Ordering, Supply, Transport and Storage of Medication Policy

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Name of Policy: Ordering, Supply, Transport and Storage of Medication Policy

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1.0 Introduction

The ordering, supply, transit and storage of medicines in hospital must comply with current legislation The Medicine Act 1968, The Misuse of Drugs Act 1971 and guidelines published by the Royal Pharmaceutical Society of Great Britain (Duthie Report, 2005). Over the last decade there have been changes to the structure, operational management and legal basis of activities and institutions within the NHS. Key areas of change incorporate the introduction of clinical governance and its requirement for accountability, responsibility for managing risk and the increased awareness of medication errors, the establishment of the National Patient Safety Agency to introduce safe systems for patients, the changing patterns of patient care with length of stay reducing and day case surgery increasing, technological advances such as electronic data transfer, and the increased use of skill mix among healthcare professionals. These systems are established to control access to medicines and to safe guard staff involved in the processes.

2.0 Policy Scope

This policy considers the processes involved with the safety and security of medicines, their handling, ordering, storage, and transport. It does not support the clinical decisions of which drug to use, how to administer, the frequency of administration etc. It does not include the ordering of medicines by pharmacy from external suppliers.

The document applies to all staff employed by Gateshead Health NHS Foundation Trust involved in the ordering, supplying, transport and storing of medicines.

3.0 Aim of the policy

This policy intends to provide guidance:-

- For ordering, supplying, transporting and storing medicines within the Trust in line with government recommendations and legislation.
- To ensure there is a clear audit trail for ordering and supplying medicines.
- To ensure the cold chain is adhered to as recommended.
- To ensure medicines are stored securely at ward and department level.
- To ensure employees understand their responsibilities to these processes.

4.0 Duties - Roles and Responsibilities

Trust Board
To ensure there is a safe and effective medicine management system that meets the requirements of the Care Quality Commission.

Executive Director
The Medical Director is the executive lead for the safety of medicines across the Trust.

Divisional Managers and Divisional Directors
The Divisional managers and Directors are responsible for ensuring that their staff, particularly new starters and locums, follow the procedures within this document, which may differ significantly from elsewhere they may have worked.
Heads of Department /Assistant Divisional Managers
Heads of Department are responsible for ensuring that their staff, particularly new starters and locums, follow the procedures within this document, which may differ significantly from elsewhere they may have worked.

All staff
All staff in the Trust who manage or handle medicines must familiarise themselves with this document and attend training updates so that they maintain their skills and are familiar with procedures. All staff should ensure any documentation pertaining to medicines should be accurate, comprehensive and legible and stored securely in line with local guidance. It is the responsibility of all staff to ensure they are competent to carry out specific medicines handling tasks relevant to their role.

Responsibilities of the Nurse/ Midwife
The sister/charge nurse is accountable for the safe custody and administration of medicines kept on the ward/department and for ensuring that stocks of controlled drugs, if held, are safe and secure and correspond with the details shown in the register.

The nurse caring for the individual patient is responsible for liaising with pharmacy to ensure the timely supply, safe storage and administration of all medicines required.

In addition the nurse in charge of each ward/department is jointly responsible with pharmacy staff to agree which medicines are held as permanent ward stock. Registered general nurses working on the ward, the most senior of which is responsible for the medicine trolley keys and the medicine stock cupboard keys. They are responsible for the safe and secure storage of medicines on their ward. To order medicine they must have completed their drugs assessment.

Responsibilities of the Pharmacy Service
Pharmacy staff are responsible for the safe & effective procurement of all medicines to be used in the Trust.

Pharmacy staff are responsible for the stock of medicines held in the pharmacy and that there is a supply and distribution process in place which ensures medicines are provided in a safe, accurate and timely manner.

Dispensing processes are managed through a range of standard operating procedures held within the pharmacy department. The Chief Technician and the Pharmacy Operational Services manager are jointly responsible for ensuring these reflect best practice and are kept up to date.

It is the responsibility of Pharmacy staff to provide evaluated, independent information and advice to patients and health care professionals, and to monitor and evaluate prescriptions for appropriateness of prescribing.

Pharmacy staff oversee the safe, effective and economic use of medicines across the trust. This process includes regular monitor of prescriptions to ensure appropriateness, accuracy, safety and clarity of prescribing. This is further described in MM04, Pharmacy Standards for chart annotation.
Personnel from pharmacy who visit the ward to undertake duties commensurate with their job descriptions:

**Pharmacy assistants Qualifications NVQL2**  
Responsibilities: ensure that drugs held as stock are topped up to an agreed level at least once a week.

**Pharmacy Dispensing assistant: Qualifications NVQL2 + additional dispensing qualifications**  
Responsibilities: To dispense medicines for In patient use, for Discharge and for Out patients under the supervision of a pharmacist.

**Pharmacy technicians Qualifications NVQL3 and BTech plus additional medicine management qualifications and technician checking**  
Role: Responsible for checking and assessing Patient Own Drugs, for ordering medicines for in patients not held as ward stock, Those with further qualifications undertake medication history and the accuracy checking of prescriptions that have had a previous clinical check by a pharmacist.

**Pharmacists Qualifications: Masters degree + post graduate clinical diploma and Independent prescribing**  
Responsible for ensuring the clinical appropriateness of what is prescribed, for ordering medicines for in patients, for dispensing and checking discharge prescriptions and for undertaking medicine reconciliation.

For giving professional clinical advise to other staff members including medical and nursing staff.

**Responsibilities of Other Registered Healthcare Staff.**  
Some other healthcare staff may be involved in the medicine supply and administration processes. The healthcare professional will be authorised to undertake a specific role and will do so in accordance with the directions of a prescriber, prescription or patient group direction and follow appropriate training and assessment, eg radiographers, operating department assistants. Access to medicines and responsibilities for medicine stocks must be clearly defined in all clinical areas and be in line with the requirements of medicines legislation.

