South Central Ambulance Service
NHS Foundation Trust

MEDICINES MANAGEMENT POLICY

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
Bicester, Oxfordshire, OX26 6HR

TABLE OF CONTENTS

DOCUMENT INFORMATION

Author: Victoria Bray, Consultant Pharmacist

Ratifying committee/group: Patient Safety Group

Date of ratification: 17/03/2022

Date of issue: 13/10/2022

Review date: 17/03/2025

Version: 8.0

1. Introduction

1.1. The South-Central Ambulance Service NHS Foundation Trust South Central Ambulance Service NHS Foundation Trust ("the Trust") is committed to the safe and secure management of medicines

1.2. Managing medicines safely, effectively and efficiently within SCAS is a key component for the delivery of good quality patient centred care. Emergency medicines play a significant role in the treatment of patients in urgent care situations

1.3. The principles that govern the management of medicines must be applied to all the activities in which medicines are involved. The key principles are:

1.3.1. Compliance with current legislation

1.3.2. Adherence to guidance issued by the Department of Health and Social Care and other national guidance

1.3.3. Management of the risks to patients and staff arising from the use of medicines

1.4. This policy should be read in conjunction with other relevant policies and Standard Operating Procedures (SOPs) for each of the activities concerned with the safe and secure use of medicines. The policies and procedures support good practice in medicines management.

1.5. Medicines are used in all areas of the Trust and are the responsibility of all staff. The importance of appropriate procedures to ensure the quality and safety of all aspects of medicines usage is paramount and is a key component of clinical governance. All members of staff dealing with medicines need to contribute to maximising their effective use and minimising medicine-related harm and morbidity for our patients.

1.6. Good clinical governance requires clear lines of responsibility and accountability and clear policies for managing risk. Systems that ensure the safe and secure handling of medicines are essential elements of good clinical governance.

1.7. This policy reflects the current legislative framework and national good practice for medicines governance within SCAS. The safe and secure management of medicines within SCAS is subject to the same principles as any other NHS trust.

1.8. In all areas regardless of storage/access systems the same medicines management principles should be followed.

1.9. The control of medicines in the United Kingdom is primarily governed by the Medicines Act (1968) and Human Medicines Regulations (2012). This policy has been formulated to ensure, as far as possible, the safe storage, administration and disposal of medicines.

1.10. Healthcare Professionals are reminded of their responsibilities under their Code of Professional Conduct in that each registered Healthcare Professional is accountable for his/her practice.

2. Scope

2.1. This policy applies to all individuals employed by the Trust including those that work under contract for services and those supplied to work by a third-party including volunteers, agency staff and students engaged by SCAS.

2.2. This policy applies to the use of all medicines in SCAS

2.3. This policy does **not** apply to any subcontracted organization whom as part of their contract with South Central Ambulance Service is required to take responsibility for management of their own medicines e.g., Voluntary Aid Society staff, such as St. John Ambulance, British Red Cross, or private organisations subcontracted by the SCAS.

3. Equality statement

3.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the afore mentioned protected characteristics, whether full or part time or employed under a permanent or a fixed term contract or any other irrelevant factor.

3.2 By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

3.3 Where there are barriers to understanding; for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the HR Department.

4. Aim

4.1 The aim of this policy is to ensure that the Trust complies with relevant legislation governing the storage, supply and administration of medicines

4.2 To ensure that all Trust staff, including contracted, bank and agency staff, are aware of the procedures for the safe and effective management of medicines.

4.3 To ensure that medicines are correctly stored, properly prescribed, and correctly administered in a safe and timely manner.

4.4 To support the Trust's strategic objective of delivering safe, high-quality care and an excellent patient experience.

4.5 To detail the responsibilities of all staff groups involved with prescribing, dispensing, carriage, safe storage, and administration of medicines.

4.6 To ensure that all SCAS Managers and staff are aware of their responsibilities as detailed in sub policies and procedures relating to procurement, storage, security and handling for all medicines and medical gases ordered, stored, administered and disposed of by SCAS staff.

4.7 To ensure that all ambulance staff are aware of their responsibilities as detailed in sub policies and procedures regarding the storage and security of medicines within their possession or held on a vehicle or other designated location during their shift period.

