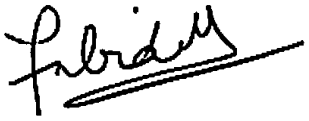
HMP Birmingham Medicines Code

Policy and Procedures for Managing Medicines HMP Birmingham

Policy number and category	**C06b**	**Clinical**
Version number and date	**5**	**February 2025**
Ratifying committee or executive director	**Prison Clinical Governance Committee** **BSMHFT Clinical Governance Committee** **BCHC Quality Safety Executive**	
Date ratified	**May 2025**	
Next anticipated review	**May 2028**	
Executive director	**Medical Director**	
Policy lead	**Chief Pharmacist, BSMHFT**	
Policy author *(if different from above)*	**Head of Prison Pharmacy** **Prison Clinical Lead Pharmacist** **Chief Pharmacist, BSMHFT**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

This Medicines Code defines the policies and procedures to be followed within HMP Birmingham for the prescribing, ordering, dispensing, carriage, and transport, storing, administering and disposal of medicines.

This policy covers all staff working in HMP Birmingham, including agency and bank staff, permanent and temporary staff, who are involved in any way with the use of medicines.

Policy requirement (see Section 2)

All staff, involved at any stage with the management of medicines (prescribing, ordering, dispensing, carriage and transport, storage, or administration), will adhere to the practices and procedures outlined within this policy document and its associated appendices.

Change Record

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
Feb 2025	**5**	**Nigel Barnes, Chief Pharmacist.**	**3 Yearly Review**	**CGC**

Contents:

Appendices:

1: Introduction:

Rationale:

NHS Trusts are required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner.
There have been several changes and developments in recent years:

- New professional practices concerning the use of medicines have developed and continue to develop.
- The formation of community based functional teams which have had to create new approaches to care provision for people who would have previously been in patients.
- New healthcare professionals are dealing with medicines as a routine part of their day-to-day work.
- The use of new information technology to assist medicine use requires new policies and procedures.
- The concepts of patient focused care and patient empowerment require a fresh approach to some long-established practices.
- Good clinical governance and risk management systems are necessary to support the safe and high-quality care of patients.

Scope

This policy covers all staff working in HMP Birmingham, including agency and bank staff, permanent and temporary staff, who are involved in some way with the use of medicines. All these staff must familiarise themselves with the correct procedures contained in this Code. Those staff in charge of Healthcare wings and departments, are responsible for ensuring that their staff, especially new starters, locum staff and healthcare officers (HCO), follow procedures in this Medicines Code, which may differ from procedures in other Trusts. Copies of the Medicines Code will be accessible on the Healthcare IT drive (Z:).

Principles:

- BSMHFT is committed to providing a safe environment of care and will ensure that there are systems and processes in place to ensure that clinical risks associated with the use of medicines are managed effectively within HMP Birmingham.
- The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2: The Policy

All staff, involved at any stage with the management of medicines (prescribing, ordering, dispensing, storing, administering or disposal) will adhere to the practices and procedures outlined within this policy document and its associated appendices.

Training

All newly appointed clinical staff will receive training with respect to the Medicines Code during their Trust induction.

Training will be provided to update and develop existing staff. Training must be repeated every three years and/or when a staff member is involved in a medication incident.

3: The procedure:

3.1 Pharmacy Services

The role of the pharmacy is to:

- Advise on and monitor the safe, effective and economic use of medicines.
- Procure medicines.
- Supply stock medicines to Healthcare wings and general wing locations.
- Dispense ready to administer medicines for self-administration in-possession medication (IP), supervised medication (not in-possession – NIP) discharge medication.
- Review the medication history of patients using Summary Care Records and other information sources to complete full medication reconciliation within a 72-hour period.
- Carry out compliance checks on patients understanding and security of IP medications.
- Advise patients and staff on their use of medicines.
- Audit medicines management within HMP Birmingham.
- Provide education and training to healthcare professionals and other staff relating to medicines management.
- Action MHRA drug alerts and product recalls according to local standard operational processes.

3.1.1 Medicines will be procured supplied and dispensed in accordance with the relevant legislation, professional standards and NHS recommended practice.

3.1.2 Pharmacists will monitor all new requests for medicines for patients in their care and place special emphasis on complex and potentially toxic medicines that require higher levels of monitoring. Continuing medicine treatment will be reviewed, as necessary by the Structured Medication Review process (SMR).

3.1.3 A request for a new medicine will be made on the patient SystmOne electronic prescription chart and the pharmacist must check the prescription and other related patient records to ensure the safe, effective and economic use of medicines. Attention must be given to each step of the medicine use process. This includes an appropriate documented licensed indication, the medicine selected, the dose regimen including the duration of treatment, the medicine formulation and the route of administration. In addition, pharmacists must monitor for medicines interactions/adverse reactions and where possible whether the therapy is achieving the desired therapeutic end points. The pharmacist will mark each entry on the electronic prescription chart to indicate that the clinical screen process has been completed.

3.1.4 Prisoners can make medication requests by a direct application to Pharmacy using the N-force kiosk or via the Pharmacy Technician led Minor Ailment Service. These requests are triaged by a Pharmacist (or suitably trained Pharmacy Technician) and minor ailment supplies can be made at this point following local processes. The Pharmacist or Technician may deem it necessary to signpost to a GP for more complex requests or those which do not sit under a minor ailment/GSL supply.

3.1.5 In order to clarify a prescription, authorised Pharmacy Staff may do the following:

- Task the prescriber on SystmOne to amend the prescription accordingly, or
- Where appropriate make a journal note in the patient records to provide supplementary information, to guide authorised professionals when they administer the medicine.

3.1.6 Where a pharmacist wishes to make a recommendation to change or modify a patient's therapy, the pharmacist should record the recommendation in the patient's SystmOne electronic record. Written records should be made in the SystmOne journal, of any verbal communication, with the prescriber concerning a patient's treatment.

3.1.7 Where possible, patients should be advised about their medicines by the prescriber at the point of consultation.

If this is not possible, the prescriber should agree with the pharmacist or a suitably trained and authorised healthcare professional to relay any additional information relating to the patients treatment. Such alternative arrangements must identify in

the SystmOne journal the person responsible for the provision of information and the nature of the information to be provided.

3.1.8 Routine supplies of newly prescribed medicines are made when the pharmacy department is open. Out of hours, emergency medicines are available via emergency or stock cupboards and the MEDI365 automated storage/dispensing cabinets (see separate policy folder).
Where necessary, advice on medicines can be sought via the BSMHFT on-call pharmacy service through the BSMHFT switchboards. A procedure on out- of-hours' access is available on the Healthcare IT drive

3.1.9 Authorised Pharmacy Staff must be involved in advising on security and medicine storage conditions on the wing or healthcare department.

3.1.10 The pharmacy will provide a medicine information service for other healthcare staff as well as patients, linking into the User Voice service as required.

3.2 Prescribing of Medicines

Prescribers should check that there is a current/valid In-Possession Risk Assessment (IPRA), as outlined in the current Medicines Possession Policy. The IPRA will indicate whether a patient is suitable for In Possession (IP) or Not In Possession (NIP) medication.

The IPRA must have been conducted within the previous six months or at any point where the patients' circumstance or risk has changed.

The IPRA six monthly review is the responsibility of the Medical Practitioners/Non-Medical Prescribers before prescribing but may be delegated to a nurse or a suitably trained and authorised healthcare professional, if more appropriately suited to carry this out.
It should be done following the Secure Estate Assessment Tool (SEAT) IPRA template guidelines from NHSE.

Prescribers may consider prescribing medications IP using the automatic IP process even where the IPRA suggests NIP. (See C7 Medicines possession policy – auto IP list) This includes medications like courses of antibiotics or creams which pose a low clinical risk and clinical judgement will be used when prescribing. Decisions must be documented in the clinical journal.

Medicines should be also prescribed in conjunction with the current RAG rating (from the current Medicines Possession Policy) for example, RED medicines should only be prescribed as NIP.

All prescribing should be via the patient electronic medical system, SystmOne (S1); this should include all reducing doses (e.g. diazepam).

28 day in-possession supply is considered routine unless the risk assessment directs otherwise as per NHS England guidance and the current Medicines Possession Policy.

Prescribers should ensure that electronic charts only display current relevant medications. All previous or inappropriate medications should be stopped to avoid confusion leading to administration errors. This includes stopping any prescriptions initiated from other establishments.

The prescriber must ensure the following patient details are checked when selecting a patient on S1:

- Patient's name, including aliases,
- Date of birth,
- Prison wing location,
- Patient's HMP number,
- IP risk assessment,
- Known sensitivities.

3.2.1 On admission

When patients are transferred into HMP Birmingham care from other prisons or establishments, or admitted into HMP Birmingham for the first time, prescriptions must be written within 24 hours. Administration of medicines must be undertaken in line with the electronic prescription to reduce the risk of medication error. Staff administering medications must do so solely from a valid HMP Birmingham electronic prescription and not administer using a chart from another establishment. For prescribing out of hours, please see section 3.2.7.

3.2.2 Initiation of Treatment

- Qualified doctors or suitably authorised non-medical independent and supplementary prescribers have the authority to prescribe medicines for patients under the care of HMP Birmingham.
- The nurse or authorised professional must not administer medicines that do not have a valid S1 electronic prescription written by an authorised prescriber.
- Repeat prescribing templates are used on S1 to authorise multiple instalment supplies. These are valid for a maximum of 6 months depending on the prescribers' instructions. When the template expires

Pharmacy will request a review and re-prescribe from the prescriber where appropriate.

3.2.3 Range of medicines to be prescribed.

- Only those medicines approved for use by the HMP Medicines Management Committee (MMC) and included in the Formulary. This formulary is consistent with the formulary approved by the Birmingham and Solihull Integrated Medicines Optimisation Committee (IMOC) Incorporating the BSSE APC.
- Medicines newly introduced to the marketplace may only be prescribed in HMP Birmingham after due consideration and approval by the HMP Medicines Management Committee, unless the patient is admitted to HMP Birmingham on other medicines and it is not clinically appropriate to prescribe a suitable alternative from the Formulary.
- Limited exception is given to patients' own medicines, medicines undergoing clinical trial and specialist therapy for individual patients that have been agreed with the relevant Clinical Lead.
- A procedure authorised by the MMC must be followed in order to request a new medicine for use within HMP Birmingham.
- Unlicensed medicines should be prescribed in accordance with guidance included in Appendix 2: Use of unlicensed medicines.
- Details for the prescribing of medical gases are included in Appendix 4.
- Dressings and consumables are ordered by the Primary Care nursing team; only Prescription only dressings e.g. medicated dressings will be supplied via Pharmacy or where an interim supply is required whilst awaiting delivery from NHS supplies. Only Prescription only dressings need to be prescribed.

3.2.4 Function of the electronic S1 Prescription

- To provide a permanent record of the patient's treatment with medicines.
- To provide a permanent record of all medicines prescribed, supplied and administered whilst a patient is in prison.
- To indicate a patients' sensitivity to medicines.
- To facilitate the supply of medicine from a pharmacy.
- To direct the supply or administration of the medicine to the patient.
- To indicate the patients' risk assessment; stating in-possession or not in-possession (supervised) medication.

3.2.5 Use of the electronic S1 Prescription

3.2.5a To indicate the start and end date the prescription is written.

3.2.5b Name and Form of the Medicine

The approved or accepted name of the medicine must be selected on S1. A medicine may have numerous brand names but only one approved name. If the medicine is a compound (with no approved name) or has unique release properties or bioavailability, then the brand name will be accepted. The form of a medicine must be selected. The BNF provides further guidance on prescription writing.

3.2.5c Dose and Route of Administration

The dose must be expressed in dose form e.g. 1 tablet. If prescribing partial, liquid or injectable dose metric units must be used, avoiding decimal points. i.e. 125 micrograms rather than 0.125mg. The word "micrograms" must be shown in full and not abbreviated to mcg, to avoid confusion with milligrams (mg). The following abbreviations are standard means of indicating the routes.

3.2.5d Times of Administration

The times of administration must be specified by the prescriber under the frequency tab on the S1 electronic prescription template. There are four available time slots:

08:00, 12:00, 16:00, 22:00hrs and options for PRN (with minimum or maximum time intervals, e.g. 6 hourly) and once only

All not in-possession (supervised medication) should be prescribed up to a maximum of TWICE DAILY. Only supervised administration on the Healthcare 1 and 2 may be prescribed at a greater frequency and varying times.

Time critical medication frequencies other than twice a day may be prescribed after confirmation with the appropriate nursing team(s) that administration will be possible.

Any night-time (nocte) or designated timed medication must be clearly indicated on the electronic administration chart and an entry made on S1. These patients may require unlock by the prison when the prison regime is reduced.

