Together for Short Lives is the leading UK charity that speaks for all children with life-threatening and life-limiting conditions and all those who support, love and care for them. When children are unlikely to reach adulthood, we aim to make a lifetime of difference for them and their families.

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This publication will be reviewed on an annual basis and amended as needed, on a discretionary basis.
About Together for Short Lives

Together for Short Lives is the leading UK charity for all children with life-threatening and life-limiting conditions and all those who support, love and care for them – families, professionals and services, including children’s hospices. Our work helps to ensure that children can get the best possible care, wherever and whenever they need it.

From the moment of diagnosis, for whatever life holds, we help to ensure that families make the most of their precious time together.

There are an estimated 49,000 children and young people in the UK living with a life-threatening or life-limiting condition that may require palliative care services. We are there for every single one of these children, and their families, so they know where to go for help and are aware of the support available to them. With the right kind of information, it can become easier to access care and support, as well as practical and emotional help for the whole family when it’s needed most. We help families to access this information so they know what to expect at different stages throughout their journey and can make informed choices about their child’s care.

We work closely with the organisations and professionals that provide important lifeline services to children and families. We support, lobby and raise funds for children’s hospices and a range of other voluntary organisations to enable them to sustain the vital work they do. We offer resources and training to help them maintain consistent, high quality care from the moment a child is diagnosed, until their eventual death, and to continue supporting families for as long as they need it.

We campaign for equal provision of specialised services for children with life-threatening and life-limiting conditions and families throughout the UK; and better co-ordination of health, social care and education. By working nationally, we give a powerful voice to children, families and the organisations that support them, ensuring their views are heard by the government and that they influence policy.

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Foreword

By Barbara Gelb
Chief Executive, Together for Short Lives
Welcome to this updated version of the Medicines Management Toolkit for children’s palliative care services.

We know that the babies, children and young people receiving palliative care often have complex medication regimes; we know that the potential for errors in the management process is recognised as a high risk and often challenging aspect of practice; we know that medicines management is the subject of many discussions at clinical governance meetings around the UK. This latest edition of the medicines management guidance aims to help you reduce and manage this high risk, high frequency, and high impact aspect of care.

In 2010, the former Children’s Hospices UK (now Together for Short Lives) invited Professor Gerry Armitage, from the University of Bradford, to co-lead a Department of Health funded project to develop a medicines management toolkit for children’s hospices. The toolkit offered formal guidance, good practice case studies and supporting evidence on regulatory frameworks, staff competencies, medicines reconciliation, non-medical prescribing and transcribing. Now, four years on, we recognise that with new evidence and new challenges facing practitioners, it is vital that you have access to the most up-to-date resources to support vital aspects in the care of children and young people.

The challenge of ensuring babies, children and young people with life-limiting conditions and their families receive consistently safe care delivered to a high standard is an issue of both corporate and individual accountability. This latest resource from Together for Short Lives aims to provide support to individual professionals, care teams and organisations as they work together to provide a high standard of care in medicines management.

I am delighted to commend this resource to you. All chapters have been updated and throughout the resource there are knowledge bites and notable practice points to encourage positive changes in practice.

So, what next? Please do let us know your feedback about the usefulness of this toolkit and its impact on your work. Our next steps in this arena will be informed by your feedback.
The use of medications is the most frequent healthcare intervention, with an estimated 860 million prescriptions issued each year across the National Health Service (NHS). Inevitably, with such a large number of interventions, there is a risk of adverse reactions and errors that can lead to patient harm. This risk is not confined to the NHS, but is present in any organisation involved in the prescribing, administration and supply of medication – including children’s palliative care services.

The care provided by our sector is not limited to traditional hospice or NHS buildings; staff are often employed in outreach teams who work with other health and social care professionals across primary care. Sometimes this involves a transition in the child or young person’s care, e.g. after hospital discharge. It is not uncommon for medication errors to arise from these transitions. Outreach teams are regularly involved in medicines management, usually in the child or young person’s home alongside the family. These outreach personnel will sometimes work as sole practitioners, which can present particular challenges in medicines management and the practitioner’s accountability.

This toolkit is designed as guidance to improve the safety and quality of medicines management in children’s palliative care services across the United Kingdom. It may also assist those working in other children’s and young people’s healthcare settings. The target audience is care professionals, such as nurses, doctors and pharmacists, and their support workers.

Defining medicines management

We have modified a definition of medicines management, originally applied to the acute hospital setting by the Audit Commission in 2001:

*The entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of [patient] care.*

However, while we accept that it is imperative that the child or young person in our care should gain the maximum benefit from their medicines, we must also minimise the risk of potential harm (MHRA, 2004). In our field, effective medicines management should be child and family centred, taking individual characteristics and needs into account. While this approach is strongly advocated, a family may also want a child to receive complementary or alternative therapies, which can put service staff in a difficult position as they balance the child’s safety, the family’s wishes and their own accountability. We have made special comment on the challenges of administering such therapies in the chapters on Regulatory Guidance and Staff and Carer Competencies. The content of the former has been discussed with the Care Quality Commission, which has endorsed our approach in this toolkit.

Shared responsibilities

Medicines management is not the responsibility of one particular profession; it is the responsibility of all staff involved in patient care (DH, 2003, 2004a, 2004b). This is particularly evident at transitions of care when, for example, the accurate sharing of medicines information between different disciplines and agencies is essential for medicines reconciliation. To promote effective clinical governance, each acute hospital has a Medicines Management Committee (sometimes called a Use of Medicines Group). The remit of some of these groups extends beyond secondary care to local primary care partners. A current example of how this works well is in Gateshead [http://gatesheadccg.nhs.uk/wp-content/uploads/2013/03/GMMC-TOR-October-2013.pdf](http://gatesheadccg.nhs.uk/wp-content/uploads/2013/03/GMMC-TOR-October-2013.pdf). Although a children’s hospice environment is very different from that of the NHS, we believe that the NHS can provide examples of notable practice, the principles of which are transferable to your service.
Currently, we propose that each service and their accompanying community team should consider having a Medicines Management Group, consisting of a representative from senior management, a medical prescriber (ranging from a resident paediatrician to a GP who has contact with the service), a hospice-based nurse, outreach nurse and a pharmacist. It is also recommended that the Medicines Management Group should include representatives from local information networks (and perhaps the nearest Clinical Commissioning Group) to avoid a particular care service working in isolation in areas such as controlled drug management. This group would be the main forum for periodically discussing medicines management and new treatments, medicines safety and any related learning. The notion of a Medicines Champion might also considered where a more senior team member has a specific remit for monitoring local developments, informing policy, learning from error and embracing new, evidence based interventions.

The imperative of safe, high quality care

The revision of the toolkit follows a spate of reports published in 2013 which paid considerable attention to reducing avoidable harm. These include the Francis Report (a public inquiry into failures at the Mid-Staffordshire Hospitals Trust), the Berwick Report (A promise to learn) and the Keogh Review. Although these reports were specific to the NHS, their conclusions have lessons for all those providing healthcare. Uppermost in Don Berwick’s report was the need to continually improve our performance and unconditionally strive for a culture of learning. It is these goals that further drive the approach of this second edition, particularly the chapter Learning for Safety.

Medicines optimisation: a growing priority

The National Institute for Clinical Excellence (NICE) is currently in the process of developing a guideline on medicines optimisation. NICE define medicines optimisation as ‘a person-centred approach to safe and effective medicines use, enabling people [children and young people in our context] to obtain the best possible outcomes from their medicines’. The Royal Pharmaceutical Society has already set out four guiding principles: to understand the patient’s experience; provide an evidence-based choice of medicines; make medicines use as safe as possible and optimisation a routine part of practice (see www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf). The recommendations in the Berwick Report and medicines optimisation converge in that Berwick advocates that those receiving healthcare, and their families, should be engaged, listened to and generally empowered. Moreover, we see the recent shift towards medicines optimisation as another welcome step towards a more family centred approach to medicines management. Of course, this also rests on the competence and capacity of all those who might be involved in what can be a complex process. As such, we enthusiastically embrace the principles of optimisation alongside a careful consideration of the ability and willingness of the child and their family to actively work with the service to optimise medicines use. We see medicines optimisation becoming an essential part of healthcare in the future.
How to use this toolkit

This toolkit provides staff with a specific resource for training and education. It is also a reference point for guiding and mandating practice in line with the values, priorities and essential standards set by legal requirements and the external regulators. The development of medicines management will be a continuing process. However, the emergence of relevant clinical evidence, along with any learning from service evaluations or safety incidents, should continue to inform and shape our approach to medicines management.

The aims of this toolkit are to:

• Provide the underlying knowledge and skills for the assessment and management of risk with medicines, recognising the physiological and intellectual differences between adults and children and the unique position of children as members of a family.

• Underpin this knowledge with an understanding of the key threats to child safety in high risk processes such as providing complex medicines across the service, using a human factors perspective as a part of organisation-wide learning.

• Develop guidance for medicines reconciliation and transcribing to improve medicines management at care transitions (i.e. when a child’s level of care or care setting changes).

• Enhance guidance around independent and supplementary prescribing.

• Encourage the sharing of notable local practice across children’s palliative care services, e.g. through publication or conference presentation.

• Enable the production of medicines management policies in each local service that share a common evidence base, common principles and shared standards.

These local policies should:

• Provide staff with guidance on each component of the medication pathway including: prescribing (by a range of staff), reconciliation and transcribing, storage, administration and self-administration and record keeping.

• Enable individual organisations to improve and add detail to the current procedures for medicines management.

• Identify specific competencies related to each of the above components of the medication pathway.

• Provide a process for reporting and learning from medication safety incidents.

• Develop a potential framework for effective clinical governance and a UK, service-wide approach to medication safety and quality management.

Toolkit structure

This toolkit has been revised and expanded by academic staff and researchers from the University of Bradford alongside practitioners and directors of care, who have consulted with the families in their care. The team is multi-disciplinary and comes from a diverse range of different organisations, all of which have developed innovative practice around medicines. The process has been overseen and validated by Together for Short Lives. Wherever possible, updated reference is made to UK policies and guidance. With a UK-wide audience in mind, the toolkit has been reviewed by the Directors of Care for hospice services in Scotland, Wales and Northern Ireland.

The chapter format has also been changed, the details of which can be seen on the contents page.
Where possible, this toolkit is structured on the basis of the funnel diagram below.

Knowledge is presented in bite-sized chunks and informed by data from children’s palliative care services. Examples of notable practice punctuate the toolkit, alongside key policy information. Finally, we also identify goals for notable practice and quality improvement that should help facilitate the achievement of high standards – the kind of standards expected by external regulators and, of course, by children, young people and their families. We will not use the term ‘patient’ but always refer to the ‘child or young person’ as our client group.


Chapter 2
Regulatory compliance

By Jenny Adams
Healthcare professionals in the UK are regulated by government appointed professional bodies. These professional bodies publish standards for practice in order to fulfil their legal duty to protect the public. Professional practice, for example medicines management, is subject to both the law and professional body standards; these are two critical considerations for practitioners working in the children’s palliative care services.

This chapter includes the standards and guidance available to healthcare professionals through legislation and via the professional regulatory and statutory bodies. It covers definitions, legislation, regulatory guidance for the medical practitioner, the pharmacist and the nurse as well as National Service Framework (NSF) Standards and the Care Quality Commission. Some of the professional body standards covered in this chapter are also discussed in more depth elsewhere in the toolkit; reference is made to other chapters when appropriate. The Nursing and Midwifery Council standards related to transcribing are mentioned here and this topic is discussed in more depth in the chapter Medicines Reconciliation and Transcribing. A separate chapter, Non-Medical Prescribing, covers prescribing by nurses, pharmacists and other health professionals.

Navigating this chapter

This chapter differs from others in the toolkit in that there are no direct examples from practice or case studies and consequently it may appear somewhat detached from your routine work. In an attempt to make this chapter more accessible for the person who wants to use the toolkit as a quick reference guide or, alternatively, the person who is reading the toolkit as a whole volume of work, we have devised a reader’s map of the content and how each of the numbered sections are related. We have set the management of controlled drugs to one side although it brings together many elements of regulation, law and professional guidance in one aspect of practice. The conclusion takes the form of goals for notable practice.
Definitions

It is useful to define certain key terms that are used in this section, some of which may be unfamiliar.

**Compliance aid:** A compliance aid is a device to aid adherence to a prescribed medication regime. The device might be purchased by a parent, carer or young person for their own use, filled from containers of dispensed medication. Alternatively, a monitored dose container or a daily/weekly dosing aid might be dispensed, labelled and sealed by a pharmacist. Sealed compliance aids are generally referred to as monitored dosage systems. Compliance aids also include other aids to the child or young person, such as large print labels, auto-droppers etc.

**Controlled drugs (CDs):** These are medicines whose management is governed by the Misuse of Drugs Act 1971 and its associated regulations.

**Dispensing:** To label from stock and supply a clinically appropriate medicine to a child, parent or carer, for self-administration or administration by another professional. Dispensing is usually done against a written prescription.

**General sales list medicines (GSLs):** These are medicines that need neither a prescription nor the supervision of a pharmacist and can be obtained from retail outlets.

**Licensed medication:** The Medicines and Healthcare Products Regulatory Agency (MHRA) operates a system of licensing before medicines are marketed. However, the Medicines Act allows certain exemptions from licensing. These are:

- the manufacture and supply of unlicensed relevant medicinal products for individual children or clients (commonly known as ‘specials’)
- the importation and supply of unlicensed relevant medicinal products for individual children or clients
- herbal remedies

The Medicines Act allows exemptions for certain healthcare groups and professionals – including occupational health schemes and midwives – to sell, supply and administer particular medicines directly to patients or clients. Provided that the requirements of any conditions attached to such exemptions are met, a patient group direction (see below) is not required.

**Medicines chart:** The record by which medicinal products administered to a child are recorded. Also known as the medicines administration record (MAR).

**Medicines Healthcare Products Regulatory Agency (MHRA):** The government agency responsible for ensuring that medicines and medical devices are effective and safe.

**Off-label:** A term commonly used to describe medication that is licensed but used outside its licensed indications.

**Patient group direction (PGD):** Written instructions for the supply or administration of named medicines to specific groups of children who may not be individually identified before presenting for treatment. Guidance on the use of PGDs is contained in Health Service Circular 2000/026 (in Wales WHC 2000/116 applies, while separate guidance has also been issued in Scotland and Northern Ireland). The circular identifies the legal standing of PGDs and provides additional guidance on drawing them up and operating within them. It is vital that anyone involved in the delivery of care within a PGD is aware of the legal requirements. Supplying or administering medicines from a PGD is not a form of prescribing. More information can be found on the following sites:

- [www.nice.org.uk/mpc/medicinespracticeguidelines/MPG2.jsp](http://www.nice.org.uk/mpc/medicinespracticeguidelines/MPG2.jsp)
**Patient information leaflet (PIL):** Information sheet produced by the manufacturer of the medicine and legally required to be supplied with all licensed medicines that should be brought to the parent or child’s attention when administering a medicinal product.

**Patient-specific direction:** Written instructions from a doctor, dentist or non-medical prescriber for a medicine to be supplied or administered to a named person. This could be demonstrated by a simple request in the child or young person’s notes, or by an entry on the child or young person’s drug chart.

**Pharmacy-only medicines (Ps):** These can only be purchased from a registered pharmacy. The sale must be by or under the supervision of a pharmacist.

**Prescription-only medicines (POMs):** These are medicinal products that may only be sold or supplied to a child on the instruction of an appropriate practitioner. An appropriate practitioner is a doctor, a dentist, a supplementary prescriber or a nurse or pharmacist authorised to be an independent prescriber.

**Summary of product characteristics:** Information on medicinal products dispensed may be found in the Electronic Medicines Compendium at [www.medicines.org.uk](http://www.medicines.org.uk).

**Transcribing (transposing):** Any act by which medicinal products are transferred from one form of written direction to administer to another is known as transcribing. This includes discharge letters, transfer letters and copying child administrations charts onto new charts (whether handwritten or computer generated).

**Unlicensed medicines:** This term refers to medicines that are not licensed for any indication or age group. A drug may not be licensed because it is undergoing a clinical trial, it has been imported, prepared extemporaneously or prepared under a special manufacturing licence. It could be that the product is not a medicine but is being used to treat a rare medical condition. This is not the same as a medicine being prescribed ‘off label’ (see definition).

**Yellow Card Scheme:** If a child or client experiences an adverse reaction to a medication, then it is the duty of the healthcare worker to:

- record details in the child or client’s notes
- notify the prescriber (if the nurse or midwife did not prescribe the drug themselves)
- notify the incident via the Yellow Card Scheme immediately

Yellow cards are found in a section at the back of the British National Formulary (BNF) and online at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk). For further information read the BNF or access the MHRA website, [www.mhra.gov.uk](http://www.mhra.gov.uk).

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**Knowledge bite**

**Accountability, the law and professional guidance**

Effective medicines management should comply with relevant legislation and with the standards set by a government-appointed professional regulatory body such as the Nursing and Midwifery Council (NMC), the General Pharmaceutical Council (GPhC) and the General Medical Council (GMC). Health professionals are accountable in law and could be subject to criminal proceedings or civil courts if medicines management does not comply with legislation. The professional regulatory body can hold a professional to account and action could be taken in respect of their professional registration if their standards are not met. Health professionals are also accountable to their employing organisation; policy and guidance set by employing organisation should be treated as mandatory. Hospice services must also meet the standards set by the relevant care regulator. Additional guidance from the government departments and professional organisations is published to support organisational policy setting and decision making for individual practitioners.
## Legislation

Detailed information about legislation can be found at: www.legislation.gov.uk

### Key Legislation

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<td><strong>Medicines Act 1968</strong></td>
<td>This was the first comprehensive legislation on medicines in the UK. The combination of this primary legislation and various statutory instruments (secondary legislation) since 1968 provides the legal framework for the manufacture, licensing, prescribing, supply and administration of medicines. Among recent statutory instruments of particular relevance to registered nurses, midwives and specialist community public health nurses is the Prescription Only Medicines (Human Use) Order 1997, SI No1830. This consolidates all previous secondary legislation on prescription-only medicines and lists all medicines in this category. It also sets out who may prescribe them. The sections on exemptions are of particular relevance to midwives, including those in independent practice, and to nurses working in occupational health settings. The Medicines Act 1968 classifies medicines into the categories of controlled drugs, prescription-only medicines, pharmacy medicines and general sales list medicines.</td>
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<td><strong>Misuse of Drugs Act 1971</strong></td>
<td>The Misuse of Drugs Act (MDA) 1971 and its associated regulations provide the statutory framework for the regulation of controlled drugs. The primary purpose of the MDA is to prevent misuse of controlled drugs (CDs). The Act makes it unlawful to possess or supply a CD unless an exception or exemption applies. A CD is defined as any drug listed in schedule 2 of the Act.</td>
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<td><strong>Misuse of Drugs (Safe Custody) Regulations 1973</strong></td>
<td>These regulations impose controls on the storage of CDs. The degree of control depends on the premises where the drugs are stored. All Schedule 2 and some Schedule 3 CDs should be stored securely in accordance with the safe custody regulations. These regulations state that such CDs must be stored in a cabinet or safe, locked with a key. It should be made from metal, with suitable hinges and fixed to a wall or floor with rag bolts that are not accessible from outside the cabinet.</td>
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<tr>
<td><strong>Misuse of Drugs Regulations 2001 (MDR) and Misuse of Drugs Regulations Northern Ireland (NI) 2002</strong></td>
<td>The use of CDs in medicine is permitted by the Misuse of Drug Regulations (MDR), under which drugs are classified in five schedules according to the different levels of control required. Schedule 1 CDs are subject to the highest level of control, whereas schedule 5 CDs are subject to a much lower level of control. Classification depends on the degree of therapeutic benefit versus harm when misused. The regulations authorise and govern certain activities that would otherwise be illegal under the Misuse of Drugs Act. The healthcare professionals who may legitimately possess and supply CDs are identified and the controls around prescribing, administration, safe custody, dispensing, record keeping and destruction or disposal are established.</td>
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<td><strong>Dangerous Drugs, England, Scotland: The Controlled Drugs (Supervision of Management and Use) Regulations 2006 and Health Act 2006 Updated 2013</strong></td>
<td>These regulations set out the requirements for NHS bodies and independent healthcare bodies to appoint an accountable officer. They also describe the duties and responsibilities of accountable officers to improve the safe management and use of CDs. The regulations require specific bodies to co-operate with each other, including information sharing, about concerns relating to the use and management of CDs. They also set out the arrangements relating to powers of entry and inspection. The Health Act 2006 specifies who may be appointed as an accountable officer. These regulations were updated in 2013 to reflect the new NHSW structures. Information about the changes is available at <a href="http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214915/15-02-2013-controlled-drugs-regulation-information.pdf">www.gov.uk/government/uploads/system/uploads/attachment_data/file/214915/15-02-2013-controlled-drugs-regulation-information.pdf</a></td>
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Knowledge bite

Children’s own medicine and the law

On many occasions, health professionals working in a children’s hospice service will administer the child’s own medicine. Once it has been dispensed, this medicine is no longer subject to the Medicines Act (1968). However, it is good practice to store, record and administer the child’s own medicines with the same care and standards that apply to stock medicines and local policy should reflect that standard.

Standards set by professional bodies

Healthcare professionals working in a children’s hospice are subject to standards set by their own specific professional regulatory body. Nurses are regulated by the Nursing and Midwifery Council (NMC), pharmacists by the General Pharmaceutical Council (GPhC), medical staff by the General Medical Council (GMC) and other health professionals by the Health Professions Council (HPC). The standards set by the professional bodies are intended to promote the public interest. Professional body standards should be regarded as mandatory, taking their authority from the legislation that underpins the function of the regulatory body.

Regulation and the nurse

The Nursing and Midwifery Council (NMC) sets detailed standards for medicines management for nurses, midwives and specialist community public health nurses. These standards, published in 2010, replaced the Guidelines for Administration of Medicines (2004). The new standards are available at: www.nmc-uk.org/Publications/Standards/

The NMC emphasises that medicines administration is not just about complying with the written direction of a prescriber; it is a process that requires the exercise of professional judgement. All directions to administer or supply a medicine should be checked by the registered practitioner, applying their knowledge of the medicines to be administered and the child’s clinical condition. The nurse may supply or administer medication on the direction of a medical practitioner or a non-medical independent or supplementary prescriber.

A nurse may supply or administer medicines in accordance with:

- a patient-specific direction
- a prescription form
- a child’s medicines administration chart
- a patient group direction (restricted to staff who have undergone appropriate training and have been identified by the organisation as competent)
- a Medicines Act exemption (this only applies to specific groups of staff, such as midwives and occupational health nurses)
- a homely remedy protocol. These are protocols agreed by the organisation to supply remedies for minor ailments, for example the use of paracetamol for headaches. Over-the-counter (OTC), general sales list or pharmacy-only (P) medicines may be supplied under a homely remedy protocol. Prescription-only medicines (POMs) may not be supplied under these protocols.

Standing orders have no legal standing in this context. All standing orders should be transferred to patient group directions.
Transcribing

This section is taken from the NMC standards for nurses, midwives and health visitors (refer to chapters Medicines Reconciliation and Transcribing for further information).

A registered practitioner may transcribe from one direction to supply or administer to another. This includes discharge and transfer letters and hand-written or computer-generated charts. Transcribing, sometimes referred to as transposing, should not be routine practice and should only be undertaken in exceptional circumstances. The registered practitioner remains individually accountable for what s/he transcribes.

Use of information technology to confirm changes to a prescription

E-mail, text or fax may be used to confirm changes to a prescription when a change in dose is considered necessary and the prescriber is not available in person to issue a new prescription or direction. A verbal order alone is not sufficient.

The nurse is responsible for ensuring confidentiality and for recording when the information was received. The fax or email should be fastened to the original medication chart.

The prescriber must re-issue the prescription or complete and sign the administration chart within 24 hours (72 hours maximum over bank holidays and weekends).

Remote prescribing

In exceptional circumstances a medical practitioner may need to prescribe remotely for a child for a previously unprescribed medicine, for example for palliative care in a remote rural area. E-mail, text or fax may be used to confirm the prescription before administration. The nurse must ensure that the prescriber has all relevant information and must also document the communication. Prescribers may not prescribe remotely if they have not assessed the child for care.

Protocols must ensure that child confidentiality is protected and that there is adequate documentation. This should include the message in full, the telephone number it was sent from, the time sent, any response given, the date and the signature of the nurse receiving the text. Text messages must be read by a second person and the documentation signed to confirm that it agrees with the text message. The text message must be documented as a child contact. Text messages should then be deleted to ensure confidentiality.

The prescriber must issue the prescription or complete and sign the administration chart within 24 hours (72 hours maximum over bank holidays and weekends).

Administration

All registered nurses are accountable for their actions and omissions. You must exercise professional judgement when administering or overseeing the administration of a medicine. Please refer also to the sections on delegation and self-administration within this chapter.

The nurse should always:

- check identity
- check allergies
- understand therapeutic use, dosage, side-effects, precautions and contraindications of the medicines to be administered
- be aware of the any existing individual care plan
- check that the prescription and the label on the medicine are unambiguous
- check expiry dates
• consider dosage, weight of the child if appropriate, route, method of administration and timing
• consider the context of the child’s condition and other therapy before administering or withholding the medicine
• contact the prescriber or another authorised prescriber when contraindications or reactions are discovered, or when assessment suggests that the medicine is no longer suitable
• assess the child, parent or carer’s understanding of how to use compliance aids and his/her ability to do so safely
• avoid preparing substances in advance of use or administering medicines drawn into a syringe or container by another practitioner when not in their presence
• immediately complete clear, accurate records of any medicines administered, withheld or refused. Signatures must be clear and legible, and the reason(s) for withholding medicines should be recorded. Normally, a single signature is all that is needed when administering a prescription-only, general sales list or pharmacy-only medicine.

Use of a child’s own medicines

Registered nurses may use the child’s own medicines. These may include prescribed medicines, over-the-counter medicines, homely remedies and complementary therapies (refer to sections on administration, self-administration and complementary therapies elsewhere in this section). These products, including controlled drugs, remain the child’s property and must not be removed without their permission. They must only be used for that child.

The nurse is responsible for asking to see the medicinal product, checking suitability for use, establishing if it is prescribed and explaining if it will or will not be used and why. If the child or parent refuses consent for use of medicines, or refuses to dispose of medicines that are unsuitable or no longer required, the nurse has a responsibility to document the refusal in the child’s notes.