5. Roles and responsibilities

5.2 Trust Board

5.1.1 The Trust Board has responsibility and accountability for ensuring the provision of appropriate resources required to implement this policy. The Board Committee and meeting structure is documented in Appendix 1.

5.1.2 The Board is ultimately responsible for ensuring that the Trust implements robust systems and processes which comply fully with legislation, national guidance and regulatory requirements, to ensure the safe and effective management of medicines.

5.2 Chief Executive

5.2.1 Has overall responsibility for ensuring that systems for the safe and secure management of medicines are followed and that the security of medicines handled by the Trust is maintained

5.2.3 They may delegate these duties but always the responsibility remains with the Chief Executive. They are the Controlled Drug License Holder and are responsible for ensuring that the systems and processes used to govern medicines are robust, comply fully with legislation, national guidance and regulatory requirements to ensure the secure and effective management of medicines.

5.3 Executive Director of Patient Care

5.3.1 Nominated by the Board to have executive clinical responsibility for the prescribing, supply, and administration of medicines to patients by Trust clinicians.

5.4 Medical Director

5.4.1 The Medical Director is responsible for ensuring the use of medicines is safe, evidence-based and delivers the best outcomes for patients. The post-holder is assisted by two Deputy Medical Directors and is the Lead Director with responsibility for medication safety.

5.5 Director of Operations

5.5.1 The Director of Operations is responsible for providing sufficient operational support to enable the full implementation of this policy and all associated standard operating procedures requirements to ensure the safe and effective management of medicines throughout the Trust.

5.6 Medicines Optimisation and Governance Group

5.6.1 Authorised by the Clinical Review Group (CRG) to ensure that high quality patient care is being delivered by the Trust through effective use and management of medicines by the Trust. They will oversee all medicines management policies and procedures and bring to the attention of the CRG any issues which it believes are relevant.

5.6.2 They will also oversee all medicines management audits, including compliance with NPSA and NICE guidance and CQC registration requirements.

5.7 Head of Pharmacy

5.7.1 The professional pharmacy lead for the Trust and is responsible for producing robust systems and processes which comply fully with legislation, national guidance and regulatory requirements to ensure the safe and effective management and use of medicines throughout the Trust.

5.7.2 The post holder is responsible for provision of expert advice on all matters relating to medicines use, prescribing, and provision of pharmaceutical services within the Trust. Key responsibilities include:

- Ensuring the procurement of pharmaceuticals of appropriate quality, in accordance with Medicines Supply Contracts & the Purchasing for Safety Policy, ensuring value for money.
- Establishing and maintaining a system for the safe and secure handling of medicines.
- Establishing and maintaining a system for the supply, distribution, return and destruction of medicines.
- Establishing a system for advising all healthcare staff and patients on all aspects of medicines management, to ensure the best use of medicines. This also ensures the availability of advice when the Pharmacy Department is closed.
- Establishing a system for recording and reporting pharmacists' medication interventions, in accordance with the Trust's Incident reporting policy (including Serious Incidents Requiring Investigation (SIRIs)) Management Policy and the Risk Management Policy.
- Ensuring that the Trust has a nominated Medication Safety Officer (MSO), with a key responsibility to promote the safe use of medicines across the Trust, and to act as an expert in Medication Safety
- Establishing a system for the MSO to routinely review all medication-related incidents reported via the Trust's reporting systems, and for producing regular reports and trends on these for the MOGG; ensuring that all staff understand how to raise concerns about the safe and secure handling of medicines
- Developing a system to provide an audit trail of all medicines at points of transfer, with particular reference to drugs which require special handling, notably Controlled Drugs (CDs) and drugs requiring refrigeration.
- Recommending to the MOGG on safety and security grounds which drugs must be ordered and supplied in a restricted manner.
- Auditing the implementation of medicines handling policies and systems.
- Monitoring the use of unlicensed medicines, and the use of licensed medicines for unlicensed indications, and to ensure their quality and suitability for use.
- Production, review and updating of this policy on behalf of the MOGG

5.8 Controlled Drugs Accountable Officer

5.8.1 The Accountable Officer has a statutory responsible to ensure the safe management of controlled drugs within the Trust.

