East London NHS
NHS Foundation Trust

Community Health Newham

POLICY FOR THE ADMINISTRATION OF MEDICINES BY NURSING STAFF

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Name of originator/author:	Maggie Parks, Education & Development Manager, George Soutar, Assoc Director of Nursing
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The principles contained within this policy are based upon the Nursing and Midwifery Council (NMC) "Standards for medicines management" (2008)

1.0 Introduction

For the purpose of this policy, the term "medicines" refers to all of the following: controlled drugs, medical gases, "prescription only medicines", pharmacy medicines and "general sales list medicines" used in situations in which Registered Nurses in Community Health Newham (CHN) are involved.

The policy covers the principles involved in the administration of medicines by all routes **excluding** intravenous, central venous/PICC or Hickman lines, for which there are separate policies.

This policy should be read in conjunction with "The safe management of patient's own controlled drugs in a domiciliary setting" (2012) and "Standard Operating Procedure for East Ham Care Centre – safe management of controlled drugs" (2009) policies.

1.1 The term Nurse is used in its generic form and applies to all Registered Nurses. When reference is made to non-Registered Nurses, the term "support worker" will be used.

1.2 It is acknowledged that the responsibility of the Nurse administering medicines in the patient's home and its associated conditions differ considerably from those within the in-patient setting and therefore different guidance must apply. For the purposes of this policy these settings will be referred to as "community".

1.3 This policy also applies to Nurses working in in-patient settings, Day Hospital and clinics within CHN..

1.4 Account must be taken of the patient's rights and freedom .

1.5 Specialist advice concerning medicines is available from pharmacists (both local community pharmacists),the Pharmacy Department.

2.0 Accountability of the Nurse

2.1 The Nurse is accountable for his/her own actions in the administration of medicines. He/she must be prepared to exercise professional judgement in any situation and be able to substantiate his/her actions/inactions.

2.2. The Nurse must be aware of the indications, action(s), usual dosage, usual route(s), side effects, interactions, contra-indications and correct storage of the medicines to be administered.

2.3. It is accepted that within the community setting, medicines are administered by one nurse only without being checked by a second nurse (except for intravenous medication – refer to intravenous medication policy)

2.4. In the in-patient setting and Day Hospital Controlled Drugs and all injectable medication *must* be checked by two Registered Nurses.

In whatever setting, the interests of the patient must remain paramount.

3.0 The Role of the Nurse

3.1 When patients require administration of medication by nurses in the community (not in-patients) it is the responsibility of the Registered Nurse to write the medicines administration record (MAR) fully and legibly at the first visit ensuring that medicines written on the MAR are consistent with the current prescription for the patient. The Registered Nurse must have received training on how to complete the MAR and have been assessed as competent to do so.
Guidance for completion of a MAR is in Appendix 1.

It is important that a clear distinction is made between the records used in the community where the legal prescription is the document written by the prescriber for the pharmacist to legally supply the medicines and the in-patient setting where medication charts have the dual role of the prescription and administration record.

3.2 As part of the ongoing patient assessment, the allergy/drug sensitivity status of the patient must be recorded on the medication chart / MAR and in the patient's notes and/or computer records. The medication chart will be fully completed indicating name of known allergies/drug sensitivity. If no allergies/drug sensitivity are known, write "no allergies known"; this ensures that, should a patient later develop an allergy, the medication chart / MAR provides evidence that the allergy was not known or declared at the time. The allergy status must be endorsed with the date on which it was made and the signature of the person who has checked the status.

3.3 Authorised Registered Midwives and certain Registered Nurses may administer or supply medicines against a Patient Group Direction (PGD). Each PGD must conform to the recommendations of the Crown Committee (2000) and have been approved and signed by the Primary Care Trust's Prescribing Sub-Committee.

3.4 With regards to Patient Group Directions (PGD), only Registered Nurses who have received training and are deemed competent in their use may supply and administer medication against a PGD. The Registered Nurse must make reference to the appropriate PGD and record the administration or supply of the medication in the patient records and / or the computer system. Only the Registered Nurse who made the original assessment of the patient may administer the medication. In the case where a supply of medication was given to the patient using the PGD, the patient may self-administer if he/she is able to do so.

4.0 Responsibilities of the Registered Nurse for safe administration, including training. The Registered Nurse must have been assessed as competent to administer medicines.

4.1 The Registered Nurse is responsible for the safe administration of a medicine to a patient under his/her care. Administration of certain medicines (except those listed in 5.6) can also be undertaken by a Support Worker who has received appropriate training and achieved competence in the administration of such medicines. However, responsibility remains with the Registered Nurse for ensuring patient safety

4.2 The Registered Nurse must make an assessment of the patient and a decision whether the responsibility for assisting with medication can be transferred to another provider e.g. Support Worker or the Home Support Service. In cases when a non–nurse is the case

manager, the Registered Nurse designated to form a care plan for the patient remains responsible for making this decision.

4.3 The Registered Nurse must organise the provision of medication support for patients who have difficulties e.g. reminder charts, large print labels or dosette boxes, see section 15 for extra information

4.4 The Registered Nurse must monitor the compliance, efficacy and any adverse effects of medication for the patients under his/her care.

4.5 The Registered Nurse must check for out of date medicine(s) (with the patient's consent),, check if the patient still requires the medication and secure a fresh supply as appropriate. The Registered Nurse must obtain the patient's consent to safely dispose of out-of-date medicines.

4.6 The Registered Nurse must arrange training sessions for Social Service carers / families as relevant and appropriate and ensure their competence to deliver medicines safely.

4.7 The Registered Nurse must liaise with other agencies about arrangements and responsibility for the collection of repeat prescriptions.

4.8 The Registered Nurse must provide up to date specimen signature sheets of any staff directly involved in the administration of medicines, a copy of which is to be kept in the patient record. Service Managers will keep and maintain an up-to-date record of all signatures of their staff.

