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Title: Medicines – Ordering, storage, transfer, security, and disposal

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Contents

1 Introduction

Medicines are used in all healthcare settings and the safe and secure handling of medicines is essential to ensure patient safety. The Royal Pharmaceutical Society (RPS) have clear professional guidance and a framework that underpins these principles and supports good practice around all aspects of the medicines journey. Our procedure for Medicines – Ordering, storage, transfer, security, and disposal procedure is therefore crucial in supporting our staff to both follow the RPS framework as well as working within their own scope of practice. The procedure clearly lays out processes to support and enable staff to work safely in all aspects of these activities.

This procedure supports our journey to change as set out in the Medicines overarching Framework.

2 Purpose

Following this procedure will help the Trust to:

- Manage risks with medicines through effective procedures for handling medicines
- Ensure medicines are supplied, transported, transferred, stored, and disposed of in a safe, legal, and timely way

3 Who this procedure applies to

- This Procedure applies to all staff involved with medicines.

4 Related documents

This procedure describes what you need to do to implement the Ordering and Receipt of Medicines section of the Medicines Overarching Framework Policy

The Medicines Overarching Framework defines compliance requirements for safe, and appropriate handling of medicines which you must read, understand, and be t before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ Electronic Prescribing and Medicine Administration (EPMA) Overarching Procedure
- ✓ Medicines – Retention of records
- ✓ Oxygen & other medical gases – administration, prescribing, storage and safety✓
- ✓ Waste management policy
- ✓ Controlled Drugs Standard Operating procedures
- ✓ Antipsychotic Depots LAIs – prescribing administration medicines management guidelines
- ✓ Medicines – Multi Compartment Compliance Aids
- ✓ Medicines - Preparation and Administration

- ✓ Access to Medicines Outside Working Hours Policy
- ✓ MSS 16 Medication Expiry Dates
- ✓ FP10 Prescription Management

5 Ordering and receipt of medicines

Controlled stationery describes all stationery which, in the wrong hands, could be used to obtain medicines fraudulently.

Controlled stationery includes inpatient prescriptions, leave/discharge prescriptions, controlled drug order books and FP10 prescriptions.

It must be kept in a secure place i.e., locked away in a locked drawer, drug trolley, drug cupboard or filing cabinet with access restricted to designated personnel, nursing staff, doctors, ward clerks and pharmacy staff.

In-patient / leave / discharge / day unit prescription pads and controlled drug order books are ordered locally from Pharmacy teams at Lanchester Road Hospital, Roseberry Park Hospital, Foss Park Hospital or West Park Hospital.

FP10 prescription pads are available on inpatient wards for emergency use out of hours. See FP10 Prescription Management

Pharmacy maintains a log of all controlled stationery issued to wards, teams, and medical staff.

All registered nurses must provide a copy of their signature to pharmacy before being able to order medicines; signatures are to be supplied using the registered nurse specimen signatures for pharmacy form – appendix 5. The ward manager is responsible for ensuring the authorised signatories list is up to date.

All Doctors and NMP's who order medication including controlled drugs must provide a specimen signature to Pharmacy. Records of authorised signatures for ordering medicines will be maintained by the Chief Pharmacist. The medicines signature list is to be sent to the relevant locality pharmacy when there are staff changes.

All records relating to medicines must be retained, stored confidentially for a set period of time and destroyed as per the Medicines - Retention of records

Local pharmacy procedures may differ between sites

5.1 Patient's own drugs

For further guidance, please refer to Patients Own Drugs procedure

Patients own controlled drugs must be stored in the controlled drugs cupboard and the receipt and use recorded in the controlled drugs register. (see Controlled drugs Standard Operating Procedures)

Where PODs are used for administration to a patient or stored in individual medicine cabinets for self-medication, it is the responsibility of the Designated Practitioner to ensure that the PODs are transferred with the patient if they are moved to a new location. The medication transfer book must be used to document the transfer of PODs.

At discharge the Designated Practitioner, pharmacist or pharmacy technician must check the patient's own drugs against the discharge prescription. If the items are no longer required, appropriate advice should be given to this effect and the patient encouraged not to take the medicines home. A record of the conversation must be made in the electronic record. If there has been a change to treatment or if additional medicines are required, supplies should be dispensed by pharmacy.

5.2 Ward stocks

Medicines kept as a ward stock will normally be the medicines that are commonly prescribed for the patients on the ward but may also include medicines that are not regularly used, but timely access is important. Ward stock lists differ significantly from one ward to another.

Care should be taken to avoid over ordering while still maintaining sufficient stocks.

Stock medicines may be ordered via the pharmacy top-up service on a scheduled visit by generating an electronic stock order via the pharmacy dispensing system.

Designated Practitioners can order stock medication in between the scheduled pharmacy top up visit if there has been an increase in usage by emailing the order to the pharmacy locality inbox.

5.3 Individually dispensed medicines

Non-stock medicines are dispensed for an individual patient and labelled with the patient's name. Prescribers and Designated Practitioner's should order medication on the appropriate stationery for the locality. Pharmacy staff order medications for individual patients electronically using the pharmacy dispensing system.

If a patient is prescribed a medication that is not a POD or ward stock, then the medication must be ordered as an individual supply for that patient. The order must meet all legal requirements and standards for writing a prescription see Medicines prescribing and initiation of treatment procedure. When all required medication has been ordered on an inpatient prescription any remaining blank lines MUST be crossed through.

Where agreed, there may be circumstances where the prescription and administration record acts as the legal prescription and the items are ordered against this by nursing or pharmacy staff.

Judgment must be exercised in relation to length of patients stay, the prescribed frequency of medication (e.g., prn) and the cost of medication. Up to 28 days' supply of medication should be ordered.

Under no circumstances should medication be added to an order that has already been signed by a prescriber

A self-check of all orders should be carried out at the end of the transcribing process.

An appropriately accredited pharmacy technician can sign the orders if the prescription and administration chart has been clinically screened and signed by a pharmacist.

If the item is required urgently or it is outside pharmacy normal working hours follow the site - specific policy. Access to medicines and pharmacy services outside working hours.

Once the patient is discharged from the ward the remaining medicines should be stored in the unwanted medication area of the drugs cupboard on the ward until removed by a member of the pharmacy team

5.4 Receipt of medicines

The Appointed Practitioner in Charge is responsible for receipt and storage of all medicines.

All medicines must be delivered to wards/departments in secure, tamper evident, locked containers by a porter or pharmacy driver.

Once delivered to the ward/department/clinic the responsibility for the security of the medicine's rests with the Appointed Practitioner in Charge who will arrange for the contents to be unpacked, checked, and put away securely as soon as possible.

The Designated Practitioner must:

- ✓ Check the medicine against the delivery note for ordered ward stock medication.
- ✓ Sign the delivery note and keep it (for 2 years) as a record that the supply was complete.
- ✓ Lock the medicines in the medicine cupboard/trolley/locker immediately ensuring the stock is rotated. Medicines that require cold storage must be dealt with immediately.
- ✓ Report any discrepancies to the pharmacy immediately.
- ✓ For receipt of CDs – please refer to Controlled Drugs Standard Operating procedures

When the Designated Practitioner is unavailable a delivery of medicines may be accepted by another appropriate member of trust staff. When this happens the receipt of the delivery must be signed for on the pharmacy delivery sheet by that member of staff, who must assume responsibility until the delivery can be handed over and signed for by the Designated Practitioner. The member of staff taking receipt of the delivery must place the delivery in a designated secure non patient area and communicate with the Nurse in charge as soon as possible.

5.5 Medicines for leave and discharge

Only medicines labelled with the patient' name and appropriate directions can be given to patients to take home.

Ward stock medicines must not be used for this purpose.

Medicines including CDs for leave and discharge are supplied for an individual patient who has authorised leave from the ward or who is to be discharged. They must be obtained in advance by sending a completed leave/discharge prescription to the pharmacy. Leave and discharge prescriptions must state the number of days treatment required.

Multi compartment compliance aids should not be requested at the point of discharge. Patients must be assessed appropriately, and support accessed for continuation of dispensing in this format, see Medicines – Multi Compartment Compliance Aids

Only in exceptional circumstances should a patient leave the ward without the medicines they require.

5.6 Collection of leave and discharge medicines from Pharmacy by patients

Supplies for leave and discharge should be sent to the ward for issue to patients (see section 5.5).

