Family Nursing & Home Care

Standard Operating Procedures
Medicines Management

May 2020

Document Profile

Type	Standard Operating Procedures
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Document Amendments

Version Number	Amendments
3	Role titles updated Inclusion of reference to Jersey Care Commission Minor changes made to provide greater clarification Adrenaline does not necessarily need to be obtained from the New Era Pharmacy Locale Process for delegation updated and link to updated delegation SOPs added SOPs updated to reflect the new Government of Jersey Administration of Controlled Drugs in the Community Policy Senior Healthcare Assistants can now also transport controlled drugs subject to the conditions detailed in SOP 5

	Community nursing staff and Senior Healthcare Assistants now no longer have a paper diary – new process in place for the transportation of controlled drugs

Contents

Introduction

These standard operating procedures (SOPs) relate to the following areas of medicines management:

- Drug errors
- Replacement of Adrenaline
- Shared Administration of Medication
- Administration of Medicines in Care Homes
- Controlled Drugs

They are to be used in conjunction with the organisational Medicines Policy and Government of Jersey document, Management of Controlled Drugs in patients homes (tabled for ratification March 2020).

SOP 1 Drug Error

Purpose

This SOP enables immediate action to be taken to safeguard the patient should an actual or near-miss drug error take place. In the event of this happening, the organisation is able to take any immediate or remedial action and review its procedures to minimise the chance of a similar incident occurring in the future.

Scope

This standard operating procedure (SOP) pertains to errors involving all medications including immunisations and covers immediate action, reporting and patient follow-up.

It must be followed in the event of a 'near-miss' or actual drug error that involves any aspect of drug administration e.g.:

- transporting drugs
- preparing medications
- prompting patients or carers
- administering a prescribed drug to a specific patient
- maintaining accurate records

Drug errors may be identified when they occur or, as and when the individual or other staff member is undertaking subsequent treatment or during follow up visits.

Core Requirements

1. Immediate action

Assess the severity of the error to the best of your ability and initiate immediate first aid, involving Emergency Services if necessary.

Telephone a senior staff member, in order to report the error and receive advice on the way forward, which must include informing the GP. All drug errors must be reported to a senior staff member as soon as the incident has been identified and after first aid is given, if necessary.

Inform the patient/relative.

Record an accurate account of the incident and actions taken in the client's nursing notes.

2. Incident Reporting

Input the incident onto the Assure system. Drug errors will be reported by the Line Manager to senior managers by the first working day following the incident and an investigation will be instigated following the Incident/Near Miss Assure process.

The Operational Lead or their deputy must inform the Head of Quality, Governance and Care that an incident has occurred and is under investigation. Where

appropriate the Pharmacy Advisor may be involved in addressing the problems/issues identified.

If the drug error has resulted in harm to the patient/client/child, this must be reported to the Jersey Care Commission within two working days of the incident occurring. Such reporting is normally undertaken by the relevant Registered Manager or the Head of Quality, Governance and Care.

If the error is deemed to be a Serious Incident (SI), the Head of Quality, Governance and Care will inform the Pharmacy Advisor and may request that they take part in the investigation and outcomes.

On a quarterly basis the Head of Quality, Governance and Care will send the Pharmacy Advisor a report of the analysis of all drug errors that have occurred including the outcomes of investigations.

3. Follow up visits

Follow up visits to check the patient's condition should be undertaken as requested by the GP or as assessed as necessary by the practitioner.

SOP 2 Annual Replacement of Adrenaline

Purpose

Adrenaline carried by staff is not always kept in optimum storage conditions therefore all adrenaline supplies issued by Family Nursing & Home Care must be replaced annually

Scope

This standard operating procedure (SOP) pertains to the annual replacement of adrenaline by all adrenaline carriers and supplies held in/for clinics.

Core Requirements

All supplies of adrenaline must be replaced annually regardless of it still being within its expiry date.

At the beginning of September, the Clinical Effectiveness Facilitator orders the adrenaline using a purchase order form and requests the GP Advisor to send written authorisation to the supplying pharmacy in support of the order.

