPENDIX FOUR: AN EXAMPLE OF A PERSONALISED  
MEDICATION SUMMARY SHEET.**



East End, Adderbury  
01295-811866

**Medication Chart for “Named Patient”**

**Regular Medication**

<b>Medication</b>	<b>Breakfast</b>	<b>Lunch</b>	<b>Supper</b>	<b>Bed time</b>	<b>Purpose</b>
Paracetamol 500mg	2	2	2	2	Pain relief
Morphine modified release 30mg	1			1	Pain relief
Co-danthrusate 50/60 capsule				1	Laxative

**“As Required” Medication**

<b>Medication</b>	<b>Instructions</b>	<b>Purpose</b>
Morphine liquid, 10mg/5ml	5ml up to every hour	Pain relief

**Notes**

You can print any information you like down here, but it is particularly useful for summarising:

- Syringe driver medication.
- Home care package arrangements.
- Follow up arrangements with the hospice.
- Follow up arrangements with the primary care team and/or hospital.
- Any important information that the patient/family might wish to refer to.

There is a semi-structured automated template on the hospice computers for generating these sheets. However, free text can be added to any part of the chart.

**APPENDIX FIVE: A LIST OF OFF-LICENCE MEDICATION USES**  
**THAT CAN BE CONSIDERED PART OF THE ESTABLISHED PRACTICE AT KATHARINE HOUSE HOSPICE**

<b>Drug</b>	<b>Common example of use beyond the Product Licence at Katharine House Hospice*</b>
Amitriptyline	Neuropathic pain, urgency of micturition, urge incontinence, bladder spasms.
Antacid	Hiccup.
Ascorbic acid	Decubitis ulcer, furred tongue.
Baclofen	Hiccup.
Celecoxib	Alternative NSAID in patients with gastric intolerance.
Corticosteroids	Long list (Please refer to the Palliative Care Formulary 2).
Cyclizine	Antiemetic for mechanical bowel obstruction or cerebral irritation.
Dalteparin	Thrombophlebitis migrans and DIC.
Depot corticosteroid	Pain in superficial bones, pain caused by spinal metastases.
Diamorphine	Dyspnoea...
Diclofenac	Cancer pain, neoplastic fever.
Docusate	To soften the stool in partial bowel obstruction.
Epoietin	Anaemia of chronic disease.
Etamsylate	Surface bleeding from ulcerating tumours.
Glyceryl trinitrate	Pain from oesophageal spasm, tenesmus or anal fissure.
Haloperidol	Antiemetic, hiccup.
Hyoscine butylbromide	Inoperable bowel obstruction, drooling, respiratory rattle.
Hyoscine hydrobromide patch	Colic, inoperable bowel obstruction, drooling, respiratory rattle.
Ibuprofen	Cancer pain, neoplastic fever.
Inhaled corticosteroid	Stridor, lymphangitis carcinomatosa, radiation pneumonitis, cough after insertion of a tracheal stent.
Ispaghula	To partially firm up the liquid output from an ileostomy.
Lansoprazole	To prevent the denaturing of pancreatic supplements.
Loperamide	To partially firm up the liquid output from an ileostomy.
Lorazepam	Acute agitation, terminal agitation, alcohol withdrawal, serotonin syndrome.
Methadone	Morphine poorly-responsive pain, pain relief in renal failure.
Methylphenidate	Depression in very advanced cancer.
Midazolam	Intractable hiccup.
Morphine	Dyspnoea.

\* All of these indications are described in the Palliative Care Formulary.

**APPENDIX FIVE: A LIST OF OFF-LICENCE MEDICATION USES**  
**THAT CAN BE CONSIDERED PART OF THE ESTABLISHED PRACTICE AT KATHARINE HOUSE HOSPICE**

<b>Drug</b>	<b>Common example of use beyond the Product Licence at Katharine House Hospice*</b>
Naproxen	Cancer pain, neoplastic fever.
Nifedipine	To relieve the pain of oesophageal spasm, tenesmus and to treat hiccup.
Octreotide	Pancreatic fistula, enterocutaneous fistula, intractable diarrhea associated with ileostomies, inoperable bowel obstruction.
Pancreatin	Enzyme supplement in certain cases of cancer of the pancreas/cholangiocarcinoma.
Progestogens	Postcastration hot flushes.
Ranitidine	Reduction of gastric secretions, to prevent denaturing of pancreatic supplements.
Risperidone	Delirium, behavioural symptoms in dementia.
Stanozolol	Itch secondary to obstructed bile duct.
Tranexamic acid	Surface bleeding from ulcerating tumours.
Venlafaxine	Hot flushes.
Vitamin K	Bleeding tendency in patients with hepatic impairment.

\* All of these indications are described in the Palliative Care Formulary.



**APPENDIX SIX: DRUG ERROR REPORTING FORM**



**REPORT OF DRUG INCIDENT**

**SECTION 1**

Date of incident

Time

Unit

Patient(s) involved

Name

Age

Hospice No

Diagnosis

---

**SECTION 2**

Drugs involved

---

**SECTION 3**

Equipment involved

---

**SECTION 4**

Reported to medical staff

Name of doctor:  
reported

Date and time

Advice given

---

**SECTION 5**

Reported to Senior Nurse/Director of Nursing

Name:  
reported:

Date and time

Advice given:

**APPENDIX SIX: DRUG ERROR REPORTING FORM**

**SECTION 6**

Account by senior member of nursing staff involved with incident.

Name:  
(Block letters)

Designation:

Signature:

Date:

**APPENDIX SIX: DRUG ERROR REPORTING FORM**

**SECTION 7**

Account by second member of nursing staff involved with incident.

Name:  
(Block letters)

Designation:

Signature:

Date:

**APPENDIX SIX: DRUG ERROR REPORTING FORM**

**SECTION 8**

Review of incident. Action/recommendation.

Name:  
(Block letters)

Designation:

Signature:

Date: