Medicines Management (Doctors)

Study Guide

Contents

1. Objectives

The purpose of this module is to provide medicines management and Trust guidance. It has four sections which should be completed in order:

A. Guidance sources and how to access them.
B. Prescribing and administering.
C. Medicines reconciliation and preparing for discharge.
D. Medicine specific instruction including storage.

Completing this module should help you to:

- Comply with Trust medicine management policies and guidance.
- Prescribe and administer high risk medicines to patients safely.
- Store medicines correctly and safely.
- Fulfill your responsibilities.

If there is anything you are uncertain about contact the most appropriate department or member of staff.

2. Why is Medicines Management Important?

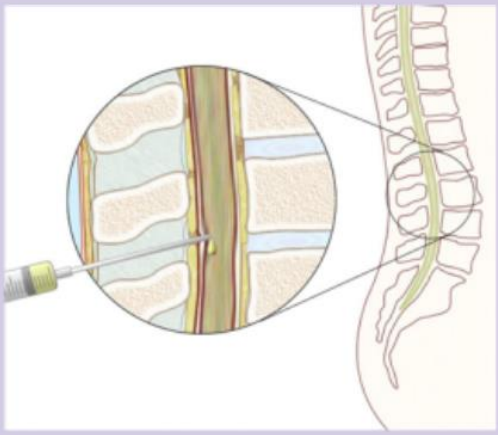
Wayne Jowett (2001)

At 18 years of age Wayne received Vincristine Treatment for his leukaemia which was injected intrathecally instead of intravenously.

He died from a slow creeping paralysis that eventually stopped his heart.

"Doctor jailed for fatal error" The Guardian 24 September 2003

An independent inquiry led to the setting up of the National Patient Safety Agency (NPSA) to make sure that the NHS learns from mistakes.



Section A: Guidance Sources and Learning from Incident

Information in Context and What the Trust does with it

The information in this module is taken from a variety of important sources:

- National Patient Safety Agency (now NHS Improvement).
- Trust incidents - continual learning from reported and investigatied incidents.
- Health Education England.
- Care Quality Commision (CQC).
- Department of Health.
- Commissioners of our services.

The Trust has a responsibility to respond to alerts and guidance issued by these bodies in addition to learning from experience and errors. This is the reason we have policy and guideline documents which help to keep our patients safe from harm.

Medicines Management Policies

There are a variety of policies / guidelines on the Source in relation to medicines management that must be followed listed below. Always refer to the latest version.

- Administration of medicines policy.
- Controlled Drugs Policy.
- Medicines Reconciliation Policy.
- Prescribing of medicines policy.
- Self-administration of medicines policy.
- Cold storage of medicines policy.
- Security, safe storage and transport of medicines policy.
- Room temperature monitoring in clinical areas where medicines are stored – clinical guideline.
- Critical list of medicines not to be omitted or delayed in adult patients – clinical guideline.

Two Common Types of Medicines Management

Delayed Or Omitted Doses

A common type of medicines mismanagement is through delay or omission of doses which can harm patients. There is an agreed list of critical medicines accessible on the Source which you need to be familiar with to help to avoid this.

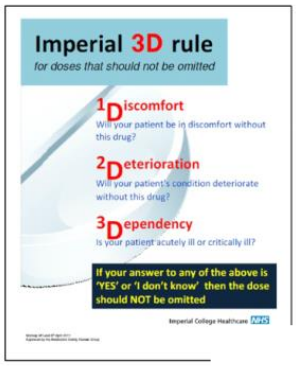
Medicine Misplacement

Medicines can often be misplaced while moving patients. To avoid this happening please make sure medication is always transferred with the patient in an easily identified green bag.

How Can you Access Medications Out of Hours?

First Considerations

When considering what to do, if you think you need to access medications out of hours, you should assess whether the dose can be omitted by applying the Imperial 3D Rule as shown below and as part of the guidance found on the Source.

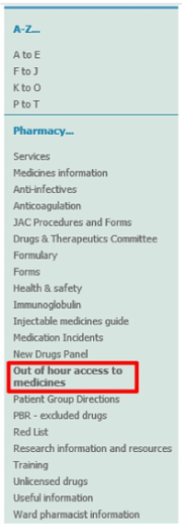


If The Doses Should Not Be Omitted

If not ommitable then consider the following:

- Has the drug already been ordered and supplied to the ward?
- Can the drug be borrowed from another ward?

If "No" to both of these questions consult the 'Out of hours access to medicines' link on the Source and follow the process.



The Source: Guidance can be found at - A-Z > Pharmacy > Out of hours access to medicines.

Trust Guidance for Accessing Medication Out of Hours

The Trust guidance for accessing medication out of hours includes ward and emergency drug cupboard stock lists.

The Trust guidance on accessing medication out of hours can be accessed here.

ALL DRUGS BY WARD AND DEPARTMENT - ALL SITES

Emergency Drug Cupboards - Stock lists
- Emergency Drug Cupboard, CXH (May 2017)
- Emergency Drug Cupboard, HH (May 2017)
- Emergency Drug Omnicell Cabinets, Manvers Ward and Samuel Lane Ward (May! 2017)

Ward - Stock Lists

Charing Cross Hospital
- Charing Cross (May 2017)

Hammersmith Hospital
- Hammersmith Hospital (May 2017)

St Mary's Hospital
- SMH (May 2017)
- WEH (May 2017)

IV Fluids

If IV fluids are needed, this document details the top users of each fluid, so they may have the IV fluids you need.

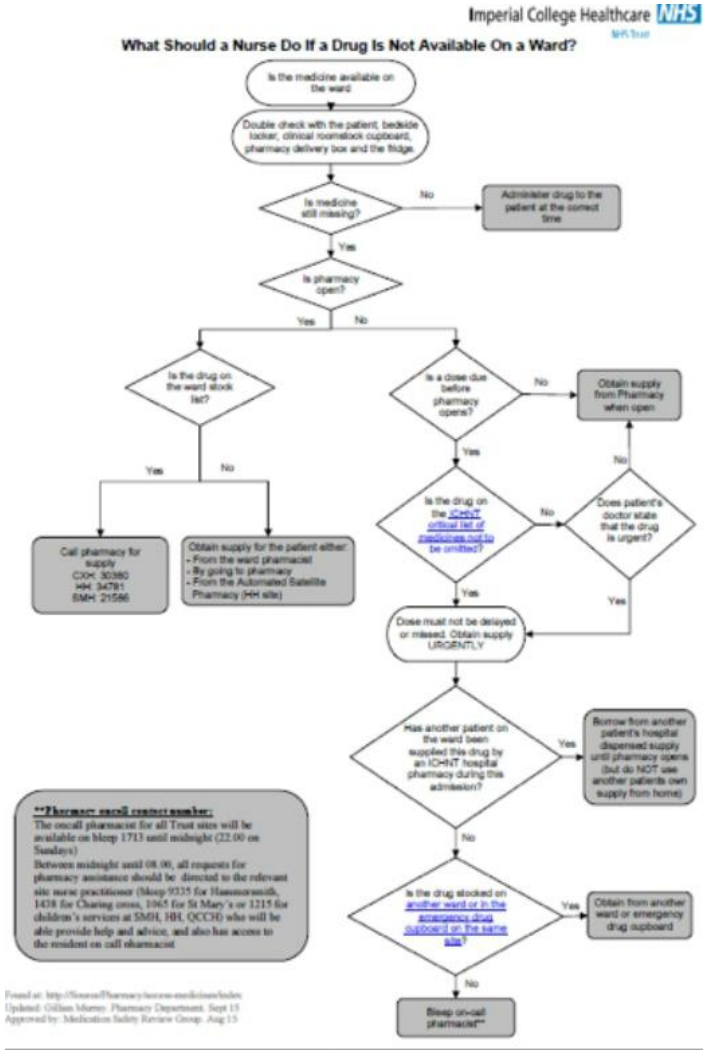
Inter-ward Drug Borrowing Form

If drugs are borrowed between wards, complete this form and return this to the ward pharmacist:

Inter-ward Drug Borrowing Form (August 2014)

The Out Of Hours Process For Nurses

There is also a flowchart for what a nurse should do if a drug is not available on a ward in this section of guidance.



Incidents and What to Do

Learning From Incidents

Policies and guidelines are there to safeguard patients and are written from valuable lessons that have been learned through errors and incidents in the past. Even with the best systems errors may occur. It is paramount we continue to learn form these mistakes.

Datix reports must be filled in for any occurrence that could cause actual or potential harm. All medication incidents should be reported on the Datix system.

Medication Incidents

Medication incidents, along with all other reported incidents are investigated and lessons learned from each. This procedure includes feedback to the individuals responsible and necessary action taken.

