NHS
Lancashire and South Cumbria
Integrated Care Board

Policy for medicine use within Virtual Wards (including Hospital at Home)

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Purpose:	This policy sets out best practice of how medicines should be managed in the VW/H@H service.
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Author (inc Job Title):	Pharmacy and Medicines Virtual Ward Task and Finish Group
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Target audience:	All staff involved in designing and delivering patient care and medicine use in Virtual Wards/Hospital at Home service.

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Document control:		
Date:	**Version Number:**	**Section and Description of Change**
12.10.22	V1.0	New policy
16.01.2023	V2.0	7.0 – paragraph 8: removed the word 'electronic' so paragraph now reads 'The rationale behind all prescribing decisions must be clearly documented in the person's record, including details of information provided and discussed with the person'.
16.01.2023	V2.0	8.0 – paragraph 4: addition of 'electronic prescriptions' so paragraph now reads 'Only authorised and trained staff should have access to systems capable of generating electronic prescriptions/FP10s'.
16.01.2023	V2.0	14.0 – paragraph 2: removed 'choices' so paragraph now reads 'Storage of medicines in a patient's own home must meet the patient's needs and be risk assessed, taking into account manufacturers storage requirements and accessibility'.
16.01.2023	V2.0	15.0 – updated links and included link to NHS England National Patient Safety Alert: Care Quality Commission requirements, NHS England National Patient Safety Alert and British Thoracic Society: Oxygen resources.
16.01.2023	V2.0	17.0 – updated link: good practice guidance
16.01.2023	V2.0	31.0 – addition of the following legal and regulatory frameworks: • The Misuse of Drugs Act 1971 and subsequent regulations • The Misuse of Drugs (safe custody) Regulations 1973 and subsequent regulations • Misuse of Drugs Regulations 2001 • The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (and amendments)
16.01.2023	V2.0	Removed Appendix 3 and 4

1.0 Introduction

Most patients entering the virtual ward/Hospital at Home service (VW/H@H) will be taking medicines. This policy sets out best practice of how medicines should be managed in the VW/H@H service. It is to be read in conjunction with relevant existing medicine-related policies and procedures as they relate to staff employed to work in the Partnership i.e. staff employed to work in the virtual ward/Hospital at Home service (VW/H@H), Trust staff providing support and advice to the service and Local Authority staff.

Medicine administration is a regulated activity under the Health and Social Care Act 2008 (Regulated Activities) 2014.

The safe and secure handling of medicines is the responsibility of all authorised staff overseeing and administering medicines in the virtual ward/Hospital at Home service.

2.0 Purpose

The purpose of this policy is to give clear guidance to all staff working in the VW/H@H service of aspects of medicine management, and to ensure safe procedures are undertaken in the VW/H@H service with regards to medicines.

The aims of this policy are:

- to ensure that, where medicines and/or medicine-related controlled stationary are used in the VW/H@H service, there are Standard Operating Procedures (SOPs) in place, which staff are familiar with and follow at all times;
- to ensure that medicines use in the VW/H@H service complies with relevant professional and legislative standards and meets the requirements of relevant external bodies;
- to ensure that all medicines are handled in a safe and secure way;
- to encourage safe systems of work, for the protection of service users and staff by reducing risk and the potential for error associated with medicines;
- to act as a reference source for guidance.

Note: Appendices are live and subject to change

3.0 Scope

This policy is applicable to all staff involved in designing and delivering the patient care and medicine use aspects of the VW/H@H service, including staff employed through bank and agency.

It is not the intention of this policy to guide or inform staff within the service of all possible scenarios linked to medicines, or of the clinical indications for the use of specific drug protocols. Providers of the service must ensure they have appropriate SOPs/policies/protocols in place to support the safe use of medicines in the VW/H@H service (see Appendix 2). All SOPs/policies/protocols etc. must go through the respective provider's governance process for sign off/approval prior to use and circulation.

Lead organisations must ensure clinical pathways defining the inclusion and exclusion criteria, patient journey (clinical assessment, referral into the VW/H@H service, admission, monitoring, self-escalation, recovery, discharge and follow up) are in place, and they include the route of prescribing, and supply of medicines for the service. Pathways must be supported by comprehensive sets of SOPs that outline standards of safe staffing and medicines related processes, including details of the out-of-hours medicines support provision.

There is acknowledgement that there may be instances where patients in the VW/H@H service are receiving medication as part of a different pathway of care e.g. end of life/palliative care. In such circumstances staff will be expected to follow the respective specialist teams policies/procedures.

4.0 Definitions

Administer: To give a medicine by introduction into the body, (e.g. orally, rectally, by inhalation or by injection etc.) or by external application (e.g. cream or ointment).

Controlled drug: A medicine whose management is controlled as defined in the Misuse of Drugs legislation.

Covert administration: A process when medicines are administered in a disguised format.

Dispensing of medicines: The preparation, packaging, labelling and transfer of a prescription drug to a named individual or their intermediary. This is the role of the pharmacy team.

FP10 prescription: A community NHS prescription form that may be presented to a community pharmacy for dispensing.

Hospital at Home: Virtual ward hybrid service model that blends digital monitoring and face-to-face care to support patients with acute needs in their own home.

Licensed medicines: Are medicines holding a UK marketing authorisation (MA) [formerly known as a Product Licence (PL)], granted by the Medicines and Healthcare product Regulatory Agency (MHRA). MAs are granted for individual medicinal products and include a summary of product characteristics (SPC).

Medicine: All prescription and non-prescription healthcare treatments, such as oral medicines, topical medicines, inhaled products, injections, wound care products, appliances and vaccines. The term *medicine* has the same meaning as 'medicinal products' as referred to in the Human Medicines Regulations 2012.

Medicines administration: The giving or application of a pharmacological or other therapeutic agent to relieve or cure illness. Only staff that have received appropriate training and been assessed as competent may administer medicines.

Administration chart: Is a chart to record all the medicines administered to a patient. It is not a prescribing chart for medicines. Although a prescriber can write on the charts for information, this does not constitute a prescription.

MCA: Multi-compartment Compliance Aid, also referred to as Monitored Dosage Systems (MDS) or blister packs, are an aid to support medicines adherence. They are usually a variation on the design of a box or a blister pack, divided into days of the week with several compartments per day to allow for the different timing of doses such as breakfast, lunch, dinner and bedtime.

MDT: Multidisciplinary team.

Medicines Reconciliation: The process of identifying the most accurate list of a patient's current medicines – including, the name, dosage, frequency and route – and comparing them to the current list in use, recognising any discrepancies and documenting any changes, thus resulting in an accurate list of medicines.

Medicines-related stationary: Any stationary, which, in the wrong hands, could be used to obtain medicines fraudulently and includes, but is not limited to, prescription forms (FP10, FP10HP, FP10D, hospital prescriptions) and administration charts.

NHSBSA: NHS Business Services Authority.

Off-label medicines: Are UK licensed medicines used outside the terms of their marketing authorisation (MA) and are also referred to as 'off-label' or 'off-licence' prescribing.

