Nursing & Midwifery Council

Standards for medicines management

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.

- We exist to safeguard the health and wellbeing of the public.
- We set the standards of education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code.
- We ensure that midwives are safe to practise by setting rules for their practice and supervision.
- We have fair processes to investigate allegations made against nurses and midwives who may not have followed the code.

Introduction

The Nursing and Midwifery Council (NMC) is the UK regulator for two professions: nursing and midwifery. The primary purpose of the NMC is protection of the public. It does this through maintaining a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK and by setting standards for their education, training and conduct. One of the most important ways of serving the public interest is through providing advice and guidance to registrants on professional issues. The purpose of this booklet is to set standards for safe practice in the management and administration of medicines by registered nurses, midwives and specialist community public health nurses.

Standards for medicine management replace the Guidelines for the administration of medicines 2004, although many of its principles remain relevant today, for example:

> "The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner (can now also be an independent and supplementary prescriber). It requires thought and the exercise of professional judgement..."

Many government and other agencies are involved in medicines management from manufacture, licensing, prescribing and dispensing, to administration. As the administration of a medicinal product is only part of the process, these standards reflect the process from prescribing through to dispensing, storage, administration and disposal. There exists an extensive range of guidance on medicines management from a range of relevant bodies. Sources of information are listed on pages 55–58. One of the best sources of advice locally is the pharmacist.

As with all NMC standards, this booklet provides the minimum standard by which practice should be conducted and will provide the benchmark by which practice is measured. Due to the complexity, speed and extent of change in contemporary health care, it is not intended to cover every single situation that you may encounter during your career. Instead, it sets out a series of standards that will enable you to think through issues and apply your professional expertise and judgement in the best interests of your patients. It will also be necessary to develop and refer to additional local and national policies and protocols to suit local needs.

Definitions

Medicinal products

"Any substance or combination of substances presented for treating or preventing disease in human beings or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product." Council Directive 65/65/EEC.

Medicines management

“The clinical, cost-effective and safe use of medicines to ensure patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm.” (MHRA 2004).

Blood and blood products

Blood is not classified as a medicinal product although some blood components are. Products derived from the plasma component of blood such as blood clotting factors, antibodies and albumin are licensed and classified as considered to be medicinal products. For the purpose of the administration of medicinal products registrants would be expected to apply the standards for medicines management to all medicinal products but should consider additional guidance by the National Patient Safety Agency – guidance launched on 9 November 2006; Right patient, Right blood (available at **www.npsa.nhs.uk**). A key requirement of this guidance is that all staff involved in blood transfusion undergo formal competency assessment on a three-yearly basis.

Use of the word ‘patient’ throughout the document

Throughout this document where the word ‘patient’ is used this refers to whoever the medication may be administered to, for example, patient, client, user or woman (midwifery).

Use of the word ‘registrant’ throughout the document

Throughout this document where the word ‘registrant’ is used this refers to nurses, midwives and specialist community public health nurses who are registered on the NMC register.

Summary of standards

This section provides a summary of the standards for easy reference. For further detail you should read, follow and adhere to the standards as detailed later in the document. It is essential that you read the full guidance.

Section 1

Methods of supplying and/or administration of medicines

Standard 1: Methods

Registrants must only supply and administer medicinal products in accordance with one or more of the following processes:

- Patient specific direction (PSD)
- Patient medicines administration chart (may be called medicines administration record MAR)
- Patient group direction (PGD)
- Medicines Act exemption
- Standing order
- Homely remedy protocol
- Prescription forms

Standard 2: Checking

Registrants must check any direction to administer a medicinal product.

Standard 3: Transcribing

As a registrant you may transcribe medication from one ‘direction to supply or administer’ to another form of ‘direction to supply or administer’.

Section 2

Dispensing

Standard 4: Prescription medicines

Registrants may in exceptional circumstances label from stock and supply a clinically appropriate medicine to a patient, against a written prescription (not PGD), for self-administration or administration by another professional, and to advise on its safe and effective use.

Standard 5: Patients' own medicines

Registrants may use patients' own medicines in accordance with the guidance in this booklet *Standards for medicines management*.

Section 3

Storage and transportation

Standard 6: Storage

Registrants must ensure all medicinal products are stored in accordance with the patient information leaflet, summary of product characteristics document found in dispensed UK-licensed medication, and in accordance with any instruction on the label.

Standard 7: Transportation

Registrants may transport medication to patients including controlled drugs, where patients, their carers or representatives are unable to collect them, provided the registrant is conveying the medication to a patient for whom the medicinal product has been prescribed, (for example, from a pharmacy to the patient's home).

Section 4

Standards for practice of administration of medicines

Standard 8: Administration

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

- you must be certain of the identity of the patient to whom the medicine is to be administered
- you must check that the patient is not allergic to the medicine before administering it
- you must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- you must be aware of the patient's plan of care (care plan or pathway)
- you must check that the prescription or the label on medicine dispensed is clearly written and unambiguous
- you must check the expiry date (where it exists) of the medicine to be administered
- you must have considered the dosage, weight where appropriate, method of administration, route and timing
- you must administer or withhold in the context of the patient's condition, (for example, Digoxin not usually to be given if pulse below 60) and co-existing therapies, for example, physiotherapy

- you must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable (see Standard 25).

- you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible. It is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

In addition:

- Where medication is not given, the reason for not doing so must be recorded.

- You may administer with a single signature any prescription only medicine (POM), general sales list (GSL) or pharmacy (P) medication.

In respect of controlled drugs:

- These should be administered in line with relevant legislation and local standard operating procedures.

- It is recommended that for the administration of controlled drugs a secondary signatory is required within secondary care and similar healthcare settings.

- In a patient's home, where a registrant is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

- Although normally the second signatory should be another registered health care professional (for example doctor, pharmacist, dentist) or student nurse or midwife, in the interest of patient care, where this is not possible, a second suitable person who has been assessed as competent may sign. It is good practice that the second signatory witnesses the whole administration process. For guidance, go to **www.dh.gov.uk** and search for safer management of controlled drugs: guidance on standard operating procedures.

- In cases of direct patient administration of oral medication from stock in a substance misuse clinic, it must be a registered nurse who administers, signed by a second signatory (assessed as competent), who is then supervised by the registrant as the patient receives and consumes the medication.

- You must clearly countersign the signature of the student when supervising a student in the administration of medicines.

Standard 9: Assessment

As a registrant, you are responsible for the initial and continued assessment of patients who are self-administering and have continuing responsibility for recognising and acting upon changes in a patient's condition with regards to safety of the patient and others.

Standard 10: Self-administration – children and young people

In the case of children, when arrangements have been made for parents or carers or patients to administer their own medicinal products prior to discharge or rehabilitation, the registrant should ascertain that the medicinal product has been taken as prescribed.

Standard 11: Remote prescription or direction to administer

In exceptional circumstances, where medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology (such as fax, text message or email) may be used but must confirm any change to the original prescription.

Standard 12: Text messaging

As a registrant, you must ensure that there are protocols in place to ensure patient confidentiality and documentation of any text received including: complete text message, telephone number (it was sent from), the time sent, any response given, and the signature and date when received by the registrant.

Standard 13: Titration

Where medication has been prescribed within a range of dosages, it is acceptable for registrants to titrate dosages according to patient response and symptom control and to administer within the prescribed range.

Standard 14: Preparing medication in advance

Registrants must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence.

Standard 15: Medication acquired over the internet

Registrants should never administer any medication that has not been prescribed, or that has been acquired over the internet without a valid prescription.

Standard 16: Aids to support compliance

Registrants must assess the patient's suitability and understanding of how to use an appropriate compliance aid safely.

Section 5

Delegation

Standard 17: Delegation

A registrant is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task.

Standard 18: Nursing and midwifery students

Students must never administer or supply medicinal products without direct supervision.

Standard 19: Unregistered practitioners

In delegating the administration of medicinal products to unregistered practitioners, it is the registrant who must apply the principles of administration of medicinal products as listed above. They may then delegate an unregistered practitioner to assist the patient in the ingestion or application of the medicinal product.

Standard 20: Intravenous medication

Wherever possible, two registrants should check medication to be administered intravenously, one of whom should also be the registrant who then administers the intravenous (IV) medication.

Section 6

Disposal of medicinal products

Standard 21: Disposal

A registrant must dispose of medicinal products in accordance with legislation.

Section 7

Unlicensed medicines

Standard 22: Unlicensed medicines

A registrant may administer an unlicensed medicinal product with the patient's informed consent against a patient-specific direction but NOT against a patient group direction.

Section 8

Complementary and alternative therapies

Standard 23: Complementary and alternative therapies

Registrants must have successfully undertaken training and be competent to practise the administration of complementary and alternative therapies.

Section 9

Management of adverse events (errors or incidents) in the administration of medicines

Standard 24: Management of adverse effects

As a registrant, if you make an error you must take any action to prevent any potential harm to the patient and report as soon as possible to the prescriber, your line manager or employer (according to local policy) and document your actions. Midwives should also inform their named supervisor of midwives.

Standard 25: Reporting adverse reactions

As a registrant, if a patient experiences an adverse drug reaction to a medication, you must take any action to remedy harm caused by the reaction. You must record this in the patient's notes, notify the prescriber (if you did not prescribe the drug) and notify via the Yellow Card Scheme immediately.

Section 10

Controlled drugs

Standard 26: Controlled drugs

Registrants should ensure that patients prescribed controlled drugs are administered these in a timely fashion in line with the standards for administering medication to patients. Registrants should comply with and follow the legal requirements and approved local standard operating procedures for controlled drugs that are appropriate for their area of work.

Contents

Standards

Section 1: Method of supplying and/or administration of medicines
Standard 1: Methods 13
Standard 2: Checking 18
Standard 3: Transcribing 18

Section 2: Dispensing
Standard 4: Prescription medicines 20
Standard 5: Patients' own medicines 20

Section 3: Storage and transportation
Standard 6: Storage 22
Standard 7: Transportation 23

Section 4: Standards for practice of administration of medicines
Standard 8: Administration 24
Standard 9: Assessment 26
Standard 10: Self-administration – children and young people 28
Standard 11: Remote prescription or direction to administer 28
Standard 12: Text messaging 30
Standard 13: Titration 30
Standard 14: Preparing medication in advance 30
Standard 15: Medication acquired over the internet 31
Standard 16: Aids to support compliance 32

Section 5: Delegation
Standard 17: Delegation 33
Standard 18: Nursing and midwifery students 33
Standard 19: Unregistered practitioners 33
Standard 20: Intravenous medication 34

Section 6: Disposal of medicinal products
Standard 21: Disposal 35

Section 7: Unlicensed medicines
Standard 22: Unlicensed medicines 35

Section 8: Complementary and alternative therapies
Standard 23: Complementary and alternative therapies 36

Section 9: Management of adverse events (errors or incidents) in the administration of medicines
Standard 24: Management of adverse events 37
Standard 25: Reporting adverse reactions 38

Section 10: Controlled drugs
Standard 26: Controlled drugs 38

Annexes

Annexe 1
Legislation

Annexe 2
Guidance on labelling and over-labelling of medicines

Annexe 3
Suitability of patients' own medicinal products for use

Annexe 4
Exclusion criteria for self-administration medicines

Annexe 5
Administering medicinal products in research clinical trials

Annexe 6
Information and publications

Annexe 7
Glossary

Annexe 8
Contributors

The standards: Section 1

Methods of supplying and/or administration of medicines

Methods to enable nurses, midwives and specialist community public health nurses to supply and/or administer may include the following:

Standard 1: Methods

1 Registrants must only supply and administer medicinal products in accordance with one or more of the following processes:

1.1 Patient-specific direction (PSD)

1.2 Patient medicines administration chart (may be called a medicines administration record (MAR))

1.3 Patient group direction (PGD)

1.4 Medicines Act Exemption (where they apply to nurses)

1.5 Standing order

1.6 Homely remedy protocol

1.7 Prescription forms

2 Once a medicinal product has been prescribed and dispensed to an individual, the drug is the individual's own property. To use it for someone else is theft . Registrants should refer to DH (2006) *Medicines Matters: A guide to mechanisms for the prescribing, supply and administration of medicines.*

Patient-specific direction (PSD)

3 A patient-specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient. In primary care, this might be a simple instruction in the patient's notes. Examples in secondary care include instructions on a patient's medicines administration chart. The direction would need to be specific as to the route of administration it cannot simply authorise a course of treatment to several patients. Where a PSD exists, there is no need for a patient group direction.

4 Each individual patient must be identified on the PSD. An example of using a PSD is in the administration of routine vaccine where a list of patients due a vaccine may be identified beforehand. In the case of controlled drugs, it is essential to comply with full prescription requirements. Go to **www.dh.gov.uk** and search for controlled drugs.

Patient medicines administration chart

5 The patient medicines administration chart is not a prescription but a direction to administer medication. It must be signed by a registered prescriber and authorises the delegation to administer medication on the prescriber's behalf. However, in doing so the registrant is accountable for their actions and for raising any concerns about the direction with the prescriber, for example, in respect to clarity.

Patient group direction (PGD)

6 Patient group directions (PGDs) are specific written instructions for the supply or administration of a licensed named medicine including vaccines to specific groups of patients who may not be individually identified before presenting for treatment. Guidance on the use of PGDs is contained within *Health Service Circular (HSC) 2000/026*.

7 See Home Office circular 049/2003. *Controlled Drugs Legislation – Nurse Prescribing And Patient Group Directions*. Go to **www.dh.gov.uk** and search for controlled drugs.

8 Guidance has also been issued in Wales (WHC 2000/116), and in Scotland and Northern Ireland.

9 The circular also identifies the legal standing of PGDs plus 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. PGDs are not a form of prescribing.

10 PGDs are drawn up locally by doctors, dentists, pharmacists, and other health professionals where relevant. They must be signed by a doctor or dentist and a pharmacist, both of whom should have been involved in developing the direction, and must be approved by the appropriate health care organisation. The NMC would consider it good practice that a lead practitioner from the professional group using the PGD and senior manager where possible, are also involved and sign off a PGD.

11 PGDs can be used by independent providers for NHS commissioned services. As medicines legislation does not apply outside the UK, a PGD would not be required – for example – on cruise ships. However, the NMC would consider it good practice for such bodies to develop protocols using PGD templates that are signed off by a doctor, dentist, pharmacist, other health professionals where relevant and a senior manager where possible.

12 PGDs should only be used once the registrant has been assessed as competent and whose name is identified within each document. The administration of drugs via a PGD may not be delegated. Students cannot supply or administer under a PGD but would be expected to understand the principles and be involved in the process. Where medication is already subject to exemption order legislation there is no requirement for a PGD.

13 When supplying under PGD, this should be from the manufacturer's original packs or over-labelled pre-packs so that the patient details, date and additional instructions can be written on the label at the time of supply. Registrants must not split packs. For more information on labelling see annexe 2.

14 See To PGD or not to PGD at:
www.portal.nelm.nhs.uk/PGD/viewRecord.aspx?recordID=422

15 PGDs in the NHS:
www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=148

16 PGDs in the private sector:
www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=147

Medicines Act Exemptions

17 Allow certain groups of healthcare professionals including occupational health nurses under occupational health schemes and midwives to sell, supply and administer specific medicines directly to patient and clients.

17.1 Provided the requirements of any conditions attached to those exemptions are met, a PGD is not required.

17.2 Registrants must work to locally agreed written protocols and procedures, and maintain auditable records.

17.3 Occupational health nurses that offer services, for example, open access travel clinics outside of occupational health schemes must comply with guidance from the appropriate regulator.

18 Registrants may only supply and administer under an exemption order where the order pertains to them. Where nurses are working as emergency care practitioners within an ambulance service they may not supply and administer under paramedic exemptions unless they are also registered as a paramedic with the Health Professions Council – to do so would contravene medicine legislation and the employer's vicarious liability would not apply.

19 Search for NMC Circular 1/2005 *Medicine legislation: what it means for midwives* at **www.nmc-uk.org**

Standing orders

20 In the past, maternity service providers and occupational health schemes have produced local guidelines, often referred to as 'standing orders', to supplement the legislation on the medicinal products that practising midwives and occupational health nurses may supply and/or administer. These guidelines are not a prerequisite under any legislation. There is no legal definition for standing orders and this term does not exist in any medicines legislation. The NMC would consider it good practice where midwives and occupational health nurses are using standing orders for medicinal products that are not covered by Medicines Act Exemptions that these should be converted to PGDs.

Homely remedy protocols

21 Homely remedy protocols cannot be used for prescription only medicines including controlled drugs. These must be supplied and administered under a PSD, a prescription or a PGD.

Guidance

22 Homely remedy protocols are not prescriptions but protocols to enable administration of general sales list (GSL) and pharmacy only (P) listed medicines in settings, for example, care homes, children's homes and some educational institutions. Although they have no legal standing they are required for liability purposes. Any registrant using a homely remedy protocol must ensure there is a written instruction that has been drawn up and agreed in consultation with other relevant qualified professionals. (Where possible this should be a medical practitioner or pharmacist.) The protocol should clarify what medicinal product may be administered and for what indication it may be administered, the dose, frequency and time limitation before referral to a GP. An example of a homely remedy could be paracetamol for a headache. All registrants using the protocol should be named and they should sign to confirm they are competent to administer the medicinal product, acknowledging they will be accountable for their actions.

23 The NMC considers it good practice that the employing organisation signs off all protocols.

Prescription forms

24 NHS prescription forms are classified as secure stationery. Prescription forms are serially numbered and have anticounterfeiting and anti-forgery features. Within the NHS they are purchased by primary care trusts (PCTs), hospital boards and hospitals via a secure ordering system, and distributed free. The range of prescription forms used by registered prescribers can be found in each UK country government website.

25 Specific controlled drug prescription forms are available from the local health care organisation, for example, PCT, LHB, for use in the private healthcare sector. Specific controlled drug prescriptions are used for treatment of addiction and for private prescriptions for controlled drugs. Only the designated prescription form should be used. Detailed guidance on how to complete prescription forms, including special requirements when prescribing controlled drugs, is available from the Department of Health (DH), Health Care Commission (HCC), Home Office, the Prescription Prices Division of the NHS Business Services Authority website and in the BNF. The Regulation and Quality Improvement Authority is equivalent to the HCC in Northern Ireland. Registrants in Northern Ireland should access their website for up-to-date information on their standards.
www.npc.co.uk/controlled_drugs/CDGuide_2ndedition_February_2007.pdf

26 For the Welsh Health circular, go to:
www.wales.nhs.uk/documents/WHC_2006_018.pdf

27 Search for the Home Office Circular Controlled Drugs Legislation – Nurse Prescribing and Patient Group Directions at: **www.knowledgenetwork.gov.uk/HO/circular.nsf**

Who may write a prescription?

28 Any qualified and registered independent prescriber may prescribe all prescription only medicines for all medical conditions. In addition, nurse independent prescribers may also prescribe some controlled drugs.

29 Supplementary prescribers may prescribe in accordance with a clinical management plan (CMP) in a tripartite arrangement with a doctor or dentist, the patient and the supplementary prescriber. A supplementary prescriber, when acting under and in accordance with the terms of a CMP, may administer and supply or direct any person to administer controlled drugs in schedules 2, 3, 4 and 5, and can prescribe unlicensed medicinal products. Please see section 5 of this document on delegation.

Prescribing by nurses, midwives and specialist community public health nurses

30 The Medicinal Products: Prescription by Nurses Act 1992 and subsequent amendments to the pharmaceutical services regulations allow nurses and midwives, who have recorded their qualification on the NMC register, to become nurse or midwife prescribers. There are two levels of nurse and midwife prescribers:

Community practitioner nurse prescribers

30.1 These are registrants who have successfully undertaken a programme of preparation to prescribe from Community Practitioner Nurse Prescribers' Formulary. They can prescribe the majority of dressings and appliances, and a limited range of prescription only medicines. The Community Nurse Prescribers' Formulary can be found on the **British National Formulary** website. Go to: **www.bnf.org**

Independent and supplementary nurse and midwife prescribers

30.2 These are nurses and midwives who are trained to make a diagnosis and prescribe the appropriate treatment (independent prescribing). They may also, in cases where a doctor has made an initial diagnosis, go on to prescribe or review the medication, and change the drug, dosage, timing or frequency or route of administration of any medication as appropriate as part of a clinical management plan (supplementary prescribing).

31 Nurse or midwife independent prescribers can prescribe all prescription only medicines including some controlled drugs, and all medication that can be supplied by a pharmacist or bought over the counter. They must only prescribe drugs that are within their area of expertise and level of competence, and should only prescribe for children if they have the expertise and competence to do so.

32 Nurse, midwife and specialist community public health nurse prescribers must comply with current prescribing legislation and are accountable for their practice.

33 For Department of Health guidance go to **www.dh.gov.uk** and search: nurse independent prescribing.

Standard 2: Checking

1 Registrants (1st and 2nd level) must check any direction to administer a medicinal product.

2 As a registrant you are accountable for your actions and omissions. In administering any medication, or assisting or overseeing any self-administration of medication, you must exercise your professional judgement and apply your knowledge and skill in the given situation. As a registrant, before you administer a medicinal product you must always check that the prescription or other direction to administer is:

2.1 not for a substance to which the patient is known to be allergic or otherwise unable to tolerate

2.2 based, whenever possible, on the patient's informed consent and awareness of the purpose of the treatment

2.3 clearly written, typed or computer-generated and indelible

2.4 specifies the substance to be administered, using its generic or brand name where appropriate and its stated form, together with the strength, dosage, timing, frequency of administration, start and finish dates, and route of administration

2.5 is signed and dated by the authorised prescriber

2.6 in the case of controlled drugs, specifies the dosage and the number of dosage units or total course; and is signed and dated by the prescriber using relevant documentation as introduced, for example, patient drug record cards.

3 And that you have:

3.1 clearly identified the patient for whom the medication is intended

3.2 recorded the weight of the patient on the prescription sheet for all children, and where the dosage of medication is related to weight or surface area (for example, cytotoxics) or where clinical condition dictates recorded the patient's weight.

Standard 3: Transcribing

1 As a registrant you may transcribe medication from one 'direction to supply or administer' to another form of 'direction to supply or administer'.

Guidance

2 This should only be undertaken in exceptional circumstances and should not be routine practice. However, in doing so you are accountable for your actions and omissions. Any medication that you have transcribed must be signed off by a registered prescriber. In exceptional circumstances this may be done in the form of an email, text or fax before it can be administered by a registrant.

3 Any act by which medicinal products are written from one form of direction to administer to another is transcribing. This includes, for example, discharge letters, transfer letters, copying illegible patient administrations charts onto new charts, whether hand-written or computer-generated.

4 When medicine administration records in a care home are hand-written by a registrant, they may be transcribed from the details included on the label attached to the dispensed medicine. However, in doing so the registrant must ensure that the charts are checked by another registrant where possible, and where not, another competent health professional.

5 The registrant is accountable for what they have transcribed.

6 Managers and employers are responsible for ensuring there is a rigorous policy for transcribing that meets local clinical governance requirements.

7 As care is being increasingly provided in more 'closer to home' settings that are often nurse-led, managers and employers should undertake a risk assessment involving registrants, pharmacists and responsible independent prescribers to develop a management process to enable transcribing to be undertaken where necessary. It should not be routine practice. Any transcription must include the patient's full name, date of birth, drug, dosage, strength, timing, frequency and route of administration.

8 Transposing is the technical term used by pharmacists for transcribing.

9 Registrants are advised to read the Health Care Commission guidance for the transcribing of prescribed medicines for individuals on admission to children's hospices. The principles apply to all settings. Go to **www.cqc.org.uk**. Registrants in Northern Ireland should refer to the Regulation and Quality Improvement Authority website at **www.rqia.org.uk**

The standards: Section 2

Dispensing

Standard 4: Prescription medicines

1 Registrants may in exceptional circumstances label from stock and supply a clinically appropriate medicine to a patient, against a written prescription (not PGD), for self-administration or administration by another professional, and to advise on its safe and effective use.

Guidance

2 The definition of dispensing is "To label from stock and supply a clinically appropriate medicine to a patient, client or carer, usually against a written prescription, for self-administration or administration by another professional, and to advise on safe and effective use". (MHRA, 2006)

3 Dispensing includes such activities as checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient.

4 If under exceptional circumstances you, as a registrant, you are engaged in dispensing, this represents an extension to your professional practice. There is no legal barrier to this practice. However, this must be in the course of the business of a hospital, and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure (SOP). In a dispensing doctor's practice, registrants may supply to patients under a particular doctor's care, when acting under the directions of a doctor from that practice. The patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.

Standard 5: Patients' own medicines

1 Registrants may use patients' own medicines in accordance with the guidance in this booklet *Standards for medicines management*.

2 The NMC welcomes and supports the self-administration of medicinal products and the administration of medication by carers wherever it is appropriate.

The use of patients' own medicinal products in any setting

3 Where patients have their own supply of medicinal products, whether prescribed, over the counter (from a pharmacy, supermarket or shop), complementary therapy, herbal preparation or homely remedy such as paracetamol, the registrant has a responsibility to:

3.1 ask to see the medicinal products

3.2 check for suitability of use

3.3 explain how and why they will or won't be used

3.4 establish if they are prescribed

3.5 ascertain if they meet the criteria for use.

4 These medicinal products including controlled drugs remain the patient's property and must not be removed from the patient without their permission and must only be used for that named individual.

5 The registrant has a responsibility to document in the patient's notes when a patient refuses consent:

5.1 to use their own medicines

5.2 to dispose of their own medicinal products no longer required

5.3 to dispose of their own medicinal products not suitable for use

5.4 when in the hospital or care home setting to send their own medicinal products home with a relative or carer

Storage of patients' own medicinal products

6 As a registrant you have the following responsibilities:

6.1 to ensure that suitable facilities are provided to store patients' own medicinal products for their safe storage

6.2 to assess patients on a regular basis using local polices to ensure that the individual patient is still able to self-administer

6.3 to document issues relating to storage in their records

6.4 that the medicines cabinet or locker is kept locked and that the master key is kept secure

6.5 that if the patient is self-administering, consent is obtained from the patient to keep the individual medicines cabinet/locker locked and the key secure with the patient

6.6 that if a patient moves to another bed, to another ward or room or is discharged, the patient's medicinal products are transferred with the patient

6.7 In a hospital setting, best practice indicates that stock medicines should not be placed in the patient's locked cabinet or locker as they are not labelled for that individual patient.

Administering medicines using the patient's own supply in the hospital or care home setting

7 When administering medicines from the patient's own supply, the registrant must check the medicines in the locked cabinet or locker with the prescription chart and use only those medicines belonging to that named patient.

8 If a supply is not available, medicines belonging to another patient must not be used.

9 For further guidance on the use of patients' own medicinal products including discharge and checking medications to take home (TTOs) see annexe 3. For self-administration of medicines see standard 9 of this document Self-administration of medicines.

One-stop dispensing

10 In some hospitals a system of one-stop dispensing is in operation and local policies should be developed for this using the guidance for patients' own medicinal products as stated under standard 5 of this document.

Guidance

11 One-stop dispensing is a system of administering and dispensing medicinal products adopted in hospitals throughout the UK (Audit Commission Report: A Spoonful of Sugar 2002 – The Right Medicine (Scottish Executive 2002). It involves using the patient's own medicinal products during their stay in hospital, either those dispensed by a community pharmacy or by the hospital pharmacy or both, providing they contain a patient information leaflet and are labelled with full instructions for use. Supplies are replenished should the supply run out whilst in hospital or when any new items are prescribed. Patients are discharged with a supply of medicinal products as agreed locally.

12 In one-stop dispensing, medicinal products are dispensed once only on or during admission ready for discharge. Registrants should check that the medication handed to the patient on discharge is as per the discharge prescription, as medicines may be altered or stopped during hospital admission. If a particular medicine has been stopped during admission and is not to be restarted on discharge, the patient must be informed. The ward pharmacist is a useful resource for advice.

The standards: Section 3

Storage and transportation

Standard 6: Storage

1 Registrants must ensure all medicinal products are stored in accordance with the patient information leaflet, summary of product characteristics document found in dispensed UK-licensed medication and in accordance with any instruction on the label.

Guidance

2 The patient information leaflet or summary of product characteristics document for UK-licensed medicinal products may be found at **www.emc.medicines.org.uk**. Policies should be in place to ensure all storage environments meet the required standards and it is the responsibility of the registrant to check such policies are in place and are being adhered to. This is particularly important for medicines requiring storage within a limited temperature range, for example, refrigeration of vaccines when maintenance of the cold chain has to be considered during transfer for school sessions or administration in the patient's home. Go to **www.the-shipman-inquiry.org.uk/4r_page.asp?id=3119**

Standard 7: Transportation

1 Registrants may transport medication to patients including controlled drugs (CDs), where patients, their carers or representatives are unable to collect them, provided the registrant is conveying the medication to a patient for whom the medicine has been prescribed (for example, from a pharmacy to the patient's home).

Guidance

2 However, it is considered good practice that registrants should not routinely transport CDs in the course of their practice. This should only be undertaken in circumstances where there is no other reasonable mechanism available. All drugs should be kept out of sight during transportation.

3 When collecting CDs from a pharmacy, the registrant will be asked to sign for them and prove identity in the form of their professional identity badge or Pin (where self-employed). Midwives must be familiar with the use of midwives supply orders. Go to *NMC Circular 25/2005* which you can find at **www.nmc-uk.org/publications**. It is anticipated as a recommendation from the *Shipman Inquiry Fourth Report* that new documentary evidence will be required in the form of a patient drug record card. Registrants would be expected to be aware of and comply with any new legislation and guidance introduced.

The standards: Section 4

Standards for practice of administration of medicines

1 Having initially checked the direction to supply or administer that a medicinal product is appropriate for your patient or client (standard 2) you may then administer medication.

Standard 8: Administration

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

2.1 you must be certain of the identity of the patient to whom the medicine is to be administered

2.2 you must check that the patient is not allergic to the medicine before administering it

2.3 you must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications

2.4 you must be aware of the patient's plan of care (care plan or pathway)

2.5 you must check that the prescription or the label on medicine dispensed is clearly written and unambiguous

2.6 you must check the expiry date (where it exists) of the medicine to be administered

2.7 you must have considered the dosage, weight where appropriate, method of administration, route and timing

2.8 you must administer or withhold in the context of the patient's condition (for example, Digoxin not usually to be given if pulse below 60) and co-existing therapies, for example, physiotherapy

2.9 you must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable (see standard 25)

2.10 you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

In addition:

3 Where medication is not given, the reason for not doing so must be recorded.

4 You may administer with a single signature any prescription only medicine, general sales list or pharmacy medication.

In respect of controlled drugs:

5 These should be administered in line with relevant legislation and local standard operating procedures.

6 It is recommended that for the administration of controlled drugs, a secondary signatory is required within secondary care and similar healthcare settings.

7 In a patient's home, where a registrant is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

8 Although normally the second signatory should be another registered health care professional (for example doctor, pharmacist, dentist) or student nurse or midwife, in the interest of patient care, where this is not possible a second suitable person who has been assessed as competent may sign. It is good practice that the second signatory witnesses the whole administration process. For guidance, go to **www.dh.gov.uk** and search for *Safer Management of Controlled Drugs: Guidance on Standard Operating Procedures*.

9 In cases of direct patient administration of oral medication, for example, from stock in a substance misuse clinic, it must be a registered nurse who administers, signed by a second signatory (assessed as competent), who is then supervised by the registrant as the patient receives and consumes the medication.

10 You must clearly countersign the signature of the student when supervising a student in the administration of medicines.

11 These standards apply to all medicinal products.

Guidance

Assessing competence to support a patient in taking their medication

12 A policy must be in place and adhered to in assessing the competence of an individual to support a patient in taking medication. A record of the individual's training and assessment should be kept, and all refresher or continuing education and training should also be routinely kept.

13 The registrant delegating should be satisfied that the individual has an appropriate level of education and training and has been assessed as competent. Where this is not the case, the registrant may refuse to delegate, even when requested to do so by another health professional. The registrant is accountable for her own actions including delegation.

Clarifying identity

14 Where there are difficulties in clarifying an individual's identity, for example, in some areas of learning disabilities, patients with dementia or confusional states, an up-to-date photograph should be attached to the prescription chart(s). For patients with burns where the wearing of a wristband is inappropriate and a photograph would not resemble the patient, local policies should be in place to ensure all staff are familiar with the patients and a system of identification is in place. Registrants are responsible for ensuring the photograph remains up to date.

Drug calculations

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

Standard 9: Assessment

1 As a registrant you are responsible for the initial and continued assessment of patients who are selfadministering, and have continuing responsibility for recognising and acting upon changes in a patient's condition with regards to safety of the patient and others.

2 The NMC welcomes and supports the self-administration of medicinal products and the administration of medication by carers wherever it is appropriate. Registrants may assess the patients as suitable to self-administer medicinal products both in the hospital and primary care settings.

Guidance

Duty of care relating to using patients' own medicinal products

3 At all times the registrant jointly with other health care professionals has a duty of care to the patient to ensure that only medicinal products which are prescribed and meet the required criteria are used by the patient.

4 Where self-administration of medicinal products is taking place, you should ensure that records are maintained appropriate to the environment in which the patient is being cared for. The Mental Capacity Act 2005 requires all those working with potentially incapacitated people to assess the individual's capacity at a particular moment about a particular decision or issue. All patients should be assessed on a regular basis using local policies to ensure that the individual patient is still able to self-administer and this should be documented in their records.

5 Patients can be assessed for suitability at the following levels:

Level 1

5.1 The registrant is responsible for the safe storage of the medicinal products and the supervision of the administration process ensuring the patient understands the medicinal product being administered.

Level 2

5.2 The registrant is responsible for the safe storage of the medicinal products. At administration time, the patient will ask the registrant to open the cabinet or locker. The patient will then self-administer the medication under the supervision of the registrant.

Level 3

5.3 The patient accepts full responsibility for the storage and administration of the medicinal products. The registrant checks the patient's suitability and compliance verbally.

6 The level should be documented in the patient's notes.

Guidance

7 Where patients consent to self-administration of their medicines the following points should be considered:

7.1 Patients share the responsibility for their actions relating to self-administration of their medicines.

7.2 Patients can withdraw consent at any time.

7.3 The pharmacy will supply medicines fully labelled, with directions for use, to every patient who is involved in self-administration.

8 Information given and supervision should be tailored to individual patient need.

9 The following information should be provided to a patient before commencing self-administration:

9.1 the name of the medicine

9.2 why they are taking it

9.3 dose and frequency

9.4 common side-effects and what to do if they occur

9.5 any special instructions

9.6 duration of the course or how to obtain further supplies.

10 The registrant must ensure that the patient is able to open the medicine containers or is offered assistance, for example, compliance aid.

