Use and Handling of Medicines Practice Guidance Note

**Administration of Medicines – V02**

<table>
<thead>
<tr>
<th>V02 issued:</th>
<th>Planned review</th>
<th>UHM-PGN-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue 1 – May 16</td>
<td>May 2019</td>
<td>Part of NTW(C)17 Medicine Policy</td>
</tr>
<tr>
<td>Issue 2 – Aug 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue 3 – Jan 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue 4 – Feb 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Issue 5 – Aug 17</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author/Designation</th>
<th>Matthew Haggerty - Lead Clinical Pharmacist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer / Designation</td>
<td>Tim Donaldson – Trust Chief Pharmacist</td>
</tr>
</tbody>
</table>

This Practice Guidance Note (PGN) is one of a series of six guidelines, developed by a working group of the Medicines Management Committee (MMC), which underpin Northumberland, Tyne and Wear NHS Foundation Trust’s (the Trust/NTW) policy, **NTW(C)17** – Medicine Management and provides step by step guidance to assist and support the following staff in the delivery of aspects of medicines management relevant to their role This guidance should be read in conjunction with other related medicines management policies and procedures as referenced:

**This Practice Guidance Note is relevant to the following groups of Trust Staff:**

- Doctors
- Registered Nurses
- Non registered nurses
- Pharmacists and Pharmacy Technicians
- Student nurses
- Allied Health Professionals
- Staff working in Residential Care Homes, Hostels and Supported Living Environments (refer to **UHM-PGN-06** - Residential Care, Domiciliary Homes, Hostels, SLEs)
History of previous versions of this document

There are no previous versions of this document as this is a new practice guideline, approved by the Medicines Management Committee, and replaces the following practice guidelines and policies:

UHM-PGN 10 Administration of Medicines
UHM-PGN 14 Self administration of medicines
UHM-PGN 17 Handling, Security and Administration of medicines in community
UHM-PGN 21 Medical Gases
UHM-PGN 22 Clinical Trials
UHM-PGN 23 Complimentary medicines
UHM-PGN 26 Dietary products
UHM-PGN 29 Patient Group Directions
UHM-PGN 33 Covert administration of medicines
UHM-PGN 36 Preparation and administration of injectable medicines
UHM-PGN 47 Administration of oxygen to adults

Statement of changes made in this version – V02

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Page / Section / paragraph</th>
<th>Amendment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V02 – Issue 1</td>
<td>May 16</td>
<td>Reviewed documentation</td>
<td></td>
</tr>
<tr>
<td>V02 – Issue 2</td>
<td>Aug 16</td>
<td>Updated Hyperlinks for new intranet policy site</td>
<td>Archive copy available upon request</td>
</tr>
<tr>
<td>V02 – Issue 2</td>
<td>Jan 17</td>
<td>Section 11.4 Essential components necessary for self-administration to begin</td>
<td>Archive copy available upon request</td>
</tr>
</tbody>
</table>
| V02 – Issue 3| Feb 17   | Section 6 – Administration of Specific Medicines - Addition to Section 6.3 – Controlled Drugs – additional 6.3.2 | 6.3.2 For controlled drugs consider the following and when necessary check with the prescriber:  
  o Whether the prescribed dose is safe for the person  
  o Whether other formulations have already been prescribed for the person  
  o Whether the formulation is appropriate  
  o That any past doses prescribed have been taken |
| V02 – Issue 5| Aug 17   | 6.6.2                                               | When medicines are to be administered via an enteral/PEG tube pharmacy will advise how this should be undertaken. An administration of medicines via enteral |
feeding tube proforma will be completed which should be stored with the medicine chart. (Appendix 10)

### Administration of Medicines

<table>
<thead>
<tr>
<th>Section</th>
<th>Contents</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Introduction</strong></td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Authority to administer medicines</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>General principles of medicines administration</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Procedures for checking, administering and recording of prescribed medicines</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4.1 Checking before administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.2 Administering medicines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.3 Recording administration</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Administration of doses under various circumstances</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>5.1 Omitted doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.2 Missed doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.3 Delayed doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.4 Once only doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.5 Remotely prescribed doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.6 As required medicines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.7 Nil by mouth</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Administration of specific medicines</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>6.1 General</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.2 Injections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.3 Controlled drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.4 Oxygen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.5 Dietary products</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.6 Enteral feeds/patients with swallowing difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.6.1 Via PEG tube</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.7 Investigational Medicinal Products (Clinical trial drugs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.8 Complementary therapies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.9 Unlicensed Medicines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.10 Patient's Own Drugs (PODs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.11 High Risk Medicines</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Contents</td>
<td>Page No.</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>7</td>
<td>Administration of medicines without a written order</td>
<td>18</td>
</tr>
<tr>
<td>8</td>
<td>Administration of medicines under a Patient Group Direction</td>
<td>21</td>
</tr>
<tr>
<td>9</td>
<td>The role of Non Registered Nurses in the administration of medicines</td>
<td>21</td>
</tr>
<tr>
<td>10</td>
<td>The role of Student nurses in the administration of medicines</td>
<td>22</td>
</tr>
<tr>
<td>11</td>
<td>Self administration of medicines</td>
<td>23</td>
</tr>
<tr>
<td>12</td>
<td>Covert administration of medicines</td>
<td>31</td>
</tr>
<tr>
<td>13</td>
<td>Guidance on crushing medicines and for nurses directed to administer mixed medicines</td>
<td>34</td>
</tr>
<tr>
<td>14</td>
<td>Reporting and Managing Medication Errors</td>
<td>36</td>
</tr>
</tbody>
</table>

**Appendix – listed separate to practice guidance note**

<table>
<thead>
<tr>
<th>Document No:</th>
<th>Description</th>
<th>Issue</th>
<th>Issue Date</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Critical Medicines Availability</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Patient Assessment Form for Self-admin Meds -SAM</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>SAM - Progress Record Level 1 and 2</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Self-Administration Progress Level 3</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Patient Medication Dose Information Sheet</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>SAM - Consent Form</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>SAM - Care Plan - Non-oral Meds</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Covert Medication Care Planning</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 9</td>
<td>Transdermal Patch Application Recording Chart</td>
<td>1</td>
<td>May 16</td>
<td>May 19</td>
</tr>
<tr>
<td>Appendix 10</td>
<td>Administration of Medicines via Enteral Tubes Proforma</td>
<td>1</td>
<td>Aug 17</td>
<td>May 19</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1 This PGN has been developed to support Trust staff in the administration of medicines. It defines the standards, legislation and principles which must be followed to ensure the safe administration of all medicines throughout the Trust to ensure that all Trust staff are aware of the quality and risk issues therein. By using the word ‘patient’ in this document this refers to both ‘service user’ and patient therefore this practice guideline will refer to patient throughout. Patient is not used consistently but interchanged with service user.

2. **Authority to administer medicines**

2.1 Medicines may only be administered to a patient by the following:

- Registered nurses
- A medical or dental practitioner
- Non-medical prescribers
- Allied health professionals authorised to administer drugs under a Patient Group Direction (PGD)
- Student nurses under supervision from a registered nurse
- Non registered nurses (limits apply - Section 9)
- Patients under the Trust Self-Administration Management system (Section 11)

3. **General Principles of medicines administration**

3.1 Single practitioner administration of medicines is normal practice. The involvement of a second person is only necessary when:

- A controlled drug is to be administered (the administration of controlled drugs is covered in practice guidance note UHM-PGN-04 - Controlled Drugs
- A calculation of dosage is required - this should be a second practitioner, pharmacist or doctor. The two individuals should perform the calculations independently. **Note: Lone working community nurses are exempt from this requirement when calculating the dose of a depot injection**
- Administering medicines to children less than 12 years of age

3.2 **Consent:** Please refer to Trust policy - NTW(C)05 - Consent to Examination and Treatment

3.3 **Authorised staff:** Medicines must only be administered if the staff member authorised to administer medicines has received the appropriate training and is qualified to do so. Registered nurses must have completed their medicines management administration competencies before administering medicines without supervision.
• Administration Medicines must only be administered in accordance with a written order or prescription from an authorised prescriber or from an approved patient group direction. Exceptions to this rule are remote authorisation by an authorised prescriber in an emergency (See Section 5.5) and certain medicines which may be administered in the short term without a written order (see Section 7).