**Porters and Couriers**  
Porters and Couriers are responsible for the safe and timely delivery of medicines from the pharmacy to the wards, departments and clinics. They transport medicines in sealed transit bags or sealed boxes and ensure they are handed to a qualified member of ward staff.

**5.0 Definition of terms**

**Patient Own Drugs**  
Medicines brought into hospital by the patient

**Stock drugs**  
Regularly used medicines held in the ward stock cupboard which are identified on a pre set agreed list

**Medicines for discharge**  
Medicines supplied by the hospital pharmacy for an individual patient, labelled with directions according to
instructions on the medicine kardex prior to a discharge prescription being written

**Temporary stock drugs** Those items required infrequently, not on the stock list and prescribed on the patient medicine kardex

**Discharge medicines** Those items written on the discharge prescription which are supplied with the patient name and directions.

6.0 Ordering Medicines

6.1 Ordering medicines when the pharmacy is open

All medicine must be ordered from the hospital pharmacy either using approved controlled stationery or electronically using the ward based electronic ordering computer system. (The latter method is only available to pharmacy staff).

6.1.1 Permanently stocked items held in the main ward drug cupboards

a) **Wards and departments with a pharmacy ‘topping-up’ service**

i) All items held as ward stock including intravenous fluids will be replenished by the ‘pharmacy top up’ service at least once a week against an agreed stock list.

ii) Wards and departments will be informed of their ‘top-up’ day.

iii) The stock list will be updated at regular intervals by agreement with the sister in charge of the ward and the designated ward pharmacist.

b) **Wards and departments without a pharmacy ‘topping-up’ service**

Each ward will be issued with a computerized list of medicines held as ward stock. The ward stock list indicates the drug name, strength, pack size and quantity of each item held as stock. Each list has a number blank columns in which to order the medicines required.

i) Each time a new order is placed use a new column

ii) Mark the ordering date at the top of the column

iii) For each item ordered indicate the number of packs required. Do not order more than the stock level indicated on the sheet.

iv) A qualified nurse must sign and date the order at the bottom of the sheet

v) Deliver the sheet to pharmacy.

vi) Items required between ‘top ups’ must be ordered by nursing staff on a temporary stock requisition identifying the items as extra stock.
6.1.2 Medicines required temporarily for in-patient use:

a) Wards with pharmacy medicine management service

A pharmacy technician and a pharmacist will visit the ward daily, Monday–Friday at a set time to check ‘Patient’s Own Drugs’ and to identify any additional medicines needed that are not held as ward stock. These items will be supplied for individual patients labelled ready for discharge.

The supply of any new medicines prescribed after this visit which are not held as permanent stock must be initiated by nursing staff, by writing the order in the temporary stock book ensuring:

i) The information required is
   For individual patients:
   - Patient hospital number or date of birth
   - Patient name
   - Drug name
   - Drug form eg tab caps inj
   - Drug strength
   - Drug dose once daily, twice daily
   - Number of days supply or quantity required

ii) For extra stock
    - Identify item as extra stock
    - Drug name
    - Drug strength
    - Drug form
    - Quantity required

iii) The order must be signed by a qualified nurse and the white and pink copy sent to pharmacy. The yellow copy remains in the book as a reference for ward and pharmacy staff.

   (Following dispensing the pink copy will be returned to the ward with the medicine)

iv) The pharmacy team must then be contacted to inform them a new medicine has been prescribed and that an order has been written. The pharmacy team will respond and if appropriate a named patient supply, labelled ready for discharge will be made.

v) If the order is made when the pharmacy team are not available to contact, send the order to pharmacy for dispensing. A supply will be made to the ward and not specifically for a patient.
b) **Wards and departments without a pharmacy medicine management service**

Medication required temporarily must be ordered by a qualified nurse using the temporary stock ordering book as in 6.1.2

i) Orders can be placed in the pharmacy transit bag for delivery to pharmacy first thing in the morning, or can be delivered by hand later in the day.

ii) Paper orders may be placed in the pneumatic tube system, but staff must be aware that orders do not necessarily reach pharmacy in a timely manner.

iii) Whilst pharmacy staff play a major role in leading the supply of medicines, the nurse responsible for administering prescribed medicines to the patient must fulfill their duties by sourcing medicines NOT available on the ward, according to the algorithm in Appendix 1

6.1.3 **Controlled Drugs**

Controlled must be ordered in the Controlled Drug order book see MM05

6.1.4 **Discharge Medication (minimum 7 days supply)**

a) **Wards with a pharmacy medicine management service**

i) Wards should work to pre-empt and ensure discharge prescriptions are written or produced electronically in preparation for discharge. When a discharge prescription is ready to be dispensed, ward staff must page the pharmacist covering the ward.

ii) They will respond and clinically check the prescription and identify those medicines still required (some will already have been supplied as in 6.2.1)

iii) The prescription will be endorsed and either completed at ward level or sent to pharmacy for completion. In the latter case an indication of what time the prescription is required back by the ward should be written onto the prescription.

iv) If all the medicines are already on the ward the nursing staff will be informed.

b) **Wards without a pharmacy medicine management service**

i) Ward staff must send the completed discharge summaries to pharmacy for processing. They must be
complete with ward, patient name and address, hospital number, date of birth, allergy status, discharge date and be signed by a doctor.

ii) A patient addressograph should be placed on each copy of the script if it is a handwritten copy. Electronically generated copies should have this information printed automatically.

iii) Any Patients’ Own Medicines should be identified as suitable for use by the qualified nurse discharging the patient as in Appendix 3 and the prescription marked POD against each item or these items should be sent to pharmacy.

iv) Any medicines already supplied by pharmacy should be marked as ‘supplied’ on the prescription.

v) The prescription should be sent to pharmacy for any remaining items required.

