

**Standard Operating Procedures**

**Medicines Management**

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**Version Control**

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| May 2025 | 4 | References changed.  Flow chart changed.  Job titles changed. |
| 2022 | 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 4](#_Toc201058829)

[SOP 1 Drug Error 5](#_Toc201058830)

[SOP 2 Annual Replacement of Adrenaline 7](#_Toc201058831)

[SOP 3 Shared Administration of Medication 10](#_Toc201058832)

[SOP 4 Administration of Medication within a Care Home (Adult Care Only) 12](#_Toc201058833)

[SOP 5 Transportation of Controlled Drugs 12](#_Toc201058834)

[SOP 6 Storage of Controlled Drugs 14](#_Toc201058835)

[SOP 7 Recording Controlled Drugs 15](#_Toc201058836)

[SOP 8 Administration of Controlled Drugs 16](#_Toc201058837)

[SOP 9 The Destruction of Controlled Drugs 19](#_Toc201058838)

[SOP 10 Theft or Loss of Controlled Drugs 21](#_Toc201058839)

# 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.

# SOP 1 Drug Error

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| ***Purpose*** |

This Standard Operating Procedure (SOP) enables immediate action to be taken to safeguard the patient in the event of an actual or near-miss drug error. It ensures the organisation can take prompt remedial action and review procedures to minimise the risk of recurrence.

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| ***Scope*** |

This SOP applies to all errors involving medications, including immunisations. It covers immediate action, reporting, and patient follow-up.

It must be followed in the event of a near-miss or actual drug error involving any aspect of medicines management, including:

* Transporting drugs
* Preparing medications
* Prompting patients or carers
* Administering a prescribed drug to a patient
* Maintaining accurate records

Drug errors may be identified at the time of occurrence, during subsequent treatment, or during follow-up visits by the individual or another staff member.

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| ***Core Requirements/Procedure*** |

**Immediate action**

* Assess the severity of the error to the best of your ability and initiate immediate first aid, involving Emergency Services if necessary.
* Contact a senior staff member to report the error and seek guidance, which must include informing the GP.
* All drug errors must be reported to a senior staff member as soon as identified, following the administration of first aid if required.
* Inform the patient and/or relative.
* Record a full and accurate account of the incident and actions taken in the client’s nursing notes and on EMIS.

**Incident Reporting**

* Log the incident on the Assure system.
* The Line Manager must notify senior managers by the next working day following the incident. An investigation will be initiated in accordance with 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 issues identified.
* If the drug error results in harm to the patient/client/child, it must be reported to the Jersey Care Commission within two working days of the incident. This reporting is usually undertaken by the relevant Registered Manager or the Head of Quality, Governance and Care.
* If the error is deemed a Serious Incident (SI), the Head of Quality, Governance and Care will inform the Pharmacy Advisor and may request their involvement in the investigation and review of outcomes.
* On a quarterly basis, the Head of Quality, Governance and Care will provide the Pharmacy Advisor with a report analysing all drug errors and the outcomes of associated investigations.

**Follow up visits**

Follow-up visits to monitor the patient’s condition should be undertaken as requested by the GP or as deemed necessary by the practitioner.

# SOP 2 Annual Replacement of Adrenaline

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| ***Purpose*** |

Due to varying storage conditions in the community, adrenaline carried by staff may not always be kept in optimal conditions. Therefore, all adrenaline supplies issued by Family Nursing & Home Care (FNHC) must be replaced annually, regardless of expiry date.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to all staff who carry adrenaline and to supplies held in or for clinics.

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| ***Core Requirements/Procedure*** |

All adrenaline supplies must be replaced annually, even if the medication is still within its expiry date.

**Ordering Process (September):**

At the beginning of September, the Head of Quality and Safety will place an order for adrenaline using a purchase order form. The Medical Director for Primary Care is requested to provide written authorisation to the supplying pharmacy in support of the order.

**Receipt and Storage of Adrenaline:**

Supplies are obtained from a local community pharmacy and stored at Le Bas in a locked cabinet. The quantity received is recorded on the appropriate documentation.

**Communication to Staff (October):**

At the beginning of October (or earlier if supplies are available), the Head of Quality and Safety will instruct Operational Leads to notify all relevant staff via email that they must replace their adrenaline by the end of the month—even if it remains in date.