• Within NTW staff members authorised to administer medicines must receive extra competency based training (identified in the Training Needs Analysis as appropriate to individual needs) to administer the following products:
  - Injectable/depot medicines
  - Enemas
  - Intravenous medicines and fluids
  - Subcutaneous fluids
  - Oxygen including piped medical gases
  - Botulinum toxin
  - Buccal midazolam

• Staff members authorised to administer medicines are responsible and accountable for the correct administration of medications to patients under their care. They must have up to date knowledge of the common indications, actions, side effects (see details below) and normal dosages of medicines that they administer. Medicines must not be administered unless these details are known and staff are aware of how to record the administration and monitor side effects:

• A side effect is an effect, whether therapeutic or adverse, that is secondary to the one intended. If a patient experiences an adverse side effect (adverse drug reaction) to a medicine all registered nurses must take action to remedy any harm caused by the reaction and:
  - Record it in the patient record and on the inpatient treatment chart
  - Report it via the Yellow Card Scheme when there is known reaction or where there is a suspicion that a medicine or a combination of medicines has caused a side effect. This can be done online on: www.mhra.gov.uk/yellowcard. The forms are also found in the back of the BNF. Refer to the MHRA Website for full details on Healthcare Professional reporting of suspected adverse drug reactions
  - Consider reporting the adverse drug reaction to the manufacturer
4. Procedures for checking, administering and recording of prescribed medicines

4.1 Checking before administration

4.1.1 Before administering any medicine the staff member will:

- Read the prescription carefully ensuring the name of the medicine, dose, administration time, route of administration and start and stop date are all present, appropriate and legible (see prescribing standards in practice guideline UHM-PGN-02 - Prescribing of Medicines)

- Check that the prescription or written order is signed by an authorised prescriber and if a PGD (see Section 8), check that this is in date

- If a dose calculation is required check that this is correct (contact a senior colleague, doctor or pharmacist for advice if unsure)

- Check to see if the medicines require any preparation (i.e. reconstitution) before administration by referring to the package insert, summary of product characteristics (available at www.medicines.org.uk) or the pharmacy department for information

- Check for any special instructions e.g. before or after food

- Check the administration section of the inpatient prescription chart that the medicine has not already been administered

- Check for any drug sensitivities/allergies, withhold medication if it is identified as sensitive/allergic and check with a doctor/pharmacist

- Check that the patient either consents to receiving the medication or has a best interest decision or the appropriate Mental Health Act (MHA) papers in place

- For patients detained under the MHA who have a consent to treatment form (T2), second opinion form (T3) or an emergency treatment form (T62) in place, check that the following details are present and correct for each medicine to treat their mental health condition:
  - The class of drug including the BNF category
  - The route of administration
  - If the drug is to be prescribed within BNF limits or where outside these limits the maximum dose allowed.
  - If clozapine is prescribed this should be specifically stated

- Check that the patient does not appear to be intoxicated with illicit drugs or alcohol which may interact with or potentiate the adverse
effects of the medication. If the staff member administering the medication is unsure whether to administer the dose, during working hours a prescriber or a pharmacist should be contacted for advice and out of hours advice may be sought from the emergency duty pharmacist or on-call doctor

- If the Staff member authorised to administer medicines is not satisfied that the medication is appropriate for the patient or if any of the above is not present/not legible they should withhold the medicines until guidance from a doctor, pharmacist or senior colleague is sought and the issue clarified

- Staff members authorised to administer medicines involved in the covert administration of medicines must be fully aware of the treatment aims, intent and outcomes of doing such practice (see Section 12 for practice guidance on covert administration)

- If the patient has difficulty in swallowing tablets or capsules then consult a member of the pharmacy team to see if a liquid form of the medicine is available. Medicines may be crushed or capsules opened and their contents placed in food or drinks to aid administration after consultation with a member of the pharmacy team

### 4.2 Administering medicines

4.2.1 Registered nurses must have completed the ‘Competency assessment for the management and administration of medicines’ as defined by the Trust (identified in the Trust Training Needs Analysis) before the nurse can administer medicines.

4.2.2 The staff member will:

- Identify the patient. If the staff member administering the medication is unfamiliar with the patient, the patient should be identified by using the photograph attached to the administration record See Trust Policy [NTW(O)45 - Visual Imaging and Audio Policy, practice guidance note – VIA-PGN-01 – Taking patients photographs within IP setting to maintain patient safety], or other possible means of identification

- Select the medicines checking the name, strength, form, expiry date of the medicines

- Administer the medicines as close to the prescribed time as possible. Medicines may be administered 1 hour either side of the prescribed time to allow for administration rounds to occur. Approval from the prescriber is required to administer if outside these timeframes

- Explain to the patient what medication they will be receiving

- Witness and be satisfied that the patient has taken the medication as prescribed
• Take steps to ensure that the administration of medicines to patients can be completed without interruption

• The staff member authorised to administer the medicines may use a non-registered nurse to assist with the following:
  o Assisting the patient to have drinks/food with the medication
  o Observe the patient after administration to monitor physical health/securing of medication

• The non-registered nurse must **not** act as a runner and must not have an active role in the administration of medicines. The non-registered nurse cannot:
  o Transport medicines from the trolley/cupboard to the patient
  o Supervise the patient taking any medicines
  o Administer medicines (exception is in Section 9)

• When administering medicines to children under 12 or where dose calculations are required (e.g. dose, weight related doses, sliding scale insulin, setting up syringe drivers, parenteral fluids, a second registered nurse shall check all aspects of administration. For situations where there is only one qualified nurse on duty it is the Unit manager’s responsibility to ensure that arrangements are in place for a second registered nurse or another registered healthcare professional when available to check all aspects of administration (an NMC good practice point)

• If a contraindication to the administration of any prescribed medicine is observed or if there is any doubt as to the safety of the medication for a patient, the medicine should not be administered until advice is sought from a senior colleague, a doctor or a pharmacist. If the doubt still exists after consultation, the original prescriber or the patient’s consultant should be contacted

4.3 **Recording administration**

4.3.1 The staff member authorised to administer medicines must sign with initials in the appropriate space on the inpatient treatment chart or the approved documents for administration, supplementary sheet or other recording card e.g. depot card, transdermal patch application recording chart, **Appendix 9** - Transdermal Patch Application Recording Chart, at the time of administration. A Depot-Medication Administration sheet must also include the site of injection (right/left), date administered, batch number and expiry date of the product injected.

4.3.2 If a medication incident occurs or potentially could have occurred during any of the administration process this must be reported – see full details in Trusts policy **NTW(O)05** – Incidents, PGN, **IP-PGN-07** - Medication Incidents
• Completed patient prescription charts (i.e. prescription /administration records) will be filed in the purple RiO support file

• **Community Based Teams** (Community Mental Health, Learning Disability and Children and Young People’s teams, Assertive Outreach teams, Crisis/Home Treatment Teams, Complex Needs Teams, Early Intervention Services, and Community Drug and Alcohol teams):

• **Administration:**
  
  o Medicines administered by community based teams must be recorded on the appropriate NTW treatment chart as above. In addition, prescribed medication must be recorded in the patient record by either:
    
    ➢ Attaching a copy of the prescription (for Trust prescriptions)
    
    ➢ Recording the medication and length of prescription in the service user’s medical notes (for FP10s – information extracted from either FP10 or community pharmacy medicines labels)
    
    ➢ Recording information from the NTW depot medication administration and prescription card

  o Completed prescription/administration records will be filed in the patient’s notes.

  o When IM injections are administered (see Section 6.2.2), the CPN administering will, in addition to the above recording requirements, identify the date the next injection is due and ensure the IM prescription is reviewed at least 6 monthly.

• **Supply:**
  
  o Where a staff member provides the medication to a patient for taking later i.e. unobserved consumption, a record should be made in the progress notes

• **Observation:** i.e. where the service user selects and administers their own medication whilst being observed by a staff member, a record should be made in the progress notes

5. **Administration of doses under various circumstances**

5.1 **Omitted doses:**
5.1.1 An omitted dose of a medicine is one that is not or cannot be administered for any reason. The staff member authorised to administer medicines must enter the appropriate ‘code’ for non-administration (codes are located on the ‘notes’ section of the administration record) in the appropriate column of the administration record and initial the entry.