5.7 Handling discharge / leave prescriptions on the ward / department

It is important that the patient receives adequate information about their medicines prior to discharge. The patient should know the purpose of the medicine, how to take it and for how long it is to be taken. Where needed, a medicines reminder chart, detailing the patient's medication, should be completed. It is the responsibility of the Designated Practitioner who discharges the patient from the hospital to ensure that the patient has received adequate information about their medicines. Where possible medicines for leave or discharge should be shown to the patient, to confirm the patient's understanding of their treatment, prior to leaving the ward.

When a handwritten prescription is used, the duplicate copy of the leave/discharge is to be stored in a file in a designated secure location for the appropriate length of time and then archived as per retention of records procedure. Where an electronic patient record prescription is used, an entry on the electronic patient record listing all medications and number of days prescribed is sufficient.

5.8 Sample medicines

No samples of medicines or dressings may be left on wards or departments. Representatives of pharmaceutical companies wishing to leave samples must be referred to the Chief Pharmacist.

5.9 Storage and security of medicines

Once medicines are received onto the ward or department the Appointed Practitioner in Charge is always responsible for ensuring the safekeeping of the medicines which includes both environmental and security aspects.

Medicines storage areas should be locked and secure. All medicines cupboards, trolleys and medicines fridges must be lockable and locked when not in use. Medicines should be adequately segregated (see section 5.10)

The lead pharmacist, medication safety officer, local security management specialist and relevant lead nurse should be involved from an early stage when planning to upgrade or build new medicines storage facilities and approve final plans.

The construction of medicine cupboards (except automated drug dispensing cupboards and those used for patients own medicines) to be used for internal (for use within the body) and external (for

use on the body) medicines should comply with the current British Standard (currently BS2881 1989,-NHS Estates Building Note No.29), which states they should be metal cupboards.

The security and physical storage conditions of medicines on wards and departments will be checked periodically by pharmacy staff who will carry out inspections of medicine stocks with reconciliation where necessary.

The necessity for checking stock balances of medicines, other than controlled drugs, will be determined by the Chief Pharmacist following discussion with the Appointed Practitioner in Charge and appropriate Service Manager.

If there is a suspicion of medicine diversion this should be reported to the Chief Pharmacist who will take appropriate action.

5.10 Storage accommodation

Clinical areas require suitably sized storage facilities for all medicines. Medicines should be adequately segregated, clearly displayed, and accessible. This may include the following:

- Controlled drugs cupboard – secured to a wall and reserved for the storage of controlled drugs. See Controlled drugs Standard Operating Procedures
- Oral solid and liquid medicines
- Injectable medicines
- Medicines to take home (leave/discharge)
- Medicines administered rectally
- Medicines to be administered externally e.g., creams, lotions
- IV fluids
- Flammable medicines
- Patients own medicines
- Medicines requiring refrigeration – The medicine refrigerator is solely for the storage of medicines. Food or pathological specimens must not be stored in the medicine's fridge.

Issues to consider include the location of the room, layout, and environmental conditions e.g., temperature, lighting

Good lighting levels should be provided to medicines storage and preparation areas (see CIBSE's (2019) LG02/19 'Lighting guide')

Where electronic systems for administration are in place, the room where medicines preparation and administration occur should have internet and intranet access and access to a power supply. If it is safe to do so and administration occurs at the point of care, mobile access to IT is required.

Medicine trolley - for storage of medicines in current use, including patients own medicines, on the medicine administration round. When not being used the medicine trolley must be locked and secured to the wall. The trolley must not be left unattended during the medicine round. If the Designated Practitioner leaves the trolley, it must be locked immediately. In areas using medicine trolleys with individual lockers or medicines cupboard with individual drawers the same principles of security apply.

Medicines for medical emergency - must be readily accessible but securely stored to prevent unauthorised access. These may be held in a tamper evident bag which should not be locked in a cupboard. If used, the emergency drug bag replacement medication form must be completed, and the pharmacy contacted to arrange for replacement. The location of the nearest emergency drug bag and defibrillator must be displayed in the clinic of the ward.

Medicines must be stored safely and securely in the correct type of cupboard.

Note – Storage of CDs must meet the requirements of the Misuse of Drugs (Safe Custody) Regulations 1973.

To ensure compliance with BS 2881, metal cupboards should be provided for medication storage. This excludes patient's bedside medication storage and automated medication cupboards.

Medicines storage areas should be secure, and risk assessed.

Sizes of medication cupboards should be determined locally, considering the clinical nature of the ward and the agreed stock list.

The following recommendations for medicine storage in clinical departments are taken from the NHS document 'Health Building Note 14-02 – Medicines storage in clinical areas May 2021'

The cupboard sizes given apply to a general 24-bed ward. All sizes shown are in mm and represent height x width x depth of the storage cupboard or unit. However, exact requirements should be determined locally.

Category of medicine	**Cupboard size**	**Cupboard quantity**	**Storage requirements**
Controlled drugs	Nominal cupboard size: 550 x 500 x 300	Dependant on quantities of CDs to be stored	A cupboard within a cupboard is not recommended. High doses (30mg or greater) of morphine and diamorphine should be stored on a separate shelf in CD cupboard
Oral solid medicines	*Nominal cupboard size: 550 x 1000 x 300 Nominal tall cupboard size:1800 x 500 x 600	3 to 5 *double wall cupboards or equivalent. multiple cupboards depending on patient group or tall cupboards, quantity to suit.	It should be possible to adjust the position of the shelves within these cupboards to allow for the wide range of product sizes. Physical barriers (dividers) should be used to separate products with similar names
Injectable medicines		Determined locally. Typically, 2 double	

		cupboards or tall cupboards	
Oral liquid medicines and rectal medicines	Nominal cupboard size: 550 x 500 x 300	Determined locally.	Note oral liquid medicines should be able to be stored upright after opening
Medicines to take home	Nominal cupboard size: 750 x 500 x 550.	Determined locally. Dependent on clinical nature of the ward	This cupboard will be used for prepared discharge medication, which may be bulky.
Flammable medicines	Nominal cupboard size: 550 x 500 x 300	Determined locally. Dependant on quantity and flammability of the medicines.	Lockable metal cupboard. Risk assessment undertaken to assess whether a fire resisting cupboard is required, dependant on quantity and flammability of the medicines. Clearly labelled with flammable warning labels
Refrigerated medicines	Undercounter nominal pharmaceutical refrigerator: 850 x 595 x 550		
Patients own medicines	Patients own medicines should be stored in locked medicines cupboards beside the patients' beds. Nominal metal cupboard size: 300 x 400 x 150	*Note: For TEWV this will be for patient's risk assessed to undertake self-medication scheme*	Positioning of cupboards should be considered to minimise health and safety risks, heat sources

Medicines Storage requirements

The following table shows the storage requirements for different categories of medicines

	Patients' own medicines	Medicines (excluding Controlled Drugs)	Medicines storage (major requirements) Medicines requiring cold storage[1]	Controlled drugs
Temperature	Ambient (not above 25°C): reduce days held	Ambient (not above 25°C)	Refrigerator (2°C-8°C), or freezer	Ambient (not above 25°C)
Regulatory and standard security levels (BS 2881 or Sold Secure Standard (SS) 314)	Not applicable	BS 2881 Security Level 1 (i.e. no entry in 5 min. knife attack & in medical or staff observed location & resistant to 980 Newtons downward force); or SS 314 'bronze' + C.2.2* (i.e. no entry in 5 min. manual attack in medical or observed location).	Solid or glass door (to facilitate product selection).	Misuse of Drugs (Safe Custody) Regulations 1973. BS 2881 Security Level 2 (i.e. no entry in 15 min. planned attack & resistant to 980 Newtons downward force); or SS 314 'silver' + C.2, C.3 & C.4* (i.e. no entry in 5 min. planned attack). The requirement for alarm systems and other additional security measures (e.g. CCTV) for controlled drugs in clinical areas within hospitals will require a local risk assessment and will be dependent on the quantity stored and 24-hour presence of staff.
Access control[2]	Should be locked with patient access but risk assess for clinical safety e.g. inhalers & insulin	Lock to comply to BS 3621 (room or cupboard) & to be locked when not in use. Electronic keys and appropriate electronic access cards preferred to ensure suitable audit trails of storage access can be maintained.	Based on risk assessment: Lock to ensure content is secure and door automatically locks when closes, or use auditable electronic control/monitoring. Electronic keys and appropriate electronic access cards are preferred to ensure suitable audit trails of storage access can be maintained.	Lock to comply with BS 3621 (room or cupboard) & to be locked when not in use. Electronic keys and appropriate electronic access cards are preferred to ensure suitable audit trails of storage access can be maintained.
Other guidance:		"Professional guidance on the safe and secure handling of medicines" (RPS, 2018)	• "Professional guidance on the safe and secure handling of medicines" (RPS, 2018) • "Control of medicinal product temperatures" (MHRA)	"Professional guidance on the safe and secure handling of medicines" (RPS, 2018)

Notes:

1. For medicines that require freezer storage, specialist advice will be required on the appropriate storage requirements.
2. There is a need to identify the requirement for suitable access-controlled key storage for medicines storage in areas not staffed 24/7 e.g. imaging or day case etc. This is essential for controlled-drug storage and may require a key safe in a staffed area.