### 6.1.5 Ordering at the Week-ends and Bank Holidays

**a) Ordering medicines on a Saturday when pharmacy is open**

i) **Medical Admissions, Short Stay**
   A pharmacist will visit the ward on a Saturday to clinically check discharge prescriptions and order any newly prescribed medicines. Nurses have a responsibility to support this process and highlight when they require a medicine to be ordered, using their temporary stock order book 6.1.2 and by informing the pharmacy team.

ii) **Surgical wards 9, 10, 14, 14A only**
   A pharmacist will visit on a Saturday to process discharge prescriptions only. Nurses are expected to order any newly required medicines using the temporary stock book as in 6.1.2.

iii) **All other wards**
   Nursing staff are expected to order any newly prescribed medicines on a temporary stock order and send it to pharmacy ready for the opening times as per 6.1.2.

iv) Discharge prescriptions should be sent to pharmacy following endorsement as in 6.1.4 b, if any medicines still need to be supplied.

**b) Sunday and Bank Holidays**

i) Pharmacy staff will **not** visit the ward on these days. A limited number of staff will provide a dispensing service.
from the main pharmacy. Nursing staff are responsible for ensuring any medicines required are ordered as per 6.1

ii) Discharge prescriptions should be sent to pharmacy as 6.1.2

6.1.6 Out of hours /On call service

a) Discharge medicines required when pharmacy is closed
It is not anticipated that it will be necessary to dispense medicines for patients being discharged when the pharmacy is closed as every effort is made to pre-empt the date of discharge and dispense medicines in advance. On the occasion that it may be necessary to discharge a patient when the pharmacy is not open three days supply may be dispensed on the ward, as follows to provide the patient with sufficient medication to cover their needs until further supplies should be obtained from the GP. Controlled drugs must not be dispensed by this method

b) Out of Hours dispensing
This process is designed to facilitate discharge of patients at short notice when the pharmacy is closed giving them sufficient medication to cover their needs until he/she can obtain supplies from their own GP. A quantity to last THREE days only will be dispensed.

NB Controlled drugs cannot be dispensed in this way

i) A discharge prescription must be written by a doctor for the medicines required.

ii) Dispensing will be carried out by 2 qualified nurses. This will be the nurse/midwife in charge and one other registered nurse.

iii) The medicines used will be obtained from ward stock or temporary stock issues.

iv) Containers and labels will be provided in ‘Dispensing Boxes’. These will be issued by the pharmacy department and contain Assortment of containers and labels. Boxes will be kept at the following locations:- Wards 9, 12, MAU, 20, 14A and Post Natal.

v) The labels must be prepared before the tablets/medicines are decanted.

vi) The following information must be put on the label to satisfy legal requirements:-
The name, formulation and strength of the drug
The quantity supplied
The dose & frequency
The patient’s name
The date of dispensing

vii) Items for external use must be so labelled.

viii) Items such as ear drops, suppositories must be labelled ‘Not to be Taken’.

ix) Medicines must be labelled, where it is not obvious from the name, if they contain paracetamol, using the supplementary labels provided: ‘contains Paracetamol’.

x) A limited supply of other supplementary labels are provided for use if necessary eg. ‘Store in Fridge’.

xi) Each item required must be dispensed and the label immediately attached to the container.

xii) Each item must be checked by a second nurse and the initials of both the dispenser and the checker must appear on each ‘dispensed by/checked by’ label which is affixed to each container.

c) Other medication required outside of normal working hours may be obtained by:-

i) Accessing the emergency drug cupboard
   The emergency drug cupboard is situated in the entrance to pharmacy and access is via the person with site responsibility holding the 1200 bleep.

ii) Contacting the pharmacist on –call via the hospital switchboard
   a) The pharmacist ‘on call’ will be able to advise if the medicine required is held by another ward. The medicines must be transferred between wards in labelled containers only. Dose units must not be decanted to other containers.

   b) In the situation when the medicine required is not available contact the ‘on-call’ pharmacist who will make a judgment as to whether or not to come into the hospital to make a supply, dependent on the urgency.

   c) It must be noted the ‘on call’ pharmacist is not resident on site. The pharmacist will answer the pager within 20 minutes to assess the urgency.
and requirements of the call. Urgent medicines will be supplied within 2 hours, if available and in stock.

d) For access to controlled drugs out of hours see MM05 Section 6.9

6.1.7 Parenteral Nutrition

i) PN must be ordered by a qualified doctor using a designated PN Request Form.

ii) The completed form must be sent to pharmacy before 2pm to ensure PN can be prepared for that day.

iii) When pharmacy is closed PN bags are available from the emergency drug cupboard together with a copy of the Guidelines for Out of Hours Parenteral Nutrition. Remember to indicate on the record sheet inside the emergency drug cupboard the product taken, the patients name and the ward.

6.1.8 Cytotoxics and other high risk medicines

a) During normal hours
   All parenteral cytotoxic drugs must be prepared by the pharmacy aseptic services department. Staff administering cytotoxic drugs must have received appropriate training.

   Pre- printed regimen specific prescriptions are available on the Trust intranet for all approved cytotoxic drugs/regimens. These drugs should only be prescribed by appropriately trained and qualified doctors – see MM06.

b) Outside of normal hours
   Cytotoxic medication should not be routinely be requested outside of normal working hours Monday to Friday except in the following circumstances.

   i) Methotrexate required for ectopic pregnancy.

   ii) Cyclophosphamide for lupus or vasculitis.

   iii) A range of pre-filled methotrexate and cyclophosphamide syringes are kept as stock in pharmacy for issue out-of –hours via the on call pharmacist.

   iv) In addition to cytotoxics and parenteral nutrition, pharmacy prepare a small range of other high risk injectable medicines and supply them in a ready to administer format – a Product List can be found on the Trust Intranet together with pre-printed prescriptions.
The preparation service is available Monday to Friday, 8.30am to 4pm

6.1.9 Intrathecal Chemotherapy

This Trust does not prepare or administer intrathecal chemotherapy – see MM06

6.1.10 Strong Potassium Injections

In line with NPSA guidelines strong potassium injections are only available on Critical care and Coronary care and from pharmacy.