Supplies of adrenaline are obtained from a local community Pharmacy and stored at Le Bas in a locked cabinet. The amount of stock received is documented on the appropriate form.

At the beginning of October (or earlier if supplies available) the Clinical Effectiveness Facilitator asks the Operational Leads to email all relevant staff to inform them that they must replace their adrenaline by the end of the month (even though it may not be out of date)

Ampoules of adrenaline will be issued to appropriate clinicians on receipt of their 'old' adrenaline supply by the Clinical Services Administrator or a member of The Hub Team.

Clinicians must also have completed all essential training.

All relevant staff must collect and sign for their new adrenaline during October. The Clinical Service Administrator / or a member of the Hub will be responsible for overseeing the signing in and out of adrenaline and will keep an up to date register of those who have done this.

It is the responsibility of Line Managers to inform the Education and Development Department of any 'new starts' or 'leavers' from the Adrenaline Users Register.

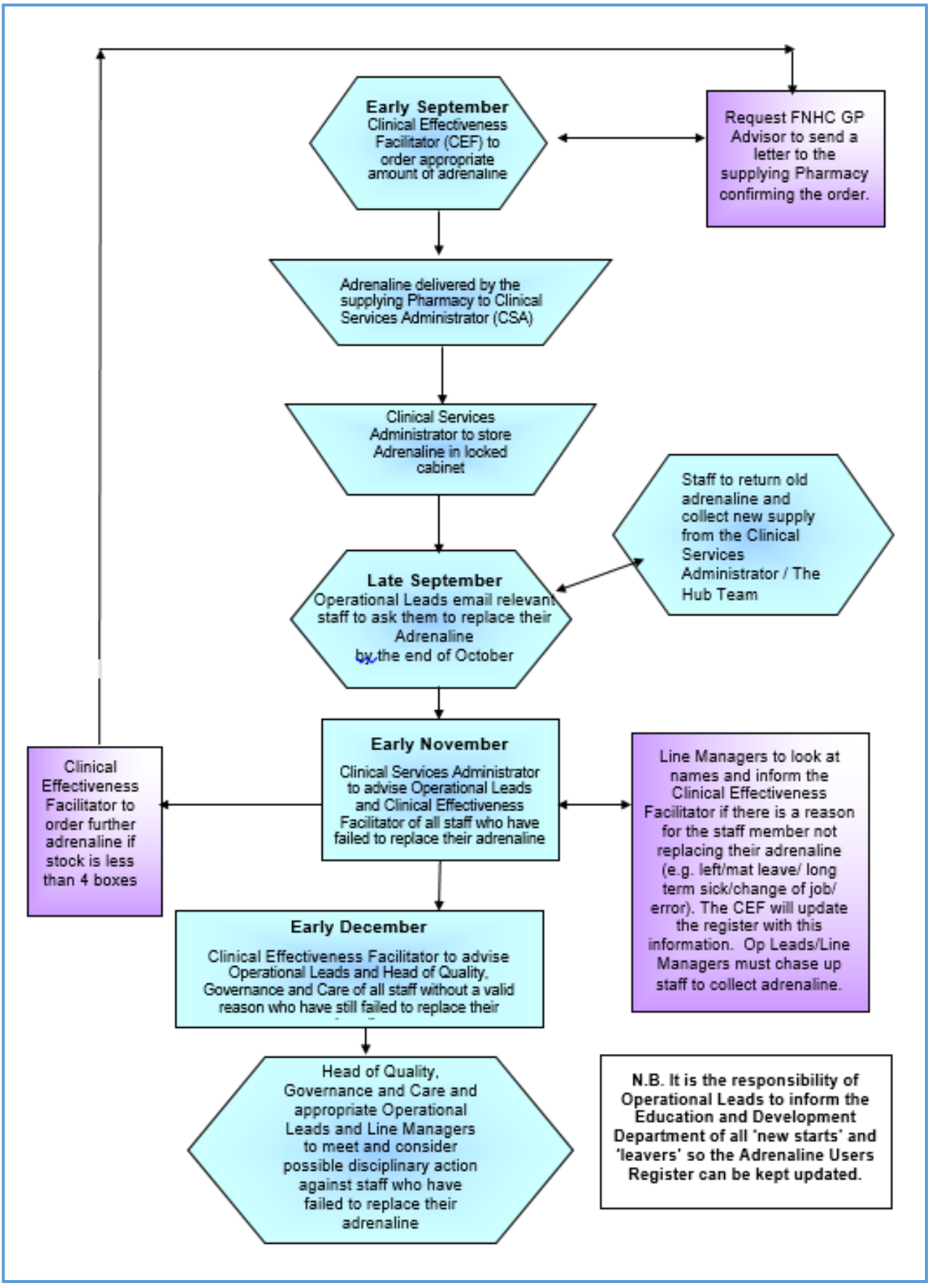
At the beginning of November the Clinical Service Administrator will inform the Clinical Effectiveness Facilitator and the Operational Leads of any staff who have failed to replace their adrenaline.