4.9 The Registered Nurse must liaise with the GP/ Consultant for regular reviews of the medications.

4.10 The Registered Nurse must ensure safe storage of medications, including storage at the correct temperature.

4.11 The Registered Nurse must liaise directly with the GP / hospital doctor / pharmacist to ensure sufficient and timely supply of prescriptions and medications.

4.12 Managers will ensure that all Registered Nurses/Support Workers new to their service who are involved in medicines administration receive training on and achieve competence in Medicines Administration prior to being allowed to administer medicines. All Registered Nurses/Support Workers will attend refresher training in Medicines Administration and have their competency reassessed every two years (more frequently if local policy dictates e.g. insulin administration by Support Workers requires 6 monthly reassessment).

4.13 The NMC Code requires all Registered Nurses to ensure that they remain competent to deliver care and to redress any deficits in their knowledge/skills.

5.0 The Role of the Support Worker (excluding those in General Practices and in-patient setting)

5.1 A Support Worker is permitted to assist in the administration of medicines, provided he/she has completed a training programme (which includes practical/theoretical sessions, oral/topical eye drops administration) and has been awarded a certificate of competency for one year. Further specific training and competency may be required for any new medications they are expected to administer.

A record of training and competency assessment will be held in the Support Worker's personal/management file.

5.2 The Support worker must understand the basic actions, dose, route, side effects and storage of the medicines he/she is expected to administer and must feel competent and confident to administer the medicines.

5.3 The Support worker administering the medicines may exercise personal judgment in withholding medication in the interest of the patient but must inform the Registered Nurse who is responsible for the patient immediately. The Support Worker will document their concern and the outcome of the conversation with the Registered Nurse in the patient record.

5.4 The Registered Nurse is responsible for the safe administration of a medicine to a patient under his/her care. If the Registered Nurse has devolved responsibility for administration to a Support Worker, the Registered Nurse remains responsible for ensuring that this has been carried out in a safe and timely way.

5.5 Home care support workers can administer medication after being appropriately trained and assessed as competent.

5.6 **The Support Worker must NOT administer the following medications:**

- **Controlled drugs, including patches containing controlled drugs**
- **Enemas and rectal foam preparations**
- **Any injectable drug unless they have received specific training and this is covered by a specific Trust policy.**
- **Any drug given on a reducing dose**
- **Topical applications not authorised by the District Nurse**
- **Vaginal preparations**

5.7 Where family / informal carers are observed as competent and have agreed to participate in the administration of medicines to a patient on the District Nursing/Matron caseload, the nature and scope of that agreement should be accurately recorded in the patient's notes and computer record and on the MAR. The family/carers should be instructed to record the medications given on the MAR.

6.0 The role of the student nurse

6.1 The Student Nurse (pre- registration) is not permitted to prepare or administer medicines to a patient unless under the direct supervision of a Registered Nurse. All drugs administered by the Student must be countersigned by the Registered Nurse.

7.0 Prescribed Medicines

7.1 Prescribed medicines are those which have been obtained against a prescription for a specific person. These medicines are the property of the patient/client to whom the prescription was issued.

7.2 In order to administer such medications in the community, a Community Nurse who has achieved competency in writing a MAR or an Independent Prescriber must write the prescribed medicines clearly in the patient's care plan and on a MAR.

7.3 In the in-patient setting medicines are prescribed by the Consultant or a non-medical Independent Prescriber on a prescription chart which serves as both the prescription and the administration record.

7.4 The name, strength, form / formulation, dose, route of administration and frequency of the medicine to be given must be recorded on the medication administration record (MAR). These must correspond to the instructions on the patient's personalised containers, which

should have been prescribed and dispensed no more than three months ago and have not expired.

Full names must be used not abbreviations e.g. isosorbide mono nitrate (not ISMN). Frequency and dose must be written in full e.g. 'to be taken twice daily' (not BD), 'micrograms' (not mcg), units (not 'u'), nanograms (not ng).

7.5 For patients newly discharged from hospital, the most current prescription issued by the General Practitioner (GP) or discharge summary letter issued by the hospital Doctor (whichever is the most recent) should take precedence and be complied with.

The hospital discharge summary (containing the current prescribed medicines) will be kept in the patient records.

7.6 Where a patient is in possession of medicines in containers not correctly labelled with precise instructions, these must not be administered. The Nurse will immediately contact the GP or Independent Prescriber for a revised prescription. The Nurse will ensure that the revised prescription is collected, dispensed and delivered to the patient.

7.7 The Nurse must not discontinue any medication without confirming with the GP/Consultant that it is no longer required. This includes creams and medications for the skin even when the skin appears to have healed.

8.0 Transcribing

8.1 The transcription of medicines may only be undertaken by a Registered Medical Practitioner or Independent Prescriber, who, by the nature of their training and qualification, may prescribe and transcribe. This is to maintain patient safety and ensure that the Physician in charge of the patient's care regularly reviews the medication prescribed.

Although, in exceptional circumstances, the NMC allows a Registered Nurse to transcribe medication from one 'direction to administer' to another form of 'direction to supply or administer' provided additional training and competence have been achieved , the NMC is clear that this should not be routine practice. To prevent such activity becoming routine practice, maintain patient safety and ensure that medication reviews occur by the responsible Physician CHN does not support transcription of medicines by anyone other than a Registered Medical Practitioner or Independent Prescriber.

8.2 Transcribing is not the same as the MAR. The MAR is a record of administration not a prescription or 'direction to administer'. In respect of patients/clients in their own home, the NMC and Care Quality Commission (CQC) recognise the importance of recording medicines that have been administered in ensuring patient safety and well-being. The CQC recommends the use of a Medication Administration Record (MAR) which details which medicines are prescribed for the person, when they must be given, the dose and any special information/instruction and will look for evidence of their appropriate use as part of their inspections.

8.3 Community Registered Nurses who have received instruction on how to complete the MAR and have been assessed as competent to do so may complete the MAR for the patient/client. In order to so, the Nurse must have a record of medicines currently prescribed for that patient, the patient's condition/history and plan of care.