5.8.2 The Accountable Officer is responsible for monitoring controlled drug use, actively representing the Trust on Controlled Drug Local Intelligence Networks and for ensuring

that all staff receive training in the physical handling and use of controlled drugs relevant to their role.

5.8.3 The Accountable Officer reports directly to the Chief Executive and liaises with the Home Office in matters relating to the Trust's Controlled Drug License.

5.9 Medication Safety Officer

5.9.1 Will act under the direction of the Medical Director and the Chair of the Medicines Management Group. The MSO will be a member of the National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and Medicines and Healthcare Products Regulatory Agency (MHRA).

5.10 Medicines Manager

5.10.1 In consultation with the Medical Director, MOGG and the supplying pharmacy, will be responsible for maintaining an on-going review of the supply arrangements to ensure that they meet SCAS needs and comply with current legislation.

5.10.2 In conjunction with the Head of Pharmacy and Lead Pharmacist, responsible for providing specialist advice to the Corporate Logistics Manager to enable them to determine stock levels and to specify the range and presentation of drugs used within the Trust.

5.11 Head of Procurement

5.11.1 Responsible for the procurement of all medicines used in the Trust, for ensuring that they are fit for purpose and for ensuring that they are procured in accordance with the Trust's Policy for Safer Procurement and the Purchasing for Safety Policy

5.12 Assistant Director of Education

5.12.1 Responsible for ensuring that all clinical staff receive education, feedback, information and training relevant to their role, which fully reflects the requirements of this policy and enables them to manage, administer and supply medicines safely to deliver the best outcomes for patients.

5.13 Head of Clinical Audit and Research

5.13.1 Responsible for ensuring that the annual audit plan fully monitors the implementation of this policy through the short station review, feedback to staff on their use of medicines and other audits requested by the Patient Safety Group, Clinical Review Group or MOGG.

5.14 Consultant Pre-Hospital Care Practitioners

5.14.1 Responsible for ensuring that the highest standard of patient care is delivered via effective clinical leadership and supervision. Thus supporting the implementation of the Medicines Management Policy. They will assist in areas including the delivery of education and training, supporting the process of feedback to staff on clinical use of medicines and implementing best clinical practice to reduce medication errors.

5.15 Prescribers (medical and non-medical)

5.15.1 Prescribers:

- Will prescribe appropriate medicines for patients in their care.

- Will prescribe legally and legibly.
- Will only prescribe within their sphere of competence.
- Will obtain informed consent (where possible) before prescribing medicines.
- Pharmacists:
- Are responsible for ensuring that medicines are prescribed, supplied, stored, prepared and administered correctly as per relevant sub policies

5.16 Pharmacy Support Workers

5.16.1 Are responsible for undertaking a range of medicines management tasks, some depending on specific accreditation, including stock control, distribution & disposal of medicines.

5.17 Heads of Operations and Clinical Operations Managers

5.17.1 Responsible for providing sufficient operational support to enable the full implementation of this policy and all associated standard operating procedure requirements within their area of responsibility to ensure the safe and effective management and use of medicines throughout the Trust.

5.18 Registered Healthcare Professionals

5.18.1 Registered Healthcare Professionals

- Will administer non parenteral medicines and parenteral medicines in line with the relevant legislation, patient group direction (PGD) or Trust procedure.
- Will check that all particulars of the prescription are safe and appropriate before administering any medicine, referring to the prescriber or a pharmacist if necessary.
- Will identify medicines management issues, particularly, but not excluding, those relating to administration, and bring these to the attention of the Lead Pharmacist or MOGG, e.g. inability to take oral medicines, lack of intravenous access, incomplete or incorrect prescriptions.
- Responsible for maintaining their professional competency in the management of medicines and to ensure their familiarity with changes to therapeutic guidelines as they are adopted

5.19 All staff

5.19.1 All healthcare staff who handle, supply or administer medicines:

- Are accountable for working within current legislation and for working within the code of conduct of their professional body, and within any Trust policy
- Are accountable for ensuring that medicines are prescribed, supplied and administered only to treat patients of the Trust.
- Must ensure they support patients to be involved in decisions about their treatment and assist them to take their medicines safely to achieve the best outcomes.
- Anyone prescribing, supplying, preparing, administering, or disposing of medicines is personally responsible and accountable. That accountability cannot be delegated or shared with another person. Anyone involved in any aspect of medicines management is responsible for bringing to the attention of their line manager any educational needs they may have in relation to ensuring safe practice, and for undertaking the necessary training.