The nurse must ensure that suitable storage facilities are provided and that the storage is documented in the child’s notes. The storage cabinet must be kept locked and the key kept in a secure place. If the child is moved to another care area, the medicines must be transferred with the child.

Delegation

The registered practitioner is responsible for applying the principles of medicines administration but may delegate the task of giving the medicinal product or assisting the child to a (competent) unregistered practitioner. Nurses should not normally delegate the task of administering a controlled drug.

Students must always be directly supervised when administering medicines.

A registered nurse delegating the task of supporting a child to take their medicine is accountable for this action and must be satisfied that the individual has an appropriate level of training and competence to carry out the task.

The registered nurse is responsible for record keeping when delegating the administration of medicines.

For further information about delegation refer to the chapter Staff Competency.
Self-administration/parent or carer administration

The nurse remains responsible for monitoring the child or parent who is self-administering medicines and for checking that medicines have been taken as prescribed.

The storage cabinet must be kept locked and the key kept in a secure place. The key may be kept by the child or parent in a secure place if the child, parent or carer is self-administering.

The registered nurse is responsible for the ongoing assessment of a child who is self-administering and for acting upon changes in a child’s condition.

The nurse may assess a child’s suitability to self-administer. Suitability can be assessed at three levels:

- **At level 1** the nurse remains responsible for the safe storage of the medicine, the supervision of administration and ensuring that the child understands the medicinal product.
- **At level 2** the nurse is responsible for the safe storage of the medicine and ensuring that the child can access the medicine when it is needed. The child self-administers under the supervision of the nurse.
- **At level 3** the child accepts responsibility for storage and administration of the medicine. The nurse checks compliance verbally. Children or carers should be reassessed on a regular basis to ensure that they are still capable of self-administration, and these reassessments should be documented.

When parents are administering medicines to a child, the nurse is responsible for checking the medicine has been administered. Nurses should ideally check this by direct observation, but can also do so when appropriate by questioning the parent, child or carer. The administration record should be signed and annotated ‘child self-administration’ or ‘parent administered’.

Administration by parents should be carefully controlled, with clear communication and documentation to avoid error.

Unsupervised administration by parents must be approved by the registrant/nurse in charge following assessment of the parent’s suitability. Local policy must be in place and adhered to. Arrangements over holding keys to secure storage and return of the keys must be agreed. The medicines must be correctly labelled before discharge, or returned to the pharmacy.

Further information is available in the Standards for Medicines Management (NMC 2010). Self-administration is also discussed in the Staff and Carer Competency chapter.

**Titration**

It is permissible for the nurse to titrate and administer doses from a prescribed range according to child responses and symptom control (especially in palliative care). The nurse must be competent to interpret test results and make appropriate assessments.

**Unlicensed medication and administration of medicines outside the terms of a licence**

Unlicensed medication refers to medicines that do not carry any marketing authorisation; they are not licensed for any indication or age group. The person who prescribes and supplies these medicines carries additional liability for any harm that may ensue. A registered practitioner may administer unlicensed medicines but the parent or child must understand that the medicine is unlicensed and give consent.

Unlabeled medicines may be administered in accordance with a patient-specific direction, but not from a patient group direction. Medication which is licensed but used outside its licensed indications (commonly known as off-label) may be administered under a patient group direction only where such use is exceptional, justified by best practice, and where the status of the product is clearly described.

A registered practitioner should be satisfied that s/he has enough information to administer unlicensed/ off-label medicines safely. Where possible, there needs to be acceptable published evidence for the use of such products for the intended indication.
The British National Formulary for children (BNFC) provides useful information about the administration of off-label medication for children. More information on unlicensed and off-label drugs can be found in the NMC publication Standards of Proficiency for Nurse and Midwife Prescribers at: www.nmc-uk.org/Publications

Storage and transport

Medicines must be stored in accordance with the instructions on the information leaflet that accompanies any UK licensed medication, or those on the label.

Registered practitioners may transport medication to a child if the child or their representative is unable to collect it.

Medicines that have not been prescribed

The nurse should not administer a child’s own medication that has not been prescribed – or medicines that have been obtained over the internet.

Quality, safety and correct storage cannot be assured when such medicines are used, and there will be no redress from the manufacturer if adverse reactions occur. If the internet pharmacy service is a registered pharmacy premises, subject to UK standards, then it is acceptable to administer the medicine.

Child’s own medication that has been purchased abroad and does not have a UK licence

The nurse should try to identify the source of the original prescription and be assured of its authenticity. Alternatively, the nurse should seek the parent or child’s consent to have a similar drug, with a UK licence, prescribed. If consent is gained the nurse should request a prescription from a qualified prescriber.

The NMC advises that in situations where the child refuses any medication but the unlicensed product, or if an emergency situation occurs, the nurse may administer the product. A contemporaneous record must be kept. The hospice service should have a locally agreed policy in place.

Complementary and alternative therapies

Registered nurses who choose to administer complementary therapies, for example herbal remedies or homeopathic medicines, must be qualified and competent to practise the administration of complementary therapies. The child or parent must give informed consent to the use of any complementary therapy.

All complementary therapies must be recorded on the child’s medicines charts. All practitioners must be aware that complementary therapies may interact with other medicinal products.

The nurse must be sure that the employer has accepted vicarious liability for any therapies that s/he undertakes. If this does not occur, the nurse must ensure that s/he has indemnity insurance to cover his/her practice.

The NMC standard relating to use of child’s own medicines also applies to complementary therapies. A suitably qualified practitioner should establish if the medicine has been prescribed or not, check that it is suitable for use by the child and establish if it has been prescribed. The practitioner should explain if the therapy will or will not be used and why.

For more information about the use of complementary therapies, refer to the Staff and Carer Competencies chapter.
Compliance aids

Nurses should assess a child’s suitability to use a compliance aid. A locally recognised assessment tool should be used to identify that the child is able to understand how to use the compliance aid safely. The aid should ideally be dispensed, labelled and sealed by a pharmacist.

The nurse may repackage dispensed medication into a compliance aid. But this increases the risk of error, and may change the properties of the medication. This activity should be covered by a standard operating procedure. It is recommended that the nurse should confirm with the dispensing pharmacist that it is appropriate to repackage medication in this way and that labelling is in line with legislation.

Crushing medicines

The crushing of medicines may alter their therapeutic properties and may not comply with the product licence. The nurse should seek advice from a pharmacist and ensure it is in the child’s best interest.

Disguising medication

This is also known as covert administration of medicine. It is not good practice to disguise medication with the intention of leading the child or client to believe they are not receiving medication when they are in fact receiving medication. The nurse is accountable for the decision to disguise medication and must be sure it is in the child’s best interests. Nurses and midwives involved in decisions relating to administration of medicines in this way must act within the principles of The Code, NMC 2008 and ascertain and record the support, or otherwise, of the rest of the multi-professional team, and where appropriate family members, carers and others. It is inadvisable for nurses and midwives to make a decision to administer medication in this way in isolation. They will need to refer to local and national policies and apply the requirements of the law, particularly in relation to capacity. The covert administration of medicines is only likely to be necessary or appropriate in the case of children who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal (Mental Capacity Act, 2005). Guidance from the NMC on disguising medication is available at: www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/Covert-administration-of-medicines/

Preparation of substances for injection

Nurses should not prepare substances for injection in advance, nor should the nurse administer medication prepared by another practitioner not in their presence.

It is acceptable to administer prepared medication from a central intravenous additive service that is clearly labelled for the child. The summary of product characteristics or child information leaflet should indicate that it has to be prepared in advance.

A registered nurse may draw up medication in advance and delegate the administration to a family member or healthcare assistant. But this named individual must be assessed as competent. The nurse is accountable for the delegation, and a risk assessment must be documented in the child’s notes.

When a nurse prepares substances for injection by another practitioner, for example in an emergency situation, the nurse must be sure the practitioner has carried out the appropriate checks.

Intravenous (IV) medication

IV medication should be checked by two registered practitioners, one of whom is to administer the IV medication. In exceptional circumstances, where this is not possible, the nurse should check with another competent person who knows the child – a parent, for example, or the child themselves. Any dose calculation must be independently checked.

The nurse is responsible for monitoring the child undergoing IV therapy.

Further guidance is available in the UK injectable medicines guide, available at [www.ukmi.nhs.uk](http://www.ukmi.nhs.uk), and from the Royal College of Nursing competencies guide at: [www.rcn.org.uk/__data/assets/pdf_file/0003/78681/003005.pdf](http://www.rcn.org.uk/__data/assets/pdf_file/0003/78681/003005.pdf)

**Adverse events related to medicines**

Please refer to the chapter *Learning from Errors*, but note that in terms of regulatory compliance, you must take action to remedy harm caused by errors or adverse drug reactions. Action must be documented and then reported as soon as possible. Errors should be reported to the prescriber and manager/employer. Adverse reactions should be reported to the prescriber and notified via the yellow card scheme.

**Disposal**

Disposal must be carried out in accordance with legislation. In primary care medicines should be returned to the pharmacy for disposal. Stock medicines should be disposed of according to local protocol as clinical waste. Community pharmacies cannot accept medicines for homes registered to provide nursing care. For further information refer to paragraph ‘disposing of controlled drugs’ below.

**Regulation and the medical practitioner**

The General Medical Council regulates medical practitioners. It gives them clear guidance on the prescribing of medicines in *Good Practice in Prescribing Medicines* (2008). This guidance is available at: [www.gmc-uk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf](http://www.gmc-uk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf)

The guidance covers the following topics:

**Principles of prescribing**

Doctors with full registration who hold a licence to practise may prescribe all medicines, but not those drugs in Schedule 1 of the *Misuse of Drugs Regulations 2001*. Doctors should only prescribe drugs to meet the identified needs of the child or young person, and never for their own convenience or simply because the child, parent or carer demand them. Doctors should avoid treating themselves or those close to them.

**Keeping up-to-date and prescribing in the child’s best interests**

Doctors should be familiar with the latest guidance in the BNF for Children available at [http://bnfc.org/bnfc/](http://bnfc.org/bnfc/). This includes guidance that covers the use, side-effects and contraindications of medicines. Guidance about the clinical effectiveness and cost-effectiveness of interventions is published by the National Institute for Health and Clinical Excellence (NICE) in England and Wales; in Wales additionally by the All-Wales Medicines Strategy Group; in Northern Ireland by the Department of Health, Social Services and Public Safety and in Scotland by the Scottish Medicines Consortium and NHS Quality Improvement Scotland (including the Scottish Intercollegiate Guidelines Network).

The doctor should:

- Be in possession of, or take, an adequate history from the child, parent or carer.
- Reach agreement with the child and parents on the use of any proposed medication and the management of the condition, by exchanging information and clarifying any concerns.
• Establish the child’s priorities, preferences and concerns and encourage the child and parents to ask
questions about the taking of medicines and the proposed treatment. Other treatment options should be
discussed, and the doctor should be satisfied that the child and parent(s) have been given appropriate,
understandable information. This information should cover any common or potentially serious side-
effects, what to do when side-effects occur, interactions with other medicines, and the dosage and
administration of the medicine (see Consent: patients and doctors making decisions together). The
doctor must be satisfied that the child, parents or carers understand how the medicine should be taken
and is able to take the medicine as prescribed.

Keeping the child’s general practitioner informed

If the child or parent does not want their general practitioner to be informed, or has no general
practitioner, then the prescriber must take steps to ensure that the child or young person is not suffering
from any medical condition or receiving any other treatment that would make the prescription of any
medicines unsuitable or dangerous. The prescriber must also take responsibility for providing all
necessary aftercare for the child or young person until another doctor agrees to take over.

Prescribing unlicensed medicines and medicines for use outside the terms of their
licence (off-label)

Doctors can prescribe unlicensed medicines. They may also prescribe medicines for purposes for which
they are not licensed. Although there are a number of circumstances in which this may arise, it is likely to
occur most frequently when prescribing for children and in a children’s hospice service. Pharmaceutical
companies do not usually test their medicines on children. As a consequence they cannot apply to
license their medicines for use in the treatment of children. The use of medicines that have been licensed
for adults, but not for children, is often necessary in paediatric practice.

Doctors who decide to prescribe unlicensed medicines or to prescribe off-label must:

• be satisfied that an alternative, appropriately licensed medicine would not meet the child or young
person’s needs
• be satisfied that there is a sufficient evidence base and/or experience of using the medicine to
demonstrate its safety and efficacy
• take responsibility for prescribing the unlicensed or off-label medicine and for overseeing the child’s
care, including monitoring and any follow-up treatment (further information is available in the guidance
regarding responsibility for prescribing medicines for hospital outpatients)
• record the medicine prescribed in the child’s notes, identifying the reasons when common practice is
not being followed

For further information consult the Royal College of Paediatrics and Child Health (RCPCH) statement on
the use of unlicensed medicines (2013). This is available at: www.rcpch.ac.uk/child-health/childrens-
medicines/childrens-medicines

Information for children, young people, carers and parents about the licence for their
medicines

Some medicines are routinely used outside the scope of their licence – in treating children, for example. It
is good practice to give as much information as children, parents/carers require or may see as significant
when prescribing medicines outside the terms of the licence. Where children, young people or their carers
express concern, the prescriber should also explain, in broad terms, the reasons why medicines are not
licensed for their proposed use. Such explanations may be supported by written information, including
the leaflets on the use of unlicensed medicines or licensed medicines for unlicensed applications
in paediatric practice produced by the Royal College of Paediatrics and Child Health/Neonatal and
Paediatric Pharmacists Group Standing Committee on Medicines. However, the prescriber must explain
the reasons for prescribing a medicine that is unlicensed or being used outside the scope of its licence
where there is little research or other evidence of current practice to support its use, or where the use of
the medicine is innovative. For specific information on prescribing medicines for children see the websites
of the Royal College of Paediatrics and Child Health and the British National Formulary for Children.
Remote prescribing via telephone, email, fax, video link or a website

From time to time it may be appropriate to use a telephone or other similar medium to prescribe medicines and treatment for children, instead of doing so face-to-face. This may occur where the prescriber has responsibility for the care of the child, is deputising for another doctor who holds that responsibility or has prior knowledge and understanding of the child’s condition/s and medical history and authority to access the child’s records. In all circumstances, prescribers must ensure that they have an appropriate dialogue with the child and their parents or carers. This is required to:

- establish the child’s current medical conditions and history and any concurrent or recent use of other medications, including non-prescription medicines
- carry out an adequate assessment of the child’s condition
- identify the likely cause of the child’s condition
- ensure that there is sufficient justification to prescribe the medicines/treatment proposed

Where appropriate the practitioner should discuss other treatment options with the child and their parents or carers and ensure that the treatment and/or medicine/s chosen are not contraindicated.

It is also the responsibility of medical practitioner to make a clear, accurate and legible record of all medicines prescribed.

If the prescriber is not providing continuing care for the child, does not have access to the child’s medical records, or is not deputising for another doctor, the advice above should still be followed. In addition, the prescriber should:

- give the child, parent or carer his/her name and GMC number and explain the processes involved in remote consultations
- establish a dialogue with the child, parent or carer, using a questionnaire, to ensure that the prescriber has sufficient information about the child to ensure safe prescribing
- make appropriate arrangements to follow the progress of the child
- monitor the effectiveness of the treatment and/or review the diagnosis
- inform the child’s general practitioner or follow the advice above if the child, parent or carer objects to the general practitioner being informed.
- make a clear record of the medicines prescribed

Where all of these conditions cannot be satisfied, remote means should not be used to prescribe medicine for a child.

Good Practice in Prescribing Medicines also includes further guidance on:

- patient group directions
- procedures to simplify the work involved in issuing repeat prescriptions
- repeat dispensing
- prescribing controlled drugs for yourself or someone close to you
- prescribing for children to whom you also dispense
- other published regulations, guidance and information relevant to prescribing
Regulation and the pharmacist

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. The GPhC provides standards for conduct, performance and ethics for pharmacists. These standards relate to seven key areas:

1. Make patients your first concern
2. Use your professional judgement in the interests of patients and the public
3. Show respect for others
4. Encourage patients and the public to participate in decisions about their care
5. Develop your professional knowledge and competence
6. Be honest and trustworthy
7. Take responsibility for your working practices.

The standards are available at:

The GPhC does not dictate how the standards should be applied. Pharmacists are professionally accountable and responsible for their own practice and are expected to undertake a risk/benefit analysis when faced with conflicting legal and professional responsibilities. Every pharmacist is expected to make decisions based on the GPhC standards with the best interest of the public and child in mind.

Care quality commission standards

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. The standards of medicines management required by the CQC reflect Regulation 13 of the Health and Social Care Act (2008). Standard 9, specific to medicines management, expects that service users (children and their parents) will get their medicines at the times they need them, and in a safe way. Wherever possible service users will have information about the medicine being prescribed made available either to them or to others acting on their behalf. Providers who comply with the regulations will handle and prescribe medicines safely, securely and appropriately.

The full guidance that accompanies the Care Quality Commission standards is available at:

Knowledge bite

Protection against unsafe use of medicines

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2010 states that “the registered person (a health professional in this instance) must protect service users against the risk associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines for the purpose of the regulated activity”.

Service providers should be aware that current advice from CQC inspectors in relation to medication errors requiring medical attention/transfer to hospital should be reported under Outcome 20: Notification of other incidents, which states “People who use services can be confident that important events that affect their health, welfare and safety are reported to CQC so that, if necessary, action can be taken”.

Readers in other countries should refer to the equivalent guidance in the relevant regulatory body.
The National Service Framework

The National Service Framework (NSF) for children, young people and maternity services, published in 2004, was developed with input from a range of professionals. NSF principles and standards are still relevant today but it is for local organisations to consider how they wish to use them. Standard 10 of the NSF has a focus on medicines management. The NSF states that children and young people, parents, carers and healthcare professionals in all settings must make decisions about medicines based on sound information about risk and benefit. Children must have access to safe and effective medicines that are prescribed on the basis of the best available evidence. Safety is enhanced by training and the use of evidence-based information and systems. Medicines in paediatric palliative care services are often used outside the terms of their licence (off-label). Practitioners using unlicensed or off-label medication should have access to enhanced decision support systems, for example access to advice and support from practitioners experienced in prescribing for children and use of the British National Formulary for Children. More information about the NSF is available at:


Controlled drugs

The following guidance on best practice comes from the National Prescribing Centre Guide to Good Practice in the Management of Controlled Drugs in Primary Care (England) 3rd edition 2009


In Scotland, the following guidance applies:


Readers in other countries should refer to the equivalent guidance in the relevant regulatory body.

Guidance is also available in the BNF, refer to the ‘Guidance on Prescribing’ section and individual drug monographs.

For a list of controlled drugs, detailing the class and schedule, refer to:

www.gov.uk/government/publications/controlled-drugs-list

The accountable officer

The Health Act 2006 specifies who may be appointed as an accountable officer.

The Accountable Officer cannot be a person who routinely supplies, administers or disposes of CDs as part of their duties. More information is available at:

www.legislation.gov.uk/uksi/2013/373/part/2/made

The hospice must notify the Care Quality Commission (CQC) of the nomination or appointment of an accountable officer, as well as the removal or change of an accountable officer. More information is available at: www.cqc.org.uk/content/controlled-drugs-accountable-officers
The accountable officer is responsible for ensuring the safe and effective use and management of controlled drugs within the hospice. He or she must have regard to best practice in relation to the management of controlled drugs by taking responsibility for the following:

- securing the safe management and use of CDs in particular
- establishing and maintaining appropriate arrangements to comply with Misuse of Drugs legislation
- ensuring adequate and up-to-date standard operating procedures are in place in relation to the management of CDs
- ensuring adequate destruction and disposal arrangements for CDs
- ensuring monitoring and auditing of the management and use of CDs
- ensuring that relevant individuals receive appropriate training
- maintaining a record of concerns regarding relevant individuals
- assessing and investigating concerns
- taking appropriate action if there are well founded concerns
- establishing arrangements for sharing information
- attending meetings of the local intelligence network (LIN)

CD regulations that set out all the responsibilities of the CD accountable officer, where applicable, can be found on the Government’s legislative web pages: www.legislation.gov.uk/uksi/2006/3148/contents/made

**Local intelligence network**

Local agencies are required by legislation to share information with a number of other bodies and authorities, including healthcare organisations, the police, social services, relevant inspectorates, the Care Quality Commission and the GPhC. The network will enable agencies that have cause for concern about the activities of any healthcare professional to share them as soon as possible with other local agencies that may be affected or that may have complementary information.

**Storage of controlled drugs**

 Controlled drugs subject to safe custody requirements must be kept in a locked receptacle, which is constructed and maintained to prevent unauthorised access to drugs. The cabinet should be made of metal, with protected hinges and fixed to the wall or floor. The bolts should not be accessible from outside the cabinet. In residential and healthcare settings it is recommended that the specifications of cabinets and safes set out in schedule 2 of the Safe Custody Regulations should be regarded as a minimum standard for the storage of CDs.

Stock should be kept to a minimum. The cabinet should not contain anything other than the drugs, or the drugs and register. Children’s own medicines and medicines awaiting destruction should be separated from stock medicines within the cabinet. Organisations may wish to offer guidance on separating similar drugs or high and lower strength opioids to reduce the risk of error.

Standard operating procedures should specify who has custody of the keys. One designated person on the premises should take overall responsibility for the management of controlled drugs, including keys/ codes. The number of sets of keys to the cabinet, and who holds them – plus details of who has access to the codes for digital key pads – must be known at all times by the designated person.

The keys should always be kept separately from the cabinet, and should never be accessible to unauthorised persons. The cabinet should only be opened by the designated person, or by a person authorised by them. The designated person remains ultimately accountable for the management of the CDs.
There must be a procedure in place to cover arrangements for reporting missing keys and the management of security and the care of children and young people if keys are missing. This procedure should include informing the accountable officer and police.

**Record keeping**

Please refer to the *Department of Health guidance Safer Management of Controlled Drugs (CDs): Changes to Record Keeping Requirements (2008)* at: www.dhsspsni.gov.uk/pas-dh-guidance-record-keeping-requirements-feb08.pdf

**Archiving controlled drug records**

The following records should be archived for a minimum of two years after the last entry in the record: requisitions, registers, external orders, delivery notes, prescriptions (inpatient and outpatient). Destruction of CD records should be kept for a minimum of seven years and clinical trial records for five years. The hospice may wish to store records for longer than the mandatory minimum period as it is possible that court cases may be held longer than two years after an event.

**Maintaining a running balance of stock**

The running balance of Schedule 2 drugs remaining should be calculated and recorded after each transaction. It is also good practice to keep a running balance of Schedule 3 drugs. Balances should be checked with the physical amount of stock at regular intervals.

Accountability for maintaining the running balance of CD stock and dealing with any discrepancies lies with the health care professional in charge.

**Physical reconciliation with stock levels**

The running balance recorded in the CD register should be checked with the physical amounts of stock at regular intervals. Weekly would be considered good practice. Two members of staff should check all stock received or removed, and both individuals should initial any entry in the CD registers. They should also initial a record made to say that the stock balance has been checked.

**Dealing with discrepancies**

SOPs should clearly define the action to be taken if a discrepancy arises. Once resolved, a note should be made in the CD register to correct the discrepancy in the balance. The record should clearly state the reason for the entry, the date of the error or omission and the signature of the person making the entry and a witness. It is also advisable to keep appropriate records of the investigation and action taken when discrepancies arise. If the source of the discrepancy cannot be identified during the stock check, then a nominated member of the relevant organisation should be informed and a formal internal investigation should be undertaken. The organisational accountable officer and local area accountable officer should be informed of any concerns in relation to the management and use of CDs.

**Disposing of Controlled Drugs**

The following information applies in England and Wales:

The Environment Agency carried out a review of their waste exemptions, which resulted in a new set of exemptions that came into force on 6 April 2010.

Premises which stock Controlled Drugs need to register a T28 with the Environment Agency so that they can denature and destroy controlled drug stock when it expires (subject to authorised witness requirements where appropriate).

Controlled Drug means a controlled drug specified in Schedule 1 to 5 of the Misuse of Drugs Regulations 2001 (this includes opiates, midazolam, temazepam, diazepam etc).
The T28 exemption can be viewed at:
www.gov.uk/waste-exemption-t28-sort-and-denature-controlled-drugs-for-disposal

If you have any further queries regarding this exemption please contact the Environment Agency directly on its customer service line 03708 506 506.

The destruction of Schedule 2 Controlled Drug stock (e.g. opiates) must only be undertaken in the presence of an authorised witness.

Disposal in Scotland is covered by the SEPA:
www.sepa.org.uk/waste/waste_regulation/application_forms/exempt_activities.aspx

For information relating to Northern Ireland, see:
www.doeni.gov.uk/niea/

Goals for best practice and to achieve high quality standards

Professionals should adhere to the following:

• Have an awareness of the law underpinning medicines management, the professional standards you should meet when managing medicines and the standards expected by the Care Quality Commission.

• Have an understanding and awareness of local policy and standard operating procedures, and work within them.

• Only administer medicines that have been prescribed by an appropriately qualified practitioner, from a patient group direction or from a homely remedy protocol.

• Ensure that children and parents are given information about their medicines and that it is at an appropriate level to ensure their understanding of the treatment. Parents and children should be involved in decision making about medicines management and supported to take their medicines as prescribed.

• Be aware of controlled drugs policy and standard operating procedures and ensure these are implemented.

• Be aware of your responsibility and accountability in medicines management, particularly when delegating tasks.

• When delegating tasks to healthcare assistants or when supporting children and parents to self-administer, ensure that an assessment of their competence has been undertaken, documented and reassessed as necessary.

• Remember that you work as part of a team; all medicines management activities should be clearly documented to reduce risk and promote continuity of care.
References


Chapter 3

Staff and carer competencies

By Alison Cooke and Sue Hogg
Children’s hospice services provide care across a variety of settings, including residential, home care and acute hospital wards, and their staff come from a broad range of professional backgrounds. In order to ensure safe and effective medicines management, it is essential that each member of the multi-disciplinary team has the requisite competencies to fulfill their role, regardless of their qualifications or status. Staff involved in the management of medicines should understand the purpose of a child’s various medicines before engaging in prescribing, dispensing or administration processes.

The message from national policy documents is clear; the provision of high quality care requires a workforce that is competent and well supported. The Department of Health document *Delivering high quality, effective, compassionate care: developing the right people with the right skills and the right values* includes a useful chapter covering competent and capable staff and can be found here ([http://hee.nhs.uk/wp-content/uploads/sites/321/2013/05/29257_2900971_Delivering_Accessible.pdf](http://hee.nhs.uk/wp-content/uploads/sites/321/2013/05/29257_2900971_Delivering_Accessible.pdf)). Any professional who is involved in medicines management, regardless of their level of registration or academic study, must be competent to carry out the task they are agreeing to undertake. The responsibility for prior competence rests in part with the individual practitioner who has a duty of care to identify any concerns regarding their own competence.

