Document facilitator: Service Leader, Pharmacy

Senior document owner Medicines Review Committee

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Type: Policy

Name: Controlled drugs – storage, security and documentation

Purpose

This policy directs the process for adherence to legislative requirements for storage, security and documentation of all controlled drugs within Capital & Coast District Health Board.

Scope

Includes

All registered medical, nursing, midwifery, medical radiation technologists, Anaesthetic technicians, Enrolled Nurses (EN) of proficient level and above on the PDRP who have successfully completed the CCDHB medication module, in accordance with the NCNZ EN extended scope of practice and pharmacy staff employed/contracted by CCDHB.

Excludes

Pharmacy department. The storage, security and documentation of controlled drugs within the Pharmacy department are covered by a number of policy documents on capitalDoc. For security reasons access to these policies is restricted.

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Policy statement

Capital & Coast District Health Board (CCDHB) staff adheres to legislative requirements for storage, security and documentation of controlled drugs.

Controlled drugs are stored securely in CCDHB departments and wards.

- All controlled drugs not for immediate use are kept in either:
  - a locked controlled drug safe, or
  - locked Pyxis medstation

- Injectable Benzodiazepines such as midazolam may be kept in emergency kits approved by Pharmacy which must be appropriately stored.

- All controlled drug prescriptions are kept in a controlled drug safe, a Pyxis medstation or a locked cupboard when not in use.

- Patients who are admitted to CCDHB with controlled drugs should be asked to surrender them for security reasons.

All transactions and documentation meet legislative requirements.

- All transactions for controlled drugs stored in Pyxis require a witness.
- All discharge prescriptions for controlled drugs are written on a triplicate Controlled Drug Prescription form (H572). (Forms are provided by Pharmacy.)

- All controlled drugs held by clinical departments or wards are:
  - Documented in the controlled drug register or
  - Recorded electronically in wards with Pyxis in the medstation. This information is available for printout as necessary.

Retention of controlled drug registers or printouts:

- All controlled drug registers are kept in a secure place for a minimum of ten years from the date of the last documented entry
- All controlled drug transaction printouts are printed in non-fading ink, stored in a permanent binder, and kept in a secure place for a minimum of ten years from the date of the last entry

All controlled drug entries are made prior to the administration of the controlled drug to a patient (Misuse of Drugs Regs 1977, Reg 45) in the:

- Controlled drug register or
- Pyxis medstation

Definitions

Controlled drugs

A controlled drug is any substance, preparation, mixture, or article specified or described in the First Schedule (Class A), Second Schedule (Class B) and of the Misuse of Drugs Act 1975, including any controlled drug analogue.

For the purposes of this policy benzodiazepines, zopiclone, and ketamine are also considered to be controlled drugs (exceptions – Diazepam, Lorazepam and Clonazepam injections).

Controlled drug safe

A locked cupboard or compartment, which is made of metal or concrete or both, which is securely fixed to or is a part of the building. The compartment or cupboard should be of a type approved by the Medical Officer of Health (Misuse of Drugs Regulations 1977, Reg 28). In the case of a steel safe, it must be of the approved type as described by the *Requirements for the Custody of Controlled Drugs: Steel Safes 2009 Medicines Control, Quality & Safety, and Sector Accountability & Funding* Appendix 4.

In the case of a Pyxis medstation used for the purpose of storing controlled drugs, this must be secured to the floor.

To ensure compliance with the legislation & MOH requirements for safes, Pharmacy must approve orders for any new safes, and approve the installation of any safes prior to use.

Controlled drug register

A bound volume of consecutively numbered pages, in which each page will have entries relating to only one form of Controlled Drug (Misuse of Drugs Regulations 1977, Reg 37).

The Charge Nurse/Midwife Manager/Team Leader (or deputy) is responsible for the ward Registers.

In the case of wards with a Pyxis medstation, all Controlled drug transactions are recorded electronically within the medstation. A hardcopy of transactions are printed daily by the Pharmacy. The printouts are stored and periodically bound by the Pharmacy. All transactions are stored electronically within Pyxis, and retrievable via the console or report writer.

Pyxis restricted medicines

A restricted medicine for Pyxis is a group of medicines that requires closer monitoring of access, such as:

- Potassium chloride ampoules

Nurse/Midwife in charge
For the purposes of this document the wording 'Nurse/Midwife in charge' is used to include the Charge Nurse/Midwife Manager (or delegate) and/or Nurse Coordinator.

Procedures: Controlled Drug Safes and Pyxis Medstations

Security
If a ward or department is closed for more than three days, all controlled drugs, controlled drug registers and keys are to be handed to pharmacy in a sealed bag for safe keeping.

Checking controlled drug safe or medstation contents
The entries must be signed and dated by the Nurse/Midwife in Charge and one other person who must be an RN/RM, EN meeting the above criteria, Anaesthetic Technician or pharmacist (Misuse of Drugs Regulations 19
77, part VI 45d).

If there are discrepancies, notify the Nurse/Midwife in Charge/After Hours Duty Manager and the Security Orderly Coordinator. The Nurse/Midwife in Charge/After Hours Duty Manager will initiate further action if required.

Patients' own controlled drugs
Patients' own controlled drugs must not be used during their hospital stay, unless the controlled drugs are not readily available from pharmacy.

The drugs must be kept in a tamper-proof/temporary custody of valuables envelope, entered into a dedicated section of the controlled drug register by two RN/RMs, and locked in the controlled drugs safe.
Each form of a controlled drug must be documented on a separate page, and the entry should state:

- date and time
- patient's name
- patient's address
- type of drug
- quantity

When returning a patient's own controlled drugs at discharge, an entry must be made signing them out of the register by two RN/RMs/ doctor/pharmacist. (See **Appendix 2** for examples.)

A patient's own controlled drugs should **not** be given to a member of the patient's family or a friend, unless they are authorised by the patient/caregiver or have Power of Attorney.

Return/destruction of controlled drugs
The following controlled drugs should be returned to Pharmacy (via the Ward Pharmacist):

- drugs that have expired
- drugs that are no longer required

Procedures specific for Controlled Drug Safes

Security of controlled drug safes

Keys for the safe are to be carried by a Registered Nurse, Anaesthetic Technician, Enrolled Nurse meeting the above criteria and/or Midwife (RN/RM), except when the keys are required by the Ward Pharmacist or a doctor. In an emergency when no RN/RM is available, the keys may be carried by a doctor.

The Nurse/Midwife in Charge is responsible for ensuring that the keys are handed to the Nurse in Charge on the next shift.
In the Operating Theatre the RN, EN meeting the above criteria or Anaesthetic Technician is responsible for ensuring that the controlled drug safe keys are put back in the key safe when they are no longer required. The Key for this safe is held by the Acute shift Coordinator.

The collection and return of controlled drug keys from the key safe must be recorded on the controlled drug key board, located in the OR control room opposite the key safe.

The acute shift coordinator checks the key safe at the end of the afternoon shift to ensure that all keys are present.

If a ward is to close for more than three days, perform a physical stock count to ensure that stock matches the balance in the controlled drug register before handing the drugs to pharmacy. In this instance, it is not necessary to sign the stock out of the controlled drug register.

The entry on the appropriate page should include the following:

- date
- “Physical stock check”
- balance
- Signature of two of: RN/RM, doctor, pharmacist

When the ward/department reopens, another physical stock check must be completed prior to any transactions.

Lost or mislaid controlled drugs safe keys

- Check the ward/department environs
- Contact all staff on current and previous shift
- Notify the appropriate Nurse/Midwife in Charge/After Hours Duty Manager, and the Security Orderly Coordinator and during business hours the Pharmacy Department.
- Make an entry in the controlled drug register for those products that are in the safe. The entry should state the following:
    - date
    - “keys mislaid or lost”
    - time
    - signature of two of: RN/RM, doctor, pharmacist;
    - Complete a Reportable Event report

When keys are lost, mislaid or removed from the ward/department, or removed from the premises, notify the Pharmacy/Pharmacist on call. All locks and keys must be replaced immediately; if this occurs on a weekend, then the following Monday.

Replacement of keys and locks

Notify the appropriate Nurse/Midwife in Charge/After Hours Duty Manager and the Security Orderly Coordinator or the Pharmacy Department. For all drug safes organise with Chubb Lock and Safe to change the lock. An authorisation from Pharmacy is required, therefore contact the Pharmacy department.

A requisition must be completed and sent to the Pharmacy Department. Note that the key may have been shut in the cupboard and this could be determined by contacting the pharmacy who can gain access to the safe using the spare key. Spare keys may not be used for any other purpose.

Checking controlled drug safe contents

If the key has been lost or misplaced, the contents must be checked immediately upon gaining access to the safe.

Check that the physical count of the contents and entries in the controlled drug register are balanced. If the safe is unsecured, relocate drugs to a safe place eg an adjacent ward or department CD safe or Pharmacy.

Documentation – for drugs stored in a CD safe

Controlled drug register

- The Nurse/Midwife in Charge, is responsible for the register
- All entries must be clearly written in ink
- Information in the register must not be deleted, crossed out or over-written. Correction fluid must not be used under any circumstances
- Corrections to entries in the register are made by placing brackets around the error and writing the correct information on another line on the same page (dated and signed by two of: RN/RM, doctor, EN meeting the above criteria, Anaesthetic Technician, pharmacist), or writing a dated and signed margin or footnote giving the correct details
- Each page shall have entries relating only to one form of one controlled drug. All receipts, drugs used, drugs returned and destruction details must be recorded
- A physical stock count must be completed to check that stock matches the balance in the controlled drug register each time an entry is made for recording receipts, use and returns to pharmacy
- All controlled drug registers must be kept in a secure place for a minimum of ten years from the date of the last entry

(See **Appendix 1** for examples.)

Documentation of receipts – for drugs stored in a CD safe

Controlled drugs may be collected from Pharmacy by a RN/RM or Anaesthetic Technician or delivered to wards/departments by pharmacy staff. Receipt is documented on the relevant page, with the following details:

- date
- annotate to words of the following effect “Receipt from Pharmacy”
- quantity received
- new balance
- Signatures of any two RN/RM/Pharmacists

When controlled drugs are collected from Pharmacy, a physical stock check must be completed as soon as practicable, before the next shift. If there are any discrepancies in the balance, refer to page 8: *Discrepancies*.

Controlled drugs for Kenepuru and Porirua hospitals are sent in secure bags via CCDHB Transport. On arrival, either pharmacy staff or the Duty Manager will deliver these drugs from the orderlies' base to the wards.

Controlled drugs for Kapiti Medical Centre are sent out in secure bags by Pharmacy Staff/security couriers.

Controlled drug deliveries for Kenepuru, Porirua, and Kapiti are accompanied by a confirmation of receipt form which must be completed by the receiving staff nurse or pharmacist, and faxed to the Dispensary on fax 5966.

If a security courier or external transport provider is used for the delivery, a physical stock check of drugs receipted must be completed by two RNs/RMs as soon as practicable.

Documentation of controlled drugs used – for drugs stored in a CD safe

All entries must be written on a separate line in the controlled drug register and include the following:

- date and time
- surname and first initial of the first name of the patient
- quantity of the controlled drug removed from stock
- balance of the controlled drug remaining
- surname and first initial of the first name of the prescriber
- Signatures of any two of: RN/RM, doctor, pharmacist

Documentation of unused controlled drugs or part doses

Doses of controlled drugs not required by the patient or balances remaining from part doses must be discarded. An entry must be made on the administration section of the Medication Chart (which includes specialist analgesic chart) specifying the date and time of destruction, quantity destroyed, and full signature of any two of RN/RM, EN meeting the above criteria, Anaesthetic Technician, doctor, pharmacist.

Certain wards/departments will be exempted from documentation of unused controlled drugs in the above manner, when patient movement prohibits entries to be made on medication charts or when their use cannot be anticipated due to the nature of the work, e.g. Emergency Department and Operating Theatres. It remains the individual responsibility of the Clinical Leader in such areas to liaise with pharmacy to ensure that departmental policies and procedures are established to cope with any variations in practice.

Return/destruction of controlled drugs – for drugs stored in a CD safe

All controlled drugs should be returned to Pharmacy for destruction if they are expired or if are patients' own, which cannot be returned to patient at discharge.

The entry in the appropriate page of the controlled drugs Register should state the following:

- date
- annotate as "Returned to Pharmacy (and give reason)"
- quantity
- new balance

- Signature of two of: RN/RM, EN meeting the above criteria, Anaesthetic Technician, doctor, pharmacist

(See **Appendix 1** for examples.)

Spillage/breakage of controlled drugs for drugs in CD safe

In the event of a spillage or breakage of a controlled drug container, an entry should be made in the appropriate page, as above, except stating "Stock destroyed (and give reason)".

Weekly Stocktake of controlled drugs for drugs in CD safe

A physical stock check of all controlled drugs is to be completed weekly, by the Nurse/Midwife in Charge/Clinical Nurse Specialist (or delegate) and another RN/RM, EN meeting the above criteria or Anaesthetic Technician (Misuse of Drugs Regulations 1977, Reg 45).

Six monthly stocktake

The Nurse/Midwife in Charge/Clinical Nurse Specialist (or delegate) and an RN / RM or Anaesthetic Technician) must complete a **physical stock-take** twice a year of the controlled drugs held in all areas, due on the 30 June and 31 December.

Six monthly quantity stock account

The Nurse/Midwife in Charge/Clinical Nurse Specialist (or delegate) has 14 days from these dates to complete the quantity stock account (Misuse of Drugs Regulations 1977, Reg 43).

A running quantity stock account should be carried out at the end of each page of the register. The 6 monthly quantity stock account is then a summation of each page for each drug. See Appendix 1 as to how to carry out the stock take and the quantity stock account.

The entry in the appropriate page, should state the following:

- date
- "physical stock check/ stock take"
- balance
- Signatures of two of: RN/RM, pharmacist, pharmacy technician

Discrepancies for drugs in CD safe

If there is a discrepancy between the actual physical stock and the balance in the controlled drug register, inform the Nurse/Midwife in Charge at that time.

The Nurse/Midwife in Charge rechecks the actual physical stock and balance as recorded in the controlled drug register. Previous entries are checked to ensure they are correct in terms of addition and subtraction. Entries against administration records are checked.

If the discrepancy remains unexplained, complete a Reportable Event report and:

- During normal working hours the Nurse/Midwife in Charge, Security Orderly Coordinator and Ward Pharmacist must be informed as soon as possible
- After normal working hours or on a weekend inform the Duty Manager and Security Orderly Coordinator as soon as possible. The Ward Pharmacist must be informed as soon as possible the next working day

If the discrepancy is due to a simple omission in the documentation, this is recorded, and no further action is required.

An additional entry must be made in the controlled drug register to document the actual balance, and the entry should be signed by the Nurse/Midwife in Charge and another RN/RM, EN meeting the above criteria or Anaesthetic Technician.

If all checks have been completed, and the discrepancy is still noted, the Nurse/Midwife in Charge/After Hours Duty Manager will initiate further action as required.

Ordering controlled drugs – for drugs stored in a CD safe

A RN/RM or Anaesthetic Technician orders controlled drugs using the CCDHB Controlled Drug Order Form which can be found on the intranet.

Each ward/department will order controlled drugs routinely on a set day each week. Some wards/departments will order more frequently than this at the discretion of the relevant pharmacist/ Nurse/Midwife in Charge.

The completed Controlled Drug Order, signed by the RN/RM or Anaesthetic Technician, is sent/faxed to the Pharmacy Department.

Urgent supplies of controlled drugs required on the same day that they are ordered must be collected from the Pharmacy Department by a RN/RM or Anaesthetic Technician

Controlled drug prescription forms

Controlled drug prescription forms are to be recorded on a unique page of the controlled drug register and issued to individual patients in the same manner as controlled drugs.

When controlled drug prescription forms are sent to the ward, receipt must be documented. The entry should include:

- date
- serial numbers of prescription forms
- quantities
- new balance
- signatures of two of: RN/RM, doctor, pharmacist

When a prescription is required, the entry should include:

- date
- serial number(s) of prescription(s) used
- prescriber and patient name
- number of prescriptions used
- new balance
- signatures of two of: RN/RM, doctor, pharmacist

(See **Appendix 3**)

Controlled drug prescription forms are obtained from Pharmacy. Alternatively individual prescription forms may be obtained as required from the ward. Under such circumstances, an entry in the controlled drug register must be made as above.

Procedures specific for Pyxis Medstations

Security of controlled drugs in medstation

The keys for the controlled drug safe and PCA pumps are stored in the medstation.
The Master keys for the medstation (to open the back of the machine) are held by Pharmacy and the Duty Managers.

Checking controlled drug medstation contents

If the medstation has to be opened and operated manually or becomes unsecure, remove the controlled drugs and relocate to a controlled drug safe eg. the ward safe, an adjacent ward or department controlled drug safe or Pharmacy. Refer to the Medicines summary report for location of controlled drugs within the medstation.