6. Definitions

6.1 Medicines Management

6.1.1 “Medicines Management is a system of processes and behaviours that determines how medicines are used by the NHS and patients. Good medicines management means that patients receive better, safer, and more convenient care. It leads to better use of professional time, and enables practitioners to focus their skills where they are most appropriate. Effective medicines management also frees up resources which means that NHS money can be used where it is most effective, Good medicines management benefits everyone.” (National Prescribing Centre).

6.2 Medicines Optimisation

6.2.1 “A person-centered approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines’. Medicine’s optimisation embodies the principles of Medicines Management, as applied to individual patients.

6.3 Adverse Drug Reaction

6.3.1 An **unwanted or harmful reaction** which occurs after administration of a drug or drugs and is suspected or known to be due to the drug. A response to a drug that is noxious, unintended, and occurs at doses normally used for prophylaxis, diagnosis, or treatment of disease, or for modification of physiological function.

6.4 Controlled Drug

6.4.1 Defined by the Misuse of Drugs Act 1971 (“the Act”) as any substance or product being specified in Part I, II or III of Schedule 2 of the Misuse of Drugs Act 1971.

6.5 Medicine/Medicinal Product

6.5.1 A substance or article or an ingredient of either of these (not being an instrument, apparatus or appliance) supplied for administration to a human being for a medicinal purpose. This excludes

- Disinfectants (being applied to inanimate objects)
- Sterile non-injectable water
- Unmedicated dressing, ligatures and sutures
- Antiseptics used as cleansing agents for the skin and wounds

6.6 Medicinal purpose

6.6.1 Any one or more of the following:

- Treating or preventing disease
- Otherwise preventing or interfering with the normal operation of a physiological function, whether permanently or temporarily
- Whether by way of terminating, reducing or postponing, or increasing or accelerating, the operation of that function or in any other way.

6.7 Patient Group Direction

6.7.1 A specific written instruction for the supply and administration of a named medicine to a group of patients in an identified clinical situation. A PGD must meet certain legal criteria. Further information is available in the PGD Policy.

7. Abbreviations

- AACE – Association of Ambulance Chief Executives
- APBI – Association of the British Pharmaceutical Industry

- CD – Controlled Drug
- COSHH – Control of Substances Hazardous to Health
- PGD – Patient Group Direction
- MHRA – Medicines and Healthcare products Regulatory Agency
- PGD – Patient Group Direction
- SOP – Standard Operating Procedure

8. Policy Framework

This framework provides access to all sub-polices within the trust linked to the Medicines Policy. These policies cover all aspects of the Medicines Policy:

- Purchasing of medicines
- Storage, security and ordering of medicines
- Prescribing (and other legal mechanisms for authorizing supply/ administration of medicines)
- Administration of medicines
- Preparing & distributing of medicines
- Monitoring of medicines management processes & risk management

Safe and Secure Handling of Medicines Policy This document outlines the safe and secure handling of medicines within South Central Ambulance Service NHS Trust aims to ensure compliance with current legislation, and good practice guidance, whilst managing the risks to patients and staff arising from the use of medicines
Controlled Drugs Policy and Procedure These documents provide detailed policy statements and individual procedures on the safe use and security of Controlled Drugs and appropriate availability.
Patient Group Directions – Development and Use Policy and Procedure This document provides good practice recommendations for the systems and processes used when South Central Ambulance Service NHS Trust is considering the need for, developing, authorizing, using and updating Patient Group Directions (PGDs).
Prescribing Policy This document details the prescribing standards and procedures
Non-Medical Prescribing Policy This document describes the process for application and implementation of Non-Medical Prescribing. Non-Medical Prescribing it is the prescribing of medications by Paramedics, Nurses, Midwives, Pharmacists and Allied Health Professionals (AHP) who have successfully qualified as prescribers.
Formulary Management Policy & The Trust Formulary These documents define the policy for how the Trust manages the medicines formulary and details the current Trust formulary medicines and their use
Antimicrobial Stewardship Policy This policy aims to ensure the safe and appropriate use of antimicrobials, in an attempt to ensure reduced antimicrobial resistance and improved stewardship
Unlicensed Medicines Policy This policy determines how unlicensed medicines are authorised and handled within the Trust.

