Chapter M9: Administration of Medicines Policy

Document Data			
Document Type:	Policy		
Document Reference:	3485		
Document Status:	Approved		
Document Owner:	Director of Pharmacy		
Executive Lead:	Medical Director		
Approval Authority:	Clinical Quality Group		
Review Cycle:	36		
Date Version Effective From:	February 2022	**Date Version Effective To:**	February 2025

What is in this policy?
This policy outlines the responsibilities for the safe administration of medicines. It defines who can administer medicines and is the parent policy that should be read in conjunction with the administration of medicines standard operating procedure.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
February 2005	1.0	Director of Pharmacy	Review	Revised guidance
June 2007	2.0	Director of Pharmacy	Review	Revised guidance
September 2010	3.0	Director of Pharmacy	Review	Revised guidance
September 2012	4.0	Director of Pharmacy	Review	Updated to current trust policy format and to further develop local application of national guidance. Incorporation of existing policy M09a1 -Administration of medicines by student and qualified non-registered anaesthetic practitioners Incorporation of paediatrics administration
August 2014	5.0	Director of pharmacy	Minor	Updated following NHS Protect, medicines security self-assessment checklist http://www.nhsbsa.nhs.uk/4430.aspx included information regarding expiry of liquid medications once opened. Information on syringes being removed from an electronic pump.
March 2015	6	Director of Pharmacy	Minor	Include comprehensive detail in verbal orders section of the policy. Define practitioner/ authorised practitioner roles to include perfusionists and physician's assistants.
May 2015	7	Director of Pharmacy	Minor	Include detail of non-registered practitioners/ technicians administration of medicines
January 2016	8	Director of Pharmacy	Minor	Include oral/ enteral syringe detail. Include ATMP. Review, update and adopt EPMA administration procedures

October 2016	9	Director of Pharmacy	Minor	Verbal order update Transport of medicines to community
May 2017	10	Director of Pharmacy	Minor	Additional staff groups to section 3.3
January 2018	11	Director of Pharmacy	Minor	Add link to management of medicines in theatres policy.
November 2018	12	Director of Pharmacy	Minor	Scheduled review of policy. Addition of section 5.9 detailing open systems. Amendment to wording in 3.3g.
September 2020	13	Director of Pharmacy	Minor	Addition of Paramedics working as part of the adult, paediatric and neonatal ITU retrieval services in section 5.3.
July 2021	14	Director of Pharmacy	Minor	Review of whole policy and merge with Weston policy detail. Addition of Nursing Associates in section 4.3.

Sign off Process and Dates	
Groups consulted	**Date agreed**
Medicines Governance Group	20/07/2021
Clinical Quality Group	03/02/2022
Policy Assurance Group	21/02/2019

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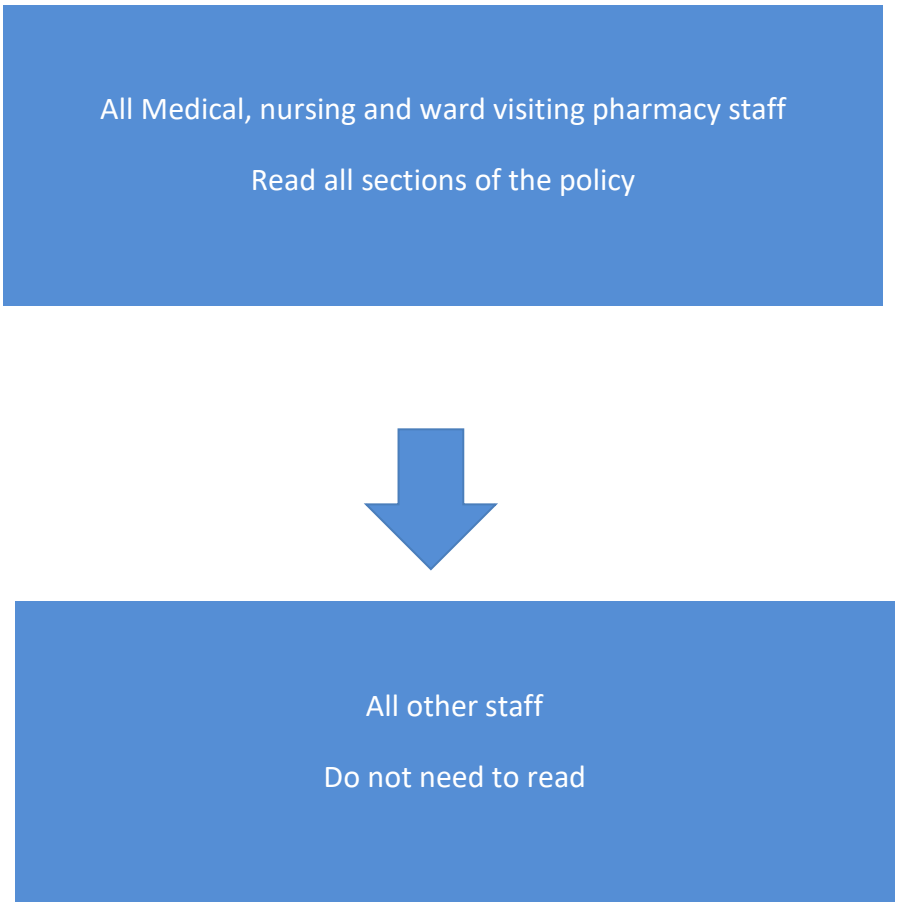
Do I need to read this Policy?