Perform a physical count of the contents and record all items in the controlled drug register. All transactions are to be recorded in a CD register as per this policy.

Controlled drug transaction – administration - PYXIS

- All controlled drug transactions require a witness
- To access a controlled drug for administration, the (Registered Nurse) RN enters their User ID number and bio-identification (fingerprint ID) into the medstation
- Enter patient's name into the medstation and select the prescribed controlled drug
- Once the controlled drug is selected on the screen, a witness must enter their User ID number and bio-identification into the medstation. The witness can be a RN/doctor or pharmacist
- Perform a stock count of the controlled drug and verify (verify count) whether this is the correct quantity on the screen (verify count) before removing item
- Remove the controlled drug from the pocket and check against the medication chart. Close the drawer

Restricted medicine transaction – administration - PYXIS

- All restricted medicines require a verify count
- Access the restricted medicine in the same way as described above, excluding the need for the witness

Documentation of receipts from PYXIS

- Controlled drugs are delivered to wards/departments by authorised pharmacy staff
- A copy of the controlled drug order will act as the packing slip, which must be signed by the issuing pharmacist and counter-signed by a Registered Nurse or Anaesthetic Technician upon delivery to the ward
- Authorised pharmacy staff will refill the medstation, with either a RN or another pharmacy staff member acting as a witness
- The quantity of stock in the medstation will be checked and the count entered on the screen. The item must be inventoried immediately after refilling for the witness to appear on the electronic register
- The printout of the entry will be attached to the controlled drug order and filed in pharmacy

If there are any discrepancies in the balance, refer to *Discrepancies* on following page.

Documentation of controlled drugs used – from PYXIS

All transactions are stored electronically on the medstation. A printout of transactions will include the following:

- date and time
- full name and NHI number of the patient
- name and strength of controlled drug
- source of receipts
- quantity of stock going in to the medstation

- quantity of stock removed from the medstation
- running balance of the controlled drug
- name of the prescriber
- Name of RN or doctor administering drugs
- Name of RN/doctor or pharmacist witnessing the transaction

A daily printout in non-fading ink is made on paper of a lasting form and kept in date order in the pharmacy. The printouts will be permanently bound periodically; the date range will depend on usage. The pages are filed in date order in the controlled drug register.

Doses of controlled drugs not required by the patient or balances remaining from part doses must be discarded. An entry must be made on the administration section of the Medication Chart specifying the date and time of destruction, quantity destroyed, reason for discard, and full signature of any two of RN, doctor or pharmacist. This transaction is also recorded in the wastage module on the medstation, stating reason for discard.

Return/destruction of controlled drugs – from PYXIS

A witness must verify the stock count and removal of any item for return, or removal of expired stock. This can be a RN, EN meeting the above criteria, Anaesthetic Technician or a pharmacist.

Spillage/breakage of controlled drugs - from PYXIS

In the event of a spillage or breakage of a controlled drug container, an entry should be made via the wastage module of the medstation.

Weekly Stocktake of controlled drugs – from PYXIS

A physical stock check of all controlled drugs is completed weekly, by the nurse/midwife in charge/clinical nurse specialist (or delegate) and another RN/RM, EN meeting the above criteria or Anaesthetic Technician (Misuse of Drugs Regulations 1977, Reg 45).

Six monthly Stocktake and Quantity stock account of controlled drugs – from PYXIS

A physical stock-take must take place on the 30 June and 31 December. The quantity stock account is provided automatically to the Pharmacy by Pyxis.

Discrepancies – from PYXIS

The Nurse/Midwife in Charge runs the Discrepancy report from the medstation on a daily basis. If there is a discrepancy between the actual physical stock and the balance in the controlled drug register in the medstation, inform the Nurse/Midwife in Charge at that time.

To clear the discrepancy on a Medstation, the Nurse/Midwife in Charge and another RN as witness, will access the documented discrepancy and will enter the reason it occurred. This will be stored electronically and will appear on the print out the following day.

The Nurse/Midwife in Charge rechecks the actual physical stock and balance as recorded in the medstation. Previous entries are checked against administration records on the medication chart and the Open Discrepancy report available from Pyxis.

If the discrepancy remains unexplained, complete a Reportable Event report and:

- During normal working hours the Nurse/Midwife in Charge, Security Orderly Coordinator and Ward Pharmacist must be informed as soon as possible

- After normal working hours or on a weekend inform the Duty Manager and Security Orderly Coordinator as soon as possible. The Ward Pharmacist must be informed as soon as possible the next working day

If the discrepancy is due to a simple omission in the documentation, this is recorded, and no further action is required.

An additional entry must be made in the medstation electronic controlled drug register to document the actual balance, reason for discrepancy, and the entry should be signed by the Nurse/Midwife in Charge and another RN.

If all checks have been completed, and the discrepancy is still noted, the Nurse/Midwife in Charge/After Hours Duty Manager will initiate further action as required.

Ordering controlled drugs - PYXIS

Orders for any controlled drugs stocked in the medstation will be automatically generated, and printed out in pharmacy.

For orders for controlled drugs not stocked in the medstation refer to page 6.

References

Misuse of Drugs Act 1975
Misuse of Drugs Regulations 1977

Appendices

Appendix 1: Controlled drugs register – example Morphine

Appendix 2: Controlled drugs register – example patient's own supply

Appendix 3: Controlled drugs register – example Prescription pad

Appendix 4: Requirements for the custody of controlled drugs- steel safes

CONTROLLED DRUGS REGISTER – APPENDIX 1 100 (One form of one drug only to each page) NAME AND FORM OF DRUG
Morphine Inj 10mg/ml amps **From Page…….*99*……**

Date (In full)	Name and address of person from whom received; or Name of patient; or Name and address of person supplied or From which or into which made; or Declaration of physical stocktaking.	Prescription No. or Reference No. or Time	In	*Out*	*Balance*	Name of Authority	Issued, dispensed or administered by (Surname & initials)	Initials of person making entry or checking balance
	From previous page		20	9	11			
Example of issues and receipt:								
13/05/02	*A. Patient*	*10.20*		*1*	*10*	*Dr A Physician*	*Nurse I*	*Nurse II*
13/05/02	*B. Smith*	*13.10*		*1*	*9*	*Dr N Jones*	*C. Curtis*	*F. Bright*
13/05/02	*J. Bloggs*	*14.35*		*1*	*8*	*Dr N Jones*	*E. Brown*	*A. Edwards*
14/05/02	*From Pharmacy*	*09.00*	*10*		*18*		*Pharmacist*	*Nurse*
Date of ***Transaction***			***Quantity added to stock***	Quantity ***Removed from stock***	New Running Balance	Prescribing Doctor	***Person administering or delivering stock***	Person Checking
Example of Amending an Error in recording:								
(15/05/02 *	*L. Green*	*14.30*		*1*	*17)*		*C. Curtis*	*F. Bright*
15/05/02	*ABOVE WRITTEN IN ERROR*		*1*		*18*		*C. Curtis*	*F. Bright*
Example of Return or Expired Stock or Destroyed Stock:								
30/06/02	*Expired stock: Returned to Pharmacy*			*1*	*17*		*C. Curtis*	*E. Brown*
30/06/02	*Stock destroyed, broken ampoule*			*1*	*16*		*C. Curtis*	*E. Brown*
							Person who spilt/ broke container	Person Checking
Example of Physical Stock Check:								
30/06/02	*Physical Stock Check: Balance Correct*				*16*		*Nurse*	*Nurse*
10/7/02	*Quantity stock account*		*31*	*15*	*16*		*Nurse*	

* 15/05/02: Written in error, wrong page. Signed: C. Curtis/F. Bright

Appendix 2

CONTROLLED DRUGS REGISTER – example patient's own supply One form of one drug only to each page)-

NAME AND FORM OF DRUG ……*Ms E Albright – LA Morp 10 mg*……. **From Page**……***39***……

Date (In full)	Name and address of person from whom received; or Name of patient; or Name and address of person supplied or From which or into which made; or Declaration of physical stocktaking.	Prescription No. or Reference No. or Time	In	*Out*	*Balance*	Name of Authority	Issued, dispensed or administered by (Surname & initials)	Initials of person making entry or checking balance
02/06/02	*Ms E Albright (Address) LA Morph 10mg Tab*	*09.00*	*9*		*9*		*E. Brown*	*C. Curtis*
04/06/02	*Ms E Albright (Address) LA Morph 10mg Tab*	*10.30*		*9*	*NIL*		*E. Brown*	*C. Curtis*
							Person placing stock into CD safe.	Person checking
							Person returning CDs to patient at discharge.	Person checking

CONTROLLED DRUGS REGISTER– example Prescription pad - Appendix 3

(One form of one drug only to each page) **NAME AND FORM OF DRUG ……*Prescription Pads*…** **From Page……*120*……**

Date (In full)	Name and address of person from whom received; or Name of patient; or Name and address of person supplied or From which or into which made; or Declaration of physical stocktaking.	Prescription No. or Reference No. or Time	In	*Out*	*Balance*	Name of Authority	Issued, dispensed or administered by (Surname & initials)	Initials of person making entry or checking balance
14/05/02	*From Pharmacy*	*12301-12310*	*10*		*10*		*Pharmacist*	*Nurse*
14/05/02	*Mrs B Knight*	*12301*		*1*	*9*	*Dr L May*	*Dr's Signature*	*Nurse*
20/06/02	*Dr L May: For Use In Clinic*	*12302-12303*		*2*	*7*	*Dr L May*	*Nurse*	*Nurse*

Appendix 4

MINISTRY OF HEALTH
MANATŪ HAUORA

REQUIREMENTS FOR THE CUSTODY OF CONTROLLED DRUGS: STEEL SAFES

The custody of controlled drugs is specified in the Misuse of Drugs Regulations 1977, Regulations 28(1) and 28(2). The Ministry of Health, after consultation with the New Zealand Police, have determined the following required minimum standards for a steel safe used for the secure storage of controlled drugs, in licensed pharmacies.

An application can be made to the Medical Officer of Health for consideration of a steel safe that does not meet the specifications listed. Where a reference is made to an official New Zealand or British Standard and a product or method used differs from that standard, it is the responsibility of the applicant to produce appropriate evidence (for example certification from an accredited locksmith or registered engineer) that the proposed or fitted security complies with, equals, or exceeds the given standard. Approval will be made on a case by case basis.

Construction

Safes used for the storage of controlled drugs should be constructed of steel:

- equivalent to 4mm mild steel strength for the body of the safe and 6mm mild steel strength for the door, for safes measuring up to and including 600mm in any dimension (height, width, depth).
- equivalent to 6mm mild steel strength for safes measuring over 600mm in any dimension (height, width, depth).

Steel safes shall have recessed door(s) and protected hinges. Steel safes shall be capable of withstanding reasonable physical attack with hand held tools and weapons, and should be built and finished in a workmanlike manner with negligible gaps between all fixed parts.

Locking Mechanism

For steel safes measuring up to and including 600mm in any dimension (height, width, depth):

- One locking mechanism of no less strength and security performance than a five lever mortice dead lock complying with BS3621:1998 shall be fitted to the safe door.

For steel safes measuring over 600mm in any dimension (height, width, depth):

- Two locking mechanisms of no less strength and security performance than a five lever mortice dead lock complying with BS3621:1998 shall be fitted to the safe door. (Note that the second mechanism may be an indirect locking mechanism, for example locking bolts activated by a handle).

Any door handle fitted shall be designed to break off under leverage.

Fixing

- When the steel safe measures up to and including 600mm in any dimension (height, width, depth) it shall be bolted to a minimum of one surface, and where practicable, one of which shall be the floor.
- When the steel safe measures over 600mm in any dimension (height, width, depth) it shall be bolted to a minimum of two surfaces, and where practicable, one of which shall be the floor.

Bolt shafts, used to attach the safe to the premise, shall be a minimum of 10mm in diameter and when bolted into concrete, expanding or chemical setting bolts may be used. Where the steel safe is bolted to a wooden floor, it shall ideally be through bolted to a steel plate which exceeds the floor area of the cabinet and is retained on at least two floor joists. All nuts must be on the inside of the safe, and bolts welded or burred to resist removal.

SUMMARY OF REQUIREMENTS FOR THE CUSTODY OF CONTROLLED DRUGS: STEEL SAFES

	Up to and including 600mm in any dimension (height, width, depth)	Over 600mm in any dimension (height, width, depth)
CONSTRUCTION		
Safes used for the storage of controlled drugs must be constructed of steel equivalent to:	4mm mild steel	6mm mild steel
In addition the door(s) must be recessed, have protected hinges and be constructed of steel equivalent to:	6mm mild steel	6mm mild steel
Note. *Steel safes shall be capable of withstanding reasonable physical attack with hand held tools and weapons, and should be built and finished in a workmanlike manner with negligible gaps between all fixed parts.*		
MECHANISM		
Number of locking mechanisms of no less strength and security performance than a five lever mortice dead lock complying with BS3621:1998 fitted to the safe door:	One	Two*
Note. *Any door handle fitted shall be designed to break off under leverage.* ** The second mechanism may be an indirect locking mechanism (e.g. locking bolts activated by a handle).*		
FIXING		
Bolted to the following minimum number of surfaces, and where practicable, one of which shall be the floor:	One	Two
Note. *Bolt shafts, used to attach the safe to the premise, shall be a minimum of 10mm in diameter and when bolted into concrete, expanding or chemical setting bolts may be used. Where the safe is bolted to a wooden floor, it shall be ideally bolted to a steel plate which exceeds the floor area of the safe and is retained on at least two floor joists. All nuts must be on the inside of the safe, and bolts welded or burred to resist removal.*		

Requirements for the Custody of Controlled Drugs: Steel Safes 2009
Medicines Control, Quality & Safety, Sector Accountability & Funding
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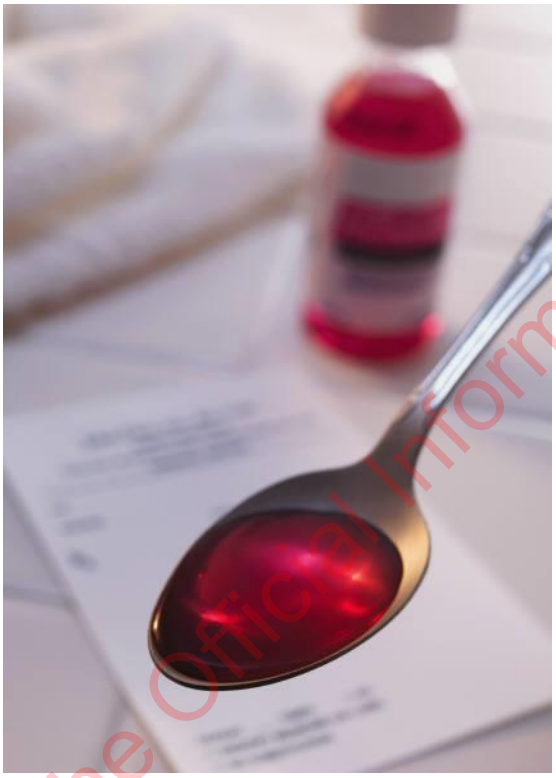
Hutt Valley DHB
Medicines Management Policy



Approved by: HVDHB Medicines Committee
Review date: March 2023

1. INTRODUCTION

This policy details the Medicines Management Policy for the Hutt Valley District Health Board (HVDHB), provider arm, and the standards for services provided under Service Level Agreements to local PHOs, Mental Health, and community nursing services. **All** staff (including **ALL** locum & casual staff) working within these areas are required to adhere to the procedures described within this document. It has been compiled by a multi-disciplinary team, and is intended to be used by all individuals who deal with medicines within the Hutt Valley DHB.

This is a generic policy covering all the Medicines Management issues across the DHB, and where appropriate, specific guidance is given for patient groups. Additional clinical policies, protocols, and guidelines may be required for specific issues, e.g. standing orders, intravenous therapy.

It is the responsibility of the individual to read the policy and acquaint themselves with the correct procedure.

During the life cycle of this policy, the Hutt Valley DHB may be moving towards electronic prescribing. This will necessitate various elements of the policy to be updated as necessary. In all cases, electronic systems will be at least as safe and secure as existing systems.

AIM

The aim of the policy is to act as a procedural guide for the prescribing, storage, supply, and administration of medicines. The intention is to minimise the risk of errors occurring in the use of medicines. The correct administration of prescribed medicines involves medical, nursing, midwifery, allied and pharmaceutical disciplines, and requires vigilance and caution.

The term medicine also includes such items as lotions, nutritional products, intravenous infusions, and interactive dressings.

THE POLICY DOCUMENT

The review date of this policy is February 2024. If difficulties are encountered implementing this policy, it should be discussed with your line manager, Chief Medical Officer, Chief Nursing Officer, Director of Midwifery, Chief Allied Professions Officer, or the Chief Pharmacist.