Partnership: The service is a collaborative partnership between primary care, secondary care, community pharmacy and Local Authority, with a dedicated core team providing daily reviews and clinical input.

Patient Own Drugs (PODs): Medicines that are the legal property of the patient. They have been prescribed for or purchased by the patient.

Patient Specific Direction (PSD): Is a written instruction, signed by a doctor, dentist, or non-medical prescriber (hereafter referred to as "the prescriber") for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. Where a PSD exists, there is no need for a Patient Group Direction (PGD).

Patient/Person/Service User: Individual in receipt of VW/H@H service.

Prescriber: Medical staff (GP/Doctor/Consultant), dentist and authorised non - medical prescribers who prescribe medication.

Self-administration of medicines: Where a patient takes or uses their own medicines, either independently or under supervision, when in a healthcare setting.

Service: Virtual Ward and Hospital at Home service (VW/H@H).

Service user: Individual in receipt of VW/H@H service.

Standard Operating Procedures (SOPs): A set of detailed, step-by-step instructions describing how to carry out a particular task. SOPs aim to provide quality, efficiency, and uniformity when the task is carried out by different operators.

Supervision of medicines: The process of observing an individual as they take their own medication to support them to take the right drug, at the right dose, by the right route, at the right time.

Unlicensed medicines: Are medicines, or substances used as medicines that do not hold a MHRA marketing authorisation (MA). 'Specials' are unlicensed medicines.

Virtual Ward: A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

5.0 Duties in the Virtual Ward/Hospital at Home service

The VW/H@H service should appoint a registered manager/medicines lead who will be responsible for the following:

- ensuring all staff working in the service, that are involved with medicines, have read the relevant sections of this policy and are fully conversant with its content;
- ensuring that where staff are involved with medicines there are SOPs in place to ensure the safe and secure handling of medicines and medicines-related stationary (including, but not limited to, ordering, receipt, storage, supply, administration, disposal of medicines and dealing with medicine alerts or recalls).
  SOPs must be dated and subject to routine update and review, with records of review maintained by the respective provider.
  SOPs must go through the respective provider's governance process for sign off/approval prior to use and circulation.

- ensuring all staff working in the service have read relevant local policies/procedures and are fully conversant with the contents;
- ensuring all staff working in the service, that are involved with medicines, are appropriately trained (with training records retained) and competent;
- ensuring that only authorised personnel have access to any stock medicine cupboards, and that there is an appropriate and effective system that records the distribution of keys and/or access codes where applicable;
- advising on secure, appropriate storage of medicines within the home environment;
- ensuring that the service implements appropriate medicines management procedures and regularly audits its activities to ensure compliance with this policy.

Prescribers (medical staff and authorised non-medical prescribers) must comply with the relevant part(s) of this policy, other relevant organisational policies, procedures and guidelines, their professional guidance and with appropriate legislation. Non-medical prescribers must also adhere to the organisation's Non-medical prescribing policy.

Registered Healthcare Practitioners must work within their scope of professional practice and be familiar with, and follow, their professional standards/code of practice or conduct in relation to medicines, e.g. NMC, GPhC, HCPC, GMC etc..

Registered healthcare professionals working in the service must remain up to date with best practice, attend appropriate training sessions and maintain their own CPD records.

6.0 Medicine reconciliation

Defined by the Institute for Healthcare Improvement as:

'The process of identifying the most accurate list of a patient's current medicines – including the name, dosage, frequency and route – and comparing them to the current list in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated'

NICE Guidance NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes recommends sharing relevant information about medicines when patients move from one care setting to another. Medicines reconciliation should be completed in line with NICE Quality Standards:

- Within 24 hours or sooner in an acute setting;
- In primary care: as soon as is practically possible, before a prescription or new supply of medicines is issued and within 1 week of the GP practice receiving the information.

Medicines reconciliation must occur at all transitions of care - i.e. admission, transfer and discharge from the VW/H@H service, and once completed documentation recorded in the patient's record.

7.0 Prescribing medicines

Prescribers must complete a full assessment of a patient (either via telephone, video, online or face to face consultation) prior to issuing a prescription.

Spurious code(s)/Cost Centre code(s) must be set up so that any prescribing occurring in the VW/H@H service can be audited and monitored as appropriate.

Where remote consultations are undertaken, prescribers should be aware of the safe prescribing practices for remote consultations as underpinned by guidance from regulatory bodies.

When prescribing, prescribers must follow relevant national guidance, GMC good practice guidance, local guidance and ensure they comply with their professional body standards. Non-medical prescribers working in the service must also comply with the organisation's Non-medical prescribing policy.

The following must be taken into account prior to prescribing:

- the allergy status of the person, including the nature of the allergy;
- the person's age, choice, medical condition(s), lifestyle (including dietary requirements and cultural/religious beliefs).

Written FP10s must comply with the prescription writing requirements in the current section of the British National Formulary.

The rationale behind all prescribing decisions must be clearly documented in the person's record, including details of information provided and discussed with the person.

All records created and maintained by prescribers must be true, accurate and current.

Any changes to a patient's medication regimen must be communicated promptly to the patient's GP.

Appropriate sources of information on medicines must be consulted where necessary, prior to prescribing. Some sources include: ELMMB website and National guidelines: NICE guidelines. All prescribing must follow locally agreed guidance.

Prescribing controlled drugs: also refer to section 21.

Antimicrobials should be prescribed in line with local guideline/formulary. Staff in the VW/H@H service must adhere to antimicrobial stewardship (AMS) with respect to the healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness.

Prescribing 'off-label' and unlicensed medicines:

Whenever possible prescribers in the service should prescribe licensed medicines for licensed indications. However, it is recognised that the use of an unlicensed medicine, or off-license (off-label) use of a licensed medicine is occasionally necessary in order to provide optimum care. In all circumstances, it is the responsibility of the prescriber to inform the patient (and nursing staff administering the medicine where applicable) about the medicines licensing status. The prescriber must discuss with the patient the supporting evidence for its use, the expected benefits of treatment and possible risks. This must be fully documented in the patient's record and reviewed periodically.

When prescribing off-label or unlicensed medicine(s):

- prescribers assume professional responsibility and product liability;
- prescribers must be aware of and follow their professional standards and the MHRA guidance: Off-label or unlicensed use of medicines: prescribers' responsibilities;
- prescribers must ensure that where responsibility for on-going care is to be transferred to the patient's General Practitioner (GP) that the GP is informed in advance of the unlicensed/off-label status of the medicine and agreement obtained that they are willing to accept clinical responsibility for prescribing.

8.0 Security of medicine-related stationary (including FP10s)

Medicines-related stationary, including electronic equipment, must be stored securely when not in use and must only be accessible to authorised individuals.

Medicine-related stationary used for obtaining medicines from the hospital pharmacy must be used in accordance with the organisational policies and procedures of the respective provider.