8.4 The MAR often looks similar to the 'prescription' chart used in in-patient settings but is NOT equivalent to it. The MAR is only a record of what care workers have administered to clients/patients under their care; it is NOT a chart for prescribing medicines. When a Nurse administers a medicine (s)he must record this on the MAR. Similarly, if a medicine has

been omitted this must also be shown on the MAR along with an explanation and action taken to ensure patient safety.

9.0 Verbal Authorisation

9.1 **A verbal order is not acceptable.**

9.2 In exceptional circumstances, where the medication has been previously prescribed and the prescriber is unable to issue a new prescription but where changes to the dose are considered necessary, the use of information technology (such as fax or email to the Nurse or pharmacist) is the preferred method. The fax or e-mail prescription/direction to administer must be stapled to the patient's existing medication chart and followed up by a new prescription signed by the prescriber who sent the fax / e-mail within 24 hours (72 hours maximum if Bank Holiday or weekend). It is the Nurse's responsibility to ensure that this is followed up by a new prescription confirming the changes within 24 hours.

9.3 Where a medication has not been prescribed before, remote prescribing (fax/e-mail) **is not** permitted. The patient must be assessed by the prescriber before a new medication is prescribed.

The only exception would be the use of adrenaline in the case of anaphylaxis, which is subject to a written Patient Group Direction. (See section 20)

9.4 For terminally ill patients where the authorised prescriber has prescribed symptom-control medication in a dosage or defined range giving a minimum and maximum dose and frequency, the Registered Nurse can vary the dose within this defined range. All such actions must be clearly recorded in the patient record.

10.0 Supplies of Medicines

10.1 In the community, it is the responsibility of the Registered Nurse initially making the assessment for the patient's ongoing care to ensure arrangements are made through the patient, carers and General Practitioner or authorised prescriber to obtain an adequate and ongoing supply of medicines on FP10 prescription.

10.2 In in-patient settings, it is the responsibility of the Registered Nurse and the appropriate pharmacy department staff to ensure that medicines are available and to take all reasonable steps to remedy any shortfall.

10.3 In the event of a Registered Nurse/Support Worker visiting a patient's home and discovering that supplies are inadequate, she/he should take all reasonable steps to ensure an adequate supply is obtained and inform the Nurse responsible for the care of the action taken. This must be recorded in the patient record and computer record to ensure good communication and continuity of care. In the event that a medicine is not obtainable and the patient does not receive the prescribed medication, the GP/Consultant must be advised and a datix form completed.

10.4 Patients have the right to choose any community pharmacy for the dispensing of their medicines. Nurses must not direct patients to any particular pharmacy except on the basis of services offered. Most community pharmacies will collect prescriptions from surgeries and do home deliveries for house bound patients. This is an unpaid service and must be reserved for those patients who are genuinely unable to make alternative arrangements for collection of their medicines.

11.0 Custody, Storage and Transportation of Medicines

11.1 In the in-patient setting medicines must be kept securely, in a locked cupboard (see CD policy in respect of CDs) and access restricted to Nursing and Pharmacy staff only. Medicines must be stored in accordance with the patient information leaflet, summary of product characteristics document found in dispensed UK licensed medication and in accordance with any instruction on the label. External preparations must be stored separately from internal preparations.

11.2 In the community setting patients should be encouraged to store medicines safely and appropriately e.g. out of the reach of children and pets and not in hot steamy rooms e.g. bathrooms. Some medicines require storage in the fridge. It is useful to record in the patients records where medicines are normally kept so all staff can find them when the regular member of staff is not present.

11.3 It must always be remembered that in the community, medicines are the property of the patient concerned and must be kept in the patient's home setting. In extreme cases where the nurse is concerned about the possible misuse of medication by the patient, the nurse should take reasonable steps to control the patient's access to the medicine in the home but only if this is considered to be in the patient's best interest. Full records should be kept of what action is taken to restrict access and why.

11.4 For in- patient areas where medicines have been dispensed on a named patient basis, these must be stored in the individual patient's drug locker where available.

11.5 Where patients are having medicines administered in the health centre or clinic, the patient must be advised to bring their medicine to the centre.

11.6 Where a nurse in the community becomes involved in collecting or returning prescribed medicines for patients, he/she must be aware of his/her responsibility for their safe transit to / from the patient's home. (see 12.2 and 12.3)

11.7 When nurses are required to transport vaccinations, they must use the appropriate cold box as recommended by the Infection Control Specialist Nurses.

Nurses are discouraged from delivering to or removing medicines from the patient's home and carrying or storing them.

12.0 Disposal of Medicines

See NMC Guidelines "Standards for medicines management" (2008), Standard 21. Medicinal products must be disposed of in accordance with legislation. Unwanted prescribed medicines should be either returned to a pharmacy for destruction or in line with local protocols.

Medicines which are no longer required by the patient should not be disposed of down sinks or toilets.

12.1 When a drug is no longer required by the patient for whatever reason, e.g. change of strength, end of treatment, death of patient, the nurse should endeavour to ensure safe disposal of the drug by:

- Strongly advising the carer/family to return them to the community pharmacy as there is a waste contract which collects unwanted medicines from Newham community pharmacies.

- If this is not possible, then medicines should be placed in a sharps box (sharps boxes should only be ¾ full when sealed) for incineration. This method of disposal is only suitable for a small amount of tablets e.g. under 5. Larger numbers should be disposed of via the local pharmacy. If this method is used, boxes must be clearly labelled with what drug is contained within the box.

- In the event of a medicines spillage in the community, normal household precautions need to be taken e.g. in case of broken glass. Disposable material must be used in cleaning up the spill and depending on the size of the spillage, must be disposed of in a sharps box labelled with the drug that was spilled. In the case of vaccines, please refer to the Community Infection Control Policy.