This chapter addresses the following key issues:

• a definition of competencies
• why competencies are important
• how services can develop their own competencies to suit their particular needs.
• suggestions on key areas where practice is deemed higher risk and therefore best supported by explicit competencies, and routinely assessed
• a section on training
• examples of competency frameworks

**What do we mean by competencies?**

A competency framework describes the range of knowledge, skills and performance required by practitioners to enable them to achieve safe, effective and accountable practice (RCN 2012). Staff competencies must be supported by training and education as well as clear and robust local and organisational policies and procedures.

Competency frameworks in medication management are a very useful way of supporting staff to be appropriately skilled, experienced and confident in this complex area. If an explicit competency framework is supported by robust local policies and procedures it can provide organisations with the means to ensure that staff members are fully prepared and supported to undertake their role within medicines management. Competencies may be measured and monitored in a number of ways, including self-assessment, peer assessment and formal assessment. There is no standardised national competency framework. However, some examples of medicines management competencies are included in appendices 5 and 6.
Nursing

The Nursing and Midwifery Council (NMC) accepts that through meeting post registration education and practice (PREP, 2011) standards, registered nurses and midwives will develop their knowledge, skills and competence beyond their initial registration throughout their careers. For this reason, the NMC does not place any boundaries on the roles of nurses or midwives in relation to the parts of the register and fields of practice. However, nurses and midwives must always be aware of the limits of their ability and role boundaries, acknowledge their professional limitations, and make accountable decisions about their ability to practise in a safe and effective manner. This is reflected in the NMC Code (2008).

Competencies of medical staff

It has already been stated that staff who work in children’s hospices come from a broad range of professional backgrounds, and this is equally true for medical staff.

In the ten to 15 years after children’s hospices first opened in 1982, medical care was largely offered by general practitioners who extended their knowledge at courses and their experience within the hospice that they worked, seeking advice from colleagues within the children’s hospice movement and from children’s hospital units. Some went on to be General Practitioners with a Special Interest in Children’s Hospice Care, and sought formal recognition of this by completing a Diploma in Palliative Care (Paediatric Option) from Cardiff University.

In 1997 the Royal College of Paediatrics and Child Health (RCPCH) published its Guide to the Development of Children’s Palliative Medicine Services. Ten years later, there were still only six specialist consultants in children’s palliative medicine in the United Kingdom. But there was an increasing number of doctors working in children’s hospices from a variety of different backgrounds, including general practitioners, paediatricians, adult palliative care physicians, and other medical specialists, many of whom had been working in children’s hospices for many years and who had developed considerable relevant expertise.

Subsequently, a working group from the British Society of Paediatric Palliative Medicine (BSPPM) and the Association of Children’s Hospice Doctors formed. It recognised the importance of this diversity and devised a competency-based rather than a qualification-based curriculum to ensure that knowledge and skills specific to the subspecialty were developed, which was appropriate to the level of expertise required for the individual setting and team. The result was the Combined Curriculum in Paediatric Palliative Medicine, which was published in 2008, and was applicable for doctors working in children’s hospices and children’s hospital units which were delivering palliative and end of life care. The curriculum that was developed was designed to complement the knowledge and skills that a medical practitioner had achieved by virtue of his core training, for instance in general practice, paediatrics or palliative medicine.

This curriculum (www.appm.org.uk/resources/Combined_Curriculum_in_Paediatric_Palliative_Medicine+$282$29.pdf) is based on a combination of a set of competencies (testable skills) and a set of tools to evaluate them. It was organised into three broad streams: knowledge, skills and attitude.

Four levels of competencies were described for children’s hospices:

- **Level 1**: a doctor just completing a medical degree
- **Level 2**: a children’s hospice doctor after one year of experience
- **Level 3**: a children’s hospice medical director, or other established children’s hospice doctor who had completed a Diploma in Palliative Medicine (Paediatrics)
- **Level 4**: a small number of children’s hospice medical directors (mainly leaders in subspecialty formation and development, and with roles beyond their local hospice)
Four general principles were developed to define the different levels:

- **Level 1**: understand the basic principles of paediatric palliative care
- **Level 2**: apply basic principles of palliative medicine to the care of children and young people.
  Recognized reversible causes of symptoms in children, whether with a life-limiting condition or not
- **Level 3**: be able to manage most common symptoms safely and effectively. Be prepared to recognize
  the need for specialist help and access it when necessary
- **Level 4**: manage uncommon symptoms and understand principles in order to develop a logical
  approach even when there is no evidence base. Additionally, a Level 4 doctor would support and also
  teach other professionals involved with children with life-limiting conditions who are not trained in
  palliative medicine

The curriculum also recommended that each children’s hospice should have a medical practitioner of
at least Level 3 status as part of their regular team and should have specifically agreed support (via
telephone or direct contact) from someone of Level 4 status.

In 2010 the BSPPM and the Association of Children’s Hospice Doctors amalgamated to become the
Association Paediatric Palliative Medicine (APPM) [www.appm.org.uk](http://www.appm.org.uk). It recognises that children’s
palliative care is continuing to rapidly develop and its Education Subgroup and the College Specialty
Advisory Committee of the Royal College of Paediatrics and Child Health is currently revising
the Combined Curriculum to ensure that these developments are acknowledged within specific
competencies.

Also of relevance to doctors and all other care staff and their managers within children’s hospices are
publications from the General Medical Council:

- *Good practice in prescribing and managing medicines and devices* (2013) can be found here
- *Treatment and care towards the end of life* (2010) (particularly paragraphs 90-104) can be found here
- *Protecting children and young people* (2012) can be found here ([www.gmc-uk.org/static/documents/
  content/Protecting_children_and_young_people_-_English_0414.pdf](http://www.gmc-uk.org/static/documents/
  content/Protecting_children_and_young_people_-_English_0414.pdf))

### Competencies in non-registered staff

Health Care Assistants (HCAs) or their equivalents are a significant part of the workforce in children’s
hospice services. The Royal College of Nursing (RCN) is clear that they are valued and integral members
of the nursing team, but they must be supported to develop the knowledge and skills required to
deliver competent patient-centred care. HCAs will usually provide care as a consequence of delegation.
Registered practitioners will commonly delegate duties to non-registered staff in the best interests of the
child or young person, but remain ultimately responsible for the overall care of that child or young person.
Supervision of staff can be part of delegation when the registered practitioner is present, but this may
not always be necessary provided the registered practitioner is satisfied that the healthcare assistant has
been suitably trained to perform the task. An excellent RCN resource to inform the training and support
of healthcare assistants can be found here ([www.rcn.org.uk/__data/assets/pdf_file/0005/441059/
Position_statement_-_HCAs_Final_2.pdf](http://www.rcn.org.uk/__data/assets/pdf_file/0005/441059/
Position_statement_-_HCAs_Final_2.pdf))
Notable practice

East Anglia Children’s Hospices (EACH) have developed a programme in medicines management for HCAs involved in administering medication to children and young people.

Care assistants are encouraged to develop a good understanding of medicines administered to children during their stay. They receive regular mandatory training relating to EACH policies in the area of medicines administration and are encouraged to participate with the nurse in supervised medicines administration as an important part of skills development.

Senior Care Assistants (SCAs) play an important role within EACH in the process of medicines administration for children and young people. SCAs are recognised as authorised practitioners who may undertake single-handed checking procedures, as part of a delegating of care agreement, once they have successfully completed a Medicines Administration Course of study (as a unit in NVQ3 qualification, EACH medicines competency) and been assessed as competent.

Delegation of care to a Senior Care Assistant can be made for nursing care provided for a child or young person in the hospice building or in the community and is only made in the best interests of the child or young person being cared for.

Medicines administration training for the SCA is child specific and the SCA is only allowed to administer the medication that has been recorded in the delegation agreement. Before any community visit, the SCA contacts the family to check if there have been any changes to the child’s or young person’s condition and medication. When there are changes to medication, the delegation agreement is reviewed and additional training is provided with the delegating nurse before the session of care takes place.

Training and support is provided for the SCA during buddying sessions in the community or in the hospice and reflective practice sessions are planned to ensure the senior care assistant is safe to perform that area of care. Regular reviews of delegation agreements take place at least annually or when there are changes to the child or young person’s condition or circumstances.

Delegation and accountability

It is important that children’s hospice and palliative care services and their managers, particularly those with clinical responsibility, recognise their responsibilities particularly in relation to the complex area of medicines management.

The range of staff involved in the various aspects of medication management includes doctors, nurses, therapists and pharmacists. As part of accepting responsibility for their own practice, they will also be expected to adhere to the relevant codes of practice for their professional body (see links in the resource section at the end of this chapter). The scope of this toolkit is to offer more detail on nursing, medical and healthcare assistant competencies because they form the largest part of the children’s hospice service workforce in relation to medication management.

The primary reason for delegation must always be to meet the needs of the child or young person, and registered practitioners must not delegate tasks that are beyond the level of skills and experience of the delegate, i.e. the person to whom the duty is delegated (NLIAH, 2010). The delegate is responsible for ensuring their knowledge and skills match the delegated task, and for informing the delegator if this is not the case. Furthermore, the competence of the person to whom the task has been delegated should be assessed and reviewed at least annually. Records of the training received and outcome of any assessment should be clearly made and be available. Organisations have a responsibility to ensure that all staff receive appropriate and standardised training and support to maintain and develop their existing skills and enable them to carry out their duties in the environment of children’s palliative care effectively.
The National Leadership and Innovations Agency for Healthcare (NLIAH) published a very useful guide to delegation called *All Wales Guidelines for Delegation* in 2010. Although published for Wales, it has UK-wide application and offers a very thorough summary of key guidelines to support clinical staff in managing delegation appropriately. It can be accessed here ([www.wales.nhs.uk/sitesplus/documents/829/All%20Wales%20Guidelines%20for%20Delegation.pdf](http://www.wales.nhs.uk/sitesplus/documents/829/All%20Wales%20Guidelines%20for%20Delegation.pdf))

### Training and education – Training checklist

A suggestion/checklist of what might be included in the medicines management training programme of children’s hospice services is:

<table>
<thead>
<tr>
<th>What</th>
<th>Who for</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medication management – including local policy and practice</td>
<td>All clinical staff</td>
<td>Mandatory – On induction and annually thereafter</td>
</tr>
<tr>
<td>Medicines reconciliation and transcribing</td>
<td>All clinical staff</td>
<td>Mandatory – On induction and annually thereafter</td>
</tr>
<tr>
<td>Clinical governance in medication management:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The error reporting process and learning from error</td>
<td>All clinical staff</td>
<td>Every two years formally but learning from error should be a standard agenda item at team meetings</td>
</tr>
<tr>
<td>• Human factors as an approach to understanding error and error prevention</td>
<td>Clinical and Senior managers Clinical governance teams</td>
<td>Desirable to continuously support a culture of learning from error and to ensure consistency in supporting staff to learn from error</td>
</tr>
<tr>
<td>• Supporting staff involved in medication error</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringe pump training</td>
<td>Clinical staff</td>
<td>Full day introduction mandatory</td>
</tr>
<tr>
<td>Medication calculations</td>
<td>Prescribers</td>
<td>Annual mandatory half day update</td>
</tr>
<tr>
<td>Specialist subjects depending on local service for example:</td>
<td>Clinical staff</td>
<td>Regularly use simulated practice if gap of more than six months</td>
</tr>
<tr>
<td>• Single checking</td>
<td></td>
<td></td>
</tr>
</tbody>
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Chapter 3: Staff and carer competencies
Developing competencies in specific medication practice areas

While this toolkit acknowledges the importance of standardising clinical practice and any corresponding competencies across the UK, there are elements in medicines management in hospice care for which it may not be appropriate or in the child or young person’s best interests to apply a generic competency framework.

This section offers suggestions to support the development of local competencies in some of the most challenging areas:

- syringe pumps
- single checking
- supporting parents, carers and children and young people to manage their own medication (incorporating patient education and support)
- complementary therapies

Syringe pumps

Continuous subcutaneous infusions (CSCIs) are used in palliative care when other routes are unsuitable or inappropriate. This is an area of practice to which staff may only be periodically exposed, with long gaps between any experience.

Several drugs may be used in combination, but advice should be sought from the pharmacist, specialist hospital or other hospice services to ensure compatibility. The legal advice obtained from the MHRA is that when two medicinal products are mixed, one cannot be described as a vehicle for the other (for example a diluting agent such as saline or water). This therefore meets the definition of manufacture under the Medicines Act and results in a new unlicensed product. However, MHRA guidance states that they would be unlikely to prosecute, when used for the purpose of palliation, even though the product is unlicensed and as such outside the legal framework.

Consequently, we recommend that all services have a local training programme in place where staff have mandatory introductory training and annual updates. All prescribers should have training in prescribing mixed content syringes and should be aware of local and national sources of advice, including the British National Formulary. The training should cover:

- why the subcutaneous route is used
- equipment needed
- how to choose and set up a subcutaneous site for a driver
- how to set up a pump
- medication used – including mixing of multiple medications
- care of the site
- care and monitoring of the pump
- problem solving
- resources and references to support practice
Single checking

Experienced registered nurses who have undergone a medication competency and annual drug calculation test may be able to single check medications in certain circumstances, provided they feel competent to do so. In such circumstances the nurse should:

• understand the nature of the drug, reason for its prescription and possible side effects
• ensure that the medication has been prescribed by a registered prescriber which includes non-medical prescribers (NMPs)
• ensure that the medication is for administration via one of the following routes: oral, buccal, nasal, rectal, inhaled, nebulized, topical (including patches), or through a nasogastric tube, jejunostomy, or gastrostomy.
• ensure that the medication does not require a calculation to be undertaken at the point of administration (including weight/dose related calculations)
• ensure that the medication is the child’s or young person’s own medication and labelled as such
• ensure that the medication is not a controlled drug (unless local policy explicitly permits single checking of CDs)
• ensure that the medication is not being titrated

Supporting parents, carers, children or young people to manage their own medication (incorporating pharmaco-education and support)

Children, young people and/or their parents or carers may wish to self-administer medication. Children or young people should be considered for self-administration in exactly the same way as adults. However, under the principles of Gillick Competence (1985) for children under the age of 16 years; and The Mental Capacity Act (2005) for those aged 16 year and over, it is essential that their competence do so is established. Parental consent is essential for children less than 12 years of age and may be for older children and young people who lack capacity to make these decisions. Where possible, it should be discussed with parents or guardians as a matter of good practice and documented in the medical notes. It is recommended that children's hospice services have robust policies in place to address this issue.

The benefits of self-administration are that it:

• allows true child and family-centred care leading to improved service-user satisfaction
• increases the child/young person/carer’s knowledge and awareness of the medication through individual education and assessment
• empowers children and young people by giving them more control and independence
• creates a partnership with those involved in their care
• promotes children or young people’s responsibility for medicines and discourages the sick role
Complementary and alternative medications (CAMs)

Given the frequent use of CAMs, it may be that a child or carer wishes to continue using such products while using a children’s hospice service. The risk of refusing to allow any alternative medication use is that such products may be covertly administered by the child or carer. Any resulting adverse reactions may not then necessarily be attributed to the herbal medications, and this may lead to incorrect diagnosis and treatment. On the other hand, a complete ban on CAMs may result in the child or carer refusing formal care.

Cochrane Collaboration’s explanation of CAMs is:

“Complementary medicine includes all such practices and ideas that are outside the domain of conventional medicine in several countries and defined by its users as preventing or treating illness, or promoting health and wellbeing. These practices complement mainstream medicine by i) contributing to a common whole; ii) satisfying a demand not met by conventional practices; and iii) diversifying the conceptual framework of medicine”.

The NMC advises that registrants are accountable for their practice and must be competent in this area (please refer to The Code: standards of conduct, performance and ethics for nurses and midwives). You must have considered the appropriateness of the therapy to both the condition of the patient and any co-existing treatments. It is essential that the child or young person and their parent or carers are aware of the proposed therapy and gives informed consent.

Complementary and alternative therapies may interact with other types of medicinal products and laboratory tests. Therefore, any complementary therapy proposed by the palliative care service should be discussed with the child or young person’s GP or consultant and consent obtained. All complementary and alternative medicines should be recorded alongside other medicinal products and prescribed on inpatient prescription charts.

The children’s palliative care service should accept vicarious liability for any complementary or alternative therapy undertaken, and indemnity insurance should be in place to cover practice.

In the wake of a House of Lords report in November 2000, it was agreed that a single federal body for complementary therapies should be established to regulate a range of professional disciplines within the sector and protect the public by providing a UK voluntary register of complementary therapists. The Complementary and Natural Healthcare Council (CNHC) was therefore set up by the government, opening its register in January 2009, with registrants who practice massage therapy, nutritional therapy and others added as they met CNHC standards.

Currently, complementary therapies which have met the standards set by the CNHC and whose practitioners are registered by them include: Alexander Technique teaching, aromatherapy, Bowen therapy, craniosacral therapy, healing, hypnotherapy, massage therapy, microsystems acupuncture, naturopathy, nutritional therapy, reflexology, Reiki, Shiatsu, sports therapy and yoga therapy. For full information see the CNHC website here (www.cnhc.org.uk)

By registering with the CNHC, complementary therapists demonstrate to the general public and to other healthcare providers that they meet national standards of practice in their work. All registrants must also have indemnity insurance and abide by a professional code of practice. Note this does not apply to physiotherapists who may use massage within their core practice and are registered with the Health and Care Professions Council (HCPC).

In a children’s hospice service, it is not unusual to see CAMs used by children and young people. One review of reports in paediatric cancer patients showed a usage of herbal medications ranging from 6% to 91% (Bishop et al, 2010). Herbal medications can have serious adverse effects, and can potentially interact with conventional medication (Barnes 2007). For example, St John’s Wort affects the metabolism of some medications, and so can lead to low serum levels of anti-rejection medications used after transplants.
There are several key themes where children’s hospice services can demonstrate good practice in this area and they include:

• Clinicians involved in the delivery of CAMs should have the agreement and authorisation of their line manager or appropriate service lead to administer the preparation or deliver the intervention.

• All clinicians who deliver complementary therapies must hold a recognised professional qualification and/or complementary therapy qualification and be able to demonstrate competency, capability and fitness to practice. CNHC registrants will have had to fulfill these criteria as part of their registration.

• All staff involved with medicines management should receive training on CAMs and should have appropriate resources available to access.

• The use of CAMs should be addressed as part of the medicines management policy.

• Advice on CAMs should not be given by healthcare professionals without appropriate training (NMC 2010, Royal Pharmaceutical Society).

• Pharmacist advice should be sought in relation to interactions with prescribed medicines.

• It is essential that any administered CAMs are documented on the medication chart so that potential adverse drug reactions can be identified. It is also necessary for any staff involved with medicines management to have either appropriate knowledge or appropriate resources available to identify any potential problems.

Insurance

It is the clinician’s responsibility to maintain regulatory standards and adhere to requirements of their particular professional/regulatory body – including the need be absolutely compliant with requirements for professional indemnity insurance. If professionals and/or qualified complementary therapy practitioners are working for the organisation (including volunteers) and as part of their duties are clinically responsible for delivering complementary therapies, then they are required to have professional indemnity insurance which covers them in this role (CNHC registrants will have had to fulfill this criteria as part of their registration).

If clarification is needed about insurance or related matters then further advice should be sought from senior managers or the organisation’s legal advisors.

Knowledge bite

One hospice service reported on a young person who was experiencing increased seizures and was awaiting review by her paediatrician. The person’s parent had taken the decision to administer evening primrose oil due anticipated hormonal changes following the onset of puberty and was not aware this was contraindicated in epilepsy. Following discussion and review of the available literature, the parent decided to withdraw the evening primrose oil and the seizures subsequently reduced.
Resources available to support the development of competencies

Skills for Health provide sector wide support and online resources in a range of ways. Their website can be found here (www.skillsforhealth.org.uk) and has links to sections on e-learning resources, competencies and many other practical tools to support medication management skill building.

The Basic Symptom Control in Paediatric Palliative Care manual (www.togetherforshortlives.org.uk/assets/0000/5325/TfSL_Basic_Symptom_Control_In_Paediatric_Palliative_Care_-_Ninth_Edition_-_PDF.pdf) is an online resource that includes a comprehensive prescribing formulary, adapted from the Association of Paediatric Palliative Medicine’s master formulary (second edition), to support those prescribing in children’s palliative medicine.

NHS Healthcare Education England and NHS Education for Scotland both offer voluntary services access to the range of resources that will support us develop our workforces effectively. Their websites are NHS England (www.england.nhs.uk) and NHS Scotland (www.nes.scot.nhs.uk).

The Royal Pharmaceutical Society is the dedicated professional body for pharmacists in England, Scotland and Wales. Their website can be found here (www.rpharms.com/home/home.asp).

The Chartered Society for Physiotherapy has a website that provides resources to their members. They have examined the legal and policy frameworks that have shaped the current position for physiotherapists when using medicines and prescribing in clinical practice and describe the frameworks and their purpose. The main website can be found here (www.csp.org.uk). A search using the term ‘prescribing’ will highlight a range of useful resources accessible by members.
References

Department of Health (2013) *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values (A mandate from the Government to Health Education)* England: April 2013 to March 2015.

Royal College of Nursing (2012) *RCN Competencies: Palliative Care for Children and Young People.*


Rainbows Hospice for Children and Young People (2012) *Policy for Self-Administration Of Medicines By Adults And Their Relatives/Carers.*

*The Royal United Hospital of Bath Medicines code: self-administration of medicines by patients* (September 2013).

Gillick v West Norfolk & Wisbech Area Health Authority (1985) *UKHL 7* (17 October 1985) (Includes Fraser Guidelines).

Chapter 4
Learning from error
By Gerry Armitage
Children’s palliative care services provide for a diverse range of children and young people. These children sometimes have conditions that have been almost entirely managed by their families, with some support from children’s palliative care services. It is increasingly likely, however, that some children will require a level of support comparable with that given in a high dependency or intensive care unit by specialist staff. The children may well be receiving numerous medications, many of which have a high potential for error.

This chapter will provide:

- operational definitions for error management and an overview of the epidemiology of medication error
- some principles of crew resource management (an approach to improving decision making and communication in high risk settings)
- a human factors perspective to enhance situational awareness and team communication so as to prevent error
- a model for improving error reporting including a grading scale for harm events
- a framework for personal risk assessment
- goals for notable practice

Effective medicines management is essential in achieving quality and safety in healthcare. Medication errors can occur at any stage in the medication pathway, which is characterised by its closely coupled nature (the time between prescription and administration can be very short), considerable complexity, variability and, of course, the medication recipient’s vulnerability due to their often immature physiology. While most errors result in near misses or potential adverse events (no harm to the recipient), some will result in harm or what is commonly known as an adverse drug event (DH 2004). It is important to understand the definition of an error: “the failure of a planned action to be completed as intended – without the intervention of some unforeseeable event; or the use of a wrong plan to achieve an aim” (Reason 1990, p9).

A medication error can then be interpreted as the failure of a planned action (or the use of a wrong plan) related to medicines management that does not achieve its intended aims. It is also worth acknowledging that errors can relate to prescribing, transcribing, product labelling, packaging, medication names, dispensing, distribution, administration, education, monitoring and (child or family) use. Errors will then have one of two outcomes, a near miss or harm event. Discrepancy (unintended) is another term associated with error and often in the context of medicines reconciliation. It would be helpful to turn to Chapter 5 (Medicines reconciliation and transcribing) to familiarise yourself with the term. The financial and personal costs to all those involved in errors can be considerable (Sirreyeh et al., 2010) and public confidence is often damaged (Wong et al., 2008). The increased media attention around avoidable harm since the reported problems at Mid-Staffordshire hospital has probably reduced public confidence in many UK health services; it has certainly led to increased scrutiny from external regulators and what appears to be a much sharper focus on safety.

Risk management and indeed medication safety strategies should be designed to prioritise learning and create sturdy defences. This reflects the ethos and recommendations of the Berwick Report (2013) which, as communicated in the introduction to this toolkit, was commissioned as a consequence of significant failures in safety in the NHS and a more general lack of quality. The central aim is to eliminate avoidable harm, while accepting that errors will sometimes occur. However, in common with the definition of error above, we must accept that sometimes treatment will lead to harm that cannot be prevented or foreseen. A good example of this is an adverse drug reaction when a routinely used drug is being given for the first time to a child.
Incidence of medication errors

It is estimated that between 2% and 14% of patients admitted to hospital will experience a medication error (Williams, 2007). Miller et al. (2007) carried out a systematic review of paediatric medication errors across primary, ambulatory and secondary care settings in the USA. They found that the percentage of errors by stage of medication delivery was 3–37% in prescribing, 5–58% in dispensing, 72–75% in administering and 7–21% in documentation. In a multi-centred hospital-based study of 21 children’s wards here in the UK, Ghaleb et al. (2010) found that 13% of prescriptions contained errors and there was an administration error rate of 19%. Nevertheless, it is difficult to develop an accurate epidemiology of error, different error definitions and methods of detection produce very different results (Dean Franklin et al, 2009).

Unintended discrepancies in patients’ medicines after discharge from hospital frequently occur, affecting 43% of repeat prescriptions in primary care and more than half of all patients discharged (Garfield et al., 2009). The findings of Garfield et al reinforce the necessity for effective medicines reconciliation. The discrete incidence in primary care is less certain, although it is thought that 11% of prescriptions can contain an error (Sanders and Esmail, 2003) and that medication errors in primary care tend to be either prescribing or monitoring errors (Avery et al, 2012). More recently, Knudson et al. (2007) have identified that most community pharmacy dispensing errors occur at the transcription stage, highlighting the high risk nature of this intervention.

Boyer et al. (2009) argue that adult hospice populations are particularly vulnerable to adverse drug events because of the frequent use of high risk medicines; this also applies to children receiving palliative care who can additionally be more vulnerable to adverse drug events due to their immaturity and poor tolerance of medicines. At the time of preparing this toolkit, the incidence and principle causes of medication error in children’s palliative care services is unknown. However, it is known that children are generally vulnerable to particular error types, and that there are often particular factors that contribute to such errors. Understanding the causes of avoidable harm is the starting point for designing effective strategies to reduce such harm.