Medical Gas Policy This policy details the safe and secure handling and management of Medical Gases
Purchasing for Safety Policy This policy documents how the Trust ensures safe, legal and efficient purchasing of medicines
Medicines Administration Policy This policy documents and defines the expectations and responsibilities of staff when administering medicines
COSHH HSE: A Brief Guide to the Regulations Sets out the regulations for using chemicals and other hazardous substances.
Standard Operating Procedures for the Management of Medicines These documents define the processes undertaken to order, prepare, distribute and dispose of medicines for use within the Trust. This includes local procedures on specific drugs, for example Investigational Medicinal Products.

9. Risk Management

9.1 Managing errors or incidents in the use of medicines

9.1.1 A medication error is a preventable incident associated with the use of medicines that has resulted in harm or potential for harm to a patient. Such incidents may be related to any step in the medicines use process, including prescribing, dispensing, administration, use of a PGD & storage or transfer of medication information.

9.1.2 Medication incidents must be reported via the Trust's incident reporting system, currently DATIX. It may also be necessary to report incidents to an individual's line manager

9.1.3 Staff should also report any near misses or potential hazards relating to any part of the medicines management process (including potential or actual administration/prescribing errors, medicines reconciliation discrepancies) via DATIX, with special reference to reporting any near miss relating to medication that is subject to a current or previous NPSA alert.

9.1.4 Following a medication incident, the well-being and safety of the patient is the prime concern and must be assured first and foremost. The incident must be reported as soon as possible to the clinical hub and Medicines Management (SCASMedicinesTeam@scas.nhs.uk), who will decide whether any further action is needed clinically.

9.1.5 Potential safeguarding implications must be given due consideration when an incident involves a child or a vulnerable adult.

9.1.6 In terms of investigating medication-related incidents, the Trust policy should be followed. Serious incidents must be reported and investigated. If a medication incident that may fall within the definition of a Department of Health 'Never Event' occurs, this should be escalated immediately to the relevant Head of Governance, Medication Safety Officer and Medical Director.

9.1.7 In accordance with Duty of Candour, the patient/ carer should be informed that an error has occurred. The member of staff informing the patient should be directly involved in their care, who will be able to have an open and honest discussion with the patient.

9.2 Learning from incidents

9.2.1 The Medication Safety Officer will review all reported medication incidents for accuracy of the medication-related details, to provide professional input, and to escalate incidents for further investigation if necessary.

9.2.2 If any trends are identified, this will be escalated via the Medicines Optimisation and Governance Group.

9.2.3 If an incident is deemed serious or significant then a patient safety case review should be established to look at causative factors and future preventative measures. The review should be organised by a suitable lead who is independent to the case in question and involve relevant members of staff related to the incident. The review should also include involvement of:

- Relevant Healthcare Professional(s) involved in case
- A Pharmacist.
- Appropriate specialists/experts related to the case

The aim of the review is to create an open environment which enables learning from the incident to occur.

9.3 Adverse Drug Reaction Reporting

9.3.1 Any drug may produce unwanted or unexpected adverse drug reactions. Detecting and reporting of these is of vital importance.

9.3.2 Prompt reporting should be carried out for any suspected adverse drug reactions to new drugs that are subject to additional monitoring by regulatory bodies. These medicines are identified in the BNF and in product literature by the inverted black triangle symbol (▼).

9.3.3 Reporting must also be undertaken for unlicensed medicines and for any serious or unusual reactions to established products. Reporting should be carried out for prescribed drugs, and for medicines obtained by patients over the counter/ herbal products.