1. Introduction

1.1 This chapter outlines the policy to be followed by all staff when administering medicines, and is to be used in conjunction with the current 'Code of Ethics' or published professional guidelines for each clinical profession.

1.2 The procedures that should be followed when administering a medicine are found in the Administration of medicines standard operating procedure

2. Purpose

2.1 To ensure that prescribed medicines are administered to patients in the correct manner, that is:

The correct medicine is given in the correct dose via the correct route to the patient for whom it is intended at the time at which it is prescribed.

3. Scope

This policy relates to all medical, nursing and ward visiting pharmacy staff.

4. Definitions

4.1 *Medicine*

A medicine is a medicinal product as defined by article 1 of the directive 2001/83/EC as detailed here:

(a) Any substance or combination of substances presented as having properties for treating or preventing diseases in human beings.

(b) Any substance or combination of substances which may be used in or administered to human beings either with a view to restoring correcting or modifying physiological function by exerting a pharmacological immunological or metabolic action, or to making a medical diagnosis.

(c) An inert substance added to some other substance or solution so that the volume of the latter substance is increased and its concentration per unit volume is decreased

4.2 *Medical Staff*

The term medical staff includes dentists, and where nurses are specifically mentioned this includes midwives.

4.3 *Practitioner or Authorised Practitioner*

(a) Registered medical staff (including dentists) and foundation doctors

(b) A registered nurse or midwife

(c) A pre-registration student nurse or pre-registration student midwife (who is not a registered nurse)

Who as part of their training has successfully undertaken the university maths test, but only as a second checker with a registered nurse (who accepts full responsibility for the correct administration and recording of the medicine prescribed).

(d) Nursing associates acting in accordance with a prescription or patient specific direction and who have achieved competencies for medicines administration.

(e) Physician's associates acting in accordance with a prescription or patient specific direction.

(f) Medical students

Under the direct supervision of a registered medical practitioner, as second checker with the registered medical practitioner (who accepts full responsibility for the correct administration and recording of the medicine prescribed).

(g) Healthcare professionals who are legally permitted to administer medicines under a Patient Group Direction.

(h) Other healthcare professionals who are acting in accordance with agreed protocols, including:

(i.) Operating Department Practitioner who is registered with the Health Care Professions Council (HCPC).

(ii.) Clinical Perfusion Scientists (Perfusionists) registered with the College of Clinical Perfusion Scientists of Great Britain and Ireland.

(iii.) Physicians' Assistant (Anaesthesia) (PA(A))

PA(A)s working practices are governed by a document produced by the Royal College of Anaesthetists as regards to supervision and limitations of scope of practice (2011) http://www.rcoa.ac.uk/node/1927

(iv.) Student anaesthetic practitioners are required to administer anaesthetic medications as part of their curriculum programme, and will undertake theoretical and practical training throughout the first year of the programme whilst working under the direct supervision of an anaesthetist. On successful progression to year two students may work within the full scope of local policy practice under the individual supervision of an anaesthetist. Qualified and student anaesthetic practitioners are able to administer medication against a patient specific written or computer generated anaesthetic prescription record or anaesthetic drug plan.

(i) Second Level Nurses

Who have undertaken some form of additional instruction regarding medicines administration following their original registration and training. This additional instruction may have been in UHBristol or in another NHS organisation as per the scope of professional practice policy. Newly employed second level nurses should be asked to provide evidence of this additional instruction. Divisions should specifically ask for verification of this when they seek references for second level nurse applicants.