It is important to look for trends across wards, clinical divisions and the entire Trust. To achieve this we must:

- Review themes.
- Learn lessons from any trends identified.

Trends or common themes should be discussed at the Divisional Quality and Safety Group. Through this group these may be escalated to the Drugs and Therapeutics Committees or the Medication Safety Review Group, for further discussion and action.

3. Section B: Prescribing and Administering

Prescribing

Prescribing Responsibilities

Doctors or non-medical prescribers who sign the prescription are responsible for its accuracy and appropriateness for the patient.

Nurses are to check the accuracy of prescribing prior to administration (pharmacists are not present 24/7 and therefore any nurse administering a drug must know what this drug is for).

Pharmacist assesses and ensures the accuracy of prescribing and appropriateness of the prescription based on the indication and also by assessing safety in relation to drug handling in the sick patient.

General Prescribing Principles

Prescribing medicine requires that you:

- Prior to prescribing medication always check the allergy status has been documented or updated on Cerner, drug charts or any other form of prescription, if documented during a previous admission the allergy status must be updated and if absent the nature of the reaction must be documented.
- Adhere to the Trust formulary and IV guide.
- Take care to select the correct medicine especially similar sounding medicines e.g. nifedipine as opposed to nimodipine.

Administering Medication and Reducing Risk

Who Can Administer?

The following people either can administer medication, have restrictions or cannot.

Staff who can administer medication:
- Registered nurses / midwives
- Doctors
- Operating Department Practitioner

Staff who can administer certain medications under restriction:
- Student nurses (restrictions)
- Radiographers (restrictions)
- Physiotherapists (restrictions)
- Clinical perfusionists (restrictions)

Staff who **CANNOT** administer medicines:
- Healthcare assistants
- Pharmacists
- Dieticians

Carrying Out Checks

When administering medication some checks require two members of staff to carry this out.

Single checks - IV fluids, flushes and injections.

Double checks - Epidurals, intrathecals, blood and blood products, cytotoxics and all controlled drugs.

Double checks might also be required for any administration involving a calculation. It is the responsibility of the individual practitioner to ask for a second check of the calculation if they feel it is necessary.

⚠ If you are unsure or unfamiliar with the medication always ask.

During Administration

Common risk factors during administration:

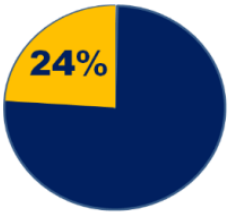
- Interruptions.
- Patient identity - always verify this as some patients may have similar names.
- Allergy status - always check this before giving any medicine.
- Correct medicine selection - some can look very similar.
- Unattended medication - do not leave medication lying around.
- Special administration instructions - ensure these are followed.
- Purple / enteral syringes must be used when administering medication - unless multiples of 5ml are required in which case spoons / cups can be used.

Injectable Medicine

Injectable Medicines Guide

The Source: You can use the 'Quick links' section on the Source homepage to find the 'Injectable medicines guide'.

Safer Use Of Injectable Medicines



24% of all reported medication incidents are attributable to injectable medicines which are more prone to error.

Potential problems are:

- Errors in calculations.
- Rate of infusion.
- Not discarding remainder after use.
- Not checking that the line is securely in place and functioning. Misplacement may resulting in extravasation.

Intrathecal Chemotherapy

Before you are involved with intrathecal chemotherapy you must:

1. Receive additional training.
2. Be on the Trust's intrathecal register.

⚠ Administration of vinca alkaloids by the incorrect route is fatal.

4. Section C: Medicines Reconciliation and Preparing for Discharge

Medicines Reconciliation

Medication errors commonly occur on transfer between care settings. The process of medicines reconciliation on admision is there to make sure that when a patient is admitted the prescription corresponds to what they were taking prior to admission and any reasons for changes should be clearly documented.

Medicines reconciliation is not restricted to admission. While an inpatient further changes to medication may be made, these should also be documented in addition to the reason for these changes. When the patient is discharged any changes to admission medication must be clearly stated on the discharge letter to the GP. This allows clear communication when the patient moves between wards, secondary care providers or discharged back to the GP.

Medication Reconcilliation Responsibilities

The doctor or admitting clinician has the responsibility to complete the medicine reconciliation on admission. This can be done by a pharmacist if present at the time. The pharmacist will verify the medicines reconciliation on admission and together with the clinical team document any changes through the inpatient's stay ensuring the process is continued.

Sources of information to obtain the correct list from include these:

- Patient.
- Relative / carer.
- Patient's own drugs.
- GP list.
- Hospital transfer.
- Nursing home to put in full MAR chart.