12.2 If the nurse returns drugs to the pharmacy he/she must record the action taken (including quantity) in the patient's notes with the signature of a witness, if possible (patient, carer or other nurse).

12.3 When a nurse or pharmacist takes a medicine for disposal, a Medicine Returned for Destruction sheet (see Appendix 4) must accompany the drug(s) and be signed by the nurse and pharmacist. This form is to be stored with the patient's notes.

12.4 For controlled drugs (CDs) – **Please also refer to the following CHN Policies: *The safe management of 'patient's own' controlled drugs in a domiciliary setting"* (2012) and *"Standard Operating Procedure for East Ham Care Centre – Safe Management of Controlled Drugs"(*2009)**

- Prescribed drugs including CDs are the property of the patient and remain so even after death. It is illegal to possess CDs that have not been prescribed for you. Relatives/carers should be advised that it is illegal to possess the CDs and that all CDs should be returned to a community pharmacy for safe destruction. The Nurse must make a written note in the patient's record that they have advised the carer/family accordingly.

12.5 If return by relatives or next of kin is not practical or possible then it would be appropriate for the Nurse to return the unwanted CDs to the pharmacy as long as consent has been obtained and the 'Return of Patient Controlled Drugs to Pharmacy for Disposal' form completed. Guidance on returning CDs and the 'Return of Patient Controlled Drugs to Pharmacy for Disposal' form are available in the 'Policy for the Safe Management of Patient's Own Controlled Drugs in the Domiciliary Setting' (2012) and must be followed.

12.6 When drugs are discontinued or are out of date in in-patient areas, these must be returned to the Pharmacy Department for destruction. The Pharmacist must be contacted in respect of controlled drugs that are no longer required/out of date., The Nurse returning the drugs must record the name, date, and quantity of the drugs being returned in the controlled drugs register book and both the pharmacist and the Nurse will sign the CD register. The Pharmacist is responsible for ensuring the safe return of CDs to the Pharmacy Department

13.0 Administration

Before the administration of any medicine the nurse must always check the MAR/Medicines chart / care plan / PGD to ensure that:

- The medication is indicated for the patient's condition
- The medication prescribed is within normal dose range
- He/she is competent to interpret the prescription
- He/she is competent to administer the medicine in the form and by the method prescribed.
- The allergy status is clearly recorded on the MAR/Medicines chart, nursing note and/or patient notes and computer records signed and dated by the Nurse.
- The dosage, strength, form / formulation, timing and route of administration are appropriate. Check that the prescription or label on a medicine dispensed by a pharmacist is clearly written and unambiguous.
- There is no contra-indication to the patient receiving the medication
- The patient is not experiencing undesirable side effects from the medication
- The patient is identified as the correct person and the patient's condition does not warrant withholding the medicine.
- He/she has taken all reasonable precautions to protect him/herself from any harm resulting from preparation or administration of the medicine, e.g. medicines that should not be directly handled, needlestick injury, contact dermatitis.
- Check expiry date, where present, on the medication containers.
- Where medicine dosages are based on weight, the patient weight must be recorded on the medicine chart/MAR and the Nurse check that the dose is appropriate.

13.1 The Registered Nurse is responsible for ensuring that he / she adheres to this Policy, the NMC Standards for Medicines Management, the NMC Code and manufacturer's guidance

13.2 It is unacceptable to prepare substances for injection in advance of their immediate use or to administer medication drawn into a syringe or container by another nurse when not in their presence.

13.3 In exceptional circumstances it may be necessary to draw up a substance for the patient to administer at a later time. This course of action can only be taken once the Nurse has discussed it with the patient, GP and manager. A full risk assessment must be carried out signed and dated by all parties. The outcome must always be in the patient's best interest.

13.4 Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations, it may be necessary for a second practitioner to check the calculation in order to minimise the risk of error. The use of calculators to determine the volume or quantity should not act as a substitute for arithmetical knowledge and skill.

13.5 Administration of medicine to children under the age of 16 years

- Community paediatric nurses must always carry out a standard check as in **13.0 above**
- A registered sick children nurse may administer medication but should risk assess each situation and make a decision to proceed to administer based on the information available at the time and in line with the NMC Standards for Medicines Management.
- Where possible, the child's weight and height (in kilograms) should be recorded on the drug chart.

- When administering injections of doses less than 1ml in volume, a 1ml syringe graduated to 0.05ml must be used

14.0 Intravenous Medication

See Intravenous Drug Administration Policy

15.0 Supervision of Self Administration

15.1 It is acknowledged that many patients/families in the community and some in in-patient areas do not need their medicine to be given by the Nurse but may need help and supervision with self medication and preparation for self administration. Wherever possible, patients should be encouraged and educated to self-administer their medicines. However, this must be allowed only after a thorough assessment of risk has been done and evidence of competency has been observed.

16.0 Use of Compliance Aids

16.1 Patients who need support with taking their medicines should have their needs individually assessed and compliance aids should only be considered as a last resort. Patients who fall under the Disability Discrimination Act have a right to receive reasonable support from their Community Pharmacist to support them in taking their medicines e.g. printed charts stating what medicines to be taken at what time of the day or large printed labels. Community Nurses should always discuss with the Community Pharmacist what support the patient needs and how it can be given.

16.2 Compliance aids are time consuming to fill and significantly increase the risks of medication errors as medicines can be unstable out of their original packaging and dispensing errors can occur. Compliance aids should not routinely be used by Nurses to administer medicines as they cannot assure themselves that the correct drug and dose is contained within; he/she must also be aware of the added risks in the use of compliance aids. However, if Nurses have to administer medicines using a compliance aid, the Nurse must only do so if this has been prepared by a pharmacist and labelled accordingly.

17.0 Recording Administration

17.1 Accurate records of medicines administered must be recorded in the MAR/Medicines Chart or patient record, and/or computer records. This must include the date and time of administration, route, frequency, site of administration and dose given. The Nurse must legibly sign the record. (Batch numbers and expiry date should also be recorded for vaccines).