Medication errors in children: Types and causes

The majority of medication errors in children are dosing errors, and involve intravenous administration (Wong et al., 2008). More recently, a multi-centred study carried out on 11 children’s wards in five hospitals showed that the most common prescribing errors were incomplete prescriptions and incorrect use of abbreviations, while the most common administration errors were incorrect preparation and incorrect rates for intravenous infusions (Ghaleb et al., 2010). Intravenous administration is not uncommon in children’s palliative care services and studies like those of Ghaleb et al. reinforce the need for vigilance with what might be perceived by staff as a routine activity.

Wong explains that the factors contributing to errors are often related to individual rather than general dosing, and to lack of arithmetical competence when alterations have to be made to standard (adult) doses. In primary care, medicines may be supplied through different community pharmacies (depending on the parent’s choice) and on different prescription layouts (Yeung et al., 2004), the inconsistency of supply and overall lack of standardisation can easily lead to difficulties in interpreting medicines information. With this in mind, we have increased our focus on both medicines reconciliation and transcribing in this second edition, as the former is a means of formally verifying a prescription and transcription is a part of medicines reconciliation.
Human factors

The former National Patient Safety Agency, through the Patient Safety First Campaign, has defined human factors as “encompassing all those factors that can influence people and their behaviour”. It adds that “in a work context, human factors are the environmental, organisational and job factors, and individual characteristics, which influence behaviour at work.”


Human factors can be a means of understanding human error, optimising human performance and designing effective systems. This perspective acknowledges that errors will usually be the outcome of various causes, or factors, that combine together. When individuals such as doctors or nurses interact with each other and their organisational systems (e.g. at a handover) the intended outcome (transfer of all patient information) is not necessarily achieved.

Human factors should be about learning from errors, modifying defences and focusing on preventative strategies. It should not be about blaming individual practitioners, unless they have been reckless or negligent (Reason, 2000). This approach has gained increasing prominence in healthcare across the developed world. The human factors approach underpins the error and risk management strategy in this toolkit. A Head of Care that we interviewed acknowledged the importance of human factors in their team’s approach to medication errors; the staff being actively encouraged to seek and share information about errors with their colleagues.

Notable practice point

“We run dedicated clinical reflection sessions on medicines and we do discuss errors... we encourage people to acknowledge how they might have done something differently, but also why things happened the way they did... recently, when somebody senior was involved in an error, we all talked about it – including the senior – and that allowed the junior staff to realise anyone can be involved... and anyone can make a mistake.” [Head of Care, Children’s Hospice]

Team work

Children’s palliative care is provided by multi-disciplinary teams and high-quality care emanates from the principles of effective team work.

There is a vast amount of information on team working but the literature related to enhancing safety in high-risk domains, such as healthcare, commonly draws upon crew resource management (CRM). CRM is concerned with how and why people make decisions in light of what is going on around them (known as situational awareness) and more broadly, the overall quality of their interpersonal skills and their leadership.

Situational awareness continues to attract much interest as a systematic means to assess and address factors such as patient deterioration in complex healthcare settings. With relevance to this toolkit, the situation-aware practitioner should recognise the potential threats to a child while they are receiving medicines, understand the meaning of these threats, and anticipate their impact over time so as to generate solutions. This should ultimately lead to a more appropriate and timely escalation of concerns to senior team members and the better co-ordination of care.
Below, we have described some potential threats, their impact and the solutions in two reflective case studies. The first is in a hospice setting; it concerns a child’s new treatment regime and was written by the child’s allocated nurse. The second, written by two community nurses, is located in a child’s home where the child is receiving high dependency care and routinely ventilated.

The family of a young girl (R) with Retts Syndrome had requested an emergency admission to the hospice for symptom control. As she was regularly screaming and not sleeping, this was having a major impact on the family. During her hospice admission her analgesia was adjusted and gabapentin (for treating nerve pain and seizures) introduced with good effect.

The new treatment regime helped with R’s condition after returning home but the family phoned to say she was still screaming and having difficulty sleeping. Consequently, propranolol was prescribed following advice from the R’s consultant; R starting treatment on 10mg four times a day. R was due to visit again within two days of her new propranolol regime. Her parents brought the propranolol with them on admission. Our medicine administration record (MAR) was written by the nurses on duty on the evening of admission, taking the instruction for administration from the pharmacy label and the parents.

My concerns on seeing the prescription on the Saturday were manifold. My background is paediatric intensive care so I had experienced very different uses for propranolol. I therefore looked up dose range in the British National Formulary, checking dose and frequency ranges.

I was aware that the drug was to be given four times a day, which meant that there were only four-hour gaps between doses. I felt this might lead to accumulated adverse side-effects which would be detrimental to R, especially overnight.

It had been reported that overnight R had looked grey in colour; her oxygen saturation levels had dropped to 80% and she had needed oxygen therapy. Oxygen treatment was not novel for R, but my concern with the use of propranolol (a beta blocker) would be her inability to respond by increasing her heart rate so as to compensate for lower saturations. Over Saturday night I asked the staff to monitor R’s heart rate and oxygen saturations. In discussion with the family we only gave three doses of medication. We made the last dose at 18.00 not 22.00 hours.

On Sunday I asked the doctor to see R to further advise the family.

Overnight the staff had noted a drop in oxygen saturations and heart rate when R was asleep, which required oxygen administration.

I checked R’s blood pressure – it was within normal range, although her heart rate was lower and outside her average range.

The doctor advised that the family should reduce the frequency of propranolol to twice a day, increasing to three times if her oxygen saturation levels at night stabilised.

I asked colleagues and R’s family to monitor the propranolol to establish whether the new propranolol regime was having the desired effect and stopping the screaming – if so the doctor prescribed continuing the treatment with an evening dose at 18.00 but if screaming returned to speak to R’s consultant in two weeks.
H is a six-year-old boy with an undiagnosed neuromuscular condition. He is continuously ventilated via a tracheostomy and is currently cared for at home by his parents. He has been unwell for the last couple of days, with a temperature and poor colour. H has been finding it difficult to clear his airway secretions, which are of a thicker consistency than normal. He's had a high temperature for the most of the last 48 hours.

Mum has been giving H regular paracetamol and he had recently started a course of oral antibiotics prescribed by his GP. This treatment appeared to have reduced H's temperature, but his secretions remained thick. H's mum has contacted the on-call nurse from the local children's hospice to request a home visit due to a suspected chest infection.

All on-call nurses are registered children's nurses with significant experience in caring for children with complex and palliative care needs, and working unaccompanied.

During the visit, the nurse perceived a number of problems that required action. H was wearing a hyoscine patch (a medicine used to reduce excessive respiratory secretions), which may have contributed to an increase in the viscosity of secretions, making them more difficult for H to manage. The patch was removed and H's paediatrician contacted.

The increased volume and viscosity of secretions was making breathing very difficult for H. On discussion with the long-term ventilation (LTV) team, his ventilator pressure settings were increased to provide increased (mechanical) respiratory support. H had a poor colour, coupled with an increased volume of secretions. Although he normally breathes satisfactorily in room air, his appearance and behaviour suggested he required supplementary oxygen. The on-call nurses started H on two litres per minute of oxygen, with a plan to titrate (modify) the dose according to his clinical signs (colour, respiratory effort, blood oxygen levels).

During a home visit two days later, H was reassessed. It was observed that H was still struggling with the volume of secretions, requiring more suction than usual. Following a discussion with his consultant, a starting dose of glypyronium bromide was prescribed and a plan made to titrate the dose to balance the volume and viscosity of secretions; this was explained to his parents, and their understanding was clarified. A clinical management plan was then written in partnership with the consultant paediatrician, the hospice nurse (a non-medical independent and supplementary prescriber) and H's parents.

His colour was greatly improved on a flow of one litre per minute of oxygen. His oxygen was reduced slowly as his symptoms improved. His ventilation settings remained at their increased settings until further review by the LTV team with the expectation of reducing the pressures to his routine (lower) settings.

Case studies: Notable practice point
Now think about your own management of medication safety. Is it based on the necessary knowledge and understanding?
Are you thinking of the potential, (and sometimes insidious) threats to the child from their medicines as well as the benefits?
If there are potential threats, and this is almost always the case, have you a process for either prevention, or early detection, and if the latter, a means of alerting significant others in a timely manner?
You might consider the concept of situational awareness in relation to the Three Buckets personalised risk assessment model proposed later in this chapter.
Crew resource management

Improving the quality of interpersonal skills in organisational teams is a continual challenge. One of the authors of this toolkit (Gerry Armitage) has worked with staff from the aviation industry to identify how crew resource management influences their attitudes and communication processes. The Aviation Skills List below shows a model of CRM in Thomson Fly. This model was adapted for medicines management (Armitage, 2008) into a medicines safety skills list. The skills list is designed to guide staff in the routine management of their workload and to influence the development of standard operating procedures. It is also available to inform professional development and staff appraisal so that a particular culture in relation to safety and learning is encouraged in the workplace – a culture that reflects the principles of human factors and acknowledges that patient safety is everyone’s business.

We believe that parents and sometimes children can be part of the care team. But occasionally there can be conflict in the relationship between staff and families, particularly if joint decisions need to be made about a child’s care and treatment. While parents and staff have the common goal of providing compassionate and effective care, they may differ on how this might be best delivered in a complex care setting. The type of staff communication described in the medicines safety skills list might allow staff to articulate why and how medicines are managed in a hospice compared to the child’s home, especially when one member of staff might be caring for several children and their families.

Notable practice point
Effective medicines management is a multi-disciplinary process. It relies on team work. Staff can be guided in their attitudes, behaviours and communication by an appropriate safety skills framework that promotes shared knowledge; open, supportive communication; and active appraisal of your own and colleagues’ practice. This approach should facilitate clear pathways and mechanisms for best-practice team working, e.g. being assertive when required, or seeking feedback.
### Aviation [safety] skills list

Reproduced with the kind permission of Captain C. Budenberg at Thomson Fly

<table>
<thead>
<tr>
<th>Crew</th>
<th>Task management</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefings</td>
<td>Situational Awareness</td>
<td>Professional Style</td>
</tr>
<tr>
<td>Outlines Plans &amp; Differences</td>
<td>Thorough Pre-flight Preparation</td>
<td>Relaxed &amp; Professional Tone</td>
</tr>
<tr>
<td>Allocates Tasks</td>
<td>Stays Ahead &amp; Updates Plans</td>
<td>Aspires to High Performance</td>
</tr>
<tr>
<td>Seeks Input</td>
<td>Makes Contingency Plans</td>
<td>Conscientious &amp; Flexible</td>
</tr>
<tr>
<td>Checks Understanding</td>
<td>Keeps Broad Perspective</td>
<td>Self-aware and Seeks Feedback</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Workload</td>
<td>Aircraft Handling</td>
</tr>
<tr>
<td>Balances Rank Authority</td>
<td>Recognises High Workload</td>
<td>Safe, Efficient, Comfortable</td>
</tr>
<tr>
<td>Flexible &amp; Shows Respect</td>
<td>Takes or Makes Time</td>
<td>Automatic/Manual Flight</td>
</tr>
<tr>
<td>Actively Monitors &amp; Supports</td>
<td>Deals with Overload/Prioritises</td>
<td>Non-normals/Emergencies</td>
</tr>
<tr>
<td>Thinks Independently</td>
<td>Avoids Distraction &amp; Distracting</td>
<td>Manages Errors</td>
</tr>
<tr>
<td>Communication</td>
<td>Decisions</td>
<td>Applied Knowledge</td>
</tr>
<tr>
<td>Shares Information/Ideas</td>
<td>Identifies Problems/Issues</td>
<td>Technical</td>
</tr>
<tr>
<td>Actively Listens</td>
<td>Involves Others if Needed</td>
<td>Use of Checklists</td>
</tr>
<tr>
<td>Assertive when Required</td>
<td>Evaluates Outcome</td>
<td>Operational/SOPs</td>
</tr>
<tr>
<td>Admits Mistakes &amp; Doubts</td>
<td>Uses Structure in New Situations</td>
<td>Company Policies</td>
</tr>
</tbody>
</table>
## Medicines safety skills list

(Armitage 2008)

<table>
<thead>
<tr>
<th>Clinical staff</th>
<th>Clinical activity</th>
<th>Approach to medicines management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical reports and handovers on drug therapy</strong>&lt;br&gt;Appraises patients’ medication therapy&lt;br&gt;Shares any concerns or misunderstandings before action</td>
<td><strong>Situational awareness</strong>&lt;br&gt;Thorough preparation&lt;br&gt;Defines role in any double checking&lt;br&gt;Implements independent checks&lt;br&gt;Identifies potential problems and high risk activities&lt;br&gt;Keeps broad perspective&lt;br&gt;Anticipates difficulties and possible changes in medication regime&lt;br&gt;Modifies documentation</td>
<td><strong>Professionalism</strong>&lt;br&gt;Abides by professional standards&lt;br&gt;Aspires to high performance&lt;br&gt;Conscientious and flexible&lt;br&gt;Self-aware and seeks feedback from colleagues and child/family</td>
</tr>
<tr>
<td><strong>Teamwork</strong>&lt;br&gt;Prioritises expertise over status in multi-disciplinary team&lt;br&gt;Flexible and shows respect&lt;br&gt;Actively monitors and supports drug therapy&lt;br&gt;Thinks independently</td>
<td><strong>Workload</strong>&lt;br&gt;Recognises high workload&lt;br&gt;Takes or makes time&lt;br&gt;Deals with overload and prioritises tasks&lt;br&gt;Avoids interruption/distraction during high risk activities</td>
<td><strong>Handling medicines</strong>&lt;br&gt;Safe, effective, efficient&lt;br&gt;Follows prescription&lt;br&gt;Amends prescription within scope of practice&lt;br&gt;Is aware of side effects and contra-indications&lt;br&gt;Manages errors&lt;br&gt;Reports near misses and adverse events according to protocol</td>
</tr>
<tr>
<td><strong>Communication</strong>&lt;br&gt;Shares information and ideas&lt;br&gt;Actively listens&lt;br&gt;Assertive when required&lt;br&gt;Admits mistakes and doubts</td>
<td><strong>Decisions</strong>&lt;br&gt;Identifies problems in medicines preparation and delivery&lt;br&gt;Involves others and child/family when appropriate&lt;br&gt;Uses structure in new situations&lt;br&gt;Evaluates outcomes</td>
<td><strong>Applied knowledge</strong>&lt;br&gt;Pharmacology and knowledge of local formulary&lt;br&gt;Use of guidelines/protocols&lt;br&gt;Practices mindful of regulatory guidance and any underpinning law&lt;br&gt;Use of medical devices</td>
</tr>
</tbody>
</table>
Chapter 4: Learning from error

Risk assessment

Knowledge bite

Protection against unsafe use of medicines

In high-risk settings, numerous handovers of information, an ever-changing caseload, errors and other unforeseen events related to medication safety will inevitably occur. In the NHS these events are often called ‘patient safety incidents’, and staff are strongly encouraged to report them (NPSA, 2004, 2005; NMC, 2007, 2010). But we know that reporting and feedback mechanisms could be substantially improved (Armitage and Chapman 2007, Armitage et al., 2010).

If the overall aim is to eradicate avoidable harm, there needs to be some degree of individual and organisational learning from errors. This learning should be part of a systematic process of collecting relevant safety data: identifying error types and causes, controlling errors through focused action and reviewing trends and improvements.

The most responsive NHS hospital trusts are often characterised by their propensity to learn from what has not gone well. We recognise, of course, that a children’s palliative care service differs from a NHS hospital in many ways – including their size and ways of working. However, the children that both services care for will often have multifaceted needs, challenging drug therapy and numerous clinicians based at various locations involved in their medicines management. Furthermore, children’s families are often instrumentally involved.

Increasing learning from reporting

An essential part of this toolkit is the provision of guidance on how to report incidents appropriately, how to seek and capture feedback; and how to put in place a systematic approach to incident prevention and monitoring. Furthermore, we advocate that reporting is driven by a culture of learning rather than individual blame. Martin House and the Rainbows hospice have successfully modified the work of Armitage et al., which was developed in the NHS to improve medication error reporting. The approach to reporting is also based on a human factors model.

In reporting, this approach accepts that human error is inevitable; causes or contributory factors are multiple, and range from those related to practitioners’ cognitive processes (e.g. a lapse) through local conditions (e.g. interruptions) to organisational factors (e.g. designated staff-patient ratios); and that the reporting of near misses can be very valuable.

Near misses are when an error has occurred but action has been taken to avoid any impact on the child, or the error was so small scale, there was no detectable harm. Near misses have been described as “free lessons in error recovery”. If reported well, they can often demonstrate how specific defences have rescued a potentially harmful situation. Guidance on how to report an error and the report form itself are available in Appendices 1 and 2. While staff should be encouraged to report contributory factors they should also provide a short narrative that summarises the context of the incident or error. We encourage all services to encourage staff to include transcription errors in any list of error types due to its high risk nature.

Reporting should also be linked to risk assessment. We have drawn upon the former National Patient Safety Agency’s Fourth Report of the Patient Safety Observatory on Medicines Safety (2007) to provide guidance that you can compare with your current practice. If the consequences of an error or unforeseen event do result in harm to the child, a senior member of the care team (along with the person closest to the medication error when it occurred) should grade the severity.
Once this has been done, the nominated members of the care team should cross-reference severity with a likelihood of recurrence scale to allocate a risk score. We suggest that all medication error reports should be reviewed by a clinical governance committee or medicines management group as mentioned in our introduction to this toolkit.

Where possible, local palliative care services should keep a record of all patient safety incidents (including medication errors, near misses, adverse and unforeseen events) and record their frequency. The record should identify the main contributory factors, along with the types of action taken and when the report was ultimately signed off by management. It would also be useful to know the medication incident rate (total number of incidents over a given time, e.g. three months). Following discussions with directors of care, we suggest the medication incident rate is counted, and then compared to all prescribed doses in the same time period. It is then possible to calculate the incidence of medication incidents from the point of prescribing through to any missed doses at the point of administration.

If a hospice service chooses to issue a governance or medicines safety newsletter, this could contain a summary of the latest information gathered from incident reports and any notable trends. The issue of a newsletter and how it might represent a shift from not talking openly about error to a transparent and collaborative, learning driven ethos could be perceived by staff as a significant cultural change. While culture is often viewed as a rather abstract concept, patient safety researchers have developed survey instruments in an attempt to systematically measure culture, especially around team work and organisational learning. The latter may be worth measuring before and after any local improvement intervention is implemented (e.g. a new method of error reporting). The Centre for Healthcare Quality and Safety at the University of Texas allow website visitors to access and download their teamwork and climate questionnaire (with guidance) and this can be found at: https://med.uth.edu/chqs/files/2012/05/Survey-SAQ-Teamwork-Safety-Climate-.pdf

**Notable practice point**

The reporting of medication errors (and their outcomes) should be strongly encouraged, both locally and perhaps nationally. Report data should be systematically analysed to promote individual and organisational learning. Families should be made aware of any error that has impacted on their child, in line with the NHS ‘statutory duty of candour’, currently being enacted into legislation by the current government. Changes in an organisation’s attitude to reporting can be seen by staff as part of a broader shift in culture.
Scoring the severity of the consequences of an error or unforeseen event

<table>
<thead>
<tr>
<th>Level of harm</th>
<th>The former NPSA definition of degree of harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>No harm</td>
<td>1. Impact prevented (near miss) — any error/event that had the potential to cause harm but was prevented</td>
</tr>
<tr>
<td></td>
<td>2. Impact not prevented — any error/incident that ran to completion (administration of medicine to patient) but no harm occurred</td>
</tr>
<tr>
<td>Low harm</td>
<td>Any error/event that required extra observation or minor treatment, and caused minimal harm</td>
</tr>
<tr>
<td>Moderate harm</td>
<td>Any error/event that resulted in a moderate increase in treatment and which caused significant but not permanent harm</td>
</tr>
<tr>
<td>Severe harm</td>
<td>Any error/event that resulted in permanent harm</td>
</tr>
<tr>
<td>Death</td>
<td>Any error/event that resulted in death</td>
</tr>
</tbody>
</table>

Knowledge bite

The three buckets model

Learning from activities that have not met their intended outcomes should also encourage healthcare professionals to individually develop error wisdom. Reason (2004) contends that although risky and often complex, health care in comparison to other inherently risky types of work is a “very personal business” (Reason, 2004, p28) that often lacks the moderating capacity of automated safeguards.

The essence of error wisdom is being able to assess one’s personal mental preparedness. The error-wise professional appreciates that s/he can reduce the likelihood of making an error but realises s/he cannot entirely eliminate error from their practice. S/he will assess his/her own ability to undertake a given task and assess the environment, but also analyse the task and assess its error potential (Reason 2004).

The three buckets model (Reason, 2004)
Reason advocates the three buckets model to allow healthcare professionals to systematise their personal risk assessment, the model also facilitates situational awareness. Each of the three buckets is filled with what we might call waste matter! The fuller each bucket is, the more likely it is that a healthcare professional will commit an error or fail to recognise and respond to an unsafe situation before a patient is harmed.

The ‘self’ bucket is the current state of the individual involved, including their level of knowledge, fatigue, and the effect of recent life events. The second bucket is the context of practice. In this toolkit that means the immediate practice environment. This environment will sometimes be full of distractions and interruptions, and staff may be hampered by a lack of time or by poor equipment.

The third bucket represents the error potential of the task, i.e. how errors can occur at each individual step in a clinical task. Error potential varies widely across the different steps of a task. The idea of error wisdom is very similar to that of foresight, and the former NPSA offers a free foresight training resource that applies the three buckets model to several practice scenarios.

See: www.nrfr.npsa.nhs.uk/resources/?entryid45=59840

Assessing risk in your practice also complements situational awareness, which we discussed earlier in the chapter.

In 2012, the Paediatric Nursing Association of Europe (PNAE) issued a position statement on medication errors which actively embraces a systems approach to medication error. Although primarily designed for an acute service, most of their proposals were applicable to children’s services across healthcare. Consequently, our own goals for notable practice are complementary to the PNAE work.

**Notable practice point**

Medicines management has considerable potential for error, especially in the children’s palliative care services where complex therapy is not uncommon and the child may routinely receive complementary alternative medications such as herbal remedies or herbal medications which are unlicensed in the UK. Staff should be sensitive to the integrity of their organisational systems and their personal mental preparedness when involved in medicines management. This approach to practice should be emphasised in staff training and should be reflected in standard operating procedures.
Goals for notable practice and to achieve high quality standards

- Manage medicines in a culture where information is actively sought, responsibilities are shared, failure causes inquiry and feedback, innovation is welcomed and staff are appropriately trained [after Westrum, 2006].
- Monitor and review medicines procedures, standards and related competencies for clarity and fitness for purpose.
- Tailor training according to the results of review.
- Have a particular focus on storage, clear prescriptions (generic names only), and intravenous medication preparation and administration is recommended – paying particular attention to effective systems for differentiating, checking and administering medicines.
- Report errors, whether they result in near misses or adverse events, and demonstrate that learning has occurred through the reporting process.
- Maintain awareness and, when required, act upon safety alerts issued by the NHS Commissioning Body for Patient Safety (formerly NPSA).
- Consider reporting errors to the Department of Health’s National Reporting and Learning System (which at the time of writing is being reviewed).
- Comply with the legal requirements identified in this toolkit’s section on regulatory guidance (chapter 2).

References


Sandars J and Esmail A. ‘The frequency and nature of medical error in primary care: understanding the diversity across studies’. 20 (3) 231-236.


Chapter 5
Medicines reconciliation and transcribing

By Hadar Zaman, Rachel Urban and Helen Crooks
Medicine reconciliation

The patient journey in healthcare has many areas of potential risk, especially where a patient’s care is transferred from one setting to another (NPC 2007). Over half of all medication errors occur at interfaces of care and most commonly at admission and at discharge (Campbell et al., 2007). Consequently, for children or young people receiving drug therapy, medicines reconciliation and transcribing of their medication is an integral part of the care they receive, but this can only be achieved when healthcare professionals have the most accurate and reliable information about the child’s or young person’s medication thus improving medication safety and the child’s or young person’s clinical outcomes (Burns et al., 2012).

This chapter’s focus will provide:

• definitions of medicine reconciliation and transcribing
• an overview of medicines reconciliation and the transcribing process considering the best evidence base to underpin notable practice
• case studies to help the reader put medicine reconciliation and transcribing into practice context
• the necessary knowledge for qualified health professionals to consider an active role in medicines reconciliation and transcribing
• goals for notable practice so as to achieve high quality standards for medicines reconciliation and transcribing

Medicines reconciliation and transcribing have now become an essential part of hospital admissions and discharge systems and the children’s palliative care sector can look at these systems and ensure similar robust systems are implemented in their settings. It is important to note that there are considerable similarities in the medicines reconciliation and transcribing process whether a child or young person is admitted to hospital or a hospice.

There are several definitions of medicines reconciliation, although healthcare professionals have yet to reach a consensus regarding a single recognised definition (Burns et al., 2012). The most commonly cited definition of medicines reconciliation is:

“The process of identifying the most accurate list of a child’s or young person’s current medicines – including the name, dosage, frequency and route – and comparing them to the current list in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated” (Institute for Healthcare Improvement, 2005).

The World Health Organisation (WHO) definition of medicines reconciliation is “a process designed to prevent medication errors at patient transition points” (WHO, 2007). The National Institute for Health and Care Excellence (NICE) and National Patient Safety Agency (NPSA) do not have a definition for medicines reconciliation, but they do describe the purpose of medicines reconciliation: “to ensure that medicines prescribed on admission correspond to those that the child or young person was taking before admission specifically highlighting the following particulars of the medication the name, dose, frequency and route of administration” (NICE & NPSA, 2007).
The term ‘discrepancy’ is often used in relation to medicines reconciliation and does not have the same meaning as ‘medication error’. It is important to know that there are both intended and unintended discrepancies, for example deliberately withholding medication for a child or young person admitted to the hospice due to a clinical reason would be regarded as an intended discrepancy. On the other hand, an unintended discrepancy occurs due to the incomplete or inaccurate information being available about the child’s or young person’s medication on admission or at discharge from the hospice which then results in a child or young person receiving medication which they are not prescribed (or failing to receive a medication for which they are prescribed), consequentially causing a direct impact on the child’s or young person’s health and clinical outcomes (Hellstrom et al., 2012). Where medication discrepancies are unintentional this has the potential to have two possible outcomes (see figure 1).