(j) Nurse Assistants and Assistant Practitioners

Nursing assistants and Assistant Practitioners may assist/support patients taking oral, nebulised or approved topical medications. It is the responsibility of the Registered Nurse to ensure that medications are taken.

(k) Assistant Practitioners

Who have completed the Trust competency on intravenous fluid management may act as the second checker for intravenous fluids with no additives via a peripheral cannula.

(l) Assistant Practitioners

Who have completed the Trust competency on naso-gastric feeding management may act as the second checker for enteral feeds.

(m) Non-registered Eye Hospital Technicians

This staff group may administer specific eye drops strictly in conjunction with the patient specific direction.

(n) Cardiac Physiologists

(o) Advanced practitioner MSK Sonographers

(p) Paramedics working as part of the adult, paediatric or neonatal ITU retrieval services

4.4 *Individuals not employed by UHBW*

(a) On children's wards parents or carers may be involved in medicines administration, particularly if they have been assessed under the self-administration scheme.

(b) Patients or their carers may be involved as part of a trust-approved self-administration of medicines scheme, providing that they have been assessed as suitable to administer medicines.

5. Duties, Roles and Responsibilities

5.1 *The Director of Pharmacy, in consultation with the Chief Nurse and the Medical Director*

(a) Responsible for establishing a safe and secure system for the handling of medicinal products within UHBristol.

5.2 *The Sister/Charge Nurse*

(a) Responsible for the system operating on a ward or clinical area.

5.3 *Nurse in charge / ODP*

(a) Responsible for ensuring that the system operating on the ward/ department is followed. Some of the duties maybe delegated, but the responsibility always remains with the appointed nurse in charge. A registered ODP is given the same responsibilities as a registered nurse regarding the management of medicines in theatre. This includes the ordering of Controlled Drugs and 'holding the keys'.

5.4 *The authorised practitioner*

(a) Responsible for their actions in administering medicines and ensuring that all medicines administration undertaken is within their competency.

6. Policy Statement and Provisions

6.1 *Principles for the administration of medicines*

Detailed procedures for the administration of medicines to all patients are found in the Administration of Medicines Standard Operating Procedure.

The practitioner administering the medicine must:

(a) Know the therapeutic uses of the medicine to be administered, its normal dose, side effects, precautions and contra-indications.

(b) Be certain of the identity of the patient to whom the medicine is to be administered

(c) Be aware of the patient's plan of care

(d) Check that the prescription is complete, clear, unambiguous, in-date and signed, saved or authorised by the prescriber in the electronic prescribing programme.

(e) Check that the medicine to be administered is labelled and clearly identified.

(f) Have considered the dosage, method of administration, route timing of the administration in the context of the condition of the patient and co-existing therapies.

(g) Be competent in calculating paediatric drug doses when a medicine is being given to a child. When administering an intravenous medicine to a child, the Medusa or BRHC IV guide should be checked prior to administration of the medicine.

(h) Check the expiry date of the medication to be administered.

(i) Check that the patient is not allergic to the medication before administering it

(j) Contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medication are discovered, where the patient develops a reaction to the medication, or where assessment of the patient indicates that the medication is no longer suitable

(k) Make a clear, accurate and immediate record of all medication administered, intentionally withheld or refused by the patient, ensuring that written entries and the signature are clear and legible. EPMA entries should be made in full at the time of administration and not in advance of the patient actually receiving the medicine. It is also the practitioner's responsibility to ensure that a record is made when delegating the task of administering medication.

(l) Where supervising the administration of medicines, clearly countersign the signature of the student.

(m) Enteral syringes must be used in the administration of enteral drugs (this includes nasogastric, gastrostomy, PEG's and other enteral feeding tubes).

(n) If a medicine is not administered within 90 minutes of the prescribed time then the Trust's policy on delayed and omitted medicines is to be followed. An omitted medicine is

to be recorded in the EPMA system or on the prescription chart in accordance with the trust approved non-administration codes. Drug rounds must be commenced in a timely fashion to ensure that all patients on the ward receive all of their medicines within the 60 minute window permitted for critical medicines and 90 minute window for all other medicines. For example, if the drug round normally takes 90 minutes, an 8am round should commence at 7.30am to ensure that all patients have received all of their medicines by 9am.

