Somerset County Council Public Health Team
Medicines Management Policy
January 2019
V 3.0

Author: Alison Bell, Clinical Governance Lead SCC Public Health
Reviewed by Jo Smith Head of Services Public Health Services
Signed of Somerset Clinical Governance Panel February 2019
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CONTENTS

1.0 INTRODUCTION

1.1 Somerset County Council Public Health Services are required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner. Staff should ensure that a client of their service can understand the information given to them regarding the medication they are being given and is able to give their informed consent. This may necessitate the use of a professional interpreter and the translation of written information.

2.0 PURPOSE, RATIONALE AND SCOPE

2.1 This policy defines the procedures to be followed by staff within Somerset County Council Public Health Services for the management of medicines used in the delivery of their services, in accordance with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This includes prescribing, obtaining, transporting, recording, handling, safe keeping, dispensing, safe administration and disposal of medicines.

2.2 Where appropriate this policy refers to other Organisational Policies which are linked to the use of medicines. It should be read in conjunction with relevant policies.

2.3 All staff working within SCC Public Health Operational Services who are involved in any way with the use of medicines must familiarise themselves with the correct procedures contained in this policy. Managers must ensure that all staff are familiar with this policy before they are involved with the use of medicines. This is especially important for all new starters and agency staff as procedures may differ from elsewhere.

2.4 This policy recognises the following statutory and advisory publications and should be read in conjunction with:

- Guidelines for records and record keeping, Nursing & Midwifery Council (NMC) 1998
- CQC Outcome 9; Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
- Health Service Circular HSC 2000/026 Patient Group Directions
- The Medicinal Products: Prescription by Nurses Etc. Act 1992
- The Prescription Only Medicines (Human Use) Order 1997
- Somerset CCG Prescribing Formulary – current edition
- Standards for Medicines Management: Nursing and Midwifery Council (2008)

This policy covers:

- Issuing of NRT by stop smoking advisors
- The recommendation for a client to source Varenicline, via PGD through a pharmacist

- The issuing of treatment for Chlamydia by School Nurses, using a PGD
- The issuing of emergency hormonal contraception by School Nurses, using a PGD
- This policy does not currently cover non-medical prescribers carrying out the prescribing function

3.0 DUTIES AND RESPONSIBILITIES

3.1 The **Chief Executive** is ultimately responsible for ensuring the trust complies with legal requirements and national recommendations for medicines management.

3.2 The **Senior Leadership Team of SCC** has a responsibility to ensure training and competency assessment is available to all relevant staff.

3.3 The **Director of Public Health** is the Executive Lead responsible for this policy covering safe medicines practice within Public Health Services, but will delegate authority for the operational implementation and ongoing management of this policy to the Registered Manager who is Head of Service for Public health operational services. There is no requirement for a nominated 'Accountable Officer' as these services do not handle Controlled Drugs.

3.4 **Each registered healthcare professional** is accountable for their own practice and will work within the Code of practice of their professional body. All staff should appreciate the importance of involving the patient and/or carer in their treatment as much as possible. This includes ensuring the patient or carer understands and agrees to the proposed treatment, to ensure maximum compliance and appreciates as far as possible any risks of side effects.

3.5 Information on medication and its side effects should be made available in a range of formats and languages to meet patient need.

3.6 **All registered healthcare professionals** involved in the medication process:

- must acquaint themselves with this policy and other related policies
- will be aware of the action that should be taken if their practice or their patients safety is compromised
- will be aware of the safe dose range, frequency, route, administration technique, side effects, contra-indications, interactions and monitoring requirements of the drugs used
- will advise patients of common side effects and adverse reactions and advise of action to be taken should these arise
- will monitor the outcomes of the treatment against identified treatment goals
- will be aware of their limitations and seek advice or support from appropriate health professionals when in doubt

3.7 All **non-registered healthcare staff** involved in the medication process:

- must acquaint themselves with this policy and other related policies
- will be aware of the action that should be taken if their practice or their patients safety is compromised
- will only undertake tasks in the medication process where suitable policies and procedures are in place, the staff member has been suitably trained for the specific task and competencies have been assessed as appropriate

3.8 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies before they are involved in any drug administration or ordering of medicines and that they are trained and competent to undertake that role.

3.9 **Line managers** are responsible for ensuring that staff attend mandatory training in line with the Staff Mandatory Training Guidance.

3.10 The **Head of Public Health Services** is responsible for ensuring that non-medical prescribers are competent to prescribe and that they follow this policy, when this is put in place in the future.

3.11 **Medicine Management systems for ordering**, storing, administration and supply of medicines, will be overseen by the **Patient Safety Office**r.