The strong potassium preparations stocked by pharmacy at Gateshead Health NHS Foundation Trust are:-

Potassium chloride 15% (20mmol) ampoules
Potassium phosphate 17.42% (10ml) ampoules
Addiphos vials.

A phosphate polyfusor is also available containing (Na+ 162mmol/L, 19mmol K+/L and PO4 3- 100mmol/L

They must only be used by wards to make up potassium infusions for individual patients where there is no ready to use commercially available product. (pharmacy keep a limited supply of commercially available ready- made potassium infusions that are not routinely available to wards).

Wards requiring potassium infusions in strengths that are unavailable commercially, must speak to a pharmacist who will advise what to do.

a) Access to Potassium Infusions when the pharmacy is open

Unusual strengths of potassium infusion held in pharmacy, may be ordered for an individual patient basis using the temporary stock order book see 6.1.2.

In the case of a strength being required that is not in a ready-made infusion pharmacy, the infusion can be prepared by pharmacy on receipt of a ‘copy ’ of the completed IV drug form.

b) Access to potassium infusions when the pharmacy is closed.

Contact the ‘on call’ pharmacist who will inform you what to do. Strengths of potassium infusion not available commercially must be made up by the staff on either CCD or CCU.

The kardex /IV prescription chart must be taken to either CCD or CCU by a qualified nurse, to allow the solution to be made by
a qualified nurse on either ward for the individual patient. Only one dose can be made at a time.

**Wards stocking Strong Potassium injection MUST NOT issue it to another ward, other than made into an infusion as above for a named patient.**

### 6.1.11 Unlicensed medicines

i) Unlicensed medicines must only be prescribed if there is no commercially available alternative to meet the clinical needs of the patient see.

ii) The first time an unlicensed medicine is ordered for a patient an unlicensed request form must also be completed Appendix 2

iii) The order must be written on a temporary stock form as 6.1.2

iv) For responsibilities and categories of unlicensed medicines refer to MM04

### 6.1.12 Controlled Drugs  see MM05

### 6.1.13 Community Midwives

See MM05 section 6.11 for ordering and supply of CDs to community midwives

Other medicines are ordered using a bar coded stock sheet see 6.1.1.b

### 6.1.14 Sexual health clinics and Family Planning Clinics

Medicines are ordered using a bar coded stock list which are sent to pharmacy on a weekly or monthly cycle and the medicines in a sealed transit box with the Trust driver see 6.1.1.b

### 6.1.15 Walk in Centres

The Walk in centre will order stock items as per 6.1.1.b

### 6.1.16 Drug Samples should not be left on the wards or departments without agreement from the formulary pharmacist, and completion of the correct paperwork

### 6.1.17 Clinical trials

This policy covers the dispensing/supply of all clinical trial products within the Gateshead Health NHS Foundation Trust Pharmacy Department.
And covers commercial and non-commercial clinical trials and investigator initiated clinical research.
The pharmacy department may support clinical trials involving medicines, biological substances, gene therapy, or radiopharmaceuticals. It is the responsibility of pharmacy to ensure compliance with the following guidelines and regulations covering the management of these products:

EU Clinical Trials Directive (EC Directive 2001/20/EC)
Medicines for Human Use (Clinical Trials) Regulations 2004
RPSGB Practice Guidance on Pharmacy Services for Clinical Trials 2005

When a clinical trial is taking place within the Trust all Investigational Medicinal Products (IMPs) should be stored and dispensed by the hospital pharmacy department. IMPs must not be stored in offices, clinics or ward areas unless by prior agreement with pharmacy.

a) Commencement of New Trials Involving IMPs

i) Pharmacy must be informed of any trial involving IMPs as part of the Trust R&D approval process

Designated pharmacy staff must review each protocol which involves the use of an IMP, to assess the feasibility of the study, cost the work to be undertaken by the pharmacy department and where appropriate assess the impact for the Trust.

ii) Prior to the commencement of a clinical trial and dispensing of any IMPs the pharmacy must be satisfied that clinical trials have the following approvals in place:

Clinical Trial Authorisation from the MHRA
Favourable opinion from the appropriate Research Ethics Committee(s)
Approval from Trust R&D Committee

In addition, the pharmacy department must be in receipt of the final copy of the protocol and any amendments and the latest version of the investigator brochure prior to dispensing any IMPs.

iii) Service Details

Range of trials

Trials permitted: Pharmaceutical Industry sponsored trials
Charitable organisation sponsored trials e.g. MRC, EORTC
In-house trials
Trials excluded: Those requiring aseptic reconstitution (other than cytotoxic trials)

iv) **Hours of Service**
Clinical trials will only be dispensed Mon-Fri 8.30am-5pm. Clinical trial dispensing is not to be carried out as part of the on-call service. (The only exception to this is the occasional opening of emergency code-break envelopes).

v) **Service Limitations**
The provision of clinical trial services is limited by: storage space, storage temperature, reconstitution time for cytotoxics, current workload and personnel.

Bulky containers/vast amounts of stock may require storage elsewhere in the department. Current staffing levels are not adequate for preparation of aseptically dispensed clinical trials (other than cytotoxic trials).

vi) **Funding**
Pharmacy fees are levied for each trial in accordance with the 'Gateshead Health NHS Foundation Trust Pharmacy Fees for Clinical Trials Work'. These cover the cost of clinical trial medication storage and the administration cost associated with the trials.

vii) **Storage**
IMPs are given designated areas of storage in the pharmacy as appropriate
In the dispensary
In refrigerated storage
In aseptic services

viii) **Monitoring**
The temperature of the dispensary and dispensary fridge is monitored daily (Mon-Fri) by pharmacy staff. Procedures exist within the pharmacy department to cover the event of power failure to the dispensary fridge where clinical trial medication may be stored.

ix) **Training**
All permanent pharmacy staff involved with clinical trials undergo Good clinical practice training on a regular basis.