(o) Liquid medications, once opened, may have a shorter expiry. Therefore practitioners must also record the date the liquid was first opened and the expiry date clearly on the bottle to ensure the medication can be checked for fitness for use at a later time. Information regarding expiry dates may be found on the bottle or product literature. Pharmacy may also be contacted to establish expiry information.

(p) For medications being administered from a syringe, using an electronic controlled programmable pump to control the flow rate of the medication, the syringe should not be removed from the pump, whilst still connected to the patient unless absolutely necessary. If the syringe needs to be removed from the pump, the line from the syringe should be clamped.

6.2 *Administration of medicines to children*

a) Complicating factors for administration of medicines in paediatrics include lack of readily available information on doses of some medicines, the frequent use of off label and unlicensed medicines, non-availability of convenient dosage forms requiring calculations, part use of dosage forms intended for adults, and administration difficulties that can vary with the age and co-operation of the child.

In addition to all points detailed in section 7.1, the following must be applied when administering medicines to children:

(i.) All medicines administered to children by nurses must have an independent check, with the exception of the medicines which are included in the paediatric administration of medicine single checking SOP.

(ii.) Where the dose has to be calculated it must be double checked with particular attention being paid to the use of decimal places.

(iii.) The dose of the medicine should always be checked against a reference. When administering an intravenous medicine to a child, the Medusa or BRHC IV guide should be checked prior to administration of the medicine.

(iv.) In the event that qualified medical staff undertake solo administration of a medicine, they are responsible for their actions in doing so.

(v.) The parent may administer the medicine under the supervision of a qualified nurse. Where the parent is administering the medicine, nurses must**:**

(A) check the medicine as outlined in administration of medicines standard operating procedure
(B) observe the administration of the medicine
(C) record the administration in the appropriate records

b) Role of student nurses in the administration of medicines to children

Student nurses (child branch or otherwise) are not permitted to check any medications for children. They may under the direct supervision of a Registered practitioner administer oral medicines to infants and children and observe practice to develop skills in the administration of medication to children.

c) The Role of Registered Physiotherapists in the Administration of Medicines to Children

Registered paediatric physiotherapists may act as a checker for the administration of mucolytics, bronchodilators and antibiotics when they are specifically administered to improve physiotherapy efficacy at the start of the respiratory physiotherapy session.

6.3 *Controlled Drugs*

Administration of controlled drugs must be in line with the controlled drugs policy and standard operating procedures. See Section 13 of the Administration of medicines standard operating procedure and the Controlled drugs chapter of the medicines code.

6.4 *Advanced Therapy Medicinal Products*

Advanced therapy medicinal products (ATMPs) are medicinal products based on genes (gene therapy), cells (cell therapy) and tissues (tissue engineering). A number of advanced therapy medicinal products combine biological materials, such as tissues or cells, and chemical structures such as metal implants or polymer scaffolds. Since these products are a combination of medical device and medicine, they need adapted requirements for administration. All ATMPs must therefore be administered strictly in line with the product specific administration information, clinical trial protocol or local protocol for use as agreed by MAG, with all necessary independent checks carried out throughout the administration process in line with UHBristol policy on medicines administration.

6.5 *Administration of Medicines to Patients with Impaired Mental Capacity*

[redacted] and the principles of the Code of Practice for the Mental Capacity Act should be followed with the use of the [redacted] and the [redacted].

6.6 *Administration of medicines following verbal orders*

(a) Trust policy is that verbal orders for medicines are not permitted except in a medical emergency where the doctor is not available to attend.

(b) In an emergency situation, it is acceptable for a doctor to give a verbal order providing two nurses independently take the order and repeat the intended medicine and dose back to the doctor. The name and dose of the required medicine, along with the full name of the prescriber issuing the verbal order must be written down in the medical notes by the nurses receiving the verbal order. Both nurses must countersign the entry in the medical notes to confirm that the name and dose of medicine written down is what the prescriber has ordered.

(c) All occurrences of administration of a medicine on the basis of a verbal order must be reported as a clinical incident, clearly stating that it was a medical emergency and why the doctor could not attend to prescribe the medicine in writing before administration.

The doctor must attend to write the prescription as soon as the situation with which they are dealing with is resolved. There is the facility to write an EPMA prescription remotely but best practise is that the prescriber attends the patient in person to write the prescription for the medicine. If a nurse has given a medicine in an emergency on a verbal order, this must be recorded in the nursing notes and then transcribed onto either the paper drug chart or the EPMA system as soon as a valid prescription is written.