**Issue of New Supplies:**

* New ampoules of adrenaline will be issued to appropriate clinicians upon return of their existing supply.
* Clinicians must have completed all essential training before receiving replacement adrenaline.
* All relevant staff must collect and sign for their new adrenaline during October.
* Line Managers are responsible for informing the Education and Development Department of any new starters or staff who have left, so that the Adrenaline Users Register remains current.

**Monitoring Compliance (November):**

Operational Leads must follow up with any non-compliant staff and inform the Head of Quality & Safety of any valid reason for non-compliance (e.g. long-term sick leave, maternity leave).

**Escalation (December):**

At the beginning of December, the Head of Quality & Safety will forward the names of any remaining non-compliant staff to the Director of Governance & Care and the relevant Operational Leads.

The Head of Quality & Safety will meet with the relevant Operational Leads and Line Managers to consider possible disciplinary action for staff who have failed to comply without a valid reason.

**Clinic Adrenaline Supplies:**

All nursing staff running clinics must ensure that adrenaline is available and in date. Adrenaline for clinics must also be collected and signed for annually, in accordance with the process outlined above.

*Please refer to the flow chart overleaf for a visual summary of the process.*

**Please note**: It is the responsibility of the Operational Leads to inform the Education & Development Department od all “new starts” and “leavers” and staff moves in teams so the Adrenaline Users Register can be kept updated.



# SOP 3 Shared Administration of Medication

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| ***Purpose*** |

To ensure that, where medication administration is shared between FNHC staff and others, all patients/children—regardless of care setting—receive their medication safely, appropriately, and in a timely manner.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies when the administration of medication is shared with others, including parents, family members, agency staff, and care home personnel.

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| ***Core Requirements/Procedure*** |

In certain situations, it may be necessary to share the administration of medication with other care providers. However, wherever possible, this practice should be avoided due to the associated risks.

When shared administration is deemed unavoidable, a risk assessment must be completed jointly with the other care provider(s).

* If the care provider is a Care Home or Care Agency, the Registered Manager of that organisation must be involved.
* The outcome of the risk assessment must be discussed with the Grade 6 District Nurse or the Children’s Community Nursing Sister, as appropriate.

Where agreement has been reached to share medication administration:

* The patient or child’s care plan in the nursing records must clearly outline the process for shared administration.
* The risk assessment and care plan must include clear documentation of how administration and recording will be managed.
* There is an expectation that other care providers will adhere to the requirements outlined in the risk assessment and care plan.
* FNHC staff must maintain a heightened awareness of the possibility that the medication may already have been administered by another caregiver.

**Insulin-Specific Guidance:**

Where the medication is insulin, an Insulin Authorisation Sheet must be completed by a Registered Prescriber. Any changes to dosage must also be authorised on this document.

Non-registrants employed by other care providers may be trained to carry out blood glucose monitoring and administer insulin to stable, named patients with diabetes—only after they have completed both theoretical and practical training and been deemed competent.

Approval for this arrangement must be given by:

* The Registered Manager of the external care provider; and
* The Grade 6 / Team Leader at FNHC.
* The care provider must be registered with the Jersey Care Commission.

**Delegation of Specialist Techniques:**

Medicines administered using specialist techniques should only be delegated to other providers if it is confirmed that:

* They have an appropriate policy or procedure in place to support this type of administration or delegated nursing task.

FNHC Registrants may delegate administration to FNHC Care Assistants working in adult home care, as a relevant medicines policy exists for that part of the service.

**Care Homes – Dual Registration:**

It is acceptable for Registered Nurses in dual-registered care homes to administer insulin to diabetic residents who are not under formal “nursing care in the home”.

* These nurses are individually responsible for maintaining competency in insulin administration and for that specific task only.
* They are not responsible for the wider diabetes management of the patient.
* The patient’s care plan must clearly reflect this arrangement.

*See the SOP: “*[*Delegation of Nursing Tasks to Non-Registrants by District Nursing Teams*](https://www.fnhc.org.je/procedure-library/)*” for more detailed guidance on delegation.*

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

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| ***Purpose*** |

To ensure that adult patients residing in care homes receive their medication safely and in a timely manner when it is administered solely by Family Nursing & Home Care (FNHC) staff.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies only when medication is administered exclusively by FNHC staff within a care home setting. It does not apply to situations involving shared administration between FNHC and care home staff *(see SOP: Shared Administration of Medication)*.