The Medicines Committee, with input from ward level patient safety committees and quality teams, will review all incidents involving medicines, and will identify actions required to reduce risk and share good practice.

The Medicines Committee, together with any associated actions required, will report compliance with the requirements of this policy to the relevant Clinical/Governance Councils.

Health care professionals should read this policy in conjunction with their own Code of Conduct and any relevant DHB documents that relate to the use of drugs including (NB: not exclusive):

- Reportable Event Policy
- Waste Management Policy
- Infection Control Policy

RELATED REFERENCES

The following documents were used as a basis for producing this policy:

Medicines Act 1981
Misuse of Drugs Act 1975
New Zealand Bill of Rights Act 1990
Mental Health Act 1992
Medicine Regulations 1984
Medicines Regulations 2011
Medicines Amendment Act 2013
Misuse of Drugs Amendment Regulations 2014
Misuse of Drugs Amendment Act 2016
Medicines (Designated Prescriber-Registered Nurses) Regulations 2016
General Disposal Authority for District Health Records; Archives New Zealand, 2006
Capital & Coast and Hutt Valley DHB Preferred medicines list (2017)
New Zealand Nurses Organisation (NZNO) Guidelines for Nurses on the Administration of Medicines (2018)
New Zealand Nurses Organisation (NZNO) Transcribing Medicines (2016)
Nursing Council of New Zealand (NCNZ) Registered Nurse Prescribing
https://ncnz.imiscloud.com/Public/Nursing/Nurse_prescribing/NCNZ/nursing-section/Nurse_Prescribing.aspx?hkey=091ed930-56ca-4f25-ae9e-52b33decb227
Framework for Registered Nurse Prescribing within the Hutt Valley District Health Board Region (2019)
Ministry of Health (2016). Standing Order Guidelines, Wellington: MoH
The Code of Health & Disability Service Consumer Rights Regulations, 1996
Medicines Management Policy 2005; Waikato DHB
Medicines Management Policy 2005; Dudley Group of Hospitals NHS Trust
Medicines Policy 2005; Guys and St Thomas NHS Foundation Trust
HVDHB Waste Disposal Policy*
HVDHB Reportable Event Policy *
NZ Universal List of Medicines 2016
New Zealand Formulary: https://nzf.org.nz/
NZHPA Notes on Injectable Drugs. 8th Edition, 2020. Electronic version: noids.nz *
Medical Council of New Zealand (2010) Good prescribing practice
Pharmacy Council of New Zealand Standards and Guidance for Pharmacist Prescribers, July 2013
Pharmacy Council of New Zealand Code of Ethics 2018
https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf
Ministry of Health (2017) National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017, Wellington: MoH
Health Quality & Safety Commission New Zealand: National Medication Chart User Guide (3rd edition), National Medication Safety Programme (2021): https://www.hqsc.govt.nz/assets/Medication-Safety/NMC-PR/NMC_user_guide_update_2021.pdf
New Zealand Dietitians Board: Dietitian Prescriber Policy, September 2020: https://www.dietitiansboard.org.nz/wp-content/uploads/2020/09/PRADRX-Dietitian-Prescriber-Policy-FINAL-2020.pdf

* These documents must be available in all areas prescribing, storing, or administering

2. PRESCRIBING GUIDELINE

The prescription form:

a. Provides a permanent legal record of the patient's medication
b. Facilitates the provision of the correct medicine from Pharmacy
c. Directs administration of the medicine to the patient

For Inpatients and "Hospital in the Home" (HITH) patients
Use the appropriate National Medication Chart **and** additional specific/supplementary prescribing documents, including IV treatment chart, anaesthetic record, and insulin, warfarin, and heparin charts.

For Discharge
Use the appropriate Hutt Valley DHB electronic discharge prescription. This is accessible through the Concerto portal. If the patient requires a Special Authority or Named Patient Pharmaceutical Assessment for funding requirements for specific medicines, then complete before discharge.

For Outpatients
Use the appropriate Hutt Valley DHB outpatient prescription form. Electronic prescriptions generated via Concerto are preferred.

When outpatients do not require immediate prescriptions, or Primary Healthcare (PHC) practices are requested to prescribe their choice of a particular class of agent, ONLY individual drugs or classes of drugs listed in PHARMAC's Pharmaceutical Schedule are to be recommended. Patients in the community on medications longer than three months require a review by their PHC practice.

PRESCRIBING GUIDELINES
Prescribing must conform to recommendations of the Medicines Act, Regulations, and Misuse of Drugs Act. Prescribing must also conform to the requirements set forth by relevant professional bodies, including the Medical Council of New Zealand (MCNZ), the Nursing Council of New Zealand (NCNZ), Dental Council of New Zealand (DCNZ), Midwifery Council of New Zealand (MCANZ), New Zealand Dietitians Board, and the Pharmacy Council of New Zealand (PCNZ).

Medical Council of New Zealand guidelines must be adhered to, in particular Good Prescribing Practice, which states, "Appropriate prescribing practice requires that a doctor's customary prescribing conforms within reason to patterns established by the doctor's peers in similar practice. Inappropriate prescribing is unacceptable, both clinically and ethically." The Medical Council of NZ guidelines also state that prescribers should, "Avoid writing prescriptions for yourself or those with whom you have a close personal relationship. It is never appropriate to prescribe or administer drugs of dependence or psychotropic medication to yourself or someone close to you." Self-prescribing will only be accepted in exceptional circumstances.

Three models of nurse prescribing exist in NZ: nurse practitioner, registered nurse prescribing in community health, and registered nurse prescribing in primary health and specialty teams. Adherence to Nursing Council of NZ requirements, competencies, and best practice guidelines is necessary for all nurse prescribers.

Pharmacist Prescribers work in collaborative healthcare environments and have a registered scope of practice via the Pharmacy Council of NZ. The Pharmacy Council of NZ states, “Pharmacist Prescribers have ethical obligations additional to those outlined in the Code of Ethics 2018 for the pharmacy profession. Standards and Guidance for Pharmacist Prescribers outlines these obligations and include the competence standards for pharmacist prescribers.”

Only *“bona fide”* and current patients of HVDHB may be prescribed drug therapy at the hospital’s expense.

2.1 LEGIBILITY OF PRESCRIPTION

The prescription must be an accurate and unambiguous description of medicine treatment.

If the prescription is ambiguous or illegible, then the medicine MUST NOT be administered. The prescriber must be contacted immediately and the prescription must be re-written.

Hospital pharmacists may clarify a prescriber's intentions, e.g. adding the generic name, clarifying ambiguous prescribing. However, this must be undertaken in a different coloured ink to the original prescription and initialled. Other unsigned alterations invalidate a prescription.

In writing prescriptions, the following advice must be observed:

a. As per National Medication Chart (NMC) guidelines, all persons involved in the medication charting process (prescribing, checking, and administering) should endeavour to complete the Sample Signature section on the medication chart. Details must include the person's full name, sample signature, registration number, and designation.

b. The inpatient's medication chart should always be available. Not more than one medication chart must be in use at any one time for any one patient, unless the number of items prescribed exceeds the available spaces. Drugs prescribed on specific/supplementary charts, e.g. anticoagulants, IV fluids, TPN, etc., must be cross-referenced to the NMC. If a patient requires TWO or more drug charts, the number of charts should be clearly identified in the box on the front of the chart.

c. When the NMC is full, all current prescriptions must be cancelled, and the cancellations must be signed and dated by an appropriate prescriber. The current therapy must then be entered by appropriate prescribing staff on the new chart. Cancelled charts must be retained with the patient's notes.

d. All prescriptions must be printed in **indelible blue or black ink** and comply with the following:

   i. The patient's full name, sex, weight on admission (if aged 12 and under or prescribing a weight based medication), date of birth, ward, hospital, NHI, and responsible lead clinician. Affix printed patient address labels if available. The first prescriber must also write the patient's name and NHI on the front of the chart. Information relating to drug allergies/adverse drug reactions (ADRs) must be recorded in the appropriate section by the prescriber when initially completing a medication chart. If there are no known allergies/ADRs, then this requires documentation.

   ii. Be individually signed and dated (not arrowed) by the prescriber, who must be a registered prescriber employed by the DHB (i.e. cannot be a medical student).

   iii. The drugs prescribed in the approved generic name written in printed letters (except where prescribing by Trade Name specifies a particular combination or sustained release product). If you are uncertain, please contact your pharmacist.

   iv. The dose stated in terms of the quantity of active ingredient not, for example, the number of tablets or volume of liquid, except in the case of compound preparations.

   v. The route of administration and an indication of where the treatment (e.g. topically to leg) must be given. Combinations of routes are not acceptable, e.g. PO/IV. To reduce risk, these must be prescribed separately. Specified routes 'Intrathecal' and 'epidural' must be written out in full.

   vi. Indicate clearly, by the prescriber, the time that each drug must be administered, utilising the 24-hour clock, or circling the times provided.

vii. Give an indication and frequency of administration of "*as required* (PRN)" drugs by clearly defined stated intervals with maximum dose over 24 hours to be included (PRN alone is unacceptable). Where defined by clinical policy, a maximum duration and indication must also be stated.

viii. Any alteration must result in the re-writing of that prescription. (Apart from clarification by a pharmacist, refer 2.1).

ix. Variable dose prescribing must clearly state the dosage range and the criteria, which determines the dosage given.

x. If abbreviations are used, only those on the following approved list are permitted:

Buc	Buccal	**PRN**	When required (as needed)
BD	Twice daily	**PR**	Per Rectum
IM	Intramuscular	**PV**	Per Vagina
Inh	Inhalation	**QID**	Four times a day
IV	Intravenous	**q4h**	Every four hours
Mane	Morning	**q6h**	Every six hours
Midi	Midday	**q8h**	Every eight hours
NG	Nasogastric	**q12h**	Every twelve hours
NJ	Nasojejunal	**Subcut**	Subcutaneous
		Subling	Sublingual
nocte	Night	**STAT**	Immediately
Neb	Nebuliser	**TDS**	Three times a day
PEG	Percutaneous endoscopic gastrostomy	**TOP**	Topical
PO	Oral		

When using abbreviations, the prescriber should ensure that the initials used are clear and unambiguous.

2.1.1 Prescribing timings for community health patients

It may not be practical for the community health teams to administer the medicines at the time specified by the prescriber because of logistical reasons. If possible, prescribers should chart daily community health medicines for 1200 noon. This will give the community teams a degree of flexibility around administration timing.

ONLY AUTHORISED, APPROVED, OR DESIGNATED PRESCRIBERS MAY PRESCRIBE MEDICINES FOR ADMINISTRATION BY OTHER HEALTHCARE PROFESSIONALS.

2.2 ADVERSE REACTION

Guidance for completion of patient allergy/adverse drug reactions (ADRs)

Hutt Valley DHB requires all prescribers to enter known drug allergies and sensitivities on prescribing documents, together with their manifestations OR specify that there are no known allergies. Each prescribing document includes the following section that must be completed.

Nursing staff must not administer drugs unless the allergy/ADR information is completed.

Allergies:
Currently drug allergy information is recorded on the prescribing document (above), in the patient notes, and on the electronic alert system. These three sources will be brought together when electronic prescribing is rolled out.

Governance and promotion of drug allergies and electronic drug alerts sits with the Medicines Committee. The procedure for entering electronic drug alerts is found in the Appendix 4 of this document. The allergies including record on the prescribing document and electronic drug alert system compliance will be audited as a part of the routine medication chart audits.

Drug allergies and electronic drug alerts will be routinely included in orientation for clinical prescribers.

If an allergy occurs in hospital/ED, then a SQUARE event report must be completed and an electronic drug alert must be entered with information on the event, as well as the usual clinical notes.

Adverse Reactions:
If a patient suffers an unknown or possible unexpected adverse reaction to a prescribed, over-the-counter, or herbal medicine, then the adverse reaction should be reported via the Reportable Events and Centre for Adverse Reactions Monitoring (CARM) systems, and documented in the SQUARE reportable events database, where appropriate.

Additional guidance on how the CARM forms should be completed is available from Pharmacy. Please note ANY health care professional may complete a CARM form. To report via online CARM form: https://nzphvc.otago.ac.nz/report/

Copies of all CARM forms submitted by Hutt Valley DHB staff are to be forwarded to the Chief Pharmacist. Summary information will be included in the Medicines Committee reports.

Definitions
A **true allergy** may be classified as one or more symptoms consistent with an immune reaction, including breathing difficulties, swelling, rash, itching, and loss of consciousness or anaphylaxis.

Intolerance may be classified as an adverse effect that may be predicted from the known side effect profile or pharmacological action of a drug, or an idiosyncratic or unpredictable reaction to a drug, e.g. GI bleeding secondary to a NSAID, or neutropenia with clopidogrel.

An **adverse drug reaction** is a response to a medicine which is noxious and unintended, and which occurs at doses normally used in humans.

When taking a medical history it is important to:

a. Verify the allergy status, drug intolerance, or ADR

b. Establish the length of time the patient has had the reported allergy/intolerance, and whether there is a record of when the drug was prescribed or administered in the patient's notes

c. Document the allergy/ADR clearly in the notes and on the chart when taking the patient's history, indicating the type of reaction/ intolerance or ADR described by the patient

d. Decide whether you would consider it appropriate to administer that drug or a drug in the same class to the patient based on the information available

e. Document the allergy/drug intolerance/ADR details on the NMC providing sufficient information for other prescribers to be able to make appropriate prescribing decisions

e.g. Severe penicillin allergy (anaphylaxis) – this may be a warning to prescribers that they need to avoid all penicillins and take great care with cephalosporins.

Acute renal failure or GI bleed with NSAIDS – avoid – this gives a clear message for prescribers to avoid NSAIDS.

Mild diarrhoea with erythromycin – if the antibiotic is needed, reassurance that the symptoms are a common side effect may be all that is needed.

2.3 VERBAL INSTRUCTIONS VIA THE TELEPHONE

In **exceptional** circumstances, an authorised prescriber familiar with the patient's current diagnosis and treatment can give verbal instructions for the administration of medicines to a registered nurse/midwife.
VERBAL INSTRUCTIONS VIA THE TELEPHONE MUST NEVER BE GIVEN OR ACCEPTED FOR CONTROLLED DRUGS.

The following outlines the advisable procedure for taking telephone orders (NZNO, 2014):

- Write the order as it is being given
- Read it back to the prescriber
- Always get a colleague to hear the order from the prescriber and write it down, and repeat it to the prescriber
- The dose should be confirmed in both words and numbers e.g. fifteen (one five) milligrams
- Resolve any discrepancy or difficulty in hearing the order before the telephone conversation is finished
- The order should be written on the verbal orders section of the NMC
- Document the time of administration of the medicine, or, if an infusion, the time the infusion was started (commenced) and completed
- Document the full name of the prescriber giving the verbal order (this must be handwritten clearly by one of the nurses taking the verbal order).
- **The ORIGINAL prescriber must confirm the telephone order by signing the medicine on the medication chart before the end of the nurse or midwife's shift**
- The nurse/midwife has the unconditional right to refuse to give a drug ordered verbally. When doing so, they must notify the prescriber of their refusal and document the reasons

2.3.1 Verbal Orders in Community Health

In Community Health, in some circumstances, an authorised prescriber may also need to prescribe remotely to a RN, who has no second colleague to check the order. This may occur in the following situations:

- Where a previously unprescribed medicine (e.g. in palliative care or remote and rural areas) is required urgently; or
- Where medication (**not including controlled drugs**) has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary.

Use information technology (such as fax, text message, or email) to confirm the prescription before the medication is administered. This should be followed up by a new prescription signed by the prescriber who sent the fax/text/email, confirming the changes within normally a maximum of 24 hours.

For remote prescriptions, a verbal order on its own is not acceptable. The fax or email prescription must be attached to the patient's existing medication chart. The RN or midwife is accountable for ensuring all relevant information is communicated to the prescriber and they may refuse to accept a remote

prescription, if it compromises care to the patient. In this instance, they should accurately document the communication that has taken place.

2.4 VERBAL INSTRUCTIONS FACE TO FACE

VERBAL INSTRUCTIONS MUST NEVER BE GIVEN OR ACCEPTED FOR CONTROLLED DRUGS.

In an emergency situation, medicines may be given by medical/nursing/midwifery staff prior to a formal prescription on an approved medication chart. It is the responsibility of the prescriber to ensure that this is recorded on the approved chart, and for the administering staff to then sign as necessary.

2.5 OUTPATIENT PRESCRIBING OF CONTROLLED DRUGS

The prescriber is referred to the Misuse of Drugs Act 1975 and the Misuse of Drugs Amendment Regulations 2014 and 2016 for full guidance.