11 Whilst the registrant has a duty of care towards all patients, the registrant is not liable if a patient makes a mistake self-administering as long as the assessment was completed as the local policy describes and appropriate actions were taken to prevent re-occurrence of the incident.

12 Guidance on exclusion criteria for self-administration of medicines can be found in annexe 4.

Standard 10: Self-administration – children and young people

1 In the case of children, when arrangements have been made for parents, carers or patients to administer their own medicines prior to discharge or rehabilitation, the registrant should ascertain that the medicinal products have been taken as prescribed.

Guidance

2 This should preferably be done by direct observation but when appropriate also by questioning the patient, parent or carer. The administration record should be initialled and 'patient self-administration' documented.

3 The administration of medicinal products by parents or carers to their children must be carefully controlled. There is the potential for inadvertent omission of doses or administration of extra doses unless there is clear communication and documentation.

4 Parents or carers can be encouraged to administer to their children in whatever setting when this is appropriate to the clinical condition of the child and when the registrant has assessed that the parent or carer is competent to do so. In a hospital setting the registrant should provide the medicinal product from the appropriate storage and supervise administration.

Unsupervised administration to children

5 Some parents and carers may administer to their children unsupervised if this has been agreed with the registrant in charge and if the medicinal products are stored in an appropriate secure locker. Responsibilities of the registrant and parent or carer must be specifically agreed and approved by the registrant in charge and agreed under local policies. Arrangements must be made for holding keys to the locker and for ensuring their return on discharge, and that any medicinal products remaining are supplied for discharge (if appropriately labelled and checked) or returned to the pharmacy.

6 The employing organisation should ensure appropriate clinical governance structures are in place.

Standard 11: Remote prescription or direction to administer

1 In exceptional circumstances, where medication (not including controlled drugs) has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology (such as fax, text message or email) may be used but must confirm any change to the original prescription.

Guidance

2 A verbal order is not acceptable on its own. The fax or email prescription or direction to administer must be stapled to the patient's existing medication chart. This should be followed up by a new prescription signed by the prescriber who sent the fax or email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends). In any event, the changes must have been authorised (via text, email or fax) by a registered prescriber before the new dosage is administered. The registered nurse should request the prescriber to confirm and sign changes on the patient's individual medicines administration record (MAR) chart or care plan.

3 Where a medication has not been prescribed before, a nurse or midwife independent prescriber may not prescribe remotely if they have not assessed the patient, except in life-threatening situations. See standard 20 of the *Standards of Proficiency for Nurse and Midwife Prescribers* which you can find at **www.nmc-uk.org/publications**

4 In exceptional circumstances, a medical practitioner may need to prescribe remotely for a previously unprescribed medicine, for example, in palliative care or remote and rural areas the use of information technology (such as fax, text message or email) must confirm the prescription before it is administered. This should be followed up by a new prescription signed by the prescriber who sent the fax/email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends). The registrant is accountable for ensuring all relevant information has been communicated to the prescriber and s/he may refuse to accept a remote prescription if it compromises care to the patient. In this instance she should document accurately the communication that has taken place. Registrants should note that remote prescribing cannot be undertaken in a care home because they do not have access to a stock of medicines.

5 A prescription is required when the drug is to be both supplied and administered. For administration only, a direction to administer is sufficient.

6 It may be helpful to refer to the GMC *Good Medical Practice Guide* for further information available on the GMC website.

Standard 12: Text messaging

1 As a registrant, you must ensure that there are protocols in place to ensure patient confidentiality and documentation of any text received include: complete text message, telephone number (it was sent from), the time sent, any response given, and the signature and date when received by the registrant.

Guidance

2 An order to administer medication by text messaging is an increasing possibility. A second signature – normally another registrant but where this is not possible another person – should sign to confirm the documentation agrees with the text message. It must be regarded as a patient contact and all documentation should be in keeping with the NMC's *Record keeping: Guidance for nurses and midwives* (2009). All received messages should be deleted from the receiving handset after documentation to maintain high standards of confidentiality. Further guidance may be helpful including RCN – Use of text messaging services; *Guidance for nurses working with children and young people* (March 2006).

3 Wherever possible local policies should ensure the use of web-based products for texting that are secure and provide a robust audit trail. Clinical governance procedures should be in place to support such practice.

Standard 13: Titration

1 Where medication has been prescribed within a range of dosages it is acceptable for registrants to titrate dosages according to patient response and symptom control, and to administer within the prescribed range.

Guidance

2 A registrant must be competent to interpret test results, for example, blood results (heparin or glucose levels (insulin)), and assess, for example, withdrawal symptoms or signs of intoxication in the management of drug or alcohol withdrawal.

Standard 14: Preparing medication in advance

1 Registrants must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence.

Guidance

2 An exception to this is an already established infusion, which has been instigated by another practitioner following the principles set out above, or medication prepared under the direction of a pharmacist from a central intravenous additive service and clearly labelled for that patient. Where the specific summary of product characteristic or patient information leaflet indicate it should be prepared in advance, for example, some chemotherapy treatments, it is acceptable to do so.

3 Where a registrant has delegated to a named individual for a named patient's medication, this may be drawn up in advance to enable the healthcare assistant (HCA) or family to administer the medication. The registrant is accountable for the delegation, and a full risk assessment should be documented in the patient's records ensuring the registrant is aware of the risks before agreeing to delegate. The person to whom they are delegating the task is a 'named individual' who has been assessed and documented as competent.

4 Where you may be required to prepare substances for injection by a doctor, for example, in an emergency situation, you should ensure that the person administering the drug has undertaken the appropriate checks as indicated above.

Standard 15: Medication acquired over the internet

1 Registrants should never administer any medication that has not been prescribed, or that has been acquired over the internet without a valid prescription.

Guidance

2 Medication over the internet may not have been stored appropriately, the quality and safety of the medication cannot be verified, and there is often no batch number and so no redress from the manufacturer should adverse reactions occur.

3 Registered pharmacy premises can operate and provide internet pharmacy services. Where medicines are supplied via the internet from a registered pharmacy, the same standards are expected as would be received in a face-to-face situation.

Patients' own medication that has been purchased abroad and does not have a UK product licence

4 In this situation, a registrant must seek to identify the source of the original prescription to confirm its authenticity. Where this is not possible, the registrant should ascertain whether or not the patient would be prepared to have prescribed for them a drug with similar properties that is licensed in the UK. If the patient is in agreement, the registrant should request a prescription from a registered prescriber.

5 In a life-threatening situation or where the patient refuses to take anything but the 'unlicensed product' and they are unable to administer the medication themselves, the registrant may administer the medication in conjunction with locally agreed policies. In all circumstances a clear, accurate and contemporaneous record of all communication and administration of medication should be maintained.

Standard 16: Aids to support compliance

1 Registrants must assess the patient's suitability and understanding of how to use an appropriate compliance aid safely.

Guidance

2 Before considering the use of compliance aids the registrant should explore with the patient other possible solutions, for example reminder charts, large print labels, non-childproof tops. Self-administration from the dispensed containers may not always be possible for some patients. If an aid to compliance is considered necessary, careful attention should be given to the assessment of the patient's suitability and understanding of how to use an appropriate aid safely. Ideally a locally recognised assessment tool should be used. However, all patients will need to be regularly assessed for continued appropriateness of the aid. Ideally, any compliance aid, such as a monitored dose container or a daily or weekly dosing aid, should be dispensed, labelled and sealed by a pharmacist. The sealed compliance aids are generally referred to as monitored dosage systems.

3 Where it is not possible to get a compliance aid filled by a pharmacist, you should ensure that you are able to account for its use. The patient has a right to expect that the same standard of skill and care will be applied by you in dispensing into a compliance aid as would be applied if the patient were receiving the medication from a pharmacist. This includes the same standard of labelling and record keeping. Compliance aids, which can be purchased by patients for their own use, are aids that are filled from containers of dispensed medicines. If you choose to repackage dispensed medicinal products into compliance aids, you should be aware that their use carries a risk of error. You should also be aware the properties of the drug might also change when repackaged and so may not be covered by their product licence. Your employer needs to be aware of this activity and it should be covered by a standard operating procedure (SOP). The NMC would recommend that you confirm the appropriateness of re-packaging dispensed medicinal products with the community pharmacist who dispensed the medicines. You also need to consider how the patient will cope with medicines that cannot be included in compliance aids.

Crushing medication

4 The mechanics of crushing medicines may alter their therapeutic properties rendering them ineffective and are not covered by their product licence. Medicinal products should not routinely be crushed unless a pharmacist advises that the medication is not compromised by crushing, and crushing has been determined to be within the patient's best interest.

Disguising medication

5 As a general principle, by disguising medication in food or drink, the patient or client is being led to believe they are not receiving medication, when in fact they are. The NMC would not consider this to be good practice. The registrant would need to be sure what they are doing is in the best interests of the patient, and that they are accountable for this decision.

The standards: Section 5

Delegation

Standard 17: Delegation

1 A registrant is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task.

Guidance

2 This will require education, training and assessment of the patient, carer or care assistant and further support if necessary. The competence of the person to whom the task has been delegated should be assessed and reviewed periodically. Records of the training received and outcome of any assessment should be clearly made and be available.

3 See the guidance section 4, standard 8.

Standard 18: Nursing and midwifery students

1 Students must never administer or supply medicinal products without direct supervision.

Guidance

2 In order to achieve the outcomes and standards required for registration, students must be given opportunities to participate in the administration of medication but this must always be under direct supervision. Where this is done, both the student and registrant must sign the patient or woman's medication chart or document in the notes. The registrant is responsible for delegating to a student, and where it is considered the student is not yet ready to undertake administration in whatever form, this should be delayed until such time that the student is ready. Equally a student may decline to undertake a task if they do not feel confident enough to do so. The relationship between the registrant and the student is a partnership and the registrant should support the student in gaining competence in order to prepare for registration. As students progress through their training, their supervision may become increasingly indirect to reflect their competence level.

Standard 19: Unregistered practitioners

1 In delegating the administration of medicinal products to unregistered practitioners, it is the registrant who must apply the principles of administration of medicinal products as listed above. They may then delegate an unregistered practitioner to assist the patient in the ingestion or application of the medicinal product.

Guidance

2 Registrants may only delegate the ingestion or application of a controlled drug where the unregistered practitioner remains under the direct supervision of the registrant whether that is in a primary care, secondary care or independent sector setting. In care homes (personal care), health care assistants, support workers and care workers will not be skilled in giving medicines by invasive techniques and appropriate delegation is essential.

3 In the care of children with complex needs where an individual care plan has been written and signed off by a registrant, and the unregistered practitioner has been assessed by a registrant as competent to undertake the specific administration of medicinal products to a specific named patient, this may be undertaken, for example, children with complex health needs in community settings, palliative care.

Standard 20: Intravenous medication

1 Wherever possible two registrants should check medication to be administered intravenously, one of whom should also be the registrant who then administers the intravenous (IV) medication.

Guidance

2 In the exceptional circumstance where this is not possible, IVs should be checked by one registrant with another competent person who knows the patient. This could be a parent, carer or the patient themself. At a minimum, any dose calculation must be independently checked.

3 Registrants should be aware of the risks identified in the NPSA fourth report from the Patient Safety Observatory *Safety in doses: medication safety incidents in the NHS* (2007 and 2009). Search for this report at **www.npsa.nhs.uk**

4 In relation to the administration of intravenous medication, throughout the duration of intravenous medication therapy the registered nurse or midwife has a duty of care to the patient to monitor the patient and their response. View the standards for administration of IV therapy on the RCN website at **www.rcn.org.uk**

5 Registrants should also be familiar with the *UK Injectable Medicines Guide* currently under development at **www.ukmi.nhs.uk**

The standards: Section 6

Disposal of medicinal products

Standard 21: Disposal

1 A registrant must dispose of medicinal products in accordance with legislation.

Guidance

2 A patient or their representative (who may be a registered nurse or midwife) should return unwanted prescribed medicinal products to a pharmacy for destruction. In primary care, unwanted medication should be returned to a community pharmacy where it can be consigned as medicinal waste – classified as household waste. The definition of household waste is taken from the Controlled Waste Regulations 1992 and includes waste medicines from a patient's own home and waste medicines from a residential care home. The definition does not extend to stock medicines from other healthcare professionals, for example, midwives, nurses or doctors. There should be local procedures in hospital for the disposal of medicinal waste often overseen by the pharmacy department. If medication is taken to another health care environment it then becomes clinical waste and must be disposed of in accordance with clinical waste regulations. A community pharmacy cannot legally accept prescription medicines for disposal from care homes registered to provide nursing care, or from care homes that provide both residential and nursing care.

3 In this situation the care home (nursing) has to make its own arrangements for disposing of medication with a licensed waste management company. When a midwife is in possession of controlled drugs (CD) that are no longer required, they should be returned to the pharmacist from whom they were obtained, or to an appropriate medical officer. A record of the return should be made in the midwife's controlled drugs register. When a schedule 2 CD has been prepared or drawn up but is no longer required or no longer usable, it should be destroyed by the midwife, in accordance with current regulations.

The standards: Section 7

Unlicensed medicines

Standard 22: Unlicensed medicines

1 A registrant may administer an unlicensed medicinal product with the patient's informed consent against a patient-specific direction but not against a patient group direction.

Guidance

2 An unlicensed medicine is the term used to refer to a medicine that has no marketing authorisation. If an unlicensed medicine is administered to a patient, the manufacturer may not have liability for any harm that ensues. The person who prescribes and dispenses or supplies the medicine carries the liability. This may have implications for you in obtaining informed consent.

Medicinal products used outside their licence

3 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 the status of the product is clearly described.

4 As a registrant, you should be satisfied that you have sufficient information to administer a medicine prescribed off-label safely and, wherever possible, that there is acceptable published evidence for the use of that product for the intended indication.

5 As a registrant, you should be satisfied that you have sufficient information to administer an unlicensed or off-label drug safely and, wherever possible, that there is acceptable published evidence for the use of that product for the intended indication. Liability for prescribing an off-label product sits with the prescriber and the dispenser or supplier.

6 The British National Formulary for children provides useful information for 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* which you can find at **www.nmc-uk.org/publications**

The standards: Section 8

Complementary and alternative therapies

Standard 23: Complementary and alternative therapies

1 Registrants must have successfully undertaken training and be competent to practise the administration of complementary and alternative therapies.

Guidance

2 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 patient is aware of the therapy and gives informed consent.

3 Complementary and alternative therapies may interact with other types of medicinal products and laboratory tests. All complementary and alternative medicines should be recorded alongside other medicinal products and prescribed on inpatient prescription charts. You need to ensure that your employer has accepted vicarious liability for any complementary or alternative therapy you may undertake, or that you have indemnity insurance to cover your practice.

The standards: Section 9

Management of adverse events (errors or incidents) in the administration of medicines

Standard 24: Management of adverse events

1 As a registrant, if you make an error you must take any action to prevent any potential harm to the patient and report as soon as possible to the prescriber, your line manager or employer (according to local policy) and document your actions. Midwives should also inform their named supervisor of midwives.

Guidance

2 The NMC supports the use of a thorough, open and multi-disciplinary approach to investigating adverse events, where improvements to local practice in the administration of medicinal products can be discussed, identified and disseminated.

3 It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents in the administration of medicines.

4 The NMC believes that all errors and incidents require a thorough and careful investigation at a local level, taking full account of the context and circumstances, and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed. If a practising midwife makes or identifies a drug error or incident, she should also inform her supervisor of midwives as soon as possible aft er the event. In the NHS, all errors (patient safety incidents) and near-misses should be reported through local risk management systems. In England and Wales you should then report the incident to the National Patient Safety Agency (NPSA) through the National Reporting and Learning System (NRLS), whereas in Northern Ireland you should report to the Northern Ireland Adverse Incident Centre, and in Scotland through the NHS Quality Improvement Scotland (NHSQIS).

5 When considering allegations of misconduct arising from errors in the administration of medicines, the NMC takes great care to distinguish between those cases where the error was the result of reckless or incompetent practice and/or was concealed, and those that resulted from other causes, such as serious pressure of work, and where there was immediate, honest disclosure in the patient's interest. The NMC recognises the prerogative of managers to take local disciplinary action where it is considered to be necessary but urges that they also consider each incident in its particular context and similarly discriminate between the two categories described above. Registrants and their managers may find the NPSA's Incident Decision Tree Tool and Being Open Tool (details on **www.npsa.nhs.uk** and/or **www.saferhealthcare.org.u**K) useful. Allegations related to midwives would also be investigated by a supervisor of midwives as set out in the NMC's *Midwives rules and standards*, rule 5.

Standard 25: Reporting adverse reactions

1 As a registrant, if a patient experiences an adverse drug reaction to a medication you must take any action to remedy harm caused by the reaction. You must record this in the patient's notes, notify the prescriber (if you did not prescribe the drug) and notify via the Yellow Card Scheme immediately.

Guidance

2 Yellow cards are found in the back of the **British National Formulary** and online on **www.yellowcard.gov.uk**. In addition you should report any near misses or adverse events to the NPSA. For further information read the BNF or access the Medicines and Healthcare Products Regulatory Agency website **www.mhra.gov.uk**. Adverse drug reactions and patient safety incidents involving medicines, where a side effect (adverse drug reaction) from a medicine was preventable and still occurred, should be reported as a patient safety incident (error) through local risk management systems to the NPSA NRLS.

The standards: Section 10

Controlled drugs

Standard 26: Controlled drugs

1 Registrants should ensure that patients prescribed controlled drugs (CDs) are administered these in a timely fashion in line with the standards for administering medication to patients. Registrants should comply with and follow the legal requirements and approved local standard operating procedures for controlled drugs that are appropriate for their area of work.

Guidance

Medicines management for controlled drugs

2 Standards for medicines management apply to controlled drugs. However, following the government response to the fourth report of the Shipman Inquiry, there has been legislative change and new governance arrangements for controlled drugs (CDs), which impact on registrants. Registrants should be familiar with the DH guide *Safer Management of Controlled Drugs 2006* and the DH document *Guidance on the Management of Safe Use and Management of Controlled Drugs in Secondary Care in England Controlled Drugs in Acute Care 2007*.

3 Go to **www.dh.gov.uk** and search: controlled drugs.

4 Changes affecting the prescribing, record keeping and destruction of controlled drugs were introduced as a result of amendments to the Misuse of Drugs Regulations (MDR, 2001), Misuse of Drugs regulations (Northern Ireland), 2002, thereafter referred to as Misuse of Drugs Regulations (MDR), and the Health Act (2006), provided for regulations to be laid relating to governance and monitoring of controlled drugs.

5 The Health Act 2006 is primary legislation and applies to the whole of the UK although the regulations may differ in each of the devolved administrations. In England, the Controlled Drugs (Supervision of Management and Use) Regulations 2006 came into force on 1 January 2007 and in Scotland on 1 March 2007.

6 Go to **www.dh.gov.uk** and search: The Controlled Drugs (Supervision of Management and Use) Regulations 2006.

7 Within the provisions of the Act, Wales and Northern Ireland will make their own regulations in relation to controlled drugs. These will be equivalent to the Controlled Drugs (Supervision of Management and use of) Regulations 2006.

8 Controlled drugs are those defined in the MDR (2001) and MDR Regulations, 2002 (NI). See annexe 1. However, on occasions, health care organisations choose to handle non-CDs in the same way as CDs to ensure a higher level of governance. This is a local decision and does not form part of this guidance, although registrants are reminded they should adhere to local policies where they exist.

9 At local level, all healthcare organisations are accountable, through the accountable officer, (not applicable to Wales or Northern Ireland until legislation comes into effect until at least 2008) for ensuring the safe management of controlled drugs.

10 The regulatory requirements for accountable officers are set out in full in the Controlled Drugs (Supervision and Management of Use) Regulations 2006; **www.legislation.gov.uk/** and a summary of the main provisions is provided at Appendix 2 of the DH Guidance on the *Management of Controlled Drugs in Acute Care 2007*.

Standard operating procedures

11 Each of the activities concerned with CDs, regardless of where in an organisation they occur, must be described in a standard operating procedure (SOP). Registrants should be aware of all SOPs within their organisation.

Requisitioning of controlled drugs

12 All stationery which is used to order, return or distribute controlled drugs (CD stationery) must be stored securely, and access to it should be restricted.

13 CD stationery should be kept in a locked cupboard or drawer.

14 There should be a list of the CDs to be held in each ward or department as stock items. The contents of the list should reflect current patterns of usage of CDs in the ward or department, and should be agreed between the senior pharmacist, appropriate medical staff and the registrant in charge.

15 Only the CDs listed in the stock list may be routinely requisitioned or topped-up.

16 The registrant in charge of a ward, department, operating theatre or theatre suite is responsible for the requisitioning of controlled drugs for use in that area.

17 The registrant in charge can delegate control of access (that is key-holding) to the controlled drugs cabinet to another, such as a registered nurse or operating department practitioner. However, legal responsibility remains with the registrant in charge. (In Northern Ireland, it is not possible to delegate key holding to another but they may allow access via the keys which are then returned to the registrant in charge).

18 Orders must be written on suitable stationery (for example, a controlled drug requisition book) and must be signed by an authorised signatory.

19 A copy of the signature of each authorised signatory should be available in the pharmacy department for validation.

20 Requisitions must contain the:

20.1 hospital

20.2 ward or department

20.3 drug name, form, strength, ampoule size if more than one available

20.4 quantity

20.5 signature and printed name of nurse

20.6 date

20.7 signature to receive goods for transit

20.8 signature for receipt at ward or department.

Receipt of controlled drugs

21 When CDs are delivered to a ward or department they should be handed to a designated person. On no account should they be left unattended. A local procedure should define the persons who are permitted to receive CDs and the way in which messengers identify them.

22 As soon as possible after delivery the registrant in charge should:

22.1 check the CDs against the requisition – including the number ordered and received. If this is correct then the relevant (usually pink) sheet in the controlled drug requisition book should be signed in the 'received by' section

22.2 place the CDs in the CD cupboard

22.3 enter the CDs into the ward controlled drug record book, update the running balance and check that the balance tallies with the quantity that is physically present.

Storage

23 The Misuse of Drugs (Safe Custody) Regulations 1973 cover the safe custody of controlled drugs in certain specified premises. The regulations also set down certain standards for safes and cabinets used to store controlled drugs.

24 Ward CD cupboards should conform to the British Standard reference BS2881 or be otherwise approved by the pharmacy department. This is a minimum security standard and may not be sufficient for areas where there are large amounts of drugs in stock at a given time, or there is not a 24-hour staff presence, or easy control of access. In this case the advice of security specialists or crime prevention officers should be sought.

25 All controlled drugs should be stored in a locked receptacle which can only be opened by a person who can lawfully be in possession, such as a pharmacist or registrant in charge, or a person working under their authority.

26 General guidance for the storage of controlled drugs should include the following:

26.1 cupboards must be kept locked when not in use

26.2 the lock must not be common to any other lock in the hospital

26.3 keys must only be available to authorised members of staff

26.4 the cupboard must be dedicated to the storage of controlled drugs. No other medicines or items may be stored in the controlled drug cupboard. Controlled drugs must be locked away when not in use.

Key-holding and access to CDs

27 The registrant in charge is responsible for the CD key and should know its whereabouts at all times.

27.1 Key-holding may be delegated to other suitably trained members of staff but the legal responsibility rests with the registrant in charge

27.2 The controlled drug key should be returned to the registrant in charge immediately after use by another registered member of staff

27.3 On occasions, for the purpose of stock checking, the CD key may be handed to an authorised member of the pharmacy staff.

28 Northern Ireland registrants: see paragraph 17 on requisitioning of controlled drugs above.

Missing CD keys

29 If the CD keys cannot be found then urgent efforts should be made to retrieve the keys as speedily as possible, for example, by contacting nursing or midwifery staff who have just gone off duty.

30 A procedure should be in place to ensure that the registrant in charge or duty nurse manager and the duty pharmacist are informed as soon as possible. The procedure should specify the arrangements for preserving the security of CD stocks and for ensuring that patient care is not impeded.

Record keeping – controlled drug record books

31 Each ward or department that hold stocks of CDs should keep a record of CDs received and issued in a CD record book. In primary care, the relevant patient drug record card (where used) or CD record card for the administration of controlled drugs should be used. The registrant in charge is responsible for keeping the CD record book up to date and in good order.

32 The CD record book (acute care) should be bound (not loose-leaf), and it should have separate pages for each preparation. Entries should be made in chronological order, in ink. If a mistake is made, it should be crossed out with a single line or bracketed in such a way that the original entry is still clearly legible. This should be signed and dated, and witnessed by a second registered nurse or midwife who should also sign the change.

33 A record should be kept of all (schedule 2) controlled drugs that are received or issued.

34 All entries must be signed by two registrants, or one registrant and one student nurse or midwife (for administration only). Exceptionally, the second signature can be by another practitioner (for example, doctor or pharmacist) provided that they have witnessed the administration of the drug.

35 For CDs received, the following details should be recorded:

35.1 date on which received

35.2 name of pharmacist making supply/serial number of requisition

35.3 amount received

35.4 form in which received

35.5 balance in stock

36 For CDs issued the following details should be recorded:

36.1 date on which issue was made

36.2 name of patient

36.3 amount issued

36.4 form in which issued

36.5 name/signature of nurse/authorised person making the issue

36.6 name/signature of witness

36.7 balance in stock

37 If part of a vial is given to the patient, then the registrant should record the amount given and the amount wasted, for example, if the patient is prescribed a diamorphine 2.5mg and only a 5mg preparation is available, the record should show, '2.5mg given and 2.5mg wasted'.

38 After every administration, the stock balance of an individual preparation **must** be confirmed to be correct and the balance recorded in the controlled drug register.

39 In the community where there may not be two registrants available, a second competent person (which may be the carer) may witness the administration and balance of a controlled drug.

40 When recording controlled drugs received from pharmacy, the number of units received should be recorded in words not figures (for example, ten, not 10) to reduce the chance of entries being altered. On reaching the end of a page in the CD record book, the balance must be transferred to another page. The new page number must be added to the bottom of the finished page and the index updated.

Stock checks

41 The registrant in charge is responsible for ensuring that regular (locally determined protocol) CD stock checks are carried out.

42 Two registered nurses or midwives, should perform this check (a student nurse or midwife may be the second checker provided they have the necessary knowledge to carry this out).

43 Checking of controlled drugs involves checking of entries in the register against the contents of the controlled drug cupboard, not the reverse, to ensure all entries are checked. It is not necessary to open packs with intact tamper-evident seals for stock checking purposes.

44 A record indicating this check has been carried out and confirming the stock is correct may be kept in a separate record book or sheet or in the controlled drug register.

45 Stock balances of liquid medicines may be checked by visual inspection but the balance must be confirmed to be correct on completion of a bottle. Any discrepancy should be reported to the registrant in charge who should inform the pharmacist.

Midwives and controlled drugs

46 A registered midwife may possess diamorphine, morphine, pethidine and pentazocine in her own right so far as is necessary for the practice of her profession. See the Misuse of Drugs Regulations 2001 at: **www.legislation.gov.uk/uksi/2001/3998/contents/made**

47 Supplies of diamorphine, morphine, pethidine and pentazocine may only be made to her on the authority of a midwife's supply order signed by the supervisor of midwives, or other appropriate medical officer who is a doctor authorised in writing by the local supervising authority.

48 The supervisor of midwives or other appropriate medical officer should be satisfied that locally agreed procedure is being followed before signing the supply order (for example, that the amount being requested is appropriate etc).

49 The order must specify the name and occupation of the midwife, the purpose for which the controlled drug is required and the total quantity to be obtained. Supplies of pethidine, pentazocine, morphine and diamorphine may be obtained from a hospital pharmacy. However, this is only when classed as within the course of the business of the hospital the midwife works in, or it is a registered hospital pharmacy, or it holds a wholesale dealer's licence. The pharmacist who makes the supply should ensure that medicines are only supplied on the instruction of an authorised person. The pharmacist must retain the midwife's supply order for two years.

50 Midwives should record full details of supplies of diamorphine, morphine and pethidine received and administered in their controlled drugs register. This register should be used solely for that purpose and be made available for inspection as required by the supervisor of midwives.

51 Once medicines are received – by midwives working in the community or independent midwives – they become the responsibility of the midwife, and should be stored safely and securely.

52 Where it is necessary for midwives to keep medicines in their homes, the medicines should be placed in a secure, locked receptacle. If necessary, this should be provided by the employing body.

53 Administration of controlled drugs by midwives should be in accordance with locally agreed procedures. A record of administration of the controlled drugs should also be kept in the patient's records.

Returns and disposal

54 When a midwife is in possession of CDs that are no longer required they should be returned to the pharmacist from whom they were obtained, or to an appropriate medical officer. A record of the return should be made in the midwife's controlled drugs register.

55 When a schedule 2 controlled drug has been prepared or drawn up but is no longer required or no longer usable, it should be destroyed by the midwife, in accordance with current regulations. A record of the destruction should be made.

56 Controlled drugs obtained by a woman by prescription from her doctor, for use in her home confinement are her own property and are not the midwife's responsibility. Even when no longer required, they should not be removed by the midwife, but the woman should be advised to return them to the community pharmacy for destruction.

Returns to pharmacy (all registrants)

57 The following details should be recorded when controlled drugs are returned to the pharmacy:

57.1 date

57.2 name, form, strength and quantity of drug being returned

57.3 reason for return

57.4 name and signature of pharmacist removing the drugs

57.5 name and signature of nurse witnessing the removal of drugs from the ward

58 The top copy will be taken from the book and transported with the drugs to pharmacy.

59 In addition, an entry must be made on the relevant page of the ward controlled drug record book, showing:

59.1 date

59.2 reason for return

59.3 names and signatures of both nurse and pharmacist

59.4 quantity removed

59.5 balance remaining.

60 The drugs must be transported to pharmacy in a safe and secure way.

Transport of CDs

61 At each point where a controlled drug moves from the authorised possession of one person to another, a signature for receipt should be obtained by the person handing over the drug.

62 Wherever possible, CDs must be transported in a secure, lockable or sealed, tamper-evident container.

63 Registrants working in the community may transport CDs, however, they should present their identity badge to the pharmacist and sign for them on receipt, and should ensure they are transported securely to the patient's home. Once in the patient's home, the registrant should sign the patient drug record card and it should be witnessed that the CD has been received by the patient. Where a second registrant is not available another competent person may witness receipt (this could be a carer).

Disposal and destruction

64 Destruction on ward may take place at the same time as a pharmacy stock check.

65 CDs should be destroyed in such a way that the drug is denatured or destroyed so that it cannot be retrieved, reconstituted or used.

66 Destruction must occur in a timely fashion, so that excessive quantities are not stored awaiting destruction.

67 All destruction must be documented in the appropriate section of the register.

68 It must be witnessed by a second competent professional authorised under Regulation 27 of the MDR. Both persons must sign the register.

69 For more detail on the methods of destruction for CDs, registrants are advised to access table 2 of the *Guidance on Controlled Drugs in Acute Care* (2007), which summarises where CDs may be destroyed and who should carry out the destruction.

70 For guidance, go to **www.dh.gov.uk** and search for Safer Management of Controlled Drugs: Guidance on Standard Operating Procedures.

Annexe 1

Legislation

There are a number of pieces of legislation that relate to the prescribing, supply, storage and administration of medicines. It is essential that you comply with them. The following is a summary of those that are of particular relevance.

Medicines Act 1968

This was the first comprehensive legislation on medicines in the UK. The combination of this primary legislation and the various statutory instruments (secondary legislation) on medicines produced 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 of the 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 following categories:

Prescription only medicines (POMs)

These are medicinal products that may only be sold or supplied to a patient on the instruction of an appropriate practitioner. An appropriate practitioner is a doctor, dentist, supplementary prescriber, or nurse or pharmacist independent prescriber. For more information on the appropriate use of medicines and the relevant legislation, it is advisable to consult with a pharmacist. The Royal Pharmaceutical Society of Great Britain (RPSGB) can also provide more detailed information on medicines legislation.

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.

General sales list medicines (GSLs)

These need neither a prescription nor the supervision of a pharmacist and can be obtained from retail outlets.

Controlled drugs (CDs)

The management of controlled drugs is governed by the Misuse of Drugs Act 1971 and its associated regulations.

Misuse of Drugs Act 1971

The Misuse of Drugs Act (MDA) 1971 and its associated regulations provide the statutory framework for the control and regulation of controlled drugs. The primary purpose of the MDA is to prevent misuse of CDs. The MDA 1971 makes it unlawful to possess or supply a controlled drug unless an exception or exemption applies. A controlled drug is defined as any drug listed in schedule 2 of the Act.

Additional statutory measures for the management of controlled drugs are laid down in the Health Act 2006 and its associated regulations.

Misuse of Drugs Regulations 2001 (MDR) and Misuse of Drugs Regulations Northern Ireland (NI) 2002

The use of CDs in medicine is permitted by the Misuse of Drug Regulations (MDR). The MDR classify the drugs in five schedules according to the different levels of control required (see below). schedule 1 CDs are subject to the highest level of control, whereas schedule 5 CDs are subject to a much lower level of control.

For practical purposes, health care staff need to be aware of the current regulations.

The MDR are periodically amended and revised. The MDR currently in force and its amendments can be found at **www.legislation.gov.uk/uksi/2001/3998/contents/made**

Schedule 1 (CD licence)

Schedule 1 drugs include hallucinogenic drugs such as coca leaf, lysergide and mescaline. Production, possession and supply of drugs in this schedule are limited, in the public interest, to research or other special purposes. Only certain persons can be licensed by the Home Office to possess them for research purposes. Practitioners (for example, doctors, dentists and veterinary surgeons) and pharmacists may not lawfully possess schedule 1 drugs except under licence from the Home Office.

The drugs listed in schedule 1 have no recognised medicinal use although Sativex© (a cannabis-based product) is exempt from the requirements for a specific licence to be held by the pharmacist or prescriber, and is currently being supplied on a named-patient basis.

Schedule 2 (CD POM)

Schedule 2 includes more than 100 drugs such as the opioids, the major stimulants, secobarbital and amphetamine.

Safe custody – schedule 2 CDs (except secobarbital) are subject to safe custody requirements (under the Misuse of Drugs Safe Custody Regulations 1973 – see below). They must be stored in a locked receptacle, such as an appropriate CD cabinet or approved safe, which can only be opened by the person in lawful possession of the CD or a person authorised by them.

A licence is required to import or export drugs in schedule 2.

Schedule 2 CDs may be administered to a patient by a doctor or dentist, or by any person acting in accordance with the directions of an appropriately qualified prescriber who is authorised to prescribe schedule 2 CDs.

Nurse independent prescribers are currently permitted to prescribe, administer, or direct anyone to administer some CDs for specific conditions and routes of administration (under review).