It would be appropriate to consider once daily modified-release preparations as a preference to avoid administering medications too early due the prison regime.

The following abbreviations are standard means of indicating a dose regimen:

Once Only Doses (Stat Doses)
Medicines that are intended to be given once only must be prescribed in the 'once only' section of the patients S1 prescription record.

‘When Required’ Prescriptions (PRN)

- The 'when required' section of the S1 prescription record must only be used for those medicines to be given at the nurse's discretion according to the needs of the service user.
- The prescriber must define the reasons for the prescription and qualify the directions
- An entry in the service user's electronic patient records must give reasons for administration and outcome. This will be subject to periodic audit.
- The minimum interval between doses and indication for administration must be clearly specified by the prescriber. The maximum dose to be given in a 24-hour period must also be stated.
- When signing to indicate that the medication has been given, in the case of a variable dosage (e.g. 1 or 2 or 5 -10mg) the actual dosage administered must be recorded by the professional administering the dose
- A 'when required' prescription must be reviewed regularly by a prescriber to determine and confirm the clinical need. To prevent the accumulation of unnecessary 'when required' prescriptions the following guidelines should be observed:
- Any PRN medicine that has not been required or administered for one month should be cancelled. This should normally be done by a prescriber but can also be done by a pharmacist in liaison with clinical staff or in line with other prescribing guidance.
- Exceptions include those medicines administered in very occasional medical emergencies, e.g. GTN spray or a salbutamol inhaler.
- Not more than one medicine from any BNF therapeutic category should be prescribed as a PRN at any one time.
- Not more than two medicines should be prescribed as a PRN at a time for any one indication.
- Prescribing a medicine on a 'when required' basis provides a useful method of assessing the person's requirements of certain medicines such as anticholinergics, analgesics and hypnotics as well as those used in alcohol detoxification regimens.
- Medicines originally prescribed 'when required', but which are needed regularly as indicated by the administration record, must be reviewed and rewritten in the regular section of the patient's S1 prescription record.
- Once a service user's medical condition has improved there may be fewer requirements for certain medicines. The 'when required' prescription can provide a useful tool to ensure that medicines that are no longer required are not continued. However, 'when required' medicines should be reviewed regularly to ensure they remain appropriate and required.
- Care must be taken not to duplicate "when required "medicines with those being taken regularly as this risks overdose. Homely remedies should not normally be given if prescribed on the 'when required' list of prescribed medicines. Combination analgesics frequently contain paracetamol, which may already be prescribed in the regular section of the prescription chart. Rapid dose escalation using combinations of PRN and regularly prescribed

antipsychotic drugs is one of the most common causes of sudden death and neuroleptic malignant syndrome in schizophrenia and should be avoided.

- Where regular mediation is prescribed in addition to 'PRN' use, the electronic 'PRN' prescription must be include a note that regular medication has also been prescribed
- Depot or long-acting injections and weekly/fortnightly doses (e.g. methotrexate, Aranesp) should be prescribed as NIP for supervised administration. On administration of these medications the administrating healthcare professional must ensure that the next dose is appropriately prescribed and task the prescriber when this is not the case.

3.2.5e Signature of Prescriber

An electronic signature via the prescriber's smartcard will be the authorised signature

3.2.5f Cancellation of Treatment

Only authorised prescribers and pharmacists should cancel electronic prescriptions, annotating appropriately on S1.

3.2.5g Length of Treatment

Supervised prescriptions are valid for up to three months except for controlled drugs.

IP prescriptions are valid for a maximum of 28 days. After this period, treatments must be re-written if they are to be continued. A repeat template can be used for Pharmacy to authorise up to 6 months' supply.

If a prescription becomes ambiguous or unclear at any time, the authorised professional responsible for the administration of the medicine or the pharmacist must request the prescriber to rewrite it.

5 days prior to the prescription chart expiring S1 will prompt the authorised professional responsible for the administration of the medicine to request a rewrite from a prescriber. This will repeat for 5 days until the prompt is actioned.

Prescriptions for Controlled Drugs are only valid for 28 days including benzodiazepines and 'Z' hypnotics. In addition, controlled drug prescriptions should be for a maximum of 28 days' supply.

3.2.5h Sensitivities

The prescriber is responsible for entering any known sensitivity in the appropriate section of the patients S1 notes. Pharmacy will endeavour to complete known sensitivities during the medicines reconciliation process.

Where there are no known medicine sensitivities, "None Known" must be entered into the patient record.

All authorised professionals should assist in identifying medicine sensitivities. At First reception screening the allergy status may be attained and the authorised professional to check allergy status before commencing treatment.

3.2.6 Verbal Prescriptions

Registered nurses or authorised professionals cannot accept verbal orders alone for medication for which there is no written prescription.

3.2.7 Remote prescribing via scanned prescription and email

Scanned and emailed prescriptions for schedule 2 and 3 Controlled Drugs are not allowed.
Scanned and emailed prescriptions for benzodiazepines and hypnotics are acceptable.

In a dispersed service it may be necessary to change medicines in cases where it is impossible for the prescriber to attend the patient in person.(e.g. out of hours Badger service)

In an emergency a scanned and emailed signed prescription accompanied by a telephone call will enable the new treatment to be administered.

The prescriber must provide a properly completed prescription on the patient's electronic prescription record within 24 hours of the emailed order. At weekends and bank holidays this period may be extended to a maximum of 72 hours. The emailed prescription should then be scanned and uploaded to the S1 record.

A record of the administration of the medicine should be made on the fax and a note made on the S1 journal.

An entry must be made onto SystmOne following consultation documenting subsequent actions.

If staff permitting it may be possible to collect the original prescription from the on-call service provider.

3.2.8 Use of e-mail audit trail

Doctors on call, providing an e-mail instruction remotely should use an nhs.net e-mail address.

3.2.9 Controlled drug prescriptions

All controlled drug prescriptions should comply with the prescription requirements under the Misuse of Drugs Regulations. Full details can be found in the BNF. Such prescriptions should be entered onto S1 printed and include:

- The name of the prescriber (automatic using S1)
- The date (automatic using S1)
- The name, form and strength of the preparation,
- The dose and frequency,
- The total quantity in words and figures or the total number of dosage units in words and figures
- The name and wing location of the patient.

Controlled drug prescriptions are only valid for 28 days by law. It is good professional practice that they cover a maximum of 30 days' supply unless there are exceptional reasons to extend this.

3.2.10 Verbal changes to prescriptions in pharmacy

Pharmacists may need to accept verbal clarification from prescribers in order to process prescriptions. Where this is the case, the pharmacist may endorse the prescription to clarify the intention and make a note on S1 or may ask the prescriber to re-write the electronic prescription.

3.2.11 Patient Group Directions (PGD)

A PGD is a written direction relating to the supply and/or administration of a prescription only medicine to patients of the prison without a prescription.

It applies to the supply and/or administration of medicines in an identified clinical situation in patients who may not be individually identified before presenting for treatment.

A range of healthcare professionals may supply and/or administer medicines under a PGD. They must be registered (or equivalent) members of their profession and act within their code of conduct and be suitably trained.

The PGD must include the following information:

- The name of the business to which the direction applies.
- The date the direction comes into force and the date it expires.
- A description of the medicine to which it applies.
- The clinical condition covered by the direction.

- A description of the circumstances in which further advice should be sought from a doctor and arrangement for referral made.
- Appropriate dosage and maximum total dosage, quantity, pharmaceutical form and strength, route and frequency of administration and minimum or maximum period over which the medicine should be administered.
- Relevant warnings including potential adverse reactions.
- Details of any follow up action and the circumstances. A statement of the records is to be kept for audit purposes. The range of medicines that can be administered via a PGD is restricted and cannot include an unlicensed medicine nor generally schedule 2 and 3 Controlled Drugs.

PGDs will be developed by a multidisciplinary team under the guidance of the HMP Medicines Management Committee and subsequently be signed by the Directors of Medicine, Nursing and Pharmacy of both Trusts. (BSMHFT and BCHC)

3.2.11a Guidance

'The majority of clinical care should be provided on an individual patient specific basis. The supply and administration of medicines under a PGD should be reserved for those where this offers an advantage in patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability' An application for a PGD will include:

- Details of the clinical situation and the medicines to which the PGD will apply
- Benefits to the patient
- Risks to the patient and the Prison healthcare of not developing the PGD
- Qualification of staff who will be involved in the supply and administration
- of the medicine
- Outline of training that staff require to operate under the PGD

3.2.11b Responsibilities

- The PGD should be reviewed regularly
- The names of authorised professionals who wish to operate under a PGD must be kept as a register and the manager is responsible for ensuring that all relevant training has been completed
- Authorised professionals who operate under a PGD should only agree to do so if they are confident that they can follow the directions within the PGD. Authorised professionals must not undertake any aspect of patient care for which they are not trained and which is beyond their competence
- All authorised professionals should have their own copy of the PGD for which they have signed.

- The manager should be responsible for ensuring that authorised professionals are given updated copies. Conversely, authorised professionals should not operate under expired PGDs
- The service manager should retain the original copy of the signed and signed up to PGDs and a forward a copy to pharmacy.
- Responsibility cannot be delegated to another member of staff for supply and administration of the medicines covered by the PGD.

3.3 Ordering and Receipt of Medicines

Stock medicines are those commonly prescribed for patients who require supervised (not in-possession) drug administration. Wing/department stocks are retained on the wing/department regardless of whether they are currently prescribed for any patient. Stock medications are replenished via a top-up service by pharmacy. If stock medicines are required within this period, a designated nurse may request items by completing a stock requisition book interim order or requesting via S1 task to Pharmacy.

Non-stock medicines are those which are uncommonly prescribed for patients on supervised (not in-possession) electronic prescriptions. Non-stock medicines are ordered in conjunction with the electronic medication chart and are dispensed as temporary named patient “non-stock”. Pharmacy will supply medication when they are newly prescribed and clinically screened for suitability. In general, the supply of medication will be for the duration of the prescription. Where a 3 month prescription is used, a supply will be managed on a monthly basis by pharmacy. The wing/department should not retain non-stock for longer than necessary.

In-possession (IP), individual patient supplies are those medicines dispensed and labelled for a specific patient. These medications are allowed in-possession of the patient. The prescriber will ensure that the In Possession Risk Assessment (IPRA) is valid for IP. Once the prescription has been written and dispensed, the item is delivered to the patient directly or stored in the Mediwell IP lockers for the patient to pick up at a time convenient to them and the prison regime. Further supplies can be made using a Pharmacy Request Form for Medication or via the N-Force kiosk electronic application (see HMP Medicines Possession Policy).

The patient should complete the request form and either place in the designated wing box, hand-in directly to pharmacy staff or hand in to nursing staff. Requests will then be processed by pharmacy and the designated prescriber, producing an IP prescription, as appropriate.

Medicines to take out (TTOs) are individually dispensed medicines which are labelled with directions for administration for an individual patient, who has authorised leave from the establishment, either being released or transferred.

3.3.1 Controlled Drugs

The responsibility for the ordering, receipt and storage of Controlled Drugs is that of the Appointed or Assigned Registered Professional in Charge of the wing/department.

Controlled Drugs can only be ordered from the pharmacy by submitting a requisition from the official Controlled Drugs Order (Requisition) Book (a bound, numbered, duplicate book). Controlled drug stocks should normally be ordered Monday to Thursday, ensuring adequate supply for weekends and bank holidays. Ordering is restricted to an Assigned or Appointed Professional in Charge. All Professionals in charge who may order Controlled Drugs must provide the Pharmacy Department with specimen signatures.

The requisition order for controlled drugs must include:

- Name of department or wing, HMP Birmingham
- Drug name (approved name), form and strength
- Total quantity in words and figures
- Signature and printed name (in capitals) of assigned or appointed professional
- Patient name and prison number for CDs other than methadone/buprenorphine.
- Date

All Controlled Drugs issued as stock must be delivered to wings or departments in a tamper evident package. The messenger must sign the controlled drugs order book in the appropriate place.

A Designated Professional must receive the tamper evident pharmacy container.

Upon receipt, a Designated Professional must ensure the unique number seal correlates with the number written on the order page and check the contents of the package containing Controlled Drugs against the requisition. Any discrepancy must be reported to the Pharmacy immediately. If correct, the Designated Professional must sign the Receipt on the pink page of the CD order book. The Designated Professional must enter the new stock into the Controlled Drugs register on the appropriate page, witnessed by another Designated Professional, an authorised member of the Pharmacy Staff or an Authorised Employee who must verify the stock level and sign the register. The date, quantity and requisition number should be documented. The Controlled Drug must then be immediately locked away in the Controlled Drug Cupboard.