FP10 prescription forms are the property of the organisation that holds the prescribing budget. Staff who order, receive, store, prescribe on, or dispose of FP10 prescription forms must do so in line with the requirements detailed in the current edition of the NHS Counter Fraud Authority's Management and control of prescription forms: A guide for prescribers and health organisations.

Only authorised and trained staff should have access to systems capable of generating electronic prescriptions/FP10s.

Permissions to prescribe must be revoked when a staff member leaves the service/employment ceases.

Signed and completed prescriptions must either be:

- sent electronically to the nominated community pharmacy, if Electronic Prescription Service (EPS) is available, or
- issued directly to the patient/patient representative/carer or to the patient's nominated community pharmacy/hospital pharmacy, if handwritten FP10s are being used.

Under no circumstances should signed and completed prescriptions be posted in the mail.

Storage of prescription forms/medicine-related stationary must be risk assessed to ensure it is secure and prevents unauthorised access.

The registered manager of the service must:

- ensure a robust process is in place to record relevant details of prescription stationary received and distributed;
- ensure an audit trail is maintained of serial numbers of the forms that have been received and issued to each prescriber;
- ensure there is a local SOP in place on the management of prescription forms, which covers the management of lost or stolen FP10s, access to prescribing functionality and unused/obsolete FP10s;
- ensure systems are in place to recover all unused prescription forms on the last day of a staff's employment or on notification of leave expected to last 4 weeks or more.

9.0 Providing advice on medicines

Advice about medicines must only be provided by authorised and trained staff.

Staff must ensure any advice given is within the scope of their practice, and advice should be evidence-based; where uncertainty exists, staff should consider seeking advice from another healthcare professional or manager.

Any advice given to a patient in the service must be documented in their record.

10.0 Supply of medicines to patients in the VW/H@H service

Supply of medicines to patients in the VW/H@H service should occur in line with organisational policies/procedures of the respective provider.

All prescribing for patients admitted to the VW/H@H service must be undertaken by the VW clinical team and continue until point of discharge from the service. In exceptional circumstances, and where the patient's regular GP agrees to prescribe a medicine, robust,

detailed communication must take place between relevant clinicians and be recorded in the patient's record.

Where a prescription is issued to a patient in the VW/H@H service, this should be issued via the electronic system e.g. EMIS or equivalent system, and sent electronically to the community pharmacy/hospital pharmacy for dispensing. Medicines dispensed by a community or hospital pharmacy should be delivered to the patient's home in a timely manner (preferably on the same day). In exceptional circumstances and where electronic access to a patient's record is not possible, a manual/paper FP10 should be issued, and the patient records updated as soon as possible in accordance with a locally approved SOP.

Where more specialist medicines i.e. home IV, fluids, high risk medicines, red drugs etc. are required, these must be prescribed by a practitioner who is part of the specialist VW/H@H team and be dispensed by the hospital pharmacy. Arrangements must be in place to ensure receipt of these medicines in a timely manner for administration in the home environment. SOPs must be in place for managing these specialist medicines which cover prescribing, transportation/supply, administration and record keeping.

During the acute episode of care and in exceptional circumstances e.g. Out of Hours, staff may supply pre-packed medicines to a patient in the VW/H@H service only under a Patient Specific Direction (PSD). In such circumstance, the medicines supplied for home use must be pre-labelled and comply with labelling requirements. Supply of pre-packed medicines to a patient must only be undertaken by trained and competent registered healthcare professionals.

11.0 Stock medicines

Oral paracetamol, some critical medicines and emergency drugs can be held as stock to support prompt administration to patients as necessary.

Wherever possible stock medicines should be stored in the hospital pharmacy/ward with storage requirements complying with local policies/procedures.

Where stock medicines are stored at a premises other than a hospital pharmacy/ward the safe and secure handing of medicines requirements must be adhered to, and a locally agreed SOP must be in place by the respective provider.

Stock lists and documents used for ordering stock must be kept secure when not in use.

Only authorised staff are permitted to order stock medicines.

Processes must be in place to manage stock, including checking of expiry dates, checking stock levels and to ensure minimum stock levels are maintained.

Overstocking must be avoided, and early review of stock lists should be undertaken if stock levels are inappropriate.

There must be an audit trail of the stock received and supplied.

Any discrepancies must be investigated immediately, and all actions and outcomes documented. Any discrepancies not accounted for must be incident reported via the appropriate Incident Reporting System.

12.0 Transport of medicines

Medicines should be transported in accordance with organisational policies/procedures of the respective provider.

Only authorised staff must transport medicines, with the following exception:

- Staff administering medicines in the VW/H@H service can transport anaphylaxis/emergency medicines. Medicines required for use in an emergency to save life are legal exemptions from the medicines act (Medications Act, 1968) and may be administered without a prescription in these circumstances.

Vaccines/medicines that require refrigerated storage must be transported in a validated medical grade cool box, and local policies/procedures for maintaining the cold chain followed. Wherever practicable, the transport of these vaccines should be undertaken as a single journey.

The safety and security of medicines in transit is a high priority, and all staff transporting medicine(s) must follow the guidelines below and any organisational policies/procedures of the respective provider:

- The medicine(s) must be transported directly to the patient;
- The medicine(s) must be transported out of sight (preferably in the locked car boot);
- If transported on foot, the bag containing the medicine(s) must be concealed so as not to draw attention;
- Medicine(s) must not be left in cars or taken home by staff members;
- Where applicable, medicine(s) must be returned to the base from which they were supplied at the end of the working day;
- Medicines must not be left unattended while they are being transported.

13.0 Medicines safety alerts, warnings and recalls

All staff working in the service must be set up to receive medicines safety alerts, warnings and recalls.

A locally agreed SOP must be in place by the respective provider for dealing with medicine alerts, recalls and warnings.

Alerts must be actioned in the specified timescales. The record of action taken must be kept by the registered manager of the service for five years.

14.0 Storage of medicines in a patient's own home

Medicines should be stored in a way that means they are safe and will be effective when administered.

Storage of medicines in a patient's own home must meet the patient's needs and be risk assessed, taking into account manufacturers storage requirements and accessibility.

All medicines stored in a patient's home must be stored safely in a way that protects against misappropriation by other parties or loss.

All medicines stored in a patient's home must be stored in a room away from direct sunlight and humidity/moisture (medicines must not be stored under kitchen sinks or in the bathroom).

Where medicines need to be stored in a fridge within the patient's home they should be placed on an individual shelf within the fridge (and not in drawers at the bottom of the fridge). The fridge should not be overstocked to an extent that air circulation and temperature of the fridge is adversely affected.

Staff must record the outline of the discussions regarding appropriate storage of medicines in the patient's records.

For storage of oxygen please also see section 15.

For storage of CDs please also see section 21.

15.0 Oxygen

Oxygen is a medical gas, and it should be treated as a medicine. Providers must ensure they have relevant policies and procedures, including a local SOP, in place for general oxygen use, including but not limited to: prescribing of oxygen, ordering, receipt, storage, transport/handling of oxygen and oxygen equipment, removal of oxygen, documentation and annual maintenance of oxygen equipment.