17.2 If for any reason the nurse decides not to administer the medicine, (including vaccinations / immunisations) the General Practitioner, in-patient doctor or emergency General Practitioner must be informed as soon as possible (the same day) and the reasons/implications discussed with the patient/carer to ensure their understanding. The Nurse must clearly document the name of the Doctor that he/she has informed, the discussion with the patient/carer, the reason for the omission and the outcome in the patient-held record, surgery note and/or computer records.

17.2 Non-administration of medicine exception must be recorded in the MAR/Medicines chart stating the reason, and the appropriate course of action discussed with the doctor, as well as the nursing record/computer record.

17.3 Any changes or discontinuations to medicines must be authorised by the prescriber with written evidence of the same.

17.4 As part of the ongoing evaluation of the patient's care and treatment, the Nurse must observe and record the effects and the side effects of the treatment and report any variances to the General Practitioner/ in- patient doctor /Authorised Prescriber.

18. 0 Errors in the Administration of Medicines

18.1 Any error in the administration or supervision of medicines must be recorded in the patient records and computer records and reported immediately to the General Practitioner/ in-patient doctor and the Line Manager and appropriate action taken to ensure patient safety must be taken. An incident form must be completed immediately.

18.2 The patient/relative/carer must be advised of the error and the patient's condition monitored and recorded as appropriate.

18.3 It is the Line Manager's responsibility to ensure that the datix has been completed.

19.0 Controlled drugs
(Please refer to *"The safe management of 'patient's own' controlled drugs in a domiciliary setting"* (2012) and *"Standard Operating Procedure for East Ham Care Centre – Safe Management of Controlled Drugs"* (2009).

19.1 In in-patient areas, Controlled Drugs must be checked and administered by two Registered Nurses.

19.2.1 In the in-patient area a stock check must be carried out at the end of each shift change by two Registered Nurses and recorded in the appropriate section of the CD Register. Medication counters if available must be used when counting tablets in bottles. Quantities of liquids should be estimated as accurately as possible.

19.3 In the community one Registered Nurse may administer Controlled Drugs without the presence of a second Registered Nurse.

19.4 In the community the stock of Controlled Drugs must be checked, counted, reconciled and clearly recorded at the time of every administration by the nurse and preferably by the patient or carer if no other authorised witness available. Medication counters if available must be used when counting tablets in bottles. Quantities of liquids should be estimated as accurately as possible. .

19.5 If a discrepancy in the number or liquid volume of a CD is found this must be reported to the Senior Manager and Pharmacist immediately so that an investigation can be carried out. A datix must be completed.

20.0 Treatment of Anaphylaxis

20.1 All Community Nurses, Practice Nurses, Nurse Practitioners involved in the administration of medicines by injection to adults must undergo annual training in the treatment of anaphylaxis and a satisfactory level of competency achieved. This will include training in the use of PGDs.

20.2 Nurses must not be involved in the administration of any injectable medicines unless they are competent to administer adrenaline and manage anaphylaxis. It is the responsibility of the individual Nurse to ensure he/she has immediate access to an in-date adrenaline pack at all times.

The above also applies to nurses administering immunisation to children.

21.0 Anaphylactic Shock Prevention

Prior to the administration of vaccines, subcutaneous, intramuscular or parenteral medicines, a detailed history must be available to the Nurse which should include:

- Current medication – to check for possible drug interactions
- History of previous drug reactions
- History of allergic reactions e.g. hay fever, asthma, eczema, nettle rash (hives)

If there is any doubt concerning the advisability of carrying out the procedure, the Nurse must withhold the Medicine and seek immediate advice/clarification.

It is advisable for the Nurse to remain/observe the patient for 10-15 minutes following an injection, particularly after the first, second and third injection (or in the waiting room, if this has been administered in clinic or general practice).

ACTION - In the event of anaphylaxis

Call for immediate assistance – dial 999 as the patient requires immediate medical attention. If in the in-patient setting, also ensure the on-call Consultant/Registrar is informed immediately.

Lay patient in recovery position – ensure airway is clear

Administer **intramuscular** adrenaline injection 1 in 1000 (1mg/mL) as per the following:
The best site for IM injection is the anterolateral aspect of the middle third of the thigh.
The needle used for injection needs to be sufficiently long to ensure that the adrenaline is injected into muscle. Use a suitable syringe for measuring small doses for children under 6 years

AGE	DOSE	VOLUME OF ADRENALINE (EPINEPHRINE) 1 IN 1000
Under 6 months	150 micrograms	0.15 mL
6 months – 6 years	150 micrograms	0.15 mL
6-12 years	300 micrograms	0.3 mL
Adult and adolescents	500 micrograms	0.5 mL
if child/adolescent is small or prepubertal	300 micrograms	0.3 mL

Do not leave the patient unattended. Record vital signs as soon as possible (conscious level, airway, pulse, blood pressure, respiratory pattern, pulse oximetry, ECG). This will help monitor the patient's response to adrenaline. Monitoring of conscious level, airway, pulse, blood pressure, respiratory pattern and pulse oximetry must must be recorded at least every fifteen minutes and an incident form must be completed.

If there is no improvement in the patient's condition in 5 minutes, repeat the administration of the IM adrenaline dose. Further doses can be given at about 5-minute intervals according to the patient's response.

22.0 Complementary and alternative therapies

Complementary and alternative therapies are increasingly used in the treatment of patients. Registered Nurses, Midwives and Health Visitors who practice the use of such therapies must have successfully undertaken training and be competent in this area**.** The Nurse must assess the appropriateness of the therapy based on the condition of the patient and any co-existing treatment. The Nurse should also discuss the use of any complementary and alternative therapies with their Line Manager and the patient's GP. It is essential that this information is discussed with the patient and informed consent is obtained and documented.

The Pharmacist should also be contacted to advise on any possible drug interactions and to answer any concerns regarding complementary and alternative therapies.