Schedule 3 (CD no register)

Schedule 3 includes a small number of minor stimulant drugs and other drugs, which are less likely to be misused than drugs in schedule 2, or are less harmful if misused.

Safe custody – schedule 3 CDs are exempt from safe custody requirements. Exceptions are flunitrazepam, temazepam, buprenorphine and diethylpropion, which must be stored in a locked CD receptacle within a secure environment.

Schedule 4 (CD benzodiazepines and CD anabolic steroids)

Schedule 4 is split into two parts.

Part 1 (CD benzodiazepines) contains most of the benzodiazepines, plus eight other substances including zolpidem, fencamfamin and mesocarb.

Part 2 (CD anabolic steroids) contains most of the anabolic and androgenic steroids such as testosterone, together with clenbuterol (adrenoreceptor stimulant) and growth hormones (5 polypeptide hormones).

There is no restriction on the possession of a schedule 4 part 2 (CD anabolic steroids) drug when it is part of a medicinal product. However, possession of a drug from schedule 4 part 1 (CD benzodiazepines) is an offence without the authority of a prescription in the required form. Possession by practitioners and pharmacists acting in their professional capacities is authorised.

Schedule 5 (CD invoice)

Schedule 5 contains preparations of certain CDs (for example, codeine, pholcodine, morphine), which are exempt from full control when present in medicinal products of low strengths, as their risk of misuse is reduced.

There is no restriction on the import, export, possession, administration or destruction of these preparations and safe custody regulations do not apply.

Invoices must be retained for a minimum of two years.

Misuse of Drugs (Safe Custody) Regulations 1973 Misuse of Drugs (Safe Custody) Regulations Northern Ireland 1973

The Safe Custody Regulations impose controls on the storage of controlled drugs. The degree of control depends on the premises within which the drugs are being stored.

All schedule 2 and some schedule 3 CDs should be stored securely in accordance with the MDR. These regulations state that such CDs must be stored in a cabinet or safe, locked with a key. It should be made of metal, with suitable hinges and fixed to a wall or the floor with rag bolts that are not accessible from outside the cabinet.

Misuse of Drugs (Supply to Addicts) Regulations 1997 and Misuse of Drugs (Notification and Supply to Addicts (Northern Ireland) Regulations 1973

These regulations prohibit doctors from prescribing, administering or supplying diamorphine, cocaine or dipipanone for the treatment of addiction or suspected addiction except under Home Office licence. A licence is not required with such drugs for the treatment of organic disease or injury.

Prescription Only Medicines (Human Use) Order 1997

This order sets out the requirements for a valid prescription. It also allows midwives to possess and administer diamorphine, morphine, pethidine or pentazocine in the course of their professional practice.

A number of health care professionals are permitted to supply or administer medicines generally in accordance with a patient group direction (PGD) under Medicines Act legislation.

Registered nurses are permitted to supply or administer some CDs in accordance with a PGD under Misuse of Drugs legislation. **www.legislation.gov.uk/uksi/2001/3998/contents/made**

Health Act 2006

The key provisions of the act are:

- all designated bodies such as healthcare organisations and independent hospitals are required to appoint an accountable officer

- a duty of collaboration placed on responsible bodies, healthcare organisations and other local and national agencies including professional regulatory bodies, police forces, the Healthcare Commission and the Commission for Social Care inspection to share intelligence on controlled drug issues

- a power of entry and inspection for the police and other nominated people to enter premises to inspect stocks and records of controlled drugs.

Controlled Drugs (Supervision of Management and Use)

Regulations 2006

The Controlled Drug (Supervision of Management and Use) Regulations 2006 came into effect in England on the 1 January 2007. These regulations set out the requirements for certain NHS bodies and independent healthcare bodies to appoint an accountable officer, and describe the duties and responsibilities of accountable officers to improve the management and use of controlled drugs.

The regulations also require specified bodies to cooperate with each other, including with regard to sharing of information, concerns about the use and management of controlled drugs, and the setting out arrangements relating to powers of entry and inspection.

Annexe 2

Guidance on labelling and over-labelling of medicines

There may be occasions when registrants are required to dispense medicinal products and it is important that they understand the requirements for labelling correctly.

General sale list medicines are sold over the counter in containers showing the product in the box. Each medicinal product includes patient information either as a leaflet or on the packet or both.

Medicines dispensed to a patient-specific prescription must be labelled with all the required information.

The standard labelling requirements for all dispensed items are:

- the name of the person to whom the medicine is to be administered
- the name and address of the person who sells or supplies the medicinal product
- the date of dispensing
- directions for use
- the words ‘Keep out of the reach of children’ or words of direction bearing a similar meaning (for example, ‘Keep out of the reach and sight of children’).

Medicines supplied for use under a patient group direction are already labelled. These labels include all the standard labelling requirements apart from the patient’s name and date of supply. On supplying these medicines to the patient, the patient’s name and date of supply must be completed. This is sometimes known as over-labelling.

Registrants are advised to access the Medicines Ethics and Practice Guide at **www.rpsgb.org.uk/informationresources/downloadsocietypublications**

Annexe 3

Suitability of patients' own medicinal products for use

Additional guidance to Standard 5 of this document

The registrant must check that the medicinal products are suitable for use by ensuring:

- correct packaging and labelling
- dispensing date
- expiry date
- instructions for use
- dose
- the medicinal product matches what is on the label
- the patient information leaflet is enclosed
- correct patient name and ownership.

If the registrant is in any doubt as to the suitability of any of the medicinal products they must discuss this with their line manager or the pharmacy department. The registrant must seek consent to dispose of any unwanted medicinal product or they must be returned to the patient. Every effort must be made to ensure the patient understands the correct use of medications and the consequences of taking unprescribed medicines.

Where the prescription is changed the registrant has a responsibility to ensure that the medicinal products are re-dispensed as soon as possible.

Where a medicinal product is discontinued, it must be removed and with the patient's permission disposed of in the appropriate manner.

Administering medicines using the patient's own supply in the hospital or care home setting

When administering medicines from the patient's own supply the registrant must check the medicines in the locked cabinet or locker with the prescription chart and use only those medicines belonging to that named patient.

If a supply is not available medicines belonging to another patient must not be used.

Discharge of patients from hospital who have used their own supply or when checking medications to take home (TTOs/TTAs)

On discharge, the registrant is responsible for ensuring:

- the medicinal products have been clinically checked by the pharmacist
- the medicinal products are over-labelled for the patient
- the patient has the correct medicines, prescription or discharge summary and the supply is checked by a pharmacist, registered nurse or by two registrants if out of hours or according to local policy
- the patient has had sufficient medicinal products prescribed, dispensed and supplied to cover a period of time to enable them to access further supplies from their usual practitioner
- the patient is aware of any changes to their medication, that is, new medicine, dose, brand, route
- the patient has been educated and given patient information leaflets relating to all medication whether current or new
- the patient takes all their medicinal products home with them or has given permission to dispose of the medicines no longer prescribed
- where the patient wishes to retain their discontinued medicines the risk of confusion and possible under or overdose needs to be pointed out to them
- in the hospital setting, if the patient has been self-administering the key is returned to the registrant in charge of the ward or unit before the patient is discharged or care transferred
- if the bedside cabinet or locker key is lost, the appropriate hospital policy must be followed.

Annexe 4

Exclusion criteria for self-administration of medicines

When assessing a patient's suitability for self-administration of medicines, if the assessing registrant, in his or her professional judgement, is at all unhappy to let the patient self-administer, then the patient should be excluded and reassessed at another point.

If the patient does not give consent to self-administer and other arrangements are made, information about their medicines and what to do aft er discharge must still be given.

Patients who may be confused must not be given custody of their medicines but may administer on levels one and two only (see Standard 9 of this document).

In the hospital setting, this includes patients who are 'nil by mouth', immediately post-op and under the influence of anaesthetic agents, acutely ill patients or confused patients. The assessment should be carried out at an appropriate time in the course of the patient's admission to determine if they should be able to self-administer at a later stage, that is, when the anaesthetic agents have worn off or the acute stage of their illness is over.

Patients with a past history of drug or alcohol abuse do not have to be excluded from self-administration of their medicines but the need for extra supervision and reinforcement of education should be highlighted and documented. These patients should spend more time on levels one and two to ensure they receive adequate supervision and education. These patients may never get to administer at level 3 but they can still be educated at levels 1 and 2.

Any change in the patient's condition would necessitate a review of their self-administration status.

Local policies should be developed for this using the guidance for self-administration of medicinal products stated under Standard 9 of this document.

Registrants should be aware that the Mental Capacity Act 2005 requires all those working with potentially incapacitated people to assess the individual's capacity at a particular moment about a particular decision or issue. This would be predominantly older people and people with learning difficulties.

Annexe 5

Administering medicinal products in research clinical trials

Registrants involved in the supply or administration of a treatment or a placebo as part of a clinical trial would not need to consent to the trial itself, however, patients are required to do so. They would, however, need to know that the trial was taking place, and be willing to take part to the extent that they would be supplying or administering the medicine or placebo. The registrant's employer would need to discuss the trial with the registrant, and provide an information sheet in order to ensure that they had all the information available and confirmation that ethical approval had been sought and approved.

The purpose of the trial would be to establish whether the treatment is effective. Therefore, patients taking the placebo are not being deprived of a medicine that is known to be effective. There should be no reason for a registrant to object to taking part in that they are not depriving a patient of effective treatment but rather contributing to the evidence base for effective treatment in the future.

Also see *Midwives rules and standards* rule 8 on clinical trials which you can find at **www.nmc-uk.org/publications**

Annexe 6

Information, advice and publications

Royal Pharmaceutical Society of Great Britain
1 Lambeth High Street
London SE1 7JN
Telephone 020 7735 9141
www.rpsgb.org.uk

The Pharmaceutical Society of Northern Ireland
73 University Street
Belfast BT7 1HL
Telephone 028 90 326 927
www.psni.org.uk

Scottish Pharmaceutical General Council
42 Queen Street
Edinburgh EH2 3NH
Telephone 0131 467 7766
www.communitypharmacyscotland.org.uk

Office of the Chief Pharmacist
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS
Telephone 020 7210 5761
www.dh.gov.uk

Home Office
50 Queen Anne's Gate
London SW1H 9AP
Telephone 020 7273 3474
www.homeoffice.gov.uk

Medicines and Healthcare Products Regulatory Agency
Market Towers
1 Nine Elms Lane
London SW8 5NQ
Telephone 020 7084 2000
www.mhra.gov.uk

The Association of the British Pharmaceutical Industry
12 Whitehall
London SW1A 2DY
0870 8904333
www.abpi.org.uk

The Association of the British Pharmaceutical Industry (Scotland)
Third Floor East

Crichton House
4 Crichton's Close
Canongate
Edinburgh EH8 8DT
www.abpi.org.uk/Scotland/scot_intro.asp

European Council for Classical Homeopathy
at **www.homeopathy-ecch.org**

Prince of Wales Foundation for Integrated Health
at **www.fih.org.uk**

Publications

Royal Pharmaceutical Society of Great Britain. *Medicines, Ethics and Practice: A guide for pharmacists* is published annually and is available from **www.rpsgb.org.uk**

National Prescribing Centre (NPC). (2004) *A guide to good practice in the management of Controlled Drugs in primary care (England)*. **www.npc.co.uk**

The British National Formulary and the British National Formulary for Children are published jointly by the British Medical Association and the Royal Pharmaceutical Society of Great Britain. Copies are available from the Pharmaceutical Press, PO Box 151, Wallingford, Oxfordshire OX10 8QU.

The *Monthly Index of Medical Specialities* (MIMS) is available from MIMS Subscriptions, PO Box 43, Ruislip, Middlesex HA4 0YT, telephone 020 8845 8545 or fax 020 8845 7696.

The Review of Prescribing, Supply and Administration of Medicines: A Report on the Supply and Administration of Medicines under Group Protocols, (Crown I) (Department of Health, London, April 1998) was published under cover of Health Service Circular (HSC) 1998/051 in England; Management Executive letter (MEL) (98)29 in Scotland; Welsh Health Circular (WHC) (98)27 in Wales, and by each Chief Professional Officer to their respective professional groups in Northern Ireland. Copies are available from the NHS response line on 0541 555 455. The *Review of Prescribing, Supply and Administration of Medicines: Final Report* (Crown II) (Department of Health, London 1999) is available from the same source.

Non medical prescribing in Wales: a guide for implementation, July 2007, Welsh Assembly Government

Drug Information at **www.druginfozone.nhs.uk** and includes a centrally maintained archive of approved PGDs.

Medicines for Older People: Implementing medicines-related aspects of the NSF for Older People. DH March 2001 Can be searched for, and downloaded at, **www.dh.gov.uk**

Medicines Partnership Programme at **www.npc.co.uk/med_partnershi**p

National Electronic Library of Medicines **www.nelm.nhs.uk**

National Health Service Quality Improvement **www.nhshealthquality.org**

National Institute for Clinical Excellence **www.nice.org.uk**

National Patient Safety Agency (2007 and 2009) *Safety in doses: medication safety incidents in the NHS*. Reports from the Patients' Safety Observatory

PRODIGY **www.prodigy.nhs.uk**

Royal Pharmaceutical Society Great Britain (March 2005) *The Safe and Secure handling of medicines: a team approach*. A revision of the Duthie Report (1988)

National Health Services Act 1977

Misuse of Drugs Act 1971

Misuse of Drugs Regulations 2001 SI2001 No 3998

Misuse of Drugs (Safe Custody) Regulations 1973 SI1973 No 798

Medicines Act 1968 (as amended)

POM Order 1983 (as amended)

Prescription by Nurses etc. Act 1992

NHS Executive (2000) The Prescriptions Only Medicines (Human Use) Amendment (No2) Order 2000 SI No 22899 The Stationery Office, London

NHS Executive HSC 2000/026 *Patient group directions (England only)* (2000)

Royal Pharmaceutical Society of Great Britain (2004) Factsheet on patient group directions **www.rpsgb.org.uk/pdfs/factsheet10.pd**f

MHRA Patient Group Directions in the NHS. Search for at **www.mhra.gov.uk**

MHRA Patient Group Directions in the Private Sector. Search for at **www.mhra.gov.uk**
EC 92/27 Labelling and Leaflet Directive

Self-administration of medicines by hospital inpatients **www.audit-commission.gov.uk/itc/doc/selfadmin.doc**

Care Standards Act 2000

The Regulation of Care (Scotland) Act 2001

The Health and Social Care (Community Health and Standards) Act 2003

The Private and Voluntary Health Care (England) Regulations 2001

Department of Health National Minimum Standards for social care services **www.csci.org.uk/choose_and_find_care/your_rights/national_minimum_standards.aspx**

Royal Pharmaceutical Society of Great Britain (2003) *Administration and control of medicines in care homes and children's services* **www.rpsgb.org.uk**

MDA/2004/001 – *Reporting adverse incidents and disseminating medical device alerts*

Medicines and Healthcare Products Regulatory Agency **www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=5**

National Patient Safety Agency (2003) *National Reporting and Learning System service datasets*. Go to **www.npsa.nhs.uk**

Nursing and Midwifery Council circular – *Medicines legislation: what it means for midwives*, London: NMC 1/2005

Nursing and Midwifery Council circular – *Midwives Supplies Orders*, London: NMC 25/2005

Nursing and Midwifery Council – *Midwives rules and standards*, London: NMC 2004

Nursing and Midwifery Council – *Standards of proficiency for nurse and midwife prescriber*s, London: NMC 2006

Royal College of Midwives, *Midwives and medicines legislation: An Information Pape*r, London 2006

Royal Pharmaceutical Society of Great Britain (2005) *Medicines, Ethics and Practice: A Guide for pharmacists*: 29th edition Pharmaceutical Press.

The British National Formulary online **www.bnf.org**

For a list of current NMC publications go to **www.nmc-uk.org/publications**

Annexe 7

Glossary

clinical governance Quality assurance activities which ensure that pre-determined clinical standards that have been set, are seen to be maintained by practitioners, and are evident within health care settings.

clinical management plan (CMP) The CMP is the foundation stone of supplementary prescribing. Before supplementary prescribing can take place, it is obligatory for an agreed CMP to be in place (written or electronic) relating to a named patient or client and to that patient or client's specific condition(s) to be managed by the supplementary prescriber. The CMP is required to include details of the illness or conditions that may be treated, the class or description of medical products that can be prescribed or administered, and the circumstances in which the supplementary prescriber should refer to, or seek advice from, the doctor or dentist. Supplementary prescribers must have access to the same patient or client health records as the doctor or dentist. Since April 2005, nurse supplementary prescribers can prescribe controlled drugs, provided the doctor or dentist has agreed to this within the clinical management plan.

competence Relates to the need for the student to demonstrate their 'capability' in certain skill areas to a required standard at a point in time.

competencies Component skills which contribute to being competent and achieving the standards of proficiency for registration. Competencies might include skills arising from learning outcomes or other requirements.

dispensing To label from stock and supply a clinically appropriate medicine to a patient, client or carer, usually against a written prescription, for self-administration or administration by another professional, and to advise on safe and effective use.

Health Care Commission The health watchdog in England. It has a statutory duty to assess performance of health care organisations, award annual performance ratings for NHS and coordinate the review of health care by others. (The Care Quality Commission has since taken over the role of the Health Care Commission – see **www.cqc.org.uk**).

independent prescriber	A prescriber who is legally permitted and qualified to prescribe and takes the responsibility for the clinical assessment of the patient or client, establishing a diagnosis and the clinical management required, as well as the responsibility for prescribing, and the appropriateness of any prescribing.
licensed medication	The Medicines and Healthcare products Regulatory Agency (MHRA) operates a system of licensing before medicines are marketed (see marketing authorisation). However, the Medicines Act allows certain exemptions from licensing which include: • the manufacture and supply of unlicensed relevant medicinal products for individual patients or clients (commonly known as 'specials') • the importation and supply of unlicensed relevant medicinal products for individual patients or clients • herbal remedies exemption.
marketing authorisation	Previously known as a 'product licence'. This normally has to be granted by the MHRA before a medicine can be prescribed or sold. This authorisation, which confirms that medicines have met standards for safety, quality and efficacy, considers all of the activities associated with marketing medicinal products.
Medicines Act exemptions	Allow certain groups of healthcare professionals including occupational health schemes and midwives to sell, supply and administer particular medicines directly to patients or clients. Provided the requirements of any conditions attached to those exemptions are met, a patient group direction is not required.
medicines administration record	Also known as patient administration chart, the record by which medicinal products administered to a patient are recorded.
Medicines Healthcare Products Regulatory Agency (MHRA)	The government agency responsible for ensuring that medicines and medical devices work and are acceptably safe.
National Patient Safety Agency (NPSA)	A special health authority created to coordinate all the eff orts of all those involved in health care to learn from patient safety incidents occurring in the NHS.

nurse independent prescribers	Nurses and midwives who are on the relevant parts of the NMC register may train to prescribe any medicine for any medical condition within their competence with the exception of controlled drugs.
Nurse Prescribers Formulary for Community Practitioners (CPF)	The formulary from which nurses who have successfully completed the integrated prescribing component of the SPQ/ SCPHN programme may prescribe independently.
one-stop dispensing	One-stop dispensing is a system of administering and dispensing medicinal products. It involves using the patient's own medicinal products during their stay in hospital, either those dispensed by a community pharmacy or by the hospital pharmacy or both, providing they contain a patient information leaflet and are labelled with full instructions for use.
parts of the register	The NMC register, which opened on 1 August 2004, has three parts: nurses, midwives and specialist community public health nurses. A record of prescriber qualifications on the register identifies the registrant as competent to prescribe as community practitioner nurse prescriber or a nurse independent and supplementary prescriber.
patient group direction (PGD)	Written instructions for the supply or administration of named medicines to specific groups of patients who may not be individually identified before presenting for treatment. Guidance on the use of PGDs is contained within *Health Service Circular (HSC) 2000/026*. (Note: In Wales WHC 2000/116. Separate guidance has also been issued in Scotland and NI.) The circular also identifies the legal standing of PGDs plus 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. It is not a form of prescribing. See also guidance at **www.npc.co.uk**
patient information leaflet	Data sheets found in all dispensed medicinal products which should be brought to the patient's attention on administering the medicinal product.
patient specific direction	Written instructions from a doctor, dentist or nurse prescriber for a medicine to be supplied or administered to a named person. This could be demonstrated by a simple request in the patient or client's notes or an entry on the patient or client's drug chart.

prescription pricing division (PPD) registrants	Is a division of the NHS Business Services Authority in England responsible for processing all prescription items. Nurses, midwives and specialist community public health nurses currently entered in the NMC register.
repeat prescribing	A partnership between patient or client and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient or client having to consult the prescriber at each issue.
Regulation and Quality Improvement Authority (RQIA)	Is an independent health and social care regulatory body for Northern Ireland which encourages continued improvement in quality of services through a programme of inspections and reviews.
rules	Rules are established through legislation and they provide the legal strategic framework from which the NMC develops standards, for example, Education, Registration and Registration Appeals Rules 2004 (SI 2004/1767). 'Standards' support the rules. Standards are mandatory and gain their authority from the legislation, in this case the order and the rules.
specialist community public health nurse	A nurse who aims to reduce health inequalities by working with individuals, families and communities, promoting health, preventing ill health and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of whole populations.
stakeholders	Those who have a major interest in ensuring an effective programme outcome, including programme providers, placement providers, students, mentors, practice teachers, external examiners, external agencies, service users and carers.
standards	The NMC is required by the Nursing and Midwifery Order 2001 (the order) to establish standards of proficiency to be met by applicants to different parts of the register. The standards are considered to be necessary for safe and effective practice [Article 5(2)(a)]. These are set out within the Standards of proficiency for each of the three parts of the register, and for the recorded qualification of nurse or midwife prescriber.
summary of product characteristics	Information on medicinal products dispensed may be found at the Electronic Medicines Compendium.

supplementary prescribing	A voluntary partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber, to implement an agreed patient or client-specific clinical management plan with the patient or client's agreement.
transcribing (transposing)	Any act by which medicinal products are written from one form of direction to administer to another is 'transcribing'. Including discharge letters, transfer letters, copying illegible patient administrations chart 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. Reasons why a drug may not be licensed include: • the drug is undergoing a clinical trial, has been imported, has been prepared extemporaneously or prepared under a special manufacturing licence • the product is not a medicine but is being used to treat a rare condition.
unregistered practitioners	Practitioners providing care who are neither registered or licensed by a regulatory body and have no legally defined scope of practice.
Yellow Card Scheme	If a patient or client experiences an adverse drug reaction to a medication the nurse or midwife should record this in the patient or client's notes, notify the prescriber (if they did not prescribe the drug) and notify via the Yellow Card Scheme immediately. Yellow cards are found in the back of the British National Formulary and online on **www.yellowcard.gov.uk** For further information read the BNF or access the MHRA website **www.mhra.gov.uk**

Annexe 8

Contributors

Anne Iveson, Medicines Manager,
General Healthcare Group of Private Hospitals

Anne Ryan,
Medicines and Healthcare Products Regulatory Agency

Cathy Cairns, Professional Adviser,
Children and Young People's Nursing, NMC

Jan Palmer, Clinical Substance Misuse Lead, Prison Health,
Department of Health, London

Julie Matthews, Senior Lecturer,
Anglia Ruskin University

Liz Dimond, Professional Officer (Shipman),
Department of Health, London

Liz Plastow, Professional Adviser,
Specialist Community Public Health Nursing, NMC

Marion Russell, Clinical Development Nurse:
Medicines Management,
Guys & St Thomas NHS Foundation Trust

Maureen Morgan, Professional Adviser, CNO Team,
Department of Health, England

Meghna Joshi, Pharmacist,
Royal Pharmaceutical Society Great Britain

Professor Matt Griffiths,
Joint Prescribing and Medicines management Adviser,
Royal College of Nursing

Professor Molly Courtenay,
Joint Prescribing and Medicines management Adviser,
Royal College of Nursing

Dr Susan Way, Professional Adviser,
Midwifery, NMC

Theresa Rutter, Joint Director Community Health Services,
East and South East England Specialist Pharmacy Services,
Kensington and Chelsea PCT

Toni Bewley, Assistant to the Chief Nurse,
The Royal Liverpool Children's NHS Trust, AlderHey

Trudy Granby, National Prescribing Centre

Valerie Smith, Professional Adviser Independent Sector,
Royal College of Nursing

First published by the Nursing and Midwifery Council in 2007.
This current design was introduced in April 2010 with the addition of paragraph numbers to standards and guidance sections and updates to various references, however the content has not changed.

Contact us

Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
020 7333 9333
www.nmc-uk.org

PB-STMM-A5-0410

Nursing & Midwifery Council

Essential skills clusters (2010) and guidance for their use (guidance G7.1.5b)

The essential skills clusters (ESCs) are to be used as guidance and should be incorporated into all pre-registration nursing programmes. How they are incorporated into programmes is left to local determination. Programme providers can use them to develop learning outcomes at different levels or to map them against existing programme learning outcomes. Some programme providers may wish to map them to specific competencies within the domains or use them to develop practice assessment tools. All the ESCs apply to all fields of nursing.

Skills have not been identified for all progression points, therefore not all columns in the ESC table have been filled. Where there is a gap, skills identified at a later progression point might be achieved at an earlier point. Where it is determined that a specific skill can be more appropriately achieved at a different progression point than that indicated the approved education institution (AEI) should show how and at what point it has been incorporated.

ESCs support the achievement of the competencies in section 3 and criteria for assessment at the first progression point in annexe 2. However, the ESCs do not include all the skills and behaviours required of a registered nurse.

There are five **essential skills clusters**:

- care, compassion and communication
- organisational aspects of care
- infection prevention and control
- nutrition and fluid management
- medicines management.

Guidance related to numerical assessment

Some ESCs identify the baseline skills needed to calculate medicines, nutrition, fluids and other areas where there is a need to use numbers. These appear in ESCs 9, 27, 28, 29, 31, 32, 33, 36 and 38. They are marked with an asterix **(*)**. Providers should incorporate all these health related numerical assessments, designed to test numeracy skills, into learning outcomes and assessment strategies.

- The focus should be on demonstration of competence and confidence with regard to judgements on whether to use calculations in a particular situation and, if so, what calculations to use, how to do it, what degree of accuracy is appropriate, and what the answer means in relation to the context.

- Providers can incorporate these health related numerical elements into their own learning outcomes and assessment strategies and should use the ESCs to underpin the nature and content of the assessment, including whether to assess through simulation. They should decide on their own pass mark and how many attempts are allowed in order to reach the first and second progression points.

- After the second progression point, and by the point of entry to the register, the ESCs should help programme providers decide the nature and content of numerical assessments where a 100 percent pass mark is required.

- Assessment should reflect competence across the full range of complexity, the different delivery modes and technical measurement issues. This may take place in a combination of settings, including computer lab and simulated practice, but must include assessment in the practice setting. The number of attempts should be decided by the programme provider.

Essential skills cluster: Care, compassion and communication

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

1 As partners in the care process, people can trust a newly registered graduate nurse to provide collaborative care based on the highest standards, knowledge and competence.

First progression point	Second progression point	Entry to the register
1 Articulates the underpinning values of *The code: Standards of conduct, performance and ethics for nurses and midwives* (the code) (NMC 2008). 2 Works within limitations of the role and recognises own level of competence. 3 Promotes a professional image. 4 Shows respect for others. 5 Is able to engage with people and build caring professional relationships.	6 Forms appropriate and constructive professional relationships with families and other carers. 7 Uses professional support structures to learn from experience and make appropriate adjustments.	8 Demonstrates clinical confidence through sound knowledge, skills and understanding relevant to field. 9 Is self aware and self confident, knows own limitations and is able to take appropriate action. 10 Acts as a role model in promoting a professional image. 11 Acts as a role model in developing trusting relationships, within professional boundaries. 12 Recognises and acts to overcome barriers in developing effective relationships with service users and carers.

		13 Initiates, maintains and closes professional relationships with service users and carers. 14 Uses professional support structures to develop self awareness, challenge own prejudices and enable professional relationships, so that care is delivered without compromise.
2 People can trust the newly registered graduate nurse to engage in person centred care empowering people to make choices about how their needs are met when they are unable to meet them for themselves.		
First progression point	**Second progression point**	**Entry to the register**
1 Takes a person-centred, personalised approach to care.	2 Actively empowers people to be involved in the assessment and care planning process. 3 Determines people's preferences to maximise comfort & dignity. 4 Actively supports people in their own care and self care. 5 Considers with the person and their carers their capability for self care. 6 Provides personalised care, or makes provisions for those who are unable to maintain their own activities of living maintaining dignity at all times.	8 Is sensitive and empowers people to meet their own needs and make choices and considers with the person and their carer(s) their capability to care. 9 Ensures access to independent advocacy. 10 Recognises situations and acts appropriately when a person's choice may compromise their safety or the safety of others. 11 Uses strategies to manage situations where a person's wishes conflict with nursing interventions necessary for the person's safety.

	7 Assists people with their care.	12 Acts with dignity and respect to ensure that people who are unable to meet their activities of living have choices about how these are met and feel empowered to do as much as possible for themselves. 13 Works autonomously, confidently and in partnership with people, their families and carers to ensure that needs are met through care planning and delivery, including strategies for self care and peer support. 14 Actively helps people to identify and use their strengths to achieve their goals and aspirations.
3 People can trust the newly registered graduate nurse to respect them as individuals and strive to help them the preserve their dignity at all times.		
First progression point	**Second progression point**	**Entry to the register**
1 Demonstrates respect for diversity and individual preference, valuing differences, regardless of personal view. 2 Engages with people in a way that ensures dignity is maintained through making appropriate use of the		4 Acts professionally to ensure that personal judgements, prejudices, values, attitudes and beliefs do not compromise care. 5 Is proactive in promoting and maintaining dignity.

environment, self and skills and adopting an appropriate attitude. 3 Uses ways to maximise communication where hearing, vision or speech is compromised.		6 Acts autonomously to challenge situations or others when someone's dignity may be compromised. 7 Uses appropriate strategies to empower and support their choice.
4 People can trust a newly qualified graduate nurse to engage with them and their family or carers within their cultural environments in an acceptant and anti-discriminatory manner free from harassment and exploitation.		
First progression point	**Second progression point**	**Entry to the register**
1 Demonstrates an understanding of how culture, religion, spiritual beliefs, gender and sexuality can impact on illness and disability. 2 Respects people's rights. 3 Adopts a principled approach to care underpinned by the code (NMC 2008).		4 Upholds people's legal rights and speaks out when these are at risk of being compromised. 5 Is acceptant of differing cultural traditions, beliefs, UK legal frameworks and professional ethics when planning care with people and their families and carers. 6 Acts autonomously and proactively in promoting care environments that are culturally sensitive and free from discrimination, harassment and exploitation. 7 Manages and diffuses challenging situations effectively.
5 People can trust the newly registered graduate nurse to engage with them in a warm, sensitive and compassionate way.		

First progression point	Second progression point	Entry to the register
1 Is attentive and acts with kindness and sensitivity. 2 Takes into account people's physical and emotional responses when engaging with them. 3 Interacts with the person in a manner that is interpreted as warm, sensitive, kind and compassionate, making appropriate use of touch. 4 Provides person centred care that addresses both physical and emotional needs and preferences. 5 Evaluates ways in which own interactions affect relationships to ensure that they do not impact inappropriately on others.		6 Anticipates how people might feel in a given situation and responds with kindness and empathy to provide physical and emotional comfort. 7 Makes appropriate use of touch. 8 Listens to, watches for, and responds to verbal and non-verbal cues. 9 Engages with people in the planning and provision of care that recognises personalised needs and provides practical and emotional support. 10 Has insight into own values and how these may impact on interactions with others. 11 Recognises circumstances that trigger personal negative responses and takes action to prevent this compromising care. 12 Recognises and acts autonomously to respond to own emotional discomfort or distress in self and others. 13 Through reflection and evaluation demonstrates commitment to personal and professional development and life-long learning.

6 People can trust the newly registered graduate nurse to engage therapeutically and actively listen to their needs and concerns, responding using skills that are helpful, providing information that is clear, accurate, meaningful and free from jargon.		
First progression point	**Second progression point**	**Entry to the register**
1 Communicates effectively both orally and in writing, so that the meaning is always clear. 2 Records information accurately and clearly on the basis of observation and communication. 3 Always seeks to confirm understanding. 4 Responds in a way that confirms what a person is communicating. 5 Effectively communicates people's stated needs and wishes to other professionals.	6 Uses strategies to enhance communication and remove barriers to effective communication minimising risk to people from lack of or poor communication.	7 Consistently shows ability to communicate safely and effectively with people providing guidance for others. 8 Communicates effectively and sensitively in different settings, using a range of methods and skills. 9 Provides accurate and comprehensive written and verbal reports based on best available evidence. 10 Acts autonomously to reduce and challenge barriers to effective communication and understanding. 11 Is proactive and creative in enhancing communication and understanding. 12 Uses the skills of active listening, questioning, paraphrasing and reflection to support a therapeutic intervention. 13 Uses appropriate and relevant communication skills to deal with difficult and challenging circumstances, for example, responding to emergencies, unexpected occurrences, saying "no",

		dealing with complaints, resolving disputes, de-escalating aggression, conveying 'unwelcome news'.
7 People can trust the newly registered graduate nurse to protect and keep as confidential all information relating to them.		
First progression point	**Second progression point**	**Entry to the register**
1 Applies the principles of confidentiality. 2 Protects and treats information as confidential except where sharing information is required for the purposes of safeguarding and public protection. 3 Applies the principles of data protection.	4 Distinguishes between information that is relevant to care planning and information that is not.	5 Acts professionally and autonomously in situations where there may be limits to confidentiality, for example, public interest and protection from harm. 6 Recognises the significance of information and acts in relation to who does or does not need to know. 7 Acts appropriately in sharing information to enable and enhance care (carers, MDT and across agency boundaries). 8 Works within the legal frameworks for data protection including access to and storage of records. 9 Acts within the law when confidential information has to be shared with others.
8 People can trust the newly registered graduate nurse to gain their consent based on sound understanding and informed choice prior to any intervention and that their rights in decision making and consent will be respected and upheld.		
First progression point	**Second progression point**	**Entry to the register**

1 Seeks consent prior to sharing confidential information outside of the professional care team, subject to agreed safeguarding and protection procedures.	2 Applies principles of consent in relation to restrictions relating to specific client groups and seeks consent for care. 3 Ensures that the meaning of consent to treatment and care is understood by the people or service users.	4 Uses helpful and therapeutic strategies to enable people to understand treatments and other interventions in order to give informed consent. 5 Works within legal frameworks when seeking consent. 6 Assesses and responds to the needs and wishes of carers and relatives in relation to information and consent. 7 Demonstrates respect for the autonomy and rights of people to withhold consent in relation to treatment within legal frameworks and in relation to people's safety.