* References to C.2, C.3 and C.4 are to clauses (and sub-clauses) in Appendix C of BS 2881 on the siting and fixing & installation of cupboards, and alarm systems to be used. A departure from the recommendations in this Table must be by risk assessment and supported by the responsible lead pharmacist & other relevant clinical staff.

Where medicines storage is not in a continually monitored area, consideration should be given to installing BS 2881 Security Level 3 or SS 314 'gold' together with other additional security including alarms and monitoring.

Definitions/abbreviations:

Patient's own medicine = held by/for them, e.g. in bedside cupboard or a self-dispenser
Medicines storage = held communally for distribution to multiple users; usually held in a dedicated room, cupboard, refrigerator or freezer Ambient = room temperature

IV = Intravenous

Taken from Health Building Note 14-02 – Medicines storage in clinical areas 2021

From the time of receipt until use or removal from the organisation, all medicines should be kept secure, with access only by authorised personnel. This includes medicines brought in by patients but not required for treatment. The legal requirements related to the category of medicine should be applied.

5.11 Sites for cupboards and trolleys

When siting medicines cupboards and medicines trollies the following should be considered:

- Store in a clean utility room which is lockable and accessible to authorised staff only
- Not visible from an outside window at ground level
- Not be positioned near sources of heat e.g., radiator. Where there are windows in a room, blinds should be fitted to support temperature management
- Have running water and a hand wash basin accessible
- The height of the top shelf of the cupboard should be safely accessible by staff.
- Room temperatures should be maintained at 25oC or less – see appendix 4.

5.12 Storage of self-administered medicines

All medicines for self-administration must be kept in an individual patient's medicine cabinet, the medicine trolley or other secure storage. A risk assessment must be carried out before siting individual patient medicine cabinets. Individual arrangements for patients who require having personal control of their medication e.g., inhalers or GTN spray should be agreed with a pharmacist. See Self Medication Procedure

5.13 Storage of refrigerated medicines

Heat sensitive medicines requiring storage below room temperature will be marked "Store between 2°C and 8°C, in a refrigerator." They must be stored in a pharmacy approved, locked medicines refrigerator with fan assisted cooling and have a temperature range of 2°C and 8°C reserved solely for the storage of medicines and not in domestic refrigerators.

The efficacy of these medicines may be reduced if the cold chain is not maintained during transport and storage up to the point of use.

When medicines are delivered to a ward/department those items requiring refrigeration should be checked immediately and placed in the refrigerator.

Refer to the Temperature monitoring of medicine fridges and medicine storage areas procedure (Appendix 4)

5.14 Flammable liquids, gases, aerosols

Contact the local Fire and Safety Officer for advice.

5.15 Medical gases

Medical gases should be stored safely, in an area with clear signage, be secured and away from sources of direct heat.

- Oxygen & other medical gases – administration, prescribing, storage and safety

5.16 Locks and custody and safe keeping of medicine cupboard keys

All cupboards closed storage units (i.e., with doors) and fridges in which medicines are stored must be lockable and should be locked when not being accessed. Locks for metal cupboards (except patients' drugs cabinets) must comply with BS 3621.

Locking mechanisms except mechanical keys can be used and must comply with BS 3621 e.g., keypads, electronic keys fingerprint recognition. Systems are to be in place to update systems when staff leave, or incidents have occurred, and codes changed regularly. Doors should lock automatically on closing. A ward can have locks that use an identical key for all stock cupboards (except CD cupboards) with the availability of copies of the key.

All medicine cupboard keys are the responsibility of the Appointed Practitioner in Charge. Custody of the medicine cupboard keys are the responsibility of the Designated Practitioner in Charge.

A second set of keys should be kept in an appropriate, secure location, such as a key cupboard in a staff only area.

5.17 Key for the controlled drugs cupboard

The controlled drug cupboard key must be kept separately from the ward keys Controlled drugs Standard Operating Procedures.

5.18 Keys for medicine cupboards, medicine trolleys and refrigerators

The keys for the external medicine cupboard, internal medicine cupboard, medicine trolley and medicine refrigerator must be kept together on one key ring reserved solely for these keys. The keys must be clearly identified.

The keys must be kept on the person of a Designated Practitioner. In the event of no Designated Practitioner being on duty in a ward or department, the keys shall be handed to a Designated Practitioner on a ward or department in the near vicinity. This information must be made known to the staff on both wards/departments.

Keys must not be relinquished to any unauthorised person, i.e., nurses not assigned to the ward/department, medical staff, or other personnel (except for pharmacy staff in the course of their duties). When providing the keys to a member of the pharmacy team, the pharmacy staff member must be able to be positively identified or steps put in place to enable the identity to be checked.

At community team bases where a number of Designated Practitioners may require access to the medicine cupboards at different times a secure system must be agreed between the Appointed Practitioner in Charge and a Pharmacy Technician or Pharmacist to limit access to authorised staff.

5.19 Keys to individual patient's medicine cupboards

The master key for individual patients' medicine cupboards must be always kept on the ward medicine cupboard key ring and must never be issued to a patient.

Keys that open individual patient medicine cupboards/ lockers must be individually numbered and stored in a locked cupboard on the ward when not in use. See Self Medication Procedure

5.20 Loss of a medicine cupboard key

Every effort must be made to find the key or retrieve it from off duty staff. Should access to the medicine cupboard be required before the keys are retrieved the Designated Practitioner in Charge should access the duplicate key. If there is no duplicate key, they should arrange for the cupboard to be broken open and a new lock fitted. Medication must then be moved to an appropriate secure and locked location. If out of normal working hours loss of keys should be reported to the Duty Manager. **An incident form must be completed.**

5.21 Closure of a ward or department

If a ward or department is due to close or move to another location, the Pharmacy Team must be contacted for advice.

6 Transport of medicines

Staff engaged in the transportation of medicines should carry Trust identification and have received appropriate Trust training relevant to the role.

The medication transfer book must be used to log all medicines transferred when:

- Patients are transferred between wards
- Stock medication is loaned between wards outside of usual pharmacy opening hours

This provides an audit trail for transferred medications.

Once complete the medication transfer book is to be stored confidentially for two years from the date of the last entry and then shredded in a confidential secure way.

Equipment used in the transport of medicines should be designed to ensure the security, integrity and quality of the medicine is not compromised and where appropriate the cold chain is maintained.

Below are the details for a bag and seals recommended to be used for the transportation of medication. They can be ordered by raising an NCI order on Cardea and are as follows

- Versapak Secure Holdall - Product Code CCBX Large (CCBX3): 584 x 406 x 254mm (23w x 16h x 10d")
- Versapak Patented T2 Plain Security Seals Product Code PLAINT2

Transfer of medicines outside the healthcare organisation should always be authorised and receipt acknowledged by the receiving body.

Where intermediate carriers (agents, taxis) are used, recording of collections and deliveries should be in place.

6.1 Transport of medicines from pharmacy

All medicines should be transported in sealed, tamper evident containers. Medications requiring maintenance of the cold chain are to be transported in cool bags.

6.2 Transport of medicines between TEWV health services premises

Medicines accompanying a patient being transferred from one hospital to another may be transported between hospitals with the patient in an ambulance or by authorised hospital transport, or taxi. It is important that medicines are packaged securely and are labelled with the destination.

When a patient is transferred from another TEWV ward, all non-stock medication (including non-stock-controlled drugs labelled for the named patient) and PODs should be transferred with the patient in a tamper evident bag or box. The medication transfer book must be completed to maintain the medicines audit trail. See appendix 2a, 2b, 3

6.3 Transportation by taxi

Taxis can be used to deliver to Trust wards or units. In addition, in extenuating circumstances, such as adverse weather conditions, hospital contract taxi drivers can deliver medicines to community patients providing a risk assessment has been carried out and documented on patients' electronic record.

Items must be collected in secure tamper proof packaging from the pharmacy, or a ward or unit as agreed with pharmacy.

A system for recording collections and receipt of deliveries must be in place.