It will be the responsibility of the Operational Leads to ensure that all their staff comply with this procedure and inform the Clinical Effectiveness Facilitator of any acceptable reason why a staff member hasn't replaced their adrenaline e.g. long term sick, maternity leave.

At the beginning of December the Clinical Effectiveness Facilitator will forward the names of any staff who have still failed to comply with requests to renew their adrenaline supply to the Head of Quality Governance and Care and relevant Operational Leads.

The Head of Quality, Governance and Care will meet with the appropriate Operational Leads and Line Managers to consider possible disciplinary action against staff without a valid reason for not replacing their adrenaline.

All nursing staff involved in running clinics must ensure that there is adrenaline available and that it is in date. Adrenaline for clinics must be collected and signed for annually as stated above. Please see flow chart overleaf


Early September
Clinical Effectiveness Facilitator (CEF) to order appropriate amount of adrenaline
Request FNHC GP Advisor to send a letter to the supplying Pharmacy confirming the order.
Adrenaline delivered by the supplying Pharmacy to Clinical Services Administrator (CSA)
Clinical Services Administrator to store Adrenaline in locked cabinet
Staff to return old adrenaline and collect new supply from the Clinical Services Administrator / The Hub Team
Late September
Operational Leads email relevant staff to ask them to replace their Adrenaline by the end of October
Early November
Clinical Services Administrator to advise Operational Leads and Clinical Effectiveness Facilitator of all staff who have failed to replace their adrenaline
Clinical Effectiveness Facilitator to order further adrenaline if stock is less than 4 boxes
Line Managers to look at names and inform the Clinical Effectiveness Facilitator if there is a reason for the staff member not replacing their adrenaline (e.g. left/mat leave/ long term sick/change of job/ error). The CEF will update the register with this information. Op Leads/Line Managers must chase up staff to collect adrenaline.
Early December
Clinical Effectiveness Facilitator to advise Operational Leads and Head of Quality, Governance and Care of all staff without a valid reason who have still failed to replace their
Head of Quality, Governance and Care and appropriate Operational Leads and Line Managers to meet and consider possible disciplinary action against staff who have failed to replace their adrenaline
N.B. It is the responsibility of Operational Leads to inform the Education and Development Department of all 'new starts' and 'leavers' so the Adrenaline Users Register can be kept updated.

SOP 3 Shared Administration of Medication

Purpose

To ensure that, where the administration of medication is shared, all patients/children, regardless of care setting, receive their medication safely and in a timely manner.

Scope

This standard operating procedure should be followed when the administration of medication is shared with others including parents, agency and care home staff and the patient's family.

Core Requirements

Occasionally it may be necessary to share administration of a medication with other care providers. Wherever possible this situation should be avoided due to the inherent risks involved in this practice.

Where shared administration is unavoidable, a risk assessment must first be carried out in conjunction with the other care providers. If the other care providers are staff from a Care Home or Care Agency, the Registered Manager for that organisation should be involved. The outcome of this must be discussed with the Grade 6 District Nurse/Children's Community Nursing Sister.

Where agreement has been given to share medication administration, the patient/child's care plan in their nursing records must clearly reflect the process for the shared administration of the medicine

All staff must exercise a heightened awareness of the possibility that the drug may already have been administered by another care giver.

Within the risk assessment & care plan, the process for administration and recording must be clearly documented.