As a summary, prescriptions ordering controlled drugs should be in the prescriber's own handwriting, using indelible blue/black ink on the MOH triplicate prescription form (H572) for a Class A or B controlled drug and state:

a. The name and address of the patient
b. The age of the patient if under 12 years
c. The full name of the preparation, e.g. morphine sulfate
d. The strength and form of the preparation, e.g. 10 mg tablets
e. The dose and frequency
f. Dangerous doses must be underlined and initialled by the prescriber
g. The total number of dose units to be dispensed, preferably in words, e.g. fourteen (14) or if a liquid preparation the total volume in words, e.g. One Hundred (100) mL
h. Prescribers address, date, and signature
i. All alterations on the prescription must be initialled by the prescriber

2.5.1 Length of supply

Medical practitioners can prescribe for patients for:

a. Up to a one month supply for Class A or B controlled drugs
b. Up to three months' supply for Class C controlled drugs

Dentists can prescribe to patients under their care and must be for dental treatment only, and for no more than SEVEN days' supply.

Midwives can prescribe to patients under their care and for no more than ONE month. Midwives can only prescribe controlled drugs specified in Schedule 1C of the Misuse of Drugs Regulations (pethidine, morphine, and fentanyl).

Nurse Practitioners can prescribe for patients **within their scope of practice** for:

a. Up to a one month supply for Class A or B controlled drugs
b. Up to three months' supply for Class C controlled drugs

Designated Nurse Prescribers in primary health and specialty teams can prescribe for patients **within their scope of practice** for:

a. Up to SEVEN days' supply of controlled drugs listed in Schedule 1A of the Misuse of Drugs Regulations

Designated Prescriber Pharmacists may prescribe for patients **within their scope of practice** for:

a. Up to THREE days' supply of controlled drugs listed in Schedule 1B of the Misuse of Drugs Regulations

New Zealand has high rate of opioid prescribing, and most prescriptions are started while patients were in the hospital. If opioid is prescribed for self-limiting condition, prescribe them for the shortest duration possible. Combined prescription of opioids and benzodiazapines are known to increase harm from these agents.

***Self-prescribing of controlled drugs is not permitted*.**

2.6 MEDICINE FORMULARY & ANTIBIOTIC POLICY

Hutt Valley DHB operates a restrictive medicines formulary based on PHARMAC's Hospital Medicines List (HML) to ensure that evidence-based, rational prescribing occurs across the organisation. An antibiotic policy has also been developed in conjunction with Capital & Coast DHB.

Prescribers should specify products from the hospital formulary or Hospital Medicines List (HML). Where alternatives are not available, patients admitted on non-formulary drugs will usually have further supplies made to maintain treatment, unless the drugs are deemed unacceptable for use within the Hutt Valley DHB health economy. In such cases, alternative therapies will be discussed with the hospital prescribers.

It is unacceptable to request primary healthcare practices to prescribe non-formulary or non-funded medicines without clear clinical justification.

2.7 PRESCRIBING OF MEDICAL GASES

Medical gases are regarded as medicines, and as such, must be prescribed in writing by authorised prescribers on the Oxygen and Medical Gases section of the NMC or other Hutt Valley DHB approved stationery, e.g. Emergency Department chart or anaesthetic record sheet.

The prescription must state:

- The medical gas required
- The delivery device, i.e. mask, nasal cannula
- Rate and percentage of oxygen
- Other instructions

Additional information can be found in the hospital Oxygen Policy (http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/adult-medicine-guidelines/respiratory/adult-oxygen-therapy-policy/inpatient-adult-oxygen-therapy-2019-final-v42.pdf). Only oxygen may be administered in an emergency (cardiac arrest or respiratory distress) without a prescription. This then should be prescribed ASAP and documented.

2.8 DISCONTINUING MEDICINES

Prescriptions should be cancelled by drawing a single bold line through the prescription and administration section. The cancellation should be signed and dated by the prescriber, **AND** the action and rationale recorded in the patient's medical notes and medication chart, where appropriate.

In the community, discontinued medications should be faxed or emailed (with an electronic signature) to the Community Health Service and a copy retained in the patient's note.

Discontinued medicines that have been individually dispensed for that patient should be returned to pharmacy for disposal as per the Hutt Valley DHB Waste Disposal Policy/Pharmaceutical Waste disposal procedure (see 6.10).

2.9 PRESCRIBING DRESSINGS

It is not necessary for dressings to be prescribed before use. It is, however, essential that ALL dressings used and the rationale behind their use, are documented within the individual patient's clinical record/care plan if the dressing is not prescribed.

2.10 PRESCRIBING WITHOUT PATIENT CONSENT

Drugs for treating psychiatric disorders may be given without the patient's consent if the patient is detained under the Mental Health Act 1992.

Someone placed under a Community Treatment Order (CTO) has to accept treatment for the first month. However, even during this first month, the health professional should:

- Still try to obtain the person's consent
- Explain the benefits and side effects of treatment
- Ensure that the only treatment which can be forced on a patient is that therapy required to treat a person's mental illness
- Complete consent in writing

After the first month's treatment, a person does not need to receive treatment unless it is:

- In the person's best interest, as decided by a second opinion or an independent review tribunal, as in the relevant section of the Mental Health Act
- For emergency treatment

2.11 REGISTERED NURSE INITIATED MEDICINES

Please see the Standing Orders Policy for "Registered Nurse Initiated Medicines in Adult In-patient Care Areas" (CL.070) for a full list of nurse initiated standing orders used within the Hutt Hospital. Some departments/services, e.g. Regional Public Health (RPH), Critical Care Outreach Nurses (CCON), Emergency Department, Theatre, Medical Day Stay Unit, Outpatients Department, and Dental may also have their own standing orders.

Individual services who wish to develop their own standing orders must follow the prescribed process and submit them to the Medicines Committee for final approval, as per the Standing Orders policy: http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/medicines/standing-orders-policy-hvdhb-final-nov-2018.pdf

2.12 TRANSCRIBING

Traditionally, transcribing has been the responsibility of the prescriber. However, there are situations in which transcribing by regulated health professionals, who are non-prescribers, may facilitate improved access to and continuity of care. Please refer to the separate "Transcribing Policy" for more detail: http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/medicines/nurse-transcribing-of-medicines-policy-2018-final-cl107.pdf. Any queries in regards to this should be directed to the Chief Pharmacist or the relevant Associate Director of Nursing. Please also refer to the "New Zealand Nurses Organisation (NZNO) Practice Guidelines: Transcribing Medicines" (2016).

2.13 MEDICINES RECONCILIATION

Medicines reconciliation is an evidence-based process of obtaining the 'most accurate' list of all medications a patient is currently taking within 24 hours of admission (Safe Medication Management Programme, 2011). Medicine reconciliation has three core steps:

1. Collecting the 'most accurate' medicines list using at least two different information sources, the primary source being the patient
2. Comparing the 'most accurate' medicines list against the current medication chart and clinical notes for any documented changes to medicines
3. Communicating any discrepancies (i.e. undocumented changes, whether intended or not) to the prescriber to reconcile and action

(Safe Medication Programme, 2011)

The **prime responsibility** for ensuring Medicines Reconciliation is undertaken remains that of the prescriber. The RN/EN/MW/Pharmacist may assist in this process by undertaking reconciliation on admission or at pre-admission, and noting any resulting discrepancies in prescribing on the formal Medicines Reconciliation form. The RN/EN/MW/Pharmacist **will not** undertake any resultant transcribing practices.

See also "Multidisciplinary Medicines Reconciliation" Guidelines (http://intranet.huttvalleydhb.org.nz/content/9ee4fb91-a776-4d19-9249-608ae029709d.cmr) and "Medicines Reconciliation" form (http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/medicines/medicines-reconciliation-form-2019.pdf).

3 SUPPLY OF MEDICINES

Pharmacy staff may only dispense prescriptions that comply with all legal requirements and are completed in accordance with the procedures outlined in this policy.

Within the Pharmacy department, a full range of Standard Operating Procedures (SOPs) are in place – in compliance with Ministry of Health standards.

The issue to a patient of pre-packed containers of medicine, supplied by the Hutt Valley DHB (e.g. PACU, DSU), is the responsibility of the relevant medical, nursing, and midwifery staff in accordance with local procedures, which identifies the responsibilities of these staff.

3.1 PHARMACY TEAM

Each ward and most clinical teams within the Hutt Valley DHB have a designated pharmacist and technician who will visit the ward regularly, when able.

Pharmacists participate in clinical ward rounds and monitor the medication charts in partnership with medicines management technicians, both in the dispensary and on the ward. Pharmacists assess prescribing for accuracy, legibility, interactions, and appropriateness of therapy in line with department standards and evidence-based clinical practice. Any clarification of a prescription made by a pharmacist will be carried out in a different colour ink (usually green) to the original prescription and initialled, following, where appropriate, consultation with the prescriber.

Pharmacists will record interventions made, and any major (life threatening) interventions will be reported using the online reportable event system SQUARE (Safety, Quality and Reportable Events). See section 4.13 for more information on Medication Incident/Error Reporting.

Pharmacy staff will assess the need for non-Imprest medicines and arrange their requisition on an 'individual named' basis from Pharmacy. All medication will be labelled with the approved 'generic' name of the preparation, except where a proprietary name defines a specific formulation or combination.

3.2 PHARMACY IMPREST TOP-UP

Specific wards will be visited at a designated time each week by a pharmacy technician or assistant. This person will ensure stocks of pharmaceutical products for that area are replenished to agreed Imprest levels. The Imprest levels will be agreed upon after discussion between the relevant ward pharmacist, technician, and appropriate medical and nursing staff. These levels will be reviewed at regular intervals by the staff concerned. Nursing and midwifery staff must notify Pharmacy if unusual amounts of any item are being utilised to allow Imprest levels to be recalculated and adjusted.

3.3 DELIVERY OF MEDICINES TO WARDS/DEPARTMENTS & COMMUNITY TEAMS

All medicines will be delivered to the ward/department/community base by orderly staff in a dedicated tamper evident container (usually a red utility bag). The nursing/department staff are responsible for the security of this container on the ward/department, and for transferring the contents of the container into the appropriate locked cupboards/drug room immediately upon receipt. Items requiring special storage conditions (e.g. refrigeration) will be clearly labelled and must be stored appropriately immediately upon receipt on the ward/department. (*For Controlled Drugs see section 6)*

3.4 SELF MEDICATION

Any clinical area wishing to instigate patient self-medication should develop a unit specific procedure that is approved and signed off by the Medicines Committee. Refer to area specific policies and section 4.7.

All procedures should outline:

a. How the patient group is to be identified
b. The process to be used for self-administration
c. Roles and responsibilities of nurse or midwife, medical practitioner, pharmacist, and pharmacy technician
d. Documentation requirements
e. The storage and safety of medications in accordance with the policy below (Section 6)
f. An on-going review process that determines patient safety

3.5 EMERGENCY SUPPLY

Emergency supply of medications, when the pharmacy is not open, can be obtained from the "after hours" cupboard. The Duty Nurse Manager must be contacted, and will then access the cupboard.

When removing items from the "after hours" cupboard, the designated member of staff must record in the book provided the patient name/NHI, name of the items, the quantity, and the ward to which these medicines have been supplied. Only remove complete packs. Individual tablets or strips of tablets **MUST NOT** be supplied to wards/patients.

- Imprest medicines may only be borrowed from another ward/unit under the instruction of the Duty Nurse Manager
- Borrowing from wards must **not** occur whilst the Pharmacy department is open
- It is the responsibility of the Duty Nurse Manager to arrange the borrowing of medicines when Pharmacy is closed
- Out of hours replacement boxes for clinical emergencies are available (refer to 6.5)
- See Appendix 1: "Obtaining Medication After-hours for Hutt Valley DHB staff" for more detail

Borrowing from wards must not occur whilst the pharmacy is open.

3.6 PHARMACY OPENING TIMES

The Pharmacy department is open during the following times for clinical advice and newly prescribed items:

Monday to Friday	0900 - 1700
Saturday	1000 - 1200

3.7 OUT OF HOURS PHARMACEUTICAL SERVICE

The pharmacy provides an on-call pharmacy service through a team of pharmacists who, when on duty, will be able to respond to requests for information and attend the department for clinically urgent supply requests, when they cannot be sourced through alternative routes.

Prescribers requiring pharmaceutical advice can contact the on-call pharmacist through the hospital switchboard. Nursing staff requiring the supply of additional medicines in an emergency should contact the Duty Nurse Manager.

Stocks of medicines that may be required urgently are available as in 3.5 above.

Discharge, leave, and outpatient prescriptions are not available via the on-call service.

3.8 SAMPLES

Pharmaceutical companies will sometimes provide samples of newly available pharmaceutical products, including dressings, to allow medical and nursing staff to 'try' products before the Hospital decides to commence using the products.

Leaving, delivering, or requesting samples is **not** permitted in any clinical area. This applies both to vendor-initiated and Hutt Valley DHB staff-initiated initiatives. The Medicines Committees will review any prescriber request for samples on an annual basis.

3.9 CLINICAL TRIAL DRUGS

The contents of this policy apply equally to clinical trial medication. All clinical trial medication should be administered in accordance with Medsafe Guideline on the Regulation of Therapeutic Products in New Zealand, Part 11: regulatory approval and good clinical practice requirements. Trial medicines will not be administered to patients unless approved and supplied by the Pharmacy, in accordance with the study protocol, and Health and Disability Ethical & Research Governance approval.

Oral clinical trial medications can be stored directly at the research site, provided pharmacy are aware, and the medicines are in secure location with access limited to the study staff only, and temperature monitored.

All nursing staff involved in the clinical trial medication administration will be familiar with the study protocol and potential side effects of the study medication.

When a patient currently taking medication as part of a clinical trial is admitted to hospital, medical staff must assess the risk/benefit of continuing/stopping trial medication. This may involve contacting the principal investigator for the trial, and, if deemed appropriate, these patients should be allowed to take their own trial medication whilst a patient within the hospital.

A pharmacist must be contacted regarding those patients who are admitted on trial medication at the earliest opportunity.

3.10 SECTION 25 AND SECTION 29 MEDICINES

In order to ensure that medicines are safe, effective, and of appropriate quality, their manufacture and sale or supply is controlled by national registration. Accordingly, no medical product may be placed on the market unless a marketing authorisation has been granted.

The informed use of some "unapproved medicines" or "approved medicines for unregistered indications" is necessary in clinical practice. The decision to use such medicines should only be made if the product offers the best prospect of benefit for the patient. The decision should also be based upon the best practice and evidence available at the time. The use of recognised formularies and textbooks/resources is recommended when making these decisions.

A Section 25 medicine is one that has marketing authorisation, but is being used for an unauthorised indication.

A Section 29 medicine is one that does **not** have marketing authorisation by MEDSAFE under the Medicines Act, and is unapproved. A Section 29 medicine is:

a. Where items are used on a named patient basis before commercial release
b. Where products are imported on a named patient basis
c. Where medicines are licensed for approved use in other countries, but are unapproved in New Zealand
d. Where products are manufactured or assembled to a practitioner's order, i.e. “specials”

The unapproved use of a registered product is commonly termed ‘off-label’ use.

In the situations (a) to (c) above, and where possible in situation (d), a practitioner prescribing (and nurse administering) these products will be advised by pharmacy staff that the product is unapproved.

If any unapproved medicine in (a) to (c) above, originally prescribed in the hospital, is to be continued in the community, the clinician responsible must continue to manage the patient unless the patient’s General Practitioner is happy to accept clinical responsibility for the treatment.

In general, it is not necessary to take any additional steps when using such medication, beyond those taken when prescribing registered medicines. However, the prescriber should obtain the informed consent of the patient, or parents/carers of children to prescribe or administer any unapproved medication. This must be recorded within the patient’s notes, because the collection of patient’s and prescriber’s names are required by the pharmacy and the supplier.

Where the use of the medicine is considered to be experimental, the clinician must ensure they discuss potential treatment with a peer, and document all conversations and outcome in the notes. They must also obtain informed consent of the patient, parents, or carers of children to prescribe or administer the medicine. This must also be recorded within the patient’s notes.

Additional information regarding the use of experimental treatments can be found in the Human Subjects Research Approval Guidelines.

4 PROCEDURE FOR THE ADMINISTRATION OF MEDICINES

A doctor, enrolled nurse, registered nurse, midwife, or other healthcare professional must only administer a medication when it has been prescribed by an authorised prescriber, using an official National Medication Chart, provided by Hutt Valley DHB, unless special arrangements exist, as identified in sections 2.3, 2.4. This also applies to medicines brought into hospital by a patient, and medicines administered by registered nurses in the patient's own home.

Medicines must be administered by a doctor, registered nurse/midwife, enrolled nurse, or pharmacist who is qualified to do so, with an appropriate witness where required. Agreement to use self-medication protocols must be part of the operational policy for defined units.

Student nurses/midwives: May administer medication under the direct supervision of a registered nurse/midwife. The supervising qualified nurse/midwife remains accountable for the administration. Both the student nurse/midwife and registered nurse/midwife must sign the National Medication Chart.

Nurses working on the casual or allocation pools: It is the responsibility of the individual CNM to decide if it is necessary that they should be accompanied for checking purposes when administering medicines to a patient.