Essential skills cluster: Organisational aspects of care

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

9 People can trust the newly registered graduate nurse to treat them as partners and work with them to make a holistic and systematic assessment of their needs; to develop a personalised plan that is based on mutual understanding and respect for their individual situation promoting health and well-being, minimising risk of harm and promoting their safety at all times.

First progression point	Second progression point	Entry to the register
1 Responds appropriately when faced with an emergency or a sudden deterioration in a person's physical or psychological condition (for example, abnormal vital signs, collapse, cardiac arrest, self harm, extremely challenging behaviour, attempted suicide) including seeking help from an appropriate person.	2 Accurately undertakes and records a baseline assessment of weight, height, temperature, pulse, respiration and blood pressure using manual and electronic devices**. (*)** 3 Understands the concept of public health and the benefits of healthy lifestyles and the potential risks involved with various lifestyles or behaviours, for example, substance misuse, smoking, obesity. 4 Recognises indicators of unhealthy lifestyles. 5 Contributes to care based on an understanding of how the different stages of an illness or disability can impact on people and carers.	12 In partnership with the person, their carers and their families, makes a holistic, person centred and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and together, develops a comprehensive personalised plan of nursing care. 13 Acts autonomously and takes responsibility for collaborative assessment and planning of care delivery with the person, their cares and their family. 14 Applies research based evidence to practice.

	6 Measures and documents vital signs under supervision and responds appropriately to findings outside the normal range. **(*)** 7 Performs routine, diagnostic tests for example urinalysis under supervision as part of assessment process (near client testing). 8 Collects and interprets routine data, under supervision, related to the assessment and planning of care from a variety of sources. 9 Undertakes the assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk factors by working with the person and records, shares and responds to clear indicators and signs. 10 With the person and under supervision, plans safe and effective care by recording and sharing information based on the assessment. 11 Where relevant, applies knowledge of age and condition-related anatomy, physiology and development when interacting with people.	15 Works within the context of a multi-professional team and works collaboratively with other agencies when needed to enhance the care of people, communities and populations. 16 Promotes health and well-being, self care and independence by teaching and empowering people and carers to make choices in coping with the effects of treatment and the ongoing nature and likely consequences of a condition including death and dying. 17 Uses a range of techniques to discuss treatment options with people. 18 Discusses sensitive issues in relation to public health and provides appropriate advice and guidance to individuals, communities and populations for example, contraception, substance misuse, smoking, obesity. 19 Refers to specialists when required. 20 Acts autonomously and appropriately when faced with sudden deterioration in people's physical or psychological condition or emergency situations, abnormal vital signs, collapse, cardiac arrest, self-harm, extremely challenging behaviour, attempted suicide.

		21 Measures, documents and interprets vital signs and acts autonomously and appropriately on findings. 22 Works within a public health framework to assess needs and plan care for individuals, communities and populations.
10 People can trust the newly registered graduate nurse to deliver nursing interventions and evaluate their effectiveness against the agreed assessment and care plan.		
First progression point	**Second progression point**	**Entry to the register**
	1 Acts collaboratively with people and their carers enabling and empowering them to take a shared and active role in the delivery and evaluation of nursing interventions. 2 Works within the limitations of own knowledge and skills to question and provide safe and holistic care. 3 Prepares people for clinical interventions as per local policy. 4 Actively seeks to extend knowledge and skills using a variety of methods in order to enhance care delivery.	6 Provides safe and effective care in partnership with people and their carers within the context of people's ages, conditions and developmental stages. 7 Prioritises the needs of groups of people and individuals in order to provide care effectively and efficiently. 8 Detects, records and reports if necessary, deterioration or improvement and takes appropriate action autonomously. 9 Evaluates the effect of interventions, taking account of people's and carers' interpretation of physical, emotional, and behavioural changes.

	5 Detects, records, reports and responds appropriately to signs of deterioration or improvement.	10 Involves the person in review and adjustments to their care, communicating changes to colleagues.
11 People can trust the newly registered graduate nurse to safeguard children and adults from vulnerable situations and support and protect them from harm.		
First progression point	**Second progression point**	**Entry to the register**
1 Acts within legal frameworks and local policies in relation to safeguarding adults and children who are in vulnerable situations. 2 Shares information with colleagues and seeks advice from appropriate sources where there is a concern or uncertainty. 3 Uses support systems to recognise, manage and deal with own emotions.	4 Documents concerns and information about people who are in vulnerable situations.	5 Recognises and responds when people are in vulnerable situations and at risk, or in need of support and protection. 6 Shares information safely with colleagues and across agency boundaries for the protection of individuals and the public. 7 Makes effective referrals to safeguard and protect children and adults requiring support and protection. 8 Works collaboratively with other agencies to develop, implement and monitor strategies to safeguard and protect individuals and groups who are in vulnerable situations. 9 Supports people in asserting their human rights. 10 Challenges practices which do not safeguard those in need of support and protection.

12 People can trust the newly registered graduate nurse to respond to their feedback and a wide range of other sources to learn, develop and improve services.		
First progression point	**Second progression point**	**Entry to the register**
1 Responds appropriately to compliments and comments.	2 Responds appropriately when people want to complain, providing assistance and support. 3 Uses supervision and other forms of reflective learning to make effective use of feedback. 4 Takes feedback from colleagues, managers and other departments seriously and shares the messages and learning with other members of the team.	5 Shares complaints, compliments and comments with the team in order to improve care. 6 Actively responds to feedback. 7 Supports people who wish to complain. 8 As an individual team member and team leader, actively seeks and learns from feedback to enhance care and own and others professional development. 9 Works within ethical and legal frameworks and local policies to deal with complaints, compliments and concerns.

13 People can trust the newly registered, graduate nurse to promote continuity when their care is to be transferred to another service or person.		
First progression point	**Second progression point**	**Entry to the register**
	1 Assists in preparing people and carers for transfer and transition through effective dialogue and accurate information.	

	2 Reports issues and people's concerns regarding transfer and transition. 3 Assists in the preparation of records and reports to facilitate safe and effective transfer.	
14 People can trust the newly registered graduate nurse to be an autonomous and confident member of the multi-disciplinary or multi agency team and to inspire confidence in others.		
First progression point	**Second progression point**	**Entry to the register**
1 Works within the code (NMC 2008) and adheres to the *Guidance on professional conduct for nursing and midwifery students*. (NMC 2010)	2 Supports and assists others appropriately. 3 Values others' roles and responsibilities within the team and interacts appropriately. 4 Reflects on own practice and discusses issues with other members of the team to enhance learning. 5 Communicates with colleagues verbally, face-to-face and by telephone, and in writing and electronically in a way that the meaning is clear, and checks that the communication has been fully understood.	6 Actively consults and explores solutions and ideas with others to enhance care. 7 Challenges the practice of self and others across the multi-professional team. 8 Takes effective role within the team adopting the leadership role when appropriate. 9 Act as an effective role model in decision making, taking action and supporting others. 10 Works inter-professionally and autonomously as a means of achieving optimum outcomes for people.

		11 Safeguards the safety of self and others, and adheres to lone working policies when working in the community setting and in people's homes.
15 People can trust the newly registered graduate nurse to safely delegate to others and to respond appropriately when a task is delegated to them.		
First progression point	**Second progression point**	**Entry to the register**
1 Accepts delegated activities within limitations of own role, knowledge and skill.		2 Works within the requirements of the code (NMC 2008) in delegating care and when care is delegated to them. 3 Takes responsibility and accountable for delegating care to others. 4 Prepares, supports and supervises those to whom care has been delegated. 5 Recognises and addresses deficits in knowledge and skill in self and others and takes appropriate action.

16 People can trust the newly registered graduate nurse to safely lead, co-ordinate and manage care.		
First progression point	**Second progression point**	**Entry to the register**
		1 Inspires confidence and provides clear direction to others. 2 Takes decisions and is able to answer for these decisions when required. 3 Bases decisions on evidence and uses experience to guide decision-making. 4 Acts as a positive role model for others. 5 Manages time effectively. 6 Negotiates with others in relation to balancing competing and conflicting priorities.

17 People can trust the newly registered graduate nurse to work safely under pressure and maintain the safety of service users at all times.		
First progression point	**Second progression point**	**Entry to the register**
1 Recognises when situations are becoming unsafe and reports appropriately. 2 Understands and applies the importance of rest for effective practice.	3 Contributes as a team member. 4 Demonstrates professional commitment by working flexibly to meet service needs to enable quality care to be delivered.	7 Demonstrates effective time management. 8 Prioritises own workload and manages competing and conflicting priorities.

	5 Uses supervision as a means of developing strategies for managing own stress and for working safely and effectively. 6 Adheres to safety policies when working in the community and in people's homes, for example, lone worker policy.	9 Appropriately reports concerns regarding staffing and skill-mix and acts to resolve issues that may impact on the safety of service users within local policy frameworks. 10 Recognises stress in others and provides appropriate support or guidance ensuring safety to people at all times. 11 Enables others to identify and manage their stress. 12 Works within local policies when working in the community setting including in people's homes and ensures the safety of others.
18 People can trust a newly registered graduate nurse to enhance the safety of service users and identify and actively manage risk and uncertainty in relation to people, the environment, self and others.		
First progression point	**Second progression point**	**Entry to the register**
1 Under supervision, works within clinical governance frameworks. 2 Reports safety incidents regarding service users to senior colleagues. 3 Under supervision assesses risk within current sphere of knowledge and competence.	7 Contributes to promote safety and positive risk taking. 8 Under supervision works safely within the community setting taking account of local policies, for example, lone worker policy.	9 Reflects on and learns from safety incidents as an autonomous individual and as a team member and contributes to team learning. 10 Participates in clinical audit to improve the safety of service users.

4 Follows instructions and takes appropriate action, sharing information to minimise risk. 5 Under supervision works within legal frameworks to protect self and others. 6 Knows and accepts own responsibilities and takes appropriate action.		11 Assesses and implements measures to manage, reduce or remove risk that could be detrimental to people, self and others. 12 Assesses, evaluates and interprets risk indicators and balances risks against benefits, taking account of the level of risk people are prepared to take. 13 Works within legal and ethical frameworks to promote safety and positive risk taking. 14 Works within policies to protect self and others in all care settings including in the home care setting. 15 Takes steps not to cross professional boundaries and put self or colleagues at risk.
19 People can trust the newly registered graduate nurse to work to prevent and resolve conflict and maintain a safe environment.		
First progression point	**Second progression point**	**Entry to the register**
1 Recognises signs of aggression and responds appropriately to keep self and others safe. 2 Assists others or obtains assistance when help is required.		3 Selects and applies appropriate strategies and techniques for conflict resolution, de-escalation and physical intervention in the management of potential violence and aggression.

20 People can trust the newly registered graduate nurse to select and manage medical devices safely.		
First progression point	**Second progression point**	**Entry to the register**
1 Safely uses and disposes of medical devices under supervision and in keeping with local and national policy and understands reporting mechanism relating to adverse incidents.		2 Works within legal frameworks and applies evidence based practice in the safe selection and use of medical devices. 3 Safely uses and maintains a range of medical devices appropriate to the area of work, including ensuring regular servicing, maintenance and calibration including reporting adverse incidents relating to medical devices. 4 Keeps appropriate records in relation to the use and maintenance of medical devices and the decontamination processes required as per local and national guidelines. 5 Explains the devices to people and carers and checks understanding.

Essential skills cluster: Infection prevention and control

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

21 People can trust the newly registered graduate nurse to identify and take effective measures to prevent and control infection in accordance with local and national policy.

First progression point	Second progression point	Entry to the register
1 Follows local and national guidelines and adheres to standard infection control precautions.	2 Participates in assessing and planning care appropriate to the risk of infection thus promoting the safety of service users. 3 Participates in completing care documentation and evaluation of interventions to prevent and control infection. 4 Aware of the role of the Infection Control Team and Infection Control Nurse Specialist, and local guidelines for referral. 5 Recognises potential signs of infection and reports to relevant senior member of staff.	7 Works within the code (NMC 2008) and in keeping with the *Guidance on professional conduct for nursing and midwifery students* (NMC 2010) and in collaboration with people and their carers to meet responsibilities for prevention and control of infection. 8 In partnership with people and their carers, plans, delivers and documents care that demonstrates effective risk assessment, infection prevention and control. 9 Identifies, recognises and refers to the appropriate clinical expert. 10 Explains risks to people, relatives, carers and colleagues and educates them in prevention and control of infection.

	6 Discusses the benefits of health promotion within the concept of public health in the prevention and control of infection for improving and maintaining the health of the population.	11 Recognises infection risk and reports and acts in situations where there is need for health promotion and protection and public health strategies.
22 People can trust the newly registered graduate nurse to maintain effective standard infection control precautions and apply and adapt these to needs and limitations in all environments.		
First progression point	**Second progression point**	**Entry to the register**
1 Demonstrates effective hand hygiene and the appropriate use of standard infection control precautions when caring for all people.	2 Applies knowledge of transmission routes in describing, recognising and reporting situations where there is a need for standard infection control precautions 3 Participates in the cleaning of multi-use equipment between each person. 4 Uses multi-use equipment and follows the appropriate procedures. 5 Safely uses and disposes of, or decontaminates, items in accordance with local policy and manufacturers' guidance and instructions.	7 Initiates and maintains appropriate measures to prevent and control infection according to route of transmission of micro-organism, in order to protect service users, members of the public and other staff. 8 Applies legislation that relates to the management of specific infection risk at a local and national level. 9 Adheres to infection prevention and control policies and procedures at all times and ensures that colleagues work according to good practice guidelines. 10 Challenges the practice of other care workers who put themselves and others at risk of infection. 11 Manages overall environment to minimise risk.

	6 Adheres to requirements for cleaning, disinfecting, decontaminating of 'shared' nursing equipment, including single or multi-use equipment, before and after every use as appropriate, according to recognised risk, in accordance with manufacturers' and organisational policies.	
23 People can trust a newly registered graduate nurse to provide effective nursing interventions when someone has an infectious disease including the use of standard isolation techniques.		
First progression point	**Second progression point**	**Entry to the register**
	1 Safely delivers care under supervision to people who require to be nursed in isolation or in protective isolation settings. 2 Takes appropriate actions in any environment including the home care setting, should exposure to infection occur, for example, chicken pox, diarrhoea and vomiting, needle stick injury. 3 Applies knowledge of an 'exposure prone procedure' and takes appropriate precautions and actions.	5 Recognises and acts upon the need to refer to specialist advisers as appropriate. 6 Assesses the needs of the infectious person, or people and applies appropriate isolation techniques. 7 Ensures that people including colleagues are aware of and adhere to local policies in relation to isolation and infection control procedures. 8 Identifies suitable alternatives when isolation facilities are unavailable and principles have to be applied in unplanned circumstances

	4 Takes personal responsibility, when a student knowingly has a blood borne virus, to consult with occupational health before carrying out exposure prone procedures.	
24 People can trust a newly registered graduate nurse to fully comply with hygiene, uniform and dress codes in order to limit, prevent and control infection.		
First progression point	**Second progression point**	**Entry to the register**
1 Adheres to local policy and national guidelines on dress code for prevention and control of infection, including: footwear, hair, piercing and nails. 2 Maintains a high standard of personal hygiene. 3 Wears appropriate clothing for the care delivered in all environments.		4 Acts as a role model to others and ensures colleagues work within local policy.
25 People can trust a newly registered graduate nurse to safely apply the principles of asepsis when performing invasive procedures and be competent in aseptic technique in a variety of settings.		
First progression point	**Second progression point**	**Entry to the register**
	1 Demonstrates understanding of the principles of wound management, healing and asepsis.	4 Applies a range of appropriate measures to prevent infection including application of safe and effective aseptic technique.

	2 Safely performs basic wound care using clean and aseptic techniques in a variety of settings. 3 Assists in providing accurate information to people and their carers on the management of a device, site or wound to prevent and control infection and to promote healing wherever that person might be, for example, in hospital, in the home care setting, in an unplanned situation.	5 Safely performs wound care, applying non-touch or aseptic techniques in a variety of settings. 6 Able to communicate potential risks to others and advise people on the management of their device, site or wound to prevent and control infection and to promote healing.
26 People can trust the newly qualified nurse to act, in a variety of environments including the home care setting, to reduce risk when handling waste, including sharps, contaminated linen and when dealing with spillages of blood and other body fluids.		
First progression point	**Second progression point**	**Entry to the register**
	1 Adheres to health and safety at work legislation and infection control policies regarding the safe disposal of all waste, soiled linen, blood and other body fluids and disposing of ‘sharps’ including in the home setting. 2 Ensures dignity is preserved when collecting and disposing of bodily fluids and soiled linen. 3 Acts to address potential risks within a timely manner including in the home setting.	4 Manages hazardous waste and spillages in accordance with local health and safety policies. 5 Instructs others to do the same.

Essential skills cluster: Nutrition and fluid management

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

27 People can trust the newly registered graduate nurse to assist them to choose a diet that provides an adequate nutritional and fluid intake.

First progression point	Second progression point	Entry to the register
	1 Under supervision helps people to choose healthy food and fluid in keeping with their personal preferences and cultural needs. 2 Accurately monitors dietary and fluid intake and completes relevant documentation. **(*)** 3 Supports people who need to adhere to specific dietary and fluid regimens and informs them of the reasons. 4 Maintains independence and dignity wherever possible and provides assistance as required. 5 Identifies people who are unable to or have difficulty in eating or drinking and reports this to others to ensure adequate nutrition and fluid intake is provided.	6 Uses knowledge of dietary, physical, social and psychological factors to inform practice being aware of those that can contribute to poor diet, cause or be caused by ill health. 7 Supports people to make appropriate the choices and changes to eating patterns, taking account of dietary preferences, religious and cultural requirements, treatment requirements and special diets needed for health reasons. 8 Refers to specialist members of the multi-disciplinary team for additional or specialist advice. 9 Discusses in a non-judgemental way how diet can improve health and the risks associated with not eating appropriately.

		10 In liaison with a registered midwife provides essential advice and support to mothers who are breast feeding. 11 Provides support and advice to carers when the person they are caring for has specific dietary needs.
28 People can trust the newly registered graduate nurse to assess and monitor their nutritional status and in partnership, formulate an effective plan of care.		
First progression point	**Second progression point**	**Entry to the register**
	1 Takes and records accurate measurements of weight, height, length, body mass index and other appropriate measures of nutritional status. **(*)** 2 Assesses baseline nutritional requirements for healthy people related to factors such as age and mobility. 3 Contributes to formulating a care plan through assessment of dietary preferences, including local availability of foods and cooking facilities. 4 Reports to other members of the team when agreed plan is not achieved.	5 Makes a comprehensive assessment of people's needs in relation to nutrition identifying, documenting and communicating level of risk. **(*)** 6 Seeks specialist advice as required in order to formulate an appropriate care plan. 7 Provides information to people and their carers. 8 Monitors and records progress against the plan. 9 Discusses progress and changes in condition with the person, carers and the multi-disciplinary team.

		10 Acts autonomously to initiate appropriate action when malnutrition is identified or where a person's nutritional status worsens, and report this as an adverse event.
29 People can trust a newly registered graduate nurse to assess and monitor their fluid status and in partnership with them, formulate an effective plan of care.		
First progression point	**Second progression point**	**Entry to the register**
	1 Applies knowledge of fluid requirements needed for health and during illness and recovery so that appropriate fluids can be provided. 2 Accurately monitors and records fluid intake and output. **(*)** 3 Recognises and reports reasons for poor fluid intake and output. 4 Reports to other members of the team when intake and output falls below requirements.	5 Uses negotiating and other skills to encourage people who might be reluctant to drink to take adequate fluids. 6 Identifies signs of dehydration and acts to correct these. **(*)** 7 Works collaboratively with the person their carers and the multi-disciplinary team to ensure an adequate fluid intake and output.

30 People can trust the newly qualified graduate nurse to assist them in creating an environment that is conducive to eating and drinking.		
First progression point	**Second progression point**	**Entry to the register**
1 Reports to an appropriate person where there is a risk of meals being missed. 2 Follows food hygiene procedures in accordance with policy.	3 Follows local procedures in relation to mealtimes, for example, protected mealtimes, indicators of people who need additional support. 4 Ensures that people are ready for the meal; that is, in an appropriate location, position, offered opportunity to wash hands, offered appropriate assistance.	5 Challenges others who do not follow procedures. 6 Ensures appropriate assistance and support is available to enable people to eat. 7 Ensures provision is made for replacement meals for anyone who is unable to eat at the usual time, or unable to prepare their own meals. 8 Ensures that appropriate food and fluids are available as required.

31 People can trust the newly qualified graduate nurse to ensure that those unable to take food by mouth receive adequate fluid and nutrition to meet their needs.		
First progression point	**Second progression point**	**Entry to the register**
	1 Recognises, responds appropriately and reports when people have difficulty eating or swallowing.	3 Takes action to ensure that, where there are problems with eating and swallowing, nutritional status is not compromised.

	2 Adheres to an agreed plan of care that provides for individual difference, for example, cultural considerations, psychosocial aspects and provides adequate nutrition and hydration when eating or swallowing is difficult.	4 Administers enteral feeds safely and maintains equipment in accordance with local policy. **(*)** 5 Safely, maintains and uses naso-gastric, PEG and other feeding devices. 6 Works within legal and ethical frameworks taking account of personal choice.
32 People can trust the newly registered graduate nurse to safely administer fluids when fluids cannot be taken independently.		
First progression point	**Second progression point**	**By entry to the register**
		1 Understands and applies knowledge of intravenous fluids and how they are prescribed and administered within local administration of medicines policy. 2 Monitors and assesses people receiving intravenous fluids. **(*)** 3 Documents progress against prescription and markers of hydration. **(*)** 4 Monitors infusion site for signs of abnormality, and takes the required action reporting and documenting signs and actions taken.

Essential skills cluster: Medicines management[1]

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

33 People can trust the newly registered graduate nurse to correctly and safely undertake medicines[2] calculations.

First progression point	Second progression point	Entry to the register	Indicative content

1 Is competent in basic medicines calculations **(*)** relating to:
 	
• tablets and capsules
• liquid medicines
• injections including:
  • unit dose
  • sub and multiple unit dose
  • SI unit conversion.
		2 Is competent in the process of medication-related calculation in nursing field involving:
		
		• tablets and capsules
		• liquid medicines
		• injections
		• IV infusions including:
		  • unit dose
		  • sub and multiple unit dose
		  • complex calculations
		  • SI unit conversion.
			Numeracy skills, drug calculations required to administer medicines safely via appropriate routes including specific requirements for children and other groups.

1 Medicines management is “the clinical cost effective and safe use of medicines to ensure patients get maximum benefit from the medicines they need while at the same time minimising potential harm” (MHRA 2004). As the administration of a medicinal product is only part of the process, these ESCs reflect the process from prescribing, through to dispensing, storage, administration and disposal.

2 A Medicinal product is “Any substance or combination of substances presented for treating or preventing disease in human beings or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product” (Council Directive 65/65/EEC).

34 People can trust the newly registered graduate nurse to work within legal and ethical frameworks that underpin safe and effective medicines management.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates understanding of legal and ethical frameworks relating to safe administration of medicines in practice. 2 Demonstrates an understanding of types of prescribing, types of prescribers and methods of supply. 3 Demonstrates understanding of legal and ethical frameworks for prescribing.	4 Applies legislation to practice to safe and effective ordering, receiving, storing administering and disposal of medicines and drugs, including controlled drugs in both primary and secondary care settings and ensures others do the same. 5 Fully understands all methods of supplying medicines, for example, Medicines Act exemptions, patient group directions (PGDs), clinical management plans and other forms of prescribing. 6 Fully understands the different types of prescribing including supplementary prescribing, community practitioner nurse prescribing and independent nurse prescribing.	Law, consent, confidentiality, ethics, accountability. Responsibilities under law, application of medicines legislation to practice, include: use of controlled drugs, exemption orders in relation to patient group direction (PGD).[3] Regulatory requirements: *Standards for medicines management* (NMC 2007), the code (NMC 2008), *Standards of proficiency for nurse and midwife prescribers* (NMC 2006). Statutory requirements in relation to mental health, mental capacity, children and young people and medicines, national service frameworks and other country specific guidance.

3 Nursing students cannot supply or administer under a PGD (*Standards for medicines management* (NMC 2007)).

35 People can trust the newly registered graduate nurse to work as part of a team to offer holistic care and a range of treatment options of which medicines may form a part.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	7 Demonstrates awareness of a range of commonly recognised approaches to managing symptoms, for example, relaxation, distraction and lifestyle advice. 8 Discusses referral options.	9 Works confidently as part of the team and, where relevant, as leader of the team to develop treatment options and choices with the person receiving care and their carers. 10 Questions, critically appraises, takes into account ethical considerations and the preferences of the person receiving care and uses evidence to support an argument in determining when medicines may or may not be an appropriate choice of treatment.	The principles of holistic care, health promotion, lifestyle advice, over-the-counter medicines, self-administration of medicines and other therapies. Observation and assessment. Effect of medicines and other treatment options, including distraction, positioning, alternative and complementary therapies. Ethical and legal frameworks.

36 People can trust the newly registered graduate nurse to ensure safe and effective practice in medicines management through comprehensive knowledge of medicines, their actions, risks and benefits.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Uses knowledge of commonly administered medicines in order to act promptly in cases where side effects and adverse reactions occur.	2 Applies knowledge of basic pharmacology, how medicines act and interact in the systems of the body, and their therapeutic action. 3 Understands common routes and techniques of medicine administration including absorption, metabolism, adverse reactions and interactions. 4 Safely manages drug administration and monitors effects. **(*)** 5 Reports adverse incidents and near misses. 6 Safely manages anaphylaxis.	Related anatomy and physiology. Drug pathways and how medicines act. Impacts of physiological state of patients on drug responses and safety, for example, the older adult, children, pregnant or breast feeding women and significant pathologies such as renal or hepatic impairments. Pharmaco-dynamics -the effects of drugs and their mechanisms of action in the body. Pharmaco-therapeutics – the therapeutic actions of certain medicines. Risks versus benefits of medication. Pharmaco-kinetics and how doses are determined by dynamics and systems in the body.

			Role and function of bodies that regulate and ensure the safety and effectiveness of medicines. Knowledge on management of adverse drug events, adverse drug reactions, prescribing and administration errors and the potential repercussions for safety.
37 People can trust the newly registered graduate nurse to safely order, receive, store and dispose of medicines (including controlled drugs) in any setting.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates ability to safely store medicines under supervision.	2 Orders, receives, stores and disposes of medicines safely (including controlled drugs).	Managing medicines in hospital or primary care settings, for example, schools and the home care setting. Legislation that underpins practice related to a wide range of medicines such as controlled drugs, infusions and oxygen. Suitable conditions for storage, managing out-of-date stock, safe handling medication, managing discrepancies in stock, omissions.

38 People can trust the newly registered graduate nurse to administer medicines safely and in a timely manner, including controlled drugs.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Uses prescription charts correctly and maintains accurate records. 2 Utilises and safely disposes of equipment needed to draw up and administer medication, for example, needles, syringes, gloves. 3 Administers and, where necessary, prepares medication safely under direct supervision, including orally and by injection.	4 Safely and effectively administers and, where necessary, prepares medicines via routes and methods commonly used and maintains accurate records. **(*)** 5 Supervises and teaches others to do the same. 6 Understands the legal requirements.	Involvement of people receiving treatment, management of fear and anxiety, importance of non-verbal and verbal communication. Use of prescription charts including how to prepare, read and interpret them and record administration and non-administration. Use of personal drug record cards for controlled drugs. Preparing and administering medication in differing environments places, including the home care setting, hygiene, infection control, compliance aids, safe transport and disposal of medicines and equipment. Safety, checking person's identity, last dose, allergies, anaphylaxis, polypharmacy, monitoring of effect and record keeping.

			Where and how to report contra-indications, side effects, adverse reactions. Skills needed to administer safely via various means, for example, oral, topical, by infusion, injection, syringe driver and pumps. Aware of own limitations and when to refer on. Legal requirements, mechanisms for supply, sale and administration of medication, self-administration including controlled drugs.
39 People can trust a newly registered graduate nurse to keep and maintain accurate records using information technology, where appropriate, within a multi-disciplinary framework as a leader and as part of a team and in a variety of care settings including at home.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates awareness of roles and responsibilities within the multi disciplinary team for medicines management, including how and in what ways information is shared within a variety of settings.	2 Effectively keep records of medication administered and omitted, in a variety of care settings, including controlled drugs and ensures others do the same.	Links to legislation, use of controlled drugs, the code in relation to confidentiality, consent and record keeping. Use of electronic records.

40 People can trust a newly registered graduate nurse to work in partnership with people receiving medical treatments and their carers.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Under supervision involves people and carers in administration and self-administration of medicines.	2 Works with people and carers to provide clear and accurate information. 3 Gives clear instruction and explanation and checks that the person understands the use of medicines and treatment options. 4 Assesses the person's ability to safely self-administer their medicines. 5 Assists people to make safe and informed choices about their medicines.	Cultural, religious, linguistic and ethical beliefs, issues and sensitivities around medication. Ethical issues relating to compliance and administration of medicine without consent. Self-administration, assessment explanation and monitoring. Concordance. Meeting needs of specific groups including self-administration, for example, people with mental health needs, learning disabilities, children and young people, adolescents and older adults.

41 People can trust the newly registered graduate nurse to use and evaluate up-to-date information on medicines management and work within national and local policy guidelines.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Accesses commonly used evidence based sources relating to the safe and effective management of medicine.	2 Works within national and local policies and ensures others do the same.	Evidence based practice, identification of resources, the 'expert' patient and client. Using sources of information, national and local policies, clinical governance, formularies, for example, British National Formulary and the British National Formulary for Children.

42 People can trust the newly registered graduate nurse to demonstrate understanding and knowledge to supply and administer via a patient group direction.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates knowledge of what a patient group direction is and who can use them.	2 **Through simulation and course work** demonstrates knowledge and application of the principles required for safe and effective supply and administration via a patient group direction including an understanding of role and accountability.	National prescribing centre competency framework www.npc.co.uk

		3 **Through simulation and course work** demonstrates how to supply and administer via a patient group direction.	

Standards of organisational aspects of care given to patients

A nurses account

Strengths

I believe that I am able to identify most risks both to myself and the service user and am able to reduce those risks. I think that I can create a safe environment both for myself, my colleagues and the service user. I feel that I am able to work using clinical governance frameworks in order to reduce risks and can promote safety. I feel that I can report incidents that pose a risk to the service user, me or others quickly to help reduce risks to their safety.

Weaknesses

I would say although I can identify most risks I may not identify all risks. Therefore my weaknesses include ensuring that I detect all risks quickly and being able to manage risks which have occurred in a quick and effective manner. Also I believe that another of my weaknesses would be working within the legal framework and remembering the legal framework. I feel that I may be weak on implicating positive risk taking. I feel that I may not know who to inform if an incident has taken place.

Concerns

My concerns are that service users may feel that I have not dealt with risks correctly and efficiently. I am also concerned that I may make mistakes if I forget the legal framework which is in place at my placement. Another of my concerns is that I may not spot risks quickly and report them to the necessary people. I am also concerned that I may not be able to promote safety due to limited clinical experience.

Expectations

During my first placement I expect to be able to overcome most or all of my weaknesses and to be able work on the areas which are of concern to me. I expect to develop my team working skills and practice the skills I learnt during the recent Inter-professional learning week (IPLU). I believe that I can expect to overcome my concerns regarding the legal framework and learn how to work within it. I expect to gain valuable experience from my first placement and achieve a good understanding of what is expected of me and how to deal with risks and how to protect the service user's health and wellbeing for the duration of my placement.

Organisational Aspects of Care: Service users can trust a registered nurse to: identify and safely manage risk in relation to the service user, the environment, self and others.

This essay will look at why risk assessment and risk management are essential processes for both student nurses and registered nurses when treating service users and working with members of the multidisciplinary team. It will identify risks and how to manage them safely to ensure that the environment, the practitioner and others remain free from hazard. The essay will look at three areas of risk. These are failure to communicate effectively with the service user and other members within a team, infection control and moving and handling. This essay will look at the legal and ethical principles which are in place to protect the service user, the nurse and others. It will cover how health and safety principles reduce risks and at prevent them from occurring. The essay will look at policies and laws which are in place to reduce risks. These risks can occur within hospitals or the community.

It is imperative that nurses can identify and prevent risks. Bird & Dennis (2005) state that 'Threats to patient safety' should 'be identified and controls introduced' in order to 'eliminate risks'. Risk management is an on-going process which nurses are obliged to perform throughout their career. The Nursing and Midwifery Council (NMC) code (2008) is a set of 'standards of conduct, performance and ethics'. It states that as a nurse 'You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk' and that 'You must report your concerns' 'if problems in the environment of care are putting people at risk.' The nurse must always remember that they are 'a professional' and are 'accountable for actions and omissions' during their practice (NMC, 2008). This means that if they make a mistake they will be held responsible for their actions. According to the NMC Guidance on professional conduct for nursing and midwifery students (2009) student nurses should 'seek help immediately' if the service user they were caring for 'has suffered harm'. However they also make clear that a student nurse must always work within their 'limits' to prevent risks (NMC, 2009). The nurse must remember to treat all service users as individuals and treat them with dignity at all times whilst caring for them.

Communication is vital in risk prevention as a lack of communication can lead to mistakes being made and the health and safety of the service user being jeopardized. A nurse must know how to communicate with service users who are unable to use verbal communication as this will help them to deliver safe and effective care. They should learn how to recognise if a service user is in pain. This may be ascertained by the facial expressions that the service user may display. It is important for the nurse to communicate with the service user to find out how capable they are at carrying out tasks such as standing and walking. If the nurse knows this then they can reduce the risk of injury to themselves when performing moving and handling tasks by getting the service user to assist them. The student nurse needs to learn how to correctly complete a service users medical record and care plan in order to ensure that the information they need to convey can be understood by any member of the multidisciplinary team. According to Elster & Grothier service user records should be 'factual, legible, clear and concise' to prevent errors from arising. It is essential that the student nurse learns effective communication skills whilst in the clinical environment, as they must be able to convey information to another member of the team in a clear and correct manner. The nurse needs to realise that using medical terms when talking to another health professional is important as this will help clarify details of a service user's condition. However it is vital that the nurse understands that whilst the doctor knows what a medical term means the service user may not. Therefore the nurse should use clear and

concise language whilst being careful not to belittle the service user. Failure to convey information to the necessary professionals could result in a service user's health being put at risk or a condition overlooked. The nurse should always listen to the service user as they may tell the nurse if they have developed new symptoms. This is important because the service user's treatment may need to be altered. The NMC code (2008) states that the student nurse 'must meet people's communication needs' and must 'share with people' any information which they may 'want or need to know about their health'.