23.0 The Covert Administration of Medicines

21.1 NMC guidance (2007) relating to the covert administration of medication should supplement and be read in conjunction with the NMC standards for Medicines Management (2008). The emphasis remains on the best interests of the patient or client being paramount.

21.2 Disguising medication (e.g. in food), in the absence of informed consent, may be regarded as deception. Exceptions to this may be people who do not possess the capacity to understand the consequences of refusing medication, where omission will prove medically detrimental to their health recovery/maintenance. Please also refer to the Mental Capacity Act 2005 and the Consent to Treatment Policy.

21.3 Registered Nurses must ascertain that they have the support, or otherwise, of the rest of the multi- professional team, make their own views known and must not make a decision to administer medication covertly in isolation. It is good practice to involve family/next of kin in such a decision.

21.4 Nurses using covert methods of administering medication must be able to fully account for their decisions. The client's GP or Registrar needs to be informed and the rationale for the decision to use covert administration of medicines needs to be documented in the client's notes and reviewed on a regular basis.

24.0 Patient Group Directions

22.1 Patient Group Directions (PGDs) are specific written instructions for the supply or administration of a licensed named medicine including vaccines to specific groups of patients who may not be individually identified before presenting for treatment.

22.2 PGDs should only be used once the Nurse has been assessed as competent and his/her name is identified within the PGD.

22.3 The administration of drugs via a PGD may NOT be delegated

22.4 Each PGD must conform to the recommendations of the Crown Committee (2000) and have been approved and signed by ELFT Medicines Committee.

25.0 Monitoring

This policy will be monitored as below in relation to ensuring the accuracy of prescription charts

Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting Arrangements**	**Actions on recommendations and leads**	**Change in practice and lessons to be shared**
How the organisation makes sure that all prescription charts are accurate	Chief Pharmacist	audit	annual	The Chief Pharmacist receives the audit	The Chief Pharmacist will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit.	The Medicines Sub Group will receive and discuss the report and monitor the action plan.

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Appendix 1

Guidelines for completion of Medicines Administration Record (MAR)

1. All entries must be made in **BLACK INK ONLY**
2. All patients admitted on to the District Nursing caseload must have their medication recorded as part of the assessment process and regularly reviewed/updated
3. Details of medication to be administered can be obtained from hospital discharge letters, current EMIS record, prescriptions and the label on medicines dispensed from a pharmacist.
4. The date and time should be written in top row of each column.
5. The Nurse will read the MAR and medicine label before administering medication
6. The Nurse will sign his/her name in the row next to the drug administered.
7. Drugs may be rewritten by Registered Nurses only.
8. Drugs must be rewritten clearly in **CAPITALS**, signed and dated.
9. Drugs discontinued by the Medical Practitioner/GP/Community Matron will be crossed through. This will be done by Registered Nurses only, signed and dated.
10. Amendments to drug dose, route or frequency will necessitate that the drug be crossed through, as above, and rewritten with changes on a new line.
11. The **dose** of the drug to be administered must be written, not the number of tablets or the measure of liquid, as values may change.
12. Write the drugs to be given by the day staff- morning drugs at the top, afternoon in the middle, and the evening staff drugs below. Draw lines between to allow space for date and time.
13. Check level of medication, if one week's supply or less, request new prescription and document in patients records. Do not allow medicines to run out.

14. For any remarks concerning the administration of medications, write ‘see notes’ in signature row. For drugs not given - liaise with the GP/Medical Practitioner/ Community Matron, write ‘Not given see notes’ then write the explanation why medication not given and the action taken in the evaluation notes of the care plan.

15. Agency or Bank staff must have been assessed as competent in this procedure before being permitted to carry it out. They must print their name in capital letters on the last row of the chart against any drug administered

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Appendix 2

Competency Assessment of Drug Administration Community Nursing/in-patient areas (Registered Nurses, Adult)

Practitioner’s Name……

Place of work……

INTRODUCTION

The NMC Code (2008) (**Standards of conduct, performance and ethics for nurses and midwives)** states that 'you must have the knowledge and skills for safe and effective practice when working without direct supervision…You must recognise and work within the limits of your competence'.

The following principles from The Code (2008) emphasize the importance of knowledge, skill, responsibility and accountability.

The registered nurse, midwife or health visitor:

- Must be satisfied that each aspect of practice is directed to meeting the needs and serving the interests of the patient or client
- Must endeavour always to achieve, maintain and develop knowledge, skills and competence to respond to those needs and interests
- Must honestly acknowledge any limits of personal knowledge and skills and take steps to remedy any relevant deficits in order to effectively and appropriately to meet the needs of patients and clients
- Must ensure that any enlargement or adjustment of the scope of professional practice must be achieved without compromising or fragmenting existing aspects of professional practice and care and that the requirements of the NMC Code are satisfied through out the whole area of practice
- Must recognise and honour the personal accountability borne for all aspects of professional practice and must in serving the interests of patients and clients and the wider interests of society, avoid any inappropriate delegation to others which compromises those interests.

The safe administration of medicines is an essential competence for admission to the NMC register and one which Registered Nurses must demonstrate.

The administration of medicines is not a task to be carried out solely in accordance with a prescription; it requires Nurses to exercise their professional judgement in determining whether it is appropriate that the patient receive a medicine. Registered Nurses are accountable for their actions and omissions. In administering any medication, or assisting or overseeing any self-administration of medication, you must exercise your professional judgement and apply your knowledge and skill in the given situation (NMC 2008).

All Nurses must familiarise themselves with the NMC Standards for Medicines Management (2010) and adhere to the standards within.

In achieving competence in the administration of medicines the Nurse must be able to demonstrate understanding and compliance with the standards set by the NMC and any local policies.

All newly Registered Nurses, Registered Nurses new to employment in NCHCS and Bank/Agency Nurses must be assessed against this tool before they may administer drugs

unsupervised. This assessment tool will also be used to re-assess any Registered Nurse whose competence is felt to be below the required standard. If a Nurse is responsible for a drug administration error, re-assessment may be necessary and single-checker privileges withdrawn until competence is assured.