3.12 The **Patient Safety Officer** is responsible for reviewing and investigating Medicines incidents and disseminating lessons learned, through **Community Practice teachers** and the **Public Health Nursing Best Practice Group.** Additionally, this officer will undertake annual audits of medicines in use under the scope of this policy and identify any required learning on an annual basis.

3.13 The **Clinical Governance Assurance Panel** reviews incident reports and provides assurance to SCC that all necessary actions have been taken as a result of audits or incidents.

4.0 DEFINITIONS AND SCOPE

4.1 **Medicinal Product**: A Medicinal Product is ‘Any substance or combination of substances presented for treating or preventing disease in human beings or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product.’ Council Directive 65/65/EEC.

4.2 **Prescribing:** The preferred way for patients to receive medicines is for an appropriately qualified healthcare professional to prescribe for an individual patient on a one to one basis.

4.3 **Patient Group Directions**: a specific written instruction for the supply, sale and/or administration of named medicine or vaccine in an identified clinical situation (HSC2006/026). It applies to a defined group of patients who may not be individually identified before presenting for treatment.

5.0 ACQUISITION OF MEDICINES

5.1 Ordering and Receiving Medicines

5.1.1 All ordering will be undertaken centrally against an agreed list of stock medicines; this list will be reviewed annually or as required should new guidance be issued.

5.1.2 All medicines must be delivered in a secure tamper evident transit container and signed for on receipt, after being checked against the order and immediately transferred to a locked, temperature monitored storage location. Each individual pack should have tamper evident features, in accordance with the FMD.

5.1.3 To be complaint with the new Falsified Medicines Directive (FMD) all medical products received by Public Health Services should have a unique identifier (a 2D matrix code and human readable information) on them and this should have been scanned prior to delivery to Public Health services. This needs to be fully implemented within 3 years of the February 2019 launch.

5.2 Storage and Stock Control

- Storage facilities should be situated in a locked room and should not be sited near sources of heat or humidity. The temperature of the room should be monitored on a daily basis to ensure it does not routinely exceed 25°C. Storage facilities should always be locked when not in use
- Medicine stock balances will be checked on a monthly basis and recorded on a stock control system (Annex I), any discrepancy will be reported to the patient safety officer
- None of the medicines covered in this policy require a cold chain to be in place

5.3 Losses and Discrepancies

5.3.1 All staff handling medicines should be security conscious at all times. Anyone discovering an apparent loss of medicines, unauthorised access to medicine storage areas or suspecting the misuse, misappropriation or abuse of drugs must report the matter immediately to patient safety officer or Head of Services. An incident form must be completed (see annex II).

5.4 **Disposal of Medicines**

5.4.1 In the rare circumstance where medicines expire before use, they must be disposed of appropriately, by being returned to the supplier.

5.5 **Samples / Free Stock**

5.5.1 Pharmaceutical company representatives must not leave samples of medicines on any SCC premises nor give them out to staff at meetings

6.0 DEFECTIVE MEDICINES

6.1 Any products found or suspected to be defective must be reported immediately to the Patient safety officer and the supplier and an incident form completed (see annex II).

7.0 PRESCRIBING AND DISTRIBUTION

7.1 **Non-Medical Prescribing –** section on hold currently pending review

7.2 **Patient Group Directives** covered by this service have been compiled in adherence with the standards set out in NICE Medicines Practice Guidance MPG2, published 2013, updated 2017. The processes for each medication is laid out in the respective annex of this policy. The following general principles apply to these were applicable:

- PGDs have been used for limited situations in which this offers an advantage for patient care, without compromising patient safety, and where there are clear governance arrangements and accountability.
- PGDs must only be used by named and authorised registered health professionals who can legally supply and/or administer medicines using a PGD
- That local and national strategies to combat antimicrobial resistance and healthcare-associated infections, have not been jeopardised by ensuring that an antimicrobial is included in a PGD only when: clinically essential and clearly justified by best practice guidance and a local specialist in microbiology has agreed that a PGD is needed and this is clearly documented
- There is a robust and transparent process for obtaining the agreement of the authorising body (which is Somerset County Council) before proceeding to develop a PGD
- There is a multidisciplinary PGD approval group with a locally defined mix of members, who develop and review local PGDs.
- All legal requirements are fulfilled by each PGD in line with the Human Medicines Regulations 2012
- All approved PGDs are available on the organisation's website **http://www.somerset.gov.uk/organisation/departments/public-health/**

7.2.1 **Before practising under a PGD, health professionals should ensure that they:**