There is an expectation that other care providers will comply with the requirements of the risk assessment & care plan.

If the medication being administered is insulin the 'Insulin Authorisation Sheet' must be completed by a Registered Prescriber. Any dose changes must be also be authorised by a Registered Prescriber on this documentation.

Non registrants working for other care providers can be trained to carry out blood sugar monitoring and the administration of insulin to **stable, named** patients with diabetes once they have completed both theoretical and practical training and been deemed competent. Agreement for this arrangement must be obtained from the Registered Manager for the care provider and the Grade 6/Team Leader. N.B. the care provider must be registered with Jersey Care Commission.

The administration of medicines by specialist technique should only be delegated to such providers once it has been established that they have a policy/relevant procedures in place to support this type of administration or undertaking delegated

nursing tasks. Registrants can delegate to FNHC Care Assistants working in adult home care as a medicines policy is in place for this part of the service.

It is acceptable for Registrants in dual registered care homes to administer insulin to diabetic patients who are not under 'nursing care in the home'. They are responsible for maintaining their competency in insulin administration and are responsible for that specific task and not all of the diabetes care of the patients. Patient care plans should reflect this.

See Standard Operating Procedure: Delegation for more information regarding delegation (pending ratification 2020).

SOP 4 Administration of Medication within a Care Home (Adult Care Only)

Purpose

To ensure that adult patients in care homes receive their medication safely and in a timely manner.

Scope

This standard operating procedure should be followed when ***only FNHC staff are administering the medication in question in the care home*** *(i.e. not shared administration with the Care Home staff).*

Core Requirements

For all medication being administered in a care home there must be written authorisation by a registered prescriber available in the hard copy patient record that is supplementary to the EMIS record. N.B. The pharmacy generated 'MAR sheet' is not an authorisation to administer as it is not signed by a registered prescriber.

The care home's 'MAR sheet' must be checked on each occasion before any medication is administered. N.B. pharmacy generated 'MAR sheets' are updated and replaced every month.

FNHC staff are responsible for checking that the care home staff have indicated on the patient's care home 'MAR sheet' any medication being administered by FNHC.

Any medication administered by FNHC staff must be recorded in the patient's hard copy care records that are supplementary to their EMIS care record.

The FNHC care plan should clearly state the process for medication administration and this should include informing the care home staff that administration of the medication has taken place

SOP 5 Transportation of Controlled Drugs

Purpose

To ensure that the security, safe handling and quality of controlled drugs are not compromised during transportation from the dispensing pharmacy to the patient's home.

Scope

Transportation encompasses the transport of all controlled drugs or prescription only medicines that have been prescribed for named patients and where it has been identified that there is no relative or carer available to collect the medicines at that time.

Core Requirements

The patients family/carers should, where possible, arrange to collect controlled drugs from the pharmacy

Registered Nurses or Senior Health Care Assistants (SHCA) should not routinely transport controlled drugs to and from the patient's home

Only in exceptional circumstances can Registered Nurses / SHCA transport controlled drugs or prescription only medicines that have been prescribed for named patients

The senior nurse on duty must be informed and agree for the Registered Nurse / SHCA to transport the controlled drugs from pharmacy to the patient's home

The rationale must be clearly recorded within the patient's nursing records

The Registered Nurse / SHCA collecting the controlled drugs will be required to produce identification to the Pharmacist in the form of their Family Nursing & Home Care identification badge.

The controlled drugs must be transported directly from the dispensing pharmacy to the patient

The controlled drugs must be transported out of sight in a locked boot and should not be left unattended in a vehicle at anytime

Any adverse incidents, near miss or issues that might have led to an adverse incident should be reported following the FNHC Incident Reporting System (Assure)

SOP 6 Storage of Controlled Drugs

Purpose

To ensure that the controlled drugs are stored in an appropriate and safe place within the patient's home.

Scope

Encompasses all controlled drugs that are dispensed to patients for administration by Registered Nurses.