Providers must be familiar and comply with the following guidelines for oxygen use: BNF guidelines, Care Quality Commission requirements, NHS England National Patient Safety Alert and British Thoracic Society: Oxygen resources.

Only appropriately trained staff should be involved in the use of home oxygen.

If a patient in the VW/H@H service requires oxygen therapy, an individualised plan must be agreed in consultation with the MDT and the Home Oxygen service. This discussion must include relevant risk assessments for the safe use and storage of oxygen in the patient's own home. Outcomes of all discussions must be documented in the patient's record.

Home oxygen should be prescribed using a Home Oxygen Order Form (HOOF). A **Initial Home Oxygen Risk Mitigation Form (IHORM) and Home Oxygen Consent Form (HOCF)** should always be completed prior to completing a Home Oxygen Order Form (HOOF). The consent form allows staff to share information with the local home oxygen provider. For local arrangements to complete a HOOF staff should always liaise with the local Home Oxygen Assessment Service or local Home Oxygen Supplier. Further guidance, including home oxygen forms, can be found on the following website: https://www.england.nhs.uk/coronavirus/publication/home-oxygen-order-form-hoof-letters-and-guidance/.

16.0 Administration of medicines

All medicines administered by the VW/H@H service must be prescribed and recorded on an administration chart/prescription chart and EMIS/equivalent system prior to administration.

Medicines should be administered as per organisational policies/procedures of the respective provider.

Medicines must be administered in line with the Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society/Royal College of Nursing).

Medicines must only be administered in accordance with a prescription or Patient Specific Direction, or other relevant exemption specified in the Human Medicines Regulations 2012 (Schedules 17 and 19, as amended). An administration chart is not a direction to supply or administer but a record of administration, and may be written on by individuals who do not hold a prescribing qualification.

Staff must only administer medicines from an original container dispensed and labelled by a pharmacy. This includes monitored dosage systems and compliance aids. Staff must not fill compliance aids or use family filled compliance aids.

Medicines that are not Prescription Only Medicines (e.g. Pharmacy (P) or General Sale List (GSL) medicines, homely remedies, vitamins etc.) may only be administered according to a locally agreed protocol.

Administration of medicines must only be undertaken by trained and competency assessed staff (including agency staff).

A list of specimen signatures and initials of all staff authorised to administer medicines in the service must be available and a copy retained by the registered manager of the service. This list must be regularly reviewed to ensure that it is up to date.

Medicines administration should always take place in an appropriate, well-lit location, free from unnecessary interruptions and distractions. A clean uncluttered surface should be identified.

Records of administration must be maintained e.g. on EMIS/equivalent system or using an administration chart.

Before supporting or undertaking the administration of medicines, staff must:

- check the administration record to ensure the medication is due and has not already been taken/administered;
- clean their hands and ensure any other infection prevention and control measures are taken where appropriate e.g. ensuring the patient has access to clean receptacles for their medicines should they wish to use one;
- confirm the identity of the patient using at least two forms of identification;
- where appropriate ensure that the patient has given informed consent;
- check the allergy status of the patient to ensure they are not allergic to or intolerant of the medicine to be administered;
- ensure the pharmacy label on the dispensed container (drug, dose, formulation) and the administration record/prescription dosage instructions correspond;
- have considered the dose, weight where appropriate, method of administration, route and timing;
- ensure any special instructions are adhered to i.e. take before food, not to have grapefruit juice etc.;
- ensure all necessary equipment/consumables for safe administration is available e.g. nebuliser;
- ensure the medication is within its expiry date;
- ensure the integrity of the medicine i.e. there is no obvious discolouration of tablets, medicines have been stored in line with manufacturer's requirements, no signs of water damage to the packaging etc.

If the dispensing label is damaged or becomes illegible the supplying pharmacy should be contacted for advice.

Where there are any ambiguities/discrepancies identified, or concerns regarding the direction for administration, contraindications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine may no longer be suitable, staff must contact the authorised prescriber without delay.

When medicines administration is undertaken by a single staff member, without a check by another member of staff, it is preferable that the patient is asked to confirm that the medicine to be administered is correct if they have capacity. The staff administering the medicine retains full responsibility for administration.

Where the medicine to be administered is an IV medicine or requires complex calculation to ensure that the correct volume or quantity of the medicine is administered, in such circumstances, it is good practice for a second registered healthcare professional to carry out a second check to minimise risk of error.

When assisting with or administering medicines staff **MUST NEVER**:

- give medicines covertly i.e. hidden in food or drinks.
  (The only exception would be a situation where the person has been assessed under the Mental Capacity Act as lacking capacity and a best interests decision has been taken by the MDT and a covert administration of medicines plan for specified medicines is in place. Refer to organisational policies and procedures of the respective provider for the covert administration of medicines);
- give medicines prescribed for one person to another individual;
- crush or break a tablet or capsule unless given specific instructions to do so by the prescriber;
- prepare medicines in advance of the time of administration (unless it is an injectable product prepared by a hospital pharmacy for administration to a service user). Such preparation includes putting tablets into a separate container, measuring a dose of a liquid medicine etc.

It is not acceptable for staff to administer medicines drawn into a syringe or container by another person when not in their presence, except for infusions already running through an infusion device at the point of administration.

Medicines dropped on the floor must not be used, they must be disposed of in line with the organisational policies/procedures of the respective provider and a record made.

For controlled drugs also see section 21.

Incomplete administration of medicines (applicable where staff are supporting administration or administering medicines to a patient)

Where staff are administering and/or supporting medicine administration, all omitted, wasted or declined doses must be recorded in the patient's record, along with the reason for incomplete administration. Where an administration chart is in use, staff must initial the administration box on the chart and annotate with the appropriate code.

If a patient declines to take their medication, a further attempt should be made 10-15 minutes later to encourage adherence if this is deemed safe and unlikely to provoke an angry response.

Delays or omission of some medicines can cause serious harm or death. The delay or omission of the following medicines has a significant potential to cause harm:

- Anti-infectives (including antibacterials, antifungals and antivirals);
- Anticoagulants;
- Antidotes (e.g. naloxone, vitamin K);
- Antiepileptics (where epilepsy is the indication for use);
- Antiretrovirals;
- Clozapine.
- Corticosteroids (e.g. hydrocortisone and prednisolone, when used for adrenal insufficiency);
- Desmopressin (when used for diabetes insipidus);
- Immunosuppressants;
- Insulin;
- Opioids;
- Parkinson's disease medicines;

Every attempt must be made to ensure patients receive these critical medicines in a timely manner.

All omissions of critical medicines must be discussed immediately with an appropriate healthcare professional or GP and this discussion must be fully documented in the patient's record. All omissions must be reported in line with the appropriate Incident Reporting Policy.

Staff must inform the prescriber immediately where doses of any medicines have been omitted, wasted or declined.

Where a patient is repeatedly declining their medication, this must be discussed with the MDT at the earliest opportunity so that a clinical decision can be made about future treatments.

Medicines that have been prepared for administration but not administered must be disposed of in line with organisational waste policies/procedures of the respective provider.