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| ***Core Requirements/Procedure*** |

**Prescriber Authorisation:**

There must be clear written authorisation from a registered prescriber for any medication administered by FNHC staff.

This authorisation must be present in the hard copy patient record held at the care home, which is supplementary to the EMIS record.

Note: The pharmacy-generated Medication Administration Record (MAR) sheet does not constitute valid authorisation, as it is not signed by a prescriber.

**MAR Sheet Review:**

The care home’s MAR sheet must be reviewed by FNHC staff each time medication is administered.

Note: Pharmacy-generated MAR sheets are typically updated and reissued monthly.

FNHC staff must ensure that any medication administered by FNHC is clearly indicated on the patient’s MAR sheet by care home staff.

**Documentation of Administration:**

All medication administered by FNHC staff must be recorded in the hard copy patient care records held at the care home, which supplement the EMIS record.

The FNHC care plan must outline the process for medication administration and include a clear instruction to inform care home staff that the medication has been given.

# SOP 5 Transportation of Controlled Drugs

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| ***Purpose*** |

To ensure that the security, safe handling, and quality of controlled drugs are maintained during transportation from the dispensing pharmacy to the patient’s home.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to the transportation of all controlled drugs or prescription-only medicines (POMs) prescribed for named patients, where no relative or carer is available to collect the medication at the time of dispensing.

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| ***Core Requirements/Procedure*** |

Wherever possible, the patient’s family or carers should collect controlled drugs directly from the pharmacy.

Registered Nurses or Senior Health Care Assistants (SHCAs) should not routinely transport controlled drugs to or from the patient’s home.

Transportation by FNHC staff should only occur in exceptional circumstances and must meet the following conditions:

* The senior nurse on duty must be informed and must approve the transportation by the Registered Nurse or SHCA.
* The rationale for transportation must be clearly documented in the patient’s nursing records.

The Registered Nurse or SHCA collecting the controlled drugs must provide official FNHC identification to the dispensing pharmacist (e.g. an FNHC ID badge).

Controlled drugs must be transported:

* Directly from the pharmacy to the patient’s home without unnecessary stops or detours.
* Out of sight, ideally in the locked boot of a vehicle.
* Never left unattended in the vehicle at any time.

Any adverse incidents, near misses, or issues that could have resulted in an adverse event must be reported via the FNHC Incident Reporting System (Assure).

# SOP 6 Storage of Controlled Drugs

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| ***Purpose*** |

To ensure that controlled drugs are stored appropriately and safely within the patient’s home, protecting both the integrity of the medication and the safety of individuals in the household.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to all controlled drugs dispensed to patients for administration by Registered Nurses.

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| ***Core Requirements/Procedure*** |

**Patient Education:** Registered Nurses have a duty to remind patients and their families/carers that controlled drugs can be dangerous if used inappropriately.

**Safe Storage Location:** Nurses must discuss suitable storage options with the patient and/or carers, and a ‘safe place’ for storage must be agreed. This is particularly important in households where there are young children, vulnerable adults, or individuals who are confused or elderly. The outcome of this discussion, including details of the agreed safe storage location, must be clearly documented in the patient’s nursing records.

**Ownership:** Controlled drugs remain the property of the patient for whom they have been prescribed.

**Storage Conditions:** Controlled drugs must be stored in a way that:

* Maintains their integrity (e.g. appropriate temperature, protection from moisture/light); and
* Minimises the risk of unauthorised access or misuse.

**‘At Risk’ Households:** Where concerns arise regarding the safety of drug storage (e.g. in at-risk households), stock levels should be kept to a minimum. Concerns must be discussed with the relevant Team Leader / Line Manager and the patient’s GP.

**Similar Packaging Warning:** Extra care must be taken when handling or administering different strengths of controlled drugs for injection, as packaging may appear similar across products.

**Incident Reporting:** Any adverse incident, near miss, or dangerous occurrence must be reported via the FNHC Assure Incident Reporting System.

# SOP 7 Recording Controlled Drugs

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| ***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 that an accurate balance of stock is maintained at all times.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to all controlled drugs with recording requirements that are dispensed to named patients for administration by authorised community staff. It includes the recording of new stock and the ongoing maintenance of stock balance.