(d) The human medicines regulations 2012 list the following medicines as exempt from regulation 214(2), meaning that they can be administered in an emergency situation without a prescription.

Adrenaline 1:1000 up to 1mg for intramuscular use in anaphylaxis
Atropine sulphate and obidoxime chloride injection
Atropine sulphate and pralidoxime chloride injection
Atropine sulphate injection
Atropine sulphate, pralidoxime mesilate and avizafone injection
Chlorphenamine injection
Dicobalt edetate injection
Glucagon injection
Glucose injection
Hydrocortisone injection
Naloxone hydrochloride
Pralidoxime chloride injection
Pralidoxime mesilate injection
Promethazine hydrochloride injection
Snake venom antiserum
Sodium nitrite injection
Sodium thiosulphate injection
Sterile pralidoxime

6.7 *Administration of Unlicensed Medicines and Medicines Used Outside the Scope of a Product Licence*

See separate policy on use of unlicensed medicines

6.8 *Mixing medicines for administration*

Mixing medicines in the clinical environment may occur where two or more enteral medicines are mixed, or where injectable medicines are combined in a container (e.g. a syringe) or intravenous line (e.g. at a 'Y site' or through a 3-way tap).

If the prescriber intends two or more medicines to be mixed before entry into the circulation, i.e. prior to or during administration then it is the prescriber's responsibility to ensure that it is safe to do so.

Prescribers must give a written direction to the nurse as to how they should mix (or not) all drugs:

(a) In situations where the mixing is in a container, (for example an infusion bag or syringe) the prescription must specify the detail for the admixture.

(b) Where medicines are to be mixed in lines, administration should only be undertaken if specific stability information is available. If the stability of any admixture is in question, the advice of Pharmacy should be sought.

6.9 *Restricted Use of Open Systems for Injectable Medication*

Open systems must never be used for injectable medicines, with the exception of embolization procedures in radiology, which must have a specific SOP for use. The 2016 Patient safety alert NHS/PSA/D/2016/008 states that 'Due to the risk posed by unidentifiable solutions in open systems (i.e. gallipots or other types of open container such as moulded plastic procedure trays), we consider their use for injectable medicines to be an indefensible practice, with the single exception of the embolization procedures'.

6.10 *Administration of medicines in the community*

Medicines that are required to be administered by UHBristol staff in the community will be administered in line with the standard operating procedure for the administration of medicines as far possible. In the event that only one practitioner or authorised practitioner is present, solo administration of a medicine will occur.

Medicines that are administered by other providers in the community to patients of UHBristol (e.g. via a recovery at home programme) will be administered in line with the providers standard operating procedures.

If UHBristol members of staff are administering medicines in the community and are transporting medicines to and from patient's homes, the member of staff must ensure safe and secure transport of the medicines at all times. The patient must consent to the removal of any medicines from their home.

6.11 *Preparation of medicines for administration in theatres*

Medicines for administration to patients in theatres must be individually prepared for each patient. The practice of 'batch' preparing medicines when several patients on one theatre list all require the same medicines must not occur.

A separate policy exists for the [redacted].

6.12 *Administration of medicines by student and qualified non-registered anaesthetic practitioners*

Qualified and student anaesthetic practitioners are able to administer medication against a patient specific written or computer generated anaesthetic prescription record or anaesthetic drug plan. They will work under the supervision of a suitably qualified anaesthetist.

All administration of medications, anaesthetic gases and inhalational agents will be restricted to clinical practice in anaesthesia. This will include both intravenous and controlled drug administration as outlined in this policy.

(a) Qualified anaesthetic practitioners

(i) Anaesthetists providing supervision to qualified anaesthetic practitioners may supervise two anaesthetic practitioners simultaneously. The supervising anaesthetist will be present in the operating theatre for induction of and during the emergence from general anaesthesia.

(ii) The accountability remains with the supervising anaesthetist to ensure responsibility is appropriately delegated within the remit of the prescribing and administration policy and this supporting addendum.

(b) Student Anaesthetic Practitioners

(i) Student anaesthetic practitioners will work one-to-one with an anaesthetist throughout their training. They will be required to administer anaesthetic medications as part of their curriculum programme, and will undertake theoretical and practical training throughout the first year of the programme whilst working under the direct supervision of an anaesthetist. As part of the curriculum a student must demonstrate theoretical knowledge which is formally assessed at month eight and provide evidence of clinical competency by the end of year one, in order to progress to the second year of the programme. (This is in compliance with their contractual terms of employment relating to training and duty of care).