- Have undertaken the necessary initial training and continuing professional development
- Have been assessed as competent and authorised to practise by Somerset County Council
- Have signed the appropriate documentation, which is validated by the team leader, copied and stored in the staff members personnel file and a note made on the staff members electronic training record.
- Are using a copy of the most recent and in date final signed version of the PGD
- Have read and understand the context and content of the PGD

7.2.2 **When practising under a PGD**, health professionals should:

- Not delegate their responsibility
- Ensure that they can determine that the patient meets the inclusion criteria as set out in the PGD
- Ensure that they can determine that no exclusion criteria apply
- Discuss alternative options for treating the patient's condition, when appropriate
- Assess each individual patient's circumstances and preferences
- Recognise when signposting or referral to another health professional or service is needed, as specified in the PGD
- Understand relevant information about the medicine(s) included in the PGD, such as:
    - how to administer the medicine
    - how the medicine acts within the body
    - dosage calculations
    - potential adverse effects and how to manage them
    - drug interactions, precautions and contraindications
    - storage requirements, including maintenance of the 'cold chain'
    - follow-up arrangements
- Be able to advise the patient or their carer about the medicine(s), as appropriate

7.2.3 When supplying a medicine(s), provide an appropriately labelled pack. Health professionals (other than pharmacists or dispensing doctors) should not split packs.

7.2.4 Ensure that the patient receives a manufacturer's patient information leaflet with each medicine.

7.2.5 **Document the following information** about the clinical assessment and supply and/or administration of the medicine(s):

- Date and time of supply and/or administration

- Patient details, such as name, date of birth, allergies, previous adverse events and how the patient met the criteria of the PGD
- Details of medicine, such as name, strength, dose, frequency, quantity, route and site (if by injection) of administration (record the batch number and expiry date for vaccines, blood-derived products and other medicines if recommended by relevant national guidance)
- A statement that supply or administration is by using a PGD
- Name and signature (which may be an electronic signature) of the health professional supplying or administering the medicine
- Relevant information that was provided to the patient or their carer
- whether patient consent to treatment was obtained, in line with the Department of Health's advice on consent (2009).

7.3 **Over the Counter Medications – Nicotine Replacement Therapy**

7.3.1 Smokefreelife Somerset core service offers a choice of support to smokers who are motivated to stop smoking depending on the intensity of support required and willingness, commitment or ability to engage in the standard 12 week face to face treatment programme.

7.3.2 ***Three Levels of Support*:**

INFORM ME: Harm from smoking, benefits of quitting, support available

ENABLE ME: In cases where face to face support is not required. Websites, apps, advice and support from SFLS on behaviour change and suitable stop smoking medications (with telephone support for up to 12 weeks). Telephone support may be offered to 'Enable' smokers to make and maintain the behaviour changes required to stop smoking.

SUPPORT ME: Smokefreelife Somerset offers support to smokers who are motivated to stop smoking and willing to engage in a 12 week treatment programme which focuses on behaviour change as well as the use of stop smoking medications. The distribution of NRT is undertaken according to the pathway for the supply of Nicotine Replacement Therapy (NRT) (see ANNEX III).

NRT can only be used alongside support from the Smokefreelife Somerset Service – See Smokefreelife Somerset Core Service Treatment Protocol (see annex IV).

8.0 PATIENT SAFETY

8.0.1 Patient safety is paramount. Staff should be appropriately trained and have read all relevant policies and guidance before using any medications as part of the scope of their practice. To ensure that the chance of doing harm is minimised. Specific issues of patient safety are addressed below.

8.1 **Adverse Drug Reaction**

8.1.1 Should a patient report an adverse reaction, appropriate immediate action should be taken according to the severity of the reaction. The patient should be advised to stop the medication and consult with a medical prescriber, to seek an alternative course of action.

8.2 **Untoward Incident / SIRI**

8.2.1 If a patient has been harmed due to the incorrect use of medication, an incident form should be completed and the patient safety officer or in their absence the head of service notified on the same working day. An investigation will be scoped, and learning cascaded across appropriate services.

8.3 **National Alerts**

8.3.1 The patient safety officer will receive all national Cas alerts and where these apply to the medications used within Public Health services will cascade to the manager of these services. The managers will be responsible for ensuring all staff using this medication is appropriately briefed and appropriate action taken. E.g product withdrawn, batch numbers removed.