Where sealed packs of Controlled Drugs are supplied with tamper evident seals, there is no requirement to open these packs for stock checking purposes. These can be assumed to contain the stated quantity. If packs are not sealed or have been

opened then the contents must be checked at each stock balance check, including after administration of a controlled drug.

Controlled Drugs must be stored in a locked, controlled drugs cabinet, approved by pharmacy and reserved for the sole storage of Controlled Drugs.

Access is limited to a nurse or authorised professional.

Stocks within wing/department controlled drug cupboards must be inspected at a minimum of six monthly intervals by an authorised member of the Pharmacy Staff.

CD Registers (Record books) and Order/Requisition Books for Controlled Drugs are controlled stationery and obtainable only from pharmacy. Requisition books should be locked away. All issues of controlled stationary should be recorded in the Pharmacy.

Orders and records must be in permanent ink and must be retained for two years. Orders should have two copies the carbon copy to be retained in the order book to be retained by the wing/department, the original copy to be retained in the pharmacy.

Nurse or authorised professional should also refer to HMP Birmingham CD SOPs.

3.3.2 All other Medicines – NIP

3.3.2a Ordering of Stock Medicines

Nurses or authorised professional shall be responsible for ordering medicines from the pharmacy for the purposes of maintaining stocks.
Stock medicines may be ordered by:

- Supplying a written requisition from the authorised stock sheet, or an order sheet signed by a nurse or authorised professional in the wing/department stock requisition book.
- By means of the pharmacy technician top-up service.
- A S1 task where the order is urgent and cannot wait until the top –up or requisition book is completed and returned (usually within 24 hours).

3.3.2b Delivery of Medicines

All medicines must be delivered to wings/departments in a secure, tamper-evident container. All supervised stock and non-stock should be checked in Pharmacy by a designated professional before packages are sealed.

Medicines are usually delivered by Pharmacy staff but may be collected by a nurse or authorised professional and must be transported back to the wing/department in a tamper evident pharmacy package or locked box. Pharmacy staff will document the name of the staff member collecting/delivering medication on the daily workload spread sheet.

3.3.2c Receipts and Records

The nurse or authorised professional must:

- Lock the medicines in the assigned medicine cupboards immediately.
- Check the contents against the pharmacy delivery note and retain the Delivery note for 2 years.
- Report any discrepancies to the Pharmacy immediately.

3.3.3 Individual IP Patient Supplies

Medicines for named patients may be ordered by:

- Submitting the patient's electronic prescription
- Sending a S1 task to pharmacy asking for a supply
- A patient submitting a request via the N-force Kiosk

3.3.3a Delivery of Individual Patient Supplies

IP individual patient supplies are in general, delivered by Pharmacy to the patient. IPs are generally delivered by wing from the medication hatch or stored in the Mediwell IP lockers for the patient to pick up at a time convenient to them and the prison regime.

IP medications may be essential, therefore if pharmacy is unable to deliver and the IP bag is left in the hatch, all staff subsequently administering medications in the next hatch time must endeavour to hand these items out.

Follow up must be made where medications are not handed out after 3 attempts, this should also be documented on the patient S1 record and Pharmacy/GP notified.

Should a new/last minute prescribed item be urgent, the in-possession medication should be sent to the evening wing hatch; where a designated nurse or healthcare professional can issue during the evening administration round.

The designated nurse or healthcare professional on wing shall administer all urgent IP supplies against the S1 electronic prescription.

3.3.3b Receipt of IP

The patient should sign and date receipt or refusal of IP medication on the printed copy of the prescription. This may not be appropriate during periods of infection control.
All administration of IP medication must always be recorded on the electronic prescription.

3.3.4 Medicines 'To Take Out' (TTO's)

TTO medication may be supplied for patients who are transferring to another establishment, attending court or who are being released with a minimum of 14 days' supply or a FP10.

TTOs can be ordered by a designated professional and prescribed by an assigned prescriber. TTOs can include benzodiazepines and hypnotics and general controlled drug medications, but not Opioid Substitute Therapy (OST).

TTOs can be ordered by prescribing the medication required on the S1 electronic TTO prescription.

The delivery of TTOs is the same as for stock medicines.

All TTO medicines coming into a wing or reception shall be received by a nurse or authorised professional, who must:

- Check them against the S1, to confirm that all details are correct i.e. name, medicine, dose, directions.
- Lock them in the medicines cupboard immediately.
- Report any discrepancies to pharmacy immediately.

It is important that the patient receives adequate information about their medicines prior to discharge. The patient should know the purpose of each medicine, how to take each medicine correctly, for how long it is to be taken, key side effects and how to manage them and what to do if they are concerned about anything to do with their medicines. This is a shared responsibility between medical staff, nurse or authorised professional and authorised pharmacy staff. It is the responsibility of the nurse or authorised professional who discharges the patient from the hospital to ensure that the patient has received adequate information about their medicines. Any information communicated verbally should be backed up and supported by an appropriate leaflet, e.g. 'Choice and Medication' leaflet that are available on the intranet.

In the event of patients going to court or video link and are subsequently released, if TTOs are not pre-prepared they can still request a TTO which will be processed in due course. This may be via an FP10 prescription sent via the Electronic Transfer of Prescriptions (ETP).

All patients identified with appropriate need and training by the prison substance misuse services must be provided with a TTO supply of Naloxone upon release. This is any history of substance misuse within the previous 12 months.

3.3.5 Borrowing of Medicines

Medicines must not be borrowed from a wing when Pharmacy is open. Only stock medicines may be borrowed, and the original container must be lent to the receiving wing**; transferring medicines into another container is forbidden.**

The senior nurse in charge must be contacted and agree that an item can be borrowed. A signed record of the transfer of medicines must be kept on both wings involved in the "borrowing transaction". The signature must be that of the Assigned Professional in Charge. A 'Borrowing Medicines' pro-forma is available in Appendix 9. Any drugs borrowed must be documented on the attached form as follows:

- Only original packs may be borrowed (with the exception of controlled drugs – see below). Transferring of medicines to other containers is forbidden.
- Details of the medicines borrowed,
- Signatures of the appointed professionals issuing and receiving the medicine(s)
- Stock can be replenished via the stock requisition order books.
- Non-stocks should be ordered by submitting an electronic prescription or sending a task on S1 to pharmacy requesting that a supply is made against the electronic prescription.

Controlled Drugs must not be borrowed except in an extreme emergency. A nurse may identify a need for additional controlled drug stocks when the Pharmacy is closed. Inform Pharmacy and the Director of Healthcare on the next available working day. This will enable stocks to be reviewed and replenished.

The borrowing of a CD should be recorded using Eclipse. A whole pack should normally be transferred. The procedure should include signing out the pack from the controlled drugs register of the wing donating the pack with signatures from each wing. The receiving wing should then sign in the pack into their controlled drugs register with signatures from both wings.
Include in each register a statement of the name of the person who has authorised borrowing e.g.

"Transfer from A wing to B wing agreed designated professional, Eclipse # completed". The whole process should be checked by at least one nurse and one primary administrator, one from each affected wing. The following working day, the transfer should also be checked by Pharmacy following contact with the Director of Healthcare.

3.3.6 Patient's own Drugs (PODs) or Medicines

All medicines brought into the prison by patients do not automatically remain their own property. Patient own medications must be assessed and prescribed, as appropriate. Those items which are allowed in-possession should not be destroyed. However, those medications which require supervision and not in-possession items may be destroyed with the consent of the patient.

Medicines brought into prison by patients should be reviewed by the admitting medical practitioner who may or may not wish to prescribe them.

Where wings are using the traditional stock system it is usual for them to receive medicines for administration to patients solely from the prison pharmacy. However, it is acceptable to use patients own medicines providing they meet specific criteria set out in the HMP Medicines Possession Policy.

Otherwise, all medicines brought into prison by patients would follow the in-possession policy and be either returned to the patient or sent to pharmacy for destruction.

3.3.7 Death in Custody

In the event of a death of a patient whilst on the wing or H2/H3:

Medications for the patient must be kept and returned to pharmacy in case they are requested by the coroner.

The medication must be placed in an evidence bag with the patients name on it. A list of these medicines, along with their quantities, must be made in the spreadsheet in the DIC folder on the shared drive by a pharmacist or doctor. The bag should then be sealed and the two people involved in witnessing the sealing should sign across the seal along with the date. The bag should then be stored in pharmacy.

If the Coroner asks for the medicines, they can be released to his or her approved representative. The wording 'Handed over to the Coroner' along with the date handed over should be written against original entry in the spreadsheet and this should be witnessed by the coroner's representative removing them and by a pharmacist.

3.4 Transportation of Medicines

3.4.1 Transport within the prison

A record of the transport of medicines from the persons issuing the medicine, transporting the medicine and receiving the medicine is required. Medicines must be transported in sealed tamper evident bags/locked

boxes. Medicines must not be left unattended at any time during transport. When medicines are received at their final destination they must not be left unattended or unsecured. They should be handed to a nurse or authorised professional and locked away in a medicine cupboard at the earliest opportunity and items for refrigeration placed in a refrigerator immediately.

3.4.2 Transportation by Taxis

- All items must be transported in tamper-evident sealed containers.
- Transport must be obtained from the Prison's contracted service and the car number and drivers name must be recorded.
- Only prison contract taxis with drivers able to produce identification bearing a photograph shall be used.
- Items must be collected from the prison reception or an agreed designated area and delivered to the addressee or pre-arranged point.
- If items are not delivered directly to the addressee the responsibility for security rests with those receiving the container until delivery is completed and documentation countersigned.
- Items to be collected and delivered to the prison must be pre-arranged by the pharmacy department. A clear collection point must be agreed and items must be delivered to prison reception.

3.5 Storage of Medicines

The Appointed nurse or authorised professional in charge is responsible at all times for the safekeeping of all medicines on their wing/department.

The design and location of all wing/department medicine storage cupboards must be approved by Authorised Pharmacy Staff and regularly monitored.

All internal and external medicines, disinfectants and reagents must be stored in locked cupboards, trolleys or other secure cabinets - all reserved solely for this purpose. The only exceptions to this requirement are medicines for clinical emergencies, intravenous fluids, sterile topical fluids and nutritional products and some bulky medicated dressings that, because of their bulk, are stored in a clean area (as agreed between the nurse or authorised professional in charge and an authorised member of the Pharmacy Staff). Ideally if storage allows use locked cupboards.

Internal medicines must be stored separately from other medicines. Under no circumstances must medicines be transferred from one container to another, nor must they be taken out of their container and left loose. All medicines in transit must be in a sealed tamper evident container.

Where cold storage of medicines is necessary, a lockable, temperature controlled/monitored medicines fridge must be made available which must be reserved solely for this purpose. All medication fridges are now monitored via the Trust Check-it automated temperature monitoring system. This is audited by the Pharmacy department and escalation procedures are in place for out of hours temperature excursions.

Ambient room temperature records must be recorded in all locations where medication is stored. Most areas are monitored by the Check-it system but some areas are still maintained using manual monitoring and record keeping. Manual temperature logs must be retained for the life of the appliance (if refrigerator) plus 10 years. (Appendices 6 and 7).

In medication hatches, these temperature checks have been amalgamated onto a hatch checklist for ease which incorporates Diazepam stock level checks, sink checks and sharps bin checks. There are accompanying Actions and codes to complete when temperatures are found to be out of range and not routinely monitored by Check-it (Appendix 8).

3.5.1 Siting of Cupboards and Trolleys**.**

The siting of medicines storage cupboards and the cupboards themselves must conform to the requirements of the British Standard 2881. Cupboards and trolleys must be sited where most convenient for staff, allowing adequate space and permitting surveillance to afford maximum security against unauthorised access. Medicine cupboards must generally be sited in a clean utility room to which the general public does not have access. Cupboards must not be sited where they may be subjected to higher than recommended humidity or temperature. Reagent cabinets must be sited in areas where testing is carried out.

3.5.2 Review of Storage of Medicines

The quantities, range and storage of medicines stocked will be reviewed regularly by the Authorised Pharmacy Staff together with the Appointed Professional in Charge.

3.5.3 Controlled Drugs (schedule 2 and 3)

Controlled drugs must be stored in a separate designated controlled drugs cupboard that is compliant with the Misuse of Drugs Regulations. Each wing or department will keep an up to date Register of Controlled drugs. This must include controlled drugs received, controlled drugs administered, a running balance and details of any controlled drugs returned to pharmacy for re-use or destruction.

No wing, clinic or department must store Controlled Drugs unless there is an Appointed Professional in Charge responsible for their storage and administration.

CD cabinets should only be accessed by two members of staff, one being an authorised designated professional.

At reception, the primary care CD cabinet, which only holds patient returned CDs, should also be accessed by two members of staff, one of which must be an authorised Designated professional.