⚠ Any unintentional discrepancies must be resolved to avoid potential harm or anxiety it may cause to the patient.

Changes During Admission

Intentional changes should be documented with the reason (s) in the:

- Medical / structured notes.
- Pharmacists also add additional comments under special administration instructions / order comments of the drug history medication list.

On discharge these reasons must be documented on the TTA for the GP.

Safe Discharge

Use the TTA to do the following.

Assemble the correct discharge medication, which could be:
- Supplied by pharmacy.
- Found in the bedside locker.
- In the fridge.

Check all labels are correct:
- Patient's name.
- Drug, strength, dose and frequency.

⚠ Ensure ONLY medication on the TTA is supplied to the patient.

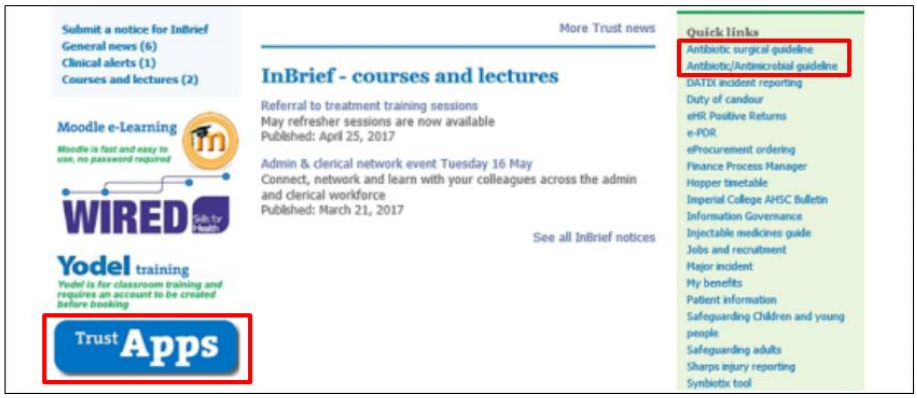
5. Section D: Medicine Specific Instruction Including Storage

Antibiotic Guidelines

Trust antibiotic guidance is accessible in two ways.

The Source: Adult Treatment Of Infection Guidelines and Surgical Antibiotic Prophylaxis – Adult Patients Guideline via 'Quick links'

The Imperial Antibiotic Prescribing App: Prescribing guidance.



About The App

The Trust has developed an app so that both adult and paediatric guidelines and guidance available on the Source are more easily accessible.

The app is available for both iPhone and Android devices and provides:

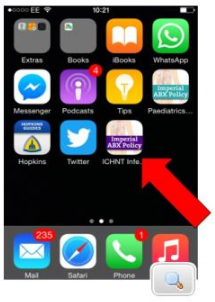
- Adult Empiric Treatment Guidelines
- Antibiotic Surgical Prophylaxis
- Antimicrobial Summary Guideline For Maternity
- Therapeutic Drug Monitoring
- IV to Oral Switch
- Calculator Contacts

Downloading And Installing

To download the app you need to access the Trust intranet via your phone / device and locate the link on the Source home page.

If you have any queries e-mail this address:

Imperial.iapp@nhs.net



Format for the Adult Treatment of Infection Guidelines

Guideline layout is themed as follows:

- Listed by site of infection / system, so that you are directed to the appropriate treatment for their respective indication.
- Antibiotics are colour coded to give directions as to the choice of antibiotics in penicillin allergic patients.

Severe CAP
co-amoxiclav 1.2g IV TDS **plus** **clarithromycin** 500mg IV/PO BD.
(Non-serious penicillin allergy: **levofloxacin** *500mg IV BD* ***OR*** **cefuroxime** *1.5g IV TDS* ***plus*** **clarithromycin** *500mg IV BD.*
Serious penicillin allergy: **levofloxacin** *500mg IV BD.*

Review IV therapy **daily** and switch to oral asap.
Treat for a total of 7-10 days, or 14-21 days if staphylococcal or Gram-negative infection confirmed.

If elderly, frail, or otherwise at risk of *C. difficile:*
amoxicillin 500mg-1g IV TDS **plus** **clarithromycin** 500mg IV/PO BD.
(Penicillin allergy: **levofloxacin** *500mg IV BD)*
Review IV therapy **daily** and switch to oral asap. Treat for a total of 7-10 days, or 14-21 days if Staphylococcal or Gram-negative infection confirmed

Pneumonia, ex-residential care
Discuss with The Infection Team; treat as for severe CAP empirically

Penicillin Allergy

Before prescribing the antibiotic establish the **nature of the allergy** and **document** this on the drug chart. In certain situations, non-penicillin based regimens may represent **less effective** therapy.