Dispensary staff undergo an induction programme involving clinical trials dispensing.

Each clinical trial has a designated file that contains a step-by-step dispensing guide specific to that trial.
The designated pharmacists for trials are readily available should problems arise.

Each trial file contains a signature log detailing all the pharmacy staff involved in the receipt, dispensing and disposing of medication related to that trial.

x) Process Details
There are departmental standard operating procedures in place for all pharmacy operations associated with clinical trials.

Signed prescriptions or orders are required for all clinical trials dispensed.

The appropriate file and stock are located using the clinical trial code found on both the relevant trial file and the shelf where the relevant IMPs are stored.

Each trial is dispensed according to the step-by-step instructions in the appropriate file.

xi) Prescription Charges
The NHS Prescription Charge applies to all clinical trials involving IMPs unless the subject is exempt or the clinical trial is placebo controlled. A trial sponsor may choose to pay the prescription charges for all subjects enrolled in the trial.

6.2 Transport of medicines

Transport of medicines to wards and departments is mainly undertaken by hospital porters. Deliveries to wards and departments off site is undertaken by a courier service.

6.2.1 Stock items

These items are transported from pharmacy to the wards in sealed or lockable boxes following the weekly ‘top-up’. On receipt ward staff should inform the pharmacist on duty if the seal or lock has been tampered with.

6.2.2 Other items

i) Prescriptions, temporary stock items and other items required between ‘top ups ‘will be returned in sealed transit bags with the porters on their regular runs

ii) If items are collected between porter runs, nursing staff or care assistants will be handed the item provided they have their
hospital ID badge with them. These items will not be in a tamper evident container.

Clinical trials are collected by the clinical trial nurse.

6.2.3 Controlled Drugs as per MM05

Ward staff are required to collect any discharge prescriptions containing schedule 2 Controlled Drugs which are sealed into special transparent CD bags. They will be asked to sign the counterfoil of the bag, to ensure a clear audit trail can be followed and must have their hospital ID badge with them.

Stock controlled Drugs
Each ward has its own CD transit bag which should be sent to pharmacy with the order book and in which the CDs are returned to the ward with the porter.

6.2.4 Intravenous Fluids

a) Theatres
Intra venous fluids for theatres are delivered directly from the manufacturer. Theatre staff are required to check the delivery note and send it to pharmacy. Pharmacy must be informed of any discrepancies and of any damaged goods.

b) Other wards
I.V fluids will be delivered by the hospital porters. Wards staff are responsible for ensuring they are stored correctly and that stock is rotated to avoid expired products being held on the shelves.

6.2.5 TPN

Will be delivered on the normal porter run in sealed transit bags. These products must be placed in the refrigerator on receipt.

6.2.6 Cytotoxics

Are transported in sealed tamper evident bags kept specifically for these products.

6.2.7 Community nursing

Midwives come to pharmacy to collect their controlled drugs.

6.2.8 Clinical trials

Will be collected from pharmacy by the Clinical Trials nurse or her representative.
6.2.9 Refrigerated Lines

i) To ensure maintenance of the cold chain transit bags are marked when they contain fridge lines highlighting to staff these items need to be stored appropriately as soon as they arrive on the ward.

ii) Medicines are kept in the refrigerator in pharmacy until the time of the next porter delivery.

iii) Medicines are put into readily identifiable fridge bags to remind staff of the storage requirements.

iv) Vaccines are collected by staff directly from pharmacy and taken straight to the ward for appropriate storage.

6.3 Storage of medicines outside of pharmacy

6.3.1 Stock Medicines

i) There should be separate lockable ward cupboards as follows:

- Controlled Drug Cabinet which complies with the Misuse of Drugs (Safe Custody) Regulations 1973
- Internal Medicines cupboards
- External medicines cupboards
- These Medicine cupboards for internal and external medicines should comply with the British Standard BS2881(1981)-NHS Estates Building Note No. 29

ii) Lockable Refrigerators/ freezers for medicines for medicines requiring theses storage facilities, fitted with a temperature monitor/alarm.

iii) In addition an identified storage areas should be made available for intravenous fluids and medical gases

iv) The responsibility for maintaining the system for the security of all medicines within the ward/ department rests with the ward/ departmental manager or senior nurse in charge of the ward.

6.3.2 Use of medicine trolleys

Where medicine trolleys are in use to take medicines to the bedside they should be lockable and immobilized when not in use and never left unattended.

6.3.3 Patients’ Own Drugs

i) Any medicines brought into hospital by a patient admitted to the ward, must be stored securely in the Patient’s Own Drug box.
adjacent to the bedside or incorporated as a locked drawer as part of the bedside locker.

ii) Patient’s Own Drugs should only be used once prescribed on the in-patient drug kardex

iii) They should be assessment for suitability of use by a doctor, qualified nurse, pharmacist or pharmacy technician. See appendix 4. Any medicines which are not clearly identifiable should not be used.

iv) Under no circumstances should Patient Own medicines be considered for re-use by any patient other than the person for whom they are prescribed and labeled

6.3.4 Medicines dispensed for individual patients prior to discharge.

Medicines dispensed for individual patients by the hospital pharmacy should be stored in the Patient’s own drug locker

6.3.5 Storage of Controlled drugs see MM05

6.3.6 Keys for drug cupboards/refrigerators

The responsibility for all medicines remains the Appointed Nurse in Charge. They should be responsible for controlling access to the medicines cupboards, trolley, refrigerator and any stock cupboards in the patient bays.