3.5.4 Closure of a Wing or Department

If a wing, clinic or team is to close, the controlled drugs must be handed over by an assigned nurse or authorised professional in Charge to an Authorised member of the Pharmacy Staff who will sign the appropriate section of the register and return the Controlled Drugs to the pharmacy. If a wing, clinic or team is to close for more than a week; all other medicines must also be returned to the pharmacy. However, if a wing is to close for only a few days, the medicines (other than Controlled Drugs) may, with the agreement of an authorised member of the Pharmacy staff and the nurse or authorised professional in charge, stay on the wing provided there is adequate security to prevent unauthorised access to the cupboards.

3.5.5 Breach of Security

Any incident must be reported immediately and investigated as soon as practical by the nurse or authorised professional in charge together with an authorised member of the Pharmacy staff. An incident form (Eclipse) should be completed for the Trust and also the prison security Incident Report (Mercury) form.

3.5.6 Storage Accommodation

Clinical areas may have some or all of the following medicine storage units.

- Controlled Drug Cupboards - reserved solely for the storage of Controlled Drugs and secured to the wall with a minimum of two RAG bolts. These cupboards may be separate from others or be inside other locked medicines cupboards used to store internal medicines. The lock must not be the same as any other lock in the prison.
- Internal Medicine Cupboard(s) - for the storage of stock tablets, liquid medicines, injections etc. Medicines should not be stored at temperatures above 25ºC unless stated otherwise on the label. They should be stored in alphabetical generic order according to approved name.
- Named patient non-stock medication should be segregated from stock medicines.
- External Medicine Cupboard(s) - for the storage of creams, lotions etc.
- Medicine Refrigerator - medicines must not be stored together with food or pathological specimens, but in a separate small, locked fridge. Medicines requiring storage below room temperature will be marked "Store between 2ºC and 8ºC, in a refrigerator". The temperature of medicine fridges must be

continuously monitored and recorded. In the case of highs and lows outside the acceptable range, estates must be contacted to correct the problem and pharmacy must be informed if not automatically notified by Check-it and the contents removed to satisfactory storage.(Appendix 6,7 and 8)

- Reagent Cupboard(s) - situated in the area where urine testing is carried out. Some wings may not require a separate cupboard if urine testing is only very rarely carried out but in such circumstances there should be an agreement about where such testing is to take place. They must not be stored with internal medicines
- A Clean Storage Room - for intravenous fluids and sterile topical fluids, if no suitable cupboard is available.
- Medicine Trolley - Where used for storage of medicines in current use on the medicine administration round. When not being used the medicine trolley must be locked and secured to the wall. The trolley must not be left unattended during the medicine round. If the Designated Professional leaves the trolley, it must be locked immediately.
- Medicines for Clinical Emergency - must be readily accessible and in a position to afford supervision to prevent unauthorised access. For further details refer to the Clinical Emergency Policy for your locality.

3.6 Checking of Controlled Drug Stock Balances

3.6.1 Controlled drug registers (CD record book) are available from the prison Pharmacy service, as bound books. A separate page should be used for each supply of controlled drugs. For each preparation, entries should be in chronological order, in BLACK indelible ink and with a running balance. If the end of the page is reached then the balance should be transferred clearly to a new page. This transfer should be witnessed and the index updated.

If a mistake is made in the CD register, then it should be bracketed in such a way that the original entry is still legible and the correction made as close to it as possible, in the margin or side, with the brackets and correction signed and dated with the original date of error. For example: (750ml)*1 780ml, in the margin/footnote - Error, *1 780ml, signature/initials/date/time.

If a second error is made on the page, then write *2 next the brackets, and Error *2 in the margin/footnote.

Controlled drug registers must be kept for a minimum of two years after the last entry has been made. If there has been any destruction of controlled drugs within a register the retention increases to 5 years.

3.6.2 Stock balances of all schedule 2 and 3 Controlled Drugs should be checked on every administration round upon opening and closing the CD cabinet. The stock balance of all Controlled Drugs entered in the CD Register must be checked against the actual

stock held in the wing/department. There is no need to open packs with intact tamper evident seals for stock checking purposes. However, when such packs are opened for the first time, this should be done in the presence of a suitable witness.

3.6.3 It may be assumed that all sealed bottles contain the volume as stated by the manufacturer. Upon opening a new bottle and removing the required dose(s) for administration the overage must be measured and recorded in the CD register at the point of performing the stock balance check (see 3.6.4).

3.6.4 Two nurses or authorised professionals, one of whom must be the assigned nurse or authorised professional in charge, must perform the stock balance check. The exact amount (including any measured overages from 3.6.3) recorded in the CD register must exactly match the volume actually present in the cabinet. Stock balance checks must be recorded in RED indelible ink.

3.6.5 The record must be dated and signed by both nurses or authorised professionals. The appointed nurse or authorised professional in charge must ensure that these checks are carried out. Where discrepancies are identified the team manager and the Pharmacist must be informed immediately.

3.6.6 The nurse or authorised professional in charge must undertake a random check of all Controlled Drugs cupboards at least once a month and record it in the wing/department CD register.

3.6.7 A Pharmacist will perform quarterly quality audit checks including audit of safe and secure handling of controlled drugs.

3.6.8 The need for more frequent checks will be decided by the nurse or authorised professional charge in liaison with the Head of Prison Pharmacy/ Lead Clinical Pharmacist.

3.6.9 Stock balance checks are also required for patient returned CDs.

Use plastic bottles provided to store patient returns in the CD cabinet until a Pharmacist collects. Complete the outer label with the drug name/quantity/date/prisoner name and number/location/signature of authorised designated professional and witness.

(Liquid medicines will only be accurately checked against full and empty bottles. Approximate measures will be made at other times).

3.6.10 Any expired stock should be marked as such and clearly segregated from active stock in the CD cabinet. An entry should be made in the CD register, stating that there is expired stock. The stock running balance must include the expired stock; the

expired stock quantity may be entered in brackets for auditing purposes, e.g. 720ml (50ml expired), the total 720ml will include the expired 50ml.

3.7 Other Medicines

Any need for checking stock balances of other medicines must be left to the discretion of the nurse or authorised professional in charge. If, however, there is suspicion of abuse of medicines this must be reported to the department manager, Lead Clinical Pharmacist, the Head of Pharmacy, the Director of Offender Health and the Chief Pharmacist. In such cases it is advised that a stock balance must be recorded and regular checking introduced. If this shows discrepancies the medicine must be made subject to similar procedures as required for Controlled Drugs and register entries must be made whenever the medicine is administered.

3.7.1 Schedule 4 CDs; Diazepam liquid should maintain a bottle stock balance. This balance should be recorded in the wing/department hatch folder.

3.8 Custody and Safe-keeping of Medicine Keys

3.8.1 The Controlled Drug Cupboard Key

On wings/departments during Controlled Drug administration times, the key must be kept on the person of the nurse or authorised professional. The key must be kept on a separate key ring that can be readily identified. Responsibility remains with the nurse or authorised professional in charge to ensure an audit trail of possession of each CD Key is in place.

No authorised nurse or authorised professional can have access to the Controlled Drug cupboard except with the agreement of the nurse or authorised professional in charge, officially holding the key. The key must not be handed over to medical staff.

The CD cabinet should only be accessed by an assigned nurse or authorised professional and a suitable witness at designated times. The CD cabinet should not be opened in isolation by one nurse or authorised professional.

Authorised Pharmacy Staff may have access to the controlled drug cupboard key for the purpose of performing the statutory checks with an appropriate witness.

In the event of the person in charge being inappropriately qualified, the key must be handed to a nurse or authorised professional in charge of a department in the near vicinity. This information must be made known to the staff in that department and to the manager in charge of that section.

CD keys should be locked away when not in use, e.g. overnight, in a tamper evident pouch/bag. The pouch should be sealed with a uniquely numbered seal.

This number should be recorded in a current diary/key log. An entry should be made on the appropriate day in the diary, documenting the seal number, signed by the appointed professional in charge and witness.

At handover of shift, the incoming appointed nurse or authorised professional in charge should check the numbered seal is in intact and that it is the same number as documented in the diary/key log. If it is, the two authorised professionals should sign confirming the number, and remove the keys (break the seal) if required. If the number is not the same as that documented from the previous shift, a full stock balance should take place and report any discrepancies to appropriate service manager and Pharmacy. Discrepancies will be investigated and escalated to the Accountable Officer and or CDLIN if needed.

If CD keys go missing, every effort must be made to find or retrieve them. The service manager should be informed immediately, a senior Pharmacist and security also informed, who will advise on any actions including emergency access to additional controlled drugs where necessary. If keys cannot be found then the Director of Healthcare, Chief Pharmacist and Medicines Management (BSMHFT) and the Head of Prison Pharmacy should be informed who will agree any additional actions with the Trust Accountable Officer for controlled drugs. Eclipse and HMP security mercury forms should be completed, as appropriate.

3.8.2 Keys for Medicine Cupboards, Medicine Trolleys and Refrigerators

The keys for the external medicine cupboard, internal medicine cupboard, medicine trolley and medicine refrigerator should ideally be kept together on one key ring reserved solely for these keys. This may be included on the main bunch of keys. The keys must be clearly identified.
The exception to this is areas with more than one set of cupboards serving multiple hatches or where cabinets require two separate locks to be opened simultaneously.

The keys must be kept on the person of an assigned nurse or authorised professional in charge or locked in the department key safe in areas that have this facility. An audit log must be completed when keys are signed in and out of the key cabinet.

In the event of no designated nurse or authorised professional being on duty on H2/H3, the keys shall be handed to a designated nurse or authorised professional on the other Healthcare wing. This information must be made known to the staff in that area or department manager in charge of that section.

Medicine cupboard keys may be handed over to Authorised Pharmacy Staff who are undertaking audit or operating a topping up service.

3.8.3 Reagent Cupboard

The key to the reagent cupboard may be kept separately and in a place designated by the appointed nurse or authorised professional in charge.

3.8.4 Loss of a Medicine Cupboard Key

An Eclipse form needs to be completed. Every effort must be made to find the key or retrieve it from off duty staff. Should access to the medicine cupboard be required before the keys are retrieved the duty manager must be informed and a duplicate key may be obtained. A second set of keys may be available in Pharmacy. The keys must be clearly identified and easily accessible to the duty manager/pharmacist. Where the cupboard keys are not found a new lock must be fitted to the cupboard. If there is no duplicate key, security will arrange for the cupboard to be broken open and a new lock fitted. The pharmacy department must also be notified when it is next open.

3.9 Dispensing, Preparation and Administration of Medicines

Only medicines that have been supplied on behalf of HMP Birmingham, approved patients own medicines, or medicines approved for use by Prison Healthcare Medicines Management Committee, may be administered to patients. This also applies to complementary medicinal products, e.g. aromatherapy oils, homeopathic medicines.

Medicines must only be prepared, checked or administered to a patient by the following categories of healthcare staff:

- A designated nurse or nursing associates
- A Medical Practitioner
- Authorised Pharmacy Staff
- A nurse or authorised professional in training, but only under the direct supervision of a designated nurse or authorised professional. The designated nurse or authorised professional remains responsible for ensuring that the correct procedure takes place
- Other authorised employees

3.9.1 Preparation of Medicines

Errors can occur during the preparation of medicines for administration, particularly where some form of dose calculation is involved. Whenever

possible medicines are presented to clinical areas from the Pharmacy in a ready-to-use form where no further dilution or minimal dose calculation is required.

Medicines must only be prepared, checked or administered to a service user by the following categories of healthcare staff:

- Nurses or Nursing Associates
- A Medical Practitioner
- Authorised Pharmacy Staff
- A student nurse, but only under the direct supervision of a registered nurse. The registered nurse remains responsible for ensuring that the correct procedure takes place
- Other Authorised Employees

Where the preparation of medicines is performed outside the Pharmacy, the following procedure must be observed:

- Read the prescription carefully. Determine the name, dose, diluent, route for administration and if available the expiry date of the medicine.
- The nurse or authorised professional administering the dose must clearly know and understand the actual amount of the medicine to be administered. If a dose calculation is required, it is recommended that the designated nurse or authorised professional checks all calculations with a second professional or a pharmacist before administration.
- Where a calculation is involved and where the medicine is intended for injection (including insulin administration), a second professional must check all aspects of the preparation of the medicines and sign and date the entry.
- If the nurse or authorised professional is unclear as to the correct diluent for a medicine or precise method for medicine preparation, he/she must obtain this information from the Summary of Product Characteristics, Pharmacy or on-call pharmacist before proceeding further.
- An appropriate area for the preparation of intravenous medications must be used. This area should be separated from the direct patient areas and enclosed (all doors and windows should be closed). These precautions reduce the risk of microbial contamination and interruptions, which can lead to errors. Good sterile technique should be used.