Overdose

If a patient in the service is given more than their prescribed dose, advice must be sought immediately from the prescriber, pharmacist or registered nurse.

A medication incident report must also be completed. If the incident involves a Controlled Drug, the registered manager and Accountable Officer for Controlled Drugs must also be informed in line with organisational policies/procedures of the respective provider.

Self-administration

All patients admitted to the service should be risk-assessed as to their capability and understanding of the medicines they take in line with organisational policies/procedures of the respective provider.

The assessment must include a review of the patient's mental and physical abilities, any potential exclusion criteria (see table 1), level of knowledge of medication (and the need for re-education), any adjustments that may be necessary to facilitate self-administration, and the appropriate stage and support required to self-administer. The outcome must be recorded in the patient's record.

Where there is a lack of capacity, this must be evidenced through a best interest process which should be documented by the decision-maker.

If a patient requires support to administer medicines their capacity to consent to this support must be assessed and documented.

Table 1: Potential exclusion criteria for self-administration of medicines

PEOPLE FACTORS	MEDICATION FACTORS
Not personally responsible for administering medication at home	Unstable medication regimen
Acute confusion	Some medicines prescribed PRN e.g. newly initiated anxiolytics
Immediately pre- or post-surgery	Controlled drugs (not an absolute exclusion)
Cognitive impairment	Parenteral medication (except insulin)
History of alcohol/drug abuse	Short term courses (e.g. antibiotics)

Where a patient in the service has been assessed as able to self-administer, they should sign a consent form accepting responsibility for taking their own medicines and storing them safely and securely.

Where a patient self-administers their medication, records of administration are not required.

An ongoing process of MDT review should be in place to continually re-assess a patient's ability to safely manage their medicines, taking into consideration the wishes of the patient. Where staff identify that a patient is not taking their medication this must be discussed with the MDT at the earliest opportunity so that a clinical decision can be made about future treatments.

17.0 Record keeping, documentation and communication

All VW/H@H documentation for assessments, interventions, administration of medicines and visits should be documented on patients records - EMIS or equivalent electronic system.

Staff in the service must follow good practice guidance on record keeping.

A medication authorisation chart should be kept in the patient's residence in case other services are required to cross cover.

Records must be kept for all medicines administered, omitted or declined. Such records must be made at the time of administration.

Records must be clear, legible, made in indelible ink if paper records are used and auditable. The name and status of any staff checking/witnessing administration must also be recorded.

Where electronic systems e.g. EMIS or equivalent system are used all records within the system must be date, time and user-stamped and maintain an audit trail.

For injectable medicines, the batch numbers and expiry dates of all the medicines, diluents and flushes must be recorded in the records.

For continuous administration of medicines (e.g. via intravenous infusions or syringe drivers) there must be a clear and legible record of all individuals involved in setting up the medicine, monitoring the administration, and stopping and taking down the medicine.

Any medicine declined, delayed or omitted must be recorded in the patient record, along with reasons for omission/delay/decline, and the prescriber informed.

Any errors in the recording of administration on paper records must be clearly cancelled by crossing out with a single line in indelible ink, initialled and dated, with an appropriate explanation provided. Electronic records must provide the same level of audit trail.

Upon completion of a package of care any paper documents e.g. administration charts must be scanned and saved in the patient's electronic record (e.g. EMIS or equivalent system).

Where a patient admitted to the service is already in receipt of medicines through use of a MAR chart this should be maintained through established processes by staff/carers already involved e.g. care home staff.

There should be communication between the VW/H@H service, the patient's general practitioner, the community team (when appropriate) and the referring clinician. As a minimum this should include notification of acceptance onto the VW/H@H service, notification of completion of therapy and notification of further follow-up/management plans.

18.0 Adverse Drug Reactions

Adverse drug reactions (ADRs) deemed to be a 'medicine-related incident' must be reported using the appropriate Incident Reporting System.

Expected ADRs that are not serious do not need be reported, e.g. nausea with opioid medicines.

The nature of the reaction must be recorded in the patient's record and, where applicable, on the administration chart, under allergies or intolerances.

The patient's GP must be informed as soon as is practicable of any adverse reaction to a medicine or dressing irrespective of who prescribed it. This is so that a clear and visible note can be made on the patient's GP record.

Staff and patients in the service should be encouraged to report suspected adverse drug reactions that fulfil the appropriate criteria using the Yellow Card Scheme run by the Medicines and Healthcare products Regulatory Agency (MHRA).

Reports can be made through the MHRA website (https://yellowcard.mhra.gov.uk/) or yellow cards found at the back of the BNF.

After emergency treatment for suspected anaphylaxis, offer people a referral to a specialist allergy service (age-appropriate where possible) in line with NICE Clinical Guidelines CG134.

19.0 Disposal and return of patient's medicines

Any medicines no longer required, or items contaminated with medicines must be disposed of in an appropriate container suitable for the type of waste e.g. a pharmaceutical waste disposal bin. Pharmaceutical waste must NEVER be disposed of in the general household waste or flushed down the toilet or sink.

Medicines (except controlled drugs) that have been prescribed and dispensed to a person remain the property of that person, even after death. When medicines are no longer needed, the ideal course of action is for the person or their representative to return unwanted medicines to a community pharmacy for safe disposal.

Staff must not remove medicines from peoples' homes unless they have grounds to believe that the health of the person, relative(s) or carer(s) may be at risk (except for inhalers, see below). In such circumstances consent must be obtained and documented in the person's record authorising removal and destruction of the medication, and the medicines must promptly be returned to a community pharmacy. A clear audit trail of medicines removed and returned to the pharmacy for destruction must be maintained and the following documented:

- Date of removal;
- Name of patient/patient representative consenting to medicine removal;
- Name, strength and formulation of medication;
- Quantity of medication;
- Name and signature of the staff member removing the medication and returning the medication to the community pharmacy;
- Reason for return;
- Name and address of the community pharmacy where being returned;
- Name and signature of community pharmacy staff accepting receipt of medicines for safe destruction.

The patient or their representative where appropriate must be asked to sign the record.

The community pharmacy should check the quantities returned and sign for receipt of waste medicine(s) to complete the audit trail. The signed document must then be retained in the patient's record.

The medicines must be transported from the patient's home directly to the community pharmacy, out of sight in a locked car or sealed container.

Used or unwanted inhalers may be removed from a service user's home as part of the 'inhaler recycling scheme'. A record of the medicines and quantities removed must be made and signed by the healthcare professional and the patient (or their representative where appropriate).

Sharps etc. must be disposed in line with organisational policies/procedures of the respective provider.

Any consumables supplied e.g. nebuliser etc. must be returned in line with the requirements of the respective provider.

Controlled drugs

The disposal of unused or expired CDs is subject to additional legal requirements. Refer to section 21.

20.0 Medication-related errors and incidents

In the event of a medication error or incident the safety and wellbeing of the person using the service is paramount, and immediate steps must be taken to ensure the person is safe and unharmed. If the senior clinician with oversight of the patients care is available they must be consulted. In the absence of the senior clinician, senior advice should be sought and options considered including contacting the emergency services, NHS 111, or the community pharmacy.