It is important for nurses to be aware of new pathogens and the infections they can cause in order to reduce risks. The nurse must know how infections can be transmitted and about the chain of infection. If one of the links in the chain of infection is broken then the transmission of a pathogen will either cease or the rate of transmission will decrease. In order for the nurse to break the chain they must follow standard precautions. These include correct hand washing, not working when ill and isolating infectious service users. The nurse should identify service users who are at high risk of infection. These include those with cancer, AIDS and the elderly. The service users immune system may be unable to provide adequate resistance due to their illness or the drugs they have been prescribed. If the nurse knows how to spot an infection then they can reduce the risks. This is because the early detection of infection will reduce the chances of it spreading between service users or to the health provider and can also increase the chances of it being successfully treated. Failing to spot infection could result in unnecessary suffering or even result in death. Rodgers et al (1999) state that 'cross infection' is increased due to 'close proximity' to other service users. The nurse is required by UK law 'to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work' (Health and Safety at Work etc. Act 1974 (c. 37) section 7). The nurse could be liable to prosecution if they have caused ill health to occur by failing to identify or treat an infection.

If the student nurse fails to identify risks when moving and handling then injury can occur to the service user, others or themselves. The Health and Safety at Work etc Act is an important piece legislation which nurses must adhere to. Roberts & Holly (1996) state that the Act aims to protect the 'health, safety and welfare' of employee's and the public from risks caused 'by the work of others'. Student and registered nurses must remember that before moving a service user they must 'gain consent' and 'respect and support people's rights to accept or decline treatment' (NMC Code 2008). Once the nurse has gained consent they should carry out a risk assessment in accordance with the local NHS trusts risk assessment policy. They should identify 'risks to both the handler and client' in order to prevent injury to themselves or the service user (Chell, 2003). The nurse needs to be able to identify the risks to prevent injury as according to the Health and Safety executive (HSE) 'musculoskeletal disorders' accounted for '40% of all sickness absence' within the health care industry. This is because health care workers are likely 'to adopt and hold awkward postures' (HSE, 2010). Moving and handling injuries can result in the nurse having to take time off from duties or may lead to them having to retire from their profession if they suffer permanent injury. The NHS are likely to have to recruit a temporary worker as well as paying the nurse whilst they are off work, this results in extra costs for the health service because they are having to pay for two people instead of one. NHS trusts have implemented risk management, moving and handling and risk assessment policies which both the student

nurse and registered nurse must adhere to. The NHS trust has the legal obligation to try to prevent 'the need for his employees' to carry out 'manual handling operations' which could cause injury (The Manual Handling Operations Regulations 1992 regulation 4).

In conclusion nurses are not only governed by the NMC when reducing risks to the service user but also by UK law. They must follow local policies which are based on these laws. These are introduced to ensure the health and wellbeing of the service user, nurse and other healthcare workers is protected at all times. The nurse must be able to identify risks such as the ones described above to protect the service user. Failure to identify risks can have serious health implications on the service user and nurse and could ultimately lead to unnecessary suffering or death of a service user or prosecution of the nurse.

Standards of care to patients

The NHS is there for us from the moment we are born. It takes care of us and our family members when we need it most.
The NHS Constitution has been created to protect the NHS and make sure it will always do the things it was set up to do in 1948 – to provide high-quality healthcare that's free and for everyone.
No government can change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for you.

What is the NHS Constitution?

For the first time in the history of the NHS, the constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.
The Constitution sets out your rights as an NHS patient. These rights cover how patients access health services, the quality of care you'll receive, the treatments and programmes available to you, confidentiality, information and your right to complain if things go wrong.

Your duty of care

Improving patient care has become a priority for all health care providers with the overall objective of achieving a high degree of patient satisfaction. Greater awareness among the public, increasing demand for better care, keener competition, more health care regulation, the rise in medical malpractice litigation, and concern about poor outcomes are factors that contribute to this change.

The quality of patient care is essentially determined by the quality of infrastructure, quality of training, competence of personnel and efficiency of operational systems. The fundamental requirement is the adoption of a system that is 'patient orientated'. Existing problems in health care relate to both medical and non-medical factors and a comprehensive system that improves both aspects must be implemented. Health care systems in developing countries face an even greater challenge since quality and cost recovery must be balanced with equal opportunities in patient care.

Non - medical aspects

The fact that the patient is the most important person in a medical care system must be recognised by all those who work in the system. This single factor makes a significant difference to the patient care in any hospital. In developing countries financial constraints often lead to compromised quality of care. This can be corrected by the introduction of

management systems that emphasise cost recovery. Our experience shows that a system should first be developed to attract patients who can afford to pay for high quality services and such a system should then be extended to non-paying patients. This system has the advantages of high quality care and good cost recovery. Some of the issues that need to be addressed to improve patient care are listed below.

1. **Access**. Accessibility and availability of both the hospital and the physician should be assured to all those who require health care.
2. **Waiting**. Waiting times for all services should be minimised. In most developing countries, the high demand for services often makes this a huge problem. Nevertheless, it has to be addressed effectively through continual review of patient responses and other data and using this feedback to make the necessary changes in systems.
3. **Information**. Patient information and instruction about all procedures, both medical and administrative, should be made very clear. Well trained patient counsellors form an effective link between the patient and the hospital staff and make the patient's experience better and the physicians' task much easier.
4. **Administration**. Check-in and check-out procedures should be 'patient friendly'. For example, for in-patients, we have instituted a system of discharging patients in their rooms, eliminating the need for the patient or the family to go to another office or counter in the hospital and waiting there for a long time. This has been favourably received by patients.
5. **Communication**. Communicating with the patient and the family about possible delays is a factor that can avoid a lot of frustration and anxiety. The creation of a special 'Patient Care Department' with a full time Administrator has helped our institution significantly and has enhanced our interactions with patients and their families.
6. **Ancillary Services**. Other services such as communication, food, etc. should be accessible both to patients and to attending families.

Medical aspects

The medical aspects of patient care are much better understood by most health care providers. This is dependent on the quality of medical and technical expertise, and the equipment and quality assurance systems in practice. The following factors contribute to the improvement of patient care.

1. **Trained Personnel.** A well-trained 'Eye Care Team' is critical to providing high quality care with desirable outcomes. Lack of adequate personnel and lack of adequate training facilities for the available personnel are major problems. The temptation to recruit untrained or poorly trained people should be resisted. The number of training programmes must be increased, and the existing programmes must be improved.

Making a uniform basic curriculum available for all training institutions/programmes should help bring about standardisation.

2. **Quality Eye Care.** There is significant concern about the outcomes of cataract surgery, and other common surgical procedures. Incorporation of quality assurance systems in every aspect of patient care is critical. For example, adherence to asepsis in the operating rooms will help reduce post-operative morbidity and proper training of ophthalmologists in diagnostic techniques will help achieve better control of sight-threatening diseases.
3. **Equipment.** All the necessary equipment must be in place and properly maintained. This is vital to the performance of the medical system and contributes significantly to better results. Eye-care equipment of acceptable standards is now available at reasonable prices, and this must be accompanied by appropriate maintenance systems.
4. **Use of Proper Instruments.** Good quality instruments are now available at lower costs. With the development of proper inventory control systems for a given operation, the costs can be lowered.
5. **Use of Appropriate Medications.** Access to low cost medicines is an absolute necessity for appropriate care.
6. **Use of Newer Technologies.** It is important to continually employ newer technologies that improve the quality of care. Of course, this must be done with reference to cost-efficiencies.

Improvement of patient care is a dynamic process and should be uppermost in the minds of medical care personnel. Development and sustenance of a patient-sensitive system is most critical to achieving this objective. It is important to pay attention to quality in every aspect of patient care, both medical and non-medical.

Communicating Effectively With Patients and Families

Communicating effectively with patients and families is a cornerstone of providing quality health care. The manner in which a health care provider communicates information to a patient can be equally as important as the information being conveyed. Patients who understand their providers are more likely to accept their health problems, understand their treatment options, modify their behaviour and adhere to follow-up instructions. If the single most important criterion by which patients judge us is by the way we interact with them, it stands to reason that effective communication is at the core of providing patient-centred care. Patient surveys have demonstrated when communication is lacking, it is palpably felt and can lead to patients feeling increased anxiety, vulnerability and powerlessness.

In one-on-one interactions with patients, and in organizational systems in place to promote dialogue, patient-centred hospitals are demonstrating the profound difference between communicating to patients and families and communicating with them. This section of the Improvement Guide details ways that these hospitals are humanizing and personalizing even the most routine interactions with patients, and how they are working to open up the

lines of communication between patients and families and providers. The representative patient comments below corroborate the profound importance of communication to the overall patient experience.

Personalization of Care

Building in processes and mechanisms to customize and personalize the patient experience is a key strategy for overcoming the fear, anxiety and stress associated with being at the hospital. To enter the hospital and subsequently be told what to wear and what and when to eat, to have normal sleeping patterns disrupted by inflexible hospital routines, to suddenly become dependent on others for basic personal needs like toileting and hygiene, and to be known as a room number versus a name, can all contribute to a feeling of being dehumanized.

Encouraging patient involvement and empowerment, including patients and families in the experience and focusing on how to create a more homelike experience are some ways health care providers may begin to reframe past practices. Patient-centered hospitals are implementing unique programs geared toward validating patient preferences, preserving patients‘ normal routines as much as possible, and maintaining the patient‘s personal identity throughout the health care experience.

Continuity of Care

While health care professionals interact with the health care system regularly, it is important for us to remember that for many patients, health care can feel like a complex and intimidating maze that they are forced to navigate without the benefit of a map or a guide to help them find their way—a metaphorical Oz minus the helpful and ever-present yellow brick road. Patients do their best to steer a clear course, but many report feeling left to wonder _why? ‘_what now?‘ and _what if?‘ with inadequate support from caregivers to help answer these pressing questions.

These patient experiences reinforce the importance of systems and tools to assist patients and their loved ones in anticipating what to expect for the duration of time that they are in our care, to address their anxiety and questions, and to help them plan for their needs once they leave the hospital. Providing information on the discharge plan from the onset of treatment (and in some cases, even before) is an extension of this work to foster continuity of care, equipping patients and their loved ones with the knowledge, skills and confidence that will enable them to better manage their health once they are no longer in our care.

By providing patients with the tools and information they need to manage their own health care needs, patient-centered hospitals are emphasizing the important role of the patient as the one constant for the duration of their health care experience. Nonetheless, patients rely on us, as the health care professionals, to help guide them through the maze. Unfortunately, many patients express frustration with their perception that caregivers are not talking with one another about their condition and plan of care, which in their view is

compromising care coordination efforts and leaving the often daunting task up to patients on their own. In a patient-centered setting, care is delivered in a manner that is coordinated among numerous caregivers and that involves the patient and family in the exchange of information between providers.

Family Involvement

Hospitals that are committed to being responsive to consumers 'needs and expectations understand the invaluable role of —family—however —family is defined by the patient. These are the people who know the patient best and those who, simply by their presence, can help to reassure patients in times of uncertainty, anxiety or vulnerability. Patient-centered hospitals welcome family members by not only lifting many of the restrictions that have historically limited their involvement, but also by actively encouraging their participation as members of the care team.

As health care institutions, we treat thousands of patients with cancer, heart disease and other chronic and terminal illnesses every year. Many of these patients are elderly or critically ill and may undergo difficult medical treatments that require lengthy and/or frequent hospital stays or outpatient visits. During their treatment, family caregivers are often a critical source of care for their loved ones. Family caregivers can offer providers a valuable source of help as well as information about the patient's history, routines, symptoms and more. For these family members, participating in this manner is essentially an extension of the ongoing caregiving role they play at home, both before and after hospitalization.

Environment of Care

Patients often enter the doors of a hospital with heightened feelings of stress, anxiety and vulnerability. The environment that meets them has the potential to profoundly exacerbate, or conversely, to profoundly assuage these states of mind, either way often leaving an indelible impression that persists long after the patient has left the hospital. The environment of care is not limited to physical surroundings and aesthetics. It encompasses the totality of the atmosphere of the organization—the sights, sounds, and smells, certainly, but also the attitudes and accommodations made around patient privacy, dignity, comfort and peace of mind.

A patient-centered environment of care is one that is safe and clean, and that guards patient privacy. It also engages all the human senses with colour, texture, artwork, music, aromatherapy, views of nature, and comfortable lighting, and considers the experience of the body, mind and spirit of all who use the facility. Space is provided for loved ones to congregate, as well as for peaceful contemplation, meditation or prayer, and patients, families and staff have access to a variety of arts and entertainment that serve as positive diversions. At the heart of the environment of care, however, are the human interactions that occur within the physical structure to calm, comfort and support those who inhabit it. Together the design, aesthetics, and these interactions can transform an institutional, impersonal and alien setting into one that is truly healing.

Spirituality

Spirituality is our own internal ability to find meaning and connectedness in life, and is not limited to religious traditions. Patients and families interacting with hospitals and health care institutions are often in the midst of challenging times or significant life events. Feelings of vulnerability, anxiety and fear abound. Patient-centered hospitals recognize the wide range of patient and family needs, and are implementing unique programs geared toward supporting the mind, body and spirit.

Integrative Medicine

A fundamental aim of patient-centered care is empowering patients with the knowledge, support and resources they need to make informed decisions and to manage their health and wellness. One way that patients are increasingly meeting their own health care needs is through the use of complementary and alternative medicine (CAM). Creating programs that support patients 'interest in and use of CAM modalities enhances patient choice and allows mind, body and spirit healing to be maximized. Top performing patient-centered hospitals are integrating CAM programs in both inpatient and outpatient settings.

Caring for the Community

Many hospitals have adopted a broader charge beyond caring for the sick and injured, focusing concurrently on promoting wellness, prevention and safety—not only for patients, but also for staff and the community-at-large. Patient-centered hospitals are increasingly providing their communities with access to prevention programs such as educational health seminars, safe driving classes, health fairs, opportunities to meet with professionals who can assist with advance directives, planning for your healthy future, and more. These community offerings all contribute to a patient-centered approach by reaching out beyond the walls of the hospital to meet the health care needs of the entire community. Included in this section are some innovative approaches in reaching out to, educating, and caring for the community.

Care for the Caregiver

Providing patient and family-centered care requires staff to give tremendous amounts of themselves—both physically and emotionally. Acknowledging and being responsive to the experience of staff, and the multi-faceted demands placed on them every day, is fundamental to patient-centeredness. Patient focus group comments underscore that when staff do not feel cared for and supported, when they feel stressed and burdened, these feelings are palpable to patients. So, despite efforts to understand and be more responsive to patient concerns and comfort, what we hear from patients is that it is they who are considering care from the perspective of staff who they perceive as over-worked, stressed and burdened for time. This translates into patients hesitating to request assistance or ask for information, and presents a sizeable barrier to providing patient-centered care.

Patient-centered hospitals not only strive to meet the full range of patient and family needs, but also those of staff. This includes putting in place a comprehensive system of reward and

recognition to acknowledge staff's dedication to putting patients and families first. Equally as important as a culture of recognition is a defined culture that encourages employee wellness and provides professional caregivers with outlets for stress reduction and work-life balance.

NMC standards for Medicine Management

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.

- We exist to safeguard the health and wellbeing of the public.
- We set the standards of education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code.
- We ensure that midwives are safe to practise by setting rules for their practice and supervision.
- We have fair processes to investigate allegations made against nurses and midwives who may not have followed the code.

Introduction

The Nursing and Midwifery Council (NMC) is the UK regulator for two professions: nursing and midwifery. The primary purpose of the NMC is protection of the public. It does this through maintaining a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK and by setting standards for their education, training and conduct. One of the most important ways of serving the public interest is through providing advice and guidance to registrants on professional issues. The purpose of this booklet is to set standards for safe practice in the management and administration of medicines by registered nurses, midwives and specialist community public health nurses.

Standards for medicine management replace the Guidelines for the administration of medicines 2004, although many of its principles remain relevant today, for example:

“The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council’s register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner (can now also be an independent and supplementary prescriber). It requires thought and the exercise of professional judgement...”

Many government and other agencies are involved in medicines management from manufacture, licensing, prescribing and dispensing, to administration. As the administration of a medicinal product is only part of the process, these standards reflect the process from prescribing through to dispensing, storage, administration and disposal. There exists an extensive range of guidance on medicines management from a range of relevant bodies. Sources of information are listed on pages 55–58. One of the best sources of advice locally is the pharmacist.

As with all NMC standards, this booklet provides the minimum standard by which practice should be conducted and will provide the benchmark by which practice is measured. Due to the complexity, speed and extent of change in contemporary health care, it is not intended to cover every single situation that you may encounter during your career. Instead, it sets out a series of standards that will enable you to think through issues and apply your professional expertise and judgement in the best interests of your patients. It will also be necessary to develop and refer to additional local and national policies and protocols to suit local needs.

Definitions

Medicinal products

“Any substance or combination of substances presented for treating or preventing disease in human beings or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product.” Council Directive

Medicines management

“The clinical, cost-effective and safe use of medicines to ensure patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm.” (MHRA 2004).

Blood and blood products

Blood is not classified as a medicinal product although some blood components are. Products derived from the plasma component of blood such as blood clotting factors, antibodies and albumin are licensed and classified as considered to be medicinal products. For the purpose of the administration of medicinal products registrants would be expected to apply the standards for medicines management to all medicinal products but should consider additional guidance by the National Patient Safety Agency– guidance launched on 9 November 2006; Right patient, Right blood

(available at www.npsa.nhs.uk). A key requirement of this guidance is that all staff involved in blood transfusion undergo formal competency assessment on a three-yearly basis.

Use of the word 'patient' throughout the document

Throughout this document where the word 'patient' is used this refers to whoever the medication may be administered to, for example, patient, client, user or woman (midwifery).

Use of the word 'registrant' throughout the document

Throughout this document where the word 'registrant' is used this refers to nurses, midwives and specialist community public health nurses who are registered on the NMC register.

Summary of standards

This section provides a summary of the standards for easy reference. For further detail you should read, follow and adhere to the standards as detailed later in the document. It is essential that you read the full guidance.

Section 1

Methods of supplying and/or administration of medicines

Standard 1: Methods

Registrants must only supply and administer medicinal products in accordance with one or more of the following processes:

- Patient specific direction (PSD)
- Patient medicines administration chart (may be called medicines administration record MAR)
- Patient group direction (PGD)
- Medicines Act exemption
- Standing order
- Homely remedy protocol
- Prescription forms

Standard 2: Checking

Registrants must check any direction to administer a medicinal product.

Standard 3: Transcribing

As a registrant you may transcribe medication from one 'direction to supply or administer' to another form of 'direction to supply or administer'.

Section 2

Dispensing

Standard 4: Prescription medicines

Registrants may in exceptional circumstances label from stock and supply a clinically appropriate medicine to a patient, against a written prescription (not PGD), for self-administration or administration by another professional, and to advise on its safe and effective use.

Standard 5: Patients' own medicines

Registrants may use patients' own medicines in accordance with the guidance in this booklet Standards for medicines management.

Section 3

Storage and transportation

Standard 6: Storage

Registrants must ensure all medicinal products are stored in accordance with the patient information leaflet, summary of product characteristics document found in dispensed UK-licensed medication, and in accordance with any instruction on the label.

Standard 7: Transportation

Registrants may transport medication to patients including controlled drugs, where patients, their carers or representatives are unable to collect them, provided the registrant is conveying the medication to a patient for whom the medicinal product has been prescribed, (for example, from a pharmacy to the patient's home).

Section 4

Standards for practice of administration of medicines

Standard 8: Administration

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

- You must be certain of the identity of the patient to whom the medicine is to be administered
- You must check that the patient is not allergic to the medicine before administering it
- You must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- You must be aware of the patient's plan of care (care plan or pathway)
- You must check that the prescription or the label on medicine dispensed is clearly written and unambiguous
- You must check the expiry date (where it exists) of the medicine to be administered
- You must have considered the dosage, weight where appropriate, method of administration, route and timing
- You must administer or withhold in the context of the patient's condition,

  (For example, Digoxin not usually to be given if pulse below 60) and co-existing therapies, for example, physiotherapy
- You must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable (see Standard 25).
- You must make a clear, accurate and immediate record of all medicine administered intentionally withheld or refused by the patient, ensuring the signature is clear and legible. It is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

  In addition:

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

  In respect of controlled drugs:

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

Standard 9: Assessment

As a registrant, you are responsible for the initial and continued assessment of patients who are self-administering and have continuing responsibility for recognising and acting upon changes in a patient's condition with regards to safety of the patient and others.

Standard 10: Self-administration – children and young people

In the case of children, when arrangements have been made for parents or carers or patients to administer their own medicinal products prior to discharge or rehabilitation, the registrant should ascertain that the medicinal product has been taken as prescribed.

Standard 11: Remote prescription or direction to administer

In exceptional circumstances, where medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use

of information technology (such as fax, text message or email) may be used but must confirm any change to the original prescription.

Standard 12: Text messaging

As a registrant, you must ensure that there are protocols in place to ensure patient confidentiality and documentation of any text received including: complete text message, telephone number (it was sent from), the time sent, any response given, and the signature and date when received by the registrant.

Standard 13: Titration

Where medication has been prescribed within a range of dosages, it is acceptable for registrants to titrate dosages according to patient response and symptom control and to administer within the prescribed range.

Standard 14: Preparing medication in advance

Registrants must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence.

Standard 15: Medication acquired over the internet

Registrants should never administer any medication that has not been prescribed, or that has been acquired over the internet without a valid prescription.

Standard 16: Aids to support compliance

Registrants must assess the patient's suitability and understanding of how to use an appropriate compliance aid safely.

Section 5

Delegation

Standard 17: Delegation

A registrant is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task.

Standard 18: Nursing and midwifery students

Students must never administer or supply medicinal products without direct supervision.

Standard 19: Unregistered practitioners

In delegating the administration of medicinal products to unregistered practitioners, it is the registrant who must apply the principles of administration of medicinal products as listed above. They may then delegate an unregistered practitioner to assist the patient in the ingestion or application of the medicinal product.

Standard 20: Intravenous medication

Wherever possible, two registrants should check medication to be administered intravenously, one of whom should also be the registrant who then administers the intravenous (IV) medication.

Section 6

Disposal of medicinal products

Standard 21: Disposal

A registrant must dispose of medicinal products in accordance with legislation.

Section 7

Unlicensed medicines

Standard 22: Unlicensed medicines

A registrant may administer an unlicensed medicinal product with the patient's informed consent against a patient-specific direction but NOT against a patient group direction.

Section 8

Complementary and alternative therapies

Standard 23: Complementary and alternative therapies

Registrants must have successfully undertaken training and be competent to practise the administration of complementary and alternative therapies.

Section 9

Management of adverse events (errors or incidents) in the administration of medicines

Standard 24: Management of adverse effects

As a registrant, if you make an error you must take any action to prevent any potential harm to the patient and report as soon as possible to the prescriber, your line manager or employer (according to local policy) and document your actions. Midwives should also inform their named supervisor of midwives.

Standard 25: Reporting adverse reactions

As a registrant, if a patient experiences an adverse drug reaction to a medication, you must take any action to remedy harm caused by the reaction. You must record this in the patient's notes, notify the prescriber (if you did not prescribe the drug) and notify via the Yellow Card Scheme immediately.

Section 10

Controlled drugs

Standard 26: Controlled drugs

Registrants should ensure that patients prescribed controlled drugs are administered these in a timely fashion in line with the standards for administering medication to patients. Registrants should comply with and follow the legal requirements and approved local standard operating procedures for controlled drugs that are appropriate for their area of work.

Contents

Standards

Section 1: Method of supplying and/or administration of medicines

Standard 1: Methods 12

Standard 2: Checking 17

Standard 3: Transcribing..... 18

Section 2: Dispensing

Standard 4: Prescription medicines 19

Standard 5: Patients' own medicines..... 20

Section 3: Storage and transportation

Standard 6: Storage..... 22

Standard 7: Transportation 23

Section 4: Standards for practice of administration of medicines

Standard 8: Administration..... 23

Standard 9: Assessment..... 26

Standard 10: Self-administration – children and young people 28

Standard 11: Remote prescription or direction to administer 29

Standard 12: Text messaging 30

Standard 13: Titration 30

Standard 14: Preparing medication in advance..... 31

Standard 15: Medication acquired over the internet..... 31

Standard 16: Aids to support compliance 32

Section 5: Delegation

Standard 17: Delegation..... 33

Standard 18: Nursing and midwifery students..... 34

Standard 19: Unregistered practitioners..... 34

Standard 20: Intravenous medication 35

Section 6: Disposal of medicinal products

Standard 21: Disposal..... 36

Section 7: Unlicensed medicines

Standard 22: Unlicensed medicines..... 36

Section 8: Complementary and alternative therapies

Standard 23: Complementary and alternative therapies 37

Section 9: Management of adverse events (errors or incidents) in the administration of medicines

Standard 24: Management of adverse events..... 38

Standard 25: Reporting adverse reactions 39

Section 10: Controlled drugs

Standard 26: Controlled drugs..... 39

Standard 1: Methods

1 Registrants must only supply and administer medicinal products in accordance with one or more of the following processes:

1.1 Patient-specific direction (PSD)

1.2 Patient medicines administration chart (may be called a medicines administration record (MAR)

1.3 Patient group direction (PGD)

1.4 Medicines Act Exemption (where they apply to nurses)

1.5 Standing order

1.6 Homely remedy protocol

1.7 Prescription forms

2. Once a medicinal product has been prescribed and dispensed to an individual, the drug is the individual's own property. To use it for someone else is theft. Registrants should refer to DH (2006) Medicines Matters: A guide to mechanisms for the prescribing, supply and administration of medicines.

Patient-specific direction (PSD)

3 A patient-specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient. In primary care, this might be a simple instruction in the patient's notes. Examples in secondary care include instructions on a patient's medicines administration chart. The direction would need to be specific as to the route of administration it cannot simply authorise a course of treatment to several patients. Where a PSD exists, there is no need for a patient group direction.

4 Each individual patient must be identified on the PSD. An example of using a PSD is in the administration of routine vaccine where a list of patients due a vaccine may be identified beforehand. In the case of controlled drugs, it is essential to comply with full prescription requirements. Go to www.dh.gov.uk and search for controlled drugs.

Patient medicines administration chart

5 The patient medicines administration chart is not a prescription but a direction to administer medication. It must be signed by a registered prescriber and authorises the delegation to administer

medication on the prescriber's behalf. However, in doing so the registrant is accountable for their actions and for raising any concerns about the direction with the prescriber, for example, in respect to clarity.

Patient group direction (PGD)

6 Patient group directions (PGDs) are specific written instructions for the supply or administration of a licensed named medicine including vaccines to specific groups of patients who may not be individually identified before presenting for treatment. Guidance on the use of PGDs is contained within Health Service Circular (HSC)

7 See Home Office circular 049/2003. Controlled Drugs Legislation – Nurse Prescribing And Patient Group Directions. Go to www.dh.gov.uk and search for controlled drugs.

8 Guidance has also been issued in Wales (WHC 2000/116), and in Scotland and Northern Ireland.

9 The circular also identifies the legal standing of PGDs plus 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. PGDs are not a form of prescribing.

10 PGDs are drawn up locally by doctors, dentists, pharmacists, and other health professionals where relevant. They must be signed by a doctor or dentist and a pharmacist, both of whom should have been involved in developing the direction, and must be approved by the appropriate health care organisation. The NMC would consider it good practice that a lead practitioner from the professional group using the PGD and senior manager where possible, are also involved and sign off a PGD.

11 PGDs can be used by independent providers for NHS commissioned services. As medicines legislation does not apply outside the UK, a PGD would not be required

– For example – on cruise ships. However, the NMC would consider it good practice for such bodies to develop protocols using PGD templates that are signed off by a doctor, dentist, pharmacist, other health professionals where relevant and a senior manager where possible.

12 PGDs should only be used once the registrant has been assessed as competent and whose name is identified within each document. The administration of drugs via a PGD may not be delegated. Students cannot supply or administer under a PGD but would be expected to understand the principles and be involved in the process. Where medication is already subject to exemption order legislation there is no requirement for a PGD.

13 When supplying under PGD, this should be from the manufacturer's original packs or over-labelled pre-packs so that the patient details, date and additional instructions can be written on the

label at the time of supply. Registrants must not split packs. For more information on labelling see annexe 2.

14 See To PGD or not to PGD at:

www.portal.nelm.nhs.uk/PGD/viewRecord.aspx?recordID=422

15 PGDs in the NHS:

www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=148

16 PGDs in the private sector:

www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=147

Medicines Act Exemptions

17 Allow certain groups of healthcare professionals including occupational health nurses under occupational health schemes and midwives to sell, supply and administer specific medicines directly to patient and clients.

17.1 Provided the requirements of any conditions attached to those exemptions are met, a PGD is not required.

17.2 Registrants must work to locally agreed written protocols and procedures, and maintain auditable records.

17.3 Occupational health nurses that offer services, for example, open access travel clinics outside of occupational health schemes must comply with guidance from the appropriate regulator.

18 Registrants may only supply and administer under an exemption order where the order pertains to them. Where nurses are working as emergency care practitioners within an ambulance service they may not supply and administer under paramedic exemptions unless they are also registered as a paramedic with the Health Professions Council – to do so would contravene medicine legislation and the employer's vicarious liability would not apply.

19 Search for NMC Circular 1/2005 Medicine legislation: what it means for midwives at

www.nmc-uk.org

20 In the past, maternity service providers and occupational health schemes have produced local guidelines, often referred to as 'standing orders', to supplement the legislation on the medicinal products that practising midwives and occupational health nurses may supply and/or administer. These guidelines are not a prerequisite under any legislation. There is no legal definition for standing orders and this term does not exist in any medicines legislation. The NMC would consider it good practice where midwives and occupational health nurses are using standing orders for medicinal products that are not covered by Medicines Act Exemptions that these should be converted to PGDs.

Homely remedy protocols

21 Homely remedy protocols cannot be used for prescription only medicines including controlled drugs. These must be supplied and administered under a PSD, a prescription or a PGD.

Guidance

22 Homely remedy protocols are not prescriptions but protocols to enable administration of general sales list (GSL) and pharmacy only (P) listed medicines in settings, for example, care homes, children's homes and some educational institutions. Although they have no legal standing they are required for liability purposes. Any registrant using a homely remedy protocol must ensure there is a written instruction that has been drawn up and agreed in consultation with other relevant qualified professionals. (Where possible this should be a medical practitioner or pharmacist.) The protocol should clarify what medicinal product may be administered and for what indication it may be administered, the dose, frequency and time limitation before referral to a GP. An example of a homely remedy could be paracetamol for a headache. All registrants using the protocol should be named and they should sign to confirm they are competent to administer the medicinal product, acknowledging they will be accountable for their actions.

23 The NMC considers it good practice that the employing organisation signs off all protocols.

Prescription forms

24 NHS prescription forms are classified as secure stationery. Prescription forms are

Serially numbered and have ant counterfeiting and anti-forgery features. Within the NHS they are purchased by primary care trusts (PCTs), hospital boards and hospitals via a secure ordering system, and distributed free. The range of prescription forms used by registered prescribers can be found in each UK country government website.

25 Specific controlled drug prescription forms are available from the local health care organisation, for example, PCT, LHB, for use in the private healthcare sector. Specific controlled drug prescriptions are used for treatment of addiction and for private prescriptions for controlled drugs. Only the designated prescription form should be used. Detailed guidance on how to complete prescription forms, including special requirements when prescribing controlled drugs, is available from the Department of Health (DH), Health Care Commission (HCC), Home Office, the Prescription Prices Division of the NHS Business Services Authority website and

In the BNF. The Regulation and Quality Improvement Authority is equivalent to the HCC in Northern Ireland. Registrants in Northern Ireland should access their website for up-to-date information on their standards. www.npc.co.uk/controlled_drugs/CDGuide_2ndedition_February_2007.pdf

26 For the Welsh Health circular, go to:

www.wales.nhs.uk/documents/WHC_2006_018.pdf

27 Search for the Home Office Circular Controlled Drugs Legislation – Nurse Prescribing and Patient Group Directions at: www.knowledgenetwork.gov.uk/HO/circular.nsf

Who may write a prescription?

28 Any qualified and registered independent prescriber may prescribe all prescription only medicines for all medical conditions. In addition, nurse independent prescribers may also prescribe some controlled drugs.

29 Supplementary prescribers may prescribe in accordance with a clinical management plan (CMP) in a tripartite arrangement with a doctor or dentist, the patient and the supplementary prescriber. A supplementary prescriber, when acting under and in accordance with the terms of a CMP, may administer and supply or direct any person to administer controlled drugs in schedules 2, 3, 4 and 5, and can prescribe unlicensed medicinal products. Please see section 5 of this document on delegation.

Prescribing by nurses, midwives and specialist community public health nurses

30 The Medicinal Products: Prescription by Nurses Act 1992 and subsequent amendments to the pharmaceutical services regulations allow nurses and midwives, who have recorded their qualification on the NMC register, to become nurse or midwife prescribers. There are two levels of nurse and midwife prescribers:

Community practitioner nurse prescribers

30.1 These are registrants who have successfully undertaken a programme of preparation to prescribe from Community Practitioner Nurse Prescribers' Formulary. They can prescribe the majority of dressings and appliances, and a limited range of prescription only medicines. The Community Nurse Prescribers' Formulary can be found on the British National Formulary website. Go to: www.bnf.org

Independent and supplementary nurse and midwife prescribers

30.2 These are nurses and midwives who are trained to make a diagnosis and prescribe the appropriate treatment (independent prescribing). They may also, in cases where a doctor has made an initial diagnosis, go on to prescribe or review the medication, and change the drug, dosage, timing or frequency or route of administration of any medication as appropriate as part of a clinical management plan (supplementary prescribing).

31 Nurse or midwife independent prescribers can prescribe all prescription only medicines including some controlled drugs, and all medication that can be supplied by a pharmacist or bought over the counter. They must only prescribe drugs that are within their area of expertise and level of competence, and should only prescribe for children if they have the expertise and competence to do so.

32 Nurse, midwife and specialist community public health nurse prescribers must comply with current prescribing legislation and are accountable for their practice.