A 'traffic light' system is used in this document to facilitate drug choice in those patients *allergic to penicillin*:

- **RED** – penicillin based drugs – contra-indicated in penicillin allergy, e.g. **flucloxacillin**, **co-amoxiclav**, **piperacillin-tazobactam.**
- **AMBER** – drugs structurally related to penicillin - approximately 0.5-6.5% of penicillin-allergic patients may exhibit cross-reactivity to these agents. If history of anaphylaxis, angioedema (blistering or swelling), erythroderma / Stevens-Johnson syndrome or bronchospasm, to a penicillin, these drugs should be avoided
  - cephalosporins (e.g. **cefuroxime**, **ceftriaxone**)
  - carbapenems (e.g. **meropenem**, **ertapenem**)
- **GREEN** – considered safe in penicillin allergy
  - e.g. **vancomycin**, **metronidazole**, **ciprofloxacin**

You should be familiar with some or all of these medicines but which of these can be given to a patient with a **severe** penicillin allergy? Select those that can be given.

- ☐ **Co-Amoxiclav**
- ☑ **Trimethoprim**
- ☐ **Cefuroxime**
- ☐ **Amoxicillin**
- ☑ **Vancomycin**
- ☐ **Tazocin**
- ☑ **Gentamicin**
- ☐ **Flucloxacillin**
- ☐ **Meropenem**
- ☑ **Moxifloxacin**

Clostridium Difficile-Associated Diarrhoea

Some antibiotics can increase the risk of C.difficile infections. To minimise the risk of Clostridium difficile-associated diarrhoea, especially in elderly or frail patients, you should do the following:

Avoid using:

- Cephalosporins (especially 2nd and 3rd generation e.g. cefuroxime, ceftazadime), clindamycin, quinolones, co-amoxiclav (unless specifically recommended by ID/micro).
- Proton pump inhibitors unless specifically indicated.

Minimise the duration of antibiotics.

This is indicated throughout the guidelines, where antibiotic recommendations differ in patients at risk, these are given in a separate box as below.

If elderly, frail or otherwise at risk of *C. difficile*, discuss with ID/micro

Anti-Infectives

Considerations

Antibiotics must be reviewed **at least daily**, at every consultant ward round.

Actions should be documented in the medical notes, you should always:

- Remember to check for previous microbiology results.
- Review therapy in light of culture results once these are available i.e broad or narrow spectrum, switch agent or stop.
- Switch intravenous therapy to oral as soon as appropriate.

Consider alternative non-infective inflammatory diagnoses before prescribing an antimicrobial and where possible send appropriate investigations prior to starting therapy.

⚠ If very severely ill do not delay therapy.

Antibiotic Therapy

Prompt antibiotic therapy saves lives in severely septic patients.

You should initiate the appropriate empiric agent from the policy as soon as the diagnosis has been made - definitely within 1 hour. Patients with known multi drug resistant bacteria must be discussed with the infection team.

In order to comply with the antibiotic policy all prescriptions must have documented on the drug chart:

- Treatment indication.
- Stop / review date.

Requiring Special Attention

Certain antibiotics have known side effects and / or require careful monitoring. Here are some examples:

Vancomycin - Gentamicin - Amikacin

- Narrow therapeutic range.
- Dose calculation.
- Renal function considerations.
- Blood monitoring.

There are guidelines available on the app or on the Source which will give dosing advice when prescribing these medicines safely.

Linezolid

- Monitoring of full blood count.
- Drug-drug interactions.

Amphotericin

- Multiple formulations are available, please prescribe by the brand name.

Safe Opiate Use

Risks And Recommendations

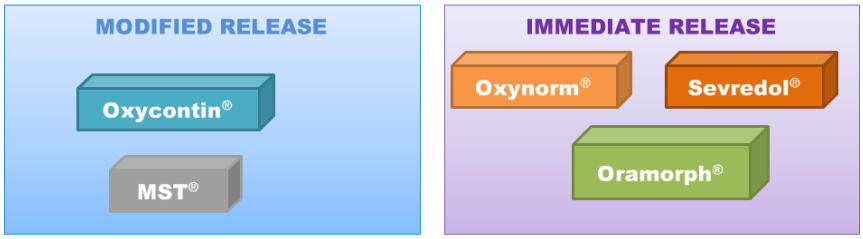
A consequence of opiate overdose can often be respiratory depression or even death. The two most common formulation types which you will come across are:

Modified release oral preparations
Usually a maximum of twice daily. For example morphine sulphate such as MST® and oxycodone such as Oxycontin® modified release preparations.