3.9.2 Administration of Medicines

The assigned nurse or authorised professional in charge is responsible for ensuring that prescribed medicines are administered within a reasonable time, normally estimated as approximately two hours either side of the designated administration time with the exception of opioid substitution therapy (OST) which includes methadone and buprenorphine which can be administered up to 8 hours after the

prescribed time. This may vary dependent on the efficacy of the medication, pharmacokinetics and possible risk regarding overdose.

Before administration of a medicine, the nurse or authorised professional must:

- Read the prescription carefully, ensuring the prescription is valid and allergy status considered.
- **Ascertain from the record of the administration of medicines that the prescribed dose has not already been given, taking particular care over PRN medications.**
- Select the medicine required and make the expected checks against the prescription according to the GPhC.
- Nurse or authorised professional must assure themselves that the service user has capacity to understand and consent to the administration of the medication.
- The nurse or authorised professional must then check and confirm the identity of the patient and administer the medicine. Extreme care is required to ensure that the patient's identity is confirmed by prisoner ID card, visual recognition and verbal questioning before proceeding to administer the dose. BRT may have access to biometric identification methods and where available should be used.

Medicines dispensed and labelled for an individual patient must be administered only to that patient; supplies labelled for individual patients must not be shared.

The nurse or authorised professional who has administered or supervised the administration of the medicine must, at the time of administration, administer the medication on the electronic SystmOne prescription chart. The electronic signature signifies that the patient has been administered the correct dose. This includes the supervision, monitoring for compliance and divergence. Multiple medicines must not be dispensed into multiple tots in preparation for administration to more than one patient.

Patients must be observed to have taken their medicines by the designated nurse or authorised professional. Prepared medicines must not be left unsupervised. If a medicine is omitted one of the options in the drop-down menu must be entered on the administration section of the electronic prescription (e.g. Patient refused/did not attend/drug unavailable etc.)

If three consecutive doses are missed or three consecutive partial doses are administered (for any reason) the assigned professional should speak with the patient to ascertain details regarding non-compliance and then contact the appropriate prescriber (group) via S1 task. If the patient is not immediately available to speak with, this may be done via booking a nurse review or by booking the patient onto the Pharmacy compliance check appointment ledger. An automatic SystmOne

pop-up requests staff administering medications to check the prescription chart where it detects the likelihood of potential missed doses.

Any essential medications as deemed by the MMC or clinicians involved, not given, must be highlighted to the appropriate prescriber group (e.g. GP or Psychiatrist) via S1.

Refer to appendix 10 for guidance on medication deemed essential or critical.

Failure to record the administration of a medicine or use an omission code, i.e. a blank box, constitutes a medication incident and must be reported via Eclipse. Such records will be the subject of regular audit.

Medicines should be administered at the prescribed time. If the patient is absent from the wing, or has missed a dose for some other reason, the delayed dose can be administered at a later time provided a medical practitioner or pharmacist has confirmed that it is appropriate to do so or that it is according to an agreed protocol. The actual time of administration must be clearly recorded in the Admin notes field on S1, if given later (e.g. weekend regime), by the designated nurse or authorised professional and appropriate entry into the patient's record is made if administrations occurs outside above agreed time window.

The appointed nurse or authorised professional should check and document a capillary glucose reading on the S1 journal note prior to any insulin administration.

3.9.3 Checking of Administration

It is good practice that, wherever possible, that all medicines be prepared and administered in the presence of another nurse or authorised professional Except in extreme emergency, the following must be checked by two qualified healthcare professionals.

- All medicines given by continuous administration, e.g. IV infusion, syringe drivers. There should be a record of the individual nurse or authorised professional setting up and replenishing each intravenous infusion.
- All bolus injections, IV additives and injections via drip tubing.
- All injections taken from multi-dose vials.

When a patient is deemed competent to self-administer the medicine (e.g. in possession insulin) the checking of administration must also be checked by a second authorised healthcare professional following local SOP 2.7 issuing injectable pen devices to patients.

3.9.4 Schedule 2 and 3 Controlled Drugs

The following points are in addition to the above information.

The administration of all Controlled Drugs must be witnessed by a second assigned nurse or authorised professional.

An entry must also be made in the wing/department Controlled Drugs register and include:

- date and time of administration
- name of patient
- patients prison number
- dose administered
- full signature of both nurses or authorised professionals

It may be assumed that all sealed bottles contain the volume as stated by the manufacturer. Upon opening a new bottle and removing the required dose(s) for administration the overage must be measured and recorded in the CD register at the point of performing the stock balance check (see 3.6.4). The remaining stock balance must be checked and confirmed. Any discrepancies must be brought to the notice of the appointed nurse or authorised professional in charge, duty healthcare manager and the pharmacy.

Any liquid medication measured into the glass graduated measures from the stock bottle can be returned to the original stock bottle opened, where the nurse has ensured the measure is clean and there is no contamination of the medication.

Any liquid medication (e.g. Methadone) measured and poured into the plastic tots (for administration), which is subsequently unwanted (e.g. patient refuses dose) should be classed as a “patient return” (PR). This unwanted volume should be recorded in the CD Patient Returns register. The entry must include the time, date, patient name and number, volume of liquid wasted, signature of registered nurse or authorised professional and assigned witness.

In the case of methadone the returned dose should then be poured into the “patient returns waste bottle”.

Other patient unwanted CDs e.g. Espranor or refused solid dose forms, should be recorded as a patient return in the PR register. All solid dose patient returns should be stored in an individually labelled bottle and segregated from stock in the CD cabinet. Complete the attached bottle label with the drug name/quantity/date/prisoner name and number/location/signature of nurse or authorised professional and witness.

Pharmacy should be tasked to inform them that CD destruction is required. A Pharmacist will appropriately destroy the patient returned methadone/ CDs and make an entry in the PR register, with an assigned witness.

3.10 Adverse Reactions and medicine defect reports

Nurse or authorised professional must observe and note any adverse side effects of medicines and inform the responsible medical staff. Any adverse side effects must be documented in the patient's S1 record.

3.10.1 Serious suspected adverse reactions to medicines are notifiable by doctors, nurses, pharmacists or patients through the MHRA Yellow Card system. For new drugs or those annotated with a black triangle in the BNF or other medicines literature then all suspected adverse reactions should be reported to the Committee on Human Medicines (CHM), part of the Medicines and Healthcare Regulatory Agency (MHRA). Advice and Yellow Cards are included in the British National Formulary are available from:
www.gov.uk/yellowcard

The yellow card can be sent to:

FREEPOST YELLOW CARD

(No other postage details required)

As above, any adverse effects (serious, suspected or otherwise) should be documented in the patients' S1 record.

3.10.2 Medicine defect reporting

The process under the "yellow card scheme" should be followed for medicinal defect reporting.

Report the defect incident to the nurse or authorised professional/team leaderand pharmacy

If a drug defect is suspected outside the normal opening hours of Pharmacy, contact the on-call Pharmacy service at Northcroft, BSMHFT. Contact details can be found on the Out of Hours flow chart.

Suspected defective medicinal products are notifiable by Doctors, Pharmacists, nursing staff or patients to:

www.gov.uk/yellowcard

Any clinician making a report of an adverse drug reaction or defective medicine, or requiring advice, should contact a clinical pharmacist and also complete an Eclipse Form. Such reports will then be considered as part of the medicines management incidents by risk management and the Prison MMC.

Further advice on reporting of medication errors is included in Appendix 3.

3.11 Homely Remedies and Minor Ailment – Pharmacy First

3.11.1 Homely remedies are medicines that can normally be purchased over the counter. A small range of medicines can be administered to patients by appropriately trained nursing staff or authorised professional, when certain conditions and criteria are met. This policy allows:

- The patient to receive rapid treatment of relatively minor, self-limiting symptoms
- Unnecessary calls to prescribers are avoided
- Medicines wastage is minimised.

For patients, the prison healthcare service allows standard doses of the medicines identified under homely remedies on S1 to be given if appropriate. These are:

Senna 7.5mg tablets	One or Two at night, STAT
Ibuprofen 400mg tablets	400mg STAT, repeat every 8 hours
Loratadine 10mg tabs	10mg STAT, max once daily
Paracetamol 500mg tab & Sol tab	Once only, 2 tablets, 1-2 tablet per admin, 1-2 tablets per dose, leaving a Four to Six hour gap in-between doses. Max 8 tablets in 24 hours. For maximum 3 days in 28 day period. (Packs of 16 may be supplied and recorded on S1 for mild to moderate pain/pyrexia related to winter viruses including COVID-19, influenza and dental pain
Peptac	5-20 ml per admin, Once only

3.11.2 In addition to homely remedies HMP Birmingham run a Pharmacy Minor Ailment Scheme for access to a wider range of P and GSL medications via N-force kiosk triage process and Pharmacy Technician led clinics.

3.11.3 Principles of administration of a homely remedy.

A nurse or authorised professional must administer the medicine.

Each medicine may only be given a maximum of three days. If the patient is administered three days within a 28 day period, the assigned professional (giving the final dose) should task the GP group via S1 (with the exception of paracetamol for mild to moderate pain/pyrexia related to winter viruses including COVID-19, influenza and dental pain, where additional supplies can be given if patient is symptomatic using professional/clinical judgement). If a medicine is required more frequently a designated prescriber must review the patient and if appropriate, prescribe the medicine on an 'as required' basis or regularly.

3.11.4 Procedure

Following a request from a patient for 'homely remedy' the nurse or authorised professional will:

- Confirm the reason for the request and the nature of the discomfort
- Ensure that the medication requested is required and appropriate to the needs of the patient
- Check that the medication requested has not been administered previously; or if it has been given before that sufficient time has elapsed for a second dose to be administered safely.
- Check that the requested medicine has not been prescribed and administered on another section of S1electronic prescription.
- After administration a record of this must be made on the homely remedies section on the patients S1 record.

3.12 Administration without a prescription for the purpose of life saving in an emergency

Under Regulation 238 section 19 of The Human Medicines Regulation, eighteen drugs are listed that may be given in an emergency without the need for a prescription. These exceptions cited in section 19 enable lifesaving drugs to be given quickly, without delay.

There is no legal issue with a nurse or authorised professional administering one of these drugs listed, which requires administration to an unknown person in a lifesaving situation. However, the healthcare provider and subsequently nurse or

authorised professional must work within their professional standards and must be competent in being able to recognise life threatening situations and act safely. For example, recognising an anaphylactic reaction and administer adrenaline safely.

Those medicines included in Schedule 19 applicable within the prison environment include:

- Chlorphenamine injection
- Glucagon injection
- Hydrocortisone injection
- Naloxone hydrochloride
- Adrenaline 1:1000 (1mg/1ml) injection(Anaphylaxis)
- Adrenaline 1:10000 (1mg/10ml) injection (Cardiac Arrest)
- Atropine 3mg/10ml PFS

Additional drugs required outside of those listed in Schedule 19 can be authorised by the prison MMC or PGD, and the same professional obligations would apply.

3.12.1 Anaphylaxis

- Adrenaline IM injection 1 in 1000 Emerade (dose of 500 micrograms) or Epipen (dose of 300 micrograms) may be administered by medical staff or registered nursing staff trained in immediate life support (ILS) or enhanced life support (ELS); and repeated after 5 minutes if necessary in line with Resuscitation Council Guidelines
- Oxygen up to 15 litres per minute (via high concentration non-rebreath mask) may be administered by all staff trained in ILS/ELS.

3.12.2 Cardiac Arrest

- Atropine Sulphate 3mg IV may be administered by medical staff or registered nursing staff trained in immediate life support (ILS) when an IV cannula is in situ in line with Resuscitation Council Guidelines
- Adrenaline injection 1 in 10,000 – an IV injection of up to 1mg may be administered by medical staff or registered nursing staff trained in immediate life support (ILS) in line with Resuscitation Council Guidelines

Oxygen up to 15 litres per minute may be administered by all staff trained in hospital life support (HLS) for patients who are acutely unwell and deemed to require oxygen. Further information on administration of other medicines required in the emergency treatment of chest pain, hypoglycaemic attacks, chest pain, seizures or status epilepticus and asthma attacks is approved via the Resuscitation Committee.

3.13 Medication Concordance

These are dealt with in Appendix 5.

3.14 Losses or Discrepancies

3.14.1 Controlled Drugs, Schedule 2 and 3

In the event of a discrepancy between the stock balance and register for Controlled Drugs, the appointed nurse or authorised professional in charge must immediately and thoroughly investigate the loss, checking the CD register against the electronic prescription administration records and brief interviews with staff if appropriate.