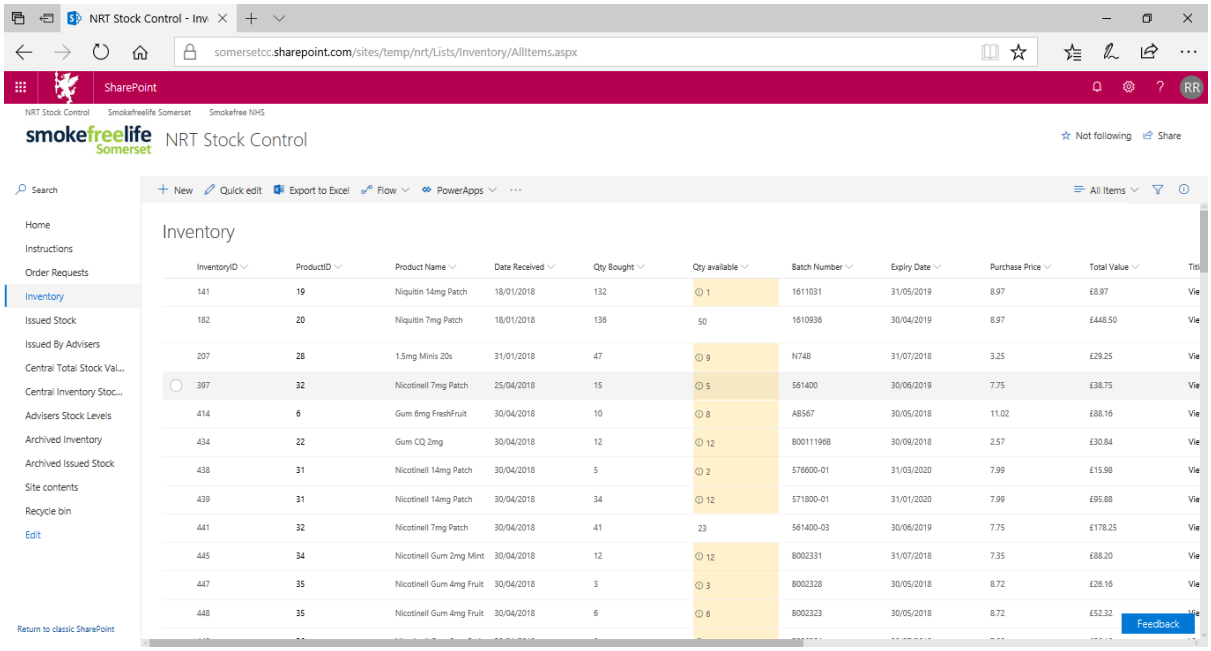
9.0 MONITORING PROCESSES

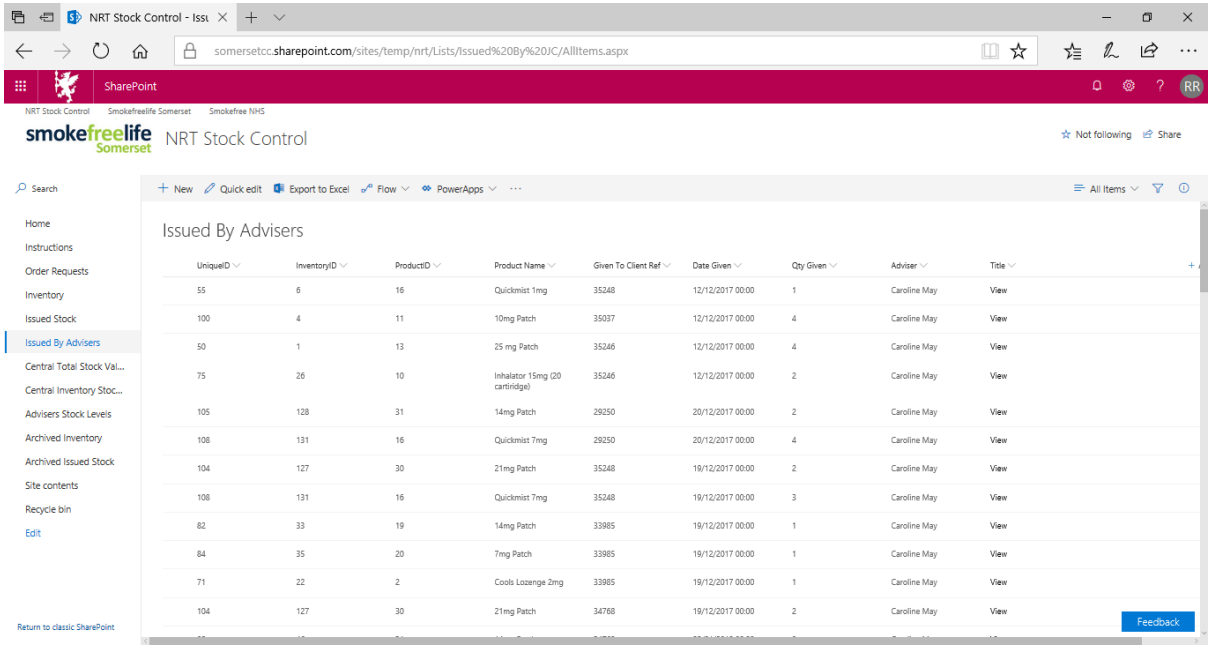
9.1 Annual check on competence, training needs and any supervision required for each individual clinicians use of PGDs and giving medication advice and support, including documentation review.