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| ***Core Requirements/Procedure*** |

**Recording New Stock:** All new stock of controlled drugs dispensed for administration by authorised FNHC staff must be recorded on the approved Controlled Drug Stock Sheet.

In residential care homes, the home’s Controlled Drug Register must be used.

For Schedule 2 controlled drugs, the quantity received must be recorded in words, not figures.

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

**Stock Check at Each Administration:** Prior to administering a controlled drug, staff must check the recorded stock against the stock level chart to confirm accuracy and identify any discrepancies.

**Drugs Collected by Relatives/Carers:** If a controlled drug is collected from the dispensing pharmacy by a relative or carer (but is to be administered by authorised FNHC staff), this must be recorded on the Controlled Drug Stock Sheet at the next visit.

**Discrepancies in Stock Levels:** If a discrepancy is identified in the stock balance:

* It must be double-checked for accuracy.
* If the discrepancy cannot be accounted for, it must be escalated and managed in accordance with the SOP: [*Theft or Loss of Controlled Drugs*](#_SOP_10_Theft).

# SOP 8 Administration of Controlled Drugs

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| ***Purpose*** |

To ensure the safe and secure handling of controlled drugs during administration to patients by Family Nursing & Home Care (FNHC) staff.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to all situations where FNHC staff:

* Administer a controlled drug to a patient, or
* Supervise the patient’s self-administration of a controlled drug.

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| ***Core Requirements/Procedure*** |

**Authorisation and Professional Responsibility**

Prior to administration, staff must ensure there is written authorisation from a Registered Prescriber, dated and detailing:

* The drug,
* The dose, and
* The route of administration.

This authorisation must be filed in the patient’s care record.

Controlled drugs may only be administered by an appropriately qualified and competent person.

Registered Nurses are expected to apply their professional judgement, knowledge, and clinical skills when administering medicines.

**Drug Integrity and Patient Consent**

Only controlled drugs that are:

* In-date,
* In original packaging, and
* Prescribed for the specific patient

may be administered.

All reasonable steps must be taken to gain the patient’s consent before administration.

Administration must follow FNHC guidance on the use of controlled drugs.

**Training and Safety Requirements**

Nursing staff administering controlled drugs must:

* Carry an Anaphylaxis Pack, and
* Have completed anaphylaxis training within the past 12 months (mandatory).

Staff administering controlled drugs via syringe driver must:

* Complete the McKinley eLearning Bodyguard Syringe Driver Training, and
* Adhere to the [Syringe Pump Policy](https://www.fnhc.org.je/procedure-library/).

**Witnessing and Double-Checks**

In the patient’s home, controlled drugs may be checked, administered, and recorded by a single healthcare professional, if no competent witness is available.

If a second competent person is available (e.g. a carer), they should:

* Be used as a witness where possible, and
* Sign the Medication Administration Record (MAR) and Controlled Drug Stock Sheet.

In recognised high-risk situations (e.g. patients needing additional support, environmental risks, unstable condition), a second check must be sought from another healthcare professional.

**Complex or Unfamiliar Dosages**

Where dosage is complex or unfamiliar, staff must request an independent check from another competent person.

All calculations must be independently verified to reduce the risk of error.

**Documentation Requirements**

The following must be recorded on the Medication Administration Record:

* Name of medication
* Dosage
* Expiry date and batch number (if applicable)
* Date and time of administration
* Route of administration
* Name of administering staff and witness (if applicable)
* Number and strength of ampoules or patches remaining as stock

**Disposal and Losses**

Any drugs prepared but not administered, or partially used ampoules must be accounted for on the Controlled Drug Stock Sheet and disposed of appropriately.

Preferred disposal method: DOOP (Destruction of Old Pharmaceuticals) denaturing kit.

If a DOOP kit is not available and the quantity is small, absorbent material (e.g. folded kitchen roll) may be placed in a sharps bin and the medication discharged onto it.

If ampoules are accidentally dropped or broken, this must be recorded in the Controlled Drug Stock Sheet and noted in the patient’s care record.

The Line Manager must also be informed.

**Discrepancies in Stock Levels**

If a discrepancy in the Controlled Drug Stock Sheet is identified, re-count stock and check for errors, and consider if another professional (e.g. GP) may have administered the drug.