5.1.2 If a medicine cannot be administered to a patient because it is out of stock every effort should be made to obtain a supply at the earliest opportunity according to the urgency of the situation – refer to section on Access to medicines when the Pharmacy is closed in PGN, UHM-PGN-01 - Safe and Secure Medicine Handling and Supply.

5.1.3 If any ‘critical’ medicines (see Appendix 1 - Critical Medicines Availability for list of critical medicines) are omitted or significantly delayed the responsible doctor must be informed verbally, a record made in the patient’s notes and an electronic incident form completed.

5.2 Missed doses:

5.2.1 If any other doses are missed on more than one occasion the doctor should be informed verbally, face to face or by telephone, at the earliest opportunity.

5.2.2 If a patient refuses a medicine an entry should be made in the patient’s notes and the patients doctor informed.

5.2.3 Any medicines prepared and subsequently omitted/missed must not be returned to their original container but instead destroyed in accordance with section 15 in practice guideline UHM-PGN-01 - Safe and Secure Medicine Handling and Supply and Section 14 in PGN, UHM-PGN-04 - Controlled Drugs.

5.3 Delayed doses: Medicines must be administered within 1 hour either side of the prescribed time (administration parameter)

5.3.1 If a medicine is not administered within 1 hour of either side of the prescribed time, the staff member must contact a prescriber or pharmacist for permission to administer the medicine at a different time.

5.3.2 For certain patients whose mental state or sleeping pattern fluctuates throughout the day/s and where administering medicines is proving problematic, a decision to widen the administration parameters may be made following discussion with a prescriber or pharmacist. The registered nurse will document this decision and rationale on the patient record.

5.3.3 Each medicine must be discussed separately and include factors such as:
- how vital the medicine is
- the frequency of administration
- effects of other medicines taken at similar times
5.3.4 The agreed parameters should be documented in the comments section of treatment chart for each individual medicine to which it applies e.g.

<table>
<thead>
<tr>
<th>Regular medication</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td>Dose</td>
</tr>
<tr>
<td>Donepezil</td>
<td>10mg</td>
</tr>
<tr>
<td>Route</td>
<td>Signature of prescriber</td>
</tr>
<tr>
<td>PO</td>
<td>A Doctor</td>
</tr>
<tr>
<td>Comments</td>
<td>Stop date</td>
</tr>
</tbody>
</table>

5.3.5 The preferred administration time will still be circled/written on the inpatient treatment chart by the prescriber and staff members authorised to administer medication should adhere to this wherever possible. If administering outside this time, the time of actual administration should be annotated on the inpatient treatment chart by the person administering the medicine.

5.4 Once only doses:

5.4.1 Once only medicines should be recorded in the ‘once only’ section of the administration record.

5.5 Remotely prescribed doses:

- A registered nurse can accept a remotely prescribed (verbal/telephone authorisation) medicine in exceptional situations when there is no resident doctor or other prescriber on site. This can happen when the balance of risks between prescribing remotely for a patient who is becoming increasingly unwell, distressed or behaviourally disturbed, favours remote prescribing for a short period rather than delaying a prescription written by the prescriber. Full details of remote prescribing are available in section 6, UHM-PGN-02 - Prescribing of Medicines

5.5.1 Alterations to an existing prescription

- Alterations to an existing prescription can be made in exceptional circumstances, where medicines (not including controlled drugs) have been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary.
- A verbal order is acceptable only when accompanied by confirmation of the changes to the original prescription using a fax message or email. The registered nurse receiving the direction must staple the fax or email prescription or direction to administer to the patient’s existing medication chart to verify that the changes have been authorised by a registered prescriber before the new dosage is administered.

- The receiving nurse will also make an entry in the patient’s progress notes specifying the details of the remote prescription, the location of any written confirmation provided and the name of the authorising doctor. The prescriber who signed the fax/email must follow this up with a signed new prescription confirming the changes within the next 24 hours (72 hours maximum – bank holidays and weekends). The registered nurse should verbally request the prescriber to confirm and sign changes on the patient’s individual medicines administration record or care plan.

5.5.2 Remote prescription for a new medicine

- In exceptional circumstances where a prescriber needs to prescribe remotely for a previously unprescribed medicine the above guidance at section 5.5.1 should be followed. The verbal order must be followed up by a new prescription signed by the prescriber who sent the fax/email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends). The registered nurse is accountable for ensuring all relevant information has been communicated to the prescriber and may refuse to accept a remote prescription if it compromises care to the patient. In this instance the prescriber should document accurately the communication that has taken place. Remote authorisation of medication should be recorded in the ‘once only’ section.

- A copy of a fax or email (a text message is not acceptable for NTW Trust services) will be stapled to the patient’s existing prescription chart and an entry made by the receiving nurse directly in the patient’s progress notes specifying the details of the remote prescription, the location of any written confirmation provided and the name of the authorising doctor. The prescriber who signed the fax/email must follow this up with a signed new prescription confirming the changes within normally the next 24 hours (72 hours max. for bank holidays and weekends). The registered nurse should verbally request the prescriber to confirm and sign changes on the patient’s individual medicines administration record or care plan.

5.6 As required (PRN) medicines:

5.6.1 When a medicine is prescribed on an as required basis and the prescriber indicates a maximum dosage allowed in 24 hours, this period is the 24 hours prior to the time of the request by the patient. The total dosage should take into consideration if a regular dose of the same medicine is in use.

5.7 Nil by Mouth
5.7.1 Medicines to be administered to patients classified ‘Nil by Mouth’ prior to a diagnostic procedure or receiving an anaesthetic prior to ECT should be clearly identified on the inpatient prescription chart.

5.7.2 Medicines which need to be withheld should be clearly identified on the inpatient prescription chart and this clearly communicated by medical staff to the staff member authorised to administer medicines.

5.7.3 Any other medicines to be administered can be given with a small amount of water to enable the patient to swallow them.

6. **Administration of Specific Medicines**

6.1 **General**

6.1.1 An Injection is the act of giving medication by use of syringe and needle. The introduction of substances into the body via needle is within the scope of professional practice for every registered nurse. All staff members authorised to administer medicines are accountable for their own practice and ensuring competence to do so.

6.1.2 For the purpose of this guidance note, a ‘depot’ injection refers to an antipsychotic depot injection. It is essential that the staff member authorised to administer medicines follow the manufacturer’s instructions closely, seeking advice from pharmacy/prescriber where necessary.

6.1.3 Student nurses may participate in the administration of medicines as long as all guidelines set out in the practice guidance note for administration of medicines is followed (See Section 10 for the role of student nurses in the administration of medicines).

6.1.4 Other authorised groups of staff may carry out the procedure under an approved Patient Group Direction (see Section 8).

6.2 **Injections**

6.2.1 **Intravenous injections**

- Administering an injection is an invasive procedure. All staff members authorised to administer medicines must adopt universal precautions (refer to NTW(C)23 - Infection, Prevention and Control Policy and use appropriate infection control measures to minimise the amount of injury and/or infection to both patient and staff when undertaking this procedure.

- For specific information on how to administer subcutaneous medicines and fluids see Trust policy, NTW(C)38 – Pharmacological Therapy practice guidance note – PPT-PGN-15 - Subcutaneous Fluid Administration in Adult Patients

- Only competent registered nurses approved for intravenous drug administration (identified in the Training Needs Analysis as
appropriate to individual needs) and doctors may carry out the administration of intravenous medicines and fluids. If any infusion devices or syringe drivers are used for the administration of intravenous or subcutaneous medicines they must only be used by competent registered nurses approved for Intravenous (IV) or subcutaneous (S/C) administration

- The type of device and Trust asset number must be documented in the patient’s records. If the appropriate type of device is not available in the hospital an electronic incident form must be completed

- Patients who are administered infusions must be closely monitored throughout administration for signs of discomfort or adverse drug reaction. The infusion pump/syringe should be checked regularly to ensure safe and effective administration. In the event of a reaction, the infusion must be discontinued immediately and the doctor must be contacted. In the event of extravasation (leakage of intravenous drugs from the vein into the surrounding tissue) staff members should contact a doctor or appropriate healthcare professional immediately

- In addition to the usual administration checking procedure, the additional checks may be required where relevant:
  
  - Site of administration
  - Concentration or total quantity of medicine in the syringe
  - Name and volume of any necessary diluent
  - Rate and duration of administration
  - Type of rate-control pump or device(s) to be used (if appropriate)
  - The age and weight of any patient under 16 years of age, where relevant

6.2.2 Intramuscular injections and depot Injections:

- Remote authorisation (verbal orders) must not be accepted for the administration of depot injections (see section 6 in practice guideline UHM-PGN-02 - Prescribing of Medicines, for remote prescribing

- In circumstances where a patient is non-compliant with their prescribed dose of a depot injection, the staff member authorised to administer medicines may deem it appropriate to administer a lesser dose if the patient is agreeable. The staff member must then liaise with the prescriber at the earliest opportunity. Any alterations must be noted on the administration record
Depot injections must be written in the ‘regular injections’ section of the inpatient treatment chart for inpatients and on a depot administration chart for outpatients. Prescriptions are valid for a maximum of six months and must be rewritten by an authorised prescriber after this time.