One possible outcome of an unintentional discrepancy could be the development of an adverse drug event and actual harm to the child or young person. The second possible outcome could be that the unintentional discrepancy had the possibility to cause harm to the child or young person which is termed a potential adverse drug event or pADE, the latter also being known as a ‘near-miss’ (See chapter Learning from Errors). The World Health Organization (WHO) defines a pADE as a “serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted (also called ‘near miss’ or ‘close call’)” (WHO, 2005). One study conducted by the NPSA reviewed medication errors between November 2003 and March 2007 and found from the 117,332 medication errors reported, 7,070 specifically related to medicines reconciliation (Khunpha, S, NPSA. Personal communication by email. 3rd November 2010). Furthermore, two studies in the United States estimated medication discrepancies per patient to vary on admission between 30% to 70% (Cornish et al., 2005 & Gleason et al., 2004). More recently, Lo et al (2013) found that 40-54% of patients experience unintended medication discrepancies upon admission to acute care settings and importantly that 46-56% of these discrepancies caused substantial clinical problems (Lo et al., 2013). Evidence such as this strongly suggests that at least basic medicine reconciliation should take place at every transfer of care to reduce any potential harm due to an inappropriate medication regime. This is directly supported by healthcare policy (NICE guidance).

Figure 1: Relationship between discrepancy and Adverse Drug Event

![Figure 1: Relationship between discrepancy and Adverse Drug Event](image-url)
In the UK (2007), NICE and the former NPSA issued formal guidance on the importance of ensuring that medicines prescribed or transcribed on admission correspond to those that the patient was taking prior to admission, see [http://guidance.nice.org.uk/PSG001](http://guidance.nice.org.uk/PSG001). In 2008, the National Prescribing Centre (NPC) went further to adopt the recommendations of NICE/NPSA, the US-based Institute of Healthcare Improvement (IHI) and the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) and recommended that medicines reconciliation be put in place at all ‘transfer of care’ situations in order to reduce the number of medication errors attributed to inadequate or lack of medicine reconciliation taking place, see: NPC 2008 ([http://www.npc.nhs.uk/improving_safety/medicines_reconciliation/resources/reconciliation_guide.pdf](http://www.npc.nhs.uk/improving_safety/medicines_reconciliation/resources/reconciliation_guide.pdf)).

To further support the case of medicine reconciliation the WHO published guidance on assuring medication accuracy at transitions of care, see [WHO,2007 ([http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution6.pdf](http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution6.pdf)).

The Health and Social Care Act 2008 Regulations 2010 require that hospices “protect service users against the risks associated with the unsafe use and management of medicines, and cooperate with other providers”. Furthermore, guidance has also been issued by the Care Quality Commission ([www.cqc.org.uk](http://www.cqc.org.uk)), also the regulator of hospices in England, based on the premise that managing medicines when a child or young person transfers from one setting to another is central to safe, high quality care. Effective management of medicines is a requirement of the CQC’s essential standards on quality and safety (Outcome 9) as is cooperation with other providers when care is transferred (Outcome 6).

Following on from the legal and regulatory guidance, good practice guidance has been issued on ensuring children or young people receive optimal treatment when taking medications. There is an emerging evidence base indicating that the use of medicines as a therapeutic intervention may often be sub-optimal. This has been acknowledged by all key organisations involved in the care of children such as Royal College of Nursing (RCN), Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP), as an issue that needs addressing and they collaborated to produce the guidance *Medicines optimisation – helping patients to make the most of medicines* issued in 2013, see RPS, 2013 ([www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf](http://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf)).

Medicines optimisation is ensuring the right child or young person gets the right choice of medication at the right time and this can be successfully done by accurately conducting the medicine reconciliation process and transcribing at admission and then at discharge. At the heart of medicines optimisation is the child or young person, parent or carer, educating them about the correct use of their medicines which will ensure maximal benefit is received from medication. To ensure medicine optimisation becomes a success, a multidisciplinary approach is needed. This should ensure that all healthcare professionals involved in the child’s or young person’s care share one common goal, namely how the child or young person can get the best out of their medications.

**Knowledge bite**

- WHO advises that medicine reconciliation should be conducted within 24 hours of admission and within 72 hours, for admissions over the weekend and has prioritised medicine reconciliation as one of five top patient safety strategies within the ‘action on patient safety’.
- Unintended discrepancies, most commonly omission of clinically relevant medication occurring on admission stands between 39-72%; implementation of medicine reconciliation looks to reduce the risk of a child or young person not receiving the most appropriate medication.
The overarching principles of medicines reconciliation are:

- Making sure the right child or young person gets the right drug, in the right dose and at the right time, via the right route (i.e. continuity of treatment).
- Reducing the risk of medication errors occurring when the care of a child or young person is passed from one care setting to another (i.e. if a child’s or young persons care is being taken over by the homecare team to ensure that the team has an up to date list of medicines the child or young person is on).
- Providing ongoing personalised medicines management care for each child or young person.
- Reducing confusion about the child’s or young persons medication regimens (for both healthcare professionals as well as for parents/carers).

The benefits of medicine reconciliation

There are many benefits to medicines reconciliation. These include:

- Improvement in communication between healthcare professionals and others involved in the care of the child or young person.
- Greater parent/carer involvement in their child’s or young person’s care – thereby helping parents/carers to develop a better understanding of their medicines and an ability to communicate that information to other healthcare professionals.
- A potential reduction in waste medicines due to unnecessary medications not being dispensed if the child or young person has stopped that particular medication.
- A reduction in duplication of effort that can occur if different healthcare professionals have to track the same piece of information, something which is routinely achieved when medicines are effectively reconciled each time a child’s or young person’s care is transferred.
- Improved record keeping – with the minimum dataset of medicines information being documented appropriately.
- An increase in the timely availability of accurate medicines information – essential for prompt and appropriate treatment.
- The potential avoidance of medicines-related admission or readmission to hospital or other care providers which can occur when unreconciled medicines lead to prescribing or medicines administration errors.

Approaches to medicine reconciliation

The National Prescribing Centre (NPC) Guide to Medicines Reconciliation makes reference to two stages:

**Basic reconciliation (stage 1)**

Basic medicines reconciliation involves the collection and accurate identification of a child’s or young person’s current list of medicines. An example of basic medicines reconciliation would include medication history-taking at admission to a hospice/service, where a complete and accurate list of a child’s or young person’s current medication regimen would be documented within 24 hours of admission.

**Full reconciliation (stage 2)**

Full medicines reconciliation builds on stage 1 of the process. It involves taking the basic reconciliation information, comparing it to the list of medicines that was most recently available for that child or young person. In addition, it involves identifying any discrepancies between the two lists and then acting on that information accordingly. In other words, interpreting the outcome of the basic reconciliation in light of a child’s or young person’s ongoing care plan, then resolving any discrepancies and accurately recording the outcome.
The process for medicines reconciliation

The NPC guide makes reference to remembering the steps in the process by adopting the ‘three Cs’ approach, endorsed by the Royal College of Nursing (RCN), the professional body of most hospice staff. Medicine reconciliation process is not only designed to ensure the correct medication is prescribed on admission but also to ensure the child or young person is discharged on the correct medication and this information is communicated to all healthcare professionals caring for this child or young person. The need for reconciliation at discharge was endorsed by the report of the CQC which identified a need for improvement in the quality of medicines information provided by hospitals to GPs in their discharge summaries (Grimes et al., 2011). It also important to bear in mind that there is an increase in care being provided at home which traditionally would have been provided in an inpatient hospice/service setting.

The requirements to conduct a full medicines reconciliation process for children and young people being cared at home still apply and the healthcare professionals should endeavour to collect the most accurate information from the most reliable sources of information regarding the child's or young person’s medication history before the prescribing and administration of any medication. In summary, there is no difference if you were conducting medicine reconciliation in a hospice or children's palliative care setting or at the child or young person’s home because the same information sources and procedures should be used. It is acknowledged that when conducting medicine reconciliation in a hospice/children’s palliative care setting, healthcare professionals will have access to more comprehensive and detailed documentation such as child's or young person's medical notes to help with medicine reconciliation. In the home environment, detailed documentation like this may not be available but they will have other useful sources of information that can be used to construct an accurate medication history such as the patient’s own medications, repeat prescriptions or clinical management plans. The three Cs are defined as:

- collecting
- checking
- communicating

**Step 1 – Collecting (basic reconciliation)**

The collecting step involves taking a medication history and collecting other relevant information about the child’s or young person’s medicines. This information may come from a range of different sources (some potentially more reliable than others). For example:

- a computer print-out from a GP clinical records system
- the tear-off side of a child’s or young person’s GP repeat prescription slip
- verbal information from the child or young person, their family, or a carer
- medical notes from a child’s or young person’s previous admission or discharge letter/prescription from hospital
- community pharmacist patient medication records
- child's or young person 's own medications that may have been bought in with them at the time of admission
- emergency care summary record (ECS)
- clinic letters

The medication history should be collected from the most recent and reliable source. Where possible, information should be cross-checked and verified with another source which can include the parent or carer. The person recording the information should always record the date that the information was obtained and the source of the information. Where there appears to be a discrepancy between what the child or young person is currently prescribed, and what the child or young person is actually taking, this should be recorded too. The reasons for any variation should be noted if these can be established.
Step 2 – Checking

The checking step involves ensuring that the medicines and doses that are now prescribed for the child or young person are correct. This does not mean that they will be identical to those documented during the basic reconciliation process. For example, a doctor now responsible for the child or young person may make some intentional changes to their medicines. Any discrepancies will need to be resolved in the final step of the process.

Step 3 – Communicating (full medicines reconciliation)

Communicating is the final step in the process, where any changes that have been made to the child's or young person’s prescription are documented and dated, ready to be communicated to the next person responsible for the medicines management care of that child or young person. Examples might include:

- when a medicine has been stopped, and for what reason (including topical preparations)
- when a medicine has been withheld for a period of time
- when a medicine has been started, and for what reason
- the intended duration of treatment (e.g. for antibiotics or steroids especially if it is a decreasing dose)
- when a dose has been changed, and for what reason
- when the route of the medicine has been changed, and for what reason
- when the frequency of the dose has changed, and for what reason

Sources of information for medicines reconciliation at stage 1 and/or 2

The following sources of medication histories are listed below in no order of preference, as reliability can vary according to the situation. However, it is usually necessary to use two or more sources to establish accurate medicines reconciliation. Medicine reconciliation can be a very complex task. It involves liaising with several sources of information and managing the medication history you receive, reconciling this information with other sources of information to ensure you have a correct and up-to-date medication history and finally highlighting and dealing with any discrepancies that may arise. This is referred to as the triangulation process (see figure 2).

Figure 2: Diagram demonstrating triangulation of medicines sources and the transfer of medical information between multidisciplinary healthcare professionals that takes place in medicine reconciliation. Clearly evident is that the child or young person, parent or carer is the common factor and at the heart of this information transfer.
The child or young person, parent or carer

- This is an important source, as the child or young person (or their family) can tell you exactly how they take their medicines, but you also need to be mindful in some circumstances that the parent or carer may have not fully understood the instructions in the first instance.
- Always try to establish how exactly a child or young person takes their medicines, as this could be very different from the formal records.
- Carers or parents can be very helpful in establishing an accurate medication history and can also give an insight into how medicines are managed at home. An important point to note is that parents or carers sometimes alter the dosing, timing and administration without seeking healthcare professional approval first. For this purpose, it is essential as a healthcare professional you build a relationship based on trust and openness with the parent or carers to ensure the best possible care for their child or young person.
- Be mindful of maintaining confidentiality.
- Some children or young people may have a hand-held record of their medicines which is updated by healthcare professionals caring for them. This is more common in children or young people under the care of an oncology or renal team. Take care if this has been hand written by the parent or carer because errors can be made or misinterpretation and then subsequent documentation of that information by the parent or carer.
- Some children or young people may also have a seizure management plan which can be useful to refer to as it documents the medicines and doses to be used in case of a seizure.
- Some children or young people, parents or carers may not speak English as their first language. Therefore, formal carers should consider whether a translator is necessary, especially for the admission process.

GP surgery

- Ideally, a faxed list is preferable compared to a telephone call as it provides a permanent record and it reduces the risk of transcription errors occurring.
- Be aware of ‘acute medicines’, ‘repeat medicines’ and ‘past medicines’ on the receptionist’s screen.
- Always check when the item was last issued and the quantity issued.
- Specific questioning may be needed for different formulations, for example different types of inhalers (metered-dose, breath-actuated, turbohaler), different calcium preparations (Calcichew®, Calfovit D3®, Adcal D3®), or medicines which are brand specific (aminophylline, theophylline).
- It may be necessary for you to speak to the GP directly to clarify any discrepancies.
- Specifically ask whether there are any ‘screen messages’. Some medications are ‘hospital only’ and do not appear on the usual ‘repeat list’.

Patient’s own drugs (PODs)

- Encourage families to bring in their child’s or young person’s medicines from home.
- Discuss each medicine with the child or young person and of course their family to establish what it is for, how long they have been taking it, how frequently they take it, what time they take it and any other additional instruction that may help the staff administer the child’s or young person’s medication during their stay in the hospice.
- Do not assume that the dispensing label accurately reflects how the child or young person takes the medication.
- Check the date of dispensing, since some parents may bring in all their child’s or young person’s medicines into the hospice, including those stopped and check each medication with the child or young person, parent or carer to see if they are still taking it.
• Confirm that the medication belongs to the child or young person. It is not uncommon for siblings’ medications to be accidentally brought in with the child or young person.

• Ensure that the medication the child or young person, parent or carer has brought in is not expired. This is especially important for medicines such as Oramorph, Baclofen, eye drops and reconstituted antibiotics as these have shortened expiry dates once they have been opened and a record should be made of the date opened.

• Some parent or carers may only bring in prescribed medication the child or young person is taking. It is important to ask the parent or carer if the child or young person is taking any over-the-counter (OTC) medications such as paracetamol, ibuprofen or hyoscine hydrobromide and also whether they are taking any herbal or homely remedies like St Johns Wort.

• Some parents may only decide to bring in the medications that the child or young person is taking but this does not necessarily mean they are not prescribed any other medications; the parent or carer maybe deliberately withholding these medications.

**Repeat prescriptions**

Some parents or carers of children or young people keep copies of all repeat prescriptions. Many of these may include medicines that have been stopped.

• The date of issue should always be checked and each item confirmed with the child or young person, parent or carer.

• Check if there have been any recent consultations/acute medications prescribed by the GP (i.e. antibiotics).

• Check if there have been any changes from other prescribers (i.e. hospital consultants/specialists).

• If there is any doubt, the GP surgery should be contacted.

**GP referral letters**

• These are not always reliable as they may not be contemporaneous.

• They are often hand written by the on-call doctor and may be illegible or incomplete and could be missing doses or formulations of medicines.

• It may be necessary to double-check the drug history with the child or young person/parent/carer or GP surgery in order to confirm its accuracy.

**Compliance aids/monitored dosage systems (MDS) (a.k.a. blister packs)**

E.g. Nomad, Dosette, Medisure, Medimax

• These may be filled by the community pharmacist, district nurses, parents or carers.

• If the pack has been filled by the parent or carer themselves then this cannot be used as a source of information for medicines reconciliation as it will be unlabelled and the contents will not be readily identifiable.

• If dispensed by a community pharmacist, the device should be checked for dispensing labels, which will provide the pharmacy contact details.

• The date of dispensing should also be checked bearing in mind that the medicines may have changed.

• Remember to check for ‘when required’ medicines and medicines that may not be suitable for compliance aids such as liquid medicines, inhalers, eye drops, once weekly tablets, patches etc.

• Consider contacting the community pharmacist with the child or young person, parent or carer’s consent to inform them of the child’s or young person’s admission to prevent unnecessary repeat dispensing. They may also inform you of the number of compliance aids that have been filled, since these may still be at the child’s or young person’s home. The community pharmacist’s contact details should be documented on the drug chart and a discharge plan agreed.
**Recent hospital or hospice discharge summary**

- Check whether any changes have been made by the GP since the child’s or young person’s previous discharge from hospital or hospice.
- If the child or young person has been home for more than two weeks it is likely that they may have visited their GP and changes made.
- Discharge summaries that are more than one month old should not be used as a sole source for a drug history.

In some cases it may be necessary to investigate additional sources to obtain a complete medication history. Examples of teams that may need to be contacted for further information include:

- community pharmacists
- specialist nurses (e.g. asthma nurse, epilepsy nurse)
- children’s community nursing teams
- mental health teams
- renal dialysis unit
- other hospitals for clinical trials/unlicensed medicines
- oncology units

**Medication administration record (MAR) charts**

- Some children or young people may be cared for in residential care homes and have their medicine administration recorded on a MAR chart.
- These can be a useful source of information for children or young people transferred from this setting.
- Take care to ensure that there are no pages of the MAR chart missing as this can lead to errors.
- Some community pharmacies produce duplicate labels for MAR charts and these are a more reliable source of information than MAR charts produced by transcribing the details from the child’s or young person’s medicines labels.
Specific information should be collected about the following drugs

The following information regarding medicines should be recorded in the child’s or young person’s medical notes and prescription chart:

**Oral steroid medications**

1. Indication
2. Most recent dose
3. Course details (i.e. maintenance or reducing dose) and length of therapy where appropriate.

**Insulin**

1. The drug, brand, administration device and dose should always be checked and annotated on the prescription chart.
2. For those children or young people that have an insulin pen, clarify whether it is a pre-filled disposable pen or a penfill cartridge insulin pen.
3. For children or young people on variable dosing based carbohydrate load, an appropriate dosing range should be stated because they are two types of insulin that may be used a slow release formulation or a fast acting preparation.

**Oral contraceptives**

1. The person undertaking medicines reconciliation should purposely but sensitively ask about contraceptives as they are not always considered as medicines by the young person.

**Methotrexate**

1. This is prescribed once weekly so the day of administration, strength and number of tablets or injection strength should be confirmed with an appropriate source.
2. Check that this is correct on the drug chart and that the six days of the week when the dose is not to be administered are crossed off.
3. Any associated folic acid prescriptions should also be asked about.

**Bisphosphonates**

1. The day of administration should be confirmed with an appropriate source.
2. Check that this is correct on the drug chart and that the six days of the week when the dose is not to be administered are crossed off. Bisphosphonates now also come in once a month preparation (Bonviva) so there should be clear record in the child or young person’s drug chart of the day of administration.
3. Ask the child or young person, parent or carer whether they take calcium preparations and confirm which brand.

**Inhalers**

1. It is important to confirm the name, strength and type of inhaler; do not go by colour of device alone.
2. Confirm if any compliance aids are used (e.g. spacer device, haleraid®).

**Nebulisers**

1. Identify whether the child or young person has their own nebuliser machine and nebules at home and document on the drug chart.
Checklist of questions that healthcare professionals can use to support medicines reconciliation and help identify any problems

- Does anyone help you with your medicines at home? If so, who? What do they do?
- Do you have any problems obtaining or ordering your repeat prescriptions (NB: relative/carer might help)?
- Do you have a regular community pharmacy that you use?
- Do you have problems getting medicines out of their packages?
- Do you have problems reading the labels?
- Some people forget to take their medicines from time to time. Do you? What do you do to help you remember?
- Some people take more or less of a medicine depending on how they feel. Do you ever do this?
- Most medicines have side effects. Do you have any from your medicines?
- Specific medication related questions, such as “have any medicines been stopped recently or have any doses been changed recently?”

Minimum dataset that should be available on admission to a hospice

The minimum information available on admission should include:

- complete details of the child or young person i.e. full name, date of birth, weight of child or young person regardless of their age, NHS number, GP, date of admission
- presenting condition plus co-morbidities
- a list of medicines currently prescribed, including those bought over the counter
- dose frequency, formulation and route of the medicines listed
- an indication of medicines that are not intended to be continued
- monitored dosage systems and compliance aid if applicable
- known allergies and previous drug interactions.

Knowledge bite

- Effectively engaging the child or young person, carer or parent at the medicine reconciliation stage has demonstrated to reduce medication related errors by 85%.
- A child or young person is at most risk to a medication error either on admission or at discharge (transition points of care) and a successful medicine reconciliation process helps to mitigate this risk.
- Medicine reconciliation is not just only about ensuring the child or young person receives the correct medication on admission and discharge but also about educating the child or young person, carer or parent about the safe and effective use of medications by providing them with access to reliable, relevant and understandable information about their medications.
A child is admitted to the hospice and his parents bring all of his labelled medications. The hospice doctor checks the medication history with the child’s mother and the medications, as well as comparing these against the medication chart from a recent admission. The doctor notices a discrepancy between the strength of glycopyrronium bromide (a broncho-dilator which reduces respiratory tract secretions) prescribed on the last admission and that prescribed currently. It is decided to investigate further.

On the last admission the child had been taking glycopyrronium bromide 5mg/5mL oral solution at a dose of 1ml three times daily (3mg daily). At this admission, the family have brought a labelled bottle of glycopyrronium bromide 1mg/5ml oral solution and the child is still taking 1ml three times a day. It seems a little strange to the doctor that the dose been reduced to a fifth of the original dose in only two weeks.

The doctor asks the child’s Mum whether she remembers why the glycopyrronium dose was reduced. She states that it hasn’t been reduced and he is still taking 1ml three times a day. She is not aware that the strength of liquid supplied has been reduced from 5mg/5ml to 1mg/5ml. However, she does mention that his secretions have become much worse recently.

After further investigation, the doctor is able to identify that the lower strength oral solution (1mg/5ml) has been prescribed in error by the child’s GP. The GP did not intend to reduce the dose of glycopyrronium and had not realised that more than one strength was available. The hospice doctor then increases the glycopyrronium strength back up to 5mg/5ml and continues the dose of 1mg three times daily and explains this to the child’s Mum. On discharge a letter is sent to the GP confirming that the strength of glycopyrronium was changed back to the initial strength of 5mg/5ml and the original dose of 1ml three times a day.

This case study highlights how effective medicines reconciliation can benefit patients by identifying discrepancies and resolving these on admission. Effective communication with other healthcare professionals minimised the risk of this prescribing error continuing on discharge from the hospice and the child’s deterioration in terms of increased secretions was resolved too.
Transcribing

The English dictionary defines transcribing as ‘the act of making an exact copy usually in writing’. This means that there must always be an original from which the transcribed copy is made. In healthcare, the act of transcribing is usually performed so that medical records, prescription details and other communications are available to the healthcare professionals caring for a child. Transcribing is not covered by the Medicines Act 1968, which includes legislation for the administration by another team member under the direction of a prescriber. Therefore, the prescriber is legally responsible for generating the original instruction, and if this instruction is transcribed accurately without any alteration, the person making the transcribed copy does not assume liability.

In the children’s palliative care setting, the child’s or young person’s needs and safety are paramount, and should be central in the decision as to how best to provide care. In many of the situations where transcribing will be necessary, the medication has been supplied, and would have been taken by the child or young person if they were still at home. The ongoing administration could well be left to the parent, carer or if competent, the child or young person themselves. However, to self-administer they must be involved in the decision as to who will administer medication and self-administration should be encouraged as it gives the child or young person ownership of their medication (see Staff and carer competencies and Regulatory guidance chapter for more information on self-administration). Only where there is genuine risk should this right be removed from the parent, carer, child or young person. The need for transcribing is still present even if the child or young person, parent or carer are self-administering the medications.

Moreover, many children’s palliative care services receive medical support from general practitioners or paediatricians who are not based on the same site. Medical staff may make daily routine visits and attend when called to see an especially unwell child or young person, but more regular visits may only take place during symptom control or end of life care admissions. Transcribing of medication is therefore an important part of a child’s or young person’s admission as there would be a significant risk of omitted or delayed administration of prescribed medication while simply waiting for a chart to be written. The failure of a child or young person to receive their medications may well outweigh the risk created by administering the drugs from a transcribed chart.

What is transcribing?

Transcribing is defined in Standard 3 of the Nursing and Midwifery Council (NMC) Standards for Medicines Management as “any act by which medicinal products are written from one form of direction to administer to another. This includes discharge letters, transfer letters, copying illegible patient administration charts onto new charts, whether hand written or computer generated” (NMC, 2010). Other scenarios that could possibly constitute transcription are when nurses are required to alter doses on medication administration charts or when generating prescriptions. When staff copy medication details from one document to another when the new document is used for a different purpose, it is not classed as transcription. Examples might include requesting a prescription or providing a parent or carer with medication information.

The NMC Standards for Medicines Management also state that registrants may transcribe but that it “should only be undertaken in exceptional circumstances and should not be routine practice”, (NMC, 2010). An exceptional circumstance is a situation where an independent prescriber is unavailable to prescribe medication and the child’s or young person’s condition is such that the risk to the child’s or young person’s safety is significant if the administration of medication is delayed until a prescriber is available (e.g. an unplanned emergency admission).
However, the NMC Standard for Transcribing also acknowledges that: “As care is being increasingly provided in ‘closer to home’ settings that are often nurse-led, managers and employers should undertake a risk assessment … to develop a management process to enable transcribing to be undertaken where necessary” (NMC, 2010). Furthermore, to ensure that transcribing is taking place safely without causing any harm to the child or young person, children palliative care services are responsible for ensuring that there is a rigorous policy for transcribing that also meets local clinical governance requirements. In some nurse-led children’s hospices, transcribing is a key part of the admission process. Nurses transcribe the direction to administer from the child’s or young person’s own medicines labels onto a medication administration record (MAR) chart. In these cases it is vital that the hospice can demonstrate that they have a robust policy for transcribing in place. There is some overlap between the process of transcribing on admission and the medicines reconciliation process. Children’s hospices that rely on transcribing on admission should ensure that their procedures meet the same standards recommended for medicines reconciliation to ensure that any discrepancies are picked up and rectified as soon after admission as possible and to ensure the safety of the children or young people using their services (see figure 3).

**Minimising the need for transcribing**

Where possible, children's hospices/palliative care services should aim to reduce the need for reliance on transcribing by nurses. This could be done by:

- encouraging nurses to undertake a non-medical prescribing course to become qualified independent prescribers
- utilising medical cover to prepare medication charts in advance of children’s or young person’s admissions where possible
- timing admissions for a time of day when a prescriber is on site where possible
- anticipating the need to re-write medication charts when a prescriber is on site to avoid nurses needing to transcribe charts
- encouraging the development and use of family hand-held medication records (Richard House Children’s Hospice has piloted a hand-held medication record). However, the major limitation found with this record that it was not kept up to date and completed by all healthcare professionals so further work is required to increase its usefulness

**Examples where transcribing maybe necessary:**

(this is not a definitive list but covers most common situations)

- transition from hospital to a hospice
- to allow administration of current prescribed medication
- transition from community homecare to hospice care
- long stay child or young person whose medication chart is complete/full with no space left for marking administration of a medicine(s)
- new drug prescribed off site and delivered to the hospice i.e. via FP10
- verbal order to use stock drug
- new drug prescribed or dose change via remote prescribing
Transcribing procedure

Prior to transcribing

• Any healthcare professional who transcribes must be competent and authorised to do so.