EVEN IF HE/SHE DECIDES TO DELEGATE THE DUTY OF CONTROLLING ACCESS

The drug keys should be carried at all times by a qualified nurse who is competent to administer drugs and is assigned to the ward/department. Keys must NOT be given to nurses not assigned to the ward.

i) Keys must not be left in cupboard locks

ii) Keys may be given to pharmacy technicians and pharmacists on request

iii) The responsibility for the whereabouts of the keys lies with the nurse in charge of the ward during the shift.

iv) In the event of the keys being lost or unable to be located an investigation must be undertaken immediately. If they are not found then the incident must be reported on a Datix.

v) The key for the Controlled Drug Cupboard must be held separately from the main drug cupboard key. Each ward and department must only have one set of keys for the controlled drug cupboards. See MM05 section 6.6
vi) Access to the Controlled Drug Cupboard must be supervised by the designated key holder at all times.

vii) The divisional manager is responsible for identifying where a spare set of keys for each ward/department will be securely located. The location security and access to the spare set must be known to relevant senior staff on the ward/department. The divisional manager is responsible for reviewing incidents relating to misplaced keys to ensure any trends are identified.

viii) Within maternity, keys must be carried by midwives with the exception of Obstetric theatre where these can be held by a nurse designated to that area, or an operating department practitioner designated as an anaesthetics assistant.

6.4 Supervision of medicine supply from within the pharmacy department and at ward level

A range of standard operating procedures are available in the pharmacy to ensure:

i) Discharge and Out-Patient prescriptions are appropriately screened by a Pharmacist and any clinical issues resolved.

ii) All items are dispensed and checked by a second independent person.

iii) All staff involved in the dispensing and checking of medicines are appropriately trained and have demonstrated competence to perform the tasks.

iv) Medicines will be dispensed in manufacturer’s original packs wherever possible and a patient information leaflet supplied.

v) Labels on dispensed products will be clear and legible and include the details required by the labeling regulations under the Medicines Act 1968 and where appropriate any cautionary and advisory labeling recommended by the British National Formulary.

vi) A pharmacist will be present in the department at all times to ensure overall supervision of staff involved in the dispensing of medicines.

vii) For out-patients, a pharmacist or suitably experienced qualified technician will ensure that patients receive sufficient information and advice to enable the safe and efficient use of medicines.

viii) The supply of appropriate, accurately dispensed medicines is the responsibility of all those involved in the process. Each member of staff must accept responsibilities for the quality of their work. Accurate working and self-checking are as important as the final check in ensuring that medicines are correctly dispensed. Standard operating
procedures are available to provide guidance to all staff involved in the dispensing of medicines.

ix) All dispensing errors are reported through the Trust's datix reporting tool. The operational services manager is responsible for reviewing errors reported and identifying trends of either processes or individuals.

6.5 Disposal of medicinal waste

i) All medicinal waste is classified as special waste and must be disposed of appropriately

ii) Medicinal Waste is disposed of in line with recommendations taken from the Health technical memorandum 7-01 ‘Safe management of healthcare waste’ and the Hazardous Waste regulations 2005 and COSHH guidelines

iii) Unused medicines no longer required by the ward must be returned to pharmacy where any unfit for use or expired will be destroyed in line with Trust policy IC09

6.6 Cytotoxic and cytostatic medicinal waste

These types of medicine are classified as being hazardous waste as they are either toxic, carcinogenic, mutagenic or Toxic for reproduction. For this reason hazardous waste must not be mixed with non hazardous waste. The Trust has adopted a colour coded system for disposal of waste. See PP Also refer to local procedures held by areas handling this type of medicine.

i) Cytotoxic and Cytostatic medicines must be disposed of in yellow waste drugs with purple lids and a purple label

ii) For a list of cytostatic and cytotoxic medicines see appendix 4.

iii) All other medicines must be disposed of in yellow bins with red labels as per IC09.

iv) Medicines are disposed of in pharmacy according to pharmacy as per IC09.

v) Controlled Drugs must be disposed of and rendered irretrievable as per MM05.

vi) Exceptions to the above:-

Part used small volume injections, which can be discarded into a sharps bin at ward level.

Part used IV fluids and TPN feeds which can be treated as other fluids and the excess discarded in the sluice with the container being put into the medicine waste container.
6.7 Medical gases

Medical gases are classified as medicines and hence are ordered through the pharmacy department. For further information refer see OP 66

7. Training

As described in MM01.

8. Equality and Diversity training

An equality analysis has been undertaken for this policy, in accordance with the Equality Act (2010) as described in MM01

9. Process for monitoring compliance with the policy

<table>
<thead>
<tr>
<th>Standard process / issue</th>
<th>Audit method</th>
<th>Person responsible</th>
<th>Frequency of audit</th>
<th>Committee Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordering medicines</td>
<td>10 patients per ward. Number of missed doses in previous 24 hours</td>
<td>Pharmacy operational services pharmacist, Practice development nurse</td>
<td>Annual</td>
<td>Trust Medicines Governance Group</td>
</tr>
<tr>
<td>Number of omitted doses</td>
<td></td>
<td></td>
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<tr>
<td>Clinical Incidents</td>
<td>Datix analysis</td>
<td>Pharmacy Clinical services manager/Operational Services manager</td>
<td>Quarterly</td>
<td>Trust Medicines Governance Group</td>
</tr>
<tr>
<td>Ward fridge temperatures recorded Weekly by</td>
<td>Ward fridge temperatures recorded Weekly by</td>
<td>Senior Technician Ward Services</td>
<td>Annual Summary</td>
<td>Trust Medicines Governance Group</td>
</tr>
<tr>
<td>Security of Medicine storage</td>
<td>Analysis tool in ward profile:- Includes Stock drugs PODs and Fridge lines</td>
<td>Pharmacy operational services pharmacist and practice development team</td>
<td>Annual</td>
<td>Trust Medicines Governance Group</td>
</tr>
<tr>
<td>Standard process / issue</td>
<td>Audit method</td>
<td>Person responsible</td>
<td>Frequency of audit</td>
<td>Committee Responsible</td>
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<tr>
<td>Pharmacy ATO staff</td>
<td>Pharmacy department fridges monitored and temperatures recorded daily</td>
<td>Pharmacy Operational Services Pharmacist</td>
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<tr>
<td>Clinical Trials</td>
<td>MHRA external audit</td>
<td>Medicine Governance Pharmacist</td>
<td>Annually</td>
<td>Research and Development Committee</td>
</tr>
<tr>
<td>Unlicensed medicines</td>
<td>Audit of products ordered and issued</td>
<td>Pharmacy Operational Services manager</td>
<td>annually</td>
<td>Trust Medicines Governance Group</td>
</tr>
<tr>
<td>Compliance with review and expiry dates</td>
<td>Monitoring of database with preparation of monthly report on outstanding policies</td>
<td>Trust Secretary</td>
<td>Monthly</td>
<td>Central Team</td>
</tr>
<tr>
<td>Compliance with each stage of the process</td>
<td>An audit of all new and revised policies during the year</td>
<td>Trust Secretary</td>
<td>Annual</td>
<td>PQRS</td>
</tr>
</tbody>
</table>