9.2 Quarterly report regarding use of PGDs and NRT issued. Include any incidents in quarterly clinical governance report.

9.3 Monthly stock control validation and check of expiry dates and rotation of stock.

Annex I- Stock Control





STOCKLIST LEVONELLE 1.5MG.d

Annex II – Incident Form

Services > NHS > Clinical Incident Reporting

Clinical Incident Reporting

Report a Clinical Incident.

Log this Incident

Name	Deborah Beer
Telephone	01823356037

The Person who is selected in the next field will become the Incident Handler and will be required to investigate the Incident. This may include your Team or Ward Manager

Your Manager	

Person affected and further persons involved

Who was directly affected or injured by the incident?

Patient(s)	☐
Staff	☐
Visitors	☐

Were any further person(s) involved in the incident?

This may include witnesses, perpetrator or other professionals	

Incident Date and Time

Incident Date		

Location

Service	
Locality	
Service Type	
Location (Type)	

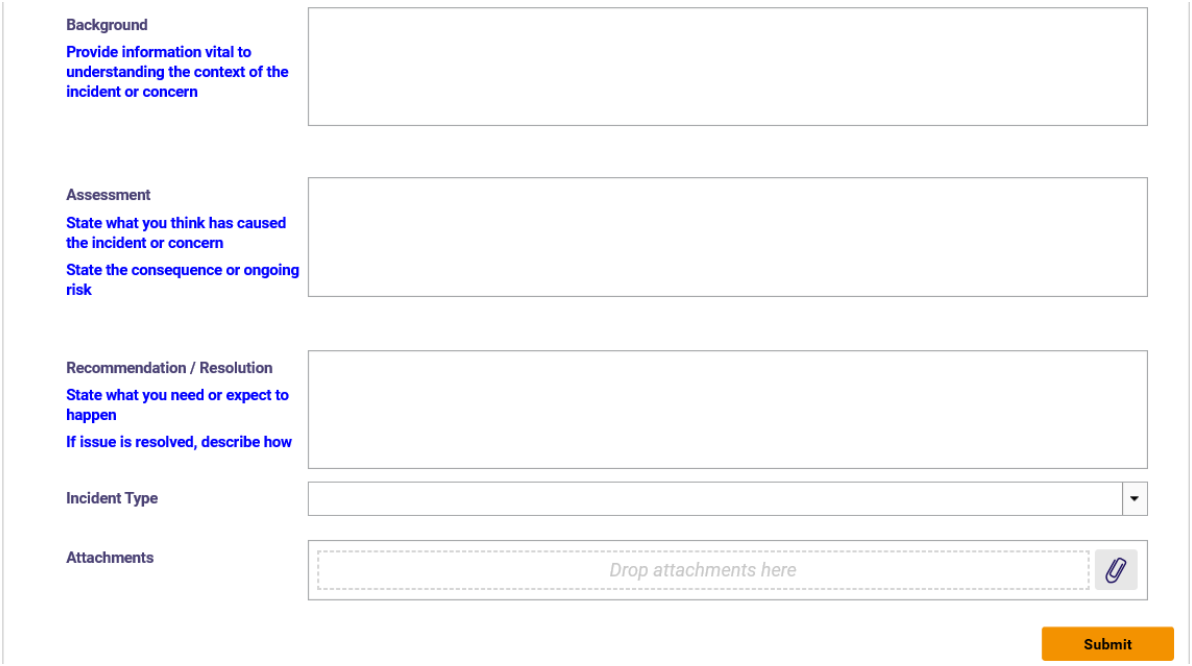
Incident description using SBAR

In this section please:

Ensure no identifiable information is used. Please use "Staff Member" or "Patient"

Use only facts and not opinions

Site/Unit/Team you are reporting from:	
Incident/concern being raised	



Annex III – NRT Pathway

SFLS NRT Pathway V010219.pdf

Annex IV – Smokefreelife Core Service Treatment Protocol

CORE SERVICE TEATMENT PROTOCC