• The authorised transcriber must ensure that the situation warrants transcribing or meets the requirements of the individual hospice transcribing policy and the items have been previously prescribed by an independent prescriber.

• The authorised transcriber must familiarise themselves with the child’s or young person’s clinical history to evaluate the accuracy and appropriateness of the medication information provided.

Acceptable sources of information to transcribe from

• Hospital discharge prescription (TTO/TTA-the take out/away prescription), which must have been written or co-signed by an independent prescriber.

• GP print out or GP letter.

• Previous medication chart (if signed by a prescriber).

• The medication information described above must be cross-checked with the child’s or young person’s labelled medicine boxes/bottles/compliance aid.

• If there is any uncertainty or ambiguity regarding the accuracy of the information, e.g. due to legibility or mismatch between the information and medicines, transcribing must not take place until a doctor has been contacted and the issue(s) resolved.

After transcribing

The transcriber must:

• attach the original source of medication information to the transcribed document where possible (e.g. faxed list of medication from the child or young person’s GP)

• record in the child’s or young person’s notes the nature of the circumstances that necessitated transcribing (i.e. the circumstances that led to transcribing and the actions taken to contact an independent prescriber); details must include names, dates and times

• take all reasonable steps to ensure that the transcribed items have been independently checked by a second member of staff before any medicines are administered

• take all reasonable steps to ensure that the transcribed items will be checked and authorised by an independent prescriber within a designated time period (e.g. 24 hours or next working day)

Second check

The transcription process must be independently checked by another registered healthcare professional (e.g. registered nurse, doctor or pharmacist) involved in the child’s or young person’s care before medicines are administered. Wherever possible, this independent check should be made by an authorised transcriber. The checker must compare the original source of information against the transcription and the labelled medicine boxes/bottles/compliance aid. They must sign or initial each of the transcribed items and co-sign the entry made in the patient’s notes.

Verification by an independent prescriber

All transcribed items must be checked and authorised by an independent prescriber within a designated time period (e.g. 24 hours or next working day). The original source of information must be used to confirm that the transcription is correct. The independent prescriber must then countersign all the transcribed items to indicate their authorisation. Items not approved for use must be clearly indicated and any new items must be prescribed as needed.
Monitoring and audit

Children’s hospices/palliative care services should have a specific category for transcription errors in their medication incident reporting procedures, so that practice can be monitored and reviewed. Children’s hospices/palliative care services that routinely use transcribing on admission should regularly audit this practice.

Figure 3: A diagram demonstrating the integral relationship between medicine reconciliation and transcribing in order to produce a drug chart for the child or young person.
The homecare team go out to visit L, a 13 year old girl with a brain stem glioma who is receiving end of life care. L is being looked after jointly by the local hospital’s paediatric oncology team, the children’s hospice homecare team and her GP.

Overnight, L’s GP had been out on a home visit. L’s pain had not been well controlled overnight. She had required five breakthrough doses of oral morphine last night and had become increasingly agitated. The GP had given L’s mum written instructions to increase L’s MST Continus® suspension dose from 8mg twice daily to 12mg twice daily, and to increase her breakthrough Oramorph® dose from 2.5mg to 4mg when required up to hourly. He also recommended that L’s mum could use the ‘just in case’ ampoules of midazolam 10mg/2mL injection via the buccal route if L became severely agitated. L has not had a benzodiazepine before and her mum is very concerned about overly sedating L, so he suggests that the midazolam should be given at a dose of 2mg for agitation to start with.

The GP had not realised that there was an NHS chart in L’s home for the nurses to administer against. When the hospice homecare nurse arrives at the home, L’s mum informs her that the GP has been out overnight and has made some changes to L’s medications. She had forgotten to ask him to update the chart and instead he has written down instructions on a piece of paper.

The homecare nurse uses the GP’s handwritten note to transcribe the new instructions onto the medication chart. The doctor’s handwriting is not very clear, but the nurse thinks she can make out the dose. There is not another nurse at the home, so the nurse asks the hospice support worker who is also present to check it with her. After reviewing the note, the staff between them are confident that they have been able to identify the doses.

A little while later L becomes agitated and the homecare nurse decides to give her a 4mg breakthrough dose of Oramorph®, which does not satisfactorily control her agitation so then the nurse decides to administer a dose of midazolam and gives L the 7mg dose that she transcribed onto the chart. L becomes increasingly drowsy and her respiratory rate slows. Mum seems quite concerned that she is so sedated and comments to the nurse “the doctor said that a 2mg dose was only a very low dose – surely she shouldn’t be this drowsy?” At this point the homecare nurse realises that she has transcribed the dose incorrectly and contacts the GP to clarify the correct dose which was 2mg and arranges for L to be urgently assessed.

- Is this a scenario that could happen in your organisation?
- How could this have been avoided?
- What should the homecare nurse have done differently?

Knowledge bite

- Transcribing should always take place from an approved, reliable source of information and verified with another independent source.
- Never undertake transcribing if you are unsure of any information relating to the medication. Always double check and verify medicines information to avoid any harm to the child or young person.
- Transcribing should always be double checked by another healthcare professional before any administration of medication takes place.
- All transcribed items should be signed off by an independent prescriber within a designated time period i.e. 24 hours or later. This should be clearly stated within the hospices transcribing policy.
- Most pADEs (Potential Adverse Drug Events) seemed to be mainly caused by prescribing or transcribing errors.
**Goals for notable practice and to achieve high quality standards relating to medicines reconciliation and transcribing**

As with any potential change in practice, indicators need to be used to identify whether the changes that are being made to the service are necessarily an improvement. Indicators therefore need to be more than the collection of process data, but also an assessment of the impact that the improved service is making for children or young people in hospice or homecare. Not only will this give hospices information they need to support their ongoing efforts to improve, it will also give hospices information they need to make informed decisions about the safety, quality and value of the service they are providing.

- The profile of medicines reconciliation and safe transcribing practice needs to be raised at an organisation level. Risk managers, prescribing leads and clinical governance teams at all hospices should be involved in the process of awareness-raising and communicating the benefits of medicines reconciliation and safe transcribing practice.

- Specify standardised systems for collecting and documenting information about current medications relating to either inpatient hospice stay and or if the child or young person is being cared at home.

- Ensure the responsibilities of staff in the medicines reconciliation/transcribing process are clearly defined. Hospices should have written policies and procedures endorsed by a multidisciplinary committee and senior management team for medicines reconciliation and transcribing not only for an inpatient hospice setting but also if homecare is being provided.

- Strategies are incorporated into medication reconciliation policy that details how to obtain information about medicines for children or young people with communication difficulties.

- Systems that are designed for medicine reconciliation and transcribing should focus on improving the safety and clinical outcomes of the child or young whether this is in an inpatient or homecare capacity thus not exposing them to harm related to ineffective medicines management policies. Hospices should consistently monitor and audit how effectively they transfer information about medicines.

- Notable and less notable practice in regards to medicine reconciliation and transcribing should be shared with other hospices to improve systems and encourage a learning culture.

- Incorporate medicines reconciliation and transcribing into the training and development of healthcare professionals and support staff that are involved in the care of a child or young person.

Finally, in the appendix of this toolkit there is a series of modules on medicines reconciliation and transcribing that have been developed as support tools for organisations to use in a number of ways:

- to train staff
- to audit current practice
- to develop policy
- to audit practice in accordance with policy

The modules are a guide and not intended to be fully exhaustive. Organisations must use relevant new guidance alongside these modules, as well as referring to the other documents we have recommended.
References


Chapter 6
Non-medical prescribing

By Michael Tatterton and Jenny Adams
Since the first edition of this toolkit, interest in non-medical prescribing, and the number of non-medical prescribers within children’s hospices and children’s palliative care services has grown significantly. This chapter focuses on issues relating to non-medical prescribing, providing a useful resource for existing prescribers, as well as those services considering the introduction of non-medical prescribing.

In preparation for the completion of this document, many non-medical prescribers and medical staff working across the children’s palliative care sector shared their thoughts and experiences, which have helped to shape the content and structure of this chapter. Examples of notable practice have been gathered from existing prescribers based within children’s hospices and wider the children’s palliative care workforce.

Non-medical prescribing is intended to improve patient care without compromising safety by:

- improving access to medication
- improving patient choice
- making better use of the skills of health professionals
- contributing to more flexible team working

DH (2006)

Non-medical prescribers work closely with children, young people and their family, meeting the vision set out in the NHS Next Stage Review for care that is fair, personal, effective and safe (Darzi, 2008). Non-medical prescribers can improve access to treatment and ensure that changes in medication are timely and responsive to changes in symptoms, in both hospices with and without resident medical prescribers.

The challenges of prescribing within children’s palliative care services are considerable – the related issues of polypharmacy and comorbidities in children with life-limiting illnesses are not uncommon. This chapter includes examples of practice models where NMPs work in isolation and alongside medical prescribers.
Case study: The implementation of non-medical prescribing at Forget Me Not Children’s Hospice

As a children's hospice with a predominant focus on community-based ‘hospice at home’ services, the benefits of non-medical prescribing were very clear from the beginning. It was understood that the addition of non-medical prescribers to our nursing workforce would enhance the quality of the community-based services offered, including short breaks, symptom control and end of life care, all of which are provided at home and in the hospice, Russell House.

Currently, three NMPs are employed (consultant nurse and two care team leaders); with a further two nurses nearing completion of training. It is planned to train all six care team leaders, giving a resource of 6.2 full time equivalent prescribers who will provide 24 hour access to prescribing. This allows for a very high level of service to be provided; which includes the provision of nurse-led symptom control and end of life care in the community, covering a significant geographical area.

The organisation has committed to two staff per year undertaking the programme, meaning that all staff will be trained by summer 2015.

Advantages to the introduction of non-medical prescribers to the hospice include:

- Children and young people are able to access medicines more effectively. This includes access to existing (repeat) prescriptions when families either:
  - forget the medicine
  - bring an inadequate supply of medicine to last the duration of the child’s planned stay
  - bring medicines that have expired or been stored inappropriately
  - the continuation of existing medications when the child is admitted from somewhere other than home, or in an emergency

- Non-medical prescribers can update prescriptions to reflect changes to doses, which parents often titrate in response to symptoms. Families usually achieve this informally with the child’s consultant/prescriber; the introduction of NMPs means that we can be immediately responsive to these changes.

- In end of life care, the ability for NMPs to introduce medicines and alter doses in response to symptoms has had a great impact on the work of the organisation – this has led to increased autonomous working, a reduction in delay and improved symptom management of children requiring symptom control.

- Undertaking the NMP course enables practitioners to be much more aware of the pharmacology behind medicines management – this has led to improved working practices amongst the prescribers, which has been cascaded throughout the entire care team, through NMP-led medicines safety training.

- We do not require a significant stock of medicines – all medicines are obtained using FP10 prescriptions, funded by the NHS, which eradicated our need for a prescribing and medicines budget.

- Supports the philosophy of nurse-led hospice care.
Like most children’s hospices, the Forget Me Not Children’s Hospice spans numerous NHS clinical commissioning group (CCG) boundaries. We are required to justify our intent to practice with each CCG medicines management lead, including providing details of our prescribing intentions, scope and competence.

To demonstrate this, along with the predicted volume of prescribing, we prepared a single document that was shared with all CCGs, which showed:

- number of children on the hospice caseload from each of the CCGs
- the anticipated caseload growth over the next two years
- our anticipated prescribing practice, structured by symptom group (e.g. pain, terminal agitation etc).

The statement of intent sent to CCGs is below:

**Scope of prescribing:**
*It is anticipated that prescribing by the hospice will enable timely and effective symptom management of children and young people with palliative care needs, largely surrounding end of life care. This will include acute and exacerbated symptoms.*

**Community:**
The hospice will provide short-term prescriptions, with requests made to their GP to continue any drugs prescribed for longer than seven days. The majority of prescribing will surround effective symptom management.

**Hospice-based care:**
The hospice will provide prescriptions for new medication required for the duration of the child’s admission, or seven days, whichever is longer. Requests will be made to GPs to continue any drugs prescribed for longer than seven days.

On some occasions, prescriptions may be written to provide repeat prescriptions, or to ensure adequate medication supplies during a child’s stay. This is not expected to generate significant numbers of prescriptions, as children are requested to bring all required medicines in from home.

The CCGs responded positively to the document, and have agreed to meet our prescribing costs – this means that our non-medical prescribers prescribe on FP10 forms, at no cost to the hospice.
Meeting the needs of children/young people and their families

Examples of non-medical prescribing in the care of children and young people with life-limiting or life-threatening conditions demonstrate:

- reducing the need for transcribing
- timely, personalised treatment
- improved quality of care
- better access to medicines
- additional support and education for parents
- increased organisational capacity
- good value for money

(Dale 2009, Fittock 2010)

**Good practice point**

The implementation of non-medical prescribing in a children’s hospice will contribute to meeting Care Quality Commission Standards related to:

- involving patients in care planning
- promoting independence
- assessment of needs
- safe, timely provision of medicines
- care provision by well qualified staff

There is evidence that adherence in taking prescribed medication is lower among children and young people than among adults (Horne et al., 2005). Rates are especially low for adolescents as they approach independence from their parents (Staples and Bravender, 2002). Estimates of non-adherence for children and adults generally range from 25% to 60% (Costello et al., 2004).

The National Institute for Health and Clinical Excellence (NICE) suggests that involving children and families in prescribing decisions may improve adherence (Nunes et al., 2009). There is evidence that both non-medical prescribers and their patients recognise that concordance, i.e. closely involving patients in decision making, is an important element in their approach to consultation and prescribing (Latter et al., 2007a).
Case study: consultation models in practice

Working within a children’s hospice means that practitioners often have very different relationships with families under their care, predominantly due to the nature, frequency and duration of contact.

A young person with a T-cell acute lymphoblastic leukaemia (ALL) was referred to the hospice for symptom control and end of life care following a failed bone marrow transplant. He had unmanaged pain, despite being prescribed optimum medication.

There were seven core components to the consultation, with the aim of identifying the needs of the young person and achieving concordance. They were:

- establishing a relationship with patients: including both children (regardless of age) and their parent(s)
- identifying the problem or reason for attendance and parental expectations
- examination: taking of a medical and medication history and physical examination if appropriate
- discussion of how the problem affects daily living
- plan: The plan is negotiated with the child/young person and parent including prescribing of medication, further investigation or referral, recommendation of adjunct, such as exercise or dietary changes, signposting to an appropriate service, or no intervention
- explanation and summing up: to ensure shared understanding and agreement
- arranging next contact, review or discharge

Central to any consultation, and key to the effectiveness of a consultation are interpersonal and communication skills. It is essential that a prescriber leading the consultation is able to draw out those points discussed above to determine their influence on decision making and the effectiveness of any prescribing decisions, including decisions not to prescribe.

Using this approach, it was identified that the young person had been prescribed medication as tablets, at his own request, as he felt it was ‘more grown up’. However, he struggled to take tablets and preferred liquid preparations. The preparations were changed, which led to more effective pain management.

Knowledge bite

Developing competency in concordance

Who can prescribe?

All prescribing is regulated by law. The provision of law restricts who can prescribe which medicinal products. Following changes in legislation and the introduction of professional standards, nurses, midwives, health visitors, pharmacists, podiatrists, physiotherapists, radiographers and optometrists have all been given different prescribing rights.

Before they are entitled to prescribe, practitioners have to undertake rigorous training and record the appropriate qualification with their professional regulator. Non-medical prescribing training is restricted to those practitioners who can demonstrate adequate clinical experience and knowledge.

Knowledge bite

Independent prescribing and supplementary prescribing

There are currently two different types of prescriber in the UK.

Supplementary prescribing

A supplementary prescriber is able to prescribe medicines in accordance with a clinical management plan (CMP). CMPs are agreed between a doctor, the supplementary prescriber and the patient. Currently registered nurses, pharmacists, optometrists, physiotherapists, podiatrists and radiographers can train to become supplementary prescribers. They may include any medicine within the scope of competence.

Independent prescribing

Currently, there are two levels of independent prescribing:

An independent non-medical prescriber is able to prescribe any medicines from the British National Formulary (BNF) or BNF for Children (BNFC) within their scope of competence. Independent prescribers include doctors and non-medical prescribers: registered nurses, pharmacists, podiatrists and physiotherapists. Recent changes to the law allows nurse and pharmacist independent prescribers to prescribe all controlled drugs listed in schedules 2 to 5 within their competence, except cocaine, diamorphine and dipipanone for the treatment of addiction (NMC, 2012).

A community practitioner nurse prescriber can prescribe from a limited formulary, the Nurse Prescribers Formulary (NPF). This can be found at the back of the BNF.

More information can be found at the following links:

- for nurses, midwives and health visitors registered with the NMC, click here: www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/
- for allied health professionals registered with the HCPC, click here: www.hcpc-uk.org/aboutregistration/medicinesandprescribing/
- for pharmacists registered with the GPC, click here: www.pharmacyregulation.org/education/pharmacist-independent-prescriber
The introduction of non-medical prescribing was effected through new legislation that amended previous law:

- The Medicinal Products: Prescription by Nurses, etc. Act 1992 updated and amended the National Health Service Act 1977 (section 41) and the Medicines Act 1968 (section 58).

- The Medicinal Products: Prescription by Nurses, etc. Act was passed in 1992 and augmented by a further Order (Commencement No 1) in 1994.

- The Government extended prescribing responsibilities to other health professions, including pharmacists, through Section 63 of the Health and Social Care Act 2001. This Act also enabled the introduction of new types of prescriber, including the concept of a supplementary prescriber.

- The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006, together with associated medicines regulations, enables nurses who have successfully completed a nurse independent prescribing course to prescribe any licensed medicine (i.e. products with a valid UK marketing authorisation/licence). This includes some controlled drugs and applies for any medical condition within the nurse’s clinical competence.

- Pharmacist Independent Prescribers are now able to prescribe CDs. The changes to the Misuse of Drugs Regulations 2001 relating to nurse and pharmacist independent prescribing of controlled drugs (Misuse of Drugs (Amendment No.2) (England, Wales and Scotland) Regulations 2012 (Statutory Instrument 2012/973: www.legislation.gov.uk/uksi/2012/973/made) came into force on 23 April 2012.

- Independent Prescribing by Physiotherapists and Podiatrists. Changes to legislation to enable the introduction of independent prescribing by physiotherapists and podiatrists were announced by the Department of Health on 24 July 2012.

**Controlled drugs**

Amendments to the Misuse of Drugs Regulations (Northern Ireland) 2002 introduced on 10 May 2012 allow a nurse independent prescriber and a pharmacist independent prescriber to prescribe controlled drugs. For details, please see the DHSSPSNI letter (www.dhsspsni.gov.uk/letter_amendments_to_misuse_of_drugs_regulations_-_cd_prescribing_by_nurse_and_pharmacist_independent_prescribers.pdf) and the DHSSPSNI circular (www.mhra.gov.uk/Howweregulate/Medicines/Medicinesregulatorynews/CON025660)

Scotland and Northern Ireland applied the UK legislation to introduce supplementary prescribing in 2003 and independent prescribing in 2006. Legislation relating to non-medical prescribing was amended in Wales in 2007 and 2010.

The Medicines and Healthcare products Regulatory Agency (MHRA) has also made changes to medicines regulations to enable mixing of medicines prior to administration in palliative care, effective from 21 December 2009. The statement from the MHRA can be found here: www.mhra.gov.uk/Howweregulate/Medicines/Medicinesregulatorynews/CON025660
Prescribers are also subject to regulation by their professional bodies. For nurses, midwives and health visitors this is the Nursing and Midwifery Council (NMC), for pharmacists the General Pharmaceutical Council (GPhC) and for other allied health professionals the Health and Care Professions Council (HCPC).

The NMC and HCPC has published standards for education and practice for prescribers.

Knowledge bite

Professional standards for non medical prescribers

The NMC Standards of Proficiency for Nurse and Midwife Prescribers can be found here: [www.nmc-uk.org/documents/standards/nmcstandardsofproficiencyfornurseandmidwifeprescribers.pdf](http://www.nmc-uk.org/documents/standards/nmcstandardsofproficiencyfornurseandmidwifeprescribers.pdf)

The HCPC Standards for Prescribing can be found here: [www.hcpc-uk.org/assets/documents/10004160Standardsforprescribing.pdf](http://www.hcpc-uk.org/assets/documents/10004160Standardsforprescribing.pdf)

The standards relate to:

- licence as a prescriber and CPD
- accountability and delegation
- patient assessment and patient need
- consent and communication
- record keeping
- clinical management plans
- prescribing in relation to the supply, dispensing and administration of medicines
- prescribing for family and others
- computer-generated, evidence-based, remote and repeat prescribing
- controlled drugs, unlicensed medicines and use of medicines outside the terms of the licence
- gifts and benefits

Both the NMC and HCPC standards are supplemented by additional guidance. Since publication of the NMC standards, the NMC has issued two circulars that should be read alongside the standards. These circulars relate to prescribing for children and changes to the use of unlicensed medication and mixing drugs.

Both circulars are important for children’s hospices:

Knowledge bite

Mixing medicines

In 2010 the Department of Health made changes to medicines legislation which now enable:

- medical and independent nurse and pharmacist prescribers to mix medicines themselves and to direct other to mix. The Statutory Instrument 2012/973 (www.legislation.gov.uk/uksi/2012/973/made) regularises the legislation around the mixing of medicines to include controlled drugs
- supplementary prescribers to mix medicines themselves and to direct others to mix, but only where a clinical management plan for an individual patient
- non-medical independent prescribers to prescribe unlicensed medicines on the same basis as doctors
- and supplementary prescribers if part of a clinical management plan for an individual patient.


Notable practice point

Non-medical prescribers working in a children’s hospice must be trained and experienced in working with children. Non-medical prescribers must work within their own level of confidence and competence. The Single Competency Framework for Prescribers (www.npc.co.uk/improving_safety/improving_quality/resources/single_comp_framework.pdf) by the National Prescribing Centre can help prescribers to define their field of practice and competence.

Implementing non-medical prescribing

Initiating non-medical prescribing within a service can be a burdensome and time-consuming task. Before prescribing can be implemented, the organisation should consider the following points to justify developing a non-medical prescribing service:

- **Who currently prescribes?** How will the addition of NMPs to the workforce enhance the care offered to children and families? How are medicines currently accessed (this may be through local GPs, paediatricians, specialist nurses or other prescribers). Arrangements may include resident or visiting prescribers, most commonly, GPs. Where are the gaps in provision?

- **How many prescribers will you need?** The number of prescribers needed will depend on the size of the organisation in terms of caseload and geography, and the times at which prescribing will be offered. Experience suggests that 24 hour access to prescribing is not necessary. Some hospices suggest that access to prescribers will only be required at peak times, for example, weekends or at the time of admission, when occupancy and service demand is greater.

- **How will you fund the drugs your NMPs prescribe?** Some hospices have a designated budget for prescribing; others have their costs met by GPs or at CCG level (see the ‘notable practice’ box below). If funding your own prescribing costs, you should be prepared to demonstrate a designated, protected budget.

- **What will NMPs prescribe?** The anticipated scope of prescribing will affect the budget requirements. Will NMPs only prescribe for routine medicines, medicines required for symptom control or to replace empty or forgotten medicines during planned short breaks? Will NMPs complement existing prescribing arrangements, e.g. prescribing outside of office hours, when access to a medical prescriber may be more limited. What about family prescribing – will NMPs be able to prescribe for siblings and parents during visits? It is important to consider scope of practice, discussed in 8.8.
• **What opportunities are there for NMPs to maintain competence?** Once qualified, will NMPs have sufficient opportunity to practice? Establishing the correct number of prescribers can be tricky; organisations need to achieve a balance, where there are sufficient prescribers to meet demand and facilitate peer support, without having so many prescribers that there is insufficient opportunity to practice, which can in turn effect competence.

• **What medical support is available to NMPs?** Who can NMPs contact for specialist and medical advice? This can be achieved with resident paediatricians, or paediatricians from local hospitals or neighbouring children’s hospices with medical staff. It’s important that prescribers have someone to refer to, and essential that an appropriately experienced doctor is available to mentor and ‘sign off’ a practitioner undertaking the non-medical prescribing course.

Many of these points need to be considered before services can access NHS-funded prescribing training, as service managers are asked to confirm that on completion of the course students will have the ‘opportunity to prescribe’.

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### Non-medical prescribing and clinical governance

Clear guidance for the governance of non-medical prescribing is available in *Improving Patients’ Access to Medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England* (DH 2006), available here ([www.prescribingforsuccess.co.uk/documentUploads/About/DHGguideApril06.pdf](http://www.prescribingforsuccess.co.uk/documentUploads/About/DHGguideApril06.pdf)).


Prescribing by non-medical prescribers does not tend to increase prescribing costs overall, as it is normally substitute prescribing. Where required, arranging a prescribing budget within a children’s hospice will require negotiation with the NHS Clinical Commissioning Groups (CCGs). It may require a budget to be arranged with a local GP practice. This budget should be identified before non-medical prescribers are trained.

Some practitioners express concern that nurses working in the children’s hospice sector may not have the knowledge and experience required to undertake prescribing for children who are subject to complex polypharmacy and using novel medication regimes. The *Improving Patients’ Access to Medicines* ([http://webarchive.nationalarchives.gov.uk/20130107105354/http//www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets@dh/en/documents/digitalasset/dh_4133747.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http//www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets@dh/en/documents/digitalasset/dh_4133747.pdf)) (DH 2006) implementation guidance confirms the responsibility of practitioners working in non-NHS organisations to demonstrate that they are competent to practice, that their practice is audited, that they keep up to date with current practice and how they safeguard patients in their care. The implementation guidance (DH 2006) also offers examples of governance frameworks used in non-medical prescribing.

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**Good practice point**

A group or committee of senior staff should be responsible for identifying where non-medical prescribing can improve access to treatment and improve patient care without compromising patient safety. Access to a prescribing budget should be identified and negotiated with the local commissioning organisation. The hospice should have a non-medical prescribing policy and appoint a non-medical prescribing lead.
**Notable practice point**

Although the example below is taken from a hospital-based service, the example of multidisciplinary working can be applied to any setting, including palliative care services.