10. **Consultation and review of this policy**

Members of the Medicines Governance Group and the Equality and Diversity Coordinator.

11. **Implementation of policy (including raising awareness)**

All members of staff will be informed via e-mail and the Medicines Management Newsletter as and when the policy is reviewed and re-implemented.

12. **References**

- Medicine Act 1968
- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Misuse of Drugs Safe Custody Regulations 1973
- Health Act 2006
- Equality Act 2010
- Controlled Drug (Supervision of Management and Use) Regulations 2006
• The Government’s response to the Shipman Inquiry’s Fourth Report
• The Duthie Report – Guidelines for the Safe and Secure Handling of Medicines (March 2005 revision The Safe and Secure Handling of medicines: A Team approach RPSGB
• NMC Standards of Conduct, Performance and Ethics for Nurses and Midwives
• NMC Standards for Medicines Management
• NMC Midwives Rules & Standards
• NMC Standards for proficiency for Nurse and Midwife Prescribers
• The Best Medicine - Health Care Commission 2007
• British National Formulary., BMJ Group & RPS Publishing, UK
• A Spoonful of Sugar: Medicines Management in NHS Hospitals.
• Audit Commission 2001
• Building a Safer NHS for Patients – improving medication safety (DH 2004)
• NHS Litigation Authority
• An Organisation with a Memory (DoH, 2000)
• Medicines Management: Everybody’s Business
• A guide for service users, carers and health and social care practitioners (DH,2008)
• Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence. NICE Clinical Guideline 76 (2009)
• National Prescribing Centre, Mixing of medicines prior to administration in clinical practice – responding to legislative changes, May 2010
• Department of Health, Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing, May 2010
• Thames Valley Y-Site Intravenous Drugs Compatibility Chart (March 2011), Thames Valley critical care network pharmacists group
• Palliative care Formulary
• The Syringe Driver: Continuous Subcutaneous Infusions in Palliative Care
• National Cancer Peer Review Programme – Chemotherapy Measures
• Updated national guidance on the safe administration of intrathecal chemotherapy
• NCEPOD Systemic Anti-Cancer Therapy: For better, for worse? (2008)
• NCAG Chemotherapy Services in England: Ensuring quality and safety (2009)
13. **Associated documents**

This policy relates to

- Drug Policies MM01 – MM06
- Standard operating policies with in pharmacy and on the wards
- OP66 Medical Gases
- IC09 Waste Policy
Medication unavailable?

What you should do before you ‘3’ it

1. If POD (patient’s own drug) or SUPPLIED, look in bedside medicines locker
2. If STOCK, look in drug trolley
3. If not in trolley/locker, check delivery box in treatment room and/or ward stock cupboard

NB: If the item has been endorsed on the drug chart as ‘Supplied’ with today’s date but is not on the ward, it may still be in pharmacy and should be delivered later that day.

Drug available?

Yes

Administer dose

No

Does the drug require parenteral administration? or Would missing a dose compromise the patient’s treatment (e.g. diabetes, epilepsy etc. Refer to Critical Medicines List* to aid decision-making?

Yes

Immediate action must be taken to obtain a supply

No

1st missed dose

2nd or subsequent missed dose

• Document No. 3 on drug chart
• Take action to obtain a supply of medication. If not possible and out of hours send temp stock to pharmacy.
• Document TS ordered, date and sign in other instructions box on drug chart

How to obtain a supply

During pharmacy opening hours: Contact ward pharmacy team
Out of hours:
• Ask family / carer to bring PODs into hospital
• Check emergency drug cupboard list (Copy on ward or Medicines Information page on the Intranet)
  Bleep 1200 to obtain supply from emergency drug cupboard
• If you know that a specific ward stocks the item, you can borrow whole, original packs from them, but do not spend time ringing around the wards
• Bleep the emergency duty pharmacist, via the switchboard, who will be able to advise you on how a supply of the medicine may be obtained, or whether or not the dose could be missed

Follow up on action taken after 1st missed dose.
Full documentary reason for and action taken to obtain medicine to be documented in patients care record (Standard 8-Standards for Medicines Management, NMC 2008)

When the drug becomes available, administer the dose after first clarifying with a pharmacist or medical staff if this is appropriate

Do everything you can to avoid missed doses

Missing doses of important medication compromises patients’ treatment, can be potentially harmful and may lengthen their stay in hospital.
# Request For A NON-FORMULARY and/or UNLICENSED Medicine For The Treatment of an INDIVIDUAL Patient

Please complete this form if you require a non-formulary and/or unlicensed medicine for the treatment of an individual patient and Return to Pharmacy.