Immediate release oral preparations
Usually up to 4 hourly or for breakthrough pain. Morphine sulphate liquids such as Oramorph®, morphine sulphate capsules such as Sevredol® or oxycodone capsules such as Oxynorm® immediate release preparations.

NOTE - When an opiate comes in different formulations please indicate the formulation.

What type of formulation are these medicines? Drag each medicine inside the relevant box.



Strong Potassium Chloride (KCl)

Risks

Special attention and consideration must be made when strong potassium chloride solution is prescribed as it can be fatal if given inappropriately - it is used in the lethal injection!

It is responsible for a large number of deaths resulting from:

- Excessively rapid infusions.
- Bolus injections.
- Being inadvertently mistaken for water or normal saline.
- Inappropriate mixing with other infusions resulting in rapid administration.

⚠ **Inappropriate administration can lead to death.**

Recommendations

You should consider the following when administering strong potassium chloride:

- The use of ready made infusions where available.
- Administration information available in the IV guide.
- Ampoules of strong KCl are treated as a controlled drug.

Methotrexate

Risks And Recommendations

Many incidents (including fatalities) have occurred with oral methotrexate.

When methotrexate is prescribed:

- Patients should have a record card.
- Regular blood tests must be carried out.
- Administer only **ONCE A WEEK**.
- Only one strength is in use which is 2.5mg, the dose is made using multiplies of this strength.
- Co-administer with folic acid which is not usually given on the same day as the methotrexate.

Oral Anticoagulation – Warfarin and DOACs

Risks

Oral anticoagulants are frequently reported as causing preventable harm and admission to hospital. This includes warfarin and Direct Oral Anticoagulants (DOACs) e.g. rivaroxiban.

Recommendations

Warfarin administration procedure:

- Follow Trust warfarin loading and maintenance dose policy - 'Warfarin Initiation for Adult inpatients'.
- Regularly monitor International Normalized Ratio (INR).
- Check INR is safe before prescribing, administering and issuing.
- Check for details of medicines interacting with warfarin (app, policy, BNF, Stockley's).

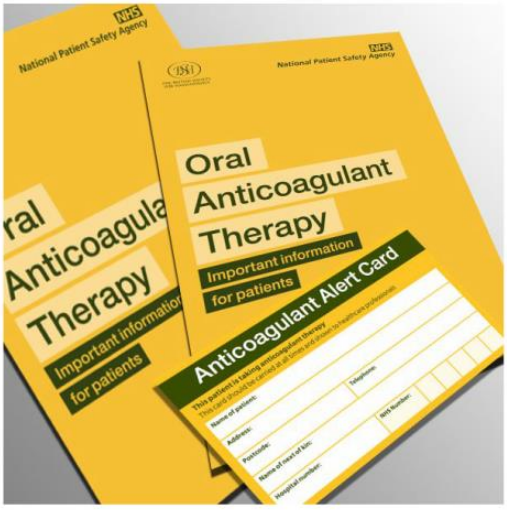
Prior to discharge the patient must have:

- An anticoagulant appointment arranged.
- Received counselling.
- Received the 'yellow book'.
- Recent INR and dose must be documented.
- Been informed of dose to take.

Direct Oral Anticoagulants require:

- Counselling.
- Issuing of an alert card.

Yellow Book And Alert Card



Low Moleclar Weight Heparins

Risks And Recommendations

Low Molecular Weight Heparins (LMWH) doses for the treatment of a thromboembolic event are based on the patient's weight and renal function.