6.4 Transport of medicines to individual patients at home

Medicines may be transported home by patients or their carers following a hospital attendance or on leave/discharge.

In exceptional circumstances, patients or carers who have left the hospital before all their medicines have been dispensed may be requested to return to the hospital later to collect their medicines.

Medicines may be transported to the patient's home (or sometimes to a local Health Centre or Community Pharmacy for subsequent collection) by authorised hospital transport, by post using the special delivery or in extenuating circumstance by hospital contract taxi drivers. It is important that medicines are packaged securely and are labelled with the destination.

6.5 Transportation of medicines by community bases staff

6.5.1 Delivery of medicines to community patients

Community staff (Registered Practitioners, Non-Registered Practitioners or Allied Health Professionals), as part of their role in the clinical treatment of patients, may deliver medicines as part of the overall care package.

This aspect of care must be documented in the care plan and the patient must be known to the member of staff delivering the medicines.

An audit trail recording receipt of medicines by community staff for transportation must be maintained.

A Trust identification badge should be worn or carried by all staff carrying medication.

All medicines must be transported in a locked box/case or tamper evident containers such as a locked briefcase or locked box out of sight within the locked boot of a car.

A selection of bags recommended for the transportation of medication has been identified but it is not mandatory that these bags are purchased. They can be ordered by raising an NCI order on Cardea and are as follows:

- Small – Elite Community Nurses Bag SKU: EB136
  - 36 x 26 x 10cm
  - Weight 1.2kg
  - Capacity – 9 litres

- Medium – Community Nursing Bag SKU: EB01.008
  - 35 x 25.5 x 14cm
  - Weight 1.35kg
  - Capacity – 12.5 litres

- Large - Elite Comfort Nursing Bag SKU: EB124
  - 40 x 30 x 13cm
  - Weight 3.35kg
  - Capacity – 15 litres

Medication must be handed to the patient (or the carer if they are known to the team). A record of delivery and receipt of the medication can be recorded on the patients' electronic record (which can act as the audit trail).

Any refusals to accept delivery must be documented in the patient's record. If medicines cannot be delivered, they must be returned to the community base on the same day and stored securely.

Medicines must never be posted through letter boxes or left with a person unknown to the team.

6.5.2 Transporting medicines for administration to community patients

Medicines carried by a Community Practitioner for administration must be prescribed as a specified dose for a named patient by a prescriber.

When carrying medicines for IM administration the lockable box/case supplied by the Trust should contain as a minimum the prescription chart, syringes, needles, disposable gloves, leak proof sharps container, and plasters. See Antipsychotic Depots Long-Acting Injectable (LAIs) prescribing administration medicines management guidelines.

Each medicine to be carried must be accompanied by the written prescription on the relevant medicine card and the dose administered must be recorded.

If medicines cannot be administered, they must be returned to the community base on the same day and stored securely.

6.5.3 Transporting and observing medication for self-administration by Non-registered Practitioners & Allied Health Professionals (AHPs)

Any Non-registered practitioner (NRP) or Allied Health Professional (AHP) may carry and deliver medicines to patients who can self-administer following the "Supporting patients with medication at home pathway" (Appendix 6). The patient must be able to complete this task independently. The NRP/AHP must not be involved in any part of the administration process (e.g., tablet manipulation in removal from packaging, including blister packs). Any patient requiring support to attend to any part of this process should only be visited by a Registered Nurse

Any NRP/AHP involved in this process MUST have completed the safe and secure handling of medication eLearning module on ESR and the Trust NRP/AHP introduction to mental health medications and side effects training.

6.5.4 Removal of medicines from community patients

Whenever possible, patients or carers should be encouraged to return any unwanted medicines to the community pharmacy. Trust staff should not be routinely removing medicines from patient's homes for destruction. See Patients Own Drugs procedure

However, in the interests of patient and public safety medicines that pose a risk to community patients should be removed if they cannot be returned by the patient or carer. An audit trail of any medicines removed must be maintained by completion of the Community settings - Consent for destruction of patient's own medicines (PODs) form, (see Patients Own Drugs Procedure). If a patient or carer does not consent to removal the risk must be escalated to the responsible clinician for action.

Non-Registered Practitioners or Allied Health Professionals should always refer to a Registered Practitioner or prescriber prior to removing any medicines from a patient's home.

Any medicines removed should be taken to the nearest community pharmacy for disposal as soon as possible or by the end of the working day. Medicines removed from a patient's home must not be stockpiled at community bases, left in cars, or taken home by staff. The community pharmacy staff member should be requested to sign the Community settings - Consent for destruction of patient's own medicines (PODs) form acknowledging receipt of the medicines and the form filed in the patient's notes. This audit trail provides protection for staff when removing medicines from a patient's home.

If medicines are removed out of normal working hours, they should be taken to the nearest trust premises with medicine storage facilities. The medication should be taken to the community pharmacy the next working day, with completion of Community settings - Consent for destruction of patient's own medicines (PODs) form.

7 Disposal of medicines

The introduction of the Hazardous Waste Regulations in 2005, The Waste (England and Wales) Regulations 2011 and the review of the legal controls on all aspects of controlled drugs have led to significant changes to the way that medicines are disposed of.

7.1 General principles

Medicines that are no longer to be administered to a patient, for whatever reason, should normally be disposed of via the Trust system for dealing with clinical waste. Medication no longer needed must be stored in the designated unwanted medication section of the medicines cupboard on the ward/clinic until removed by pharmacy staff.

Medicines must never be disposed with domestic type waste.

Most medicines are not considered to be hazardous waste but are still subject to controlled disposal. Only cytotoxic/cytostatic medicines waste is considered hazardous, and this is subject to additional control (consult pharmacy for full list of hazardous medicines).

Within Pharmacy medicine waste for destruction will be secured in designated bins and labelled appropriately. A consignment note for destruction of waste will be completed at the point of waste collection by the contracted waste management company and a copy retained by pharmacy.

Additional controls apply to the disposal of controlled drugs to make them irretrievable from the waste (Controlled drugs Standard Operating Procedures)

7.2 Disposal of controlled drugs

See Controlled Drugs Standard Operating procedures

7.3 Disposal of part-used medicines and medicines prepared and subsequently not given

Once medicines are prepared for administration, they must never be returned to the container from which they were originally taken, nor stored in another container on the ward or department.

Medicines such as half tablets, part used injections and refused doses, other than cytotoxic/cytostatic, should be disposed of in a sharp's container along with the syringes, needles and ampoules used during the preparation and administration process. The sharps bin will then be incinerated.

7.4 Disposal of part used cytotoxic / cytostatic medicines

Small quantities of cytotoxic/cytostatic medicines (i.e., doses prepared and not administered and unused part-doses etc.), syringes, needles, ampoules may be disposed of in a sharps container specifically reserved and labelled for this type of hazardous waste and disposed of via the waste disposal service. Contact the pharmacy team for advice related to cytotoxic/cytostatic medication.

7.5 Disposal of suspected defective medicines

Suspected defective medicines and medicines involved in any suspicious or unusual incident must not be destroyed. Follow Medicines - management of alerts, recalls and reporting or contact the Pharmacy Team immediately for advice.

7.6 Disposal of patient's own drugs

See Patients own drugs procedure

See Section 10.7.3 for Controlled drugs belonging to patients (see Controlled drugs Standard Operating Procedures)

7.7 Interpretation of expiry dates

Expression	Interpretation
Use by May 2021 Use by 20 May 2021	Do not use after 30 April 2021 Do not use after 19 May 2021
Use before May 2021 Use before 20 May 2021	Do not use after 30 April 2021 Do not use after 19 May 2021

Expires 31 May 2021 Expiry date 31 May 2021	Do not use after 31 May 2021 Do not use after 31 May 2021
Expires May 2021	Do not use after 31 May 2021

See MSS 16 Medication Expiry Dates

7.8 Pharmacy endorsements on the prescription and administration record

Expression	Interpretation
Use by May 2021 Use by 20 May 2021	Do not use after 30 April 2021 Do not use after 19 May 2021
Use before May 2021 Use before 20 May 2021	Do not use after 30 April 2021 Do not use after 19 May 2021
Expires 31 May 2021 Expiry date 31 May 2021	Do not use after 31 May 2021 Do not use after 31 May 2021
Expires May 2021	Do not use after 31 May 2021
Endorsement in pharmacy comments box	Interpretation
POD	Patients Own Drugs
P	Named patient supply
S	Stock medication
SM	Self-medication
OSD	One stop dispensing
CD	Controlled drug medication