Assessment of a Registered Nurse may only be made by an experienced Registered Nurse with a recognised teaching/assessing qualification. Direct observation of administration to a minimum of 12 patients is required to assess competence.

The following criteria form Standard 8 of the NMC Standards for Medicines Management and will be used as part of the assessment process:

As a registrant, in exercising your professional accountability in the best interests of your patients:

- you must be certain of the identity of the patient to whom the medicine is to be administered
- you must check that the patient is not allergic to the medicine before administering it
- you must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- you must be aware of the patient's plan of care (care plan or pathway)
- you must check that the prescription or the label on medicine dispensed is clearly written and unambiguous
- you must check the expiry date (where it exists) of the medicine to be administered
- you must have considered the dosage, weight where appropriate, method of administration, route and timing
- you must administer or withhold in the context of the patient's condition, (for example, Digoxin not usually to be given if pulse below 60) and co-existing therapies, for example, physiotherapy
- you must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable
- You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible. It is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

In addition:

- Where medication is not given, the reason for not doing so must be recorded and discussed with the prescriber.
- You may administer with a single signature any prescription only medicine (POM), general sales list (GSL) or pharmacy (P) medication.

In respect of controlled drugs:

- These should be administered in line with relevant legislation and local standard operating procedures.
- It is recommended that for the administration of controlled drugs a secondary signatory is required within secondary care and similar healthcare settings.
- In a patient's home, where a registrant is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.
- Although normally the second signatory should be another registered health care professional (for example doctor, pharmacist, dentist) or student nurse or midwife, in the interest of patient care, where this is not possible, a second suitable person who has been assessed as competent may sign. It is good practice that the second signatory witnesses the whole administration process. For guidance, go to www.dh.gov.uk and search for safer management of controlled drugs: guidance on standard operating procedures.

It is imperative that the Nurse has competence in essential mathematics in order to calculate and administer the correct dose of a medicine. If in doubt or if a calculation is complicated the Nurse must ask another competent practitioner to calculate and verify the correct dose.

Appendix 3 gives some examples for testing mathematical ability in relation to drug administration.

ASSESSMENT TOOL FOR MEDICINES ADMINISTRATION

Name of Candidate: **Date of Assessment:**

Name & Signature of Assessor:

	Competence achieved?		
Criteria	**Yes**	**No**	**Comments**
Demonstrates clear understanding of the NMC Standards and criteria within			
Clearly explains and demonstrates the correct process for storage of medicines			
Attends to hand hygiene policy before, during and after administration of medicines to each patient			
Retrieves the correct chart for the correct patient; checks patient identity as per local policy			
Check allergy status and takes action accordingly			
Checks which medicines are due and that they have not already been administered			
Confirms prescription is legible, dated, signed by authorised prescriber, dosage, route and timings are correct, has not already been administered			
Articulates the therapeutic uses of the medicines to be administered, normal dose, route, side effects, precautions and contra-indications			
Articulates knowledge of the patient's condition and care plan			
Makes appropriate decision to administer/withhold the medication in the context of patient's condition			
contacts the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable			
Gains patient consent for administration			
Selects appropriate medicine, correct dose, correct formulation (tablet/ liquid/ injection etc), expiry date			
Explains medicines/gives appropriate education to the patient;			
Ensures patient takes medicines			
Is able to explain why it is unacceptable to leave medicines on table/locker/ unsecured			
makes a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible and appropriate action follows if medicine withheld/refused			

Demonstrates clear understanding of what to do if a patient has an anaphylactic reaction			
Clearly explains what constitutes a drug error			
Demonstrates clear understanding of the steps to take in the event of a drug error			
Able to demonstrate the correct process for storage, administration and documentation of controlled drugs (CD)			
Demonstrates clear understanding of what to do if written error occurs in CD book			
Demonstrates the correct process for managing patient's own CD			
Takes correct action if prescription is not correct/clear/appropriate			
Shows clear understanding of the need to countersign student Nurse signature when teaching and supervising student in drug administration			
Shows clear understanding of the role of the Pharmacist and works in collaborative manner with Pharmacy department			
Shows clear understanding of how to order all types of medicine and how to obtain medicines 'out of hours'			
Has successfully completed drug calculation test paper			

ASSESSOR COMMENTS:

……..

……..

……..

……..

In the event that the Nurse does not demonstrate competence, an action plan must be outlined above and re-assessment made within 2 weeks. Failure to achieve competence within 2 weeks will need to be referred to Senior Management.

Assessor: I certify that ……. has demonstrated competence in drug administration in line with the above criteria/has not demonstrated competence and requires a development plan (delete as appropriate)

Name & signature of Assessor…….. Date……..

Nurse: In line with the above criteria, I confirm that I am competent to administer medicines. Should my level of proficiency fall, I will seek immediate remedial action and support and advise my Manager

Name & Signature of Nurse……...Date…….

Appendix 3a

Drug Calculation Questions (Adult Nurses)
Examples

1 How many mgs in a gram?

2 How many mcg in 1mg?

3 how many mls in a litre?

4 change 0.78 grams to mg

5 change 34 mgs to grams

6 change 0.086mg to mcg

7 change 50ml to litres

8 Change 0.25mg to mcg

9 calculate the amount of distilled water which must be added to 350ml of stock solution to make 2 1/2 litres of diluted solution

10 An injection of 8mg of morphine is prescribed. The ampoule you have contains 10mg in 1ml. What volume would you draw up?

11 Pethidine 85mg is prescribed i/m. Stock ampoules contain 100mg/2ml. What volume do you draw up?

12 How many 30mg tablets of codeine phosphate are required for a dose of 0.06g?

13 A patient is prescribed 375mg of penicillin orally. Stock tablets are 250mg. How many tablets should the patient have?