If the initial investigation is unsuccessful, the discrepancy must be reported immediately to the senior manager responsible for the ward or wing, the Head of Prison Pharmacy/Pharmacist (who will report to the Chief Pharmacist of Pharmacy and Medicines Management) and the Director of Offender Health, at the earliest opportunity who will then consider appropriate further actions and reporting to the Trust Controlled Drugs Accountable Officer and Local Intelligence Network for Controlled Drugs.

An Eclipse should be completed. This also applies to all medicines similarly assigned as controlled drugs by local agreement.

Other discrepancies may include overdose of methadone to patient e.g. double dosing. In conjunction with the overdose policy, this must be immediately reported to the Director of Healthcare. An Eclipse form should be completed. Also refer to local CD SOP.

3.14.2 Other Medicines

Any loss of other medicines must be reported to the senior manager responsible for the wing/department (via the nurse or authorised professional in charge) and the Head of Prison Pharmacy/ Pharmacists, who can then decide on a further course of action.

An Eclipse form should be completed for any unexplained loss of medication.

3.15 Disposal of Medicines no Longer Required

3.15.1 Controlled Drugs

Controlled Drugs must not be returned from the wings/departments. Controlled drugs no longer required by a wing/department (due to expiry or change in patient prescription) must be removed by a Pharmacist.

Upon removal of the expired controlled drug, the Pharmacist will transfer the required quantity from the relevant controlled drugs register to the expired stock register held in Pharmacy. This must be done using the Pharmacy CD Transfer SOP. The new stock balance must be documented and signed by the Pharmacist. The transaction will be witnessed by the nurse or authorised professional in charge who will also sign the register.

Any stock Controlled Drug (non-patient return) for re-use removed from the ward or wing by the Pharmacist must be returned to the pharmacy department where an appropriate entry will be made in the pharmacy Controlled Drug (stock) Register.

Controlled Drugs brought into the prison by the patient may be used by the wing/department staff for administration to the patient (see Patient's Own Medicines section CD SOP3.4), in exceptional circumstances.

In Reception, the patients' own Controlled Drug in question must be stored in the designated CD cupboard and entered in the patient returns CD Register.

(The destruction of the patient returned Controlled Drug must be completed by a designated Pharmacist in the presence of a second nurse or authorised professional. An appropriate entry should be made in the Patient Returns Controlled Drug Register, which includes the signatures of the two professionals involved in the destruction, using an approved CD destruction kit.)
All unwanted Controlled Drugs returned to the pharmacy must be recorded as having been received in the CD register before being stored in a segregated part of the CD cabinet until the Authorised Person can witness their destruction.

The Prison Pharmacy service will assess returned stock CDs for reuse or destruction. Where CDs are to be destroyed (unwanted or expired); they should be destroyed in accordance with current Home Office guidance, the BSMHFT Waste Management policy and waste management regulations.

The Accountable Officer, or approved representative will witness the destruction of CDs. Upon destruction they will sign the appropriate CD register entry, witnessing the destruction.

Refer to local CD SOPs.

3.15.2 Other Medicines

All out of date medicines as well as those no longer required by the wing/department must be returned to the pharmacy in a tamper evident bag.

The pharmacy will review and reuse medicines as appropriate. Any medication which has been returned via the patient will be destroyed and not reused.

4: Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities
Executive Director	The **Executive Medical Director** is the identified Trust lead for Safe Medicines Practice. This role is supported by the functions of the Clinical Lead, the Head of Healthcare, the Chief Pharmacist (BMSHFT), the Head of Pharmacy (HMP Birmingham) and the Chair of Medicines Management Committee.
HMP Medicines Management Committee	The **MMC** will review every 5 years or if there is a significant change.
Policy Lead	The **Policy Lead** will initiate review of this policy every 3 years or sooner should an incident occur which requires a change to be implemented
Prescribers	Medical and Non-Medical Prescribers (NMP) are responsible for prescribing medicines for patients within the legal framework for medicines, the HMP Birmingham Medicines Code and this policy when performing these duties. It is the prescribers' responsibility to ensure an IPRA has been completed for patients requiring medication, when considering prescribing.
Pharmacy	The Chief Pharmacist for BSMHFT and Medicines Management Committee will be responsible for the organisation, monitoring and reporting of a system for assuring the safe and secure handling of medicines. The Head of Pharmacy and clinical Lead Pharmacist, HMP Birmingham will be responsible for the Pharmacy service, ensuring safe and secure handling of medicines within the prison. A record showing appointments and signatures of all prescribers (including locum appointments) must be kept in the pharmacy and updated, upon any change, by the appropriate manager. Pharmacists and Pharmacy staff are responsible for the stocks of medicines held in the pharmacy, their manipulation and preparation

	into user ready presentations and for their supply to wings/departments. Pharmacists and Pharmacy staff are also responsible for advising on the safe, effective and economic use of medicines. These responsibilities include advising professionals on the storage of medicines in clinical areas. Authorised Pharmacy Staff will inspect the stocks of medicines held on the wing/department at any time to ensure the medicines are in date and stored under the proper legal and environmental conditions. This will occur at least annually.
Nursing staff	The appointed nurse or authorised professional in charge of a wing/department is ultimately accountable for the stock of all medicines held and is responsible for ensuring that the Medicines Code is followed correctly and that the security of medicines is maintained. The assigned nurse or authorised professional in charge of the wing/department is responsible for the stock of medicines held in the wing/department and for ensuring that stocks of Controlled Drugs, if held, correspond with the details shown in the register. The appointed nurse or authorised professional in charge is responsible for ensuring that this is carried out. Any discrepancy must be reported according to the procedure laid down in 3.14. The administration of medicines is the responsibility of the assigned nurse or authorised professional in charge of the wing who may delegate these duties to a nurse or authorised professional, but who must exercise supervision as is necessary. Professionals in training must be given every opportunity to become proficient in medicines related activities under appropriate supervision. The supervising Professional has responsibility for medicine procedures at such times.
All healthcare staff	Must follow this policy
Medication Administration staff	Must follow this policy
The Patient	The patient must adhere to the Medication Compact signed as part of the initial Reception. This will be printed by the Reception nursing staff

	as part of the first night screen. The patient must agree to and sign the compact with the copy scanned on to S1

5: Development and Consultation process

Consultation summary		
Date policy issued for consultation	July 2024	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s) November 2024**	
Prison Medicines Management Committee	December 2024	
HMP Birmingham Clinical Governance	December 2024	
BSMHFT Clinical Governance	February 2025	
BCHC Quality Safety Executive	December 2024	
Where received	**Summary of feedback**	**Actions / Response**

6: Reference documents

Royal College of Nursing and Royal Pharmaceutical Council (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings
https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567

Police and Criminal Evidence Act 1984 (PACE) – Code of Practice Guide
https://www.gov.uk/guidance/police-and-criminal-evidence-act-1984-pace-codes-of-practice#history

Mental Health Act 1983.
http://www.legislation.gov.uk/ukpga/1983/20/contents

BSMHFT – 'Consent to Treatment Policy MHL10
Policies - Consent to Treatment Policy Final.pdf - All Documents (sharepoint.com)

BSMHFT – 'Mental Capacity Act (2005)
Policies - Mental Capacity Act 2005 Policy.pdf - All Documents (sharepoint.com)

BSMHFT – 'Advance Statements and Advanced Decisions 2022
Advance Statements and Advance Decision policy .pdf

BSMHFT – Medicines Reconciliation Policy HMP SOP6.1 2024
SOP 6.1 medicine reconciliation.pdf

BSMHFT – Medicines Possession Policy
https://bsmhftnhsuk.sharepoint.com/sites/connect-policies

RCGP – Safer Prescribing in Prisons, 2019
Safer Prescribing in Prisons: Guidance for clinicians (rcgp.org.uk)

7: Bibliography:

Royal Pharmaceutical Society of Great Britain - The Safe and Secure Handling of Medicines: (date accessed 30/05/2024)
Professional guidance on the safe and secure handling of medicines (rpharms.com)

Medicines Act (1968)
Medicines Act 1968 (legislation.gov.uk)

DH Safer Management of Controlled Drugs: A guide to good practice in secondary care (England) (date accessed 30/05/2024)
Safer Prescribing in Prisons: Guidance for clinicians (rcgp.org.uk)

Misuse of Drugs Act (1971) & Misuse of Drugs Regulations (2001) and subsequent legislation. (date accessed 30/05/2024)
Misuse of Drugs Act 1971 (legislation.gov.uk)

HSC 2000/026 Patient Group Directions
026hsc.PDF (nationalarchives.gov.uk)

Department of Health (2004) Building a Safer NHS for patients: Improving Medication Safety
Medication Safety - [PDF Document] (vdocument.in)

National Audit of Royal Pharmaceutical Society Standards in Secure Environments.
Medicines-Optimisation-in-Secure-Environments-Audit-report-SPS-June-2019.pdf

8: Glossary:

Throughout this Code, certain specialist titles describe healthcare staff who have defined responsibilities regarding the management of medicines. Only staff with contracts (or honorary contracts) of employment to work in Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) or Birmingham Community Health Trust (BCHC) are recognised as having any involvement with medicines.

Administer

To give a medicine by either, introduction into the body, (e.g. orally or by injection) or by external application, (e.g. cream or ointment).

Adverse Drug Reaction

Any untoward and unintended response in a patient to whom a medicinal product has been administered or taken including occurrences that are not necessarily caused by or related to that product.

Appointed nurse or authorised professional in Charge

The senior professional appointed in charge of a wing/department e.g. Healthcare2/3 Manager, Registered Nurse, Superintendent Physiotherapist, Team Manager, Pharmacists, Pharmacy Technicians or Community Psychiatric Nurse (CPN) given that role.

Authorised Employee

A member of staff who has, following training, been authorised by BSMHFT or BCHC to undertake specific duties in relation to medicines, e.g. support workers, healthcare assistants (HCA), Registered Nursing Associates and HMP healthcare officers (HCO).

Medicines, whether for internal or external use, will be regarded, for the purpose of this Code, as comprising the following categories:

- Controlled Drugs controlled under the provisions of the Misuse of Drugs Act 1971, with stringent requirements for supply, storage and administration.
- All other medicines and medicinal products prepared for administration to patients and which are controlled by the Medicines Act, 1968. This also includes many diagnostic agents, X-ray contrast agents and medical gases.
- All medicines and medicinal products must be treated with care and responsibility.
- All complementary medicines e.g. aromatherapy, herbal or homeopathic remedies. These products are used for therapeutic purposes and require the same safeguards as other medicines.

This policy applies to all medicines and medicinal products used in HMP Birmingham. These include topical lotions, applications, intravenous infusions, medicated dressings and complementary medicines.

Authorised Pharmacy Staff

Any pharmacist, pharmacy technician, pharmacy support worker or assistant technical officer (ATO), authorised by the Head of Pharmacy as competent and appropriate to perform a specific function.

Authorised Prescriber

Any medic or non-medical prescriber authorised to perform their role in HMP Birmingham. A signatory list of all prescribers should be retained in pharmacy and updated accordingly.

Birmingham Recovery Team Clinical BRTC and Cranstoun (psychosocial)

BRT aims to increase the access to and quality of substance misuse treatment available to prisoners, with particular emphasis on early custody, improving the integration between clinical and psychosocial interventions, reinforcing continuity of care from the community into prison, between prisons, and on release into the community

Defective Medicine

A medicine that proves to be harmful under normal conditions of use, lacking in therapeutic efficacy or the qualitative and quantitative composition of the product is not as declared or the controls on the medicinal product and/or the controls at an intermediate stage of the manufacturing process have not been carried out or if some other requirement or obligation relating to the grant of the manufacturing authorisation has not been fulfilled.

Designated nurse or authorised professional

A Registered Nurse, CPN, Medic, nursing associate, Pharmacist or Pharmacy Technician.

Medicine

Any substance or combination of substances presented for treating or preventing disease. Any substance or combination of substances which may be administered with a view to making a medical diagnosis or restoring, correcting or modifying physiological or psychological functions.

Nurse or authorised professional in Charge

The senior registered professional on-duty for the wing/department, who has been delegated as the professional in charge, for that shift or during the absence of the appointed professional in charge.

Prescribe

To authorise, by full signature, the supply and administration of a medicine.

Primary Dispensing

To prepare a clinically appropriate medicine for a patient either for self-administration or administration by another. The act of dispensing includes supply and also encompasses a number of other cognitive functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product). These functions are performed under the supervision of a pharmacist or in exceptional circumstances a medical practitioner.

Secondary Dispensing

This is the re-packaging of medicines that have been dispensed for an individual service user into another container bearing another label or identifying information**. This is not permitted in HMP Birmingham.**
(NB: Only nurses who have undertaken Trust approved training are able to undertake secondary dispensing).

Supply

To supply a medicine to a patient or appointed professional for administration.