The site of injection (including right/left) should be recorded, along with the batch number and expiry date of the injection used.

Depot injections must not be administered by NTW staff to a patient following their admission to a ward in another organisation. To enable continuation of a patient’s depot injections during their inpatient stay a copy of the Depot Medication and Administration Sheet should be sent to the other organisation to enable the prescription and administration by staff in the other organisation. When the patient is discharged the CPN who takes responsibility for the administration of the depot injections will follow up the appropriate transfer of care details issued by the other organisation to ensure continuation of the patient’s treatment.

**IM Injections administered by CPNs:**

- The CPN will ensure that they have correctly identified the person for whom the prescription is written. If the CPN is in any doubt as to the identity of the service user, the medication should not be administered until confirmation of identity is obtained.

- If a CPN decides to withhold medication, they must notify the GP / Consultant Psychiatrist as soon as possible, and document their reasons for doing so in the patient’s records.

- If a service user refuses medication, the CPN must notify the GP/Consultant Psychiatrist as soon as possible, and document the refusal in the service user’s records.

**Caution:** It should be noted that incorrect intravenous administration of oral liquid medicines has resulted in a number of deaths and incidents of serious harm to patients across the UK (see NPSA Alert - promoting safer measurement and administration of liquid medicines via oral and other enteral routes). Appropriate oral/Enteral syringes should be used to measure oral liquid medicines if a medicine spoon or graduated measure cannot be used. Oral/Enteral syringes should be clearly labelled ‘oral’ and/or ‘enteral’ to aid selection and use. When specifically designed oral syringes are used and a patient is being treated concurrently with parenteral drugs, the two procedures must be carried out separately.
6.3 **Controlled drugs**

6.3.1 The management of Controlled Drugs (CDs) is governed by the Misuse of Drugs Act (1971) and associated Regulations. Additional statutory measures for the management of CDs are laid down in the Health Act (2006) and associated Regulations – see PGN, [UHM-PGN-04](#) - Controlled Drugs for full details on administering Controlled Drugs and Trust policy, [NTW(C)38](#) – Pharmacological Therapy, practice guidance note [PPT-PGN-18](#) – Reducing Dosing Errors with Opioid Medication.

6.3.2 For controlled drugs consider the following and when necessary check with the prescriber:

- Whether the prescribed dose is safe for the person
- Whether other formulations have already been prescribed for the person
- Whether the formulation is appropriate
- That any past doses prescribed have been taken

6.4 **Oxygen**

6.4.1 The administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions; however oxygen is a medicine and therefore requires prescribing in all but emergency situations – see practice guideline for [UHM-PGN-02](#) - Prescribing of Medicines, Section 10.4 for details.

6.4.2 Administration of oxygen must be recorded as for any other medicine.

6.4.3 Further information set out as a practice guidance note on administering oxygen therapy, will be available when ratified, (approximately Aug 13).

6.4.4 Before using a cylinder, ensure that:

- The cylinder with the oldest filling date is selected, provided that this is within the expiry date on the label
- The cylinder has a full, complete product label identifying the product and gas pressure inside the cylinder
- The correct cylinder is being used for the application and not for a non-medical application
- Cylinders are handled with care and not knocked violently or allowed to fall. When in use, cylinders should be firmly secured to a suitable cylinder support.
- Only correctly designed valve spindle keys are used to open the cylinder valve
- There are no signs of oil or grease on the cylinder valve. If either are discovered, do not use the cylinder, and arrange for it to be collected by the porters for immediate return to the supplier
- You have received the appropriate training in the use of medical gas cylinders; if in doubt, do not proceed and discuss with line management

6.4.5 **After use ensure that:**

- The cylinder valve is closed immediately, using a correctly designed cylinder valve spindle key with moderate force only and the pressure in the regulator released. Remove the cylinder key from the valve
- The pressure in the regulating equipment is safely released before removal
- On cylinders with bull-nose valves, the valve outlet protection cap is replaced to protect the valve outlet from contamination
- All empty cylinders are collected by the porters for return to the gas cylinder store

6.4.6 **Safety precautions**

- Cylinders must only be moved with the appropriate size and type of trolley
- Smoking and naked lights must not be allowed within the vicinity of cylinders
- Cylinders must only be handled by suitable trained staff members

6.5 **Dietary products**

6.5.1 All Enteral feeding products must be administered using the same principles described for any medicinal product. The choice of the most appropriate Enteral feeding product should be based on the advice of a Dietician who will recommend the product to a doctor or non-medical prescriber for prescribing onto the inpatient treatment chart.

6.6 **Enteral feeding or via an Enteral/PEG tube for Patients with swallowing Difficulties**
6.6.1 See Trust policy, **NTW(C)29** - Trust Standard for the Assessment and Management of Physical Health, Practice Guidance Notes AMPH-PGN-02 – AMPH-PGN-02.8 listed within the clinical policy documents.

6.6.2 When medicines are to be administered via an enteral/PEG tube pharmacy will advise how this should be undertaken. An administration of medicines via enteral feeding tube proforma will be completed which should be stored with the medicine chart. (Appendix 10)

6.7 **Investigational Medicinal Products (Clinical trial drugs)**

6.7.1 If a patient is admitted taking a clinical trial drug and the prescriber has assessed if it is suitable to prescribe, the staff member authorised to administer the medication should firstly:

- Receive from the Investigator information on expected beneficial effects, potential adverse effects, interactions (may require access to the protocol and investigator’s brochure), confirmation that ethical approval has been obtained and have contact details and be aware of procedure should there be an adverse event or query
- Identify whether the medication has special storage requirements from the drug label and store appropriately (e.g. in fridge)
- Check that the prescribed medication is the same as the medication on the label
- Check that the dose is the same as prescribed on the label.
- Check the expiry date of the medication
- Inform pharmacy if further supplies of the medication are required, as it may take longer to obtain (should have a minimum of one week’s worth of medication) Administration of medicines shall be in accordance with locally agreed clinical trial procedures
- Administration of medicines to trial participants should be in accordance with sections 3 and 4 of this guideline
- The patient information sheet (part of the informed consent package) should be available when medicines are given as part of a trial

6.8 **Complementary and Over the Counter (OTC) medicines**

6.8.1 Pharmacy will not supply complementary medicines and patients should be informed that they will need to obtain further supplies if they have insufficient to last their stay

- Complementary medicines in the scope of this policy include:
- herbal medicines
- homoeopathic medicines
- essential oils
- traditional (e.g. Chinese, Ayurvedic) medicines
- food supplements and nutraceuticals (a food with health promoting ingredients or natural components such as phytochemicals which are non-nutritional plant chemicals with protective or disease preventing properties) and OTC medicines

- Complementary, OTC medicines and other ‘patient’s own drugs’ (see Section 6.10) prescribed by the hospital doctor or non-medical prescriber on the patient’s inpatient treatment chart are administered in the same way as other prescribed medicines including checks on indications, contraindications, interactions with other prescribed medicines etc.

- If a staff member, authorised to administer medicines, administers a complementary medicine to a patient, they take on the responsibility for their actions as for any other medicine

- Prior to the patient taking the medicine the registered nurse/pharmacy team member must complete a patient’s own drug assessment (POD) see PGN, UHM-PGN-01 - Safe and Secure Medicine Handling and Supply , Section 7,

- For further information on prescribing complementary and OTC medicines see section 4.4 in PGN, UHM-PGN-02 - Prescribing of Medicines

6.9 Unlicensed Medicines

6.9.1 Registered nurses are allowed to administer unlicensed medicines with the patient’s informed consent. The Pharmacy over-label unlicensed medicines to indicate their unlicensed status.