Staff must follow the policies/procedures of the respective provider for the reporting of medication errors and near misses.

The registered manager must be notified of all medication incidents to facilitate onwards reporting as necessary, and identify any learning and action required.

If a staff member realises that a medication error has been made, e.g. a medicine has been given incorrectly, the following principles must be followed (not necessarily in this order):

- Inform the patient of what has happened, unless they have been assessed as lacking capacity;
- Seek medical/pharmaceutical advice (e.g. from the prescriber, pharmacist, hospital medicines information department, as appropriate) and plan for immediate treatment and follow up as necessary;
- Inform line manager/duty manager;
- Document details of the error and all advice or actions taken in the patient's record;
- Complete an Incident Report (using the appropriate Incident Reporting System).

For controlled drugs also see section 21.

21.0 Controlled drugs

The Misuse of Drugs Act 1971 controls the availability of drugs that are considered sufficiently 'dangerous or harmful' with a potential for misuse. The drugs are termed Controlled Drugs (CDs) and it is a criminal offence to possess, possess with intent to supply or administer these drugs without authorisation.

Controlled drugs are likely to cause dependence or misuse in varying degrees. They are classed according to the extent of harm they may cause when misused.

There are strict criteria for prescribing, administering, safe custody, record keeping and disposal of controlled drugs 'Misuse of Drugs Act 1971'.

Prescribing Controlled Drugs

CDs must be prescribed in line with national guidance and NICE Guideline NG46.

Registered medical practitioners are authorised to prescribe CDs.

Some non-medical prescribers (independent or supplementary) are authorised to prescribe CDs in line with their legal and professional restrictions.

When writing a prescription for a CD, prescribers must comply with the requirements of the Misuse of Drugs Regulations 2001. See the latest version of the BNF or online version for prescribing requirements.

The Department of Health have issued a strong recommendation that the maximum quantity of Schedule 2, 3 or 4 Controlled Drugs prescribed should not exceed 30 days; exceptionally, to cover a justifiable clinical need and after consideration of any risk, a prescription can be issued for a longer period, but the reasons for the decision should be recorded in the patient's record.

Receipt of controlled drugs in patient's home and record keeping

Record keeping must comply with national guidance, NICE Guideline NG46 and with any organisational policy/procedure of the respective provider.

Records of receipt are only required where staff in the service administer CDs to patients in their own home. Where a patient self-administers CDs, records are not required.

Records can be made either on EMIS/equivalent system, or on a locally agreed CD record sheet.

Any errors in the recording of administration on paper records must be clearly cancelled by crossing out with a single line in indelible ink, initialled and dated, with an appropriate explanation provided. Electronic records must provide the same level of audit trail.

Records for receipt, supply and administration of CDs must be kept for at least 2 years from the date of the last entry.

Records for the disposal/return of patient's own controlled drugs must be kept for 7 years from the date of last entry.

Once an episode of care has been completed, all paper records (containing the records of receipt, supply and administration and disposal/return of patient own CDs) must be incorporated into the patient's electronic record (e.g. EMIS or equivalent system).

Transport of CDs

The provider must have a policy/procedure in place for the transportation of CDs, any policies/procedures must comply with NICE Controlled drugs: safe use and management guidance.

If possible, the patient, patient's family member or carer should collect CDs from the dispensing pharmacy, or the dispensing pharmacy deliver the CDs to the patient's home.

Staff in the service should only collect a patient's CD from the dispensing pharmacy in exceptional circumstance, and where the manager deems this is the most appropriate course of action. If this occurs, the rationale for this action must be recorded in the patient's record and steps must be in place to ensure a clear audit trail is maintained.

Where staff are authorised to collect CDs from the dispensing pharmacy appropriate forms of identification must be provided to the pharmacy.

When transporting CDs, the following good practice guidelines must be followed:

- CDs must be transported in a locked vehicle and kept out of sight, preferably in the boot of the vehicle;

- CDs being transported by foot must be transported in a concealed bag, and where applicable tamper-proof seals must remain intact;
- CDs must not be left in vehicles or unattended and must remain on the staff member at all times;
- CDs must be transported directly to the patient's home.

Storage of CDs in patient's own home

Patients in the service should be reminded of the dangers associated with CDs if used inappropriately.

Appropriate places of storage must be discussed with patients, taking into account humidity, temperature, accessibility. Within the home environment, the CDs must be stored securely in a way which minimises the risk of unauthorised access, misuse or diversion. If possible, CDs should be stored in a locked cupboard or drawer.

Staff must record the outline of the discussions regarding appropriate storage of CDs in the patient's records.

Different strengths of CDs should, wherever possible, be stored separately to avoid risk of mis-selection.

Administration

Only trained and competent registered staff are permitted to administer CDs.

CDs must be administered in line with section 16 of this policy, NICE guideline NG46, Royal Pharmaceutical Guidance: Professional guidance on the administration of medicines in healthcare settings and with any organisational policy/procedure of the respective provider.

CDs may only be administered if there is a clear written authorisation (e.g. a copy of the signed and dated FP10 prescription, a signed and dated discharge prescription) from a prescriber. The authorisation must be incorporated into the patient's record. For CD schedule 2, 3 and 4 the authorisation is only valid for 28 days from the date written i.e. for a prescription this will be date on the prescription.

Out of date authorisations must be re-written by the prescriber.

Authorisations cannot be amended, therefore where a prescriber makes a change to the CD (dose, route, formulation etc.) a new signed and dated authorisation must be provided by the prescriber.

When administering a CD to a patient in the service, a second check must be performed by an appropriately trained and competent registered healthcare professional. If unavailable, a suitably trained and competent unregistered healthcare professional may act as a witness and provide a second signature on documentation.

Administration records of all CDs that have been dispensed/supplied for staff to administer to patients in the VW/H@H service must be recorded either on a locally agreed administration chart or on EMIS/equivalent system. The name, form, strength, injection size (where applicable) and quantity of the CD must be recorded. A running balance/stock balance for each type/strength of CD must also be maintained and recorded each time a CD is administered.

Any risks associated with the self-administration of a CD must be considered as part of the MDT assessment for self-administration.

Disposal

Under the Misuse of Drugs Act 1971, patients are allowed to possess CDs that have been prescribed to them. Upon death, or when there is no longer a clinical need for the CD, the

patient, their representative/carer is not entitled to possess the CD, apart from to transport it to a community pharmacy for safe destruction.

Providers must have a policy/procedure in place for the disposal of CDs, including patient own CDs (see Controlled drugs: safe use and management (nice.org.uk)).

Unused/expired or remaining patient own CDs no longer clinically needed should be returned to the community pharmacy by the patient, or their representative/carer for safe destruction and disposal. In this situation the staff member must ask the patient/carer or representative to sign a record of destruction form confirming that they are taking responsibility for returning the CDs to the community pharmacy.