The Second nurse or authorised professional

The second professional, is responsible for checking the accuracy of the designated (first) professional (a qualified, registered professional) and immediately bringing to their attention any errors or discrepancies for correction, prior to administration. The second professional must be qualified to a minimum NVQ level 3 Health and Social Care Award; and minimum Key skills Level 2 Literacy and Numeracy (or working towards the latter). Other than registered nurses, staff authorised to second check must be approved competent by the Head of Pharmacy/Lead Clinical Pharmacist or Head of Healthcare. This may include, for example, healthcare assistants, prison healthcare officers, pharmacy technicians and pharmacy support workers.

9: Audit and assurance:

This policy will be formally reviewed by the Medicines Management Committee in 2027. The Committee will, however, continuously monitor its implementation and practice through an agreed programme of audit covering healthcare wings and community teams. These audits will ideally include:

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Management of Controlled Drugs	Clinical Lead Pharmacist	Audit report	12 months	MMC and CE&A
The safe and secure handling of medicines	Clinical Lead Pharmacist	Audit report	12 months	MMC and CE&A
Audits of prescription standards by pharmacy or prescribers	Clinical Lead Pharmacist	Audit report	12 months	MMC and CE&A
Missed dose audits by Pharmacy or Nursing staff	Clinical Lead Pharmacist	Audit report	12 months	MMC and CE&A
Homely remedy prescribing and use	Clinical Lead Pharmacist	Audit report	12 months	MMC and CE&A
Audits of the administration, of medicines by nursing staff	Service leads for primary care, mental health and BRT	Audit report	12 months	MMC and CE&A
Allergy recording on S1	Clinical Lead Pharmacist	Audit report	12 months	MMC and CE&A
Medication incidents and recommendations	Head of Pharmacy	Incident summary report	Quarterly	MMC and CE&A

Appendix 1 **Equality Analysis Screening Form**

A word version of this document can be found on the HR support pages on Connect

Title of Proposal	Medicines Code Policy HMP Birmingham		
Person Completing this proposal	Nigel Barnes	**Role or title**	Chief Pharmacist
Division	Offender Health	**Service Area**	Pharmacy – HMP Birmingham
Date Started	17th February 2025	**Date completed**	17th February 2025

Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.

This Medicines Code defines the policies and procedures to be followed within HMP Birmingham for the prescribing, ordering, dispensing, carriage, and transport, storing, administering and disposal of medicines.

This policy covers all staff working in HMP Birmingham, including agency and bank staff, permanent and temporary staff, who are involved in any way with the use of medicines.

Who will benefit from the policy?

Service users and all HMP Birmingham healthcare staff in the course of their duties.

Does the policy affect service users, employees or the wider community?
Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward

Positive – clear guidece in place

Does the policy significantly affect service delivery, business processes or policy?
How will these reduce inequality?

Continuity

Does it involve a significant commitment of resources?
How will these reduce inequality?

NA

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
NA				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this proposal promote equality of opportunity? ***No impact*** *Eliminate discrimination?* ***No impact*** *Eliminate harassment?* ***No impact*** *Eliminate victimisation?* ***No impact***			*Promote good community relations?* ***No impact*** *Promote positive attitudes towards disabled people?* ***No impact*** *Consider more favourable treatment of disabled people?* ***No impact*** *Promote involvement and consultation?* ***No impact*** *Protect and promote human rights?* ***No impact***	
Please click in the relevant impact box or leave blank if you feel there is no particular impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	x			Medicines should be provided to all patients on the basis of clinical need. Modifications of dose or formulation may be required for younger or older patients. It is anticipated that age will not have an impact in terms of discrimination as this policy ensures that all employees / service users should be treated in a fair, reasonable and consistent manner irrespective of their age
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	x			Medicines should be provided to all patients on the basis of clinical need. Modifications in the delivery of medicines may be required for patients with disability and sections of the Medicines Code help with this. it is anticipated that disability will not have an impact in terms of discrimination as this policy ensures that all employees / service users should be treated in a fair, reasonable and consistent manner irrespective of their age. Where reasonable adjustment are recognised we will support when necessary.

Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	x			Medicines should be provided to all patients on the basis of clinical need. It is anticipated that male will not have an impact in terms of discrimination as this policy ensures that all employees / service users should be treated in a fair, reasonable and consistent manner irrespective of their age
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	x			Medicines should be provided to all patients on the basis of clinical need. Marriage or civil partnership should not affect this.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	x			It is anticipated that not affected as it is a male prison & will not have an impact in terms of discrimination as this policy ensures that all employees / service users should be treated in a fair, reasonable and consistent manner irrespective of their age.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	x			Medicines should be provided to all patients on the basis of clinical need. Race or ethnic background may affect the handling of some medicines and this should be taken into account in the prescribing of medicines.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	x			Medicines should be provided to all patients on the basis of clinical need. Some patients may require some changes to formulation of

				medicines to avoid medicines for example with animal derivatives or pork derivatives this will be reviewed case by case and adjustments made accordingly
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	x			Medicines should be provided to all patients on the basis of clinical need. Sexual orientation should not affect this. This will be reviewed case by case and adjustments made accordingly.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	x			Medicines should be provided to all patients on the basis of clinical need. This will be reviewed case by case and adjustments made accordingly
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	x			This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010. This policy applies to **all**, including, staff, agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger?				

The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns				
How will any impact or planned actions be monitored and reviewed?				
Feedback from reports of concerns including HC1 form, escalating concerns through governance routes. Regular audits and policy updates, communication to managers through service meetings				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				
Policy will be shared trust wide and promoted in ways accessible to ALL staff without the reliance upon electronic communications				
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at **bsmhft.edi.queries@nhs.net**. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis				

Appendix 2: USE OF UNLICENSED MEDICINES

In the UK no medicine can be marketed for human use without a Product Licence (PL) granted by the Licensing Authority (Ministry of Health). The PL specifies the indications for which a product may be used and also the dose, route of administration etc. Licensing arrangements are determined by the Medicines Act 1968 and implemented through the Medicines and Healthcare Products Regulatory Agency (MHRA).

Professional guidance on the use of unlicensed medicines is available from the General Medical Council and General Pharmaceutical Council. The Royal College of Psychiatrists College Report CR142 'Use of licensed medicines for unlicensed applications in psychiatric practice' 2007 offers useful advice to prescribers.

Unlicensed medicines fall into 6 broad categories

1. Products derived from licensed medicines and prepared by the NHS or commercial unit with a "specials" manufacturing licence or prepared in a hospital pharmacy under a Medicines Act exemption e.g. liquids for patients with swallowing difficulties.
2. Low dose formulations for children
3. Products whose licence has been abandoned, suspended, revoked or not renewed
4. Products for which a licence has yet to be given, but available and licensed outside the UK.
5. Some clinical trial medicines.
6. Medicines used outside the terms of the Product Licence e.g. off-label indication, dose, route, age

Negligence Liability

Prescribers have a duty in common law to take reasonable care and to act in a way consistent with the practice of a responsible body of their peers of similar professional standing. In using an unlicensed medicine the prescriber must act responsibly and with reasonable care and skill. Not to meet these standards lays the prescriber open to claims of negligence liability.

Strict Product Liability (or liability without fault)

The Product Liability Directive (EEC/85/374) and the Consumer Protection Act 1987, makes the producer or supplier liable for damage caused by a defect in the product. The product can be considered defective on the basis of what the patient is entitled to expect. This may be affected by the verbal and written information and warnings given to the patient.

Practical Implications

The responsibility for use of unlicensed medicines lies with the prescriber. Mechanisms must be in place to ensure that a prescriber knows when a medicine prescribed/supplied is unlicensed and that he/she is aware of his/her responsibilities.

Unlicensed medicines should only be used to fulfil the special needs of an individual patient (MCA). Use of an unlicensed medicine on a wider scale e.g. for routine stock use, must be approved by the Medicines Management Committee.

Trust Procedure

- The Prison Pharmacy will advise prescribers of the unlicensed nature of the medicine at the time of dispensing.
- Clear record of intended use of unlicensed medication or indication and patient consent must be made in the patients S1 record
- Prescribers should consider carefully the use of unlicensed medicines and only use this form of therapy when the benefits outweigh the risks and where there is no licensed alternative available.
- Prescribers must obtain consent to treatment and inform the patient of the medicines' licence status. The patient must also be informed that the effects of an unlicensed product will be less well understood than those of a licensed product.
- Prescribers should inform their medical colleagues (especially General Practitioners) of the medicine's licence status when advising them to use unlicensed medicines.

Appendix 3: MEDICATION ERRORS

A medication error is a preventable incident associated with the use of a medicine that may put a patient at risk. Such incidents may be related to any of the steps of the medicine use process. This includes the storage, carriage, prescribing, dispensing and administration of medicine, or the transfer of information.

Medical Review of the Patient

The well-being of the patient is of prime importance following a medication error. The error must be reported as soon as possible to an appropriate member of the medical staff who will decide whether any further action is needed.

Monitoring and Reporting System

One of the responsibilities of the Medicines Management Committee is to oversee a monitoring and reporting system with the objective of preventing medication errors. At the current time medication errors will be reported via the BSMHFT Eclipse System.

- The objective of a reporting system is improvement in care and not the disciplining of staff. The Medicines Management Committee should advise professional managers of the need to focus on systems rather than on individuals.
- In addition to serious incidents involving medicines, it is anticipated that a much larger number of less serious and near miss reports will also be reported to the Medicines Management Committee.
- An incident report form must be completed by the Assigned Professional in Charge or by the individual concerned. Details of the incident and of the immediate action taken should be given. A professional self-reflection by the individual concerned must take place.

Review of Medication Errors and External Reporting

The Medicines Management Committee should review reports of medication errors on a quarterly basis, to establish trends and to take action intended to prevent such errors. Action may involve system redesign and improvement and/or education, training and competency assessment of employees on any aspect of medicine use.

The Medicines Management Committee will report regularly to the Prison Clinical Governance Committee on medication errors.

Advice on reporting medicines defects and adverse drugs reactions to MHRA is available from the prison Pharmacy service. Duty of Candour may be applicable.

Appendix 4: Medical Gases

All medical gases used in the prison are Licensed Medicines and as such are subject to the Medicines Act and must be treated in the same way as any other medicines.

Before a medical gas is administered to a patient, written authority from a prescriber must be obtained. This authority must include the name, and concentration of the medical gas (where appropriate), the method of administration and the rate of flow. This can be achieved by:

- An electronic prescription for an individual patient
- Oxygen therapy, further information and advice is contained within the BCHC policy on oxygen therapy
- A Designated Professional administering a medical gas to a patient must make a S1 entry or by administration of an electronic prescription that treatment with the particular medical gas has been initiated.

Appendix 5: Medicines Adherence/concordance/compliance

Up to half of all patients with long term conditions are known not to take their medicines as intended. In schizophrenia rates of non-compliance around 50% are consistently found. The following guidance has been developed to assist clinical staff in adopting a more consistent and collaborative approach with service users to apply a range of strategies to maximise concordance. BSMHFT also has a medication management 5 day module which can be accessed in-house as part of an overall package of training for nurses and other professional staff within the trust.

Documentation

Concerns that service users are not taking their medication must be recorded in SystmOne and where appropriate on Rio. Additionally, the care plan must be amended to address issues of non-compliance. Alert prescriber after 3 days of non-compliance. Any discussions about choice, benefits and risks of medication and the provision of information such as the Choice and Medication leaflets should also be documented in the notes.

Managers must raise non-concordance with staff during supervision on an ongoing basis. (Handover)

What can be done to improve compliance?

1. Involve service users in decisions about medicines

a) Engage service users, communicate effectively and have a good relationship with the service user. Adapt your consultation style to the clients' need and encourage them to ask questions.