Health Care Assistants (HCAs) working in Community Health: HCAs working in Community Health may administer certain medications (listed below):

- Creams
- Blister packs
- Certain patches
- Eye drops
- Administration also includes prompting patients to take their prescribed medications

The circumstances under which a Community HCA may administer medications are as follows.
The HCA:

- works under the direction and delegation of a registered nurse (including informing the RN if they do not believe they, as an HCA, have the necessary skills and knowledge to carry out the delegated task and report concerns about risks in the medication process to the RN and management)
- is familiar with the Medicines Policy
- has undergone training in use of the National Medication Chart
- has achieved the New Zealand Certificate in Health & Wellbeing (level 3) Health Assistance (or equivalent)
- ensures the National Medication Chart is countersigned by the patient's primary nurse or Associate Clinical Nurse Manager by the end of the duty

NB: When accepting delegated activities, the HCA understands that he/she retains responsibility for their actions, and remains accountable to the RN.

4.1 Independent Double Checking (IDC)

IDC - means a procedure in which two clinicians separately check (alone and apart from each other, then compare results) each component of prescribing, dispensing, and verifying the medication before administering it to the patient. An **Independent Double Check** is conducted independently by a second person to reduce the risk of bias that occurs when the person preparing and checking the medication is

likely to see what they expect to see. The second person does not simply verify the first person's work; they follow a series of steps to arrive at a conclusion which can then be compared against that of the first person's, to ensure that they are in agreement (see Appendix 3 for IDC process in detail)
The second independent check may be provided by a:

- Registered nurse/midwife/anaesthetic technician
- Doctor
- Pharmacist

Independent double checking and *witnessed* administration is required for:

- All blood and blood products
- All IV controlled medicines
- All IV cytotoxic medicines
- IV heparin
- IV insulin
- Patient Controlled Analgesia (PCA) – setting up and changing bags/syringes
- Epidural additives
- IV bronchodilators
- IV glucose >10%
- IV cardiac medicines – antiarrythmics, inotropes
- Medications administered to children (with some exceptions) see Section 4.6 *Administration of Medicines to Children*

Independent double-checking and *single* administration is required for:

- Oral, subcutaneous, and intramuscular (IM) controlled drugs
- Any medicine which is not supplied in the required dose and therefore the dosage needs to be calculated (not including number of tablets/capsules)

NB: These lists are not exclusive. Any clinician, may, at any time, request an independent double check- in particular if they are unfamiliar with the medicine, clinical environment, and/or patient diagnosis.
Some clinical areas may also have their own requirements in regards to IDC.

4.2 ADMINISTRATION

The person administering a medicine will:

4.2.1 Prior to Administration:

a. Check the prescription - legible and signed, allergies, medication dose, route, time last dose given, any special instructions
b. Pre-administration assessment – be aware of the diagnosis, indications of medicine, side effects, and any special instructions
c. Prepare medication - 5 Rights (5Rs) + 3: Right patient, Right medicine, Right dose, Right route, Right time, Right indications, Right documentation, Right for patient to refuse
d. Ensure that any special storage requirements have been adhered to (refer to 6.1)
e. Perform calculation if required

4.2.2 Administration:

a. Take the medication chart to the patient
b. Perform a bedside check - 5Rs + 3 as per above, confirm allergy status
c. Ensure the patient has swallowed the medicine, received an injection or suppository, or received the total amount of prescribed inhalation/spray

4.2.3 Post Administration:

a. Monitor the patient for any side effects and document in the patient record if necessary
b. Document on medication chart – date (PRN meds), time, dose, and signature (including second signature if required). If the prescription includes variable doses, the amount given must be recorded
c. In outpatient or home settings, a record must be made on the appropriate patient notes National Medication Chart
d. If medicine is not administered/omitted, it must be documented on the medication chart using appropriate non-administration code. Document in notes the reason for non-administration, as listed below, and discuss with appropriate prescriber:

U- Patient unavailable
N- Not administered – document reason in notes
R- Patient refused
SM- Self medicating
D – Prescriber's instructions
CP-Carer/parent administered
RV-Review
W-Withheld

N.B: If a medicine is not available, record as N – and document reason in patient record, including process undertaken to obtain medicine. See Appendix 1 for flow-chart "Obtaining Medications After-hours". If the preparation of the medicine is in a multi-dose container, then the patient's name, and time and date of its first use must be clearly recorded on the container. Multi-dose containers of parenteral products must only be used for single patients.

e. Where a maximum number of doses or a specified maximum length of treatment is prescribed, that number or length must not be exceeded. The prescription must be re-written
f. Where the administration of liquid preparations involves the use of volumes other than 5ml spoonfuls/aliquots, then only **ORAL** syringes must be used
g. Where Controlled Drugs (CDs) are administered, both administrator and witness must sign the CD register. Administration of medicines prescribed on other forms from that of the NMC, e.g. outpatients notes or anaesthetic record sheet, must be recorded adjacent to the signed prescription, including the date/time and the signature of the person who has administered the medicine

4.2.4. Omitted Doses:

Rationale: Areas have identified on-going issues with nurses recording N/A (not available) on the medication chart when the medication is not been available for administration. N/A is not an approved non-administration code. Please refer to section 4.2.3 (d) above.

4.3 Requests to Clarify or Re-chart Prescriptions:

- Where a prescription does not comply with the prescribing guidelines outlined in Section 2, the drug must not be administered, and the chart returned to the prescriber for re-writing
- Where there is any doubt regarding the prescription, it is the responsibility of the administrator to notify the prescriber promptly, stating the reason for concern, seek clarification, and recommend re-charting if required
- If the original prescriber is not available, the administrator should approach their senior, e.g. registrar, consultant, or the medical staff on call
- A prescriber must respond professionally to all requests to clarify or re-chart prescriptions. If a satisfactory response is not obtained, the administrator must notify the clinical/charge nurse/midwife manager or the duty nurse manager, and raise the issue with the relevant consultant

- Any unresolved concerns relating to prescribing must be raised with the Chief Medical Officer by the senior staff involved, i.e. medical and/or nursing
- All discussions and actions must be clearly documented in the patient's clinical record, and trigger a "good catch" record in the SQUARE reportable events database, where appropriate

4.4 Patients classified as Nil by Mouth (NBM)

Patients classified as NBM prior to a diagnostic procedure or operation should still have their prescribed oral medicines administered to them at the prescribed time, unless specifically advised, AND documented otherwise. It is the responsibility of the prescriber to provide clear written instructions to nursing staff concerning omission of prescribed doses.

4.5 ADVERSE DRUG REACTIONS

See Section *2.2 Allergy Status* (page 10)

4.6 ADMINISTRATION OF MEDICINES TO CHILDREN

In the context of this policy, children are defined as any patient under the age of 15 years. The policy will apply to any clinical area where children are cared.

Where children's medicine doses are calculated according to the weight of the child, it is essential that this be recorded in kilograms on the NMC. The child's weight must be checked at regular agreed intervals, according to their plan of care.

See section 4.19 for information on measuring oral liquid doses.

4.6.1 CHECKING

All medicines administered to children are required to be independently double-checked. In addition, for IV medications, administration is to be witnessed (whether a dose calculation is required or not).

On occasions where appropriately experienced and identified Registered Nurses are working on the Children's Ward at HVDHB and the Children's Assessment Unit, they are exempt from double-checking of specific medications. See Policy *"Medications: Paediatric Single Checking"* for additional information (http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/paediatrics/single-checking-of-medicines-children/single-checking-medications-paediatric-2017.pdf).

4.6.2 CHILDREN WHO REFUSE MEDICATION

All staff administering medication to children should take into account their age and understanding. Where it is considered that a child recognises the implications of refusing medication, medical staff will be informed, and the incident recorded in the medical records. If the child is considered incapable of recognising the implications of refusing medication, provided parental consent is given, medication should be administered.

4.6.3 CONSENT

Written consent for administration of vaccinations by school nurses/health visitors must be obtained from children's parents or guardians **UNLESS** the child is deemed "Gillick competent", and can therefore sign their own consent.

4.6.4 SELF or PARENT/GUARDIAN ADMINISTRATION TO CHILDREN

In the case of patients under 15 years, parents/guardians may administer the prescribed medicine to their child, but the nurse must take the overall responsibility for ensuring the medication has been given to the child.

Where appropriate, and with appropriate assessment and nursing supervision, children are permitted to self-administer medications.

4.7 SELF-ADMINISTRATION OF MEDICATION BY PATIENTS **(also see Section 3.4)**

Staff care for many patients within their own homes; consequently, patients are encouraged, where appropriate, to manage their own medicines, as prescribed by their PHC practice.

A formal scheme involving assessment of all or most patients on a ward for their suitability for self-administration requires the approval of the Medicines Committee. All ward pharmacists, as a one-off, can sanction self-administration by an individual patient in a ward that does not have a formal scheme, when this is seen as being clinically beneficial. This should be recorded as "SM" (self medication) on the administration of the National Medication Chart and documented in the patient's clinical notes.

In the community setting, medication administration may be overseen by an unregulated worker, e.g. health care assistant (HCA) assisting a patient using a blister pack. In these circumstances, the HCA must have undergone a formal assessment process around medication administration, and work under the direction and delegation of a RN.

4.8 DISCHARGE MEDICATION

Patients may be given a discharge prescription that can be taken to their local community pharmacy. It is acceptable for the ward staff to make contact with the community pharmacy before the patient is discharged, and fax a copy of the prescription to the community pharmacist. This will ensure timely availability of the patient's medicine after discharge.

Under no circumstances may ward Imprest or inappropriately labelled in-patient supplies be given to patients to take home.

Supplies specifically dispensed by pharmacy for an individual in-patient in preparation for discharge (i.e. with directions included on the label) may be supplied directly from the ward to that patient upon discharge, provided their supply is requested on the discharge prescription and checked by the prescriber at the time of generating the prescription.

Pharmacy will supply patient's leave medications for short courses (usually less than seven days) if they receive notification at least 24 hours before the leave commences. If leave medications are requested for more than seven days, then the prescriber/clinician should consider providing the patient with an outpatient prescription to be filled and collected at their local community pharmacy.

Leave medicines require secure storage at ward level until the patient leaves the hospital and must be locked in an appropriate cupboard/drug room.

Refer to section 6.6 for advice on the return of patient's own medication on discharge.

4.9 INTRAVENOUS ADMINISTRATION (Also see IV and Related Therapies specific policies)

This remains the joint responsibility of nursing/midwife/anaesthetic technicians and medical staff. Nursing and midwifery staff must:

- Work within their scope of practice
- Not administer a medicine by the intravenous route unless they are IV certified and satisfied with their competence
- At least one health care professional involved in the double checking of intravenous medicines must be IV certified

- Comply with HVDHB's Intravenous and Related Therapies Policies, and all associated documents
- Be familiar with the patient, the medicine, and the administration device
- Be available to monitor the response to treatment and administer further care

NB: If these criteria cannot be met, consideration must be given to alternatives to ensure safe and timely administration (See Appendix 2: IV Decision Making Flowchart)

4.10 CYTOTOXIC DRUGS

4.10.1 INTRAVENOUS ADMINISTRATION OF CYTOTOXIC DRUGS

The administration of cytotoxic drugs is not part of the routine administration of medicines within all areas of the DHB. The fundamental principles of intravenous therapy apply to administration of cytotoxic drugs. Where cytotoxic drugs are to be administered by nurses, there must be a locally approved training package.

Cytotoxic drugs may only be administered in designated ward/department areas, such as Medical Day Stay and Theatre. Please refer to unit specific policies on the HVDHB intranet.

4.10.2 ORAL ADMINISTRATION OF CYTOTOXIC DRUGS

A minimal touch technique must be used, and hands washed immediately before and afterwards. Tablets must not routinely be crushed; a suspension **may** be available from pharmacy.

4.10.3 SUBCUTANEOUS AND INTRAMUSCULAR ADMINISTRATION OF CYTOTOXIC DRUGS

The standard administration technique is used.

4.10.4 CYTOTOXIC ADMINISTRATION BY OTHER ROUTES

Medical staff will only administer cytotoxic drugs given by other routes if locally approved training packages are adhered to, e.g. bladder instillation.

4.11 INFUSION DEVICES

All medicines (categorised as high risk) which require administration by an infusion device must be administered using a pump/infusion device of the appropriate risk category according to the classification of the drug risk.

4.12 USE OF STRONG POTASSIUM CHLORIDE INJECTION

The Health Quality & Safety Commission (HQSC) national guidance stipulates the controls required for the safe administration of potassium chloride concentrate and other strong potassium solutions.

The Hutt Valley District Health Board safety controls for potassium chloride concentrate and other strong potassium solutions will be followed at all times. Commercially available, ready to use intravenous solutions of potassium, are available from the stores department and shall be used whenever possible.

Please refer to the Safe Use and Storage of Intravenous Potassium Chloride Policy (http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/medicines/safe-storage-of-potassium/safe-storage-of-potassium-v30.pdf).

4.13 MEDICATION INCIDENT/ERROR REPORTING

A culture of reporting on all medicine related incidents, errors, and/or near misses is to be encouraged across all disciplines involved in the medicine process (prescribing, dispensing, and administration). Such reporting and the subsequent investigation is not about apportioning blame, but to ensure that learning occurs and to reduce the risk of same/ similar incidents happening in the future.

The following *may be considered as examples* of incidents, errors, and near misses that may generate a Reportable Event:

Prescription

- Failure to date prescription
- Failure to indicate time of administration
- Incorrect dose, drug, or route charted
- Failure to chart medicine
- Illegible charting
- No prescriber signature

Administration

- Incorrect patient, drug, dose, or route
- Incorrect date or time, including when the medicine has not been administered within one hour of prescribed time
- Omission of a dose

Note: A medication event does not occur if there is a valid reason for delay or omission documented in the patient notes.

Dispensing

- Incorrect drug, dose, strength, or patient name
- Incorrect or confusing labelling

All incidents, errors, and near misses relating to the use of medicines must be reported using the online reportable event system SQUARE (Safety, Quality and Reportable Events).

Copies of all such incidents will be forwarded to the Chief Pharmacist via an alert system in SQUARE.

4.14 DISPENSING LABELS

If the dispensing label on any container is damaged, altered, or obliterated, then the container must be returned to the Pharmacy for replacement. Staff must not alter labels, except to indicate the addition of a prescribed drug into a container of intravenous fluid, or to mark the date of first use on a container. If the appearance of the product differs from normal, then seek the advice of a pharmacist.

4.15 TRANSFER

Transfer of any medicinal item from one labelled container to another is not allowed, except by pharmacy staff. Keep all medicines in their original container where possible and do NOT decant into other boxes, vials, or containers, etc.

4.16 INTER-WARD TRANSFER

When patients transfer to another ward or hospital within the DHB, it is important to ensure that any medicines dispensed specifically for that patient accompany them.

Any Patient's Own Medicine OR individually dispensed medicines for a patient held on the ward MUST be transferred with the patient if they move to another ward.

A patient transferred temporarily (for special treatment, e.g. chemotherapy or investigation) must have their medication chart sent with them, along with any specifically required medicines (NOT including controlled drugs).

4.17 EXTERNAL APPLICATIONS

In view of the possible hazards inherent in the use of such preparations, the nurse or midwife must not administer external applications unless they have been either prescribed, or specified in a written protocol, e.g. Ametop Gel.

4.18 STAFF REQUIRING MEDICATION

Self-medication with medicines that are the property of the Hutt Valley DHB by nursing, medical, and all other staff is strictly prohibited. Medical staff may not self prescribe other than in exceptional circumstances.

In urgent circumstances, where staff are not bona fide and current patients of the DHB, prescriptions will be treated as private prescriptions, and charges for medicines supplied will be levied. The recommended course of action for staff requiring prescriptions filled is to go to any of the local community pharmacies in the area; there are several located within walking distance from the hospital.

Small supplies of simple analgesics, such as paracetamol and ibuprofen (when available), will be supplied by the Pharmacy Department for personal use by staff. These should be stored in an appropriate manner under the direction of the CNM or nominated representative.

4.19 ORAL LIQUID MEDICINES

Where oral liquid medicines require measurement of a dose that is not a multiple of 5mL, an **ORAL** syringe to measure the dose is required. Oral syringes are single use.

Advice on the crushing of solid oral medication is available from the Pharmacy Department.

Do not use standard, sterile injection syringes for measuring oral liquid medicines.

4.20 CRUSHING OF SOLID ORAL MEDICINES

Where patients are unable to swallow solid oral medicines, contact the pharmacy about the availability of alternative liquid formulations. Where a liquid is not available, crush tablets using a tablet crusher available from pharmacy or stores. To prevent cross contamination, do not use a mortar and pestle.

Guidance on administering drugs via enteral feeding tubes is available from pharmacy.