6.9.2 Nurses should satisfy themselves that they have sufficient information to administer the medicine and, whenever possible, that there is acceptable published evidence for the intended indication. Further information on unlicensed medicines can be obtained from the Pharmacy.

6.9.3 The Pharmacy will over-label unlicensed medicines to indicate their unlicensed status.
6.10 Patient’s Own Drugs (PODs)

6.10.1 For full details on the use and handling of PODs refer to PGN, UHM-PGN-01 - Safe and Secure Medicine Handling and Supply, Section 7

- All PODs must be assessed and only those medicines deemed suitable may be used for administration to the patient
- PODs must not be entered into ward stock or administered to any other patient
- PODs must be checked against the inpatient treatment chart and only administered to the named patient

6.11 Administration of high risk medicines

6.11.1 The Trust classifies a number of medicines as **high risk** to patient safety if administered incorrectly. Note this is different from the High Risk classification for unlicensed medicines. High risk medicines include the following categories:

- **Anticancer drugs**
  - Refer to NTW(C)38 – Pharmacological Therapy, practice guidance note, PPT-PGN-09 - Anti Cancer Medicine and Oral Methotrexate

- **Disease Modifying Anti-Rheumatic Drugs (DMARDs) and Immunosuppressant medicines**
  - A Trust policy for DMARDS is not currently available – please contact a pharmacist for information

- **Insulin**
  - A Trust practice guidance note for the safe use of Insulin will be available when ratified (approximately Aug 13) – please contact a pharmacist for any urgent information

- **Oral and parenteral anticoagulants**
  - Refer to Trust Policy, NTW(C) 38 – Pharmacological Therapy, practice guidance note – PPT-PGN-03 - Anticoagulation Therapy (including appendices)

- **Opiate analgesics**
7 Administration of medicines without a written order (formerly known as homely medicines)

- Registered Nurses may administer the following non-prescription medicines in defined circumstances, without a prescription:

<table>
<thead>
<tr>
<th>Indication</th>
<th>Medicine</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Paracetamol tablets 500mg</td>
<td>2 tablets every 4-6 hours (maximum of 8 tablets in 24 hours)</td>
</tr>
<tr>
<td>Constipation</td>
<td>Senna tablets</td>
<td>2 tablets at night</td>
</tr>
<tr>
<td>Cough</td>
<td>Simple Linctus</td>
<td>5ml 3 or 4 times daily</td>
</tr>
<tr>
<td>Indigestion</td>
<td>Peptac</td>
<td>10ml 3 times daily</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Dioralyte sachets</td>
<td>Contents of 1 sachet in 200ml of water at each loose stool. Refer to doctor if fluid loss is excessive</td>
</tr>
</tbody>
</table>
| Aspirin    | 300mg | Once only for emergency situations (not pain relief/fever), following advice from a 

- Lithium
  - Refer to Trust Policy, NTW(C) 38 – Pharmacological Therapy, practice guidance note - **PPT-PGN-18** – Reducing dosing errors with opioid medication

- Medicines with a loading dose and maintenance dose schedule
  - A Trust document is not currently available – please contact a pharmacist for information

- Clozapine
  - Refer to information pack **Clozapine Treatment**, which should be read in conjunction with NTW(C)38 – Pharmacological Therapy Policy, practice guidance note, **PPT-PGN-05** – Safe Prescribing of Clozapine
<table>
<thead>
<tr>
<th><strong>Nicotine replacement</strong></th>
<th><strong>HIGH STRENGTH</strong></th>
<th><strong>Must call for emergency assistance in first instance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A nicotine patch can be used with either a nicotine mini lozenge or nicotine inhalator</td>
<td>Nicotine patch 21 mg in 24 hours</td>
<td>Aspirin may also be given for the above situation by non-registered staff in outlying units of the Trust which run without qualified nursing staff.</td>
</tr>
<tr>
<td></td>
<td>For individuals &gt;12 years of age smoking 20 cigarettes or more a day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apply to non-hairy skin on the hip, trunk or upper arm. Hold in position for 10-20 seconds to ensure adhesion.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remove patch after 24 hours or sooner if patient doesn’t want patch at night (if pregnant) or experiences side effects of nicotine.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rotate the area of skin to which the patch is applied.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nicotine replacement</strong></th>
<th><strong>LOW STRENGTH</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A nicotine patch can be used with either a nicotine mini lozenge or nicotine inhalator</td>
<td>Nicotine patch 14 mg in 24 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For individuals &gt;12 years of age smoking less than 20 cigarettes a day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apply to non-hairy skin on the hip, trunk or upper arm. Hold in position for 10-20 seconds to ensure adhesion.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remove patch after 24 hours or sooner if patient doesn’t want patch at night (if pregnant) or experiences side effects of nicotine.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rotate the area of skin to which the patch is applied.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nicotine replacement</strong></th>
<th><strong>Nicotine mini lozenge 4 mg</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A nicotine patch can be used with either a nicotine mini lozenge or nicotine inhalator</td>
<td>Give one lozenge when the patient feels the urge to smoke.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advise patient to allow the lozenge to dissolve in the mouth, moving it from one side of the mouth to the other. This may take 10 minutes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum 15 lozenges in 24 hours.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nicotine replacement</strong></th>
<th><strong>Nicotine mini lozenge 1.5 mg</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A nicotine patch can be used with either a nicotine mini lozenge or nicotine inhalator</td>
<td>Give one lozenge when the patient feels the urge to smoke.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advise patient to allow the lozenge to dissolve in the mouth, moving it from one side of the mouth to the other. This may take 10 minutes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum 15 lozenges in 24 hours.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nicotine replacement</strong></th>
<th><strong>Nicotine inhalator 15 mg</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A nicotine patch can be used with either a nicotine mini lozenge or nicotine inhalator</td>
<td>Give one cartridge when the patient feels the urge to smoke.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insert the cartridge into the device. Advise patient to inhale through the mouthpiece, more frequently than when smoking a cigarette.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each cartridge can be used for approximately eight 5-minute sessions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum of 6 cartridges daily</td>
<td></td>
</tr>
</tbody>
</table>

Where the strength of NRT being administered through homely remedy is found to be too low or too high for the patient, the lower/higher strength of NRT product can be administered whilst maintaining the maximum daily allowance for that product.
<table>
<thead>
<tr>
<th>Indication</th>
<th>Medicine</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infantile Colic</td>
<td>Gripe water</td>
<td>As indicated on the bottle</td>
</tr>
<tr>
<td>Pain and/or fever</td>
<td>Paracetamol</td>
<td>Age 2-3 months: 60mg repeated once after 4-6 hours</td>
</tr>
<tr>
<td></td>
<td>suspension</td>
<td>Age (max 4 doses in 24 hours)</td>
</tr>
<tr>
<td></td>
<td>120mg/5ml</td>
<td>3-6 months: 60mg</td>
</tr>
<tr>
<td></td>
<td>(up to 6 years)</td>
<td>6 months-2 years: 120mg</td>
</tr>
<tr>
<td>or</td>
<td>Paracetamol</td>
<td>2-4 years: 180mg</td>
</tr>
<tr>
<td></td>
<td>suspension</td>
<td>4-6 years: 240mg</td>
</tr>
<tr>
<td></td>
<td>250mg/5ml</td>
<td>Age (max 4 doses in 24 hours)</td>
</tr>
<tr>
<td></td>
<td>(6-12 years)</td>
<td>6-8 years: 250mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-10 years: 375mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-12 years: 500mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12-16 years: 750mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16+: 1000mg</td>
</tr>
</tbody>
</table>

- Medicines should only be administered in this way if access to an independent prescriber is not available and delaying treatment would be detrimental to the patient.
- The staff member authorised to administer medicines must check the patient does not have any drug allergies or sensitivities to the medicine before administering it.
- A record of administration of these medicines must be made in the ‘Once Only Medication’ section of the Drug Prescription and Administration Record.
- A record should also be made in the patient’s RiO progress notes detailing the reasons why the medicine was administered.
- Administration **must not** be continued for more than 48 hours without consulting a doctor. The doctor must then write a new prescription for the medicine if it is to be continued.
- If the patient’s condition deteriorates medical attention should be sought immediately.
- The British National Formulary (BNF) should be consulted for further information on drug dosing, adverse effects, and potential drug interactions between non-prescription medicines and other medicines.