- explain the pros and cons of treatment
- clarify what the service user hopes treatment will achieve
- talk and listen to the service user and note any non-verbal cues
- help service users make decisions based on likely benefits and risks rather than misconceptions
- accept that service users may have different views from healthcare professionals about risks, benefits and side-effects

b) understanding the service user's perspective

- ask what they know and believe about medicines and their need for medication
- ask about general and specific concerns and address these remember to discuss what will happen if they don't take medication, treatment options, reducing or stopping medication and fitting medicines into their routine

c) provide information

- The choice and medication website is an excellent source of information and has been designed for use by both service users and mental health professionals www.choiceandmedication.org.uk
- Document what information is given and record a summary of the discussion
- Summary of Product Characteristics

2. Supporting compliance

a) Assess compliance

- ask clients if they have missed any doses recently (e.g. in the last week) and about medicine-taking habits
- monitor side-effects as a sign of compliance- use recognised rating scales such as LUNSERS or GASS
- ask for empty compliance aids, medicine boxes/bottles and any untaken medicines etc.
- consider taking blood samples for antipsychotic levels. Further information is available on the intranet
- check the client has been collecting their prescription from their GP and having them dispensed at a pharmacy if medicines are obtained from primary care

b) Interventions to increase compliance

- assess if non-compliance is intentional or unintentional
- discuss any beliefs or concerns clients have about their medicines
- undertake a critical medicines review to simplify the number of medicines taken, address side effects and maintain or improve overall effectiveness (see 3. below)
- possible interventions include: clients recording their medicine taking (the pharmacy can provide stickers that can be placed on medicine boxes/bottles which can be ticked when a dose has been taken), simplify the regimen, use alternative packaging or a compliance aid, phone/text reminders to take medicines, staff to supervise medicine taking, consider compliance therapy/motivational interviewing
- If side-effects are a problem: discuss benefits versus side-effects and how the client might deal with these, suggesting strategies for managing side-effects, e.g. consider adjusting the timing or dosage or switching to an alternative medication

3. Review medicines – Medicines Reconciliation

Medicine Usage Review/ New Medicine Service-Critically review the patient's medicines including any medicines they may be receiving from their GP. This may be a carried out if necessary as part of a multidisciplinary review of the patient.
This should include a clear indication, assessment of the medicine's effectiveness, checking of the clients understanding of the medicines they are prescribed, doses, side effects and how to manage them, interactions between medicines and any changes required.

- Review the clients' knowledge, understanding, experiences and concerns about their medicines and whether they think they still need them
- Ask about compliance when reviewing medicines. Clarify reasons for non-compliance and agree any action with the client
- Ask clients if they have their own way of assessing medication e.g. by stopping and starting treatment
- The Pharmacist must follow approved formulary and cost effective prescribing suggesting appropriate changes or continuation of treatment to the prescriber.

After the medicines review, assess the effectiveness of the medicines review and if necessary, tailor the approach in line with the service users' needs

Medicines Reconciliation – Will be performed by a Senior Pharmacy Technician and authorised by a Pharmacist. The Senior Pharmacy Technician will check various sources to confirm a patient's current medication history. Sources may include Summary Care Records, first night screening on Reception, previous prison establishments, POD assessments etc. Consent must be obtained to access and share patient records. Follow local SOPs.

4. Improve communication between healthcare professionals

Many clients have some or all of their medication prescribed in primary care thus any reviews carried out by the Trust must be communicated with other prescribers involved with the clients care.
The following information should be communicated:

- The outcome of any medication review/reconciliation
- The clients diagnosis
- A list of all medicines the client should be taking
- State any new medicines that have been started
- State any medicines that have been changed or stopped with reason
- Information on duration of treatment
- Any known adverse drug reactions and allergies
- Any difficulties with adherence and any actions taken (e.g. compliance aid)

5. Practical Interventions to aid adherence

The table below gives solutions to some problems that service users may encounter.

Problem	Action
Difficulty reading labels	Possible solutions include: • Large print • Colour coded bottles • Use numbers and not words • Use symbols • Translation into different languages
Difficulty opening and closing bottles	Use non child resistant tops, or winged tops
Difficulty handling boxes and bottles	Use larger bottles or boxes Consider compliance aid where this will improve handling
Half tablet dose	Pharmacy will halve tablets if appropriate
Difficulty pushing tablets out of blister pack	Pharmacy will de-blister if appropriate
Difficulty with liquid measurements	Provide alternative formulation
Difficulty swallowing	Change formulation. Many tablets may be dispersed in water where a liquid formulation is not available. Further advice is available from the prison Pharmacy
Is patient confused	Support/counselling. Synchronise doses to daily events. Reduce frequency of doses, if possible all medicines to be taken at same time of day. A supplementary administration chart with tick boxes may help. Supply medicines on a weekly basis, rather than monthly.
Does patient forget to take medicines	Simplify regime. Organise support, e.g. with carer. Supply a system for reminding patient such as an alarm or chart. Consider a compliance aid .
Understand the risks associated with not complying Unacceptable side effects	Educate and support. Provide verbal and written information. Identify side effects Improve therapy to minimise side effects.

	Use of slow-release preparations if available, changing times of administration. Treat side effects
Have poor or no motivation	Provide education about benefits
Understand the need for the medicine	Provide education and consider treatment regime and support.

Appendix 6: Fridge Temperature Log

Birmingham Community Healthcare NHS
NHS Trust

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Appendix 6: Fridge Temperature Log

HMP BIRMINGHAM DAILY FRIDGE MONITORING

Make & Model of ……MONTH:……WING/AREA…….

Temperature Range: 2C-8C
Warning Limits: Below 3C & above 7C - **Re-check and contact pharmacy if consistently at warning limit**
Action Limit: Below 2C & above 8C - **Contact pharmacy if temperature falls below 2C or exceeds 8C**

Date	Time	Temperature C			Action Taken	Reset (√)	Sign	Pharm check
		Actual	Min	Max				
1st								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								
21st								
22nd								
23rd								
24th								
25th								
26th								
27th								
28th								
29th								
30th								
31st								

Appendix 7: Room Temperature Log

Birmingham Community Healthcare NHS
NHS Trust

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Appendix 7: Room Temperature Log

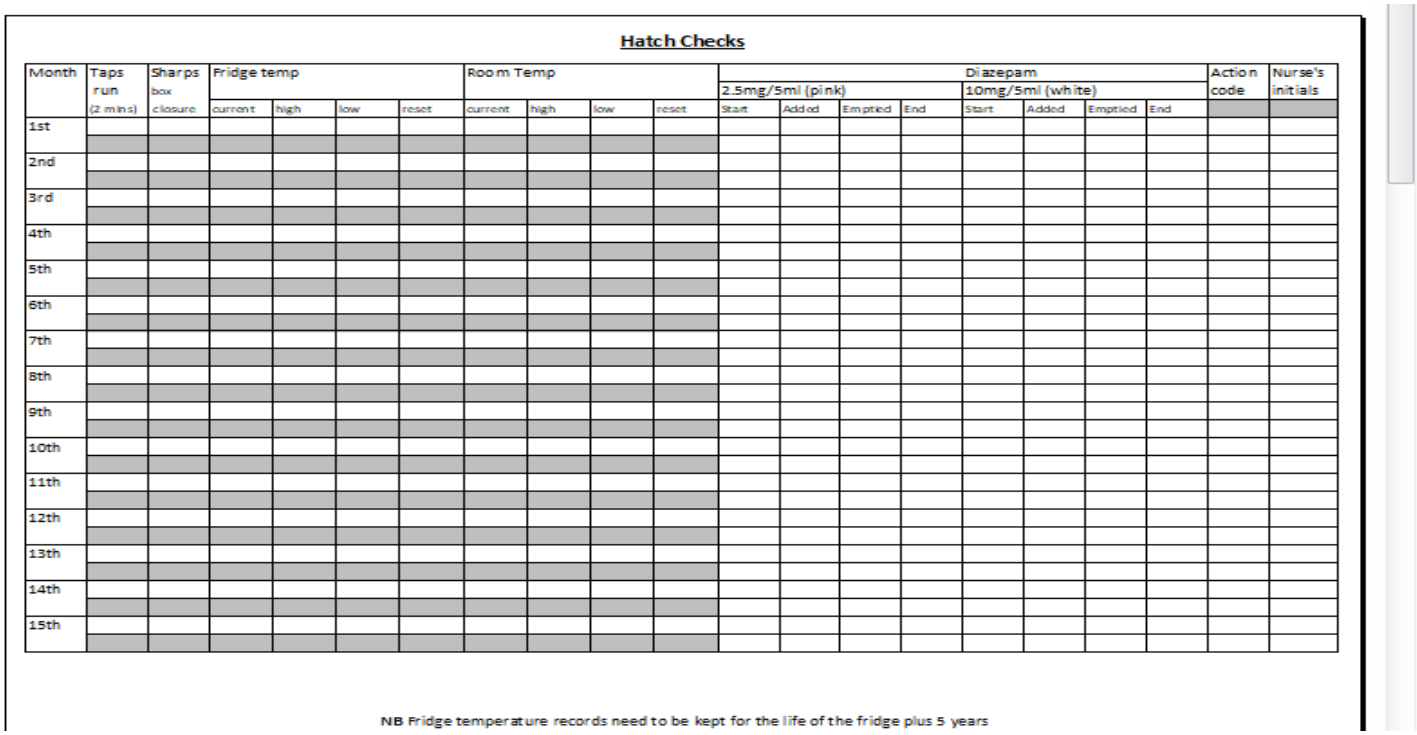
HMP BIRMINGHAM DAILY ROOM TEMPERATURE MONITORING

MONTH: WING/AREA……

Temperature Range: Below 25C
Warning Limits: Above 24C
Action Limit: Above 25C
Inform pharmacy when temperatures exceed 25C

Date	Time	Temperature C			Action Taken	Reset (√)	Sign	Pharm Check
		Actual	Min	Max				
1st								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								
21st								
22nd								
23rd								
24th								
25th								
26th								
27th								
28th								
29th								
30th								
31st								

Appendix 8: Hatch checklist and action codes when out of range



Hatch Checks

Month	Taps run (2 mins)	Sharps box closure	Fridge temp current	Fridge temp high	Fridge temp low	Fridge temp reset	Room Temp current	Room Temp high	Room Temp low	Room Temp reset	Diazepam 2.5mg/5ml (pink) Start	Added	Emptied	End	Diazepam 10mg/5ml (white) Start	Added	Emptied	End	Action code	Nurse's initials
1st																				
2nd																				
3rd																				
4th																				
5th																				
6th																				
7th																				
8th																				
9th																				
10th																				
11th																				
12th																				
13th																				
14th																				
15th																				

NB Fridge temperature records need to be kept for the life of the fridge plus 5 years

- **Ensure room and fridge temperatures are recorded on a daily basis.**
- Check the thermometer is working correctly and place probe in the centre of the fridge. If out of range; reset and recheck after a short period of time. **(Action code: 1)**
- Report malfunctions of fridges to your line manager **(Action code: 2)**
- Report thermometer malfunctions to Pharmacy for replacement **(Action code: 3)**
- Note: Our thermometers read both Room and Fridge temperatures by pressing the Room/Fridge button. The display will indicate which temperature you are currently reading.
- Remove medications & store in a nearby fridge when outside of the optimal range (2C – 8C) and send a S1 task to pharmacy. Include the temperatures (max/min/current) of the fridge, the approximate timeframes involved and the name of any medication affected within the task to pharmacy**(Action code: 4)**

Ambient room temperature Monitoring
Temperature range: Below 25C
Warning Limits: Above 24C
Action Limit: Above 25C

Inform Pharmacy via S1 task when temperatures are above 25C **(Action code: 5)**

Fridge temperature monitoring

Temperature Range: 2C – 8C

Warning Limits: Below 3C & above 8C .Re-check and contact pharmacy if consistently at warning limit **(Action code: 6)**

Action Limit: Below 2C & above 8C. **(Action code: 4- as above)**

If any Eclipse reporting is required, this will be completed by Pharmacy after investigating the temperature discrepancy

Diazepam checks

Where a discrepancy is noted with Diazepam balance checks please inform your team manager **(Action code: 7)**

If any Eclipse reporting is required, this will be completed by you team manager after investigating the balance discrepancy.

Appendix 9: Form for Borrowing Stock From Other Wards/Units/Teams

WING_____

Date	Staff initials	Item	Stock	Non-stock	Quantity	Patient Name	Patient number	To Wing

Appendix 10: Critical or essential medication list

Positive inotropic drugs
Cardiac glycosides

Anti-arrhythmic drugs
Drugs for arrhythmias

Beta-adrenoceptor blocking drugs
For oral maintenance in angina & arrhythmias

Hypertension and heart failure
Vasodilator antihypertensive drugs for hypertensive crisis

Nitrates, calcium-channel blockers, and other anti-anginal drugs For treatment of acute angina

Anticoagulants

Anti-epileptic drugs

Oral Antipsychotics For treatment of acutely unwell mental health

Drugs used in parkinsonism and related disorders

- Dopaminergic drugs used in parkinsonism
- Antimuscarinic drugs used in parkinsonism
- Drugs used in essential tremor, chorea, tics, and related disorders

All systemic anti-infectives

Insulins

Cytotoxic agents

Drugs affecting the immune response.
Corticosteroids (including replacements) and other immune suppressants.

Thyroxine

Painkillers for severe pain relief (e.g. terminal care)

Treatments for severe glaucoma

Opioid substitution therapy for severe withdrawal

Short acting beta antagonists (note: inhalers are automatically in-possession)

Reference:

https://www.sps.nhs.uk/articles/npsa-rapid-response-report-reducing-harm-from-omitted-and-delayed-medicines-in-hospital-a-tool-to-support-local-implementation/

WHO Model Lists of Essential Medicines 23rd edition/2023