See MSS 16 Medication Expiry Dates

8 Definitions

Term	Definition
Administration	• Giving a medicine by the introduction into the body orally or by injection or by external application e.g., cream or ointment.
Allied Health Professionals (AHPs)	• Professions allied to medicines who are regulated by a professional body e.g., physiotherapists, occupational therapists, dietitians.
Appointed Practitioner in Charge	• The senior nursing appointment for the ward or department e.g., ward manager, community nurse or team manager with 24-hour responsibility for that ward, team, or department.
Associate practitioner	• Associate practitioners have skills and experience in a particular area of clinical practice and develop a high level of knowledge and skill through their experience and training. They are not registered healthcare professionals and do not administer medication.
Controlled Drug	• Any medicine regulated by the Misuse of Drugs Act 1971. This may also include any locally agreed substances that it would be appropriate to monitor.
Controlled Stationery	• All stationery, which in the wrong hands, could be used to obtain medicines fraudulently e.g., pharmacy requisition books, Trust prescription forms and FP10 prescription forms.
Designated Practitioner in Charge	• The senior nurse on duty for the ward or department who has been identified as the nurse in charge for a particular span of duty.
Designated Practitioner	• Any registered nurse who has been identified by the Appointed Practitioner in Charge as competent and appropriate to perform a specific function
Dietician	• A dietitian with a current registration with the Health professions Council
Dispensing	• To prepare a clinically appropriate medicine for a patient for self-administration or administration by another. The act of dispensing includes supply and encompasses a number of other cognitive and practical functions which are usually performed under the supervision of a pharmacist
Illicit Substance	• A substance covered by the Misuse of Drugs Act or other legislation, which is not lawfully held in accordance with the relevant legislation.

Licensed Medicines	• Medicines which hold a UK Marketing Authorisation and are being used in accordance with the terms of the marketing authorisation.
Nursing Associate	• Nursing Associates are registered with the NMC so work in line with the code. They administer medication with some exceptions (see Medicines Overarching Framework)
Non-Registered Practitioners	• Health care assistants and support workers who are not registered or regulated by a professional body.
Patient Group Direction (PGD)	• A specific written instruction, authorised by a doctor and a pharmacist, for the supply and/or administration of a named medicine in a specified clinical situation in the absence of a written prescription.
Pharmacist	• A pharmacist with a current registration with the General Pharmaceutical Council (GPhC).
Pharmacy Assistant	• A member of the pharmacy team organises ward stock top up orders and/or issues original packs of medicines to a ward or department against a list, under the supervision of a pharmacy technician and/or pharmacist. Dispense medicines against prescriptions/orders in a dispensary
Pre-registration Technician	• Pre-Registration Trainee Pharmacy Technicians (PTPTs) are trained within a pharmacy setting and complete a 2-year training programme
Pharmacy Technician	• Having achieved an NVQ3 qualification in Pharmacy with BTEC underpinning knowledge in pharmaceutical sciences or equivalent with a current registration with the General Pharmaceutical Council (GPhC). Pharmacy Technicians work under the supervision of a registered Pharmacist.
Senior Pharmacy Technician	• A Pharmacy Technician with a current registration with the General Pharmaceutical Council (GPhC) who has successfully undergone further training to undertake additional specified medicines management duties at ward/department level.
Lead Pharmacy Technician	• A Pharmacy Technician with a current registration with the General Pharmaceutical Council (GPhC) who specialises in an area of practice e.g., IT, medication safety
Chief Pharmacy Technician	• Professional lead for all pharmacy technicians, pre-registration trainee pharmacy technicians and pharmacy assistants.
Practitioners in Training	• Student nurses
Prescribers	• Doctors and suitably qualified nurses, pharmacists, and other designated healthcare professionals.

9 How this procedure will be implemented

• This procedure will be published on the Trust's intranet and external website.
• Line managers will disseminate this procedure to all Trust employees through a line management briefing.
• Via medicines management training for Registered Nurses
• Via Safe and Secure Handling of Medicines for non-registered practitioners

9.1 Training needs analysis

See Medicines Overarching Framework Policy

10 How the implementation of this procedure will be monitored

See Medicines Overarching Framework Policy

11 References

Underpinning legislation, information, and guidance:
Professional Standards for Hospital Pharmacy Services (RPS)
Health Building Note 14-02 – Medicines storage in clinical areas

12 Document control (external)

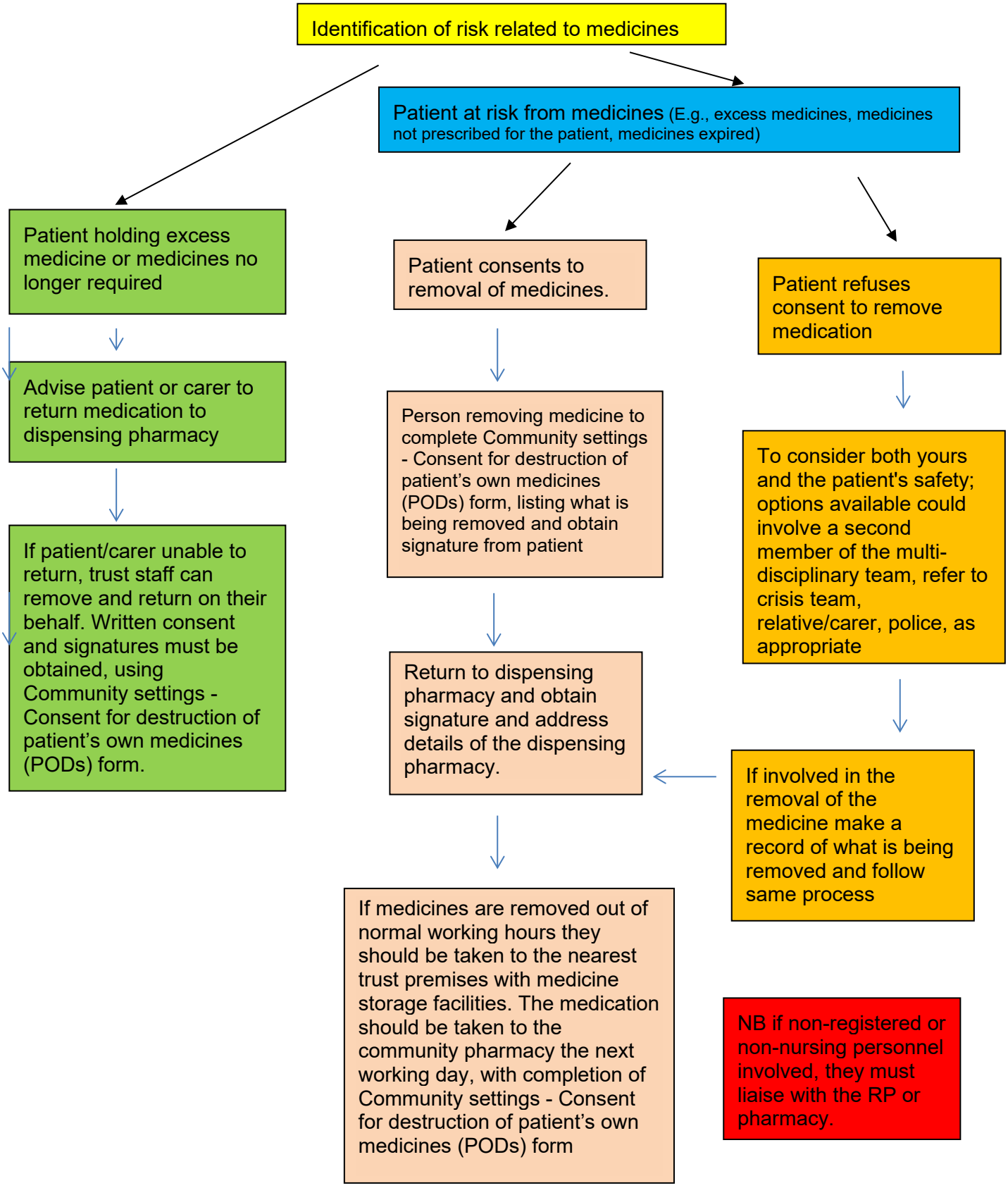
To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	28 March 2024
Next review date	01 February 2026
This document replaces	Medicines: Ordering, storage, transfer, security, and disposal PHARM-0002-004-v3
This document was approved by	The Drug & Therapeutics Committee
This document was approved	28 March 2024
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	N/A – Sits under the Medicines Overarching Framework EA
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
2.0	May 2018	Full review	Superseded
2.1	July 2018	Medicines room temp monitoring guide added	Superseded
2.2	July 2019	Updated to reflect Pharmacy Implementation	Superseded
3.0	December 2022	Full review	Superseded
3.1	28 Mar 2024	Amendments. Updated to reflect EPMA. Supporting patents with medication at home added	Approved

Appendix 1 – Removal of medicines from a patient's home



Appendix 2a -Transferring medication – when a patient is transferred between care settings

TRANSFERRING WARD

Gather all medication to be transferred

Check:

***Fridge** items (contact pharmacy team for advice for cold chain transportation)

***Controlled drugs** cupboard – note only patient own drugs or named patient supply can be transferred – **NEVER** stock

Patient's drawer/locker

Excess or overflow cupboards

Patient own drugs in use or awaiting return to the patient

Check prescription and administration record – are all medications available to transfer?