* THIS IS NOT A PRESCRIPTION – A PRESCRIPTION IS ALSO REQUIRED *

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>1. Product Requested:</strong> (incl. Form &amp; strength)</td>
<td><strong>Date Requested:</strong></td>
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<td></td>
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<tr>
<td><strong>2. Patient Details:</strong></td>
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<tr>
<td>Name:</td>
<td></td>
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<tr>
<td>Hospital No:</td>
<td></td>
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<tr>
<td>Ward / Dept:</td>
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<tr>
<td>Requesting Consultant:</td>
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<tr>
<td>Consultant Signature:</td>
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<tr>
<td><strong>3. Reason for Prescribing a NON-FORMULARY / UNLICENSED medicine &amp; Indication:</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
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<tr>
<td><strong>4. Unlicensed Medicine</strong> (Complete only if product is unlicensed)</td>
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</tr>
<tr>
<td>I am aware that the use of this product is unlicensed. I understand when I prescribe and use this product that I am clinically responsible, and that there currently isn't an alternative licensed product available that I could use, and that if necessary I may be called to justify my actions. □ (please tick if applicable)</td>
<td></td>
</tr>
<tr>
<td>I confirm that I wish to use this product for above named-patient and understand that it does not hold a United Kingdom Product Licence. If a GP is asked to continue to prescribe this product I will fully inform them of its unlicensed status and give sufficient information to allow the GP to discharge his/her responsibilities.</td>
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<tr>
<td>Consultant Signature:</td>
<td>Date:</td>
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<td></td>
<td></td>
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<tr>
<td><strong>FOR PHARMACY USE ONLY</strong></td>
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</tr>
<tr>
<td>Prescription received:</td>
<td>Ordered by:</td>
</tr>
</tbody>
</table>
ALGORITHM FOR THE USE OF PATIENTS' OWN DRUGS ON THE WARD

1. Prescribed by their GP or bought over-the-counter?
   - Y do not use
   - N

2. In the original dispensed container?
   - Y do not use
   - N

3. Label, container and drug in good condition?
   - Y do not use
   - N

4. Dispensed within the last six months?
   - Y do not use
   - N

5. The patient's name on the label is the same as the patient
   - Y do not use
   - N

6. Within the expiry on the original manufactured container or within the expiry date on the label of the dispensed container if there is one
   - Y do not use
   - N

7. If there are tablets or capsules in a bottle
   - Rogue tablets / capsules
     - Y do not use
     - N
   - Easily identified
     - Y do not use
     - N

8. Drug name, form and strength on the label agrees with the actual drug?
   - Y do not use
   - N

9. If the drug is a liquid, eye drop, eye ointment, suppository or a pessary
   - Unopened?
     - Y do not use
     - N
   - Cold storage required
     - Y do not use
     - N do not use

   DRUG IS SAFE TO USE
### Appendix 4  List of drugs that are Cytostatic or Cytotoxic

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldesleukin</td>
<td>Interferons</td>
</tr>
<tr>
<td>Alemtuzumab</td>
<td>Lanreotide</td>
</tr>
<tr>
<td>Alprostadil</td>
<td>Leflunomide</td>
</tr>
<tr>
<td>Anastrozole</td>
<td>Letrozole</td>
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<tr>
<td>Azathioprine</td>
<td>Leuprorelin</td>
</tr>
<tr>
<td>Bacillus Calmette-Guerin</td>
<td>Levonorgestrel</td>
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<tr>
<td>Basiliximab</td>
<td>Lutropin alfa</td>
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<tr>
<td>Bicalutamide</td>
<td>Medroxyprogesterone acetate</td>
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<tr>
<td>Busrelin</td>
<td>Megestrol</td>
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<tr>
<td>Carbetocin</td>
<td>Menotrophin</td>
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<tr>
<td>Carboprost</td>
<td>Mesterolone</td>
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<tr>
<td>Cetorelix acetate</td>
<td>Mifepristone</td>
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<tr>
<td>Chemotherapy / Cytotoxics</td>
<td>Mycophenolate mofetil</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>Nafarelin</td>
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<tr>
<td>Choriogonadotropin alfa</td>
<td>Nandrolone</td>
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<tr>
<td>Chorionic Gonadotropin</td>
<td>Natalizumab</td>
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<tr>
<td>Ciclosporin</td>
<td>Norethisterone</td>
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<td>Norgestrol</td>
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<tr>
<td>Clomifene</td>
<td>Octreotide</td>
</tr>
<tr>
<td>Colchicine</td>
<td>Oestrogens, conjugated</td>
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<tr>
<td>Cyproterone acetate</td>
<td>Oestrogens</td>
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<tr>
<td>Cytoxotics / Chemotherapy</td>
<td>Oxytocin</td>
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<tr>
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<td>Peginterferon alpha</td>
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<td>Pentamidine isethionate</td>
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<td>Pegvisomant</td>
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<tr>
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<td>Podophyllotoxin</td>
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<tr>
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<td>Podophyllum resin</td>
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<tr>
<td>Dutasteride</td>
<td>Progestrone</td>
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<td>Progestogens</td>
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<td>Protirelin</td>
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<td>Raloxifene</td>
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<td>Sirolimus</td>
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<td>Tacrolimus</td>
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<td>Flutamide</td>
<td>Tamoxifen</td>
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<tr>
<td>Follitropin alfa and beta</td>
<td>Testosterone</td>
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<tr>
<td>Fulvestrant</td>
<td>Thalidomide</td>
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<tr>
<td>Ganciclovir</td>
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<td>Goserecin</td>
<td>Zidovudine</td>
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</table>

**Notes:**

- All drug names stated are generic names
- All parenteral formulations of the above drugs must be discarded on the ward in containers reserved for cytostatic or cytotoxic waste
- All oral formulations of the above drugs must be returned to the Pharmacy for disposal
- Drugs in bold are included on the Gateshead Health NHS Foundation Trust drug formulary