9.3.4 Suspected adverse reactions related to a drug or combination of drugs should be reported on the Datix reporting system & to the Medicines and Healthcare Products Regulatory Agency (MHRA) using the national yellow card reporting scheme. Copies of the card can be found at the MHRA website (www.mhra.go.uk)

9.3.5 Adverse Drug Reactions (ADRs) should be recorded in accordance with the Clinical Records Policy.

9.4 Medicine Defect Reporting

9.4.1 A defect is present if the product, as supplied by the manufacturer, is not of the expected standard. Defects may relate to inadequate or incorrect labelling, ineffective packaging, contamination, discolouration, breakage, or incorrect contents.

9.4.2 If a defect is found or suspected in a medicine, it should be reported to the Pharmacy Team using the Datix reporting system. Any remaining product and associated equipment should be retained and quarantined. If the product has been administered to a patient, the patient's GP should be informed, and details of the defect should be recorded in the patient's medical record.

9.5 Medication Safety Alerts and Drug Recalls

9.5.1 Defective medicines may relate to quality issues with the product itself, the packaging or other packaging components such as the patient information leaflet.

9.5.2 Defective medicines may be identified or suspected locally or may be identified and cascaded nationally.

9.5.3 Local identification or suspicion of a defective medicine:

9.5.3.1 Refer to SOP MED301 for the quarantine of medicines

9.5.3.2 Report the medicines defect to the SCAS Medicines Team (SCASMedicinesTeam@scas.nhs.uk) and raise an incident report as per the Adverse Incident Reporting and Investigation Policy

9.5.3.3 The Head of Pharmacy and the MOGG will decide if it is appropriate to withdraw from use all medicine of the same batch in accordance with the Adverse Incident Reporting and Investigation Policy

9.5.3.4 Defective medicines should be reported via the MHRA Yellow card scheme. Yellow card reports of defective medicines are submitted to the defective medicines report center (DMRC). The role of the DMRC is to minimise the hazard to patients arising from the distribution of defective medicines by providing an emergency assessment and communication system between manufacturers, distributors, regulatory authorities, and users.

9.5.4 National cascade of defective medicines:

9.5.4.1 Central Alerting System cascade will be actioned in accordance with the Central Alerts System and other Alerts Policy

9.5.4.2 In the event of a batch recall SOP MED313 details actions to be taken.

9.5.5 Electronic stock management systems should support the efficient and effective identification of batches effected by a batch recall notification.

10. Control of Substances Hazardous to Health

10.1 Some medicines are, by their nature, hazardous. COSHH regulations is the UK legislation on chemical hazards at work. The main legal duties of employers under COSHH are contained in regulations 6 -12, which cover risk assessment, prevention or control of exposure, use and maintenance of controls, monitoring exposure, health surveillance and provision of information and training.

10.2 The Trust Control of Substances Hazardous to Health Policy covers the management of these medicines/substances

11. Liability

11.1 The Trust generally accepts responsibility for the negligence of its qualified staff who, in emergency situations within the United Kingdom, administers medicines in the treatment of patients. This applies both during and outside working hours whilst a member of staff acts in accordance with his or her training and not for any private or voluntary organisation.

11.2 The Trust is not liable for the activities of staff undertaking work for private or voluntary organisations. In these circumstances, to avoid the imposition of personal liability, staff are advised to check beforehand that appropriate insurance cover is in place.

12. Training

12.1 The Trust recognises the importance of Training and Education in increasing awareness of the safe and effective use of medicines.

12.2 On Induction, all clinical staff will receive information and education on medicines and Trust medicines policies and procedures.

12.3 The Trust has a training plan in place for all staff involved in handling medicines. This plan is reviewed and developed by training & education under the guidance of the Lead Pharmacist.

13. Equality and diversity

13.1 An initial screen equality and diversity impact assessment has been carried out on this policy and, as per appendix 1, is available on request.

12. Monitoring

12.1 The effectiveness of this policy will be monitored through audit structures outlined in sub policies as listed in section 8 and through quarterly medication incident reports

13. Consultation and review

13.1 A consultation exercise on the policy will be carried out with the stakeholders every 3 years, or less if there are any relevant changes to legislation or best practice.