Yes

No

Contact receiving ward to ensure supplies are available.

If the item is not ward stock on receiving ward:

- Order in advance if time allows, or
- Minimum quantity of ward stock to be sent with the patient until supplies would be available to prevent omissions e.g., overnight or over the weekend (follow ward stock transfer process – note **MUST** be in original container)

If neither available contact the on-call doctor for advice.

Make required entries in the controlled drug register (if transferring named patient-controlled drugs) with an appropriate witness

Complete details of medication to be transferred in Medication Transfer Book

Confirm details are correct and sign, print name & date as the transferring nurse

Green pharmacy bags can be used.

Seals provided

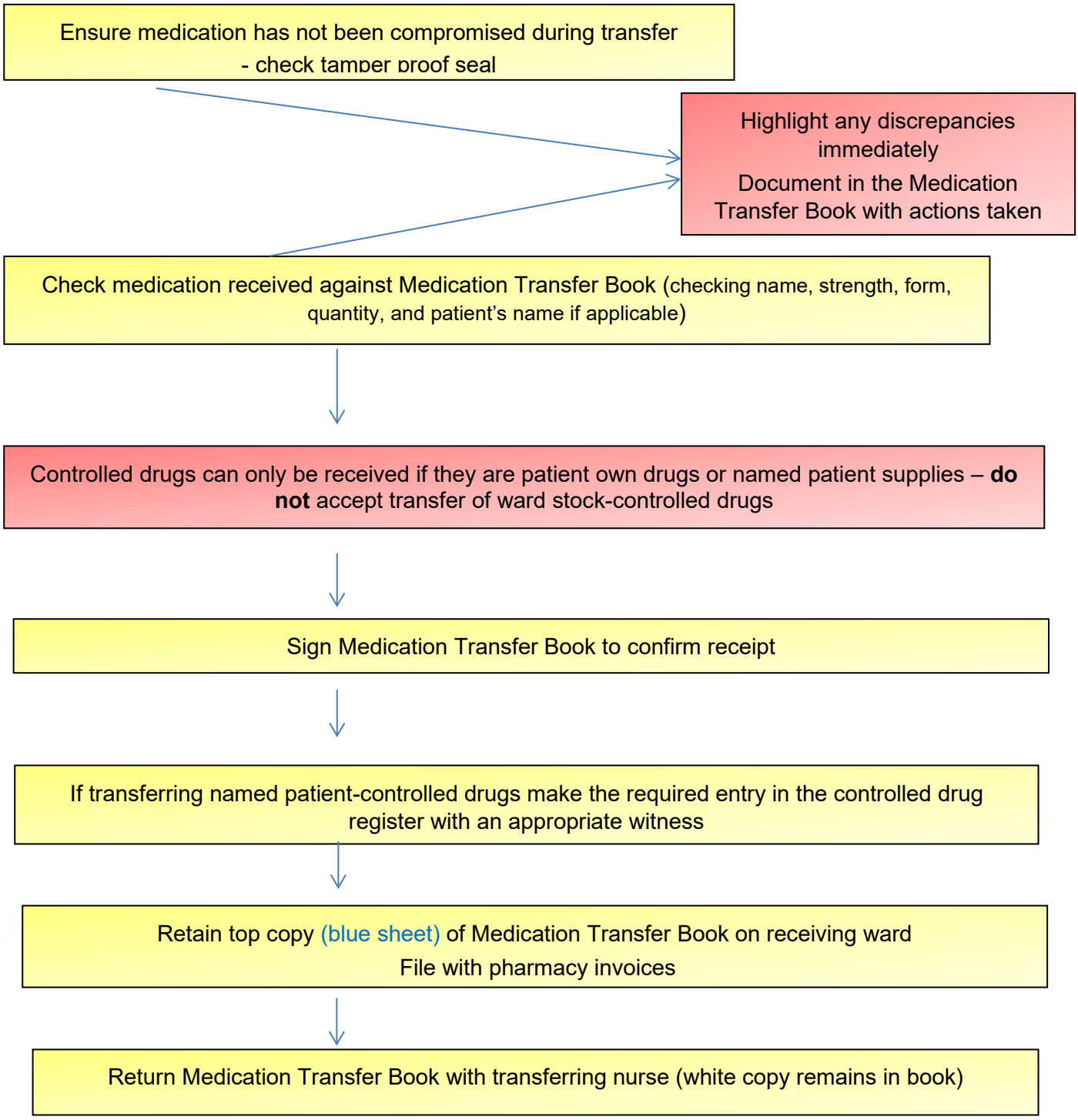
Seal medication in appropriate tamper proof container for transfer (for fridge items contact pharmacy team for advice)

Ensure Medication Transfer Book is returned to transferring ward following transfer

Appendix 2b – Transferring medication – when a patient is transferred between care settings

RECEIVING WARD

On receipt of medication

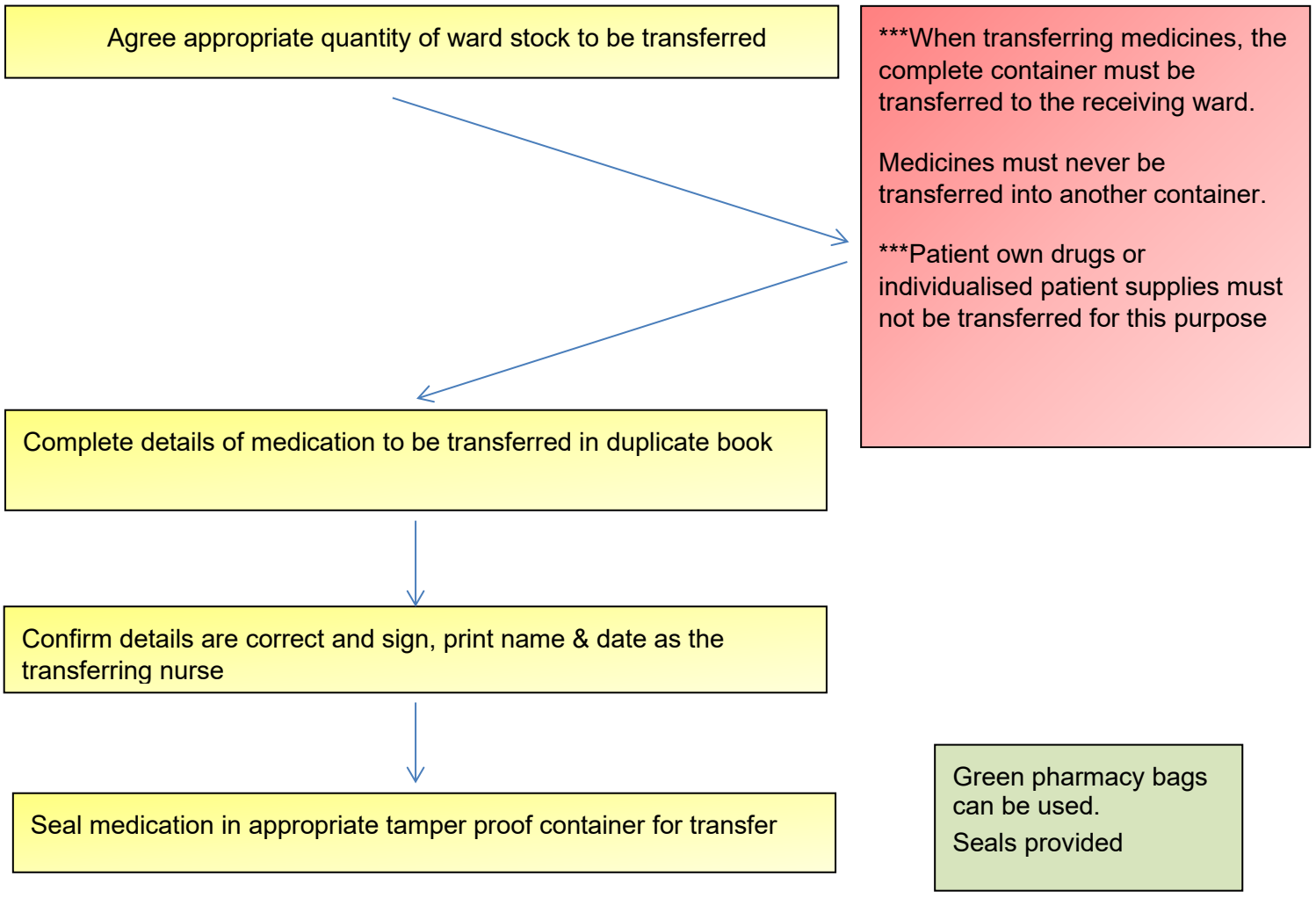


Appendix 3 – Transferring ward stock medication

Transferring WARD STOCK Medication (Previously Referred to As Ward Stock Loans)