4.21 COVERT ADMINISTRATION OF MEDICINES

The covert administration of medicines is not to be confused with the administration of medicines against a person's will, which may be considered unlawful.

As a general principle, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication, when in fact they are. This covert administration of medicines is only likely to be necessary or appropriate in the case of patients who actively refuse medication, **but** are judged not to have the capacity to understand the consequences of their refusal.

Where adult patients are capable of giving or withholding consent to treatment, no medication should be given without their agreement. A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect their health or shorten their life. The exception to this principle concerns treatment authorised under the relevant mental health legislation, when specialist advice is necessary.

Every adult must be presumed to have the mental capacity to consent or refuse treatment, including medication, unless they:

- Are unable to take in and retain the information about it provided by the treating staff, particularly as to the likely consequences of refusal,
- Or is unable to weigh up the information as part of the process of arriving at a decision

The assessment of capacity is primarily a matter for the treating clinicians, but nurses and midwives retain a responsibility to participate in discussions about this assessment.

The DHB recognises that there may be exceptional circumstances, in the absence of informed consent, in which covert administration may be considered necessary to prevent a patient from missing essential treatment. However:

- The best interests of the patient must be considered at all times
- The treatment must be necessary in order to save life, or to prevent deterioration, or ensure an improvement in the patient's physical or mental health, or for the safety of others
- The decision to administer a medication covertly should not be considered routine and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient individually
- There should be a broad and open discussion among the multi-professional clinical team and the supporters of the patient, and agreement that this approach is required in the circumstances. It is inadvisable for the nurse or midwife to make a decision to administer medication in this way in isolation. Those involved should include carers, relatives, advocates, and the multidisciplinary team. Family involvement in the care process should be positively encouraged
- The method of administration of the medicines should be agreed with the pharmacist
- The decision, the reasons for it, and the action taken, including the names of all parties concerned, should be documented in the care plan and reviewed at appropriate intervals
- Regular attempts should be made to encourage the patient to take their medication. This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual

The administration of medicines to patients who lack the capacity to consent, and who are unable to appreciate that they are taking medication (unconscious patients, for example) should not need to be carried out covertly. If such patients recover awareness, seek their consent at the earliest opportunity.

4.22 ADMINISTRATION OF MEDICATION TO PATIENTS WHO REFUSE TREATMENT

Medicines, as with all form of treatment, must only be administered with the patient's consent. This consent is implied by the fact that the patient takes the prescribed medication. The only situation in which medicines may be administered without the patient's consent is under the Mental Health Act 1992 – see 2.10.

5 CONTROLLED DRUGS (CDs)

5.1 PRESCRIBING OF CONTROLLED DRUGS

Prescribers: please refer to the Misuse of Drugs Act 1975, the Misuse of Drugs Amendment Regulations 2014, and the Misuse of Drugs Amendment Act 2016 for full guidance.

As a summary, outpatient prescriptions ordering controlled drugs should be in the prescriber's own handwriting, using indelible blue/black ink on the MOH triplicate prescription form (H572) for a Class A or B controlled drug and state:

a. The name and address of the patient
b. The age of the patient, if under 12 years
c. The full name of the preparation, e.g. morphine sulfate
d. The form and strength of the preparation, e.g. tablets 10 mg
e. The dose and frequency
f. Dangerous doses must be underlined and initialled by the prescriber
g. The total number of dose units to be dispensed, preferably in words, e.g. fourteen (14) or if a liquid preparation the total volume in words, e.g. One Hundred (100) mL
h. Prescribers address, date, and signature
i. All alterations on the prescription must be initialled by the prescriber

5.1.1 Length of supply

Medical practitioners can prescribe for patients:

a. Up to a one month supply for Class A or B controlled drugs
b. Up to three months' supply for Class C controlled drugs

Dentists can prescribe to patients under their care and must be for dental treatment only and for no more than SEVEN days' supply.

Midwives can prescribe to patients under their care and for no more than ONE month. Midwives can only prescribe controlled drugs specified in Schedule 1C of the Misuse of Drugs Regulations (pethidine, morphine, and fentanyl).

Nurse Practitioners can prescribe for patients **within their scope of practice**:

c. Up to a one month supply for Class A or B controlled drugs
d. Up to three months' supply for Class C controlled drugs

Designated Nurse Prescribers in primary health and specialty teams can prescribe for patients **within their scope of practice**:

a. Up to SEVEN days' supply of controlled drugs listed in Schedule 1A of the Misuse of Drugs Regulations

Designated Prescriber Pharmacists may prescribe for patients **within their scope of practice**:

a. Up to THREE days' supply of controlled drugs listed in Schedule 1B of the Misuse of Drugs Regulations

***Self-prescribing of controlled drugs is not permitted*.**

5.2 CONTROLLED DRUG REGISTER

The controlled drug register must be completed at the time of administration of the controlled drug within the inpatient setting.

The CNM/CMM of the department/ward is responsible for the register.

- All entries must be clearly written in blue or black ink
- Information in the register must not be deleted, crossed out, or over-written
- Correction fluid must not be used under any circumstances
- Corrections to entries in the register are made by placing brackets around the error and writing the correct information on another line on the same page (dated and signed by two of: RN/RM/MW, doctor, pharmacist, RAT), or writing a dated and signed margin or footnote giving the correct details
- Each page shall have entries relating only to one form of one controlled drug. Record details of all receipts, drugs used, drugs returned, and destruction

5.2.1 Documentation of controlled drugs used

All entries must be written on a separate line in the controlled drug register and include the following:

- Date and time
- Surname and first initial of the first name of the patient
- Quantity of the controlled drug removed from stock
- Balance of the controlled drug remaining
- Surname and first initial of the first name of the prescriber
- Signatures of any two of: RN/EN/MW, RAT, doctor, pharmacist

5.2.2 Documentation of controlled drugs discarded

All discarded controlled drugs must be documented in the CD register. Please see Controlled Drug Waste Documentation Policy (http://intranet.huttvalleydhb.org.nz/policies-guidelines/clinical/medicines/cd-waste-documentation-policy-final-august-2019.pdf).

5.3 ADMINISTRATION OF CONTROLLED DRUGS

The Misuse of Drugs Act (1975) strictly controls 'dangerous drugs' together with some other drugs subject to abuse or liable to cause addiction, collectively referred to as CONTROLLED DRUGS. The individual doctor/nurse/midwife must be aware of the drugs under this heading.

All controlled drugs must be checked by a doctor, midwife, registered nurse, or registered anaesthetic technician (who has undertaken an approved training programme and been assessed as competent).
Where the term 'approved witness' is used, this refers to a registered nurse/midwife, doctor, pharmacist, registered anaesthetic technician (RAT), or a student nurse/ midwife (who has received formal instruction on the administration of controlled drugs).

In a hospital environment:

- Controlled drugs must only be checked out for one patient at a time
- Controlled drugs, once checked, must not be left unattended at any time – including in the locked drug room or at the patient's bedside
- All syringes of 'In use" controlled drugs e.g. bolus analgesia, must be placed inside the locked controlled drug cupboard and clearly named with a patient label on the syringe when not required

The 'In use' controlled drug syringes must be signed in and out of the cupboard each time by any two of: RN/EN/MW, RAT, doctor, or pharmacist.

The keys to the controlled drugs cupboard must be kept separate from other ward keys, and on the person of a registered nurse/midwife or RAT at all times.

Medical doctors may administer controlled drugs without a second check; however, controlled drug register entries must be completed. It is good practice for doctors, who do not commonly undertake complex drug calculations, to have any drug calculations checked prior to administration.

5.4 ORDERING OF CONTROLLED DRUGS

The standard controlled drug requisition form must be used at all times. Controlled drugs should be ordered weekly. It is essential to give full information regarding name of drug, dose form, strength, and quantity required. Nurses/midwives must also print their name next to their signature.

5.5 RECEIPT OF CONTROLLED DRUGS FROM PHARMACY

Controlled drugs will be dispensed by the pharmacy, and during the normal work weekdays, the designated pharmacy technician will deliver the CDs in a locked red utility bag to the locked drug room between the hours of 1300-1400. When the pharmacy technician arrives to the ward/unit drug room, the call bell will be pushed, and an enrolled or registered nurse, midwife, or RAT must sign and print name on the CD requisition form attached to the front of the red bag. The signed requisition form will be collected by the pharmacy technician and filed in the pharmacy department. If no one is available to sign for the CDs during the delivery time, then the red bag containing the CDs will be brought back to the pharmacy, and an enrolled or registered nurse, midwife, or RAT must collect them at a later time.

When CDs are signed for by appropriate/qualified ward staff member, another qualified person must witness and countersign the ward CD registers.

5.6 INSPECTION & CHECKING

Inpatients: The designated registered nurse will check the stock balance of controlled drugs **weekly** with an approved witness, and record that this has been undertaken in a format agreed by the CNM.
In theatres, stocks are to be checked at the beginning and end of each day by two staff. One of these must be a RN, and the other a doctor, RAT, pharmacist, or another RN. A record must be made of each stock check in a format agreed by the theatre manager.

When inspecting controlled and recorded drugs during weekly drug stock accounts, labels should be reviewed for clarity and legibility, and medications should be visually checked for compromised integrity (crumbling, wearing). If any aspects of the container or medication are in question, return to the Pharmacy for appropriate destruction and disposal.

It is not permissible to transfer half tablets from one medicine container to another; refer to Section 4.15. Repacked medications are subject to pharmacy services standards and legislation. If medications are placed in different containers, the stock is mixed and the medicines from different batches are not identifiable if a recall is necessary. If half tablets are not used in a reasonable timeframe, please return to pharmacy for appropriate destruction and disposal.

NB: Stocktaking of the Physical Controlled Drug Register must be undertaken SIX (6) monthly at the end of 30 June and 31 December, as per legal requirements specified in the Misuse of Drugs Act, 1975.

5.7 DISCREPANCIES IN CONTROLLED DRUGS STOCKS

Any of the following circumstances must be reported immediately to the senior nurse/midwife who will inform the pharmacy during normal working hours, and complete a SQUARE event report:

- Any incorrect entry in a register (do not erase or alter except by a further note)
- Any error

- Any actual or suspected drugs loss

If any drug appears to be lost due to misuse or theft, the senior nurse/midwife and CNM/CMM (Duty Nurse Manager if outside normal office hours) must be informed immediately. It will be their responsibility to notify the on call Pharmacist, who will advise the Chief Pharmacist or nominated representative on the next working day.

5.8 DISPOSAL OF CONTROLLED DRUGS

Any doses of controlled drugs (tablets or liquids) spilled, dropped, not required by the patient, or balances remaining from part doses must be discarded in the sharps bin located in the locked drug room and witnessed. Sharps bins should contain Vernagel sachets, which absorbs liquids and solidifies them, so they can be disposed of properly and reduces risk of diversion of controlled drugs, or hazardous medications.

An entry must be made in the controlled drug register specifying the date and time of destruction, quantity destroyed, and full signature of any two of RN/EN/MW, doctor, pharmacist, or RAT.

The exception is syringes or bags from an epidural or Patient Controlled analgesia (PCA); the disposal of these controlled drugs is documented on the Advanced Analgesia form (double signing required).

5.9 CONTROLLED DRUGS & ILLEGAL SUBSTANCES BROUGHT INTO HOSPITAL BY PATIENTS

When a patient is admitted with a controlled drug in their possession, the doctor must be informed. Drugs dispensed previously (by the GP or community pharmacist) are the property of the patient to whom they are supplied. Best practice is that the patient sends the controlled drug home in the custody of a responsible adult. If this is not possible or practical, the drug must be handed over to the nurse in charge, stored immediately in the controlled drug cupboard having had a tamper evident seal attached, and an entry made both in the back of the controlled drug register/separate "Patient's Own" controlled drug register, and in the nursing/midwifery records. Upon discharge, the sealed envelope is to be returned to the patient, who is to be advised to contact their own GP to confirm that the drug is still required. A record of return must be made in the controlled drug register.

If controlled drugs are present in the green "Patient's Own Medicines" bag, the doctor or registered nurse must review the contents, and follow the above recommendations for secure storage in the controlled drug cupboard and recording.

An illegal or suspicious drug or substance is defined as a "drug suspected of being obtained illegally or an illicit substance".

It is an offence to possess an illegal substance. Contact a pharmacist for advice if any doubt exists over the legality of a substance.

5.9.1 Patient in possession, or suspected of being in possession of an illegal substance

If a patient is in possession, or suspected of being in possession of an illegal substance, they should be advised that possession is unlawful and should be instructed to have the illicit substance removed from Hutt Valley DHB premises as soon as reasonably practicable.

It is essential that the person in charge and the clinician responsible for the patient are informed. A SQUARE reportable event must be completed and the incident documented in the patient's clinical record.

If a patient continues to possess, use, or supply an illegal substance on HVDHB premises, the patient must be assessed to determine whether he or she is competent to understand the consequences of his or her actions. If the patient is competent, he or she is advised that further treatment may be terminated if the illegal behaviour continues. The patient must be informed of the potential risks associated with termination of treatment.

The options for the patient include:

- To continue treatment with a plan agreed to by the patient and clinical team
- Referral, e.g. to Alcohol and Drug Services
- Compulsory treatment under legislation (where this is applicable)
- Development of an appropriate discharge plan and termination of treatment if the illegal behaviour continues

The patient must be medically assessed and appropriate arrangements made for follow-up care before treatment on Hutt Valley DHB premises is terminated. Any decision to terminate treatment must be made by the senior clinician responsible for the patient's treatment.

If the patient lacks the capacity to understand the consequences of his or her actions, Hutt Valley DHB will take all reasonable steps to ensure that the patient is not supplied with illegal substances while at Hutt Valley DHB. If the illegal behaviour continues, legal advice should be sought from Hutt Valley DHB legal processes.

5.9.2 Disposal of illegal substances

Because of culpability issues, it is generally inadvisable for staff to touch any illegal substance discovered on Hutt Valley DHB property. In the first instance, the patient should be asked to immediately dispose of the substance, or have the substance removed from Hutt Valley DHB premises. Two staff members should witness the disposal and record events on a SQUARE reportable event form. Both staff members should documented on the form.

If the patient is not able to dispose of the substance, or have the substance disposed of, two members of staff may take possession of the substance for the purpose of preventing the patient from committing an offence in connection with the substance. The person who is in possession of the substance, must as soon as possible, take all reasonable steps to destroy the substance, or where applicable, hand the substance to the police (Misuse of Drugs Act section 7(3)). Hutt Valley DHB staff should not take possession of an illegal substance for any other purpose. Seek advice from Hutt Valley DHB's legal counsel where there is any doubt. The events must be documented on a SQUARE event report and in the clinical notes, which should be signed by both staff members.

5.9.3 If a patient denies possession or use of an illegal substance, but staff continue to believe that the patient has an illegal substance in his or her possession

Prior to undertaking any search or seizure of a patient's property, the patient's consent must be sought. It will only be lawful to undertake a physical search of, and seize, a patient's property without the patient's consent where it is **reasonable and necessary** to do so. The following factors should be taken into account when deciding if the situation is reasonable and necessary in law:

- Staff must weigh up all considerations of public and private interest. That is, the public interest and Hutt Valley DHB's responsibility, for ensuring the safety of the patient, other patients, and third parties, against the private interests of the individual patient.
- Staff must **believe** that it is necessary to search and/or seize the substance, and the belief must be based on **reasonable** grounds.

- The purpose for the search (and therefore, why the information is being collected) should be made plain. The patient must be kept informed, if possible, of the circumstances of the case.
- It is important to act in a reasonable manner from the start of the search and seizure process.

5.9.4 The Search Procedure

The search must be carried out in a reasonable manner, having regard to the purpose of the search and the circumstances of the case.

The search must be carried out in private and in a manner which otherwise respects the patient's privacy, and with at least one member of staff of the same gender as the patient when possible.

5.9.5 Seizure/possession of an illegal substance

There must always be two staff members present when a staff member is taking possession of an illegal substance. The illegal substance must be destroyed immediately, preferably in front of the patient, and **always** with at least one other staff member as a witness to the actions taken.

The actions taken must be recorded on the SQUARE event report form, and must be documented in the clinical notes, which must be signed by all staff present.

5.9.6 Visitors' Rights

Hutt Valley DHB staff do not have the right to search visitors or their property. However, where it is strongly suspected or witnessed that a visitor is supplying a patient with an illegal substance, the visitor may be asked to leave Hutt Valley DHB premises, and may, if the circumstances warrant, be issued with a trespass notice.

If visitors do not leave when asked, contact security or the police as necessary.

5.9.7 Recording events

A SQUARE event report must be completed if a patient is searched and/or an illegal substance is removed from, or found on a patient.

5.9.8 Security and the Police

Any decision to contact the police is the responsibility of the consultant clinician in charge of the patient's care, or if after hours, the Duty Nurse Manager.