If the discrepancy cannot be accounted for, refer to the SOP: *Theft or Loss of Controlled Drugs*.

If a legitimate reason is verified (e.g. damaged ampoule), report the incident via the Assure system.

If the discrepancy is due to a mathematical error (e.g. in stock totals):

* Asterisk the incorrect total
* Add a clear explanatory note
* Inform the relevant staff member and Line Manager.
* Log the issue via the Assure system.

# SOP 9 The Destruction of Controlled Drugs

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| ***Purpose*** |

To ensure that controlled drugs, which are the property of the patient within the community, are either returned to a community pharmacy or safely destroyed in the patient’s home, following appropriate procedures.

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to all controlled drugs that are the property of the patient, where Family Nursing & Home Care (FNHC) staff have been involved in their administration.

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| ***Core Requirements/Procedure*** |

**General Responsibilities**

Controlled drugs that are no longer required, and have been prescribed to an individual patient, remain the property of the patient.

Staff should advise patients or carers to return any unwanted or unused controlled drugs to a community pharmacy for safe disposal.

It is the responsibility of the family or carer to return the drugs to the pharmacy when they are able to do so.

**Removal of Controlled Drugs by FNHC Staff**

Registered Nurses may only remove controlled drugs from a patient’s home in exceptional circumstances, such as:

* A risk of misuse or abuse if the medication is left in the home;
* No available carer or relative to return the drugs to the pharmacy.

In these cases:

* Refer to the SOP: Transportation of Controlled Drugs.
* The community pharmacist receiving the returned medication must sign the Controlled Drug Stock Sheet to confirm receipt.

**Small Amounts of In-Use Medication**

For small quantities of controlled drugs already in use (e.g. residual medication in syringe drivers, part-used ampoules), staff may dispose of these safely in the patient’s home.

Disposal should ideally be witnessed, and recorded accordingly.

Refer to the SOP: *Administration of Controlled Drugs* for witness guidance.

**Unexpected Death of a Patient**

In the case of an unexpected death, do not remove or destroy the patient’s controlled drugs.

If the death is under investigation, the Police may seize the controlled drugs as evidence and assume responsibility for their disposal.

**Disposal of Fentanyl Patches**

Used or opened Fentanyl patches can be rendered irretrievable by:

* Removing the backing (if still present)
* Folding the patch in half (sticky sides together)
* Disposing of it in a sharps bin.

**Ensuring a Traceable Audit Trail**

There must be a clear and auditable record for the disposal or return of any controlled drug.

All actions related to the destruction or return of controlled drugs must be documented in the patient’s nursing record and reflected in the Controlled Drug Stock Sheet.

**Patient Unexpectedly Absent (e.g. Hospital Admission or Death)**

Where a patient is unexpectedly absent from their home (e.g. hospital admission or death) staff must notify the appropriate relative or carer of the need to return controlled drugs to the pharmacy.

If no appropriate person is available and the drugs are unattended in the property, staff must seek advice on who may be authorised to access the property to retrieve and return the controlled drugs.

# SOP 10 Theft or Loss of Controlled Drugs

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| ***Purpose*** |

To ensure that the correct procedure is followed in the event of the theft or loss of controlled drugs within the community nursing services of Family Nursing & Home Care (FNHC).

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| ***Scope*** |

This Standard Operating Procedure (SOP) applies to all controlled drugs that are being administered by FNHC community staff.

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| ***Core Requirements/Procedure*** |

**Immediate Action**

If controlled drugs are found to be missing, and the discrepancy cannot be verified or accounted for, and theft or loss is suspected, the Line Manager must be informed immediately.

An incident report must be submitted via Assure as soon as possible, in line with FNHC’s *Incident Reporting Policy and Procedure*.

**Escalation Process**

The Line Manager will notify the Operational Lead, who will, in agreement with the Head of Quality and Safety (or, in their absence, the most Senior Manager or Chief Executive Officer), decide whether to inform the Police.

**Out-of-Hours Incidents**

If the suspected theft or loss occurs outside of normal working hours, staff must immediately contact the FNHC On-Call Manager on 07700 716794.

The On-Call Manager is responsible for deciding whether it is appropriate to inform the Police, and informing the Head of Quality and Safety the next working day.