PLEASE NOTE: Controlled drugs ward stock should **NEVER** be transferred between wards
(Contact Trust pharmacy team/on-call pharmacist if controlled drugs are not available)
Medication transfer (loan) from another ward must only take place when pharmacy is closed

TRANSFERRING WARD



Appendix 4 – Temperature monitoring of medicine fridges and medicine storage areas

Purpose

- To ensure all medicines fridges are maintained within a safe temperature range of between +2ºC and 8ºC.
- To take appropriate actions for consistent medicine storage room temperatures above 25ºC
- To ensure the temperature is monitored and logged daily and appropriate actions are taken to maintain the integrity of the medicines held within the fridge and the medicine storage area.

Scope

To cover all wards, units and CMHT's who may need to store medication.

Responsibility

The nurse in charge of the ward/unit/CMHT is responsible for ensuring this procedure is followed and may delegate a member(s) of staff to monitor the medicines fridge and room temperatures. The person with responsibility for the management of the ward or department has responsibility for ensuring staff are adequately trained and can comply with this procedure.

Process

The current, maximum, and minimum temperature of the refrigerator and room must be monitored and recorded each working day using a digital calibrated maximum-minimum thermometer. If the unit/ward is closed document this on the appropriate days for both the room and the fridge temperatures.

For the appropriate month, using the combined temperature monitoring sheet for medicines storage areas and medicines fridges located on the front of the fridge, record the following information:

- The minimum temperature – use correct procedure depending on thermometer type.
- The maximum temperature – use correct procedure depending on thermometer type.
- The current temperature – use correct procedure depending on thermometer type.
- After recording the above information reset the thermometer using correct procedure for thermometer type.
- Initial the form and return it to the front of the medicine's fridge.
- Completed forms must be filed and stored for one year.

At the end of each month, it is the responsibility of the nurse in charge of the ward/unit/CMHT to review the monitoring form and sign the bottom of the form

Medicines Fridges

Temperatures falling outside the accepted range

Lec medical model

The alarm will sound, and the HI symbol will flash on the panel if the current temperature has been out of range for 15 minutes or more, which means the cold chain has been broken. Take the appropriate steps below if this occurs:

- Immediately move the medication to another medicines fridge and inform the pharmacy team the next working day.
- If medication is needed for administration, contact on-call pharmacist for advice.

If the temperature goes out of range for less than 15 minutes the alarm will not sound. Therefore, it can be assumed that the cold chain has not been broken, and pharmacy advice is needed only if the alarm sounds and panel show HI.

Labcold Model RLDF0210

If the temperatures goes below +2ºC or above 8ºC the alarm will sound immediately. Take the appropriate steps below if this occurs. If after 6 hours, the temperature has not returned to an acceptable temperature then take the appropriate steps below

- Immediately move the medication to another medicines fridge and inform the pharmacy team the next working day.
- If medication is needed for administration, contact on-call pharmacist for advice.

High/Low Temperature Alarm

If the temperature in the refrigerator rises above 8ºC an alarm will sound and the front panel will display **Hi** and the current temperature inside the fridge alternately.

The cause of the rise in temperature should be investigated immediately. Usually, it is simply because the door has been open for a long time, for example while the fridge has been restocked; however, it is recommended that the fridge is checked to make sure that the temperature returns to normal over the next 6 hours.

If the temperature in the refrigerator drops below 2ºC an alarm will sound and the front panel will display **Lo** and the current temperature alternately. There could be a number of reasons for this, such as extremely cold items being placed in the fridge.

The cause of the drop in temperature should be investigated immediately and the refrigerator should be monitored to check that it returns to the correct temperature over the next 6 hours. Action must be taken by ward staff to find out when the room in which the fridge is located was last accessed to estimate a timescale when the temperature may have gone out of range.

Door Alarm

If the door of the fridge is left open for more than 90 seconds an audible alarm will sound, and the front panel will display door and the temperature inside the chamber alternately. To silence the alarm, for example while the fridge is being re-stocked, simply press the ‘alarm mute’ button under the temperature display

If the door has been left open for a prolonged period a Hi alarm may be heard. This is because warm air from the room will have entered the fridge while the door was open. It is recommended that the door is closed and check that the temperature returns to normal over the next 6 hours.

Note – document actions taken within the notes section on the temperature monitoring form including contacting pharmacy and estates.

Trust pharmacy team contact details

- Lanchester Road Hospital - 0191 4415778
- Roseberry Park Hospital - 01642 838360
- West Park Hospital - 01325 552105
- Cross Lane Hospital - 01723 384638
- Foss Park Hospital - 01904717780
- Medicines Information - tewv.medicinesinformation@nhs.net
- Out-of-hours – Access to medicines and pharmacy services outside working hours

Security

- Medicines fridges must be lockable and must remain locked when not in use.
- The medicines fridge must be kept always locked other than when being accessed for medicines

Maintenance of the medicine's fridge

- Food, drink, or pathological specimens should not be stored within the medicine's fridge. (Please note supplement drinks such as Fortisip are acceptable to be stored in the fridge).
- Medicines fridges are to be cleaned with warm soapy water monthly & the date of cleaning is to be recorded on the temperature record log in the notes section.
- The fridge should have auto defrost function OR should be defrosted every three months. A record of defrosting should be made on the temperature record log follow instructions supplied by the fridge manufacturer.
- Avoid ice build-up by not over stocking or blocking vents
- Avoid prolonged door openings and always make sure the fridge door is closed properly after use.
- Refrigerators should be connected to the mains via a fused spur to prevent the fridge from accidentally being switched off. Only unplug the fridge or switch off for maintenance purposes.
- In the event of accidental switching off or a power failure or temperatures recorded outside the manufacturers' recommended temperature ranges, the pharmacy should be contacted to confirm the medicines remain suitable for use before any are administered.
- Practice good stock rotation principles and ensure longer expiry dated stock of the same drugs are kept at the back (multiple drugs only).
- Only use fingertips with the thermometer (no pens or sharp objects)
- The Trust-approved temperature log sheet must be used.
- Store previous monitoring forms for one year.

Temperature Excursion - Escalation Process

Room

Room Temperature >25°C

- Record current, maximum and minimum temperature on record sheet
- Reset thermometer and place inside drug cupboard to establish ambient temperature of the drugs
- Record actions on temperature monitoring record
- Inform pharmacy team

Temperature remains high

- Inform pharmacy and request advice: Pharmacy to advise whether any specific medicines are at greater risk
- Complete incident report
- Contact estates & facilities
- Provide ventilation
- Record actions

No improvement

- Add to risk register
- Consider alternative storage arrangements in short term
- Consider long term storage options / requirements
- Appropriate actions could include provision of air conditioning or alternate methods of cooling / ventilation

journey to change

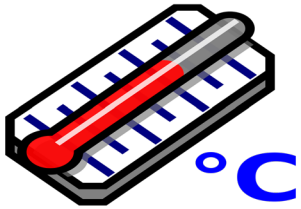
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Ambient Medicines Storage Room Temperature Monitoring

- The ambient temperature of any room used to store medicines outside of a refrigerator must be monitored and recorded at least once daily. This should be documented on the temperature monitoring sheet.
- It is best practice for this recording to take place during the afternoon, in-order-to account for peak room storage temperatures and enable appropriate action to be taken in a timely manner.

Where the ambient medicines storage room temperature exceeds 25°C:

- Action should be taken locally to reduce this by e.g., opening windows (whilst not compromising medicines security) or switching on available ventilation or air conditioning units
- Document action taken on monitoring sheet.