33 For Department of Health guidance go to www.dh.gov.uk and search: nurse independent prescribing.

Standard 2: Checking

1 Registrants (1st and 2nd level) must check any direction to administer a medicinal product.

2 As a registrant you are accountable for your actions and omissions. In administering any medication, or assisting or overseeing any self-administration of medication, you must exercise your professional judgement and apply your knowledge and skill in the given situation. As a registrant, before you administer a medicinal product you must always check that the prescription or other direction to administer is:

2.1 Not for a substance to which the patient is known to be allergic or otherwise unable to tolerate

2.2 Based, whenever possible, on the patient's informed consent and awareness of the purpose of the treatment

2.3 Clearly written, typed or computer-generated and indelible

2.4 specifies the substance to be administered, using its generic or brand name where appropriate and its stated form, together with the strength, dosage, timing, frequency of administration, start and finish dates, and route of administration

2.5 is signed and dated by the authorised prescriber

2.6 in the case of controlled drugs, specifies the dosage and the number of dosage units or total course; and is signed and dated by the prescriber using relevant documentation as introduced, for example, patient drug record cards.

3 And that you have:

3.1 Clearly identified the patient for whom the medication is intended

3.2 Recorded the weight of the patient on the prescription sheet for all children, and where the dosage of medication is related to weight or surface area (for example, cytotoxics) or where clinical condition dictates recorded the patient's weight.

Standard 3: Transcribing

1 As a registrant you may transcribe medication from one 'direction to supply or administer' to another form of 'direction to supply or administer'.

Guidance

2 This should only be undertaken in exceptional circumstances and should not be routine practice. However, in doing so you are accountable for your actions and omissions. Any medication that you have transcribed must be signed off by a registered prescriber. In exceptional circumstances this may be done in the form of an email, text or fax before it can be administered by a registrant.

3 Any act by which medicinal products are written from one form of direction to administer to another is transcribing. This includes, for example, discharge letters, transfer letters, copying illegible patient administrations charts onto new charts, whether hand-written or computer-generated.

4 When medicine administration records in a care home are hand-written by a registrant, they may be transcribed from the details included on the label attached to the dispensed medicine. However, in doing so the registrant must ensure that the charts are checked by

another registrant where possible, and where not, another competent health professional.

5 The registrant is accountable for what they have transcribed.

6 Managers and employers are responsible for ensuring there is a rigorous policy for transcribing that meets local clinical governance requirements.

7 As care is being increasingly provided in more 'closer to home' settings that are often nurse-led, managers and employers should undertake a risk assessment involving registrants, pharmacists and responsible independent prescribers to develop a management process to enable transcribing to be undertaken where necessary. It should not be routine practice. Any transcription must include the patient's full name, date of birth, drug, dosage, strength, timing, frequency and route of administration.

8 Transposing is the technical term used by pharmacists for transcribing.

9 Registrants are advised to read the Health Care Commission guidance for the transcribing of prescribed medicines for individuals on admission to children's hospices. The principles apply to all settings. Go to www.cqc.org.uk. Registrants in Northern Ireland should refer to the Regulation and Quality Improvement Authority website at www.rqia.org.uk

The standards: Section 2

Dispensing

Standard 4: Prescription medicines

1 Registrants may in exceptional circumstances label from stock and supply a clinically appropriate medicine to a patient, against a written prescription (not PGD), for self-administration or administration by another professional, and to advise on its safe and effective use.

Guidance

2 The definition of dispensing is "To label from stock and supply a clinically appropriate medicine to a patient, client or carer, usually against a written prescription, for self-administration or administration by another professional, and to advice on safe and effective use". (MHRA, 2006)

3 Dispensing includes such activities as checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient.

4 If under exceptional circumstances you, as a registrant, you are engaged in dispensing, this represents an extension to your professional practice. There is no legal barrier to this practice. However, this must be in the course of the business of a hospital, and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure (SOP). In a dispensing doctor's practice, registrants may supply to patients under a particular doctor's care, when acting under the directions of a doctor from that practice. The patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.

Standard 5: Patients' own medicines

1 Registrants may use patients' own medicines in accordance with the guidance in this booklet Standards for medicines management.

2 The NMC welcomes and supports the self-administration of medicinal products and the administration of medication by carers wherever it is appropriate.

The use of patients' own medicinal products in any setting

3 Where patients have their own supply of medicinal products, whether prescribed, over the counter (from a pharmacy, supermarket or shop), complementary therapy, and herbal preparation or homely remedy such as paracetamol, the registrant has a responsibility to:

3.1 ask to see the medicinal products

3.2 check for suitability of use

3.3 explain how and why they will or won't be used

3.4 establish if they are prescribed

3.5 ascertain if they meet the criteria for use.

4 These medicinal products including controlled drugs remain the patient's property and must not be removed from the patient without their permission and must only be used for that named individual.

5 The registrant has a responsibility to document in the patient's notes when a patient refuses consent:

5.1 To use their own medicines

5.2 To dispose of their own medicinal products no longer required

5.3 To dispose of their own medicinal products not suitable for use

5.4 when in the hospital or care home setting to send their own medicinal products home with a relative or carer

Storage of patients' own medicinal products

6 As a registrant you have the following responsibilities:

6.1 To ensure that suitable facilities are provided to store patients' own medicinal products for their safe storage

6.2 To assess patients on a regular basis using local polices to ensure that the individual patient is still able to self-administer

6.3 To document issues relating to storage in their records

6.4 That the medicines cabinet or locker is kept locked and that the master key is kept secure

6.5 That if the patient is self-administering, consent is obtained from the patient to keep the individual medicines cabinet/locker locked and the key secure with the patient

6.6 That if a patient moves to another bed, to another ward or room or is discharged, the patient's medicinal products are transferred with the patient

6.7 In a hospital setting, best practice indicates that stock medicines should not be placed in the patient's locked cabinet or locker as they are not labelled for that individual patient.

Administering medicines using the patient's own supply in the hospital or care home setting

7 When administering medicines from the patient's own supply, the registrant must check the medicines in the locked cabinet or locker with the prescription chart and use only those medicines belonging to that named patient.

8 If a supply is not available, medicines belonging to another patient must not be used.

9 For further guidance on the use of patients' own medicinal products including discharge and checking medications to take home (TTOs) see annexe 3. For self-administration of medicines see standard 9 of this document

Self-administration of medicines.

One-stop dispensing

10 In some hospitals a system of one-stop dispensing is in operation and local policies should be developed for this using the guidance for patients' own medicinal products as stated under standard 5 of this document.

Guidance

11 One-stop dispensing is a system of administering and dispensing medicinal products adopted in hospitals throughout the UK (Audit Commission Report: A Spoonful of Sugar 2002 – The Right Medicine (Scottish Executive 2002). It involves using the patient's own medicinal products during their stay in hospital, either those dispensed by a community pharmacy or by the hospital pharmacy or both, providing they contain a patient information leaflet and are labelled with full instructions for use. Supplies are replenished should the supply run out whilst in hospital or when any new items are prescribed. Patients are discharged with a supply of medicinal products as agreed locally.

12 In one-stop dispensing, medicinal products are dispensed once only on or during admission ready for discharge. Registrants should check that the medication handed to the patient on discharge is as per the discharge prescription, as medicines may be altered or stopped during hospital admission. If a particular medicine has been stopped during admission and is not to be restarted on discharge, the patient must be informed. The ward pharmacist is a useful resource for advice.

The standards: Section 3

Storage and transportation

Standard 6: Storage

1 Registrants must ensure all medicinal products are stored in accordance with the patient information leaflet, summary of product characteristics document found in dispensed UK-licensed medication and in accordance with any instruction on the label.

Guidance

2 The patient information leaflet or summary of product characteristics document for UK-licensed medicinal products may be found at www.emc.medicines.org.uk. Policies should be in place to ensure all storage environments meet the required standards and it is the responsibility of the registrant to check such policies are in place and are being adhered to. This is particularly important for medicines requiring storage within a limited temperature range, for example, refrigeration of vaccines when maintenance of the cold chain has to be considered during transfer for school sessions or administration in the patient's home.

Go to www.the-shipman-inquiry.org.uk/4r_page.asp?id=3119

Standard 7: Transportation

1 Registrants may transport medication to patients including controlled drugs (CDs), where patients, their carers or representatives are unable to collect them, provided the registrant is conveying the medication to a patient for whom the medicine has been prescribed (for example, from a pharmacy to the patient's home).

Guidance

2 However, it is considered good practice that registrants should not routinely transport CDs in the course of their practice. This should only be undertaken in circumstances where there is no other reasonable mechanism available. All drugs should be kept out of sight during transportation.

3 When collecting CDs from a pharmacy, the registrant will be asked to sign for them and prove identity in the form of their professional identity badge or Pin (where self-employed). Midwives must be familiar with the use of midwives supply orders. Go to NMC Circular 25/2005 which you can find at www.nmc-uk.org/ publications. It is anticipated as a recommendation from the Shipman Inquiry Fourth Report that new documentary evidence will be required in the form of a patient drug record card. Registrants would be expected to be aware of and comply with any new legislation and guidance introduced.

The standards: Section 4

Standards for practice of administration of medicines

1 Having initially checked the direction to supply or administer that a medicinal product is appropriate for your patient or client (standard 2) you may then administer medication.

Standard 8: Administration

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

2.1 You must be certain of the identity of the patient to whom the medicine is to be administered

2.2 You must check that the patient is not allergic to the medicine before administering it

2.3 You must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications

2.4 You must be aware of the patient's plan of care (care plan or pathway)

2.5 You must check that the prescription or the label on medicine dispensed is clearly written and unambiguous

2.6 You must check the expiry date (where it exists) of the medicine to be administered

2.7 You must have considered the dosage, weight where appropriate, method of administration, route and timing

2.8 You must administer or withhold in the context of the patient's condition (for example, Digoxin not usually to be given if pulse below 60) and co-existing therapies, for example, physiotherapy

2.9 You must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable (see standard 25)

2.10 you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

In addition:

3 Where medication is not given, the reason for not doing so must be recorded.

4 You may administer with a single signature any prescription only medicine, general sales list or pharmacy medication.

In respect of controlled drugs:

5 These should be administered in line with relevant legislation and local standard operating procedures.

6 It is recommended that for the administration of controlled drugs, a secondary signatory is required within secondary care and similar healthcare settings.

7 In a patient's home, where a registrant is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

8 Although normally the second signatory should be another registered health care professional (for example doctor, pharmacist, dentist) or student nurse or midwife, in the interest of patient care, where this is not possible a second suitable person who has been assessed as competent may sign. It is good practice that the second signatory witnesses the whole administration process. For guidance, go to www.dh.gov.uk and search for Safer Management of Controlled Drugs: Guidance on Standard Operating Procedures.

9 In cases of direct patient administration of oral medication, for example, from stock in a substance misuse clinic, it must be a registered nurse who administers, signed by a second signatory (assessed as competent), who is then supervised by the registrant as the patient receives and consumes the medication.

10 You must clearly countersign the signature of the student when supervising a student in the administration of medicines.

11 These standards apply to all medicinal products.

Guidance

Assessing competence to support a patient in taking their medication

12 A policy must be in place and adhered to in assessing the competence of an individual to support a patient in taking medication. A record of the individual's training and assessment should be kept, and all refresher or continuing education and training should also be routinely kept.

13 The registrant delegating should be satisfied that the individual has an appropriate level of education and training and has been assessed as competent. Where this is not the case, the registrant may refuse to delegate, even when requested to do so by another health professional. The registrant is accountable for her own actions including delegation.

Clarifying identity

14 Where there are difficulties in clarifying an individual's identity, for example, in some areas of learning disabilities, patients with dementia or confusional states, an up-to-date photograph should be attached to the prescription chart(s). For patients with burns where the wearing of a wristband is inappropriate and a photograph would not resemble the patient, local policies should be in place to ensure all staff are familiar with the patients and a system of identification is in place. Registrants are responsible for ensuring the photograph remains up to date.

Standards of communication with patients

The importance of communication in clinical practice: a medical student's view

Modern medicine is just as much about communication as it is about science.

My experience of clinical medicine is a patchwork of different experiences, different doctors and different specialities. I have worked with GPs, surgeons, hospital doctors and a whole range of healthcare professionals including nurses and therapists. The one thing they all have in common is communication.

The draconian medical school experience of old is an intense education that championed scientific knowledge, examined rigorously and applied subsequently in the real world. Communication training took a back seat to scientific excellence. Today's medical education is very much different. Although a robust scientific expertise is still required, patient - i.e. real world - interaction is at the forefront of our education from the first year.

The application of our new scientific knowledge is no more important than the tools needed to communicate it. The same way as a doctor's knowledge is no more useful to a patient than what the patient can understand. From witnessing GP and patient interaction, the main focus of the consultation was open communication of the implications of a diagnosis, not the diagnosis itself. My experience of medicine so far is that a patient does not come to their clinic to just be told a diagnosis, but to be told how it will affect their lives, whether they will have any lifestyle limitations and, most importantly, whether they will be okay.

Answering these questions requires scientific knowledge, but the communication of this knowledge is an important facet in the training of the new doctor. The simple relation of information must be re-invented to take into context a patient's expectations, as well as establishing a rapport and, more than anything else, breaking down the old paternalistic barrier portrayed by the doctor behind the desk.

Communication can change a patient's experience of a disease drastically. If their questions are not answered, uncertainty can lead to years of unjustified fear. If the doctor appears apathetic, the faith can be lost in the doctor or even in the healthcare system as a whole. A friendly doctor who takes the time to explain a disease in the context of a person's lifestyle establishes a relationship that goes far deeper than one that does not. A relationship breeds trust and it is trust that breeds security in the mind of the patient. My best experiences of

being a medical student so far have been sitting opposite a patient, and taking the time to discuss their condition, their experience of it and their plans to live with it.

So it seems to me that communication is a cornerstone of modern medicine, where understanding and context-driven consultation lead the way in improved patient experience.

THE FIFTH Principle of Nursing Practice

'Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.' Communication is central to human interaction. Without it, people cannot relate to those around them, make their needs and concerns known or make sense of what is happening to them. One of the most basic goals for nursing staff is that their patients and clients and those who care for them experience effective communication (Department of Health (DH) 2010a).

National benchmarks for communication require that communication needs are assessed and appropriate methods are used to enable patients and carers to communicate effectively. Information that is accessible, acceptable and accurate, and that meets patients' and clients' needs, should be shared actively and consistently. Staff should communicate effectively with each other to ensure continuity, safety and quality of health care for all (DH 2010a). Documentation, communication during handover, information sharing, managing complaints, and reporting incidents and concerns are the more formal aspects of communication, and the main focus of principle E. The importance of Principle E is demonstrated when things go wrong. The National Patient Safety Agency (2007) identified communication difficulties as a major factor affecting patient outcomes. Particular concerns included unclear documentation and nurses not being clear and confident in their reporting. The Scottish Public Services Ombudsman (2010) reported that communication and confidentiality were 'once again' near the top of the list of complaints about the NHS. The ombudsman's monthly commentaries repeatedly recommend that organisations improve documentation, communication and reporting processes, and apologise for poor handling of complaints. In England, the ombudsman reported that poor explanations or an incomplete response were the most common reasons for dissatisfaction with complaint handling (Parliamentary and Health Service Ombudsman 2010). Breaches in confidentiality are not so well reported, but they occur regularly in all settings, as researchers observed in GP practice reception and waiting areas (Scott ET al2007). Frequent instances occurred where patient identifiable information was overheard, including names, conditions and test results. Simple measures can be taken to improve such inappropriate disclosures, for example placing signs

in hospital lifts reminding staff that they are in a public place and must not discuss patients. The documents Confidentiality: NHS Code of Practice (DH 2003) and NHS Code of Practice on Protecting Patient Confidentiality (NHS Scotland 2003) are part of the guidance on information governance, which helps to ensure patient information is kept confidential and secure. The NHS Care Record Guarantee (National Information Governance Board for Health and Social Care 2010) is an important reminder of how the NHS should use patient records 'in ways that respect individual's rights and promote health and wellbeing'.

Documentation

Nurses are required to maintain up-to-date and accurate records of assessments, risks and problems, care, arrangements for ongoing care and any information provided (Nursing and Midwifery Council (NMC) 2010a). The primary purpose of these records is to support patient care and improve communication. Audits of record-keeping should consider whether the content of the records is supporting safe, effective care and communication. Record-keeping by nurses is supposed to be an integral part of practice, not 'an optional extra to be fitted in if circumstances allow' (NMC 2010a). Attitudes need to change so that records are valued and well used, rather than being viewed as a necessary evil in case of litigation. However, for attitudes to change, records have to become useful communication tools. An example of how this can be achieved is the 'reading handover' described by Tucker et al (2009). Using documentation as the main method of communication at shift handover resulted in improvements in the quality of nursing records. To help ensure the records were accurate, nurses were encouraged to 'Do it. Document it' rather than write notes at the end of a shift (Tucker et al 2009). Electronic records have the potential to support improvements in documentation because they can eliminate repetitive recording and provide more structure.

Reporting

Handing the care of a patient over to another clinician requires good communication and co-ordination. Incomplete or delayed information can compromise safety, quality and the patient's experience of health care (British Medical Association (BMA) 2004). Evidence suggests that communication improves where nursing handover involves the patient and is carried out using a structured reporting format (Mascioliet al 2009, Tucker et al 2009).The World Health Organization (2007) recommends the use of the SBAR (Situation, Background, Assessment and Recommendation) tool to standardise handover communications. A study by Christie and Robinson (2009) demonstrated that the SBAR tool improved the quality of telephone referrals to the critical care outreach team, greatly reduced the time for shift handovers and helped reduce adverse patient outcomes. A single format for patient handover would not suit all settings, but there are elements in common to all, including patient name, diagnosis or problems, plan and tasks to be done (BMA 2004). Nursing teams that do not yet use a standard structure could use these common elements as the basis for agreeing the handover content that is relevant to their patient context. Incident reporting has received increased attention since An Organisation with A Memory (DH 2000) identified an NHS culture in which people are swift to blame or seek retribution. The NPSA (2004) suggests that the more incidents are reported, the more lessons are learnt and action taken

to make health care safer. The document Seven Steps to Patient Safety (NPSA 2004) requires that 'staff know what patient safety incidents to report and how to report them'. The ideal culture is one that is open and fair where reporting is congratulated and individuals are not blamed or penalised if they speak out about safety incidents or other concerns. However, a survey in 2009 of more than 5,000 Royal College of Nursing (RCN) members found that only 43% would be confident to report concerns without thinking twice because of fears about personal reprisals (RCN 2009). Following this survey, the RCN introduced a dedicated telephone line for members to talk in confidence about any concerns that patient safety is being put at risk in their workplace. The Code (NMC 2008) is clear on the nurse's duty to speak out on behalf of patients, stating that: 'doing nothing and failing to report concerns is unacceptable'. The NMC's (2010b) guidance on raising and escalating concerns includes a toolkit to encourage discussion among nursing teams and promote the importance of speaking out on behalf of patients. Further support will soon be available, at least in England, in the form of changes to the NHS Constitution, which is being updated to include a pledge to support all staff in raising concerns about safety, malpractice or wrongdoing at work (DH 2010b).

Handling complaints

In 2009 the NPSA published a safety alert encouraging organisations to promote a culture of openness, honesty and transparency in relation to safety incidents, including apologising and explaining what happened. Being Open (NPSA 2009) is a theme picked up in the Parliamentary and Health Service Ombudsman's (2010) report on complaints handling in the NHS in England. According to this report, providing an apology and a full explanation of what went wrong can help to alleviate distress and reassures complainants that mistakes will not recur. Local policies for handling complaints should be reviewed to see if they align with the Being Open (NPSA 2009) guidance.

Conclusion

Accurate, timely and concise documentation and reporting underpin safe and effective nursing practice. Respecting confidentiality and taking care when sharing information are required by laws but are often overlooked in busy care settings. Regular, practical audit and review of these aspects of communication should be part of nursing staff's daily work. The presence of an open and fair culture is difficult to measure, but is a prerequisite for improving quality and requires that staff feel able to speak out about their concerns.

Good practice

Communicate effectively

You must listen to patients, take account of their views, and respond honestly to their questions.

You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

Communicating Effectively with Patients

The significance of effective communication to the quality of patient care is immeasurable. The way in which health care providers communicate with their patients may be as important as the actual information being delivered. Patients who grasp what their caregivers are saying are more likely to understand and follow treatment, modify life choices and everyday behaviours, and adhere to follow-up instructions. Patient surveys have demonstrated that poor communication may lead to negative patient outcomes, an increase in a patient's anxiety levels and feelings of vulnerability and powerlessness.

Where does effective caregiver-patient communication begin? With effective listing.

Caregivers must listen with more than just their ears and brush up on core listening skills. Meeting a patient on his or her level logistically, eliminating physical barriers and maintaining solid eye contact are key. "Being here NOW" is also critical… making sure patients know they have undivided, focused attention will help them feel comfortable enough to express their core concerns and will help to build a solid rapport.

Withholding judgment is also a part of effectual listening. Patients should be encouraged to express themselves and be exempt from interruption or critique. Interest in patients' comments should be encouraged with "interest statements" such as: "Can you tell me more?" or "How often does this event occur?" Caregivers should also reflect back to the patients their understanding of what has been said, and induce elaboration.

When speaking with patients, caregivers should keep these simple approaches in mind.

- Avoid use of medical jargon. It may demonstrate the caregiver's knowledge and expertise, but it won't generate understanding for the patient. Language should be appropriately tailored to fit the audience and situation.
- Cover important information *slowly.* If time is running short, the patient should be scheduled to return for further explanation or to ask questions.
- Be repetitive if needed. Many patients don't remember what they are told verbally. Repeating key points and asking whether the patient understands the information will improve recall and follow-up.
- Include a patient's companion or family member. The old saying "two heads are better than one" can hold true for patient care discussions. Be sure to address questions from the companion with as much attention as if they came directly from the patient.

- Don’t rush through negative information. When speaking about possible side effects or complications, be kind but *candid.* Complications don’t occur often, but if a patient could suffer from one, it is important he or she know what could happen.

Please remember that communication does not just mean vocal

Please note that communication can refer to verbal, nonverbal, electric, written and sometimes displayed through body language for those that cannot express verbally.

Standards of compassion to patients

Exploring how to enable compassionate care in hospital to improve patient experience

Introduction

Care, compassion and respect have always been enshrined in the value statements of the health professions (NMC, 2009; 2008).

However, 'compassion' has recently gained a higher profile with policymakers. The NHS Constitution sets out certain NHS values, including respect, dignity and compassion:

The NHS touches our lives at times of most basic human need, when care and compassion are what matter most

Why does enabling compassionate care matter?

Healthcare staff want to be able to care for patients with humanity and decency and to give to patients the same kind of care that they would want for themselves or their own family and loved ones (Goodrich and Cornwell, 2008).

For many staff, such a desire may have been a motivating factor in their decision to enter the healthcare professions in the first place. Practitioners want to be able to show compassion to the patients under their care.

Compassionate care matters to patients. Anecdotally, it is the presence or absence of compassion that often marks the lasting and vivid memories patients and family members retain about the overall experience of care in hospital and other settings.

Improving patients' satisfaction about their experience of care is an outcome that most patients and families would agree has value in and of itself, and is emphasised in the goals in recent key policy documents (Department of Health, 2008).

Research evidence suggests that compassion affects the effectiveness of treatment. For example, patients who are treated by a compassionate caregiver tend to share more information about their symptoms and concerns, which in turn yields more accurate understanding and diagnoses (Epstein et al, 2005).

In addition, since anxiety and fear delay healing (Cole-King and Harding, 2001), and compassionate behaviour reduces patient anxiety (Gilbert and Procter, 2006), it seems likely that compassionate care can have positive effects on patients' rate of recovery and ability to heal.

The elements of compassion

Compassion, in simple terms, is 'a deep awareness of the suffering of another coupled with the wish to relieve it' (Chochinov, 2007).

Compassion requires that staff give something of themselves. When fatigue, personal factors and organisational circumstances conspire to create workplace stress, it becomes more difficult for staff to feel and show compassion, creating a gap between their intentions and their capabilities.

Sometimes it is easier to identify when compassion is missing than when it is there. In the broadcast and print reports of failures in hospital care – such as, for example, the reports of the Healthcare Commission's (2009) and (2007) investigations into Mid Staffordshire and Maidstone and Tunbridge Wells NHS trusts – it is the apparent lack of compassion that fuels media outrage.

It is important to note that the focus on compassion should not reside merely at the 'sharpest ends' of care – that is, in emergency situations, or when a patient is known to be dying. Lack of compassion in mundane aspects of acute and everyday care also takes its toll on patients and staff. Indeed, it is the 'little things' that patients or carers often recall as having been either present or lacking in their experiences of care

The elements of compassion, as defined in particular relation to health care, are described below:

The elements of compassion

- Compassion starts with good basic care and can be demonstrated in very practical ways – for example, making sure that a patient's feeding needs are addressed, that pain is managed and that the patient is helped to the toilet as needed. It can be equated with providing both dignity and respect.
- Compassion goes beyond essential care, however, to encompass 'empathy, respect, a recognition of the uniqueness of another individual, and the willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both the patient and the [caregiver] can be fully engaged' (Lowenstein, 2008).
- As such, compassion involves 'real dialogue': communication that is human to human rather than clinician to patient.
- The compassionate caregiver never stereotypes but appreciates difference, recognising the common humanity shared by both patient and caregiver.
- Compassion should not necessarily be seen as being sweet and nice. It includes honesty and may require courage.
- It is not a one-size-fits-all: compassion can mean very different things in different situations and to different people. In recognising the individuality of each patient, compassionate carers will also recognise how best to tailor their behaviour to show compassion based on a particular patient's needs.

- In short, for healthcare professionals, compassion means seeing the person in the patient at all times and at all points of care.

Assessing compassion

How do we assess how good we are at delivering compassionate care? The question is important, but it also presents an immediate, inherent challenge in an NHS reliant on quantified targets and measures.

If we accept that compassion is a felt experience, it follows that the closest we can come to measuring compassion is to ask patients whether or not they experienced it. Measures of compassion must rely to a large degree on patients' own subjective assessments of their experiences of care, which can be obtained in a variety of ways: interviews; questionnaires; frequent feedback mechanisms; and surveys.

There are other types of measure that might also be considered: measures of process and measures of structure. Since compassion can demonstrate itself in very practical ways, there are objective, practical measures that may indicate or point to its presence or absence (the 'feeling for' the patient) in the way care is delivered.

In this way, we can say that many of the physical indicators already assessed, while they might not measure compassion directly, do point towards it. The measures we have in mind are ones such as: how quickly staff respond to call bells; whether patients' feeding needs are attended to; how well pain is managed; and how often and at what times of day or night patients are moved from ward to ward. All of these have an impact on continuity of care and relationships between staff and patients.

These basic indicators of aspects of quality of care may tell us something about attitudes and behaviours that are important with respect to compassion. Poor performance in any of these dimensions may not be caused by a lack of compassion but rather might be taken as indications of environments in which patients are at risk of feeling uncared for, and that therefore merit further investigation.

The structural measures that complete the more rounded attempt to measure compassion would be measures of risk in the physical environment or risk to staff capability to deliver compassionate care. Risk in the physical environment of care would need to be observed and audited. Risks to staff capability would be available from feedback in staff surveys to questions about the quality of leadership and support and team-working. They would also be available in some of the human resource data such as: measures of staff turnover; vacancy rates; and the use of bank and agency staff in different locations.

What stops compassionate care from happening?

Why, when staff may have entered the healthcare profession with high ideals, abundant stores of compassion and a strong motivation to treat patients as they themselves would want to be treated, do lapses in compassionate care sometimes occur?

First and foremost of these reasons, perhaps, is the natural human defences we develop in reaction to trauma. In care settings of all kinds, staff experience regular, frequent or in some cases continuous exposure to their fellow human beings in varying states of pain and distress, to suffering, terminal illness and death. Sometimes the defence takes the form of inappropriate joking; sometimes it manifests itself in numbing, a distancing reaction and withdrawal, as described by an acute care nurse below:

An acute care nurse's view

On staff coping with constant exposure to death and dying:

'I went to work on an elderly ward where patients died daily and there was great pressure on beds. At first, I did all I could to make the lead-up to a death have some meaning and to feel something when one of them died. But, gradually, the number of deaths and the need to strip down beds and get another patient in as fast as you can got to me and I became numb to the patients; it became just about the rate of turnover, nothing else' (Firth-Cozens, 2009).

The key point is that under these conditions, practitioners must develop coping mechanisms – some more effective or appropriate than others.

Staff who do not find effective ways of coping may be more susceptible to stress and burnout. Self-reported stress of health service staff in general is considerably greater than that of the general working population (Wall et al, 1997).

Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens, 1997), and a lack of compassion towards oneself is likely to work its way through to a lack of compassion towards patients (Gilbert, 2009).

Stress and burnout have their origins in different sources, some of them individual, some of them situational.

Individual factors:

- Age and experience;
- Self-esteem levels;
- Personal resilience;
- Job satisfaction
- Regular exposure to pain and distress;
- Conflicting information about what the organisation expects from staff or what is valued in the organisation;
- Poor feedback systems or lack of recognition or praise for individual acts of compassion and care;
- Lack of time and simultaneous pressure to meet targets.

Compassion, too, can become problematic for staff in settings where displays of emotion are treated as a failure to maintain an appropriate professional distance or authority. Though not necessarily unique to any one profession or role within the hospital, this is particularly relevant to those in roles that place a high value on professional detachment. Such attitudes are more commonly associated with doctors but perhaps increasingly prevalent in nursing.

The role of education in teaching healthcare staff professional values and standards is also important. In medicine, the psychosocial aspects of caregiving have tended to command secondary status, and workshop participants felt this was increasingly common in nursing training. Training that emphasises professional detachment and positions compassion as 'soft and fluffy' may have a detrimental impact later on the interpersonal relationships between staff and patients – and to the quality of care delivered.

Finally, even where the value of compassion is taught in the syllabus, there is a concern that, without systematic modelling and explicit endorsement and support for striving to be compassionate towards every patient, every time, it will be eroded and more difficult to practise.

Enabling compassion

In the practical circumstances in which staff caring for patients feel under pressure, and experience themselves as having very little time, it is often difficult to do just that one thing for the patient that makes her or him feel cared for. Enabling staff to feel and be compassionate towards patients in their care, at all times, requires action on multiple levels.

At the level of the individual, one of the most powerful resources that healthcare professionals consistently cite is patients' stories.

In cases where professionals themselves, or their loved ones, become patients, the nature of their personal experience of care very often has a profound effect on how they carry out their clinical practice. Where first-hand experiences of care are not available, exercises in which staff are asked to role-play or write a narrative imagining themselves as patients can have a similar usefulness.

Providing practitioners with a forum for open and honest dialogue about their experiences of *delivering* care is similarly important. A safe and recrimination-free environment in which to discuss the everyday challenges, frustrations and pressures of the job – in which sharing stories and feelings about patients and their care is legitimised – is essential.

It helps to remind busy staff that every patient is individual and unique; it provides support to individuals; encourages communication within the team; and it helps to improve team dynamics.

Good team relations make a difference not only to the quality of interactions among team members but also to the quality of care delivered to patients (see Box 3 for the markers of a good team). As such, enabling good team working is important.

Within teams, those in senior positions can enable compassion among staff by modelling compassionate behaviours – towards themselves, other staff and patients – often through relatively simple gestures, for example, by encouraging a junior colleague to take a meal break or by taking one themselves.

We need to focus our attention, too, on the formative stages of the professions, while nurses and doctors are learning their roles within a hospital. If modelling compassionate

behaviour is crucial in the message it sends to all levels of staff, it is especially so when students are in hospital to observe and learn. Mentoring is particularly important in teaching settings and for practitioners at the start of their careers.

None of these suggestions will make much impact, however, if staff remain unaware of what is valued in the organisation or feel undervalued in their jobs. Feeding back regularly to staff on their performance and providing recognition when they deliver compassionate care can help alleviate stress and counter poor organisational morale.

Finally, acute care could learn a lesson from palliative care. With its primary emphasis on patients' experience, on their physical and psychological comfort and quality of life, the palliative care setting can serve as a model of how to better integrate a focus on compassion into care delivery.

- Its task is defined and its objectives are clear
- It has reasonably clear boundaries and is not too large (ideally fewer than 10 people)
- Its members know who leads it and the leadership is good
- There is participation in decision-making by all members, good communication and frequent interaction between them
- It meets regularly to review its objectives, methods and effectiveness
- Its meetings are well conducted
- Its members trust each other and feel safe to speak their minds
- There is a shared commitment to excellence of patient care

Source: Firth-Cozens (2009)

Patients and their families need compassion, support and education along the health-illness continuum from a time of wellness to chronic illness to advancing illness and frailty to death. Those facing serious life-threatening illness and approaching death deserve to be treated with dignity, respect and compassion and receive care that is focused on the individual's goals for care.

Studies show patients need compassion, acceptance, to be treated as a whole person and not to be abandoned. They need clear information that enables identification of the person they trust to make decisions when they are unable to do so and helps in the determination of goals of care.

Further, studies show people want quality end-of-life care that includes:

- Receiving adequate pain and symptom management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving the burden on loved ones

- Strengthening the relationship with loved ones
- Respecting the uniqueness of individual
- Providing an appropriate environment
- Addressing spiritual issues
- Recognizing cultural diversity
- Effective communication between the dying person, family and professionals

Life is full of personal choices. Education is essential to help us know our choices and share our wishes in conversations around the kitchen table with family and health care professionals.

The compassionandsupport.org website seeks to improve health literacy and help individuals make sound, informed medical decisions. This web site addresses health literacy from a functional standpoint by providing information focused what the individual needs to know and what they need to do. The goal is to improve care for seriously ill patients and those nearing the end-of-life and their families.

Yet, anyone can face sudden and unexpected serious illness or injury. Thus, we all need to become educated and plan ahead for the future. Ultimately it comes down to personal choice but the choices about what works best for an individual are best made with reliable information. What patients and families need and want is delivered by Palliative Care, an interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families. It is offered simultaneous with all other appropriate medical treatment.