14 How many drops of blood per ml does a blood infusion set administer?

15 How many drops of crystalloid fluid does a standard infusion set administer?

16 1 litre of normal saline is prescribed for administration over 10 hours. How many drops per minute should be given?

17 A unit of whole blood is prescribed over 4 hours. The unit contains 480mls of blood. How many drops per minute should be administered?

18 75 mg of aspirin is prescribed. Stock tablets are 300mg. How much of the tablet would you administer?

Drug Calculation Questions
Answers

1 1000

2 1000

3 1000

4 780mg

5 0.34g

6 86mcg

7 0.05L

8 250mcg

9 2150ml

10 0.8ml

11 1.7ml

12 2

13 1.5

14 15

15 20

16 33 drops per min… $\frac{\text{volume}}{\text{Time in minutes}}$ X drops of giving set ….. $\frac{1000}{600}$ X 20 = 33

17 30 drops per min …….$\frac{480}{240}$ X 15

18 0.25 or ¼

Appendix 3b

Paediatric Drug Calculations

Paediatric dose calculation is usually based on either body surface area (mg/m²) or body weight (mg/kg) of the child. Body weight is used more frequently for ease of calculations.

The calculation of body surface area (BSA) used to require both weight and height. In 1998, the UK Chemotherapy Standardisation Group (UKCCSG) approved the use of the estimation of body surface area in infants and children based on weight alone.

To calculate drug doses, use the following formula:

Dose required / Present Standard Quantity of Drug X Present Quantity of Liquid in which Standard Quantity of Drug is Dissolved

In other words:

What you want / What you have X What it is in (dilution)

Example 1: A child is prescribed 90mg of Paracetamol and the medication supplied is 120mg of Paracetamol in 5mls:

90 / 120 X 5 = 3.75mls

Example 2: A child is prescribed oral solution of Ranitidine 60mg. medication supplied is 75mg in 5mls:

60 / 75 x 5 = 4mls

Example 3: A child is prescribed intraveinous injection of Teicoplanin 180mg. A vial of Teicoplanin 400mg with diluent of 4mls:

180 / 400 x 4mls = 1.8mls

Consider the displacement value to determine volume after dilution. Some intraveinous injections or infusion may need further dilution before administering IV, follow instructions written on the drug chart, check the paediatric formulary/BNF or use Trust guidelines.

Medication errors arising from poor mathematical skills of nurses are an ongoing problem (Preston, 2003).

To ensure safety:

•Take time working out calculations
•Recheck answers
•Do not be rushed by colleagues/patients/parents/ carers
• Answers that look wrong probably are wrong and an initial mental estimate of the dose may be useful.
The use of calculators should never be used as a substitute for arithmetical knowledge and skills (NMC, 2008). The use of calculators has caused much debate but it is acknowledged it is safe to use calculators as part of the checking process (Preston, 2003).

Appendix 4

MEDICINES RETURNED FOR DESTRUCTION RECEIPT

Name of Chemist

Quantity	Item	CD	INITIALS Pharmacy	Returnee

I confirm that I have returned the above items to the Pharmacy indicated above	Name: Signature: Date:

I confirm that I have received the above items	Name: Signature: Date:

Appendix 5

Equality Impact Assessment Tool

Incorporating:
Equality and Diversity; Human Rights and Environmental Issues

			Comments
1	**Briefly describe the procedure/decision?**		Policy for the administration of medicines - updated
1.1	**Briefly describe the purpose or objective of the procedure/decision?**		To ensure medicines are safely administered in accordance with statute and professional guidance
1.2	**Does the procedure/decision have a legitimate aim?**	**Yes**	As above
1.3	**Is the procedure/decision necessary, proportionate and lawful?**	**Yes**	
2	**Will the procedure/decision affect one group or a combination of groups less or more favourably than others on the basis of:** Race, Colour, Nationality, Gender, Age, Sexual orientation, Disability, Religion, Language (Disability includes: learning disabilities, physical disability, sensory impairment and mental illness)	**No**	
2.1	**List or describe the evidence that some groups will be affected differently?**	**N/A**	
3	**Will the procedure/decision affect or restrict anyone's human rights? (see attached list)**	**No**	Reference is made to patient rights, choice and freedom as well as mental capacity act and best interest decisions
3.1	**If the answer to Q3 is yes, which rights will be affected or restricted?** **a) absolute right** e.g. the right to protection from inhuman & degrading treatment **b) limited right** e.g. the right to liberty **c) qualified right** e.g. the right to respect for private and family life; freedom of expression; peaceful enjoyment of property etc;	**N/A**	Explain your answer

			Comments
3.2	**Can the procedure/decision be achieved without the infringement of human rights?**	**Yes**	
4	**Will this procedure/decision:** • **Reduce or increase waste** • **reduce or increase use of energy** • **Have an impact on the use of transport** • **Create community employment opportunities**	**No** **No** **No** **No**	Any waste is dealt with in accordance with Medicines Legislation and best practice
5	**What action is to be taken to minimise the impact that the procedure/decision will have on equality and diversity and human rights.**		There is no impact. Policy is based on legislation and NMC standards
5.1	**What action is to be taken to minimise the impact that the procedure/decision will have on the environment**		There is no foreseeable impact. This is procedural guidance
6	**Have you consulted with relevant groups around this procedure/decision?** - **Staff members** - **Service Users** - **Carers** - **Other agencies**	**Yes** **No** **No** **No**	This is procedural guidance in accordance with existing legislation and regulatory body standards
6.1	**Do you have further plans to consult with the relevant groups**	**No**	
7	**Will the procedure/decision be monitored?**	**Yes**	There are regular medication audits
7.1	**Will the procedure/decision be reviewed?** **If yes, when?**	**Yes**	In 2015 unless regulation/statute changes
7.2	**Will this procedure/decision and this Impact assessment be published?** **If yes, list when and where this information will be available.**	**Yes**	Trust intranet

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