8 **Administration of medicines under a Patient Group Direction (PGD)**

8.1 For full details on developing, authorising, monitoring and using PGDs – refer to PGN, **UHM-PGN-01** - Safe and Secure Medicine Handling and Supply Section 8.
8.2 The individual working within the PGD must have been signed off by their authorising manager for each PGD they use.

8.3 Non-registered staff cannot administer medicines using a PGD.

8.4 When administering medicines under a PGD the usual administration procedure must be followed.

8.5 Where a PGD is used to supply or administer a medicine an entry should be made in the patient’s notes by the person authorised to supply/administer the medication this should include: Name and designation of person making the entry, date, medicine(s) supplied/administered, condition for which the medicine (s) is being used for and the fact it was administered under a PGD. For inpatients an entry must also be made in the ‘once only’ section of the inpatient treatment chart and/or RiO progress notes for patients in community units.

8.6 The entry must be made by the person authorised to administer the medicine under the PGD and must include the following: signature (if a administration record used), date, medicines used, route, dosage and quantity administered or supplied and the condition for which the drug is being used.

8.7 The person making the entry must also record their name and designation.

8.8 They must record that the administration was in accordance with a PGD.

8.9 The administration must be carried out by the practitioner recording the use of the PGD.

8.10 Where a PGD is used to supply and administer a medicine to a patient, subsequent doses may be administered by another authorised registered nurse (except for injections) and recorded as above.

9 Role of Non-registered Nurses in the Administration Process

9.1 Witnessing the administration of medicines to patients is an important part of the administration process. To be involved in the witnessing the administration of medicines non-registered nurses must have completed the appropriate training (identified in the Training Needs Analysis). Schedule 2 controlled drugs are excluded but non-registered nurses may assist in the witnessing the administration of the schedule 3 CDs temazepam and buprenorphine after appropriate training and deemed competent to fulfil the role – see PGN, UHM-PGN-04 - Controlled Drugs for details.

9.2 Non-registered staff cannot administer medicines using a PGD.

9.3 Non-registered nurses are able to assist patients to take their medicines only if they have witnessed the registered nurse selecting the medicines for that patient from the inpatient treatment chart and they are satisfied that this is the correct medicine. Non-registered nurses must not select medicines for patients.
9.4 Both the non-registered nurse and the staff member authorised to administer medicines must sign the administration box on the administration record.

9.5 The registered nurse who delegates the administration to the non-registered nurse is accountable for the appropriateness of this delegation and must ensure that they have understanding of the task they are assisting with.

9.6 **Non-medicated topical skin products:**

- A registered nurse may delegate non-registered nurses to apply non-medicated topical skin products e.g. emollients for use in dry skin conditions
- A care plan must be in place where this occurs, detailing the patient’s condition, application details and review details

9.7 Both the non-registered nurse and the staff member authorised to administer medicines must sign the administration box on the administration record

9.8 The non-registered nurse must report back to the staff member authorised to administer medicines after the application and inform them of any deterioration in the condition

9.9 The patient’s condition should be reviewed regularly by a doctor or appropriate practitioner

10 **Role of the student nurse in the administration of medicines**

10.1 Student nurses should never administer or supply medicines without direct supervision from a registered nurse.

10.2 Registered nurses may delegate the procedure to a student nurse in order for them to achieve competencies related to medicines; this is always done with supervision.

10.3 The registered nurse that delegates the procedure of care to the student nurse is accountable for the appropriateness of this delegation and must ensure that the student has received the necessary training.

10.4 The student nurse must have knowledge and understanding of the Trust’s medicine management policies.

10.5 The registered nurse delegating the procedure of administering and checking medication to a student nurse will remain responsible and accountable for the correct administration of the medicines.

10.6 A student nurse must not administer medicines following a remote instruction/verbal order.
10.7 A student nurse will be able to act as a witness in the administration of schedule 2 and 3 controlled drugs, once they have received the appropriate training and demonstrated competence (identified in the Training Needs Analysis as appropriate to individual needs).

10.8 Student nurses cannot countersign any errors/mistakes made in the controlled drug register (this must be done by 2 staff members authorised to administer medicines) see PGN, UHM-PGN-04 - Controlled Drugs.

10.9 A student nurse may administer IM and SC injections with supervision once they have received the appropriate training and demonstrated competence. **However, A student nurse cannot administer IM injections when it forms part of rapid tranquilisation.**

10.10 Cytotoxic medicines must not be administered or checked by a student nurse.

11 **Self-administration of medicines**

- The Trust position is that every patient is assessed and supported to self-administer their medication at some point during their admission. Responsibility for self-administration of medicines is a vital part of rehabilitation or continuing independence for some patients.

- Self-administration is split into two distinct categories:
  - (i) self-administration of all medicines (exemptions apply)
  - (ii) self-administration of certain non-oral medications where it is more appropriate for the patient to keep the medicine on their person.

11.1 **Assessment for self-administration - initial assessment**

- On admission each patient will be assessed as to whether they are suitable at that point in time to (i) self-administer all their medications and (ii) self-administer any non-oral medications which they may keep on their person. This assessment should be done as part of the admission documentation.

- Every inpatient should be then assigned a level of self-administration which is recorded in their clinical notes (Core Clinical Documents, Medications, Allergies and Sensitivities form).

11.1.1 **Further assessment**

- Patients, who are in hospital for longer periods of time, and were not initially suitable for self-administration may at some point, become
suitable to enter either part of the scheme. This may be appropriate where:

- Mental health is relatively stable
- The patient takes responsibility for taking their medicines at home, including those who have some support from a carer
- Medication regime is relatively stable
- The patient will be able to give informed consent
- Is undergoing rehabilitation/stepped care to try and enable transfer back to a community setting or promote independence

- Patients should be assessed on a regular basis (as part of the CPA review as a minimum) to identify whether it is appropriate to self-administer. Regular review in the MDT meetings is encouraged
- With these patients an initial risk assessment (used in conjunction with a Trust recognised risk profile e.g. FACE) should be carried out by a registered nurse, doctor, pharmacist or pharmacy technician (see Appendix 2 - Patient assessment for self-administration of medicines
- If the patient is thought to be suitable the Multi-Disciplinary Team should be consulted and be in agreement before the scheme is commenced
- The level of self-administration should be amended in the patient’s clinical notes (Core Clinical Documents, Medications, Allergies and Sensitivities form) and monitored

11.2 Self-administration of non-oral medication

- For certain non-oral medicines e.g. inhalers, glyceryl trinitrate sprays, nicotine replacement, certain topical creams/ointments, it may be more appropriate for the patient to keep on their person and self-administer. For patients on insulin therapy the NPSA Patient Safety Alert, The adult patient’s passport to safer use of insulin, aims to empower patients with diabetes to take a more active role in their treatment to avoid being given the wrong insulin (See Trust's policy, NTW(C)38 – Pharmacological Therapies practice guidance note - PPT-PGN-06 - Guidelines for the Safe Prescribing and Administration of Insulin). These non-oral medicines may be assessed separately and independently from the full self-administration scheme; patients who are deemed as not suitable for full self-administration scheme may still be suitable to self-administer non-oral medications.

- The steps to be followed:
  - The patient must agree to enter the scheme
The medicines that the patient will be able to self-administer should be identified in the care plan for non-oral medicines, Appendix 7 - Self administration medicine – Care Plan – Non-oral medicines.

The care plan must record how frequently the named registered nurse will review the patient in terms of their ability to self-administer and also to review the clinical condition being treated. The review of the clinical condition may be conducted in conjunction with a doctor if deemed necessary.

The level of self-administration should be recorded in the patient’s clinical notes (Core Clinical Documents, Medications, Allergies and Sensitivities form).

11.3 Self-administration of all medicines

- Self-administration of medicines allows patients to administer their own medicines while in hospital, with support and education provided by the multidisciplinary team (MDT).