If the patient/patient representative is not able to return the CDs to the community pharmacy, staff in the service should follow the respective provider's policy/procedure for return of CDs.

Providers must have a robust process in place for disposal of consumables and sharps.

Incidents involving controlled drugs

Any loss, misplacement or variation of Controlled Drugs should be managed in line with organisational policy/procedure of the respective provider, notifying the Accountable Officer as appropriate. Any loss or variations should also be reported via the online CD reporting tool: www.cdreporting.co.uk.

Where a potential loss of a CD is identified (e.g. discrepancy in running CD balance), every effort must be made to search for the missing CD. Actions for investigation can include, but are not limited to:

- Checking all CD entries completed are calculated correctly since the last time the balance was checked;
- Checking all the CD entries in reverse chronological order are calculated correctly;
- Where applicable, checking all the CD entries for different strengths/forms of the same CD are correct;
- Checking CDs are being stored in line with this policy and any organisational policies/procedures;
- Checking if any household members (carers/family members) could have access.

22.0 Transfer between care settings

Providers must have an SOP in place for the transfer of care that complies with NICE guidance: Improving transfer of care and NICE [NG27] Transition between inpatient hospital settings and community or care home settings for adults with social care needs.

If a situation arises where a service user requires transfer to another care setting e.g. hospital admission, social care etc. it is important that the following principles are adhered to:

- Ensure any administration records are up to date, showing recently started/stopped medication and allergy status;
- Ensure an accurate list of patient's medicines are communicated clearly (and in a timely manner) with the new care provider;
- Confirm any medicines that can be transferred with the patient. Any medicines that cannot be transferred must be disposed off in the appropriate manner (see section 19).

23.0 Discharge from Virtual Ward/Hospital at Home service

On discharge from the service, accurate and timely transfer of medicines information (included details of any medicines stopped, changed or newly commenced) must be communicated to the patient's usual GP.

Any person being discharged from the service should have a supply of medicine in line with local policy/procedure of the respective provider.

If the person uses a multi-compartment medicines compliance aid (MCA), advanced communication must take place in advance of discharge with the person's usual community pharmacy to arrange ongoing supplies of medication.

Upon completion of a package of care any paper documents e.g. administration charts must be scanned and saved in the patient's electronic record.

24.0 Audit of medication processes

The safe and secure handing of stock medicines for the virtual ward/H@H service must be audited quarterly in accordance with an agreed audit tool for the service.

Internal and external audit processes across the partnership should be undertaken to demonstrate that the service operates adequate management controls to minimise the risk to patient's safety, as well as prevent potential harm through the inappropriate use, misuse or abuse of Controlled Drugs and non-controlled drugs.

25.0 Training and competency assessments

Training must be provided to staff involved in the ordering, storage, disposal or administration of medicines for the service.

Staff required to administer medicines must receive additional training to the level that is required in accordance with organisational and employer standards. Following training for administration, competency assessments should be performed to ensure staff are able to fulfil the role.

Competencies must be managed by either the registered manager, Nursing Team Managers, Social Care Team Coordinators and/or GP Medical Director.

Refresher training should be provided to all staff.

Records must be kept, and a training matrix maintained to demonstrate all training completed by staff.

26.0 Liability

The service, as a partnership, accept responsibility for any negligence from its qualified personnel, provided medicines support and administration are in line with its policies and procedures, individual qualifications and training.

The registered service will not be liable for any of its personnel if/when working for organisations, whether private or voluntary, other than the virtual ward/H@H service.

27.0 Monitoring

The effectiveness of this policy will be monitored through routine medication audits, along with investigation into any adverse medication events, errors and near miss events.

28.0 Equality and Health Inequalities Impact Risk Assessment (EHIIRA)

This policy forms part of the overall Virtual Ward Equality and Health Inequalities Impact and Risk Assessment (EHIIRA).

29.0 Implementation plan

Category	Action(s)	Target date	Responsible person
Engagement	Discuss this Procedure in induction, training, supervision and team meetings	September 2022	Lancashire & South Cumbria VW Clinical Teams
Training	Identify any additional training needs in supervision	Ongoing	Lancashire & South Cumbria VW Clinical Teams

30.0 Consultation

Date	Name of Individual or Group and Designation	Were comments received, considered and incorporated Yes/no	If not incorporated record reason why
19.07.22 02.08.22 16.08.22 06.09.22 20.09.22 27.09.22	**Pharmacy and medicines virtual ward task and finish group:** *Dr Lisa Rogan (Chair)*: LSC ICB, Pharmacy and Medicines Optimisation *Dr Lindsay Dickinson*: LSC ICB, Clinical Primary Care *Dr Sheila Jackson*: LSC ICB, Clinical Primary Care *Dr John Dean*: ELHT, Clinical Secondary Care *Dr Bilaal Adam*: ELHT, Clinical Secondary Care *Dr Sonia Ramdour*: LSCFT, Pharmacy secondary care	Yes	

	Gareth Price: LTH, Pharmacy secondary care *Rebecca Bond*: BTH, Pharmacy secondary care *Jenny Oakley*: UHMB, Pharmacy secondary care *Vince* Goodey: ELHT, Pharmacy secondary care *Nick Howcroft*: BTH, Pharmacy secondary care *Nicola Baxter*: LSC ICB, Pharmacy and Medicines Optimisation *John Vaughan*: LSC ICB, Pharmacy and Medicines Optimisation *Jatinder Saimbi*: LSC ICB, Pharmacy and Medicines Optimisation *Lisa Kay*: ELHT, Clinical secondary care *Katherine Greenhalgh*: LSC ICB, Transformation *Kathryn Best*: FCMS, Clinical *Nicola Feeney*: CPL, Community Pharmacy *Elizabeth Fleming*: LSC ICB, Transformation *Catherine Wright*: LSC ICB, Transformation *Karen Henderson*: LSC ICB, Transformation *Lauren Lalor*: LSC ICB, Transformation *Celine Salisbury*: LSC ICB, Transformation *Chris Hendry*: Informatics		
22.09.22	*Dr David Levy*: LSC ICB Medical Director	Yes	
19.07.22 – 22.09.22	*Dr Andy Curran*: LSC ICB Associate Medical Director	Yes	
22.09.22	*Andrew White*: LSC ICB Chief Pharmacist	Yes	
Organisations			
LSC ICB – Lancashire and South Cumbria Integrated Care Board			
ELHT – East Lancashire Hospitals Trust			
LSCFT – Lancashire and Soth Cumbria Foundation Trust			
LTH – Lancashire Teaching Hospital			
BTH – Blackpool Teaching Hospital			
UHMB – University Hospitals of Morcambe Bay			
FCMS – Fylde Coast Medical Services			
CPL – Community Pharmacy Lancashire			

The ICS virtual ward governance structures and associated members are responsible for ensuring the document is fit for purpose, approved, monitored, reviewed/updated as necessary and before the expiry date in support of the Registered Manager and the Chief Officer.