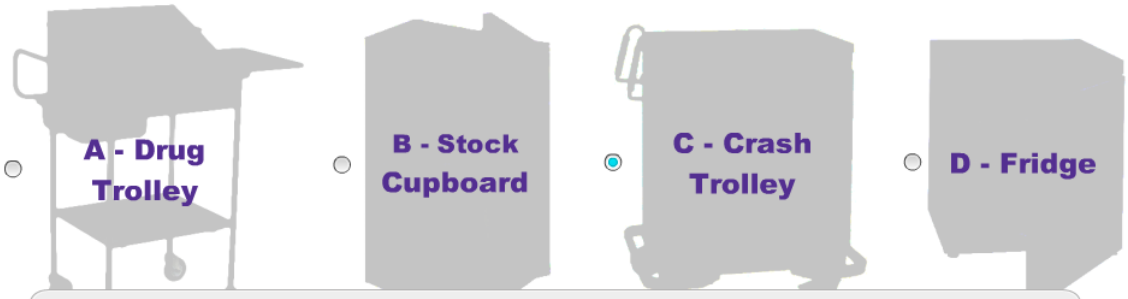
Under-dosing - Increased risk of a further thromboembolic event.

Overdosing - Increased risk of bleeding.

When administering LMWH medicines accurate weight must be recorded on the drug chart or on Cerner.

Adrenaline for Anaphylaxis

You should be aware of where adrenaline for anaphylaxis is always stored on the ward or clinic areas. Select one of the options from A, B, C and D.



Correct

Well done. Option C - Crash Trolley is where you can find adrenaline for anaphylaxis. In certain areas it may be kept in additional locations. Familiarise yourself with all storage locations in your ward or clinic area.

Dose and route: 500mcg of 1:1000 adrenaline injection IM.

Continue

Insulin

Risks

Insulin appears in the Top 10 list of high alert medicines. The wrong amount of insulin can cause a hypogylcaemic episode.

Errors can occur with:
- Delayed / missed doses.
- The wrong insulin product being administered.
- The wrong insulin dose being given.

NPSA alert and DoH Never Event (2015/16) highlights these reasons for overdose of insulin due to abbreviation of 'units' or the use of an incorrect device:
- U or u can be misread as 0 and a ten-fold overdose administered to the patient, prescriptions must always state 'units' in full.
- Always use an insulin syringe or insulin pen to measure insulin.

! Good practice is for a second independent check for all SC and IV adminsitration of insulin (NMC guidance).

Recommendations

Insulin Vigilance - Be aware of and give particular attention to the following when administering insulin as many different products and devices exist:

- Pay extra vigilance to the prescription versus the product you are administering - some look and sound similar. For example novorapid versus novomix are often confused but are different.
- Make sure the device is the correct one.
- Make sure it is the correct insulin.
- Make sure the amount of insulin is correct.

Prescriptions

All prescriptions for insulin must:

- Be prescribed on the variable section of the drug chart, on Cerner it is in the regular medication section unless for hyperglycaemic episodes when it is prescribed in the 'when required' section.
- Specify the **brand** name.
- Have **units** written in full after the dose.
- Include the administration **device**.

SC Insulin Administration

SC Insulin administration.

1st line: Self-administration (safest option)
- Use patient's own device and needles or supply with BD Microfine Ultra 4mm needle.

2nd line: Nurse administration
- Patient's usual pen device with BD Autoshield Duo 5mm needle (minimise risk of needle stick injury).
- Or for insulins only available in a vial draw up and administer with BD SafetyGlide 0.5ml syringe.

⚠ Do not omit long acting insulin in patients with Type 1 Diabetes, doses can be altered if indicated.

IV Insulin Administration

IV Insulin administration:

- Use standard BD Insulin 0.5ml syringe to prepare IV insulin infusions
- Ensure both the IV infusion and infusion rates are prescribed on the prescription chart.
- **NOTE** - Two different types of IV Infusions:
  - Variable Rate Intravenous Insulin Infusion (VRIII) (sliding scale).
  - Fixed Rate Intravenous Insulin Infusion (FRIII) (DKA and HHS).
- Continue long acting SC insulin for all patients with Type 1 diabetes whilst on IV Insulin Infusion.
- IV insulin only remains active for 5-10mins.

See the Diabetes and Surgery in Adults Guidelines for transition to usual diabetes therapy.

Storage

The safe storage of insulin requires the following:

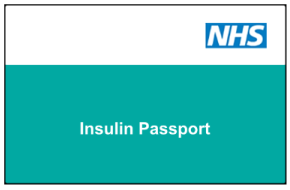
- Labeling all insulin with the date and time of opening.
- Insulin in use must be stored at room temperature, do not inject when cold as affects efficacy as it is painful when injected.
- For patient's self-administering, keep insulin in use at the bedside.
- **NOTE** - Insulin does not need to be locked in a bedside locker (See the Security, Safe Storage and Transport of Medicines Policy).
- Additional supplies of insulin are stored in a fridge.