- The aims of self-administration are:

  - To promote and maintain patient independence and autonomy
  - To establish a standardised approach for determining the ability of patients to take their own medicines safely and reliably

  - To ensure the patient will have the skills and knowledge to be independent and responsible for their medicines on discharge

  - To increase patient understanding of their medicines and prevent re-admission due to problems with non-adherence

  - To aid recovery and support transition from hospital to community settings

- Each clinical area should look at the feasibility of self-administration by ensuring that systems are in place which allows safe practice. This should include a clear understanding of roles and responsibilities, assessment of patient suitability and risk factors, educational needs, monitoring and supervision. A local standard operating procedure may be required for implementation to cover all aspects of the process from admission to discharge.
• The levels of self-administration that are used within NTW are (see below for details):
  o **Level 0** = not for self-administering, nurse administration
  o **Level 1** = Nurse supervision and prompting (treatment chart = sign)
  o **Level 2** = Patient prompting, nurse supervision (treatment chart = 9 and sign)
  o **Level 3** = Patient in full control (treatment chart = 9 and sign on day medication supplied. Use note section to record further information)
  o **Level 3 (non-oral medication)** = Patient in full control of certain non-oral medications as per care plan (treatment chart = 9 and sign on day medication supplied. Use note section to record further information)

• See further details in section 11.4 below on each level

• Patients administering all of their medicines should start at the appropriate level of self-administration reflected by the risk assessment and can progress through the stages if and when ready to do so

• **Schedule 2 controlled drugs and temazepam** may not be self-administered. Patients self-administering should be given ward stock, or the patient’s own drugs, in the usual way. Schedule 3 CDs (except buprenorphine, temazepam and tramadol) and Schedule 4 CDs can be given to patients who self-administer

### 11.4 Essential components necessary for self-administration to begin

• Self-administration must only be operated on clinical areas when sufficient numbers of staff members on duty are familiar with the policy and the scheme can be offered to all patients who are deemed suitable for inclusion

• A risk assessment should be carried out for each clinical area that wishes to use self-administration to determine the most appropriate storage requirements for medicines. The risk assessment should be carried out by a registered nurse in conjunction with the registrant in charge of the clinical area and a member of the pharmacy team pharmacist. Part of UHM-PGN-01 - Safe and Secure Handling of Medicines, Appendix 15 - Risk assessment for storage of medicines outside clinical room

• Medicines labelled with the patient’s name and full dosage instructions must be available on the ward
- Patients on any level of self-administration should be given enough verbal and/or written information about their medication for them to participate in the scheme including name of drug, why they are taking it, dose, frequency and method of administration and the possible side effects

- Patient’s medicines should be stored securely in approved lockable bedside medicines cabinets, a drug trolley or drug cupboard. Patients on level 3 non-oral medicines may store these medicines securely in their bedroom or on their person

- Patients on any level of self-administration should have a relevant care plan

- The level of self-administration should be clearly marked on the inpatient treatment chart

- There are different levels involved in the self-administration process:

  o **Level 0**: Patient is not suitable for self-administration

  o **Level 1**: At the appropriate medication time the staff member authorised to administer medicines will give the medicines to the patient and supervise the selection and administration of the correct dose(s). They will then sign the inpatient treatment chart and the self-administration record (See Appendix 3 – Self administration – Progress Level 1 and 2) for each medicine taken. This is an educational period and an opportunity to discuss the different medicines with the patient. A monitored dosage system (e.g. dosette box) is not required at this level

  o **Level 2**: As for level 1 except that it is the patient’s responsibility to request their medicines at the correct time. If the patient fails to remember, after 1 hour the staff member authorised to administer medicines should remind them. The Self Administration Progress Record Level 1/2 should be completed at each administration time until the patient is assessed as competent at the agreed level of self-administration. This monitoring must continue for a minimum of two weeks and the process should be repeated if there are any changes - see Section 11.7

  o **Level 3**: The patient’s medicines will be stored in their own locked medicines cabinet. The patient will hold a key and will be responsible for the administration of their medication. The patient must sign a temporary stock order indicating they have taken possession of the key. This form must be attached to the back of the patient’s treatment chart. On discharge or when the patient is no longer self-administering their own medicines, the key must be returned to safekeeping. The nurse does not need to sign
the prescription chart for administration. The staff member authorised to administer medicines checks on a regular basis that the patient has taken the medicines as prescribed, and completes the self-administration progress record. See Appendix 4 - Self Administration Progress Level 3

- **Level 3** (non-oral medication) – The patient will keep certain non-oral medications such as inhalers, sprays, creams on their own person and will self-administer. As other medicines may be administered by a staff member authorised to administer medication the inpatient treatment chart should be annotated by the nurse which medicines the patient has self-administered

### 11.5 Exclusions from self-administration

11.5.1 Forensic wards should only use level 3, self-administration if local policies and procedures are in place to allow this.

11.5.2 Self-administration must not be used: If any of the following apply:

- The patient is at risk of self-harm, is confused or has an unstable mental state
- Any patient with a current history of alcohol/drug abuse – although in a settled period it may be possible for them to self-medicate subject to the agreement of the MDT. A risk assessment and management plan must be recorded in this instance
- Patient is prescribed a schedule 2 CD or temazepam
  - Variable doses (excludes 'when required' medicines)
  - Injections (except where the patient will be self-administering at home following discharge)
  - if the assessing registered nurse, in their professional judgement, is at all unhappy to let the patient self-administer (patient can be reassessed at another point)
  - Where the patient does not give consent to self-administer

11.5.3 Registered nurses should be aware of the importance of the Mental Capacity Act 2005 with respect to potentially incapacitated people and assessing an individual’s capacity.

### 11.6 Patient consent
11.6.1 Patients should be issued with a Patient Medication Dose Information sheet Appendix 5 – Patient Medication Dose Information Sheet for self-administration. It is good practice to regularly review this information sheet with the patient. If there are changes made to the medication, this sheet must be updated. This can be done by any registered member of staff as agreed by the MDT.

11.6.2 Patients must demonstrate that they understand the principles of the scheme and their responsibility at each level.

11.6.3 Patients must demonstrate their responsibility with regard to key security and the safe storage or their medicines before proceeding to self-administration level 3.

11.6.4 If the patient agrees to proceed with self-administration, written consent should be obtained from the patient Appendix 6 - Self Administration Medicine - Consent Form and scanned into the ‘Assessment Other’ section of RiO.

11.6.4 The patient should then enter the self-administration scheme at the appropriate level and the inpatient prescription chart endorsed accordingly (i.e. circle the appropriate level of self-administration. The patients named registered nurse should make a record in the patient’s care plan.

11.6.5 Patients who do not consent cannot be entered into the programme. It should be documented in the patient’s notes that this has been offered and declined.

11.6.6 Patients detained under the Mental Health Act and have a T3 form in place cannot participate in the self-administration programme. (Note: an exception can be made for non-oral items prescribed for physical health purposes). In preparation for discharge, it may be appropriate to supervise patients physically administering their own medicines following the principles of Level 1 self-administration.

11.6.7 Patients may withdraw from the scheme at anytime.

11.7 Ongoing assessment

11.7.1 If at any time it is felt that the patient’s mental state has deteriorated, or they are no longer able to self-administer at a particular level, self-administration should cease. The reasons for stopping should be documented in the care record (Core Clinical Documents, Medications, Allergies and Sensitivities page) and a discussion with the MDT should take place.

11.7.2 Patients may go up or down the self-administration levels as deemed appropriate by the MDT; any changes should be documented and their care plan amended.

11.7.3 Any adverse incidents relating to self-administration must be reported to the medical staff and pharmacist (if appropriate) and recorded with incident and/or accident forms completed.
11.7.4 Patients on level 3 self-administration should have:

- On-going adherence checks carried out as a minimum on a weekly basis in the initial stages with progression to once monthly checks
- Daily checks on the cupboard to ensure it is being kept locked

11.8 Changes in medication

11.8.1 Any changes to medication should be communicated with the patient and their written instructions amended (if appropriate). Any alterations made should be dated and initialled by the registered nurse.

11.9 Identifying problems

11.9.1 If during assessment a staff member authorised to administer medicines discovers that a patient is not managing to self-administer (e.g. missing doses or taking medicines incorrectly) then the patient must be given additional support. The level of self-administration of medicines must be reviewed to accommodate this.

11.9.1 If a patient is found to have taken too much medicine the patient should be referred to a member of medical staff for assessment. The patient's condition should be monitored and the level of self-administration of medicines reviewed. This principle should also be applied when medicines have been missed by the patient (particularly for ‘critical’ medicines).

11.9.2 The incident should be recorded in the patient’s clinical records and as per web based reporting; an electronic incident form must be completed. It may be necessary to cease self-administration until the patient can be re-assessed and the situation reviewed in the next MDT.