31.0 References and Bibliography

The policy is drawn from the following legal and regulatory frameworks:

- The Human Medicines Regulations 2012
- The Misuse of Drugs Act 1971 and subsequent regulations
- The Misuse of Drugs (safe custody) Regulations 1973 and subsequent regulations

- Misuse of Drugs Regulations 2001
- The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (and amendments)
- The Health Act 2006

BNF: Guidance on prescribing (accessed 11.08.2022)

CQC: *The safer management of controlled drugs. Annual update 2021* (accessed 11.08.2022)

Department of Health and Social Care: *Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing* (2010) (accessed 11.08.2022)

Department of Health: *The controlled drugs (supervision of management and use) regulations 2013* (accessed 11.08.2022)

Draft NHS England: Guidance on pharmacy services and medicines use within virtual wards (including Hospital at Home) September 2022

General Medical Council: *Good practice in prescribing and managing medicines and devices* (accessed 11.08.2022)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (accessed 11.08.2022)

Medicines Act 1968 (accessed 11.08.2022)

Medicines and Healthcare products Regulatory Agency (MHRA): *Off-label or unlicensed use of medicines: prescribers' responsibilities* (accessed 11.08.2022)

Misuse of Drugs Regulations 2001, and subsequent amendments

NHS Controlled Drug CD reporting https://www.cdreporting.co.uk/

NHS Counter Fraud Authority: *Guidance for prescribers and organisations on the management and control of prescription forms* (accessed 11.08.2022)

NHS: Records Management Code of Practice 2020 (accessed 11.08.2022)

NICE Guidance [NG46]: *Controlled drugs: Safe use and management (2016)* (accessed 11.08.2022)

Public Health England Guidance: Protocol for ordering, storing and handling vaccines (accessed 22.08.2022)

Royal Pharmaceutical Society: *Professional guidance on the administration of medicines in healthcare settings* (2019) (accessed 11.08.2022)

Royal Pharmaceutical Society: *Professional guidance on the safe and secure handling of medicines* (2018) (accessed 11.08.2022)

Specialist Pharmacy Service: *Guidance on retention and storage of Pharmacy Records (England) 2020-21* (accessed 11.08.2022)

Associated trust/CCG/Intermediate care documents:

- Bolton Council Adult Social Care Services Medicines Policy
- Camden and Islington NHS Foundation Trust: Medicines Management Policy August 2019
- Doncaster and Bassetlaw Teaching Hospital Safe and Secure Handling of MEDICINES POLICY Part B Controlled Drugs Version .8
- Hertfordshire Partnership University NHS Foundation Trust: Medicines Policy Version 8.1
- Intermediate Care Albion Mill: Medicines Management Procedure

- Manchester Foundation Trust (MLCO/TLCO): Medicines Policy (Community Health Services) Version 1.0
- Manchester Foundation Trust (MLCO/TLCO): Controlled Drugs Policy (Community Health Services) Version 1.2
- NHS Greater Glasgow and Clyde: Safe and Secure Handling of Medicines in Hospital Wards, Theatres and Departments
- Pennine Care NHS Foundation Trust: Medicines Homecare Services Policy Version 3
- Pennine Care NHS Foundation Trust: Medicines Policy Version 10
- Pennine Care NHS Foundation Trust: Safe Management of Controlled Drugs Policy Version 8
- Rotherham Doncaster and South Humber NHS Foundation Trust: Standards for the Transport of Medication (Safe and Secure Handling of Medicines Manual) Version 1

32.0 Appendices (Note: Appendices are live and subject to change)

Appendix 1: Template/Blank SOP
Appendix 2: Provider Checklist

Appendix 1: Template/Blank Standard Operating Procedure (SOP)

Standard Operating Procedure

Text in red requires amending as per the local service

SOP Title			
Version number	e.g. V2.0		
Review Date	2 years post approved date	Supersedes version number	N/A
Service	Name of service		
Applicable Site(s)	e.g. East Lancashire		

Author/Reviewer Full Name	Full Name	Author Designation	Job Role
Reason for review	N/A for 1st version		
Changes made	N/A for 1st version		
Implementation Method	Read on induction and task related Is additional training offered? Signature list for training, where will it be stored, how will it be monitored and recorded?		
Who needs to read this SOP	List Staff type e.g. A. Nursing staff B. Pharmacist(s)		

Approved by	
Date approved	

Authorisation	Print Name	Date	Signature

SOP made obsolete on	Date made obsolete

Objectives:

To ensure that:……..

This procedure is compliant with the Policy for medicine use within Virtual Wards (including Hospital at Home) and ensures an audit trail is maintained at all times.

Roles & Responsibilities

Service/Clinic Lead/Manager(s) – Is responsible for ensuring that:

Type of staff – are responsible for ensuring that:

Scope:

The scope should detail tasks affected by the SOP, when the SOP needs to be followed and in which areas the SOP applies to. It must include any other procedures and policies that must be read in conjunction with the SOP. Where applicable, it must also include areas that the SOP does not cover or excludes.

This SOP should be read in conjunction with the Policy for medicine use within Virtual Wards (including Hospital at Home).

Stages of the procedure:

This must be a numbered step by step method of performing a task. Each step must be an action and not just information. Language should be kept simple and words which can be misinterpreted avoided e.g. 'may'. Where there is more than one option for a process, each must be mapped out and clearly documented.

Supporting Information:

Include any additional information, resources, documentation in this section e.g. record log for destruction of CDs, general standards, training etc..

References:

Appendix 2: Provider Checklist

Provider Checklist

Providers must ensure they have the necessary policies and procedures in place to support the safe use of medicines in Virtual Wards/Hospital at Home service. The below checklist can be used as a guide.

All SOPs/policies/protocols etc. must go through the respective provider's governance process for sign off/approval prior to use and circulation.

Document/SOP	**Tick to confirm**
Prescription chart	
Administration chart	
Medicine reconciliation form	
SOP for medicine reconciliation	
SOP for management of medicine-related stationary & prescription forms (to cover ordering, receiving, storage, supply and return of FP10s, managing lost/stolen FP10s, managing unused/obsolete FP10s)	
SOP for the supply and record keeping of medicines to patients in VW/H@H service (to cover supply of stock medicines under a PSD, prescriptions and specialist medicines prescribed by secondary care practitioner)	
SOP for management and supply of stock medicines	
SOP for safe transport of medicines (including CDs)	
SOP for safe management of oxygen	
SOP for managing medicine safety alerts, warnings and recalls	
SOP for administration of medicines (including CDs)	
SOP for covert administration	
SOP for managing the self-administration of medicines	
SOP for managing and reporting medicine related incidents	
SOP for safe disposal of medicines (including patient own medicines and CDs)	
SOP for safe disposal of sharps	
SOP for management of consumables (including ordering, receiving, storage and removal/disposal)	
SOP for receipt and record keeping of patient CDs	
SOP for safe transfer of care	
SOP for staff training and records	
SOP for managing specialist/hospital medicines e.g. IV, fluids, red drugs. (to cover prescribing, supply, transportation, administration and record keeping of hospital medicines e.g. IV, red drugs, fluids etc.)	