“The prescribers within the multidisciplinary team (MDT) include a paediatrician, children’s nurse and a paediatric pharmacist that bring together the perspective and experience of each individual discipline. This in turn has led to improvement in the delivery of patient care and enhanced understanding of pain internally at this paediatric tertiary cancer centre and externally in the community setting.

The development of independent non-medical prescribing within this MDT has enabled improvements in rapid access and alteration of analgesia to children both in the tertiary centre and the community setting.

As part of our service we provide an outreach symptom advice service covering a wide geographical area, to support local services to deliver care in the preferred place of care for the family.”

Breen (2012)

**Maintaining competency in prescribing**

During the consultation prior to writing this chapter, non-medical prescribers described pressures placed on them by colleagues and families to prescribe medicines outside of their scope of practice. Scrafton et al., 2012 report that prescribers who work across specialties, such as palliative care, are particularly susceptible to this, where opportunities to prescribe outside of their field of expertise are frequent and recurrent.

Prescribing for children and young people with life-limiting and life-threatening conditions is a complex and often daunting task, and not one that should be taken lightly. As has been stated, children with palliative care needs frequently present with comorbidities and polypharmacy, highlighting the need for precise and methodical medication review (see section 8.2), enhanced clinical assessment and a critical awareness of the risks associated with polypharmacy including drug interactions and compatibility which increase the risk of adverse drug reactions (ADR) (Smyth et al., 2012).

**Prescribing resources**

In addition to the BNF, BNFC and Palliative Care Formulary (PCF), there are a number of useful resources written specifically for use in children’s palliative care. These resources are updated frequently and so are best accessed electronically to ensure that the most up to date edition is being used. Key resources include:

- **Basic Symptom Control in Paediatric Palliative Care**
  (www.togetherforshortlives.org.uk/professionals/resources/2434_basic_symptom_control_in_paediatric_palliative_care_free_download)

- **Association of Paediatric Palliative Medicine (APPM) Master Formulary**
  (http://www.appm.org.uk/10.html)

We are also aware of some organisation-specific formularies that reflect local practices, which may be useful to some organisations. If there are any resources you think would be of benefit to other prescribers, please email mtatterton@martinhouse.org.uk.
Some nurse prescribers have found difficulty in meeting their continuing professional development (CPD) needs and in accessing continuing education as prescribers (Courtenay et al., 2007, Latter et al., 2007b). This issue was confirmed by one non-medical prescriber working in a children’s hospice that was not routinely included in local prescribing support groups and did not have access to dedicated CPD opportunities.

### Good practice point

CPD for non-medical prescribers can be sought from a number of sources: conferences, formal taught sessions, support groups and reflective clinical supervision. Resources are also available online via the National Prescribing Centre (now part of NICE) and from websites including Together for Short Lives (www.togetherforshortlives.org.uk/search?q=prescribing) and the International Children’s Palliative Care Network (www.icpcn.org).

Contact Michael Tatterton, deputy director of care at Martin House Children’s Hospice, mtatterton@martinhouse.org.uk to discuss prescribing experiences in a children’s hospice and a potential support network for non-medical prescribers.

### Scope of practice

The approach and scope of practice of non-medical prescribers in children’s palliative care varies significantly around the UK. Discussions during the completion of this chapter highlight the challenges in balancing the expectations of service managers and the ability of prescribers to prescribe within their scope of competence and confidence. The role of independent prescribers during the hospice admission process has been discussed frequently, particularly in light of the challenges that surround transcribing (see chapter 5).

Examples of prescribing on admission within children’s palliative care services are difficult to source. However, independent prescribers have been used widely in other areas of healthcare, for example the introduction of a pharmacy admission service to two acute medical wards (including 13 high dependency beds) in a London hospital. The pharmacist independent prescribers prescribe medicines for a range of conditions, undertaking prescribing that was previously done by junior doctors. An evaluation of the service suggested that the introduction of independent prescribers improved the reconciliation process, concluding that the independent prescribers added value to the ward-based team (Thakkar and Jani, 2009).

Safe prescribing requires more than an independent prescribing qualification. Practitioners must have adequate knowledge and clinical experience, enabling them to take a history, perform appropriate examinations to rule out life threatening causes and to consider differentials before diagnosing.

The specific challenges to prescribing in children’s palliative care services, variance in prescriber confidence and competence and the level of medical support available means that there is not a ‘one size fits all’ model. Independent prescribers are accountable to their employer, and the Department of Health expects employers to specify the parameters of their prescribing. Organisations need to be clear about the boundaries between transcribing, medicine reconciliation and when changing medicines and doses etc. becomes prescribing. The role and expectations of independent prescribers should be negotiated in each organisation, based on the experience and knowledge of the prescriber as well as the needs of the service.

This will inform decision making about how independent non-medical prescribing will be used on admission, which must be reflected in the organisational policy as well as the job descriptions of those undertaking independent prescribing.
Monitoring prescribing

The Yorkshire and Humber Quality Observatory has published a briefing paper outlining the data available to prescribers to support audit and monitoring of prescribing. The paper, ‘Primary and secondary care prescribing data: opportunities and limitations’ can be found here: www.ypho.org.uk/resource/view.aspx?RID=89423

A tool specifically designed to audit medicines in children’s hospices, which includes a specific chapter on non-medical prescribing is available from Help the Hospices National Audit Tools Group, and can be found here: www.helpthehospices.org.uk/our-services/clinical-governance/audit-tools/national-audit-tools-group/

Goals for best practice and to achieve high quality standards

• The hospice should have a senior member of staff in the role of non-medical prescribing lead.
• The organisation should identify where non-medical prescribers can improve access to care and reduce error.
• The organisation should have a non-medical prescribing policy, and all prescribers should be aware of the policy.
• Before non-medical prescribers are trained, a prescribing budget should be identified.
• Non-medical prescribing responsibilities should be identified in the prescriber’s job description, to ensure the organisation carries vicarious liability for prescribing activity.
• Non-medical prescribers in a children’s hospice must be trained and experienced in caring for children.
• Non-medical prescribers must work within their own level of confidence and competence and must only prescribe for children they themselves have assessed for care.
• Nurse prescribers must be aware of and adhere to the NMC standards for non-medical prescribing.
References


Appendices
Appendix 1
Guidance for reporting a drug/medication error

Thank you for reporting. Here is some guidance on reporting a drug/medication error.

The reporter is the person completing the report and may or may not be the person closest to the error at the time of its occurrence.

A drug/medication error is the failure of a planned action or the use of a wrong plan related to medicines management that does not achieve its aims. Errors can relate to prescribing; transcribing, product labelling, packaging, medication names, dispensing; distribution; administration; education, monitoring and child or family use.

A near miss is defined as a situation in which an action or omission, or a sequence of actions or omissions arising during care, fails to develop further so the child does not suffer any harm. For example, the child receives the wrong dose of an antibiotic but there is no harm; or a pharmacist detects that a drug is prescribed incorrectly and alerts the prescriber before the nurse administers the drug. Near misses can be very valuable to your hospice’s learning. If possible use the report to explain why harm did not occur. Try to describe what prevented any escalation to harm.

An adverse drug event is an action or omission arising during the process of providing a drug to a child that causes physical or psychological harm.

Describe the circumstances carefully and use the contributory factors list to help.

Firstly record what happened and what those involved were doing. If you were directly involved, consider your own thought processes at the time and why you acted as you did. What influenced you in mentally planning what you were going to do? How did you do it? For example, did you take a course of action that didn’t work out as anticipated? Did you forget something? Did you make a slip – such as pressing the wrong button on a syringe driver? Did you steer away from routine policy? It is important to think of the time order of events, the environment and any problems in care delivery or hospice systems that could have led to the error. Finally, if the error led to a near miss – how did you or another limit the impact of the error?

There should be linked logical comments between circumstances, cause and action taken. It is unlikely that there will be a single cause, and it is more likely that various factors will come together to produce the error. You have a choice of contributory factors to choose from and prioritise but also the chance to write free text to expand your thoughts. Thinking of how the error might not have occurred will also allow you to identify the contributory factors that actually led to the error.

If you are a manager, carefully consider the options for action taken.

There are options for individual support, specific preventative actions and the dissemination of learning. Any discussions or meetings following the submission of a report should include the strategies for error reduction of prevention. If a medical device has malfunctioned, the device details should be recorded and the device examined according to local policy.
## Appendix 2

### Drug/medication error report form

<table>
<thead>
<tr>
<th>Incident no.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Exact location</td>
</tr>
<tr>
<td><strong>2.</strong> Date of error</td>
</tr>
<tr>
<td><strong>3.</strong> Time of error (24 hour)</td>
</tr>
<tr>
<td><strong>4.</strong> Name and address of child/young person</td>
</tr>
<tr>
<td><strong>5.</strong> Child/young person informed of error</td>
</tr>
<tr>
<td>✗ Yes ✗ No</td>
</tr>
<tr>
<td>Parent/carer informed of error</td>
</tr>
<tr>
<td>✗ Yes ✗ No</td>
</tr>
<tr>
<td>If not informed, please state why</td>
</tr>
<tr>
<td><strong>6.</strong> Staff involved</td>
</tr>
<tr>
<td>Person(s) closest to error when it occurred</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Profession:</td>
</tr>
<tr>
<td>Reporter (if different to above)</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Profession:</td>
</tr>
<tr>
<td>Witness(s)</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Profession:</td>
</tr>
</tbody>
</table>
### Stage at which the error occurred (tick all that apply)

- Booking In Stage
- Administration Stage
- Transcribing Stage
- Discharge Stage

### Outcome (tick ONE box only)

- Near miss
- Adverse drug event

### Circumstances leading up to and surrounding the error:

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</table>

### Drug name(s)

### Drug error type (tick ALL that apply)

1. Drug omission
2. Drug expired
3. Drug given without authorisation
4. Drug not available
5. Monitoring error: drug to drug allergic patient
6. Monitoring error: inadequate clinical observations as part of drug administration
7. Overdose
8. Under dose
9. Extra dose
10. Wrong drug to child/young person
11. Wrong child/young person
12. Wrong rate
13. Wrong route
14. Wrong time
15. Drug labelled incorrectly on admission

- Transcribed only
- Administered

Other (please state)

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</tbody>
</table>
### Contributory factors: rate each of the following factors (from 0-5) for their importance in causing the error

<table>
<thead>
<tr>
<th>Factor</th>
<th>NOT AT ALL IMPORTANT</th>
<th>EXTREMELY IMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Arithmetic error/miscalculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Verbal communication between staff involved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Written communication between staff involved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Device not used effectively</td>
<td></td>
<td></td>
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<tr>
<td>5. Device not working effectively</td>
<td></td>
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<tr>
<td>6. Double check error</td>
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<tr>
<td>7. Interruption/distraction</td>
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<tr>
<td>8. Knowledge deficit</td>
<td></td>
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<tr>
<td>9. Knowledge misapplied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Labelling error</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Length of staff experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Lookalike/soundalike drug name</td>
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<td></td>
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<tr>
<td>13. Personal stress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Protocol or policy broken</td>
<td></td>
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<td>15. Protocol unavailable</td>
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<tr>
<td>16. Skill mix substandard</td>
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<tr>
<td>17. Staffing levels reduced</td>
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<tr>
<td>18. Stock control substandard</td>
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<tr>
<td>19. Workload high</td>
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</tr>
</tbody>
</table>

Write below any other contributory factor(s) not listed in table above and rate their importance from 1-5

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### Manager or equivalent to complete sections 13 and 14

#### 13. Action taken (tick ALL that apply)

<table>
<thead>
<tr>
<th></th>
<th>Interpersonal support for those involved</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Education/training</td>
</tr>
<tr>
<td></td>
<td>Supervision</td>
</tr>
<tr>
<td></td>
<td>Medical device change</td>
</tr>
<tr>
<td></td>
<td>Systems review</td>
</tr>
<tr>
<td></td>
<td>RCA or equivalent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Discuss with person closest to error and/or reporter</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Discuss with team</td>
</tr>
<tr>
<td></td>
<td>Discuss at clinical governance forum</td>
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<tr>
<td></td>
<td>Disseminate any learning to all staff</td>
</tr>
<tr>
<td></td>
<td>Potential for claim</td>
</tr>
<tr>
<td></td>
<td>Potential for complaint</td>
</tr>
</tbody>
</table>

#### 14. Further information on preventative measures taken

<table>
<thead>
<tr>
<th></th>
<th>Name, title and profession of person(s) taking action</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td>Job Title:</td>
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<tr>
<td></td>
<td>Profession:</td>
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<td>Date:</td>
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</tbody>
</table>
Appendix 3

Medicine reconciliation modules

This appendix includes a series of modules that have been developed as support tools for organisations to use in a number of ways:

• To train staff
• To audit current practice
• To develop policy
• To audit practice in accordance with policy

The modules are a guide and it is not intended to be fully exhaustive. Organisations must use relevant new guidance alongside these modules, as well as referring to the other documents we have recommended.

Each question within the modules 1-5 is of immediate priority. Module 6 is a more long-term goal.

Module 1: Collecting information

This module involves the collection of medication history and other relevant data. This could be from a variety of sources, where some are more reliable than others.

Question 1.1
Have the child’s/young person’s details been documented for this admission? (ensure dated and signed, with name and profession of person recording)

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Yes</td>
<td></td>
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<tr>
<td>❑ Yes, partially</td>
<td></td>
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<tr>
<td>❑ No (explain why not)</td>
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</tr>
</tbody>
</table>

Details include:

• date of admission
• child/young person’s full name, date of birth, address, NHS number (CHI in Scotland)
• registered GP name, address and telephone/fax number
• next of kin name and contact details
• reason for admission
• active conditions and child/young person’s last consultation
• family history
• weight of child
### Question 1.2
Does the child/young person have any known adverse drug reactions or allergies?

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
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</thead>
<tbody>
<tr>
<td>❑ Yes</td>
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<tr>
<td>❑ No (explain why not)</td>
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</table>

- Record response to adverse drug reaction/allergy and date when last experienced.
- Healthcare professional asking and recording must sign, date and state profession.
- Document the source of information used to ascertain drug allergy status.

### Question 1.3
Are you able to use a reliable source of information to collect medication history? (record the date, source name and profession of person recording.)

<table>
<thead>
<tr>
<th>Response</th>
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<tbody>
<tr>
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<td>❑ No (explain why not)</td>
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</table>

Not all sources are reliable – establish if the child/young person is able to provide a good source of information. If the child/young person is confused or too ill they should not be approached. Some examples of sources of information include:

- verbal information from the child/young person, their family, carer or ambulance staff, etc. Document name of source. Care must be taken to ensure that the patient is taking the medication as prescribed
- computer print-out or fax from a GP records system. Treat with caution, as this may not include hospital-only, or other specialist medicines
- GP referral letter
- Medicines brought in by the family. Occasionally these will be brought in without labelled directions
- medical notes or discharge summary from a child/young person’s previous recent admission
- medical notes transferred from another unit or ward
- medication administration record (MAR) sheet
- medication reminder card or record card from a community pharmacy
- tear-off side of a child/young person’s repeat prescription. Check to see the date medicine was last issued
- emergency care summaries (ECS)

When using sources, ensure that they are for your child/young person and they are current. Record sources of information used; a range of sources should be used.
### Question 1.4
Is the source reliable?

<table>
<thead>
<tr>
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<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>Yes, partially</td>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- Ensure that the most reliable source has been used. Some sources are not reliable.
- If unreliable, use another source and document the reasons for doing so.
- Obtain faxes from GP surgeries or community pharmacy/chemist of current medicines.

### Question 1.5
Is the source current/recent?

<table>
<thead>
<tr>
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<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tbody>
<tr>
<td>Yes</td>
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<tr>
<td>Yes, partially</td>
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<tr>
<td>No (explain why not)</td>
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</table>

- Record date of source used.

### Question 1.6
Does the child/young person have any communication barriers?

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<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tbody>
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<td>Yes</td>
<td></td>
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<tr>
<td>Yes, partially</td>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- If the child/young person uses a hearing aid, is it turned on or charged? Write notes for the child.
- If the child/young person is visually impaired, talk to them. Ensure they are wearing their reading glasses if used.
- If the child/young person has learning difficulties, confused, agitated or is under 16, use information from their carers, family or friends.
- If the child/young person cannot speak English, consider a translator if necessary, or use family/carer/friend.
**Good practice point**
Training in the basics of interpreting should be given to those who regularly act as interpreters, to promote best practice.

**Question 1.7**
Is support needed to manage medicines appropriately in the home?

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>Yes, partially</td>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- Record how medicines are administered.
- Do carers administer medicines?
- Any compliance aids used?
- Which community pharmacy fills it? Document the details of the pharmacy that supplies the medicines in a compliance aid.
- Does anyone help you with your medicines at home?
  - If so, who?
  - What do they do?
- Do you have problems reading the labels?
- Do you have problems reading the labels?
- Some people forget to take their medicines from time to time. Do you?
- What do you do to help you remember?
Module 2: Documenting of medication history

This module aims to establish what the child/young person is currently taking, and also to tell you about recent changes that may not be on the GP’s records.

**Question 2.1**
Has the child/young person brought in their own medicines?

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<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<td>Yes</td>
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<tr>
<td>No (explain why not)</td>
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</table>

- Record all information of medicines brought in.
- Record drug name, form, route, dose, frequency, course length (where appropriate) and date when last issued (these should be stated on labels from community pharmacy/chemist) on appropriate documentation.
- If the child/young person has not brought any of their medicines, use one of the sources stated in Module 1.3 and record on appropriate documentation.

**Question 2.2**
Have you used further prompts to ensure that all medicines have been recorded with required information?

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<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<td>Yes</td>
<td></td>
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<tr>
<td>Yes, partially</td>
<td></td>
<td></td>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- Use simple vocabulary to ensure the patient will understand.
- If eye/ear/nasal preparations have been used, establish if left, right or both sites.
- Details of insulin preparations must include strengths and presentation, brand, administration device (cartridges or pre-filled pens) and dose.
- Site of any topical preparations.
- State day of any once-weekly medicines such as methotrexate; you should confirm the number of tablets taken weekly and the day. On the medicines chart, cross off the remaining six days the medicine is not taken.
- Indications and durations to be stated for antibiotics.
- State strength and type of device for inhalers.
- If patches are used, state when the last patch was used, how often it should be replaced and most importantly where the patch should be applied.
- Are any nebulues or oxygen therapy used?
- Is the young person taking any oral contraceptives?
- Is the child/young person taking any steroids? Ask about any recent courses (within last six months). If so, what was the dose and duration of the course (was it a short course or reducing dose?). Document on the medicines chart if on long term steroids to ensure the steroids are not abruptly stopped.

- Is the child/young person taking any opioid medications? Confirm the brand, strength, dose, frequency of use and any recent dose changes that have happened.

**Question 2.3**
Have any of the child’s/young person’s medicines been stopped or doses changed prior to admission?

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<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- Has the child/young person discontinued any medicines prescribed by the prescriber?
- Indicate reason why medicine has been stopped or changed.
- Have any medicines been stopped recently in the past six months?
- Any recent dose changes?

**Question 2.4**
Have any of the child’s/young person’s medicines been stopped or doses changed at the point of admission?

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tbody>
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<td>Yes</td>
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<td>Yes, partially</td>
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<td>No (explain why not)</td>
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</table>

- Indicate clinical reason why medicine has been stopped or choice/doses changed
- Has the hospice doctor signed and dated the change to the patient’s treatment?

**Question 2.5**
Does the child/young person take any medicines with specialist requirements/monitoring; anticoagulants or opioids (eg. controlled drugs)?

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- Record drug name, form, dose, frequency, course lengths and date when last used.
- Contact specialist to confirm drug particulars, course lengths and intervals of medications as appropriate, before transcribing.
- Please refer to hospice policy on handling and storage of these medicines.
**Question 2.6**
Does the child/young person take any additional medicines, eg. over-the-counter, homeopathic or herbal, vitamins or supplements?

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<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<tbody>
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<tr>
<td>No (explain why not)</td>
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</tbody>
</table>

- Record drug name, form, dose, frequency, course length (where appropriate) and date when last used
- Is the prescriber aware of these medicines?
- Record if the above medicines have been recently stopped/doses changed and reason.

**Question 2.7**
Any issues of concern with drug therapy that require further intervention?

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<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
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<td>Yes, partially</td>
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<tr>
<td>No (explain why not)</td>
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</tr>
</tbody>
</table>

- State issues and inform hospice doctor/pharmacist/nurse (as appropriate).
Module 3: Verifying information

This module ensures that the original list is verified and that any discrepancies are accounted for and actioned appropriately.

Question 3.1
Have you been able to conduct medicines reconciliation within 24 hours of admission, checking with an alternative source to confirm history obtained?

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence and supporting information</th>
<th>Follow-up action required</th>
</tr>
</thead>
<tbody>
<tr>
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- The history should be checked with other sources within 24 hours of admission.
- Information may be checked with prescribers (e.g. GP surgery, hospital specialist, community prescriber) within 72 hours, for admissions over the weekend.
- Refer to 1.3 for examples of sources of information. Note: Local Risk Assessment should determine the checks for appropriateness. From a regulatory point of view, there would be a need to verify the information.

**Good practice point**
Medicines reconciliation should be conducted as soon as possible within 24 hours of admission.

Question 3.2
Have discrepancies been noted and accounted for?

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- It is important that any intentional changes made by the hospice doctor have been documented in the child/young person's medical notes, signed and dated.
- Any discrepancies established by the nurse must be reported to the hospice doctor and dealt with accordingly. Serious discrepancies must be dealt with by speaking with the doctor and rectified as soon as possible.
- Does a prescriber need to be contacted? Refer to hospice procedures and nurse manager.

**Good practice point**
As recommended by NICE/NPSA1, pharmacists/prescribers should be involved in medicines reconciliation, as soon as possible after admission.
Module 4: Communicating

This module looks to ensure that any changes, omissions and discrepancies related to medicines are communicated through appropriate documentation to where the child/young person’s care is transferred.

Question 4.1
Is there clear documentation in discharge summaries and child/young person’s medical notes of discrepancies, omissions or changes?

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- Discrepancies must be acted upon and resolved.
- State reason why and when medication was stopped/started, detailing route, frequency or formulation change.
- Any actions must be signed, dated and recorded in the child/young person’s medical notes or discharge summaries.
- Does a prescriber need to be contacted? Refer to hospice procedures and nurse manager.

Question 4.2
Are discharge summaries up to date?

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- Signed copies must be placed in child/young person’s medical notes and sent to where the child/young person is being transferred, e.g. GP.
- Copies to be given to the parent, guardian or carer.
Module 5: Defining roles and responsibilities for key healthcare professionals

This module looks at the roles and responsibilities that affect key healthcare professionals in the medicines reconciliation process.

**Question 5.1**
Has the doctor/nurse checked the child/young person?

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- Ensure the child/young person has been admitted and history documented in their medical notes.

**Question 5.2**
Has the doctor/nurse obtained a medication history?

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- Refer to modules 1 and 2.
- Ensure that child/young person’s medication history has been documented.
- Healthcare professional has signed, dated and stated source in child/young person’s medical notes.

**Question 5.3**
Has prescriber documented, signed and dated any intentional changes to child’s/young person’s medication record?

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- All changes to be signed and dated (and reasons given) in the child/young person’s medical notes.
**Question 5.4**
Has doctor/nurse verified first history taking with alternative source, within 24 hours of admission, as stated in Module 3?

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- Doctor/nurse to document second source within 24 hours, unless admitted over a weekend, hence 72 hours.
- Refer to Module 2 to obtain comprehensive medication history.
- Has the nurse identified any support/compliance aid required/side-effects for adherence to medicines.

**Question 5.5**
Has nurse notified doctor of any discrepancies as appropriate?

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- Serious discrepancies must be dealt with as soon as possible.

**Question 5.6**
Has hospice doctor/prescriber dealt with discrepancies?

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- Ensure that identified discrepancies are resolved before child’s/young person’s care is transferred, as appropriate.
### Question 5.7
Has a prescriber/nurse/pharmacist been involved in the medicines reconciliation process?

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- Pharmacist/prescriber should be involved as soon as possible after admission.

### Question 5.8
Has the doctor/nurse completed the discharge summary for the child/young person?

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- Refer to Module 4.

### Question 5.9
Has the doctor/nurse transferred the discharge summary?

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- Refer to Module 4.
Module 6: Monitoring and audit

An audit is a process for checking that procedures are in place to assure quality, integrity or standards of provision and outcomes. Audits should be conducted annually. The objective of the audit in this case is to measure current practice in medicines reconciliation on admission of a child/young person to a children’s hospice. Monitoring requires you to standardise data collection and repeat the process to help support continuous improvement.

**Good practice point**

It is important to monitor the implementation of policy, ensuring that annual audits are undertaken and patient safety incident reports are reviewed. An audit tool is available from the NICE website.

**Question 6.1**

Has an audit been conducted to assess medicines reconciliation, as outlined by NICE?

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- An audit should identify any areas of weakness to meet the required standards.
- This enables the organisation to put its principles and policies into practice.
## Action plan worksheet for modules

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### References


Institute for Healthcare Improvement; [www.ihi.org](http://www.ihi.org) (accessed 31.10.10).


Appendix 4

Modules for transcribing medication

Module 1: Transcribing and collecting information

This module ensures that all particulars relating to transcribing are met.

**Question 1.1**
Are you transcribing from an approved source? (ensure dated and signed, with name and profession of person recording.)

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Record source of information used. Approved sources include:

- medication record or prescription already written and signed by an independent prescriber
- medication reminder card or record card from a community pharmacy
- GP/hospital letter
- patient’s own drugs in original labelled containers can be used, providing that the instructions on the label are up to date. However, medicines which have been decanted by family members cannot be used as an approved source of information

**Question 1.2**
Are you transcribing from an approved source? (ensure dated and signed, with name and profession of person recording)

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- Use black indelible ink.
- Write clearly and legibly.
Question 1.3
Have you documented the patient’s details on the front of the medication record?

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Write in BLOCK CAPITALS:

- name of hospice
- date of admission
- patient’s name and address
- patient’s weight and date of birth
- consultant, unit name and hospice record number
- any known allergies and details/dates

Question 1.4
Is this a re-written chart?

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- Ensure once complete that a diagonal line is placed on the old record, state re-written and sign and date
Module 2: Guidance notes on transcribing medicines

This module aims to ensure that all medication information is ascertained to ensure accurate transcribing.

Question 2.1
Have you ensured that all the details for the medicines have been recorded?