A Nurses personal account

Action, not Emotion: Compassion and Respect in Nursing Care

As a new nurse giving care, I was handed the report on my patient's condition and was warned by seasoned nurses about his anger. "You better watch out for that one, he is a grumpy and angry patient," I was told. After having received this information, and on my way to making my rounds, I approached his room with caution. I knocked on the door and when I heard a somewhat gruff, "come in," I nervously wondered what to expect from this angry man. Getting to Know As I made my assessment, I tried to think of things I could discuss with this grey, whiskered gentleman. While I wrapped the blood pressure cuff around his arm, I made small talk asking if he had any family and what type of job he held. I asked if he would like fresh water in his pitcher, if he would like ice in his water, and I made sure that he had extra drinking straws and Styrofoam cups. I tried to keep lines of communication open and show him that I respected his desires. As I continued communicating with him, he started responding back. He explained that he didn't like the

way people came in and out of his room with no regard for his feelings. He told me that he wanted some privacy and independence, and that he really appreciated that I had knocked before entering his room. After this, throughout my shift, I did my best to service him in ways that showed him respect. Kindness Begets Kindness I knocked before each entrance to his room and I carefully explained each procedure before it was performed, even if it was just a routine procedure. I listened as he talked about his life and, by the end of my nursing shift, he began to open up to me about his true feelings regarding his illness. He was frustrated and frightened that his career might be over due to the development of his illness. His doctor had made a remark that led him to believe this was possible. He further explained that he was a bus driver and loved his job, and that he would miss his playful interactions with the kids. I could tell by the sorrow filled tone in his voice how much this meant to him. I did my best to show compassion while nursing and hope for his situation, and mostly rendered a listening ear while he shared what was on his heart. When I entered his room the next day he was very chipper. "I have something for you," he explained. He riffled through a few papers on his bedside stand and picked up a small piece of newspaper with tattered edges. I could tell it was a small section he had ripped out. This piqued my curiosity. A Small Gift I reached out my hand to receive his gift and he gently handed it over to me. My eyes quickly scanned the paper. It was a clipping of a cartoon character with a caption that read, "Love is...respect." He personalized the message to me by placing my name on the top corner and signing his name at the bottom. That day, I learned a profound personal lesson through this patient. I kept the clipping with its tattered edges and hung it on my bedroom mirror. It stayed there for years and served me as a daily reminder to have compassion and respect for others, especially the patients I was caring for. Respect is not an emotion. It is an action we perform. It is something we do to show others we value them. Showing respect is one way we can show compassion in our nursing care and bring healing to someone during a compromising time of illness and loss.

Infection, prevention and control manual

This manual provides guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures. The national manual is mandatory for NHS employees and applies to all NHS healthcare settings. In all other care settings the content of this manual is considered best practice.

The manual aims to:

• Make it easy for care staff to apply effective infection prevention and control precautions.

• Reduce variation and optimise infection prevention and control practices

• Help reduce the risk of Healthcare Associated Infection (HAI).

• Help align practice, monitoring, quality improvement and scrutiny.

Standard Infection Control Precautions (SICPs), are to be used by all staff, in all care settings, at all times, for all patients

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agent from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. whether infection is known to be present or not to ensure the safety of those being cared for, staff and visitors in the care environment.

The application of SICPs during care delivery is determined by an assessment of risk to and from individuals and includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

To be effective in protecting against infection risks, SICPs must be used continuously by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to patient, staff and visitor safety.

Patient Placement/Assessment for infection risk

Patients must be promptly assessed for infection risk on arrival at the care area (if possible, prior to accepting a patient from another care area) and should be continuously reviewed throughout their stay. This assessment should influence placement decisions in accordance with clinical/care need(s).

Patients who may present a cross-infection risk include those:

• With diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms.

• Known to have been previously positive with a Multi-drug Resistant Organism (MDRO) e.g MRSA, CPE.

Hand Hygiene

Hand hygiene is considered an important practice in reducing the transmission of infectious agents which cause HAIs.

Before performing hand hygiene:

• expose forearms

• remove all hand/wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene)

• ensure finger nails are clean, short and that artificial nails or nail products are not worn

• cover all cuts or abrasions with a waterproof dressing.

To perform hand hygiene:

Alcohol Based Hand Rubs (ABHRs) must be available for staff as near to point of care as possible. Where this is not practical, personal ABHR dispensers should be used.

Perform hand hygiene or before touching a patient or before clean/aseptic procedures, or after body fluid exposure risk or after touching a patient; and or after touching a patient's immediate surroundings.

Wash hands with non-antimicrobial liquid soap and water if:

Hands are visibly soiled or dirty; or caring for a patient with a suspected or known gastro-intestinal infection e.g. norovirus or a spore forming organism such as Clostridium difficile.

In all other circumstances use ABHRs for routine hand hygiene during care.

Hand wipes should not be used by staff in the hospital or care home setting for hand hygiene unless there is no running water available. Staff may use hand wipes followed by ABHR and should wash their hands at the first available opportunity.

Skin care:

• Dry hands thoroughly after hand washing using disposable paper towels.

• Use an emollient hand cream during work breaks and when off duty.

• Do not use or provide communal tubs of hand cream in the care setting.

Surgical Hand Antisepsis

Surgical scrubbing/rubbing: (applies to persons undertaking surgical and some invasive procedures)

• Perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times e.g. prior to insertion of vascular access devices.

• Remove all hand/wrist jewellery.

• Nail brushes (if used) must only be used for decontamination of nails. Nail picks can be used if nails are visibly dirty.

• Use an antimicrobial liquid soap licensed for surgical scrubbing or an ABHR licensed for surgical rubbing (as specified on the product label).

• ABHR can be used between surgical procedures if licensed for this use.

Respiratory and Cough Hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross-transmission of respiratory illness (pathogens):

• Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose.

• Dispose of all used tissues promptly into a waste bin.

• Wash hands with non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions.

• Hand wipes should not be used by staff in the hospital or care home setting for hand hygiene unless there is no running water available. Staff may use hand wipes followed by ABHR and should wash their hands at the first available opportunity.

• Keep contaminated hands away from the eyes nose and mouth.

Staff should promote respiratory and cough hygiene helping those (e.g. elderly, children) who need assistance with this e.g. providing patients with tissues, plastic bags for used tissues and hand hygiene facilities as necessary.

Personal Protective Equipment (PPE)

Before undertaking any procedure staff should assess any likely exposure and ensure

PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

All PPE should be:

• located close to the point of use;

• stored to prevent contamination in a clean/dry area until required for use (expiry dates must be adhered to);

• Single-use only items unless specified by the manufacturer; and

• disposed of after use into the correct waste stream i.e. healthcare waste or domestic waste.

Reusable PPE items, e.g. non-disposable goggles/face shields/visors must have a decontamination schedule with responsibility assigned.

Gloves must be:

• worn when exposure to blood and/or other body fluids is anticipated/likely;2

• changed immediately after each patient and/or following completion of a procedure or task;

• changed if a perforation or puncture is suspected; and

• Appropriate for use, fit for purpose and well-fitting to avoid excessive sweating and interference with dexterity.

Double gloving is recommended during some Exposure Prone Procedures (EPPs) e.g. orthopaedic and gynaecological operations or when attending major trauma incidents.

Aprons must be:

• worn to protect uniform or clothes when contamination is anticipated/likely e.g. when in direct care contact with a patient; and

• changed between patients and/or following completion of a procedure or task.

Full body gowns/Fluid repellent coveralls must be:

• worn when there is a risk of extensive splashing of blood and/or other body fluids e.g. in the operating theatre; and

• changed between patients and immediately after completion of a procedure or task.

Eye/face protection (including full face visors) must be:

• worn if blood and/or body fluid contamination to the eyes/face is anticipated/likely e.g. by members of the surgical theatre team and always during Aerosol

Generating Procedures. Regular corrective spectacles are not considered eye Protection.

Fluid repellent surgical face masks must be:

• worn if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated/likely;

• worn to protect patients from the operator as a source of infection e.g. when performing an epidural or inserting a Central Vascular Catheter (CVC);

• Well-fitting and fit for purpose (fully covering the mouth and nose) (manufacturers' instructions must be adhered to ensure effective fit/protection); and

• removed or changed;

• At the end of a procedure/task;

• If the integrity of the mask is breached, e.g. from moisture build-up after extended use or from gross contamination with blood or body fluids; and

• In accordance with specific manufacturers' instructions.

Footwear must be:

• non-slip, clean and well maintained, and support and cover the entire foot to avoid contamination with blood or other body fluids or potential injury from sharps

• removed before leaving a care area where dedicated footwear is used e.g. theatre

Headwear must be:

• worn in theatre settings/clean rooms e.g. Central Decontamination Unit (CDU);

• Well-fitting and completely cover the hair; and

• Changed/disposed of between sessions or if contaminated with blood and/or body fluids.

Safe Management of Care Equipment

Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently it is easy to transfer infectious agents from communal care equipment during care delivery. Care equipment is classified as either:

• Single-use – equipment which is used once on a single patient and then discarded. Must never be reused even on the same patient. The packaging carries this symbol.

• Needles and syringes are single use devices. They should never be used for more than one patient or reused to draw up additional medication.

• Never administer medications from a single-dose vial or intravenous (IV) bag to multiple patients.

• Single patient use – equipment which can be reused on the same patient.

Reusable invasive equipment - used once then decontaminated e.g. surgical instruments.

• Reusable non-invasive equipment (often referred to as communal equipment) - reused on more than one patient following decontamination between each use e.g. commode, patient transfer trolley.

Before using any sterile equipment check that:

• The packaging is intact;

• There are no obvious signs of packaging contamination; and

• The expiry date remains valid.

Decontamination of reusable non-invasive care equipment must be undertaken:

• Between each use;

• After blood and/or body fluid contamination;

• At regular predefined intervals as part of an equipment cleaning protocol; and

• Before inspection, servicing or repair.

Adhere to manufacturers' guidance for use and decontamination of all care equipment.

All reusable non-invasive care equipment must be rinsed and dried following decontamination then stored clean and dry.

Decontamination protocols should include responsibility for; frequency of; and method of environmental decontamination.

Safe Management of the Care Environment

It is the responsibility of the person in charge to ensure that the care environment is safe for practice (this includes environmental cleanliness/maintenance). The person in charge must act if this is deficient.

The care environment must be:

• Visibly clean, free from non-essential items and equipment to facilitate effective cleaning;

• Well maintained and in a good state of repair

• Routinely cleaned in accordance with the Health Facilities National Cleaning Specification:

• A fresh solution of general purpose neutral detergent in warm water is recommended for routine cleaning. This should be changed when dirty or at

15 minutes intervals or when changing tasks.

• Routine disinfection of the environment is not recommended. However, 1,000ppm available chlorine should be used routinely on sanitary fittings.

Staff groups should be aware of their environmental cleaning schedules and clear on their specific responsibilities. Cleaning protocols should include responsibility for; frequency of; and method of environmental decontamination.

Safe Management of Linen

Clean linen should be stored in a clean, designated area, preferably an enclosed cupboard. If clean linen is not stored in a cupboard then the trolley used for storage must be designated for this purpose and completely covered with an impervious covering that is able to withstand decontamination.

Clean linen that is deemed unfit for re-use e.g. badly torn, should be disposed of locally or returned to the laundry for disposal.

Any linen used during patient transfer e.g. blankets, should be categorised at the point of destination.

For all used linen (previously known as soiled linen):

• Ensure a laundry receptacle is available as close as possible to the point of use for immediate linen deposit.

Do not:

• Rinse, shake or sort linen on removal from beds/trolleys;

• Place used linen on the floor or any other surfaces e.g. a locker/table top;

• Re-handle used linen once bagged;

• Overfill laundry receptacles; or

• Place inappropriate items in the laundry receptacle e.g. used equipment/needles

For all infectious linen (this mainly applies to healthcare linen) i.e. linen that has been used by a patient who is known or suspected to be infectious and/or linen that is contaminated with blood and/or other body fluids e.g. faeces:

• Place directly into a water-soluble/alginate bag and secure; then place into a plastic bag e.g. clear bag and secure before placing in a laundry receptacle. This applies also to any item(s) heavily soiled and unlikely to be fit for reuse.

• Used and infectious linen bags/receptacles must be tagged e.g. ward/care area and date

• Store all used/infectious linen in a designated, safe, lockable area whilst awaiting uplift. Uplift schedules must be acceptable to the care area and there should be no build-up of linen receptacles.

Safe Management of Blood and Body Fluid Spillages

Spillages of blood and other body fluids may transmit blood borne viruses. Spillages must be decontaminated immediately by staff trained to undertake this safely.

Responsibilities for the decontamination of blood and body fluid spillages should be clear within each area/care setting.

Safe Disposal of Waste (including sharps)

Waste

Classification, segregation, storage, packaging, transport, treatment and disposal. The

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to the safe disposal of sharps.

Categories of waste:

• Healthcare (including clinical) waste – is produced as a direct result of healthcare activities e.g. soiled dressings, sharps.

• Special (or hazardous) waste – arises from the delivery of healthcare in both clinical and non-clinical settings. Special waste includes a range of controlled wastes, defined by legislation, which contain dangerous or hazardous substances e.g. chemicals, pharmaceuticals.

• Domestic waste – must be segregated at source into:

• Dry recyclates (glass, paper and plastics, metals, cardboard).

• Residual waste (any other domestic waste that cannot be recycled).

Waste Streams:

• Black – Trivial risk

Domestic waste or yellow and black stripes (small quantities of hygiene waste).Final disposal to Landfill. Clear/opaque receptacles may also be used for domestic waste at care area level.

• Orange, Light Blue (laboratory) – Low risk3

Orange - consists of items which are contaminated or likely to be contaminated with infectious blood and/or body fluids. Final disposal following heat disinfection is to landfill.

Light Blue – laboratory/microbiological waste that must be autoclaved before disposal via the orange stream.

• Yellow– High risk

Waste which poses ethical, highly infectious or contamination risks. This includes anatomical and human tissue which is recognisable as body parts, medical devices and sharps waste boxes that have red, purple or blue lids.

Disposal is by specialist incineration.

• Red – Special waste

Chemical waste.

Safe waste disposal at care area level

Always dispose of waste:

• immediately and as close to the point of use as possible; and into the correct segregated colour coded UN 3291 approved waste bag (either orange/yellow for healthcare waste or black/clear/opaque for domestic) or container (sharps box).

Liquid waste e.g. blood must be rendered safe by adding a self-setting gel or compound before placing in a healthcare waste bag.

Waste bags must be no more than 3/4 full or more than 4 kgs in weight; and use a ratchet tag/or tape (for healthcare waste bags only) using a ‘swan neck’ to close with the point of origin and date of closure clearly marked on the tape/tag.

Store all waste in a designated, safe, lockable area whilst awaiting uplift. Uplift schedules must be acceptable to the care area and there should be no build-up of waste receptacles. Sharps boxes must:

• have a dedicated handle;

• have a temporary closure mechanism, which must be employed when the box is not in use;

• be disposed of when the manufacturers' fill line is reached; and

• be labelled with point of origin and date of closure.

Occupational Safety: Prevention and Exposure Management (including sharps)

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to: arrangements for the safe use and disposal of sharps; provision of information and training to employees; investigations and actions required in response to work related sharps injuries.

Sharps handling must be assessed, kept to a minimum and eliminated if possible with the use of approved safety devices. Manufacturers' instructions for safe use and disposal must be followed.

Needles must not be re-sheathed.

A significant occupational exposure is:

• A percutaneous injury e.g. injuries from needles, instruments, bone fragments, or bites which break the skin; and/or

• Exposure of broken skin (abrasions, cuts, eczema, etc.); and/or

• Exposure of mucous membranes including the eye from splashing of blood or other high risk body fluids.

There is a potential risk of transmission of a Blood Borne Virus (BBV) from a significant occupational exposure and staff must understand the actions they should take when a significant occupational exposure incident takes place.

Transmission Based Precautions (TBPs)

SICPs may be insufficient to prevent cross transmission of specific infectious agents. Therefore additional precautions (TBPs) are required to be used by staff. SICPs must still be applied with these additional considerations.
TBPs should be applied when caring for:
• Patients with symptoms of infection;
• Asymptomatic patients who are suspected or incubating an infection; or
• Patients colonised with an infectious agent.

TBPs are categorised by the route of transmission of infectious agents (some infectious agents can be transmitted by more than one route:

Contact precautions: Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of cross-infection transmission.

Droplet precautions: Used to prevent and control infections spread over short distances (less than 3 feet (1 metre)) via droplets (>5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level.

Airborne precautions: Used to prevent and control infections spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level.

Patient Placement/Assessment for Infection Risk

The potential for transmission of infection or infectious agents must be assessed at the patient's entry to the care area and should be continuously reviewed throughout their stay. The assessment should influence placement decisions in accordance with clinical /care need(s).
Patients who may present a cross-infection risk include those:

- With diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms.
- Known to have been previously positive with a Multi-drug Resistant Organism (MDRO) e.g MRSA, CPE.
- Who have been hospitalised outside Scotland in the last 12 months.

These patients should be prioritised for placement in a suitable area to minimise cross transmission pending investigation e.g.

- In a single room with a clinical wash hand basin; or
- Cohort area/room with a clinical wash hand basin.

Patients being transferred by ambulance should be transported in accordance with SAS local guidance.
Isolation within a care home for a known/suspected infection may be necessary to prevent spread. In most cases this can be achieved in the persons' bedroom.

The clinical judgement and expertise of the staff involved in a patient's management and the Infection Prevention and Control Team (IPCT) or Health Protection Team (HPT) should be sought particularly for patient placement decisions such as the application of TBPs e.g. isolation prioritisation when single rooms are in short supply.

Patient/Staff cohorting

If multiple patient cases of the same infection are confirmed or if single rooms are unavailable, cohorting of patients may be appropriate. Patients should be separated by at least 3 feet (1m) if cohorted.
Consider assigning a dedicated team of care staff to care for patients in isolation/cohort rooms/areas as an additional infection control measure (staff cohorting). This can only be implemented if there are sufficient levels of staff available (so as not to have a negative impact on non-affected patients' care).

Duration of isolation/cohort
Patient(s) should remain in isolation/cohort whilst they remain symptomatic and/or are considered infectious and the door must remain closed.
Before discontinuing isolation; individual patient risk factors should be considered (e.g. there may be prolonged shedding of certain microorganisms in immunocompromised patients); and the clinical judgement of those involved in the patient's management should be sought.

Avoid unnecessary transfer of patients within/between care areas.
All patient placement decisions and assessment of infection risk (including isolation requirements) must be clearly documented in the patient notes.

Safe Management of Patient Care Equipment in an Isolation Room/Cohort Area

- Use single-use items if possible.
- Reusable non-invasive care equipment should be dedicated to the isolation room/cohort area and decontaminated prior to use on another patient.
- An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.

Safe Management of the Care Environment

Routine environmental decontamination
Patient isolation/cohort rooms/area must be decontaminated **at least daily** using either:
• A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
• A general purpose neutral detergent in a solution of warm water followed by disinfection solution of 1,000ppm av.cl.

Increased frequency of decontamination should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.
• Toilets/commodes particularly if patients have diarrhoea; and
• "frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails.

Equipment used for environmental decontamination must be either single-use or dedicated to the affected area then decontaminated following use e.g. mop and bucket.

Terminal decontamination

Following patient transfer, discharge, or once the patient is no longer considered infectious: Remove from the vacated isolation room/cohort area, all:
• Healthcare waste and any other disposable items (bagged before removal from the room);
• bedding/bed screens/curtains and manage as **infectious linen** (bagged before removal from the room); and
• Reusable non-invasive care equipment (decontaminated in the room prior to removal)

The room should be decontaminated using either:
• A combined detergent disinfectant solution at a dilution (1,000ppm av.cl.); or
• A general purpose neutral detergent clean in a solution of warm water followed by disinfection solution of 1,000ppm av.cl..

The room must be cleaned from the highest to lowest point and from the least to most contaminated point.

Personal Protective Equipment (PPE): Respiratory Protective Equipment (RPE)

PPE must still be used in accordance with SICPs when using Respiratory Protective Equipment.

Where it is not reasonably practicable to prevent exposure to a substance hazardous to health (as may be the case where healthcare workers are caring for patients with suspected or known airborne micro-organisms) the hazard must be adequately controlled by applying protection measures appropriate to the activity and consistent with the assessment of risk.

Respiratory Protective Equipment (RPE) i.e. FFP3 and facial protection, must be considered when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne or droplet route and when carrying out aerosol generating procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route.

All tight fitting RPE i.e. FFP3 respirators must be:

- Fit tested on all healthcare staff who may be required to wear a respirator to ensure an adequate seal/fit according to the manufacturers' guidance.
- Fit checked (according to the manufacturers' guidance) every time a respirator is donned to ensure an adequate seal has been achieved.
- Compatible with other facial protection used i.e. protective eyewear so that this does not interfere with the seal of the respiratory protection. Regular corrective spectacles are not considered adequate eye protection.
- Donned and removed in a safe area (e.g. outside the isolation/cohort room/area).

Powered respirator hoods are an alternative to tight-fitting FFP3 respirators for example when fit testing cannot be achieved.

FFP3 respirator or powered respirator hood:
• may be considered for use by visitors if there has been no previous exposure to the infected person or infectious agent; **but**
• must never be worn by an infectious patient(s) due to the nature of the respirator filtration of incoming air not expelled air.

Glossary

Abrasion – A graze. A minor wound in which the surface of the skin or a mucous membrane has been worn away by rubbing or scraping.
Aerosols – See Airborne Particles.

Aerosol Generating Procedures (AGPs) – Certain medical and patient care activities that can result in the release of airborne particles (aerosols). AGPs can create a risk of airborne transmission of infections that are usually only spread by droplet transmission.

Airborne particles (aerosols) – Very small particles that may contain infectious agents. They can remain in the air for long periods of time and can be carried over long distances by air currents. Airborne particles can be released when a person coughs or sneezes, and during aerosol generating procedures (AGPs).

Airborne (aerosol) transmission – The spread of infection from one person to another by airborne particles (aerosols) containing infectious agents.

Alcohol based hand rub (ABHR) – A gel, foam or liquid containing alcohol that is rubbed into the hands as an alternative to washing hands with soap and water.

Alert organism – An organism that is identified as being potentially significant for infection prevention and control practices. Examples of alert organisms include Meticillin Resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (C.diff) and Group A *Streptococcus*.

Alveolar – Refers to the alveoli which are the small air sacs in the lungs. Alveoli are located at the ends of the air passageways in the lungs, and are the site at which gas exchange takes place.

Antimicrobial – An agent that kills microorganisms, or prevents them from growing. Antibiotics and disinfectants are antimicrobial agents.

Antimicrobial hand wipes – Hand wipes that are moistened with an antimicrobial solution/agent at a concentration sufficient to inactivate microorganisms and/or temporarily suppress their growth.

Aseptic technique – A healthcare procedure designed to minimise the risks of exposing the person being cared for to pathogenic micro-organisms during simple (e.g. dressing wounds) and complex care procedures (e.g. surgical procedures).

Asymptomatic – Not showing any symptoms of disease but where an infection may be present.

Alveolar – Refers to the alveoli which are the small air sacs in the lungs. Alveoli are located at the ends of the air passageways in the lungs, and are the site at which gas exchange takes place.

Antimicrobial – An agent that kills microorganisms, or prevents them from growing. Antibiotics and disinfectants are antimicrobial agents.

Antimicrobial hand wipes – Hand wipes that are moistened with an antimicrobial solution/agent at a concentration sufficient to inactivate microorganisms and/or temporarily suppress their growth.

Aseptic technique – A healthcare procedure designed to minimise the risks of exposing the person being cared for to pathogenic micro-organisms during simple (e.g. dressing wounds) and complex care procedures (e.g. surgical procedures).

Asymptomatic – Not showing any symptoms of disease but where an infection may be present.

Autoclave – Machine used for sterilising re-usable equipment using superheated steam under pressure.

Body fluids – Fluid produced by the body such as urine, faeces, vomit or diarrhoea.
Blood Borne Viruses (BBV) – Viruses carried or transmitted by blood, for example Hepatitis B, Hepatitis C and HIV.

Carbapenemase Producing Enterobacteriaceae (CPE) - A group of bacteria that have become extremely resistant to antibiotics including those called carbapenems.

Care areas/environment – Any place where care is carried out. This includes hospital wards, treatment rooms, care homes and care at home.

Care staff – Any person who cares for patients, including healthcare support workers and nurses.

Central Decontamination Unit (CDU) – A large, centralised facility for the decontamination and re-processing of re-usable medical equipment e.g. surgical instruments.

Central Vascular Catheter (CVC) – An intravenous catheter that is inserted directly into a large vein in the neck, chest or groin to allow intravenous drugs and fluids to be given and to allow blood monitoring.

Chlorine – A chemical that is used for disinfecting, fumigating and bleaching.

Cleaning – The removal of any dirt, blood, sickness, etc by use of an appropriate cleaning agent such as detergent.

Clinical setting – Any area where a patient is observed or treatment is carried out such as a treatment room or hospital ward.

Clinical wash hand basin – A sink designated for hand washing in clinical areas.

***Clostridium difficile (C.diff)* –** An infectious agent (bacterium) that can cause mild to severe diarrhoea which in some cases can lead to gastro-intestinal complications and death.

Cohorting – Placing a group of two or more patients (a cohort) with the same confirmed infection in the same room or area.

Cohort area – A bay or ward in which two or more patients (cohort) with the same confirmed infection are placed. A cohort area should be physically separate from other patients.

Cohort nursing – A dedicated team of healthcare staff who care for a cohort of patients, and do not care for any other patients.

Colonisation – The presence of bacteria on a body surface (such as the skin, mouth, intestines or airway) that does not cause disease in the person or signs of infection.

Conjunctivae – Mucous membranes that cover the front of the eyes and the inside of the eyelids.

Contact transmission – The spread of infectious agents from one person to another by contact. When spread occurs through skin-to-skin contact, this is called direct contact

transmission. When spread occurs via a contaminated object, this is called indirect contact transmission.

Contaminated – Dirty, soiled or stained.

Cross-infection/Cross-transmission – Spread of infection from one person to another.

Decontamination – Removing, or killing pathogens on an item or surface to make it safe for handling, re-use or disposal by cleaning, disinfection and/or sterilisation.

Detergent – A chemical cleansing agent that can dissolve oils and remove dirt.

Diarrhoea – 3 or more loose or liquid bowel movements in 24 hours or more often than is normal for the individual.

Direct contact transmission – Spread of infectious agents from one person to another by direct skin-to-skin contact.

Disinfectant – A cleaning chemical used to remove infectious agents from objects and surfaces.

Disinfection – A process, for example using a chemical disinfectant, to reduce the number of infectious agents from an object or surface to a level that means they are not harmful to your health.

Domestic waste – Waste produced in the care setting that is similar to waste produced in the home.

Droplet – A small drop of moisture, larger than airborne particle that may contain infectious agents. Droplets can be released when a person talks, coughs or sneezes, and during some medical or patient care procedures such as open suctioning and cough induction by chest physiotherapy. It is thought that droplets can travel around 1 metre (3 feet).

Droplet transmission – The spread of infection from one person to another by droplets containing infectious agents.

Emollient – An agent used to soothe the skin and make it soft and supple.

En-suite – A room containing a sink and toilet and sometimes a shower/wet room or bath.

Excretions – Waste products produced by the body such as urine and faeces (bowel movements).

Exposure – The condition of being exposed to something that may have a harmful effect such as an infectious agent.

Exposure Prone Procedures (EPPs) – Certain medical and patient care procedures where there is a risk that injury to the healthcare worker may result in exposure of the patient's open tissues to the healthcare worker's blood e.g. the healthcare worker's gloved hands are in contact with sharp instruments, needle tips or sharp tissues inside a patient's body.

Fit testing – a method of checking that a tight-fitting face piece respirator fits the wearer and seals adequately to their face. This process helps identify unsuitable face pieces that should not be used

FFP3 – Respiratory protection that is worn over the nose and mouth designed to protect the wearer from inhaling hazardous substances, including airborne particles (aerosols). FFP stands for filtering face piece. There are three categories of FFP respirator: FFP1, FFP2 and FFP3. An FFP3 respirator or hood provides the highest level of protection, and is the only category of respirator legislated for use in UK healthcare settings.

Fluid repellent – Does not absorb liquid.

GP – 'General practitioner' (your family doctor).

Hand Hygiene – The process of cleaning your hands by using either alcohol based hand rub or liquid soap and water.

Health Protection Team (HPT) – A team of healthcare professionals whose role it is to protect the health of the local population and limit the risk of them becoming exposed to infection and environmental dangers. Every NHS board has a HPT.

Healthcare Associated Infection (HAI) – Infections that occur as a result of medical care, or treatment, in any healthcare setting.

Healthcare Waste – Waste produced as a result of healthcare activities for example soiled dressings, sharps.

Hygiene Waste – Waste that is produced from personal care. In care settings this includes feminine hygiene products, incontinence products and nappies, catheter and stoma bags. Hygiene waste may cause offence due to the presence of recognisable healthcare waste items or body fluids. It is usually assumed that hygiene waste is not hazardous or infectious

Hypochlorite – A chlorine-based disinfectant such as bleach.

Immunisation – To provide immunity to a disease by giving a vaccination.

Immunocompromised patient/individual – Any person whose immune response is reduced or deficient, usually because they have a disease or are undergoing treatment. People who are immunocompromised are more vulnerable to infection.

Impervious – Cannot be penetrated by liquid.

Indirect contact transmission – The spread of infectious agents from one person to another via a contaminated object.

Infection – Invasion of the body by a harmful organism or infectious agent such as a virus, parasite or bacterium.

Infectious agent – Any organism, such as a virus, parasite, or bacterium, that is capable of invading body tissues, multiplying, and causing disease

Invasive device – A device which penetrates the body, either through a body cavity or through the surface of the body. Central Venous Catheters (central line), Peripheral Arterial Lines and Urinary Catheters are examples of invasive devices.

Invasive procedure – A medical/healthcare procedure that penetrates or breaks the skin or enters a body cavity.

Isolation – Physically separating patients to prevent the spread of infection.

Isolation suite/room – An isolation suite comprises a single-bed room, en-suite facilities and a ventilated entry lobby.

Microorganism (microbe) – Any living thing (organism) that is too small to be seen by the naked eye. Bacteria, viruses and some parasites are microorganisms.

Mode of transmission – The way that microorganisms spread from one person to another. The main modes or routes of transmission are airborne (aerosol) transmission, droplet transmission and contact transmission.

MRSA – Strains of the infectious agent (bacterium) *Staphylococcus aureus* that are resistant to many of the antibiotics commonly used to treat infections.

Mucous membranes/mucosa – The surfaces lining the cavities of the body that are exposed to the environment such as the lining of the mouth and nose.

Needle safety device – Any device designed to reduce the risk of injury from needles. This may include needle-free devices or mechanisms on a needle, such as an automated resheathing device, that cover the needle immediately after use.

Nitrile – A synthetic rubber material used to make non-latex gloves.

Non-sterile procedure – Care procedure that does not need to be undertaken in conditions that are free from bacteria or other microorganisms.

Occupational exposure – Exposure of healthcare workers or care staff to blood or body fluids in the course of their work.

Organism – Any living thing that can grow and reproduce, such as a plant, animal, fungus or bacterium.

Outbreak – When there are two or more linked cases of the same confirmed infection or illness or when there are more cases than the number expected.
Pathogen – Any disease-producing infectious agent.

Percutaneous injury – An injury caused by a sharp instrument or object such as a needle or scalpel, cutting or puncturing the skin.

Personal Protective Equipment (PPE) – Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infections e.g. disposable gloves and disposable aprons.

Pyrexia – Fever. Rise in body temperature above the normal level >37.2°.

Respiratory droplets – A small droplet, such as a particle of moisture released from the mouth during coughing, sneezing, or speaking.

Respiratory Protective Equipment (RPE) – There are two main types of RPE: respirators and breathing apparatus. Respirators are devices worn over the nose and mouth or head and are designed to filter the air breathed in to protect the wearer from inhaling hazardous substances, including airborne particles (aerosols). Breathing apparatus provides a supply of breathing quality air from an external source such as a cylinder or an air compressor. The most commonly used item of RPE in healthcare settings is an FFP3 respirator.

Re-sheath – To put a needle or other sharp object back into its plastic sheath.

Sanitary fittings – Pieces of furniture that are in a bathroom, such as a toilet, bath etc.

Secretions – Any body fluid that is produced by a cell or gland such as saliva or mucous.

Segregated – Physically separating or isolating from other people.

Sharps – Sharp instruments used in healthcare settings such as needles, lancets and scalpels.

Sharps injury – See **percutaneous injury**.

Spore – A form that some types of bacteria take under certain environmental conditions. Spores can survive for long periods of time and are very resistant to heat, drying and chemicals.

Sterile – Free from live bacteria or other microorganisms.

Sterile procedure – Care procedure that is undertaken in conditions that are free from bacteria or other microorganisms.

Sterilisation – The procedure of making some object free of all germs, live bacteria or other microorganisms (usually by heat or chemical means).

Surgical face mask – A disposable fluid repellent mask worn over the nose and mouth to protect the mucous membranes of the wearer's nose and mouth from splashes and infectious droplets and also to protect patients.

Swan-neck – Way of closing bag by tying in a loop and securing with a zip tie to make a handle.

Terminal decontamination – Cleaning/decontamination of an area or room following transfer/discharge of patient or when they are no longer considered infectious to ensure the area safe for the next patient or for the person to go back into their room in a care home setting.

Vascular access devices – Any medical instrument used to access a patient's veins or arteries such as a Central Venous Catheter or peripheral vascular catheter.

Standards for nutrition and fluid management

Food and water are essential for life. When someone is unwell they need to eat the right food, in the right amounts, at the right time in order to get better. Despite this there are still serious concerns about nutrition in health and social care sectors:

Malnutrition affects more than 10 per cent of older people (British Association for Parenteral and Enteral Nutrition (BAPEN), 2006)

Between 30-40 per cent of people admitted to hospitals, care homes or mental health units are at risk of malnutrition (BAPEN, 2009)

The UK Home Care Association estimates that up to 90,000 people who receive home care services could be at risk of malnutrition (Grove, 2008)

Malnutrition is estimated to cost the UK more than £13 billion a year (BAPEN, 2009)

Malnourished patients stay in hospital longer, are three times as likely to develop complications during surgery, and have a higher mortality rate (Age Concern, 2006; BBC, 2006). Malnutrition, in terms of undernourishment, is both a cause and consequence of disease in adults and children. It is common and affects over 3 million people in the UK with associated health costs exceeding £13 billion annually.

It is often unrecognised and untreated, yet it has a substantial impact on health and disease in all community care settings and hospitals.

The benefits of improving nutritional care and providing adequate hydration are immense, especially for those with long term conditions and problems such as stroke, pressure ulcers or falls. The evidence shows clearly that if nutritional needs are ignored health outcomes are worse and meta-analyses of trials suggest that provision of nutritional supplements to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%.

Better nutritional care for individuals at risk can result in substantial cost savings to the NHS4 and even a saving of 1% of the annual health care cost of malnutrition, would amount to £130 million annually.

Recent guidance from the NICE identifies better nutritional care as the fourth largest potential source of cost savings to the NHS5 and nutrition and hydration are identified in the SHA Chief Nurses eight 'high impact' clinical areas that could make huge cost savings for the NHS if Trusts and Care Homes improved performance.

It is crucial when redesigning nutritional care, to consider the overall health costs associated with malnourishment.