Core Requirements

Registered Nurses have a responsibility to remind patients and their families/carers that controlled drugs can be dangerous if used inappropriately

Appropriate places for storing drugs must be discussed with patients and carers and a 'safe place' agreed. This is particularly important if there are young children resident, visiting or where there are confused/elderly members of the family

Registered Nurses must record the outline of the discussion within the patient's records

Controlled drugs remain the property of the patient from whom they are prescribed

Controlled drugs should be stored in an environment which does not threaten their integrity

Where Registered Nurses have highlighted concerns regarding 'at risk' households, stock levels should be kept to a minimum with concerns being discussed with the relevant Team Leader / Line Manager and the patient's General Practitioner

Extreme care should be taken when different strengths of controlled drug for injection are in use as packaging of different products may appear similar.

Any adverse incident, near miss or dangerous occurrence should be reported following the FNHC Assure incident reporting system.

SOP 7 Recording Controlled Drugs

Purpose

To ensure that all schedule 2 controlled drugs administered by FNHC staff are accurately recorded on the relevant approved controlled drug stock sheet and an accurate balance of stock is maintained.

Scope

This standard operating procedure encompasses all controlled drugs with recording requirements, dispensed to a named patient for administration by authorised community staff and includes recording the receipt of stock and maintaining stock balance.

Core Requirements

All new stock of controlled drugs dispensed for administration by authorised community staff to a named patient, must be recorded on the approved controlled drug stock sheet. In residential homes the home controlled drug register is used.

All new stocks of schedule 2 controlled drugs should be accurately recorded on the controlled drug stock sheet with the number of units received, recorded in words not figures.

The name, strength and quantity of the drug must be recorded and signed by the authorised staff member entering the details.

Stock levels of all drugs should be checked against the ‘stock level’ chart at each administration

Controlled drugs collected from the dispensing pharmacy by relatives/carers - for administration by authorised FNHC staff - should be entered within the record at the **next** visit

Any discrepancies in the stock levels should be double checked and if it still cannot be accounted for, manage as per the ‘Theft or Lost Controlled Drugs’ standard operating procedure.

SOP 8 Administration of Controlled Drugs

Purpose

To ensure the safe and secure handling of controlled drugs during their administration to patients.

Scope

Any occasion where Family Nursing & Home Care staff administer a controlled drug or supervise the self-administration of a controlled drug to the patient.

Core Requirements

Prior to the administration of a controlled drug, the staff member must ensure there is written authorisation from a registered prescriber. A dated, authorisation is required from the prescriber detailing the drug, dose and route of administration and this should be filed in the patient's record.

Administration shall be by an appropriately qualified and competent person.

Registered Nurses should apply their professional judgment, knowledge and skill in a given situation when medicines are administered to a patient

Only controlled drugs checked to be quality assured will be administered e.g. within date, original packaging, prescribed for that specific patient

All reasonable endeavours will be made to gain the patient's consent prior to administration

Administration of drugs will comply with FNHC guidance on the administration of controlled drugs

Nursing staff who administer a controlled drug should ensure they carry an Anaphylaxis Pack and have undertaken anaphylaxis training within the last 12 months [mandatory]

All staff administering controlled drugs via a syringe driver must have completed the McKinley eLearning T34 Syringe Driver Training and ensure the Adult Palliative and Supportive Care: Ambulatory Syringe Pump Policy including Symptom Management [CME McKinley T34 (ml/hour)] Guidelines are followed.

Where staff are administering controlled drugs in a patient's home, these may be checked, administered and recorded by one health care professional if no competent witness is available. However, if a second competent person is available, this must be utilised. This person could be a carer and they should be asked to sign the relevant medicine administration chart and stock sheet.

In recognised 'high risk' situations e.g. family / patients requiring extra support, unstable patient or environmental concerns, a second check must be sought from another healthcare professional.

Where a controlled drug dosage is complex or unfamiliar it is the responsibility of the staff member to ask another competent person to check the calculation. Calculations should be independently checked.

Community staff must record the following information on the relevant medication administration record the:

- medication that is given
- dosage
- expiry date and batch number*
- date and time of administration
- route of administration
- person who administers it and the witness (if available)
- number and strength of ampoules / patches remaining as stock

Any drugs that have been prepared but not administered or where only part ampoules are used, must be accounted for on the controlled drug stock sheet and disposed of, ideally, in a Destruction of Old Pharmaceuticals (DOOP) denaturing kit. Where this is not available and the amount is small, a folded piece of kitchen roll may be placed in a sharps bin and the liquid medication discharged onto the absorbent paper.