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The following must be stated:

- Approved name for the drug (exceptions include lithium, theophyline and some anti-epileptics where brand names are required).
- Form of the drug (e.g. tablet, capsule, liquid, type of inhaler or insulin device).
- Preparation (e.g. slow release).
- Strength – write drug strengths in full where doses are below 1mg (e.g. micrograms) or doses are expressed in other ways (e.g. units). Exceptions are:
  - g: gram
  - mg: milligram
  - ml: millilitres
- Dose for liquid preparations should include the dose in mg and ml. Avoid using decimal points, where possible.
- Frequency and time for administering each dose especially if a liquid has been diluted.
- Route. All should be written in full, except for the following accepted abbreviations:
  - IV: Intravenous
  - PEG: Percutaneous Endoscopic Gastrostomy tube
  - IM: Intramuscular
  - INH: Inhale
  - SC: Subcutaneously
  - Top: Topical
  - PO: by mouth
  - LE: Left eye
  - PR: Per rectum
  - RE: Right eye
  - NG: Nasogastric
- Start date of medication.
- Any additional information, eg one hour before food.
- Refer to the latest edition of the BNF for transcribing.
Question 2.2
Is the patient on a Schedule 2 or 3 controlled drug?

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- BNF should be used to see which schedule drug falls under (covers some opioids, barbiturates, amphetamines and benzodiazepines such as temazepam/midazolam). The BNF has a box symbol indicating which schedule the drug belongs to (i.e. CD 2 means it is a schedule 2 CD).

Question 2.3
Have any of the patient’s medicines been stopped or doses changed prior to admission?

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- Has the patient discontinued any medicines prescribed by the GP?
- Indicate reason in patient’s medical notes why medicine has been stopped or changed. Inform doctor as soon as possible.
- Do not transcribe medication onto hospice record.
- Do not amend or initiate any medication, unless authorised prescriber.

Question 2.4
Any issues of concern with drug therapy that require further intervention?

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- Issues stated and hospice doctor/pharmacist/senior nurse informed as soon as possible (as appropriate).
Question 2.5
Has the patient more than one medication record?

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- This should be clearly stated on the front of the medication record chart (e.g. ‘This is one of two’).
- It would also be good practice to keep enteral and parenteral medicines on separate drug charts to minimise risk of drug administration via the wrong route.

Good practice point
Sign and date each transcription on completion.
Module 3: Verifying transcribing

This module aims to ensure that the transcription is double-checked to maintain patient safety.

**Question 3.1**
Has the transcription been checked?

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- All transcribing is checked by another registered nurse, pharmacist or doctor, before medicines are administered.
- All transcriptions and checks have been signed and dated in the relevant section.
- Some medicines may be administered via a patient group direction, if in existence.
- Transcribing should be signed off by a registered prescriber within an agreed time period (i.e. 24 hours).
Module 4: Authorisation and responsibilities for transcribing by healthcare professionals

This module looks to ensure that healthcare professionals involved in the medicines transcribing process are competent and authorised. They should also be aware of their responsibilities.

**Question 4.1**
Have you been authorised to perform medication transcribing?

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- I am a registered healthcare professional.
- I have received training.
- My line manager has deemed me competent.
- I have completed and signed the authorisation form. A signed copy has been placed in my personal file. My authorisation to transcribe is reviewed annually.

**Question 4.2**
Are you held responsible for any transcribing errors/omissions, and is adequate support provided?

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- The authorised healthcare professional transcribing is held accountable for any transcription errors/omissions.
- The person transcribing a medication record is responsible for each transcription.
- Support is provided to staff as appropriate.
- Transcribing errors must be reported as medication incidents.
- Your medication incident log should have a specific category for transcribing errors so that practice can be monitored and reviewed.
Module 5: Monitoring and audit

An audit is a process for checking that procedures are in place to assure quality and integrity in the provision of services. In the case of transcribing practice in children’s hospice services, such audits should be conducted annually.

The objective of the audit is to measure current practice in the transcribing of medicines by authorised healthcare professionals, to detect any errors and highlight good practice.

Errors can occur at different stages, including transcribing on to a hospice record.

**Good practice point**

To monitor implementation of policy, you should ensure that annual audits are undertaken. You should also ensure that patient complaints and adverse incident reporting data are reviewed.

**Question 5.1**

Has an audit been conducted to assess medication transcribing?

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- Any adverse incident reporting data have been collected.
- An audit has identified any areas of weakness in pursuit of the required standards.
- Current practice in medical transcribing enables the organisation to put its principles and policies into practice.
## Transcribing action plan

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## References

Children's Hospices UK; *Medicines Reconciliation Module*, 2008.


Appendix 5
Medicines management – example of a competency framework

This has been developed by Children’s Hospice Association Scotland and adapted from a framework developed by Naomi House and Jack’s Place Children’s Hospices

Verification of your competence is achieved by assessment against the statements below, which describe the skills, knowledge and attitudes that contribute to this competence area. You must be able to respond positively to all the statements before considering yourself to be competent. If you are not able to verify competence you need to discuss this with your line manager. Resources and training are available to support individual competencies.

<table>
<thead>
<tr>
<th>Assess your competence against the following statements</th>
<th>Signature and date</th>
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</thead>
<tbody>
<tr>
<td>1. I have completed a programme of learning delivered by a recognised competent practitioner in medicines management.</td>
<td>Nurse:</td>
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<td>2. I understand my accountability within the ‘The Code: Standards of conduct, performance and ethics for nurses and midwives’ (NMC 2008) and/or my responsibility within the law.</td>
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<td>3. I can locate the CHAS policies, operating procedures, information or guidelines that relate to medicines management and state the key components of these.</td>
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<td>4. I can give examples of all the information required on a completed medicine chart.</td>
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<td>5. I understand that I must be certain of the identity of the child/young person to whom the medicine is to be administered and I can explain/demonstrate how I would ensure this.</td>
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<td>6. I can explain the importance of having an accurate recent weight and how to record this using CHAScare.</td>
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<td>7. I know the importance of knowing the method of administration, route, timing and the expiry date of the drug stating the ‘5 rights’.</td>
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<tr>
<td>Assess your competence against the following statements</td>
<td>Signature and date</td>
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<td></td>
<td>Nurse: Verifier:</td>
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<td>8. I can discuss the importance of understanding the</td>
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<td>therapeutic uses of the medication to be administered,</td>
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<td>normal dosage, side effects, precautions and contra-</td>
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<td>indications. e.g. paracetamol.</td>
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<td>9. I can describe the meaning of the term ‘half-life of</td>
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<td>a medication’.</td>
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<td>10. I am aware of and can discuss the importance of</td>
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<td>checking that the prescription and the label on the</td>
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<td>medication are clearly written, unambiguous and</td>
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<td>signed by a doctor.</td>
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<td>11. I have fulfilled the criteria for single checking</td>
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<td>and have been assessed in practice by a recognised</td>
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<td>competent practitioner.</td>
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<td>12. I can explain/demonstrate when to administer or</td>
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<td>withhold medication in the context of the child/young</td>
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<td>person’s condition.</td>
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<td>13. I can explain/demonstrate the importance of hand</td>
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<td>hygiene and infection control in relation to</td>
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<td>medicines management.</td>
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<td>14. I know and can explain rationale of how many times a</td>
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<td>purple enteral syringe can be used.</td>
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<td>15. I can explain and give examples of when, in</td>
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<td>exceptional circumstances, medication may be</td>
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<td>administered without a written prescription.</td>
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<td>16. I can explain/demonstrate the procedure to follow if</td>
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<td>a child/young person refuses to take their</td>
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<td>medication.</td>
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<td>17. I can explain/demonstrate the procedure to follow</td>
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<td>should a drug error occur.</td>
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<td>18. I can explain/demonstrate the procedure to follow</td>
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<td>should a child/young person have an adverse drug</td>
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<td>reaction.</td>
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<td>19. I can discuss use of the British National Formulary</td>
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<td>yellow card system and how to report an adverse</td>
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<td>drug reaction using it.</td>
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<td>20. When medication has been prescribed within a range</td>
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<td>of doses I can explain the need to titrate doses</td>
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<td>according to patient response and symptom</td>
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<td>management.</td>
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<td>21. I can discuss my role as a registered nurse in that</td>
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<td>I am responsible and accountable for the delegation</td>
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<td>of any aspect of the administration of medicinal</td>
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<td>products.</td>
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</table>
Assess your competence against the following statements

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>22.</td>
<td>I can demonstrate a knowledge of the NMC standards stating that student nurses, and non-single checking nurses must never administer or supply medication without the direct supervision of a registered nurse.</td>
</tr>
<tr>
<td>23.</td>
<td>When supervising a student nurse or non-single checking nurse in the administration of medicines I can discuss my understanding of why I must clearly countersign the signature of the student.</td>
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<tr>
<td>24.</td>
<td>I can discuss the rationale for using preparations that are unlicensed.</td>
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<td>25.</td>
<td>I can explain what medication off label means and can give an example.</td>
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<tr>
<td>26.</td>
<td>I can explain the role of the Accountable Officer and know who the Accountable Officer for CHAS is.</td>
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<td>27.</td>
<td>I can explain the procedure for requesting and collecting medication and controlled drugs from pharmacy.</td>
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<td>28.</td>
<td>I can discuss/demonstrate how controlled drugs are stored in accordance with the Misuse of Drugs Act (Safe Custody) Regulations (1973) and the Health Act (2006).</td>
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<tr>
<td>29.</td>
<td>I can discuss/demonstrate the procedure for administration of controlled drugs.</td>
</tr>
<tr>
<td>30.</td>
<td>I can explain/demonstrate the procedure to follow if there is a discrepancy regarding a controlled drug.</td>
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<tr>
<td>31.</td>
<td>I can explain/demonstrate how to safely dispose of medicinal products including controlled drugs.</td>
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<tr>
<td>32.</td>
<td>I can describe how I would review and update the care plan and where I would record my observations and care on CHASCare.</td>
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<tr>
<td>33.</td>
<td>I can explain how to report an error or clinical incident in relation medicines management.</td>
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<tr>
<td>34.</td>
<td>I acknowledge the importance of maintaining an open culture in order to encourage the immediate reporting of errors or incidents relating to medicines management.</td>
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</tbody>
</table>

Signature and date

Nurse: Verifier:
Statement of Competence – Medicines Management

I certify that I am aware of my professional responsibility for continuing professional development and that I am accountable for my actions. I am competent and confident in the practice for medicines management, and can accurately and timeously document the care delivered or actions taken relating to this competency area.

I confirm that my current level of competence is (please tick as appropriate):

- [ ] Level 1, Competent;
- [ ] Level 2, Highly Developed;
- [ ] Level 3, Expert

Signature: ______________________________________

Date: ______________________________________

Verified by: ______________________________________

Signature: ______________________________________

Designation: ______________________________________

Date: ______________________________________

Competence must be verified by a recognised competent practitioner.

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Key resources


Appendix 6
Medication competency

Introduction

This pack is designed for all clinical staff working at Rainbows Children's Hospice. It is intended to direct all staff about the safe care of children and young people receiving medication and support from the service and highlight individual responsibilities to maintain safety and reduce clinical risk. It is intended that additional ‘knowledge and understanding’ relating to policies, guidelines and the philosophy of caring for children and young people and their families within Rainbows Children’s Hospice will be completed on an annual basis alongside these specific task based competencies. Competency for this task can only be signed off once the ‘knowledge and understanding’ element has been completed.

The Role of health care workers

Within Rainbows health care workers are expected to provide care to children and young people requiring medication receiving a service. Although Health Care Workers are not ‘responsible’ for administering medication they may be involved in the process through their usual care routines, at meal times/enteral feeding for example. It is the responsibility of all staff to ensure they are trained, assessed and competent to care for all children and young people you accept responsibility of care for.

The role of the qualified nurse

Within Rainbows qualified nurses are expected to provide care to children and young people requiring medication receiving a service. It is the responsibility of all staff to ensure they are trained, assessed and competent to administer medication for all children and young people you accept responsibility of care for.

The role of the deputy matron/senior nurses/educator

As Deputy Matron it is your responsibility to check that all qualified nurses both in the team and on the Bank are assessed on an annual basis, this assessment should provide evidence of competency in all areas detailed in the performance criteria for ‘medication administration’. Competency must be reviewed as part of the PDP process. The Deputy Matron with the training/educator must ensure that competency assessments and training materials are maintained and relevant to current practice. When they no longer meet the needs of practitioners and the service this must be reported to the Matron and Clinical Governance and arrangements made to ensure they are amended.
**Training**

All care staff must undertake this training pack designed for medication administration. They must be assessed using the assessment documentation that will produce a written record on an annual basis.

**Theoretical Knowledge**

Will be assessed on an annual basis using the self-directed learning and theory sessions.

**Assessment**

Documentation must be completed for all training and assessment, and presented at PDP as evidence of competency.

**Medication Competency**

<table>
<thead>
<tr>
<th>Performance Criteria (You must be able to)</th>
<th>Range statements</th>
<th>Evidence used</th>
<th>Competence demonstrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate that you are aware how to establish what the effects and side effects of medication to be administered, including indications and contraindications.</td>
<td>1. Checking the BNF. Q *</td>
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<td></td>
<td>2. Checking patient information. Q *</td>
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<td></td>
<td>3. Liaison with senior colleague when uncertain. Q *</td>
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<tr>
<td>Demonstrate that you are aware of the effects and side effects of any medication that is to be administered, including indications and contraindications.</td>
<td>1. Demonstrates an awareness of effects, side effects, indications and contra-indications for a range of commonly used medications administered. Q</td>
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<tr>
<td>Performance Criteria</td>
<td>Range statements</td>
<td>Evidence used</td>
<td>Competence demonstrated</td>
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<tr>
<td><strong>Prepare the child/young person prior to administration of medication, this will include gaining consent.</strong></td>
<td>1. Communicating to the child/young person. <strong>DO</strong> *</td>
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<td></td>
<td>2. To include gaining consent. <strong>DO</strong> *</td>
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<td>3. Correct positioning if necessary. <strong>DO</strong> *</td>
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<td>4. Involvement of play specialist in difficult circumstances. <strong>DO/Q</strong> *</td>
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<td><strong>Demonstrate an awareness of infection control measures by adopting correct hand-washing and preparation of the environment and equipment.</strong></td>
<td>1. Hand washing. <strong>DO</strong> *</td>
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<td></td>
<td>2. Preparation of the environment to reduce risk of infection. <strong>DO</strong></td>
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<td></td>
<td>3. Preparation of equipment to reduce the risk of infection. <strong>DO</strong> *</td>
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<td></td>
<td>4. Appropriate use of sterile/non-sterile gloves. <strong>DO/Q</strong> *</td>
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<td></td>
<td>5. Correct clothing and appearance. <strong>DO</strong> *</td>
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<td></td>
<td>6. Disposal of waste. <strong>DO</strong> *</td>
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<tr>
<td><strong>Safely transcribe medications onto the Rainbows prescription chart.</strong></td>
<td>1. Form completed in full. <strong>DO/Q</strong></td>
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<td></td>
<td>2. Childs name identifiable. <strong>DO/Q</strong></td>
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<td></td>
<td>3. Clearly written and easy to understand.</td>
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<td></td>
<td>4. Contains child’s weight. <strong>DO/Q</strong></td>
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<td></td>
<td>5. Exactly as label details. <strong>DO/Q</strong></td>
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<td>6. Document form that medication is in i.e. tablet/suspension for example. <strong>DO/Q</strong></td>
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<td></td>
<td>7. Checking when unsure with: parents, BNF, Pharmacist, GP <strong>DO/Q</strong></td>
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<tr>
<td>Performance Criteria (You must be able to)</td>
<td>Range statements</td>
<td>Evidence used</td>
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<tr>
<td>Locate and check for accuracy the safety the prescription sheet.</td>
<td>1. Form completed in full. DO/Q</td>
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<td></td>
<td>2. Childs name identifiable. DO/Q</td>
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<td></td>
<td>3. Clearly written and easy to understand. DO/Q</td>
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<td>4. Contains child’s weight. DO/Q</td>
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<td>5. Signed by the prescribing Doctor. DO/Q</td>
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<td></td>
<td>6. Contains allergies. DO/Q</td>
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<td>7. Indications completed where appropriate. DO/Q</td>
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<td>8. Check that dose and frequency are correct. DO/Q</td>
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<tr>
<td>Perform drug calculations to ensure correct doses are measured from bottles/ampoules (if liquid preparation) or number/portions of tablets.</td>
<td>1. Perform complex calculations for preparations administered via all routes, to ensure correct volume of liquid medication is administered/portion of tablets are administered. DO/Q</td>
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### Performance Criteria
(You must be able to)

Demonstrate an awareness of different **routes for administration** and adopt the appropriate techniques for each alternative route.

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<thead>
<tr>
<th>Range statements</th>
<th>Evidence used</th>
<th>Competence demonstrated</th>
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<tbody>
<tr>
<td>1. Oral. € Q &amp; DO *</td>
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<td>2. Rectal. Q &amp; DO *</td>
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<td>3. Naso-gastric Tube. Q &amp; DO *</td>
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<td>4. Gastrostomy Tube. Q &amp; DO *</td>
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<td>5. Topical. Q &amp; DO *</td>
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<td>6. Instillation. Q &amp; DO *</td>
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<td>7. Inhalation. Q &amp; DO *</td>
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<td>8. Buccal. Q &amp; DO *</td>
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<td>9. Intranasal. Q &amp; DO *</td>
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<td>10. Sublingual. Q &amp; DO *</td>
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<td>11. Sub-cutaneous. € Q &amp; DO *</td>
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<td>12. Intra-muscular. € Q &amp; DO *</td>
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<td>13. Intravenous. € Q &amp; DO *</td>
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</table>

€ - indicates those that are compulsory for observation and assessment of qualified nurses, others are discretionary and simply require knowledge.
<table>
<thead>
<tr>
<th>Performance Criteria (You must be able to)</th>
<th>Range statements</th>
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<th>Competence demonstrated</th>
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</thead>
<tbody>
<tr>
<td>Demonstrate that you have considered drug, dosage, method of administration, route and timing in <strong>relation to health status.</strong></td>
<td>1. Consider when not to administer medication. Q</td>
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<td></td>
<td>2. When to contact the visiting Doctor requesting a change in treatment. Q</td>
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<td></td>
<td>3. Demonstrating knowledge of care/treatment plan. Q</td>
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<td></td>
<td>4. When there has been a reaction to the medication. Q</td>
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<td>Accurately record medication that has been administered.</td>
<td>1. On medication sheet. DO</td>
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<td>2. None routine occurrences documented on the evaluation. DO *</td>
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<td></td>
<td>3. What to do in the event that medication is refused. Q</td>
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<td>Demonstrate an awareness of the appropriate <strong>safety and storage of medication</strong> within the working environment.</td>
<td>1. In the hospice environment. Q *</td>
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<td>2. Temperature. Q</td>
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<td>3. Light. Q</td>
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<td>4. In relation to siblings, visitors and the child/young person receiving support. Q *</td>
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<tr>
<td>Performance Criteria (You must be able to)</td>
<td>Range statements</td>
<td>Evidence used</td>
<td>Competence demonstrated</td>
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<tr>
<td>Demonstrate an awareness of what constitutes a <strong>drug error</strong> and the actions to be taken should an error occur or be identified.</td>
<td>1. Any alternation to prescription involving patient, route, time, dose and drug that is administered. <strong>Q</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
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<td>2. Liaison with the Pharmacist/prescribing Doctor when uncertain prior to administration where possible. <strong>Q</strong></td>
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<td>3. Inform prescribing professional. <strong>Q</strong></td>
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<td>4. Seek additional medical advice. <strong>Q</strong></td>
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<td>5. Inform manager. <strong>Q</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
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<td></td>
<td>6. Complete Incident Form. <strong>Q</strong></td>
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<td>7. Not administering any further Medication until assessment completed. <strong>Q</strong></td>
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<tr>
<td>Safely prepare medication for administration.</td>
<td>1. Check the prescription sheet against the medication and check. <strong>DO</strong></td>
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<td></td>
<td>2. Name. <strong>DO</strong></td>
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<td></td>
<td>3. Drug name. <strong>DO</strong></td>
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<td>4. Dose. <strong>DO</strong></td>
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<td>5. Time. <strong>DO</strong></td>
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<td></td>
<td>6. Route. <strong>DO</strong></td>
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<td>7. Expiry date. <strong>DO</strong></td>
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<tr>
<td>Safely administer medication to children and young people adopting all aspects of the performance criteria and range.</td>
<td>1. Check the prescription sheet against the medication and check. <strong>DO</strong></td>
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</tbody>
</table>

Evidence: **DO** = Direct Observation  **Q** = Question  **= Those that apply to HCW

Competency demonstrated: ________________________________

Signed: ________________________________
Workbook

Oral/written questions for use during direct observation assessments

Effects and side effects, including indications and contraindications
1. Where would you look to establish what the side effects/effects of medication are if you were unsure?

2. Where else do you think you could try if these two options were not available to you?

3. Familiarise yourself with the medication list of commonly used medications at Rainbows.
   a) what is Levetiracetam used for?
   b) what are the common side effects?
   c) what is Hyoscine used for?
   d) what are the common side effects?
   e) what two uses would midazolam be used for at Rainbows?
   f) what route typically would it be given (both answers)?
   g) what are the cautions (in the BNF) for administering morphine?
   h) why would these not be considered important at Rainbows?

Preparation of the child/young person
1. Who could you involve in preparing the child/young person for this procedure?

Infection Control
1. Can you explain when you would need to wear sterile gloves?

Check for accuracy and safety of medical authorisation/prescription sheet
1. What are you looking for when you check the medication sheet in relation to accuracy and safety?

2. What would you need to do if medication supplied were incorrect?

Transcribe prescribed medication
1. What do you need to do/check when you transcribe medication information onto the prescription sheet?
   a)
   b)
   c)
   d)
   e)
   f)

2. If you were unsure about medication that has been prescribed what resources could you use to check?
   a)
   b)
   c)
   d)

Drug Calculations
1. You have lamotrigine 5mg tablets   }  
   25mg tablets } dispersible
   100mg tablets }  

You need 170mg to be given via gastrostomy tube. Briefly describe how you would obtain 170mg for administration.

2. You have paracetamol 240mg in 5mls. You need 175mg to be administered. How may mg in each ml? How many mls do you need to administer?

3. You have lamotrigine 100mg dispersible tablets. You need 80mg to be administered. How would you obtain 80mg from a 100mg tablet?
**Routes for administration**

Complete the following table:

<table>
<thead>
<tr>
<th>Route</th>
<th>Description of route</th>
<th>Points to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oral</td>
<td>By mouth</td>
<td>Child must be able to swallow – must be oral preparation</td>
</tr>
<tr>
<td>2. Rectal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Naso Gastric.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gastrostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Topical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Instillation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Inhalation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Buccal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Intranasal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Sublingual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Subcutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Intravenous</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health status
1. When might you decide not to administer medication?

2. When would you consider contacting a Doctor about specific treatments?

Record medication that has been administered
1. What would you do if medication was refused?

Safety and storage of medication
1. Tell me how medication should be stored safely in the hospice.

Drug Error
1. Explain what constitutes a drug error.

2. What steps do you need to take upon discovering a drug error, either as result of your own or another’s actions?

3. Who else could you contact for guidance?
Appendix 7
Glossary

Care pathway/journey
Together for Short Lives’ description of a ‘care pathway’ approach to working with children who have life-limiting or life-threatening conditions is a way of engaging with a child and their family’s needs, which can be used to ensure that everything is in place so that families have access to the appropriate support at the appropriate time.

Children’s palliative care
Palliative care for children and young people with life-limiting conditions is an active and total approach to care, from the point of diagnosis or recognition, embracing physical, emotional, social and spiritual elements through to death and beyond. It focuses on enhancement of quality of life for the child/young person and support for the family and includes the management of distressing symptoms, provision of short breaks and care through death and bereavement (ACT, 2009).

Care of the dying
Care of the dying is the care of the patient and family in the last days and hours of life. It incorporates four main types of care: physical, psychological, social and spiritual, and supports the family at that time and into bereavement.

Children’s hospice services
Children’s hospice services provide palliative care for children and young people with life-limiting conditions and their families. Delivered by a multi-disciplinary team and in partnership with other agencies, children’s hospice services aim to meet the needs of both child and family – physical, emotional, social and spiritual - through a range of services. These include:

• 24 hour end of life care
• support for the entire family (including siblings, grandparents and the extended family)
• bereavement support
• 24 hour access to emergency care
• specialist short break care
• 24 hour telephone support
• practical help, advice and information
• provision of specialist therapies, including physiotherapy as well as play and music therapy
• provision of information, support, education and training where needed to carers
• children’s hospice services deliver this care in the home (commonly termed ‘hospice at home service’) and/or in a purpose built building

Complex care/continuing care
Complex care, sometimes known as continuing care, is an individualised package of care beyond what is available through standard health services. It is provided to children with highly complex health care needs or intense nursing care needs.

Community services
Community services refer to a service that an individual or organisation performs within the local community. This might include community children’s nurses (CCNs) who deliver nursing care and support within the local community including visiting a patient’s home. Community services may also include some of the services delivered by the local council.
End of life
The end of life phase begins when a judgement is made that death is imminent. It may be the judgement of the health or social care team, but it is often the child/young person or their family who first recognises its beginning.

End of life care
End of life care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It focuses on preparing for an anticipated death and managing the end stage of a terminal medical condition, this includes care during and around the time of death, and immediately afterwards. It enables the supportive and palliative care needs of both child/young person and their family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support and support for the family into bereavement. This is not confined to specialist services but includes those services provided by any health or social care professional in any setting.

Family
The term ‘family’ includes parents, other family members involved in the child's care, or other carers who are acting in the role of parents. Family includes informal carers and all those who matter to the child/young person.

Hospice at home
Hospice at home is a term commonly used to describe a service which brings skilled, practical children's palliative care into the home environment. Hospice at home works in partnership with parents, families and other carers.

Life-limiting/life-shortening conditions
Life-limiting conditions, sometimes known as life-shortening conditions, are those for which there is no reasonable hope of cure and from which children or young people will die. Some of these conditions cause progressive deterioration rendering the child increasingly dependent on parents and carers.

Life-threatening conditions
Life-threatening conditions are those for which curative treatment may be possible but can fail, such as children with cancer. Children in long-term remission or following successful curative treatment are not included.

Medicines management
The entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of [patient] care” (Smith 2003)

St John’s Wort has been used for centuries as a natural alternative to conventional medicine to help improve mood, and is frequently prescribed for mild depression by doctors throughout Europe.