(ii) On successful progression to year two students may work within the full scope of local policy practice under the individual supervision of an anaesthetist.

(iii) For the purpose of this policy, the supervising anaesthetist remains accountable for all delegated clinical practice relating to administration of medications throughout the trainee programme.

Administration of Medications, Anaesthetic Gases and Inhalation agents:

a) The supervising anaesthetist will complete and sign an individual patient anaesthetic medication plan enabling the qualified or student anaesthetic practitioner to administer drugs in line with anaesthetic practice.
b) Students will second check and draw up a range of agreed drugs with the supervising anaesthetist. This will include diluted preparations and pre-filled syringes.
c) All medications required during the anaesthetic that have not already been checked and drawn up must be checked with the supervising anaesthetist.
d) The student may only give medication checked by the supervising anaesthetist
e) Students will check vaporisers with the supervising anaesthetist and administer in line with the patient specific anaesthetic medication plan.
f) All intravenous medications for a specific patient will be clearly labelled in a designated tray that will stay with the patient throughout anaesthesia.
g) All drug administration will be recorded on the anaesthetic record and signed by the qualified or student anaesthetic practitioner and the supervising anaesthetist.

Intravenous administration

i) Qualified anaesthetic practitioners may administer intravenous medication on evidence of appropriate intravenous training and competency based clinical practice and in line with local policy.

ii) All student anaesthetic practitioners will undertake recognised training in intravenous additives and other appropriately related skills, (such as IV cannulation and IV equipment training) as part of the curriculum, as do other registered professionals in order to undertake the administration of intravenous drugs to the equivalent standard. Training will take place as part of module three of the national curriculum. It will include theoretical and practical skills training and a calculation test delivered locally, and must be successfully completed by all students. Students will be required to demonstrate evidence of successful assessment within the workplace as part of the curriculum by the end of the first year of training.

iii) On progression to year two, students may work within the scope of practice set out in section 2.2 of this policy.

Controlled Drug Handling and Administration

i. In line with current theatre practice, controlled drugs will be issued only to the supervising anaesthetist.

ii. Supervising anaesthetists may delegate the administration of controlled drugs to a qualified or appropriately trained student anaesthetic practitioner against a patient specific anaesthetic medication plan.

iii. Both qualified and student anaesthetic practitioners may have possession of a controlled drug (schedule 2, 3, 4 & 5) for the purpose of administration in accordance with the directions of an anaesthetic medication plan.

iv. Disposal of all unused controlled drugs will be carried out with the supervising anaesthetist.

Exclusions

(a) Anaesthetic practitioners will not administer medications using patient group directions (PGD).
(b) Anaesthetic practitioners cannot prescribe drugs.
(c) Anaesthetic practitioners will not administer drugs to children under 15 but may work as an assistant to an anaesthetist.

6.13 *Oral / Enteral syringes*

There is a risk that oral liquid medications can be incorrectly administered into the intravenous system if intravenous syringes are used to measure and administer oral liquid medication, either orally or via enteral feeding tubes.
Intravenous syringes must not be used to measure any form of liquid medication, feed or fluid, intended for oral or enteral administration

(a) Oral Medicines

(i.) Oral syringes or a measuring spoon must be used to administer all liquid medication via the oral route.

(ii.) All oral syringes are single use only and should be disposed of following one use. Single use means the use of one syringe during one uninterrupted process with one patient and a process that does not involve the syringe being washed. Under no circumstances should syringes be washed and reused.

(iii.) An appropriately sized syringe or measuring spoon should be selected to measure liquid medication for oral or enteral feeding tube delivery

(iv.) The administration of oral liquid medication should be one uninterrupted process from measurement to administration. If this is not possible, the syringe should be labelled with the name and strength of medicine, the patient's name and the date and time that it was prepared.

(b) Enteral Medicines

(i.) Enteral syringes must be used to administer all liquid medication, feeds and fluid via an enteral feeding tube.

(ii.) The use of three-way taps in enteral systems should be avoided due to the additional ports that enable wrong route errors, additional risks of infection and creating a more complex system where multiple lines may be attached.

(iii.) Care should be taken when administering medication via an enteral feeding tube. Small syringe sizes are able to generate large pressures within the enteral feeding tube.