If ampoules are accidentally dropped or broken, this must be recorded within the Controlled Drug Stock Sheet, an entry to this effect made in the patient's care record and the line manager must be informed.

When a discrepancy occurs on the recorded stock level on the Controlled Drug Stock Sheet the staff member should attempt to verify the source of the discrepancy by re-counting, exploring the possibility of another health professional administering the drug e.g. GP

If the discrepancy **CANNOT** be accounted for refer to the standard operating procedure (SOP) 'Theft or Loss of Controlled Drugs.'

If discrepancy verified with legitimate reason e.g. accidental damage to ampoule, this should be recorded as an 'incident' via Assure.

If discrepancy relates to an inaccuracy in adding / subtracting totals on the stock sheet, the attending member of staff should asterisk incorrect total and make a note next to this, informing the staff member this relates to. This should be logged via the Assure system and the relevant line manager informed.

SOP 9 The Destruction of Controlled Drugs

Purpose

To ensure controlled drugs which are the property of the patient within the community are either returned to the community pharmacy or destroyed within the patient's home in a safe and controlled manner.

Scope

All controlled drugs which are the property of the patient but staff have been involved in their administration.

Core Requirements

Individual doses of controlled drugs which have been prescribed for a patient and are no longer required, are the patient's property. Staff should advise patients or carers to return the controlled drugs to a Community Pharmacy.

It is the responsibility of the family/carer to return unwanted/unused controlled drugs to the Community Pharmacy when able.

Registered Nurses can only remove controlled drugs from a patient's house in exceptional circumstances. Exceptional circumstances will include:

- a likelihood of abuse of the drugs if left at the patient's house
- no identified carer to take the controlled drugs to the Community Pharmacy

See 'Transportation of Controlled Drugs' SOP. The Community Pharmacist receiving the returned medication must be asked to sign the Controlled Drug Stock Sheet to verify their return.

Small amounts of controlled drugs already in use e.g. unused medication being administered via a syringe pump, only part of an ampoule required – it is acceptable for staff to dispose of this medication and ideally this should be witnessed (see 'Administration of Controlled Drugs' SOP re witnesses).

In cases where the death of a patient is classed as an unexpected death, the patient's controlled drugs should not be destroyed or removed from the house/care home.

In circumstances of the unexpected death requiring further investigation, the Police may seize the patient's controlled drugs as evidence and take responsibility for the appropriate disposal.

Opened/used Fentanyl patches can be rendered irretrievable by removing the backing (if not already removed) and folding the patch upon itself. The patch may then be disposed of in a sharps bin.

The audit trail for controlled drugs must always be traceable.

In situations where a patient is unexpectedly absent from home e.g. admitted to hospital or dies, staff should notify the appropriate relatives of the need to return controlled drugs to the pharmacy for destruction. Where no appropriate person is available and the controlled drugs are unattended in the house, advice should be

sought regarding who could access the property to remove the drugs and return them to the pharmacy.

SOP 10 Theft or Loss of Controlled Drugs

Purpose

To ensure the correct procedure is followed in the event of theft or loss of controlled drugs within the community nursing services of FNHC.

Scope

All controlled drugs which are being administered by Community staff.

Core Requirements

The Line Manager must be informed immediately when controlled drugs are missing and it has not been possible to verify the discrepancy and the controlled drugs are thought to be stolen or 'lost'. An Assure incident record must be completed in line with the Incident Reporting Policy and Procedure as soon as possible.

The Line Manager will inform the Operational Lead who, in agreement with the Head of Quality Governance and Care, or in their absence, the most Senior Manager or C.E.O who will inform the police if this is necessary.

If the theft or loss occurs out of normal working hours, staff must inform the on-call Manager for FNHC (tel. 07700 716794). The on-call Manager has the responsibility to inform the police if deemed appropriate and to inform the Head of Quality Governance and Care the next working day.