11.10 Accountability

11.10.1 Staff members authorised to administer medicines owe their patients a duty of care during the hospital stay

11.10.2 During traditional administration the duty of care means ensuring that the correct medicine is selected, assembled and physically administered to the patient

11.10.3 Where the patient is self-administering, the staff member authorised to administer medicines still owes a duty of care but this will relate to proper assessment and monitoring of the patient rather than the act of giving medicines

12 Covert Administration of Medicines

- If a medicine is administered to a patient covertly, the patient is unaware that they are being given a medicine. This guidance note has been
developed to ensure that a consistent safe and best patient interest approach is used throughout the Trust for the covert administration of medicines, including disguising medicines in food or drink, and to enable staff members authorised to administer medicines to understand the associated legislation

12.1 General Principles

- The practice of administering medicine covertly should only be undertaken in exceptional circumstances. Nothing should replace the techniques used to encourage the person to accept the prescribed medicine. This stresses the importance of building a rapport with patients and enabling a trusting relationship. Covert administration of medicines should never be done for the convenience of staff members.

- Unless the patient is detained under Section 2 of the Mental Health Act 1983, (MHA 1983) or one of the treatment orders such as Section 3, and the medication is for their mental disorder, the therapeutic administration of any medication to a patient who lacks capacity must comply with the principles and procedures set out in the Mental Capacity Act 2005, it's Code of Practice and the Trust's NTW(C)05 - Mental Capacity Act Policy. The covert administration of medicines to patient’s detained under the MHA 1983 (specifically for the presenting mental disorder and related symptoms) is a separate legal issue, details of which may be found in the Mental Health Act 1983, the Trust’s NTW(C)05 - Consent to Treatment and Examination Policy and Appendix 8 - Covert Medication Care Planning of this practice guidance note.

- The decision to covertly administer medicines should be made on a case by case basis. The best interests’ framework within the Mental Capacity Act must be followed in coming to a decision. Consideration must be taken that the covert administration does not constitute Deprivation of Liberty.

- When deciding to use covert medication, consideration should be given as to whether the patient will later be informed that they have been receiving medication covertly. This can help patients to make the link between medication and their recovery. The multidisciplinary team should consider how this will be done and the potential reaction of the patient.

- An assessment and care plan for covert administration should be formulated following consultation with the multidisciplinary team. Relatives and carers must also be consulted unless there is a reason not to (see Planning/Assessment form – Appendix 8 - Covert Medication Care Planning).

- The form of the drug must be safe to use covertly and a pharmacist should always be consulted for advice on drugs that are available in...
syrup form and any tablets that can or cannot be crushed. This includes drugs that may be denatured by mixing with milk and other liquids/food substance. Any alternative medicines that may be available such as long acting drugs that may reduce the frequency of administration

- The method of administration of medicines should be agreed with a pharmacist and documented in a covert administration care plan. The pharmacist will also put instructions in the ‘comments section’ as appropriate

- The decision to administer medication covertly must be reviewed regularly by the multidisciplinary team as the clinical situation changes

- If covert administration continues for longer than 3 months it would be good practice to seek an informal second opinion from within the Trust. If second opinion sought this should be documented in the care record

- Applying these conditions to the administration of covert medication means that the person giving it will be protected from legal liability provided they are not negligent

12.2 Covert Administration in Children

- The principals of this policy apply equally to children and young people, however many young children will and do simply refuse to take medicines. The concordance of children with medicines is enormously variable and many factors contribute to their willingness to take medicines

- It is important that the principles governing consent are applied to all forms of care; including the paediatric clinical setting. It is the personal responsibility of any doctor proposing to treat a patient to determine whether the patient has capacity to give valid consent. Children and Young People under the age of 16 are generally considered unable to consent or refuse treatment, including medicines. The right to do so remains with the parents, or those with parental responsibility, unless the child is considered to have significant understanding and intelligence (Gillick Competence, Fraser Guidelines)

- Young People of 16-17 years are presumed to be able to consent for themselves, but the parents or those with parental responsibility may override the refusal of a child/ young person of any age. In exceptional circumstances this may involve seeking an order from the court or making the child a ward of court

- Encouraging and supporting parents to be involved in the procedure and ensuring the child/young person understands and is adequately prepared helps promote concordance with drug therapy
• It is essential to be truthful to the child/young person about how the medicine will taste and if it will hurt. Never threaten to administer a drug by injection if a child/young person is refusing oral medicines

• Disguising medicines in food or drink to improve concordance is acceptable when a child refuses to take medicines, when the medicine is given in the best interests of the child; it should be undertaken only after all other efforts to encourage the child to take their medicines have failed. It must be done with the consent of the child’s parent or legal guardian and the agreement of the clinical team

• The actions should be fully documented in the child/young person’s care plan and regular attempts must be made to encourage the child/young person to take the medicine voluntarily

13. Guidance on crushing medicines and for nurses directed to mix and administer mixed medicines

13.1 Crushing medicines

• In certain circumstances crushing tablets or opening capsules may be the only method available to administer a medication to the patient. The risk of the patient not receiving the medication must be weighed against the risk of crushing the tablet or opening the capsule

• However, crushing tablets or opening capsules may be unnecessary, dangerous to the patient and may not be suitable for administration through enteral feeding tubes. By opening or crushing tablets that are intended to be given whole may mean that they are being used outside of their product license. Always consider crushing or opening medications carefully, firstly seeking advice from your pharmacy team to obtain another form of the medicine or to ensure that crushing or opening the tablet is safe

• Tablets that you must never crush:-
  o Enteric coated (EC)
  o Modified Release/Slow release/Extended release/Long acting/Retard (MR/SR/LA/XL)
  o Buccal or Sublingual tablets (with the exception sublingual buprenorphine used in the Trust Drug Addiction Service where crushing the tablets is necessary for administration to individuals)
  o Cytotoxic tablets
  o This list is **not** exhaustive, and advice should be sought from the pharmacy team
• **Consider the form/route of administration:-**
  
  o Can an alternative form/route be used? Parenteral, rectal, liquid, dispersible tablets
  
  o When the formulation is changed the medicine may require a dosage adjustment

• **Giving medicines via enteral feeding tubes:-**
  
  o Absorption characteristics must be verified with your pharmacy team prior to administration of medicines via this route
  
  o Some medicines which are crushed and administered via an enteral feeding tube may cause blockages
  
  o Some medications have interactions with the feed
  
  o If the medicine is to be administered on an empty stomach, the above advice still applies and the feed would have to be stopped before and after the medication for an appropriate length of time
  
  o It is not possible to list all the drugs that may be affected and so specific reference should be made to pharmacy or individual manufacturer’s product information before interfering with any medicine forms
  
  o For more specific information regarding the administration of medicines via an enteral feeding tube please contact the dietician

13.2 **Nurses directed to mix and administer mixed medicines**

• Mixing of medicines is defined as the combination of two or more medicinal products together for the purposes of administering them to meet the needs of a particular patient. Mixing two licensed drugs, where one is not the vehicle for administration of the other, creates an unlicensed medicine. Further details are available on the [MHRA website](https://www.gov.uk). Staff members must not therefore mix any medicines without prior instruction from a prescriber

• The mixing of medicines should not occur for the convenience of any staff member authorised to administer medicines. The sole rationale of such practice should be benefit to the patient

• Products resulting from the mixing of medicines cannot be supplied or administered under PGD arrangements

• Staff members must not:
- Mix and administer medicines if the directions to mix medicines on the inpatient treatment chart or other chart are unclear or unambiguous.

- Mix medicines if the mixture is not usual practice, and instead should assess the appropriateness of mixing, firstly by satisfying themselves that they are competent to mix and secondly, whether a mixture is essential for patient care. The prescriber must be informed or another practitioner contacted who is competent to mix. Staff members authorised to administer medicines should not feel pressurised to mix medicines if they do not feel competent or confident to do so.

- The staff member authorised to administer medicines should question whether there is an alternative to mixing. Discussion with the prescriber and a pharmacist may be helpful.

- The NPC has produced e-learning material to support individuals involved in the mixing of medicines.

14. Reporting and Managing Medication Errors

14.1 All medication errors, including near misses occurring in the Trust, no matter how minor, must be managed appropriately and reported promptly to all parties that need to be informed, and, where required, a formal investigation is conducted, and to ensure that lessons learnt from medication errors are shared across the Trust – see Trust Policy, NTW(O)05, Incidents, practice guidance note, which must be followed, IP-PGN-07 – Medication Incidents for full details.