(iv.) Blocked enteral feeding tubes should not be attempted to be unblocked using a syringe size of less than 20 ml due to the risk of generating pressures that could cause the tube to burst.

(v.) Enteral feeding administration sets must be labelled with the words 'ENTERAL'. If this is not an integral part of the tubing then a label should be applied with the word 'ENTERAL' clearly written and visible.

7. Standards and Key Performance Indicators

7.1 *Applicable Standards*

(a) Administration of all medicines in the trust will be in accordance with the policy provisions detailed in section 5.

(b) Administration of all medicines in the trust will be in accordance with the procedure detailed in the [redacted]

7.2 *Measurement and Key Performance Indicators*

(a) Administration of medicines will be audited on a regular basis, at least once every two years.

(b) Ward managers are responsible for ensuring that all administrations of medicine on their ward are according to the medicines administration standard operating procedure.

8. References

(a) Royal Pharmaceutical Society. The Safe and Secure Handling of Medicines: A Team Approach. (A Revision of the Duthie Report 1988). March 2005.

(b) Department of Health Modernisation Agency. Medicine Matters. March 2005.

(c) Department of Health Modernisation Agency. Anaesthesia Practitioner Curriculum Framework. June 2005.

(d) www.modern.nhs.uk/workforce

(e) Appelbe G.E. & Wingfield J. - Dale and Appelbe's Pharmacy Law and Ethics, 7th Ed. Pharmaceutical Press

(f) Toft B. Independent review of the circumstances surrounding four serious adverse incidents that occurred in the Oncology Day Beds Unit, Bristol Royal Hospital for Children on Wednesday, 3 January 2007

9. Associated Internal Documentation

[redacted]

10. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table. **The first line is an example for you and should be removed prior to submission**.

Objective	Evidence	Method	Frequency	Responsible	Committee
Audit practice against policy and SOP	Audit report	Audit	2 yearly	Senior nurse, quality and practice development. Director of Pharmacy	Medicines governance group.

11. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Director of Pharmacy
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	A
If answer above is B: Alternative documentation this policy will replace (if applicable):	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	All staff administering medicines including; Doctors, Nurses, Pharmacy Staff, Health Care Assistants etcetera.
Method of dissemination:	E-mail, DMS.
Is Training required:	Yes
The Training Lead is:	Director of Pharmacy

Additional Comments	
Requires summary of place in Medicines Code of 21 Chapters	

12. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:

[redacted]

Query	Response
What is the main purpose of the document?	This policy outlines the responsibilities for the safe administration of medicines. It defines who can administer medicines and is the parent policy that should be read in conjunction with the administration of medicines standard operating procedure.
Who is the target audience of the document? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ **Staff** ✓ **Patients** **Visitors** **Carers** **Others**

Could the document have a significant negative impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment in relation to your response.
Age (including younger and older people)		✓	Administration of Medicines Policy is the same for all patients.
Disability (including physical and sensory impairments, learning disabilities, mental health)		✓	Administration of Medicines Policy is the same for all patients.
Gender reassignment		✓	Administration of Medicines Policy is the same for all patients.
Pregnancy and maternity		✓	Administration of Medicines Policy is the same for all patients.
Race (includes ethnicity as well as gypsy travelers)		✓	Administration of Medicines Policy is the same for all patients.
Religion and belief (includes non-belief)		✓	Administration of Medicines Policy is the same for all patients.
Sex (male and female)		✓	Administration of Medicines Policy is the same for all patients.
Sexual Orientation (lesbian, gay, bisexual, other)		✓	Administration of Medicines Policy is the same for all patients.
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		✓	Administration of Medicines Policy is the same for all patients.
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		✓	Administration of Medicines Policy is the same for all patients.

Will the document create any problems or barriers to any community or group? ~~YES~~ / NO

Will any group be excluded because of this document? ~~YES~~ / NO

Will the document result in discrimination against any group? ~~YES~~ / NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant positive impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		✓	
Will it help to get rid of discrimination?		✓	
Will it help to get rid of harassment?		✓	
Will it promote good relations between people from all groups?		✓	
Will it promote and protect human rights?		✓	

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				**Negative Impact**		
~~Significant~~	~~Some~~	~~Very Little~~	NONE	~~Very Little~~	~~Some~~	~~Significant~~

Is a full equality impact assessment required? ~~YES /~~ NO

Date assessment completed: 26/09/19

Person completing the assessment: [redacted]