14. Implementation (including raising awareness)

14.1 The policy will be implemented and communicated to managers and staff within the Trust via the weekly newsletter, Staff Matters. Emails will also be sent to senior managers and area managers asking them to bring the existence of the policy to their staff.

15. References

- UK Statutory Instruments (2012) Human Medicines Regulations 2012
- UK Statutory Instruments (2001) Misuse of Drugs Regulations
- UK Public General Acts (1971) Misuse of Drugs Act
- MHRA (2006) Healthcare professional reporting of suspected adverse incidents. Medicines and Healthcare products Regulatory Agency
- Department of Health (2009) Reference Guide to Consent for Examination or Treatment
- General Medical Council (2021) Good practice in prescribing and managing medicines and devices

- National Institute for Health and Care Excellence (2017) Medicines Practice Guidelines: Patient Group Directions
- Royal Pharmaceutical Society (2016) A competency framework for all prescribers
- NHS Counter Fraud Authority (2018) Management and control of prescription forms: A guide for prescribers and health organisation
- NHS Protect (2013) Security standards and guidance for the management and control of controlled drugs in the ambulance sector
- Nursing and Midwifery Council (2006) Standards of Proficiency for Nurse and Midwife Prescribers
- Royal Pharmaceutical Society (2018) Professional guidance on the safe and secure handling of medicines
- Royal Pharmaceutical Society (2019) Professional Guidance on Administration of Medicines in Healthcare Settings
- Tan, K., Petrie, K.J., Faasse, K., Bolland, M.J. and Grey, A. (2014) Unhelpful information about adverse drug reactions. BMJ 349

15. Associated documentation

15.1 There are also the following documents associated with this policy:

- Safe and Secure Handling of Medicines v1.0
- Controlled Drug Policy v6.0
- Medicines Administration Policy v1.0
- Purchasing for Safety Policy v1.0
- Formulary Management Policy v1.0
- Patient Group Direction Policy v2.0
- Adverse Incident Reporting and Investigation Policy v10
- Medical Gases Policy v1.0
- Antimicrobial Policy v1.0

16. Appendix 1: Review Table

16.1 This policy is regularly reviewed and updated with information in line with relevant national guidance and legislation. A full 'Review Table of Contents' is available on request.

17. Appendix 2: Responsibility

17.1 The responsibility for this policy is shared between various Policy Groups, Lead Director/Officers, Working Groups and Committee members.

17.2 A full list of all responsible parties can be made available upon request.

18. Appendix 3: Equality impact assessment - Screening

18.1 An initial screening equality impact assessment has been carried out and has identified that the policy does not have an adverse or detrimental impact on any of the proscribed equality groups as the policy is designed to protect all staff who carry out work for or on behalf of the Trust.

18.2 The screening element of the initial 'Equality Impact Assessment' is available on

request.

19. Appendix 4: Equality impact assessment form – Section Two – Full assessment

19.1 Due to the outcome of the initial screening equality impact assessment, it has not been necessary to carry out a full equality impact assessment.

20. Appendix 5: Ratification

Policy Title: Medicines Management Policy

Author's Name and Job Title: Victoria Bray, Consultant Pharmacist

Review Deadline: 26/09/22

Consultation From – To (dates): 05/09/22 – 26/09/22

Comments Received? (Y/N): Yes

All Comments Incorporated? (Y/N): Yes

If No, please list comments not included along with reasons: Comments about including restraining in this policy were not applicable.

Equality Impact Assessment completed (date): Yes 01/09/22
.
Name of Accountable Group: Patient Safety Group

Date of Submission for Ratification: 03/10/22

Template Policy Used (Y/N): Y

All Sections Completed (Y/N): Y

Monitoring Section Completed (Y/N): Y

Date of Ratification: 13/10/22

Date Policy is Active: 20/10/22

Date Next Review Due: 01/03/2024

Signature of Accountable Group Chair (or Deputy):

Name of Accountable Group Chair (or Deputy): Jane Campbell