For example, although it is tempting to create a simple target to reduce the prescribing costs of oral nutritional supplements (ONS), which have risen steeply in recent years, ill thought out measures to do so will be detrimental to some individuals and may result in increased overall costs. Properly planned nutritional care will reduce costs from inappropriate use or wastage of ONS but will also identify more individuals who will benefit from them. However, since the health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient spells, more primary care consultations and the greater long-term care needs of malnourished individuals, even a net increase in use of ONS, enteral tube feeding and parenteral nutrition, will be more than offset by cost savings since the current costs of these nutrition support modalities only amounts to about 2% of overall malnutrition related costs.

Providing good nutritional care is therefore a matter of quality, clearly delivering against all elements of fair, personalised, safe and effective care7 as well as ensuring equality, improved outcomes and best patient experience.

Improved nutritional care is dependent on effective management structures to ensure joined up multidisciplinary care pathways across acute and community settings. Clinical leadership, innovation and continual improvement are fundamental to the delivery of high quality nutritional care.

NICE guidance on Nutrition Support in Adults8 sets out clear recommendations for nutritional screening in hospital and community and the development of personalised nutritional care pathways for patients at risk. There are also national minimum standards for food provision in care homes, patient experience surveys10 and annual assessments of nutritional care in hospitals by the Patient Environment Action Team (PEAT), and the Royal College of Nursing (RCN) has published a position statement on malnutrition in children and young people.

Many other organisations including the Council of Europe, the Department of Health, NICE, the National Patient Safety Agency (NPSA), the National Association of Care Catering (NACC), the Royal College of Physicians (RCP), and the RCN also recognise the importance of screening for malnutrition and treating all those at risk. Recently, the Care Quality Commission (CQC) produced guidance for healthcare and adult social care services on ‘Essential standards of quality and safety’ which include ‘meeting nutritional needs’. These are much more detailed than the previous core standards.

BAPEN has produced a number of reports on the causes, consequences and health economics of malnutrition as well as national surveys on the prevalence of malnutrition and the use of nutritional screening in hospitals, mental health units, care homes and sheltered housing. The charity has also contributed to national government and NHS strategies, such as the Nutrition Action Plan14 and the NHS core learning15 units on nutrition. We are therefore in a good position to provide commissioners and providers with information on nutritional care and standards.

The BAPEN Nutritional Care Tools in this document were developed in consultation with many organisations including all the Core groups that make up BAPEN. The generic issues that surround commissioning for adults and children are similar but some specifics of childhood nutritional needs and monitoring are different with issues such as poor parenting needing to be addressed. Child specific contributions were therefore made by the Nutrition Working Group of the British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) and the document contains a specific appendix focused on paediatric issues and transitional care to adult services.

The principles underlying the tools are that potentially vulnerable individuals should be screened for malnutrition and that those identified as at risk should be offered individualised nutritional care plans appropriate to their needs. To achieve this all care staff must understand the importance of nutritional care and be trained to identify those at risk, a training need that can be met by e-learning modules available from BAPEN. All health or social care organisations must also have management structures in place to ensure best nutritional practice.

This BAPEN Toolkit is based on world-class commissioning competencies16 and enables commissioners and providers in local authorities, primary care organisations, hospital trusts and foundation hospitals to include best nutritional care when commissioning / redesigning all care services in all health and care settings. It will help service providers to include nutritional care in the development of new business cases and support them in collecting the data needed to prove they meet nutritional quality standards and recommendations. It will also assist commissioners to set appropriate and achievable key performance indicators (KPIs) and to effectively contract and monitor services against an appropriate quality specification.

The BAPEN Toolkit contains guidance for commissioners and providers on defining the relevant, measurable outcomes related to nutritional care within services in order to gain value for money, a summary of national nutritional care standards and recommendations and the following tools:

• Tool 1: Assessment of population at risk of malnutrition – Guidance on quantifying the numbers in the local population likely to be malnourished or at risk of malnutrition and hence the scale of need for nutritional care.

• Tool 2: Assessment of current screening and provision of nutritional care – Guidance on the assessment of current levels of local nutritional care provision.

• Tool 3: Development of nutritional screening, assessment and care pathways – Guidance on how to ensure that nutritional care pathways meet agreed standards and recommendations, based on available evidence for effective and efficient identification of malnutrition in patients and subsequent management.

• Tool 4: Education and training: Knowledge, skills and competencies of staff involved in nutritional screening, assessment and care planning – Guidance to ensure that staff are appropriately trained to deliver high standards of nutritional care that are appropriate to the needs of individuals in health and social care settings.

• Tool 5: Service specifications and management structures for nutritional care – A checklist to assist teams in developing specifications for nutritional care within services for adults and children across all local settings.

• Tool 6: Quality frameworks for nutritional care – A framework to check that organisations involved in providing care to the local population put nutrition at the heart of that care.

• Tool 7: Quality indicators, monitoring and review – Guidance on measurable markers of quality in nutritional care and information to assist in the development of data collection systems embedded in routine care wherever possible (rather than systems requiring specific ad hoc audits). The markers will also permit confirmation of quality and will enable commissioners to set appropriate KPIs, ensuring value for money.

Malnutrition is a state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), function or clinical outcome.

Although the term 'malnutrition' can encompass both over nutrition/obesity and under nutrition, for the remainder of this document the term is only used to mean under nutrition.

Malnutrition is often under-recognised and under-treated to the detriment and cost of individuals, the health and social care services and society as a whole. It is a common problem with more than 3 million people at any one time in the UK malnourished.

1 Around 30% of admissions to acute hospitals and care homes are at risk when evaluated using criteria based on the 'Malnutrition Universal Screening Tool' ('MUST') as well as 10 - 14% of the 700,000 people living in sheltered accommodation; and 14% of the elderly at home or in care, whilst evaluation based on body mass index shows that even in individuals living at home, 5% of the elderly are underweight (BMI <20kg/m2), a figure that rises to 9% for those with chronic diseases.

The prevalence of malnutrition is therefore set to rise as the population ages.

In children the prevalence of acute malnutrition varies between 6-14% in hospitalised children surveyed in Germany, France and the United Kingdom and the overall prevalence of malnutrition including chronically growth restricted children was 19% of admissions in the Netherlands.

Additionally an important feature of much of malnutrition in children relates to micronutrient deficiency, especially iron and vitamin D.

Management of weight faltering often requires a multi-agency approach in which health visitors and social workers intervene to support parents with poor parenting skills and nutritional problems of their own such as obesity

All malnutrition is inevitably accompanied by increased vulnerability to illness, increased clinical complications and even death (Table 1). However, these risks can be significantly reduced if it is recognised early and specifically treated with relatively simple measures. For example, meta-analyses on the effectiveness of using oral nutritional supplements in malnourished patients, suggest that clinical complications associated with malnutrition can be decreased by as much as 70% and mortality reduced by around 40%.

Effective nutritional screening, nutritional care planning, high standards of food service delivery and appropriate nutritional support are therefore essential in all settings, and there is no doubt that a health service seeking to increase safety and clinical effectiveness must take nutritional care seriously.

The prevalence of malnutrition

Screening for malnutrition is not routinely carried out in every care setting and so opportunities for intervention are missed. BAPEN and other organisations have carried out a number of large surveys to identify the prevalence of nutritional problems in adults in different care settings and these are illustrated in Figure 1. This figure also conveys the adverse consequences and costs that can ensue if malnutrition is not prevented, recognised or treated appropriately.

Table 2 analyses the current situation, summarising the current standards and initiatives and some of the barriers to their implementation. It supports the analysis stage of the commissioning cycle.

Strengths

- Good evidence for nutritional interventions in both hospital and community settings
- Multiple recommendations and initiatives from Department of Health and professional bodies.

Weaknesses

- Too many national initiatives and recommendations from Department of Health and professional bodies causing confusion Lack of overall structure
- Focus on systems and processes rather than outcomes and the experience of service users
- Lack of communication across different community and healthcare boundaries
- Services not sufficiently patient-focussed
- Opportunities for intervention missed
- Nutrition screening patchy
- Education and training in nutrition patchy

Opportunities

- Promoting nutritional care as an integral part of all care pathways could reduce admissions and readmissions and shorten hospital stay
- Promoting nutritional care could promote independent living and quality of life
- Promoting nutritional care could reduce health inequalities
- Promoting nutritional care could lead to substantial financial savings
- Promoting nutritional care could reduce requirements for Domiciliary Care
- Promoting nutritional care could reduce Care Home admissions

Threats

- Nutritional care seen as a low priority by many organisations
- Lack of awareness re: causes and impact of malnutrition
- Nutrition not 'disease specific'
- Lack of mechanism for coding nutritional care – no specific HRG
- Lack of adequately trained staff
- Collaborative working not promoted by purchaser/provider split
- Difficult to define and realise benefits Inappropriate use of oral nutritional supplements sometimes leading to unnecessary cost
- The national focus on obesity which although essential, should not over-shadow the separate problem of malnutrition.

Implementing Standards and Guidelines in Nutritional Care

Key standards and guidelines: Embedding good nutritional care into the commissioning of every service is crucial in meeting current nutritional standards and guidelines. These and other recommendations are effectively summarised by the NICE Guidelines, Essence of Care benchmarking and the CQC standards.

Implementation guidance: Many of the other publications and initiatives listed [on page 5] provide guidance on how standards and recommendations can be implemented across a variety of settings to improve the quality of nutritional care delivered.

Evidence of delivery of good nutritional care: There are a number of audits and monitoring systems and processes to enable organisations to record evidence and report on achievement of key targets and KPIs, for example, PEAT annual assessments.

Work streams and frameworks: National work streams provided through the National Quality Board provide leadership to drive the quality agenda within the NHS and frameworks such as the Commissioning for Quality and Innovation53 (CQUIN) payment framework provide incentives to achieve improved quality and innovation in the delivery of nutritional care.

1.The NICE Guidance8 provides recommendations on:

• Malnutrition and the principles of nutrition support

• Organisation of nutrition support in hospital and the community

• Screening for malnutrition and the risk of malnutrition in hospital and the community

• Indications for nutrition support

• What to give in hospital and the community

• Monitoring of nutrition support in hospital and the community

• Oral nutrition support in hospital and the community

• Enteral tube feeding in hospital and the community

• Parenteral nutrition in hospital and the community

• Supporting patients in the community

2. Essence of Care Benchmarking

The Essence of Care benchmark for food and drink (previously nutrition) has recently been out for consultation and review to ensure it is has a person focused outcome. The revised version will be designed to ensure individuals are enabled to consume food and drink (orally) which meets their needs and preferences.

Benchmarks of best practice will be identified for ten factors which are summarised below:

• Screening: individuals identified as at risk on screening have a full nutritional assessment

• Care: care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink

• Monitoring: food and drink intake is monitored and recorded

• Environment: the environment is conducive to eating and drinking

• Assistance: individuals are provided with the care and assistance they require with eating and drinking

• Information: sufficient information is provided to enable individuals and their carers to obtain their food and drink

• Provision: food and drink is provided to meet an individual's needs and preferences

• Availability: individuals can access food and drink at any time according to their needs and preferences

• Presentation: food and drink are presented in a way that is appealing to individuals

• Promoting Health: individuals are encouraged to eat and drink in a way that promotes health

4. BAPEN make the following recommendations, based on the NICE Nutrition Support Guidelines and best practice:

• Information on healthy living and the importance of maintaining a healthy weight should be available in all care settings and in the community.

• Prevention of malnutrition should be an integral part of preventative health care and should be located within the public health agenda.

• Nutritional screening should be undertaken in:

• All hospital inpatients - on admission and weekly or when there is clinical concern

• All hospital outpatients - at first outpatient appointment and where there is clinical concern

• All residents of care homes - on admission and repeated monthly given the high prevalence and general frailty of residents (particularly in nursing homes)

• At initial registration in GP surgeries, annually for those aged over 75 years, where there is clinical concern, and at other opportunities such as health checks or vaccinations

It is however also important to identify nutritional risk in care settings beyond those addressed by NICE including day care, sheltered housing and domiciliary settings.

• Agreed local procedures and policies should be in place which ensure that a detailed nutritional assessment is undertaken and recorded for all individuals identified as malnourished, or at risk of malnutrition, when screened.

• Care plans: All individuals identified as malnourished or at risk should have an appropriate care plan containing clearly identified goals of treatment which must be recorded. This may include social measures to ensure provision of meals, help with cooking or feeding, food and fluid intake records, modified menus, dietetic advice, oral nutritional supplements and or artificial nutritional support. They should then be monitored to ensure goals are met with further action as necessary.

• Discharge/transition planning: the flow of nutritional information from one setting to another is crucial to the delivery of good nutritional care. BAPEN's Nutrition Screening Week 2008 found that nutrition information regarding patients identified as malnourished during their hospital stay was not routinely included in discharge communications. This omission could result in nutritional care being overlooked at one of the most vulnerable points during a patient's journey.

• Training: All healthcare professionals should receive appropriate training in the importance of nutritional care, how to screen for malnutrition, basic nutritional care measures and the indications for onward referral for nutritional assessment and support. E-learning modules that all hospital staff can use to complete training on the principles and practice of 'MUST' are available from BAPEN and 'MUST' training modules suitable for community and social care staff will become available during 2010. Fluid balance is also an integral part of the nutritional management of individuals and training for staff should include a focus on fluid management, as both fluid overload and dehydration should be avoided to prevent unnecessary clinical complications.

EFFECT CONSEQUENCE

Impaired immune response	Impaired ability to fight infection
Reduced muscle strength and fatigue	Inactivity and reduced ability to work, shop, cook and self-care. Poor muscle function may result in falls, and in the case of poor respiratory muscle function result in poor cough pressure – delaying expectoration and recovery from chest infection
Inactivity	In bed-bound patients, this may result in pressure ulcers and venous blood clots, which can break loose and embolise
Loss of temperature regulation	Loss of temperature regulation Hypothermia with consequent further loss of muscle strength
Impaired wound healing	Increased wound-related complications, such as infections and un-united fractures
Impaired ability to regulate salt and fluid	Predisposes to over-hydration, or dehydration
Impaired ability to regulate periods	Impaired reproductive function
Impaired fetal and infant programming	Malnutrition during pregnancy predisposes to common chronic diseases, such as cardiovascular disease, stroke and diabetes (in adulthood)
Specific nutrient deficiencies	Anaemia and other consequences of iron, vitamin and trace element deficiency
Impaired psycho-social function	Even when uncomplicated by disease, malnutrition causes apathy, depression, introversion, self-neglect, hypochondriasis, loss of libido and deterioration in social interactions (including mother-child bonding)
Additional effects on children and adolescents	Growth failure and stunting, delayed sexual development, reduced muscle mass and strength, impaired neuro-cognitive development, rickets and increased lifetime osteoporosis risk

PLEASE NOTE THAT THE FOLLOWING CHARTS ARE SAMPLES ONLY

"Your Hospice" 1/2

REGISTERED DIETITIAN NUTRITION ASSESSMENT

❑ VISIT ❑ T.C.	AGE:	DOB:	SOC:
DIAGNOSIS:		CO-MORBIDITIES:	

Ht:	Mid-Arm Circ:	Wt:	Usual Wt:	Recent Wt. Change:	Over:

ALLERGIES	TYPE OF ALLERGY RESPONSE
SENSITIVITIES	TYPE OF SENSITIVITY RESPONSE
PAIN INTENSITY ❑ NOTIFIED RNCM	PAIN LOCATION ❑ NOTIFIED RNCM

TEETH	DENTURES ❑ FULL ❑ PARTIAL ❑ NONE	PROBLEM W/CHEWING	SWALLOWING

MEDICATIONS
VITAMINS/SUPPLEMENTS

APPETITE	FLUID INTAKE	ABILITY TO EAT/SELF-FEED

WHO DOES MEAL PREPARATION?	SHOPPING?
DIET ORDER (INCLUDE ENTERAL FEEDINGS)	
FEEDING TUBE ❑ YES ❑ NO	TYPE OF FEEDING TUBE
CULTURAL/RELIGIOUS FOOD PREFERENCE	
BOWEL ROUTINE: CONSTIPATION	BOWEL ROUTINE: DIARRHEA

PT/FAMILY NUTRITION GOAL (IF ANY):

NARRATIVE SUMMARY:

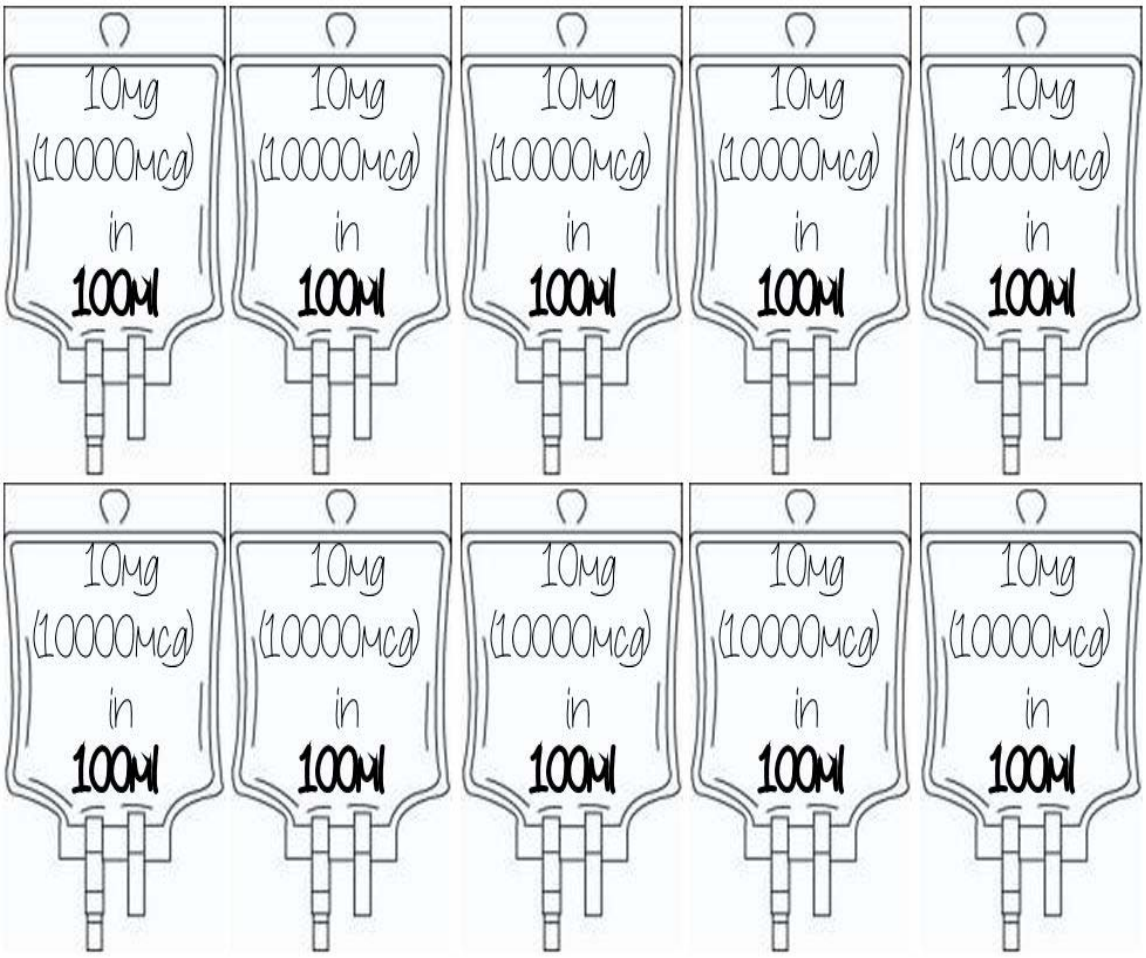
COLLABORATION ON REVISION OF CARE PLAN WITH FOLLOWING MEMBERS OF IDT:

Employee: (Last, First)	Signature:	Discipline:
Patient Name: (Last, First)	MR #:	Date:

White - Medical Record Yellow - Facility/Home Record
nutrition_assessment – Updated 11/30/2011

SAMPLE

A a 1litre bag can be divided down into 10, 100mls bags. each 100ml will then contain 10mg or 10000mcg



AM I HYDRATED?

Urine Color Chart

1		
2		If your urine matches the colors 1, 2, or 3, you are properly hydrated.
3		Continue to consume fluids at the recommended amounts.
4		If your urine color is below the RED line, you are
5		DEHYDRATED and at risk for cramping and/or a heat illness!!
6		YOU NEED TO DRINK MORE WATER!
7		
8		

MPSSAA Health and Safety
11/22/2012

FLUID BALANCE CHART

Patient Label Here

Date: Weight: (kg)

Input (mls)												Output (mls)							
	Oral/NG/NJ		Line 1 (I/V)			Line 2 (I/V)			Line 3 (I/V)										
Time	Fluid Type	Volume (mls)	Fluid Type	Hourly Total	Running Total	Fluid Type	Hourly Total	Running Total	Fluid Type	Hourly Total	Running Total	Time	Urine	Vomit/NGT Loss	Bowel/Stoma	Drain(s) Total (Drain Output Chart)	Hourly Total	Running Total
2400												2400						
0100												0100						
0200												0200						
0300												0300						
0400												0400						
0500												0500						
0600												0600						
0700												0700						
8 hr total												8 hr						
0800												0800						
0900												0900						
1000												1000						
1100												1100						
1200												1200						
1300												1300						
1400												1400						
1500												1500						
8 hr total												8 hr						
1600												1600						
1700												1700						
1800												1800						
1900												1900						
2000												2000						
2100												2100						
2200												2200						
2300												2300						
8 hr total												8 hr						
24 hr total												24 hr						

Intravenous 'Fluid Type' Abbreviations

NS=0.9% Saline / D5W=5% Dextrose / D10W=10% Dextrose
DS=Dex Saline / P148=Plasmalyte / Har=Hartmann's /
Vol=Voluven / Gel=Gelofusine / Alb=Albumin / RBC=Blood /
Plt=Platelets / FFP=Fresh Frozen Plasma / TPN

Input	
Output	
Balance (indicate + or -)	

Date: Weight: (kg)

Input (mls)												Output (mls)							
	Oral/NG/NJ		Line 1 (I/V)			Line 2 (I/V)			Line 3 (I/V)										
Time	Fluid Type	Volume (mls)	Fluid Type	Hourly Total	Running Total	Fluid Type	Hourly Total	Running Total	Fluid Type	Hourly Total	Running Total	Time	Urine	Vomit/NGT Loss	Bowel/Stoma	Drain(s) Total (Drain Output Chart)	Hourly Total	Running Total
2400												2400						
0100												0100						
0200												0200						
0300												0300						
0400												0400						
0500												0500						
0600												0600						
0700												0700						
8 hr total												8 hr						
0800												0800						
0900												0900						
1000												1000						
1100												1100						
1200												1200						
1300												1300						
1400												1400						
1500												1500						
8 hr total												8 hr						
1600												1600						
1700												1700						
1800												1800						
1900												1900						
2000												2000						
2100												2100						
2200												2200						
2300												2300						
8 hr total												8 hr						
24 hr total												24 hr						

Intravenous 'Fluid Type' Abbreviations

NS=0.9% Saline / D5W=5% Dextrose / D10W=10% Dextrose
DS=Dex Saline / P148=Plasmalyte / Har=Hartmann's /
Vol=Voluven / Gel=Gelofusine / Alb=Albumin / RBC=Blood /
Plt=Platelets / FFP=Fresh Frozen Plasma / TPN

Input	
Output	
Balance (indicate + or -)	

HOW NUTRITION AND FLUID NEEDS CHANGE WITH AGE

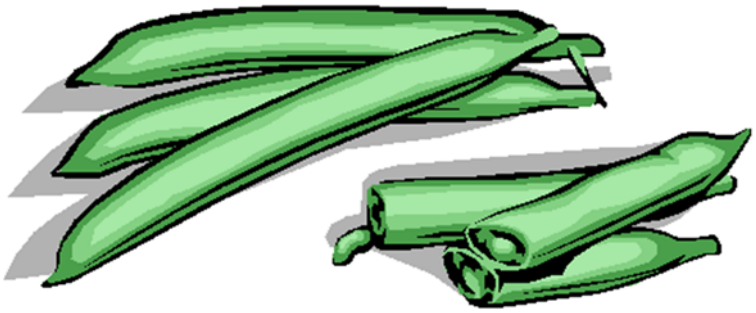
Food and nutritional needs change as a person gets older and older. The need for a lot of calories decreases when a person gets older. These needs were highest when the person was an infant, a teen, and when they were pregnant or breast-feeding their baby.

Old patients and residents need the least calories of all age groups. They do not burn calories and food as quickly as they did when they were younger and more active. This doesn't mean, however, that the elderly do not need a good diet. Older patients do need a good diet just like the other age groups. They need the same amount of vitamins, minerals and protein that they needed when they were younger. They need even more vitamins, minerals and protein when they are sick or have a pressure ulcer. They also need fibre to prevent constipation. Breads, cereals, fruits and vegetables have fibre.

The older age group is at risk for a poor diet for many reasons. Although some older people may gain weight from eating too much, most older people are at risk for losing weight. They may lose weight without wanting to. This loss of weight can cause them to be weak and ill.

A good diet must have all four food groups. The four food groups are:

- *Dairy*. Cheese, milk and yogurt are dairy foods



- *Meat*. Chicken, steak, fish, beans, pork and veal products are members of the meat group.
- *Fruits and vegetables*. Apples, pears, lettuce, tomatoes, orange juice and potatoes are some of the foods that people can eat to get their daily fruits and vegetables.
- *Grains*. Bread and cereal belong to the grains food group.

The appetite and the digestive process also slow down as the human body ages. Old adults do not feel as hungry as they did when they were young. Also, when they eat meals they feel full and they may not want to eat another meal for a long time. They may even skip a meal. Old adults often do better with small snacks during the day rather than large meals three times a day.

Old adults may also lose their sense of taste and smell. Half of the taste buds are lost by the age of 60. Sweet and salty taste is lost first. Sour taste lasts the longest. Men lose their taste more often and sooner than women. These losses make many elderly people less interested

in food than they were in the past. They do not enjoy the food as much because they do not taste it and they may not be able to smell the apple pie baking in the oven. Many older people will over salt their food to taste it.

Human beings are also more apt to eat when they see something that looks good to eat. Older adults, who lose their eyesight, are not able to see the food. They may be not interested in eating when they cannot see what they are eating. They will also have trouble feeding themselves if they have poor vision. If the patient or resident has eyeglasses, they should be worn during their meals.

In terms of fluid needs (hydration), a patient or resident may not be able to swallow fluids. They may not even feel thirst when they should under normal conditions. We must, therefore, offer fluids very often to older people. Nursing assistants should ask their patients and residents if they want a drink of water every time they speak to them unless they are not allowed to drink.

Some other old people may not be able to safely drink liquids unless they are thick. They may choke with water, juice and other thin fluids like tea or coffee. Nursing assistants are often asked by nurses to give the patient water and fluids that are made as thick as honey. These thick fluids help provide fluids to patients who have trouble swallowing.

Aging people may also not be able to use a spoon or a fork. They may be too confused to know how to feed themselves. Their lack of ability to eat or drink often makes it necessary to go to an assisted living facility or a nursing home so that they can be helped with eating, a basic ADL. It is the nursing assistant that most often provides the necessary food and fluids to these patients and residents

Other things that can decrease the amount and kinds of food and fluids that an elderly person will eat are:

- *Money*. An old person will not get a good diet if they do not have the money to pay for it.
- *Physical health*. If a person is not able to drive or walk to the store, if they are not able to make and cook good meals, if they are not able to use a fork or a spoon, they will need the help of others to get a good diet and enough fluids. Also, people that are sick and ill may not eat as much as they should.

- *Mental ability*. If a person is confused they may not be able to buy, cook and eat meals. Again, the help of others is needed so that they get a good diet. People will also eat less if they are lonely, sad, depressed or in pain.

- *Medications*. Some medications decrease the appetite.

- *Activity level*. If a person is active they will want to eat more than if they get no exercise.

- *Teeth*. If a person has no teeth, poor dentures or is not given their dentures before a meal, they will probably not get a good diet.

- *The ability to swallow*. It is dangerous when a person chokes on food or fluids. It can cause death. Unless they get a tube feeding or special care, like thick fluids, these people will not get enough food and fluid.

- *The environment*. Dining rooms that are noisy, not clean and attractive, poorly lit, and filled with bad odours, like urine do NOT help people eat and enjoy their meal. People will also eat less when the nursing assistant or other health care worker hurries and rushes them to eat quickly.

- *The food itself*. People will not eat a good diet when they are forced to eat foods they do NOT like. They will also not eat food that looks, tastes or smells bad. Patients and residents must have food choices. The meals must be attractive and pretty to look at. They must also taste good.

- *Access to food and fluids*. A person cannot eat or drink if they cannot reach their food or fluid. Nursing assistants and other health workers must give meals and fluids to their patients who cannot reach it on their own.

NUTRITION PROBLEMS

Older people at home and in a hospital or nursing home are at risk for poor nutrition. They will lose weight and have malnutrition if they do NOT get a good diet. They will also be dehydrated if they do not get enough fluids. They will get weak, less able to fight off an infection or illness. When people have malnutrition and dehydration, they are:

- confused
- irritable
- sleepy
- nervous and anxious
- dizzy
- at risk for infection
- at risk for pressure ulcers

They may also have dry skin. The human body needs a good diet and fluids in order to work properly. If the diet is poor, the body will not work the way it should. If a person eats too much they will get fat and obese. It is also important to make sure that a person is not

getting obese. These people may have to decrease the amount and kinds of food they eat and they may also have to exercise in order to burn off extra calories and fat.

HYDRATION PROBLEMS

The human body is made mostly of water. Water makes up about 2/3 of the body's weight. Water is needed to control the temperature of the body, to keep all body cells alive and to keep the blood flowing. This water is given to the body in some foods and by drinking fluids, such as tea, water, juice and coffee. As a person gets older, the amount of water that is found in the body gets smaller.

People will become dehydrated when they drink or consume less fluid than the body needs to perform its functions. When a person is dehydrated, the whole body is affected. Older patients and residents may not get enough fluid for a number of reasons. They may:

- not feel thirst and want to drink fluids. Older people do not feel thirsty like young people do.
- not be able to reach fluids. Nursing assistants must provide fluids to patients and residents who cannot reach their cup without help.
- not be able to swallow fluids. Many older patients and residents have a swallowing problem that makes them choke when they drink fluids. Nursing assistants are often asked to thicken fluids to a honey thickness for these people. These thick fluids allow many people with a swallowing problem to get their needed fluids without choking.
- choose to not drink fluids when they are incontinent of urine. They think that not drinking fluids will keep them dry. Nursing assistants and other health care workers should provide these residents with their necessary fluids during the day so they may not be incontinent during the night hours.
- be sick or ill. People that are ill and have a fever or are sweating a lot, vomiting or have diarrhoea will often lose more body fluid than they take in.
- be taking medications that take water from the body. Some medications, like diuretics or water pills take water from the body. This may lead to a lack of necessary fluid in the body.

A doctor may limit fluids for a person with a heart or kidney disease. If fluids are not limited for a heart or kidney disease, the patient or resident should consume at least 1,500 cc of fluid each day. It is better if they can get 2,000 cc a day.

If a person is not taking in enough fluid, they may have:

- eyes that appear sunken
- dry skin
- skin that is loose
- dry mouth and dry tongue
- confusion
- a fever
- nausea
- vomiting
- a lack of interest
- weakness
- a lack of appetite
- constipation
- low blood pressure
- a weak and fast pulse rate
- dark urine
- less than normal urinary output
- dizziness when going from a lying to standing position
- weight loss

THINGS YOU CAN DO TO PREVENT NUTRITION AND HYDRATION PROBLEMS

Some of the things that nursing assistants can do to help the patient or resident get a good diet and enough fluids are:

- helping them to be as independent as they can be
- feeding them when needed
- proper positioning for safe eating and drinking
- helping them with their meals, their plate, spoon and fork if they need help. Many older adults need help cutting their food.
- using special plates, spill proof cups, straws and utensils if needed
- making fluids and healthy snacks available. Many older people prefer small meals more often during the day instead of 3 big meals
- making honey thick fluids for those with a swallowing problem
- providing good mouth and tooth care
- giving dentures to those that need them
- giving patients and residents their eye glasses and hearing aid so they can see their food and so they can talk with others, including the nursing assistant

- using spices, low sodium salt and other flavourings to increase the taste of the food
- telling the person what foods they are eating so that those with poor eye sight and taste can think about the foods, its taste and smell
- making meal times happy and nice. Soft music that a resident or patient chooses can help.

- helping residents socialize and talk with others
- letting patients and residents chose their foods
- giving any ordered vitamins and supplements, like Ensure
- monitoring, reporting and documenting how much food or fluid is taken. You must also look at the patient or resident to see if they are having a problem chewing or swallowing.
- using finger foods when preferred. Carrot and celery sticks, apple slices and bananas are some good finger foods.
- giving the person enough time to eat. Allow the person to chew and swallow every bite of food before giving them another
- serving foods at the right temperature. Hot foods and liquids, like coffee or tea, should NOT be too hot to cause a burn if spilled. They should be warm enough to safely eat. Cold foods should be cold and NOT at room temperature.

- weighing patients and residents very carefully. Accurate weights are one way to find out if a person is losing weight because they are not eating enough food. It is also a good way to find out if a person is eating too much. Weights should be done at the same time of the day and with the same amount of clothing each time they are weighed. They should be wearing light slippers, NOT boots or heavy shoes. Patients and residents are usually weighed before breakfast in their night clothing, pyjamas or night gown. Foley urinary drainage bags must be empty when the person is weighed. An accurate weight cannot be done if 8 hours of urine is added to the patient's actual weight.

- keeping residents and patients in a sitting position for at least 30 minutes after eating. This prevents choking on food.
- be skilled in dealing with choking. Know the Heimlich manoeuvre and CPR.

Other health care workers also play a role in nutrition and hydration.

Nurses. Nurses, doctors and some other members of the healthcare team assess patients for their risk of malnutrition when they are admitted and during the course of their stay in the hospital or nursing home.

Dietitian. The dietitian assesses the patient's nutrition status. They plan nutritional care with the doctor and other members of the health care team.

Laboratory workers. These health care team members may process blood and urine samples to make sure that the patient or resident is well nourished.

Activity coordinators. Activity coordinators often plan events like a cook out, a special meal or an afternoon tea time to promote healthy eating, hydration and socialization.

Occupational therapists. Occupational therapists work with patients and residents so they can be independent with their activities of daily living (ADLs), including eating. They often find special plates, cups, forks, etc. so person that has a disability can still feed themselves.

Speech therapists. Speech therapists assess patients with a swallowing problem. They recommend ways that patients with a swallowing problem can eat and drink safely.