5.10 RETURN OF UNWANTED/OUT OF DATE CONTROLLED DRUGS TO PHARMACY

Expired controlled drugs must be returned to the pharmacy. A record of the return must be made in the ward/unit register as per the Misuse of Drugs Act, 1975.

5.11 COLLECTION AND TRANSPORT OF CONTROLLED DRUGS

When controlled drugs are collected from the pharmacy:

If the person collecting the Controlled Drug (CD) is the patient or the patient's representative, the pharmacy staff will request evidence of that person's identity, and may refuse to supply the CD if they are not satisfied as to the identity of the person. Pharmacy staff have the discretion to decide whether to ask for proof of identity, and also the discretion to supply the CD, even if there is no ID available, or refuse to supply if they are not satisfied that the person collecting is who they say they are.

Health Professional

If the person collecting the CD is a health professional, the Pharmacy staff will request evidence of that person's identity, and may refuse to supply the CD if they are not satisfied as to the identity of the person.

5.12 CONTROLLED DRUG PRESCRIPTION PADS

Controlled drug prescriptions pads (in packs of 10 prescriptions) must be ordered from the pharmacy department using the CD requisition form. Each triplicate CD prescription has a red serial number, and these must be recorded in a dedicated CD register or other appropriate document. CD prescription pads should be kept locked in the CD safe on the wards/units, or if no safe is available, secured in a locked office or desk drawer.

For inpatient wards/units: when a CD prescription is required, then it should be signed out of the CD register by two qualified individuals (prescriber/doctor, enrolled or registered nurse, midwife, or RAT).

For outpatient clinics or other areas: when a CD prescription is required, then best practice is to have two qualified (most likely the prescriber and registered nurse) people signing the CD register, if available and practicable. If there is no other qualified person available to witness and sign, then it is acceptable for the prescriber to provide signature without a counter-signatory.

All three copies of the CD prescription is given to the patient to be filled at a community pharmacy.

6 MANAGEMENT & STORAGE OF MEDICINES

This section applies to inpatient units, outpatients, and other clinical settings (including clinical trials areas), where medicines are stored. It does not apply to patients' homes; however, advice should be given to individual patients with regard to appropriate storage of medicines within their home.
Any occasion where wards or departments wish to change their medicine storage facilities, the Chief Pharmacist must be contacted for advice and approval.

6.1 STORAGE

- Medicines when not attended are to be stored in a locked cupboard or locked refrigerator specifically designated for the storage of medicines only
- Medicines are to be stored in conditions that maintain their pharmaceutical stability and prevent contamination at an ambient room temperature of 25˚C or less; documentation of ambient room temperature in drug room is required
- Medicines are to be stored in the containers in which they are supplied by the pharmacy department and may not be transferred to other containers
- Individual ampoules are to be left in the original manufacturer or pharmacy packaging until immediately prior to administration to an individual patient
- Blister strips may not be cut into individual dose units

Each ward/department requires separate storage areas **where relevant** as follows:

Controlled drug safe
All Controlled Drugs (CDs) are to be stored in a CD safe, used only to store CDs, plus other specific medicines liable to misuse. Specific construction and location legislative requirements apply.

Internal medicines
All medicines for internal administration, other than CDs, are to be stored in a medicine cupboard or area that complies with design specification standards consistent with common practice.

External medicines
All preparations for external use are to be stored in a cupboard or area that complies with design specification standards consistent with common practice.

Temperature monitored pharmaceuticals refrigerator
Temperature must be monitored by means of a digital thermometer and recorded daily. Temperature outside 2-8 ^{O}C must be investigated. Please see the HVDHB Cold Chain: The Management of Vaccines and Refrigerated Medicines Policy. Supporting documents for this policy can be found on the intranet under Cold Chain in the Clinical Policies and Guidelines section.

Reagents
All substances for clinical tests, for example urine testing, are to be stored in a cupboard or area that complies with design specification standards consistent with common practice.

Intravenous fluids and irrigation fluids
Intravenous fluids and irrigation fluids should be stored in distinctly different parts of the utility areas and in such a way to prevent identification/medication errors.

6.2 SECURITY

All health professionals (and anyone in possession of medicines) must take all practical steps to ensure that medicines (including medicines that are self-administered) are secured from access by unauthorised persons.

Keypad codes for accessing medicines storage cupboards/areas are to be kept confidential to relevant staff only. Codes must be changed at least every 6 months, and as necessary if security concerns arise.

The safekeeping and whereabouts of medicine cupboard keys is the responsibility of the nurse/midwife/other healthcare professional currently holding the keys at any given time.

Medical and pharmacy staff may access keys temporarily, as necessary, for fulfilment of their duties and are responsible for safe return to the registered nurse in charge. On such occasions, that particular clinical professional is responsible and accountable for ensuring that all relevant medicines policies and procedures are adhered to. The most senior registered nurse retains the overall responsibility for medicine security for that area.

Doors controlling access to medicine storage cupboards/areas are to remain shut and locked **at all times**.

When an area is closed, e.g. overnight or over the weekend, medication keys are to be returned to a place of safe keeping and unauthorised access prevented. For closure of longer than three (3) days, consult the Chief Pharmacist (or delegate).

The nurse or midwife in charge is to inform the ward pharmacist or pharmacy if:

- Medicine cupboards and/or the locks are replaced, or
- Keys are lost and/or new keys are cut, and provide pharmacy with a spare key (to be signed out to the ward if the key is temporarily misplaced)

The area responsible for the loss will incur the cost of all replacements.

6.3 DISCREPANCY OF IMPREST BALANCE

In the event of a suspected discrepancy in the IMPREST balance at ward/department level, the designated nurse must be informed immediately. They will inform the pharmacist during normal opening hours. If a controlled drug is involved, refer to 5.7. If there is a suspicion of 'medicines abuse', then this should be reported to the Clinical Nurse Manager (After Hours Manager – out of normal hours) and a senior pharmacist (on call pharmacist – out of normal hours). An incident form must be completed in line with the DHB event reporting policy.

Where a Community Nurse has concerns regarding inappropriate use of patient's own controlled drugs, their manager should be informed.

6.4 ACCIDENTAL LOSS

Any drug spilled or tablet dropped must be destroyed in accordance with the Hutt Valley DHB Waste Management Policy. Disposal of dropped/spilled/broken vials of *controlled drugs* must be as carried out in section 5.8, and a reportable event form must be completed in line with the DHB Reportable Event policy.

6.5 CLINICAL EMERGENCIES (e.g. cardiopulmonary arrest)

All wards/departments will have a source of urgent supplementary medicinal products. These boxes will be tamper-evident and must not be held in a locked cupboard, but at strategic and accessible sites. Once a box has been opened, its seal has been broken, or its expiry date has been reached, a replacement shall be obtained from Pharmacy (see also 3.3). Nursing/midwifery staff will check daily that these boxes are intact and in date.

6.6 MEDICINES BROUGHT TO HOSPITAL BY PATIENTS

Patients are asked to bring their medication into hospital when they are admitted. This enables the medical, nursing, and midwifery staff to determine the patient's current drug therapy. Should the patient self-discharge or abscond, and then return to the ward, the patient's recent drug history should be re-established.

Medicines brought into hospital are the property of the patient to whom they are supplied, and cannot be taken from them without their consent (unless he/she is detained under the Mental Health Act).

When a patient is admitted, the nurse/midwife will enquire whether they have any medicines with them.

If these medicines are no longer required for treatment in hospital and the patient agrees, they must be sent home in the care of a responsible adult or placed in a hospital Patient's Own Green Medication bag, which is stored within a locked drug room until the patient is discharged.

The use of a patient's own medication may only be allowed in certain circumstances:

a) Where the drug is non-formulary and this, or an alternative, is not available from Pharmacy
b) Where the ward operates a self-administration medication programme (refer to 3.4)
c) If use of the drug is essential (e.g. overnight) until supplies are available from Pharmacy. The person administering the medicine must satisfy themselves that the patient's own medicine is safe to administer, until confirmation is received from pharmacy
d) Where the medicine is contained within a patient's blister pack and not available in the hospital. In these cases, the individual medicine must have identifiable markings, and the prescription on the patient's medication chart annotated with these markings by the prescriber

On discharge, if any specific patient's own medicines are not required (i.e. a change in therapy), staff will offer to dispose of the medicines and record the patient's agreement to do so.

All remaining patient's own medicines must be returned to the patient, after being checked by the registered nurse/midwife undertaking the discharge, to ensure that the medicines are for that named patient.

6.7 CONTROLLED DRUGS AND ILLEGAL SUBSTANCES BROUGHT TO HOSPITAL (refer to 5.9)

6.8 CONTROLLED STATIONERY

Controlled stationery is any stationery, which, in the wrong hands, could be used to obtain medicines fraudulently. The following stationery is considered controlled by the Hutt Valley DHB, and must be stored in a secure manner:

- Controlled drug register
- Outpatient prescription form (controlled and non-controlled)

6.9 SAFE KEEPING OF CONTROLLED & OTHER MEDICINES BY NURSES WORKING IN THE COMMUNITY

In exceptional circumstances, community nurses may need to transport patient's own prescribed medicines. These medicines must be kept in a locked receptacle which, when not being carried by the nurse, must be in a locked container. During the hours of duty, the locked receptacle may be in the locked boot of their car.

6.10 DISPOSAL OF MEDICINES

Pharmaceutical waste is classified as hazardous, and must be disposed of appropriately.

Acute hospital stocks must be returned to the pharmacy. Patient's own drugs must only be returned for destruction if the patient or their parent/guardian gives approval.

Expired controlled drugs must be returned to pharmacy for destruction in accordance with the Misuse of Drugs Act 1975.

Cytotoxic or cytostatic agents must be disposed of in a purple cytotoxic waste bags or plastic bins; cytotoxic agents are segregated from other pharmaceutical waste and are disposed of as hazardous waste.

Other non-cytotoxic pharmaceutical waste must be disposed of in yellow waste bags or yellow sharps bins.

Certified and trained orderlies will collect hazardous waste from the ward/department disposal area and transport it to the designated waste hold. This waste is then collected by Interwaste, who transports it to Wellington to be treated and disposed of appropriately.

Community nursing staff must not remove any drugs from a patient's home without consent from the patient or authorised carer.

When a patient dies or medication is discontinued, the community nurse must either obtain consent from the family to remove the drugs **OR** instruct the family to dispose of the drugs immediately by returning them to the supplying pharmacy. In exceptional circumstances, (e.g. when the patient lives alone), the nurse may return such items for appropriate disposal. Full records of the nature of the medicines, quantity, and disposal method must be maintained within the patient's records.

For more information on waste management, see the Waste Management Policy.

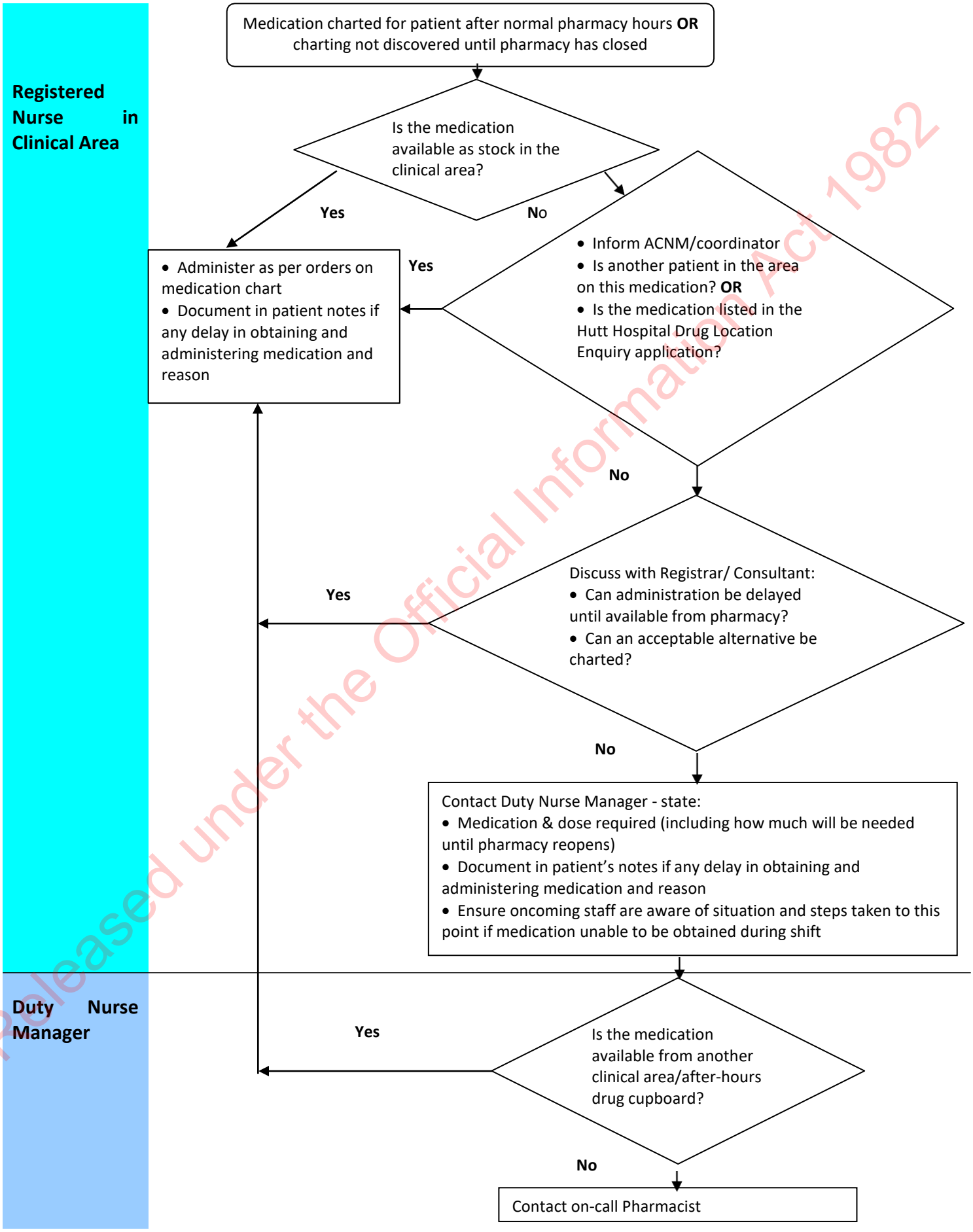
6.11 COLD CHAIN STORAGE OF VACCINES AND OTHER PHARMACEUTICAL PRODUCTS

Hutt Valley District Health Board staff who perform duties away from their normal base must ensure that any pharmaceuticals requiring refrigeration are stored in an appropriate temperature controlled container (i.e. cooler bag or chilly bin with ice packs).

Vaccines must be stored and handled in accordance with the Ministry of Health's National Standards for Vaccine Storage and Transportation for Immunisation Providers (2017).

Items that require refrigerated storage MUST NOT be allowed to return to room temperature before re-chilling. Particular care must be taken during summer months.

Appendix 1: Obtaining Medication After-hours



Appendix 2: IV Medication Decision Making Framework

What is concerning you about administering this IV medication?

Identify the concern:

Skill/knowledge:

- You lack the knowledge or skill to administer and/or monitor the patient
- Other nursing staff in the area lack the knowledge or skill to administer and/or monitor the patient

The Medication:

- Rarely given in the clinical/practice setting
- High risk of side effects/potential for error (see list)

Monitoring:

- Staffing skill mix inadequate/does not allow for close monitoring of patient
- High degree of monitoring/frequency of observations required e.g. telemetry

The Route:

- Route of administration increases risks e.g. central line

Re-Constitution methods (environmental considerations):

- Closed system required

Examples (list not exclusive):

- Concentrated potassium bolus
- Heparin
- Insulin infusion
- Opioids
- Cytotoxics
- Cardiac medications—inotropes, antiarrhythmics

Make the decision:

Discuss with senior nurse in charge:

- Analyse the individual situation
- Use clinical judgment to make a decision to administer or not based on the risks vs. benefits to the patient
- Use resources (see list) available to guide administration decision
- Inform Dr of issues involved

Resources:

- Senior nurses in area/ Coordinator/ACNM/CNM/Educator
- Duty Nurse Manager (DNM)
- Critical Care Outreach Nurse (CCON)
- Notes on Injectable Drugs
- Pharmacist
- Transfusion medicine department
- IV & related Therapies Manual
- MIMS & Compendium
- Medsafe web site
- Clinical Educator – IV & Related Therapies

Can you or another nurse in the clinical area safely administer the medication?

Yes

Medication Administered

- Ensure management plan in place (monitoring requirements, when to notify Dr etc.)
- Document process & actions taken.
- Complete reportable event if required (e.g. significant delay in administration)

No

The nurse caring for the patient takes responsibility for ensuring the patient receives medication in a timely manner by making alternative arrangements

NB: Inform medical staff of potential delay to administration.