⚠ **Do not stockpile insulin, return excess to pharmacy to reduce risk of errors.**

Passport and Patient Information Booklet

All adult patients on insulin must be offered an Insulin Passport and Patient Information Booklet. The Insulin Passport is a patient held record to help improve patient safety and empower patients

The diabetes team and pharmacy team are jointly responsible for issuing these to patients. Prescribers and nurses cross reference the Insulin Passport on admission and discharge. All clinical areas are to hold supply of both documents (Full guidelines and order codes can be found on the Source).



Safe Storage of Medicines

Requirements

Safe storage of medicines is a legal requirement, you should be aware that:

- The CQC monitor our compliance.
- Drug security storage audits are carried out every 6 months by pharmacy to ensure medication is stored appropriately.

Locked Away

All medication (including IV fluids and sterile topical fluids) must be appropriately locked away at all times when unattended. **Always ensure that the door is locked.**

Facilities for locking up medicines may include:

- Bedside lockers.
- Locked fridges.
- Locked cupboards.
- Locked rooms.
- Secure areas with no public access.

Outside Of Bedside Lockers

Items which can be kept outside of bedside lockers include:

- Inhalers and insulin pens.
- GTN tablets and sprays.
- Nasal preparations.
- Creams, ointments and lotions.
- Pancreatic enzyme supplements (e.g. Creon®).
- Artificial saliva.
- Lubricating eye drops.
- Sublingual and oral sprays.
- Mouthwashes.

External Or Internal Preparations

External preparations should be stored separately to internal preparations which requires that:

- Storage areas for bulk fluids must be kept locked when unattended.
- Flammable liquids must be stored in a separate storage area must be locked when unattended.
- Medical gases must be kept secure so they cannot fall.

Controlled Drugs

Controlled drugs (CD) must be stored appropriately in the CD cupboard which requires that:

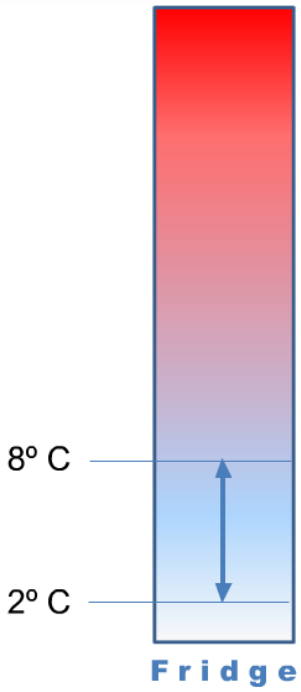
- Keys for the CD cupboard should be kept separate to all other keys.
- Daily checks must be carried out of all stock, with a witness.
- There is a 6 monthly audit to ensure the CD medicines are stored appropriately.

⚠ **This is a legal requirement.**

Fridge Storage – Temperature Awareness

Storing medicines in a fridge requires that:

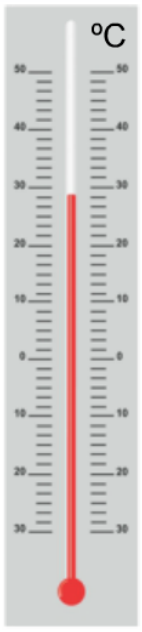
- The temperature must be monitored at least daily using the Trust proforma.
- If the temperature is out of range you must follow the procedure on the Trust form.
- Nurses and pharmacists alternate every month to audit the fridge monitoring to ensure the temperatures are measured daily and are in range.



Treatment Room Storage – Temperature Awareness

It is important to be aware of the temperature of the clinical areas where medication is stored. If you notice that the clinical area is warm and uncomfortable to work in please follow the 'Room temperature monitoring in clinical areas where medicine are stored policy'.

To summarise - Let the ward manager or nurse in charge of the area know and inform either the ward pharmacist or the pharmacy dispensary if there is no designated pharmacist for the area. Pharmacy will work with the ward manager and estates to investigate and plan an approach to manage the risk.



Summary

In this module we have looked at:

- Guidance sources and learning from incidents.
- Prescribing and administering.
- Medicines reconciliation and preparing for discharge.
- Medicine specific instruction including storage.

Completing this module should help you to:

- Comply with Trust medicine management policies and guidance.
- Prescribe and administer high risk medicines to patients safely.
- Store medicines correctly and safely.
- Fulfill your responsibilities.

There are module related links in the Resources and contacts in the Information menus top right of this screen.

For further information and the latest versions of the policies look on the Source.

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