Remember the four "R's":

- **Read** the thermometer
- **Record** the temperature
- **Reset** the thermometer
- **React** to any temperature excursions

Where the ambient medicines storage room temperature exceeds 25°C for more than 7 days out of any 30:

- Seek advice from the Pharmacy team on the management of the medicines stored in the room (this may include a reduction in expiry date)
- Seek advice from Estates to identify any adjustments needed to storage room (s)
- Complete Inphase Report
- Document action taken on monitoring sheet

Where the ambient medicines storage room temperature rises above 30°C:

Ward Team:

- Inform the Pharmacy team so that specific advice can be provided where necessary.
- Take remedial action to reduce the temperature in the medicine storage room as quickly as possible and document, e.g., windows opened, portable air conditioning unit installed, drugs relocated, etc.
- Document action taken on monitoring sheet
- Visually inspect medicinal products carefully for signs of deterioration regularly.
- Complete Inphase report
- Any Controlled Drugs must remain in CD cupboard

Pharmacy Team:

- Consider storing more temperature-sensitive products in the fridge (if space is available) e.g., creams, ointments, suppositories, suspensions, emulsions & insulin
- Mark affected stock with a green cross and date to indicate stock that has been stored in temperatures >30°C and document revised expiry date
- Order non-ward stock (patient specific) items for a maximum of 14 days
- Top up to minimum stock levels only Medicine returns from affected wards should not be

Temperature Excursion - Escalation Process

Medicines Fridge

Fridge Temperature outside of 2-8°C

- Record current, maximum and minimum temperature on record sheet
- Reset thermometer and check temperature again
- Consider; power supply, ventilation, ice build-up, door left open - see procedure above
- Record actions on temperature monitoring record
- Inform Trust pharmacy team and ascertain whether medicines need to be disposed of or have expiry reduced
- Complete Inphase report

Temperature remains low / high

- Immediately move the medication to another medicines fridge and inform the Pharmacy team the next working day.
- If medication is needed for administration when pharmacy is closed, contact on-call pharmacist for advice
- Complete additional Inphase report
- Contact estates & facilities
- Record actions

No improvement

- Add to risk register (if appropriate)
- Consider continued alternative storage arrangements in short term
- Consider long term requirements including purchase of new fridge as appropriate. Medicines fridge to be ordered via cardea is the Labcold RLDF0219 model.

WARD / UNIT:		
MONTH:	**YEAR:**	**Fridge Model:**

Date	Time	Fridge Temperature Check Range +2°C to +8°C				Room Temperature Check Temp should be 25°C or less				Staff Initials	NOTES & ACTIONS Document when cleaned / defrosted / alarmed. An action must be recorded for every day a temperature is out of range (e.g., pharmacy contacted, estates contacted, pharmacy risk assessment)
		Actual Temp	Min Temp	Max Temp	Reset	Actual Temp	Min Temp	Max Temp	Reset		
1											
2											
3											
4											
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Completed record checked by:-	Date:-

Appendix 5 – Registered Nurse specimen signatures for pharmacy

Registered Nurse Specimen Signatures for Pharmacy	
WARD/DEPARTMENT	

Each registered nurse below should be authorised by the ward manager in the final column. The ward manager is responsible for ensuring the list is up to date. The original signature sheet should be held by the ward manager. Where there are any amendments made, a copy of the amended form should be resubmitted to the email inbox for the locality Trust Pharmacy department.

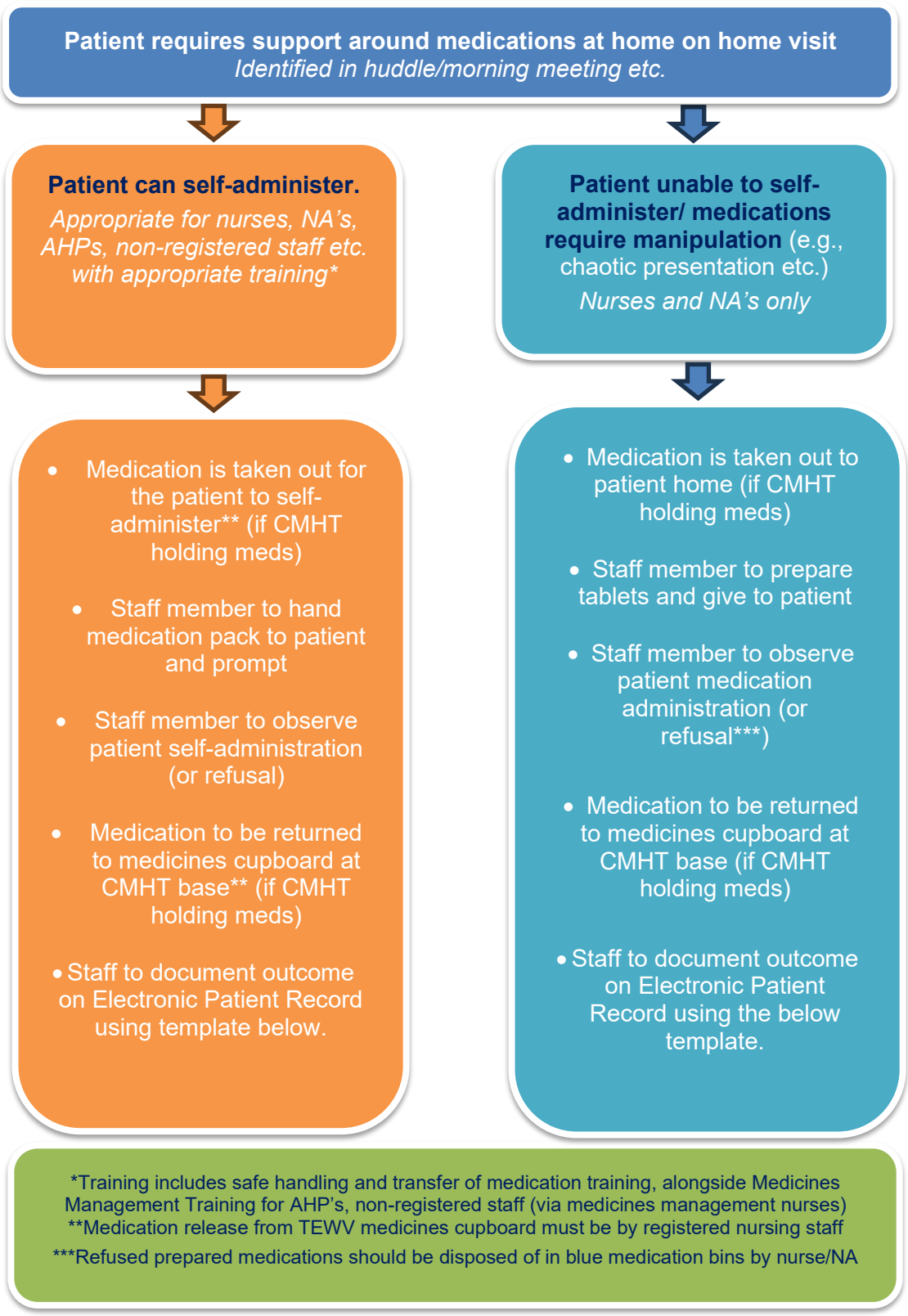
A copy of the up-to-date signature sheet should be kept in the front of the CD order book.

A copy of this form will be held within pharmacy. Only nurses authorised on this form may order medication including stock-controlled drugs. Pharmacy will not be able to dispense stock-controlled drugs if the ordering signature does not match their copy.

Print Name	Signature	Designation	Authorised by & date

Please scan a copy of the completed form and send to the local Trust pharmacy email
Tees Locality tewv.pharmacytees@nhs.net **Durham& Darlington Locality** tewv.pharmacycdd@nhs.net **NYY & S Locality** tewv.pharmacyyork@nhs.net

Appendix 6 – Supporting Patients with medication at home pathway.



Template for EPR

Medication observed: [name, strength, and form of medication].

Number of tablets administered *(nurses/NA's only)*/self-administered [delete as appropriate]**:**

Outcome: *Accepted / refused*

Remaining level of medication:

Appendix 7 – CMHT instalment medication log

CMHT INSTALMENT MEDICATION LOG

Name: **Date of Birth:**	**Team:**
Patient electronic number:	**Care Coordinator:**

Booking in Medication					Booking out Medication		
Date:	Medication Received:	Quantity (days):	Received by:	Received from: e.g., Foss Park, Service User, Local pharmacy	Date:	Quantity Removed (days):	Removed by:

Appendix 8 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	Pharmacy Overarching document
	Have Equality and Diversity reviewed and approved the equality analysis?		
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the document been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	