Options for administration include:

1) Medical staff administers
   - Remains in the ward/unit for appropriate timeframe after administration
   - Ensures doctor to doctor handover
   - Clearly documents a management plan in patients notes (monitoring requirements, when to notify Dr etc)

Senior nurse in charge supports following:

2) Appropriately trained and skilled senior nurse from another area administers or supervises administration, e.g. DNM; CCON; RN from ICU, CCU
3) Patient is transferred to a more appropriate clinical area for administration, e.g. ICU, CCU

Resolved

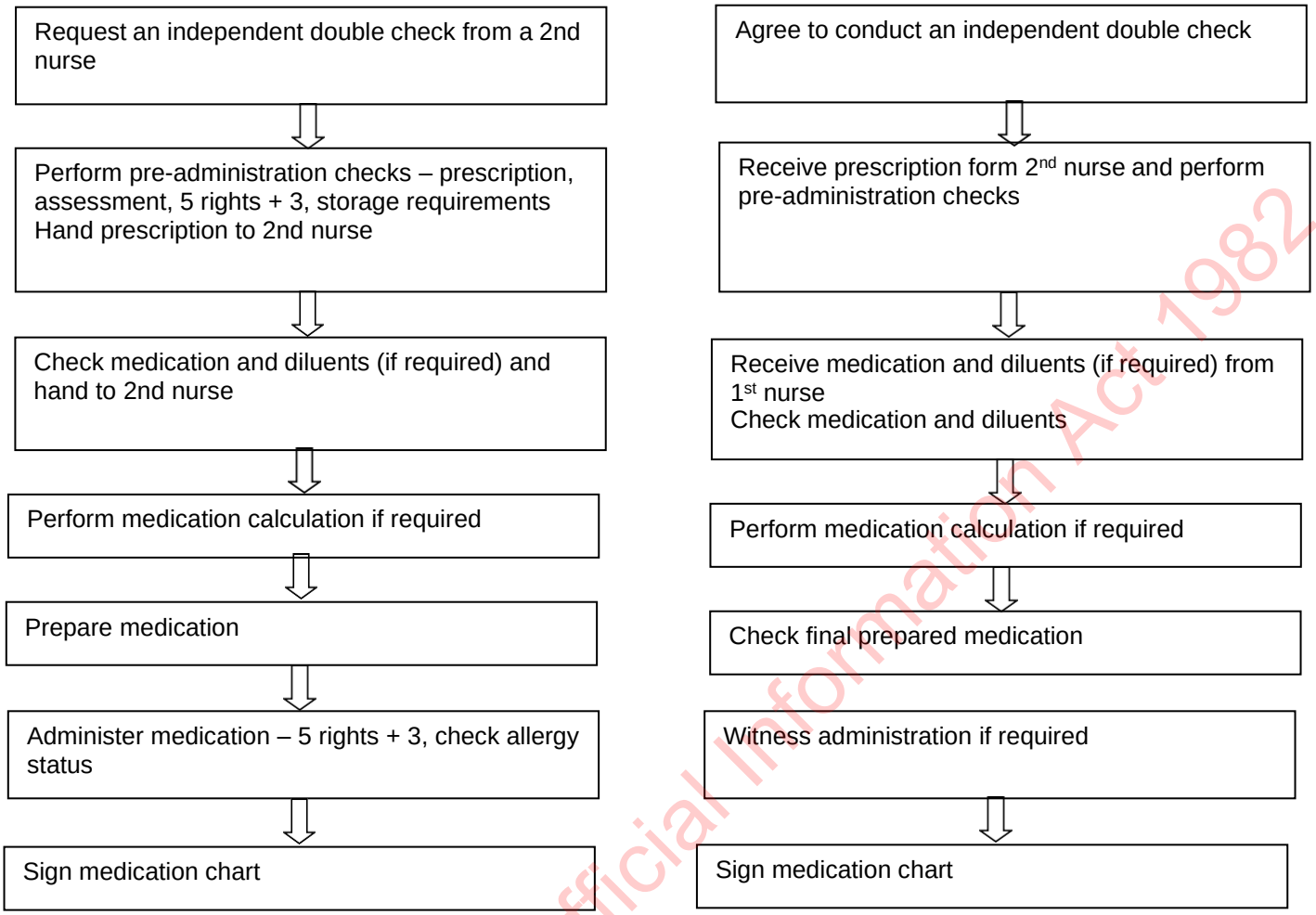
Yes

No

Seek arbitration from Senior Nurse in Charge/ DNM

- Document
- Complete reportable event
- Inform Dr of issues involved

Appendix 3: The Independent Double Check Process (with Acknowledgement to Starship Hospital)



Independent double checking and *witnessed* administration is required for:

- All blood and blood products
- All IV controlled medicines
- All IV cytotoxic
- IV heparin
- IV insulin
- Patient Controlled Analgesia (PCA) – setting up and changing bags/ syringes
- Epidural Additives
- IV Bronchodilators
- IV Glucose >10%
- IV Cardiac Medicines – antiarrythmics, inotropes
- Medications administered to Children (with some exceptions) see Section 4.6 *Administration of Medicines to Children*

Independent double checking and *single* administration is required for:

- Oral, subcutaneous, and IM controlled drugs
- Any medicine which is not supplied in the required dose, and therefore, the dosage needs to be calculated (not including number of tablets/capsules)

NB: These lists are not exclusive. Any clinician, may at any time, request an independent double check – in particular if they are unfamiliar with the medicine, the clinical environment and/or patient diagnosis. Some clinical areas may also have their own requirements in regards to IDC.

Appendix 4: Entering Electronic Drug Alerts

Drug Alerts

Drug	Type of Reaction	Detail of Reaction	Created by	Date Created
AMINOPHYLLINE	1 - Life Threatening	-	AlertAll	23-Apr-09

Infection Control Alerts

Alert	Comment	Review Date	Created by	Date Created
IC CONTACT TRACING	Patient has had contact with infectious patient and requires screening. Contact isolate and discuss with Infection Control nurses.	22-Jul-09	AlertAll	23-Apr-09
VRE	MDRO - contact isolation on admission and inform Infection Control nurses.	-	AlertAll	23-Apr-09

Other Alerts

Category	Alert	Comment	Created by	Date Created
DISEASE	ASTHMA	-	AlertAll	23-Apr-09
OTHER	ALCOHOL	-	AlertAll	23-Apr-09

NHI Medical Warnings

Severity	Date of Onset	Warning Desc
WARNING	01-Jan-08	Test Warning

Drug alerts and Infection Control Alerts are in red because they are validated.

Other Alerts and NHI Medical Warnings show in blue because they are for your information only, and have not been reviewed by the Ministry of Health.

*******Junior Medical Staff can only enter Drug Alerts*******

 Click on the Alert icon for more information / to create / update alerts.

Red indicates the patient has an alert. Grey indicates there is no alert.

Add Alert Via Concerto

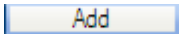
Choose Alert type from the drop down box

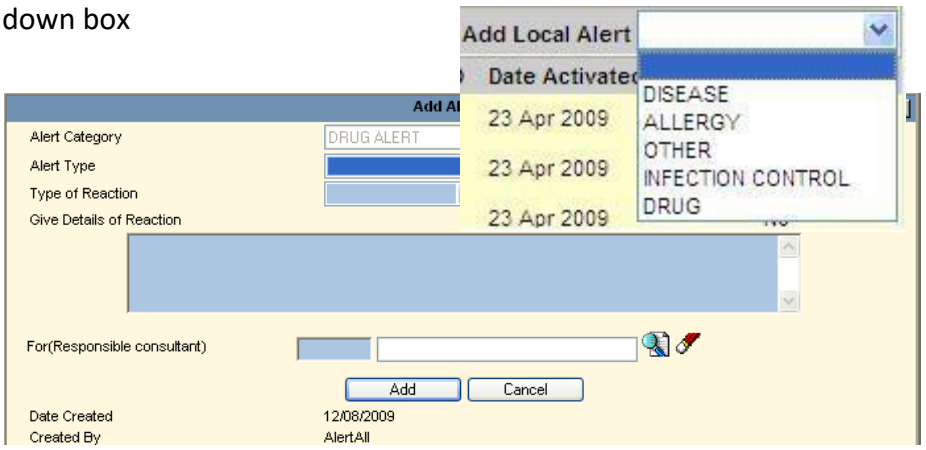
Fill in the blue mandatory fields and others as required

 Click on the search icon to find the Responsible Consultant

 Select the date

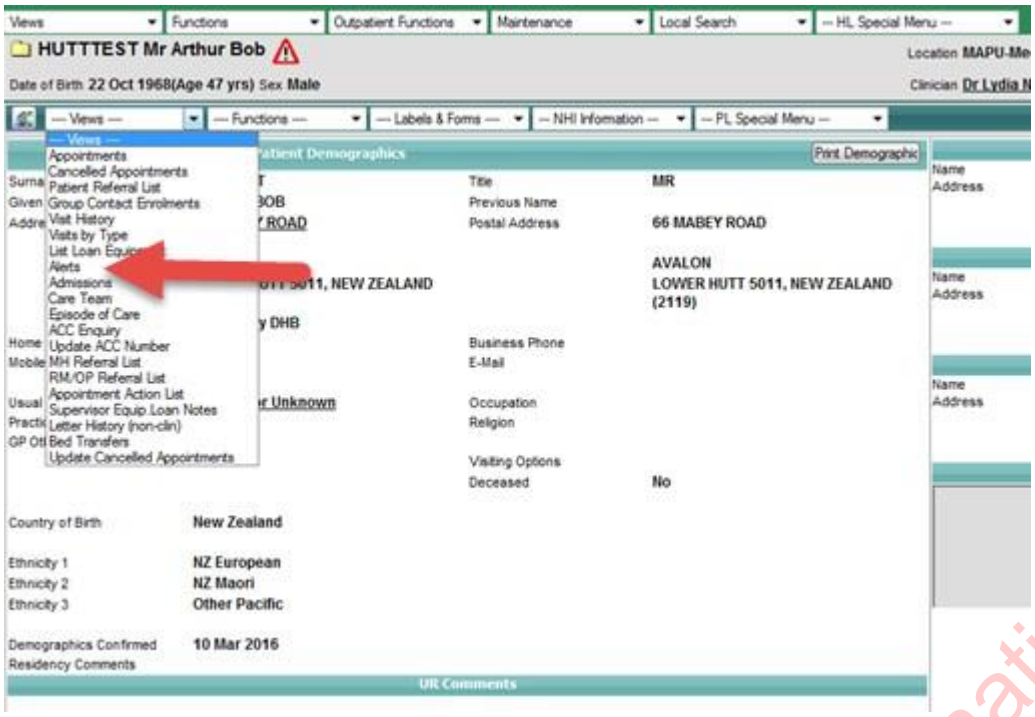
 Enter the time now

Click on 



Add Alert Via WebPAS

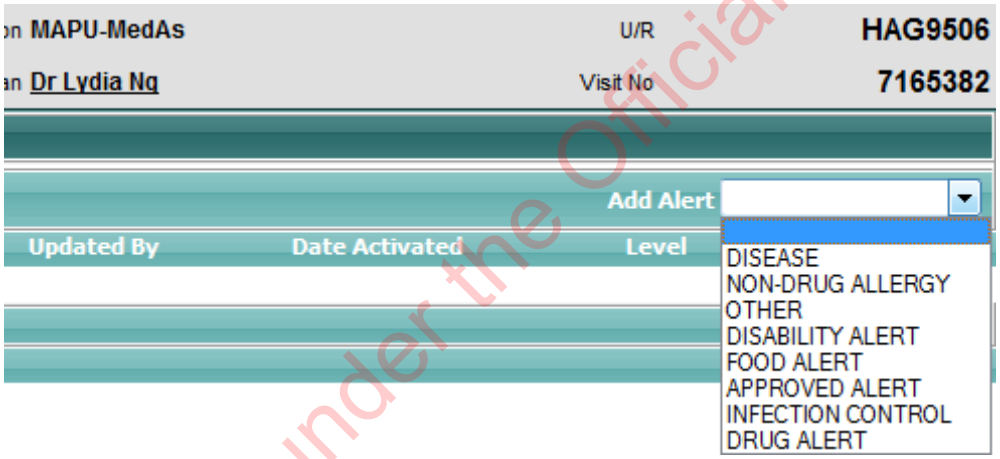
Search patient

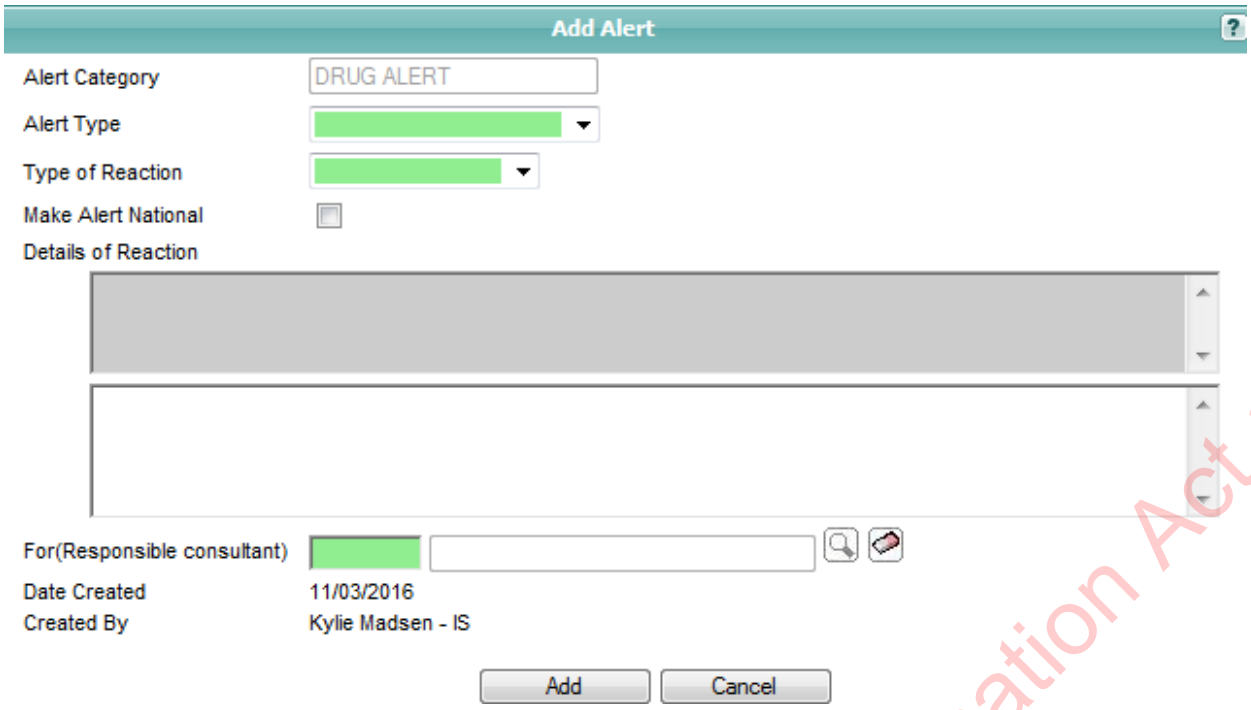


Select Alerts

This will show a list of current alerts for this patient. Choose Add Alert, top right hand corner.

Select Alert Type.





Fill in the blue mandatory fields and others as required.

Click on the search icon to find the Responsible Consultant.

Click on Add

Adding Drug Alert Guidelines

There are four categories of drug alerts: Life Threatening, Allergy, Possible Allergy and Intolerance / Side effect.

Give as much detail about the reaction as possible: e.g.

- How soon after the drug was administered did the reaction occur?
  - Immediately or a few days into the treatment?
- What type of reaction was it?
  - Urticarial rash, macular rash?
  - Itchiness?
  - Tongue swelling?
  - Hypotension?
  - Bronchospasm?

Be as specific and complete as possible.

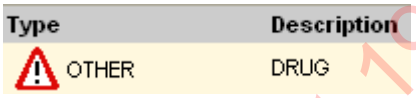
If the reaction is unknown (because it occurred in childhood) make this clear in the comment. E.g the patient "had a bad reaction, when they were a child but they do not know what this was". This can be updated when other family members are present.

If there are multiple new drugs and the drug to which the patient has had the reaction is uncertain please refer the patient to Immunology in Wellington. If the reaction is uncertain but the drug is important such as penicillin in a patient with recurrent chest infections please refer to Immunology.

If you need to add a drug alert, but there is no drop down option displayed, use category 'Other' and type the drug name into the 'please specify' field.

Contact the IS Helpdesk to ensure you can add drug alerts in the future: helpdesk@huttvalleydhb.org.nz or x8227

Update / Deactivate Alert



Click on Alert icon in the alert screen to make changes

Click on Update to update changes

Click on Deactivate to deactivate the alert

View Inactive Alerts

Click on Inactive Alerts to view Inactive alerts

Click on Alerts to return to the Active Alerts view

Print Alerts

Click on 'Print Preview Patient Alerts' then click on the printer